Psychotherapy: Shifting from Technique to Client

In reviewing recent research findings, the Task Force on Evidence-Based Therapy Relationships commissioned by the American Psychological Association, concluded, "The therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment" (Norcross & Wampold, 2011, p. 98). The authors go on to say, "The therapy relationship accounts for why clients improve (or fail to improve) at least as much as the particular treatment method." A number of relationship elements, including the alliance, client feedback, empathy, collaboration, goal consensus, and positive regard have been found to be important in treatment. The Task Force states that the effectiveness of treatment is enhanced when one tailors the therapy relationship to specific client characteristics.

The Task Force findings bolster an accumulation of research over the past twenty years showing that our focus on technique in psychotherapy is misplaced. The psychotherapy outcome research has shown that specific technique accounts for only 1% of outcome variance in treatment (Asay & Lambert, 2008; Wampold & Bhati, 2004). Various studies have revealed that the relationship between client and therapist is an important predictor of outcome (Bachelor & Horvath, 2008; Horvath & Bedi, 2002; Krupnick, et al., 1996). However, although the therapeutic alliance is an important predictor of outcome, it only accounts for about 7% of outcome variation. About 87% of outcome variability is related to extratherapeutic-client factors—unique aspects of each client and his or her environment—about which little is known (Wampold, 2001).

A growing body of research indicates that all bona fide psychological approaches are comparable in effectiveness (Asay & Lambert, 2008; Beutler, 2009; Wampold, Imel, & Miller, 2009). Equality in treatment effectiveness has been found for PTSD (Benish, Imel, & Wampold, 2008),

depression (Wampold, Minami, Baskin, & Tierney, 2002), and substance abuse problems (Imel, Wampold, Miller, & Fleming, 2008). The evidence for robust differences in the effectiveness of different models of treatments does not exist. Dismantling studies have shown that specific ingredients are not necessary for treatment effectiveness. In short, a convergence of findings shows that technique is not the powerful tool we once thought it to be.

Despite research findings showing that different psychotherapies are equal in effectiveness, the medical model remains the predominant paradigm. We distinguish ourselves by the techniques we use, by our specific models of therapy; that is, by *what* we do to the client. In the medical model paradigm, the therapist is foremost a mechanism of delivery of techniques or approaches rather than an individual uniquely involved in the interpersonal transaction, and the client is a recipient of the applied technique. *The relationship is in service of the technique.* Cognitive-behavior therapy is particularly suited to this paradigm.

There are over 200 different models of psychotherapy with more than 400 associated techniques. There are at least sixteen distinct trauma focused protocols for the treatment of PTSD. Each of these purports to have the corner on effectiveness, and requires that implementation be carried out exactly as stipulated. After years of one powerful, cutting edge protocol supplanting another, one would think that by now treatment outcome should be approaching perfection, and yet, there is no evidence that the effectiveness of psychotherapy has substantively changed over the past several decades (Miller, Hubble, & Duncan, 2007). Still, our appetite for technique has not diminished. Workshops that teach the latest, most powerful, cutting edge methods of change still abound and attract large audiences. What is the explanation for this tireless search for the 'holy grail' of treatment?

Medicine, driven by the engine of technology, is capable of creating new, powerful chemicals that will do what no pill has done before. Psychotherapy's appropriation of the medical model gave us, at least in appearance, an equal footing with medicine—we used the RCT research design to test our curative tools. It was an appealing approach to gain legitimacy. It is natural to defend a paradigm grounded in science. It is natural to doubt evidence undermining the basis of our familiar beliefs. We may reluctantly admit that some treatment approaches are more or less equal in effectiveness—except our own…

In his historical analysis of the scientific process, Thomas Kuhn came to the important insight that the manner in which science proceeds is strongly influenced by psychological factors, and that paradigm shifts involve perceptual shifts—a kind of conversion process in which the world is seen in a new way (Kuhn, 1975, p. 151). From a Kuhnian perspective, our reluctance to let go of our attachment to technique and accept the evidence of equality of different treatment methods might reflect resistance to giving up an old paradigm. The physicist, Max Planck, made the astute, but somewhat depressing observation that "a new scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die, and a new generation grows up that is familiar with it" (Planck, 1949, pp. 33-34).

As psychologists, we pride ourselves in being objective, but after all we are human. Our image as healers with powerful therapeutic agents is good for the ego. One does not easily shed a deeply etched perception of the world. Some hundred years had to pass after Copernicus' death before the earth centered universe gave way to a heliocentric one. If we abandon our notions of possessing powerful tools of change, we feel naked, impotent. We must then content ourselves with more modest aims, such as improving communication, improving how messages are sent and received. We are loath to be converted. Resistance, of course, has its value. If we simply

changed our ideas and methods willy-nilly, the world would be a chaotic mess. But eventually there is a tipping point. And perhaps now that time has come.

If we let go of the medical model and orient ourselves to a client-directed relationship model, we are not tossing out technique, but rather consigning it to its proper place. In this client-directed relationship model, the world of psychotherapy then looks different. Figure becomes ground. Technique, rather than being a turnkey of change, becomes an element of the client-therapist relationship. *How* we use these tools in the context of the relationship is more important than *what* specific tools we use. It is a subtle shift in perspective, but an important one, that would change our focus of research and practice.

When we realize that technique is of relatively little importance per se in treatment outcome, and that therapeutic alliance, allegiance, and extratherapeutic-client factors account for the larger proportion of outcome variance in treatment, we come to a more realistic, humbling perspective of our role. The technique-focused medical model has probably contributed to our inflated self-appraisal as change agents. We tend to evaluate our performance as supernormal. For example, in one study in which therapists were asked to gauge their effectiveness, nearly one quarter of the sample believed that 90% or more of their clients improved. Half the sample reported that none of their clients deteriorated while under their care (Walfish, McAlister, O'Donnell, & Lambert, 2010). Our self-distorted view was revealed in an outcome study showing that the least effective therapists rated themselves as being on par with the most effective therapists (Hiatt & Hargrave, 1995). Such exuberant self-appraisals as change agents may be harmful to clients. The client-directed relationship model of psychotherapy would help correct such biases in self-appraisal. Our more modest role becomes that of mentor, guide, or facilitator. Feedback from the client becomes more important.

Studies of therapeutic alliance have found that client ratings of the therapeutic relationship rather than therapist ratings are better in predicting treatment outcome. A client-directed relationship model emphasizes the importance of the client's perception of the treatment process. Studies have shown that when feedback is obtained from the client regarding treatment progress and the alliance, the likelihood of improvement increases, and the likelihood of deterioration decreases. In an aggregate study, those clients in the feedback group had 3.5 times higher odds of achieving improvement and less than half the odds of experiencing deterioration than those in the no feedback group. At six month follow up, the couples in the feedback group had a lower rate of separation or divorce (Lambert & Shimokawa, 2011).

A client-directed relationship model can help us see what is hidden when looking down from the lofty perch of the medical model. Relying on the client to gauge the treatment process seems a foreign concept: it goes against the grain of a paradigm that gave us tools that distinguished our practice, that gave us a sense of empowerment. But research informs us that the psychologist's energy would be better invested in attending more to the client-therapist relationship. Use of client-rated brief feedback measures of alliance and progress in treatment would help ensure that we are on the right track and would increase the likelihood of successful outcome. In adopting the client-directed relationship model, technique no longer rules the roost. Instead, *technique is used in service of the alliance.* The new sense of empowerment comes from knowing that the client benefits.

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