“The Great Psychotherapy Debate does not break new ground; instead, it plows it like it has never been plowed before. With scrupulous care and unquestioned fairness, Bruce Wampold has assumed the mantle of foremost proponent of the general factors explanation for psychotherapy efficacy. This work will reverberate far beyond the narrow confines of the seminar room. It touches the most important policy questions that will be faced by the clinical uses of psychology in the next decade.”

—Gene V Glass
Arizona State University

“I believe this book is destined to become a classic in the psychotherapy literature because it offers a logical theory to explain decades of perplexing empirical findings on psychotherapy outcomes. The book is revolutionary. It challenges the long-held belief that psychotherapy can best be understood from a medical model and presents a radical new approach to understanding why psychotherapy works. Like a good detective novel, the author presents the problem, offers compelling hypotheses, then goes about meticulously fitting existing empirical evidence into the competing hypotheses. By the time the reader gets to the end, the evidence is overwhelmingly in support of the author’s contextual model.”

—Martin Ritchie
University of Toledo

“This is a fascinating book that is well-reasoned, thoroughly documented, and clearly written. The logic of the author’s presentation is persuasive without being adversarial. The thesis is one that will challenge many in the psychological establishment. I will most certainly adopt this book for use in my own graduate training program in counseling psychology and I will recommend it to others. I think the book is suitable for use in both introductory and advanced courses in psychology and counseling theory.”

—James Lichtenberg
University of Kansas

“I am not engaging in hyperbole when I say that it is the best scientific analysis of psychotherapy ever written. It is certain to have a sensational impact on the psychological community, and in particular, those scientists who are concerned with teasing out the mechanisms of therapeutic change.”

—Charles Ciarrochi
Arizona State University

The Great Psychotherapy Debate: Models, Methods, and Findings comprehensively reviews the research on psychotherapy to dispute the commonly held view that the benefits of psychotherapy are derived from the specific ingredients contained in a given treatment (medical model). The author reviews the literature related to the absolute efficacy of psychotherapy, relative efficacy of various treatments, specificity of ingredients contained in established therapies, effects due to common factors such as the working alliance, adherence and allegiance to the therapeutic protocol, and effects that are produced by different therapists. In each case, the evidence convincingly corroborates the contextual model and disconfirms the prevailing medical model.”

Bruce E. Wampold
Routledge
The Great Psychotherapy Debate
Models, Methods, and Findings
The Great Psychotherapy Debate
Models, Methods, and Findings

Bruce E. Wampold
University of Wisconsin–Madison
To those who have loved me, and to B.C.,
whose challenging support created
the opportunity for growth and exploration
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The “common factors” position on the effectiveness of psychotherapy—whose lineaments were sketched between fifty and thirty years ago by such scholars as Jerome Frank, Hans Strupp, Victor Raimy, and Lester Luborsky among others, and whose empirical foundations were laid scarcely more than 25 years ago—here attains its most forceful expression; and Bruce Wampold dons the mantel of foremost defender of a position with enormously important implications for mental health training, treatment, and public policy.

The common factors position (namely, that all of the many specific types of psychotherapeutic treatment achieve virtually equal—or insignificantly different—benefits because of a common core of curative processes) can move the focus of psychotherapy training and theory itself from therapist to client, from how the therapist “cures” to how the client “heals.” The medical model of psychotherapy that Wampold so meticulously deconstructs in *The Great Psychotherapy Debate* has led us to accept a view of clients as inert and passive objects on whom we operate and whom we medicate. The implausibility that the great variety of specific ingredients in the multitude of psychotherapeutic approaches would yield indistinguishable outcomes is a strong clue that either it is instead a set of often unacknowledged common elements that is effective, or else it is a set of processes residing largely in the clients and merely mobilized by therapy that carries the power to improve clients’ lives. This potential shift in perspective (from an emphasis on the differences among therapies to an awareness of the broad context in which therapeutic relationships are played out) can cause both therapists and theo-
reticians to reflect less on their interventions and more on clients’ efforts at making themselves whole. The shift carries a threat of narcissistic injury.

The common factors versus specific ingredients debate is at the heart of policy questions about the scope of national health care, as well as private insurance. There are those health policy analysts who argue that any therapy that uses non-specific diagnoses and non-specific treatments is somehow bogus witchcraft lacking indications of when to begin and when to end, and its application should be excluded from third-party coverage. There are two sides to this question, obviously. This debate is not just about mental health treatment—although mental health has been a very central issue in it—but it is a debate that extends through all aspects of medical insurance. The Great Psychotherapy Debate may well come to serve as a model for the empirical research that will inform—or fundamentally challenge—the various sides in this important contest.

After nearly a century of marginally productive investigations based on a medical conception of psychotherapy, Professor Wampold is asking researchers to face the facts and move forward.

—Gene V Glass

Arizona State University
I am borne of two worlds. From about as long as I can remember, I loved mathematics, and the thrill of understanding deep structures and their beauty. Simple definitions leading to complex relationships; form and pattern expressed as chaos. The prime numbers, solid in definition, scattered seemingly at random. Rule governed, but complex and defying understanding. Mathematics, pure and pristine, yet finding application at every turn.

And the other world. The despair of losing unconditional and genuine love at the throw of a die. At five, I happily went into the woods to play, not knowing that I would never see my mother again. I struggled to understand that singularity, failing to understand that sheer rational logic would be insufficient.

For so many years, the wound to my soul that wouldn’t heal, tugging at my consciousness, and created a world slightly out of focus. Along with the support of those who love and have loved me, psychotherapy provided the opportunity to explore, to see the wound from the inside out, to grieve, and to heal.

So, I approached this book from a personal perspective. Of course, I was drawn to a scientific understanding of psychotherapy, the same way I approached all academic endeavors. The natural inclination was to accept psychological treatments on the same basis as medical treatments—to embrace them as a clinical scientist. To a scientist, clinical trials, specific active ingredients, diagnoses, standardized treatments, and the aura of medicine, are all naturally attractive. Yet, the more I taught students about psychotherapy and the research that supports it, the more I realized that the medical model could
not explain the preponderance of the research results. A scientist, above all else, listens carefully to the data, seeking a resonance of theory and results.

From my perspective, psychotherapy is a very personal and life changing experience, one that cannot be forced into a medical-like treatment without losing the essence of the endeavor. This perspective may be shaped by my experience. I would happily give up my perspective if the scientific evidence supported the current trend to conceptualize psychological treatments as analogues of medical treatments. On the contrary, however, the scientific evidence overwhelmingly supports a model of psychotherapy that gives primacy to the healing context, to the understanding of one’s difficulties, to the faith in the therapy, and to the respect for the client’s world view. The purpose of this book is to present the scientific evidence that supports a contextual, rather than a medical, model of psychotherapy.

The first chapter of this book presents two competing models of psychotherapy—the medical model and the contextual model. The medical model focuses on the specificity of treatments. In this model, theoretical explanations for disorders, problems, or complaints are formulated, treatments contain specific ingredients that are theoretically purported to be necessary for change, the therapist focuses on these specific ingredients, and researchers attribute the benefits of psychotherapy to those ingredients. The contextual model emphasizes the commonalities among therapies. All therapies involve the relationship of a client and therapist, each of whom believes in the efficacy of the treatment. The therapist provides the client with a rationale for the disorder and administers a procedure that is consistent with that rationale. The client discusses the most intimate details of his or her life, confident that the therapeutic relationship will continue. The particular specific ingredients contained in the treatment, according to the contextual model, are not responsible for therapeutic benefits. The debate between advocates of the two models has existed since the origins of psychotherapy, although phrased in many ways (e.g., as “common factors” versus “specific ingredients”). However expressed, this great debate separates practitioners and researchers into two camps, each confident that they know how and why psychotherapy works.

In chapter 2, various hypotheses that distinguish the two models are presented, along with a discussion of methods that can be used to test these hypotheses. The evidence related to the hypotheses is presented in chapters 3 through 8. Because understanding research methods is critical to interpreting findings from thousands of studies of psychotherapy, each chapter discusses research strategies and important details of design related to the hypotheses. Simply stated, the evidence overwhelmingly supports a contextual model of psychotherapy. Chapter 9 discusses the implications of accepting the contextual model and rejecting the medical model.
The defining feature of this book is that a scientific perspective is taken toward the great debate. I have strived to examine the results of thousands of studies and present them fairly and accurately. As I progressed with this project, the astonishing consistency of the results with the contextual model was surprising. It would be difficult to imagine how a scientist could examine these data and come to a different conclusion.

ACKNOWLEDGMENTS

I want to acknowledge those who have contributed to the thinking, writing, and understanding that have made this book possible. The ideas for this book emanated from my teaching a seminar on the research of individual interventions, and thus I thank the students who participated in the 951 seminars. Our clear and challenging discussions were invigorating; the students' diversity of perspectives widened the scope of my thinking. The Otsego group was also instrumental in the formulation of ideas and in encouraging me when I doubted that I could pull this project together. Don Atkinson has been a steadfast influence on my intellectual and personal development. R. Serlin's collaboration with regard to the effects of therapists, was critical in the development of chapter 8. M. J. Patton’s suggestions helped clarify the opening arguments. L. McCubbin and S. Tierney provided critical suggestions regarding the presentation. D. Nelson provided valuable assistance in the preparation of the manuscript. Fenwick accorded lively company by my side on those long days at the computer, although he showed an indifferent attitude toward the content of the book.
Understanding the nature of psychotherapy is a daunting task. There are over 250 distinct psychotherapeutic approaches, which are described, in one way or another, in over 10,000 books. Moreover, tens of thousands of books, book chapters, and journal articles have reported research conducted to understand psychotherapy and to test whether it works. It is no wonder, that faced with the literature on psychotherapy, confusion reigns, controversy flourishes, converging evidence is sparse, and recognition of psychotherapy as a science is tenuous.

Any scientific endeavor will seem chaotic if the explanatory models are insufficient to explain the accumulation of facts. If one were to ask prominent researchers to list important psychotherapeutic principles that have been scientifically established and generally accepted by most psychotherapy researchers, the list would indeed be short. On the other hand, an enumeration of the results of psychotherapy studies would be voluminous. How is it that so much research has yielded so little knowledge? The thesis of this book is that there is a remarkable convergence of research findings, provided the evidence is viewed at the proper level of abstraction.

Discovering the scientific basis of psychotherapy is vital to the efficient and humane design of mental health services. In the United States, psychotherapeutic services occupy a small niche in the enormous universe of health service delivery systems. The forces within this universe are com-
pressing psychotherapy into a tiny compartment and changing the nature of the therapeutic endeavor. No longer can therapists conduct long-term therapy and expect to be reimbursed by health maintenance organizations (HMOs). In many venues, therapists can only be reimbursed for treating clients with particular mental disorders (i.e., clients who have been assigned particular diagnoses). A client in a troubled marriage who is experiencing the sequelae of this traumatic event (e.g., attenuated work performance, absenteeism, depression) must be assigned a reimbursable diagnosis, such as major depressive disorder, in order to justify treatment. Accordingly, a treatment plan must be adapted to the objective of alleviating the symptoms of depression with the insured patient rather than, say, resolving marital disagreements, changing lifelong patterns of relationships that are based on childhood attachments with parents, or improving the couples’ communications.

The pressures of the health care delivery system have molded psychotherapy to resemble medical treatments. Psychotherapy, as often practiced, is laden with medical terminology—diagnosis, treatment plans, validated treatments, and medically necessary conditions, to name a few. The debate over prescription privileges for psychologists is about, from one perspective, how much psychologists want to conform to a medical model of practice. As “talk” treatments become truncated and prescriptive, doctoral level psychologists and other psychotherapy practitioners (e.g., social workers, marriage and family therapists) are economically coerced to practice a form of therapy different from what they were trained and different from how they would prefer to practice.

Sliding into the medical arena presumes that psychotherapy is best conceptualized as a medical treatment. In this book, the scientific evidence will be presented that shows that psychotherapy is incompatible with the medical model and that conceptualizing psychotherapy in this way distorts the nature of the endeavor. Cast in more urgent tones, the medicalization of psychotherapy might well destroy talk therapy as a beneficial treatment of psychological and social problems.

In this chapter, the medical model and its alternative, the contextual model, are presented. To begin, the definition of psychotherapy as well as terminology are presented. Second, the competing models are placed at their proper level of abstraction. Finally, the two models are explained and defined.

DEFINITIONS AND TERMINOLOGY

Definition of Psychotherapy

The definition of psychotherapy used herein is not controversial and is consistent with both the medical model and the contextual model, which are examined subsequently. The following definition is used in this book:
Psychotherapy is a primarily interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who has a mental disorder, problem, or complaint; it is intended by the therapist to be remedial for the client's disorder, problem, or complaint; and it is adapted or individualized for the particular client and his or her disorder, problem, or complaint.

Psychotherapy is defined as an interpersonal treatment to rule out psychological treatments that may not involve an interpersonal interaction between therapist and client, such as bibliotherapy or systematic desensitization based on tapes that the client uses in the absence of a therapist. The term interpersonal implies that the interaction transpires face-to-face and thus rules out telephone counseling or interactions via computer, although there is no implication that such modes of interacting are not beneficial. The adverb primarily is used to indicate that therapies employing adjunctive activities not involving a therapist, such as bibliotherapy, listening to relaxation tapes, or performing various homework assignments, are not excluded from this definition.

Presumably psychotherapy is a professional activity that involves a minimum level of skill, and consequently the definition requires that the therapist be professionally trained. Because the relationship between training and outcome in psychotherapy is controversial, the amount of training is not specified, but herein it is assumed that the training be typical for therapists practicing a given form of therapy.

Psychotherapy has traditionally been viewed as remedial, in that it is a treatment designed to remove or ameliorate some client distress, and consequently the definition requires that the client have a disorder, problem, or complaint. Moreover, the treatment needs to be adapted to help this particular client, although standardized treatments (i.e., those administered to a client with a disorder without regard for individual manifestations or client characteristics) are considered as they relate to the hypotheses of this book. The generic term client is used rather than the alternative term patient because the latter is too closely allied with a medical model.

Treatments that do not have a psychological basis are excluded. It may well be that nonpsychological treatments are palliative when both the client and the practitioner believe in their efficacy. Treatments based on the occult, indigenous peoples' cultural beliefs about mental health and behavior, New Age ideas (e.g., herbal remedies), and religion may be efficacious through the mechanisms hypothesized in the contextual model, but they are not psychotherapy and are not considered in this book. This is not to say that such activities are not of interest to social scientists in general and psychologists in particular; simply, psychotherapy, as considered herein, is limited to therapies based on psychological principles. It may turn out that psychotherapy is efficacious because Western cultures value the activity rather
than because the specific ingredients of psychotherapy are efficacious, but
that does not alter how psychotherapy should be defined.

Finally, it is required that the therapist intends the treatment to be effec-
tive. In the contextual model, therapist belief in treatment efficacy is neces-
sary. In chapter 7, evidence that belief in treatment is related to outcome
will be presented.

Terminology

The presentation that follows depends on a careful distinction between var-
ious components of psychotherapeutic treatments and their related con-
cepts. Over the years, various systems for understanding these concepts
have been proposed by Brody (1980), Critelli and Neuman (1984),
Grübaum (1981), A. K. Shapiro and Morris (1978), Shepherd (1993), and
Wilkins (1984), among others. Although technical, the logic and terminol-
ogy presented by Grübaum (1981) is adapted to present the competing
models because of its consistency and rigor. Some time is spent explaining
the notation and terms as well as substituting more commonly used termi-
ology. Grübaum’s (1981) exposition is as follows:

The therapeutic theory $\Psi$ that advocates the use of a particular treatment modal-
ity $t$ to remedy [disorder] $D$ demands the inclusion of certain characteristic con-
stituents $F$ in any treatment process that $\Psi$ authenticates as an application of $t$.
Any such process, besides qualifying as an instance of $t$ according to $\Psi$, will typi-
cally have constituents $C$ other than the characteristic ones $F$ singled out by $\Psi$.
And when asserting that the factors $F$ are remedial for $D$, $\Psi$ may also take cogni-
zance of one or more of the non-characteristic constituents $C$, which I shall de-
nominate as “incidental.” (p. 159)

An example of a therapeutic theory ($\Psi$) is psychodynamic theory; the
particular treatment modality $t$ would then be some form of psychodynamic
therapy. The treatment ($t$) would be applied to remediate some disorder ($D$),
such as depression. This treatment would contain some constituents ($F$)
that are characteristic of the treatment that are consistent with the theory. At
this point, it is helpful to make this concrete by considering Waltz, Addis,
Koerner, and Jacobson’s (1993) classification of therapeutic actions into
four classes: (a) unique and essential, (b) essential but not unique, (c) ac-
ceptable but not necessary, and (d) proscribed. Waltz et al. provided exam-

---

1To some in the field, the terminology and the conceptual principles underlying their adoption are
critically important: “I hope it is now apparent that there is no justification for the ineptitude of the cus-
tomary terminology.... Workers in the field may be motivated to adopt the unambiguous vocabulary
that I have proposed” (Grübaum, 1981, p. 167). Although a case could be made for the various alter-
ative models proposed, the important aspect is that a system be logical and consistent. It should be
noted that the validity of the thesis of this book is not dependent on the adoption of a particular logical
exposition.
bles, which are presented in Table 1.1, of these four therapeutic actions for psychodynamic and behavioral therapies. Grünbaum’s (1981) characteristic constituents are similar to Waltz et al.’s unique and essential therapeutic actions. Forming a contingency contract is a unique and essential action in behavioral therapy (see Table 1.1), and it is characteristic of the theory of operant conditioning. A term ubiquitously used to refer to theoretically derived actions is specific ingredients. Thus, characteristic constituents, unique and essential actions, and specific ingredients all refer to the same concept. For the most part, the term specific ingredients will be used in this book.

Grünbaum (1981) also referred to incidental aspects of each treatment that are not theoretically central. The common factor approach, which will be discussed later in this chapter, has identified those elements of therapy, such as the therapeutic relationship, that seem to be common to all (or most) treatments and therefore called them common factors. By definition, common factors must be incidental. However, there may be aspects of a treatment that are incidental (i.e., not characteristic of the theory) but not common to all (or most) therapies, although it is difficult to find examples of such aspects in the literature. Consequently, the term common factors will be used interchangeably with incidental aspects. In Waltz et al.’s (1993) classification, the “essential but not unique” and some of the “acceptable but not necessary” therapeutic actions (see Table 1.1) appear to be both theoretically incidental and common. For example, behavioral therapy and psychodynamic therapy, as well as most other therapies, involve establishing a therapeutic alliance, setting treatment goals, empathic listening on the part of the therapist, and planning for termination. Thus, incidental aspects and common factors are actions that are either essential but not unique or acceptable but not necessary. Because common factors is the term typically used in the literature, it is the prominent term used in this book, although incidental aspects, which connotes that these ingredients are not theoretically central, is used as well.

There is one aspect of the terminology that, unless clarified, may cause confusion. If treatment $t$ is remedial for disorder $D$ (in Grünbaum’s terms), then, simply said, the treatment is beneficial. However, there is no implication that it is the characteristic constituents (i.e., specific ingredients) that are causal to the observed benefits. Thus, the language of psychotherapy must distinguish clearly cause and effect constructs (see Cook & Campbell, 1979). Specific ingredients and incidental aspects of psychotherapy are elements of a treatment that may or may not cause beneficial outcomes and

\[\text{characteristic constituents} \neq \text{unique and essential actions}\]  

This is an empirical issue, and the question of whether a particular ingredient is a factor in creating beneficial outcomes is central to this book.
TABLE 1.1
Examples of Four Types of Therapeutic Actions

<table>
<thead>
<tr>
<th>Psychodynamic Therapy</th>
<th>Behavioral Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unique and Essential (Specific Ingredients)</strong></td>
<td></td>
</tr>
<tr>
<td>1. Focus on unconscious determinants of behavior</td>
<td>1. Assigning homework</td>
</tr>
<tr>
<td>2. Focus on internalized object relations as historical causes of current problems</td>
<td>2. Practicing assertion in the session</td>
</tr>
<tr>
<td>3. Focus on defense mechanisms used to ward off pain of early trauma</td>
<td>3. Forming a contingency contract</td>
</tr>
<tr>
<td>4. Interpretation of resistance</td>
<td></td>
</tr>
<tr>
<td><strong>Essential But Not Unique</strong></td>
<td></td>
</tr>
<tr>
<td>1. Establish a therapeutic alliance</td>
<td>1. Establish a therapeutic alliance</td>
</tr>
<tr>
<td>2. Setting treatment goals</td>
<td>2. Setting treatment goals</td>
</tr>
<tr>
<td>3. Empathic listening</td>
<td>3. Empathic listening</td>
</tr>
<tr>
<td>4. Planning for termination</td>
<td>4. Planning for termination</td>
</tr>
<tr>
<td>5. Exploration of childhood</td>
<td>5. Providing treatment rationale</td>
</tr>
<tr>
<td><strong>Acceptable But Not Necessary</strong></td>
<td></td>
</tr>
<tr>
<td>1. Paraphrasing</td>
<td>1. Paraphrasing</td>
</tr>
<tr>
<td>2. Self-disclosure</td>
<td>2. Self-disclosure</td>
</tr>
<tr>
<td>3. Interpreting dreams</td>
<td>3. Exploration of childhood</td>
</tr>
<tr>
<td>4. Providing treatment rationale</td>
<td></td>
</tr>
<tr>
<td><strong>Proscribed</strong></td>
<td></td>
</tr>
<tr>
<td>1. Prescribing psychotropic medications</td>
<td>1. Prescribing psychotropic medications</td>
</tr>
<tr>
<td>2. Assigning homework</td>
<td>2. Focus on unconscious determinants of behavior</td>
</tr>
<tr>
<td>3. Practicing assertion in the session</td>
<td>3. Focus on internalized object relations as historical causes of current problems</td>
</tr>
<tr>
<td>4. Forming contingency contracts</td>
<td>4. Focus on defense mechanisms used to ward off pain of early trauma</td>
</tr>
<tr>
<td>5. Prescribing the symptom</td>
<td>5. Interpretation of resistance</td>
</tr>
</tbody>
</table>

thus are putative causal constructs. A psychotherapy treatment contains both specific ingredients and incidental aspects, both, one, or none of which might be remedial. The term *specific effects* is used to refer to the benefits produced by the specific ingredients; *general effects* is used to refer to the benefits produced by the incidental aspects (i.e., the common factors). If both the specific ingredients and the incidental aspects are remedial, then there exist specific effects (i.e., the ones caused by the specific ingredients) and general effects (i.e., the ones caused by incidental aspects). If the treatment is not effective, then neither specific nor general effects exist, although specific ingredients and incidental aspects of psychotherapy are present. In sum, specific therapeutic ingredients cause specific effects, and incidental aspects cause general effects.

Having adopted certain terminology, it should be noted that the following terms used to describe specific ingredients and incidental factors as well as their effects are eschewed: active ingredients, essential ingredients, nonspecific ingredients, nonspecific effects, and placebo effects. Active ingredients and essential ingredients, terms often used to refer to specific ingredients, inappropriately imply that the specific ingredients are remedial (i.e., there exist specific effects); whether specific ingredients produce effects is an empirical question. Nonspecific ingredients and nonspecific effects are avoided because they imply that the incidental factors act inferiorly vis-à-vis specific ingredients. Placebo effects, which are discussed in chapter 5, are often denigrated as effects produced by pathways that are irrelevant to the core elements of a treatment. For example, the therapeutic alliance, a common factor that has been shown to have potent beneficial effects (see chap. 6), is sometimes denigrated by referring to the effects it produces as nonspecific effects or placebo effects. The term general effects is used here because it is comparable linguistically and logically with its counterpart, specific effects.

Attention is now turned to placing the two models that are investigated in this book (viz., the medical model and the contextual model) at their proper level of abstraction.

**LEVELS OF ABSTRACTION**

As psychotherapy is an exceedingly complex phenomenon, levels of abstraction are indeterminate to some extent. Nevertheless, a short discussion of various levels is needed to understand the central thesis of this book. Four levels of abstraction are presented herein: therapeutic techniques, therapeutic strategies, theoretical approaches, and meta-theoretical models. These four levels are not unique, and it would be impossible to classify each and every research question and theoretical explication into one and only one of the levels. Some studies have examined questions that do not fit
neatly into one of the levels, and some studies have examined questions that seem to span two or more levels. Nevertheless, it is necessary to understand how the thesis of this book, which contrasts the medical model with the contextual model, exists at a meta-theoretical level. At this level of abstraction, the vast array of research results produced by psychotherapy research creates a convergent and coherent conclusion. In this section, three levels of abstraction presented by Goldfried (1980) as well as a fourth, higher level, will be discussed. These levels of abstraction are summarized in Table 1.2.

The highest level of abstraction discussed by Goldfried (1980) is the theoretical framework and the concomitant individual approaches to psychotherapy and their underlying, although sometimes implicit, philosophical view of human nature. In Grünbaum's terms, this is the level of the therapeutic theory and the particular treatment modality. Although Table 1.2 gives three examples of theoretical approaches to psychotherapy (cognitive–behavioral, interpersonal, psychodynamic), by one estimate there are over 250 approaches to psychotherapy if one considers the many variations proposed and advocated in the literature (Goldfried & Wolfe, 1996). At this level of abstraction, there is little agreement among researchers or practitioners. Advocates of a particular approach defend their theoretical positions and, to varying degrees, can cite research to support the efficacy of their endeavors. For example, recent reviews of research have found evidence to support behavioral treatments (e.g., Emmelkamp, 1994), cognitive treatments (e.g., Hollon & Beck, 1994), psychodynamic approaches (e.g., Henry, Strupp, Schacht, & Gaston, 1994) and experiential treatments (e.g., Greenberg, Elliott, & Lietaer, 1994). The plethora of research results emanating from clinical trials in which the efficacy of a particular treatment is established by comparisons with a no-treatment control or with another treatment is testimony to the importance of this level of abstraction. Unfortunately, the use of a particular approach seems to be divorced from this research.

The popularity of a therapy school is often a function of variables having nothing to do with the efficacy of its associated procedures. Among other things, it depends on the charisma, energy level, and longevity of the leader; the number of students trained and where they have been placed; and the spirit of the times. (Goldfried, 1980, p. 996)

The lowest level of abstraction involves the techniques and actions used by the therapist in the process of administering a treatment. Well-articulated treatments prescribe the specific ingredients that should be used; consequently, techniques and approaches coincide, and therefore discussions of the efficacy of a particular treatment are related to the corresponding techniques. Psychodynamic psychotherapists make interpretations of the transference, whereas cognitive–behavioral therapists dispute maladaptive
TABLE 1.2
Levels of Abstraction of Psychotherapy and Related Research Questions

<table>
<thead>
<tr>
<th>Level of Abstraction</th>
<th>Examples of Units of Investigation</th>
<th>Research Questions</th>
<th>Research Designs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Techniques (i.e., specific ingredients)</td>
<td>Interpretations</td>
<td>Is a given technique or set of techniques necessary for therapeutic efficacy?</td>
<td>Component designs</td>
</tr>
<tr>
<td></td>
<td>Disputing maladaptive thoughts</td>
<td>What are the characteristics of a skillfully administered technique?</td>
<td>Parametric designs</td>
</tr>
<tr>
<td></td>
<td>In vivo exposure</td>
<td></td>
<td>Clinical trials with placebo controls</td>
</tr>
<tr>
<td>Strategies</td>
<td>Corrective experiences</td>
<td>Are strategies common to all psychotherapies?</td>
<td>Passive designs that examine the relationship between technique and outcome (across various treatments)</td>
</tr>
<tr>
<td></td>
<td>Feedback</td>
<td>Are the strategies necessary and sufficient for change?</td>
<td></td>
</tr>
<tr>
<td>Theoretical Approach</td>
<td>Cognitive–behavioral</td>
<td>Is a particular treatment effective?</td>
<td>Clinical Trials with no treatment controls</td>
</tr>
<tr>
<td></td>
<td>Interpersonal approaches</td>
<td>Is a particular treatment more effective than another treatment?</td>
<td>Comparative clinical trials (Tx A vs. Tx B)</td>
</tr>
<tr>
<td></td>
<td>Psychodynamic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meta-Theory</td>
<td>Medical model</td>
<td>Which meta-theory best accounts for the corpus of research results?</td>
<td>Research Synthesis</td>
</tr>
<tr>
<td></td>
<td>Contextual model</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

thoughts. Advocacy for the theoretical bases of cognitive–behavioral treatments is also advocacy for the actions prescribed by the treatment. As presented in Table 1.2, various research designs have been used to test whether techniques described at this level of abstraction are indeed responsible for positive therapeutic outcomes.

According to Goldfried (1980), a level of abstraction exists between individual approaches and techniques, which he labels clinical strategies. Clinical strategies “function as clinical heuristics that implicitly guide [therapist] efforts during the course of therapy” (Goldfried, 1980, p. 994). Goldfried’s purpose of identifying this intermediate level of abstraction was to show that therapeutic phenomena at this level would exhibit commonalities across approaches and provide a consensus among the advocates of the various theoretical approaches. The two clinical strategies identified by Goldfried as generally common to all psychotherapeutic approaches are providing corrective experiences and offering direct feedback. The research questions at this
level of abstraction are concerned with identifying the common strategies and identifying whether they are necessary and sufficient for therapeutic change. Although innovative and potentially explanatory, the strategy level of abstraction has not produced much research (Arkowitz, 1992), particularly in comparison with research devoted to establishing the efficacy of particular approaches.

The thesis of this book is situated at a level of abstraction beyond the theoretical perspectives that undergird the major approaches to psychotherapy. It is generally accepted that psychotherapy works (but just in case there is any doubt, this evidence is reviewed in chap. 3). However, the causal determinants of efficacy are not as well established. In more mundane terms, one might ask: What is it about psychotherapy that makes it so helpful? Explanations exist at each of the three lower levels of abstraction. During the course of presenting the research evidence, it will become clear that (a) logical impediments to understanding causal mechanisms exist at each of these levels of abstraction, and moreover (b) when viewed at these levels, the research evidence does not converge to answer the causality question. Consequently, a fourth level of abstraction is needed—theories about psychotherapeutic theories. In this book, two meta-theories are contrasted: the medical model and the contextual model.

The next sections of this chapter will define and explain the two meta-theories. At this juncture, it should be noted that these meta-theories have been explicated elsewhere. The contribution of this book is the presentation of the research evidence and the claim that this evidence conclusively supports the contextual model of psychotherapy.

**MEDICAL MODEL**

In this section, a brief history of the medical model is presented. This history serves to introduce the tenets of the medical model as well as to situate the medical model within the current psychotherapeutic context. Following the history, the tenets of the medical model are stipulated.

**Brief History of the Medical Model of Psychotherapy**

The origins of psychotherapy lie in the medical model. Sigmund Freud, in his practice as a physician, became involved with the treatment of hysterics. He believed that (a) hysterical symptoms are caused by the repression of some traumatic event (real or imagined) in the unconscious, (b) the nature of the symptom is related to the event, and (c) the symptom could be relieved by insight into the relationship between the event and the symptom. Moreover, from the beginning (as in his discussion of Anna O.), sexuality became central to the etiology of hysteria, with many symptoms associated
with early sexual traumas. Freud experimented with various techniques to retrieve repressed memories, including hydrotherapy, hypnosis, and direct questioning, eventually promoting free association and dream analysis. From these early origins of psychoanalysis, the components of the medical model that are enumerated later were emerging: a disorder (hysteria), a scientifically based explanation of the disorder (repressed traumatic events), a mechanism of change (insight into unconscious), and specific therapeutic actions (free association).

During his lifetime, Freud and his colleagues differed on various aspects related to theory and therapeutic action, creating irreconcilable rifts with such luminaries as Joseph Breuer, Alfred Adler, and Carl Jung, the latter two of whom were expelled from Freud’s Vienna Psychoanalytic Society. As we shall see, the medical model is characterized by insistence on the correct explanation of a disorder and adoption of the concomitant therapeutic actions. Although Freud claimed that his theory was correct and supported by scientific evidence, the truth is that the empirical bases of Freudian psychoanalysis and competing systems (e.g., Adler’s individual psychology or Jung’s analytic psychology) were tenuous at best. Interestingly, as we shall see, interpersonal psychotherapy, which has become what is known as an empirically supported treatment, is derived from Sullivan’s neo-Freudian interpersonal psychoanalysis.

Another historical thread of the medical model emanated from behaviorism. Although behavioral therapists often claim to reject the medical model, defined as a meta-theory, the medical model encompasses most, if not all, behavioral treatments. Behavioral psychology emerged as a parsimonious explanation of behavior based on objective observations. Ivan Petrovich Pavlov’s work on classical conditioning detailed, without resorting to complicated mentalistic constructs, how animals acquired a conditioned response, how the conditioned response could be extinguished (i.e., extinction), and how experimental neurosis could be induced. John B. Watson and Rosalie Rayner’s “Little Albert Study” established that a fear response could be conditioned by pairing an unconditioned stimulus of fear (viz., loud noise) with an unconditioned stimulus (viz., a rat) so that the unconditioned stimulus elicited the fear response (Watson & Rayner, 1920). Although Watson and Rayner did not attempt to alleviate Albert’s fear, Mary Cover Jones (under the supervision of Watson) demonstrated that the classical conditioning paradigm could be used to desensitize a boy’s fear of rabbits by gradually decreasing the proximity of the stimulus (i.e., the rabbit) to the boy.

Over the years, Freud’s conceptualizations evolved, encompassing drive theory (libidinal and aggressive motivations), sexual development, and the tripartite theory of personality (viz., id, ego, superego) and spawning additional techniques, such as interpretation of the transference.
A major impetus to behavioral therapy was provided by Joseph Wolpe’s development of systematic desensitization. Wolpe, who like Freud was a medical doctor, became disenchanted with psychoanalysis as a method to treat his patients. On the basis of the work of Pavlov, Watson, Rayner, and Jones, Wolpe studied how eating, an incompatible response to fear, could be used to reduce phobic reactions of cats, which he had previously conditioned. After studying the work on progressive relaxation by physiologist Edmund Jacobson, Wolpe recognized that the incompatibility of relaxation and anxiety could be used to treat anxious patients. His technique, which was called systematic desensitization, involves the creation of a hierarchy consisting of progressively anxiety-provoking stimuli, which are then imagined by patients, under a relaxed state, from least to most feared.

Although the explanation of anxiety offered by the psychoanalytic and classical conditioning paradigms differ dramatically, systematic desensitization has many structural similarities to psychoanalysis. It is used to treat a disorder (phobic anxiety), is based on an explanation for the disorder (classical conditioning), imbeds the mechanism of change within the explanation (desensitization), and stipulates the therapeutic action necessary to effect the change (systematic desensitization). So, although the psychoanalytic paradigm is saturated with mentalistic constructs whereas the behavioral paradigm generally eschews intervening mentalistic explanations, they are both systems that explain maladaptive behavior and offer therapeutic protocols for reducing distress and promoting more adaptive functioning. Proponents of one of the two systems would claim that their explanations and protocols are superior to the other. Indeed, Watson and Rayner (1920) were openly disdainful of any Freudian explanation for Albert’s fears:

The Freudians twenty years from now, unless their hypotheses change, when they come to analyze Albert’s fear of a seal skin coat—assuming that he comes to analysis at that age—will probably tease from him the recital of a dream which upon their analysis will show that Albert at three years of age attempted to play with the pubic hair of the mother and was scolded violently for it. (p. 14)

Given this brief introduction, the components of the medical model are now presented.

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*There is evidence that the effects of systematic desensitization are not due to the purported classical conditioning explanations offered (e.g., Kirsch, 1985). The general finding that the purported explanations for various generally accepted efficacious treatments have not been verified empirically is discussed in chapter 5.*
Components of the Medical Model

As conceptualized for the purpose of this book, the medical model has five components.

**Client Disorder, Problem, or Complaint.** The first component of the medical model of psychotherapy is a client who is conceptualized to have a disorder, problem, or complaint. In medicine, the patient presents with a set of signs and symptoms that are indicative of a medical disorder. The analogous system in psychotherapy is the taxonomy of disorders developed in the *Diagnostic and Statistical Manual of Mental Disorders* (e.g., *DSM-IV*, American Psychiatric Association, 1994). Those who adhere to this taxonomy use signs and symptoms to provide a diagnosis for the patient in much the same way as physicians do.

As framed in this book, the medical model of psychotherapy does not require that a diagnosis be assigned to the client. It is sufficient that there is a system that identifies any aspect of the client that is amenable to change and that can be described in a way understandable to those who subscribe to a given therapeutic approach. For example, a behavioral psychotherapist could identify a social skills deficit as the presenting problem. To the behavioral psychotherapist, a social skill deficit is clearly not a mental disorder, yet it is a problem and as such qualifies as a component of the medical model of psychotherapy.

**Psychological Explanation for Disorder, Problem, or Complaint.** The second component of the medical model is that a psychological explanation for the client’s disorder, problem, or complaint is proposed. The various psychotherapeutic approaches offer widely different theoretical explanations for a particular disorder. In medicine, there is greater convergence on the causes of a particular disorder. For example, few medical experts would disagree on the medical explanations of tuberculosis, diabetes, Down’s syndrome, or angina. Of course there are medical disorders for which alternative explanations exist, but medical researchers recognize these differences and seek to collect evidence that will rule in or out various explanations.

For most psychological disorders, many alternative explanations exist. For example, depression may be due to irrational and maladaptive thoughts (cognitive therapies), lack of reinforcers for pleasurable activities (behavioral therapies), or problems related to social relations (interpersonal therapies). The important aspect of the medical model of psychotherapy is that some psychological explanation exists for the disorder, problem, or complaint.

**Mechanism of Change.** The medical model of psychotherapy stipulates that each psychotherapeutic approach posit a mechanism of
change. Generally speaking, psychoanalytic therapists make the uncon­
scious conscious, cognitive therapists alter maladaptive thoughts, inter­
personal therapists improve social relations, and family therapists 
disrupt destructive family dynamics. It is probably safe to say that the 
exposition of every psychotherapeutic approach contains a statement of 
the mechanism of change.

Specific Therapeutic Ingredients. To varying degrees, psycho­
therapeutic approaches prescribe specific therapeutic actions. The trend 
over the past few decades has been to explicate these actions in manuals, 
carefully laying out the specific ingredients that are to be used in treating 
a client.

Specificity. To this point, the medical model stipulates that the cli­
ent presents with a disorder, problem, or complaint; the therapist as­
cribes to a particular theoretical orientation, which provides an 
explanation for the disorder, problem, or complaint and a rationale for 
change; and the therapist provides treatment that contains specific ther­
apeutic ingredients that are characteristic of the theoretical orientation 
as well as the explanation of the disorder, problem, or complaint. Speci­
ficity, the critical aspect of the medical model, implies that the specific 
therapeutic ingredients are remedial for the disorder, problem, or com­
plaint. That is, in a medical model, the specific ingredients are assumed 
to be responsible (i.e., necessary) for client change or progress toward 
therapeutic goals. Specificity implies that specific effects will be over­
whelmingly larger than the general effects.

Medical Model of Psychotherapy Versus Medical Model 
in Medicine

It is important to discriminate between the medical model of psychotherapy 
and the medical model in medicine. Essentially, the medical model of psy­
chotherapy is an analogue to the medical model in medicine, rather than a 
literal adoption.

The medical model in medicine contains the same components as the 
medical model of psychotherapy except that the theories, explanations, and 
characteristic techniques are physiochemically based. Specificity, in medi­
cine, is established by demonstrating the efficacy of a technique as well as 
the physiochemical basis of the technique:

The professional question for organized medicine was not whether [alternative] 
treatments were efficacious, but whether they involved physiochemical causes. 
For example, mesmerism was discredited not on the basis of efficacy issues but
because its adherents failed to demonstrate physical mechanisms involving magnetic fluids. (Wilkins, 1984, p. 571)

It is important to note that in medicine it is recognized that extraphysiochemical effects are present. That is, the model takes into account that treatments contain ingredients that are not characteristic of the explanatory theory and that these incidental factors may, in and of themselves, be partially remedial for a given disorder. For example, the medical patient's belief that a drug is beneficial will increase its potency. In medicine, these effects are called placebo effects and are presumed to be caused by nonphysiochemical (i.e., psychological) processes. Although these extraphysiochemical effects are recognized in medicine, they are simply uninteresting (Wilkins, 1984). The left panel of Figure 1.1 illustrates the specific physiochemical effects as well as the placebo effects in medicine. In medicine, placebos are used to control for the nonphysiochemical effects. As is discussed briefly in this section and then developed in chapter 5, psychotherapy analogues to medical placebos are not possible, and the attempt to rule out effects due to incidental factors are rendered problematic.

The medical model of psychotherapy differs from the medical model in medicine primarily because in psychotherapy the effects due to specific therapeutic ingredients and the effects due to incidental factors are both psychological, creating conceptual as well as empirical ambiguities. However, in medicine it is possible to deliver a purely physiochemical treatment. For example, a patient may inadvertently take a substance that purportedly is remedial for their disorder, or a surgery may be performed on a comatose patient. In psychotherapy, the specific ingredients cannot be de-

![Figure 1.1. Medical models in medicine and in psychotherapy.](image-url)
livered without the incidental ingredients. A therapeutic relationship is always present in psychotherapy and affects the manner in which the specific ingredients are delivered. In psychodynamic therapy, an interpretation will be more powerful when made by a therapist with a strong alliance with the client. The fact that the effects due to specific ingredients and common factors are psychological makes both of these effects interesting and relevant to psychotherapists. Accordingly, psychotherapy research has been devoted to both of these effects.

In the medical model in medicine, the focus is clearly on physiochemical effects, and psychological effects are considered as nuisance. Although in the medical model of psychotherapy there are two types of psychological effects, adherents of the medical model, including advocates of particular theoretical approaches, give primacy to specific ingredients and their effects. That is, medical model adherents recognize that general effects exist, but find them relatively uninteresting and believe that the preponderance of the therapeutic effect is due to specific ingredients. For example, a cognitive–behavioral advocate is interested in how cognitive schemas are altered and how this alteration is beneficial and is relatively uninterested with incidental aspects, such as the therapeutic relationship, and their effects.

To summarize, the medical model of psychotherapy presented herein takes the same form as the medical model in medicine but differs in that (a) disorders, problems, or complaints are held to have psychological rather than physiochemical etiology; (b) explanations for disorders, problems, or complaints and rationale for change are psychologically rather than physiochemically based; and (c) specific ingredients are psychotherapeutic rather than medical. Because the medical model of psychotherapy requires neither physiochemical nor mentalistic constructs, strict behavioral interventions would fit within this model.

There are areas for which the demarcation of the medical model of psychotherapy and the medical model in medicine becomes ambiguous. Some disorders that were thought to be psychological have been shown to have a clear and unambiguous physiochemical etiology. For example, general paresis was considered a psychologically based disorder until it was understood to be caused by the spirochete responsible for syphilis. Other disorders are clearly organic, but psychological treatments are nevertheless effective; behavioral interventions to manage the problems associated with autism or attention deficit disorder are of this type. On the other hand, attempts have been made to locate the physiochemical processes involved with the placebo effect in medicine, an attempt that is directed toward transforming a nuisance psychological process into a specific physiochemical and medical one. As a final instance of the crossover between psychotherapy and physiochemical models, it has been shown that psychotherapy affects brain chemistry (e.g., Baxter et al., 1992). These crossovers create
some ambiguity regarding the distinctiveness of the two medical models and raise the specter of a false mind–body dualism; nevertheless, these theoretical ambiguities are not central to the thesis of this book.

Current Status of the Medical Model of Psychotherapy

The brief history presented earlier demonstrated that the roots of psychotherapy are planted firmly in the medical model. It is apparent that the psychotherapy research community has continued to adhere to the medical model. Two recent developments in psychotherapy research, psychotherapy treatment manuals and empirically supported treatments, have constrained psychotherapy research to the medical model, effectively stifling alternative meta-theories.

Psychotherapy Treatment Manuals. A treatment manual contains “a definitive description of the principles and techniques of [the] psychotherapy, ... [and] a clear statement of the operations the therapist is supposed to perform (presenting each technique as concretely as possible, as well as providing examples of each)” (Kiesler, 1994, p. 145). The purpose of the treatment manual is to create standardization of treatments, thereby reducing variability in the independent variable in clinical trials, and to ensure that therapists correctly deliver the specific ingredients that are characteristic of the theoretical approach. With regard to the latter point, manuals enable “researchers to demonstrate the theoretically required procedural differences between alternative treatments in comparative outcome studies” (Wilson, 1996, p. 295). Credit for the first treatment manual is usually attributed to Beck, Rush, Shaw, and Emery (1979), who delineated cognitive–behavioral treatment for depression. The proliferation of treatment manuals since Beck et al.’s manual in 1979 has been described as a “small revolution” (Luborsky & DeRubeis, 1984). Treatment manuals have become required for the funding and publication of outcome research in psychotherapy: “The treatment manual requirement, imposed as a routine design demand, chiseled permanently into the edifice of psychotherapy efficacy research the basic canon of standardization” (Kiesler, 1994, p. 145).

It is straightforward to understand how the treatment manual is imbedded in the medical model. The typical components of the manual—which include defining the target disorder, problem, or complaint; providing a theoretical basis for the disorder, problem, or complaint, as well as the change mechanism; specifying the therapeutic actions that are consistent with the theory; and the belief that the specific ingredients lead to efficacy—are identical to the components of the medical model. In chapter 7, the research
evidence is presented relative to the question of whether using manuals results in better therapy outcomes.

**Empirically Supported Treatments.** The second development in psychotherapy research is the identification of empirically supported treatments (ESTs). The emphasis in the 1990s on managed care in medicine and related health areas, including mental health, created the need to standardize treatments and provide evidence of efficacy. As diagnostic related groups (DRGs), which allowed fixed payment per diagnosis, became accepted in the medical community, psychiatry responded with psychopharmacological treatments (i.e., drugs) for many mental disorders; the medical model in medicine was making significant inroads in the treatment of mental disorders. A task force of Division 12 (Clinical Psychology) of the American Psychological Association (APA) reacted in a predictable way: “If clinical psychology is to survive in this heyday of biological psychiatry, APA must act to emphasize the strength of what we have to offer—a variety of psychotherapies of proven efficacy” (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 3). Accordingly, to identify treatments that would meet the criteria of being empirically validated (the term originally used), the task force developed criteria that if satisfied by a treatment, would result in the treatment being included on a list published by the Task Force. Although the criteria have evolved, they originated from the criteria used by the Food and Drug Administration (FDA) to approve drugs. The criteria stipulated that a treatment would be designated as empirically validated for a particular disorder provided that at least two studies showed superiority to groups that attempted to control for general effects and were administered to a well-defined population of clients (including importantly the clients’ disorder, problem, or complaint) using a treatment manual.

The first attempt to identify treatments that satisfied the criteria netted 18 well-established treatments (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Revisions to the list were made subsequently (Chambless et al., 1996; 1998) and included such treatments as cognitive behavior therapy for panic disorder, exposure treatment for agoraphobia, behavior therapy for depression, cognitive therapy for depression, interpersonal therapy for depression, multicomponent cognitive–behavioral therapy for pain associated with rheumatic disease, and behavioral marital therapy for marital discord. Recently, a special issue of the *Journal of Consulting and Clinical Psychology* was devoted to a discussion of ESTs and the identification of empirically supported treatments for adult mental disorders, child and adolescent disorders, health related disorders (viz., smoking, chronic pain, cancer, and bulimia nervosa), and marital distress (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Beutler, 1998; Borkovec &
Competing Meta-Models

It is abundantly clear that the EST movement is deeply imbedded in a medical model of psychotherapy. First, the criteria are clear that to be designated as well-established empirically validated treatments, the treatments should be directed toward a disorder, problem, or complaint: “We do not ask whether a treatment is efficacious; rather, we ask whether it is efficacious for a specific problem” (Chambless & Hollon, 1998, p. 9). Although use of the DSM as the nosology for assigning disorders is not mandated, Chambless and Hollon indicated the DSM has “a number of benefits” for determining ESTs; those who have reviewed research in order to identify ESTs typically use the DSM (e.g., DeRubeis & Crits-Christoph, 1998).

The requirement that only treatments administered with a manual are certifiable as an EST further demonstrates a connection between ESTs and the medical model because, as discussed earlier, manuals are intimately tied to the medical model. The lists of empirically supported treatments are predominated by behavioral and cognitive-behavioral treatments, which may reflect the fact that such treatments are easier to put in the form of a manual than are experiential or psychodynamic treatments.

A third perspicuous aspect of the EST movement is the criteria, which were patterned after the FDA drug approval criteria that require that evidence is needed relative to specificity as well as efficacy. According to the EST criteria, specificity is established by demonstrating superiority to pill or psychological placebo or by showing equivalence to an already established treatment. 

Clearly, specificity, a critical component in the medical model of psychotherapy undergirds the EST movement.

Indeed, the motivation to adopt a medical model in order to bolster the status of psychotherapy was evident from the beginning:

We [The Task Force] believe establishing efficacy in contrast to a waiting list control group is not sufficient. Relying on such evidence would leave psychologists at a serious disadvantage vis-a-vis psychiatrists who can point to numerous double-blind placebo trials to support the validity of their interventions. (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 5)

It has been pointed out that the designs stipulated in the criteria are insufficient to establish specific effects because the control groups do not control for general effects (Wampold, 1997), a point that is discussed further in chapter 5.

Interestingly, some of those involved with the EST movement have recommended dropping the specificity requirement: “Simply put, if a treatment works, for whatever reason, ... then the treatment is likely to be of value clinically, and a good case can be made for its use” (Chambless & Hollon, 1998, p. 8). Nevertheless, treatments that could demonstrate specificity as well as efficacy would be “highly prized,” indicating the continued belief that specificity remains central as is discussed later in this chapter.
Although the medical model is pervasive in the academic community and, as has been shown, is now required de facto for examining outcomes in psychotherapy, a small but persistent group of researchers has resisted adopting the model. Practitioners have increasingly felt enormous pressure to conform to the medical model as reimbursements require diagnoses, treatment plans, and all of the other trappings of the medical model. Nevertheless, practitioners have not, for the most part, constrained their treatments to the dictates of manuals, and they are reluctant to shape their treatments to a unitary theoretical approach.

In this section, an alternative to the medical model, which will be labeled the contextual model of psychotherapy, is presented. First, a brief history of alternatives to single theoretical approaches is presented.

**Brief History of Alternatives to Allegiance to Single Theoretical Approaches**

According to Arkowitz (1992), dissatisfaction with individual theoretical approaches spawned three movements: (a) theoretical integration, (b) technical eclecticism, and (c) common factors. The contextual model is a derivative of the common factors view.

*Theoretical Integration.* Theoretical integration is the fusion of two or more theories into a single conceptualization. Although earlier attempts were made to explain psychoanalysis with learning theory, Dollard and Miller's (1950) seminal book *Personality and Psychotherapy: An Analysis in Terms of Learning, Thinking, and Culture* was the first true integration of two theories that provided an explanation of behavior (in this case neuroses; Arkowitz, 1992). Because behavior therapy was not well developed at this time, Dollard and Miller's work was considered theoretical and provided little direction for an integrated treatment. Following the introduction of behavioral techniques (e.g., systematic desensitization), behavior therapists were generally more interested in remarking on the differences rather than the similarities of the two theories. Nevertheless, during the 1960s and 1970s, psychodynamic therapists shed the orthodoxy of psychoanalysis and became more structured, more attentive to coping strategies in the here-and-now, and more inclined to assign responsibility to the client (Arkowitz, 1992). At the same time, behavior therapists were allowing mediating constructs such as cognitions into their models and began to recognize the importance of factors incidental to behavioral theories, such as the therapeutic relationship.
The softening of the orthodoxy of both psychodynamic and behavioral approaches set the stage for Wachtel’s (1977) integration of psychoanalysis and behavior therapy, *Psychoanalysis and Behavior Therapy: Toward an Integration.* Wachtel, in this and other writings, demonstrated how psychodynamic and behavior explanations could stand together to explain behavior and psychological disorder and how interventions from the two theories could facilitate therapeutic change, both behavioral and intrapsychic. The essence of the integration was nicely summarized by Arkowitz (1992):

> From the psychodynamic perspective, he [Wachtel] emphasized unconscious processes and conflict and the importance of meanings and fantasies that influenced our interactions with the world. From the behavioral side, the elements included the use of active-intervention techniques, a concern with the environmental context of behavior, a focus on the patient’s goals in therapy, and a respect for empirical evidence.... Active behavioral interventions may also serve as a source of new insights (Wachtel, 1975), and insights can promote changes in behavior (Wachtel, 1982). (Arkowitz, 1992, pp. 268–269)

Since Wachtel’s seminal work, psychotherapy integration has grown in popularity, with new integrations and refinements of others. The central issue for psychotherapy integration is to avoid having the integrated theory become a unitary theory of its own and to generate hypotheses that are distinct from the theories on which the integration is based (Arkowitz, 1992). The latter point is particularly relevant here because the purpose of this book is to review the empirical evidence to test whether it supports the medical model or an alternative. It is vital for empirical testing that the two meta-theories generate different predictions, and for that reason, theoretical integration does not provide a viable alternative to the medical model.

**Technical Eclecticism.** The guiding light of technical eclecticism is Paul’s question: “What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?” (Paul, 1969). Technical eclecticism is dedicated to finding the answer to Paul’s questions for as many cells as possible in the matrix created by crossing client, therapist, and problem dimensions. The search is empirically driven, and theory becomes relatively unimportant. The two most conspicuous systems for technical eclecticism are Arnold Lazarus’ *Multimodal Therapy* (see, e.g., Lazarus, 1981) and Larry Beutler’s *Systematic Eclectic Psychotherapy* (see, e.g., Beutler & Clarkin, 1990). Essentially, technical eclecticism is focused on the lowest level of abstraction—techniques (see Table 1.2). As such, it involves one aspect of the medical model, specific treatments for specific disorders, but shies away from the explanatory aspects of the
medical model. Consequently, it would be impossible to derive hypotheses that would differentiate technical eclecticism from a medical model basis for the efficacy of psychotherapy. Nevertheless, some of the empirical evidence generated by technical eclecticism applied at the strategy level of abstraction (see, e.g., Beutler & Baker, 1998) is cited in chapter 5 as evidence for the contextual model.

Attention is now turned to the common factor approach, which forms the basis of the contextual model.

Common Factors

By the 1930s, psychoanalytic therapies had proliferated, with various theoretical variations advocated by such luminaries as Karen Horney, Alfred Adler, Carl Jung, and Harry Stack Sullivan (Cushman, 1992). The advocate of each therapeutic approach was encouraged by treatment successes, which quite naturally were interpreted as evidence to support the theory and the characteristic therapeutic actions. In 1936, Rosenzweig realized that each of the advocates were singing the same refrain and used an Alice in Wonderland metaphor to refer the equivalence in outcomes: “At last the Dodo said, ‘Everybody has won, and all must have prizes.’” The general equivalence of outcomes in psychotherapy has now been firmly labeled as the Dodo Bird effect (which is the focus of chap. 4).

To Rosenzweig, the conclusion to be drawn from the general equivalence of psychotherapy outcomes was clear:

The proud proponent, having achieved success in the cases he mentions, implies, even when he does not say it, that his ideology is thus proved true, all others false.... [However] it is soon realized that besides the intentionally utilized methods and their consciously held theoretical foundations, there are inevitably certain unrecognized factors in any therapeutic situation—factors that may be even more important that those being purposely employed. (Rosenzweig, 1936, p. 412)

In terms of the terminology used in this chapter, Rosenzweig was arguing against specificity and for the aspects of the therapy that are not central to the theoretical approach.

Since Rosenzweig proposed that common elements of therapy were responsible for the benefits of psychotherapy, attempts have been made to identify and codify the aspects of therapy common to all psychotherapies. Goldfried (1980), as mentioned previously, discussed the strategy level of abstraction in order to propose that when considered at this level, psychotherapies had particular strategies in common (see Table 1.2). Castonguay (1993) noted that focusing on therapist actions, such as therapeutic strategies, ignored other common aspects of psychotherapy. He dis-
tungished three meanings that can be applied to understanding common factors in psychotherapy. The first meaning, which is similar to Goldfried's strategy level of abstraction, refers to global aspects of therapy that are not specific to any one approach (i.e., are common across approaches), such as insight, corrective experiences, opportunity to express emotions, and acquisition of a sense of mastery. The second meaning pertains to aspects of treatment that are auxiliary to treatment and refer primarily to the interpersonal and social factors. This second meaning encompasses the therapeutic context and the therapeutic relationship (e.g., the working alliance). The third meaning of the term involves those aspects of the treatment that influence outcomes but are not therapeutic activities or related to the interpersonal–social context. This latter meaning includes client expectancies and involvement in the therapeutic process.

In an attempt to bring coherence to the many theoretical discussions of common factors, Grencavage and Norcross (1990) reviewed publications that discussed commonalities among therapies and segregated commonalities into five areas: client characteristics, therapist qualities, change processes, treatment structures, and relationship elements. Table 1.3 presents the three most frequent elements in each category. These elements span the three meanings given by Castonguay (1993) as discussed earlier.

The common factor model proposes that there exists a set of factors that are common to all (or most) therapies, however identified and codified, and that these common factors are responsible for psychotherapeutic benefits rather than the ingredients specific to the particular theories. In terms of Figure 1.1, the common factor model claims that the area of the outer, specific effect ring would be small in comparison with that of the area for general effects. Statistically, one could say that a large proportion of the variance would be due to common factors, and a small proportion of the variance would be due to specific ingredients—in chapter 9, the variance due to these sources is estimated.

The common factor model is a diffuse model in that it stipulates that (a) there are a set of common factors and (b) these factors are therapeutic. There are more comprehensive models that contain common factors components, and although these models are often lumped into the common factor camp (e.g., Arkowitz, 1992), they are, from the standpoint of this book, distinct, as will be discussed later in this chapter. The alternative to the medical model, which is called the contextual model of psychotherapy, is presented next.

**Definition of Contextual Model**

The model presented in this section is called a contextual model because it emphasizes the contextual factors of the psychotherapy endeavor. Various
TABLE 1.3
Common Factors Gleaned From the Literature
by Grencavage and Norcross (1990)

<table>
<thead>
<tr>
<th>Category</th>
<th>Commonalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client characteristics</td>
<td>Positive expectation–hope or faith; Distressed or incongruent client; Patient actively seeks help</td>
</tr>
<tr>
<td>Therapist qualities</td>
<td>General positive descriptors; Cultivates hope–enhances expectations; Warmth–positive regard</td>
</tr>
<tr>
<td>Change processes</td>
<td>Opportunity for catharsis–ventilation; Acquisition and practice of new behaviors; Provision of rationale</td>
</tr>
<tr>
<td>Treatment structures</td>
<td>Use of techniques–rituals; Focus on “inner world”—exploration of emotional issues; Adherence to theory</td>
</tr>
<tr>
<td>Relationship elements</td>
<td>Development of alliance–relationship (general); Engagement; Transference</td>
</tr>
</tbody>
</table>


contextual models of psychotherapy have been proposed (e.g., Brody, 1980; Frank & Frank, 1991). As was true for the medical model, there are philosophy-of-science distinctions that can be made amongst the variations; these distinctions are important to theoreticians and philosophers of science, but are relatively unimportant from the standpoint of this book. For the purpose of the present argument, the working model adopted is the one proposed by Jerome Frank in the various editions of his seminal book, Persuasion and Healing (Frank & Frank, 1991). Because space permits only a brief synopsis of the model, the reader is encouraged to read the original.

**Frank’s Model.** According to Frank and Frank (1991), “the aim of psychotherapy is to help people feel and function better by encouraging appropriate modifications in their assumptive worlds, thereby transforming the meanings of experiences to more favorable ones” (p. 30). Persons who present for psychotherapy are demoralized and have a variety of problems, typically depression and anxiety. That is, people seek psychotherapy for the demoralization that results from their symptoms rather than for symptom relief. Frank has proposed that “psychotherapy achieves its effects largely by directly treating demoralization and only indirectly treating overt symptoms of covert psychopathology” (Parloff, 1986, p. 522).
Frank and Frank (1991) described the components shared by all approaches to psychotherapy. The first component is that psychotherapy involves an emotionally charged, confiding relationship with a helping person (i.e., the therapist). The second component is that the context of the relationship is a healing setting, in which the client presents to a professional who the client believes can provide help and who is entrusted to work in his or her behalf. The third component is that there exists a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient’s symptoms and prescribes a ritual or procedure for resolving them. According to Frank and Frank, the particular rationale needs to be accepted by the client and by the therapist, but need not be “true.” The rationale can be a myth in the sense that the basis of the therapy need not be “scientifically” proven. However, it is critical that the rationale for the treatment be consistent with the worldview, assumptive base, and attitudes and values of the client or, alternatively, that the therapist assists the client to become in accord with the rationale. Simply stated, the client must believe in the treatment or be lead to believe in it. The final component is a ritual or procedure that requires the active participation of both client and therapist and is based on the rationale (i.e., the ritual or procedure is believed to be a viable means of helping the client).

Frank and Frank (1991) discussed six elements that are common to the rituals and procedures used by all psychotherapists. First, the therapist combats the client’s sense of alienation by developing a relationship that is maintained after the client divulges feelings of demoralization. Second, the therapist maintains the patient’s expectation of being helped by linking hope for improvement to the process of therapy. Third, the therapist provides new learning experiences. Fourth, the clients’ emotions are aroused as a result of the therapy. Fifth, the therapist enhances the client’s sense of mastery or self-efficacy. Sixth, the therapist provides opportunities for practice.

It is important to emphasize the status of techniques in the contextual model. Specific ingredients are necessary to any bona fide psychotherapy whether conceptualized as a medical model treatment or a contextual model treatment. In the contextual model, specific ingredients are necessary to construct a coherent treatment that therapists have faith in and that provides a convincing rationale to clients. This point is cogently articulated by Frank in the preface to the most recent version of his model (Frank & Frank, 1991):

My position is not that technique is irrelevant to outcome. Rather, I maintain that, as developed in the text, the success of all techniques depends on the patient’s sense of alliance with an actual or symbolic healer. This position implies that ideally 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. Also implied is that therapists should seek to learn as many approaches as they find congenial and convincing. Creating a good therapeutic match may
involve both educating the patient about the therapist's conceptual scheme and, if necessary, modifying the scheme to take into account the concepts the patient brings to therapy. (p. xv)

Interestingly, Frank's recognition that in the contextual model, a viable treatment must have a consistent, rational explanatory system was first articulated in 1936 by Rosenzweig:

It may be said that given a therapist who has an effective personality and who consistently adheres in his treatment to a system of concepts which he has mastered and which is in one significant way or another adapted to the problem of the sick personality, then it is of comparatively little consequence what particular method that therapist uses.... Whether the therapist talks in terms of psychoanalysis or Christian Science is from this point of view relatively unimportant as compared with the formal consistency with which the doctrine employed is adhered to, for by virtue of this consistency the patient receives a schema for achieving some sort and degree of personality organization. (Rosenzweig, 1936, pp. 413–415)

Comments on the Contextual Model. The first important point to make is the distinction between the common factor model and the contextual model. Common factor models contain a set of common factors, each of which makes an independent contribution to outcome. Although Frank and Frank (1991) discussed components common to all therapies, the healing context and the meaning attributed to it by the participants (therapist and client) are critical contextual phenomena. According to Frank and Frank, provision of new learning experiences, as an example, will not be therapeutic unless the client perceives the therapy to be taking place in a healing context in which he or she as well as the therapist believe in the rationale for the therapy; the therapist delivers therapeutic actions consistent with the rationale; the client is aroused and expects to improve; and a therapeutic relationship has been developed. In a contextual conceptualization of common factors, specific therapeutic actions, which may be common across therapies, cannot be isolated and studied independently. As we shall see (primarily in chap. 5), many researchers who ascribe to the medical model design control groups to rule out common factors, native to the contextual factors critical to a contextual model.

It is vital to understand the status of the contextual model vis-à-vis other psychotherapeutic theories. Previously, Grümbaum's (1981) system was adapted to explain the medical model. Interestingly, Grümbaum considers Frank's model as another theory with characteristic ingredients:

Frank credits a treatment-ingredient common to the rival psychotherapies with such therapeutic efficacy as they do possess.... He is tacitly classifying as "incidental," rather than as "characteristic," all those treatment factors that he deems to be therapeutic. In adopting this latter classification, he is speaking the
According to this interpretation, the contextual model is a theory on the same level of abstraction as behavioral, psychodynamic, and interpersonal theories, obviating its status as a meta-theory. There are a number of (interrelated) arguments that mitigate against classifying the contextual model as a psychotherapeutic theory rather than a meta-theory. First, the characteristic ingredients of a psychotherapeutic theory are unique to that theory or are shared by a few closely related theories, whereas the common ingredients discussed by Frank and other common factor conceptualizations are shared by all theoretical approaches. In this sense, all treatments are characteristic of the contextual model. Second, the contextual factors and common ingredients of the contextual model, which are considered incidental by psychotherapeutic theories, cannot be removed from the treatments prescribed by the various theories. Third, the contextual model dictates that a treatment be administered but that the particular components of that treatment are unimportant relative to the belief of the therapist and the client that the treatment is rational and efficacious. The contextual model states that the treatment procedures used are beneficial to the client because of the meaning attributed to those procedures rather than because of their specific psychological effects.

If one considers the contextual model to be at the same level of abstraction as other psychotherapeutic theories, then one could design studies comparing a particular approach—for instance, cognitive-behavioral—with a contextual model approach. This is not possible, however, because one cannot construct a manualized contextual model treatment. In another sense, all treatments are examples of contextual model treatments in that they all contain the features of the contextual model. So, when one compares cognitive-behavioral treatment for depression with an interpersonal treatment for depression, one is also comparing a cognitive-behavioral model with a contextual model. If the two treatments are equally effective, is it because of their respective specific ingredients or because both are instances of contextual model treatments? This is the central question answered by this book.

A final point that causes confusion in the design of comparison groups in psychotherapy outcome research is the status of Rogerian therapy. This approach to therapy, which is now called person-centered therapy, fits the description of a theoretical approach subsumed under the medical model in many ways. It contains a clear theory of the person and therapeutic change as well as techniques for facilitating such change (e.g., Rogers, 1951). Although the techniques are generally not directed toward a specific disorder, as is typical of the medical model, the person-centered therapist conceptu-
alizes the nature of client problems within the humanistic explanatory system. Moreover, client-centered approaches have been adapted and tested with various populations, illustrated by Rogers's work with individuals with schizophrenia (Rogers, Gendlin, Kiesler, & Truax, 1967). Many equate client-centered therapy with common factors because of the emphasis on relationship and therapeutic process, but client-centered and other experiential therapists provide a level of treatment more sophisticated and complex than simple empathic responding. As will be shown in chapter 5, attempts to control for common factors by using Rogerian or nondirective therapy are flawed.

**Status of Contextual Model**

As mentioned previously, the medical model definitely holds the superordinate position in academia, particularly in the research environment. However, there are conspicuous examples of contextual model and common factor approaches that are supported by research evidence, such as Sol Garfield's *Psychotherapy: An Eclectic-Integrative Approach* (1995). Clearly, however, adherents of a contextual model or common factor approach are considered "soft" or unscientific by medical model adherents. Consider Donald Klein's criticism of psychotherapy as a treatment for depression:

> It is remarkably hard to find differences between the outcomes of credible psychotherapies or any evidence that a proposed specific beneficial mechanism of action has anything to do with therapeutic outcome.... These findings ... are inexplicable on the basis of the therapeutic action theories propounded by the creators of IPT [interpersonal therapy] and CBT [cognitive–behavioral therapy]. However they are entirely compatible with the hypothesis (championed by Jerome Frank; see Frank & Frank, 1991) that psychotherapies are not doing anything specific: rather, they are nonspecifically beneficial to the final common pathway of demoralization, to the degree that they are effective at all [italics added].... The bottom line is that if the Food and Drug Administration (FDA) was responsible for the evaluation of psychotherapy, then no current psychotherapy would be approvable, whereas particular medications are clearly approvable. (Klein, 1996, pp. 82–84)

Klein clearly denigrates any psychotherapeutic effects that are not specific. Moreover, any benefits of psychotherapy that may be attributable to a "demoralization pathway" is so suspect that it casts doubts about the efficacy of psychotherapy generally, in spite of the overwhelming evidence of the benefits of the psychotherapeutic enterprise. Chambless and Hollon (1998), who recognized the importance of demonstrating efficacy regardless of the causal mechanisms, nevertheless believe that "treatments found to be superior to conditions that control for such nonspecific processes or to
another bona fide treatment are even more highly prized and said to be efficacious and specific [italics added]" (p. 8). Clearly, they value effects attributable to specific ingredients, demonstrating the tendency to value the presumably scientific medical model of psychotherapy over a contextual model. Parloff (1986), as well, noted the disrespect given to general effects:

Some seemingly positive effects of psychotherapy are attributable primarily to such mechanism as "suggestion," "placebo," "attention," or "common sense" advice, then the credibility of psychotherapy as a profession is automatically impugned. (pp. 523–524)

Clinical "scientists" are so enamored with the medical model of psychotherapy that they begrudgingly acknowledge that benefit could accrue through mechanisms other than those characteristic of theoretical approaches, and they denigrate such mechanisms much in the way that medical researchers recognize but are uninterested in nonspecific effects.

It might be informative to know whether practitioners subscribe to a medical model or a contextual model of psychotherapy. Numerous surveys have been conducted to determine the theoretical orientation of practitioners (see Garfield & Bergin, 1994, for a summary; see also Jensen & Bergin, 1990; Norcross, Prochaska, & Farber, 1993). On all such surveys, whether the respondents are psychologists, social workers, or psychiatrists, practitioners indicate that, relative to any single theoretical approach, they ascribe to an eclectic orientation. However, it is difficult to know whether these responses indicate an allegiance to a theoretical integration of two theories and the concomitant characteristic ingredients or to a rejection of the orthodoxy of theoretical approaches and the medical model. Jensen and Bergin (1990) asked respondents who indicated that they practiced eclecticism to indicate the combinations of theoretical approaches used in their practice; most therapists indicated that they used dynamic, cognitive, and behavioral approaches. In these surveys, the degree to which those who endorse a single theoretic approach adhere to the manualized version of these treatments is unknown, although most suspect that adherence to a manual is doubtful. However, therapists believe that the expertness of their therapeutic technique as opposed to more relationship-oriented constructs lead to successful outcomes (Eugster & Wampold, 1996; Feifel & Eells, 1963). Interpretation of these results is difficult because both the medical model and the contextual model recognize that therapists will have a theoretical rationale for client distress and will implement interventions that are consistent with that explanation. However, it is clear that practitioners do not share the orthodoxy of theoretical approach with advocates or developers of these approaches.
CONCLUSIONS

In this chapter, two competing meta-models were presented. The medical model proposes that the ingredients characteristic of a theoretical approach are the important sources of psychotherapeutic effects. Developments in psychotherapy research (viz., manualization of treatments and empirically supported treatments) have assumed the medical model is true and have progressed accordingly. The contextual model, which emphasizes a holistic common factors approach, provides an alternative meta-theory for psychotherapy.

The purpose of this book is to examine the research evidence to determine whether it is consistent with one of the two meta-theoretic models. In the next chapter, a series of hypotheses that discriminates between the two models will be discussed. The following chapters examine each of the hypotheses.
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