WHAT SHOULD WE BE TEACHING FUTURE PSYCHOTHERAPISTS?

THE NATURE OF THE CHALLENGE FOR PSYCHOTHERAPISTS

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TAKE AWAYS

(Observations gleaned from Miller and Moyers, 2021 and Miller, Hubble & Chow, 2020)

The interpersonal skillfulness of the therapist is more critical in predicting treatment outcomes than is the specific interventions that are employed. It is NOT only WHAT the therapist does, but HOW and WHEN he/she does it that influences treatment outcomes.

Treatment outcomes can be predicted from the first session, as measured by working alliance measures.

Strict adherence to manual-guided interventions lead to poorer treatment outcomes, whereas the therapist's ability to respond flexibly to the client's needs and preferences leads to better treatment outcomes.

Changes in the therapist's clinical practice are minimally and poorly maintained after participating in classroom instruction and clinical training workshops. Such training is rarely sufficient to develop proficiency in performing complex clinical skills.

Psychotherapists who obtain the best treatment outcomes are distinguished by the fact that they spend more time in DELIBERATE PRACTICE and they solicit ongoing FEEDBACK from their clients, and they receive COACHING in improving both their relationship and technical clinical skills. Without FEEDBACK no matter how much experience the therapists have, the level of their treatment outcomes do NOT improve.

1. There has been no improvement in treatment outcomes in the field of psychotherapy over the last 30 years, as reflected by changes in Effect Sizes (ES) and by meta-analytic studies (Budd & Hughes, 2009; Hunsley & D. Guilio, 2002).

2. The dropout rate from psychotherapy averages between 20% and 47% for adult patients. The dropout rate for children and adolescents ranges from 28% to 85%.

3. Some 30% to 50% of adult patients do not benefit from psychotherapy. In the treatment of patients with Substance Abuse Disorders, the relapse rate is 75%, no matter what substance is being used.

4. The deterioration rate among adult patients in psychotherapy is 5% to 10%. Those patients who deteriorate in psychotherapy account for 60% to 70% of the total expenditure of mental health care costs.

5. Psychotherapists routinely fail to successfully identify patients who are not progressing. Such patients who are deteriorating are at most risk of dropping out and having negative treatment outcomes (Lambert, 2007; Lambert & Shimokawa, 2011).

6. Psychotherapists lack knowledge and usually do not seek treatment outcome data and as a result tend to overestimate their effectiveness. There is a need to check-in with patients on a regular basis regarding the quality of the therapeutic relationship and their progress (Sperry & Carlson, 2013).

7. The Partners for change Management System which is a SAMHSA National Registry evidence-based program provides a session-by-session tool kit for obtaining real-time patient feedback. Also see Lambert's OQ-45 measure (Duncan, 2010; Lambert 2007, Miller et al. 2020).

8. Psychotherapists need to focus on early changes and monitor and bolster patient progress. There is a dose-response relationship between early improvement and treatment outcome of patients who are engaged in treatment:

    a) 30% of them improve by the second session;
    b) 50%-60% evidence improvement by session 7;
    c) 70%-75% by 6 months;
    d) 85% by the end of the year.

    Sudden gains in symptom reduction contributes to improved therapeutic alliance, and in turn, to a "positive spiral" of change. Early improvement and patient progress predicts positive treatment outcomes (Tang & DeRebeis, 2005).

9. With experience psychotherapists treatment effectiveness does not improve. What does change with experience is the psychotherapists' confidence in their competence and effectiveness (Wampold, 2001).

10. For example, a study by Branson et al. (2015) provided 43 psychotherapists with 300 hours of training in CBT. They tracked outcomes in 1247 patients and found that the 300 hours of training significantly improved adherence to CBT protocols, but the extensive training did not result in better treatment outcomes, relative to untrained psychotherapists. The CBT therapists were no more effective following training than before. There was little support of a general association between CBT competence and patient outcome. Moreover, Webb et al. (2010) have reported that the psychotherapists'

strict adherence to evidence-based treatment manuals is not related to treatment outcomes. In fact, "loose compliance" that is tailored to the patients' individual needs and preferences may be the best treatment approach (See doi.10.1016/jbrat.2015.03.002 for the Branson et al. study).

11. There is substantial variation in outcomes between providers with similar training and experience. Some psychotherapists are more "expert" in achieving better treatment outcomes and "lasting changes" in their patients.

    Patients of effective psychotherapists improve at a rate of at least 50% higher and their drop-out rate is at least 50% lower than the less effective psychotherapists (Norcross, 2002; Skovholt & Jennings, 2004).

12. A variety of studies have shown that the difference in effectiveness of individual psychotherapists, within a given treatment, accounts for a larger proportion of variance than the variance accounted for between various treatments. The person and his/her clinical skills are more important than the specific treatment being implemented in contributing to treatment outcomes (Sperry & Carlson, 2013).

13. The person of the psychotherapist is more important than the psychotherapists' theoretical orientation, years of experience, and discipline or professional affiliation (Horvath et al. 2011).

14. Over 90% of the differences in treatment outcome between more and less effective psychotherapists is attributable to differences in their ability to establish, maintain and monitor on a regular basis, the quality of the therapeutic alliance and patient progress toward achieving the collaboratively-generated treatment goals. For example, in DBT with Borderline Personality Disorder patients, those patients who perceived their therapist as both affirming and protective had longer lasting changes and were less self-injurious (Thoma et al., 2015).

TRANS -THEORETICAL BEHAVIORAL PRINCIPLES THAT ARE COMMON TO ALL PSYCHOTHERAPEUTIC TREATMENT APPROACHES: CORE TASKS OF PSYCHOTHERAPY

These are proposed consensual foundational principles of behavior change and psychotherapeutic interventions that contribute to effective long-lasting behavior changes in patients. The most effective psychotherapists engage in DELIBERATE PRACTICE and seek PATIENT FEEDBACK and COACHING when implementing these Core Tasks of psychotherapy.

1. The ability to establish, maintain and monitor on a session-by-session basis the quality of the therapeutic alliance and the patients' progress. For example, use Feedback Informed Treatment Scales and the Working Alliance Inventory. The therapeutic alliance needs to be culturally, ethnically, developmentally and gender-sensitive.

2. The ability to collaboratively generate with patients a set of SMART treatment goals and the means by which to achieve their treatment goals ("pathways thinking"). SMART goals are Specific, Measurable, Attainable, Relevant/Valued, and Timely. The establishment of such treatment goals need to incorporate the patients' implicit theories about the causes of their presenting problems and their thoughts about what is needed to bring about long-lasting behavior changes. Such agreed upon treatment goals nurture HOPE in patients.

3. All therapeutic approaches incorporate some form of psycho-education using the "Art of questioning", especially the use of HOW and WHAT questions. This is NOT a mini-lecture. It is designed to increase the patients' awareness of the entrenched habitual patterns of their behavior and how they inadvertently. unwittingly, and perhaps unknowingly, emit the very behaviors that elicits responses from others that reinforces their beliefs.

The psycho-educational process should also help patients better understand the interconnections between their feelings, thoughts, behaviors and reactions of others. They are NOT mere "victims " or their feelings, thoughts, and past histories. The initial assessment and the accompanying psycho-educational process also helps patients identify any strengths or evidence of resilience that they bring to therapy. Effective psychotherapy helps and challenges patients to access and employ any strengths that they possess, even if they are not fully aware of their" islands of competence."

4. Patients are encouraged to self-monitor and collect data that helps them learn how to de-automatize their automatic-pilot "scripted" behavioral patterns and not permit the emotionality triggered by their lower brain stem (Amygdala and hippocampus) to HIJACK their self-regulatory Executive frontal lobes.

5. All effective psychotherapeutic approaches employ some form of Case Conceptualization Model that informs both assessment and treatment decision-making and that is shared with the patients, and in some instances with significant others, as well as with other involved health-care providers.

6. The treatment interventions should be flexibly individualized and tailored to what the patients need and want, addressing the occurrences of any co-occurring disorders and responsive to the patients' dominant emotional needs (anxiety, guilt, shame, prolong and complicated grief and traumatic bereavement, depression and possible accompanying suicidality). A prominent clinical concern is the patients' safety. Psychotherapeutic interventions need to address the full range of the patients' needs in the form of "wrap around services", where indicated.

7. When patients have a history of victimization, either recent or sometime in the past, this creates the need for a set of additional Core psychotherapeutic tasks, namely ensuring safety and avoiding any possible revictimization. In addition, there is a need to provide interventions tailored for presenting clinical problems such as emotional dysregulation, hypervigilance, sleep disturbance, self-injurious behaviors, interpersonal conflicts, and substance abuse disorders. Besides providing such target specific interventions, therapists can work collaboratively to bolster the patients' resilience in various domains (physical, interpersonal, emotional, cognitive, behavioral and spiritual).

8.Therapists need to challenge patients to perform personal experiments and "corrective emotional experiences" that yield data (results) that disconfirm their beliefs and expectations that they hold. In order to help patients, develop long-lasting behavioral changes psychotherapists need to build into the training program generalization guidelines (not merely train and hope for transfer), place the patients in a consultative mode so they can describe, teach and offer self-generated reasons self-efficacy ratings and a consideration of possible potential barriers that can be anticipated and addressed.

When behavior changes do occur, there is a need for patients to engage in self-attributions of taking credit for such changes. Therapists should reinforce the patients use of metacognitive verbs such as "notice, catch, monitor, plan, back -up plan" and various RE -verbs (RE-connect, RE-store, Re-prioritize, RE-author and the like). Psychotherapists should RE-enforce the patients' CHANGE TALK and take the therapist's voice with them and become their own therapist.

Consider the following question that therapists can ask their patients:

"DO YOU EVER FIND YOURSELF OUT THERE IN YOUR DAY TO DAY EXPEIRENCE', ASKING YOURSELF THE KIND OF QUESTIONS THAT WE ASK EACH OTHER HERE IN THERAPY?"

The following article by Marvin Goldfried, "On obtaining consensus in psychotherapy: What holds us back?" reinforces my efforts to identify the trans-theoretical principles of behavior change and the value of identifying the Core tasks of psychotherapy that therapists should deliberately practice.

https://www.stonybrook.edu/commcms/psychology/_pdfs/clinical/Goldfried%20AP%20Consensus%20AP.pdf

HOW TO SPOT “HYPE” IN THE FIELD OF PSYCHOTHERAPY CHECKLIST TAKE AWAY

The National Registry of Evidence-based treatment programs and practices (NREPP) has generated a list of 479 effective interventions.

When choosing an intervention BEWARE OF THE FOLLOWING:

Exaggerated claims of efficacy "revolutionary treatment" /Endorsements by gurus / Slick marketing / Psychobabble and Neurobabble / Anecdotal "fits all" claims / Allegiance and decline effects /

See below for a more detailed Critical Consumer Checklist

CHARACTERISTICS OF "HYPE" IN THE FIELD OF PSYCHOTHERTAPY

Your attendance at this conference reflects your interest in increasing your knowledge and your clinical strategies and skills to help your patients achieve better treatment outcomes. Such concerns are timely given the research findings in the field of psychotherapy on the marked variability in effectiveness across psychotherapists. The most effective psychotherapists average 50% better outcomes and 50% fewer dropouts than psychotherapists in general (Wampold, 2017). One of the characteristics of more "expert" psychotherapists is their penchant for maintaining a critical attitude apropos of Paul Meehl's (1973), admonition of "Why he does not attend case conferences," and the presence of "SELF-DOUBT." Research indicates that psychotherapists self-reported self-doubt predicted treatment outcomes- more doubt about their skill in helping patients (e.g., "Lacking confidence that you might have about a beneficial effect on a patient." and "Unsure about how best to deal effectively with a patient."), had better treatment outcomes, particularly if they also had a positive sense of self. Consistent with the article by Nissen-Lie et al. (2015) entitled " Love yourself as a person, doubt yourself as a therapist " , the present Psychotherapy Consumer Checklist is designed to plant the seed of self-doubt and nurture a healthy sense of "HUMILITY ", and hopefully improve treatment outcomes. What follows is a Checklist of "Psychotherapy Beware Signals."

1. Advocates for a therapeutic approach state that their treatment is "revolutionary" and offer outlandish unsubstantiated claims for its superiority (Over 90% improvement rates). "Simple, but powerful" treatment approach. "A breakthrough treatment."

2. Make claims that you can learn from a "master", "leading expert" or "guru" and use marketing terms like "powerful", "transformative", "unique and ultimate training," "life-changing benefits", "deep psychological healing", and moreover, assure that your "complete satisfaction is guaranteed."

3. Advocates use Acronyms (Acronym Therapies) and "psycho-babble" to sell their treatment approach.

4. Claim that the treatment approach could be applied successfully with patients who have a wide variety of psychiatric and physical conditions, and across multiple age groups without any clinical trial demonstrations. Advocates often imply that their treatment approach "fits all" ("One size fits all").

5. Claims that treatment approach is "evidence-based", scientifically proven, because it has met the criteria of two randomized controlled trials, but they do <u>not</u> report Effect Sizes, nor provide details about the exclusionary criteria of the patients. "Cherry-pick" the patients. Also, does <u>not</u> report on the attrition and drop-out rates, follow-up data. Advocates often broadly and subjectively define "evidence" (e.g. "I saw it work with my clients, and that is my evidence".)

6. Advocates state that "Over X number of studies have consistently demonstrated efficacy and superiority", without citing or critiquing these studies.

7. Compare proposed treatment to "weak" comparison groups. Does not compare treatment to "bona-fide" comparison groups that are intended to be effective (See Wampold et al., 1997).

8. Compares the proposed treatment versus a reduced, or weaker version of the comparative treatment. For example, see Foa et al. (1999) comparison of Prolong Exposure versus Stress inoculation training (SIT), where the third application phase of SIT was omitted.

9. Do not report on possible "allegiance effects" of who conducted the controlled outcome studies. Moreover, the cited supportive studies that were initially conducted yielded more effective results than later conducted studies. ("***Strike while the iron is hot***", and when the enthusiasm for the new therapeutic approach is highest.) See the provocative informative article by Lehrer (2010) of the "decline effect" in research attempts to replicate clinical trials. For example, the efficacy of antidepressant medication has gone down as much as threefold in recent decades. Effect Sizes from studies from treatment studies drop off. He observes that the researcher's belief can act as a kind of blindness.

10. Do not independently determine if the treatment rationale offered to the alternative treatment and control groups is judged as being as credible and believable as for the advocated treatment. This can lead to differences in expectancy effects across groups.

11. Do not highlight the role of non-specific treatment factors, such as therapeutic alliance, expectancy effects, and other placebo considerations. For example, does not include any measures of the ongoing quality of the therapeutic alliance, such as the Therapeutic Alliance Scales, or the Quality of Relationship Measures, or the session-by-session treatment-informed feedback (Prescott et al., 2017).

12. Does not include a critical account of the scientific validity, or theoretical basis, for the effectiveness of the proposed treatment. Offers little scientific basis for the proposed change mechanisms for the treatment. See controversy over so-called "energy –based" treatments such as Tapping, Eye Movements, Magnetic fields, Meridian band techniques and the like. The intervention may work, but it has little to do with the proposed treatment model. The proposed treatment may do better than no treatment, or weak control and comparison groups because of non-specific factors, such as placebo effects.

13. Advocates use "neuro-babble" and "neuro-networks" and reductionism (often with colored versions of the brain) to explain the treatment approach. They resort to a dubious neurological basis for the explanation of their treatment approach.

14. Advocates fail to discuss criticisms of their treatment approach. They fail to mention the results of dismantling studies that question the basis of their treatment approach.

15. Advocates tell their patients that "If this treatment does not help you, then nothing else will." They convey an expectancy that reinforces treatment outcomes.

16. Advocates promote advance training, sell paraphernalia, tapes that go along with their treatment approaches. They require that trainees sign statements that they will not share treatment protocols with others. “Commercialism is rampant.”

17. Advocates are very defensive and “thin-skinned” about their approach. They often question the motives and background of those who have questioned the efficacy, theoretical basis of their treatment approach. They fail to question what they are proposing and readily dismiss skeptics. They may disregard “inconvenient truths” and offer “alternative facts”, thus, holding onto debunked theories.

18. The advocates of their treatment approach rely on the endorsements of a leaders in the field. For example, some therapists in the trauma field cite Bessel van der Kolk as an advocate and endorser of their treatment approach.

19. Advocates establish a coterie of trainers and an International organization to promote the treatment. Advocates use public media (television, blogs, print) and they over sell their treatment approach. Advocates are “slick salespersons,” setting up clinics, training settings, and conferences.

20. The advocates will provide a Certificate that you have taken the training and can call yourself an X therapist. Offers to put you on a referral list of Certified X practitioners.

HOW MANY OF THESE 20 ITEMS DOES YOUR TREATMENT APPROACH INCORPORATE?

REFERENCES

Foa, E.B., Dancu, C.V. et al. (1999). A comparison of exposure therapy, stress inoculation training and their combination for reducing PTSD in female assault victims. Journal of Clinical and Consulting Psychology, 59, 715-723.

Lehrer, J. (2010). The truth wears off: Is there something wrong with the scientific method? The New Yorker. (https://www.newyorker/com/magazine/2010/12/13/the-truth-wears-off).

Meehl, P.E. (1973). Why I do not attend case conferences. Psychodiagnosis Selected Papers. (pp. 225-302). Minneapolis: University of Minvits Press.

Nissen-Lie, H.A., Ronnestad, M.H. et al. (2015). "Love yourself as a person, doubt yourself as a therapist?" Clinical Psychology and Psychotherapy (doi:10.1002/cpp.1977). http://www.dgapractice.com/documents/meehl_case_conferences_adapted.pdf

Prescott, H.D., Mareschalack, C.C., & Miller, S.D. (eds.). (2017). Feedback informed treatment in clinical practice. Washington, DC: American Psychological Association.

Wampold, B.E. (2017). What should we practice? In T. Rousmaniere, R.K. Goodyear, S.D. Miller & B.E. Wampold (Eds.). The cycle of excellence (pp. 49-65). New York: Wiley.

Wampold, B.E., Modin, G.W. et al. (1997). A meta-analysis of outcome studies comparing bona-fide psychotherapies: " All must have prizes." Psychological Bulletin, 122, 203-215

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Thank you for your interest,
Don Meichenbaum