Psychotherapy Networker

Point of View

Research or Reality? The Flawed Science of Psychotherapy

By Ryan Howes

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Get into grad school. Choose an approach. Make sure it's evidence based. Build your practice.

This formula has been the standard for aspiring therapists for decades, and no one saw any reason to challenge it.

Not so fast, says Jonathan Shedler, a psychoanalytic psychologist, re-searcher, and former professor of psychiatry at the University of Colorado School of Medicine. He argues that the various therapeutic schools are brands and labels that distract us from developing our most important tool in therapy—the person of the therapist. Furthermore, the research for evidence-based therapies is misguided and conducted by the wrong professionals.

"The Efficacy of Psychodynamic Psychotherapy," Shedler's landmark article in American Psychologist, had the dual impact of establishing psychodynamic therapy as an evidence-based therapy and calling into question the validity of psychotherapy research. His ideas are revolutionary and at times controversial.

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Ryan Howes: What brought you into this field?

Johnathan Shedler: As an undergrad, I didn't understand the difference between psychologists, psychiatrists, and psychoanalysts. I went to the psychology department thinking I was going to learn about our inner world, which is the subject matter of psychoanalysis. Instead, I found myself in a hardcore research department. Then I went to grad school at the University of Michigan, which at the time was like being in an analytic institute. We were all in psychoanalysis four or five days a week, and studying it the rest of the time. But throughout, I kept my feet firmly in two distinct worlds: psychoanalysis and research psychology.

Now, these worlds are alien to each other. Straddling them throughout my career has had consequences—some positive, and a lot negative. In a way, I was seen as not really legitimate in either world. Even though I've been a practicing psychoanalytic therapist my entire career, psychoanalysts would classify me as a researcher, which is to say not really one of them. And in the research world, psychoanalysis is, well—

RH: It's a fossil.

Shedler: Yeah, it's seen as this relic of a time gone by that's sort of joked about and ridiculed. So even though I'm a widely cited researcher by anyone's standards, with publications in the highest-impact research journals, the fact that I'm known as psychoanalytic makes academic researchers view me as an outsider.

RH: Given your work, you've really become the spokesperson for psychodynamic therapy in the field right now.

Shedler: That's a humbling thought.

RH: What do you worry about for our field?

Shedler: I think we've created a terrible situation in psychology that I fear we may not recover from. Mine was probably the last generation that got serious clinical training within a major research university. The psychoanalytic clinicians and the academic researchers were in the same buildings; they shared adjacent offices. They knew each other, interacted, and developed an appreciation of what the other did. I think this led to some mutual understanding and respect, and modulated the kind of excesses on both sides that now run rampant.

Now we've bifurcated the field and institutionalized the science–practice schism. By and large, real clinical training now takes place in PsyD programs, and research training takes place in PhD programs. Most of the PsyD programs are freestanding, so they're separated from the intellectual traditions of university life. I think that impoverishes critical thinking among clinical practitioners, because they're isolated from what's going on in adjacent fields. And it's profoundly impoverished training in clinical psychology PhD programs, which aren't clinical anymore except in name: they're research programs, taught by faculty who don't engage in clinical practice and are often disdainful of it.

People outside of psychology don't understand this bifurcation between science and practice. They think psychologists who are career academics and researchers know and understand what psychotherapists do. Actually, they don't. They don't know how to treat patients. They don't know what it means to sit with another human who's in profound pain—and whose suffering doesn't fit neatly into the checkboxes of a DSM diagnostic category—and say, in effect, I'm in this with you, and I'm going to stay with you as long as it takes.

RH: There's a similar distortion people often have about psychiatry.

Shedler: A few generations ago, the most prominent psychiatrists were trained as psychoanalysts, and psychiatry in the past straddled medicine and psychotherapy. Now, the field of psychiatry is mostly psychopharm: you get a diagnosis and a prescription, then you're sent on your way. And academic psychology is mostly basic science research without direct application to real-world clinical practice.

RH: I've heard the APA is considering renaming the training model for clinical psychology "healthcare professional psychology."

Shedler: It's like they want us to pretend we're medical providers, like physicians except not really, and somehow that's going to buy us more legitimacy. To me, positioning psychology that way feels demeaning. We should strive to be first-class psychologists, not junior, second-class MDs. Our message should not be that psychology is like medicine. Our message should be that psychotherapy is like psychotherapy, and we should be telling the world what meaningful therapy is.

RH: Psychoanalysis was the standard for a long time; then CBT charged in and took over. Why did it take so long for psychoanalysis to respond?

Shedler: Psychoanalysis still hasn't responded. The psychoanalytic world is chaotic, disorganized, and preoccupied with internal disputes. Some in the profession want to blame the decline on insurance companies, managed care, and the rise of CBT and so-called "evidence-based" treatment. This is all true, but I think the larger share of the blame lies with psychoanalysis itself. We've been too insular and blind to what's been going on all around us for at least 25 years. People are only now waking up and saying, "Oh gee, what happened?"

The public doesn't know what contemporary psychoanalytic therapy is. Nobody knows what we do and what we offer. Nobody knows what really happens in therapy sessions and how it helps. Nobody understands our most fundamental insights. They know stereotypes and caricatures, and they mistake those caricatures for psychoanalytic therapy. What we haven't been doing is communicating to the world: this is what contemporary psychoanalytic therapy is about. This is how it can make your life better.

RH: And you're trying to be the prophet, saying, "Look everybody, something is wrong."

Shedler: It's hardly prophecy when it's been going on for more than 25 years and obvious to anyone paying attention. The question is, what do we do about it now? We're losing a profoundly important way of understanding and alleviating human suffering. We're losing crucial, time-tested knowledge about how to help people. It's dying out and being replaced by things that are just embarrassingly trivial.

RH: You're talking about CBT and other modalities?

Shedler: I'm talking about one-size-fits all instruction-manual therapy, where the therapy agenda is set before the patient even walks in the office. Master therapists don't work this way, and that includes master CBT therapists. It's a mistake to talk about CBT as if it's one monolithic thing, because it isn't. I draw a sharp distinction between CBT practitioners and CBT researchers.

The 10,000-hour rule came from Anders Ericsson's work, and Malcolm Gladwell popularized it in Outliers. The idea is that it takes 10,000 hours of meaningful, focused practice experience to develop mastery at any truly skilled activity. So a working CBT therapist, someone who has 10,000 hours of meaningful practice experience, may not use the same terminology I use, but we're siblings professionally. They're in the trenches, dealing with the same problems I am, and we can have a meaningful conversation. That CBT therapist probably knows something I can learn from, and vice versa.

Most academic researchers, in contrast, don't practice clinically. They don't see real patients. They don't have 10,000 hours of practice experience and may not have any meaningful practice experience at all. But they're the ones writing treatment manuals and promoting eight- or 12-session instruction-manual therapy. The push for protocol-driven therapy is coming from academic researchers, not working clinicians. It's an attempt at a wholesale takeover of the profession by people who don't really understand what clinical work is about and have a kind of underlying disdain for clinical practice. In fact, they're promoting treatments that fail vast numbers of people—that's an empirical fact—and that a great many people don't actually want.

RH: I guess that's the disconnect. There are still clients who want to talk with somebody who's interested in getting to the origin of their problems.

Shedler: There's research on this. If you ask patients what they're looking for from therapy, they're pretty clear. They'd like to connect more meaningfully with other people, have a clearer sense of who they are, and find meaning and purpose in their lives. They'd like to feel more at peace and more comfortable in their skin. If you ask clinical practitioners what they're working on with clients, they'll tell you largely the same thing. Managing symptoms listed in the DSM is way down the list of what most people want from therapy.

So here we've got these parallel universes. One universe is the real world; the other is an academic bubble of artificial laboratory experiments. It creates a real problem because when journalists and policy makers look for experts, they look to the academic world, not realizing that the people doing academic research are not experts at therapy. They are operating in a parallel universe that has little to do with meaningful psychotherapy.

RH: So your main beef with the evidence-based research is that it's not really measuring what we encounter in the real world.

Shedler: My main beef, and the most important message to understand, is this: psychotherapy researchers today aren't studying psychotherapy. They're studying fictions of their own invention and calling it psychotherapy. The research questions they're addressing have almost nothing to do with practicing psychotherapy.

RH: You make the case in your work that psychodynamic therapies are just as evidence based as the CBT therapies.

Shedler: Of course they are. Even if we accept all the mistaken assumptions underlying psychotherapy outcome studies, even if we accept the highly questionable definitions of outcome, even if we accept the research designs that don't actually fit the subject matter—even if we accept all that, psychodynamic therapy still has outcomes at least as good as the therapies being promoted and marketed as "evidence based."

Some of the rhetoric around so-called evidence-based therapy seems dangerously close to consumer fraud. People think the term evidence based means supported by evidence. It's actually become a code word for protocol-driven, manualized therapy. The public doesn't know "evidence-based therapy" really means therapy conducted by instruction manual. And when people appropriate the term to refer to one specific approach to therapy, the implicit message is that other forms of therapy don't have evidence and are therefore not legitimate. That is factually untrue. But it's the message the public and policy makers hear and take away.

RH: Don't the insurance companies have a lot to do with it as well?

Shedler: There's a kind of an accidental, unholy alliance between evidence-based therapy researchers and insurance companies. It's not like they're in cahoots. It's not the kind of financial conflict of interest where researchers are on the payroll of insurance companies. It's not that kind of overt corruption. But there's a synergy, a way in which researchers and insurance companies mutually benefit from the other's activities. But patients don't benefit.

RH: In your article, you point out that parts of CBT that are effective were borrowed from psychodynamic therapy.

Shedler: Well, that's another issue. Where are the active ingredients in therapy? What really makes for effective therapy? I think most people who don't have an ideological ax to grind and have some real clinical experience to draw from would tell you that it's the expertise, knowledge, sophistication, and sensitivity of the clinician, and the fit between clinician and patient.

But if the purported active ingredients can be located in a manual, then therapy brands become commodities to buy and to sell. Clinician expertise is dismissed, academic researchers who write the manuals are now the authorities, and therapists can be treated as interchangeable.

Just look at the language. Therapists aren't clinicians; they're providers, which already implies a kind of interchangeability. What are they providing? Techniques and interventions from instruction manuals. It's eroding the very idea of clinical expertise. It's a denial that therapy is an incredibly complex and nuanced skill, to which clinicians devote a lifetime to master.

RH: You once said, "It's hard to think of anything more destructive to our profession than the idea that we should choose a theoretical orientation." Choosing a theoretical orientation is so ingrained in the graduate school ethos. What's the problem with it?

Shedler: It shifts the focus to studying brands of therapy and away from fundamental psychological principles and methods. It fosters tribalism rather than critical thinking and scholarship. I don't think we should be doing these horse-race comparisons of therapy brand names, my brand versus your brand. Human beings are human beings; there are certain fundamental truths of human psychology. Any form of therapy that's going to be effective must reckon with these fundamental truths.

RH: You make it seem like the creators of these theories just want a certain specialness.

Shedler: Doesn't everyone? One truth of human psychology is that people are egotistical and seek to advance their own interests. Academics and researchers are as motivated by self-interest as anyone else. It doesn't further an academic career to identify yourself with and study concepts that have been with us for generations. No, you advance a career by building your own brand around something new and different, or that seems so. Right? We'd all do well to drop this idea that academic research is this purely objective, noble pursuit, immune from the vanities that affect all other human pursuits.

RH: What do you think is next for psychodynamic therapy?

Shedler: I don't know if psychodynamic therapy is going to have a future. Unless we make fundamental changes in the culture of the profession and start engaging with the larger world, I think we are in serious trouble. And when I say we, I don't just mean the profession: I mean humanity, because people who need psychological help are being offered smoke and mirrors and told that's the best there is.

RH: So what can we do about it?

Shedler: Honestly I've come to feel increasingly pessimistic about the prospect for change. There's no way for policy makers or educated consumers to sort out who has something authentic and meaningful to say amidst the cacophony of voices claiming to be expert.

But to offer a more optimistic answer, I think psychoanalytic therapists need to get outside our own echo chambers. First, we need to understand clearly how others perceive us. If that hurts our pride or egos, too bad, because there's something bigger at stake. Second, we need to make our concepts and methods more accessible. Third, we need to figure out how to communicate our concepts in ways that people can relate to, which is not about aggrandizing our own traditions and theories. It's about speaking to people, without jargon, about what we can offer them that they won't get in other forms of therapy.

Right now, public perceptions of psychoanalytic therapy are largely negative. Undergraduate psychology textbooks are filled with dated caricatures and stereotypes that have nothing to do with contemporary psychoanalytic therapy—and the media reinforces these caricature and stereotypes. The average person just has no idea what contemporary psychoanalytic therapy is.

In contrast, websites for organizations devoted to CBT provide a lot of information about how to talk to the media. The people promoting so-called evidence-based therapy have been treating it like a marketing campaign for many years. They employ professional publicists. They have lists of talking points. They're media-savvy. You know who's not doing any of this? Psychodynamic therapists. If we're going to compete in the marketplace of ideas, we actually need to be in the marketplace.

RH: But they can't get unified enough to do that, right?

Shedler: I think that's been true. Just look at the difference between how we study and talk about psychoanalysis versus any other academic or scholarly discipline. There are no university departments of Darwinism. There are university departments of evolutionary biology. Yet the study of psychoanalysis is often organized around names of theorists. People don't say, "Right now, I'm studying this idea." They say, "I'm studying Winnicott." Or Klein. Or Kohut. Instead of emphasizing a shared corpus of knowledge and ideas, we sometimes sound like competing personality cults.

RH: What you're proposing is going to be a tough sell to brand-identified psychoanalysts.

Shedler: I'd approach it by emphasizing common, core principles. What are the core principles—not in jargon, but in English—that are shared by people who consider themselves psychoanalytic thinkers and practitioners? Point one: we humans don't fully know our own hearts and minds. That's simple, right?

Point two: the things that we don't know about ourselves still impact our lives and our relationships. They can limit us and cause us pain. Point three: there's value in coming to know our hearts and minds more fully, because it gives us the option to be able to do things differently. It offers an alternative to recreating and reliving the same painful patterns.

I didn't use one word of theoretical jargon. These are ideas a sixth-grader could grasp without much difficulty. Now, why don't we build from that?

RH: I think any clinician, regardless of theoretical orientation, would agree with those principles.

Shedler: Certainly. The more sophisticated CBT therapists all understand those things: it's woven into their day-to-day work. I had an email exchange with Aaron Beck, the father of cognitive therapy, who said CBT, as he understands and practices it, is closer to psychodynamic therapy than it is to the manualized therapies now being promoted in the name of CBT.

RH: A lot of people might be shocked to hear that.

Shedler: Maybe. But it shouldn't be a surprise, because Aaron Beck was a fully trained psychoanalyst first, and he brought that knowledge, that understanding, into his work—knowledge and understanding that's now being eroded.

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