

The truth about what works in psychotherapy

Short Communication

The truth about what works in psychotherapy

Why do we believe things that are not true? The answer to this question may be best considered in terms of the list of possible explanations and include categories such as true-truths, true-lies, and false-truths. True-truths might be considered things we believe to be true which genuinely are (e.g., the world is round; losing weight requires eating fewer calories and exercising). True-lies may be thought of as things we believe to be false and which actually are (e.g., the Easter Bunny, Santa Claus). False-truths are those things that we believe to be true but are not (e.g., drinking eight glasses of water a day improves health, Napoleon was unusually short). Basically, we seem to trust in assumptions about the way the world operates that seem so obviously true that we fail to test them - and in failing to check these basic assumptions, we slam the door shut on finding new and better ways to do things.

Why is this important for psychotherapy? What are the implications for therapists?

The results of outcome research over the past 75 years have consistently shown that all psychotherapy models work about equally well, despite the nearly endless claims by model developers that their approach is superior to all others.¹ To date, no differences in outcome have been found between different treatment approaches for psychotherapy in general.² In addition, while we have naturally assumed that years of education and experience in the field were equivalent to therapeutic effectiveness, the results of recent studies do not support this conclusion. Moreover, our field has spent decades privileging the therapist's perspective of progress and what is important over client's, yet the client's perception of the alliance and agreement with the goals, tasks, and methods used in therapy have been consistently shown to be a robust predictor of outcome.³

Perhaps it is this reliance on faulty beliefs and the emphasis on treatment models in professional discourse and training that has resulted in the fact that *psychological treatments have not improved appreciably over the last three decades*. In fact, the failure to address dropouts in psychotherapy is one of the biggest challenges facing our field. Research to date suggests that premature termination or dropout averages about 47%;⁴ for children and adolescents, the range varies from 28% to 85%.⁵ Furthermore, results of outcome research also reveals the following alarming statistics:

1. A significant percentage (30% to 50%) of clients do not benefit from therapy.
2. Deterioration rates among adult clients range between 5% and 10%.
3. It is estimated that the clients who do not benefit or deteriorate while in psychotherapy are responsible for 60-70% of the total expenditures in the health care system.

The news is not all bad - The average treated person is better off than 80% of those without the benefit of treatment. Psychotherapy is also cost-effective. Perhaps most importantly, clinicians who have access to outcomes data can better identify clients who are not improving

Volume 10 Issue 1 - 2019

Keith Klostermann,¹ Theresa Mignone,²
Melissa Mahadeo,¹ Emma Papagni¹¹Marriage and Family Therapy Program, USA²Enlightened Therapies of Western New York, USA

Correspondence: Keith Klostermann, Medaille College, 18 Agassiz Circle, Buffalo, NY 14214, USA, Tel 716-932-2559, Email kc35@medaille.edu

Received: December 23, 2018 | **Published:** February 21, 2019

or getting worse and respond to those clients, thereby reducing the risk of dropout and negative outcome.⁶ According to Scott Miller, the developer of Feedback Informed Treatment (FIT) and founder of the International Center for Clinical Excellence (ICCE), "Seeking and obtaining valid, reliable, and feasible feedback from consumers regarding the therapeutic alliance and outcome as much as doubles the effect size of treatment, cuts dropout rates in half, and decreases the risk of deterioration." Thus, the challenge for providers and the field in general is to reconsider the traditional ways that we think about the psychotherapy process as well as how we train future therapists. More specifically, clinicians and educators must move beyond the inertia of 'more of the same' mentality and shift toward re-imagining psychotherapy based on what really works and modify training programs to better train students in the skills that make a difference to clients and ultimately outcome. While the core ingredients of the therapeutic process have not changed (model/technique, relationship, etc.), perhaps the biggest difference may be in terms of should be emphasized in clinical practice and training; in other words, rather than the near exclusive focus on theories, perhaps efforts aimed at better understanding how to effectively build, maintain, and sustain therapeutic relationships would be a better investment of time and resources. Moreover, particular training on how to monitor and assess the strength of the alliance as well as how to deal with ruptures in the alliance could prove incredibly valuable given the alarming dropout rates plaguing psychotherapists.^{7,8}

Acknowledgments

None.

Conflicts of interest

The author declares that there is no conflicts of interest.

References

1. Imel Z, Wampold BE, Miller S, et al. Distinctions without a difference. *Psychology of Addictive Behaviors*. 2008;22(4):533-543.
2. Miller SD, Wampold BE, Varhely K. Direct comparisons of treatment modalities for youth disorders: A meta-analysis. *Psychotherapy Research*. 2008;18(1):5-14.
3. Norcross J. The Therapeutic Relationship. In: Duncan B, Miller S, Wampold B, Hubble M, editors. *The Heart and Soul of Change*. Washington, D.C.: APA Press. 2009.
4. Wierzbicki M, Pekarik G. A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice*. 1993;24(2):190-195.

5. Garcia JA, Weisz JR. When youth mental health care stops: Therapeutic relationships problems and other reasons for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology*. 2002;70(2):439–443.
6. Lambert MJ. *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. Washington, DC: American Psychological Association. 2010.
7. Baldwin S, Wampold B, Imel Z. Untangling the Alliance- Outcome Correlation. *Journal of Consulting and Clinical Psychology*. 2007;75(6):842–852.
8. Kazdin AE. Dropping out of child psychotherapy: Issues for research and implications for practice. *Clinical Child Psychology and Psychiatry*. 1996;133–156.