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SO YOU WANT TO BE A BETTER THERAPIST

It's never too late to be who you might have been.

—George Eliot

A long time ago in a galaxy far way, I was in my initial placement in graduate school at the Dayton Mental Health and Developmental Center, the state hospital. While I often don't remember where I leave my glasses, I still vividly recall my first client, including her full name, but I'll call her "Tina." Tina was like a lot of the clients: young, poor, disenfranchised, heavily medicated, and in the revolving door of hospitalizations—and at the ripe old age of 22, she was called a *chronic schizophrenic*.

Although this practicum offered some group experience, it was largely devoted to assessment, and that's how I met Tina. I gathered up my Wechsler Adult Intelligence Scale—Revised, the first of the battery of tests I was attempting to gain competence with, and was on my merry but nervous way to the assessment office, a stark, run-down room in a long-past-its-prime, barrack-style building that reeked of cleaning fluids overused to cover up some other worse smell, the institutional stench. But on the way I couldn't help noticing all the looks I was getting—a smirk from an orderly, a wink from a nurse, and

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funny-looking smiles from nearly everyone else. My curiosity piqued, I was just about to ask what was going on when the chief psychologist put his hand on my shoulder and said, "Barry, you might want to leave the door open." And I did.

I greeted Tina, a young, extremely pale woman with brown cropped hair (who might have looked a bit like Mia Farrow in the *Rosemary's Baby* era had Tina lived in friendlier circumstances) and introduced myself in my most professional voice. Before I could sit down and open my test kit, Tina started to take off her clothes, mumbling something indiscernible. I just stared in disbelief, in total shock, really. Tina was undaunted by my dismay and quickly was down to her underwear when I finally broke my silence, hearing laughter in the distance, and said, "Tina, what are you doing?" Tina responded not with words but with actions, removing her bra like it had suddenly become very uncomfortable. So, there we were, a graduate student, speechless, in his first professional encounter, and a client sitting nearly naked, mumbling now quite loudly but still nothing I could understand, and contemplating whether to stand up to take her underwear off or simply continue her mission while sitting.

Finally, in desperation, I pleaded, "Tina, would you please do me a big favor? I mean, I would really appreciate it." She looked at me for the first time, looked me right in the eye, and said, "What?"

I replied, "I would really be grateful if you could put your clothes back on and help me get through this assessment. I've done them before, but never with a client, and I am kinda freaked out about it."

Tina whispered, "Sure," and put her clothes back on. And although Tina struggled with the testing and clearly was not enjoying herself, she completed it.

I was so genuinely appreciative of Tina's help that I told her she really pulled me through my first real assessment. She smiled proudly, and ultimately she smiled at me every time she saw me from then on. I wound up getting to know Tina pretty well and often reminded her of how she helped me, and I even told her that I thought she looked like Mia Farrow, to her immense enjoyment. The more I got to know Tina and realized that her actions, stemming from horrific abuse, were attempts to take control of situations in which she felt powerless, the angrier I became about her being used as a rite of passage for the psychology trainees—a practice that I subsequently put a stop to in that institution.

I'll never forget the lessons that Tina taught me in the very beginning of my psychotherapy journey: Authenticity matters, and when in doubt or in need of help, ask the client, because you are in this thing together. Wherever you are, Tina, thanks for charting my course toward the power of real partnerships with clients.

I am a true believer in psychotherapy and in therapists of all stripes and flavors. In the 34 years and over 17,000 hours of my experience with clients

since I saw Tina, I have been privileged to witness the irrepressible ability of human beings to transcend adversity—clients troubled by self-loathing and depression, battling alcohol or drugs, struggling with intolerable marriages, terrorized by inexplicable voices, oppressed by their children's problems, traumatized by past or current life circumstances, and tormented with unwanted thoughts and anxieties—with amazing regularity. As a trainer and consultant, I have rubbed elbows with thousands of psychotherapists across the globe, and the thing that strikes me most is their authentic desire to be helpful. Regardless of discipline, theoretical persuasion, or career level, they really care about people and strive to do good work. The odds for change when you combine a resourceful client and caring therapist are worth betting on, certainly cause for hope, and responsible for my unswerving faith in psychotherapy as a healing endeavor.

It's no secret, however, that this is a tough time to be a therapist. In public agencies, we're underpaid, overworked, and often held to unattainable productivity standards. We're subjected to a continual onslaught of paperwork and frequently face cutbacks and layoff threats. While some of us still thrive in private practice, most of us make far less than we did during the "golden age" of fee-for-service insurance reimbursement, and we endure oversight that challenges our patience. Furthermore, the nature of clinical work itself is sometimes frustrating, even anxiety provoking, exposing us to high levels of human suffering, stories that are at times tough to shake.

Adding insult to injury, the culture at large doesn't seem to admire therapists particularly, or understand what we do. This point is clear if you take a moment to think about popular portrayals of therapists, such as Dr. Marvin Monroe of *The Simpsons* or Jack Nicholson in *Anger Management* or Barbra Streisand in *Meet the Fockers*. Sure, good examples of competent clinicians exist, but they're far outweighed by those that cast us as self-indulgent crackpots endlessly mouthing psychobabble. Perhaps one sobering indication of how much we are valued is provided by the online salary database PayScale.com, which reveals that the two worst-paying master's degrees are in counseling and social work. It is amazing to think, in these hard economic times, that smart, creative individuals make the necessary sacrifices to attain advanced degrees only to earn far less money than those with comparable degrees in other fields. So, why *would* anybody choose to enter such a field?

To be sure, most of us didn't chose this work because we thought we'd acquire the lifestyles of the rich and famous—and we knew at the outset that devoting our lives to trying to assuage human misery wouldn't be a walk in the park. The fact of the matter is that the overwhelming majority of psychotherapists, as corny as it sounds, want to be helpful. Many of us, including me, even answered in graduate school applications "I want to help people" as the reason we chose to be therapists (see Figure 1.1). Often, some well-meaning

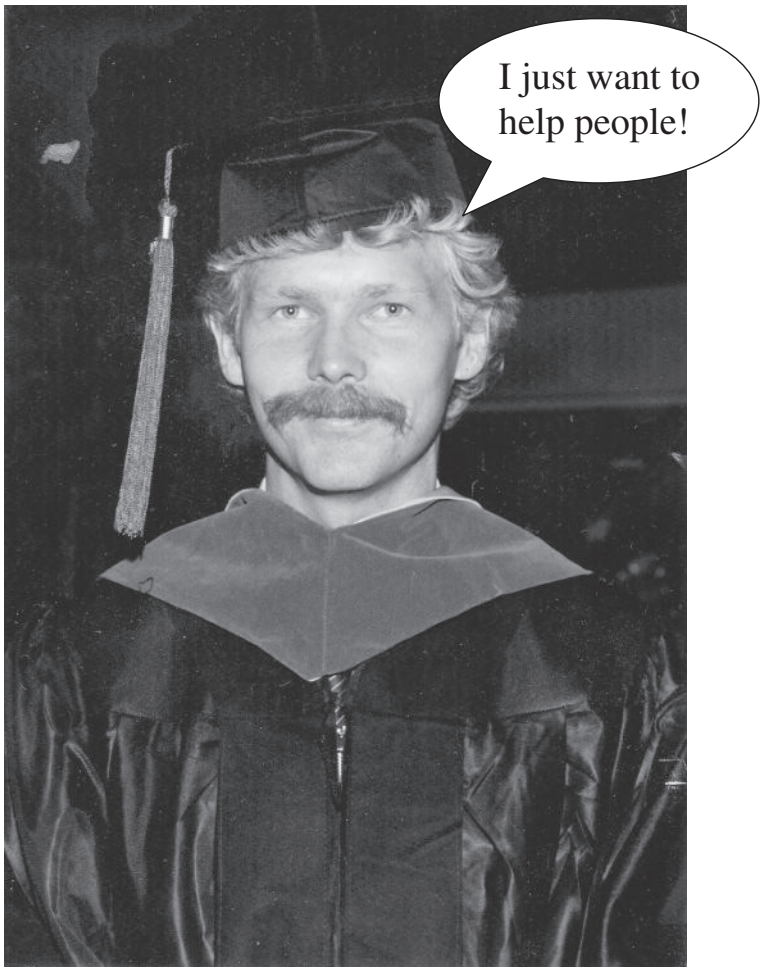

Figure 1.1. Barry just wanted to help people.

person dissuaded us from that answer because it didn't sound sophisticated or appeared too "co-dependent." Doing the required servitude without the promise of a rags-to-riches future only makes sense because being a psychotherapist is more of a calling than a job—a quest for meaningful activity and personal fulfillment (Orlinsky et al., 2005) and a desire to make a difference in the lives of those we serve.

But when the realities of everyday practice set in, answering the call to the work brings with it an immediate conundrum: We want to build on our original aspirations and get better over the course of our careers, but how do we make sense of the cacophony of "latest" developments, all the fully manualized

treatments hot off the press, each promising increased effectiveness with this or that disorder? Call me cynical, but the field doesn't seem to know what professional development means or how we can get better at therapy.

We are often told that developing ourselves as psychotherapists requires that we become more self-aware through personal therapy. This makes a lot of intuitive sense, and gaining an appreciation of what it is like to sit in the client's chair seems invaluable. But a look at probably the best source, *The Psychotherapist's Own Psychotherapy* (Geller, Norcross, & Orlinsky, 2005) reveals that the cold, hard truth is that although therapists rave about its benefits, personal therapy has nothing to do with outcome.

And although the need and value of training seem obvious, it has long been known that professional training and discipline are not related to positive outcomes (Beutler et al., 2004). A more recent study only confirmed this conclusion. Nyman, Nafziger, and Smith (2010) reported that, as strange as it seems, it didn't matter to outcome if the client was seen by a licensed doctoral-level counselor, a predoctoral intern, or a practicum student; all levels of training achieved about the same outcomes. As for continuing professional education, despite its requirement in nearly every state, there is no evidence that therapists learn anything from such experiences or that their participation translates to better outcomes (Neimeyer, Taylor, & Philip, 2009).

What about experience? Surely, years of clinical encounters make a difference. But are we getting better, or are we having the same year of experience over and over? How would we even know whether experience really improved our outcomes? More bad news here: Experience just doesn't seem to matter much (Beutler et al., 2004). Results are mixed at best, with recent studies suggesting no effects on outcome of experience (Hill & Knox, 2013). In large measure, generic experience does not improve outcomes—experienced and inexperienced therapists achieve about the same outcomes. (I revisit the issue of experience later in the chapter.)

Does this mean that we should forget the whole thing? No, not at all. But getting better is not about learning the latest and greatest miracle technique, or a never-before-available way to unravel the mysteries of the human psyche, or the most recent breakthrough in brain neurochemistry. There will be no husky voiceover here declaring a winner of the battle of the psychotherapy brands or adding yet another fashion to the therapy boutique of techniques. Most of you have already been there and done that. Rather, this book is about you—this time it's personal, from one therapist to another. Contrary to my cynical portrayal of the state of the field's efforts to help you get better, this book describes an evidence-based method that will both improve your outcomes and accelerate your development. *On Becoming a Better Therapist* intends to help you answer your calling and remember why you became a therapist in the first place.

This chapter sets the stage. I start with a broad look at the field of psychotherapy and its problems, and then I present an evidence-based solution that provides a seemingly contradictory way to become evidence based across all your clients while tailoring services to the individual client's needs, preferences, and culture—evidence-based practice one client at a time. Two other relevant topics are addressed: First, those aspects of the work that really matter in therapeutic change, the so-called, but not so common, *common factors*, and the apparently never-ending controversy surrounding evidence-based treatments and evidence-based practice.

THE GOOD, THE BAD, AND THE UGLY

> To exchange one orthodoxy for another is not necessarily an advance. The enemy is the gramophone mind, whether or not one agrees with the record that is being played at the moment.
>
> —George Orwell

The good news is that the efficacy of psychotherapy is very good—the average treated person is better off than about 80% of the untreated sample (Duncan, Miller, Wampold, & Hubble, 2010; Lambert, 2013), translating to an effect size (ES) of about 0.8.[1] Moreover, these substantial benefits extend from the laboratory to everyday practice. For example, a large (N = 5,613) real-world study in the U.K. (Stiles, Barkham, Mellor-Clark, & Connell, 2008) comparing cognitive behavioral therapy (CBT), psychodynamic therapy (PDT), and person-centered therapy (PCT) as routinely practiced reported a pre–post ES of around 1.30. Moreover, three benchmarking studies have demonstrated that observed results in not only managed care (Minami et al., 2008) and university counseling settings (Minami et al., 2009) are comparable to those in randomized clinical trials (RCTs), but also to those attained in a public behavioral health setting (Reese, Duncan, Bohanske, Owen, & Minami, 2014). In short, there is a lot to feel proud about our profession: We know that psychotherapy works, even in the trenches.

But there's more to the story. The bad news is twofold: First, dropouts are a significant problem in the delivery of mental health and substance abuse services, averaging at least 47% (Wierzbicki & Pekarik, 1993). When dropouts are considered, a hard rain falls on psychotherapy's efficacy parade, both

[1]*Effect size* (ES) refers to the magnitude of change attributable to treatment, compared with an untreated group. The ES most associated with psychotherapy is 0.8 standard deviations above the mean of the untreated group. An ES of 1.0 indicates that the mean of the treated group falls at approximately the 84th percentile of the untreated one. Consequently, the average treated person is better off than approximately 80% of those without the benefit of treatment.

in RCTs and in clinical settings. Second, despite the fact that general efficacy is consistently good, not everyone benefits. Hansen, Lambert, and Forman (2002), using a national database of 6,072 clients, reported a sobering picture of routine clinical care in which only 35% of clients improved as compared with the 57% to 67% rates typical of RCTs. Whichever rate is accepted as more representative of actual practice, the fact remains that a substantial portion of clients go home without help.

And the ugly: Explaining part of the volatile results, variability among therapists is the rule rather than the exception. Not surprising, although rarely discussed, some therapists are much better at securing positive results than others. Moreover, even very effective clinicians seem to be poor at identifying deteriorating clients. Hannan et al. (2005) compared therapist predictions of client deterioration to actuarial methods. Though therapists were aware of the study's purpose, familiar with the outcome measure used, and informed that the base rate was likely to be 8%, they did not identify 39 out of the 40 clients who deteriorated. In contrast, the actuarial method correctly predicted 36 of the 40.

So, despite the overall efficacy and effectiveness of psychotherapy, dropouts are a substantial problem, many clients do not benefit, and therapists vary significantly in effectiveness and are poor judges of client deterioration. Perhaps the ugliest of the ugly is that most of us don't know how effective we really are. Do you know how effective you are? With dropouts considered, how many of your clients leave your office absent of benefit? Which clients in your practice now are at risk for dropout or negative outcome?

What is the solution to these problems? Sometimes our altruistic desire to be helpful hoodwinks us into believing that if we are just smart enough or trained correctly, clients would not remain inured to our best efforts. If we found the Holy Grail, that special model or technique, we could once and for all defeat the psychic dragons that terrorize clients. We come by this belief honestly. We hear it all the time, constantly reinforced on nearly all fronts. The warring factions carry on the struggle for alpha dogma status in the psychotherapy pack and claims of "miracle cures better than the rest" continue unabated. The subtext is that if we don't avail ourselves of these approaches we are doing our clients a reprehensible disservice. But these admonitions leave out a vital fact: None of the heralded models have reliably demonstrated superiority to any other systematically applied psychotherapy.

This, of course, is the famous *dodo bird verdict* ("All have won and all must have prizes"), taken from the classic Lewis Carroll (1865/1962) tale, *Alice in Wonderland*, first invoked by Saul Rosenzweig way back in 1936 to illustrate the equivalence of outcome among approaches (see Duncan, 2010b). The dodo verdict is a much-replicated finding encompassing a broad array of research designs, problems, populations, and clinical settings. For

example, the study mentioned previously (Stiles et al., 2008), comparing CBT, PDT, and PCT as routinely practiced, once again found no differences among the approaches.

A more controversial illustration is provided by the treatments for the diagnosis du jour, posttraumatic stress disorder (PTSD). CBT has demonstrated its efficacy and is widely believed to be the treatment of choice, but several approaches with diverse rationales and methods have also been shown to be effective: eye-movement desensitization and reprocessing, cognitive therapy without exposure, hypnotherapy, psychodynamic therapy, and present-centered therapy (PRCT). A meta-analysis comparing these treatments found all of them about equally effective (Benish, Imel, & Wampold, 2007). Two of the treatments, cognitive therapy without exposure and PRCT, were designed to exclude any therapeutic actions that might involve exposure (clients were not allowed to discuss their traumas because that invoked imaginal exposure). Despite the presumed extraordinary benefits of exposure for PTSD, the two treatments without it, or in which it was incidental (psychodynamic), were just as effective (Benish et al., 2007).

Unfortunately, the mountain of evidence researchers have amassed has had little impact on the training of mental health or substance abuse clinicians or, sad to say, on professional attitudes. We spend thousands of dollars on workshops, conferences, and books to learn highly publicized methods of treatment. Instead of feeling hopeful or validated and experiencing the oft-promised better outcomes, we often wind up feeling demoralized. Why didn't the powerful sword slay the dragon of misery of the client in my office now? The answer all too often is to blame ourselves—we are just not measuring up. The Holy Grail seems just out of reach.

Don't get me wrong. There is nothing wrong with learning about models and techniques—in fact, it is a good thing, as I'll discuss throughout the book. You definitely want to bring the best to your client that the field has to offer, but becoming beholden to any approach is not a good idea, nor is believing that salvation will come from any of them. They are indeed false gods. Why?

First, given the robust findings supporting the dodo verdict, it is important to keep in mind that the much ballyhooed models have only shown themselves to be better than sham treatments or no treatment at all, or to less than equal opponents, which is not exactly news to write home to mom about. Think about it. What if one of your friends went out on a date with a new person, and when you asked about the guy, your friend replied, "He was better than nothing—he was unequivocally better than watching TV or washing my hair." (Or, if your friend was a researcher: "He was *significantly* better, at a 95% confidence level, than watching TV or washing my hair")? How impressed would you be?

And second, the idea that change primarily emanates from the model or techniques you wield is a siren call destined to smash you against the jagged rocks of ineffective therapy. That therapists might possess the psychological equivalent of a "pill" for emotional distress resonates strongly with many, and is nothing if not seductive, because it teases our desires to be helpful. A treatment for a specific "disorder," from this perspective, is like a silver bullet, potent and transferable from research setting to clinical practice. Any therapist need only to load the silver bullet into any psychotherapy revolver and shoot the psychic werewolf stalking the client. In its most unfortunate interpretation, clients are reduced to a diagnosis and therapists are defined by a treatment technology—both interchangeable and insignificant to the procedure at hand. This product or medical view of psychotherapy is most empirically vacuous because the treatment model itself accounts for so little of outcome variance, whereas the client and the therapist—and their partnership—account for so much more.

Fear is also a potent motivator for the ongoing search for the Holy Grail. Going well beyond subtext, we are told that not administering the "right" treatment is unethical (Chambless & Crits-Christoph, 2006) and even "prosecutable!" A *New York Times* article reported: "Using vague, unstandardized methods to assist troubled clients 'should be prosecutable' in some cases, said Dr. Marsha Linehan . . . " (Carey, 2005, p. 2). Given the lack of demonstrated superiority of dialectical behavior therapy (DBT) or any other approach and the relative contribution of model and technique to change (see below), such rhetoric seems a bit over the top.

Perhaps the most publicized study of DBT (Linehan et al., 2006) compared it with community experts (CE), examining suicidal behavior, emergency room and hospital admissions, and other variables. Results indicated that DBT led to significantly fewer suicide attempts and emergency room and hospital admissions, as well as reduced medical risk, but no differences were found with CE on the rest of the outcome measures: suicidal ideation, the Reasons for Living Inventory, and the Hamilton Rating Scale for Depression. DBT therapists received 45 hours of specialized training as well as weekly supervision and support; the CE therapists received none. Moreover, in addition to the individual treatment component of DBT, the DBT therapists administered 38 group therapy sessions of 2.5 hours' duration largely focused on keeping people out of the hospital, perhaps accounting for the reduced ER and hospital admissions. Although the study reports that the dose of treatment was comparable, an examination of the tables revealed that the 2.5-hour group sessions were counted only as 20 minutes of therapy, a somewhat curious way to record 95 hours of additional treatment. Given the unequal doses of treatment as well as the differential training and attention that the DBT therapists received, it is surprising that DBT didn't outperform CE on all measures.

In truth, we are easily smitten by the lure of flashy techniques and miracle cures. Amid explanations and remedies aplenty, therapists courageously continue the search for designer explanations and brand-name miracles—disconnected from the power for change that resides in the pairing of two unique persons, the application of strategies that resonate with both, and the impact of a quality partnership. Despite our herculean efforts to master the right approach, we continue to observe that clients drop out or, even worse, continue without benefit.

TO THE RESCUE: CLIENT FEEDBACK

> Great doubt: great awakening. Little doubt: little awakening. No doubt: no awakening.
>
> —Zen mantra

Dan Ariely (2008) tells a horrendous story of an explosion that left him with 70% of his body covered with third-degree burns. His treatment included a much-dreaded daily removal of his bandages. In the absence of skin, the bandages were attached to raw flesh and their removal was both harrowing to witness and excruciatingly painful. The nurses removed the bandages as fast as possible, quickly ripping them off one by one. Believing that a slower pace would be less painful, Ariely repeatedly asked the nurses to slow down the removal process. The nurses, however, asserted that finishing fast was the best approach, and continued to do so. This ordeal inspired Ariely to research the experience of pain as well as other phenomena. His investigation of pain demonstrated that a slow and less intense experience of pain over longer periods was far easier to tolerate than more intense pain over shorter time frames.

Consider this story and its relevance to psychotherapy. It is noteworthy that the nurses disregarded Ariely's response to their removal methods—his experience of his own pain did not hold much weight for them! But the nurses ignored his response as well as his pleadings to slow down not because they were evil or had any malevolent intentions—in fact, Ariely reports that he grew to love the nurses and believed that they loved him as well. Rather, the nurses assumed they knew more about his pain than he did and went full steam ahead for his own good! He also later learned that the nurses considered it easier *for them* to remove the dressings quickly. Clinical lore about the rapid removal of bandages, as well as what was convenient for the nurses, prevailed over Ariely's experience of his own pain.

When services are provided without intimate connection to those receiving them and to their responses and preferences, clients become

cardboard cutouts, the object of our professional deliberations and subject to our whims. Valuing clients as credible sources of their own experiences allows us to critically examine our assumptions and practices—to support what is working and challenge what is not—and allows clients to teach us how we can be the most effective with them.

A relatively new research paradigm called *patient-focused research* (Howard, Moras, Brill, Martinovich, & Lutz, 1996) rescues us from the problems noted above (the bad and ugly) as well as Ariely's unfortunate circumstance. Howard et al. (1996) advocated for the systematic evaluation of client response to treatment during the course of therapy and recommended that such information be used to "determine the appropriateness of the current treatment . . . [and] the need for further treatment . . . [and] prompt a clinical consultation for patients who [were] not progressing at expected rates" (Howard et al., 1996, p. 1063).

Although several systems have emerged that answer Howard's original call (for a review, see Castonguay, Barkham, Lutz, & McAleavey, 2013; Lambert, 2010), only two have demonstrated treatment gains in RCTs and gained evidence-based-practice designation. The pioneering work of Michael Lambert and colleagues stands out—not only for the development of measurement systems and predictive algorithms but also for their groundbreaking investigations of the effects of providing therapists feedback about client progress in treatment.

In a meta-analytic review of the Outcome Questionnaire 45.2 (OQ) system, Shimokawa, Lambert, and Smart (2010) reanalyzed the combined data set (N = 6,151) from all six of the OQ feedback studies that compared the OQ system with treatment as usual (TAU; Harmon et al., 2007; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Lambert et al., 2001, 2002; Slade, Lambert, Harmon, Smart, & Bailey, 2008; Whipple, Lambert, Vermeersch, Smart, Nielsen, & Hawkins, 2003).When the odds of deterioration and clinically significant improvement were compared, those in the feedback (OQ) group had less than half the odds of experiencing deterioration while having 2.6 times higher odds of attaining reliable improvement than the TAU group.

The other RCT-supported method of using continuous client feedback to improve outcomes is the one presented in this book, the Partners for Change Outcome Management System (PCOMS; Duncan, 2010a, 2012; Duncan, Miller, & Sparks, 2004; Duncan & Sparks, 2002). Much of this system's appeal rests on the brevity of the measures and therefore its feasibility for everyday use in the demanding schedules of frontline clinicians. The Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) are both four-item measures that track outcome and the therapeutic alliance, respectively. PCOMS was based on Lambert and colleagues' (1996)

continuous assessment model using the OQ, but there are differences beyond the measures. First, PCOMS is integrated into the ongoing psychotherapy process and includes a transparent discussion of the feedback with the client (Duncan & Sparks, 2002). Session-by-session interaction is focused by client feedback about the benefits or lack thereof of psychotherapy. Second, PCOMS assesses the therapeutic alliance every session and includes a discussion of any potential problems. Lambert's system includes alliance assessment only when there is a lack of progress.

Moreover, unlike most other outcome instruments, the ORS is not a list of symptoms or problems checked by clients or others on a Likert scale. Rather it is an instrument that evolves from a general framework of client distress to a specific representation of the client's idiosyncratic experience and reasons for service; the ORS is individualized for each client. It therefore requires collaboration with clients as well as clinical skill and nuance in its application; the therapist is intimately involved and inextricably linked to its success.

Six studies have demonstrated the benefits of client feedback with PCOMS. The first (Miller, Duncan, Brown, Sorrell, & Chalk, 2006) explored the impact of feedback in a large ($N = 6{,}424$) culturally diverse sample utilizing a telephonic employee assistant program (EAP). Although the study's quasi-experimental design qualifies the results, the use of feedback doubled overall effectiveness and significantly increased retention. Several RCTs conducted by those affiliated with my organization, the Heart and Soul of Change Project (hereafter the Project), used PCOMS to investigate the effects of feedback versus TAU. Norwegian therapist and researcher Morten Anker and other colleagues from the Project (Anker, Duncan, & Sparks, 2009) randomized couples seeking couple therapy ($N = 410$) at an outpatient clinic in Norway to PCOMS or TAU; therapists saw both PCOMS and TAU clients to control for therapist effects. This study, the largest RCT of couple therapy ever done, found that nearly 4 times more feedback couples than non-feedback couples reached clinically significant change, and over doubled the percentage of couples in which both individuals reached reliable and/or clinically significant change (50.5% vs. 22.6%). At 6-month follow-up, 47.6% of couples in the feedback condition reported reliable and/or significant change versus 18.8% in TAU. The feedback condition not only maintained its advantage at 6-month follow-up but also achieved a 46% lower separation/divorce rate. Feedback improved the outcomes of 9 of 10 therapists in this study. It is noteworthy that the therapists in this study were naïve to feedback; they had not used PCOMS in their work prior to the study and therefore were not "true believers."

University of Kentucky professor and Project Leader Jeff Reese and colleagues (Reese, Norsworthy, & Rowland, 2009) found significant treatment

gains for feedback when compared with TAU. This study was two small trials in one. Study 1 occurred at a university counseling center ($n = 74$) and Study 2 at a graduate training clinic ($n = 74$). Clients in the PCOMS condition in both studies showed significantly more reliable change versus TAU clients (80% vs. 54% in Study 1, 67% vs. 41% in Study 2). In addition, clients using PCOMS achieved reliable change in significantly fewer sessions than TAU. Reese, Toland, Slone, and Norsworthy (2010) replicated the Anker et al. (2009) study with couples and found nearly the same results. Finally, a meta-analysis of PCOMS studies (Lambert & Shimokawa, 2011) found that those in the feedback group had 3.5 higher odds of experiencing reliable change and less than half the odds of experiencing deterioration.

The applicability of PCOMS to other modalities and populations was recently demonstrated. Schuman, Slone, Reese, and Duncan (in press) conducted an RCT ($N = 263$) of group treatment of returning Iraq and Afghanistan veterans and active duty soldiers struggling with alcohol and drug problems that compared a minimal PCOMS intervention (only using the ORS) to TAU. Soldiers in the feedback condition achieved significantly more improvement on the ORS, higher rates of clinically significant change, and higher ratings of success by both clinicians and commanders, and they attended significantly more sessions compared to the TAU condition. Similarly, a recent RCT ($N = 85$) by Slone, Reese, Mathews-Duvall, and Kodet (2014) of group psychotherapy found that clients in the PCOMS condition achieved significantly higher gain on the ORS compared with TAU. Additionally, significantly more clients in the feedback condition experienced reliable (feedback: 31.8%; TAU: 17.0%) and clinically significant (feedback: 40.9%; TAU: 29.3%) change, attended significantly more sessions (feedback: 8.5 sessions; TAU: 6.0 sessions), and dropped out at a lower rate (feedback: 34%; TAU: 56%) than clients in the TAU condition.

Regarding children, using a cohort design comparing outcomes in the schools with 7-to-11-year-olds in Northern Ireland, University of Rhode Island professor and Project Leader Jacqueline Sparks and University of Strathclyde professor Mick Cooper and his team from the U.K. (Cooper, Stewart, Sparks, & Bunting, 2013) found that school-based counseling incorporating systematic feedback via PCOMS was associated with large reductions in psychological distress for children ($N = 288$). In addition, comparing caretaker and teacher ratings on the U.K. standardized measure, the Strength and Difficulties Questionnaire (SDQ) revealed an approximate twofold advantage in ES on the caretaker-completed SDQ when PCOMS was used and a small but significant advantage in effect on the teacher-completed SDQ.

These studies collectively support the effectiveness of PCOMS across various treatment sites, client populations, and therapeutic models, and they make a strong case for routine outcome management. Because of the

RCTs conducted by me and my colleagues from the Project, PCOMS is designated as an evidence-based practice by the Substance Abuse Mental Health Services Administration and listed in the National Registry of Evidence-based Programs and Practices. PCOMS, however, is not your average evidence-based practice: It is not a specific treatment model for a specific client diagnosis. First, it is a-theoretical and may be added to or integrated with any model of practice. PCOMS does not suggest how to understand client problems nor does it prescribe a treatment for them. Rather, it provides a vehicle to partner with clients around their views of benefit and the alliance, and the ability to identify when whatever chosen model is not helping. Second, PCOMS applies to all diagnostic categories. So, in effect, one size does fit all, allowing you to be evidence based across your clients in contrast to the ridiculous notion that you can learn an evidence-based approach for each of the seemingly ever-growing list of diagnoses. Finally, PCOMS is "evidence based" at two levels. It is evidence based by virtue of the RCTs that found significant benefits for both clients and therapists when feedback was part of the work, regardless of the theoretical orientations of the therapists or the diagnoses of the clients. More important, PCOMS is evidence based at the individual client–therapist level. Not just relying on the *past* evidence of efficacy in RCTs (e.g., Anker et al., 2009), or even past evidence of effectiveness in real clinical settings (e.g., Reese et al., 2014), PCOMS focuses you on the *present* evidence of effectiveness with the client in your office right now. In other words, it is *evidence-based practice one client at a time*.

PCOMS has the potential to significantly improve your outcomes, but it's not a miracle cure, nor does it explain human behavior. It also doesn't make you any smarter or better-looking or serve as a panacea for the complexity and difficulty of the psychotherapy process. It does, however, identify your clients who aren't responding to your therapeutic business as usual so that you can address the lack of progress in a positive, proactive way that keeps clients engaged while you collaboratively seek new directions. Think about this for a minute. Even if you are one of the la crème de la crème now (my looks at many data sets reveal that the best therapists are effective about two-thirds of the time), for every cycle of 10 clients you see, three will go home without benefit. Over the course of a year, this amounts to a lot of unhappy clients. You can recover a substantial portion of those folks who don't benefit by first identifying who they are, keeping them engaged, and tailoring your services accordingly.

That's it in a nutshell. PCOMS is your ticket to both better outcomes and to taking charge of your development. Knowing how effective you really are sets the stage for you to proactively get better at this work. Unfortunately, up to now, therapeutic outcomes have been hard to define and even harder to actually measure in everyday practice, leaving us to our own devices and

judgment—which aren't so good. Consider a study (Dew & Riemer, 2003) that asked 143 clinicians to rate their job performance from *A+* to *F.* Two thirds considered themselves *A* or better; not one therapist rated him- or herself as below average. More recently, Walfish, McAlister, O'Donnell, and Lambert (2012) surveyed practitioners and found that therapists likely inflate their effectiveness, reporting that 85% of their clients improve and seeing themselves as above average in effectiveness (90% saw themselves as above the 75th percentile). If you know anything about the Bell curve, you know this can't be true. We are not all above average—we are not from Lake Woebegon!

But of course it is not that we're naïve or stupid; it's simply hard, if not impossible, to accurately assess your effectiveness without some quantitative standard as a reference point; you need to measure outcomes. And the field has not been very useful to us in this regard. Until recently, measures of outcomes were only for researchers and totally impractical for everyday clinical use. But that has changed with PCOMS. Measuring outcomes allows you to cut through the ambiguity of therapy, using objective evidence from your practice to help you discern your clinical development without falling prey to that perennial bugaboo of the therapeutic endeavor: wishful thinking.

As this book details, measuring outcomes relates directly to both having an awareness about our development and doing something about it. PCOMS can help you survive—indeed thrive—in a profession that is under siege, yet still compelling; a profession that offers a lifetime training ground for human connection and growth, and frequently yields small victories that matter in the lives of those we see.

WHAT WORKS IN THERAPY: GUIDELINES FROM RESEARCH

> Whoever acquires knowledge and does not practice it resembles him [sic] who ploughs his land and leaves it unsown.
>
> —Sa'di, *Gulistan*

A story illustrates the sentiments that many practitioners feel about research. Two researchers were attending their annual conference. Although enjoying the proceedings, they decided to find some diversion to combat the tedium of sitting all day and absorbing vast amounts of information. They settled on a hot-air balloon ride and were quite enjoying themselves until a mysterious fog rolled in. Hopelessly lost, they drifted for hours until, finally, a clearing in the fog appeared and they saw a man standing in an open field. Joyfully, they yelled down at the man, "Where are we?" The man looked at them, and then down at the ground, before turning a full 360 degrees to survey his surroundings. Finally, after scratching his beard and what seemed to

be several moments of facial contortions reflecting deep concentration, the man looked up and said, "You are above my farm."

The first researcher looked at the second researcher and said, "That man is a researcher—he is a scientist!" To which the second researcher replied, "Are you crazy, man? He is a simple farmer!" "No," answered the first researcher emphatically, "that man is a researcher and there are three facts that support my assertion: First, what he said was absolutely 100% accurate; second, he systematically addressed our question through an examination of all of the empirical evidence at his disposal, and then carefully deliberated before delivering his conclusion; and finally, the third reason I know he is a researcher is that what he told us is absolutely useless to our predicament."

In this book, I strive to present only research that is useful to conducting psychotherapy, and the common factors, I believe, represent the best of what empirical investigation has to offer "our predicament."

The common factors—what works in therapy—have a storied history that started with Rosenzweig's (1936) classic article "Implicit Common Factors in Diverse Forms of Psychotherapy." In addition to the original invocation of the dodo bird and seminal explication of the common factors of change, Rosenzweig also provided the best explanation for the common factors, still used today: namely, that given that all approaches achieve roughly similar results, there must be pantheoretical factors accounting for the observed changes beyond the presumed differences among schools (Duncan, 2010b). Rosenzweig's four-page article is still well worth the read (and available at https://heartandsoulofchange.com).

If Rosenzweig penned the first notes of a common factors chorus, Jerome Frank (1961, 1973; Frank & Frank, 1991) composed an entire symphony. He advanced the idea that psychotherapy orientations (and other forms of healing) are equivalent in their effectiveness because of factors shared by all: (a) a healing setting; (b) a rationale, myth, or conceptual framework that provides an explanation for the client's complaint and a method for resolving it; (c) an emotionally charged, confiding relationship with a helping person; and (d) a ritual or procedure that requires involvement of both the healer and client to bring about "cure" or resolution. Frank's work is particularly helpful, as noted below, in understanding the role of model and technique as the vehicle for providing the other factors.

Several others have identified these elements found in all therapies, but Brigham Young University's Michael Lambert deserves special mention. After an extensive analysis of decades of outcome research, Lambert (1986, 2013) identified four factors—and their estimated percentages of outcome variance—as the principal elements accounting for improvement: client/life variables (40%); relationship factors (30%); hope, expectancy, and placebo (15%); and model/technique (15%). Although these factors are not derived

from a statistical analysis, he suggested that they embody what studies indicated about treatment outcome. Lambert's portrayal of the common factors bravely differentiated factors according to their relative contribution to outcome, opening a new vista of understanding models and their proportional importance to success—a bold challenge to the reverence many researchers and therapists feel toward their preferred models.

Inspired by Lambert's proposal and the integration movement, my colleagues and I (Duncan & Moynihan, 1994; Duncan, Solovey, & Rusk, 1992) proposed a "client directed" perspective to apply the common factors based on their differential impact on outcome. *Client directed* spoke to the influence of clients on outcome: their resources, strengths, and resiliencies, their view of the alliance, their ideas and theories of how they can be helped, and their hopes and expectations. The common factors, in other words, make the case that clients should direct the therapeutic process: Their views should be the privileged ones in the room. Intervention success was described as dependent on rallying client resources and as a tangible expression of the quality of the alliance. I have been attempting to operationalize the factors ever since (e.g., Duncan, 2010a, in press; Duncan et al., 2010; Sparks & Duncan, 2010). The common factors help us take a step back and get a big-picture view of what really works, suggesting that we spend our time in therapy commensurate to each element's differential impact on outcome.

Recent findings from meta-analytic studies (see below) point to the biggest omission of Lambert's portrayal of the common factors, namely, the profound impact of the therapist, and they paint a more complicated but satisfying representation of the different factors, their effects, and their relationship to each other. The "pie chart" view of the common factors incorrectly implies that the proportion of outcome attributable to each was static and could be added up to 100% of therapy effects. This suggested that the factors were discrete elements and could be distilled into a treatment model and that techniques could be created and then administered to the client. Any such formulaic application across clients, however, merely leads to the creation of another model. On this point, the jury has deliberated and the verdict has been rendered; model differences ultimately matter little in terms of outcome. In truth, the factors are interdependent, fluid, dynamic, and dependent on who the players are and what their interactions are like. Five factors comprise this meta-analytic perspective: client, therapist, alliance, model/technique (general and specific effects), and feedback.

Client/Life Factors

To understand the common factors, it is first necessary to separate the variance due to psychotherapy 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 (Asay & Lambert, 1999)—everything about the client that has nothing to do with us. Calculated from the often-reported 0.80 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 in Figure 1.2. The remaining 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. More conservative estimates put the client's contribution at 40% (Lambert, 2013). As examples, persistence, faith, a supportive grandmother, depression, membership in a religious community, divorce, a new job, a chance encounter with a stranger, a crisis successfully managed all may be included. Although they are hard to research because of their idiosyncratic nature, these elements are the most powerful of the common factors—the client is the engine of change (Bohart & Tallman, 2010).

In the absence of compelling evidence for any specific variables that cut across clients to predict outcome or account for the unexplained variance, this most potent source remains largely uncharted. Client factors cannot be generalized because they differ with each client. These unpredictable differences can only emerge one client at a time, one alliance at a time, one therapist at a time, and one treatment at a time.

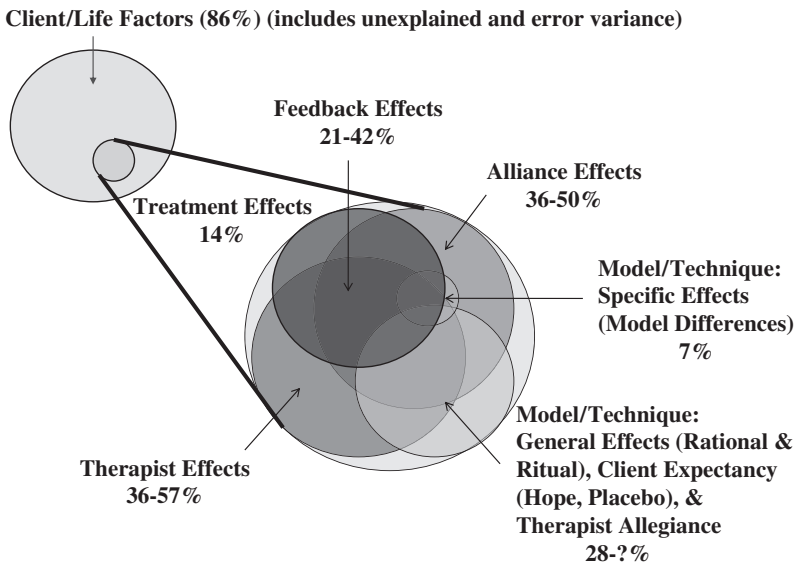

Figure 1.2. The Common Factors.

But we do know one thing for sure: If we don't recruit these idiosyncratic contributions to outcome in service of client goals, we are inclined to fail. Indeed, in a comprehensive review of 50 years of literature for the 5th edition of the *Handbook of Psychotherapy and Behavior Change*, Orlinsky, Rønnestad, and Willutzki (2004) observed that "the quality of the patient's participation . . . [emerges] as the *most* important determinant of outcome" (p. 324; emphasis added).

> ***Bottom Line:*** *Becoming a better therapist depends on rallying clients and their resources to the cause. PCOMS sets the context for client participation in the monitoring of therapy outcome and the alliance.*

Figure 1.2 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 treatment. Visually, the relationship among the common factors, as opposed to a static pie-chart depicting discreet elements adding to a total of 100%, is more accurately represented with a Venn diagram, using overlapping circles and shading to demonstrate mutual and interdependent action. The factors, in effect, act in concert and cannot be separated into disembodied parts (Duncan et al., 1992).

To exemplify the various factors and their attending portions of the variance, the tried- and-true Treatment of Depression Collaborative Research Program (TDCRP; Elkin et al., 1989) will be enlisted. The TDCRP randomly assigned 250 depressed participants to four different conditions: CBT, interpersonal therapy (IPT), antidepressants plus clinical management (IMI), and a pill placebo plus clinical management. The four conditions—including placebo—achieved about the same results, although both IPT and IMI surpassed placebo (but not the other treatments) on the recovery criterion (yet another example of the dodo verdict). Although the TDCRP is now over 20 years old, the data continue to be analyzed and remain relevant.

Therapist Effects

Therapist effects represent the amount of variance attributable not to the model wielded but rather to *who* the therapist is—it's no surprise that the participants in the therapeutic endeavor account for the lion's share of how change occurs. Depending on whether therapist variability is investigated in efficacy or effectiveness studies, a recent meta-analysis suggested that 5% to 7% of the overall variance is accounted for by therapist effects (Baldwin & Imel, 2013). This is a conservative finding, compared with earlier estimates that suggested that at least 8% of the variance is accounted for by

therapist factors, including the TDCRP (Kim, Wampold, & Bolt, 2006) and a recent investigation by my Project colleagues and me (Owen, Duncan, Reese, Anker, & Sparks, in press). Therefore, in Figure 1.2, a 5% to 8% range is depicted or 36% to 57% of the variance (the 14%) attributed to treatment.[2] The amount of variance, therefore, accounted for by therapist factors is about 5 to 8 times more than that of model differences. In many respects, you *are* the treatment. This is why attention to your development is important.

The psychiatrists in the TDCRP illustrate—the clients receiving sugar pills from the top third most effective psychiatrists did better than the clients taking antidepressants from the bottom third, least effective psychiatrists (Kim et al., 2006). *Who* was providing the medication or sugar pill was far more important than *what* the pill contained. 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 (Beutler et al., 2004), 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 two preliminary possibilities and one absolute certainty.

One possibility—and building on the Orlinsky et al. (2004) quote above—is what Gassmann and Grawe (2006) called *resource activation v. problem activation*. They conducted minute-by-minute analyses of 120 sessions involving 30 clients treated for a range of psychological problems. They found that unsuccessful therapists focused more on problems while neglecting client strengths. Successful therapists attended more to identifying client resources and channeling them toward achieving client goals.

Another possibility is experience, but not the generic kind that we are often told that will make us better. A criticism often leveled at research investigating therapist experience is that it is not operationally defined and that a more sophisticated look may yield more positive findings (Beutler et al., 2004). For example, Kraus, Castonguay, Boswell, Nordberg, and Hayes (2011) found that therapist competencies can be domain specific, as some therapists were better at treating certain "conditions." Specificity, therefore, in the definition of experience may be important. My colleagues and I put this to the test in our examination of therapist effects in the study mentioned above (Owen et al., in press). Similar to other studies, demographics were not significant, but specific experience in couple therapy explained 25% of the variance accounted for by therapists. So, experienced therapists

[2]The percentages are best viewed as a defensible way to understand outcome variance but not as representing any ultimate truths. They are meta-analytic estimates of what each of the factors contributes to change. Because of the overlap among the common factors, the percentages for the separate factors will not add to 100%.

can take some solace that getting older does have its advantages—as long as it is specific to the task at hand.

And the absolute certainty: The client's view of the alliance is not only a robust predictor of therapy outcomes, but also is the best avenue to understand therapist differences. Marcus et al. (2009) noted:

> High levels of consensus in client ratings of their therapist indicate that clients of the same therapist tend to agree about the traits or characteristics of their therapist, suggesting that there is something about the therapist's manner or behavior that evokes similar response from all of his or her clients. (p. 538)

Baldwin, Wampold, and Imel (2007) found only modest therapist variability (2%) compared with other studies but reported that therapist average alliance quality accounted for 97% of that variability. Our study of therapist differences found that therapist average alliance quality accounted for 50% of the variability in outcomes attributed to therapists (Owen et al., in press). In general, research indicates that clients seen by therapists with higher average alliance ratings have better outcomes (Crits-Christoph et al., 2009; Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010). There is really no mystery here. 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.

> ***Bottom Line:*** *Therapist differences loom large and may be related to the ability to mobilize client resources and participation and gain specific experience. More importantly, therapist variability is related to the ability to form strong alliances across clients. PCOMS by design engages clients in a partnership that increases participation and resource activation, while not leaving the alliance to chance.*

The Alliance

Researchers repeatedly find that a *positive alliance*—an interpersonal partnership between the client and therapist to achieve the client's goals (Bordin, 1979)—is one of the best predictors of outcome. Historically, the amount of variance attributed to the alliance has ranged from 5% to 7% of overall variance or from 36% to 50% of the variance accounted for by treatment (e.g., Horvath, & Bedi, 2002). More recently, Horvath, Del Re, Flückiger, and Symonds (2011) examined 201 studies and found the alliance to account for a slightly higher 7.5% of the variance. Putting this into perspective, the amount of change attributable to the alliance is about five to seven times that of specific model or technique. In addition, a recent meta-analytic longitudinal study examining the alliance outcome relationship found that it remained largely intact

regardless of the type of investigation or analyses used (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012).

Krupnick et al. (1996) analyzed data from the TDCRP and found that the alliance, from the client's perspective, was predictive of success for all conditions; the treatment model was not. Mean alliance scores explained 21% of the overall variance (Wampold, 2001). Keep in mind that treatment accounts for, on average, 14% of the variance (see Figure 1.2). The alliance in the TDCRP, therefore, explained more of the variance than typically attributed to treatment, illustrating how the percentages are not fixed and depend on the particular context of client, therapist, alliance, and treatment model.

Some have suggested that the relationship between alliance and outcome could be a consequence of how much clients are benefiting from therapy (e.g., Barber, 2009). However, several recent studies have confirmed that there appears to be little evidence that controlling for prior change substantially reduces the alliance–outcome correlation (Crits-Cristoph, Connolly Gibbons, & Mukherjee, 2013; Horvath et al., 2011). Similarly, my colleagues and I (Anker, Owen, Duncan, & Sparks, 2010) found that the alliance at the third session significantly predicted outcome over and above early reliable change. The fact that the alliance is predictive beyond early benefit suggests a more causal relationship.

> ***Bottom Line:*** *The alliance makes significant contributions to psychotherapy outcome and therefore should be actively monitored and tailored to the individual client.*

Model/Technique: Specific and 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 (Wampold, 2001), or 7% of that attributable to treatment. But the *general effects* of providing a treatment (an explanation of the problem and solution for it) that harness both client expectancy and therapist allegiance 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.

When a placebo or technically "inert" condition is offered in a manner that fosters positive expectations for improvement, it reliably produces effects almost as large as a bona fide treatment (Baskin, Tierney, Minami, & Wampold, 2003). (There is some controversy surrounding how potent this effect is, hence the question mark in Figure 1.2.) As long as a treatment makes sense to, is

accepted by, and enhances the active engagement of the client, the particular approach used is unimportant. Said another way, therapeutic techniques are placebo-delivery devices (Kirsch, 2005). Placebo factors are also fueled by a therapist belief that change occurs naturally and almost universally—the human organism, shaped by millennia of evolution and survival, tends to heal and to find a way, even out of the heart of darkness (Sparks & Duncan, 2010).

Allegiance and expectancy are two sides of the same coin—the belief by both the therapist and the client in the restorative power and credibility of the therapy's rationale and related rituals. The TDCRP is again instructive. First, across all conditions, client expectation of improvement predicted outcome (Sotsky et al., 1991). And second, an inspection of the Beck Depression Inventory scores of those who completed the study (see Elkin et al., 1989) reveals that the placebo plus clinical management condition accounted for nearly 93% of the average response to the active treatments (Duncan, 2010a).

To punctuate the point about the more powerful general effects, consider present centered therapy mentioned earlier as a treatment that works for PTSD (see Wampold, 2007, for a full description). Researchers testing the efficacy of CBT for PTSD wanted a comparison group that contained curative factors shared by all treatments (warm, empathic relationship) while excluding those believed unique to CBT (exposure). This control treatment, PRCT, contained no treatment rationale and no therapeutic actions. Moreover, to rule out any possibility of exposure, even covert in nature, clients were not allowed to talk about the traumatic events that had precipitated therapy. PRCT was, of course, found to be less effective than CBT—it was really a sham treatment without "active" ingredients. However, when later a manual containing a rationale and condition-specific treatment actions was added to facilitate standardization in training and delivery, few differences in efficacy were found between PRCT and CBT in the treatment of PTSD (McDonagh et al., 2005). In fact, significantly fewer clients dropped out of PRCT than CBT. Thus, when PRCT was made to resemble a bona fide treatment, that is, it added placebo, expectancy, and allegiance variables, it was not only as effective but also more acceptable than CBT.

The act of providing treatment is the vehicle that carries allegiance and placebo effects in addition to the specific effects of the given approach. It pays, therefore, to have several rationales and remedies at your disposal that you believe in, as well as believing in the client's ideas about change. Keep in mind that the selection of the tasks of therapy, that is, model and technique, is also a critical component of the alliance, hence the overlap between model and alliance depicted in Figure 1.2. Finally, it is important to note that, in suggesting that specific effects are small in comparison with general effects and that psychotherapy approaches achieve about the same results, I do not

mean that models and techniques are not important. On the contrary, while there is no differential efficacy on aggregate, there are approaches that are likely better or worse for the client in your office now and ones that better fit or match the client's view of what could be helpful. Once again, the TDCRP is helpful. Clients' perceptions of treatment match with their beliefs about the origin of their depression and what would be helpful (psychotherapy or medication) contributed to early engagement, continuation in therapy, and the development of a positive alliance (Elkin et al., 1999).

> ***Bottom Line:*** *The specifics of any approach are not as important as the cogency of the rationale and ritual to both the client and the therapist, and, most important, as the client's response to the delivered treatment.*

Feedback Effects

At first blush, feedback may seem like an odd addition to the list of factors that cut across all approaches. The process of attaining formal client feedback and using that input to tailor services, however, seems a worthy addition for several reasons. First, the effects of feedback seem largely independent of the measures used. Second, systematic feedback improves outcome regardless of the specific process used, whether in collaboration with clients (although collaboration tends to yield better results) or merely giving the feedback to therapists—over the phone or face-to-face, paper-and-pencil administrations versus electronic formats, matters not. Third, feedback increases client benefit across professional discipline, clinical setting, client population, as well as beginning or experienced therapists. Fourth, feedback significantly improves outcome regardless of the model practiced—the feedback process does not dictate what technique is used but, rather, is a vehicle to modify any delivered treatment for client benefit. Fifth, attaining informal client feedback about progress and the alliance is common practice among psychotherapists. Any approach that openly discusses the outcome of services or checks in about the relationship is incorporating informal client feedback into the therapeutic mix. Feedback speaks to an interpersonal process of give-and-take between the clinician and client and, at least to some extent, can be argued to be characteristic of many therapeutic encounters. Finally, the evidence regarding feedback continues to build. Feedback, then, similar to the concept of the alliance (see Gaston, 1990), was initially viewed as an important aspect of conducting effective psychotherapy and is garnering a growing evidence base that supports a more formal understanding and systematic inclusion.

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. An inspection of Figure 1.2 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 alliance quality and client participation, and is itself a core feature of therapeutic change. Feedback embodies the lessons I learned from Tina, providing for a transparent interpersonal process that solicits the client's help in ensuring a positive outcome.

Bottom Line: *Given its broad applicability, lack of theoretical baggage, and independence from any specific instrument, feedback can be understood as a factor that demonstrably contributes to outcome regardless of the model predilection of the clinician.*

EVIDENCE-BASED TREATMENTS AND EVIDENCE-BASED PRACTICE

> Seek facts and classify them and you will be the workmen of science. Conceive or accept theories and you will be their politicians.
>
> —Nicholas Maurice Arthus, *De l'Anaphylaxie à l'immunité*

All approaches have valid explanations and solutions for the problems that clients bring us. It only makes good clinical sense to expand our model/technique horizons and learn multiple ways to serve client goals. Similarly, it also makes good clinical sense to be evidence based in our work. In truth, no one says, "Evidence, schmevidence! It means nothing to my work—I fly by the seat of my pants, meander willy-nilly through sessions, and rely totally on the wisdom of the stars to show the way." Saying you don't believe in the almighty evidence is tantamount to not believing in Mom or apple pie, or whatever your sacrosanct cultural icons happen to be. So what is the controversy about?

On the heels of the American Psychiatric Association's development of practice guidelines in 1993, to ensure their continued viability in the market, psychologists rushed to offer magic bullets to counter psychiatry's magic pills—to establish empirically supported treatments or what is now more typically called *evidence-based treatments* (EBTs). With all good intentions, a task force of Division 12 (Society of Clinical Psychology; Task Force on Promotion and Dissemination of Psychological Procedures, 1995) reviewed the available research and cataloged treatments of choice for specific diagnoses based on their demonstrated efficacy in RCTs. On the one hand, the Division 12 task force effectively increased recognition of the efficacy of psychological intervention among the public, policy makers, and training programs; on the other

hand, it simultaneously promulgated gross misinterpretations—such as the idea that EBTs have proven their superiority over other approaches and, therefore, should be mandated and/or exclusively reimbursed. Unfortunately many people, including many state government funders, to paraphrase Orwell, now believe that some therapies are more equal than others.

The notion, however, that any approach is reliably better than another and should be exclusively practiced or funded is indefensible in light of the evidence that supports the dodo verdict, as well as the relative influence of factors other than model and technique. Efficacy over placebo, sham, or no treatment does not mean efficacy over other approaches. In the minority of studies that claim superiority over TAU or another approach, you need only to ask one question of the investigation (see Duncan & Reese, 2012, for a full discussion): Is it a fair contest? Is the study a comparison of two valid approaches that are intended to be therapeutic, administered in equal amounts by therapists who equally believe in what they are doing and are equally supported to do it? Recall the DBT example: Are the therapists from the same pool with equal caseloads or is the experimental group special—selected, trained, and supervised by the researcher/founder of the approach and with reduced caseloads? I have never seen a purported advantage of any approach over another (or TAU) that wasn't a lopsided contest that had its winner predetermined.

In the face of growing criticism, 2005 American Psychological Association (APA) President Ronald Levant appointed the APA Presidential Task Force on Evidence-Based Practice (hereafter Task Force). The Task Force defined *evidenced-based practice* (EBP) as: "the integration of the best available research with clinical expertise in the context of patient [*sic*] characteristics, culture, and preferences" (American Psychological Association [APA]Task Force, 2006, p. 273). This definition transcends the "demonstrated efficacy in two RCTs" mentality of EBTs and makes common clinical sense.

In fact, the Task Force's EBP definition emphasizes the major themes of this book: The first part, "the integration of the best available research," includes the consideration of EBTs without privileging them, as well as the wide range of findings regarding the alliance and other common factors. Next, "with clinical expertise," in contrast to the EBT mentality of the therapist as an interchangeable part, brings you back into the equation—your interpersonal skill plus everything about you attained through education, training, and experience—highlighting what therapists bring is consistent with the growing research about the importance of clinician variability to outcome. This part of the EBP definition supports attention to your development. Moreover, the Task Force submitted:

> Clinical expertise also entails the monitoring of patient progress (and of changes in the patient's circumstances—e.g., job loss, major illness) that may suggest the need to adjust the treatment (Lambert, Bergin, &

> Garfield, 2004). If progress is not proceeding adequately, the psychologist alters or addresses problematic aspects of the treatment (e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment) as appropriate. (APA Task Force, 2006, p. 276–277)

So, attaining feedback, as described in this book, on yet another level is an EBP.

Next, "in the context of patient characteristics, culture, and preferences" rightfully emphasizes what the client brings to the therapeutic stage, as well as the acceptability of any intervention to the client's expectations and how well any model or technique resonates. In short, EBP now accommodates the common factors, reinforces the importance of your development of clinical expertise, and includes client feedback as a necessary component.

The two approaches, EBT and EBP, take radically different stances about defining and disseminating evidence. One seeks to improve clinical practice via the dissemination of treatments meeting a minimum standard of empirical support (EBT), and the other describes a process of research application to practice that includes clinical judgment and client preferences (EBP; see Littell, 2010, for a full discussion of the two approaches). In essence an EBT approach, as characterized by Division 12, depicts confidence in the available evidence and appeals to those who believe that more structure and consistency and less clinician judgment is needed to bring about positive outcomes. On the other hand, EBP reflects the understanding that scientific evidence is tentative and that outcome is dependent not only on applying the various types of empirical research but also on the participants. EBP appeals to those who value clinician autonomy and individualized treatment decisions based on unique presentations of clients. The APA Task Force on EBP exemplifies this approach to the evidence.

Finally, the Task Force (2006) said:

> The application of research evidence to a given patient always involves probabilistic inferences. Therefore, ongoing monitoring of patient progress and adjustment of treatment as needed are essential. (Task Force, p. 280)

Proponents from both sides of the EBT-versus-EBP aisle recognized that outcome is not guaranteed regardless of evidentiary support of a given technique or the expertise of the therapist. The APA definition, as does this book, supports an identity of plurality, essential attention to client preferences, a focus on therapist expertise, and the importance of feedback.

Bottom Line: *APA's definition brings clinical common sense to the controversy. There is nothing wrong with EBTs. But the evidence doesn't justify mandates, exclusive reimbursement, or dictates about the way to address client problems. The only way to know what the "right" treatment is to measure the client's response to any delivered treatment—to conduct EBP one client at a time.*

ABOUT THIS BOOK

> Feedback is the breakfast of champions.
>
> —Ken Blanchard and Spencer Johnson, *The One-Minute Manager*

On Becoming a Better Therapist intends to help you remember your original aspirations, continue to develop as a therapist, and achieve better outcomes more often with more clients. It draws on the experiences of the two most important people to psychotherapy outcome: the client and you: Client perspectives about the benefit and the alliance and your perceptions of your professional growth. Regardless of your approach, this book will help you continue what you are doing well while expanding your influence to those clients who do not respond to your usual efforts. Through a transparent process of attaining client feedback, you'll learn ways to deepen the therapeutic conversation, intensify the power of a collaborative alliance, and more effectively recruit clients' resources in the service of change. In short, you'll accelerate your development and learn how to become a better therapist—one client at a time.

Psychotherapy is not an uninhabited landscape of technical procedures. It is not the sterile, stepwise process of surgery, nor does it follow the predictable path of diagnosis, prescription, and cure. It cannot be described without the client and therapist, co-adventurers in a journey across what is largely uncharted territory. The common factors provide useful landmarks for this intensely interpersonal and idiosyncratic trip, and specific models and techniques provide well-traveled routes to consider, but feedback offers a necessary compass to provide bearings of the psychotherapy terrain and guidance to the desired destination.

This book has nine chapters. Chapter 2, "Becoming a Better Therapist With PCOMS," shows you how to get started using PCOMS to help clients help you do good work—not sometime, next month, or even next week, but with your next client. It begins with a discussion of the measures and then covers the first-session pragmatics, detailing all you need to know to start becoming a better therapist. Chapter 3, "How Being Bad Can Make You Better," describes how recapturing the clients who are not benefiting will make the difference between being an average therapist or a better one. Rather than only learning from failed cases, this chapter details how to turn them around before a negative outcome ensues. Chapter 4, "Getting Better With Couples, Families, and Youth," reviews the lessons from the five published couple studies that arose from the Norway Feedback Trial and details the clinical process of using PCOMS with youth, couples, and families. "Using PCOMS to Accelerate Your Development" is the topic of Chapter 5. Integrating the groundbreaking work of Orlinsky and Rønnestad (2005) regarding therapist

development, Chapter 5 shows you how to take charge of your professional growth and ensure that you learn from your experience rather than repeat it. Building on Chapter 5's framework to track your development and outcomes, Chapter 6, "The Heart and Soul of Change," delineates strategies to improve your effectiveness based on the most potent common factors—the client and the therapeutic alliance. Chapter 7, "Wizards, Humbugs, or Witches," encourages you to reflect about your identity as a therapist and what it is that you do—to create a description of your work that you can believe in and that provides clinical flexibility. Next, Chapter 8 broadens the focus. "Becoming a Better Agency" addresses implementation of PCOMS in public behavioral health (PBH) and other organizations, detailing what it takes for success. In addition, Chapter 8 presents the results of our benchmarking study of a large PBH agency in Arizona. Contrary to earlier dire accounts of PBH effectiveness, this agency achieved outcomes comparable to benchmarks from RCTs of depression and feedback. How? This agency implemented PCOMS.

Each of the first eight chapters concludes with a story that documents key lessons that clients have taught me over my career—meaningful moments that reminded me of why I made the choice to become a therapist. These examples are not intended to depict everyday therapeutic encounters but, rather, the ones that made the most dramatic impact on my identity as a psychotherapist. Finally, Chapter 9, "For the Love of the Work," continues the focus on your development, exploring ways for continued reflection about the work you love. It concludes with my parting thoughts about the controversial issues of the day as they pertain to our identity as therapists, as well as what I think it takes to become a "master" therapist.

CLIENTS ARE THE BEST TEACHERS: THEIR STORIES DOCUMENT OUR DEVELOPMENT

> At bottom every man [*sic*] knows well enough that he is a unique being, only once on this earth; and by no extraordinary chance will such a marvelously picturesque piece of diversity in unity as he is, ever be put together a second time.
>
> —Friedrich Nietzsche

When I was an intern, I worked in an outpatient unit euphemistically called Specialized Adult Services (SAS). While it included a stress management program, SAS was really an aftercare facility devoted to working with clients labeled *severely mentally ill*. By that time, I had acquired experiences in two community mental health centers and an assessment stint in the state hospital. But the hospital experience lingered, leaving me with

a bad taste in my mouth. I saw firsthand the facial grimaces and tongue wagging that characterize the neurological damage caused by antipsychotics and sadly realized that these young adults would be forever branded as grotesquely different, as "mental patients." I witnessed the dehumanization of people reduced to drooling, shuffling zombies, spoken to like children and treated like cattle. I barely kept my head above water as hopelessness flooded the halls of the hospital, drowning staff and clients alike in an ocean of lost causes. I could not even imagine what it would have been like to live there in the revolving-door fashion that many endured. Now, in my internship, my charge was to help people stay out of the hospital, and I took that charge quite seriously.

One of my first clients was Peter. Peter was not well liked at SAS. He sometimes said ominous things to other clients in the waiting room, or spoke in a boisterous way about how the fluorescent lights controlled his thinking through a hole in his head. When he wasn't speaking, he grunted and squealed and made other sounds like a pig. As a new intern, I was put under considerable pressure to address Peter's less-than-endearing behaviors, particularly because he sometimes offended the stress management clients, who were seen as coveted treasures not to be messed with. Actually, I found Peter to be a terrific guy with a very dry sense of humor, but a man of little hope who lived in constant dread of returning to the state hospital. His behaviors were mostly his efforts to distract himself from tormenting voices that told him people were trying to kill him and other scary things.

Peter would be routinely terrorized by these voices until he started taking actions that led him to ultimately wind up in the state hospital. He might empty his refrigerator for fear that someone had poisoned his food, creating a stench that would soon bring in the landlord and ultimately the authorities. Or, occasionally, he would start threatening or menacing others, those he believed were trying to kill him. Once he was hospitalized, his medications were changed, usually increased in dose, and he essentially slept out the crisis. These cycles occurred about every 4 to 6 months and had done so for the previous 8 years. Peter's treatment brought with it tardive dyskinesia and about a hundred pounds of extra weight.

Peter hated the state hospital, and I could truly commiserate, after my own less-than-inspiring experience there. I felt profoundly sad for this young man, who was about my age. I also felt completely helpless. Nothing in my training provided any guidance. I had no clue about what to do to be helpful to him. I was trying to apply strategies I had learned from my supervisor about addressing the voices, which were helpful to others but not with Peter. I knew he was ramping up for another admission—he told

me that he had already emptied his refrigerator and left the contents on the kitchen floor. It seemed that nothing I said could convince Peter to get off the merry-go-round to the state hospital. The anguish in his eyes about his impending hospitalization haunted me.

Only because I had no clue about what to do, I asked Peter what he thought it would take to get a little relief from his situation—what might give him just a glimpse of a break from the torment of the voices and the revolving-door hospitalizations. After a long pause, Peter said something very curious: He said that it would help if he would start riding his bike again. This led to my inquiry about the word "again." Peter told me about what his life was like before the bottom fell out. Peter had been a competitive cyclist in college and was physically fit as only world class cyclists can be. I heard the story of a young man away from home for the first time, overwhelmed by life, training day and night to keep his spot on the racing team, and topped off by falling in love for the first time. When the relationship ended, it was too much for Peter, and he was hospitalized, and then hospitalized again, then hospitalized again, and so on until there was no more money or insurance—then the state hospitalization cycles ensued.

On a roll now and enjoying a level of conversation not achieved before, I asked Peter what it would take to get him going again on his bike. He said that his bike was in need of parts and what he needed was for me to accompany him to the bike shop. Peter was afraid to go out in public alone for fear of threatening someone and ending up in the hospital. I immediately consulted with my supervisor, who gave me an enthusiastic green light. The next day, I went with Peter to the bike shop, where I bought a bike as well. Peter and I started having our sessions biking together. Peter still struggled with the voices at times, but he stayed out of the hospital and they never kept him from biking. He eventually joined a bike club and moved into an unsupervised living arrangement.

You can read a lot of books about "schizophrenia" and its treatment, but you'll never find one that recommends biking as a cure. And you can read a lot of books about treatments in general, and you'll never read a better idea about a client dilemma than will emerge from a client in conversation with you—a person who cares and wants to be helpful.