What Is New in Psychotherapy and Counseling in the Last 10 Years?

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Workshop Description
An opportunity for participants to reflect on important developments in psychotherapy and counseling in the last 10 years. There will be considerable participant interaction.

Learning Objectives
By the end of this program the workshop participants will be able to

1. List ideas that they have learned in the last 10 years related to their work as psychotherapists; and
2. Link ideas to their work as psychotherapists

Introductory Comments
About the speaker

Continuing Competence

Sharing our Knowledge

Appreciation to previous workshop participants:
Philadelphia, November 2016; Erie, April 2017

Overview of the Presentation
Brief Comments on “What Is New?”

Group Exercise on Sharing Perspectives
Create a Top Twenty List

Sam Knapp’s Top Ten

Practical Applications

Do We Get Better With Age?
Most psychotherapists think that they get better with age (Orlinsky et al. 1999)
We Do Not Necessarily Get Much Better with Age
Goldberg et al. (2016): outcomes of more experienced therapists declined slightly as a group, although some individual psychotherapists improved.
Huppert et al. (2001): therapy experience had a small association with outcomes using CBT with panic attacks.
Spengler et al. (2015): “the accuracy of clinical judgments was enhanced as a result of experience, although not by much” (p. 221).

How Do We Interpret This Data?
Data: Variability in outcome with age—on the aggregate slight improvement
Interpretation by SJK: But most likely variability with some psychologists continuing to improve and some declining

The Statements
Created by Samuel Knapp and John Gavazzi
October 2016; revised March 2017
Articles in forthcoming PA Psychologist
Working document
Ever open to change
Based on our reading and experience

What in the Last 10 Years?
Last 10 years- more or less
In psychotherapy or counseling– more or less
Differences in
populations treated
theoretical orientations
personal interests
other factors

Goal of Exercise
Perhaps there are some ideas in the statements that will help you in your professional practice.
In addition, perhaps if we share our ideas on what is new we can learn from each other.

Step One
In the last 10 years what was the best
1. Book you read on psychotherapy/counseling?
2. Article you read?
3. Workshop you attended? AND/OR
4. What Ideas did you learn from them?
Step Two
Give everyone a chance to speak
Contrast and compare the ideas generated?
Are they similar, different, or do they connect in any way?

Step Three
Groups Identify Your Top Ideas
Did you find overlap or common themes?

Collaborate Among Groups
Groups talk to each other.
Which group had the best idea?
What was it?
Why did it interest you?

Putting it Together
Can We Develop a Top 20 List?

Ideas, Publications, Implications
My top ideas, publications, and practical implications of them

Sam Knapp’s Top 10 Ideas
1. The importance of self-reflection (e.g., Walfish et al.)
2. Literature on “supershinks”—deliberate practice, conscientious, focus on relationships, use of skills, etc.; (Variability among psychotherapists across skills; Krauss et al.)
3. Evidence based relationships, treatments
Sam Knapp’s Top 10 (2)

4. Cultural competence (not matching) improves outcomes
5. Collectivist practice improves outcomes (Johnson et al., 2012)
6. Some forms of CE can improve patient outcomes

Sam Knapp’s Top 10

7. Changes CE delivery (MOOCs, Coursera)- not caught up with APA approval system
8. Telepsychology has evidence for effectiveness, including use of apps as adjuncts
9. Evidence suggests caution in evaluating psychology (and medical) data base
10. Science of morality data base (positive habits of practice)

Top 10 Publications

Not necessarily the same as top 10 ideas

1. Open Science Collaboration (2016)
   About 40% of scientific findings in cognitive and personality psychology could be replicated—others are
   a. Wrong
   b. Accurate (?)
   c. Insufficiently qualified
   d. Not as robust as once believed

2. Walfish et al. (2012)
   The “better than average effect” applies to psychotherapists
   No one rated themselves in the bottom 50%

3. Kraus et al. (2011)
   Competence varies widely across many dimensions.
   A few psychologists are high competent in most dimensions; a few are competent in a very limited number of dimensions.
Looks at the literature on decision making and finds physicians are vulnerable to confirmation bias, fundamental attribution error.

5. Atul Gawande (2011)
Gawande, a surgeon in Boston, describes his use of a “coach” during surgery.

Pro-athletes have coaches, as to actors, musicians and others. Why not health care professionals?

6. e.g. Boswell et al. (2015)
Unified protocol; instead of looking at which theoretical orientation is better for what diagnosis—Looking at which techniques (which may be used by psychologists of different theoretical orientations) are effective with which symptom (which may occur across many different diagnoses).

7. Vieten et al. (2016)
Developing a list of competencies of persons who want to integrate spiritual or religious practices into psychotherapy.

The CAMS (Collaborative Assessment and Management of Suicide) is an effective assessment and suicide management protocol.

It represents a growing sophistication in suicide prevention research.

Introduces the term “competent community” to refer to a network of colleagues who can facilitate one’s professional development.
10. Khoury et al. (2013)
Mindfulness (which refers to a variety of techniques with the commonality of nonjudgmental focus) is demonstrating helpfulness across a wide range of problems, either as a stand alone or as part of other treatments.

11. Anything by . . .
Louis Castonguay: e.g., helpful and harmful events
Michael Lambert: data on predicting outcomes
Scott Miller: Research on “supershinks” what features distinguish those who are exceptional as psychotherapists

Honorable Mention
Lisa Sanders: Every patient tells a story
Steven Johnson: Where Good Ideas Come From
Matthew Ridley: The Rational Optimist
Steve Pinker: The Better Angels
Robert Wright: Non-Zero Sumness
Paul K. Chappel: The Art of Waging Peace

Practical Implications
Being “supershink” improving outcomes
Matching patients
Biological options
Changing needs of patients
Questions about science of psychology (and other health care professions as well)
Education and training

Expanding on This Topic
Matching on race, ethnicity, or religion needs to be done carefully with a recognition that it is no guarantee of an improved outcome and can lead to a false sense of competence.

In Addition
Awareness of effectiveness of biological interventions
Stimulation, ECT- possibly
Ketamine-- no
Furthermore
Sensitivity to emerging issues
Marijuana/Opioid addiction
single/blended families
CAMS
Suicide rates increasing
More diverse populations

Science
Getting more consistent with our scientific roots and a focus on theory drive and replicable studies

Education
Trying to get more specific about types of CE most linked to improved patient outcomes
Ethics training—focus on self-reflection and enactment of positive values

Personal Big Ideas
Quality Enhancement Strategies
Prompt List
Ethics Acculturation Model

How to Become a “SuperShrink?”
Deliberate practice
Collaborative
Hypervigilant in monitoring progress
Domain specific strategies
Cultural competence makes a difference

Quality Enhancement
“Any purported risk management principle that tells a psychologist to do something that appears to harm a patient or violates a moral principle needs to be reconsidered”
Knapp et al., 2013, p. 32
False Risk Management Principles

1. Always get a safety contract signed
2. never keep detailed records
3. never self-disclose to or touch a patient
4. informed consent only consists of getting patients to sign a form
5. risk management is only concerned with keeping psychotherapists from being disciplined by an oversight body

Focus on Quality

Atul Gawande- coach

Steve Johnson– history of good ideas

Literature on teamwork–

Four Session Rule

If, at the end of four sessions, you do not have a good working relationship with the patient OR the patient is not improving- for no obvious reason,

Then you need to rethink therapy

Prompt List

1. rethink diagnosis and goals- do you need a consultation
2. discuss issues with patients
3. are there second sources of data to explore?

Prompt List- Additional Reflections

• Do YOU think you and the patient have a good working relationship?
• Is your assessment of the patient adequate?:
• Are there unresolved ethical issues?
• Do unresolved clinical issues impede treatment?
• What does your System I say about the patient? System II?

References

References-2

References-3

References-4