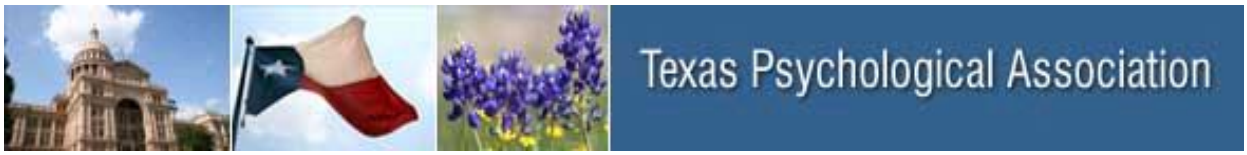

Psychotherapy: We Have LOTS of Evidence!

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This is a follow up on last month's article that reviewed the attacks on psychotherapists that have been mounted by the proponents of treatments that have been validated in very narrowly defined clinical trials. While the treatment X diagnosis studies have an important role, this is not the only data relevant to improving psychotherapy, nor is it the only research that is scientifically credible. The present paper reviews the research support for the common factors that cut across treatment modes and theoretical divides. It is argued that the common factors research provides compelling support for the continued practice of psychotherapy.

Since Hans Eysenck (1952) upset the mental health profession with data suggesting that psychotherapy is not effective and perhaps might be harmful, psychotherapy researchers have worked to determine whether---and how---psychotherapy works. Six decades later the consensus is unshakable; psychotherapy does work, and we are now about the business of how to make it work best. Despite this progress, tensions between psychotherapists and researchers have persisted. Indeed many have described a state of war.

The combat metaphor is not unjustified. On one side are those the academics (although that is an oversimplification) who argue that the only legitimate activity for therapists is the application of procedures which have been demonstrated to be effective in ameliorating certain of the problems associated with a tightly specified diagnosis. This approach is highly operationalized and generates replicable findings on the efficacy of a number of psychosocial interventions for DSM-IV diagnostic entities (e.g. Nathan and Gorman, 1998). The academicians have claimed the high ground. Their fundamental premise is beyond reproach: we ought not to promote procedures (therapy, medication, lifestyle changes) if we have no empirical support.

While it is common to characterize the schism in the psychotherapy world as a split between researchers and practitioners, the controversy echoes a more profound debate on the degree to which psychotherapy is constrained to be the minor stepchild of the medical profession (or whether it should be constrained at all). Exemplified by

pharmacological research, the medical model emphasizes specificity---what's the best way to kill the infection? By focusing on symptom reduction, the medical model dismantles and objectifies persons, and decontextualizes problems. Embracing the notion that psychotherapy is only about suppressing symptoms obscures the possibility for personal growth, enhanced quality of life, and other "intangible" benefits that practitioners and their clients hope to realize from treatment.

There are both conceptual and evidentiary critiques of the EST model. For example Wachtel (2011) argues that the rules of evidence employed by the EST movement are often misapplied, resulting in distorted conclusions. He suggests that the trend toward dichotomous thinking leads to neglect of important data when said data may not pristinely fit the ideal EST criteria. Krause has prompted enthusiastic commentary with his argument that clinical trials are reported too simplistically, at times inflating the apparent superiority of one treatment over another when either therapy may be effective for many patients. He also argues that the usual EST report, with the emphasis on the evidence for one treatment over another, often obscures the non-treatment factors (context, patient personality variables, cultural forces, etc) which may mediate outcomes.

Other critics object that the evidence for treatment specificity has not been all that good. Of all the contributions to successful psychotherapy, the evidence suggests that 15% of the variability in therapy outcomes can be attributed to differences in treatment models, versus the contributions of the patient's own self-change efforts, therapist variables, expectancy effects, therapeutic common factors, and factors extrinsic to the therapy (Norcross and Lambert, 2011). If psychotherapy consistently yields effect sizes in the neighborhood of .8 (Wampold, 2011) and if less than 15% of this efficacy is attributable to therapeutic specificity, we may ask about the efficacy of the non-specific factors that are common across treatments. A large base of evidence for many of these factors has emerged, and two recent books detail the empirical support for process variables that are beneficial across diagnostic categories and theoretical models.

Psychotherapy Relationships That Work (Norcross, 2011) is an update of a similar volume that was sponsored by Division 29 (Psychotherapy) in 2002. This second edition is cosponsored by Division 12 and 29. As Dr. Norcross notes in the preface, the project represents efforts to embrace the need for empirical verification but broaden the evidentiary scope beyond the narrow treatment X diagnosis model of the usual EST approach. The book reflects a very uniform and systematic conceptual approach to the data: all reviews were commissioned as meta-analyses. Although each review employed somewhat disparate methods to conduct these analyses, the procedures are well specified, permitting replication and reanalysis. Reviewers were highly regarded experts in the study of relationship dimensions including positive regard, working with resistance, obtaining client feedback, empathy, and many others. Each

group of reviewers was asked to provide the conceptual and methodological context for their investigation, to discuss/critique the measures generally employed in the research literature, to provide a clinical example, describe the meta-analytic review with relevant moderator analyses, discuss the patient's contribution to the relationship variable under scrutiny, and present recommendations for therapeutic practice.

What have we learned about the relationship?

It is clear that the therapy relationship has a substantial role to play in the outcome of psychotherapy. This effect is both independent of, and at least as large as the impact of the particular treatment method. Some authors argue that it may be incomplete or misleading to promote ESTs without integrating the role of the relationship.

We may also conclude that the research base is strong and growing stronger. This seems particularly true for literature dealing with adapting treatments to clients' extra-diagnostic characteristics. For example the research on working with resistance and client reactance is now sufficiently robust to permit upgrading it to "demonstrably effective" (previously the research record could only support classifying this as "promising"). Many domains that were previously examined have benefitted from broader and deeper research and several new areas could now be examined, including the role of the alliance in child and adolescent treatment and in couple and family therapy.

In 2002 four aspects of the therapy relationship were found to be "demonstrably effective", that is significant predictors of positive outcomes: the alliance in individual therapy, cohesion in group therapy, the expression of empathy, and establishing collaborative consensus on the goals of treatment. The more recent research has elevated several other factors to "demonstrably effective" status. These include strategies for gathering client feedback throughout treatment, and several ways to tailor treatment to the particular characteristics of the client (such as modifying treatment to accommodate gender, ethnicity, religious orientation, and other client preferences).

Other aspects of tending the relationship or modifying the treatment to fit the client remain promising but still lack sufficient data to permit endorsement. These include repairing ruptures, managing countertransference, and tailoring treatment to such client attributes as attachment style, stages of change, and coping strategies. It is disappointing to find that intuitively appealing therapeutic practices are merely promising. We should recall that the paucity of demonstrated effectiveness does not justify rejection of a procedure. Rather, we need more and better data. This book serves to highlight areas where further research efforts are most promising.

Many of these ideas are echoed by another recent compilation, *The Heart and Soul of Change*: *Delivering What Works in Therapy* (Duncan, Miller, Wampold, & Hubble, 2011).

This is a compilation of literature reviews on a variety of techniques that have been shown to improve clinical outcomes and, like *Psychotherapy Relationships That Work*, it is an update reflecting new research developments. A number of forces shape the outcome of a given therapy case, and the editors acknowledge that very little of this variability is due to treatment modality. The first part of the book details several other factors that have greater predictive power. The most substantial source of outcome variability is what the client brings to the game; resilience, the corrective effect of self-disclosure, placebo responses, client motivation, client's independent efforts at self-healing often interact to overshadow the effect of treatment model according to a chapter by Bohart and Tallman. Norcross contributes a summary of the data in the importance of the qualities of the relationship between therapist and patient. There are other discussions of the importance of common factors with adolescence, couples, and substance abuse populations.

Another example of a strategy which will optimize outcomes in any treatment mode is the systematic collection of client feedback throughout the course of treatment. Michael Lambert has developed several tools for real time treatment monitoring and provides an excellent review of their efficacy at prompting early identification of potential therapeutic failures. The research demonstrates that signs of potential adverse outcomes are present well before they are obvious to the clinicians. Early detection that a patient is dissatisfied or deteriorating clinically is shown to prompt clinicians to make mid-course adjustments and thereby improve outcomes.

Taken together these approaches counterbalance the assertion that psychotherapy is dead (a sentiment attributed inaccurately to Alan Kazdin----see last month's eTP). It is clear that much of what goes on in "traditional" psychotherapy has very good evidentiary support. Will this all provide the scientific grounding to counter the critiques levied by the EST camp? That is the wrong question---it just reifies the adversarial and tendentious tone that characterizes much of the disagreement about psychotherapy. As with the nature/nurture debates of the last century, our discipline and our patients are poorly served by polarized discussion. As with that controversy, what are needed are new, more nuanced questions.

In any case the practice of psychotherapy is not static. New diagnosis-specific treatment protocols are in continuous development and testing and this approach will certainly expand and solidify our therapeutic expertise. The EST model itself is changing. There recently have been interesting suggestions that the EST model should broaden the evidentiary base to distinguish techniques that have empirical support which are based on theories that have empirical support, as opposed to techniques that are shown to work but which lack evidence for underlying theory (David & Montgomery, 2011). Just as the EST model will evolve, our understanding of the role of common factors and relationship variables must evolve as well. Ultimately neither model will be sufficient. They are each necessary and they are complementary.

References

David, D. & Montgomery, G.H. (2011). The scientific status of psychotherapies: A new evaluative framework for evidence-based psychosocial interventions. *Clinical Psychology: Science and Practice, 18 (2)*, 89-99.

Duncan, B.L., Miller, S.D., Wampold, B.E. & Hubble, M.A. (Eds.), (2011). *The heart & soul of change second edition: delivering what works in therapy.* Washington, D.C., American Psychological Association.

Eysenck, H.J. (1952). The effects of psychotherapy: an evaluation. *Journal of Consulting Psychology, 16*, 319-324.

Krause, M.S. (2011). Statistical significance testing and clinical trials. *Psychotherapy, 48* (3), 217-224.

Nathan, P.E., & Gorman, J.M. (Eds.). (1998). A *guide to treatments that work.* New York: Oxford University Press.

Norcross, J. C. (Ed.) (2011). *Psychotherapy relationships that work.* New York: Oxford University Press, 440 pages.

Norcross, J. C. (ed.). (2002). *Psychotherapy relationships that work: therapist contributions and responsiveness to patients.* New York: Oxford University Press.

Norcross, J. D. & Lambert, M (2011). Evidence-based therapy relationships. In Norcross, J. C. (Ed.) (2011). *Psychotherapy relationships that work.* New York: Oxford University Press,

Wachtel, P. L. (2010). Beyond "ESTs": Problematic assumptions in the pursuit of evidence-based practice. *Psychoanalytic Psychology, 27* (3), 251-272.

Wampold , B. E. (2011). The research evidence for common factors models: a historically situated perspective. In Duncan, B.L., Miller, S.D., Wampold, B.E. & Hubble, M.A. (Eds.), *The heart & soul of change second edition: delivering what works in therapy.* Washington, D.C., American Psychological Association.