How Psychotherapy Actually Works

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> "You will not apply my precept," he said, shaking his head. "How often have I said to you that when you have eliminated the impossible, whatever remains, *however improbable*, must be the truth?" --Sherlock Holmes

Psychotherapy works. 80% of people who experience treatment are better off than the untreated. And psychology is confident it knows how and why it is effective; we use the medical model which consists of assessment, diagnosis, and then application of evidence-based techniques. All seems well and good until we examine the therapy outcome literature more closely; inside that literature are a number of findings that seem to make no sense—that jar us out of our feelings of complacency. For example, the literature documents that training and experience do not predict better outcomes in psychotherapy[i]. Hard as it may be to believe, a new life coach with two weekend workshops of training achieves the same positive outcomes as a licensed, doctoral-level psychologist with twenty years of experience. The literature also documents that all of our techniques work, which sounds reassuring at first glance. Unfortunately, they all get equal results and no technique or school of thought has ever proved to be consistently better.[ii] This finding is so robust that Bruce Wampold, one of our leading outcome researchers, has actually recommended against evaluating new techniques, pointing out that we will always find that both work but neither is superior[iii]. This equivalency is both unusual and alarming; we expect professional fields to evolve—we appreciate when older techniques are replaced by better ones. This does not occur in psychotherapy.

The best way to explore these anomalies is to make things concrete and examine how they play out in therapeutic case studies. Imagine that, Ed, a typical client, approaches a doctoral-level clinical psychologist who is an expert in cognitive behavioral therapy (CBT). Ed explains that he has become progressively more anxious about leaving his house and particularly nervous about driving. He used to be a confident driver, but 10 years ago, when driving through traffic to a job in a new city, he had a mild panic attack. Since then, he has had increasingly disturbing symptoms when at the wheel; he is scared to drive on the freeway; he avoids crossing bridges, and he is nervous in heavy traffic. When the doctor questions Ed about his panic attack, he tells her that he had followed his wife to a new city because she had gotten a big promotion. He had loved his previous job and wasn't that happy with his new sales job. He states that he had been

in busy traffic on the way to the new job, and was thinking about how he hated his new life, when he had the panic attack. He claimed that he didn't resent his wife for the move—at least not much—because he loved her and it was such a great opportunity for her.

The psychologist, who has 20 years of experience, tells Ed that they are going to use CBT to treat his driving anxiety. She helps Ed bring some irrational thoughts into conscious awareness, thoughts that mostly concerned "rules" that Ed had about fear of conflict and hesitations about expressing his needs directly. The therapist explores these rules with Ed and asks him to discuss them with his wife. She teaches him assertiveness skills and asks him to practice at work and with his family to cement his new learnings. She also begins an exposure therapy program with Ed by getting in the car with him and encouraging him to push his comfort level and drive in challenging situations. By the end of 12 sessions, Ed can drive on the freeway, has decreased anxiety, reports that relationships are better in general, and feels significantly improved.

This approach is a standard method of treating anxiety. CBT believes that uncomfortable emotions occur secondary to dysfunctional cognitions; hence, the approach begins by eliciting and disputing inappropriate thoughts. The anxiety had become associated with driving; as a result, exposure therapy was employed to replace the fearful associations with feelings of comfort and mastery. Everything seems clear; the theories make sense and the approaches appear to be solid.

Now imagine that Ed brings his anxiety problems to Maxine, a masters-level intern who has only been working for three months under supervision. Maxine has just taken a weekend course on EMDR (Eye Movement Desensitization and Reprocessing) and is interested in using it with a real client. After taking Ed's history, Maxine explains that he has a form of PTSD and there is a new technique called EMDR that is specifically designed for his condition. EMDR was accidentally discovered when a psychologist was in a park thinking about some challenging personal issues. Something occurred that caused her eyes to move rapidly back and forth and she was surprised to discover that her issues now seemed much more manageable. Subsequent neuroscientific research showed that this occurred because trauma becomes stuck or blocked. If you hold the trauma in mind and move your eyes back and forth rapidly, a process similar to REM sleep is initiated and the trauma becomes open to reprocessing and integration. People who experience this report that their anxiety and depression issues are frequently resolved and they often get helpful insights as well.

Ed undergoes four sessions of EMDR and reports feeling much better. His general anxiety is reduced, he is driving in situations that he had previously avoided, and has even travelled several miles on the freeway.

This approach is not as common as CBT but it is a widely accepted technique; typically both clients and therapists report meaningful, positive changes. Critics point out that there is no evidence for the eye movements doing anything "neuroscientifically;" they dismiss it as placebo

and consider it an affront to scientific psychology. Regardless of this criticism, the research on EMDR shows that it gets the same positive results as CBT, no better but no worse[iv].

We are seeing the factors described in the introduction playing out: a beginner equals the results of an expert and a new technique—which may not have any neuroscientific foundations—is achieving the same results as the standard technique. This disappoints the EMDR advocates in that EMDR was designed to push the field forward, to be more effective than the standard approach. It certainly looks more mysterious and complicated and its reference to neuroscience aligns it with "the up and coming thing." The fact that it simply achieves equivalent results is discouraging.

The equivalent outcomes also disappoint the conservative psychologists who see EMDR as "mere placebo." If it is only placebo, then CBT, which is seen as scientific and evidence-based, ought to be superior. After all, CBT gets placebo or expectancy effects just as much as EMDR; it's famous in its own right and is often cited as the "best" treatment for anxiety. How come placebo plus science doesn't beat the outcome of EMDR?

Now let's imagine that Ed brings his anxiety to a different psychotherapist, this one offering a very unusual approach. This therapist is a retired OB/GYN who was trained to use hypnosis to minimize labor pain. In his personal life this doctor occasionally attended a spiritualist church where the church leader channeled both the recently deceased and "evolved spiritual masters." The retired OB/GYN was interested in continuing to work; he had decided to open a psychotherapy practice which specializes in exorcizing confused and/or malevolent spirits who have attached themselves to people and are causing mental health symptoms.

He met with Ed, took his history, and explained that it was easy to discover if spirits were to blame for his anxiety. He put Ed into a hypnotic trance and by use of ideomotor signaling (involuntary finger movements directed by the unconscious mind) was able to determine that Ed had indeed attracted a spirit. The OB used various trance techniques to accomplish an exorcism of the spirit. At the end of the session, Ed reported that he "felt like a new person." He was immediately able to drive with increased comfort. When he felt some anxiety returning in about a month, one follow-up session allowed him to regain his sense of confidence.

This approach, of course, would never be considered psychotherapy by any reputable psychologist. Instead the positive results would be explained as a placebo effect—the beliefs and expectancies of the therapist and the client, combined with the impressive hypnotic phenomena--resulted in a good outcome. The technique of hypnotic exorcism, in spite of being effective, would be seen as a procedure with no inherent power.

This argument certainly seems valid but it has one glaring problem: we can all agree that the exorcism *lacks* inherent power but how can we prove that CBT and EMDR *have* inherent power. All three have placebo/expectancy effects. All three have equal outcomes. Can we argue that CBT is scientific and has inherent power but lower placebo effects and just accidentally the sum

of its inherent power and its expectancy effect exactly equal the pure placebo effects of EMDR and exorcism? Seems pretty unlikely….

CBT does look more scientific. And its claim to being scientific rests on its underlying theories and how its techniques are derived from these theories. "Cognitions precede emotions" is the central idea in CBT. This sounds fine until we consult other schools of psychotherapy. For example, psychodynamic practitioners believe that emotions arise out of childhood learnings and traumas and systems theorists propose that emotions are often transactions in larger family and social systems. And, of course, the psychodynamic techniques and the systems techniques get the exact same positive outcomes as CBT even though the underlying theories conflict. Which is the most scientific of the three and which has the largest expectancy effect?

But the *coup de grace* to the hope that there is inherent power in techniques is administered by the earlier finding that training and experience fail to improve outcomes. Trained and experienced therapists know more techniques and have more practice with them; if techniques had inherent power, then the trained would best the untrained and the experienced would best the inexperienced.

We all agree that the exorcism technique gets its power from belief and expectancies; isn't it clear that the effectiveness of all of our psychotherapy techniques are based on the same factors? What else can explain why everything works, why they all have the same effect size, and why all our new techniques—after some initial enthusiasm and some anecdotal magical claims—seem to become the "same old, same old." Our techniques ought to be evolving and getting better; instead we are just reinventing the wheel, developing new techniques that have the same effectiveness as the preceding ones. We need to accept that techniques have no inherent power. Techniques in psychotherapy are essentially healing rituals.

Given that the vast majority of the effort in psychotherapy--our books, workshops, and research--is focused on developing, learning and evaluating techniques, this conclusion that techniques have no inherent power is enormously provocative. Yet, the research, as illustrated by our three clinical examples, leaves us with little choice; Sherlock Holmes was correct when he asks us to accept the improbable when other options have been eliminated.

While this conclusion is true, it does not feel true. Something happens in the room—apparently a technique—and it feels like the technique changes the client. Ask any therapist and they will tell you that they are sure that they are a better therapist because of training and experience. And every time some new technique is invented, it feels like it pushes the field forward. Moreover, the finding that all approaches get equivalent results also feels wrong; advocates for the different schools are certain that their particular school captures more of the truth about the psyche.

The reason that psychologists still believe in techniques is because all of the research results, although well known, are so counter-intuitive that the conclusions are simply rejected or ignored. To make sense of all these contradictions, we need to find the underlying factor that ties them all

together--the factor that explains why there are so many findings that feel so wrong in psychotherapy. Fortunately, the literature points towards a single unifying answer: *psychotherapy operates in constructed reality.*

To understand this statement, it is useful to begin with a cross-profession analysis of "privileged knowledge." Privileged knowledge refers to the techniques, theories and experiences that are necessary for a practitioner to accomplish the tasks of the profession. Cardiology, for example, has privileged knowledge; no lay person could install a pacemaker without training. Conversely, in psychotherapy, education and leadership, any competent cultural member can be successful without training. That's because these later fields lack privileged knowledge. And that's not because psychotherapy (and the other fields) has not attempted to build privileged knowledge; clinical psychology has literally produced thousands upon thousands of books, papers, and research studies trying to establish privileged knowledge. However, there appears to be something in the nature of psychotherapy that precludes the accumulation of privileged knowledge.

And it's not difficult to figure out what's different. Fields with privileged knowledge—engineering, biology, astrophysics, boat building—operate in the material world or what might be termed fundamental reality. The fields without privileged knowledge operate in constructed reality. We are all familiar with the concept of fundamental reality. A broken leg and the way to treat it is the same across all cultures. How to build a suspension bridge does not vary depending on whether you are a medieval prince or an Aztec at the time of Cortes. Fundamental reality is based on the material world and is discovered.

Conversely, most of human culture is created and operates in constructed reality. More specifically, values, the definition of self, and meaning are essentially "made up." For example, the definition of femininity or honor might vary significantly from culture to culture. More relevantly, psychological feelings and experiences are also constructed; clearly, romantic love, individuation, and psychological mindedness are central in our culture and yet they may hardly exist in another culture. In this sense, each different culture creates its own social reality. However, this constructed reality feels "discovered and true" not an "arbitrarily invented creation" primarily because all other cultural members accept the same reality and live it to each other. The way in which a constructed view of reality acquires social validation is the "social" part in Social Constructionism.

Fundamental reality is connected to the objective world and constructed reality is "invented" by the specific cultures. Fundamental reality is solid; constructed reality "feels" solid due to social endorsement but, in actuality, it is fluid, malleable, and impermanent. Moreover, fields that operate in fundamental reality will always be characterized by techniques that are discovered. Training and experience are always powerful when operating in fundamental reality; the absence of an effect for either is one of the big arguments that psychotherapy functions in constructed reality.

Lest this discussion of constructed reality become too intellectual or dry, let's apply its principles to our three clinical examples. Constructed reality implies that mental health problems in general, and Ed's anxiety in particular, are as constructed, or "made up," as the techniques that cure it. Fully letting in that virtually everything works to cure psychopathology changes our sense of the solidity of psychological reality. Remember that we only reviewed 3 techniques. Ed would be equally cured if he were a devout Catholic and a priest asked him to wear a St. Christopher medallion that had been blessed by the pope. Or if a family therapist had told him that his anxiety was a symbolic symptom that could be resolved by being assertive with his wife. Or if a hypnotist had regressed him back to a time before he had driving anxiety and then had him come out of trance experiencing those feelings of confidence.

What psychologist could have imagined—before EMDR—that telling a client to move their eyes rapidly could "cure" all sorts of symptoms? EMDR is such a helpful clinical example because once its neuroscientific explanation is debunked, it shows that virtually anything—even something as unlikely as moving eyes back and forth—cures mental health problems.

Those results could never happen in fundamental reality. For example, some mental health problems occur due to brain tumors. Moving eyes back and forth, or hypnosis, or exorcism are simply not going to help those symptoms. Fundamental reality is solid, predicable and makes sense. Constructed reality is so fluid and malleable that it constantly insults common sense.

The reason that beginners equal experts is because it's so easy to change constructed pathology; all you need is a belief in a technique and the suggestion that you will get better. And it's even easier to explain why psychotherapists don't get better with experience. When they mistakenly believe that techniques have power, and they simultaneously believe that psychopathology is real, these twin misconstruals cripple their ability to see what's actually going on. How can you get better from experience when you are fundamentally confused about the therapeutic process?

That's not to say that some therapists aren't more effective than others; the research clearly indicates that some practitioners achieve superior results. Since client change is based on belief, we can say that the superior therapists are more credible individuals, or they help their clients have more belief in their techniques, or they convey more hope to the client. Typically these qualities are called the therapeutic relationship or the therapeutic alliance.

Imagine, however, how much better therapists could be if they become aware that techniques have no inherent power, that psychopathology is constructed, and that change is so easy that virtually anything can accomplish it. A whole new world opens up for therapists who allow the implications of the outcome research to alter their worldview.

Similarly, imagine how easy personal growth can be for clients. Instead of believing that they have a serious mental health disorder that can only be resolved with months of hard work, perseverance, and setbacks, they could believe that change and transformation are relatively

easy—that they can be accomplished through insights into the nature of constructed reality and the application of a healing ritual.

Constructionism prioritizes the therapist. When techniques have inherent power, it is appropriate to pursue their development and to see therapists as technicians trained in their administration. The therapists heal though selecting and administering potent procedures. When techniques have no inherent power, and therapy becomes a ritual, then the ability to achieve superior results rests on the charisma of the therapist. Scott Miller tells us, "far more important than what the therapist is doing is who the therapist is.[v]" In this sense a constructivist psychology develops the therapist not the techniques.

Something continues to happen in the room, even though it is now understood as a ritual as opposed to a technique. Constructionism suggests new definitions for both terms: a technique is something that creates a change in fundamental reality, a ritual is something that changes the set of beliefs and assumptions that support constructed reality. We already know a great deal about rituals. For example, a wedding is a powerful ritual that changes the couples' beliefs/identity from "single" to "married." As we fully accept that both psychopathology and its cure are constructed, our ability to work effectively with rituals will be enhanced. We will finally be focusing our energies in areas that can make a meaningful difference.

There will always be significant confusion about what is constructed and what is fundamental. From inside the culture, it is always difficult to discern the difference because everyone else in the culture validates and endorses the same realities. Moreover, there is an implicit force in the culture that encourages belief in our particular construction of reality; this force helps all of us feel that life is safe, stable and predictable. Conversely, fully embracing constructionist ideas makes much of what we know seem so fluid and malleable that it is threatening. This fear about the constructed nature of social reality is not new. It is as old as human culture and various philosophers have been dealing with it for hundreds of years. As an example, let us close this paper with a short stanza from Rumi referring to just this issue.

> Sit, be still, and listen,
> because you're drunk
> and we're at
> the edge of the roof.

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