

Introduction

Increasing evidence shows that common factors, and particularly human factors (e.g., client factors, therapist factors, the therapeutic alliance), are the primary determinants of effectiveness in psychotherapy, dwarfing the effects of modalities and techniques. This evidence undermines the medical model of psychotherapy with its assumption that modalities and techniques are the instruments of change and calls for a new, non-medical model that places the human elements at the center of therapeutic work.

I did not begin my professional career believing that the human elements of psychotherapy were the primary determinants of effectiveness. As a graduate student in clinical psychology in the 1970s, I was taught that the human elements of psychotherapy were important because they helped build a good therapeutic relationship that, in turn,

<http://dx.doi.org/10.1037/14751-001>

The Human Elements of Psychotherapy: A Nonmedical Model of Emotional Healing, by D. N. Elkins
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made the client more cooperative and compliant with the treatment. The “treatment” was the techniques and procedures used by the therapist. However, as I gained clinical experience as a young psychologist, I began to notice that when I had a good relationship with a client, he or she tended to get better, and I wasn’t convinced that the change was due to the techniques I used. I was also aware that Carl Rogers’s research in the 1950s and 1960s had shown that personal and interpersonal factors such as empathy, unconditional positive regard, and congruence were responsible for therapeutic change. Thus, I began to suspect that the human elements of therapy were the primary factors in emotional healing.

However, about this time in my career, proponents of cognitive–behavior therapy (CBT) began to publish articles and books indicating that certain CBT techniques had been scientifically proven to be effective for various disorders. By this time, I had begun to train therapists as a full-time professor at Pepperdine University. Excited about the “scientifically validated” techniques of CBT, I invited a leading CBT clinician to speak to one of my graduate classes. The students and I were very impressed. Like many clinicians during that era, I thought that CBT techniques were the royal road to scientific effectiveness. I continued to believe that the human elements of therapy were important but became convinced, once again, that the real agents of change were scientifically validated techniques.

Then, during the late 1990s and early 2000s, something happened that changed my understanding of how psychotherapy works. Bruce Wampold, a professor at the University of Wisconsin–Madison, published what would become landmark studies on psychotherapy effectiveness (Ahn & Wampold, 2001; Messer & Wampold, 2002; Waehler, Kalodner, Wampold, & Lichtenberg, 2000; Wampold, 2001a; Wampold et al., 1997). Wampold conducted analyses and meta-analyses of hundreds of published studies to identify the factors that were responsible for therapeutic effectiveness. Remarkably, the findings showed that techniques had little to do with effectiveness and that common factors were the real agents of change. Subsequent research confirmed these original findings (see, e.g., Benish, Imel, & Wampold, 2008; Imel, Wampold, Miller, & Fleming, 2008; Miller, Wampold, & Varhely, 2008). This evidence had a major impact on my understanding

of psychotherapy and how it works. It also had a major impact on our profession. In fact, it shook, and continues to shake, the foundations of clinical psychology. The evidence showed that the medical model was wrong and that for more than a century, clinical research, training, and practice had focused on the wrong factors in psychotherapy.

Today, we are in the midst of a paradigmatic shift that is moving our profession toward a new understanding of emotional healing and a new understanding of how psychotherapy works. In essence, that's what this book is about. It presents a new, nonmedical model that places the human elements at the center of therapeutic work. But before delving into this new model, we need to examine its precursor, the medical model.

DEFINITION OF THE MEDICAL MODEL

The term *medical model of psychotherapy* can be confusing. For example, some clinicians think the term refers only to the neurobiological model and the use of psychiatric drugs. Because these clinicians use "talk therapy" to help clients, they think the medical model has nothing to do with them. Thus, it's important to emphasize that the term *medical model of psychotherapy* refers to any therapeutic approach, including talk therapy, that focuses on modalities and techniques and uses a medical schema and medical language to describe what is taking place. Elsewhere (Elkins, 2009a) I defined the medical model as follows:

The medical model in psychotherapy is a descriptive schema borrowed from the practice of medicine and superimposed on the practice of psychotherapy. The schema, including its assumptions and language, accurately describes the processes and procedures of medical practice and has been highly useful in that field. However, the schema does not accurately describe the processes and procedures of psychotherapy and has proven itself to be problematic when superimposed on that field. In medicine, a doctor diagnoses a patient on the basis of symptoms and administers treatment designed to cure the patient's illness. In psychotherapy, medical model adherents *say* that a doctor diagnoses a patient on the basis of symptoms and administers treatment designed to cure

the patient's illness. However, when they say this, they are superimposing a medical schema on psychotherapy and using medical terms to describe what is essentially an interpersonal process that has almost nothing to do with medicine. (p. 40)

In other words, the medical model is a template or mold that Freud and other pioneers borrowed from medicine and superimposed on psychotherapy, forcing the language, processes, and procedures of psychotherapy into a medical-like pattern. Unfortunately, succeeding generations of clinicians also embraced the medical model. Thus, psychotherapy never had a chance to reveal its own natural or indigenous character. Today, we have become so accustomed to viewing psychotherapy through the lens of the medical model that it's difficult to see psychotherapy as it really is.

WHAT PSYCHOTHERAPY REALLY IS

When we examine the medical model from a clinical perspective, one of the first things we notice is that a typical psychotherapy session has almost nothing to do with medicine. A typical session consists of a client with some type of personal or interpersonal problem talking to a therapist who listens, offers support, and may suggest some ideas or an approach to the problem that might help. There is nothing about the process, if viewed objectively, that would lead one to describe it in medical terms. Of course, we can force the process into the medical model mold and then say that a "doctor" is "administering treatment" to a "patient." Such a description, however, seems forced and alien to what is actually taking place. If we describe what is happening without first forcing it into the mold of the medical model, it's really quite simple: Two people are talking; one is talking about a problem, and the other is listening and trying to help. There's no reason to distort what is taking place by forcing it into a mold borrowed from medicine. Psychotherapy has its own character. It's a social interaction, an interpersonal process. Surely, even ardent supporters of the medical model can see that it requires a stretch in logic, not to mention a certain lack of sensitivity, to say that listening to a woman pour out her grief about the loss of a child and offering support is a medical treatment

or that trying to comfort an old man talking about his abject loneliness since his wife died is a medical procedure. Yet, these are the kinds of real-life issues that psychotherapists deal with every day.

Those of us who practice psychotherapy have the privilege of being invited into the most private chambers of our clients' lives. If we remove our medical model glasses, it's easy to see that psychotherapy is not a medical procedure. Instead, it's a special kind of relationship between a client who is having a difficult time and a therapist who is trying to help. The medical model has no language to describe these human and relational aspects of psychotherapy. Indeed, the medical model is a cold, insensitive system that distorts and obscures what is a deeply human, interpersonal process. Thus, even before we consider the scientific evidence that undermines the medical model, it's obvious that the model is problematic and that we need a new model of psychotherapy—one that reflects the true nature of psychotherapy and one whose language is not so cold and insensitive to the emotional pain and struggles of our clients.

WHY THE MEDICAL MODEL DOMINATES THE FIELD

If the medical model of psychotherapy is so problematic, then why does it continue to dominate our field? To answer this question, we must examine the politics and economics of the medical model.

Politics

I use the term *politics* here to refer to the dynamics of power associated with the medical model. First, most of the power structures associated with contemporary psychotherapy are permeated by the medical model. These power structures include psychology associations, training programs, research centers, research funding agencies, health insurance organizations, hospitals, mental health centers, and even private practice settings. These organizations are deeply rooted in the medical model, and if they abandoned that model and adopted a nonmedical model, they would have to make radical changes. In fact, they would

have to change almost everything they have assumed about psychotherapy and how it works.

Second, the medical model provides a type of status and prestige for psychotherapy because of the model's association with two powerful systems in our culture: medicine and science. When we use terms such as *doctor*, *patient*, *symptoms*, *diagnosis*, *illness*, and *treatment*, we align psychotherapy with medicine, the most respected and powerful system of healing in Western culture. Similarly, when we use such terms as *scientifically validated techniques* or *empirically supported treatments*, we align psychotherapy with science, the most respected and powerful epistemological system in our culture. Thus, when psychotherapy is described in medical and scientific terms, it takes on an aura of prestige and power borrowed from medicine and science. Imagine the loss of prestige and power that would occur if we described psychotherapy as "listening to a person who is demoralized, experiencing emotional pain, or having other difficulties in life and giving that person support and guidance based on our experience and psychological knowledge." Although this description is quite accurate in terms of what most of us actually do, it lacks the connotations of prestige and power that are associated with saying that we are "doctors who diagnose psychopathology and administer empirically supported treatments to cure mental disorders." The first description conjures up images of a teacher, pastor, counselor, or even a caring friend who is helping another human being who is having a difficult time. The second description conjures up images of physician-like experts administering medical treatments that are scientifically proven to cure mental disorders. The power and prestige differential in these two descriptive systems is obvious. The first description suggests that psychotherapy is a special kind of relationship and human interaction. The second suggests that psychotherapy is a medical procedure that has all the power and credibility of medicine and science. Add to this the fact that health insurance companies are willing to pay "doctors" for "treating" "mental disorders" but are not willing to pay someone, even a professional with years of training and clinical experience, to listen to a demoralized person and offer support and guidance, and one can see why the medical model is so entrenched

in our profession. To put it simply, the medical model remains the dominant descriptive system in psychotherapy not because it offers the most accurate description of what actually occurs in psychotherapy but, rather, because the model gives psychotherapy a level of prestige and power that other descriptive systems do not.

Economics

Another reason the medical model remains dominant is money. The economic well-being of thousands of clinicians, researchers, professors, administrators, and others is intertwined with the medical model. The same is true with hundreds of psychology-related organizations, as noted previously. To change the model could have a negative financial impact on these professionals and organizations.

Fortunately, our profession is based on science, not on power and money, so evidence must be the ultimate criterion by which we decide the future directions of our field. However, because of the political and economic forces that hold the medical model in place, the transition to a nonmedical model will not be easy. As Duncan, Miller, Wampold, and Hubble (2010) wrote,

The medical model for psychotherapy remains robust, and its reach into every aspect of clinical work is deep. To move beyond it, to accept and then put to use the latest science, will require nothing short of a paradigmatic shift. (p. 428)

PURPOSE AND ORGANIZATION OF THE BOOK

Because the evidence undermining the medical model of psychotherapy is now so compelling, this may be the best time in the history of psychotherapy to replace it. Thus, at a practical level, the purpose of this book is to show that the medical model has been scientifically discredited and to present an alternative model that is aligned with the findings of science. However, at a deeper level, the purpose of the book is to provide a new understanding of emotional healing and thus a new understanding

of psychotherapy. These two purposes converge as they are fleshed out in the following chapters.

The organization of the book is straightforward. Drawing on evidence from clinical psychology, attachment theory, social relationships research, neuroscience, evolutionary theory, and history, the first four chapters present a new understanding of emotional healing and lay foundations for a new model of psychotherapy. Chapter 1 summarizes evidence from clinical research to show that common factors, and particularly human factors, are the most potent determinants of effectiveness in psychotherapy. Chapter 2 describes evidence from attachment theory and social relationships research to show that we are evolved to develop, maintain, and restore our emotional well-being through supportive relationships with others and that psychotherapy is an expression of that evolutionarily derived ability. Chapter 3 presents findings from neuroscience and evolutionary theory to show that our brains evolved in a social context with remarkable abilities, including the ability to change in response to social experience and the ability to give and receive emotional healing through social means. The chapter shows how psychotherapy draws on these abilities to heal the client. Chapter 4 describes moral treatment as a historical example of an approach that used social means to heal those with severe psychological problems. Building on the scientific and historical foundations laid in the first four chapters, Chapter 5 presents a summary of the nonmedical model of psychotherapy and discusses the implications of the model for clinical research, training, and practice. The book concludes with a brief afterword.

I hope the book contributes to the growing realization among clinicians and researchers that the real power of emotional healing lies not in medical-like techniques but, rather, in the human elements of psychotherapy.