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The Therapist Matters in Psychotherapy Outcomes

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The Cairnmillar Institute acknowledges the Traditional Owners of the land on which we are meeting.

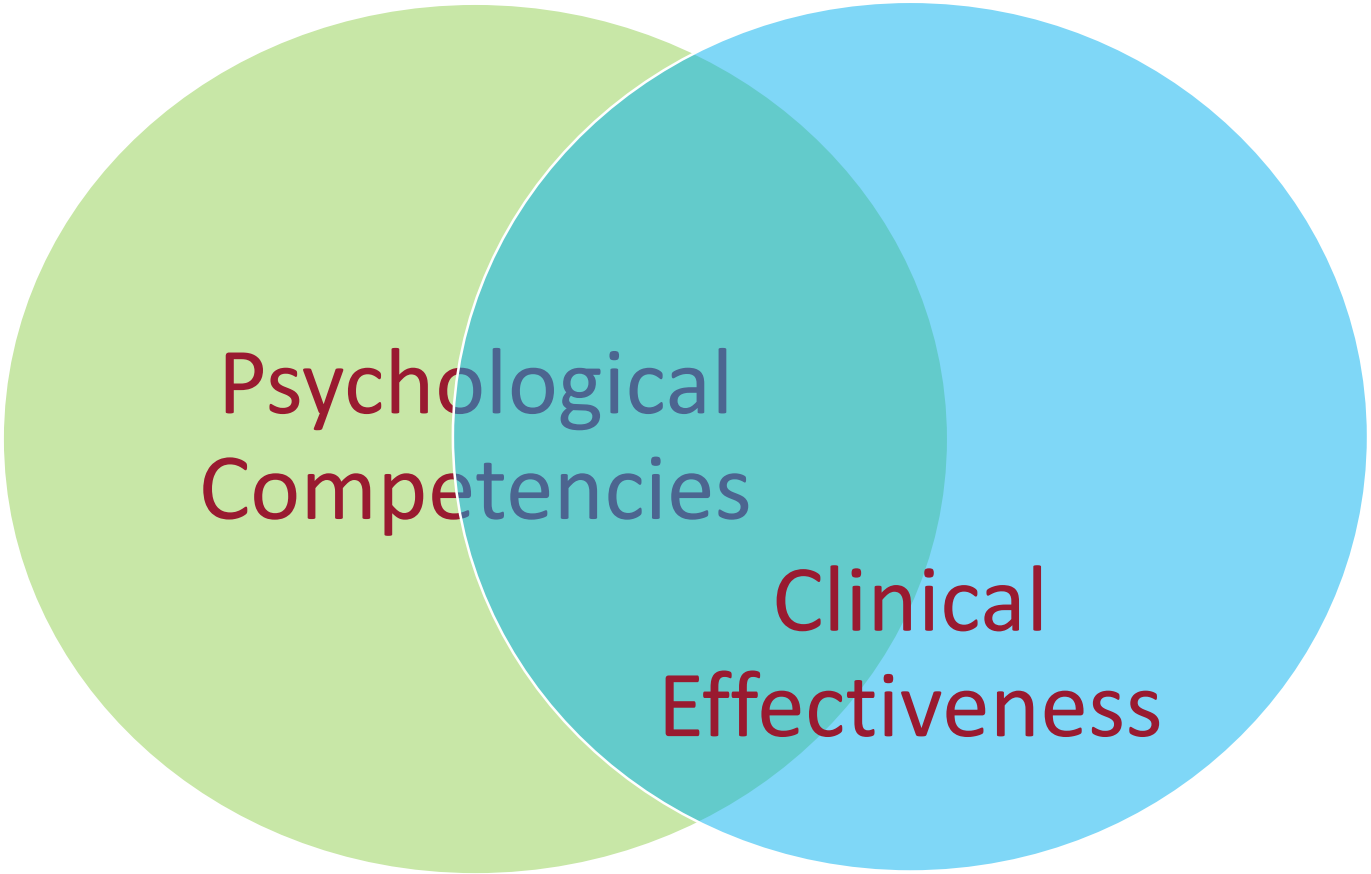
We pay our respects to their Elders, past and present, and the Aboriginal Elders of other communities who may be here today.

Clinical Effectiveness and Competencies

The interlacing between competencies and therapist effectiveness is a vexed one – We may be competent, and act within the norms of the profession, but not be that effective

Miller, Madsen and Hubble (2018) stated that there is an argument to be made that effectiveness needs to be the foundation of any formulation and assessment of competence. Such an approach moves the notion of competence away from a state achieved to an active, dynamic process of **continuous achieving** by the psychologist.

Interrelated but not Equivalent



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The Dodo Bird Effect in Psychotherapy Research

Over the years energy and lots of money has gone into delivering psychotherapy in a manner designed to parallel the delivery of medical services

Psychotherapy research however highlights the **Dodo bird effect** (Rosenweig, 1936).

> “At last the Dodo bird said, ‘Everyone has won and all must have prizes’”.

This has given rise to alternatives to the use of the Medical Model in Psychotherapy research

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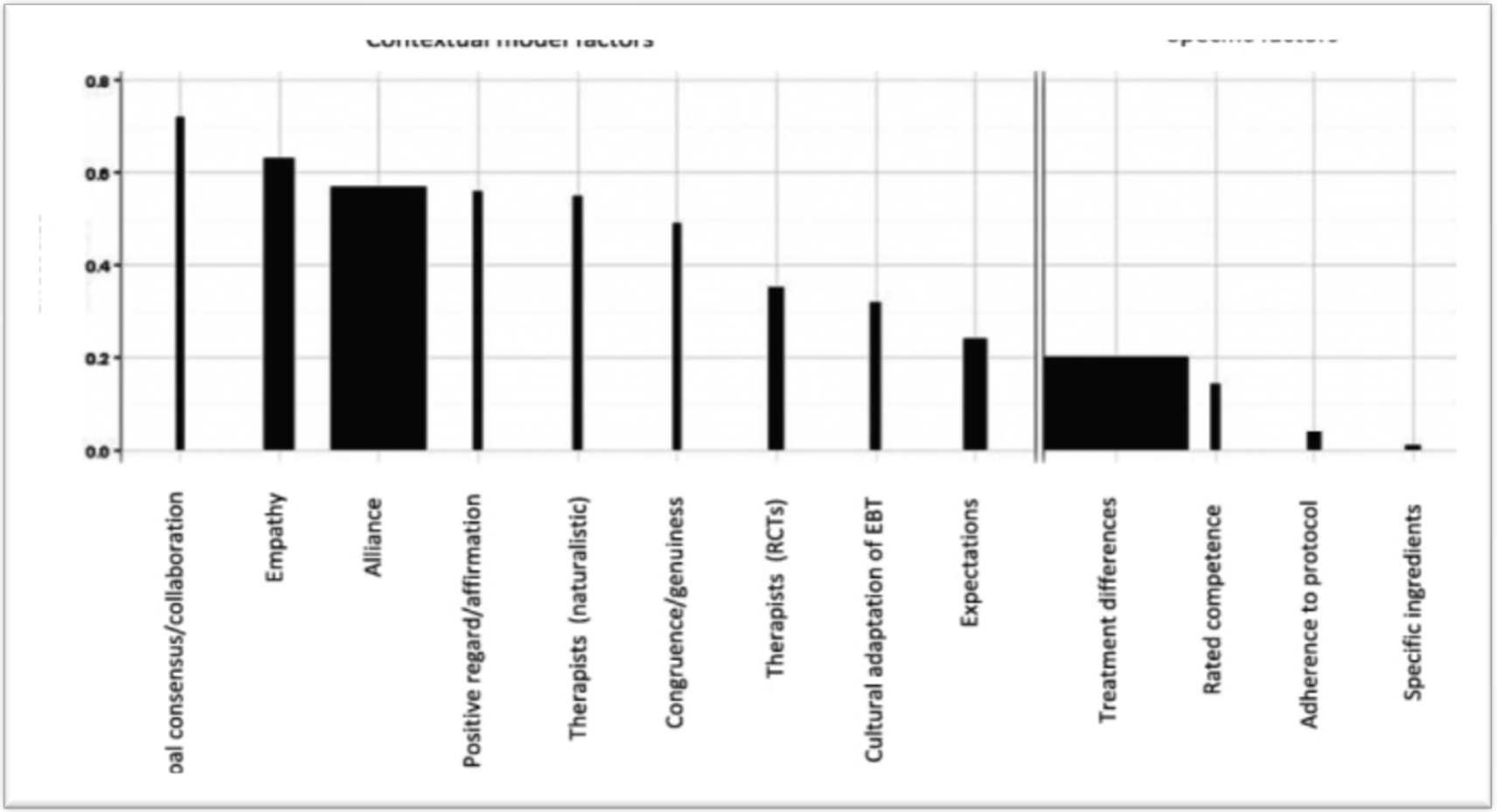
The value of the contextual model

‘The contextual model provides an alternative explanation for the benefits of psychotherapy to ones that emphasise specific ingredients that are purportedly beneficial for particular disorders due to remediation of an identifiable deficit.’ (Wampold, 2015)

The model posits three pathways when an initial therapeutic relationship is established that leads to psychotherapeutic benefits: The pathways are:

1) A real relationship between the therapist and the patient
2) The creation of expectations through an explanation of the disorder and the treatment involved
3) The enactment of health promoting actions or specific ingredients that will remediate the patients difficulties

The Common Factors in Change (Wampold, 2015)



Effect sizes for common factors of the contextual model and specific factors. Width of bars is proportional to number of studies on which effect is based. RCTs – randomized controlled trials, EBT – evidence-based treatments

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Medical Model vs Contextual Model – Reconsidering Treatment Effectiveness

(Wompald and Imel, 2015)

Medical Model		Contextual Model
Psychological treatment (PT) more effective than no treatment	Absolute Efficacy	Psychological treatment (PT) more effective than no treatment
Variability in efficacy of treatments (i.e. some treatments more effective than others). PTxA is more effective than PTxB for a particular disorder	Relative Efficacy	Homogeneity of treatment effects: All treatments **intended to be therapeutic** will be equally effective
Psychologist effects are small, particularly when providing an evidence-based treatment and adhering to the model	Therapist Effects	Psychologist effects will be relatively large, especially in comparison to effects of specific ingredients Psychologist differences will be due to relationship factors
Relationship factors not critical to outcomes	General Effects	The alliance is associated with outcomes Other r/ship factors associated with outcomes Expectations are important to outcomes Researcher allegiance and psychologist allegiance will be related to outcomes Cultural adaptations will increase effectiveness
Removing or adding specific ingredients will effect efficacy and adherence and specific competence is related to outcomes	Specific Effects	Removing or adding specific ingredients will not effect efficacy and adherence and specific competence is not related to outcomes

A Classic Study into Efficacy of Psychotherapy

- The NIMH funded Treatment of Depression Collaborative Research Project (TDCRP) is one of the largest studies of the treatment of depression conducted (Elkin, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Leber, & Doherty, 1989).
- The study evaluated outcomes for Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT), Anti-depressant Therapy, and Placebo.
- 40+ articles published in peer reviewed journals

Initial Findings -TDCRP

- Cognitive/behavioral Therapy (CBT) and Interpersonal therapy (IPT) were found to produce comparable benefits for depressed patients
- Imipramine found to be superior to placebo
- Tendency for IPT to be superior for the treatment of patients with more severe depression.

However, the within-group variance was greater than the between-group variance and most articles published failed to account for the single largest source of variance … the therapist

Reanalysis –where the therapist was a variable in treatment efficacy

- No difference between CBT and IPT for severe depression

  0% of variance due to treatment method; 8% was due to clinicians

  Kim DM, Wampold BE, Bolt DM (2006)

- Reanalysis of placebo - imipramine comparison included the 9 psychiatrists as a variable

  3.4% of variance due to medication; 9.1% was due to the psychiatrist treating

  Top third of psychiatrists had a better outcome with placebo than the bottom third who used the ‘active’ ingredient imipramine

  McKay, K. M., Imel, Z. E., & Wampold, B. E. (2006).

The Good News
Psychological Treatments Work

- In most studies of psychological treatments conducted over the last 30+ years the average treated person is better off than 80% of those without the benefit of treatment

Note: this is a summary snapshot – research into absolute efficacy is quite complicated).

- The average therapist achieves outcomes on a par with success rates obtained in RCTs (with or without patient co-morbidity) – effectiveness matches efficacy

See Duncan B, Miller S, Wampold B, Hubble M (eds) (2009); Minami T, Wampold B, Serlin R, Hamilton E, Brown G , Kircher J (2008)

But hang on - not by everyone and for everyone!

- The average therapists achieves reliable clinical improvement (RCI) with 50% of patients – don't be depressed this is a good result.
- However the best therapists achieve around 70% clinical improvement
- 10% of patients deteriorate through treatment and 47% drop out before achieving a positive RCI. Sadly, we are not very good at identifying these cases.

Harmon, S.J., Lambert, M.J., Smart, D.M., Hawkins, E., Nielsen, S.L., Slade, K., Lutz, W., (2007); Lambert, M.J., Whipple, J., Hawkins, E., Vermeersch, D., Nielsen, S., & Smart, D. (2004).

And the troubling news
We often think we are doing good!

- In a survey in the USA 50% of therapists polled considered that they achieved success with 80% of their clients
- 90% of therapists thought that none of their clients ever deteriorated from seeing them

Walfish S, McAllister B, Lambert M.J, (2012)

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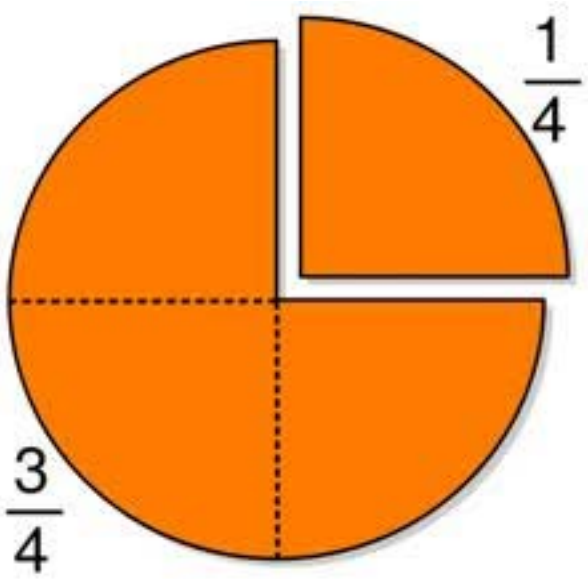
What is clear is that some things the therapist does really do matter

25% of psychotherapists reliably achieve results that are twice as good as others

Wampold, B., & Brown, J. (2006). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73 (5), 914-923.*



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Psychologist variables that do matter

(Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Baldwin, Wampold, & Imel, 2010; Lambert, Harmon, Slade, Whipple, & Hawkins, 2005; Wampold, 2007)

Sophisticated set of interpersonal skills

Develop trust with patients and develops expectancy effects

Form a working alliance with the patient

Provides an acceptable and adaptive explanation for the patients distress

The treatment plan is consistent with the explanation provided to the patient

Is influential, persuasive, and convincing

Is flexible and will adjust treatment if there is resistance to the treatment or the patient is not making progress

Does not avoid difficult material in the treatment and uses the treatment difficulties to aid treatment

Monitors patient progress in an effective way – **Routine Outcome Measurement**

Communicates hope and optimism

Is aware of the client's characteristics and the context in which they live

Is aware of his/her own psychological processes and does not inject this material into the treatment unless such actions are deliberate and thoughtful

Is aware of the available evidence

Continually seeks through feedback

What is not related to Effective Therapist (Wampold, 2017)

Characteristics and Actions **Not Related** to Outcome
Age
Gender
Profession / qualifications / years of practice
Self-reported social skills
Responses to interview questions about clinical skills
Theoretical orientation
Adherence to treatment protocol
Rated competence delivering specific ingredients of treatment

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Routine Outcome Measurement and Feedback Informed Treatment

- Dozens of RCTs and meta-analysis now show that providing clinicians with feedback, generated by ongoing measurement of the quality and outcomes of treatment, leads to better results

  (Lambert and Shimokawa, 2011; Lambert et al. 2003; Shimokawa et al. 2010; Ostergard et al. 2018).

- These studies show both significant increases in the amount of client improvement, the effectivness of treatment whilst also reducing treatment dropout and deterioration (Lambert, 2010)
- Examples include the PCOMS system. There is also a growing body of computer bases systems that can provide alerts of variations in rates of progress or risk of treatment drop-outs.

To Summarise

ROM is the smoke detector and FIT is the smoke that requires taking action

CROMS, PREMS and PROMS – An example

However ROM and FIT are not enough

- The effects of ROM and FIT are not distributed equally amongst practitioners.
- As is true of therapists in RCTs of specific treatment approaches, the impact of ROM and FIT on outcomes varies with as many as half of therapists not benefiting from using them (de Jong and De Goede, 2015; Lutz, 2014)

- De Jong et all (2012) highlighted that the characteristics of those who have the greatest impact have been found:

1) To be receptive to feedback
2) Actively incorporate in their work
3) Possess higher self-efficacy
4) Put less stock in their own assessment/feelings about treatment progress.

Deliberate Practice (DP) – Why are some therapists consistently better than others

DP is **a highly specialised** process.

- It is defined as "individualised training activities, especially designed … to improve specific aspects of an individual's performance through repetition and successive refinement (Ericsson and Lehman (1996; pp. 278-279)
- The amount of time therapists spend alone in DP has been found to be significantly related to outcomes (Chow, Miller, Seidel, Kane, & Thornton, 2015)
- Effective therapists spend two and half times more hours engaged in deliberate practice in a typical work week than their less effective colleagues (Chow et al. 2015).
- What is done in that time varies but there are some things that stand out as DP.

- Reviewing difficult/challenging cases alone
- Attending training for specific models of treatment
- Mentally running through and reflecting on past sessions and what to do in future sessions (Chow, Miller, Seidel, Kane, & Thornton, 2015)

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What matters regarding outcomes (Wampold, 2017)

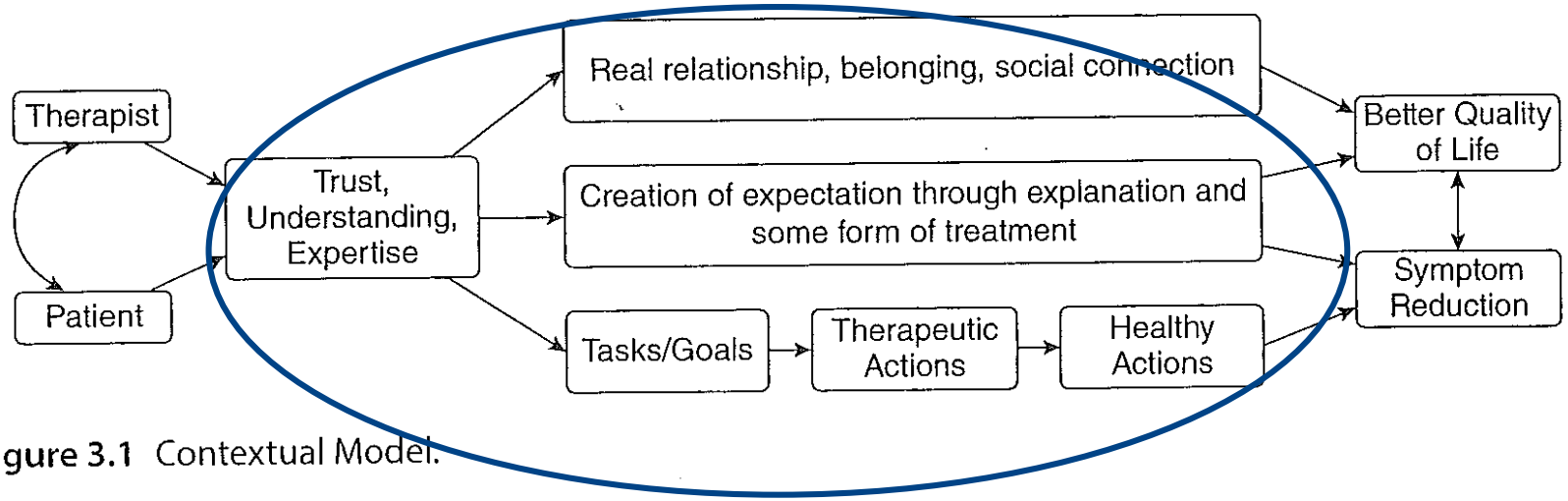

Figure 3.1 Contextual Model.

The Zone of Deliberate Practice

An effective psychologist…

- Uses the best available data on treatment outcomes and experience to inform the treatment for each client/patient
- Stays current on the latest research on what makes a difference in treatment outcomes.
- Recognizes the importance of clinician skills in providing effective treatments.
- Accepts personal responsibility for evaluating and improving in a continuous way to improve his or her outcomes.

Questions & Comments

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