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Documenting the Effectiveness of Psychotherapeutic Interventions

ORDRE DES PSYCHOLOGUES DU QUÉBEC

RESEARCH AND PRACTICE: EVOLVING TOGETHER

The Ordre des Psychologues du Québec is proud to present a new publication, *Integrating Science and Practice*, which deals in its first issue with the question of evaluating therapeutic effectiveness. The aim of this "research and practice" publication is to serve as a bridge between researchers in psychology and clinical practitioners, who want to be informed on the state of knowledge in their field and draw inspiration from it to improve their interventions with clients. The papers constituting this publication, contributed by researchers wishing to share their research results, will cover a variety of subjects, focusing in particular on current issues that relate to the practice of many Order members.

In addition to the texts written by researchers, we will publish in each issue an annotated bibliography providing an overview of the literature on a given subject. This will give you, the reader, an opportunity to see and subject to your professional judgment the work being done in your area of practice.

The content of this publication will be available on the Order's website, but we will also produce a paper copy, which you can keep as an available, easy-to-consult reference tool in your office or wherever needed. We hope that our enthusiasm for this new series of documents will be contagious, and that, with our readers, we will create a synergy network that will help us achieve our common goal of improved professional practice.

The *Integrating Science and Practice* is published by the Communications Department of the Ordre des psychologues du Québec.

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Your comments and suggestions on this first issue of *Integrating Science and Practice* are very welcome. We hope that this publication will stimulate your interest in research and that you will send us your questions and research references so we can share them with all psychologists.

Address your e-mails to:
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It Is Up to Psychologists to Interpret and Give True Meaning to the Empirical Evidence

It is time to take stock. While certain milieus would appear to have discovered evidence-based practice only recently, it is far from new to psychologists. The same holds true for psychotherapy treatments, among other things. Psychologists have in fact been interested in psychotherapy for over half a century. Their research has investigated its short-, medium- and long-term effectiveness and efficacy, often through comparison to other types of interventions; the underlying processes that explain its outcomes; the different factors at work and that impact on the initiation, carrying out and termination of the process; the impacts that psychotherapy can have on different aspects of the patient's functioning and that of his or her family and close acquaintances; as well as its costs and the financial savings it engenders.

These decades of research have made psychotherapy one of the most frequently studied interventions in the health field today, a quality that cannot be ascribed to numerous other treatments that are nonetheless routinely offered in different settings. Psychologists have long shown, through empirical evidence, that psychotherapy is an intervention of true benefit to clients. However, this scientific interest in psychotherapy has also resulted in a proliferation of empirical publications that are sometimes difficult to navigate. Compounding the matter are other problems–often based on theoretical and epistemological differences–such as the absence of a true consensus on what constitutes evidence-based practice. Some therefore advocate the use of "empirically supported therapies," while others lean more toward "empirically supported relationships" or again, "empirically supported psychotherapists." Still others defer to "empirically-informed principles of change." Concurrently, or in the backdrop, is the debate about specific factors such as techniques and so-called common factors such as the therapeutic alliance. This debate remains essentially empirical, since both sets of factors go hand in hand in clinical practice. Everyone is right in part.

One thing is clear: over and above these issues and differences, we know that no treatment and no professional, whatever or whoever they may be, are effective with all clients. The challenge of identifying which treatment, offered by whom and under what circumstances, is the most effective for a particular patient grappling with a particular problem, therefore remains pertinent, even if research already points us to a number of possibilities and options that must be taken into account. In concrete terms, for practitioners, this constant questioning translates into accountability regarding the treatment offered to each patient in light of his or her specific request and needs. This accountability includes, among other things, the need to thoroughly assess the patient and to take into account a set of anamnestic and scientific evidence[1], using a bona fide and methodical process of clinical evaluation and reflection. Moreover, this accountability translates into an obligation to clearly inform the client of the different treatment options available for his or her situation and particular request, and thus goes well beyond simply choosing a recognized treatment for a specific disorder. Indeed, it involves continually documenting the impacts of our interventions on each of our clients, possibly using methods or tools that not only require and enable us to remain sensitive and to reflect on the therapeutic process and adjust it as needed, but that also enable us to identify our own strengths and weaknesses, and even to anticipate possible treatment-related complications.

The Ordre des psychologues du Québec has therefore produced this document following a conference held at McGill University on October 23 and 24, 2009. Financially supported by the Canadian Institutes of Health Research (CIHR), this conference was the result of a collaborative initiative undertaken by representatives of the McGill Psychotherapy Process Research Group, the Ordre des psychologues du Québec, the Université de Montréal, the Université du Québec à Montréal (UQAM), the Université de Sherbrooke, the North American chapter of the Society for Psychotherapy Research (SPR) and various clinics offering psychotherapy services[2]. It provides an overview of a series of short papers written by some of the psychologists who presented their work and reflections at this conference.

1 See the Ordre's policy on evidence-based practice posted on our website in the section reserved for members, at: www.ordrepsy.qc.ca/extranet/pdf/2008_09_01_Politique_donnees_probantes_traduction_APA.pdf

2 The content of the presentations made to practitioners at the conference is posted at: www.mpprg.mcgill.ca

Psychologists have generated the empirical evidence in the field of psychotherapy. It is now up to us as psychologists, not up to others who cannot fully appreciate the scientific principles of our profession or who too often confuse efficacy with clinical relevance or usefulness, to interpret these practices and to give them their true meaning

It is now time that we all take a position on these major questions surrounding the efficacy of psychotherapy treatments and evidence-based practice. This issue is particularly important given that some practitioners may still be tempted today to believe that their work and accountability are limited to choosing a treatment recognized as effective for a given disorder, while others may interpret the presumed equivalence of the different treatment methods as carte blanche not to be accountable for their work, to the point that they inadequately inform their patients of the treatment options available for their particular requests. The Ordre therefore hopes to facilitate knowledge transfer between practitioners and researchers, more specifically, a two-way transfer that will give practitioners access to research and even the chance to contribute to it, and that will give researchers the opportunity to examine issues of concern to practitioners.

Psychologists have generated the empirical evidence in the field of psychotherapy. It is now up to us as psychologists, not up to others who cannot fully appreciate the scientific principles of our profession or who too often confuse efficacy with clinical relevance or usefulness, to interpret these practices and to give them their true meaning. We are faced with a very real mission–that of carrying out an in-depth reflection on our practices here in Québec–in which I urge you all to take part. It is a mission we must pursue for the good of all those to whom we offer our services and for the credibility of our profession.

Dr. Martin Drapeau, Clinical Psychologist

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Professor of Counselling Psychology and Psychiatry

Director of the McGill Psychotherapy Process
Research Group

Research for Clinicians

Dr. Louis G. Castonguay, PhD
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Society for Psychotherapy Research

The Society for Psychotherapy Research (SPR) is composed of researchers, clinicians and students representing various theoretical approaches and working in different professional environments who are devoted to the advancement of scientific knowledge in the psychotherapy field. The research conducted by SPR members uses a wide range of methods and covers a variety of treatment approaches targeting different client groups and different psychological problems.

The SPR's chief goal is to promote the development and dissemination of rigorous, clinically-relevant studies focusing on therapeutic interventions, the change process in psychotherapy and patient and clinician characteristics liable to influence the outcomes of psychotherapeutic interventions.

For more information, visit www.psychotherapyresearch.org or write directly to Louis Castonguay, SPR President, at lgc3@psu.edu

Research can, at times, be very helpful to clinicians. For example, it has proven to us, to our clients, and to third party payers that psychotherapy works. More than fifty years of outcome research has demonstrated that most clients will benefit from different forms of psychotherapy (Lambert& Olges, 2004). Research, however, is not always enlightening, especially when it is used by some researchers and scholars to preach about one side of a controversy while ignoring (or unfairly dismissing) other sides of the same debate. One of the most controversial questions in psychotherapy, and one that has triggered much debate in many Babel towers of academia, has been how psychotherapy works.

To a substantial extent, attempts to address these questions have largely been consolidated as an argument between two perspectives: those who attribute change primarily to specific treatments and those who attribute it mostly to common (or "non-specific") variables. Indeed, benefits of psychotherapy have frequently been ascribed to either the techniques prescribed by particular approaches (e.g., systematic desensitization) or to relationship factors that are assumed to operate similarly in all forms of psychotherapy (see Castonguay, 1993). More recently, participant characteristics have received serious consideration as a legitimate candidate in what could be viewed as a three-horse race aimed at determining the most important determinant of change. For example, whereas Bohart has defined the client self-healing capacity as "the 'engine' that makes therapy work" (Tallman and Bohart, 1999, page 91), Wampold (2006) has argued that the psychotherapist "is an important, if not the most important, source of variability in outcomes" (page 201).

Whether this horse race mentality has been explicitly espoused or merely implied, the categorization of therapeutic variables that underlies such thought fails to do justice to the complexity of the factors that are associated with therapeutic change. In fact, there is enough empirical evidence to conclude that each of these three sets of factors plays a role in effective therapy.

As an attempt to delineate and integrate what we know about numerous variables that contribute to change in psychotherapy, the Division 12 and the North American Society for Psychotherapy Research (NASPR) sponsored a Task Force on empirically based principles of change (Castonguay & Beutler, 2006). The Task Force was set up to meet this challenge by simultaneously reviewing (and thus reporting within one single volume) the contribution of three sets of variables (i.e., participant characteristics, relationship variables, and technical factors) that have not only been shown to be related to outcomes but that, more than likely,

operate in constant interaction in clinical practice. The Task Force was also guided by two other goals. Rather than examining the empirical evidence indiscriminately across all disorders, it elected to examine the role of therapeutic variables for four clusters of clinical problems frequently encountered by clinicians: dysphoric, anxiety, personality, and substance use disorders. In addition, the Task Force aimed to translate research-based evidence into principles of change that could serve as helpful guidelines to clinicians without being tied to particular jargons or theoretical models. In sum, the Task Force was built to attenuate what was seen as unnecessary controversy and make research more helpful to clinicians.

Members of the Task Force included respected psychotherapy researchers[1] who were asked to work in pairs (with the exception of one work group made up of three individuals) to review the empirical evidence related to one type of therapeutic factor for one particular problem area. Efforts were also made to join together researchers who were associated with contrasting theoretical orientations (e.g., cognitive-behavioral and psychodynamic; radical behaviorism and experiential) to cover the literature from broad perspectives.

The findings of the Task Force were recently reported in a book published by Oxford University Press (Castonguay & Beutler, 2006). Reflecting the structure of the Task Force, the book is divided into four main sections (one for each problem area covered). In addition to including a chapter for each of the three specific types of therapeutic variables targeted, each section includes a chapter aimed at integrating (into a cohesive and comprehensive set of clinical guidelines) the principles of change related to participant characteristics, relationship factors, and technical procedures. As a complementary effort to integrate the massive empirical literature examined, the concluding chapter of the book identified principles of change that are common to the treatment of at least to two of the clinical problems covered by the Task force and those which appear to be unique to the treatment of one of these specific disorders. Delineated in this final chapter are 61 "Research Informed Principles" (26 common and 35 unique) that can be used to help clinicians of different theoretical orientations to plan and provide treatments that are consistent with contemporary research findings.

Because it is difficult to take all research findings into consideration given the plethora of studies conducted over the years, such efforts that are a-theoretical and have a clear clinical focus are needed to help clinicians to develop an appropriate initial treatment plan.

REFERENCES

Bohart, A., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association

Castonguay, L.G. (1993). "Common factors" and "nonspecific variables": Clarification of the two concepts and recommendations for research. Journal of *Psychotherapy Integration, 3*, 267-286

Castonguay, L.G., & Beutler, L.E. (2006). (Eds), *Principles of therapeutic change that work*. New York: Oxford University Press.

Lambert, M.J., & Olges, B.M. (2004). The efficacy and effectiveness of psychotherapy. *In* M.J. Lambert (Ed.). *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 139-193). New York: John Wiley and Sons

Wampold, B. E. (2006). The psychotherapist. *In* J.C. Norcross, L.E. Beutler, & R.F. Levant (Eds). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions (pp. 200-208)*. Washington, DC: American Psychological Association.

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Anxiety Disorders. Participant Factors: Michelle G. Newman and Paul Crits-Christoph; Relationship Factors: William B. Stiles and Barry E. Wolfe; Treatment Factors: Sheila R. Woody and Thomas H. Ollendick
Personality Disorders. Participant Factors: Héctor Fernández-Alvarez, John F. Clarkin, and Kenneth L. Critchfield; Relationship Factors: Lorna Smith Benjamin and Jacques P. Barber; Treatment Factors: Marsha M. Linehan and Gerald C. Davison
Substance Use Disorders. Participant Factors: David A. F. Haaga and Sharon M. Hall; Relationship Factors: Jay Lebow and Rudolf Moos;
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How Can Therapeutic Effectiveness Be Improved?

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At a time when psychotherapists are increasingly required to demonstrate their effectiveness, and even more, their cost-effectiveness, the problem of therapeutic effectiveness takes on greater importance. In a culture focused on effectiveness, efficiency and profitability, psychotherapists, managers and often patients ask themselves various questions, including: which treatment is most effective and least costly for dealing with a given problem?

Faced with these facts, the Ordre des psychologues du Québec, like the American and Canadian psychological associations, advocates practice based on the integration of research and practitioners' clinical expertise, while taking account of individual clients' characteristics and preferences (Lambert and Ogles, 2004). This raises other questions, for example, which scientific data can the clinician rely on, to what extent are empirically-supported treatments generalizable and relevant for clinical practice, how can research results be applied judiciously and responsibly to guide clinical decisions for the patient's well-being or, more generally, how can scientific data really be integrated with the psychotherapist's clinical expertise? When research results are used to influence practice, training and administrative decisions, it is essential to determine what conclusions can really be drawn from the research (Norcross, Beutler and Levant, 2006).

SOME QUESTIONS INVITING FURTHER THOUGHT

If I use treatments that are supported empirically and approved, for example, by the American Psychological Association (Division 12), am I assured of obtaining positive outcomes or improving my effectiveness?

Following the debate regarding evidence-based treatments, it was concluded in some quarters that practice based on empirically-supported treatments provided assurance of efficacy (Nathan and Gorman, 2007). However, the research results provide some important qualifications to this assertion. Generally, regardless of the treatment given, some 30 to 40% of patients discontinue their therapy or do not report any significant changes, while 5 to 15% experience negative effects (Lambert and Ogles, 2004). Psychotherapy is remarkably effective, but patients have to complete the treatment.

To what can we ascribe therapeutic effectiveness? The right treatment or the right psychotherapist?

The examination of therapeutic efficacy and change makes clear that the impact of techniques and interventions is very closely linked to the characteristics of the psychotherapist and the patient and their therapeutic relationship. For close to 30 years, studies have shown a result that has too often been overlooked, that is, that the variance in patient outcome is more closely linked to the differences among individual psychotherapists than to the techniques or treatments used (Lecomte et al., 2004; Wampold, 2001). In research examining both randomized clinical trials and studies done in the field, Wampold demonstrated that the factor that is most explanatory of the variability of outcomes is unquestionably the therapist, regardless of the client's diagnosis or the type of treatment given (Wampold and Brown, 2005).

Approximately 30% of therapists obtain results superior to those of their colleagues, independently of the approach they use. After more than 10 years of research, Lambert (2007) clearly established the great variability of therapists' effectiveness. Some therapists obtain deterioration effects of around 19% with 160 patients, while others have barely a 1% deterioration rate with over 300 patients. Comparing therapists, we find that with certain therapists, patients improve up to 50% more and their discontinuation rate is 50% lower than with others. Thus, despite all the efforts to mitigate variance due to the psychotherapist's influence by using standardized training and intervention manuals, this factor seems to significantly influence the outcomes: the psychotherapist largely explains the variability of the results obtained in any therapeutic process, whatever approach is used (Lecomte et al., 2004).

What is the secret of effective psychotherapists?

A general literature review suggests that an effective psychotherapist delivers optimal interventions facilitating therapeutic change when he[1] is aware of his own emotional experience, sensitive to the interactive context and attentive to the patient's subjective experience. An effective therapist not only masters the theories, techniques and treatments, but is able to apply them flexibly and adapt them as needed to facilitate the connection and the process of therapeutic change (Castonguay and Beutler, 2006; Skovholt and Jennings, 2004).

According to the literature, effective psychotherapists are characterized by four basic factors (Lecomte et al., 2004; Skovholt and Jennings, 2004). In these clinicians, we observe:

- A complex interaction of skilled application of a treatment and optimal control of the therapeutic relationship;
- Control of relational fluctuations and ruptures and restoration of the therapeutic alliance;
- Support and management or treatment of the tensions arising from the patient's resistance and openness to change;
- Development of awareness of the self and the other in interaction.

So how can psychotherapists' therapeutic effectiveness be improved? How can we help the therapist be sensitive to the patient's experience, the patient's-therapist's interactive experience and their reciprocal impact? And how can we show more awareness of the four factors underlying therapeutic effectiveness? Several avenues exist.

First, we should recognize the therapist's need to be able to evaluate, accurately and concretely, the patient's progress. Offering the therapist a variety of appropriate instruments, in keeping with his approach and the problems or the form of the therapy, is an option that may help the therapist not only assess the patient's progress but also develop self-aware practice. A number of questionnaires are available for evaluating the patient's progress, the therapist's interventions, the therapist's self-awareness and the therapeutic alliance. Their use can help the therapist correctly decode the patient's experience and prevent discontinuation of the therapy and deterioration of the patient's mental health in certain routine clinical situations. The therapist can also use feedback obtained through brief questionnaires completed by the patient at each session, as proposed by Lambert (2007), and Miller and colleages (2006).

Lambert (2007[2]) uses a brief impact questionnaire comprising 45 items (Outcome Questionnaire-45) to get patients to evaluate each therapy session. This instrument is simple, short, sensitive to change and compatible with most approaches. It measures the symptoms of psychopathology and interpersonal difficulties, as well as social functioning and general wellbeing. In five clinical trials done with over 4,000 patients, the results showed that therapists who receive brief feedback on a weekly basis significantly improve their therapeutic effectiveness and reduce the rate of patient deterioration. The proportion of improved patients doubles when the psychotherapist receives feedback accompanied by recommendations.

The impact of techniques and interventions is very closely linked to the characteristics of the psychotherapist and the patient and their therapeutic relationship

In a similar vein, Miller et al. (2006), inspired by Lambert's work, have developed an even briefer impact measure, as well as a measure of alliance. Their results essentially confirm Lambert's work. It is interesting to note that the mere fact of the therapist's awareness of the way in which the patient perceives his therapeutic progress and the therapeutic relationship, as measured by a very succinct instrument comprising four items for impact and four items for therapeutic alliance, appears sufficient to make a significant difference in improving therapeutic effectiveness and reducing the rate of deterioration.

These results seem to suggest that the therapists who obtain the best therapeutic outcomes are those who are attentive and sensitive to the patient's feedback and their impact and are flexible in adjusting their interventions to the patient's needs. What is troubling is that a very large majority of therapists are not able to do this on their own; they require external feedback.

1 For the sake of readability, we use the masculine pronoun to designate both genders.

2 See also Lambert's article in this same issue.

Outside routine clinical situations, when the issues are more complex, for example, involving relational tensions characterized by hostility or withdrawal or situations or moments requiring the therapist to tolerate and support intense emotional experiences, it often seems necessary, even essential, to have a place and time for reflection with a supervisor (Lecomte, 2009). It is almost impossible to learn on one's own the complex relational intervention skills that often reactivate in the therapist issues from his own relational history. In these difficult situations and moments, the therapist seeks a space for reflection, where he can safely disclose and share everything that happens with a client and become aware of and understand his own control of his internal states, the interactive control between him and client and the nature and impact of his interventions. He also seeks this space to be able to share his reactions in interaction with the supervisor, be able to delineate the appropriate avenues and intervene with skill and effectiveness. From this perspective, supervision becomes essential for competent and effective practice (Lecomte and Savard, 2004).

Above and beyond the mastery of theoretical and technical skills, the psychotherapist must be capable of integrating theoretical and technical knowledge and self-management skills within the specific interaction with the client. The work of reflection in a supervision situation becomes all the more important as a majority of therapists consider themselves above average in terms of effectiveness, while the research results paint a more qualified and modest picture, inviting us to further thought (Lambert, 2007).

REFERENCES

Castonguay, L.-G. and Beutler, L. E. (2006). *Empirically Supported Principles of Therapeutic Change: Integrating Common and Specific Therapeutic Factors across Major Psychological Disorders*. New York: Oxford University Press.

Lambert, M. J. and Ogles (2004). The Efficacy and Effectiveness of Psychotherapy. *In* M. Lambert (Ed.), *The Bergin and Garfield Handbook of Psychotherapy and Behavior Change*. (5th ed.), 139-193.

Lambert, M.J. (2007). Presidential Address: What Have We Learned From a Decade of Research at Improving Psychotherapy Outcome in Routine Care? Psychotherapy Research: 17 (1), 1-14.

Lecomte, C. and Savard, R. (2004). La supervision clinique: Un processus de réflexion essentiel au développement de la compétence professionnelle. *In* T. Lecomte and C. Leclerc (Eds.). Manuel d'intervention psychiatrique: Interventions de pointe. Montreal: Presses de l'Université du Québec.

Lecomte, C., Savard, R., Drouin, M.S. and Guillon, V. (2004). Qui sont les psychothérapeutes efficaces? Implications pour la formation en psychologie clinique. *Revue québécoise de psychologie, 25* (3), 73-102.

Lecomte, C. (2009). La supervision clinique: une composante essentielle dans le traitement de la personnalité dite limite. *In* Leclerc C. and Labrosse C. *Trouble de personnalité limite: points de vue de différents acteurs*. Montreal: Presses de l'Université du Québec.

Miller, S.D., Duncan, B.L., Brown, J., Sorrell, R. and Chalk, M. (2006). Using Formal Client Feedback to Improve Outcome and Retention: Making Ongoing Real-Time Assessment Feasible. *Journal of Brief Therapy, 5*, 5-22.

Nathan, P. E. and Gorman, J. M. (2007). *A Guide to Treatments That Work, 3rd ed*. New York: Oxford University Press.

Norcross, J.C., Beutler, L.E. and Levant, R.F. (2006). *Evidence-Based Practices in Mental Health. Debate and Dialogue on The Fundamental Questions*. Washington: APA.

Skovholt, T. M. and Jennings, L. (2004). *Master Therapists: Exploring Expertise in Therapy and Counselling*. New York: Allyn & Bacon.

Wampold, B. E. (2001). *The Great Psychotherapy Debate: Models, Methods and Findings*. Mahwah, New Jersey: Erlbaum.

Wampold, B.E. and Brown, G.S. (2005). Estimating Therapist Variability: a Naturalistic Study of Outcomes in Managed Care. *Journal of Consulting and Clinical Psychology, 73,* 914-923.

REAL-TIME MONITORING OF PSYCHOTHERAPY TREATMENT RESPONSE:

An Evidence-Based Practice

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Psychotherapy of various orientations and formats has been found to be effective across a variety of patient disorders. The extent and richness of this finding extends over decades of research, thousands of treated individuals, hundreds of settings, and multiple cultures. Psychotherapists should be encouraged by the mass and breadth of empirical results that clearly demonstrate that the treatments they provide reduce distressing symptoms, resolve interpersonal problems, restore work performance, and improve quality of life for the majority of those who seek treatment (Lambert & Ogles, 2004). Nevertheless, it is also clear that psychotherapy can occasionally be harmful or result in no detectable progress in a minority of patients. Estimates of the number of patients who deteriorate while in treatment is between 5 and 10% for adults and double this number for children (Lambert & Ogles, 2004). Even in clinical trials that support the value of a particular treatment with a particular disorder, a sizable minority of patients find no benefit (somewhere around 40%; Hansen, Lambert, & Forman, 2002).

This problem is compounded by the inability of clinicians to identify and predict negative change (Hannan, et al 2005). The current climate of placing primary emphasis on studying and documenting effective treatments for specific disorders increase the likelihood that an "empirically supported" or "evidence-based" *treatment* will be offered to the patient. Unfortunately, offering the right treatment for the right disorder is not a remedy that has a proven track record at reducing patient deterioration. No patient is in need of an empirically-supported psychotherapy that does not work for them. An alternative evidence-based practice is to formally monitor patient treatment response in order to become more responsive to patients if they fail to benefit. This can be done with simple self-reporting measures such as the Outcome Questionnaire (OQ-45), a 45-item measure developed specifically for the purpose of tracking and assessing a client's symptomatic states, degree of interpersonal problems, role functioning, and well-being. The OQ-45 is a well-established instrument that has been validated across the world and across a broad range of normal and client populations from various ethnic groups (Lambert, et al., 2004).

The session-by-session-treatment response of thousands of patients was tracked using this measure, thus allowing for the accurate prediction of treatment failure for individual clients before they left treatment. The next step that we took to reduce treatment failure was to conduct controlled experiments to test the consequences of supplementing clinical practice with this feedback. There is little point in predicting an event and accurately identifying upcoming deterioration unless this information can help to alter the course of the event. Feedback information in the form of

progress graphs and warning messages was given to psychotherapists prior to each session of treatment with half their ongoing caseload; these patients' outcomes were then compared with the other half of the therapists' caseload in six large-scale published studies. In addition to providing feedback on progress and predicted treatment failure, we also created and investigated the effects of supplying therapists with a Clinical Support Tool aimed at assisting them with problem-solving the failing cases (about 20% of cases are identified as off-track).

The results of giving feedback to therapists versus treatment as usual (no formal feedback) reached statistical significance in each study, had an effect size of about .40, and resulted in a clinically meaningful reduction of deterioration and recovery. To the great surprise of practicing therapists who participated in our studies, they were able to cut deterioration by about two-thirds. Given the large samples and replications of the individual studies in this summary, the current findings seem compelling. Providing feedback to therapists about patients who are failing to have a positive response to therapy has a significant positive impact on patient well-being. We believe that a fundamental reason is that the actuarial information provided by feedback is not available to the therapist through intuition. This supposition is supported by the fact that clinicians do not seem to learn how to predict treatment failure as a result of feedback. Mental health vital sign measurement behaves something like blood pressure–it is not precisely known until measured. Importantly, practitioners are able to make inroads into reducing negative outcomes based on their own problem-solving capacities once alerted to the presence of a problem (Lambert, 2010).

Offering the right treatment for the right disorder is not a remedy that has a proven track record at reducing patient deterioration. No patient is in need of an empirically-supported psychotherapy that does not work for them

REFERENCES

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., et al. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology: In Session, 61*, 155-63.

Hansen, N. B., Lambert, M. J., & Forman, E. V. (2002). The psychotherapy dose-effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9*, 329-343.

Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. Washington, DC: APA Press.

Lambert, M. J., Morton, J.J., Hatfield, D., Harmon, C., Hamilton, S., Reid, R. C., Shimokawa, K., Christopherson, C., and Burlingame, G. M. (2004). *Administration and Scoring Manual for the Outcome Questionnaire -45*. Orem, UT: American Professional Credentialing Services (www.oqfamily.com).

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. *In* M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change* (5th ed., pp. 139-193). New York: Wiley.

THE EMPIRICALLY SUPPORTED THERAPIST:

All Clinicians Have Strengths and Weaknesses

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Behavioral Health Labs[1]

Therapists should ideally collect outcome data on all their patients as part of standard care

There is a substantial unmet need for providing validated behavioral health treatments. Despite the high rates of behavioral health disorders (nearly 30% of people have a diagnosed psychiatric or substance use disorder, (US Surgeon General, 1999)) and the availability of proven behavioral treatments that can effectively eliminate or reduce disorders (Kessler, et al., 2003; Mintz, Mintz, Cerruda, & Hwang, 1992; Wampold, 2001), most patients receive substandard care or no care at all (Hepner, et al., 2007; US Surgeon General, 1999). And while researchers pursue an important quest, looking for the determinants and relative efficacy of the roughly 150 *empirically supported treatments* for 51 of the 397 DSM-IV disorders (Castonguay & Beutler, 2006), the marketplace may be best served with information about *empirically supported therapists*.

We have known since the 1970s that there are major differences in therapist skill and outcomes (Ricks, 1974; Barber, Crits-Christoph, & Luborsky, 1996). Both Luborsky (Luborsky, McLellan, Diguer, Woody, & Seligman, 1997) and Lambert (Okiishi, Lambert, Nielsen, & Ogles, 2003) have found that some therapists achieve negative outcomes while a few achieve remarkably positive results for their patients, even in randomized controlled trials with random case assignment and specifically selected, experienced clinicians. Differences between therapists–even those delivering manualized treatments in controlled efficacy trials–may account for the majority of controllable variance in behavioral health treatments (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Crits-Christoph, et al., 1991; Crits-Christoph & Mintz, 1991; Huppert, Bufka, Barlow, Gorman, Shear, & Woods, 2001; Kim, Wampold, & Bolt, 2006; Luborsky, et al., 1986).

Barber has shown that patients bring significant variance and challenges to their therapy (Barber & Gallop, 2009; Barber, 2009) at least among substance dependent patients. However, Hayes suggests that the way that therapists respond to these challenges is critical to client improvement (Gelso & Hayes, 2007; Hayes, 2004). Choosing the right therapist appears to be so important that an effective psychiatrist using a placebo can achieve better results than a poor physician using an effective psychoactive agent (McKay, Imel, & Wampold, 2006). Just writing a prescription is obviously not enough. As also shown by Wampold and his colleagues, controlling for therapist effects nullifies the significant between-treatment effects (e.g., Cognitive Behavioral Therapy vs. Pharmacology) reported in some studies (Kim, Wampold, & Bolt, 2006). Moreover, these important findings are not limited to efficacy studies and are also seen in real-world effectiveness studies (Lutz, Leon, Zoran, Lyons, & Stiles, 2007; Okiishi J. C., Lambert, Eggett, Nielsen, Dayton, & Vermeersch, 2006; Wampold & Brown,

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2005). Furthermore, such findings are not limited to out-patient treatment (Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008).

Choosing the right therapist for the right problem

Our team has conducted studies that show that when using multi-dimensional measurements of outcome (e.g., the Treatment Outcome Package – TOP, Kraus, Seligman, & Jordan, 2005), most therapists can demonstrate proficiency in treating numerous disorders. In a study of 6,960 patients seen by 696 therapists (Kraus, Castonguay, Nordberg, Boswell, & Hayes, 2009), we defined an *effective* therapist as one whose average patient reliably improves (i.e., the level of patient improvement exceeds the reliable change index (Jacobson & Truax, 1991) for the scale). We showed that the average therapist had five domains on the TOP of documented effectiveness; 96% of therapists were effective with at least one patient group; and no therapist was effective with all disorders. On the other hand, as shown in **TABLE 1** (below), many therapists are practicing outside of their areas of proficiency, with their average patients ending treatment reliably worse.

For example, in treating homicidal intent and violence, only 38% of therapists have average patients who are reliably improved while 16% have patients ending treatment more violent than when they started, and 46% of therapists are billing for scarce healthcare dollars without delivering any clear benefit to patients or to society. Similar data for substance abuse is shown in **FIGURE 1**. By avoiding these harmful practice patterns and referring patients to effective therapists, we estimate that effect sizes of treatment improvement can be increased between 54 to 448%, depending on the disorder category. It is important to realize that the numbers of problematic outcomes is highest in the areas for which specialized training and experience is typically expected (e.g., treating violence, substance abuse and sexual dysfunction).

In another study (Kraus, Castonguay, Boswell, Nordberg, Hayes, & Wampold, 2009), we analyzed differences in therapist effectiveness when treating uncomplicated depression as compared to depression with co-morbid substance abuse while comparing multiple ranking methods. The study included 891 patients treated by 45 participating therapists (each of whom had at least 4 patients in each condition). Analyses compared three statistical approaches to evaluate therapist effectiveness and ranking as seen in the literature (c.f., (Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Wampold & Brown, 2005; Okiishi, Lambert, Nielsen, & Ogles, 2003). Findings demonstrate good convergence between various ranking methods. On the other hand, therapist skill at treating uncomplicated depression had little relationship to their ability to treat depression with co-morbid substance abuse, with approximately 2% of the variance explained when predicting effectiveness with one group with information from the other. Thus, there is some evidence that treating substance abuse with or without depression should be left to experts. This conclusion is consistent with the findings of the NIDA cocaine collaborative study (Crits-Christoph, et al., 1999), which has shown that drug counselors providing drug counseling had better outcomes than cognitive or dynamic therapists.

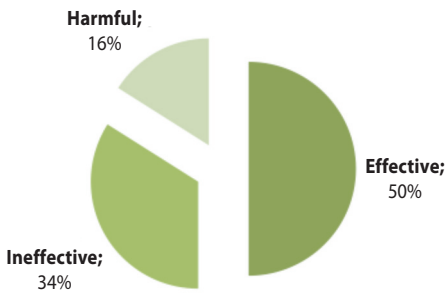
TABLE 1 **Effective and Harmful Therapists by TOP Domain**

TOP DOMAIN	% Effective Therapists	% Ineffective Therapists	% Harmful Therapists	Effect size (All therapists)	Effect size (Effective therapists)	% effect size when using only effective therapists
Sexual Funct.	29%	59%	12%	0.27	1.48	448%
Work Funct.	35%	58%	7%	0.44	1.52	245%
Violence	38%	46%	16%	0.31	1.02	229%
Social Funct.	45%	41%	14%	0.48	1.46	204%
Panic/Anxiety	43%	47%	10%	0.42	1.17	179%
Subst. Abuse	50%	34%	16%	0.47	1.14	143%
Psychosys	46%	45%	9%	0.43	1.00	133%
Quality of life	47%	48%	5%	0.68	1.51	122%
Sleep	54%	37%	9%	0.57	1.20	111%
Suicidality	58%	35%	7%	0.64	1.30	103%
Depression	67%	30%	3%	0.91	1.41	54%
Mania	0,7%	99%	0,3%	Little data	Little data	N/A

Public Policy Implications

A thirty-year quest for empirically supported treatments has yielded mixed

FIGURE 1 **Therapist Effectiveness: Treating Substance Abuse**



Kraus et coll., 2009

results. While some treatments have been found superior for certain conditions, some of these findings are being called into question by statistical techniques that do not treat therapist effects as random noise, but take seriously the unique abilities of each therapist (Wampold, 2001). On the other hand, renewed research into the effectiveness of therapists is delivering promising results.

There is good news and bad news here. The bad is obvious. Healthcare resources are scarce, and if approximately half of these resources are being consumed by therapists who provide little value to their patients and sometimes even harm them, then clearly, there is a public health crisis. On the other hand, the data suggests that a solution is readably available. All therapists appear to have their own unique set of abilities and, if they practice within these parameters, then their patients often benefit. Furthermore, all therapists can dramatically improve their outcomes by identifying the types of patients with whom they work well, as identified by outcome data, and referring those whom they do not elsewhere.

For the good to outweigh the bad, several things need to change. First, therapists should ideally collect outcome data on all their patients as part of standard care. There are multiple reasons to do this, including solid data that suggests that patients benefit from the process (Lambert, 2007). Second, transparent referral data must be made available for therapists and other referral sources to use. Such data needs to be patient specific (i.e., tailored to their individual needs and concerns) and positive (i.e., a therapist should never show up on a "do not refer" list). To this end, our team is building an *Individualized Assessment and Referral* [sm] (IRA) system that will help clinicians identify their strengths, reward them with referrals with which they are most likely to succeed, and facilitate customized access to continuing educational resources for those who wish to improve their future success. We believe such a system will lead to greater therapist and patient satisfaction and dramatically improve outcomes while reducing overall healthcare costs.

All therapists appear to have their own unique set of abilities and, if they practice within these parameters, then their patients often benefit. Furthermore, all therapists can dramatically improve their outcomes by identifying the types of patients with whom they work well

REFERENCES

Barber, J. P. (2009). Towards a working through of some core conflicts in psychotherapy research. *Psychotherapy Research , 19* (1), pp. 1-12.

Barber, J. P., & Gallop, R. (2009). Disentangling the contributions of the therapists and the patients in complex therapeutic processes predictive of outocme. *Submitted for publication*.

Barber, J. P., Crits-Christoph, P., & Luborsky, L. (1996). Effects of therapist adherence and competence on patient outcome in brief dynamic therapy. *Journal of Consulting and Clinical Psychology , 64*, pp. 619-622.

Blatt, S. J., Sanislow, C. A., Zuroff, D. C., & Pilkonis, P. A. (1996). Characteristics of effective therapists: Further analyses of data from the National Institute of Mental Health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology , 64*, pp. 1276-1284.

Castonguay, L. G., & Beutler, L. E. (Eds.). (2006). *Principles of Therapeutic Change That Work*. New York: Oxford Univeristy Press.

Crits-Christoph, P., & Mintz, J. (1991). Implications of therapist effects for the design and analysis of comparative studies of psychotherapies. *Journal of Consulting and Clinical Psychology , 59*, pp. 20-26.

Crits-Christoph, P., Baranackie, K., Kurcias, J. S., Carroll, K., Luborsky, L., McLellan, T., et al. (1991). Meta-analysis of therapist effects in psychotherapy outcome studies. *Psychotherapy Research, 1*, pp. 81-91.

Crits-Christoph, P., Siqueland, L., Blaine, J., Frank, A., Luborsky, L., Onken, L., et al. (1999). Psychosocial Treatments for Cocaine Dependence: Results of the National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Archives of General Psychiatry, 56*, 493-502.

Dinger, U., Strack, M., Leichsenring, F., Wilmers, F., & Schauenburg, H. (2008). Therapist effects on outcome and alliance in inpatient psychotherapy. *Journal of Clinical Psychology, 64*, pp. 344-354.

Gelso, C. J., & Hayes, J. A. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities*. Mahwah, NJ: Erlbaum.

Hayes, J. A. (2004). The inner world of the psychotherapist: A program of research on countertransference. *Psychotherapy Research, 14*, pp. 21-36.

Hepner, K., Rowe, M., Rost, K., Hickey, S., Sherbourne, C., Ford, D., et al. (2007). The effect of adherence to practice guidelines on depression outcomes. *Annals of Internal Medicine, 147(5)*, pp. 320-329.

Huppert, J. D., Bufka, L. F., Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. W. (2001). Therapists, therapist variables, and cognitive–behavioral therapy outcomes in a multicenter trial for panic disorder. Journal of Consulting and Clinical Psychology , 69, pp. 747-755.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. Journal of Consulting & Clinical Psychology , 59, pp. 12-19.

Kessler, R., Berglund, P., Demler, O. R., Koretz, D., Merikangas, K., Rush, A., et al. (2003). The epidemiology of Major Depressive Disorder: Results from the National Comorbidity Survey replication. *Journal of the American Medical Association, 289*, pp. 3095-3105.

Kim, D., Wampold, B. E., & Bolt, D. M. (2006). Therapist effects in psychotherapy: A random-effects modeling of the National Institute of Mental Health Treatment of Depression Collaborative Research Program data. *Psychotherapy Research, 16(2)*, pp. 161-172.

Kraus, Castonguay, L. G., Boswell, J. F., Nordberg, S. S., Hayes, J. A., & Wampold, B. E. (2009). Identifying effective therapists with the Treatment Outcome Package: The need for a multi-dimensional approach. *Unpublished manuscript*.

Kraus, Castonguay, L. G., Nordberg, S. S., Boswell, J. F., & Hayes, J. A. (2009). Therapist competencies and their implications for patient care. *Submitted for publication*.

Kraus, D. R., Seligman, D., & Jordan, J. R. (2005). Validation of a behavioral health treatment outcome and assessment tool designed for naturalistic settings: The Treatment Outcome Package. *Journal of Clinical Psychology, 61(3)*, pp. 285-314.

Lambert, M. J. (2007). Presidential address: What have we learned from a decade of research aiming at improving psychotherapy outcome in routine clinical care. *Psychotherapy Research, 17*, pp. 1-14.

Luborsky, L., Crits-Christoph, P., McLellan, A. T., Woody, G., Piper, W., Liberman, B., et al. (1986). Do therapists vary much in their success? Findings from four outcome studies. *The American Journal of Orthopsychiatry, 56(4)*, pp. 501-512.

Luborsky, L., McLellan, A. T., Diguer, L., Woody, G., & Seligman, D. A. (1997). The psychotherapist matters: Comparison of outcomes across twenty-two therapists and seven patient samples. *Clinical Psychology: Science and Practice, 4*, pp. 53-65.

Lutz, W., Leon, S. C., Zoran, M., Lyons, J. S., & Stiles, W. B. (2007). Therapist effects in outpatient psychotherapy: A three-level growth curve approach. *Journal of Counseling Psychology, 54*, pp. 32-39.

McKay, K., Imel, Z., & Wampold, B. (2006). Psychiatrist effects in the psychopharmacological treatment of depression. *Journal of Affective Disorders, 92(2)*, pp. 287-290.

Mintz, J., Mintz, L., Cerruda, M., & Hwang, S. (1992). Treatments of depression and the functional capacity to work. *Archives of General Psychiatry, 49*, pp. 761-768.

Okiishi, J. C., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D., & Vermeersch, D. A. (2006). An analysis of therapist treatment effects: toward providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology, 62 (9)*, pp. 1157-72.

Okiishi, Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology and Psychotherapy, 10*, pp. 361-373.

Ricks, D. F. (1974). Supershrink: Methods of a therapist judged successful on the basis of adult outcomes of adolescent patients. In D. F. Ricks, M. F. Roff, & A. Thomas (Eds.), *Life History Research in Psychopathology* (Vol. 3, pp. 275-297). Minneapolis, MN: University of Minneapolis.

US Surgeon General. (1999). *Mental Health: A Report of the Surgeon General*. US Department of Health and Human Services. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services, National Institutes of Health, National Institute on Mental Health.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.

Wampold, B. E., & Brown, G. S. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73 (5)*, pp. 914-923.

WEBSITES AND RESOURCES on Evidence-Based Practice and Practice Guides in the Mental Health Field

Ordre des psychologues du Québec Policy on Evidence-Based Practice
www.ordrepsy.qc.ca/extranet/pdf/2008_09_01_Politique_donnees_probantes_traduction_APA.pdf

We remind you that the Order publishes **guidelines** and **scopes of practice** which can be downloaded in the section reserved for members.

Report of the Presidential Taskforce on Evidence-Based Practice
www.apa.org/practice/resources/evidence/ebpreport.pdf

This document gives an excellent overview of the history of evidence-based practice and the related issues.

American Psychological Association (APA) Guidelines for Practitioners
www.apa.org/practice/guidelines/index.aspx

These guidelines relate particularly to work with children, older adults and gays and lesbians. In view of the large number of practice guides produced by different professional associations and the variable quality of these guides, the APA guidelines help you evaluate the quality of a guide before using it. These guidelines are available online at the above address.

APA Division 12 list of empirically-supported treatments for different disorders
www.psychology.sunysb.edu/eklonsky-/division12/

Division 12 (Clinical Psychology) maintains a list of empirically-supported treatments for different disorders, which is updated regularly.

American Psychological Association evidence-based information:

Division 29 on psychotherapy
www.divisionofpsychotherapy.org

Division 42 on psychologists in independent practice
www.42online.org

Division 17 on counselling psychology
www.div17.org

Division 39 on psychoanalysis
www.division39.org/index.php

This site posts a recent article by Jonathan Shedler on "The Efficacy of Psychodynamic Psychotherapy".

Documentation on the other divisions is accessible on the APA site in the "Divisions of APA" section
www.apa.org

Canadian Psychological Association guidelines, particularly concerning school psychology and work with children and women
www.cpa.ca

EBMsources: directory of websites providing evidence-based clinical information, including in mental health
www.ebmsources.fmed.ulaval.ca

The Cochrane Library: summaries of systematic reviews for various disorders, including in mental health
www3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME
www.cochrane.org/reviews

National Institute for Clinical Excellence: systematic reviews and practice guides
www.nice.org.uk/guidance/index.jsp

Social Care Institute for Excellence
www.scie.org.uk

NHS Clinical Knowledge Summaries: collection of practice guides, including many in mental health
www.cks.nhs.uk/home

Additional information on evidence-based approaches and practice guides

Guidelines Advisory Committee
www.gacguidelines.ca

Scottish Intercollegiate Guidelines Network
www.sign.ac.uk

Centre de liaison sur l'intervention et la prévention psychosociales
http://www.clipp.ca

Agence d'Évaluation des Technologies et des Modes d'Intervention en Santé
www.aetmis.gouv.qc.ca

TRIPDataBase
www.tripdatabase.com

Qualaxia Network
www.qualaxia.org

National Guideline Clearinghouse
www.guideline.gov

Health Evidence
www.health-evidence.ca

Collaboration between Clinicians and Researchers

Dr. Marilyn Fitzpatrick, psychologist, is striving to establish a Quebec-wide collaborative network of researchers and clinicians working in mental health and more specifically, in psychotherapy. The purpose of this network is to create true collaboration between research psychologists and clinical psychologists, giving clinicians the opportunity to contribute to all phases of research projects and researchers the chance to become familiar with the real issues in the field and focus their interest on problems that have significant clinical impact. Dr. Fitzpatrick invites all psychologists to complete a brief questionnaire, in which they can indicate their interest in participating in this network and identify their current needs. The questionnaire is accessible at: www.mpprg.mcgill.ca, in the "Surveys" section.

Dr. Fitzpatrick can also be contacted directly by e-mail at: marilyn.fitzpatrick@mcgill.ca