The Heart and Soul of Change: Getting Better at What We Do

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Editor's note: Dr. Duncan, the Director of the Heart and Soul of Change Project, was the featured speaker at the spring IPA conference in Des Moines.

There seems to be a prevailing view that to be an accomplished psychotherapist one must be well versed in evidence based treatments (EBT), or in those models that have been shown in randomized clinical trials (RCT) to be efficacious for different "disorders." The idea here is to make psychological interventions dummy-proof, where the people—the client and the therapist—are basically irrelevant (Duncan, 2010). Just plug in the diagnosis, do the prescribed treatment, and voila, cure or symptom amelioration occurs! This medical view of therapy is perhaps the most empirically vacuous aspect of EBTs because the treatment itself accounts for so little of outcome variance, while the client and the therapist—and their relationship—account for so much more. In fact, it is the factors common to all psychotherapies that matter the most.

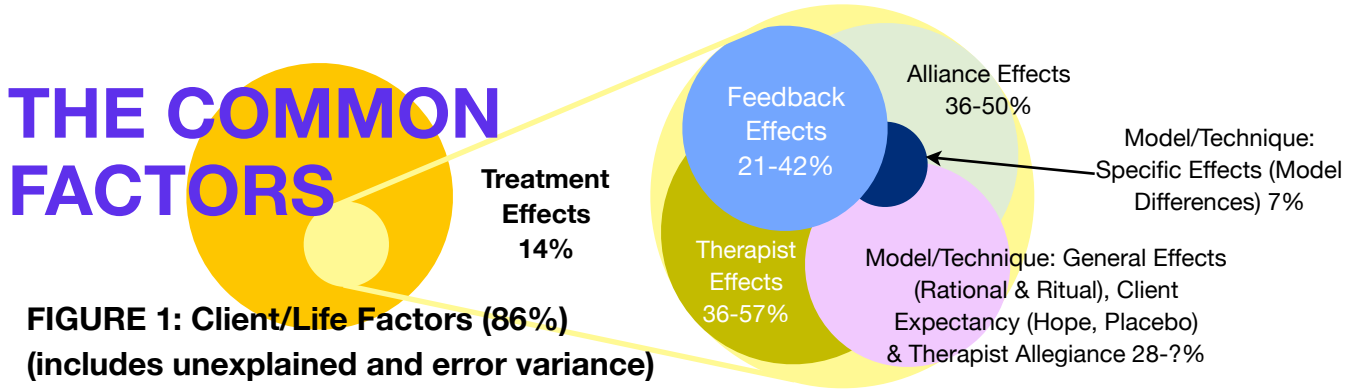

FIGURE 1: Client/Life Factors (86%) (includes unexplained and error variance)

The Common Factors

To understand the common factors, it is first necessary to separate the variance due to psychotherapy (see Figure 1) from that attributed to client/life factors, those variables incidental to the treatment model, idiosyncratic to the specific client, and part of the client's life circumstances that aid in recovery despite participation in therapy (Lambert, 2013)—everything about the client that has nothing to do with us. Calculated from the oft reported 0.80 effect size (ES) of therapy, the proportion of outcome attributable to treatment (14%) is depicted by the small circle nested within the larger circle at the lower right side of the left circle. The variance accounted for by client factors (86%), including unexplained and error variance, is represented by the large circle on the left. Even a casual inspection reveals the disproportionate influence of what the client brings to therapy—the client is the engine of change (Bohart & Tallman, 2010).

Figure 1 also illustrates the second step in understanding the common factors. The second, larger circle in the center depicts the overlapping elements that form the 14% of variance attributable to therapy. Visually, the relationship among the common factors is more accurately represented with a Venn diagram, using overlapping circles and shading to demonstrate mutual and interdependent action.

Therapist Effects

Therapist effects represent the amount of variance attributable not to the model wielded, but rather to whom the therapist is—it's no surprise that the participants in the therapeutic endeavor account for the lion share of how change occurs. Recent studies suggest that 5-8% of the overall variance is accounted for by therapist effects (Baldwin & Imel, 2013), or 36-57% of the variance accounted for by treatment. The amount of variance, therefore, accounted for by therapist factors is about five to eight times more than that of model differences.

Although we know that some therapists are better than others, there is not a lot of research about what specifically distinguishes the best from the rest. Demographics (gender, ethnicity, discipline, and experience) don't seem to matter much, and although a variety of therapist interpersonal variables seem intuitively important, there is not much empirical support for any particular quality or attribute (Baldwin & Imel, 2013). So what does matter? There are a couple of possibilities and one absolute certainty. First, highlighting the importance of recruiting client strengths and resiliencies suggested by the variance attributed to client/life factors, Gassman and Grawe (2006) found that therapists who spend more time in what they called "resource activation" than "problem activation" got better outcomes. The next possibility is experience, but not the generic kind that we were often told that would make us better. Recent studies suggest that specific experience with particular populations or "conditions" may yield better outcomes (Crits-Cristoph, Connally Gibbons, & Mukherjee, 2013). And the absolute certainty: The client's view of the alliance—not only a robust predictor of therapy outcomes, but also is perhaps the best avenue to understand therapist differences. Research strongly suggests that clients seen by therapists with higher average alliance ratings have better outcomes (Crits-Cristoph et al., 2013). So the answer to the oft heard question about why some therapists are better than others is that tried and true but taken for granted old friend, the therapeutic alliance.

The Alliance

Researchers repeatedly find that a positive alliance—an interpersonal partnership between the client and therapist to

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achieve the client's goals (Bordin, 1979)—is one of the best predictors of outcome. Horvath, Del Re, Fluckinger, and Symonds (2011) examined 201 studies and found the correlation between the alliance and outcome to be r = .28, accounting for 7.5% of the overall variance and 36-50% of treatment. The amount of change attributable to the alliance, therefore, is about five (counting other studies) to seven times that of specific model or technique.

We all have clients who rapidly respond to us. But what about the folks who are mandated by the courts or protective services or who just plain don't want to be there (like almost all kids)? What about people who have never been in a good relationship or have been abused or traumatized? What about folks that life just never seems to give a break? Well, the therapist's job, our job, is exactly the same regardless. If we want anything good to happen, it all rests on a strong alliance —we have to engage the client in purposeful work. The research about what differentiates one therapist from another as well as my personal experience suggest that the ability to form alliances with people who are not easy to form alliances with—to engage people who don't want to be engaged—separates the best from the rest.

Model/Technique: General Effects (Explanation and Ritual), Client Expectancy (Hope, Placebo), and Therapist Allegiance

Model/technique factors are the beliefs and procedures unique to any given treatment. But these specific effects, the impact of the differences among treatments, are very small, only about 1% of the overall variance or 7% of that attributable to treatment. But the general effects of providing a treatment are far more potent. Models achieve their effects, in large part, if not completely through the activation of placebo, hope, and expectancy, combined with the therapist's belief in (allegiance to) the treatment administered. As long as a treatment makes sense to, is accepted by, and fosters the active engagement of the client, the particular approach used is unimportant.

Feedback Effects

Common factors research provides general guidance for enhancing those elements shown to be most influential to positive outcomes. The specifics, however, can only be derived from the client's response to what we deliver—the client's feedback regarding progress in therapy and the quality of the alliance. Although it sounds like hyperbole, identifying clients who are not benefiting is the single most important thing a therapist can do to improve outcomes. Combining Lambert's Outcome Questionnaire System (Lambert & Shimokawa, 2011) and our Partners for Change Outcome Management System (PCOMS; Duncan, 2012), nine RCTs now support this assertion. A recent meta-analysis of PCOMS studies (Lambert & Shimokawa, 2011) found that those in feedback group had 3.5 higher odds of experiencing reliable change and less than half the chance of experiencing deterioration. In addition, collecting outcome and alliance feedback from clients allows the systematic tracking of therapist development so that neither client benefit nor your growth over time is left to wishful thinking. Visit heartandsoulofchange.com for more information (The measures are free for individual use and available in 23 languages.). PCOMS is listed by the Substance Abuse and Mental Health Administration as an evidence based practice. It is different than what is usually considered evidence-based because feedback is a-theoretical and therefore additive to any therapeutic orientation and applies to clients of all diagnostic categories (Duncan, 2012).

An inspection of Figure 1 shows that feedback overlaps and affects all the factors—it is the tie that binds them together—allowing the other common factors to be delivered one client at a time. Soliciting systematic feedback is a living, ongoing process that engages clients in the collaborative monitoring of outcome, heightens hope for improvement, fits client preferences, maximizes therapist-client alliance potential and client participation, and is itself a core feature of therapeutic change.

I was recently asked (Kottler & Carlson, 2014) what is it that I do, and who I am that most made my work effective (assuming that it is). What I do that is the most important in contributing to my effectiveness is that I routinely measure outcome and the alliance via PCOMS—it boils down to identifying clients who aren't responding to my therapeutic business as usual and addressing the lack of progress in a positive, proactive way that keeps clients engaged while we collaboratively seek new directions.

That's what I do. But what I bring to the therapeutic endeavor is that I am a true believer. I believe in the client and his or her irrepressible ability to overcome adversity, I believe in the power of relationship and psychotherapy as a vehicle for change, and I believe in myself, my ability to be present, fully immersed in the client, and dedicated to making a difference. The odds for change when you combine a resourceful client, a strong alliance, and an authentic therapist who brings him/herself to the show, are worth betting on, certainly cause for hope, and responsible for my unswerving faith in psychotherapy as a healing endeavor.

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