2 ESCAPE FROM BABEL

Building a Unifying Language for Psychotherapy Practice

> No psychotherapy is superior to any other, although all are superior to no treatment. . . . This is the conclusion drawn by authoritative reviews . . . , and well-controlled outcome studies. . . . This is really quite remarkable, given the claims of unique therapeutic properties made by advocates of the various treatments available today.
>
> *Joel Weinberg, 1995, p. 45*

> No theory, just as no profession, can claim preeminence for long if it cannot firmly establish that its adherents agree on the use of its basic organizing concepts.
>
> *Stuart A. Kirk and Herb Kutchins, 1992, p. 31*

THE PATHOLOGICAL basis of *paralysis agitans*—the shaking palsy—defied medical understanding for more than a hundred years. With the greying of the population, this brain-based condition bearing the name of the man who provided the best first description, Parkinson, has become all too familiar to patients, their families, family physicians, psychiatrists, and neurologists. What is less appreciated are the singular, almost bizarre, psychological explanations offered by mental health professionals for the genesis of the disease.

From the earliest accounts, observers noticed that those afflicted with the disease displayed an "emotional and attitudinal inflexibility, a lack of affect and a predisposition to depressive illness, which may antedate the development of motor abnormalities by several decades" (Todes & Lees.

1985, p. 97). In 1875, the famous French neurologist Charcot considered that emotions in combination with hereditary factors were instrumental in bringing on the condition. Over the years, the notion that a patient's affects were the culprits in Parkinson's disease has kindled highly speculative but nonetheless influential explanations.

To illustrate, in the late 1940s Booth hypothesized that the pre-Parkinson patient lived in a tenuous balance between striving for independence and freedom from authority while conforming to social expectations and standards. He further believed that these patients were inculcated from their childhood with the idea that they should abide by social norms at the expense of their feelings. According to Booth, this resulted in the development of a social mask to cover or screen hostile and sadistic impulses. The disease emerged when the equilibrium of a patient's psychological economy—the social mask—was upset through frustration, loss of independence, or eruption of aggression. Although this description fits *most people* growing up and living in American society, not just patients with Parkinson's disease, Booth believed that the factors he had identified were causally linked to the onset of the disease (Booth, 1948).

Looking back, the purpose of this kind of wild character analysis was to establish a psychogenic or functional cause (read: explanation) for Parkinson's disease. Using supposedly "hard" data, such as Rorschach responses, clinical experience, and professional observation, to support their hypotheses, professionals confidently promoted their etiological hunches—mainly in the vocabulary of psychodynamics. What is troubling is that this edifice of psychological conjecture stood largely unchallenged until researchers established that the depletion of the neurotransmitter dopamine in the substantia nigra (part of the midbrain) accounted for the debilitating motor disorder (Hubble & Koller, 1995).

Sadly, the story of Parkinson's disease highlights a recur-

ring theme in the mental health professions. Intoxicated by models and a penchant for complex but mostly vacuous psychological theories, clinicians often accord their beliefs the status of clinical reality. Throughout the history of the field, virtually every school of therapy has forcefully championed its own explanation of problem formation, treatment goals, and unique methods for resolving or mitigating clients' complaints. With an immodesty approaching outright hubris, the proponents of each school have insisted that the explanations and outcomes of their paradigm are far superior to other treatment models. As clear as this pattern may be, however, the field seems doomed to repeat it. It is as though there is no end to the impulse to exaggerate the explanatory power and therapeutic effectiveness of psychotherapy models.

Consider, for instance, a recent article in *The Family Therapy Networker* (the magazine with more readers than any other professional publication in the field) on one of the latest trends to sweep the therapy model marketplace: narrative therapy. One writer claimed that the new approach not only has "an immediate impact on troubled people's lives" but, through "its ability to put ideology into action," could also end racism, sexism, and any other political "ism" to which it was applied (O'Hanlon, 1995, p. 24). Or, how about a nationally circulated ad for a therapy called, "NLP Eye Movement Integration." The ad asks the would-be consumer, "Would you like to learn a method that is *faster, simpler, safer, and more effective*?" Well, what provider wouldn't? In this era of managed care, survival increasingly depends on how well and how quickly clinicians can get results—a consideration not lost on advertisers. Lastly, how about the latest book by Albert Ellis (1995), entitled *Better, Deeper, and More Enduring Brief Therapy*, in which readers are promised to learn methods:

> . . . not only useful with less severely disturbed clients, but also with difficult clients such as those afflicted with *personal-*

> *ity disorders, psychotic states, organicity, and mental deficiency.* (Brunner/Mazel Bulletin, 1995, p. 6, emphasis added)

Yet, when Ellis's claims are contrasted with available research on the outcome of brief therapy, the rhetoric simply does not add up to reality. In reviewing the brief therapy literature for their chapter in the latest edition of the *Handbook of Psychotherapy and Behavior Change*, Koss and Shiang (1994) found the following:

> [There is] compelling empirical evidence that brief psychotherapy is effective with specific populations. . . . brief therapy has been found to be *less effective with more severe disorders, such as those of personality, substance abuse, and psychosis.* (p. 681, emphasis added)

What can the practicing clinician conclude regarding most of the claims made by the developers of treatment models? Given the very real difference between their rhetoric and empirical reality, it is safe to assume that while creating a great deal of heat they throw very little light on the subject at hand.

THE VOCABULARY OF A UNIFYING LANGUAGE

> It is the familiar that usually eludes us in life. What is before our nose is what we see last.
>
> *William Barrett*

With almost forty years of research findings in hand, we can say with confidence that the various manifestations of therapy are *more alike* than different. Therapies work not because of their unique explanatory schemes or specialized language; on the contrary, as was pointed out in the previous chapter, their success is largely based on what they have

in common. In this regard, veteran psychotherapy outcome researcher Michael Lambert (1994, personal communication) has observed:

> When you watch good therapy being done, you know it and it has a lot of commonalities . . . [G]ood cognitive therapists and good behavior therapists, psychodynamic therapists act an awful lot alike.

It is the very commonalities noted by Lambert that form the basis of a *unifying language* for psychotherapy practice. Fortunately, adopting such a language does *not* mean that therapists must learn an entirely new or even different language of psychotherapy practice. In fact, the words and concepts of the unifying language will already be familiar to most clinicians, based as they are on what all therapists already do that contributes to successful clinical work. For those weary of keeping up with the endless number of new treatment models, the unifying language will certainly be welcomed.

Therapists will also find that their clients are attuned to the commonalities linking all good therapy. Indeed, most speak the language with ease and require no special training. In this regard, when researchers ask clients about the helpful aspects of their experience in therapy, they rarely mention specific, model-driven interventions or techniques. Instead they consistently identify the *same* variables as therapeutic—for example, the importance of "being respected, being understood and being cared for" (Lambert, personal communication, 1992). This same body of research shows that clients also expect their therapists *not* to be bound to any one brand or language of treatment. Consider, for example, a study conducted by Kuehl, Newfield, and Joanning (1990), which found that clients who viewed their therapist as *not* rigidly adhering to a particular point of view were more likely to be satisfied with their experience in treatment.

THE ELEMENTS OF A UNIFYING LANGUAGE

Four common curative elements, each central to all forms of therapy despite theoretical orientation, mode (i.e., individual, group, family, etc.), or dosage (frequency and number of sessions), constitute the unifying language. These four elements, in order of their relative contribution to change in therapy, are: (1) extratherapeutic factors; (2) therapy relationship factors; (3) model and technique factors; and (4) expectancy, hope, and placebo factors (Lambert, 1992).

Extratherapeutic factors: Clients and their environment

> Everything is luck and timing. Ability counts, but ability is always third.
>
> *Donald Lamberti, 1995*

In the clinical literature, clients have long been portrayed as the "unactualized," message bearers of family dysfunction, manufacturers of resistance, and in most therapeutic traditions, targets for the presumably all-important technical intervention. Indeed, it seems that once people decide to enter treatment they suddenly become something less than they were before. They cease knowing their own mind, are disconnected from their feelings, certainly have "something" wrong with them that requires fixing, and, of course, will do their devilish best to resist the therapist's efforts to help them. It is curious that the very profession that makes helping a virtue has also made a cult out of client incompetence. A testament to the success of this cult of incompetence is the significant degree to which the pathology- and deficit-based language of the recovery movement and the *Diagnostic and*

Statistical Manual of Mental Disorders (APA, 1994) have been embraced by American popular culture (Kaminer, 1992).

In the same way that clients are assumed to be fragile or ineffective in some way, therapists are considered the masters and heroes of the therapeutic encounter. There are hundreds of books about great therapists but few, if any, books about great clients.

Nowhere is this tendency more obvious than in professional workshops and conferences where some woebegone individual, couple, or family is recruited for a live demonstration conducted by some recognized expert in the field. Especially desirable for these productions are those clients thought to be at an "impasse" with their current therapist. Before an audience of perhaps hundreds of mental health professionals, clients bare their dilemmas and ill fortune to the "master," who invokes reportedly innovative concepts and techniques to transform the client—at least that is what the audience is paying to see. Underscoring the point, videotapes of these demonstrations can be rented or purchased by practitioners through a proprietary operation called, what else, *The Master Therapists* (trademarked by AAMFT).

As these examples illustrate, much of the writing and thinking about psychotherapy practice places the therapist at center stage in the drama known as *Therapy*. Rarely is the client cast in the role of the chief agent of change. Nevertheless, the research literature makes clear that *the client is actually the single, most potent contributor to outcome in psychotherapy*. The quality of clients' participation, their perception of the therapist and what the therapist is doing, determine whether *any* treatment will work. In fact, the total matrix of who they are—their strengths and resources, the duration of their complaints, their social supports, the circumstances in which they live, and the fortuitous events that

weave in and out of their lives—matters more than anything therapists might do. Clients, the research makes abundantly clear, are the true masters of change in psychotherapy; they are always more powerful than their therapists.

In the research literature, the client's contribution to outcome is part of a category of common therapeutic elements called "extratherapeutic factors." These factors are estimated to account for the *major* portion of improvement that occurs in any treatment, a whopping 40%. They refer to any and all aspects of the client *and* his or her environment that facilitate recovery, regardless of formal participation in therapy (Lambert, 1992). As such, extratherapeutic factors are the cornerstone of the unifying language for psychotherapy practice.

All therapies benefit from the operation of extratherapeutic factors, whether or not they are a part of the formal language or technique. By making these factors a part of the everyday lexicon of psychotherapy practice, therapists can enhance their contribution to psychotherapy outcome. In Chapter 3, detailed information and suggestions will be given for both recognizing these factors and including them more deliberately in the treatment process.

The therapy relationship: Client and therapist together

> I don't believe in just ordering people to do things. You have to sort of grab an oar and row with them.
>
> *Harold Geneen*

The therapeutic relationship is the medium through which the process of therapy is enacted and experienced. While they may use different words and concepts, most therapists and schools of therapy acknowledge the importance of the therapeutic relationship in producing beneficial outcomes.

Over the last forty years, the influence of the therapeutic relationship has been tracked across an array of treatments (e.g., behavioral and cognitive, psychodynamic, experiential, eclectic, group, and pharmacotherapy [Henry et al., 1994]). In all these approaches, a correlation has been found between the therapeutic relationship and psychotherapy outcome. Researchers estimate that as much as 30% of the variance in psychotherapy outcome is due to so-called "relationship factors"—making them second in importance to extratherapeutic factors (Lambert, 1992). In fact, the evidence is so strong that veteran psychotherapy researcher Hans Strupp recently wrote, "*the quality of the interpersonal context* is the sine qua non in all forms of psychotherapy" (1995, p. 70; emphasis in original).

Studies further show that the quality of the client's participation in the therapeutic relationship is the single most important determinant of outcome (Orlinsky, Grawe, & Parks, 1994). Clients who are motivated, engaged, and join in the work with the therapist benefit the most from the experience. Of course, the quality of clients' participation in treatment is greatly affected by the bond or alliance they form with the helping professional. In contrast to what one might expect, the research does not show that the strength of this therapeutic alliance or bond is a function of the length of time a client has been in therapy (Horvath & Luborsky, 1993). Therapists who worry that managed care—with its unrelenting emphasis on cost-effective and time-sensitive therapy—may make having helpful therapeutic relationships impossible can rest a little easier.

Far more important to the formation of a strong therapeutic alliance, the research shows, are what humanistic psychotherapist Carl Rogers considered the "core conditions" of effective psychotherapy—empathy, respect, and genuineness (Horvath & Lurborsky, 1993). The latest research and

thinking indicate that strong alliances are formed when *clients* perceive the therapist as warm, trustworthy, nonjudgmental, and empathic. Therapists' evaluations of their success in providing this kind of therapeutic environment for the client are not enough. The core conditions must actually be felt by the client, and each client may experience the core conditions differently (Bachelor, 1988). In this regard, a growing number of studies has found that *clients'* ratings of the therapeutic alliance, rather than therapists' perceptions, are more highly correlated with outcome (Horvath & Luborsky, 1993; Orlinksy et al., 1994). For this reason, the most helpful alliances are likely to develop when the therapist establishes a therapeutic relationship that matches the client's definition of empathy, genuineness, and respect (Duncan, Solovey, & Rusk, 1992).

As was true of extratherapeutic factors, all therapies benefit from the operation of relationship factors, whether or not such factors are an explicit part of a particular model's theory or technique. Adding relationship factors to the unifying language for psychotherapy practice builds on what most treatment professionals already know about successful clinical work and will enable therapists to further enhance the contribution of these important factors to psychotherapy outcome. Recognizing and empowering relationship factors is the topic of Chapter 4.

Therapeutic technique: The doings of therapy

> Techniques are ritualized methods of human relatedness and communication. . . . Techniques and the personal meanings they invoke are always embedded in human relationships.
>
> *Michael Mahoney*

Another element in the unifying language encompasses the category of therapeutic technique. All therapists make use of

technical procedures. In any given session, for example, one may see a therapist asking particular questions, listening and reflecting, dispensing reassurance, confronting, providing information, offering special explanations (reframes, interpretations), making suggestions, self-disclosing, or assigning tasks to be done both within and outside the therapy session. There are also technical considerations informing where the therapist and client should sit, when the session should begin and end, who is seen, and even whether or not the client should be offered tissues.

The content of the talk or questions is different depending on the therapist's theoretical orientation and technique. Indeed, as was illustrated in Chapter 1, differences in technique and the language used to describe those techniques are often convenient markers for telling therapists apart and engaging in heated professional debate. Whatever model is employed, however, most therapeutic procedures have the common quality of preparing clients to take some action to help themselves. Across all models, therapists expect their clients to do something different—to develop new understandings, feel different emotions, face fears, take risks, or alter old patterns of behavior.

In spite of the field's interest and investment in technical factors, however, their actual percentage-wise contribution to outcome pales in comparison to extratherapeutic and relationship factors. In his widely cited review of psychotherapy outcome research, Lambert (1992) estimates that the therapist's model and technique contribute only 15% to the overall impact of psychotherapy. Though this finding may be troubling to schools of therapy that have prided themselves on their unique conceptualization of therapeutic process or innovations in intervention methods (e.g., primal screaming, genograms, miracle questions, EMDR, letter writing, etc.), the data are clear: clients are largely unimpressed with their therapists' techniques. As Lambert put it:

> [P]atients don't appreciate these techniques and they don't regard these techniques as necessary. They hardly ever mention, ever, a specific technical intervention the therapist made. I'd encourage therapists to realize their phenomenological world about the experience of therapy is quite different than their patients'. The nontechnical aspects are the ones patients mention. Also, when objective judges listen to tapes of therapy, the nontechnical aspects are the ones that correlate with outcome more than any technical intervention. (personal communication, December 9, 1993)

When the practice of psychotherapy is guided by a unifying language, therapeutic technique stops being a reflection of a particular theoretical doctrine or school of therapy and instead becomes the vehicle for enhancing the effects of the other common factors. The immediate result is that therapists spend less time trying to figure out the *right* intervention or practicing the *right* brand of therapy and spend more time doing what they do best: understanding, listening, building relationships, and encouraging clients to find ways to help themselves.

Expectancy, hope, and placebo:
The unsung triad

Contributing the same percentage-wise amount to outcome as therapeutic technique are the final words in the vocabulary of the unifying language—expectancy, hope, and placebo (Lambert, 1992). These factors are responsible for that portion of improvement that clients experience simply by making their way to therapy. Research shows that merely expecting therapy to help goes a long way toward counteracting demoralization, mobilizing hope, and advancing improvement (Frank & Frank, 1991).

As one might expect, the creation of such hope is strongly influenced by the therapist's attitude toward the client during

the opening moments of therapy. Pessimistic attitudes conveyed to the client by an emphasis on psychopathology or the difficult, long-term nature of change are likely to minimize or curtail the effect of these factors. At the same time, an emphasis on possibilities and a belief that therapy can work will likely work to instill hope and a positive expectation for improvement. It should be noted, however, that creating this hopeful therapeutic atmosphere is not the same as adopting a pollyannish, "every cloud has a silver lining," attitude toward client difficulties. Rather, hopefulness results from acknowledging both the client's present difficulties *and* the possibilities for a better future.

The research literature shows that hope and expectancy give people a measurable advantage in many areas of life—in academic achievement, managing major illness, and dealing with difficult job situations (Goleman, 1991). In the psychotherapy literature, studies further show that fostering a positive expectation for change may actually be a prerequisite for successful treatment (Snyder et al., 1991; Snyder, Irving, & Anderson, 1991). In Chapter 5, detailed information and suggestions will be given for making these factors an active part of the treatment process.

CONCLUSION

To generations of therapists reared on the proposition that ingenious and intellectually stimulating treatment models and their associated techniques make the real difference in therapy, the four common factors that really count may seem pallid and anticlimactic. Therapists have been subjected to the most intense forms of marketing. Books, continuing education seminars, and graduate school training most often portray the process of producing change as a complicated, technical, and often dramatic business. Faced with the ardors

of day-to-day clinical work, many therapists may feel that the four factors of the unifying language are simply too inert, offering little help in addressing the complex problems modern clients bring to the consulting room.

The fact of the matter is, however, that while therapists' formulation of problems and experience of the therapeutic process may be complex, the factors that contribute to successful psychotherapy are not. The data indicate that successful psychotherapy would be best understood as a rather simple, straightforward, and oftentimes boring business, distinguishable from other helpful experiences in life only by the explicit, socially sanctioned contract to be helpful that exists between a therapist and client. No doubt, the practice of psychotherapy is not always as easy one. *Easy* and *simple* are, however, two very different matters. Clinical work may frequently be trying, but that does not mean that the factors contributing to successful psychotherapy are necessarily complicated.

The best way for therapists to begin speaking a more unifying language is for them to set aside their chosen model or theory and look for and identify the four common factors currently operating in their own clinical work. For instance, because research has established that the quality of a client's participation in treatment is the single best predictor of psychotherapy outcome, clinicians might begin by closely examining what they already do in order to engage the client in the therapeutic process. Given the magnitude of the contribution made by extratherapeutic factors, therapists would also do well to look at what they presently do to utilize clients' strengths and resources in the achievement of treatment objectives. Additionally, therapists can examine what they do to engender hope and a positive expectation for change in their clients.

Before reading the suggestions and recommendations contained in the following chapters, therapists might look for

evidence of the operation of the common factors that constitute the unifying language currently operating in their clinical work. Like Dorothy in *The Wizard of Oz*, therapists have always had the means to get back to Kansas. No guru or master therapist, no complex theory of human behavior or "advanced workshop" is necessary. Neither is allegiance to any one model or combination of models, methods, or doctrines. In effective therapy the common factors operate regardless of the model or technique being employed. True, the language may lack the technical precision or theoretical elegance that makes some existing treatment models so compelling. Yet it has the advantage of forty years of empirical support. More important, perhaps, it has the potential to unify clinicians from disparate traditions in their common interest to help those in need of treatment.