
Syllabus
PSY-R8314 – Intervention: The Practice of Psychotherapy
Clinical Psychology Year-in-Residence

Residency Description
PSY-R8314 - Intervention: The Practice of Psychotherapy (non-credit). This face-to-face residency course synthesizes the learner’s intervention and assessment skills that provide the foundation for the practice of psychotherapy. Learners practice gathering information and assessing client’s needs for treatment. Additionally, learners begin practicing the implementation of treatment using various theoretical approaches and common treatment modalities such as individual, couples, family, and group in preparation for the practicum experience.

This residency is associated with PSY8316, Evidence-Based Practice in Psychology.

The following courses prepare students for this residency:

PSY8220 Advanced Psychopathology
PSY8310 Theories of Psychotherapy
PSY8316 Evidence-Based Practice in Psychology
PSY-R8302 Intervention: Building Effective Relationships
PSY-R8305 Intervention: Diagnostic Interviewing
PSY-R8306 Intervention: Case Formulation
PSY-R8307 Intervention: Treatment Planning
PSY-R8308 Intervention: Crisis Intervention and Risk Management
PSY-R8313 Measuring Treatment and Program Effectiveness

This residency helps prepare students for the following courses:

PSY839x Doctoral Practicum Series
PSY-R8315 Practicum Readiness Evaluation
PSY-R8316 Residency Capstone: Preparing for Practicum
Residency Objectives
By successfully completing this course, students will have demonstrated their ability to:

1. Gather information and engage mock clients in the treatment planning process with a focus on determining an appropriate therapeutic approach and modality (individual, couples, family, group). GOCs 4.1.2, 4.2.2, 4.2.3, 4.2.4
2. Apply appropriate theoretical approaches to the treatment of mock clients and discuss strengths and limitations of various theories when applied to different client situations. GOCs 4.3.1, 4.3.2
3. Apply individual, couples, family, and group treatment modalities with mock clients and discuss strengths and limitations of these modalities when applied to different clients. GOCs 4.3.1, 4.3.2
4. Engage mock clients in the treatment process while collaboratively developing clear, goal-oriented treatment plans. GOCs 4.1.1, 4.2.4, 4.3.3
5. Identify, integrate and display an understanding of diversity and individual difference issues in the practice of psychotherapy. GOCs 3.1.1, 3.3.1
6. Identify, integrate and display an understanding of ethical issues in the practice of psychotherapy. GOCs 2.1.1, 2.1.2
7. Discuss one’s own psychotherapeutic strengths and weaknesses, engage in the process of individual awareness, and use effective self-reflection and self-correction. GOCs 1.2.1, 1.3.2
8. Actively seek and provide objective, constructive, and supportive feedback with peers related to the psychotherapeutic process to enrich the learning experience. GOCs 1.2.2, 1.2.3
9. Apply professional competencies associated with successful training and practice of psychology. GOC 1.3.1, 1.3.2, 1.3.3, 1.3.4, 1.3.5

Course Materials
- Manual of Treatment Approaches (developed by cohort)
- SCID
  http://www.agpa.org/guidelines/AGPA%20Practice%20Guidelines%202007-PDF.pdf

Handouts and Reference Materials
- Case Presentations (Sample Outline)
- Elkins – Myth of EST’s
- Blow, Spreenkle, & Davis 2007
- AGPA Practice Guidelines 2007
- Client Satisfaction Questionnaire (CSQ-8)
- Assessment of Psychotherapy Factors

Course Requirements
1. Full attendance throughout the residency.
2. Participation in all learning activities.
3. Completed outcome documentation.

Personal Disclosure
To provide the best learning experience, the residencies encourage students to participate in experiential exercises and discussion topics that may include disclosure of information that is personal. Students are asked to use their best judgment to determine what is appropriate involvement and disclosure. Students are always welcome to decline to share. Also, to provide the most conducive learning environment, we request that you keep confidential all the personal material that is shared in the residencies.
Americans with Disabilities Act
Students with an ADA disability on file with Capella University should communicate with the Director of Residency Training and the faculty instructor prior to the beginning of this residency about any accommodations needed to allow the student to demonstrate competence in skills of this residency.

Course Schedule and Learning Activities

Monday

7:00am - 8:00am   Breakfast with cohort and faculty: Professional topics

8:00am – 10:00am  Welcome and Introductions
Instructor will introduce the course and discuss the course format and objectives. Instructor will lead a discussion of students’ strengths and weaknesses regarding psychotherapy approaches and modalities. An overview of the importance of positive relationships, effective communication, openness to criticism and self-reflection will be emphasized.
Handouts: Course Syllabus
Residency Objectives: 7, 8, 9

10:00am – 10:30am  Break

10:30am – 11:30pm  Medical Model vs. Contextual Model OR Finding a Happy Medium
Instructor will lead a discussion of the student’s knowledge and skills in both empirically supported treatments and the common factors in psychotherapy, including what each can offer psychotherapy and how each can be detrimental. Students will develop a model for ensuring that evidenced based practice encompasses both empirically supported treatments as well as the common factors found to be beneficial within the psychotherapeutic relationship in order to ensure an evidenced based practice.
Handouts: Elkins – Myth of ESTs
Residency Objectives: 2, 9

11:30pm - 1:00pm  Lunch with students and faculty: Networking and advising

1:00pm – 3:30pm    First Session – Engage, Gather, Plan
In groups of three, students will rotate playing the therapist, client, and observer with the goal of engaging the client and establishing a therapeutic relationship, gathering information and ultimately determining the client’s needs for treatment leading to a treatment plan (to include theory, techniques, and modalities). Students playing the mock clients will work with the instructor to develop client attributes that are conducive to various theories, techniques, and modalities.
Handouts: Case Presentations (Sample Outline)
Residency Objectives: 1, 9

3:30pm – 4:00pm   Break

4:00pm - 5:00pm   Special Topic Presentation: Building your Practice
The multiple issues you need to consider to design, implement, build and maintain an independent practice in psychology will be discussed. The issues faced by individuals seeking to develop psychotherapy, public speaking, psychological assessment and/or
consultation practices will be addressed. This session will cover issues involved in establishing practices for all age ranges, from children, adolescents, adults and geriatric populations, and specializations including family, school, forensic, neuropsychology and general psychological practice. Additionally, we will address issues of consultation relationships, psychotherapy, psychological assessment and the delivery of workshops.

**Residency Objectives:** 5, 6, 9

**Tuesday**

7:00am - 8:00am  Breakfast with cohort and faculty: Professional topics

8:00am – 10:00am  First Session – Treatment Planning
In the large group, students will briefly introduce the mock client they worked with, including demographics and problem identification, and will present a brief treatment plan that includes treatment goals, techniques to be used, and treatment modality (individual, couples, family, or group). The cohort will discuss the strengths and limitations of various theories, techniques, and treatment modalities when applied to the mock client with an emphasis on ethical issues as well as issues of diversity and individual differences.

**Residency Objectives:** 2, 3, 5, 6, 9

10:00am – 10:30am  Break

10:30am – 11:30pm  Second Session – Engaging the Client in the Treatment Planning Process
Students will return to the same small groups used in the previous exercise with their treatment plans in mind. The goals of this exercise are to continue building the therapeutic relationship, discuss symptoms and symptom etiology, and to engage mock clients in the treatment process while collaboratively developing clear, goal-oriented treatment plans. (Client Satisfaction Questionnaire (CSQ-8), Youth Client Satisfaction & Common Factors Assessment)

**Residency Objectives:** 4, 5, 6, 9

11:30pm – 1:00pm  Lunch with students and faculty: Networking and advising

1:00pm – 3:00pm  Individual Psychotherapy (Role-Play)
In small group format, students will return to their triads to begin initiating treatment with their clients. As closely as possible, students will utilize the treatment plans developed in the previous exercises to begin applying therapeutic technique in their work with their clients while continuing to focus on the common factors associated with therapeutic change.

**Residency Objectives:** 2, 9

3:30pm – 4:00pm  Break

4:00pm – 5:00pm  Special Topic Presentation: Don't Worry, Be Happy!  Evidence-based practice in a private practice setting.
Anxiety Disorders are prevalent in private practice settings and require the practitioner to have expertise in treating these disorders. Anxiety disorders may also co-occur with other disorders or present at sub-threshold but still interfere with everyday functioning. The goal of this presentation is to provide learners with information regarding assessment and treatment of anxiety disorders in a private practice setting.

**Residency Objectives:** 5, 6, 9
Wednesday

7:00am - 8:00am  Breakfast with cohort and faculty: Professional topics

8:00am – 9:00am  Discussion of Individual Psychotherapy
In the large group, instructor will lead a discussion of the previous exercise. Students will discuss their individual strengths and weaknesses and make a plan for practicing focused skill development throughout the remainder of the residency. Students will engage in the process of individual awareness, and use effective self-reflection and self-correction and will provide objective, constructive, and supportive feedback to peers.

Residency Objectives: 2, 7, 8, 9

9:00am – 10:00am  Introduction to Couples Psychotherapy
Instructor will lead a discussion of couples psychotherapy that introduces the modality, discusses similarities and differences with individual psychotherapy, and engages the students in a discussion of their individual strengths and weaknesses. Particular focus is placed on a continuation of the importance of building a therapeutic relationship with clients with an emphasis on the common factors associated with psychotherapeutic change.

Handouts: Blow, Sprenkle, & Davis 2007

Residency Objectives: 2, 3, 7, 9

10:00am – 10:30am  Break

10:30am – 11:30pm  Couples Psychotherapy (Role-Play and Discussion)
In the large group, students will rotate playing the therapist and clients (as a couple of some sort – life partners, siblings, parent/child, coworkers, business partners, etc.) with the goal of gathering information and establishing a therapeutic relationship. Focus for the therapist will be on engaging the couple and establishing a relationship with both clients. When appropriate, instructor will stop the role-play and ask students to provide objective, constructive, and supportive feedback to the therapist. Students should engage in self-reflection and self-correction as well in order to improve their skills in working with mock clients. (Case Vignettes)

Residency Objectives: 3, 9

11:30pm - 1:00pm  Lunch with students and faculty: Networking and advising

1:00pm - 5:00pm  Lab

Thursday

7:00am - 8:00am  Breakfast with cohort and faculty: Professional topics

8:00am – 9:00am  Discussion of Couples Psychotherapy
In the large group, instructor will lead a discussion of the previous exercise. Students will discuss their individual strengths and weaknesses and make a plan for practicing
focused skill development throughout the remainder of the residency. Students will engage in the process of individual awareness, and use effective self-reflection and self-correction and will provide objective, constructive, and supportive feedback to peers.

**Residency Objectives:** 7, 8, 9

### 9:00am – 10:00am

**Introduction to Family Therapy**
Instructor will lead a discussion of family psychotherapy that introduces the modality, discusses similarities and differences with individual and couples psychotherapy, and engages the students in a discussion of their individual strengths and weaknesses. Particular focus is placed on a continuation of the importance of building a therapeutic relationship with clients and an emphasis on the common factors associated with psychotherapeutic change.

**Handouts:** Seaburn, Landau-Stanton & Horwitz 1995

**Residency Objectives:** 2, 3, 7, 9

### 10:00am – 10:30am

**Break**

### 10:30am – 11:30pm

**Family Psychotherapy (Role-Play and Discussion)**
In the large group, students will rotate playing the therapist and clients (as a family or system of some sort – parents/children, grandparents/children, step family, coworkers, etc.) with the goal of gathering information and establishing a therapeutic relationship. Focus for the therapist will be on engaging the family or system and establishing a relationship with all clients. When appropriate, instructor will stop the role-play and ask students to provide objective, constructive, and supportive feedback to the therapist. Students should engage in self-reflection and self-correction as well in order to improve their skills in working with mock clients.

**Residency Objectives:** 3, 9

### 11:30pm - 1:00pm

**Lunch with students and faculty: Networking and advising**

### 1:00pm – 3:30pm

**Discussion of Family Psychotherapy**
In the large group, instructor will lead a discussion of the previous exercise. Students will discuss their individual strengths and weaknesses and make a plan for practicing focused skill development throughout the remainder of the residency. Students will engage in the process of individual awareness, and use effective self-reflection and self-correction and will provide objective, constructive, and supportive feedback to peers.

**Residency Objectives:** 7, 8, 9

### 3:00pm – 3:30pm

**Break**

### 3:30pm – 5:00pm

**Role-Plays – Instructor Choice**
Based on previous exercises and discussions, instructor will determine cohorts and individual student needs and organize this time to allow students to practice psychotherapy with mock clients, observe others, and discuss individual strengths and weaknesses. Emphasis should be placed on the therapeutic relationship, gaining comfort with various modalities, understanding the strengths and limitations of the various modalities, and on incorporating both ethical considerations and an understanding of diversity and individual differences.

**Residency Objectives:** 2, 3, 5, 6, 9
Friday

7:00am - 8:00am  Breakfast with cohort and faculty: Professional topics

8:00am – 9:00am  Discussion of Individual, Couples, and Family Psychotherapy Exercises
In the large group, instructor will lead a discussion of the exercises up to this point in the residency. Students will discuss their individual strengths and weaknesses with the various modalities and discuss their goals for training in these areas as they move to the practicum phase of the program. Students are encouraged to provide objective, constructive, and supportive feedback to peers.

**Residency Objectives:** 7, 8, 9

9:00am – 10:00am  Introduction to Group Therapy
In the large groups, instructor will lead a discussion of group psychotherapy that introduces the modality, discusses similarities and differences with individual, couples, and family psychotherapy, and engages the students in a discussion of their individual strengths and weaknesses. Particular focus is placed on a continuation of the importance of building a therapeutic relationship with clients and an emphasis on the common factors associated with psychotherapeutic change.

**Handouts:** AGPA Practice Guidelines 2007

**Residency Objectives:** 2, 3, 9

10:00am – 10:00am  Break

10:30am – 11:30pm  Group Psychotherapy (Role-Play and Discussion) – Part 1
In the large group, students will rotate playing co-therapists and clients (as a group of some sort) with the goal of gathering information and establishing a therapeutic relationship as well as group cohesion and collaboration. Focus for the co-therapists will be on engaging the group, establishing a relationship with all group members, and gaining comfort in working as co-therapists. When appropriate, instructor will stop the role-play and ask students to provide objective, constructive, and supportive feedback to the therapists. Students should engage in self-reflection and self-correction as well in order to improve their skills in working with mock clients and increase their knowledge and skill with ethical issues and diversity within the group setting.

**Residency Objectives:** 3, 5, 6, 7, 8, 9

11:30pm – 1:00pm  Lunch with students and faculty: Networking and advising

1:00pm – 3:00pm  Group Psychotherapy (Role-Play and Discussion) – Part 2
In the large group, students will rotate playing co-therapists and clients (as a group of some sort) with the goal of gathering information and establishing a therapeutic relationship as well as group cohesion and collaboration. Focus for the co-therapists will be on engaging the group, establishing a relationship with all group members, and gaining comfort in working as co-therapists. When appropriate, instructor will stop the role-play and ask students to provide objective, constructive, and supportive feedback to the therapists. Students should engage in self-reflection and self-correction as well in order to improve their skills in working with mock clients.

**Residency Objectives:** 3, 5, 6, 7, 8, 9

3:00pm – 3:30pm  Break

3:30pm – 5:00pm  Cohort Group Exercise: Self-Reflection, Course Discussion, and Course Completion
In the large group, instructor will lead a discussion of the theories, techniques, and modalities covered in this residency and students will share their reflections about their personal growth and development during the previous five days. Students will provide objective, constructive, and supportive feedback to both fellow students and the instructor. Instructor will provide group and individual feedback as appropriate. Students will complete end-of course evaluations and sign attendance logs.

*Residency Objectives: 7, 8, 9*
STUDENT SKILLS RATING FORMS

PSY-R8301
http://survey.capella.edu/se.ashx?s=0DC63DB36EF9ACA7
PSY-R8302
http://survey.capella.edu/se.ashx?s=0DC63DB36EF9AC52
PSY-R8303
http://survey.capella.edu/se.ashx?s=0DC63DB36EF9ACA3
PSY-R8304
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EMPIRICALLY SUPPORTED TREATMENTS: THE DECONSTRUCTION OF A MYTH

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Summary

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

Keywords: psychotherapy; treatment; empirical; evidence; contextual

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

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

So far, APA has refused to take such an extreme position. It is unsettling, however, that APA (2002) now specifically requires, as part of its official accreditation criteria, that psychology programs provide training in ESTs. Clearly, training programs seeking initial or renewed accreditation will view this as an endorsement of ESTs by APA, and most will do whatever is necessary to make sure their students receive such training. As this article will show, there is no scientific basis for this requirement, and APA has clearly gone beyond the evidence to burden programs with this questionable requirement. On the other side of the coin, in 2005, under the leadership of Ronald F. Levent as APA president, the APA Council of Representatives approved the policy statement of the APA Presidential Task Force on Evidence-Based Practice (2006), which
represented a more moderate position on the use of ESTs. (This is discussed later in this article.) Nevertheless, APA remains a “house divided”—especially at the division and at individual member levels—over the issue of EBP and the use of ESTs in psychotherapy.

POLITICS AND ELITIST ATTITUDES CLOUD THE SCIENTIFIC ISSUES

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

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

Empirically-validated treatments is a difficult topic for a practitioner to discuss with clinical scientists. In my attempts to discuss this informally, I have found that some clinical scientists immediately assume that I am anti-science, and others emit a guffaw, asking incredulously: “What, are you for empirically unsupported treatments?” McFall (1991, p. 76) reflects this perspective when he divides the world of clinical psychology into “scientific and pseudo-scientific clinical psychology,” and rhetorically asks “what is the
alternative [to scientific clinical psychology]? Unscientific clinical psychology." (See also Lilienfeld, Lohr, & Morier, 2001)

There are, thus, some ardent clinical scientists . . . who appear to subscribe to scientific faith, and believe that the superiority of scientific approach is so marked that other approaches should be excluded. Since this is a matter of faith rather than reason, arguments would seem to be pointless. . . . Punctuating these interactions from the practitioner perspective, the controversy seems to stem from the attempts of some clinical scientists to dominate the discourse on acceptable practice, and impose very narrow views of both science and practice. (p. 219)

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

**EMPIRICALLY SUPPORTED TREATMENTS: A BRIEF HISTORY**

In the late 1970s, psychology began to put “all of the eggs in the ‘technique basket’” (Bergin, 1997, p. 83). In the 1980s, managed care
companies and the health insurance industry in general put pressure on psychology to demonstrate that it could do both efficient and effective psychotherapy. In keeping with their medical model assumptions, the companies wanted psychology to identify specific treatments that were scientifically proven to be effective for specific disorders. In 1993, responding to the pressure and wanting to ensure that psychologists got a piece of the health insurance pie, Division 12 of APA, Society of Clinical Psychology, formed a task force to identify effective therapies and publicize these to psychologists, health insurance companies, and the public. The task force created a list of treatments that they referred to as “well-established” and “probably efficacious” (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 3). In time, the terminology was changed to “empirically validated treatments” and later to ESTs. The general term EBP is also widely used to designate therapeutic approaches that use ESTs. The Division 12 list of ESTs was dominated by short-term behavioral and cognitive-behavioral treatments. Traditional psychotherapies, which tend to be longer-term, more complex, and less technique focused, did not make the list. By creating and publishing their list of ESTs, the Division 12 task force joined with managed care and health insurance companies in taking psychotherapy down a road that many of us in humanistic psychology feared would be the end of psychotherapy as we had known it. When the task force made it clear that ESTs must be administered using manualized instructions, we were even more disturbed. Then, when the task force urged APA to make adherence to ESTs a major criterion for accreditation and even for approving continuing education sponsors, some of us were about ready to throw in the towel. Then, when it was rumored that clinicians who failed to use ESTs would be vulnerable to charges of professional incompetence and unethical practice and could be sued by clients for not meeting “standard of care” requirements, we became nauseous and fell into existential despair. Finally, when some proponents of ESTs, apparently getting into the spirit of things a bit too much, went so far as to say that APA should enforce the use of ESTs and sanction or expel those who refused to comply, many of us concluded the apocalypse was here and the end of the world was at hand. Those of us with weak ego strength and paranoid tendencies were haunted by visions of being lined up against clinic walls or in university commons and shot for having humanistic or existential inclinations. The more reality-oriented ones among us envisioned a managed care world where technician-like
therapists, manuals in hand, would administer ESTs to treat depression, panic, phobias, generalized anxiety disorder, and other emotional problems using the short-term formats demanded by managed care and enforced by its checklist-using clerks. A few humanistic clinicians, perhaps panicked about their economic futures, began offering workshops on short-term therapy, trying to show that we, too, could fit into the new managed care world. Others, believing in the basic scientific soundness of humanistic therapies, criticized traditional research methods and called, with little success, for the inclusion of qualitative approaches in determining what treatments would be deemed empirically supported.

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

The general outcry from researchers and clinicians, along with the actions of Division 32, Division 17, Division 29, and other APA divisions, had an effect. Indeed, those efforts may have saved psychotherapy, at least for the time being, from being redefined as a short-term, manualized, technique-dominated enterprise. To date, neither Division 12 nor APA has mandated the exclusive use
of ESTs, and, to my knowledge, no clinicians have been shot, sued, sanctioned, kicked out of APA, or charged with professional incompetence or unethical conduct for refusing to follow the official list of ESTs. In fact, as noted earlier, when clinician Levant was president of APA in 2005, he commissioned a task force on evidence-based practice in psychology (EBPP). The APA Presidential Task Force on Evidence-Based Practice (2006), as the committee was called, issued a policy statement on EBPP that was approved by the APA Council of Representatives. The report of the task force, which was published in the American Psychologist (APA Presidential Task Force on Evidence-Based Practice, 2006), makes it clear that EBPP is a broader concept than ESTs, giving psychologists greater leeway in using clinical expertise to determine which treatments are best for a particular client and how, considering all research evidence, to adapt treatments to individual situations. The task force defined EBPP as follows: “Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). This definition, which represents APA’s current position on EBP, is clearly a more moderate posture than the extreme position taken by the original task force of Division 12. Thus, a battle was won, at least in part, for those of us who believed in the effectiveness of traditional psychotherapies and who did not endorse the exclusive use of ESTs.

WHY TRADITIONAL PSYCHOTHERAPIES ARE IN DANGER

We must not, however, think the conflict is over. Although we may have won a battle, we are still in grave danger of losing the war. Many psychologists believe the Division 12 task force was right to advocate the use of ESTs. Many graduate training programs, internship sites, and mental health clinics endorse the use of ESTs. Managed care and the health insurance industry in general, along with governmental agencies and research centers, still believe that ESTs are the only way to go. Many professors and clinical supervisors in graduate training programs tell students that competent treatment can only be delivered by using ESTs. Perhaps most disturbing of all, as noted earlier, APA (2002), in Guidelines and Principles for Accreditation of Programs in
Professional Psychology, prescribed competencies in ESTs. The guidelines specifically mention that students should receive such training in programs (p. 9), practicum experiences (p. 10), and internships (p. 17). As Wampold (2001) said,

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

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

Meanwhile, those of us who are committed to traditional psychotherapies look for effective ways to respond to students and others who ask about the scientific bases of our approaches. As this article will show, some scholars among us are able to reframe the issue and provide very clear and convincing answers. Most of us, however, tend to respond in one or more of the following ways. First, because we, too, respect science, we sometimes say that our therapeutic approach, although perhaps not scientifically proven, is nevertheless supported by softer forms of “clinical evidence” and many years of “clinical experience.” Second, we may launch into a short lecture about the limitations of traditional research methods, implying that if qualitative methods were used, our approach undoubtedly would do well. Third, if we happen to practice from the person-centered approach, we may dust off some of the old research by Carl Rogers and his associates that showed
the scientific validity of his “necessary and sufficient” conditions of psychotherapy. (Of course, this does not do much for those of us who practice from existential, psychodynamic, and systems approaches.) Fourth, as a last resort, we may respond that our therapeutic approach is merely “untested,” implying that if we ever get around to testing it, it will surely prove to be just as scientific as those that are said to be empirically based.

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

DECONSTRUCTING ESTs: THE SCIENTIFIC EVIDENCE

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

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

The debate referred to in the title of Wampold’s (2001) book is the debate over why and how psychotherapy works. That therapy works is no longer a question in the research literature. As noted earlier, since the late 1970s and early 1980s, we have known that psychotherapy is highly effective. But why psychotherapy works and how it works are questions over which there is still much debate.
As Wampold pointed out, there are two sides to this debate. One side, the medical model, says that therapy works because of “specific ingredients” (i.e., specific techniques). Thus, for example, proponents of the medical model would say that CBT alleviates clinical depression because of the “specific ingredients” in CBT, meaning the techniques such as challenging negative thoughts that are hypothesized to be maintaining the depression. Thus, the medical model supports the search for specific psychotherapy techniques that will cure specific mental disorders, in much the same way that medical researchers search for specific medications that will cure specific physical illnesses. For obvious reasons, ESTs are the “superstars” of the medical model in psychotherapy.

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

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

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

From the various meta-analyses conducted over the years, the effect size related to absolute efficacy appears to fall within the range of .75 to .85. A reasonable and defensible point estimate for the efficacy of psychotherapy would be .80, a value used in this book. This effect would be classified as a large effect in the social
sciences, which means that the average client receiving therapy would be better off than 79% of untreated clients. . . . Simply stated, psychotherapy is remarkably efficacious. (pp. 70-71)

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

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

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

Third, no therapeutic techniques are any more effective than any other therapeutic techniques. This finding agrees with other studies (e.g., Gloaguen, Cottraux, Cuchert, & Blackburn, 1998; Lipsey & Wilson, 1993; Shadish, Navarro, Matt, & Phillips, 2000) that
show no significant differences in the effectiveness of techniques from various therapeutic approaches. To make sure his findings were correct on this point, Wampold took the additional step of analyzing the research that specifically focused on the efficacy of techniques. He found no evidence for “specificity,” meaning he found no evidence to support the view that specific techniques are responsible for therapeutic outcome. As Wampold (2001) put it,

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

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

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

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

In specific regard to this article and the debate about ESTs, Wampold’s findings mean that so-called “empirically supported” techniques are no more effective than the techniques of traditional psychotherapies. Going even further, Wampold’s findings show that techniques, in and of themselves, are not responsible for therapeutic outcome. These scientific findings are a devastating blow to ESTs, which are based on the medical model assumption that specific techniques are responsible for therapeutic healing. As Wampold (2001) said,
The evidence presented in this book has undermined the scientific basis of the medical model of psychotherapy, thus destroying the foundation on which ESTs are built. (p. 214)

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

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

**THE PLACE OF THEORY AND TECHNIQUES IN THE CONTEXTUAL MODEL**

One might conclude from what has been said that theories and techniques have nothing to do with therapeutic outcome. In one sense, this is true because Wampold’s research shows that theories and techniques, *in and of themselves*, have very little, if anything at all, to do with therapeutic benefits. On the other hand, although they have no inherent power to heal, theories and techniques do contribute to therapeutic outcome by providing a credible rationale and set of procedures that serve as a vehicle for the therapeutic work and by expressing, and serving as a conduit for, other factors in the therapeutic situation known to be responsible for outcome. In other words, in their role and function as contextual factors found in all therapeutic systems, theories and techniques do contribute to therapeutic outcome.
Thus, Wampold would support cognitive-behavioral therapists who explain to clients that their depression is due to negative thoughts and then proceed to show the client how to change those thoughts using the “specific ingredients” of CBT, meaning the specific techniques designed for thought modification. In the same way, Wampold would support psychoanalysts who tell their clients that their depression is due to unconscious conflicts and that through analytic techniques they can uncover those conflicts and alleviate their depression. However, unlike the clinicians using these approaches (probably), Wampold does not believe that the theories and techniques, in and of themselves, are responsible for alleviating the depression. Instead, he believes other factors in the therapeutic situation are responsible for the therapeutic benefits. Thus, paradoxically, one can say that theories and techniques have nothing to do with therapeutic benefits, and, in the same breath, one can also say that theories and techniques do contribute to therapeutic benefits. The key to this apparent conundrum is to understand that although theories and techniques are not effective in and of themselves, they are effective in the sense that they provide a credible rationale and set of procedures for the therapeutic work and they serve as expressions of, and conduits for, other factors in the therapeutic situation that are known to contribute to outcome, such as the alliance, the therapist, the relationship, and so forth.

FACTORS RESPONSIBLE FOR THERAPEUTIC BENEFITS

More than 70 years ago, Rosenzweig (1936) wrote an article titled “Some Implicit Common Factors in Diverse Methods of Psychotherapy: ‘At Last the Dodo Said, ‘Everyone has won and all must have prizes.’’” Rosenzweig was the first to suggest that all therapies are effective because of certain factors that are common to all therapeutic approaches. (The reference to the dodo is from Alice in Wonderland, where the dodo bird, after watching a race, decided that everyone had won, the point being that every therapy “wins” or is as effective as any other therapy. Since the publication of Rosenzweig’s article in 1936, the idea that therapeutic effectiveness is because of common factors has been referred to as the “dodo bird effect”).
In 1991, Frank and Frank published *Persuasion and Healing: A Comparative Study of Psychotherapy*. In the tradition of Rosenzweig, the authors took the position that therapeutic effectiveness is due to factors common to all therapeutic systems. Wampold (2001), who based his “contextual model” on Frank and Frank’s thesis and list of four major “common factors,” said,

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

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

How much influence do contextual factors have on therapeutic outcome? Perhaps the best known “pie chart” for contributions to outcome is that of Lambert (1992, p. 97), who partitioned the variability in improvement of psychotherapy clients into four parts. He attributed 40% to extratherapeutic change, 15% to expectancy (placebo effects), 15% to techniques, and 30% to common factors. However, as Wampold (2001) pointed out, these percentages are somewhat arbitrary. Lambert (1992) did not use meta-analytic techniques to arrive at the percentages and admitted that “no statistical procedures were used to derive the percentages” and that they appeared “somewhat more precise than
perhaps is warranted” (p. 98). Nevertheless, even using Lambert’s questionable percentages, if one combines his expectancy or placebo effects (15%) with his common factors (30%), this means that contextual factors (expectancy plus common factors) account for 45% of the variance versus only 15% for techniques. In other words, even in Lambert’s schema, contextual factors account for 3 times as much of the variance as do techniques!

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

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

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

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

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

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

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

Second, researchers and clinicians associated with humanistic psychology and other traditional psychotherapies should reduce efforts to prove that particular modalities and techniques are more efficacious than others and focus instead on understanding the factors that are actually responsible for therapeutic outcome. Much work needs to be done to understand contextual factors and exactly how they contribute to therapeutic effectiveness. Bohart and Tallman (1999; Tallman & Bohart, 1999) have provided an excellent example of what is needed. Their work has focused on the client as a “common factor” in therapy and as active agent in the healing process, a perspective that challenges the medical model view that
the client is the passive recipient of “treatments.” Rennie’s (1990, 1994, 1997) work also demonstrates how the client is active in therapy and exercises control of the therapeutic process. Once we throw off the shackles of medical model thinking and begin to focus on the factors that are actually responsible for therapeutic healing, we will radically “revision” psychotherapy. This is an exciting opportunity for researchers and clinicians who wish to make substantive contributions to our understanding of therapeutic healing.

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

Fourth, training programs in clinical and counseling psychology should include a strong focus on the contextual factors so that students do not spend an undue amount of time learning modalities and techniques to the neglect of cultivating skills, attitudes, and values associated with the factors actually responsible for therapeutic effectiveness. Unfortunately, most graduate training
programs focus generous amounts of time on modalities and techniques and relatively little time on helping students develop the qualities and skills associated with contextual factors. Based on the evidence presented in this article, programs that put all their eggs in the modality and technique basket are shortchanging their students’ education. Such programs, it could be said, are “majoring in minors and minoring in majors.” In regard to the focus of training, the research already provides considerable guidance. For example, Orlinsky et al. (1994) reviewed more than 2,000 studies and identified several therapist-related variables that consistently have been shown to contribute to therapeutic outcome. Based on this research, Lambert and Barley (2002) published the following list:

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

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

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

Similarly, Burns and Nolen-Hoeksema (1992) examined the role of empathy in the treatment of depression by cognitive-behavioral therapists. The findings were clear: “The patients of therapists who were the warmest and the most empathic improved significantly more than the patients of the therapists with the lowest empathy ratings” (p. 447). As a result of this finding and wanting to be as effective as possible, the CBT clinic began asking patients to complete a form after every session indicating the level of their therapist’s empathy.
The point is this: If one therapist-related variable such as empathy can have such a profound effect on therapeutic outcome, one can only wonder what the effect might be if training focused on an aggregate of therapist-related variables and other contextual factors known to contribute to therapeutic outcome. Clearly, if our goal is to turn out highly effective therapists, this is the area on which training should focus.

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

Sixth, when evaluating current graduate students on their clinical abilities, training programs in clinical and counseling psychology should avoid focusing on theoretical and technical knowledge to the exclusion of the personal and interpersonal qualities and abilities of the student. The evidence summarized in this article suggests that it would be more helpful (and scientifically more defensible) to emphasize personal and interpersonal qualities and skills related to contextual factors. For example,
evaluators should ask, Is this student able to establish an effective working alliance with clients? Does the student exhibit the personal and interpersonal qualities and skills that we know are associated with the ability to form healing relationships? Does the student extend warmth, empathy, and respect to clients? Is the student able to structure and use the therapeutic situation to promote client improvement? It might even be worthwhile to ask, Do the clients of this student tend to get better? This is not to suggest that client improvement or lack of improvement should be the main criterion by which students are judged. Certainly, the kinds of clients a student works with, the level of experience and training of the student, the fact that practicum rotations can interfere with therapy, and other factors outside the student’s control can affect therapeutic success. Nevertheless, if the clients of a student do indeed tend to get better, this suggests that the student may be doing something right (even if his or her theoretical and technical knowledge is not perfect), and this fact should receive appropriate consideration in the overall evaluation of the student.

CONCLUSION

Rollo May (1983) warned us about the American tendency to focus on techniques to the neglect of other, deeper dimensions of psychotherapy. As May knew, America is a frontier nation, and we want practical, simple solutions, even to complex problems. Above all, we want to “fix things.” It is no accident that behaviorism has thrived in America and that CBT and other short-term, technique-dominated approaches are popular with American clinicians. In time, I suspect we will view psychology’s current obsession with techniques and “quick fixes” as an historical expression of this cultural tendency gone wild in a time of economic fears brought on by managed care. In the meantime, we have a debate of historical proportions on our hands. I would urge humanistic psychologists and other proponents of traditional psychotherapies to embrace the scientific findings summarized in this article because they will help us to win the current debate. We should embrace these findings not only because they undermine so-called ESTs and EBP but also because they show that it is not modalities and techniques that heal the client but other factors in the therapeutic situation, most of which have to do with the deeply human experience of two persons reaching out to each other. One reaches out for help; the
other reaches out to give it. And although some of us may have to relinquish cherished beliefs that humanistic theories and techniques are more effective than other approaches, we should welcome the information that therapeutic healing, wherever it occurs, is largely due to such human factors as the strength of the alliance, the qualities of the therapist, and the nature of the therapeutic relationship. These findings are a powerful confirmation of what humanistic psychologists have maintained for years: It is not theories and techniques that heal the suffering client but the human dimensions of therapy and the “meetings” that occur between therapist and client as they work together. While writing this article, I often thought of Carl Rogers. His prescient insights always amaze me. If he were alive today, I suspect this “new” information about what heals in psychotherapy would cause him to smile. He was the first to discover, and raise to the level of theory, that what most clients need is simply a therapist in whom healer and human are seamlessly joined, one who knows how to create a healing context and a therapeutic relationship where empathy, respect, and genuineness are offered to the client, as one might extend one’s hand to a friend who has fallen.

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Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that “everyone has won and all must have prizes”? *Archives of General Psychiatry, 32*, 995-1008.


Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy: “At last the Dodo said, ‘Everyone has won and all must have prizes.’” American Journal of Orthopsychiatry, 6, 412-415.


Case Presentation
Sample Outline

I. Demographic Information
   a. First name
   b. Age, Sex, Race, Ethnicity
   c. Religion
   d. Family status / Significant relationships
   e. Educational status
   f. Employment status
   g. Family of Origin
   h. Living arrangement
   i. Financial status

II. Presenting Issue
   a. Method of referral
   b. Reason for referral

III. Mental Status Examination
   a. Appearance
   b. Behavior and mannerisms
   c. Attitude
   d. Mood and affect
   e. Speech
   f. Perceptual disturbances
   g. Thought
   h. Sensorium and cognition
   i. Impulse control
   j. Judgment and insight

IV. Historical Information
   a. Childhood / Developmental issues
   b. Social history
   c. Medical history
   d. Mental health history

V. Clinical Impressions
   a. Current symptoms
   b. Symptom history
   c. Severity of symptoms
   d. Strengths
   e. Weaknesses

VI. Supporting Information
   a. Assessment results
   b. Previous psychological reports

VII. Diagnostic Impressions
   a. Axis I
   b. Axis II
   c. Axis III
   d. Axis IV
   e. Axis V

VIII. Case Conceptualization
   a. Summary of case
   b. Origin of disorder(s)
   c. Progression of disorder(s)
   d. Theoretical conceptualization of disorder(s)

IX. Research and Theoretical Opinions
   a. Supporting research
   b. Theoretical opinions
   c. Case examples

X. Recommendations
   a. Treatment goals
   b. Treatment mode
   c. Treatment protocol
   d. Assessment recommendations
   e. Referrals
   f. Treatment conceptualization
   g. Outcome measures
Client Satisfaction Questionnaire (CSQ-8)

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinion, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWER

1. How would you rate the quality of service you received?

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<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
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</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>Good</td>
<td>Fair</td>
<td>Poor</td>
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2. Did you get the kind of service you wanted?

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</thead>
<tbody>
<tr>
<td>No, definitively not</td>
<td>No, not really</td>
<td>Yes, generally</td>
<td>Yes, definitively</td>
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3. To what extent has our program met your needs?

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<tr>
<th>4</th>
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<tbody>
<tr>
<td>Almost all of my needs have been met</td>
<td>Most of my needs have been met</td>
<td>Only a few of my needs have been met</td>
<td>None of my needs have been met</td>
</tr>
</tbody>
</table>

4. If a friend were in need of similar help, would you recommend our program to him or her?

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<tbody>
<tr>
<td>No, definitively not</td>
<td>No, not really</td>
<td>Yes, generally</td>
<td>Yes, definitively</td>
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5. How satisfied are you with the amount of help you have received?

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<tbody>
<tr>
<td>Quite dissatisfied</td>
<td>Indifferent or mildly dissatisfied</td>
<td>Mostly satisfied</td>
<td>Very satisfied</td>
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6. Have the services you received helped you to deal more effectively with your problems?

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7. In an overall, general sense, how satisfied are you with the service you have received?

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<tbody>
<tr>
<td>Very satisfied</td>
<td>Mostly satisfied</td>
<td>Indifferent or mildly dissatisfied</td>
<td>Quite dissatisfied</td>
</tr>
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</table>

8. If you were to seek help again, would you come back to our program?

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<tbody>
<tr>
<td>No, definitively not</td>
<td>No, not really</td>
<td>Yes, generally</td>
<td>Yes, definitively</td>
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</table>
IS WHO DELIVERS THE TREATMENT MORE IMPORTANT THAN THE TREATMENT ITSELF?
THE ROLE OF THE THERAPIST IN COMMON FACTORS

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Michigan State University

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Alliant International University—Sacramento Campus

In this article, we discuss the role of the therapist in change in couple and family therapy. We argue that the therapist is a key change ingredient in most successful therapy. We situate our discussion in the common factors debate and show how both broad and narrow common factor views involve the therapist as a central force. We review the research findings on the role of the therapist, highlight the strengths and weaknesses of this literature, and provide directions for future research. We then use this review as a foundation for our recommendations for theory integration, training, and practice.

It seems obvious that therapists differ in their effectiveness. Wampold (2001) notes that just as some lawyers achieve better results, some artists create more memorable sculptures, and some teachers facilitate greater student achievement, it makes sense that some therapists will achieve better results than others. For this reason, when most of us consider referring a close friend or relative to a therapist, we are more likely to consider the competence and expertise of the therapist more than his or her theoretical allegiance.

In spite of the significant role of therapists in therapeutic change, the research literature (reviewed below) points to significant gaps in our knowledge. We still know surprisingly little about the variables and characteristics that exemplify a skilled and effective marital and family therapist (MFT; Holmes, 2006), and we know even less about how these therapist variables interact with varying therapy approaches, clients, or presenting problems (Davis & Piercy, 2007a, 2007b).

We situate this article in the context of debates about change in MFT (Sexton & Ridley, 2004; Sexton, Ridley, & Kleiner, 2004; Sprenkle & Blow, 2004a, 2004b). As common factors researchers, we believe that MFT works largely because of common elements found in effective models of therapy and the process of therapy itself, rather than because of specific ingredients found in models. On the other side of the debate, Sexton and his colleagues criticize common factors and suggest that they are merely a static list of variables, that they derive their conclusions from meta-analyses of weak clinical studies, and that they are not able to inform the therapist about what to do and when in the process of therapy (Sexton & Ridley, 2004; Sexton et al., 2004). They instead argue that the unique change ingredients found in mature clinical...
models explain the bulk of change in therapy and that these models inform the thinking and
decision making of the therapist.

In a recent article, Simon (2006) proposed that the bridge between the common factors ver-
sus models dilemma takes place in the self of the therapist. This occurs, in his view, when a
therapist becomes aware of his or her worldview and adopts an effective model of change that
is congruent with this worldview. This congruency between worldviews (model and therapist)
allows the therapist to reach his or her potential in that therapy becomes a personalized vehicle
for self-expression. Furthermore, the model’s intended change qualities are maximized at the
same time because they are authentically practiced through the person of the therapist. Simon
concludes in his argument that this synergistic effect will lead, in theory, to the best possible
treatment for the client.

In an editorial discussing the common factors debate along with the argument of Simon
(2006), Ivan Eisler (2006) suggests that this debate regarding change in MFT is one of critical
importance for the future of research, theorizing, and training in the couple and family therapy
field. In reading his editorial, it becomes clear that there remains confusion about change in
therapy. Therefore, it is our intent in this article to expand and clarify our understanding of
the role of the therapist in common factors in relation to therapeutic change.

We agree in several areas with Simon’s premise about the therapist’s role in change. We
believe that a competent therapist is a central ingredient of effective therapy. We acknowledge
that it is usually important that a therapist is in tune with, enthusiastic about, and allegiant to
the model or part of a model that he or she is practicing at any point in therapy. We believe
that this enthusiasm for a treatment approach is typically crucial for the confident, authentic,
and precise delivery of therapeutic interventions. Eisler (2006) says it well when he states,
“Doing something we are wholeheartedly committed to must surely be more effective than
something we only half believe in . . .” (p. 330). We also agree that therapist awareness of his
or her worldview and relevant personal issues is an important component of therapist training,
development, and effectiveness (Timm & Blow, 1999). We further concur with Simon that it is
the human therapist-client encounter that provides the best explanation as to how treatment
works in most of psychotherapy and that it falls on the therapist to connect the dots in terms
of how change occurs within specific treatment models, with specific clients, and with specific
presenting problems (Blow & Distelberg, 2006).

In spite of this agreement, we have several concerns about Simon’s (2006) ideas. We believe
that Simon provides a somewhat constricted, one-sided view of the change process, especially
when one considers working with diverse families in complicated contexts. We side with Eisler
(2006), who believes that Simon’s view “leads to the same narrow vision that so much of
psychotherapy research suffers from—namely that it is just asking another what works question
rather than how it works questions” (Eisler, 2006, p. 331). Further, we believe that having the
therapist choose an effective model that closely matches his or her worldview is out of step with
current research on the role of the therapist, particularly research on the therapeutic alliance
that suggests the importance of the fit between the model and the clients’ worldviews (e.g.,
Johnson & Talitman, 1997).

In this article, we will expand our work on common factors by stressing the crucial role of
the therapist. In the broad sense of the term “common factors,” which includes all aspects of
the therapeutic context that contribute to change (see Hubble, Duncan, & Miller, 1999, and
Spenkle & Blow, 2004a, for these distinctions), we will argue that being a competent therapist
is itself a major common factor. In the more narrow sense of the term, where common factors
refers to the common mechanisms of change that are embedded in all effective models of ther-
apy, we will stress the therapist’s role in activating these change mechanisms. Just as many
common factors work through models, models in turn work through therapists. We will argue
that most key changes in therapy are either initiated by the therapist or influenced by the
therapist and that a therapist’s ability to identify and maximize these change opportunities largely determines the therapist’s—and hence the therapy’s—effectiveness. In this regard, we emphasize both what a therapist does in the therapy context to facilitate change along with how he or she goes about the process of intervening in therapy. We will also review research on the role of the therapist in MFT and outline the paradigm shift in therapist training and the role of theory in practice that we believe our stance justifies. We begin with a review of the literature on the role of the therapist in change. We follow this review with a discussion of the role of the therapist in effective models. The article concludes with implications of our stance for training and research.

THE DEARTH OF RESEARCH STUDIES ON THE THERAPIST IN MFT AND IN PSYCHOTHERAPY IN GENERAL

It is rather surprising, indeed shocking, that relatively little attention is paid to therapist variables as contributors to outcome. This is true in the field of psychotherapy research generally, as well as in MFT research specifically. A number of authors (Blatt, Sanislow, Zuroff, & Pilkonis; Lebow, 2006; Najavits & Strupp, 1994) have bemoaned that therapist variables are often neglected and poorly understood. Lebow (2006) summarizes these critiques:

Psychotherapy researchers typically focus exclusively on different clinical interventions while ignoring the psychotherapists who make use of them. It’s as if treatment methods were like pills, in no way affected by the person administering them. Too often researchers regard the skills, personality, and experience of the therapist as side issues, features to control to ensure that different treatment groups receive comparable interventions. (pp. 131–132)

Interestingly, Beutler et al. (2004), in the most recent edition of the *Handbook of Psychotherapy and Behavior Change*, indicate that there has probably been less attention given to therapist factors in the past two decades due to the emphasis on testing specific therapy models in randomized clinical trials. These authors note:

In efficacy research, the focus is on maximizing the power of treatments. Thus, efforts are made to control the influences of therapist factors by constructing treatment manuals that can be applied in the same way to all patients within a particular diagnostic group, regardless of any particular clinician. This research gives scant attention to any curative role that might be attributed to therapist factors that are independent of the treatment model and procedures. (p. 227)

We have argued in an earlier debate (Sprenkle & Blow, 2004a) that clinical trials are important for the field (especially for gaining credibility from external stakeholders), and we do not want to be misinterpreted as denigrating them. However, we challenge the extent to which they overfocus on treatment variables and make often-erroneous assumptions about therapist homogeneity.

*Why Research on Therapists Is Lacking*

In the first place, the attention to treatments at the cost of deemphasizing therapist effects reflects the “triumph” of the medical model among many prominent investigators. Many psychotherapy researchers subscribe (or at least acquiesce in order to get funding) to the belief that therapies “are analogous to medications that need to be assessed in tightly controlled research that establishes specific variants of therapy as safe and effective for the treatment of particular disorders; essentially drug research without the drugs” (Lebow, 2006, p. 31). A major implication of
the medical model is that the specific ingredients of the treatment are what are important in therapy, not who delivers the ingredients. If you have high cholesterol and take a statin drug, what is in the drug matters more than who prescribes or administers the drug. Wampold (2001) contrasts the medical model with what he calls the contextual view (Frank & Frank, 1991), which posits that who delivers the treatment in psychotherapy is actually far more potent than the specific ingredients of the treatment, and offers evidence (reviewed below) to support this position.

Second, the focus on treatments reflects where the money is found. Lebow (2006) states frankly in reference to medical model type research that “this kind of research makes up the preponderance of research on mental health treatment funded over the last 20 years by the National Institutes of Health” (p. 31). Beutler et al. (2004) are more caustic when they indicate that the current research emphasis may be driven more “by funding patterns and political agenda than by true promise for improving psychotherapy” (p. 291). In chasing the government-tal carrot, our consideration of variables influencing therapeutic change becomes increasingly narrow. Of course, not all psychotherapy researchers subscribe to the narrow view that care-fully controlled clinical trials focusing on treatments are the only or best way to inform clinical practice. Westen, Novotny, and Thompson-Brenner (2004) used the platform of the prestigious journal Psychology Bulletin to write a spirited critique of this approach that has become a rally-ing cry for those championing a broader view of research that informs practice. Nonetheless, the pressure to follow the funding seems to be dictating the research agenda.

In the third place, model developers and their students, who are understandably interested in proving that their models work, conduct the majority of efficacy research in MFT. These developers are under pressure to fund their research through contextual pressures (e.g., universities) or by demands to add credibility to their treatment approaches. Lest we sound judgmental, if we were model developers we would do the same thing! However, as we will note below, doing clinical trials does not preclude also giving attention to therapist variables, which we will argue should be an important part of clinical research agendas.

Fourth, manualized clinical trials aim to control for therapist effects. The intent is to achieve a point where all therapists in the trial operate at similar levels of competence so that therapist effects can be treated as sources of error rather than sources of variance, allowing change to be ascribed to the treatment model. Fidelity measures attempt to control for the spe-cific contributions of the therapist. However, there is strong evidence that there is considerable variability in therapist effectiveness even in highly controlled investigations. As Beutler et al. (2004) put it, “Unfortunately, standardizing the treatment has not eliminated the influence of the individual therapist on outcomes” (p. 245).

WHAT THE RESEARCH LITERATURE SAYS ABOUT THE IMPORTANCE OF THERAPIST IN CHANGE

Therapist Belief in a Treatment (Allegiance)

In Wampold’s (2001) thorough review of the research literature on change in psycho-therapy, he devotes an entire chapter to the issue of allegiance. Therapist belief in a treatment and in its abilities to effect change is an important quality of an effective therapist, and insuffi-cient therapist buy-in will likely jeopardize therapy outcomes (Davis & Piercy, 2007a, 2007b; Spreinke & Blow, 2004a; Wampold, 2001). This may help explain why, when model developers test their own models (the rule, not the exception, in MFT research), therapists in control conditions often get poorer results than therapists in the experimental (preferred) condition. The model developer and close colleagues typically implement the experimental treatment, have procured funding to test the model, and generate enthusiasm for the model being tested. This unwittingly leads to a halo-type effect for the approach in the experimental condition.

Allegiance is based on the idea that when a therapist has a positive attitude toward a treat-ment and its healing properties, he or she will practice the treatment with higher levels of
tenacity, enthusiasm, hopefulness, and skill (Wampold, 2001). Wampold concludes that allegiance to a model by a therapist is a strong determinant of outcome in clinical trials and is typically more important than the type of treatment used.

**Evidence for Therapist Variability**

While treatment fidelity is often addressed in MFT research investigations, to the best of our knowledge, there are no detailed reports regarding therapist variability in outcome in MFT specific studies. However, evidence from arguably the best and most comprehensive psychotherapy outcome study ever completed, the National Institute of Mental Health (NIMH) Collaborative Depression Study (Elkin et al., 1989), is quite compelling. The therapists in this large multisite trial were carefully trained in each of the manualized treatment conditions and were not allowed to participate until they reached high standards of adherence. They were also experienced and had an allegiance to the model they represented. In spite of these attempts to control therapist factors, the results showed major differences in therapist effectiveness, even though there were only minimal differences among treatment models!

Blatt, Sanislow, Zuroff, and Pilkonis (1996) divided the therapists in the study into those who were less effective, moderately effective, and more effective based on the composite outcome scores of the clients that each treated. Their results indicate that “significant differences exist in the therapeutic efficacy among therapists, even with the experienced and well-trained therapists in the [NIMH study]” (p. 1281). In addition, they indicated that these differences were independent of the treatment model, the setting, and even the experience level of the clinician. Perhaps even more telling, Blatt et al. (1996) indicated that the most favorable results in the study were achieved by a female psychiatrist who saw clients only in the drug clinical management and placebo (half of her completed cases) clinical management conditions, and not in one of the two active clinical treatment models (Cognitive-Behavioral Therapy or Interpersonal Therapy). They add:

> It is noteworthy that this therapist’s high level of therapeutic effectiveness was accomplished while seeing patients for a relatively brief time each week (approximately 25 min) as part of . . . a procedure designed as a minimal therapeutic condition to provide only therapeutic support and encouragement. (p. 1281)

These findings suggest that the history of the NIMH depression study may prove to say more about “empirically validated therapists” than about empirically validated therapies.

In his book *The Great Psychotherapy Debate*, Wampold (2001) devotes an entire chapter to the critical role of therapist effects in treatment. He presents convincing statistical evidence that when therapists are assumed to achieve similar results, when in fact their results vary, Type I error is significantly increased, and treatments may appear to be significantly different when they are not. Wampold (2001) writes: “Clearly, ignoring the variability of therapists, whether in a nested [different therapists do different treatments] or a crossed design [same therapists do all treatments] produces a liberal $F$-test and overestimates treatment effects” (p. 194).

Wampold’s (2001) and Blatt and Colleagues’ (1996) work confirms earlier work by Luborsky et al. (1986), who had reanalyzed the data from four major psychotherapy projects to determine the size of therapist effects. They concluded that the therapist effects exceeded the treatment effects. Crits-Christoph et al. (1991) reanalyzed data from 15 previously published studies and reported that for all outcome measures and treatments, the effect size for the therapists’ contribution to the variance was greater than the effect sizes for the difference among treatments they practiced. Therapists accounted for about 9% of the variance in outcome. While this may not sound large, it translated into an effect size of .60, whereas the effect size for difference among treatments average at most .20 (Wampold, 2001). Crits-Christoph et al. (1991) did report that better controlled studies that used treatment manuals and were published more recently had smaller therapist effects. However, other reanalyses completed since 1991
(Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Project MATCH Research Group, 1998) support the finding that even among experienced and well-trained therapists practicing manualized treatments, there is often considerable variability in outcome.

We think the fairest conclusion is that while not all studies show significant therapist variability, the preponderance of the evidence suggests that such variability is frequently alive and well, even when therapist fidelity is carefully monitored. Until there is good evidence to the contrary, we accept Wampold’s (2001) conservative estimate that therapists contribute at least 6–9% of the outcome variance in psychotherapy. The reader will note that if these numbers (reflecting the relationship between therapist competency and outcome) were expressed as correlation coefficients, they would range from .24 to .30. Of course, the variability in therapist competence in the general population of practitioners is likely much larger than the variability among therapists in research studies.

**Research on Specific Therapist Contributions**

Beutler et al. (2004) have published the definitive review on therapist effects. In this work, the authors limit themselves to studies for which there are data to generate effect sizes relating therapist characteristics to outcome. Frankly, not many therapist characteristics have been identified which make substantial contributions to outcome. Furthermore, results are typically inconsistent and most effect sizes are small. Additionally, after reviewing these studies we believe that most do not pay sufficient attention to mediating and moderating variables that may influence the relationship between therapist characteristics and outcome. This may help to explain the small effect sizes. So, although we know there is often considerable therapist variability (as measured by therapist performance in the NIMH Collaborative Depression Study), we do not have much solid evidence for why it exists.

Beutler et al. (2004) categorized the therapist variables into four categories: (a) observable traits (fixed characteristics that could be coded by an external coder and that describe the therapist independent of his or her role as a therapist) like gender, race, and age; (b) observable states (potentially changeable characteristics, specifically related to the role of therapist, that do not need to be inferred—that is, they could be potentially identified by procedures independent of the therapist) like therapist training and experience; (c) inferred traits (relatively stable characteristics that can only be inferred from information provided by the therapist but that transcend the therapist’s role as a therapist) like personality, well-being, and values; and (d) inferred states (relatively changeable therapist variables that can only be inferred by information from the therapist) like the therapist’s view of the therapeutic relationship.

**Observable traits.** It is relatively easy to do research on variables like the impact on outcome of therapist gender, age, and ethnicity as these data can easily be coded retrospectively. One meta-analysis, based on 58 studies (Bowman, Scogin, Floyd, & McKendree-Smith, 2001), found a significant small effect size favoring female therapists ($d = .04$). Beutler et al. (2004), however, report that the most recent studies find no relationship—including no relationship for the matching of therapist and client gender, nor for the impact of gender or gender matching on dropping out of therapy. In a somewhat old review of MFT research, Bischoff and Spenkle (1993) did find some modest evidence that matching gender of therapist and client diminishes premature termination.

The impact of therapists’ age is difficult to tease out as it is confounded with experience and other variables. Some older studies, including a large MFT investigation (Beck, 1988), suggested that if therapists are much younger than clients (10 years or more) outcome is impacted negatively. However, Beutler et al. (2004) conclude that there is “little contemporary research to suggest that age or the similarity of patient and therapist contributes significantly and meaningfully to treatment outcome” (p. 231).

There is almost no outcome research on the impact of therapists’ race/ethnicity alone, and not as much as one might expect on the matching of therapist and client given recent attention to
the importance of ethnicity in MFT and in psychotherapy. Beutler et al. (2004) report that in research since 1990 there are small effect size enhancements when Mexican American and Asian American therapists and clients are matched. While not a true outcome study, Gregory and Leslie (1996) found Black females (but not males) rated initial MFT sessions with White therapists more negatively than with Black therapists, but these differences vanished by the fourth session. An old but very large sample \( N = 3,956 \) MFT study (Beck & Jones, 1973) found that Black clients were significantly more likely to drop out if assigned to White counselors, whereas there was no impact when White clients were assigned to Black counselors. However, Beutler et al. (2004) conclude from recent research that what small effect sizes are found “cast doubt on the value of ethnic similarity as a predictor of treatment effects” (p. 234) even though in an earlier publication Beutler and his colleagues (Beutler, Machado, & Neufeldt, 1994) suggested that this variable was a promising area of investigation. Beutler et al. (2004) further note that perhaps therapist and client “cultural beliefs” or other unidentified variables may moderate the impact of racial/ethnic identity on outcome (see section on inferred traits for a discussion of therapist cultural attitudes).

In summary, studying the impact on outcome of static therapist observable trait variables has not borne as much fruit as we had hoped. Perhaps the good news is that competent, creative, and compassionate therapists can apparently often transcend whatever limits are potentially imposed by their age, gender, or skin color.

Observable states. In this section, we will briefly review therapist training and level of experience, and give some attention to therapist styles, like level of directiveness. For a much more comprehensive overview, see Beutler et al. (2004). Regarding disciplinary training, the findings of the large sample \( N = 4,100 \) Consumer Reports Study (1995) have received considerable attention. In this survey, clients reported improvement in the severity of their problems about equally when treated by psychologists and psychiatrists, somewhat better results from social workers, and somewhat worse outcomes from marriage and family counselors. What was unacknowledged is that many therapists practice marriage and family counseling with no special training, and that MFT therapists often have to reconcile incompatible agendas (e.g., one wants “in” the marriage while the other wants “out,” making it more likely that one partner will be dissatisfied). This is another example of the peril of ignoring potential mediating or moderating variables that may influence results.

Several studies suggest that overall, persons with specific mental health training do better than primary care providers, as do those with a psychological as opposed to a biomedical orientation (Blatt et al., 1996). Beutler (1997) has stressed that the impact of training cannot be accurately assessed without knowing the content of training. Rather than focusing on academic degrees, more attention must be paid to the amount of time studying specific concepts and practices.

Regarding the level of experience, several authors (Christensen & Jacobson, 1994; Tallman & Bohart, 1999) have reported the counterintuitive and somewhat depressing finding that the impact of added experience on outcome is weak at best. Stolk and Perlesz (1990) offered data that students in the second year of a strategic therapy MFT training program achieved results that were actually worse than first-year students. Other reviews (Stein & Lambert, 1995) are more sanguine about the benefits of experience. It appears that merely putting in time as a therapist does not automatically increase competence and certainly not all activities after graduate school should be considered equivalent—say working as an administrator versus extensive training and supervision on difficult cases. Beutler, Bongar, and Shurkin (1998) suggest that experience is likely more important when it comes to treating more difficult clients and complex and long-standing problems, whereas for easier cases the results between novice and expert therapists are not very different. Perhaps because not all these moderating variables have been teased out, with some notable exceptions (Blatt et al., 1996; Hupert et al., 2001), effect sizes relating experience to outcome remain relatively small.

Regarding therapeutic style, therapist positivity/friendliness is consistently associated with good outcome, and criticism/hostility has the opposite impact (Beutler et al., 2004). Another
consistent finding is the importance of therapists utilizing a sufficiently high level of activity/directiveness to prevent couples and families from simply replaying their dysfunctional patterns; and giving the session enough structure to encourage family members to face their behavioral, emotional, and cognitive issues (Bischoff & Sprenkle, 1993; Lebow, 2006). Waldron, Turner, Barton, Alexander, and Cline (1997) studied therapist defensiveness and its relationship to the process and outcome of marital therapy. They concluded that therapist defensiveness early on in therapy led to poorer outcomes for both husbands and wives.

Most aspects of therapist style are highly dependent on therapists adapting to client preferences, expectations, and characteristics. Beutler, Consoli, and Lane (2005), for example, offer strong evidence that therapists should decrease their directiveness when client resistance is high and vice versa. They also provide evidence that therapists should adjust their style to keep the client’s level of emotional arousal moderate (neither too high nor too low) as moderate arousal facilitates change.

**Inferred traits.** These include therapist characteristics such as personality, coping patterns, emotional well-being, values and beliefs, and cultural attitudes (Beutler et al., 2004). Some research suggests that a fit between the personality style of the therapist and the client may lead to improved outcomes (Herman, 1998) while other research suggests the exact opposite (Berry & Sipps, 1991). Clearly further research is needed in this area, especially in MFT where therapists work with multiple family members with widely varying personality styles. Possibly this ability to juggle varying personalities at one time is what distinguishes couple and family therapists from those who are more comfortable in working with individuals alone.

In terms of the relationship between therapist emotional well-being and outcomes, Beutler et al. (2004) conclude that there is evidence showing a positive relationship between therapist well-being and client benefit. They also note that high levels of therapist emotional well-being should not be assumed (especially of therapists in research studies) and that therapists who receive their own personal therapy do not necessarily have better outcomes. We could find no studies that looked at therapist well-being from an MFT standpoint. We believe that this kind of research might provide important clues, especially in terms of how, for example, a therapist’s “dead marriage” might negatively influence his or her work with couples or how a therapist’s own struggles with his or her rebellious adolescent child might hurt or even help the work with adolescents in other families.

Values, attitudes, and beliefs are an important aspect of a therapist’s practice and MFTs, in particular, are faced with a multitude of value-related issues. For example, clients present with a wide array of issues that may tap deeply into a therapist’s most personal value systems—e.g., infidelity, drug use, and poor parenting—and yet we were unable to find any MFT specific studies that focused on therapists that shed any light on the role of values in outcomes. We note that even the issue of deciding beneficial outcomes can be value laden in that for some, divorce might be a bad outcome, and within a couple, one party may be satisfied after divorce while the other may feel extremely bitter. In referencing individual psychotherapy, Beutler et al. (2004) state, “Indeed, little progress has been made in determining what values are important to the practice of psychotherapy or how values should be integrated into psychotherapeutic practice” (p. 227). We believe that this is another area worthy of intensive study in MFT.

We were most hopeful about studies focused on therapists and cultural attitudes. It seems clear that therapists who are knowledgeable about and highly sensitive to the unique cultural worlds of their clients (i.e., are culturally competent) do a far better job of engaging and retaining clients in therapy and as a result achieve better outcomes. In studies of specific family therapy interventions with diverse populations, effective therapists are able to adapt and change when unique cultural mores and conditions suggest that treatment needs to be different. For example, in a summary of family therapy studies done in Miami by José Szapocznik and colleagues, Muir, Schwartz, and Szapocznik (2004) discuss working with poor African
American and Hispanic families in this city. These researchers emphasize the need for high levels of respect for minority cultures and believe that successes in engaging these families in treatment (an impressive 80% engagement rate) are largely due to specific interventions that are in step with the unique cultural values and beliefs of these communities. They refer to these as culturally syntonic (in tune)—interventions that fit well with the clients and communities in which the therapists work. In another example in a recently published study, Breuk et al. (2006) discuss the challenges of implementing Functional Family Therapy in the Netherlands. These authors discuss the important role of cultural sensitivity on the part of the therapist to ensure the effective implementation of this model in an international setting. Key to this is the ability of the therapist to match the treatment to the unique client system. In short, therapists who learn about and are sensitive to the unique cultures in which they work, and who match their interventions to these contexts, are more successful in engaging families in treatment and effecting change.

Similarly, in a recent Delphi study focused on working with lesbian, gay, and bisexual clients, Godfrey, Haddock, Fisher, and Lund (2006) concluded that the consensus of a panel of therapists and educators was that therapists need to possess certain values, qualities, and sensitivities, particularly related to being open minded and having an awareness of their comfort levels, values, biases, and prejudices about sex, gender, and sexual orientation. These therapists are also seen to need knowledge of societal ideologies related to this population as well as awareness of theories of sexual orientation formation. These authors also advocate for specific therapist preparations in working with this population as well as intensive self of the therapist work. While these therapist characteristics were not linked to outcomes in actual clients, it seems clear that when working with diverse populations, therapists need to be prepared through education about a specific group and sensitivity to unique issues within a group, and have an awareness of and control over their own personal biases and issues.

Inferred states. In this section, we will focus on the role of the therapist in the therapeutic relationship. The relationship was valued back in 1978 when Gurman and Kniskern (1978) stated that:

The ability of the therapist to establish a positive relationship with his or her clients, long a central issue of individual therapy, receives the most consistent support as an important outcome-related therapist factor in marital-family therapy. Therapist empathy, warmth, and genuineness, “the client-centered triad,” appear to be very important in keeping families in treatment beyond the first interview … Apparently it is important for the marital-family therapist to be active and to provide some structure to early interviews, but not to assault family defenses too quickly … [A] reasonable mastery of technical skills may be sufficient to prevent worsening or maintain pretreatment functioning, but more refined therapist relationship skills seem necessary to yield truly positive outcomes in marital-family therapy. (p. 875; italics in original)

We believe that it is in the therapeutic relationship that therapists either make or break therapy. Studies of the therapeutic relationship have shown consistently that the strength of the relationship (in the view of the client) is a significant contributor to change, especially early ratings of the relationship (Horvath & Greenberg, 1994). Horvath and Symonds (1991), in a meta-analysis involving the therapeutic alliance that involved diverse theories, found an effect size of ES = .26, concluding that the alliance is an excellent predictor of outcome. A recent study of couple therapy (Symonds & Horvath, 2004) indicates differences in alliances when working with more than one family member in the room. In their study, the alliance with the therapist seemed to be mediated by the allegiance (loyalty) that the members of a couple felt towards each other. The ability of the therapist to determine the level of agreement between partners on the strength of the alliance seems to be an important variable in working with multiple family
members. An MFT therapist needs advanced skills to keep all parties engaged, as damage to the alliance in one family member will likely lead to damage in other family alliances. Bachelor and Horvath (1999) talk about a “window of opportunity” (p. 139) that is available to therapists in order to establish and maximize the therapeutic relationship. The establishing of a sound relationship should be the number one priority for the therapist early on in treatment.

Certain qualities of therapists are essential in forming strong therapeutic relationships with clients. Assy and Lambert (1999) point out that more effective therapists demonstrate more positive behaviors and fewer negative behaviors than do their less effective counterparts. Further, they also have a style that is strong in basic capacities of human relating which include warmth and affirmation along with minimal attacking and blaming. Above all, therapists should avoid behaviors that are critical, attacking, rejecting, blaming, and neglectful.

Bachelor (1995) conducted a phenomenological study on the therapeutic relationship from the perspective of the client. She concludes that the way that clinicians and theoreticians view the alliance is not congruent with the ways in which clients view the alliance. This is important because what the therapist thinks about the therapeutic relationship is irrelevant if the client is not thinking the same as the therapist. It is important for the therapist to be attuned to the phenomenological and idiosyncratic qualities of client systems, especially when it comes to the therapeutic relationship.

Heatherington and Friedlander (1990) studied the therapeutic relationship in MFT and asked members of families to rate their emotional bonds with their therapists. Stronger bonds characterized sessions that were smoother and easier. It is unclear whether the bonds were stronger because the sessions were smoother or if the sessions were smoother because of the stronger bonds (see also Friedlander, Escudero, & Heatherington, 2006). In other studies on the therapeutic relationship in MFT, clients were found to value a caring therapist including warmth, trust, security, and informality (Bischoff & McBride, 1996; Christensen, Russell, Miller, & Peterson, 1998; Greenberg, James, & Conry, 1988; Sells, Smith, & Moon, 1996).

Research has shown that agreement on the tasks of the alliance is important in working with couples and families. For example, in Emotionally Focused Couple Therapy, the strength of the alliance is an important predictor of outcome, particularly the tasks dimension (Johnson & Talitman, 1997). It seems that therapist skill in negotiating this aspect of the alliance is critical to change in this approach.

Flexibility and a sense of relating seem to be key therapist qualities. The specific therapist responses that best foster a strong therapeutic relationship will vary from client to client. Good therapists are sensitive to clients’ responses and are able to change their interactions based on this feedback (Duncan, Miller, & Sparks, 2004). Clearly, a one-approach-fits-all strategy does not work.

Santisteban, Suarez-Morales, Robbins, and Szapocznik (2006) discuss the impressive studies of engagement of reluctant family members in Brief Strategic Family Therapy by reporting on two studies. In the first study (Szapocznik et al., 1988), the group engaging families in treatment using specialized engagement techniques reported a 93% success rate compared with 42% in the engagement as usual condition. A second study (Santisteban et al., 1996) using more stringent engagement criteria reported an 81% success rate compared with 60% in the control condition. Standing out in these results is the idea that if therapists learn different ways of building alliances and engaging families, significant changes can occur (as opposed to blaming clients for being uninterested or unmotivated).

What Therapists Do in Sessions

There is a growing body of process research that uses methods such as discourse analysis, conversation analysis, and content analysis to discover what therapists do in therapy (Couture & Sutherland, 2006; Gale & Newfield, 1992; Kogan & Gale, 1997; McGee, Del Vento, & Beavin Bavelas, 2005; Rober, van Eesbeek, & Elliot, 2006). Although an in-depth review of this body of
research is beyond the scope of this article, this type of research points to the complex processes involved in therapy, and that the therapist is working in a context that involves clients and the myriad responses they have to what the therapist offers. In this research, it appears that adept therapists are able to respond to what clients offer in ways that move the therapy forward in the direction of the clients’ goals. For example, Couture and Sutherland (2006) suggest that even a slight change in what a therapist says, or when he or she says it, can change the meaning of the interaction. In essence, every therapy encounter is interactive, leading to forward-moving conversations that are generative and ultimately therapeutic. In the future, this kind of research will be important as our understanding grows of the role of therapists in the “how” of change.

The Role of the Therapist in Effective Models

While randomized clinical trials attempt to control for therapist variables by having therapists practice the treatment at similar levels of effectiveness, therapists play a prominent role in manualized treatments. For example, Blow and Distelberg (2006) did a review of four evidence-based treatment models focused on working with adolescent substance abusers. The four models are Brief Strategic Family Therapy (BSFT; Szapocznik, Hervis, & Schwartz, 2003), Functional Family Therapy (Sexton & Alexander, 2003), Multidimensional Family Therapy (Liddle, 2002), and Multisystemic Therapy (Sheidow, Henggeler, & Schoenwald, 2003). Blow and Distelberg conclude that in these four manualized treatments, the role of the therapist is critical. The therapist is highly active in engaging family members and preparing them for a change; works to create a strong fit between him- or herself and the clients (matching); is able to negotiate with clients; is flexible, responsive, creative, and committed; and has competent decision-making abilities related to how to best proceed in therapy at any given moment in the process. We believe that reviews of other evidence-based models would lead to similar findings about the role of the therapist in manualized treatments.

Summary

It is clear that the therapist is intertwined with change in many ways. From a broad common factors perspective, the therapist is central in most models of change, and from a narrow common factors perspective, the therapist decides when and how change mechanisms play out in the therapy process.

THE INTEGRATION OF THEORY IN THE PERSON OF THE THERAPIST

We believe that Simon’s (2006) stance that the congruence between a therapist’s worldview and his or her model is of primary importance to outcome fails to take into account a myriad of other relevant variables. We also reject the notion that the unique contributions of a mature MFT model are the main contributors to therapeutic change (Sexton & Ridley, 2004). So what is the relationship between the engaging therapist, common factors, and the MFT model in effective therapy? We believe that effective clinical models are an indispensable part of good therapy—not because a particular model contains unique healing power, but because models provide the vehicle through which many common factors are potentiated (Davis & Piercy, 2007a, 2007b; Spremkle & Blow, 2004a, 2004b). We further believe that models work through—and therefore largely as well as—the therapist. Models are words on paper, and as such are not “effective” in and of themselves; rather, models help therapists be effective. Similarly, therapists help models appear effective. Models either come alive or die through the therapist.

Effective Therapists’ Mastery of Principles of Change

At any given moment in therapy, a therapist is interfacing with thousands of bits of information (Watzlawick, Beavin, & Jackson, 1967). A model helps guide therapy as it suggests how therapists should handle that information—what should be accentuated, downplayed, reframed,
reprocessed, ignored, redirected, and so forth as well as how these acts should be accomplished. However, no model is—or ever will be—capable of telling a therapist what to do and how to do it in every clinical situation. It is up to the therapist to decide what to do, how to do it, and when to do it. Rather than relying on rigid guidelines for making those decisions, many effective models provide guidance through principles of change (Christensen, Doss, & Atkins, 2005). Beutler (2002) says that principles of change:

... identify the conditions, therapist behaviors, and classes of intervention that are associated with change under identified circumstances and for particular kinds of patients. Principles are not theories—they are descriptions of observed relationships. They are more general than techniques and they are more specific than theories. They are the “if ... then” relationships that tell us when to do and what to do, and who to do it to. (p. 3)

Said differently, principles are concentrated “truths” of therapeutic change, applicable to a wide variety of clinical circumstances and present across diverse models of therapy. An example of a principle of change in relational therapies would be, “Couples enjoy greater relationship satisfaction as they free themselves from destructive interactional cycles by slowing down the process, standing meta to themselves and their partner, and taking personal responsibility for altering their role in the cycle” (Davis & Piercy, 2007a). We propose that effective therapists have an understanding of many principles of change (and the models within which these principles lie) and that a therapist’s skill will improve with a more thorough understanding of principles of change (see Castonguay & Beutler, 2006, for a thorough discussion of principles of change; Christensen et al., 2005, provide a discussion on principles of change in MFT).

We believe that effective therapists understand principles of change from several models well enough to be able to adapt to a wide variety of clients and presenting problems. Having a solid grasp on principles of change from many different models allows therapists to follow their intuition (Piery & Nelson, 2000/2001) yet be theory driven at the same time. Furthermore, we believe that effective therapists integrate knowledge of principles of change with a wide array of other relevant knowledge such as normative development, how to establish a therapeutic alliance, healthy in-session processes, and so forth. A common factors framework provides guidance through this course of action, thus becoming a dynamic part of therapy rather than merely static lists of variables, as critics often charge (Sexton & Ridley, 2004).

TRAINING THE NEXT GENERATION OF FAMILY THERAPISTS: A PARADIGM SHIFT

A Shift Away From “Choose Your Favorite Model”

When meeting an MFT colleague for the first time, “What model do you use?” can be as predictable a question as “Where are you from?” or “Where did you get your degree?” Many MFT training programs socialize students early on to choose their favorite model, communicating the assumption that there is one model with which a student will do his or her best work (Simon, 2006). Our field’s theory battles can reinforce this notion (Sprekle & Blow, 2004a). The ideas we have discussed so far suggest a shift in our thinking away from encouraging a student to be passionate about a theory towards being passionate about theory.

We believe that encouraging a therapist to be passionate about only one theory may unwittingly give a therapist the proverbial hammer with which he or she must turn every client into a nail before treatment can proceed. We advocate that a more client-centered approach would be to encourage the therapist to have a thorough familiarity with several diverse models so that he or she can adapt to his or her clients’ contexts rather than vice versa. Research suggests that ensuring a fit between the model and the client’s worldview can influence whether or not the
client remains in treatment (Johnson & Talitman, 1997; Muir et al., 2004). Clients should not have to add “figure out how to adapt to my therapist” to their already lengthy list of challenges.

We do not propose that a therapist forsake all study of models, as the famous dodo bird verdict stating “all models have won and must have prizes” implies (Rosenzweig, 1936). Rather, we believe that having a coherent model the therapist is passionate about and the client is comfortable with is an indispensable component of good therapy (Davis & Piercy, 2007a, 2007b; Sprenkle & Blow, 2004a). Having such a model gives a therapist and client a common language with which to talk about the client’s difficulties, orients the therapist to processes that need to be addressed, provides interventions to help a therapist guide the client from dysfunction to health, and—through providing a new way of relating to the problem that is credible to the client—can be an integral part of establishing hope (Davis & Piercy, 2007a, 2007b). We agree with Simon (2006) that a therapist needs to be passionate about his or her model—a therapist cannot sell what he or she does not believe in. However, we believe that problems can arise when therapists only have one model that they know well enough or are comfortable with in order to be able to accomplish the above-mentioned tasks. Therefore, we believe that training should shift from “choose your favorite model” to “become thoroughly familiar with and passionate about several models (effective, traditional, and promising) and change principles so you can adapt to your clients rather than vice versa.”

We acknowledge that it could be correctly argued that model developers practice only one particular model and that they are good therapists. On the surface, most models appear unique. At a closer look, however, many models are themselves quite integrative. For example, Emotionally Focused Therapy (EFT) is a blend of structural, strategic, Satir experiential, and other approaches (Johnson & Denton, 2002). Integrative Behavioral Couple Therapy (Jacobson & Christensen, 1996) is, as the name implies, an integrative blend of behavioral, cognitive, emotion-focused, strategic, and narrative therapies. The Internal Family Systems model (Breunlin, Schwartz, & Mac Kune-Karrer, 2001) is a blend of structural/strategic, psychodynamic, Bowenian, and postmodern therapies, to name a few. So, at first glance many models seem to stand independent of their predecessors. In reality, however, many models are developed in response to perceived limitations of existing models and as a result contain significant elements of those models. Model developers know several models well enough to see the models’ strengths and limitations, use feedback from their clients to understand how the strengths of one model complement the weaknesses of another, and use that knowledge to build a new model.

We propose that an in-depth knowledge of several theories is part of what makes model developers such good therapists and suggest that others would do well to follow suit. The risk comes when it is implied that a newly developed model has no limitations, and that it is therefore the only model a therapist needs to learn. We believe that all models—even integrative models designed to address inadequacies in earlier models—have limitations in areas where others have strengths. No one model is so comprehensive that it precludes mastery of another.

Mastering several different models can seem daunting at first, both to trainees and educators. We believe that a common factors lens lends itself well to such a training approach. A common factors approach proposes that when it comes to conceptualizations of dysfunction, treatment goals sought, and interventions used to reach those treatment goals, seemingly diverse models have much more in common than often appears at first glance (Davis & Piercy, 2007a, 2007b; Sprenkle & Blow, 2004a). By helping therapists have a solid grasp of these commonalities, educators may be able to train therapists in diverse models more efficiently. Commonalities across models may never be noticed, and a therapist’s resultant flexibility may be hindered should a therapist be encouraged to pick one model and stick with it.

For example, I (SD) once saw a client who was struggling with establishing a healthy relationship with her mother. My client and her husband had recently moved near her parents after
being away for several years, and she saw her mother as being too intrusive. I thought that Bowen therapy would fit well, as my client showed an aptitude for using abstract concepts as a guide for changing her behavior. I had her buy a book on Bowenian concepts, and we focused sessions on practical applications of those concepts. After three sessions, she was excited about the prospect of setting up boundaries with her mom by taking a more differentiated stance with her, but she expressed discomfort with Bowenian terminology. Her discomfort was strong enough that it was hindering her progress. As I knew that structural therapy could provide a different means (i.e., language, interventions) to reaching the same end (i.e., setting up healthy boundaries with her mother), I switched to structural therapy. She loved it, and made excellent progress towards setting up healthy boundaries with her mother.

This simple example does not suggest that structural therapy is superior to Bowen therapy. Rather, it suggests that both models focus at least partially on similar processes and that the therapist’s job is to be familiar enough with each model to recognize that and to switch comfortably between the two models (or others) based on client feedback. We believe that emphasis in clinical training should be altered accordingly.

**A Shift of Emphasis in Training**

If what we have written above has any validity, then therapist training needs to shift in areas of focus related to theoretical knowledge and therapist development. We briefly suggest competencies in five areas.

**Therapist competence in common factors.** We believe therapists’ training should be grounded in common factors. Therapists should achieve positive outcomes in the areas of alliance building, client engagement, hope and expectancy generation, relational conceptualization of problems, changing meanings, matching to the unique worlds of clients, and the like (see Davis & Piercy, 2007a, 2007b, and Sprenkle & Blow, 2004a, for an exhaustive list).

**Therapist competence in evidence-based clinical models and the traditional models on which they are based.** We advocate that therapists be knowledgeable of empirically supported models and the traditional models upon which they are based. We believe that this immersion in models is critical for the ability of therapists to match to a wide variety of clientele and for the understanding of important change principles found in many of these approaches. From an evidence-based perspective, we would like to see more therapists possess knowledge of current best practices. Further, we believe that grounding in these theories will address some of the difficulties in transporting evidence-based models into real-world settings in that therapists will be trained in these approaches from the outset of their training.

**Therapist competence in other relevant nonclinical research information related to the human experience.** We believe that therapists should have a thorough grasp of theory and research related to topics of human development, culture, gender, aging, relationships, family studies, spirituality, human communication, and the like.

**Therapist skills and aptitudes.** What are the standards that guide our field’s selection of trainees in training settings? By far, in our academic training programs, we have favored criteria of intellectual intelligence—including Graduate Record Examination scores, Grade Point Averages, and writing skills. However, individuals who do a good job of talking and writing about therapy are not necessarily proficient in the therapy room itself. As discussed earlier, there are likely several qualities that make couple and family therapists proficient, and finding ways to identify and recruit those with inherent talent would serve our clients and field well.

**Resolution of self of the therapist issues.** Intense self of the therapist work is required that will bring to awareness the unresolved issues and biases that contribute to lack of effectiveness with clients, as well as therapist strengths and resources that can help the therapist be more effective (Timm & Blow, 1999). We believe that this should be an ongoing part of all therapist training and development, both for beginning and seasoned practitioners.
IMPLICATIONS FOR RESEARCH

An Increased Focus on the Study of Therapists Separate From the Study of Models

We need to study therapists. It may be better to talk about empirically supported therapists than models. We are encouraged to hear that prominent family therapy researchers are beginning to include measures of therapist variables in their clinical trials. In describing their research on BSFT, Santisteban et al. (2006) report:

…we are also empirically examining the training process and training outcomes. Therapists’ characteristics prior to training (e.g., professional experience, recovery status, theoretical orientation) and their conceptualization and implementation of BSFT will be examined to identify those factors that predict BSFT skill-acquisition trajectories. (p. 268)

We applaud these efforts, and hope to see similar research increase.

The Inclusion of Therapist Variables as Mediators and Moderators in Future Research

Given the widely held belief that randomized clinical trials are the gold standard for clinical research, and the funding support for them, it is not likely this method will be minimized anytime soon. However, we urge investigators to consider therapist variables as mediators and moderators in such trials.

Kraemer, Wilson, Fairburn, and Agras (2002) offer an excellent discussion of mediators and moderators in clinical trials. They define mediators as variables that explain why and how treatments have effects. As we noted (for example, in our discussion of the NIMH Collaborative Study of Depression), there is strong evidence in some studies that therapist competence may indeed explain why treatments work. We strongly urge that in all future clinical trials, investigators assess and report the relative results of therapists, and when differences exist, adopt the appropriate statistical procedures (see Wampold, 2001) to avoid inflating the impact of treatment differences.

Moderators identify the circumstances under which treatments have effects. We believe that some of these moderators may be therapist variables, or more often therapist variables in interaction with client variables. For example, going back to the tasks of the alliance in EFT, Johnson and Talitman (1997) demonstrated that EFT effectiveness is moderated by the ability of the therapist to create an alliance with the client around (even more than other aspects of the therapeutic alliance) the “tasks” of therapy. That is, the effectiveness of EFT is likely moderated by the extent to which the therapist makes this approach (particularly emotional processing) appear credible to the clients.

Kraemer et al. (2002) note that identifying mediators and moderators is often a post hoc process that is hypothesis “generating” rather than hypothesis testing, and journals should not dismiss these conclusions as mere “fishing expeditions,” even though subsequent hypothesis testing may be required to substantiate these findings. Also, given the general low level of knowledge about therapist variables, we argue for other hypotheses-generating methods like multiple case studies of highly competent therapists, or comparisons of novice and expert therapists using qualitative (Holmes, 2006) or mixed (Sprenkle & Piercy, 2005) methods. Process research, which explores the mechanisms of change, and qualitative inquiry, can also be embedded in clinical trials and we strongly encourage these activities. It will probably take a variety of research methods to begin to untangle the complex issue of why and how therapist variability contributes to the outcome of therapy.

Recommendations of the American Psychological Association (APA) Presidential Task Force

In 2006, the APA Presidential Task Force on Evidence-Based Practice (2006) made some recommendations for the field of psychology that we believe are important for the MFT field
and which support what we have written above. In short, the task force recognizes the importance of the therapist along with methodological plurality in studying clinical phenomena. The task force concludes that

The individual therapist has a substantial impact on outcomes, both in clinical trials and in practice settings … The fact that treatment outcomes are systematically related to the provider of the treatment (above and beyond the type of treatment) provides strong evidence for the importance of understanding expertise in clinical practice as a way of enhancing patient outcomes. (p. 276)

Therefore, the report stresses the need to understand the personal attributes and interventions of therapists and their relationship to strong outcomes. Recommendations include studying practices of clinicians in community settings who achieve consistently good outcomes and their technical skills in delivering interventions. Further, the report advocates building on our knowledge of clinical expertise, and developing a list of competencies that promote positive therapeutic outcomes. These include competencies in the following: (a) assessment, diagnostic judgment, systematic case formulation, and treatment planning; (b) clinical decision making, treatment implementation, and monitoring of patient progress; (c) interpersonal expertise; (d) continual self-reflection and acquisition of skills; (e) appropriate evaluation and use of research evidence in both basic and applied psychological science; (f) understanding the influence of individual and cultural differences on treatment; (g) seeking available resources (e.g., consultation, adjutive, or alternative services) as needed; and (h) having a cogent rationale for clinical strategies. MFTs will do well to focus their research and clinical efforts on similar therapist practices.

CONCLUSION

We agree with Eisler (2006) that

Once we move away from simply asking what are the most important factors and what works best, to questions of how treatments work, how different factors interact to enhance or interfere with the process of change, we stop being driven towards focusing all our research on randomized trials, which although important are not the only way of moving our understanding forward. (p. 332)

Therefore, we believe that an intensified focus on the role of the therapist in change is warranted. Such a focus would include therapist inherent and learned qualities, how therapists think and make decisions in therapy, and how therapists choose to shine light on some things but not on others so that therapy moves forward and deepens. This shift could provide answers to many of our dilemmas about change. In essence, we believe that models are important and that common factors are the best explanation for how models work. However, as a skillful therapist is the point of convergence for models and common factors, it is up to the therapist to bring to life a model’s change mechanisms with clients, to know what to do when, with what clients, with their specific presenting problem, and in their specific familial and cultural context. We hope to have provided guidance in those efforts.

REFERENCES


**NOTE**

We use the word *most* here because we acknowledge that many clients or potential clients are able to find ways to change without entering into psychotherapy of any kind. We also are aware that some clients are able to change in spite of an inept therapist (Tallman & Bohart, 1999). Our statement is particularly pertinent to that group of clients who are having difficulty changing on their own and who seek out a therapist to help them with their dilemmas.
CHAPTER 1

CORE TECHNIQUES IN FAMILY THERAPY

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INTRODUCTION

The family therapy field is fast approaching a half century of accomplishment. During its evolution, a variety of models have been born and nurtured to maturity (see Guerin, 1976; Gurman & Kniskern, 1981, 1991; Haley & Hoffman, 1968; Nichols, 1984). As with any new discipline establishing its own identity, practitioners and theorists have often held tightly to their perspectives while at the same time trying to maintain a dialogue across their differences. With the emergence of the third and fourth generations of family therapists, the field has progressed to the point of recognizing both our roots and our commonalities. As a result, the current generation of family therapists is trained in multiple orientations and is cognizant of the shared theoretical threads that hold the field together. This change has ushered in a new era marked by the development of integrative models of family therapy. (See especially chap. 31 in this volume.)

Many researchers and theorists have examined and compared various tenets and aspects of family therapy (Figley & Nelson, 1989, 1990; Goldenberg & Goldenberg, 1980; Gurman, 1979; Kaslow, 1987; Madanes & Haley, 1977; Nelson & Figley, 1990; Nelson, Heilbrun, & Figley, 1993; Stanton, 1981a; Strupp & Hadley, 1979). In line with their search for understanding, this chapter will focus on what family therapists actually do in therapy. We will identify the techniques or interventions that most family therapists perform in the course of their practice, regardless of the model of family therapy that they espouse. We believe that these core techniques or interventions are related more to a common approach family therapists use than to the model of family therapy or the philosophical position they hold.

If one examines the development of family therapy in context, it becomes apparent that family therapy emerged in parallel with other major changes in society. It arose at a time when industrialization, urbanization, and advances in communication technology were exploding, all accompanied by increased mobility and separation of extended family members. The nature of literature and drama had changed dramatically, and people were living much more in and for the here and now. Two world wars had accelerated the sense of urgency for connectedness in view of the potential fragility of relationships. The advances in communication technology resulted in the replacement of leisurely academic pursuits and the art of letter writing with skills more suited to the less personal expediency of computers.

Family therapy mirrored this process of change closely, with some of the pioneer family therapists holding on to more traditional ideas and others acceding to the pressures of a fast-paced and demanding society. Several of the early family therapists (e.g., Ackerman, 1958, 1966; Bell, 1961, 1975; Boszormenyi-Nagy & Spark, 1973; Bowen, 1978; Framo, 1992), developing an approach to families that grew out of the fields of psychoanalysis and developmental psychology, treated families from a predominantly historical, analytical, or transgenerational perspective. The approaches developed by others (e.g., Erickson as cited in Haley, 1973; Epstein, Bishop, & Levin,
1978; Haley, 1963, 1976; Jackson, 1965; Minuchin, 1974; Napier & Whitaker, 1978; Satir, 1967, 1972; Weakland, 1960) mirrored the changing times. These theorists and practitioners attended more to the here and now, focusing on current behavior, immediate family experience, interaction, communication, and the needs of the family. Napier and Whitaker (1978) also included in this view the perspective of the person of the therapist. Yet others (e.g., Speck & Attaneave, 1973) took a larger systems or more socioanthropological approach, or viewed the behavior of the family from an *ecosystemic* (Auerswald, 1974) perspective, examining the larger context over time to discover events that might have determined present behavior. Many of these early theorists were influenced by the field of cybernetics (Bateson, 1972; von Bertalanffy, 1968) and its applicability to human systems. The early development of the field also saw the beginnings of integration with therapists such as Satir (1967, 1972), who combined, communication and here and now interventions in her model of conjoint family therapy, as did Wynne (1958, 1961) and Duhl and Duhl (1981). In addition, clusters of interventions focusing on problem areas or social issues have arisen as family therapists have tapped into their creativity. These types of interventions have made a major impact on the way we do therapy, and frequently their influence extends well beyond the original problem for which they were designed. Two examples of this are bereavement (e.g., Horwitz, in press; Paul, 1986; Paul & Grosser, 1965; Walsh & McGoldrick, 1991) and addiction (Bersonson, 1976; Kaufman & Kaufman, 1979; Krestan, 1991; Stanton & Todd, 1982; Steinglass, 1987). These clusters of interventions tend to be adaptations of the core techniques or different combinations of interventions often arising from the early family therapy models. In fact, many of these problem-driven classes of intervention might be regarded as the forerunners of the integrated models.

The therapist's personal perspective and beliefs largely determine how he or she conceives of the change process and therefore influence the approaches used to facilitate change (Kaslow, 1987). Therapists may view family relationships and interactions as primary and superseding the nature of the problem or believe that the particular symptomatology or presenting problem is the most important variable. In this way, whether interventions focus on the interaction among family members, the problem being treated, or the context from which the family has come or the problem has emerged appears to depend at least as much, if not more, on the therapist as on the family (Whitaker & Keith, 1980).

Despite differences among therapists and models of family therapy, certain techniques and interventions tend to be applied by most therapists. These classes or clusters of interventions often cross the boundaries of differing schools and may reflect an inherent effort to be integrative in clinical practice. In Part I, we describe these broad classes of core family therapy interventions as we see them and then apply them to a clinical case. In Part II, we describe the case in greater detail and attempt to search for the commonalities between the classes of intervention that have led to the integrative models of family therapy. To illustrate this integration, we apply aspects of transitional family therapy, developed at the University of Rochester, to the family presented in Parts I and II.

**PART I**

**Core Family Therapy Interventions**

Arising from the schools of family therapy mentioned above, core family therapy interventions can be organized into three broad classes: (a) here and now, (b) transgenerational, and (c) ecosystemic. Elements of each of these classes can be found in almost every school and model of family therapy. In this section we give a simple definition of these intervention classes. We then apply them each to a clinical case in an attempt to illustrate the interventions that form the core of family therapy.

**Here and now interventions.** Here and now interventions emphasize the organization of the family and its process of change as they manifest in the present. Individual problems are conceptualized as reflecting difficulties within the family system as a whole. A dysfunction may be viewed as a current sequence of behavior that originated as an attempt to resolve a problem but subsequently became a repeating problematic pattern. A problem may also be understood as reflecting an ineffectual family structure.
In any case, family problems are seen as both affecting and being affected by how the family interacts as a whole.

Here and now interventions may focus primarily on the family (its structure or its communication or both) or on the specific problem (or solution). Here and now interventions are goal oriented and problem or solution focused (De Shazer, 1980, 1982, 1985). The therapist accepts the responsibility to facilitate change. Consequently, the therapist is active and at times directive, for example, making restructuring moves (Minuchin, 1974). Interventions are designed to alter the family’s organization or accepted patterns of relating so that symptoms may be alleviated and problems may be addressed differently in the future (Haley, 1963; Madanes & Haley, 1977).

Family therapy based on here and now interventions is often brief. The emphasis is on behavioral change rather than insight. The therapist may work with the whole family as defined by the family or the therapist. The therapist may also work with sub-systems, dyads, and individuals. Interventions may be enacted during the therapy session or directives may be prescribed for the family to accomplish between sessions. In either case, the family is continually encouraged to work on tasks that are designed to facilitate change.

Here and now interventions may be direct or indirect (Stanton, 1984). Direct interventions, such as suggesting that parents work together to set limits with a rebellious adolescent, are compliance based. These interventions assume the cooperation of the family. Indirect interventions, such as prescribing that a couple having sexual problems refrain from intercourse, are noncompliance based. Such interventions are designed to circumvent family reluctance to change by “going with” the resistance. This creates a paradox in which the behavior that is prescribed (sex) is difficult to resist (Watzlawick, Weakland, & Fisch, 1974).

Common examples of here and now interventions include tasks that may be performed both in and outside of the therapy session:

Rereenactment and enactment (Minuchin & Fishman, 1981). A common in-session task involves instructing the family to reenact a problematic family interaction and then demonstrating an enactment of new patterns of interaction and communication. In Moreno’s psychodrama (Compereolle, 1981), the patient was instructed to experiment with and practice new methods of relating during a simulated interaction. The extension of this technique to use by actual family members (as opposed to fellow patients on a psychiatric ward) served as a major breakthrough in here and now interventions and is applied across many schools and models. For example, the therapist actively engages family members in demonstrating their difficulties, such as arguing. The therapist then directs the family to talk to each other about the changes they would like to make regarding family fights. Finally, the therapist has the family enact, demonstrate, or practice the new behavior in session.

Reframing/positive connotation/noble ascription and symptom prescription. These techniques of viewing or framing the problem in a more positive way (Watzlawick et al., 1974) are commonly used when the therapist wants to recognize an individual’s or family’s positive intention and when resistance to change is high. The attribution of a positive value to an interaction, event, or pattern has been variously called reframing (Minuchin & Fishman, 1981), noble ascription (Stanton & Todd, 1979, 1982) and positive connotation (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978). In the case of symptom prescription (Selvini-Palazzoli et al., 1978), this perspective is taken to its natural conclusion, as the family is not only helped to see the beneficial nature of the symptom or problem but also is asked to do more of the same.

For example, in a hypothetical case, parents may present their child’s temper tantrums as an insoluble problem. These parents might disagree on how to approach the problem but also insist that they have “tried everything.” They are likely to be angry at each other and at the child and to feel sure that it is the child’s problem. The therapist may suggest that far from being a bad child, the child is actually quite loving and is expressing his or her love by behaving in ways that invite the parents to come together and work as a unit. In fact, the child may fear that if he or she cannot keep the parents together they will break apart. The therapist may suggest that the child have a temper tantrum whenever he or she is afraid that the parents may be moving apart.
Restructuring the family in session. Restructuring may be facilitated by helping the family identify the repeating patterns on which structures are based (Madanes & Haley, 1977) or by encouraging a change in the physical positioning of family members (Minuchin & Fishman, 1981). The therapist may use nonverbal behavior as much as verbal behavior to alter problematic family interactions and to restructure a family. A common example of this latter technique is changing how a family is seated during a session. For example, in the case of the hypothetical child mentioned above, he or she might be seen as effectively splitting the parents. It would be likely that this child would sit between the parents at the family therapy session. The therapist might ask him or her to move (or ask the parents to have the child move out from between them) and the parents’ chairs may be thus brought closer together. Another method by which the system is changed in the here and now is family sculpting, an action (as opposed to verbal) technique that allows for the alteration of how the family occupies and represents its relationships in space (Duhl, Kantor, & Duhl, 1973). A typical sculpting exercise might depict the family structure at various points in time or during a particular situation. The family takes the form of a silent tableau in which people are placed at set distances from one another and in postures that depict their relationships.

Defining the problem and establishing goals and action plans. Depending on the orientation of the therapist, these techniques may be seen as two parts of the same whole. The definition of the problem leads to the clarification of goals needed for the development of a solution (Haley, 1976; Landau-Stanton & Stanton, 1985; Watzlawick et al., 1974; see especially chap. 3 in this volume). For example, the parents of the problem child presented above were able to develop an understanding of the repeating pattern that resulted in the child’s gaining a position of power vis-à-vis the parents. The child was able to control the parents’ behavior by acting out in order to bring them closer together each time they were experiencing conflict. The action plan developed for the purpose of altering this pattern might be for the parents to decide that they will (a) spend time together by going on a date, rather than in response to their child’s bad behavior; (b) not respond to their child’s cue of acting out; and (c) define more clearly their mutual goals for their child.

Family psychoeducation. These techniques were developed primarily to treat schizophrenia (Anderson, Hogarty, & Reiss, 1986; McFarlane, 1991; see chap. 10 in this volume) but are also used in many other areas, such as substance abuse and chronic medical illness. At the core of this technique is a belief that families can be trained to create a relational context that may compensate for, and in many instances correct, a disability faced by a particular family member. The therapist functions as an educator, teaching members about the disability and training them how to respond and interact differently. Families often meet in multifamily groups that are designed to educate families and provide a setting in which families can support and guide each other.

Between session homework tasks. The therapist may devote the end of each session to codesigning tasks with the family that will be done between sessions. These homework tasks are generally clearly linked to the stated family goals for therapy. In the case described above, during the session, the couple may have planned a date or an outing. They might have negotiated the time of the outing and established some of the details. The parents may be encouraged to get a sitter and to block any of their child’s efforts to keep them from going out together. The process of designing a task creates different forms of interaction during the session. Carrying out the tasks at home supports the family’s sense of competence and accomplishment in reaching their goals for treatment.

Therapist’s use of self with the family (Satir, 1967; Whitaker & Keeth, 1980). The therapist may use self-disclosure, humor, metaphor, and other personal means to increase or decrease energy or anxiety in the therapy session. This active unbalancing of the family is intended to interrupt homeostatic processes and to stimulate new ways of thinking, feeling, and interacting within the family that commence during the therapy session. (See especially chaps. 2, 3, 13, and 20 in this volume.)

These examples should not be considered exhaustive. There are as many here and now interventions possible as the interaction of family and therapist can
stimulate. Common elements of here and now interventions are a focus on the identified problem; a perception of family structure, organization, boundaries, and interactional process as central to problem maintenance; active intervention in current family organization and process to resolve problems; and therapist responsibility for facilitating change. (See especially chaps. 6, 17, 18, 20, 25, 27, and 30 in this volume.)

Transgenerational interventions. Transgenerational interventions emphasize the evolution of both problems and solutions across many generations of the family. Here and now family interactions are viewed as reflecting patterns that have been developed by and inherited from ancestors. Solutions involve addressing relationship issues in one’s family of origin.

The therapist applying a transgenerational perspective believes that families are held together through time by invisible strands of loyalty (Boszormenyi-Nagy & Spark, 1973; see also chap. 3 in this volume). Family members must maintain a delicate balance between how they choose to behave and what is owed to family members (Boszormenyi-Nagy & Spark, 1973). These loyalties transact the genogram in both vertical (e.g., parents and children) and horizontal (e.g., siblings, cousins, and partners) directions. At the intersection of these vertical and horizontal loyalties, the transgenerational projection process is enacted (Bowen, 1976). Unresolved problems from the family’s past are bequeathed to the present generations (Bowen, 1976; Framo, 1992; Paul, 1986; Paul & Grosser, 1965; Williamson, 1978).

Transgenerational therapists are attuned to how the family projection process is manifest in the family’s current journey through the life cycle (Carter & McGoldrick, 1988; see also chap. 5 in this volume). An assumption of transgenerational therapists is that family difficulties are most likely to emerge during transitional periods from one life cycle phase, such as adolescence, to another, such as leaving home. How families navigate their life cycles is influenced by how each branch of the family has navigated similar stages in previous generations. For example, when an offspring develops problems while preparing to leave home, such as unexplainable failure in school, these difficulties may reflect similar problems of leaving and self-differentiation in the parent, grandparent, and even great-grandparent generations (Boszormenyi-Nagy & Spark, 1973; Bowen, 1976; Landau, 1982; Landau-Stanton, 1990).

The key that unlocks the door to change in the present is held in the family’s past. This is a crucial point when working with families who may be reluctant to explore patterns or problems in the past. Transgenerational issues are directly linked to the current issues facing the family. The efforts of past generations may provide a map for how present generations will traverse their life cycles or tackle their problems. The transgenerational therapist may function as a coach or guide to family members (Bowen, 1976). Although transgenerational patterns are linked to present concerns, the therapist is less likely to focus on interventions that directly address the problem as it exists in the present. Instead, the therapist addresses family of origin issues that are impinging on the present. The therapist may work with the whole family but frequently works with couples or even individuals. The basic assumption is that addressing issues from the past will help the family resolve difficulties in the present.

With child problems, some therapists working from a transgenerational perspective might intervene primarily at the parental level. They might regard the parent generation’s capacity to resolve family of origin issues as the key to eliminating these problems in the present. For example, parents who have problems with child rearing might be encouraged to work on their relationships as children to their own parents, couples who argue and cannot communicate may be diverted to work out their unresolved problems with their own opposite-sex parent because these are likely to be influencing their current conflict with their partner. Other transgenerational therapists might work only with the individual. Therapy may include sending him or her “back home again” (Framo, 1976) to resolve earlier issues, or to individual (Bowen, 1976) from family of origin. In these ways, the patient is helped to work through the problem patterns, relationships, and events.

Transgenerational therapy interventions tend to be less directive than here and now interventions. The responsibility for change in the family is more shared or mutual. The therapist may coach but is less likely
to enter the game actively to intervene, other than by offering advice or guiding homework tasks. The patient has greater responsibility for taking action. Transgenerational interventions are more closely tied to the analytical roots of therapy and are more likely to generate insight that are here and now interventions. Insight or understanding of the impact of earlier relationships enables the patient to make decisions and take action.

Common examples of transgenerational interventions (like here and now interventions) include tasks that may be performed both in and outside of the therapy session:

Genogram development (Bowen, 1978; McGoldrick & Gerson, 1985). The therapist will usually develop a genogram early in therapy in order to map relationship patterns and transitional conflicts (Landau-Stanton, 1990). It is an effective way to elicit the patient's story and bring absent family members into the room. The therapist will help the patient understand how roles, triangles, losses, transitions, and other family dynamics influence the functioning of current family relationships.

Trips home (Bowen, 1976; Framo, 1976). The therapist will use genogram information to help patients develop an understanding of what changes need to occur in their family of origin. It is not enough, though, to identify and understand family of origin issues. Patients often are encouraged to return home to deal directly with those relationships that are contributing to current problems. The goal is to help patients differentiate from their families of origin (Bowen, 1976). Self-differentiation involves maturing sufficiently to relate to members of the family of origin without behaving in an involuntary and emotionally reactive way. Patients who are able to differentiate in this manner are better able to decide for themselves how they will relate to family members. They are less likely to be pulled unwittingly into unhealthy family patterns (Framo, 1992).

Inviting extended family into therapy. Transgenerational therapists may involve members of the patient's family of origin in the therapy. In couples therapy, for example, parents of each partner may be included (Framo, 1976). Issues between partners often reflect problems both partners have had in their relationships with their own parents. By including parents in therapy the couple can work directly on family of origin issues that have an influence on the couple's current relationship. In this way, the therapist brings the family's home into the office, where family patterns can be addressed directly and the wisdom of previous generations can be utilized in solving current problems (e.g., Horwitz, in press; Landau-Stanton, le Roux, Horwitz, Baldwin, & McDaniel, 1991; Whitaker & Keith, 1980).

Symbolic inclusion of family of origin. The therapist may bring family of origin into therapy in a variety of other creative ways. The therapist may talk about other family members being present in the room; often these "ghosts" are seen as alive in current family members (Whitaker & Keith, 1980). Or the therapist may have a family member sculpt his or her family of origin (Duhl et al., 1973). The sculpting may entail having current family members represent members of previous generations (Landau-Stanton, 1990) or may employ therapy teams, empty chairs (Duhl et al., 1973), and role play dialogue (Satir, 1967) to manifest the hidden family that is always present. In this way, the family member can return to scenes from the past that are being replicated in the present. By facilitating sculpting of this nature, the therapist can "act as a bridge between generations" (Duhl et al., 1973, p. 62). The opportunity to refashion the past can loosen the logjam that is occurring in the present.

The common elements underlying transgenerational interventions include the following premises: that transgenerational processes across time influence the development of current problems, that these problems often arise during transitional periods such as family life cycle changes, and that solving current problems often involves resolving relationship issues with family members from the past. (See especially chaps. 4, 5, 6, 13, 17, 18, 22, 25, and 26 in this volume.)

Ecosystemic approaches. An ecosystemic approach emphasizes the interaction of multiple factors both within the family and beyond the relational bonds of the family (see Imber-Black, 1988). The term ecosystemic was coined by Auerswald (1968), who described the balanced interaction of family and larger social systems, which forms an interdependent rela-
tional ecology occupying both time and space. For purposes of this chapter we are expanding that original concept to include work by a variety of theorists and therapists who have focused attention on dimensions of the larger ecosystem. Therapists dealing with the ecosystem might consider the immediate social system or extend their hypothesizing to the entire natural and artificial support system as depicted by Lewin (1935), including larger social systems and institutions; political and economic issues; ethnicity, race, culture, religion, gender, language, and social construction; geographical and historic events; the neighborhood; and the immediate and extended family.

Truly ecosystemic interventions are inherently biopsychosocial (Engel, 1977, 1980; see also chaps. 21 and 25 in this volume). Problems develop due to the interaction of multiple factors inside and outside the family (Epstein et al., 1978). The family is seen as one system among many larger systems that influences family and individual functioning. This multi-system, or contextual, perspective has led some ecosystemic therapists to focus on the “problem-determined system” (Anderson & Goolishian, 1988) or the “system of import” (Stanton, 1984) as the unit of treatment. The system of import includes everyone who is involved meaningfully in conversation about the presenting problem. This could include nuclear family members, extended family members, and significant others such as friends, members of families of choice, and representatives of the legal, religious, medical, and social services systems (Berger, Jurkovic, & Associates, 1984; Imber-Black, 1988; Landau-Stanton et al., 1991; Landau-Stanton & Clements, 1993; Mirkin, 1990; Speck & Attneave, 1973; Wynne, McDaniel, & Weber, 1986). Meaningful solutions are co-constructed in the dialogue that occurs among these many participants (Anderson & Goolishian, 1988; Goolishian & Anderson, 1987; Hoffman, 1990; White & Epston, 1990; see especially chap. 21 in this volume).

An ecosystemic approach is inherently collaborative (see especially chaps. 2 and 27 in this volume). The therapist is a partner with the family and other social resources in defining the origin of, and developing solutions to, the family's problems. Depending on the therapist's orientation within an ecosystemic approach, the therapy may have a unique focus. For example, feminist family therapists are particularly attuned to issues of power in relationships (e.g., male/female) and how the unequal distribution of power is supported by social structures and cultural mores (e.g., Goldner, 1988, 1991; Goodrich, Rampage, Ellman, & Halstead, 1988; Hare-Mustin, 1978, 1987; Krestan & Bepko, 1980; McDaniel, 1990; McGoldrick, Anderson, & Walsh, 1989; Reid, McDaniel, Donaldson, & Tollers, 1987; Walters, Carter, Papp, & Silverstein 1988; see especially chaps. 17, 18, and 31 in this volume). A therapist who pays particular attention to ethnicity in a family may explore how ethnic origins (see especially chaps. 19, 20, and 23 in this volume) influence current family values, communication patterns, and problem resolution (e.g., Boyd-Franklin, 1989; Landau, 1982; le Roux, 1992; McGoldrick, Pierce, & Giordano, 1982; Sotomayor, 1991; Sue & Sue, 1990; Szapocznik, Scopetta, Kurtines, & Arenalde, 1978). Such a therapist would also be sensitive to how the family's ethnicity is perceived and influenced by the larger culture.

An ecosystemic approach has few technical interventions that are directly identified with this perspective but tends to include many of the techniques mentioned in both the here and now therapies and the historical approach. Of special note, though, is the use of network sessions developed by Speck and Attneave (1973) as a therapeutic intervention. As they describe, network sessions bring together the important participants and resources to the family problem. Some therapists employ network sessions throughout the course of the therapy. Others call for a network to deal with special issues or when the therapy appears to be stuck. Network sessions may be designed to elevate the family and focus on its own competence (Landau-Stanton, 1986). The therapist works with the family to identify extended family, friends, associates, and professionals who either are currently involved with the problem, have experience with similar problems, or are defined by the family as an important resource to them. Any member of the ecosystem may be called upon for help. Therapists might invite not only extended family members but neighbors and support systems into the therapy session to throw light on some of the prob-
lematic patterns (e.g., Landau-Stanton & Clements, 1993; Rueveni, 1975; Speck & Atteave, 1973). Therefore, network sessions may involve large numbers of participants. The group works together to find solutions to the family’s problems. This collaboration helps the family break out of its stuck position and move forward. By increasing the diversity of perspectives on the problem and then focusing the network’s energy on solutions, the therapist, family, and network co-evolve a new reality. Change occurs because the entire ecosystem has moved together in a new direction.

Common elements in ecosystemic interventions are sensitivity to extrafamilial factors in the development of problems, utilization of larger systems resources in the assessment and treatment process, the therapist’s function as more than that of orchestrator than that of performer, and the therapist’s role as “ecosystemic detective” (Auerswald, 1968). (See especially chaps. 2, 3, 6, 7, 9, 12, 20, 21, 23, 26, and 27 in this volume.)

The Application of Core Interventions

The three broad classes of intervention that we have described—here and now, transgenerational, and ecosystemic—certainly do not include every possible intervention in family therapy, but they do reflect the broad center of the family therapy field. In order to illustrate techniques from each of these classes, we will present a case that was seen by one of the authors using transitional family therapy. ¹ We will then discuss the case hypothetically by demonstrating how therapists using techniques representing each of the intervention classes might approach the case. Later in the chapter we will present the case as it actually was treated.

CASE EXAMPLE

Louis, age 20, had been hospitalized for depression and suicidality for two months prior to being referred for family therapy. His parents, Angelo and Madeline, with whom Louis lived, wanted to help in any way possible. Louis’s parents had felt hopeless about Louis for quite some time. His father did not understand Louis’s problems but was willing to do “whatever it takes to get Louis right.” Louis’s mother told the intake worker at the family clinic that all of Louis’s problems stemmed from the death of his maternal grandfather. She contended that Louis felt guilty because of the time he had spent abusing alcohol and drugs with his friends while his grandfather was dying. Louis also had a brother, Mario, 18, who was a dean’s list student at a local college and a sister Emily, 10, who was the “apple of her father’s eye.” Everyone planned to attend the first session.

Here and now interventions. The therapist using here and now interventions helps the family define the problem as clearly and concretely as possible. In the process, the therapist pays close attention to the way family members interact with one another. The therapist attends to such issues as repeating interactional patterns and confused hierarchy. Interventions may be designed to restructure the hierarchy so that boundaries among subsystems are more clear. Alternatively, the therapist might actively alter how family members interact with each other. This might be done by nonverbal methods such as sculpting or re-arranging seating. It may also be achieved by directly intervening to alter verbal communication through such methods as blocking, reframing, or noble ascription. A combination of verbal and nonverbal techniques, such as enactment, may be used.

During the initial interview the here and now therapist may notice that Louis and his mother, Madeline, are very close, in fact their chairs are touching. In defining the problem Madeline speaks repeatedly for Louis. Louis sits in silence that his mother defines as depression. Louis’s father, Angelo, on the other hand, sits across the room from his wife and son. The seating positions of Emily and Mario further separate their father from Louis and Madeline. Angelo expresses helplessness and confusion about his son, Louis. At this stage a therapist might note

¹ Susan H. Horwitz, MS, was the therapist for this family. Some material has been added to further protect anonymity and highlight aspects of the treatment approach.
that whenever Angelo talks he is interrupted not only by his wife but also by Mario and Emily. Angelo seldom completes his sentences and soon withdraws from the conversation. The therapist may also notice that Louis and Angelo often sit in silence, forming mirror images of each other.

The main concern of the family is that since Louis has left the hospital he is silent and withdrawn. He spends little time with the family and seldom goes out. The therapist assesses Louis's suicidality. The family feels Louis is in no immediate danger of committing suicide, but they remain anxious and worried for his safety. Louis agrees that his silence and withdrawal are problems, but he has no solutions. Having clarified the problem and observed the family's interaction, the therapist may proceed in the following manner:

The therapist asks the family to change their seating so that Madeline and Angelo can sit together. The therapist feels this will make it easier for the parents to discuss how to approach their son's problem. The therapist then asks the father and mother to discuss ways to address Louis's silence and withdrawal. The other family members are encouraged to listen to their parents and are blocked from interrupting their parents' discussion.

The therapist asks Angelo "as Louis's father and as the most experienced man in the family" to share his ideas on what to do. The therapist supports Madeline in listening to her husband because she "has had to carry the responsibility alone too long." Mother and father talk together for the first time about their fears and frustrations. They also decide on a plan of action. Louis, who has not been eating with the family, will be expected to eat dinner with them daily. In order to support Louis in getting out more often, Angelo and Louis will plan an outing to be accomplished before the next therapy session.

Since Angelo and Louis are "quiet," the therapist asks Madeline to coach Angelo on talking effectively with his son. The thera-

pist then has Angelo and Madeline brainstorm appropriate and enjoyable outings. Angelo and Louis discuss these options and decide to go to a basketball game. The therapist cautions the family that a whole basketball game may be too much togetherness and suggests staying for half the game. Angelo and Louis, with Madeline's support, say they will decide at half time whether or not to stay longer.

In this intervention, the therapist maintains a focus on what the family defines as the main problem. The therapist is concerned that the family's structure may be part of the problem and may reflect problems between the mother and father. The therapist actively restructures the hierarchy in the family and alters how communication takes place. Louis has been elevated to peer status with his mother as the central dyad in the family. The family's interaction also reveals a pattern in which the father is either excluded or excludes himself from meaningful involvement in family decisions. The therapist moves quickly to bring mother and father together, thus reestablishing a generational hierarchy. This elevates Angelo, the father, and provides much needed support to Madeline, the mother, and allows Louis to rejoin the sibling generation.

In this example, the therapist addresses the problem in the here and now process of therapy. The therapist intervenes to restructure family interaction and enables the family to enact a different process of communication and decision making. The therapist also adds a restraint-from-change maneuver designed to protect the family from failure and to stimulate their confidence to move ahead. The therapist takes responsibility for creating a context and facilitating a process that helps the family arrive at solutions.

Transgenerational interventions. The therapist who approaches the family with transgenerational interventions in mind listens for evidence of transgenerational processes that may influence the family's current functioning. Are there issues of unresolved loss and grief? Have relationship patterns been passed on from one generation to the next? Have other family members faced similar problems in the past when entering the leaving-home phase of devel-

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opment? Does each generation of the family usually have a “sick” member? Are there strands of loyalty to past generations that make it difficult for parents to deal effectively with the current generation? What family legacies may influence the roles family members play in the family now? The therapist may have these and other considerations in mind when meeting with the family.

During the initial interview the transgenerational therapist might be particularly interested in Madeline’s explanation of her son’s difficulties. All of Louis’s problems stem from guilt over the death of his maternal grandfather. The therapist may hypothesize that grief is the central issue not only for Louis but for Madeline and the family as a whole. The guilt Madeline sees in her son may reflect her own guilt and pain. The therapist may want to learn more about other losses on both sides of the family and how the family has dealt with grief traditionally.

The therapist listens to Madeline discuss the impact her father’s death has had on Louis. Angelo and Louis both confirm Louis’s sadness and guilt. The therapist says: “I can see that family ties are very strong in your family and that I will not be able to understand your family well until I understand more about the larger family from which you’ve come.” The therapist then engages Angelo and Madeline in describing members of their families. The therapist constructs a four-generation genogram on an easel. The therapist learns about previous deaths, births, methods of leaving home, and the like. This discussion helps the family recognize that drug and alcohol abuse have been ways some family members have dealt with loss and grief for several generations. The therapist suggests that Louis may not have wanted to neglect his grandfather but that it may have been just too painful for Louis to face his grandfather’s death without drugs and alcohol. With this Madeline discusses her own unresolved grief over her father, and Angelo talks movingly about problems he has never resolved with his father who is also deceased. The therapist then asks what Louis’s grandfather would want the family to do at this time. Louis is unsure how to respond. He becomes tearful. Madeline says her father would want them all to “be strong.”

In this session, the therapist’s use of the genogram broadens the family’s perspective on Louis’s problem to include patterns of coping with loss. By expanding the family’s view, Louis’s substance abuse is presented as a sign of pain and hurt rather than irresponsibility. In addition, the therapist may describe it as a form of grieving that is loyal to the way others in the family have grieved before. The therapist may also feel it is important to understand how men are taught to grieve. By including the father’s family of origin the therapist develops an understanding not only of how men grieve but of how they deal with each other’s grief. This may be valuable later in therapy if the therapist wants to bring father and son closer together. The therapist then brings the deceased grandfather into the session by asking what he would say to the family. In this way the therapist makes more overt (the grandfather’s presence) what has been covert.

From these beginning steps, the therapist may do more extensive work with the patient alone or may work more directly with the parents. The therapist may feel that when the parents have been helped to deal more effectively with loss, they will provide a better model for their son as he deals with loss. The therapist may also believe that by dealing with their own losses, the parents may be saving their son from having to deal not only with his grief but also with the grief of his parents and past generations.

**Ecosystemic approaches.** The therapist who utilizes an ecosystemic perspective with the family is interested not only in intrafamilial relationships but also in relationships with larger systems. The therapist may want to include members of other systems that influence or are influenced by the problem being addressed in the family. The therapist may also be interested in the impact of social currents in the development of the family. These currents may include such considerations as the impact of ethnicity on how the family deals with problems, establishes roles.
for family members, and maintains its own identity, as well as how gender plays a part in the family's problems and solutions. In these ways, the therapist regards the family as one system in a multiverse of systems that interact and evolve together. Because the therapist sees these larger systems as integral to the family's life and progress, the therapist may actively collaborate with members of other systems in order to treat the family in a comprehensive manner. This collaborative approach may include network sessions in which members of other systems are included in the therapy.

During the initial interview the therapist may be particularly attuned to how members of other systems are an active part of the family's life. The therapist may learn, for example, that Louis was particularly attached to his art therapist while he was an inpatient. The therapist may also learn that the family's priest has been very involved in their lives since the death of Madeline's father. As the therapist learns more about the family's connections to members of other systems, he or she may actively elicit identification of the family's support system. He or she may learn that Angelo's main supports, for example, are friends with whom he socializes at the Sons of Italy hall.

The therapist may also explore the role that being Italian plays in the family's life:

The therapist comments on the importance of the Catholic church and organizations that support their identity as Italians. The therapist asks the family to teach him or her about their ethnic identity. Angelo says they have very strong ties to their relatives in Italy even though they do not see them. Both Angelo and Madeline speak Italian but their children do not. As they talk about their relatives, Madeline becomes tearful. She explains, though, that these are not tears of sadness. She simply says, “For us, family is everything.” The therapist learns that the family is defined broadly and includes friends and neighbors and members of their parish. The therapist asks the family if it would be valuable to include these important “family members” in the therapy to help with Louis's problem and to be a support. The family agrees and together they decide who should be invited to the next appointment. They include their priest, two friends, a great aunt and uncle, Louis's godparents, and the art therapist, who they came to see as a member of their family as well.

The therapist demonstrates respect for the culture of the family by asking the family members, as experts in their own ethnicity, to educate him or her about who they are and how they are connected to their community. The therapist learns how important family is and how broadly family is defined. With that in mind, the therapist asks the family to identify members of the larger ecosystem who might be a help to them. By identifying and mobilizing the larger network the therapist adds diversity (le Roux, 1992) to the family's approach to the problem. No longer alone in their troubles, the nuclear family can draw from the wisdom of professionals, friends, and family whom they have named as resources. The therapist might work with the patient or nuclear family alone or choose to involve other members of the larger system as needed. The therapist using an ecosystemic perspective is inherently confident in the larger system's capacity to work together to resolve the presenting problem.

In this section, we discussed the differences in therapeutic approach that a hypothetical therapist may take with a family depending on the class of intervention he or she chooses. We want to emphasize that each approach can be effective depending on the needs of the family and the skill of the therapist. In the next section we will take the process another step forward by considering an integrative approach to the same case.

PART II
Integration
Many, if not most, later generation family therapists apply an amalgam of core techniques as suits the pragmatic needs of the case. Even when they officially espouse a circumscribed family therapy model, we believe that their actual therapy is likely to incorporate core techniques from other models, involving

With all the integrated models, the process of integration results in a larger and more complex entity than just the sum of its parts. To illustrate, we will return to our clinical example and explore how the family was actually treated using transitional family therapy (Horwitz, in press; Landau-Stanton, 1986, 1990; Landau-Stanton et al., 1991; Landau-Stanton & Clements, 1993; Landau-Stanton & Stanton, 1983, 1985; le Roux, 1992; McDaniel, 1990; McDaniel, Hepworth, & Doherty, 1992; McDaniel & Landau-Stanton, 1991, 1992; Seaburn, Gawinski, et al., 1993; Seaburn, Lorenz, & Kaplan, 1993; Stanton, 1981a, 1981b, 1984, 1992; Stanton & Landau-Stanton, 1990; Weber, McKeever, & McDaniel, 1985). We will limit our discussion to one key element of the model, family competence, which depends upon an interweaving of here and now, transgenerational, and ecosystemic themes.

Family competence is elicited by assisting the family in exploring their history across multiple generations in order to familiarize them with the strengths and resources that their family has been able to access and utilize (see especially chaps. 6, 8, 9, 20, and 34 in this volume). Interventions are directed toward creating continuity among past, present, and future with careful consideration of the context across time (Landau, 1982). This bridging enables the family to understand its current functioning in terms of both its past and its present relational interactions. A key tenet of this approach is that the therapist does not have secrets from the family, but shares his or her philosophy and hypotheses with them in order to reconstruct the transitional pathway together. The therapist's innate belief that current problem patterns resulted from adaptive and effective solutions from the past allows him or her to engender a sense of competence in the family that enhances their solutions and interactions in the here and now. This transgenerational perspective encourages an examination of relationships across the genogram, how transitions have been completed in the past, and how this impacts relationships in the current extended family system.

In assessing aspects of the context from an ecosystemic perspective, the therapist may discover events from the past (such as losses from war and migration that had an impact on Louis's family) that are being played out again in the present. By construction of a transitional map (Landau-Stanton, 1990) and timeline (Stanton, 1992), the family discovers the "why now" of their current difficulties. It also allows the therapist and family to examine whether and how effectively its resources (within both family and community) are being utilized. In order to understand the context of the presenting problem, the therapist elicits information about family history and life cycle stage, ethnic and cultural background, and the extent to which situational and developmental transitions have been resolved. This information is normalized by the therapist, rephrasing the information in terms of the events and changes the family has experienced. The family is then able to recognize that earlier adaptive solutions to unavoidable events have led to patterns that have become entrenched and problematic.

During this process, the family frequently discovers that their current symptoms result from patterns (repeated over time and multiple generations) that may have worked in the past but no longer are effective. Strategic here and now therapists believe that the problem is a failed solution (Watzlawick et al., 1974). We believe that problems develop from the continuation of patterns that arise from solutions that were once successful but are no longer relevant and therefore become problematic. By gaining an understanding of what was happening in the family and its larger context at the time of onset, the family members are able to perceive the intrinsic health of their multigenerational family.

The discussion of the strengths, resources, patterns, and themes that appear across generations allows the family to realize the inherent assets of their traditions, heritage, and values and how these may have extended across generations. This, in turn, pro-
vides an understanding of current events that offers relief from guilt and blame, freeing them to work toward solving their current difficulties (Landau-Stanton, 1986, 1990; Landau-Stanton et al., 1993). The family, aware of its own potential health and competence, is then able to identify both the focus of the therapy and who will be needed to assist in its process.

Integrative Interventions
The process of therapy is both interactive and evolutionary, with family and therapist constantly revisiting earlier tasks and information and integrating them into new directions and solutions. As this occurs throughout the therapy, family and therapist influence each other and the process of change. The family takes increasing responsibility for change and feels more competent to take charge of resolving their problems.

The initial phase of treatment. In the initial phase of therapy, the integrative therapist utilizing transitional family therapy accomplishes several key tasks that will form the foundation of the whole therapy. These include many of the first session tasks that might be accomplished by therapists following here and now, transgenerational, and ecosystemic approaches. In the interest of brevity, only a few of these key interventions will be described below:

Hypothesizing. As Louis and his family prepared to engage in the first phase of treatment, the therapist constructed several working hypotheses that, if correct, would provide the foundation upon which she would build the primary interventions. For example, the therapist hypothesized that for Louis, difficulties were related to his and his family’s unresolved grief over past losses. While taking into account all the ideas presented in Part I (here and now, transgenerational, ecosystemic), the therapist also used the intake information to develop hypotheses about family strengths, areas of competence, and who might be engaged from the extended family and the larger system. The therapist hypothesized, for example, that the longevity of the couple’s marriage, maintained despite considerable pain, reflected strengths, such as loyalty and commitment, that were a part of the value systems of both families of origin.

Joining and mapping. The therapist began the therapy by spending time joining with the family, not only to establish rapport, but also to begin mapping the players in the family’s system. Joining is a critical factor in the process of successful treatment. Through joining, the therapist communicated sensitivity to a variety of family issues, such as generational hierarchies and gender. Joining also provided an initial opportunity for the therapist to validate family members and highlight the importance of their roles in the family. The tone of the overall therapy was set by communicating respect and affirmation of the individuals, the family as a whole, and its various support systems. Joining was utilized throughout, but it was an especially important intervention at the outset of therapy.

The use of the transitional map constructed during this initial phase had two primary purposes, in addition to providing the transitional perspective mentioned above. First, the mapping process was a natural and comprehensive vehicle through which the therapist continued to join the family. Second, while the family began to relate its history, symptoms, and relationships, the therapist learned the family’s “terrain” and was able to assess whether or not her initial hypotheses fit the family’s experience over time.

At this stage the mapping process included identifying members of the immediate and extended family, plus the family’s natural and professional support systems. The therapist also mapped other issues: the symptoms that had shaped the family’s responses to each other, the ways they had protected and cared for each other, and their unique qualities. All of these assisted the therapist in bringing them to a successful resolution of their problems. (See Figure 1).

Establishing goals for treatment. Often families come to treatment discouraged and overwhelmed by the longevity and/or repetition of their problems. Setting goals is a way to provide forward movement, direction, and hope for resolution. This family’s articulation of goals, fashioned in specific and workable language, gave them a new way of thinking about their problems, offering a clearly defined path to achieve change. Among the family’s goals in Louis’s case were to help him decrease his depression, elimi-
FIGURE 1. Map of Louis's family.
nate substance abuse, grieve his grandfather's death, and move on in his life in a meaningful and productive way. The therapist listened carefully to the family's goals while continuing the mapping process. The therapist ascertained how the family's goals were connected to events and issues that spanned many generations. This process created a context and direction for the family's therapeutic endeavor.

Assessing family strengths. The therapist spent a portion of the initial phase helping the family identify and articulate their perception of the family's strengths and resources. This helped family members identify and own their areas of competence and enabled them to plan how they would apply those strengths to the problems they faced.

Formulating the transitional perspective. Once the family had traced symptoms and strengths back across three or four generations, they were able to recognize how patterns and events from the past both contributed to current problems and shaped the family's future. A pattern of coping that had been adaptive or appropriate in the past no longer served its original purpose and actually created problems for the family. This family's very traditional family structure may have served them well at the time of immigration. But in the current generation, the same traditional structure was hindering family members who were trying to individuate or leave home. The family did not recognize that they had inherited patterns of interacting that were no longer productive. Consequently, they found themselves stuck in repeating patterns they neither understood nor could change. Therefore, issues related to loss, immigration, and trauma were explored early in the treatment process.

In this way, the therapist and the family began to understand how each family member was connected to the generations before them. They began to appreciate the individual "scripts" they had inherited, as well as the contributions they had made to the continuation of old patterns (Byng-Hall, 1991; Stanton & Landau-Stanton, 1995a, 1995b). The therapist also helped the family focus on the origins of their own strengths and competencies within previous generations. This process helped the family recognize a broader range of options for planning their present and future tasks.

Louis and his family were forthcoming, sincere, and eager to explore their history. They realized that there had been a great deal of love and loss across the generations and that one of the key values and strengths of their family was the willingness to make sacrifices for each other and to protect each other. In concluding the first phase of treatment, the therapist talked about ways in which the family expressed these strengths:

I am very impressed with the creative ways in which your family has worked together over these many years to honor the cultural origins of your family and to protect the way in which grandparents have maintained a special place in the family. I can see that both of these issues are of the greatest importance and must be respected throughout our work together.

The family has taught Louis to be a loving and responsible son and grandson. Somewhere along the line Louis misunderstood his mission and appointed himself sole guardian of the family's pain, so as to free up his loved ones to live, love, and be happy. He has become the reservoir of the family's sadness and grief, centralized among and between all his family members. He is so protective of everyone, he cannot dare to move forward for fear he might not be there if someone needs him.

Our job is to find new creative ways to maintain the respect for your Italian heritage and the role of grandfathers in the family while finding a way to lift the depression and overwhelming feeling of total responsibility from Louis's shoulders. In that way he can carry his share without depriving the other men and women of their rights and privileges to membership in the family.

Through this message to the family, the therapist communicated respect for the family's issues and values and sensitivity to the family's need to maintain and continue those values for future generations. At the same time the therapist framed Louis's behavior
as no longer necessary to the survival of the family. The family was now well established in the new country and would not fall apart at the loss of a single member. The family no longer needed to be bound to the grave of the departed in order to prevent splintering and dissolution. In this way the therapist gave both the family and Louis the noble ascription they well deserved, and created a climate of hope and nonthreatening change. She taught the family that they could continue their heritage without sacrificing their son.

**The mid phase of treatment.** The treatment moved into the second phase when clearly defined goals and a working map had been determined, and the family was beginning to take charge of the process. The mid phase was characterized by prioritizing, planning, and working on the goals identified in the initial phase. The strengths and resources of the family were utilized and homework continued the process between sessions. The therapist maintained a focus on the goals established in the earlier phase and developed the theme of the transitional pathway in greater detail. During this mid phase, the therapist expanded the treatment system to include resources identified in the initial phase. This phase continued until both therapist and family believed that the family's work was well under way and that they had established new ways of resolving their problems.

Once the initial phase of therapy had been summed up, the therapist invited Louis to share what he had learned through the process:

> Louis painfully disclosed his memories of the excessive physical punishment he remembered receiving throughout his childhood, particularly from ages 7 through 13. In session, he confronted his parents, especially his father, for the lack of judgment and control Angelo had displayed during those years. In an emotionally charged session, Louis expressed his pain; the long-standing poor self-concept he had come to despise, the fear of his father and his father's rage that he carried with him always, and his need for solace, which he believed he could only find in alcohol, drugs, or suicide. Louis expressed his fear that his father could "pop off" at any time and that he felt he needed to "be there" to protect his mother and sister.

After several sessions of working through the pain, Angelo was coached to embrace his son and to reassure Louis he would work to understand the reason for the long-standing frustration in their family. Both parents made a commitment to him and the other children that they would find a way to correct the problems from the past and renew their relationship with their son using love, rather than rage, as a basis of their future relationship.

At this point, the therapist began to explore rage in the family. The therapist returned to the transitional map to discuss in greater detail the tension-filled environment within which fathers and sons had struggled for several generations. Angelo explained to his family that his father was physically harsh with him as a young boy. This left Angelo angry and confused about what he had done to make his father so angry. When his older brother left home, Angelo's father withdrew all meaningful contact with him, again leaving him confused and deeply saddened. Further investigation led to Angelo's memories of his grandparents, who were his primary source of nurturance. He explained that his paternal grandfather had served in World War I in Italy and had become a highly respected soldier, serving in a special corps. After immigrating to the United States, he had lost his status and had to work in a factory. He began to drink and became the "town drunk," often thrown out of bars onto the streets. This behavior brought much shame to the family and resulted in Angelo's parents' forbidding him from having contact with his grandparents. Angelo explained further that this grandfather had been sent away from his home and family at age 7 because his father was off to war and his mother could not feed all of the children. The grandfather was the oldest child and so it was decided he would go to live with a relative and work on their farm. The family was astounded by the power and sadness of this story, which they were hearing for the first time. The family was able to understand how the issues of father absence, loss of
family and status, and alcoholism all contributed to Angelo's rage and Louis's depression.

Angelo's mother was invited to join the therapy to talk about family life when she and her husband were children. She, too, had experienced a sad and deprived childhood. She was able to confirm Angelo's report, and she added valuable information. She also gave Angelo permission to find his grandparents' grave and to visit them as often as he wanted. Angelo agreed to make a trip across country to visit his brother, with whom he had a somewhat strained relationship, to discuss his rage and sadness. Together they were to construct a plan for grieving the past and for finding meaningful ways of staying connected with each other. The therapist shared her thoughts with the family at this juncture:

I am very impressed with how courageous you all have been over these many years. Each son, though confused and sad, has suffered in silence and, at some level, has understood the pain of his father. You have all been busy protecting and caring for your families, while taking on the growing burden of grief and sadness. It is no wonder that Louis grieves deeply over the loss of his mother's father, a loving grandfather who understood and nurtured him, much like Angelo's experience with his grandfather. While unfortunate circumstances deprived Angelo of his grandfather, illness and death deprived Louis of his grandfather. Indeed, both Angelo and Louis have much in common. We need to find a way to continue to honor and respect the grandfathers in this family, but first we must find a way to put the grief and sadness in its proper place. With the support of all the family members, I believe we can accomplish this necessary work. Angelo, you will need to lead the way.

The therapist weaved the transgenerational perspective together with an ecosystemic view of the family's movement over time. The therapist paid close attention to the repeating patterns of father-son conflict and absence, as well as the burden of unresolved grief over the many losses both parents' families had carried from one generation to another. The transitional map was used to guide the discussion of the family history and to define the points of transitional conflict, namely when sons reach 7 years of age, when fathers go off to war, when families immigrate, when marriages are tension-filled, and when sons both prepare to leave home (age 13) and actually leave. The therapist expanded the system by bringing in the extended family to help heal the wounds and to relieve Louis of sole responsibility for protecting his family and grieving their losses. The role of the women in the family was key in this task. For example, Louis's maternal grandmother attended a session in which she helped Madeline grieve her father's death and "let go." Then, Madeline was encouraged by her mother to turn her attention more to her current family. Madeline's example and ongoing support were vital as Louis and his father struggled to forge a new relationship.

Here and now techniques were also included in that Angelo is sent to talk with his older brother. This intervention served to strengthen the sibling subsystem, thereby removing pressure from Louis (the elder son) to be both son and lost brother to Angelo. It also legitimized Louis's symptoms of depression and withdrawal and offered the family a context in which to resolve the etiology of the problems. The transgenerational perspective was woven into the assignment in that the therapist "sent Angelo home" to do this work with the one other person who was most appropriate.

The final phase of treatment. The final phase of treatment was typified by the family being more in charge of the direction of therapy. They felt they were achieving some of the goals they had set in the initial phase; the family also felt confident that they were utilizing their strengths and resources toward planning their future. The primary task of the final phase was to help the family recognize its own capacity to deal with difficulties that may present in the future.

As Louis's family moved toward the end of the mid phase of treatment, they began to see the progress they were making. They had completed many tasks designed to reorganize the family's structure, reconstruct and enact (in and out of session) Louis's
and Mario’s childhood in the way the parents wished it could have been, and to create safe, productive ways of expressing anger and pain to one another. Because the yarn of tangled family interaction found itself unknotting and smoothly rewinding, several previously unstated issues began to emerge. Convinced Louis was now “safe” from suicide and major depression, Mario expressed his rage at his brother for having treated him in the same way their father had treated Louis, abusively and at times cruelly. The brothers were able to work out their unfinished business to both of their satisfaction. Mario also disclosed that he and his girlfriend were beginning couples therapy at the university’s counseling center to work on their chronic conflicts. Emily began to show signs of withdrawal and anxiety similar to those that started Louis on his journey of pain and suffering. The parents quickly stepped in and helped her manage her fears and anxiety in productive ways.

Angelo shared with his family that the depth of his rage was significantly diminished and that even though he could not promise he would never be angry again, he felt certain he would not lose control. In a moving session Angelo and Madeline sat together, holding hands, and told Louis they did not want him to take care of them anymore; they wanted him out of the middle of their marriage and they had decided to engage the therapist for 6 to 8 sessions of marital therapy. Because Louis continued to express a high degree of anxiety, individual time-limited sessions were arranged for him with a co-worker at the clinic. In this way, the overall treatment plan could be coordinated between the two therapists. The separate therapies were critical at this juncture. Drawing an appropriate boundary between the two therapies assisted Louis in differentiating from his parents and their marriage.

The final phase of treatment constituted marital therapy for Angelo and Madeline. This therapy included utilizing extended family members (ecosystemic) to deal with current difficulties (here and now), grief work related to Madeline’s father’s death (transgenerational), exploration of spousal relationships in both families of origin over multiple generations (transgenerational), and reminiscences and reenactments of “the good days” of their relationship.

In the course of these discoveries Madeline and Angelo were able to respectfully share both their painful perspectives of the bad times and a newfound ability to hear each other, even though they disagreed about many of the facts. The couple’s 25th wedding anniversary served as an incentive for cooperation and forgiveness leading to termination of the marital therapy.

Louis’s individual work was slow, but he learned to manage his anxiety through the use of several tasks, one of which was the employment of relaxation techniques (here and now). Even within the context of individual therapy, the therapist utilized transgenerational and larger system techniques by sending Louis to his mother’s great-grandmother, still alive in her 90s, who coached Louis to move on with his life and to let her son (his revered grandfather) rest in peace. He became more productive at school and reported greater satisfaction with his limited, but significant, relationships. He began to move away from his former group of friends with whom he had been drinking and began to form new relationships.

Louis became a full-time student in a local college, majored in psychology, and received high grades. He moved in with a girlfriend and they cared for lots of pets. Angelo and Madeline continued “dating,” looking forward to getting closer to each other in new ways. Mario graduated from the university with honors. He and his girlfriend were getting along well. He anticipated going on to graduate school in the next academic year. Emily was doing well in school and had lots of friends.

At the time this chapter was written, the family was ready to terminate therapy. They were working on their last assigned task, which was to discuss and agree on the most desirable way to punctuate their progress and their many accomplishments. A follow-up family session was planned to bring proper closure to the therapy.

CONCLUSION

This case demonstrates that integrating all three classes of intervention—here and now, transgenerational, and ecosystemic—enables the therapist and family to
create a working environment in which problems can be resolved effectively. Problem resolution occurs not just within the patient and nuclear family but across the extended family both vertically and horizontally. The therapist’s broad and inclusive perspective enhances the family’s ability to develop tools to stop ineffectual patterns from repeating across the genogram.

Our discussion of core interventions in family therapy reflects a desire for integration. Integration involves more than borrowing from various models of family therapy—the heart of integration is dialogue. To integrate is first and foremost to facilitate a meaningful exchange between viewpoints that may differ. Such dialogue is much like weaving a fine tapestry. Each strand contributes its own color, texture, and strength. Together all the strands create a fabric that no single strand could have created alone. Exploration of here and now interactions, processes, and structure; inquiry into the evolution of family life and legacies; and curiosity about how families are woven into the larger ecosystem of culture, values, gender, and ethnicity teaches us more about the tapestry of family resilience, competence, and strength than any single strand or perspective could.

Integration is the future of family therapy. Integrative approaches hold the key to a more complete and in-depth understanding of the family. The implications of integration for the field of family therapy are far reaching. As we look at the family through integrative eyes, how we practice, how we train family therapists, and how we do research will surely change and grow.

References


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Core Techniques in Family Therapy


