The Survival of Psychotherapy:

How Humanistic Accountability Will Transform Our Profession and Your Practice

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Reference: Seidel, J.A. (2006, November-December). The survival of psychotherapy: How humanistic accountability will transform our profession and your practice. *Colorado Psychological Association Bulletin, 34*(7), 6-9.

On a recent Sunday evening, *60 Minutes* ran a story called "Changing Minds: Area 25" about a new surgical treatment developed by two psychiatrists for "treatment resistant" depression (http://www.cbsnews.com/stories/2006/09/29/60minutes/main2053537.shtml). These researchers are applying for a patent for their new version of psychosurgery that uses implanted electrodes to try to improve symptoms. Meanwhile in the latest issue of *Wired* magazine (October, 2006) the cover story is entitled "The Thin Pill: How Big Pharma Turned Fat into a Disease—and Then Invented a Drug to Cure It."

Following the *60 Minutes* program, viewer after viewer posted messages on CBS's website about taking dozens of ineffective medications with horrible side effects, scores of ECT treatments, failed VNS trials, and years wasted in therapy. Some begged for help, even posting their phone numbers in case researchers or doctors might read their pleas. Others touted theories about Candida infections and various nutritional cures.

Professional psychology is in serious trouble. The medical model has taken hold of the public's view of psychological distress like never before. If psychotherapy is to survive another century, psychologists must balance the rigors of research, accountability to our clients and other payers, ethical marketing savvy, and the complex realities of psychological suffering. In other words, we are going to have to get our act together and demonstrate our value in ways that make a clear impression on the public. Here is the good news: Much of what we can do toward that end has been tested in the field, and with stunningly good results. Now we need to wake up and make use of it.

Here is the case for our survival, and how we can bring our expertise down from the ivory tower of "efficacy" studies and into the marketplace to make a stronger stand against simplistic, unethical, or overhyped solutions to psychological and emotional struggles.

Several decades of psychotherapy research make it clear that Saul Rosenzweig, who coined the "Dodo Bird Verdict" in 1936, was right: Every psychological treatment has won, and all must have prizes. All therapy techniques and models in the long run are about equally effective, somewhat more effective than placebo treatments, and substantially more effective than no treatment (Wampold, 2001). Recent meta-analyses by Wampold, among other researchers, continue to debunk our perennial hope of the next "new and improved" technique or model of psychotherapy. After controlling for

researcher allegiance, after the novelty wears off, and after new treatments are pitted against other bona fide treatments for serious clinical problems, the difference between therapies drops to about 1% of the variance. Practically all psychotherapy treatments appear to be significantly effective, with effect sizes hovering at about 0.80.

This is great news, and equivalent to saying that the average treated client is better off at termination than about 79% of untreated clients. Meta-analyses of various psychotherapies suggest that it is likely that *any* bona fide treatment, if studied, would be shown to meet the APA's criteria for "empirically supported treatment" (by being more effective than nothing) and constitute "evidence-based practice."

What explains this strange phenomenon?

The short answer is in the fact that therapists, not therapies, are driving more of the effect. Extratherapeutic factors (things that happen that have nothing to do with the therapy) and the common factors of therapy (elements common to all good therapists regardless of theoretical orientation) are responsible for the bulk of what makes change happen when our clients work with us. The specific factors (e.g., technique) are insignificant in terms of the average variance responsible for the change in clients' distress. Also, clients report that it is our warmth, our empathy, our ability to be on the same page as them rather than forcing them to our way of thinking, that help them get where they want to go. Again, the big differences appear to be between therapists (about 6-9% of the variance), not therapies (about 1% of the variance; Brown, Lambert, Jones, & Minami, 2005; Miller, Duncan, Sorrell, & Brown, 2005; Okiishi, Lambert, Nielsen, & Ogles, 2003). Various techniques and models provide multiple lenses or ways of characterizing problems, solutions, and how to join with our clients (what Jerome Frank called the mythology and healing rituals of therapy), but none fulfill their promise of being a silver bullet.

Clients may need to try several therapists to find one that can help them achieve their desired outcomes the way clients in the current zeitgeist are encouraged to try several medications (sometimes concurrently), several ECT treatments, or soon perhaps several surgeries.

The alliance and other general effects such as clients experiencing a healing ritual that the therapist believes in, and clients setting aside time in their week to attend to their difficulties with a caring witness, contribute to change more than the particulars. But it gets even better. Not only is this "common factors" result probably the single most robust finding in all of psychotherapy research, but it has been replicated hundreds of times by researchers who attempted to falsify it and find that their brand of therapy was superior. In other words, it is one of those rare findings in therapy research that actually meets Karl Popper's definition of science: a consistent result which is divorced from the hopes and biases of scientists hoping to find something else.

It turns out that there is a simple and very powerful way we can use this information to improve our effectiveness as *therapists* and improve our effectiveness as *competitors* in

the mental health marketplace against the medical model juggernaut. We don't need to change our models, and yet we still can improve our effectiveness. This new approach (some call it a "meta-model") also allows individual therapists to see when they may be wreaking havoc on their clients and need to make major adjustments in the therapy. Not only is this immensely helpful from a "quality of service" perspective, but also from a liability perspective. And while scores of agencies have picked up on this approach because it increases efficiency and facilitates change, private practitioners have been slower to adopt it, not realizing that they don't have to give up what they already do *well* to do it *better*.

What is this new approach? It is called client-directed, outcome-informed (CDOI) therapy. Using two ultra-brief validated scales (each of them has 4 items and takes about 30-60 seconds), a therapist tracks alliance and outcome with clients in each session. By tracking alliance toward the end of a session, therapists can immediately catch breaches in the alliance and start repairing them before the end of the session rather than having a new client no-show a week later. Therapists do not check in with their clients about the alliance nearly as often as they think they do (and most of us think we do it often). Therapists are also poor estimators of the client's view of the alliance; and it is the client's view of the alliance that predicts whether clients will continue with therapy and get the benefit.

The research on the effect of doing this kind of alliance-tracking is compelling, with consistent findings from several independent research groups (notably Michael Lambert's group and Duncan and Miller's group). The data indicate massive declines in no-shows and early terminations and substantially better outcomes when therapists adopt this approach in their sessions.

It is important to note here that *outcome* does not refer to client *satisfaction* with therapy, which research shows to be quite high among most clients, and mostly unrelated to outcome (low satisfaction may predict a *poor* outcome, but high satisfaction does not predict a *good* outcome). *Outcome* means "reduction in distress," which factor analyses reveal to be the single factor on which the individual items on large outcome scales such as the SCL-90-R and the OQ-45 and their derivatives such as the BSI and the LSQ tend to converge. This is why a 4-item instrument can be valid and reliable, correlating with much longer scales, discerning clinical from non-clinical samples, and being highly sensitive to clinical change. There are several ultra-brief, reliable, and valid instruments on the market for therapists, but the ultra-briefest are the *Outcome Rating Scale* and the *Session Rating Scale* (ORS and SRS; together, they are known as the PCOMS) by Duncan, Miller et al. They are available at no charge (at http://www.talkingcure.com) and can be scored with a ruler in about 60 seconds (there are also computerized versions).

In sessions, clients are shown a graph of their total scores from the ORS and SRS from their previous sessions as a way to stimulate any conversation that may need to occur to either explore problems (e.g., with the alliance or change process) or to highlight successes. There are no cookbook-like rules for how to use these data, except to partner

with clients in interpreting the data, and to honor the client's voice, preferences, and perspective around what the data reveal about the therapy process.

One concern that often comes up among colleagues is whether such a simple tool can adequately capture the range and complexity of human experience. Of course not! All such assessments, even much longer ones, are ways of simplifying and coding and nailing down things that are fluid, complex, and mysterious. And individual clients may have specific outcomes that they are looking for other than a reduction in distress. The ORS and similar outcomes instruments are only one example of what we can use. The point is that *in general* (and there are exceptions) we need to use *something* in addition to our own intuition and best intentions to provide the missing accountability in our field, and to offer a reason for potential clients, funders, or referrers to value us other than our charm or an empty allegiance to "evidence based practice." Doing so will allow us to re-establish our credibility when we are competing alongside industries that may not adhere to ethical standards and that are much better funded and organized for marketing.

Is doing CDOI therapy better than business as usual? Does it help clients more than what we are doing already? Let's face it: Unless we have some other method, we cannot possibly know how well we are doing except through our self-serving fantasies and biased recollections. The answer from the research and from my own practice is that CDOI therapy helps clients improve their chances of obtaining a good outcome from therapy. It helps me catch things that I would otherwise miss. It helps me be more accountable to my clients; and rather than dictating some course of action or conceptualization or leaving me working from my faith alone, it keeps me asking my clients whether our way of working is the right one for them or needs some adjustment. As opposed to merely asserting that I am "client-centered" or an "intersubjectivist" who does this kind of alliance building on a continual basis, CDOI provides a reality-check, a much-needed guardrail for the therapeutic process. And the vast majority of my clients express appreciation for that kind of humility and respect coming from their therapist.

I have used this approach now for over two years with over 70 clients in short and long-term therapy and the results have been striking. Humanistic therapists who loathe the objectification of clients through data can rest easy. The data fit within a contextual, collaborative dialogue of meaning-making with the client; and are subordinated to the reality of the client, not the other way around.

Clients are incredibly varied in how they perceive the meaning of these forms. For some clients, the ORS at the beginning of the session and the SRS at the end create a kind of mindfulness ritual for opening and closing the sessions. Others who make slow progress find it reassuring to see patterns over time that are hard to remember otherwise. Transferences (and shifts in transference) can be tracked and discussed in a surprisingly open way. Others find the forms or graphs to be mildly interesting, or to be a simple chore which if it helps me (to help them) then that is fine with them. A small minority object to using the forms and I simply do not use them with these few clients, though we may discuss why they find them objectionable.

The data provide other ways of keeping me grounded in the reality of therapy: Despite my previous assumptions about deep and lasting change often requiring many sessions or that things often get worse before they get better, my data echo the research data that clinical change often happens within the first five to seven sessions and persists through deep and difficult work; and that clients who do not experience early improvement have a higher likelihood of not experiencing a good outcome by the end of therapy. The data also help us put our clients' needs first by giving them information that can be useful in helping them discern if this therapy is the right one for them. Accountability is coming to therapy; and this is excellent news for our field and our clients considering how good we generally are at what we do.

The research on outcomes is both humbling and uplifting, showing that clients change mostly due to their own efforts and happenstance that have nothing to do with therapy; but for the portion of the variance for which therapy is responsible, therapy exerts most of its effects through the common factors of the alliance and doing work that both therapist and client believe in. By having a systematic, simple, cheap, valid, and unobtrusive way to improve the alliance and be more accountable to our clients for helping them change, we have something to sell to the public again: *our demonstrated effectiveness*. The alternatives to therapy are being pushed much too hard for us to keep quiet any longer. And our allegiance to particular models which have some research backing them is a poor substitute for real accountability with real clients.

CDOI is here and has been used around the world for about a decade with tens of thousands of clients. But (and here is the secret purpose of this article), *we do not yet have norms for private-practice clients*. Because the research on this approach has been driven by a push for accountability, norms have been gathered among thousands of clients within community mental health, EAP, and military settings. In fact, the state of Arizona recently adopted the CDOI approach as a "best practice" for their state mental health services. While we do not have data to indicate that there would be a substantial difference between public agency settings and private practice settings, we just do not know until we collect the data.

Bruce Wampold and I are beginning a norms study for private practitioners using the PCOMS (ORS and SRS). I will train study participants in the Denver area how to use the PCOMS in their practice. I encourage you first to read and learn more about CDOI at http://www.talkingcure.com where you can also sign up for free ongoing discussion and support on the heroicagencies listserv. If you are in private practice and are interested in participating in the first-ever norms study of outcomes measurement in private practice, please contact me at jason@jasonseidel.com or 303-377-0999, and help us breathe new life into the field of professional psychology. The time for change is now, and you may be amazed by the transformation of your work (and your marketing), without having learned a single new therapy model.

Author Note: I am indebted to Barry Duncan, Psy.D., Scott Miller, Ph.D., and the members of the heroicagencies listserv for conceptualizations in this article.

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References for further reading:

Asay, T.P., Lambert, M.J., Gregersen, A.T., & Goates, M.K. (2002). Using patient-focused research in evaluating treatment outcome in private practice. *Journal of Clinical Psychology, 58*(10), 1213-1225.

Brown, G.S., Lambert, M.J., Jones, E.R., & Minami, T. (2005). Identifying highly effective psychotherapists in a managed care environment. *American Journal of Managed Care, 11*, 513-520.

Duncan, B.L., Miller, S.D., & Sparks, J.A. (2004). *The heroic client: A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy*. San Francisco: Jossey-Bass.

Gawande, A. (2004, December 6). The bell curve: What happens when patients find out how good their doctors really are? *The New Yorker Online*. Available through http://www.ihi.org

Hansen, N.B., Lambert, M.J., & Forman, E.M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9*(3), 329-343.

Hawkins, E.J., Lambert, M.J., Vermeersch, D.A., Slade, K.L., & Tuttle, K.C. (2004). The therapeutic effects of providing patient progress information to therapists and patients. *Psychotherapy Research, 14*(3), 308-327.

Hubble, M.A, Duncan, B.L. & Miller, S.D. (1999). *The heart and soul of change: What works in therapy*. Washington, D.C.: American Psychological Association.

Lambert, M.J. (2004). *Bergin and Garfield's handbook of psychotherapy and behavior change, 5th Ed*. New York: Wiley.

Miller, S.D., Duncan, B.L., Brown, J., Sparks, J.A., & Claud, D.A. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2*(2), 91-100.

Miller, S.D., Duncan, B.L., & Hubble, M.A. (2004). Beyond integration: The triumph of outcome over process in clinical practice. *Psychotherapy in Australia, 10*(2), 2-19.

Miller, S.D., Duncan, B.L., Sorrell, R., & Brown, G.S. (2005). The Partners for Change Outcome Management System. *Journal of Clinical Psychology, 61*(2), 199-208.

Okiishi, J., Lambert, M.J., Nielsen, S.L., & Ogles, B.M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology and Psychotherapy, 10*(6), 361-373.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods in psychotherapy. Journal of Orthopsychiatry, 6, 412-15.

Wampold, B.E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, N.J.: Lawrence Erlbaum.

Wampold, B.E., Mondin, G.W., Moody, M., Stich, F., Benson, K., Ahn, H.-N., Crits-Christoph, P., Howard, K.I., Krause, M.S., Saunders, S.M., & Kopta, S.M. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "All must have prizes." *Psychological Bulletin, 122*(3), 203-215.