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**Selling Bad Therapy to Trauma Victims**

Patients and therapists should ignore new guidelines for treating trauma.

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Jonathan Shedler, PhD

The American Psychological Association (APA) just issued guidelines for treating [trauma](https://www.psychologytoday.com/basics/trauma). Patients and therapists would be [wise](https://www.psychologytoday.com/basics/wisdom) to ignore them.

The guidelines are supposed to reflect the best scientific evidence. In fact, they ignore all scientific evidence except one kind of study, called randomized controlled trials (RCTs).

RCTs randomly assign people to treatment or control groups. They can answer certain questions (Is a [medication](https://www.psychologytoday.com/basics/psychopharmacology) more effective than a [sugar pill](https://www.psychologytoday.com/basics/placebo)?) and not others (How does the medication work? What is the disease? What are its causes?). In the absence of careful scientific reasoning, RCTs can lead to foolish conclusions.

Here’s an example: Some people wrongly concluded that tooth flossing lacks scientific support, after a review of RCTs found little evidence of benefits. But flossing is beneficial in the long run and the RCTs followed patients for only brief periods. They found exactly what you would expect—pretty much nothing. Knowledge about flossing's benefits comes from other sources, including dentists’ observations over more than a century, and an [understanding](https://www.psychologytoday.com/basics/empathy) of the mechanism of action—how it works.

The RCT researchers conducted studies that were expedient to carry out, not studies that answered meaningful questions about tooth flossing. They could not have conducted them if they wanted to. An RCT that could provide meaningful information would require some people to avoid flossing for years. Institutional review boards would reject that as unethical.

**Most science does not rely on RCTs**

The basic or hard sciences, like physics, chemistry, and astronomy, do not rely on RCTs. No astronomer in history ever conducted an RCT, but knowledge in astronomy progresses. Astronomers had no problem predicting the time and path of the recent solar eclipse over North America, down to the millisecond.

But some people, primarily in the social sciences, would have us believe that RCTs are the gold standard of scientific knowledge and all else can be ignored.

This is misguided and it does not require a science degree to understand why.

No RCT has ever shown that the sun causes sunburn, [sex](https://www.psychologytoday.com/basics/sex) causes [pregnancy](https://www.psychologytoday.com/basics/pregnancy), or food deprivation leads to starvation.  We know these things because we can observe cause and effect relationships and because we understand the mechanisms of action. Ultraviolet radiation damages skin cells. Sex allows sperm cells to fertilize egg cells. People die without food. Flossing removes dental plaque which harbors bacteria that attack teeth and gums.

Copernicus, Galileo, Darwin, Einstein, Niels Bohr, Marie Curie, Stephen Hawking. What do they have in common? None of them ever conducted an RCT.

Most scientific knowledge does not come from RCTs.

**Wrong questions, wrong answers**

What does tooth flossing have to do with new guidelines for treating trauma? As it turns out, everything.

[Psychotherapy](https://www.psychologytoday.com/basics/therapy) takes time. Psychotherapy follows a “dose-response” curve. It takes more than 20 sessions, or about 6 months of weekly therapy, before 50% of patients show clinically meaningful improvement. It takes more than 40 sessions before 75% of patients show meaningful improvement.1 These findings, based on more than 10,000 therapy cases, dovetail with what therapists report about successful treatments2 and what patients report about their own therapy experiences.3,4

The RCTs behind the trauma treatment guidelines studied *only* therapies of 16 sessions or less. Many were 8 sessions or less. In other words, the guidelines considered only therapies that are inadequate.

It was a foregone conclusion that the guidelines would recommended only brief, standardized forms of [CBT](https://www.psychologytoday.com/basics/cognitive-behavioral-therapy), conducted according to instruction manuals. They are the only therapies that are expedient to study with RCTs (in contrast, say, to studying patients who actually get better and what helped them).

More than a century of scientific research and clinical experience points to other therapy approaches as more helpful. But since this knowledge does not come from RCTs, APA ignored all of it.

The guidelines are by researchers for researchers. The interests of patients and therapists are secondary. The guidelines comprise 675 pages of densely complex minutia about research methodology and statistical analysis, including 537 pages of tables and forms. Therapies are designated as “highly recommended” because of the research methods used to study them, not because patients get well.

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“These guidelines offer the field a number of benefits,” says APA. “For providers, they offer recommendations… that quickly summarize which treatments have been shown to work for hundreds or even thousands of patients… For families, they provide *clear information on best treatments and what to expect of them*” (emphasis added).5

Let’s fact check this by seeing how it aligns with the findings of the largest and arguably best RCT behind the guidelines. The RCT was funded by the U.S. Department of Veterans Affairs and the Department of Defense and published in the *Journal of the American Medical Association*.6 It studied 255 female veterans. Most of the trauma was not combat related. The most frequent trauma was sexual trauma followed by physical assault.

Patients received “highly recommended” CBT or a control treatment.

Here is what the study found.

* Nearly 40% of those who started CBT dropped out of treatment. They voted with their feet about its usefulness.
* 60% of the patients still had [PTSD](https://www.psychologytoday.com/basics/post-traumatic-stress-disorder) when the study ended.
* Only one in 6 patients who completed treatment got better (according to statistics reported in the article and buried in a table). At six-month follow up, that number dropped to 1 in 11.
* All patients were clinically depressed at the start of treatment and remained clinically depressed after treatment.
* At six-month follow up, patients who received CBT were no better off than those who received the control treatment.
* Nineteen serious “adverse events” occurred over the course of the study, including [suicide](https://www.psychologytoday.com/basics/suicide) attempts and [psychiatric](https://www.psychologytoday.com/basics/psychiatry) hospitalizations.
* The authors soberly noted that the patients “may need more treatment than the relatively small number of sessions typically provided in a clinical trial.”

I did not choose this study as an example because it is a poor study. I chose it because it is arguably the best.

“Clear information on best treatments and what to expect of them.”  Really?

**First, Do No Harm**

Many [health](https://www.psychologytoday.com/basics/health) insurance companies discriminate against psychotherapy. Congress has passed laws mandating mental health “parity” (equal coverage for medical and mental health conditions) but health insurers circumvent them. This has led to class action lawsuits against health insurance companies, but [discrimination](https://www.psychologytoday.com/basics/bias) continues.

One way health insurers circumvent parity laws is by shunting patients to the briefest and cheapest therapies—just the kind of therapies recommended by APA’s treatment guidelines. Another way is by making therapy so impersonal or dehumanizing that patients drop out. Health insurers do not publicly say the treatment decisions are driven by economic self-interest. They say the treatments are scientifically proven—and point to treatment guidelines like those just issued by APA.

It’s bad enough most Americans don’t have adequate mental health coverage, without also being gaslighted and told inadequate therapy is the best therapy.

APA’s [ethics](https://www.psychologytoday.com/basics/ethics-and-morality) code begins, “Psychologists strive to benefit those with whom they work and take care to do no harm.” APA has an honorable history of fighting for patients’ access to good care and against health insurance company abuses.

Blinded by RCT ideology, APA inadvertently handed a [trump](https://www.psychologytoday.com/basics/president-donald-trump) card to the worst apples in the health insurance industry.

References

1. Lambert, M.J., Hansen, N.B., Finch, A.E. (2001). Patient-Focused Research: Using Patient Outcome Data to Enhance Treatment Effects. *Journal of Consulting and Clinical Psychology*, 69, 1590-172.

2. Morrison, K.H., Bradley, R., Westen, D. (2003). The external validity of controlled clinical trials of psychotherapy for depression and anxiety: A naturalistic study. *Psychology and Psychotherapy: Theory, Research and Practice*, 76, 109-132.

3. Mental Health: Does Therapy Help (1995, November).  *Consumer Reports*, 734-739.

4. Seligman, M.E.P. (1995). The Effectiveness of Psychotherapy: The Consumer Reports Study. *American Psychologist*, 50, 12, 965–974.

5. Deangelis, T. (2017, November). PTSD guideline ready for use. *Monitor on Psychology*, 48(10), 26-27.

6. Schnurr, P.P., Friedman, M.J., Engel, C.C., et al. (2007). Cognitive Behavioral Therapy for Posttraumatic Stress Disorder in Women: A Randomized Controlled Trial. *Journal of the American Medical Association*, 297, 820-830.

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**The Therapy Relationship in Psychodynamic Therapy versus CBT**

A therapy relationship is more than an "alliance"

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Jonathan Shedler, PhD

Our earliest attachments form the templates for our subsequent relationships. As a result, we repeat patterns in our relationships throughout our lives. Because they are present from the beginning, these patterns may be as invisible to us as water to a fish. Yet they shape our destinies.

[Therapy](https://www.psychologytoday.com/basics/therapy) is a relationship, and patients bring their templates and patterns into it. As therapists, we enter the gravitational field of patients’ problematic relationship patterns, experiencing and participating in them. Through recognizing our own unavoidable participation in these patterns, we can help our patients understand and rework them.

This is therapy that changes lives. This is the heart of [psychodynamic therapy](https://www.psychologytoday.com/therapy-types/psychodynamic-therapy).

Caroline, a woman in her late thirties, is elegant, educated, successful. She carries herself with a regal bearing and looks and dresses like a *Vogue* model.  She is pursued by the kind of men most women only [fantasize](https://www.psychologytoday.com/basics/fantasies) about. Yet she is lonely. She has been unable to keep an intimate relationship and she suffers from bouts of [depression](https://www.psychologytoday.com/basics/depression).

Caroline has attempted therapy several times. She says, unhappily, that it has never really changed anything, and the therapists always end up wanting *her* approval.

Colleagues trained in [CBT](https://www.psychologytoday.com/basics/cognitive-behavioral-therapy) and other “evidence-based” therapies rarely attach much significance to Caroline’s comment about her past therapy relationships. Some venture that Caroline may need a “secure” therapist who won’t be intimidated by her looks or status.

From a [psychodynamic](https://www.psychologytoday.com/basics/psychoanalysis) perspective, it is irrelevant whether Caroline’s therapist is personally secure or insecure. She doesn’t need a secure therapist. She needs a therapist with the self-awareness and courage to notice that twinge of insecurity in Caroline’s presence, treat it as information, and use it in the service of [understanding](https://www.psychologytoday.com/basics/empathy).

Such a therapist might say: “You know, you have come here for my help and yet in many of our interactions, I am aware of a vague feeling of wanting to impress you or gain your approval, which of course doesn’t help you at all. I’m trying to figure out what it means, and whether it could be a window into understanding something about what happens in your relationships more generally. Perhaps this is something that feels familiar to you.”

And there, real therapy may begin.

Caroline could not have described what went wrong in her relationships: The things she did to try to draw people closer were the very things that precluded real connection and intimacy. Women were [envious](https://www.psychologytoday.com/basics/jealousy) or deferential. Men viewed her as a conquest, or out of their league. Either way, intimate connection was impossible.

Caroline couldn’t *tell* her therapist this; she *showed* him.  What the patient does in the room with the therapist reveals lifelong relationship patterns. And in the therapy relationship, these patterns can be recognized, understood, and reworked.

This is central to psychodynamic therapy and notably absent from other therapies.

A prominent CBT author and thought [leader](https://www.psychologytoday.com/basics/leadership) wrote an article about myths and realities of CBT. One myth, according to the author, is that CBT downplays the therapy relationship. To show this is not so, the author explained that CBT therapists “do many things to build a strong alliance. For example, they work collaboratively with clients… ask for feedback… and conduct themselves as genuine, warm, empathic, interested, caring human beings.”

I expect that much from my hair stylist or real estate broker. From a psychotherapist, I expect something more. The CBT thought leader seemed to have no concept that the therapy relationship is a window into the patient’s inner world, or a relationship laboratory and sanctuary where lifelong patterns can be recognized and understood, and new ones created.

Some people may be satisfied with therapists who “work collaboratively” while conducting therapy according to an instruction manual (read my blog about "manualized" therapy [here](https://www.psychologytoday.com/blog/psychologically-minded/201310/bamboozled-bad-science)). Those who want to change their destiny will want a therapist with the self-awareness, knowledge, and courage to see and speak about what matters.

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**Bamboozled by Bad Science**

The first myth about "evidence-based" therapy

Posted Oct 31, 2013

Media coverage of [psychotherapy](https://www.psychologytoday.com/basics/therapy) often advises people to seek "evidence-based" therapy.

Few outside the mental [health](https://www.psychologytoday.com/basics/health) professions realize that the term “evidence-based" has become a form of [marketing](https://www.psychologytoday.com/basics/consumer-behavior) or branding (see my previous [blog](https://www.psychologytoday.com/blog/psychologically-minded/201310/where-is-the-evidence-evidence-based-therapies)). It refers to therapies conducted by following instruction manuals, originally developed to create standardized treatments for research trials. These pre-scripted or "manualized" therapies are typically brief, highly structured, and almost exclusively identified with [cognitive behavioral therapy](https://www.psychologytoday.com/basics/cognitive-behavioral-therapy) or CBT.

Academic researchers routinely extoll the “evidence-based” therapies studied in research settings and denigrate psychotherapy as it is [actually practiced](https://www.psychologytoday.com/blog/psychologically-minded/201310/where-is-the-evidence-evidence-based-therapies) by most therapists. Their comments range from the hysteric (“The disconnect between what clinicians do and what science has discovered is an unconscionable [embarrassment](https://www.psychologytoday.com/basics/embarrassment).”–Professor Walter Mischel, quoted in *Newsweek*) to the seemingly cautious and sober (“Evidence-based therapies work a little faster, a little better, and for more problematic situations, more powerfully.”–Professor Steven Hollon, quoted in the *Los Angeles Times*). Even former American Psychological Association president Alan Kazdin jumped on the bandwagon, telling [*Time*](http://healthland.time.com/2011/09/13/qa-a-yale-psychologist-calls-for-the-end-of-individual-psychotherapy/) magazine that psychotherapy is “overrated and outdated” and lamenting that it is hard to find referrals for “evidence-based treatments like [cognitive](https://www.psychologytoday.com/basics/cognition)-behavioral therapy.”

One might assume from such comments that strong scientific evidence shows that “evidence-based” (read *manualized*) therapy is superior to psychotherapy as practiced by most clinicians in the real world.

Does scientific evidence really show this?

**Myth #1: “Evidence-based” therapy is more effective than other psychotherapy**

Nearly all the evidence supporting “evidence-based” therapy comes from studies that compare “evidence-based” therapy to *no* therapy, or to control groups that receive sham therapies that serve as foils and are not designed to be serious alternatives.

This research tells us only that “evidence-based” therapy is better than doing *nothing* (or doing something that is not meant to be a serious alternative). It does not tell us how "evidence-based" therapy compares to real-world psychotherapy that a person would receive from a qualified mental health professional.

What about studies that compare “evidence-based” therapies to legitimate alternative therapies?  Such studies are scarce but their results are clear and consistent: they show no advantage for “evidence-based” therapies. An analysis published in the prestigious *Clinical Psychology Review* explored the topic in depth. As control groups more closely approximate legitimate psychotherapy provided by qualified mental health professionals (*any* kind of legitimate therapy), any apparent advantage for “evidence-based” therapy vanishes. Writing in careful academic language, the authors conclude: “There is insufficient evidence to suggest that transporting an evidence-based therapy to routine care that already involves psychotherapy will improve the quality of services.”1

The same article offers a truly disturbing glimpse into psychotherapy research trials. Interventions provided to control groups and labeled “Treatment As Usual” by the original researchers “were predominantly ‘treatments’ that did not include any psychotherapy.” In other cases, so-called “Treatment As Usual” involved hobbled pseudo-therapy, where therapists were prevented from providing the treatment they normally provide. The authors expressed their frustration with these misleading research practices in, again, understated academic tones: “Training therapists to prevent them from using certain therapeutic actions that are typically employed in their practice cannot logically be classified as a Treatment As Usual.”

Another way to evaluate how “evidence-based” therapies compare to real-word therapy is through naturalistic studies. These studies follow patients treated by ordinary clinicians in day-to-day practice. The patients are evaluated before and after treatment to measure improvement, or effect size. The effect size can then be compared to effect sizes for “evidence-based” therapies in published research trials.

An especially rigorous naturalistic study, reported in the *Journal of Consulting and Clinical Psychology,* followed 5,704 depressed patients who received real-world therapy from licensed clinicians covered by their health insurance plans.2 The clinicians were not specially trained or qualified; they were ordinary practitioners with master’s degrees or higher in psychology, [marriage and family therapy](https://www.psychologytoday.com/therapy-types/marriage-and-family-therapy), clinical social work, psychiatry, or [psychiatric](https://www.psychologytoday.com/basics/psychiatry) nursing—not a “high power” group by any means. The results obtained by the real-world clinicians did not differ from those for “evidence-based” therapies in controlled research trials. Five published studies used similar methods to evaluate real-world therapy. Not one showed an advantage for “evidence-based” therapy.

Even these studies overestimate the real benefits of “evidence-based” therapy, because published effect sizes for "evidence-based" therapy are skewed by “publication [bias](https://www.psychologytoday.com/basics/bias)”: favorable research findings tend to get published and unfavorable findings tend to be suppressed. Publication bias plagues many areas of research and creates the impression that treatments work better than they really do.

In research on “evidence-based” therapy, the level of publication bias is shocking: an analysis in the *British Journal of Psychiatry* calculated that published effect sizes for CBT are exaggerated by 60% to 75% due to publication bias.3 In other words, the real benefits are just a fraction of what the research literature portrays. If “evidence-based” and real-world therapy are compared on a level playing field by adjusting for publication bias, real-world therapy appears to be more effective.

**Reality:**

Claims that "evidence-based” therapy is more effective than real-world therapy lack scientific basis. Academic researchers have been selling a myth—one that enhances the careers of academic researchers, but not necessarily the well-being of patients.

It is not just my conclusion that the therapies promoted and marketed as "evidence based" confer no special benefits. It is the official scientific conclusion of the American Psychological Association, based on a comprehensive review of psychotherapy research by a blue-ribbon expert panel. This conclusion is spelled out by the American Psychological Association in an official [policy resolution](http://www.apa.org/about/policy/resolution-psychotherapy.aspx).

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