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Reconsidering Psychotherapy Training Programs: Recommendations for Producing More Skilled

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Editorial

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Editorial

The results of nearly four decades of psychotherapy outcome research do not support the emphasis on models and techniques in psychotherapy training programs. According to Wampold and Imel [1], the results of available evidence reveals that model and technique account for only 1% of the change that takes place in therapy. The purpose of the present commentary is to briefly describe the state of psychotherapy and make recommendations for re-thinking clinical training programs with an emphasis on teaching skills related to what works in therapy.

Throughout his teaching career in both clinical mental health counseling and marriage and family therapy programs, the first author has consistently supervised students entering the internship/practicum phase of the training program. Before students begin clinical work, one of the most frequently asked questions (and sources of apprehension and anxiety) involves how to choose a model or theoretical orientation along with how to apply the model/technique in session. Thus, the emphasis is not on the client(s), but the trainee's desire to properly apply the chosen model in practice, often at the expense of being intellectually and emotionally present with the client. Given the near myopic focus on theories and emphasis on techniques as mechanisms for eliciting change in many training programs, it is not surprising that this is at the forefront of students thinking before entering the room with clients.

Yet, the results of nearly four decades of psychotherapy outcome research do not support the emphasis on models and techniques and instead, detail a very different vantage of the factors which seem to account for change. According to Wampold and Imel, the results of available evidence reveals that model and technique account for only 1% of the change that takes place in therapy. So why should we care? Students need a model to guide them in the therapy process so they will have to learn about the various approaches anyway. Although on the surface, this distinction may seem like a matter of semantics or an academic exercise, the reality is that by not training students in a manner consistent with what the data support seems to make a difference in therapy and overemphasizing specific factors not responsible for change, we are putting them and their clients at a disadvantage. Consider the following alarming statistics: 1) Psychotherapy outcomes have not improved over the past 40 years, 2) the modal number of sessions attended by clients is one, 3) dropout rates average 25-49%, and 4) approximately 35-40% of clients do not benefit from therapy and some even get worse (5-10%). Epidemiological studies consistently show that the majority of people who could benefit from seeing a therapist, do not go and among those who do seek help, fewer are turning to psychotherapy-33% less than 20 years ago-and an alarming 56% either don't follow through after making contact or drop out after a single visit with a therapist [2]. Moreover, the result of a recent large-Consumer Reports style survey found people rated

psychics and other "spiritual advisers" *more* helpful than therapists, physicians and friends [3].

In some ways these findings are not surprising as most training programs do not value therapists for their humanness or personhood, but rather their theoretical knowledge and technical proficiency. In others words, we aim to produce technicians who can successfully apply an approach or technique to clients in the belief that strong adherence and competence in delivering the model will result in a greater likelihood of change, often at the expense of the variables which have been historically and consistently shown to be necessary for change to occur. A recent study done in Australia finds between 40 and 47% of graduate programs in psychology do not refer to relationship skills in their course syllabi, program descriptions, or list of training competencies [3]. These facts, combined with frequent "admonitions against over-involvement, breach of boundaries, …and other such departures from good technique", establishes a "vicious cycle" that continues after graduate school-one in which practitioners, and the field, are forever attempting to improve effectiveness by learning new diagnoses, therapy-related terminology, and treatment models [4].

Given these findings, it is critical that the field re-think current training models to focus more deliberately on what seems to matter the most in treatment. As noted by Orlinky and colleagues [5] two decades ago, "The quality of the patient's participation in therapy stands out as the most important determinant of outcome…[this] can be considered fact established by 40-plus years of research on psychotherapy. Rather than emphasizing models/techniques and diagnostic labels/characteristics, we contend that the emphasis for therapists-in-training should be on alliance building and more specifically, how that is done. According to Horvath [6], the client's perception of the alliance by the end of the second session is one of the best predictors of a successful outcome. Although often considered the thing that done in the first session to connect with clients, the alliance is a dynamic concept which evolves over time and can be created or enhanced by engaging in particular and deliberate activities. Thus, students would benefit from more detailed and specific coursework and training on the nuances of the alliance and relationship building and how to assess the quality on a regular and on-going basis to ensure the client feels connected to the therapist. Moreover, training programs should foster a sense of interest in people as individuals and help therapists-in-training develop insight into their personality characteristics and how these may influence the client's perception of the counselling experience.

To be clear, theory and technique are necessary parts of the therapeutic process–they are well-developed systems for understanding, explaining, predicting, and controlling human behavior [7]; theories provide a roadmap for understanding what is happening in the room. However, they should not be the primary considerations driving the therapy process. In our effort to identify and teach specific techniques which could be applied universally, training programs have minimized the importance of human connection. Consequently, we recommend training programs revise their curricula to emphasize therapist factors which seem to impact outcome including developing sensitivities to the complexities of client motivation, improving tolerance, and the ability to establish warm and productive relationships with others. Students would also benefit from developing skills necessary to access client or non-specific factors (strengths, resources, etc.) which seem to account for the most significant percentage of change. Finally, clinical training programs would be wise to shift from a focus on evidence-based practice to a practice-based evidence mindset and teach students how to use client feedback (on both process and outcome) as a mechanism to inform the treatment and clinical decision-making process on an ongoing basis. Given that therapist outcomes do not improve with time and experience and may deteriorate, coupled with the current stagnation of outcomes in the field, it is critical that the field reconsider current training approaches.

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