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Michael J. Lambert

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THE EFFECTS OF PSYCHOTHERAPY: A PROFESSIONAL UPDATE

Michael J. Lambert, Ph.D.*
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The following review attempts to summarize research on the effects of psychotherapy and its implications for the practice of psychotherapy. This review deals mainly with research on adult non-psychotic outpatients. It is based on the assumption that controlled investigations will lead to replicable, trustworthy, and significant findings. It is also assumed that it will result in findings that are specific—in the sense of identifying the actual causal components in psychotherapy. The end result will be to place the practice of psychotherapy on a scientifically substantiated body of knowledge.

In such a review, I recognize that few therapist's practice is based upon research, and further that the interpretation of research evidence is influenced by defensive processes on those rare occasions when therapists do read research reports. For example, a recent well-controlled study indicated that therapists are much more critical of methodology in studies that contradict the therapy system with which they are identified.

I also recall Carl Rogers' comments about the apprehensiveness with which he undertook extensive evaluations of client centered therapy. What if his cherished beliefs and deep commitments were not supported by the results of careful investigation? It is unusual to be open and to conclude as Rogers did: "The facts are always friendly."

Recognizing that therapists may feel somewhat threatened by information that comes from a base other than their own experience, I realize that presenting a list of conclusions is not the most effective way to proceed. Given the time available and the scope of this presentation, however, little more than a list of conclusions can be offered. The interested participant may wish to consult two resources that provide clearer documentation of these conclusions (Bergin and Lambert, 1978; Lambert, 1979; Lambert, in press). The following conclusions were based upon these extensive reviews of psychotherapy outcome literature.

Let me proceed now with a list of conclusions that have implications for the practice of psychotherapy.

General Conclusions

1. Psychotherapy works, is effective, causes positive personality change.

2. It is not the result of "placebo effects"—although some "placebo" and genuine treatments generate "hope" and other emotions that increase successful coping and symptomatic improvement.

3. It is not due to "spontaneous remission." The effects of therapy clearly surpass no treatment or spontaneous remission baselines. The "unsystematic" curative factors within society and the individual do not result in as rapid improvements as psychotherapy.

4. Deterioration. Despite controversy, it is clear that a portion of patients are made worse by the therapists who intend to help them.
   a) Most recent evidence comes from video self-confrontation techniques.
   b) Several reports now suggest these negative effects occur in sex therapies with conservative couples.

5. The demonstrated effectiveness of those therapies which have proved successful has led to attempts to specify the causal components of treatment. The search for causality can be categorized into three main headings:
   a) Those variables related to the client (e.g., symptom severity).
   b) Those related to the therapist (e.g., empathic attitude).
   c) Those that are related to the treatment method or technique.

In general, outcome can best be predicted from patient variables, next by therapist attitudes of the client centered variety, and finally by technique variables. This conclusion is illustrated in Figures 1 and 2.

An important speculation related to these figures is the idea that therapist attitude/relationship variables are least strongly related to outcome in the most and least disturbed patients.

Prescriptive Psychotherapy

Although technique variables are not nearly as powerful as we would hope, the rest of this presentation focuses on techniques and upon the idea of prescriptive therapy interventions. There are several empirical strategies for investigating prescription. For example, patients can be assigned to treatments on the basis of compatible and incompatible personality traits, sex, racial background, and the like. Research on these

*Brother Lambert is an Associate Professor of Psychology at Brigham Young University.
Figure 1. The relative contribution of client, therapist, and technique variables to psychotherapy outcome.

**Client:** Included here would be such variables as age, sex, socioeconomic level, IQ, marital status, diagnosis, motivation, ego strength, interaction with environmental factors, therapy readiness, degree of disturbance, duration of symptoms prior to seeking treatment. Some of these are overlapping variables, but each considered separately interacts with treatment variables to produce outcome.

**Therapist relationship variables:** Include therapist offered conditions such as empathy, genuineness, warmth and respect.

**Therapist experience:** May include unspecified variables including perhaps poise, confidence, good judgment, accurate expectations, personal maturity and even relationship skills.

**Technique and treatment variables:** Include specified procedures which are clearly delineated and distinguishable from other procedures. Included would be diverse methods such as assertive training, EMG feedback, gestalt therapy, cognitive behavior therapy. In general it represents the conclusions drawn from comparative studies.

**Error term:** Represents unaccounted components of outcome such as measurement error (e.g. Since most outcome measures have reliabilities which do not exceed .80, 35% error could be due to this level of reliability).

Strategies does not support this practice at this time. It is more common to assign patients with certain problems to therapists offering a specific treatment technique. Overall, this practice is not supported by research. There are, however, some notable exceptions. Since the possibility of prescriptive assignment seems to be one of the goals of controlled research let us focus on research conclusions in those exceptional cases where prescription seems possible.

**Conclusion 1.** Current research continues to support the exposure hypothesis: Systematic exposure to fear producing stimuli reduces or eliminates fears in genuine phobic patients. Substantial evidence indicates that phobias are significantly reduced by exposure techniques such as systematic desensitization, behavioral rehearsal modeling, and flooding. When contrasted with relationship therapy, insight oriented psychotherapy, etc., systematic exposure procedures are clearly more effective.

Even greater prescription is possible when we consider that exposure *in vivo* is more effective than exposure in fantasy. The success of these prescriptive treatments is dependent on patients who are willing to carry out the exposure procedures and a therapist who can properly influence motivation and cooperation.

**Recent Examples.** Emmelkamp, Kuipers, and Eggeraat

Figure 2. The hypothetical contribution of client, therapist, and technique variables to psychotherapy outcome in patient populations that differ in degree of psychological disturbance.

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A. Highly Disturbed

- Error 50%
- Therapist experience 5%
- Therapeutic relationship 10%
- Technique/treatment 0%
- Client 35%

B. Moderately Disturbed

- Error 50%
- Therapeutic relationship 15%
- Therapist experience 5%
- Technique/treatment 3%

C. Slightly Disturbed

- Error 50%
- Technique/treatment 30%
- Client 10%
- Therapist experience 5%
- Therapist relationship 5%
(1978) compared cognitive restructuring and prolonged exposure in vivo in a cross-over design with twenty-one agoraphobics. Assessments were made at the beginning of treatment, at cross-over, at the end of treatment, and at the follow-up one month later. Cognitive restructuring consisted of relabeling, elimination of irrational beliefs, and self-instructional training. Prolonged exposure in vivo resulted in significant improvements on most variables. There was not one variable on which cognitive restructuring resulted in more improvement than in vivo exposure. Some improvement, however, did result from the cognitive approach. The success obtained through cognitive restructuring seemed to depend upon the imaging ability of the patient. The better the patient's ability to imagine the situation, the more easily he could overcome it. The authors suggest that the relatively poor results for cognitive therapy compared to past research was caused by its application to a patient population that is more disturbed than the college student groups upon which past research was based.

Limitations. a) Exposure treatments are less effective with more complex phobias; b) Some patients who improve on target fears, generalize these improvements to other fears; c) Some patients improve without systematic exposure; and d) Some patients who are continuously exposed to phobic objects fail to improve.

Conclusion 2. Current research continues to support the use of some exposure techniques with performance anxiety problems such as test anxiety, speech anxiety, and sexual dysfunctions. Substantial evidence suggests that behavioral rehearsal, systematic desensitization, and cognitive restructuring methods are much more effective at reducing performance anxiety than insight and relationship oriented methods.

Recent Examples. (a) Goldfried, Linehan, and Smith, (1978) compared two procedures for reducing test anxiety with a waiting list control. The first was systematic rational restructuring where the subjects were asked to imagine test-taking situations and then realistically re-evaluate them. The second was a prolonged exposure condition where the same items were given without the instruction to cope cognitively. Questionnaire measures of anxiety indicated that greater anxiety reduction was found in the systematic rational restructuring condition, followed by the prolonged exposure group. The waiting list control showed no changes. The subjects in the rational restructuring condition reported a decrease in subjective anxiety when placed in an analogue test-taking situation as well as in social evaluative situations. This result adds to the increasing belief that the cognitive reappraisal of anxiety-provoking situations can offer a markedly effective treatment procedure for the reduction of anxiety.

(b) Riley and Riley (1978) presented the results of a controlled study that compared the effects of "directed masturbation" in combination with sensate focus and supportive psychotherapy versus sensate focus and supportive therapy in the management of female primary orgasmic failure. Fifteen married patients participated in the sensate focus/supportive psychotherapy treatment, while 20 married patients participated in this combined treatment plus the directed masturbation. After treatment, both partners were questioned about success or failure of the treatment because it was considered that this would give a more reliable assessment of outcome. Eighty-five percent of the patients who experienced the directed masturbation program, and 47 percent of the combined treatment group, became coitally orgasmic on at least 75 percent of coital occasions. The results suggest directed masturbation is an effective and necessary component in the management of primary female orgasmic failure. This result could be contrasted with secondary female dysfunction where communication between partners is more important to attend to in treatment.

Limitations. The above conclusions, while based upon a large, diverse body of research, have several important limitations.

a) The studies so far conducted have been directed toward test anxiety, speech anxiety, heterosexual/social anxiety and sexual dysfunctions. The subjects studied have not in general been "patients." Thus, the generalization of results to persons who are socially/vocationally incapacitated is not well substantiated.

b) The results with sexual dysfunctions seem to hold up for persons with liberal sexual attitudes who have a relatively conflict-free marriage, and who are free from more complex psychological conflicts. The early success rates reported by Masters and Johnson seem to be highly inflated by the sample studied, and the rather unclear criteria for "success."

c) The criteria for success in other performance anxiety problems provide results that are impressive on a self-report basis but unimpressive when actual performance on tests (GPA, actual speeches and similar, more rigorous criteria) is considered.

Conclusion 3. The treatment of physical disorders that interact with psychological problems (Raynauds Disease, migraine and tension headaches, asthma, etc.) are more effectively treated with therapies that "engage the body" rather than insight, verbal methods. Evidence indicates that systematic desensitization, systematic relaxation training to a lesser degree, hypnosis, and autogenic training, are useful methods of dealing with many psychosomatic disorders.

Recent example. Hock, Rodgers, Reddi, and Kennard (1978) evaluated the effectiveness of relaxation...
training, assertive training, and combined relaxation plus assertive training in increasing respiratory function and decreasing the number of recurrent asthmatic attacks. The study was carried out in an allergy outpatient clinic and the subjects were ten 17-year-old male asthmatic patients. The psychotherapeutic treatment was combined with medical treatment. A 5x4 analysis of variance was used to analyze the forced expiratory volume (FEV) data, and a significant difference was found between the groups. A Newman-Keuls statistical comparison led to the conclusion that both relaxation training by itself and combined relaxation plus assertive training increased respiratory functioning and reduced the number of attacks. Assertive training alone failed to improve respiratory function and had a tendency to increase the frequency of asthmatic attacks.

Limitations. Several variables make the seemingly specific nature of treatment for these disorders difficult to rely upon.

a) The seemingly clear-cut relationship between biofeedback, hand temperature increases and improvement in Raynauds Disease and migraine headache appear less certain. Although it seemed that relaxation for tension headache and hand warming for migraine was a prescriptive difference, this is confounded by the fact that many patients improve without control over hand temperature.

b) A portion of patients who show clear control fail to improve.

c) Lasting improvements seem to be related to continued use of relaxation over long periods of time, thus the idea that biofeedback causes a permanent change is not true for a large number of those who are treated.

d) Placebo and expectancy effects cannot be ruled out as important contributions to positive outcome. Their effects are in need of further exploration.

Conclusion 4. Cognitive psychotherapies which are rapidly replacing dynamic strategies may be uniquely effective with unipolar depression. Recent investigations tend to support the use of cognitive and cognitive/behavioral strategies with some depressed patients. In some instances, their unique effects not only surpass traditional dynamic therapies, but antidepressant medications. These therapy strategies tend to be time limited and highly structured and are best represented in the work of Beck and his associates.

Rush, Beck, Kovacs, and Hollon (1977) recently reported a study investigating the effects of cognitive therapy on the symptomatic relief of depressive symptoms on a group of 41 outpatients.

The clients were carefully selected to include a homogeneous symptom pattern typical of neurotic depression. They were screened with the Beck Depression Inventory, Hamilton Rating Scale for Depression, and a clinical judgment consistent with unipolar depressive syndrome. Patients who had a history of schizophrenia, drug dependence, character disorder, and the like were excluded as well as patients who had a medical history that suggested prior prescription of antidepressant medication or a prior history of a poor response to tricyclic antidepressants.

Patients were assigned to cognitive therapy (N = 19) or anti-depressant treatment (N = 22) on a random basis prior to inclusion in the study. Therapists were, for the most part, inexperienced in psychotherapy but experienced in the use of drugs with depression. The majority were psychiatric residents. Treatment via cognitive therapy followed the training manual developed by Beck and lasted for a maximum of twenty 50-minute sessions over 18 weeks, but averaged 15 sessions for 11 weeks. Drug treatment averaged 11 weeks in duration with one 20-minute session per week.

Results suggest that both procedures reduce the symptoms of depression; but that the patient's self-report, as measured by the Beck Depression Inventory and clinician's judgment of improvement, as rated by the Hamilton and Raskin scales, showed the cognitive therapy patients to be improved significantly more than drug patients at termination and at three-month follow-up. This trend held up at the six-month follow-up, but was not statistically significant. In addition, there was a tendency for drug patients to drop out of therapy early. When these dropouts are included in the analysis, cognitive therapy was superior to drug treatment at six months. In addition, 13 of 19 pharmacotherapy patients re-entered treatment for depression, while only 3 of 19 psychotherapy patients sought additional treatment.

Limitations.

1) Cognitive and behavioral approaches are relatively recent and have not been fully studied as prescriptive treatments in depression. As with most "new" treatments, original successes may be followed by a gradual loss in enthusiasm and eventual disappointment.

2) The effects attained may be limited to "least disturbed" unipolar depression patients.

3) Their prescriptive, almost "programmed" approach with depression needs to be replicated by others. In fact, this is currently taking place in a world-wide study.

REFERENCES


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