



MANUAL 1

# WHAT WORKS IN THERAPY: A PRIMER

ICCE MANUALS ON FEEDBACK-INFORMED TREATMENT (FIT)



# INTERNATIONAL CENTER FOR CLINICAL EXCELLENCE

The ICCE Manuals on Feedback-Informed Treatment (FIT)

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**ICCE MANUALS ON FEEDBACK-INFORMED TREATMENT (FIT)**

## | INTRODUCTION TO THE SERIES OF MANUALS |

### **THE INTERNATIONAL CENTER FOR CLINICAL EXCELLENCE (ICCE)**

The International Center for Clinical Excellence (ICCE) is an international online community designed to support helping professionals, agency directors, researchers, and policy makers improve the quality and outcome of behavioral health service via the use of ongoing consumer feedback and the best available scientific evidence. The ICCE launched in December 2009 and is the fastest growing online community dedicated to excellence in clinical practice. Membership in ICCE is free. To join, go to: [www.centerforclinicalexcellence.com](http://www.centerforclinicalexcellence.com).

### **THE ICCE MANUALS ON FEEDBACK-INFORMED TREATMENT (FIT)**

The ICCE Manuals on Feedback-Informed Treatment (FIT) consist of a series of six guides covering the most important information for practitioners and agencies implementing FIT as part of routine care. The goal for the series is to provide practitioners with a thorough grounding in the knowledge and skills associated with outstanding clinical performance, also known as the ICCE Core Competencies. ICCE practitioners are proficient in the following four areas:

**COMPETENCY 1: RESEARCH FOUNDATIONS**

**COMPETENCY 2: IMPLEMENTATION**

**COMPETENCY 3: MEASUREMENT AND REPORTING**

**COMPETENCY 4: CONTINUOUS PROFESSIONAL IMPROVEMENT**

The ICCE Manuals on FIT cover the following content areas:

**MANUAL 1: WHAT WORKS IN THERAPY: A PRIMER**

**MANUAL 2: FEEDBACK-INFORMED CLINICAL WORK: THE BASICS**

**MANUAL 3: FEEDBACK-INFORMED SUPERVISION**

**MANUAL 4: DOCUMENTING CHANGE: A PRIMER ON MEASUREMENT, ANALYSIS, AND REPORTING**

**MANUAL 5: FEEDBACK-INFORMED CLINICAL WORK: SPECIFIC POPULATIONS AND SERVICE SETTINGS**

**MANUAL 6: IMPLEMENTING FEEDBACK-INFORMED WORK IN AGENCIES AND SYSTEMS OF CARE**

## **FEEDBACK-INFORMED TREATMENT (FIT) DEFINED**

Feedback-Informed Treatment is a pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services. It involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery. Feedback-Informed Treatment (FIT), as described and detailed in the ICCE manuals, is not only consistent with but also operationalizes the American Psychological Association's (APA) definition of evidence-based practice. To wit, FIT involves "the integration of the best available research...and 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...(e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment)" (APA Task Force on Evidence-Based Practice, 2006, pp. 273, 276-277).

## MANUAL 1

# WHAT WORKS IN THERAPY: A PRIMER

In this manual, significant research findings that form the foundation of Feedback-Informed Treatment (FIT) are reviewed and discussed. Also included in this manual are a short quiz, Frequently Asked Questions (FAQ), and a list of references for the sources cited.

## SIGNIFICANT RESEARCH FINDINGS

In this section we review the major research findings that provide empirical support for FIT. These findings are divided into four parts:

- 1) **BEHAVIORAL HEALTH OUTCOMES;**
- 2) **THE THERAPEUTIC ALLIANCE;**
- 3) **PROPERTIES OF ALLIANCE AND OUTCOME MEASURES; AND**
- 4) **EXPERT PERFORMANCE AND CLINICAL PRACTICE.**

## | 1) BEHAVIORAL HEALTH OUTCOMES |

Psychotherapy is an efficacious approach for the amelioration of psychological distress and improvement of functioning. In a major review of the available evidence, outcome researchers Lambert and Ogles (2004) conclude that, “psychotherapy facilitates the remission of symptoms and improves functioning. It not only speeds up the natural healing process but also often provides additional coping strategies and methods for dealing with future problems. Providers as well as patients can be assured that a broad range of therapies, when offered by skillful, wise and stable therapists, are likely to result in appreciable gains for the client” (p. 180).

**SIGNIFICANT RESEARCH FINDINGS IN BEHAVIORAL HEALTH OUTCOMES INCLUDE:****THE AVERAGE TREATED PERSON IS BETTER OFF THAN 80% OF THOSE WITHOUT THE BENEFIT OF TREATMENT.**

Research over the last 50 years has consistently demonstrated that psychotherapy across populations, age, gender, and diagnosis has a large and consistent effect size, between 0.8 and 1.2 (Asay & Lambert, 1999; Lambert & Ogles, 2004; Smith & Glass 1977; Smith, Glass, & Miller, 1980; Wampold, 2001). Effect size refers to the magnitude of change (in standard deviation units) attributable to treatment, either by comparing the clinical status of a treated sample with that of an untreated sample, or by comparing a sample's clinical status before and after treatment.

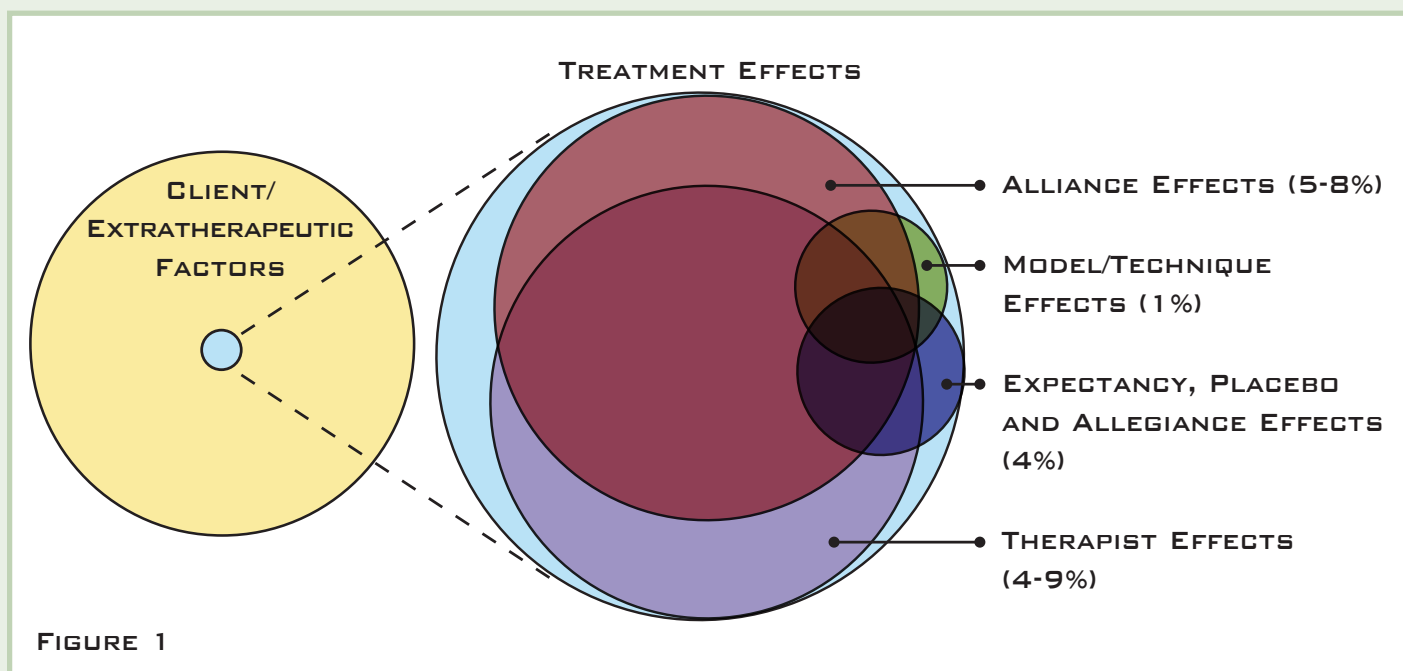
**PSYCHOTHERAPY IS COST-EFFECTIVE.**

Therapy has been shown to reduce inpatient stays, consultations with primary-care physicians, use of medications, care provided by relatives, and general health care expenditures by 60% to 90% (Chiles, Lambert, & Hatch, 1999; Kraft, Puschner, Lambert, & Kordy, 2006). These findings have been demonstrated with persons with high-utilization rates of medical and health-related services who received individual, family, and marital therapy (Cummings, 2007; Law, Crane & Berge, 2003).

**THERAPY WORKS LARGELY BECAUSE OF GENERAL FACTORS THAT ARE EXPRESSED IN VARIABLE PROPORTIONS THROUGH THE INTERACTIONS BETWEEN CLINICIANS AND CONSUMERS.**

Despite attempts to identify specific ingredients in psychotherapy, research has found that a core group of general therapeutic factors is responsible for successful outcomes, regardless of the approach or model (see Hubble, Duncan, & Miller, 1999; Lambert, 1992; Lambert, Shapiro, & Bergin, 1986). In this manual the term therapeutic factors is used to describe any factor known to contribute to effective psychotherapy. As these are presented and discussed, it is important to remember that these factors are not invariant, proportionally fixed, or neatly additive; they are fluid and dynamic. The role and degree of influence that any one factor has on outcome is dependent on the context; specifically, who is involved, what takes place between therapist and client, when and where the therapeutic interaction occurs and, ultimately, from whose point of view these matters are considered. Figure 1 provides a visual representation of therapeutic factors that research has shown account for the outcome of psychological treatments.

## | THE THERAPEUTIC FACTORS |



### THERAPEUTIC FACTORS INCLUDE AND ARE DEFINED AS:

#### ● **CLIENT/EXTRATHERAPEUTIC FACTORS.**

These factors are independent of treatment and include clients' readiness for change, strengths, resources, level of functioning before treatment (premorbid functioning), social support systems, socioeconomic status, personal motivations, and life events (Hubble et al., 2010). It is estimated (e.g., Wampold, 2001) that client/extratherapeutic factors account for 80-87% of the variability in scores between treated and untreated clients. Much of the variability is attributable to general statistical error – unexplained, uncontrolled, or unrecognized influences, including

the shortcomings and inevitable fallibility of experimental methodology and measurement. Some of those unexplained or unrecognized influences are what clients bring to therapy, their circumstances and events that take place in their lives while they happen to be in therapy that either aid or hinder improvement.

● **TREATMENT EFFECTS.** These effects represent a broad class of factors that are considered relevant to the influence of treatment. It is estimated that treatment in total contributes about 13-20% to overall outcome. Treatment effects include:

- **THERAPIST EFFECTS:** Research shows that “who” provides the therapy is an important determinant of outcome. Numerous studies demonstrate that some clinicians are more effective than others (e.g., Brown, Lambert, Jones, & Minami, 2005; Luborsky et al., 1986; Wampold & Brown, 2005). “Better” therapists, it turns out, form better therapeutic relationships with a broader range of clients. In fact, 97% of the difference in outcome between therapists is accounted for by differences in forming therapeutic relationships (Baldwin, Wampold, & Imel, 2007). By contrast, other therapist qualities have little or no impact on outcome, including: age, gender, years of experience, professional discipline, degree, training, licensure, theoretical orientation, amount of supervision or personal therapy, and use of evidence-based methods.
- **ALLIANCE EFFECTS:** The amount of change attributable to the quality of the relationship between therapist and client is due to alliance effects. It turns out that the therapeutic relationship is the largest contributor to outcome in behavioral health services. In essence, the alliance works by engaging the client in the treatment process. Research shows that client level of engagement is the most potent predictor of change in therapy.
- **EXPECTANCY, PLACEBO, AND ALLEGIANCE EFFECTS:** These factors relate to *both* the client and therapist’s expectations and beliefs about therapy and its potential effects. For the client, these effects relate to the installation of hope and expectations about the healing properties of therapy, and more specifically to the client’s belief in the therapist and the treatment provided (also known as the “placebo effect”). For the therapist, these factors include positive expectations, faith in therapy as a practice, and a belief in (allegiance to) the approach and methods utilized.
- **MODEL/TECHNIQUE EFFECTS:** All therapies involve methods – healing rituals – the effect of which depends on the degree to which these methods fit with clients’ preferences and expectations and activate other factors such as placebo and hope to foster improvement. Models and techniques work best when they engage and inspire participants; and they can provide structure to therapy. Studies have indicated that a lack of structure and focus in treatment are good predictors of a negative psychotherapy outcome (e.g., Lambert & Bergin, 1994; Mohl, 1995; Sachs, 1983).

Available evidence indicates that psychotherapy contributes to symptom amelioration and improved client functioning. It also is cost effective. With the effectiveness and benefit of therapy well-established, we move to address two critical questions in the sections that follow: “What does not work in therapy?” and more positively, “What does work in therapy?”

## | WHAT DOES NOT WORK IN THERAPY |

This section focuses on what does not work in therapy by addressing two primary areas: (1) the lack of overall improvement in therapy outcomes dating back to the first meta-analytic studies in the 1970s; and (2) a list of non-predictors and weak predictors of outcome.

### THE LACK OF IMPROVEMENT IN THE EFFECTIVENESS OF THERAPY

Available research points to the reasons why the effectiveness of psychological treatments has not improved appreciably over the last three decades.

#### • THE EMPHASIS ON TREATMENT MODELS IN PROFESSIONAL DISCOURSE AND TRAINING:

Though popular, there are actually few if any meaningful differences in outcomes between competing approaches – especially when the following factors are taken into account:

*Equal comparison conditions between bona fide approaches intended to be therapeutic.* Bona fide approaches are defined as treatments that are: (1)

intended to be therapeutic (having a theoretical base and associated techniques); (2) considered viable by the psychotherapeutic community (e.g., through professional books or manuals); (3) delivered by trained therapists; and (4) containing ingredients common to all legitimate psychotherapies (e.g., a therapeutic relationship) (Anderson, Lunnen, & Ogles, 2010; Benish et al., 2008; Frank & Frank, 1991; Imel & Wampold, 2008; Wampold, 2007; Wampold et al., 1997). In sum, when treatment conditions are equal there are no discernible differences between bona fide treatment approaches.

*The statistical strength of meta-analytic studies as compared to single studies.* Meta-analyses are a method of pooling together numerous studies with varying methodologies, sample sizes, and treatment approaches, all of which improves statistical power, flexibility, and generalizability compared to single studies. Numerous meta-analyses find no difference in effect between bona fide treatment approaches. To date, no differences in outcome have been found between different treatment approaches for psychotherapy in general

(Wampold et al., 1997), depression (Wampold et al., 2002), PTSD (Benish, Imel, & Wampold, 2008), alcohol use disorders, (Imel et al., 2008) and the four most common diagnoses in children and youth (depression, ADHD, anxiety, and conduct disorder; Miller, Wampold, & Varhely, 2008). Despite claims that certain methods are superior to others, or that evidence-based practice is defined by specific treatments for specific diagnoses, meta-analytic studies fail to support such claims. Furthermore, any differences between approaches reported in specific studies do not exceed what would be expected by chance (Wampold, 2001). The failure to find any difference in effect between competing treatment is referred to as “The Dodo Verdict,” an expression first coined by psychologist Saul Rozenzweig who borrowed a line of text from *Alice’s Adventures in Wonderland* to summarize the evidence regarding differential efficacy: “All have won, and therefore all deserve prizes.”

- **THE FAILURE TO ADDRESS DROPOUTS IN PSYCHOTHERAPY:**

Research to date suggests that premature termination or dropout – the unilateral decision by clients to end therapy – averages about 47% (Wierzbicki & Pekarik, 1993). For children and adolescents, the range varies from 28% to 85% (Garcia & Weisz, 2002; Kazdin, 1996). Clinicians,

it turns out, achieve solid outcomes with clients who stay but too many decide early to discontinue services.

- **THE FAILURE TO IDENTIFY WHICH CONSUMERS OF BEHAVIORAL HEALTH SERVICES WILL NOT BENEFIT AND WHICH WILL DETERIORATE WHILE IN CARE:**

Even with well-trained and supervised clinicians, a significant percentage (30% to 50%) of clients do not benefit from therapy. Deterioration rates among adult clients range between 5% and 10% (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004). Regarding children and adolescents, rates of deterioration vary between 12% and 20% (Warren et al., 2010). It is estimated that the clients who do not benefit or deteriorate while in psychotherapy are responsible for 60-70% of the total expenditures in the health care system (Miller, 2011). Moreover, clinicians routinely fail to identify clients who are not progressing, deteriorating, and at most risk of dropout and negative outcome (Hannan et al., 2005). Conversely, clinicians who have access to outcomes data can better identify clients who are not improving or getting worse and respond to those clients, thereby reducing the risk of dropout and negative outcome (Lambert, 2010; Miller et al., 2004).

- **THE SUBSTANTIAL VARIATION IN OUTCOMES BETWEEN CLINICIANS WITH SIMILAR TRAINING AND EXPERIENCE:**

In practice settings, some psychotherapists consistently achieve better outcomes than others, regardless of the psychiatric diagnoses, age, developmental stage, medication status, or severity of the people they work with across a range of patients (Brown, Lambert, Jones, & Minami, 2005; Wampold & Brown, 2005). Findings indicate that clients of the most effective therapists improve at a rate at least 50% higher and drop out at a rate at least 50% lower than clients who work with less effective therapists (Wampold & Brown, 2005). The latest research indicates that 97% of the difference in outcome between therapists is attributable to differences in their ability to form alliances with clients (Baldwin, Wampold, & Imel, 2007). Such findings indicate that the most effective therapists work harder than their counterparts at seeking and maintaining client engagement, as well as invest more time, energy, and resources into improving their craft (Hubble et al., 2010). Research consistently shows that the best predictor of engagement in psychological services is the client's rating of the therapeutic alliance (Bachelor & Horvath, 1999).

- **THERAPISTS' LACK OF KNOWLEDGE REGARDING THEIR OVERALL RATE OF EFFECTIVENESS AND THE TENDENCY OF AVERAGE CLINICIANS TO OVERESTIMATE:**

The majority of therapists have never measured and do not know how effective they are (Hansen, Lambert & Forman, 2002; Sapyta, Riemer, & Bickman, 2005). Naturally, it is impossible for clinicians to know if they are improving if they do not know their level of effectiveness. Additionally, therapists are not immune to a self-assessment bias in terms of comparing their own skills with those of their colleagues and in estimating the improvement or deterioration rates likely to occur with their clients (Dew & Reimer, 2003; Lambert, 2010). Walfish, McAlister, O'Donnell, and Lambert (2010) found that therapists on average rated their overall clinical skills and effectiveness at the 80th percentile – a statistical impossibility. Even worse, less than 4% considered themselves average and not a single person in the study rated his or her performance below average. The issue of therapists overestimating their personal effectiveness puts clients at risk for higher rates of dropout and negative outcome.

- **CLINICIAN EFFECTIVENESS TENDS TO PLATEAU OVER TIME IN THE ABSENCE OF CONCERTED EFFORTS TO IMPROVE IT:**

During their careers, clinicians acclimate to their settings, rely more on specific methods and strategies with which they are trained or are more comfortable, and become more confident in what they believe to be true about their clientele. Although these and other clinician factors may benefit specific clients in specific situations, they more often contribute to a plateauing of clinician effectiveness. Clinicians need to establish personal baselines of effectiveness and employ reliable and valid methods to monitor and track client feedback in relation to outcomes and the alliance to improve on those baselines.

#### **NON-PREDICTORS AND WEAK/ABSENT PREDICTORS OF OUTCOME**

Myriad studies over the last three decades have identified variables that have little or no correlation with the outcome of treatment, including:

- **CONSUMER AGE, GENDER, DIAGNOSIS, AND PREVIOUS TREATMENT HISTORY** (Wampold & Brown, 2005)
- **CLINICIAN AGE, GENDER, YEARS OF EXPERIENCE, PROFESSIONAL DISCIPLINE, DEGREE, TRAINING, LICENSURE, THEORETICAL ORIENTATION, AMOUNT OF SUPERVISION, PERSONAL THERAPY, SPECIFIC OR GENERAL COMPETENCE, AND USE OF EVIDENCE-BASED PRACTICES** (Beutler et al., 2004; Hubble et al., 2010; Nyman, Nafziger, & Smith, 2010; Miller, Hubble, & Duncan, 2007; Wampold & Brown, 2005)
- **MODEL/TECHNIQUE OF THERAPY** (Benish, Imel, & Wampold, 2008; Imel et al., 2008; Miller, Wampold, & Varhelyi, 2008; Wampold et al., 1997; Wampold et al., 2002)
- **MATCHING THERAPY TO DIAGNOSIS** (Wampold, 2001)
- **ADHERENCE/FIDELITY/COMPETENCE TO A PARTICULAR TREATMENT APPROACH** (Duncan & Miller, 2005; Webb, DeRubeis, & Barber, 2010)

## WHAT DOES WORK IN THERAPY

This section focuses on two areas that form the foundation of what works in therapy: (1) evidence of the role of routine and ongoing client feedback in improving outcomes; and (2) predictors of outcome. Each area is central not only to improving outcomes, but also in elevating consumer confidence, ensuring the long-term viability of psychotherapy as a treatment option and creating greater accountability, stewardship and return on mental health service investments. There is a worldwide shift toward outcomes that is not specific to mental health. It is essential that clinicians follow this lead and demonstrate – through reliable and valid methods – a greater degree of accountability for the value of psychotherapy.

#### EVIDENCE OF THE ROLE OF ROUTINE AND ONGOING FEEDBACK IN IMPROVING OUTCOMES

The best available research reveals that the use of routine and ongoing client feedback provides practitioners and the field with a simple, practical, and meaningful method for

documenting the usefulness of treatment. Seeking and obtaining valid, reliable, and feasible feedback from consumers regarding the therapeutic alliance and outcome as much as doubles the effect size of treatment, cuts dropout rates in half, and decreases the risk of deterioration. As the APA Task Force on Evidence-Based Practice (2006) concludes, “providing clinicians with real-time patient feedback to benchmark progress in treatment and clinical support tools to adjust treatment as needed” is one of the “most pressing research needs” (p. 278).

Miller (2011) summarized the impact of routinely monitoring and using outcome and alliance data from 13 RCTs involving 12,374 clinically, culturally, and economically diverse consumers and found:

- *Routine outcome monitoring and feedback as much as doubles the “effect size” (reliable and clinically significant change);*
- *Decreases dropout rates by as much as half;*
- *Decreases deterioration by 33%;*
- *Reduces hospitalizations and shortens length of stay by 66%;*
- *Significantly reduces cost of care compared to non-feedback groups (which increased in cost).*

Additional evidence indicates that regular, session-by-session feedback (as opposed to less frequent intervals, i.e., every third session, pre- and post-services, etc.; Warren et al., 2010) is more effective in improving outcome and reducing dropouts.

## PREDICTORS OF OUTCOME

The following factors have been shown to be consistent, robust predictors of eventual outcome.

- **DURATION OF THERAPY WITHOUT POSITIVE CHANGE:**

The longer clients attend therapy without experiencing a positive change, the greater the likelihood they will experience a negative or null outcome or drop out (Duncan, Miller, Wampold & Hubble, 2010).

- **EARLY CLIENT CHANGE:**

Referred to as the “dose-effect relationship” in psychotherapy, research indicates that approximately 30% of clients improve by the second session, 60% to 65% by session seven, 70% to 75% by six months, and 85% by one year (Howard, Kopta, Krause, & Orlinsky, 1986). Although the rate of client change differs somewhat from person to person, early response in therapy is a strong indicator of eventual outcome, making the monitoring of improvement from the start of therapy essential.

- **CONSUMER RATING OF THE ALLIANCE:**

The client’s rating of the alliance is a consistent and reliable predictor of treatment outcome. A

significant body of evidence further indicates that the client’s rating is superior to the therapist’s as a predictor of retention in treatment and eventual outcome.

- **LEVEL OF CONSUMER ENGAGEMENT:**

Orlinsky, Rønnestad, and Willutzki (2004) observe, “the quality of the patient’s participation... [emerges] as the most important determinant in outcome” (p. 324). Clients who are more engaged and involved in therapeutic processes are likely to receive greater benefit from therapy. The best predictor of client engagement is the alliance. In this regard, recall findings cited earlier showing that most of the difference in outcome between clinicians was in the ability to form, nurture, and sustain alliances with diverse clients.

- **IMPROVEMENT IN THE ALLIANCE OVER THE COURSE OF TREATMENT:**

Client-therapist alliances that strengthen and improve from intake to termination tend to yield better outcomes than alliances which start and stay good or deteriorate over time (Anker, Duncan, & Sparks, 2009; Anker et al., 2010). (See also Section 2.)

- **THE CLIENT'S LEVEL OF DISTRESS AT THE START OF THERAPY:**

More so than diagnosis, the severity of the client's distress at intake predicts eventual outcome. Clients with higher levels of distress are more likely to show measured benefit from treatment than those with lower levels or those who present as non-distressed (Duncan, Miller, Wampold & Hubble, 2010). Knowledge about client distress can inform decisions regarding the dose and intensity of services.

- **CLINICIAN ALLEGIANCE TO THEIR CHOICE OF TREATMENT APPROACH:**

While research shows few if any meaningful differences in outcome among treatment approaches, research documents that clinicians must have faith in the restorative power of therapy as a healing ritual. Further, it is important that clinicians have therapeutic rationales, employ strategies consistent with those rationales, and believe in their approaches (Hubble et al., 2010).

## | 2) THE THERAPEUTIC ALLIANCE |

The therapeutic alliance refers to the quality and strength of the collaborative relationship between the client and therapist (Norcross, 2010). The alliance is comprised of four empirically established components: (1) agreement on the goals, meaning, or purpose of the treatment; (2) agreement on the means and methods used; (3) agreement on the therapist's role (including being perceived as warm, empathic, and genuine; and (4) accommodating the client's preferences. Over 1,100 separate research findings document the importance of the alliance in successful therapy, making it one of the most evidence-based concepts in the psychotherapy (Norcross, 2011; Orlinsky, Rønnestad, & Willutzki, 2004). Significant findings from this research are detailed in this section.

**THE THERAPEUTIC ALLIANCE MAKES SUBSTANTIAL AND CONSISTENT CONTRIBUTIONS TO CLIENT SUCCESS ACROSS DIFFERENT TYPES OF PSYCHOTHERAPY.**

Over 20 meta-analyses have demonstrated the impact of the therapeutic alliance on treatment outcome (Norcross, 2011). The relationship and alliance act in concert with treatment methods, client characteristics, and clinician qualities in determining effectiveness. The alliance accounts for between five to nine times more of the outcome of treatment than the model or technique.

**NEXT TO THE LEVEL OF CONSUMER FUNCTIONING AT INTAKE, THE CONSUMER'S RATING OF THE ALLIANCE IS THE BEST PREDICTOR OF TREATMENT OUTCOME AND IS MORE HIGHLY CORRELATED WITH OUTCOME THAN CLINICIAN RATINGS.**

The partnership between the therapist and client, as rated by the client, is a consistent predictor of eventual treatment outcome and more reliable than therapist ratings (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Norcross, 2010, 2011). Some therapists form better alliances with clients and achieve better outcomes. In contrast, clients of therapists with weaker alliances tend to drop out at higher rates and experience poorer outcomes (Hubble et al., 2010; Lambert, 2010).

**A SIGNIFICANT PORTION OF THE VARIABILITY IN OUTCOME BETWEEN CLINICIANS IS DUE TO DIFFERENCES IN THE THERAPEUTIC ALLIANCE.**

Variability between clients is to be expected with regard to client ratings of the alliance. However, some therapists consistently form better alliances with clients and variability in the alliance accounts for a large portion of the differences in outcomes between therapists (Baldwin et al., 2007).

**MONITORING THE ALLIANCE ALLOWS CLINICIANS TO IDENTIFY AND CORRECT PROBLEMS WITH ENGAGEMENT AND REDUCE EARLY DROPOUT OR RISK OF NEGATIVE OUTCOME.**

Routine and ongoing monitoring of the alliance through real-time client feedback processes helps to both identify potential ruptures and create opportunities for clinicians to take corrective steps (Anker, Duncan, & Sparks, 2009; Anker et al., 2010). In addition, improvements in the alliance (intake to termination) are associated with better outcomes and lower dropout rates (Duncan, Miller, Wampold, & Hubble, 2010; Harmon et al., 2007; Lambert, 2010; Miller, Hubble, & Duncan, 2007).

### | 3) PROPERTIES OF ALLIANCE AND OUTCOME MEASURES |

Two key factors have proven useful in predicting and improving treatment outcome: (1) the quality of the alliance; and (2) early change in treatment. Literally hundreds and hundreds of outcome and alliance measures exist. Few, however, have documented validity and reliability. Fewer still are feasible for use in routine clinical care and are sensitive to change. In the material that follows, properties of valid, reliable, and feasible alliance and outcome measures that are sensitive to change are defined and illustrated. Thereafter, the properties of the outcome and alliance scales used in FIT will be reviewed.

**RELIABILITY:**

To be reliable, any differences between two administrations of the same measurement tool must be attributable to the changes in the variable being measured. A thermometer, for example, that gives different readings under similar circumstances is not trustworthy and would not be deemed a reliable measure of the temperature. Similarly, scores that vary in spite of little or no difference in the functioning of or relationship with the client would not be considered reliable measures of outcome or alliance.

**VALIDITY:**

To be valid, evidence must be provided to show that a scale measures what it purports to measure. With outcome and alliance scales, this is most often accomplished by correlating a scale with other well-established or documented scales (known as concurrent validity), testing whether the measure can accurately differentiate between clinical groups and non-clinical groups (discriminate validity), reviewing and estimating whether the scale measures what it purports to measure (face validity).

**FEASIBILITY:**

Feasibility is the degree to which an instrument can be explained, completed, and interpreted quickly and

easily. Available evidence indicates that any measure or combination of outcome and alliance measures taking more than five minutes to complete, score, and interpret are less likely to be used by clinicians and increase the likelihood of complaints by consumers of mental health services (Duncan, Miller, & Sparks, 2004). As a result, a strong argument can be made that, in addition to being reliable and valid, any outcome and alliance tool employed in routine clinical care must also be brief. Importantly, research provides little evidence that longer and less feasible (multifactor) outcome and alliance measures are more useful in predicting, evaluating, and guiding treatment than shorter (single-factor, general distress) scales.

**SENSITIVITY TO CHANGE:**

To be useful for evaluating the practice of psychotherapy, outcome and alliance scales need to be sensitive to change among those receiving services but return stable (or unchanging) scores among those who do not receive treatment. An instrument's sensitivity to change enables researchers, clinicians, and clients to be confident that any resulting changes are attributable to the services being offered.

**THE OUTCOME AND SESSION RATING SCALES:**

The ORS and SRS are the measures of outcome

and alliance used in feedback-informed treatment. Multiple studies have proven the measures to be valid, reliable, feasible, and sensitive to change (Miller, 2011; Duncan, Miller, Wampold, & Hubble, 2010). Both instruments take less than a minute to administer, score, and interpret (examination copies are available in Manual 2 of this series). As noted earlier, studies conducted to date document that routine use of the ORS and SRS in clinical practice improves outcome, cuts dropout rates, and decreases the cost of and time spent in treatment (Miller, 2011). Detailed instructions for using the measures to inform and improve behavioral health service delivery can be found in Manual 2.

## | 4) EXPERT PERFORMANCE AND CLINICAL PRACTICE |

A significant body of research across multiple domains (e.g., medicine, music, sports, mathematics) documents the steps required for achieving superior performance. The steps are: (1) establishing a performance baseline; (2) engaging in deliberate, reflective practice; and (3) obtaining ongoing feedback/coaching. These steps are reviewed below.

### **ESTABLISHING A BASELINE PERFORMANCE LEVEL:**

Whether in sports, music, medicine, or psychotherapy, top performers are able to accurately assess their knowledge, skills, and effectiveness. What's more, the best are always comparing their current performance to: (1) their own personal best; (2) the performance of others; and (3) a known national standard or benchmark (Ericsson, Charness, Feltovich, & Hoffman, 2006).

### **ENGAGING IN DELIBERATE, REFLECTIVE PRACTICE:**

Expert performers engage in a specific form of practice designed to improve individual target performance

just beyond their current level of proficiency. The best engage in such efforts up to four hours a day, every day of the week, including weekends and holidays. This highly focused, deliberate effort is extremely taxing. As a result, most practice periods last no longer than 45 minutes at a time and are followed by periods of rest.

What constitutes deliberate practice differs across domains of expertise. All forms, however, include the highly focused, repetitious practice of skills focused on improving the parts of performance that are not yet mastered.

Over time, deliberate practice results in the development of what researchers refer to as, “deep domain-specific knowledge.” The best not only know more, but also when, where, how, and with whom to use what they know.

### **OBTAINING ONGOING FEEDBACK/ COACHING:**

Expert performers are usually guided in their practice by a coach or mentor who provides directions for practice that will push professionals just beyond their current realm of reliable performance.

## IMPLICATIONS FOR THERAPISTS

Research on expertise makes clear that, in order to improve, clinicians need to: (1) measure outcomes and determine their overall rate of effectiveness; (2) identify areas of practice just beyond their current level of proficiency; (3) develop and execute a plan of deliberate practice; (4) obtain coaching, instruction and/or training; (5) measure the impact of the plan and training on performance; and (6) adjust the plan and steps.

The above noted process has been termed TAR: Think, Act, and Reflect. To move beyond the realm of reliable performance, the best engage in forethought. This means setting specific goals for improvement and developing a plan to reach those goals. In the act phase, successful experts track their performance: they monitor on an ongoing basis whether they used each of the steps or strategies outlined in the thinking phase and the quality with which each step was executed. The sheer volume of detail gathered in assessing their performance distinguishes the exceptional from their more average counterparts. During

the reflection phase, top performers review the details of their performance, identifying specific actions and alternative strategies for reaching their goals. Where unsuccessful learners paint in broad strokes, attributing failure to external factors and uncontrollable events, the best know exactly what they do, most often citing controllable factors.

The findings from the expert performance are directly applicable to mastering the knowledge and skills associated with feedback-informed practice:

- *Accept that mastering FIT will take time;*
- *Schedule time each day to study and practice, spending no more than 45 minutes at a time, with periods of rest in between (15 minutes minimum);*
- *Discuss FIT with a more knowledgeable peer or colleague (joining the ICCE provides instant access);*
- *Set small, measurable goals and identify discrete indicators of performance (a good place to start is completing the quiz that follows).*

## | MANUAL 1 QUIZ |

Research indicates that people retain knowledge better when tested. Take a few moments and answer the following 10 questions. If you miss more than a couple, go back and reread the applicable sections. One week from now, complete the quiz again as a way of reviewing and refreshing what you have learned.

1. **The best therapy outcomes are likely when the following pattern of alliance scores are found:**
  - a. Start good, end good.
  - b. Start good, end fair.
  - c. Start fair, end good.
  - d. Start poor, end good.
2. **The factors that contribute most to therapeutic change, going from least to most, are:**
  - a. Technique, theory, alliance, placebo.
  - b. Theory and technique, allegiance, alliance.
  - c. Therapist, theory, technique, alliance.
  - d. Theory, allegiance, alliance, diagnosis.
3. **Why is it recommended to measure the alliance and outcome with clients at every visit?**
  - a. To optimize opportunities to adjust and improve treatment.
  - b. To provide supervisors earlier opportunities to correct therapists.
  - c. To encourage earlier termination.
  - d. To make the administration of the measure more automatic and less prone to discussion.
4. **Which of the following statements is true?**
  - a. There is ample evidence to prove that some therapeutic approaches are more effective than others for treating certain disorders.
  - b. All treatment approaches work about equally well.
  - c. Technique makes the largest percentage-wise contribution to treatment outcome.
  - d. Dismantling studies show that certain specific ingredients are necessary for therapeutic effectiveness.
5. **The therapeutic alliance is made up of the following components:**
  - a. Positive outcome, agreement on methods, consumer preferences, bond between consumer and provider.
  - b. Therapist empathy, level of engagement, agreement on goals, agreement on methods.
  - c. Consumer preferences, agreement on goals, agreement on methods, bond between consumer and provider.
  - d. Consumer preferences, client strengths, client compliance to treatment, client's belief in treatment.

6. It is a good idea to monitor the alliance on an ongoing basis because:
  - a. It allows clinicians to identify and reduce the risk of early dropout or null or negative change.
  - b. It allows clients to be more assertive.
  - c. It helps the clinician feel supported by the large proportion of high scores.
  - d. It allows agencies to identify the least effective therapists based on the low alliance scores.
7. What is the average deterioration rate in psychological treatments?
  - a. Between 20-25% of clients deteriorate while in treatment.
  - b. Between 5-10% of clients deteriorate while in treatment.
  - c. Between 0-5 % of clients deteriorate while in treatment.
  - d. Between 30-40% of clients deteriorate while in treatment.
8. Which of the following is a predictor of outcome?
  - a. Consumer diagnosis.
  - b. Early positive change.
  - c. Clinician licensure, discipline, training, degrees, personal therapy, certifications, clinical supervision.
  - d. Consumer's previous treatment history.
9. Why is it recommended to measure outcome and alliance of your clients at every session?
  - a. Measuring outcomes and alliance in real-time provides the treatment provider an opportunity to adjust the treatment in order to maximize the potential for a positive therapeutic outcome from the client's perspective.
  - b. This allows your supervisors and managers to know if you are doing your job.
  - c. This will convince your client that you will definitely be helpful to him or her.
  - d. None of the above.
10. Which of the following statements is false?
  - a. Improvement as a clinician is directly related to how much continuing education one has completed.
  - b. The first step in improving as a clinician is to be able to calculate one's own baseline of performance.
  - c. Both a and b are true.
  - d. Both a and b are false.

**| ANSWER KEY |**

- |      |       |
|------|-------|
| 1. d | 6. a  |
| 2. b | 7. b  |
| 3. a | 8. b  |
| 4. b | 9. a  |
| 5. c | 10. a |

## | FAQ |

**QUESTION**

If all models are equally effective, does that mean that you can do whatever you want – that having a technique doesn't matter?

**ANSWER**

No, it doesn't mean that having a theory and technique doesn't matter. Theory and technique achieve their effects through the activation and operation of placebo, hope and expectancy in the client. Having a theory and technique provides the therapist with a set of beliefs and procedures unique to the specific approaches, a rationale for the client's difficulties, strategies or "healing rituals" to follow for problem resolution. The theory and technique provide a structure and focus without which can result in a disorganized or "hit and miss" approach.

**QUESTION**

How come some meta-analyses show there is a difference between the effectiveness of models but this manual says that there is no difference?

**ANSWER**

The main explanation is that the results of a meta-analysis depend on the studies included. Some meta-analyses include studies that are not direct comparisons between bona-fide treatments, leading to the mistaken conclusion that some treatments are more effective than others. Such studies don't control for researcher allegiance effects (e.g., a researcher's belief in the superiority of his or her chosen model) and include "unfair comparisons" (e.g., where treatment is compared to wait list conditions, to psychoeducation or to other types of interventions that are not equivalent with the treatment being offered). In short, the validity of a meta-analysis depends on the studies reviewed. (For a more detailed description, read Imel et al., 2008.)

**QUESTION**

How come this manual states that a professional degree, training, and years of experience have no impact on client outcome? Does this mean my professional training is not necessary? How am I supposed to improve my skills if what I have done so far is not effective?

**ANSWER**

The main conclusion from research on the development of expertise is improvement results from practicing in a very specific, deliberate, and focused way. Experience is not enough. Daily work with clients will not improve outcome if such “deliberate practice” is absent from in the work. In fact, therapeutic skills and outcomes plateau and even deteriorate over time due to the absence of focused practice of the basic therapeutic skills related to the specific context of therapy. More detail on this subject can be found in the “Expert Performance and Clinical Practice” section under “Implications for Therapists.”

**QUESTION**

Does the idea of “deliberate practice” mean that I just need to see as many clients as possible each week in order to become a superior therapist?

**ANSWER**

No. In fact, research shows no correlation between the number of hours spent conducting therapy and effectiveness. Improving one’s skills requires being pushed beyond one’s current level of proficiency. The process includes first identifying areas for improvement, setting small goals, developing and implementing an action plan, and then reviewing the results and adjusting the plan. Without deliberate effort, superior results remain elusive. You can read more about this in the “Expert Performance and Clinical Practice” section under “Implications for Therapists.”

**QUESTION**

This manual states that “Even with well-trained and supervised clinicians, 30% to 50% of clients do not benefit from therapy and fail to respond to treatment.” Does this mean 30% to 50% of clients will never improve?

**ANSWER**

No. Recall that successful treatment is about the FIT between a particular client and therapist. Perhaps the client needs something other than the intervention being offered by a given therapist. Perhaps problems in the alliance stand in the way of success. The good news is that once a client is referred to another clinician or program, available evidence indicates that the probability of success is unaffected by the prior treatment failure.

**QUESTION**

This manual states that “early change is predictive of outcome at the end of treatment.” I have heard from colleagues and supervisors that clients need to get worse in order to get better. Is this not true?

**ANSWER**

There is no empirical evidence supporting the statement that “clients need to get worse in order to get better.” Some clients do deteriorate. Understandably, however, they are at increased risk for dropping out of service. This is a theoretical assumption that might fit with some but not across all clients. Early change is the pattern supported by research.

**QUESTION**

How do I start getting feedback? Which tool should I use and where can I find it?

**ANSWER**

You can download the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) for free at [www.centerforclinicalexcellence.com](http://www.centerforclinicalexcellence.com). These are valid, reliable, and feasible tools with each taking under a minute to administer and score. Manual 2 provides detailed information regarding the application of ORS and SRS in clinical practice.

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