What Makes for Good Psychotherapy

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As I delved into the literature, I found an abundance of research and opinions on psychotherapeutic outcome and on the factors affecting the outcome, but with many diverse results and objectives. As I began to look for the seminal papers/contributors, I began to feel overwhelmed not by quantity, but by the divergence of viewpoints – all claiming scientific validity. It took me quite a while to get a lay of the land. Especially helpful was an edited volume by M. Lambert (2004) – he and his contributors took a more objective stance than many researchers I have encountered and helped to me to begin to make sense out of what at first appeared to be chaos. The picture that began to appear surprised me.

First, I found agreement among almost everyone in the last 40 years that psychotherapy did do significant good for the client (Lambert, Bergin & Garfield, 2004) – that was affirming to find.

Second, I found a tremendous volume of psychotherapy research literature focused on attempting to prove that one therapy treatment was better than another treatment. Most of this work was done using the FDA pharmaceutical model of random clinical trials (RCT) trying to treat psychotherapy treatment as if it were a drug in a drug-testing clinical trial.

Third, meta-analyses of these hundreds of psychotherapy research studies indicated that there was no significant difference between individual treatments – in other words, all were equally effective. Furthermore, the specific treatment accounted for at best only 15% of the variability contributing to the psychotherapy outcome of the client.

Fourth, Wampold (2001) and Wampold, Ahn & Coleman (2001) make a convincing case that "the empirical support for a medical model of psychotherapy is nonexistent." Instead, they recommend the contextual model. Slife (2004 & 2005) takes it a bit further and recommends that a hermeneutic model be used and that the assumptions be clearly identified with whatever model is used to do psychotherapy research. Both Slife and Wampold, Ahn & Coleman give extensive critiques of the use of the medical model for psychotherapy.

Last, the research indicates that the lion's share of the variability with respect to psychotherapy outcome is with the client, followed by therapist-related factors, the most important of which is the client-therapist alliance/relationship. The SURPRISE here was that these particular findings were all but ignored by the organizations funding the psychotherapy research. The bulk of the psychotherapy research funding continues to go into specific treatments (based on the medical model), rather than elucidating the client and client-therapist factors that together account for 80% of the variability related to psychotherapy outcome. Obviously, other factors that have nothing to do with good science are driving the funding allocations. Something is amiss here – maybe this is an area our CAMFT PAC should try to influence.

So many of the authors of these meta-analyses would end their studies with a plea such as this one by Quoting Ahn & Wampold (2001): "Combined with the evidence that all bona fide treatments are equally efficacious…, the results of this meta-analysis suggest that comparative [treatment] outcome studies will yield non-significant differences and therefore are costly experiments in futility. It is safe to say that hundreds of millions of dollars have been spent on outcome research that has shown that bona fide psychological treatments are efficacious but that all such treatments produce about the same benefits. Continued outcome research will only support that general pattern of results and yield little informative evidence about counseling and psychotherapy."

I concur with Allan Shore that the research using the infant-caretaker split-video studies and attachment studies points to the healing space in the therapy room as being the client-therapist attunement, co-regulation and repairs. Hopefully, someday funding shifts will occur allowing such split-video analysis studies to be conducted on the client-therapist relationship, and begin to elucidate the sphere of greatest potential impact for our profession – the client-therapist relationship.

During this literature search, I found a couple of simple measurement tools that I have been using over the past 2 ½ years with my clients. They assist me in picking up client-therapist breaks, which has helped to improve the therapeutic alliance. If you are interested, I would be happy to direct you to these tools, or if you would like my list of references, just give a call at the number below.

Myron Walters, MA CMT, Marriage and Family Therapist Registered Intern, has recently started a private practice internship in Mill Valley. Myron works somatically and transpersonally. He is continuing to work as an intern at Lomi Psychotherapy Clinic (since Feb, '06), honing his body psychotherapy skills. At Lomi, Myron's focus has been working with adults who have experienced childhood trauma and dissociation disorders. He also works well with spiritual emergence/growth, work addiction, adult life transitions, and increasing intimacy, including the sexual sphere. Myron has also served as the Marin CAMFT Student-Intern co-chair for the past two years. Deborah Morris, LCSW # 6189, supervises him. Myron welcomes your calls and referrals at (415) 686-3445.

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