Introduction to Articles on
What Is New in Psychotherapy and Counseling in the Last 10 Years?

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Psychologists want to do a good job, but keeping up-to-date with changes in the field is difficult. Neimeyer et al. (2012) estimated that the half-life for a professional psychologist is 9 years and will soon decline to 7, although the half-life varies across specialty. These articles strive to help psychologists keep up-to-date by encouraging them to reflect on the most significant changes in the field of psychotherapy in the last 10 years. Because of space limitations we had to summarize complex issues into a brief paragraph or a few sentences. These articles are enriched by the feedback of participants in a November 2016 continuing education workshop of the same name. We refer to their contributions in several of these articles.

These articles are neither definitive nor final, but they are the basis for more discussion and reflection. Remember the adage “the map is not the territory.” This document is not the territory; nor does it even purport to be the map. It is only a fragment of the map that readers need to complete for themselves. Furthermore, our own conception of what is sufficiently important to include in this review is ever changing. It seems like every week we encounter an article, book, or idea that we should add to our review.

Individual psychologists will differ in what they believe are important developments, in part, because they work within specific subfields of psychotherapy, have different areas of interest, have different theoretical orientations, are exposed to different sources of information, or simply know more than we do.

We chose 10 years from our review because it comes close to the 9 years identified by Niemeeyer et al. (2012) as the half-life of psychological knowledge. Our 10-year time frame for this review is flexible. What is “new” is a subjective decision. For example, we identify the rise of Motivational Interviewing as new. Although the technique dates to at least 1991, we opine that its use and the evidence supporting its efficacy has increased in the last 10 years. Because we include the increased validation of older concepts, there may be times that we include something as new that the reader had “known all along,” or thought was common knowledge. Although we focus on psychotherapy and counseling, it is sometimes difficult to separate an advancement in psychotherapy/counseling and from an advancement in another related field of psychology (or another discipline).

References

What Is New in the Scientific Basis of Our Profession?

Much of what we “know” to be true in mental health treatment (including outcomes for pharmacology or psychotherapy) may not be true or may have been inadequately qualified. Many reported treatment effects in health care, including psychotherapy and pharmacology, are based on studies with methodological shortcomings that allow a high risk of false positives.

Concerns about the accuracy of published data are not unique to psychology. The methodological problems associated with psychotropic drug studies are so substantial that some researchers have questioned the efficacy of many commonly used medications. Ioannides et al. (2013) estimated that perhaps one half of the purported significant effects of drugs may be inaccurate. Kirsch (2014) argued that antidepressant medications may have a greater placebo effect than once believed. Driessen et al. (2015) decreased the effect size by 25% for anti-depressant medication and psychological treatments when they have added unpublished studies to their meta-analyses. Ebrahim et al. (2014) found that the re-analyses of data from medical studies sometimes led to changes in the direction of the findings. Furthermore, evidence suggests that the blinded studies of drug effects were not well-blinded. Participants could accurately identify whether they were receiving a placebo or active drug, sometimes as high as 80% (Greenberg, 2017). Finally, what was learned in studies with WEIRD research participants (Western, educated, industrialized, rich, and democratic) may not generalize to other non-Western cultures (or even to subcultures within Western democracies; Henrich, Heine, & Norenzayan, 2010).

The Center for Open Science sought to determine if some recent psychological findings could withstand replication. They coordinated replication studies of 100 published findings and found that less than one half of the replication studies confirmed the positive results found in the original studies (for p values, it was 36% of the replicated studies; for effect size, it was 47% of the replicated studies; Open Science Collaboration, 2015). The rate of successful replications was lower in social psychology journals and higher in cognitive psychology journals. None of these studies subject to replication dealt with the treatment of mental illness. Nonetheless, the methodological issues raise could apply there as well.

Despite these problems with replication, psychologists need to continue to review, evaluate, and utilize current research in psychotherapy and other fields (e.g., behavioral economics) because it enhances their ability to provide high quality psychological services. We need to remember that no study is perfect; simultaneously, we need to remain current as to what the preponderance of the research supports.

Critics have called for systemic reforms for publishing psychological studies. Efforts to reduce inaccurate or misleading findings include changing the statistics used in studies, encouraging the replication of previous studies, publishing studies with good methodology that did not find significance, encouraging the sharing of data sets, and interpreting results with cultural factors in mind.

Despite the concerns about methodology, we are especially encouraged by the development of practice research networks for studying psychotherapy outcomes and processes. All health care fields have a gap between the latest research of scientists and the actual practice patterns of practitioners in the field—called the scientist-practitioner gap—and psychology is no exception. In the past, many
would blame practitioners for this gap, arguing that they were not adequately scientifically trained or sufficiently motivated to learn about the latest scientific findings. Others, such as Louis Castonguay of the Pennsylvania State University, expressed a more sophisticated perspective and noted, among other things, that sometimes the findings from clinical trials do not generalize to the actual practices of clinicians or that the problems that clinicians experience are not addressed by psychotherapy researchers. One goal of practice research networks is to generate research that has more direct relevance to the needs of practicing psychologists.

Effective practitioner networks must minimize intrusions into the daily routine of practicing psychotherapist. The daily lives of psychotherapists depend highly on structure and routine with little free time for non-essential tasks. The project must have an infrastructure (or resources) to support the studies. Finally, the studies must involve practitioners in every meaningful aspect of the research project. They need to avoid “empirical imperialism” (“I am the scientists in the room and you have to do what I say”). Instead, practitioners must fully participate in the development of the research questions, and in all major decisions throughout the project (see a description of the experiences of research members in Castonguay et al., 2010).

References

What is New in Psychotherapy Processes and Outcomes?

Good outcomes come from the quality of the therapeutic relationship, the techniques used, and the qualities of the patients. Controversies still exist concerning the relative contributions of techniques versus relationship in determining patient outcomes. Wampold (2015) concluded that specific treatments have an impact on outcomes, although not as much as patient relationships (we understand that other researchers give greater weight to the value of specific treatments than Wampold). We review specific treatments and outcomes in more detail in the article in this issue entitled “What is New in the Advances in Psychotherapy?” However, the entire debate between technique and relationship may be misplaced. Good interventions strengthen the relationship and strong relationships facilitate the effectiveness of interventions (Hill et al., 2017). It may be better to ask what techniques combined with what relationship factors with what patients produce what outcomes. Markin states “Contrary to this artificial dichotomy between the treatment and the relationship, research suggests that the client, therapist, relationship, and treatment method all contribute to treatment success and failure” (2014, p. 328).

Most of this article focuses on psychotherapist qualities related to outcome. Some psychotherapists consistently get better than others. Even so, psychotherapist effectiveness may not necessarily be a general quality that cuts across all patients and diagnoses. For example, Kraus et al. (2011) found that no psychotherapist was considered highly competent in all 16 domains measured, although some psychotherapists consistently had better outcomes than others.

If some psychotherapists are better than others, then it should be worthwhile to look at their attributes. Psychotherapist effects appear unrelated to years of experience, gender, age, profession, or educational qualifications (Chow et al., 2015). Better outcomes are related to the ability to develop collaborative treatment relationships, have a repertoire of effective strategies, a process to monitor patient progress (Wampold, 2009).

Psychotherapist effectiveness is likely to improve when the therapists (a) establish a baseline of performance; (b) get feedback on how they are doing; and (c) engage in deliberate practice (Chow et al., 2015). Monitoring patient progress is only effective if the psychotherapists invested in the process sufficiently so that the cost (in terms of time and disruption of the interactions with the patient) do not overtake the benefits (Wampold, 2015). Deliberate practice appears especially important in achieving high levels of expertise (Goodyear et al., 2017).

Do Psychotherapists Get Better Over Time?

Do psychotherapists get better over time? Orlinsky et al. (1999) found that psychotherapists tended to rate themselves more competent as they grew more experienced. They found that “overall and within every subgroup, perceived therapeutic mastery was positive and significantly related to therapists’ years in practice” (pp. 208-209).

However, the data on improvement over time is not so positive. Goldberg et al. (2016) found that the outcomes of more experienced psychologists declined slightly, as a group, although some individual psychotherapists improved their outcomes. Huppert et al. (2001) found that therapy experience had a small association with outcomes using cognitive behavioral therapy with panic
attacks. Spengler et al. (2015) found that the accuracy of clinical judgments improved only modestly over time.

How do we interpret this conflicting data? The participants in our November 2016 workshop strongly believed that they got better with experience and we tend to give high deference to their perspectives. We have no little data to support our interpretation, but we believe that some psychologists improve over time, some stay the same, and some get worse. In addition, we acknowledge that some psychologists may become more proficient with a wider range of problems over time.

Promoting Self-Reflection

One of the major impediments toward productive self-reflection is the “better-than-average” effect, or a tendency for people to interpret their performance as overly positive. Walfish et al. (2012) found that 25% of the psychotherapists that they surveyed rated themselves in the top 10% of competence. None rated themselves in the bottom 50%. They gave themselves a mean ranking at the 80th percentile. It is possible that more of the better psychotherapists had responded to the survey. Nonetheless, the direction of the responses is so substantial that we think it is unlikely that selection bias accounts for the direction of the findings.

This overconfidence can reduce receptiveness to feedback. Younggren (2007) warned against professional narcissism or the tendency to over value one’s expertise and knowledge. In contrast, Nissen-Lie and Rønnestad (2016) claimed that humility is an essential ingredient of highly effective psychotherapists. Humility refers to recognition of one’s limitations and healthy self-doubt. Psychotherapists who showed humility (combined with self-love and self-tolerance) tended to have better patient outcomes. Perhaps one important ingredient is the willingness to accept feedback.

What Patient Factors Are Related to Outcomes?

All knowledgeable psychologists would agree that treatments need to be tailored to the individual characteristics of the patients receiving them. It is beyond the scope of this short article to summarize of the factors that should be considered when making these adaptations (for one recent review see Journal of Clinical Psychology: In Session, Vol. 67 (2)). Across studies, the patient characteristics most closely related to outcomes are resistance/reactance (highly sensitive to being controlled by others), preferences, culture, and spirituality. Also, stages of change and coping style probably related to outcome, and patient expectations and attachment style might be related to outcome although the data is not so clear with them (Norcross & Wampold, 2011b).

What Relationship Factors Are Related to Outcomes?

Some participants in our November 2016 workshop felt strongly about the importance of building relationships. One participant stated that “nothing knew has been learned since Carl Rogers.” While we appreciate the great importance of Carl Rogers, we note that the evidence on effective elements of treatment has expanded upon his triad: congruence, empathy and unconditional positive regard.
A thorough review by a task force of APA’s Division 29 (Psychotherapy) and Division 12 (Clinical Psychology) found that the following relationship factors are related to patient outcome: alliance in individual psychotherapy, youth therapy, or family therapy; cohesion in group therapy; empathy; and collecting patient feedback. The following are probably effective: goal consensus; collaboration; and positive regard. The following are promising but not yet definitive given the need for more research: congruence; repairing alliances; and managing counter transference (Norcross & Wampold, 2011a).

The quality of psychotherapy can be informed by identifying factors that linked to lack of patient progress or deterioration. These harmful factors per Norcross and Wampold (2011a) and Castonguay et al. (2010) include: confrontations; negative processes (hostile, pejorative, critical); making assumptions about the patient’s perceptions; psychotherapists centricity (failing to obtain patient’s perceptions); ignoring patient needs; and rigidity, such as failing to be flexible when implementing protocols.

References


What is New in Diversity and Psychotherapy?

Psychology is continuing to make progress in addressing shortcomings in the delivery of services to patients who have been traditionally marginalized. For example, there is an increased awareness of the extent to which some patients have gender nonconforming behaviors, including transgendered behaviors, and the unique features of psychotherapies designed to help them. Competence remains an issue when working with TGNC patients, but efforts are being made to improve the quality of services (see for example, American Psychological Association, 2015; Mizock & Lundquist, 2016).

Race or Ethnicity

Many health professionals are uncomfortable egalitarians who hold implicit biases that impact behavior, even if they are unaware of them. Implicit prejudice or unconscious bias (Banaji & Greenwald, 2013) can lead to differential treatment of patients by race, gender, weight, age, language, income, attractiveness, etc. Implicit bias may be one reason that Black Americans often receive a lower quality of health care than White Americans as measured by objective standards. Implicit biases can be overcome through multicultural education, perspective taking, and partnership building skills.

The relationship between ethnicity and psychotherapy outcome is complex. On the one hand, Weisz et al. (2017) found that the psychotherapy outcomes for minority youth approximated the outcomes for Caucasian youth. This outcome is consistent with other studies that found that “psychological therapy is efficacious for ethnic minority youths and adults across multiple problem areas, and about equally efficacious for minorities and Caucasians” (p. 93). Nonetheless, the data base for psychotherapy outcomes with minority youth is substantially smaller than the data base for Caucasian youth. In addition, evidence suggests that outcomes can improve if the psychotherapists are culturally competent and modify treatments accordingly.

Hayes et al. (2015) found that psychotherapists differed in their effectiveness with racial or ethnic minorities. “Cultural competence can be distinguished from general therapist competence” (p. 312). The data on matching psychotherapists and patients on racial or ethnic basis has been mixed (in part because White psychotherapists vary in their effectiveness with REM, and in part because of the wide diversity within diversity). “Ethnic matching alone does not ensure cultural competence . . . given within-group diversity related to other cultural experiences and identities . . . clinicians of all ethnic backgrounds and within interracial therapist/client dyads (e.g., Caucasian therapist and African-American clients) can develop effective, culturally competent therapeutic relationships” (Chu, p. 21).

Modifying treatments to culture of patients can be important and lead to better outcomes, although the overall effect is modest (Wampold, 2015). Here is an example of where group based studies have limitations. It is possible that for some patients—perhaps those who are highly assimilated—that the cultural adaptation makes little difference. However, for other patients the cultural adaption is crucial in ensuring any reasonable possibility of success.

Effective treatments also recognize the importance of intersectionality, or the way that race, ethnicity, culture, acculturation, gender, gender identity, socioeconomic status, religion, etc. interact to influence the behavior or identity of the individual patient. Race or ethnicity alone may be insufficient
to fully understand the life experience of any individual. For example, the experiences of a Black male one generation removed from the Caribbean who has a college education and a professional career might differ substantially from the experiences of a Black male of the same age who is a high school dropout and lives in poverty in a major American city. As stated by Rosenthal et al. (2016) Intersectionality highlights the importance of attending to multiple, interacting identities and ascribed social positions (e.g., race, gender, sexual identity, class) along with associated power dynamics as people are at the same time members of many different social groups and have unique experiences with privileges and disadvantage because of those intersections” (p. 475)

Religion as an Aspect of Diversity

Religious or spiritual orientation is an aspect of diversity and a question arises as to whether religiously modified treatments can enhance psychotherapy outcomes. Researchers disagree on this issue. Anderson et al. (2015) found many methodological limits in the studies looking at the outcomes with religious or spirituality modified psychotherapy. Some studies found statistical differences, although the practical differences were small. Other reviews (cited in Hook, 2012) are more optimistic about the effects of religious or spiritually accommodated therapy. Both sources agree that religious or spiritually accommodated therapies have results that are no worse than standard treatment. Of course, one of the challenges is that religious or spiritual modifications can take many different forms and may have to be tailored to the unique background of the patients.

Those who incorporate religion or spirituality into psychotherapy need to be competent to do so. Vieten et al. (2014) identified 16 required attitudes, knowledge statements, and skills. For example, one of the attitudes was that “psychologists view spirituality and religion as important aspects of human diversity, along with factors such as race, ethnicity, sexual orientation, socioeconomic status, diversity, gender, and age” (p. 135); one of the knowledge statements was that “psychologists know that many diverse forms of spirituality and/or religion exist, and explore spiritual and/or religious beliefs communities, and practices that are important to their clients” (p. 135); and one of the skills was “psychologists help clients explore and access their spiritual and/or religious strength and resources” (p. 135). In a follow-up study, Vieten et al. (2016) found wide support for the proposed 16 competencies among practicing clinicians, although few respondents had training in all these areas.

So far, no evidence suggests a consistent benefit in matching patients and psychologists by religion (Cummings et al., 2014). However, no evidence suggests it would be harmful either. We are open to the possibility that research may eventually find benefits to matching, if it increases the alliance between psychotherapists and patient, reflects a patient preference, or reflects a general appreciation or agreement on world views. Moreover, it is possible that the categories used in research are so broad (e.g., Christian v. non-Christian) that the comparisons are not meaningful

References

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1 Religion differs from spirituality, although the concepts overlap. One common definition of religion is “participation in an organized system of beliefs, rituals, and cumulative traditions” (Hage, 2006, p. 303); in contrast, spirituality is “meaning and purpose in one’s life, a search for wholeness, and a relationship with a transcendent being.” (p. 303). The two concepts are not entirely distinct, however. Many individuals express their spirituality through religious activities.


The Changing Evidence Base for Specific Treatments

We have been impressed by the growing evidence for the use of psychological interventions for a wide range of disorders including depression, anxiety, insomnia, substance abuse disorders, post-traumatic stress disorders, borderline personality disorder, eating disorders and others (Society for Clinical Psychology, n. d.). Psychological treatments can also be very effective for serious mental illness as part of a more comprehensive treatment plan. For example, with bipolar disorder, psychological interventions involving “structured psychological treatment emphasizing psychoeducation, effective coping, and monitoring of activities and moods” was an important adjunct to medications. For severe depression, a combination of psychotherapy and medication appears to do better than either one of them alone (Cuijpers et al., 2009).

The popularity of certain psychological treatments has changed in recent years and is expected to change in the future. A Delphi poll (Norcross et al., 2013) found that psychologists predicted that mindfulness, cognitive behavior therapy, integrative therapy, and multicultural therapy, motivational interviewing and dialectical behavior therapy would become more common, while EMDR, Gestalt therapy, Reality Therapy, Jungian treatment, Adlerian approaches, and Transactional Analysis would be less common.

Let us consider some of those treatments in more detail. Motivational therapy “is an empirically supported interviewing strategy and delivery style based on the premise that when an individual is adequately motivated, change is likely to occur” (Steinkopf et al., 2015, p. 350). It “is primarily concerned with helping clients to make a decision to change” (Moyers, 2014, p. 358). It involves two elements: the relationship and then promoting change talk. Apodaca et al. (2016) found that change talk was more likely to occur after open questions and reflections and less likely to occur after giving information or asking closed questions. Motivational Interviewing can be used as a stand-alone technique, incorporated into other modalities, or used as a pre-treatment intervention. It originally was used with alcohol interventions, but expanded to other areas and it can also be used across theoretical orientations.

Mindfulness refers to a cluster of interventions that use nonjudgmental awareness. It can be used as a stand-alone technique or integrated with other treatments such as Acceptance and Commitment Therapy, Mindfulness-based stress reduction, etc. As such, it is sometimes considered a transdiagnostic intervention (Dunn et al., 2013; see Statement 5) that can be effective across a wide range of diagnoses in which rumination or excessive self-criticism occur. Khoury et al. (2013) and others reviewed many studies and showed that mindfulness can reduce anxiety, depression, and other symptoms. disorders. Participants in our November 2016 workshop emphasized the contributions of mindfulness and were frequently using it in their psychotherapy sessions.

Despite the proliferation of interest and research, mindfulness is hard to study because it involves an internal mental state (not overt behaviors that are easier to measure) and can take many different forms (making it harder to compare studies to determine the specific elements responsible for improvement). Furthermore, Dimidjian and Segal (2015) describe a continuing problem whereby a program proven effective in a laboratory has diminished effectiveness in the community because of resource limitations lead to its implementation by undertrained practitioners.
In addition, we believe that emotional focused therapy will continue to increase in acceptance. According to emotion focused therapy, the therapeutic relationship allows for a safe environment and helps with affect regulation so that the patients can process emotions. Once an alliance has been established, “the therapist guides clients toward new ways of processing emotion, coaching them to become aware of, regulate, reflect on and transform their emotions” (Greenberg, 2014, p. 356). The mechanisms of change are awareness of emotions, expression, regulation, reflection, transformation, and corrective emotional experiences. It shares commonalities with other experiential therapies in that it understands emotions as central to a wide range of thoughts, desires, motivations, and memories.

**Biological Interventions**

We do not believe that researchers have made any significant breakthroughs in biological interventions for mental illness in the past 10 years. Most new drugs are refinements on older medications. Promises of increasing the effectiveness of medications through genetic matching are controversial. Some claim that the practice implications have not met the promises (Harrison, 2015). In addition to the limitations inherent with medications, Swift et al. (2017) found that patients who were assigned to medication treatment programs had a higher rate if refusing treatment and had higher drop-out rates than patients assigned to psychotherapy. Recent research has focused on the interpersonal nature of prescribing. Even if patients stay within treatment, their actual adherence to the protocol (i.e., taking the drugs as prescribed) will depend largely on the relationship they have with the prescriber (Greenberg, 2017).

Electroconvulsive Therapy (ECT) was a popular intervention during the 1960s and 1970s, but it fell into disuse because of concerns over its side effects and effectiveness. However, ECT treatments have evolved over time in terms of its safety and in limiting the circumstances in which it is used. Evidence in favor of ECT as a secondary or back up treatment for depression is regaining acceptance (Fink, 2014).

Some attention has been given to some unique biological therapies. For example, transcranial stimulation therapies, which use concentrated energy to influence brain functioning, holds promise as a treatment for depression and anxiety. In contrast, deep brain stimulation, a surgical procedure to implant electrodes into the brain, has not lived up to promises as a treatment for psychiatric disorders. “There is insufficient evidence at this point in time to support the use of deep brain stimulation as a clinical treatment for any psychiatric disorder” (Fritzgerald & Segrave, 2015, p. 979). Also, evidence for ketamine for use with treatment-resistant depression is limited. There are some anecdotal successes, but insufficient long-term clinical data to support its routine use.

**Psychological Interventions Compared to Biological Treatments**

It is difficult to state categorically that psychological treatment is better than biological treatments. Studies with insomnia illustrate the complexity of this issue. Medications are often used as a first-line tool to treat insomnia. The short-term benefit of insomnia medication is justified by the research. However, evidence supporting the long-term use of medications, such as anxiolytics and hypnotics, for insomnia is lacking. A variety of psychological interventions, such as CBT, mindfulness meditation, and sleep hygiene are effective for both acute and chronic forms of insomnia. Increased exercise, decreasing caffeine intake, decreasing food intake prior to bed, and decreasing alcohol intake
near bedtime are also important components to a healthy sleep-wake cycle. Some of the effective programs are stimulus control therapy, sleep restriction therapy, relaxation training, paradoxical treatments, CBT, or biofeedback based treatments.

However, for other disorders, such as unipolar depression or anxiety, we would recommend that patients be usually offered the psychological treatments, with medication offered in unusual situations or after a trial of psychotherapy has failed.

References


