Resolving the Common Factors Debate: Training and Practice Development after the Collapse of the Specific Factors Paradigm.

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

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

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

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

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

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

Accepting such a stance—that psychotherapeutic interventions are placebos/rituals—makes psychotherapy "unscientific," feels counter-intuitive, and reduces the status of the profession. As a result, there has been a strong push-back against endorsing the Dodo bird argument. The primary counter argument is simple: there are literally hundreds of studies that have found one technique superior to another, at least in certain circumstances. In addition, there are dozens of metanalytic dismembering studies—studies that attempt to determine statistically the factors responsible for the effectiveness of psychotherapy. These studies allocate a certain percentage of the variance of the effectiveness to, for example, client factors, therapist factors, and the specific factors connected to the inherent power of techniques. These estimates of the variance due to specific factors range from a low estimate of 5% (Groth-marnat, Roberts & Beutler, 2001)) to a more commonly cited number of 15% (Lambert & Ogles, 2004).

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

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

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

This stalemate has resulted in the field attempting to synthesize the two viewpoints with statements such as "common factors are very important—probably more important than specific factors—but we

still believe that it is valuable to study, master and employ powerful psychotherapeutic techniques." And, in spite of the common factors critiques, the field as a whole continues to embrace the concept that psychotherapeutic techniques have inherent power; a simple glance at the program of the annual American Psychological Association convention finds hundreds of workshops based on learning or applying psychotherapeutic techniques.

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

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

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

This lack of a therapist experience effect was both provocative and anti-common sense; virtually every therapist feels that their effectiveness has been enhanced by their experience. Not surprisingly, the finding resulted in a series of efforts attempting to repudiate the research. The best counterargument comes from a metanalysis done by Stein and Lambert (1995) who found: "It is concluded that a variety of outcome sources are associated with modest effect sizes favoring more trained therapists. In many outpatient settings, therapist with more training tend to suffer fewer therapy dropouts than less trained therapists (p. 182)." In a 2013 review article on experience effects, Hill and Knox summarize two other studies that provide some supporting evidence. One found small effect sizes for experience but no

effects for therapist age while another study found a small effect for therapist age but none for experience. Hill and Knox then sum up the more recent findings.

> Two recent analyses of very large numbers of therapists perhaps provide the most definitive evidence about therapist experience. Wampold and Brown (2005) found no effects for therapist experience level (years of practice) when they analyzed the outcomes of 6,146 clients seen by 581 therapists in a managed care setting (all therapists were postdegree). Similarly, Okiishi et al. (2006) found no effects of therapist experience level (pre-internship, internship, post internship) on the speed of client improvement in their study of more than 5,000 clients seen by 71 therapists at a university counseling center. (p. 797)

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

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

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

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

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

> The evidence shows individual therapists do not get better with time and experience (Wampold & Brown, 2005, Chow et al., 2015). Worse, instead of improving, effectiveness plateaus early, then steadily declines (Miller & Hubble, 2011). In the

> largest study of professional development to date, Goldberg and colleagues (2016b) documented a diminution in performance, not unlike a slow leak from an inflated balloon. Importantly, the deterioration was unrelated to several factors often advanced as moderating variables, including client severity, number of sessions, early termination, caseload size, or various therapist factors (e.g., age, gender, theoretical orientation). (p. 2)

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

The preponderance of the evidence in this review supports the finding that there is no solid support for the common-sense idea that more experienced therapists achieve better outcomes. The early metanalyses that found no relationship between experience and outcome were partly rebuked by Stein and Lambert's (1995) conclusion that there is a small positive effect size from experience and by a few small and inconsistent studies noting reduced dropout rates and better results from older therapists. But these limited positive findings were overwhelmed by more recent and better designed studies finding no effects. The paraprofessional studies completely refuted the value of experience and mildly reinforced the idea that therapists might get worse as their careers continue. Finally, the two studies comparing therapists with no experience against experienced professionals were convincing in their own right.

Common sense makes it hard to accept these results. Given that therapists are required to notice whether their clients are improving or not, it stands to reason that they would be able to deduce which interventions, in what interpersonal context, predict success. Even though some analysts have argued (Miller, Hubble & Duncan, 2007) that therapists sometimes miss important client cues and feedback about improvement, it impossible to believe that most therapists consistently fail to discern whether psychotherapy is generating a positive result in a specific case. They simply ought to be able to use this information to determine which therapeutic choices predict success.

Using this argument, it seems most likely that at least some therapists learn something from experience; hence, the very modest findings of Stein and Lambert. But the preponderance of other evidence suggests that the best summary of the effects of experience on outcome is offered by Wampold and Imel (2015b, p. 2): "Therapists do not get better with time or experience. That is, over the course of the professional careers, on average, it appears that therapists do not improve, if by improvement we mean 'achieve better outcomes'."

The question of an explanation for this provocative finding will be taken up later in this paper. Returning, now, to the central question of specific factors versus common factors, it is safe to state that

the absence of an experience effect eviscerates the argument that psychotherapeutic techniques have inherent power. There are two alternative explanations, neither of which is particularly supportive for the specific factors school. First, techniques have inherent power but that power is so small that it didn't show up on the hundreds of studies reviewed in the experience literature. Second, techniques have inherent power but there are confounding reasons—perhaps therapist burnout, for example—that have cancelled out the positive effects of knowing and practicing techniques. This last theory lacks credibility and the first theory is unhelpful. In sum, the experience finding needs to be refuted or the specific factors adherents need to renounce their current position.

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

The first training finding is the inability of doctoral-level therapists to achieve better outcomes than masters-level therapists. Doctoral-level psychotherapists receive approximately six years of training, supervision and clinical experience and masters-level practitioner receive approximately half that. To put this into perspective, this difference in training is roughly equal to comparing the expertise of a nurse practitioner or a physician's assistant to the boarded medical doctor who supervises them.

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

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

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

> Nevertheless, after reviewing research spanning a century, Watkins (2011) writes: "We do not seem any more able to say now (as opposed to 30-years ago) that psychotherapy supervision contributes to patient outcome" (p. 235). Using a large,

> five-year naturalistic dataset consisting of 6521 clients, seen by 175 therapists, who were supervised by 23 supervisors, Rousmaniere, Swift, Wagner, Whipple and Berzins (2016) confirmed and extended Watkins's conclusions Once more, supervision was found not to be a significant contributor to client outcome. (p. 2)

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

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

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

Putting all these studies together, we can conclude that training is reasonably effective at teaching techniques and skills and at reducing trainee anxiety. However, when we look at whether training directly effects outcomes, we get a different picture. Doctoral-level professionals—who get almost twice as much training—do not achieve better outcomes than masters-level professionals. The two studies on completely untrained counselors show that they achieve the same outcomes as trained professionals. And the hundreds of studies with paraprofessionals shows their almost complete lack of training fails to diminish their effectiveness with actual clients. Results like these have led different reviewers to bemoan the absence of evidence for the effectiveness of training on outcomes. For example, Malouff (2012) in his review of training in psychology graduate programs noted that, "There appears to be no evidence to suggest that coursework and research completion, which make up a great deal of required psychology training, have any value to future psychotherapy clients of the students" (p. 31). And his evaluation of training programs as a whole concluded, "Overall, research findings provide little support for the idea that typical professional training of psychologists leads to better outcomes for their psychotherapy clients" (p. 29).

Returning to our Dodo bird controversy: it is clear that the more highly trained professionals know and have practiced many more psychotherapeutic techniques than the lessor trained. The doctoral-level know more than the masters-level; the licensed, clinically trained professionals knew more than the paraprofessionals, and the college professors and the history graduate students from the last two studies knew no techniques at all. Specific factors advocates need to recognize that the absence of a training finding means that either techniques have clinically insignificant power or they have no power at all and are, instead, rituals driven by beliefs and expectancies.

Obviously, the mutual confirmation of the training and experience findings make each individual conclusion stronger and more convincing. Evidence-based treatment advocates were already pressed by the Dodo bird finding and the dismissal of the dismantling findings. Now, in order to support the concept of the inherent power of techniques, they need to dispute 50 years of research on training and experience; frankly, such disputation appears to be exceedingly difficult. In sum, the common factors adherents and the specific factors adherents had fought each other to a draw. The addition of the training and experience evidence shifts to the controversy firmly in the common factors direction.

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

This knowledge has been accumulated via a great deal of work; the field of psychotherapy rests on literally hundreds of thousands of books, articles, and experimental studies designed to contribute to our professional knowledge. Moreover, we have a myriad of trained, motivated, and competent professionals and academics who work unceasingly in the area. Unfortunately for this effort, the lack of experience and training effects suggest that initiation into this knowledge base fails to contribute to enhanced clinical outcomes.

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

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

graduate students need to accept that what they are learning in their training program is irrelevant in terms of enhancing outcomes.

In sum, taking the training and experience findings seriously requires us to not only renounce our belief in specific factors and the inherent power of techniques, it also requires us to question profoundly the utility of psychotherapy's privileged knowledge. How serious is this? Perhaps it might best be illustrated by an imaginary research study. Suppose that a researcher decided to test the twin hypotheses that come out of the research: 1) techniques have no inherent power and 2) knowledge of psychotherapy's privileged knowledge fails to enhance client outcomes. Both of these hypotheses could be tested in a single study. What if the researcher could demonstrate that new graduate students, upon arrival at their program, could achieve the same therapeutic outcomes as their professors?

Wild as that hypothesis might seem, the evidence cited in this article certainly predicts this outcome. If the untrained match the trained in terms of positive outcome, and psychotherapists don't improve as the result of experience, shouldn't the students do as well as the professors? Of course, the experiment would need to be done carefully. The students and the professors would need to be matched by age, office status, and title. The new graduate students might want to do two or three cases before the experiment to diminish their anxiety. A careful researcher might come up with several other extraneous factors that would have to be controlled.

Imagine how a series of well-conducted, credible studies might affect the psychotherapy field. Recall that Miller et al argued that the debate between common and specific factors was so immobile that nothing short of an alchemical miracle could resolve it. These imaginary studies would serve as that sort of miracle. It would be hard to ignore the arguments above if the graduate students actually equaled their professors…..

The second half of this article will focus on the corelates and implications of these analyses and findings. The next section proposes theories explaining why "techniques" are actually rituals and why our privileged knowledge fails to create better outcomes. The last section explores some of the implications of the research analyses for practice, experience and training.

Why Does Psychotherapy Work Differently than Medicine?

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

Imagine that two different cultures believe that spirit possession is the primary explanation for mental health problems. In the first culture, which represents standard assumptions about how psychotherapy works, there are real spirits and spirit possession actually does cause mental health symptoms. Exorcists, after much experimentation, have developed a number of effective techniques that tend to eliminate the spirits. Many other techniques have failed to remove the spirits. Study of the spirits has led to theories that predict additional techniques that might work. While most of these also fail, the ones that work tend to improve outcomes and there is a sense that the field is evolving. Trained exorcists best the untrained because they are using proven and inherently powerful techniques. In addition, more experienced exorcists best less experienced as they become more proficient with the techniques and master more of them.

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

The first culture represents the reality that is endorsed by most therapists and clients; the second reality is the one that is supported by the research results. Imagine you are a victim of spirit possession in the second culture. If your exorcist knows the "hidden truth"—that the spirits are constructs—he or she would have quite the edge over traditional exorcists. First, they would be more confident and optimistic; standard therapists would believe they are fighting an actual, powerful negative force but your exorcist knows they are only battling a misconstrual. Standard therapists would be putting all their energy into figuring out what kind of demon they are exorcising and which exorcism works best; your exorcist is simply paying attention to you and to what makes sense to you. This attention comes across as caring and accepting. Finally, your exorcist has a kind of quiet confidence based on understanding what is really going on; this confidence helps you trust them more and helps you respond better to whatever intervention is co-developed between the two of you.

This metaphor is relatively easy to understand using the twin paradigms of cultural anthropology and social constructionism. Anthropology has taught us that different cultures inhabit different realities; each culture has its own version of what is true and—even if those beliefs are social constructs—they seem completely real to the person who dwells in that culture. Social constructionism teaches us that if all around us endorse a certain view of reality, it is highly likely that this view will be endorsed by us as well. If everyone I know believes that my depression or panic attack is caused by malevolent spirits, I

will not only believe in the spirits but the symptoms of my panic attack or depressions will take on a characteristic form associated with the cultural beliefs.

If I am outside the culture looking in, I may call such beliefs superstitions. From inside the culture they are self-evident truths. Examine the following quote.

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

Lawson-Te is looking at western culture's view of psychopathology and critiquing it as not only inappropriate but oppressive. Clearly, he considers our view of mental health a social construct. He is angry because—as the nondominant culture—this viewpoint is being imposed on his people. If his culture were dominant, he would probably feel sorry for our simple, confused ideas about psychopathology and how to get better.

Of course, it's also possible to critique our psychological "truths" from the inside. One of our most famous psychotherapists, Irving Yalom, has this to say about western psychology.

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

Yalom is not a formal constructionist—although like all of us he is aware of the postmodern trends in western culture. When he wrote the passage, he did not have the benefit of the research analyses. Instead he relied on his many years of doing therapy, his innumerable explanations to clients, listening to their varied beliefs about what made them sick and better, and intimate knowledge of the psychotherapeutic literature and he simply said: "none of these really exist." They are only useful because they help people improve and this improvement is based on beliefs and expectations.

With this statement, Yalom is beginning to explain the research results. The concepts he calls "fictions" are the basis for western explanations about the etiology of mental health problems and they are also intimately connected to the psychotherapeutic techniques that allegedly "heal" these problems. In this quote, Yalom calls psychotherapy's privileged knowledge "fictitious" and claims that these fictions are only created for explanatory purposes. In our metaphor, as western cultural members, we see the concepts of spirits and exorcisms as equally fictitious. Yalom is simply agreeing with Lawson-Te that our psychotherapeutic knowledge is equally constructed.

Western psychology and the medical model adherents would certainly agree that other culture's views of mental health are socially constructed and, furthermore, would see their interventions as

superstitious rituals—rituals that only function because the patient believes in them. However, they might argue, because western psychology is based on science, it is not a construct. In this sense, they believe that Yalom is confused and Lawson-Te is confused; our paradigm is superior to other cultures and is solidly grounded in reality and supported by scientific research.

However, if that were true, the research results would not have come out as they have. If that were true, western psychological techniques would have inherent power and training in our privileged knowledge would have a positive effect on outcomes. Put another way: the research results demonstrate that western psychotherapy is as constructed as every other culture's view of mental health.

Examine this famous quote from noted constructionists, Berger and Luckmann (1966).

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

Western psychology assumes that man "has a nature" and that the scientific method will discover the mental health aspects of that nature and reveal principles that can be the basis of psychotherapeutic techniques. Berger and Luckmann are arguing that this nature is not discovered; rather, it is created. We "produce" our nature. From a mental health point of view, we produce our psychopathologies, our explanations for those pathologies, and our ways of healing those pathologies. Western psychology believes that it is operating in culture 1 where the spirits actually exist and they are actually removed by the exorcisms. In truth, we are producing both the spirits and the healings. Yalom is right when he tried to awaken us by calling them "fictions." It is not too much of a stretch to argue that the research results "prove"—or, at least, strongly support—the idea that psychotherapy is operating in a constructed reality not a scientific/material one.

This is the correct general explanation for why we can't develop techniques with inherent power and why our privileged knowledge fails to generate better outcomes: the essential quality of constructed reality is fluidity; as Burger and Luckmann argue, it is "socio-culturally variable." This fluidity appears to take on solid shapes and forms secondary to beliefs and expectations but these forms collapse back into fluidity or rapidly morph into other forms with every meaningful shift in thought and feeling.

Burger and Luckmann argue that human suffering is real; it is a component of every culture and a byproduct of every individual life. The form the suffering assumes, however, is constructed. Moreover, the degree to which the form is filled with dread and malevolent power can enhance and reify the suffering. Conversely, the degree the suffering can be understood as produced—as a fluid construction sustained by expectations and beliefs—facilitates healing and efficacy. The reason that therapeutic rituals can affect psychopathology is because the pathology is constructed. If, the pathology existed in the material world--for example, if we had a personality change secondary to a brain tumor--then it would require a technique with inherent power like surgery or radiation. Conversely, if the pathology exists in constructed reality—like a typical depression or anxiety disorder—rituals are not only sufficient

to address it, rituals are the preferred method when attempting to resolve constructed psychopathology.

In this sense, fluidity is associated with healing and reification is associated with pathology. Put another way, the medical model defines and solidifies psychopathology. By creating etiologies, diagnoses, associated prognoses and client characteristics, human suffering takes form and becomes daunting and dreadful. In this sense, the explanation for the research findings also points the way towards implications for practice. We can't develop privileged knowledge because we are operating in the fluid milieu of constructed reality. But the quotes from Yalom and Lawson-Te imply that we are engaged in an unceasing effort to reify this reality in hopes that this reification will allow us to master the milieu. This is an understandable effort given the assumption that psychotherapy operates in scientific or material reality. Unfortunately, the disappointing research results demonstrate the futility of this strategy.

The opposite strategy—enhance fluidity and reduce reification—is a more fruitful direction. Saying, "I sometimes get angry under stress or when I lack sleep" is far more benign that saying, "I am an angry person," and light years better than saying, "I have an *Intermittent Explosive Disorder*." Returning to our two-culture metaphor, it is useful in culture 1—with real spirits and inherently powerful exorcisms—to investigate the characteristics of the spirits and the exact steps of the interventions. Conversely, in culture 2, the awakened exorcist is disinterested in such investigations. Knowing that the spirits are constructed changes the exorcist's focus from the nature of the spirit to the expectations of the client; similarly, knowing that the exorcisms are rituals changes the exorcist's focus from the precise steps of the exorcism to the client's beliefs about the power of the exorcism and the credibility of its inherent explanation.

This focus issue is the best explanation for why therapists fail to learn from experience even when they are able to notice whether the interventions lead to client improvement. A standard therapist has many beliefs about the nature of a certain diagnosis including associated prognoses, etiologies, and client characteristics. These beliefs serve as filters or cognitive sets; they minimize openness to experiencing "what is" and point towards "what I expect." In addition, success and failure is seen in large part as picking the right technique and getting the right response to it. When something succeeds or fails—and I credit the outcome to the right or wrong technique—I lose the chance to notice what is actually going on. To learn from experience, it is vital to deconstruct our inappropriate attachments to techniques and privileged knowledge. Success is actually all about client beliefs and expectations. Therapists believe it is all about picking the right diagnosis, jamming the client's actual experience into that category, and then using the "right" technique. These inappropriate strategies block the ability to learn from experience.

The failure of privileged knowledge to facilitate outcomes is a bit more complicated. To begin to analyze that failure, examine the concept: "regular, restful sleep is conducive to positive mental health outcomes." Certainly, this principle appears to be part of psychotherapy's privileged knowledge and virtually no one can doubt its truth and usefulness. Here's the problem: the word, "privileged," means that it is special knowledge owned by the profession of psychotherapy. However, when trainees come

to graduate school, they already know this principle. Hence, while it is true and useful, it isn't privileged; rather, it's common knowledge. Our analysis of the training literature showed that privileged knowledge is unrelated to outcomes; it didn't demonstrate that common knowledge is unrelated to outcomes.

This argument can be used to analyze the remainder of psychotherapy's privileged knowledge; while we can't be certain exactly what percentage of our knowledge is actually common knowledge, the lack of a training effect suggests that the vast majority of our useful and effective knowledge and interventions fall into this category. Conversely, the part of our knowledge that isn't common—for example, diagnoses and complex ways to envision underlying pathology—is the part that holds no value in terms of enhancing outcomes. Put another way: the useful part of psychotherapy's knowledge is already familiar to new graduate students; the part we teach in graduate school is the part that fails to contribute to enhancing outcomes.

This differentiation between common knowledge and privileged knowledge also helps understand the "techniques have no inherent power" finding. Imagine Strupp's college professors trying to do therapy with normal neurotics. After they listen to the presenting problem, they probably came up with interventions that sounded something like this: "Your depression appears to occur because you're hard on yourself. I heard you say that you've been hard on yourself because you had a critical father. Tell me more about it." Or, conversely, "you're anxious at work because you are scared to ask your boss for a promotion. What's the worst thing that could happen if you ask for the new position?" These sorts of psychodynamic or cognitive interventions are endemic in the culture. Many people can have lunch with their sister and get some of the same interventions over a salad that they can get from a therapist. The difference, of course, is that the therapist has more status and, hence, her interventions are likely to be more effective than the ones suggested by the sister. In addition, it's probably true that the sister is likely to make simpler interventions. Since the untrained match the effectiveness of the trained, it seems likely that the greater elaborations available to the trained are overkill; the simpler interventions work just as well. Put another way, many therapeutic interventions used by psychotherapy's primary therapeutic systems have simple versions circulating in the culture. Once again, common knowledge contributes to outcomes when the greater complexity of privileged knowledge adds little or nothing.

In sum, the cross-cultural/social constructionist explanations reveal that psychotherapy operates in a fluid and amorphous constructed reality and not in the scientific/materialist reality required by techniques with inherent power and an effective privileged knowledge. Put another way, western psychotherapy is as constructed as shamanic healing ceremonies. In addition to this generalist critique, specific explanations for the lack of effects due to techniques and privileged knowledge rest on understanding the proliferation of psychotherapeutic concepts in the culture; it appears that new therapists arrive at graduate school with an extant ability to create standard therapeutic rituals and to form basic judgments about health versus psychopathology. Finally, the lack of an experience effect can be explained by inappropriate focus; the predisposition to understand progress in terms of techniques, diagnoses, prognoses, and etiological theories blocks the ability to grasp the essence of client beliefs and expectations.

Implications for Practice

Scott Miller has argued that there has been no progress in terms of psychotherapy outcomes for the past 30 years (Miller, Huble & Duncan, 2007); in spite of the efforts of hundreds of thousands of practitioners, researchers and theoreticians, the client improvement rate has remained stable—it has stalled out. The previous section showed why; when the focus is on developing new techniques and theories—which is essentially a fruitless endeavor—little progress is possible. Fortunately, the research results—and the constructionist explanations—offer a new way forward that has the potential to actually enhance outcomes.

We can use the two-culture metaphor as a kind of map to illustrate a way forward. First, it should be clear that the awakened exorcists have quite the edge over the standard exorcists. They know that the spirits aren't real and the exorcisms are rituals not techniques. They understand that the spirit possessions/exorcisms exist in constructed reality and have a concomitant sense of creativity and positive prognosis as a result. Conversely, the standard exorcists are limited by assumptions linked to beliefs about material reality. In addition, the awakened exorcists are much more client-centered than the standard exorcists; given that the spirits and the exorcisms are constructed, client factors are the sole foundation of every intervention. Finally, the persuasiveness of the exorcists also becomes more central. When techniques have inherent power, knowing them is central to success. When they are rituals—and have no innate power—the charisma and persuasiveness of the exorcist becomes a relatively more important factor.

The Dodo bird thesis argues that every school of therapy works and they all work equivalently. Taking this "everything works" thesis seriously and literally opens the doors to experiencing the innate fluidity of constructed reality. An imaginary training exercise can illustrate the possibilities.

Suppose a new therapist wanted to experience the research results discussed above in a visceral manner. One approach would be to select 10 prominent psychological systems and understand them well enough to provide an explanation and a healing intervention aligned with that system. Each system could be applied to 10 clients; after treating those ten clients, they could move on to the next system. For example, they might begin with a psychodynamic approach and then shift to a cognitive one. Next they could work with reality therapy—which forbids analyzing the past—and then switch to systems theory which, of course, emphasizes the individual in relation to others. They could move on to Rogerian client-centered therapy and then practice the eye movements central to Eye Movement Desensitization and Reprocessing. At some point, they would feel that they had experienced sufficient different approaches to draw some conclusions.

> I now know that clients will accept pretty much any explanation for their problems as long as I take the time to link the theories to their current worldview. I see that all these explanations are interchangeable. Put another way, the clients get better

> regardless of how I explain their problems and what I ask them to do. As long as they think the actions are therapeutic, pretty much anything suggested leads to healing.
>
> Putting together those two ideas, I guess you could say that I learned that people will change simply because I ask them to. They have to see me as a credible healer; they need to believe that I care about them and am invested in their wellbeing; but what I actually do really isn't important. More than half of the clients got better no matter what I did. Essentially, everything I do works.
>
> Finally, I wasn't successful with all my clients. Trying to figure out what was lacking with those clients is going to make me a more effective therapist. The three areas that seem most important are: 1) missing important elements in client fit, 2) working effectively with hierarchy issues (not always being the expert) and 3) not being sufficiently persuasive and credible/being intimidated by the client.

Transforming the theoretical insights of the research results and the constructionist explanations into visceral experience is the key to using the new insights to improve practice results. In attempting to understand and explain the experience of this training exercise, the imaginary therapist outlines the factors that are central to enhancing outcomes: client fit, sharing power, the fluidity of the therapeutic milieu, the authenticity of the experience, and the charisma of the therapist.

Client Fit: Standard therapists attempt to understand each client as a unique individual; however, this understanding is profoundly influenced by what psychotherapy's privileged knowledge assumes about the client. In addition, most therapists have favorite techniques; the assumptions implicit in each technique also change the therapist's ability to see the client as *sui generis*. Conversely, the constructionist psychotherapist has deconstructed both privileged knowledge and techniques; they understand that they are working with rituals, expectations and beliefs. Put another way, these therapists see the client more clearly, not simply because they are less distracted by privileged knowledge assumptions, but because the client's reality is the only significant factor in the room. We understand that when a blind person loses vision, the other senses accommodate by becoming more sensitive and powerful. Similarly, when the constructionist therapist has only the client factors to lean on, those factors become proportionally more central and important.

The imaginary training exercise above moves the therapist far beyond what is normally described as an eclectic approach. In the eclectic approach the therapist continues to believe in the inherent power of techniques; they simply have included techniques and explanations from more than one approach in their armamentarium. They continue to believe that they are working in material reality; they embrace a modernist worldview not a postmodern one. Our imaginary therapist, however, has practiced a sufficient number of approaches—sufficient to destroy their belief that each competing technique has inherent power. They have viscerally experienced that the only factor that matters is client fit; everything else is constructed.

It is generally recognized in psychotherapy that the therapeutic experience is co-created by the client and the therapist. Subtracting the therapist's claim to the expertise of privileged knowledge necessarily enhances the client's share of the co-creation. This does not imply that constructionist therapists are all

non-directive; showing up for the client includes understanding whether a directive or non-directive therapeutic relationship is more appropriate for them. But it does mean that everything about the client is given more weight in creating a therapeutic explanation and in the ensuing healing ritual. As the imaginary therapist opined above: one of the main reasons that an intervention fails is ignoring the centrality of client factors.

Fluidity: Social constructionists have long understood the psychotherapeutic possibilities available when doing therapy in constructed reality. Hoyt (1996) comments.

> The doors of therapeutic perception and possibility have been opened wide by the recognition that we are actively constructing our mental realities rather than simply uncovering or coping with an objective "truth." (p.1)

The research results have transformed a constructionist perspective from a philosophical idea to a leading—or perhaps *the leading*—explanation for how psychotherapy works. Hoyt's possibilities are dependent on the degree to which a therapist can see the psychotherapeutic milieu as fluid. This milieu includes all the psychotherapeutic components: the history of the client, the client's cognitive sets, the therapist's assumptions, the perceived level and nature of psychopathology. The primary task is to stand in Yalom's and Lawson-Te's sense that western psychotherapy is essentially constructed; therefore, there are many more choices and many more possibilities for healing.

Naturally, this is an ideal not a reality. Everyone is aware that there are many factors—physical disease, genetics, biochemical processes—that limit our ability and our clients' abilities to respond to psychotherapy. And given that most therapists and most clients are members of western culture; the socially endorsed realities of that culture also limit us. Finally, there are a plethora of client factors—e.g., finances, health, the influence of others—that restrict the power of fluidity. That said, the knowledge that the client's problems are constructed and that the solution is a ritual empowered by beliefs really does "open the doors of therapeutic possibilities."

Endorsing fluidity implies that the therapist has the kind of freedom enjoyed by our imaginary psychotherapist in the training program: the knowledge that clients will accept virtually every credible explanation and participate in virtually every credible healing ritual and be able to achieve a meaningful positive result. This has one simple but profound implication: *the explanation for the problem is relatively unlimited and should be structured for maximal client benefit.* Put another way, the standard or default explanation for a mental health condition has no innate credibility for the constructionist therapist; it is only chosen if it has some particular advantage over alternative explanations.

In the two-culture metaphor, the exorcists get to decide which spirit is possessing the client. The standard exorcist—resting on their "spirit expertise"--will pick the spirit that they believe corresponds to the client's symptoms. Conversely, the awakened exorcist will pick the least powerful, least malevolent spirit; obviously, exorcising the least powerful spirit is easier than removing a more powerful one. In terms of western psychotherapy, when psychopathology is a construct, the therapist has the opportunity to choose the explanatory syndrome that is the least daunting, the most useful, the easiest to resolve, and the most empowering.

Most clients arrive in therapy with an implicit or explicit explanation for their issue. Often they will share a specific diagnosis that has been previously assigned or make a statement like, "I have anxiety, so does my mother and my uncle. Really anxiety runs in my family." While it can sometimes be useful to accept these preexisting explanations, the constructionist therapist will typically replace them with something more benign, something easier to resolve. For example, if a new client informs a constructionist that they have borderline personality disorder, one reply might be, "I understand why your last therapist diagnosed you with BPD and I agree to a point. However, your history reveals that you have a particular type of BPD. It appears that only one part of your psyche—the part connected to romantic relationships—has BPD traits. And when you have this kind of partial diagnosis, the therapy tends to go more quickly and the outcomes are much better."

An explanation that is easier to resolve is clearly superior to one that has more implicit obstacles. But the constructionist therapist can go much further. For example, therapists at the Mental Research Institute (Watzlawick et al, 1974) argued that the client's problems are often and ironically sustained by their attempted solutions. The constructionist therapist can create an explanation that functions to provoke and startle clients in terms of their standard assumptions about their pathology. Such novel explanations not only disrupt embedded, dysfunctional patterns, they also create hope in the client in the sense of, "I've never thought about it like that before."

Moreover, explanations can easily be linked to the common, post Enlightenment idea that each person has an authentic path and the explanation and the resolution of the problem can be conceptualized as a possibility for realignment with that path. For example, imagine a client who reported experiencing OCD around any encounter with religious content (for example, if she saw a church or even if someone mentioned the word, "priest.") Following the encounter, she felt required to tap a numerical pattern on a wooden surface and think "holy thoughts" or some unnamed calamity could befall her family. During an earlier bout with OCD, she had worked with another therapist and gotten modest, positive results using a response prevention strategy. She had attempted to use that strategy with the religious stimuli but had been unable to make significant progress. She also reported that she had a relatively new boyfriend and was concerned that, although he was attractive overall, he seemed somewhat egotistical and self-centered. Finally, she mentioned that she felt that she was a "very spiritual person."

The therapist could suggest that she was clearly suffering from OCD again; however, this time it was a special form of OCD that included a meaningful message. She should know that across history and across different cultures spiritual seekers had attempted to think of God incessantly, believing that such focused thoughts would advance their spiritual development. Instead of thinking of this as normal OCD, and trying to extinguish the intrusive religious thoughts, perhaps she should try and understand them and then do something aligned with their underlying meaning.

After a bit of discussion, she said that she believed the underlying message was that she had been minimizing her spiritual work and her experience of new boyfriend, and his self-centeredness, had impelled her into the OCD pattern. She resolved to respond to the religious stimuli by replacing the tapping/counting response with either a prayer to relieve universal suffering or a prayer that she might be an instrument in terms of helping her new boyfriend realize the connected nature of the world. She

was told that she was "lucky" to have the spiritual thoughts. The intrusive nature of the religious thoughts almost immediately decreased. She continued her prayer strategies for over a month although she reported that she no longer felt the religious thoughts were troublesome or disturbing.

These two examples illustrate how much easier it is to achieve successful outcomes when explanations are liberated from the burdens of privileged knowledge and replaced with a freedom to choose something that inherently is easier to solve, or helps the client out of a cognitive rut, or moves them down their own authentic path. The "right" explanation doesn't come from training in privileged knowledge, it becomes a creative act dependent on client fit but simultaneously rooted in the freedom, originality and inspiration of the therapist. Psychotherapy is often envisioned as an art as much as a science; deconstructing extant limitations and embracing choice and autonomy in terms of explanations is a central aspect of that "art." It stands to reason that if every client's situation can be reframed as less pathological, or more meaningful, or easier to resolve, then better results can be expected.

The second part of the ritual, the healing action, arises from the explanation. In the OCD example above, given that the OCD symptom was explained as a message about the need for a more spiritual perspective, it was reasonable—to therapist and client—that the healing action involved a remediating spiritual behavior. The healing action in the borderline example wasn't specified but it would be easy to imagine that it might go something like:

> We can begin by you studying ideal ways of communicating and responding in an intimate relationship. At present, you aren't living up to those ideals. But there are a lot of ways of being in a loving relationship that work very well. After your study, pick the ways that seem best to you and then we'll give you homework in terms of practicing them in your relationship. When you can consistently—albeit, not perfectly—stay in those behaviors, you'll know that you've healed this part of your psyche.

Would such an intervention work? This is where it gets interesting…. Clearly, it would be much too mild an intervention if the client is perceived as a "real borderline." However, it can be argued that the embrace by client and therapist of the reframed, relatively benign explanation has already begun to transform the client. When the psychopathology is constructed, why can't "reality" change simply because of the therapist-client agreement? The co-creation of a new narrative has already and implicitly altered client reality.

Reframing psychopathology in a more workable and benign manner is just the beginning when it comes to the full potential of constructionism and psychotherapeutic change. Constructionists argue (Hoyt, 1996; Gergen, 2009; Burr, 2003) that the self is a construct, that psychopathology is a construct, that identity is a construct, and that the seeming stability of each person's individual reality is fundamentally based on a narrative authored and co-authored by self and others. Given this level of fluidity, it is not a stretch to argue that client "reality" has already been altered simply by co-creating a new frame for the pathology and the healing opportunity. Reframing is the pragmatic first step; infusing the new frame with the sense that it has already transformed reality is the underlying active mechanism.

That said, we are all aware that there are complementary forces that act to sustain client stability—forces within the client and forces in the client's relationships. In the case of our BPD example above, her husband, family members, and significant others expect her to "act like a borderline" and these beliefs sustain the negative identity and negative behaviors. Her history, and the implicit effects of her experiences and conditioning, have set her up to have strong psychological and biochemical reactions to certain key social stimuli and these associations exist outside of the therapeutic relationship. For example, her perception of certain social situations can trigger a release of epinephrine; this release means she will have a physiological experience of fear and activation that will act to make aggressive or fearful behaviors more likely. These stabilizing factors can be likened to a web or net with strands emanating from the client—strands that link identity to multiple factors in their life. This net can be conceptualized as the factors that sustain human identities and behaviors in all of us and they are certainly relevant to this client.

Of course, these stabilizing factors not only limit constructionist psychotherapy, they limit all psychotherapeutic attempts to help a client resolve their problems. Awareness of these factors falls under the category of client fit; when the constructionist therapist incorporates these limiting factors in the explanation and the healing action, then the full capacity to change reality by belief and expectation becomes unleashed.

The constructionist therapist is very aware of the fragile and brittle nature of the client's pathological identity; after all, it is based on, to quote Yalom, "fictions." Our imaginary therapist who has experienced the fully constructed nature of explanations and interventions also has an easy time accepting the fluidity of the therapeutic milieu and the responsive nature of identity and psychological reality. To those two, it makes sense to argue that simply presenting and accepting a more benign frame has already changed the client and the shared and co-created therapeutic reality. And, of course, the more that the therapist "believes in" the new frame, the more real it becomes.

Milton Erickson was renowned for resolving problems in ways that operated well outside of conventional wisdom. He once treated a woman with a psychotic delusional disorder (Haley, 1993) by telling her she could write her delusions down on paper and he would lock them in his office safe. He promised her that this guardianship would ensure that the delusions would no longer torture her. Ericson reported that he needed to lock up "fresh" delusions every six months or so. However, the intervention worked so well she was able to keep her job as a teacher and, several years later, to get married.

Certainly, this case might be criticized from a number of perspectives including whether he treated the core issue, whether medication might have also helped, and other factors. However, from the perspective of seeing the psyche as fluid and capable of a profound healing response to an intervention, this case is both remarkable and impressive. Ericson would certainly never have accomplished this unusual outcome if he couldn't imagine that the woman's psyche was capable of this kind of profound mastery. Even more importantly, it seems likely that the woman was only able to accomplish this level of control by leaning on Erickson's belief. This case is not simply an example of reframing; it exemplifies the way that the therapist's beliefs can actually alter the client's reality directly.

Allegiance and Authenticity Factors: "Allegiance" refers to the fact that outcomes are enhanced when the therapist believes that they are using a powerful and effective approach (Wampold & Imel, 2015a). A subfactor of allegiance is therapist authenticity; when the therapist feels that they are being honest, truthful and authentic, these feelings also contribute to outcomes (Anderson, Lunnen & Ogles, 2010). In material reality it is relatively easy to assess allegiance and authenticity; in constructed reality—where truth can be relative and fluid—achieving authenticity is more challenging.

The problem with constructionism, of course, is that the therapist is aware that the explanations are constructs; while all of them have the potential to work, none of them can be certified as "actually true." After accepting this principle, how can the therapist authentically support any explanation as the "right" one? That said, to match, or perhaps to supersede, a standard level of allegiance and authenticity is vital in terms of maximizing outcomes and practicing ethically.

The solution to this dilemma is contained in the previous section and its exploration of how to create explanations. Standard explanations are derived from psychotherapy's privileged knowledge. Constructionist explanations begin with client fit and then are filtered through pragmatic and existential questions such as, "Is this problem easier to solve?", "Does this explanation jolt the client out of an unproductive strategy?", and "Might this explanation be perceived as an opportunity to further one's personal evolution?" Melding client fit and these useful questions with client expectations and beliefs results in the development, and the co-development, of "best" explanations. They are not the best in terms of absolute truth; rather, they are the best client/therapist effort in terms of meeting both short-term goals—resolving the presenting problem—and long-term goals--personal growth and evolution. The therapist can authentically say, "To the limit of my ability, this is the best explanation for this issue."

From a larger perspective, the constructionist therapist is aware that the problem, the explanation, and the healing, prescriptive actions are all constructs. At that higher level, all explanations are untrue. However, at that level, the client problems—as constructs—are also unreal. The constructionist therapist can understand this level of reality—and use it as a wellspring for creativity, fluidity, and optimism—without being forced to concretize it in the therapeutic alliance. Gergen (2009) offers an analogy to explain the overlap of these two levels of consciousness: the "best explanation" described in the previous paragraph and the deconstructed reality where neither problems nor explanations truly exist.

Gergen asks us to imagine that these two levels of reality can be compared to a "flat earth" versus "global earth" navigation model. For short distances, assuming the earth is flat and connecting two points with a straight line works well; for long distances, curved lines and great circle routes are superior. The constructionist therapist can authentically live in a flat earth/straight line reality when that best suits the client and the situation. Conversely, when a global perspective is helpful, the therapist can switch into that model. Unless it serves the needs of the client, discussions about the differences between the models are irrelevant.

The constructionist is always aware that all explanations are co-created with the client. The needs of the client dictate whether a "best explanation" model of reality prevails or whether it needs to be replaced with a "fully constructionist" one. The therapist can endorse either model with full authenticity in that they both embody effective methods of navigation—effective methods of healing and moving forward.

Therapist Charisma: Scott Miller, as one of the leading proponents of the common factors school and a strong critic of the concept that techniques have inherent power, has summarized his recommendations for training in a pithy quote: "…far more important than what the therapist is doing is who the therapist is (Duncan, Miller, Wampold, & Hubble, 2010, Kindle Locations 385-386)." Wampold (2017, p. 56-7) extends this concept by listing a set of research-based, therapist factors that predict enhanced outcomes. These include persuasiveness, verbal fluency, interpersonal skills, alliance-bond capacity, hopefulness and emotional expressiveness. For purposes of this article, we are going to bind these qualities together under the concept of therapist "charisma."

Etymologically, charisma is associated with gift of grace or favor freely given. In the Christian tradition, it refers to one who is touched by spirit. In modern usage, it is connected to influence, magnetism, and persuasiveness. Unfortunately, it is also associated with rich, powerful and famous individuals and can be connected to manipulation and inappropriate use of personal power. Most challenging for therapists, however, is that it can be linked to paternalism and a destructive form of therapeutic hierarchy.

That is not the way the word is used in this article. First, it should be understood that cultivating charisma is not simply cultivating the authoritarian ability to order the reality of another. Yes, communicating a sense of personal power and wisdom is vital, but the idealized therapeutic relationship is equally characterized by compassion, caring, and the ability to listen—particularly the ability to discern the client's ultimate concern. Each therapist has their own way to cultivate charisma and it can be just as impactful on a client to feel that the therapist is especially humble, caring and connected as it is to feel that they are confident and know life's secrets.

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

While space precludes a full discussion of this important topic, a few key points can be offered. First, the "not-knowing" aspect of constructed reality requires a prioritization of client fit and eliminates the narcissistic sense that I have an obligation/right to impose my "validated" truth on the confused client. Second, this paper is about enhancing therapeutic outcomes; adopting a traditional medical model/expert stance will limit outcomes to the extant standard. Third, as Guilfoyle (2003) notes, power differentials are structurally present in all therapeutic relationships; he believes that it is more effective

to work with them consciously as opposed to believing that they can be eliminated by simplistic strategies such as framing insights as possible suggestions. In sum, understanding that psychotherapy operates in constructed reality does not guarantee that there will be no client exploitation, but it is far safer than the concept of "cultivating charisma" might be in modernist therapies.

Developing charisma is a low priority with standard therapists. In the modernist model, effectiveness and power lies in selecting and administering the right technique; the persuasiveness and charisma of the therapist is seen as helpful but far less central. In constructed reality, however, the importance of therapist charisma is amplified. Since techniques and privileged knowledge fail to enhance outcomes, we have only three significant variables: client fit, awareness of the fluidity of the psychotherapeutic milieu, and therapist charisma. Cultivating therapist charisma becomes essential.

The first step in this cultivation is to recognize that psychotherapy needs to join the ranks of other professions that already emphasize charisma. For example, in the area of military leadership, a general is seen as an inadequate leader unless he has had combat experience, especially combat experience where he was particularly heroic, resolute, or skilled. Similarly, certain types of religious leaders—primarily mystics--are expected to have personal spiritual experiences to support their underlying credibility, and test pilots have to demonstrate the "right stuff" to be fully respected by their peers.

In this sense, it is beneficial for constructionist psychotherapists to acquire some experiences outside the room that mark them as "special." Examples might include climbing Mount Everest, working at an orphanage in a third world country, or spending six months in a meditation retreat. While it is more common to cultivate personal charisma via an unusual experience such as these, charisma can also be enhanced in more common experiences such as raising children or caring for an aging parent. Clearly, a challenging and unusual external structure can be helpful, but what is essential is that the experience has the capacity to expand internal confidence and awareness.

Can this kind of charisma-enhancing experience be required? Of course not. However, when charisma is seen as central to enhancing outcomes, such experiences can be expected and desired. When therapists missing such experiences feel as deficient as a military leader lacking combat experience, then this factor begins to achieve appropriate recognition. And, in truth, it is difficult to maximize outcomes without the therapist investing in transformative experiences outside the room.

The second area for cultivating charisma is implicit in the imaginary exercise described above that focuses on practicing 10 different approaches. In that exercise, our therapist was equally skilled at every approach whether it was directive, nondirective, feeling-focused or employed altered states. In practice, this equivalence would not exist; virtually every therapist will be more comfortable and natural with some approaches and more hesitant and unsure with others. Examine this quote from Anderson, Lunnen and Ogles (2010).

> Contrary to the claims of critics of common factor models, therapists need to be able to deliver many different kinds of treatments. To ensure a good fit with the individual consumer of psychological services, therapists need to carefully monitor client

> acceptance of and agreement with the treatment and agreement about the tasks and goals of therapy (i.e., the alliance). Resistance to the treatment provided is viewed as a function of the type of treatment delivered or the manner in which it is delivered rather than the result of a "resistant" client; that is, it is the therapist's responsibility to address resistance to treatment, and it is not the fault of the client. (Kindle Locations 4120-4128)

In this quote, the authors recommend mastering many approaches to maximize client fit. Recall that this mastery is much less onerous than "full" mastery of any approach; the therapist needs to only learn enough to build meaningful rituals. That said, the degree to which each is comfortable/challenging will become apparent as therapists attempt to achieve competence in a variety of approaches. Charisma is cultivated when therapists identify the approaches which are relatively difficult and work to improve their performance in those areas.

This is very different than the eclecticism cultivated by a number of standard therapists. Eclectic therapists tend to sample from several approaches that naturally appeal to them; they are not trying to master the number and different types of approaches recommended by Anderson et al and they are not forcing themselves to learn challenging interventions. This "master what is challenging" is quite similar to the concept of deliberate practice championed by Scott Miller and his colleagues (Rousmaniere, Goodyear, Miller and Wampold, 2017; Miller, Hubbard, & Chow, 2017; Miller, Hubble, Chow, & Seidel, 2015). Essentially, deliberate practice requires identifying one's weak points and focusing practice on remediating them. It is contrasted with a standard practice model made famous by the book Outliers (Gladwell, 2008) where expertise is defined as accumulating 10,00 hours. Deliberate practice adherents point out that merely practicing, without a focus on weak points, can result in defaulting to what one already does well; this strategy leaves problem areas unaddressed and, hence, results in little or no improvement in outcomes over time. Conversely, the focus on weak points highlighted in deliberate practice results in meaningful and relatively rapid improvements.

In Miller's approach, weak points are identified by reviewing unsuccessful cases or by presenting challenging therapeutic vignettes; it stands to reason that our hardest and least successful cases will point towards our weak points. The constructionist variation on this strategy is to identify the ways of seeing reality that are the most challenging. It can be helpful to visualize each different psychological system as embodying a unique western worldview of mental health and healing; for example, cognitive therapists live in a reality where cognitions control emotions; humanistic/existential therapists live in a reality where emotions provide clues about the authentic path; and hypnotherapists live in a reality where discontinuous change is both possible and expected. Examine the following Robert Neimeyer (2003) quote.

> In this view, each system of psychotherapy embodies a distinctive set of epistemological commitments, ranging from core, often implicit, metatheoretical beliefs about the nature of reality and human beings' relationship to that reality, through formal theories of human functioning and clinical theories of the nature of human distress and disorder, to therapeutic strategies and techniques. (p. 126)

In this sense, the constructionist approach to deliberate practice identifies the worldviews that are most challenging for a given therapist. Remediate those challenges—those weak points--and the constructionist therapist is not only better prepared to fit the client, they have also become a kind of renaissance person; they are not only well-rounded, they become more expansive and, hence, more charismatic.

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

One perspective on this type of charisma is illustrated by the following quote from Milton Erickson.

> And he didn't think it was at all necessary to tell me that he had passed the law examination. Because my attitude towards patients is: You are going to accomplish your purpose, your goal. And I am very confident. I look confident. I act confident. I speak in a confident way, and my patient tends to believe me.
>
> And too many therapists say, "I hope I can help you," and express a doubt. I had no doubt when I told her to go into a trance. I had no doubts about her. (Erickson points to Carol.) I had no doubt about those two either. (Erickson points to two women on the couch.) I was utterly confident. A good therapist should be utterly confident. (Zeig, 1980, p.61)

Erickson's use of the concept, "confidence," implies that his clients can "lean on" his confidence in them to accomplish therapeutic tasks; moreover, he is recommending that all "good therapists" offer this level of support to their clients. Putting aside for the moment whether this kind of confidence can create dysfunctional therapeutic hierarchies, it is worth speculating on how Erickson arrived at these recommendations.

Erickson's "confidence thesis" arises naturally out of his work popularizing and exploring clinical hypnosis. The client's ability to achieve a trance state depends in large part on the therapist's ability to convey confidence that the client can enter hypnosis. In this sense, the therapist lives in a "reality"—that is projected to the client--where trance is not only possible, in many ways, it is inevitable. It is a small stretch from "confidently" helping clients into altered states to projecting assuredness that they can attain therapeutic goals.

Significantly, the altered state of hypnosis is characterized by the concept that "anything is possible." The fact that this assumption is only partially true does not distract from its implicit presence. Put another way, reality is fluid in hypnosis. Significant changes are possible simply by asking for them. Going even further, the suggestibility component of hypnosis allows certain clients—when working with a "confident" hypnotherapist—to alter their psyche significantly merely because being in an altered state grants permission for discontinuous change.

It is a small step from the sense of "anything is possible" in a hypnotic trance to "anything is possible" in the fluidity of constructed reality. The explicit belief in the fluidity of the psyche of the client unites the two. At that point a kind of self-reinforcing cycle becomes possible. The more the constructionist therapist feels the fluidity of constructed reality and the malleability of the psyche of the client, the more they can ask for and expect from the client. The more the client fulfills those expectations, the more the therapist believes that, indeed, change can be driven and fostered by beliefs and frames. More successes lead to more confidence—more therapist charisma. Greater charisma makes rapid and profound change more possible. Put another way, each successful case challenges the therapist to see reality as more fluid and change as more belief-driven. This helps the therapist be more daring--to ask more and expect more from the client.

A related but different perspective on this development of "utter confidence" comes from Berger and Luckmann's view of culture-driven reality. They point out that every culture constructs its unique reality; the credibility of that reality is sustained by the social agreement between cultural members. In this sense, being conscious or awake in any culture can be defined as the degree to which an individual becomes free from their own cultural programming. Put another way, cultivating discernment between what is material reality and what is constructed defines a kind of existential wisdom in all cultures. In mystical traditions (Shah, 2016; Huxley, 2009), this awareness is sometimes referred to as the hidden wisdom or the secret wisdom.

Making this more specific for psychotherapists: cultivating this type of existential wisdom begins with the recognition of the constructed nature of privileged knowledge. Utilizing it in practice—by developing frames and explanations outside of standard assumptions—furthers the development. Knowing that the therapeutic milieu of constructed reality is so fluid that it can be altered by expectancies and beliefs—and witnessing the utility of such knowledge—pushes the boundaries even more. Therapist charisma is cultivated first by discernment, then by creativity, and finally by productivity.

Finally, while this sense of consciousness and existential wisdom is vital to developing therapist charisma, an awareness of connection and compassion is just as central. The following Dalai Lama (2012) quote illustrates how wisdom and compassion appear to be discrete concepts but are actually two sides of the same coin.

> In the Buddhist tradition, there are two qualities seen as essential both to our own well-being and to being able to be of appropriate help to others. These are compassion and wisdom. They are said to be like the two wings of a bird or the two wheels of a cart, for

> the bird cannot fly and the cart cannot roll with only one. Compassion involves wishing to free someone else from suffering, recognizing that she or he wishes to be happy and to avoid distress and misery just as we do. Wisdom involves seeing things as they are, with clear, open eyes, appreciating the interdependence and constantly changing nature of people, things, and events. (p. iii)

The most frequently cited definition of common factors is "a relationship with a wise and caring therapist." The parallels in the Dalai Lama quote are not coincidental. This third method of cultivating charisma—immersing oneself in the feeling that reality is so fluid that any strongly held belief allows it to change—is a central charisma-facilitating practice. It is just as important to understand that immersing oneself fully in all of the principles of client fit—signaled by a readiness to share therapeutic creations with the client or defer to them—is just as central to charisma cultivation. As the Dalai Lama points out: they appear to be different but, in actuality, at the end of the experience, they are interdependent and inseparable.

Summary

Given the research results, there are no credible arguments supporting the concept of specific factors, or the inherent power of techniques, or the efficacy of psychotherapy's privileged knowledge. While most of the field will have a hard time accepting these points without actually conducting the proposed "graduate students versus professors" outcome study, it should be logically recognized that specific factors are a "dead man walking" sort of idea--only sustained by the difficulties and discomfort inherent in any meaningful paradigm shift.

This leaves us in a quandary; it seems foolish to tear down all that we have built without a sense of what might replace it. Is there a new way forward? Can a constructionist analysis address Scott Miller's challenge that there has been no real progress in psychotherapy outcomes for over 30 years? Can we actually develop a training curriculum that makes the trained more effective than the untrained and which lets us profit from experience?

The old joke about the speed of grizzly bears suggests a way forward.

> Two people were travelling through grizzly bear territory and noticed that the amount of scat on the trail indicated that they were likely to encounter a bear. One traveler sat down, removed his hiking boots, and put on running shoes. The other commented, "Grizzlies can run as fast as 30 miles an hour; those shoes aren't going to help you." The first traveler replied, "I'm not trying to out run the Grizzly; I'm just trying to be faster than you."

The entire section on practice is speculative; there's no research that supports the idea that the constructionist therapist is superior to the standard therapist. However, it is reasonable to argue that the constructionist therapist has an outcome-related edge over the standard therapist. First, and

perhaps most important, the constructionist therapist is clear that most psychopathology is constructed and that the resolution of these problems consists of rituals powered by beliefs and expectations. All the specific recommendations in this paper fall out of this basic insight.

Second, a constructionist therapist profoundly prioritizes client fit; when there is nothing else to lean on, client factors become relatively more central. Third, the understanding of the fluidity of constructed reality allows the constructionist therapist to propose or co-create explanations that are simpler, easier-to-resolve, and more meaningful. Moreover, the focus on beliefs and expectations create a more powerful therapeutic alliance; the optimism regarding personal growth of the constructionist therapist helps turn beliefs and theories into meaningful change.

Fourth, standard psychotherapy—with its focus on expertise, privileged knowledge, and evidence-based techniques--necessarily underemphasizes the personal qualities of the therapist. Conversely, directly cultivating charisma—an almost completely undeveloped area—should result in positive effects. Emulating the requirements of other professions like military leadership in terms of seeking transformative life experiences ought to lead to enhanced outcomes. In addition, developing charisma through deliberate practice and the cultivation of discernment and existential wisdom logically predict better results.

The research results have destroyed the extant psychotherapeutic paradigm. Fortunately this deconstruction has opened new avenues that have the potential to advance the field. Psychological papers are famous for recommending more research at the end of the article. And this paper follows that tradition in the recommendation for the professors/graduate students study. But even more important is the recommendation that our best thinkers take some time to speculate on the full implications of the research analyses. This paradigm shift has put the psychotherapy field back into a potentially creative space reminiscent of the times of our revered early thinkers like Freud, Jung and Adler. The doors are open wide; there is ample space for a spirited dialog about new directions.

References

Anderson T, Crowley ME, Himawan L, Holmberg JK, Uhlin BD. (2016). Therapist facilitative interpersonal skills and training status: A randomized clinical trial on alliance and outcome. *Psychotherapy Research*, 26(5): 511-29. doi: 10.1080/10503307.2015.1049671.

Anderson, T., Lunnen K. M. & Ogles, B. M. (2010). Putting models and techniques in context. In B. L. Duncan, S. D. Miller, B. E. Wampold & M.A Hubble's *The heart and soul of change* (Kindle

Locations 3795-4399). Retrieved from https://www.amazon.com/Heart-Soul-Change-Second-Delivering-ebook/dp/B004T9YTEG

Burr, V. (2003). *Social constructionism* (2nd edition). New York, NY: Routledge.

Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: a treatise in the sociology of knowledge*. New York, NY: Anchor Books.

Beutler, L. E., Malik, M., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S., & Wang, E. (2004). Therapist variables. In M. J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (pp. 227–306). Hoboken, NJ: Wiley.

Christensen, A., & Jacobson, N. S. (1994). Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapies. *Psychological Science, 5*(1), 8–14. https://doi.org/10.1111/j.1467-9280.1994.tb00606.x

Dalai Lama. (2012). Foreward. In C. K. Germer & R. D. Siegel (Eds) *Wisdom and compassion in psychotherapy: deepening mindfulness in clinical practice*. Retrieved from https://www.amazon.com/Wisdom-Compassion-Psychotherapy-Deepening-Mindfulness-ebook/dp/B007W4ED6O

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change*: *delivering what works in therapy* (2nd edition). Retrieved from https://www.amazon.com/Heart-Soul-Change-Second-Delivering-ebook/dp/B004T9YTEG

Durlak, J. A. (1979). Comparative effectiveness of paraprofessional and professional helpers. *Psychological Bulletin, 86*(1), 80–92. https://doi.org/10.1037/0033-2909.86.1.80

Gergen, K. J. (2009). *An invitation to social construction* (2nd edition). Los Angeles, CA: SAGE Publications Ltd.

Gladwell, Malcolm. (2008) *Outliers: The Story of Success*. New York :Little, Brown and Company.

Groth-marnat, G., Roberts, R. and Beutler, L.E. (2001), Client Characteristics and Psychotherapy: Perspectives, Support, Interactions, and Implications for Training. *Australian Psychologist*, 36: 115-121. https://doi.org/10.1080/00050060108259643

Guilfoyle, M. (2003). Dialogue and Power: A Critical Analysis of Power in Dialogical Therapy. *Family Process*, 42(3), 331–343. doi:10.1111/j.1545-5300.2003.00331.x

Haley, J. (1993). *Jay Haley on Milton H. Erickson*. New York, NY: Routledge.

Hill, C. E., & Knox, S. (2013). Training and supervision in psychotherapy. In *Bergin and Garfield's Handbook of psychotherapy and behavior change (6th ed*.). New York: John Wiley & Sons.

Hoyt, Michael F. (1994). *Constructive therapies 2*. New York: Guilford Press

Hubble, Mark; Duncan, Barry; Miller, Scott & Wampold Bruce. (2010) Introduction. In Wampold, Bruce E.; Duncan, Barry L.; Miller, Scott D. (Eds). *The Heart and Soul of Change, Second Edition: Delivering What Works in Therapy*. Retrieved from https://www.amazon.com/Heart-Soul-Change-Second-Delivering-ebook/dp/B004T9YTEG

Huxley, A. (2009). *The perennial philosophy*. New York, NY: HarperCollins.

Lambert, M., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change (5th ed*.). New York: John Wiley & Sons.

Lawson-Te, A. (1993). The socially constructed nature of psychology and the abnormalization of the Maori. *New Zealand Psychological Society Bulletin*, 76, 25-30.

Madigan, S. (2012). *Narrative therapy (theories of psychotherapy).* Retrieved from https://www.amazon.com/Narrative-Therapy-Theories-Psychotherapy-Stephen-ebook/dp/B006X3F4LS

Malouff, John. (2012) The need for empirically supported psychology training standards*, Psychotherapy in Austrailia*, 18:3, 28 – 32.

Miller, S., & Hubble, M. (2011). The road to mastery. *Psychotherapy networker*, 35 (3), 22.

Miller, Scott; Hubble, Mark & Chow, Daryl. (2017) Professional development: From oxymoron to reality. In Rousmaniere, Tony; Goodyear, Rodney K.; Miller, Scott D.& Wampold, Bruce E. (Eds). *The Cycle of Excellence: Using Deliberate Practice to Improve Supervision and Training*. Retrieved from http://www.amazon.com/

Miller, Scott, Hubble, Mark & Chow, Daryl. (2018). The question of expertise in psychotherapy. *Journal of Expertise,* 1(2), 1-9.

Miller, S. D., Hubble, M. A., Chow, D. L., & Seidel, J. A. (2013). The outcome of psychotherapy: Yesterday, today, and tomorrow. *Psychotherapy, 50*(1), 88–97. https://doi.org/10.1037/a0031097

Miller, S. D., Hubble, M. A., Chow, D., & Seidel, J. (2015). Beyond measures and monitoring: Realizing the potential of feedback-informed treatment. *Psychotherapy*, 52 (4), 449–457. Doi: 10.1037/pst0000031

Miller, S., Hubble, M., & Duncan, B. (2007). Supershrinks: what is the secret to their success? *Psychotherapy networker*, 31 (6), DOI:10.1037/e526322010-003

Neimeyer, R.A. (2003).Two paths diverge in a wood: Cognitive-constructivist contrasts and the future evolution of Adlerian psychotherapy. In R. E.Watts (Ed.), *Adlerian, cognitive, and constructivist therapies: An integrative diaglogue*. New York: Springer.

Nyman, S. J., Nafziger, M. A., & Smith, T. B. (2010). Client outcomes across counselor training level within a multitiered supervision model. *Journal of Counseling & Development, 88*(2), 204–209. https://doi.org/10.1002/j.1556-6678.2010.tb00010.x

Rousmaniere, Tony; Goodyear, Rodney K.; Miller, Scott D.& Wampold, Bruce E.. (2018) Introduction. In Rousmaniere, Tony; Goodyear, Rodney K.; Miller, Scott D.& Wampold, Bruce E. (Eds). *The Cycle of Excellence: Using Deliberate Practice to Improve Supervision and Training*. Kindle Edition. Retrieved from http://www.amazon.com/

Shah, I. (2016). *The dermis probe*. United Kingdom: ISF Publishing.

Stein, D. M., & Lambert, M. J. (1995). Graduate training in psychotherapy: Are therapy outcomes enhanced? *Journal of Consulting and Clinical Psychology, 63*(2), 182–196. https://doi.org/10.1037/0022-006X.63.2.182

Strupp, H. H., & Hadley, S. W. (1979). Specific vs nonspecific factors in psychotherapy. A controlled study of outcome. *Archives of General Psychiatry*, 36 (10), 1125–1136. doi:10.1001/archpsyc.1979.01780100095009

Wampold, Bruce. (2010). The research evidence for the contextual model models: A historically situated perspective. In Wampold, Bruce E.; Duncan, Barry L.; Miller, Scott D. (Eds). *The Heart and Soul of Change, Second Edition: Delivering What Works in Therapy*. American Psychological Association. Retrieved from http://www.amazon.com/

Wampold, Bruce E.. (2017) What should we practice?: A contextual model for how psychotherapy works. In Rousmaniere, Tony; Goodyear, Rodney K.; Miller, Scott D.& Wampold, Bruce E. (Eds).

The Cycle of Excellence: Using Deliberate Practice to Improve Supervision and Training. Retrieved from http://www.amazon.com/

Wampold, B. E., & Imel, Z. E. (2015a). *The great psychotherapy debate: The evidence for what makes psychotherapy work (2nd edition).* New York: Routledge.

Wampold, B., & Imel, Z. (2015b). What do we know about psychotherapy?—and what is there left to debate? [Web Article]. Retrieved from http://www.societyforpsychotherapy.org/what-do-we-know-about-psychotherapy-and-what-is-there-left-to-debate

Watzlawick, P., Weakland, J. H., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. New York: W. W. Norton.

Weisz, J. R., Weiss, B., Han, S. S., Granger, D. A., & Morton, T. (1995). Effects of Psychotherapy With Children and Adolescents Revisited:: A Meta-Analysis of Treatment Outcome Studies. *Psychological bulletin*, *117*(3), 450-468. https://doi.org/10.1037/0033-2909.117.3.450

Yalom, I. D., & Leszcz, M. (2008). *The Theory and Practice of Group Psychotherapy (5th edition).* New York: Basic Book

Zeig, J. K. (Ed.) (1980). *A teaching seminar with Milton H. Erickson*. New York, NY: Brunner / Mazel.