News You Can Use: Three Ways to Improve our Effectiveness

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Garrison Keillor observes of the residents of Lake Wobegon, "All the women are strong, all the men are good-looking, and all the children are above average." As psychotherapists, it is likely that we similarly believe we are above average, but as Keillor's folksy humor reminds us, it ain't so—half of us are below average, as a statistical necessity! Moreover, the variability in outcomes due to psychotherapists is greater than what is expected by chance (Wampold, 2001) and the differences are meaningful. In practice settings, some psychotherapists consistently attain better outcomes than others and this seems to be true regardless of patient diagnoses, age, developmental stage, medication status, severity, and so forth—good psychotherapists get consistently better outcomes across a range of patients (Wampold & Brown, 2005). The Wobegon flip side, is that some psychotherapists consistently have poorer outcomes. What characterizes the psychotherapy provided by psychotherapists who consistently get better outcomes and how can we all adopt such practices to improve our effectiveness?

Unfortunately, definitive answers to this question have eluded us for decades and distressingly, as Beutler (2004) suggests, interest in psychotherapist variables is waning. Nevertheless, there are some emerging trends that we should consider. But first, we should be clear about what does not appear to make a difference. The particular treatment delivered by psychotherapists does not appear to make a difference, in clinical trials (see Wampold, 2001) or in practice (e.g., Stiles et al., 2006). Indeed, and this is very good news for clinicians; it appears that services delivered in private practice, using a variety of treatments, produces benefits equivalent to those obtained by empirically-

supported treatments (ESTs) in clinical trials (Minami et al., in press). So, don't give up your preferred treatment model in favor of an EST.

There are three areas where we should focus our attention with regard to increasing benefits to our patients. First, to attain benefits of psychotherapy, patients must be engaged in the therapeutic process. We know that many patients in clinical trials drop out of treatment and those who do have poorer outcomes than those who remain in treatment (Westen & Morrison, 2001). Patients engage in psychotherapy when, it appears, that they received a treatment that is consistent with their expectations, have positive expectations for success, and feel understood by the psychotherapist (Wampold, in press). Rather than administer OUR preferred treatment to all patients, we must be exquisitely sensitive to how patients wish to heal—they have expectations for the nature of treatment and we cannot think that "one size fits all." CBT for PTSD (prolonged exposure, relaxation, and cognitive restructuring) is an effective treatment (although not more effective than some very different alternatives), but in clinical trials nearly half of patients prematurely terminate (McDonagh et al., 2005). This does not mean that we should rapidly change our approach, but rather we should be attuned to patients' attitudes, values, context (including culture), and expectations and to be convincing in our presentation of treatment rationales, whether we do this implicitly or explicitly. We should be aware of each client's motivation for change, their coping styles, and their tendency to resist, and select or adapt treatments accordingly (see Norcross, 2002). Our power to create positive expectations is great—but that task is accomplished in large part by employing treatment procedures that patients find acceptable.

A second critical component of effective therapy is a positive working alliance, as noted previously in *News You Can Use*. It is important to keep in mind that alliance is more than the relationship formed by being empathic and caring—it is also an agreement about the goals and tasks of psychotherapy. Again, the acceptance of the treatment provided is critical—the working alliance will be weak if the patient does not find the treatment convincing. The literature points to a few critical aspects of the alliance. Psychotherapy involves considerable risk to patients—we ask them to change core aspects about their beliefs in themselves and others. Patients naturally are willing to undergo this change only if they believe the psychotherapist *understands* them and that the treatment offered will *benefit* them (Wampold, in press). Moreover, alliance research points to the importance of collaborative work between the psychotherapist and the patient (Hatcher & Barends, 2006). Finally, we must recognize that some patients, perhaps due to poor attachment history, will have difficulty forming an alliance, but we should not be deterred, as it is the psychotherapist's contribution, not the patient's contribution, to the alliance that makes a difference (Baldwin, Wampold, & Imel, in press).

A final way to increase effectiveness is to monitor the outcomes we produce. Michael Lambert's groundbreaking research on providing feedback to psychotherapists demonstrably has shown that such feedback systematically leads to increased benefits to patients (Lambert et al., 2005). Without such feedback, we really are blind to whether we belong to the Lake Wobegon "false" above average folks or not. Reliable benchmarks exist for disorders (Minami et al., 2007) and we need to understand how effective we are with our patients relative to benchmarks and to use that feedback to improve the quality

of our services. There are a number of outcomes systems available and more on coming on line, including Miller and Duncan's ORS ASIST (http://www.talkingcure.com/bookstore.asp), Lambert's OQ Analyst (http://www.oqmeasures.com/), Grissom's Polaris Mental Health Measures (http://www.polarishealth.com/index.html), and Brown's ACORN project (http://www.clinical-informatics.com/), among others.[1] Typically, the measures asses psychological functioning generically by assessing general symptoms, well-being, and social and role functioning, Although the use of outcomes in practice is not without significant issues for clinicians, the benefit of receiving feedback about the quality of our services seems to be great enough that we should pursue outcome-informed practice (Miller, Duncan, & Hubble, 2005).

In summary, our efforts to improve the effectiveness of our psychotherapy could profitably focus on ensuring engagement in the psychotherapy process, attending to the working alliance by focusing on the collaborative nature of our work, and receiving feedback about our effectiveness by measuring outcomes.

Footnotes

[1]Please note that I am not endorsing these particular measures and systems or recommending these over others. Psychotherapists will need to determine which set of measures and systems is cost effective for their particular practice, should they decide to use outcomes to inform their delivery of service.

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