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5

WHAT CAN WE SAY ABOUT THE EFFECTIVENESS OF PSYCHOTHERAPY?

There has been considerable debate about the effectiveness of psychotherapy. This chapter examines that debate and available findings about outcomes in psychotherapy.

In 1953, Hans Eysenck (Lambert & Bergin, 1994) issued a major challenge to the practice of psychotherapy by suggesting that the data available indicated that psychotherapy was ineffective. Eysenck compared the impact of a diverse array of psychotherapies aimed at a wide range of undifferentiated difficulties by comparing the change in clients who received treatment with a set of norms he developed for the change in individuals who did not receive psychotherapy. Eysenck's comparisons found little difference between those who received therapy and those who did not, an effect partially attributable to the considerable improvement of those who did not receive treatment.

Eysenck's challenge raised a question about whether psychotherapy, long shielded behind closed doors, could withstand examination into its effectiveness in helping individuals with their problems. And

although this represented somewhat of a public relations disaster for psychotherapy in the mid-1950s, it also spurred the growth of psychotherapy research. Eysenck's challenge was met by several thoughtful rejoinders illuminating his errors in evaluating contemporary research of that time, especially in grossly overestimating the level of change that typically occurs without treatment (Garfield et al., 1990). Fortunately, the debate spurred much more methodologically rigorous psychotherapy research.

Today, we are heirs to the 50 succeeding years of psychotherapy research. What ultimately does this research tell us?

1. Psychotherapy works! The great majority of clients who receive psychotherapy improve. Typically, three clients of four decrease their dysfunctional symptoms and increase their positive functioning in psychotherapy. Meta-analyses point to an effect size for psychotherapy of about 0.8, suggesting that statistical effects in studies that compare psychotherapy with no therapy are what is termed "large" (compared with, for example, the effect of smoking on health, which is statistically a small effect) (Smith & Glass, 1977). Not only is this a considerable level of success but also compares quite favorably with the approximately 25–30% who improve without psychotherapy (Lambert & Bergin, 1994; Smith & Glass). And these changes remain substantial when comparisons are to placebo control groups who receive something that looks like psychotherapy (that is, clients and therapists talking), but without a method of intervention.
2. Psychotherapy significantly ameliorates such commonly encountered problems as depression, anxiety, substance abuse, adolescent delinquency, and childhood conduct disorder (Lambert & Bergin, 1994; Lambert & Hill, 1994). Psychotherapies have been found to impact a wide array of client difficulties, and to be particularly effective when the treatment is specifically shaped in relation to the client difficulty. Psychotherapies appear to be roughly equally effective in treating adults, children, and families (Lambert & Bergin, 1994; Lebow & Gurman, 1995; Weisz, Huey, & Weersing, 1998). These rates of success are typically at least as good as, and often superior to, the effects of medication.
3. Psychotherapy in combination with medication offers the most effective treatment for such pervasive disorders as schizophrenia, bipolar disorder, and childhood autism (Dixon et al., 2001). Again, treatments work best when specifically structured in response to these disorders.

These conclusions provide considerable support for the impact of psychotherapy. Yet research on psychotherapy also points to the limitations of psychotherapy, including the following considerations.

1. Not all clients are helped by psychotherapy. Whatever the difficulty, there remain 20%–40% of clients who do not achieve the level of functioning of those who never had the particularly presenting problem. There are always some who don't change and even a small percentage (approximately 5%) who deteriorate over the time of treatment (Lambert & Bergin, 1994).
2. Change is often temporary. Long-term follow-ups at 2–10 years after the end of treatment typically find large percentages of clients who return to having difficulties without further treatment (Lambert & Bergin, 1994). The maintenance of change seems to present a particular challenge in problems such as substance abuse and depression (Moos, 2003).
3. Many clients abandon psychotherapy prematurely, before it is able to have an effect. Although there are many cases in which change occurs quickly through some brief, focused intervention or through simply generating greater hope (psychologist Ken Howard [Kopta, Howard, Lowry, & Beutler, 1994] pointed that 5%–10% of clients improve before the first session), most clients who leave treatment early benefit insufficiently (Lambert & Bergin, 1994).
4. Psychotherapies have been principally tested on middle- to upper-class populations around the world. Indications are that at least some methods of psychotherapy do less well with the economically disadvantaged. A major issue within these populations is a demonstrated lower level of client engagement (Sue, Chun, & Gee, 1995).
5. There is much less evidence about the impact of psychotherapy in real-world settings than in special settings created for the purposes of conducting treatment research. There's both good news and bad news here. The good news is that large-scale research surveying outcomes in typical practice settings finds outcomes as good or better than in those obtained in academic research settings. The bad news is that when the treatments that are established as effective in academic research settings are disseminated to real-world settings, the outcomes are almost always less positive than in the more rarefied settings (though the outcomes remain positive) (Lambert & Bergin, 1994; Lambert & Hill, 1994;

Nathan & Gorman, 2002a; Weisz, Jensen, & McLeod, 2005; Weisz, Weiss, & Donenberg, 1993).

These limitations have led to efforts to (1) create special therapies that target particular problems for which the end states achieved at termination are less than optimal, (2) build stronger alliances that help more clients engage in psychotherapy, and (3) develop ways to help clients maintain change. Specific treatments have been developed that target a myriad of difficulties, including obsessive-compulsive disorder, depression, generalized anxiety disorder, attention deficit disorder, substance use disorders, and bipolar disorder. These treatments are aimed at increasing the levels of impact on individuals with these problems beyond that which can be achieved with broad psychotherapies (Nathan & Gorman, 2002b). The research indicates that these treatments have indeed increased the level of impact, though still there remains a substantial group of nonresponders to treatment for all these problems.

Treatments are also continually being reshaped to increase the likelihood of maintaining change. Although in the early stages of assessment, methods that extend over longer periods and that include booster sessions appear to be promising (Snyder & Ingram, 2000). And how to increase the acceptability of treatment and successfully build therapeutic alliances is increasingly a focus of psychotherapy research (Kazdin & Wilson, 1978; Norcross, 2002). Several innovative methods have been developed, particularly in the context of clients who typically are less interested in treatment (Miller, Meyers, & Tonigan, 1999; Santisteban et al., 1996).

Looking at comparisons of how well various kinds of treatments work compared with one another, the research suggests a mixed set of conclusions. On the whole, meta-analyses show no differences between schools of treatment in their impact (Lambert & Bergin, 1994). However, it is clear that in considering several very difficult-to-treat problems such as obsessive-compulsive disorder and panic disorder, highly specialized treatments are more successful (Nathan & Gorman, 2002b).

Nonetheless, research shows that common factors underlie much of what is effective in psychotherapy regardless of the treatment (Hubble, Duncan, & Miller, 1999; Lambert & Bergin, 1994; Norcross, 2002; Orlinsky, Grawe, & Parks, 1994). A recent volume, the result of a task force within the American Psychological Association, documented the enormous importance that has emerged for such factors as the therapeutic alliance, therapist empathy, and goal consensus involved in the therapy relationship (Norcross, 2002). Other potent common factors, such as the generation of hope and positive expectation, also clearly

transcend the particular treatment (Frank, 1963; Lambert & Bergin, 1994; Lambert & Hill, 1994).

In sum, today's psychotherapist can take comfort in the strong support psychotherapy research has had for the field. Yet, we should not fall prey to the myths proffered by the pharmaceutical companies who oversell what drugs can do, assuring us that change is certain and easy. The best practice of psychotherapy is grounded in the full range of research available about psychotherapy. That kind of therapy draws on the research on common factors to maximize these aspects of treatment, yet also seeks to choose the most appropriate intervention strategy for a specific case.

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6

THE SCIENCE OF CLINICAL ARTISTRY: RESEARCH-BASED PRINCIPLES FOR EFFECTIVE PRACTICE

Some views of the essence of effective treatment accentuate treatment strategies, whereas others have focused on client factors or the client–therapist relationship. This chapter describes the viewpoint developed by Larry Beutler that concentrates on articulating principles of change across all of these dimensions.

Larry Beutler is a researcher who doubles as a perpetual-motion machine. He has served as lead investigator in countless research studies and won numerous awards, including the Distinguished Research Career Award from the International Society for Psychotherapy Research. In his spare time, he has managed to write more than 200 articles and several books, as well as edit two of the most prominent journals in psychology, the *Journal of Consulting and Clinical Psychology* and the *Journal of Clinical Psychology.* But for all of his academic

absorption, Beutler, a therapist himself, remains deeply attuned to the real-life, everyday concerns of clinicians.

For some time, he has been grappling with a question that nearly every working therapist asks: How can I get better treatment outcomes? One pathway may be to use only "empirically supported treatments" (ESTs) that have been scientifically demonstrated to work well for specific disorders; this list of mostly cognitive-behavioral approaches has been compiled and endorsed by a task force of the American Psychological Association's (APA) Division of Clinical Psychology (Chambless & Hollon, 1998). A significant limitation of the EST concept, however, is that relatively few therapists have been trained in the highly structured, manualized therapies that have been sanctioned by the APA task force. If a couple seeks your help for intimacy troubles, for example, but you don't happen to be well-versed in the EST approved for couple work—behavioral marital therapy—you're out of luck.

It occurred to Beutler, therefore, that it would be far more useful for therapists to have access to a set of guiding principles that would maximize the chances that clients would improve *regardless* of a clinician's favored theoretical orientation (Beutler, Consoli, & Lane, 2005). So Beutler and colleagues John Clarken and Bruce Bongar plumbed through the research on psychotherapy (Beutler, Clarkin, & Bongar, 2000). First, they looked to see which client and therapist factors have consistently proven to have an effect on treatment outcome in psychotherapy research, examining 2,000 studies assessing a wide range of therapies aimed at treating depression, chemical dependency, and severe mental illness. They looked at these studies, not for the main findings about whether a particular treatment worked, but for how client or therapist characteristics, such as the client's level of functioning and kind of problem, affected treatment outcome. Through these efforts they pared an initial list of 30 key aspects of clients' lives that appeared to affect subsequent treatment decisions to less than a dozen key factors. They then proposed a number of hypotheses about how client, therapist, and pairings of client and therapist factors would affect change. Beutler and his colleagues then tested how well these hypotheses fit the data in 248 of the best studies assessing treatment outcome, arriving at a number of guidelines for treatment. To be sure what they found was broadly applicable, they also assessed how well their hypotheses held up in a large number of studies assessing clients with other diagnoses and problems, and conducted a number of studies themselves testing whether these hypotheses applied in a group of clients treated locally. This extensive state-of-the-art process has led to Beutler and his colleagues offering a number of guidelines for practice that they hold to be widely applicable across therapists, problems, and clients. Beutler believes that these guiding principles support a treatment planning model he calls "Systematic Treatment Selection," which allows therapists to work with maximum flexibility, creativity, and effectiveness within their favored approaches and—with luck—put an end to the clash of "dueling modalities" that has plagued the field for so long.

Some of Beutler's guidelines center on the type of client, some on the type of treatment, some on relationship factors, and some on the interactions between these kinds of factors.

CLIENT PROGNOSIS

Beutler's first set of guidelines focus on client predisposing variables, such as level of distress and coping style. Some of these findings are surprising; for example,

- Less change can be expected when clients show low levels of distress about their problems.

The implication seems clear: When clients appear unruffled about serious difficulties, an effective early strategy may be to ratchet up their distress level, rather than immediately trying to soothe them. For instance, if a client, Mike, comes into mandated therapy after a drunk-driving arrest, yet dismissively claims he "just likes a few brews," his therapist, Susan, might look for ways to heighten Mike's concern about his alcohol consumption. If Mike is a runner who cares about his physical condition and appearance, Susan might give him factual information about the health consequences of alcohol abuse and recommend Alcoholics Anonymous meetings, where the group process would be likely to further raise his level of concern.

Also striking is the extent to which the social support that clients experience in the world is directly linked to their outcomes in psychotherapy. Specifically, Beutler finds that

- Clients experiencing multiple problems or chronic difficulties have better outcomes when their therapists facilitate their gaining social support.

Following this guideline, when Mike presented for therapy after a recent hospitalization, Susan worked with him to build a support network of friends. As Mike encountered difficulties, he was able to draw on these friends to help him avoid rehospitalization.

LEVEL AND INTENSITY OF CARE

Beutler's second set of guidelines are concerned with the level and intensity of care, such as choosing the frequency of sessions or choosing between group, family, and individual therapy. These guidelines include the following:

- Multiperson (group or family) therapies increase the likelihood of improvement in those who have multiple problems or chronic problems.
- More frequent sessions are called for with clients who are more functionally impaired.

Again, the clinical implications are clear: favor group or family therapy in those with chronic or multiproblem difficulties, and see those with great impairment more than once per week. At first blush, the first finding may seem somewhat counterintuitive, because the focused, one-on-one attention provided by individual therapy might seem a more logical choice for an overwhelmed client. On the other hand, the role modeling and range of coping skills offered by multiperson therapy may be particularly valuable for clients who have trouble generating workable solutions of their own. Irrespective of modality, group-based treatment can provide a solid sense of belonging and support that may be especially important for severely troubled clients, who often feel isolated and stigmatized.

THERAPIST SKILLS

Beutler's third set of guidelines focus on the intervention, relationship, and skill factors the therapist brings to the therapy, such as the therapeutic alliance. These guidelines include some widely circulated understandings about psychotherapy:

- Change is greatest when the therapist is skillful and provides trust, acceptance, acknowledgement, collaboration, and respect for the client, and does so in an environment that supports risk and provides maximal safety.
- Therapeutic change is most likely when procedures do not evoke client resistance.

Client change depends substantially on the creation and maintenance of a good therapeutic alliance, and therapists must work to be skillful and maintain a strong sense of acceptance, empathy, and connection. Change also depends on the therapist's being able to deliver

interventions in an acceptable manner that does not evoke forces within clients that move against change.

Beutler also suggests that

- Therapeutic change is most likely when clients directly deal with the behavioral and emotional aspects of life they avoid.
- Therapeutic change is most likely if the initial focus of change efforts is to build new skills and alter disruptive patterns.

Both of these guidelines support directly helping clients to engage with their difficulties. Change is enhanced when therapists help clients to directly and safely experience aspects of life they are avoiding, and first build new skills and enable symptom reduction through direct interventions aimed at these targets. Although "let the client set the agenda" sounds like an enlightened policy, it can also be a recipe for stalled therapy. This finding suggests that the effective clinician will not hesitate to be directive—gently but persistently encouraging foot-dragging clients to confront their most disabling problems. For a psychodynamic therapist, this may mean nudging a reluctant client to deal with painful, unresolved feelings about his distant father. For a Bowenian, it might involve coaching the client to pay a visit to his elderly parents to find out more about his father's life. The bottom line: especially with avoidant clients, be prepared to take charge. For example, early in therapy, Jane actively intervened to help Bob, her client, to face his shyness and its consequences, rather than supporting his attempts to defocus from these issues that brought him in to therapy. She helped Bob move through a set of behavioral tasks around social situations aimed to help him lessen his fears, leading to considerable gains in alleviating his symptoms.

MATCHING THE INTERVENTION TO THE CLIENT

Perhaps the most interesting and valuable set of principles Beutler and colleagues articulate focus on matching treatment and clients. The first of these guidelines holds that

- Therapeutic change is greatest when interventions favor skill building and symptom removal for clients who externalize (i.e., who are action oriented, aggressive, extroverted, hedonistic, and stimulation seeking) or insight and relationship-focused procedures among clients who internalize (i.e., who are self-critical, withdrawn, self-reflective, and inhibited).

This finding points to the crucial importance of the personality dimension of the tendency to internalize or externalize for therapist decision making. Beutler concludes that direct interventions that build skills such as cognitive or structural interventions work best with those who externalize, whereas the generation of insight through methods such as psychoanalytic approaches or relating as in experiential methods has more effect for those who internalize. The concept of tailoring your approach to your client's personality is far removed from the one-size-fits-all philosophy of certain schools of therapy—"insight is necessary" (psychodynamic), "you need to better manage your feelings" (cognitive), or "you must get in touch with your emotions" (Gestalt and humanistic). A more appropriate maxim would be "different strokes for different folks." This finding rings with common sense: a client is apt to be more willing to take the kinds of risks that therapy demands if the path toward change is in tune with his or her character.

When faced with a depressed client who internalizes, a therapist might therefore focus therapy toward the process of understanding the antecedents of the client's difficulty in the events in his family of origin. In a client who externalizes, the same therapist would do better to begin with some active mode of intervening directly with the depression, such as questioning the beliefs of the client about depressive ideas, as in cognitive therapy.

The second matching guideline suggests that

- Therapeutic change is greatest when the directiveness of the intervention is lower when resistance is high and higher when resistance is low, or when the intervention meets resistance with paradoxical prescription.

In this way, encountering client cooperation or indifference to the therapy process becomes a marker for a choice of the direction for intervention. Those clients who cooperate and work directly to change are best served with direct means that help them move toward their goals. However, clients who show difficulty with cooperation and compliance are best treated with interventions that do not push them to change, or even suggest the merits of not changing. Following this guideline, when Susan discovered that following her directive interventions focused on stress reduction that Harvey, her client, failed to attend several sessions, she switched to a strategy of suggesting that he did not need to change his behavior if he was not ready to. This, in turn, allowed Harvey to become comfortable again with the therapy process, leading to his eventual improvement.

Beutler's final matching principle is that

- The likelihood of change is greatest when the client's level of emotional stress is moderate.

This guideline suggests that the importance of keeping the client's level of emotional arousal moderate; when the client is flooded with emotion or without emotion change, is likely to occur less. The implication here is that in the most successful therapies, therapists help clients high in emotional stress to reduce their levels of emotion, and those low in emotion to deepen their feeling. Following this guideline, when Sandra presented overwrought about the loss of her job, Lisa first worked with her to help her moderate her level of stress through cognitive-behavioral interventions, and, only then, began to explore the meaning of her job loss.

These matching principles are far removed from some well-known edicts of certain schools of therapy. It is not that "insight is necessary," "you need to better manage your feelings," or "you need to get in touch with your emotions," but "different strokes for different folks." The level of emotion, the directiveness, and the balance of skill building and insight need to be matched to the needs of the client.

These guidelines have been demonstrated to have considerable power in predicting who will change in Beutler's own research samples of clients in therapy (Beutler et al., 2005; Beutler & Harwood, 2000; Norcross, Beutler, & Clarkin, 1998). In one study assessing treatment of alcoholism, three-quarters of the changes occurring could be accounted for by simply looking at the matching of clients' functional impairment and the intensity of treatment, clients' resistance and therapists' directiveness, and therapists' emotional activation and level of client distress. That is, when therapists intervened in ways that fit with the qualities of the client (e.g., provided more direction with less resistant clients), change was far more likely to occur. Similarly, in another study of the treatment of depressed clients, benefit was greatest when the level of client resistance was properly matched with directive or nondirective intervention, and when the level of client distress was properly matched with the level of arousal induced in the therapy to keep the level of distress moderate. In more recent studies, Beutler and his colleagues have also begun to show that when such guidelines guide intervention, better outcomes are achieved than when they do not.

In directing his attention to the way he wishes his findings to be utilized, Beutler surprisingly draws on his hobby, natural horsemanship, once prominently depicted in the movie, *The Horse Whisperer.*

Natural horsemanship does not use the pain and dominance typical in the "breaking" of a horse, but rather a gentle approach in which the trainer is a partner and a guide. He states he can teach anyone to be able to display this form of horsemanship in the right context in 30 minutes, but that the true test of the student's learning comes when asked to teach the horse a complex task in a new environment. Skillfulness involves not following rote programs, but bringing creativity to the new situation. Beutler relates that if the student has become an artist-practitioner, she will know how to break the tasks down and to construct inventive methods for evoking wanted behaviors. If not, the techniques will get in the way. Beutler suggests truly effective psychotherapy requires clinicians to master basic principles of therapeutic influence, then to use them creatively and flexibly within the changing settings created by the endless variety of clients' personalities and needs. Therapy, he believes, is both careful science and inspired art. Beutler's deepest hope is that the research-based principles he articulates will serve as a platform from which genuine clinical artistry can spring.

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7

TRANSFORMATION NOW! (OR MAYBE LATER): CLIENT CHANGE IS NOT AN ALL-OR-NOTHING PROPOSITION

Some crucial aspects of psychotherapy transcend the particular clients, therapists, or treatments involved. The research of James Prochaska and his colleagues has illuminated one such crucial dimension: the clients' stage of change. Understanding where clients are in the stages of change can be enormously beneficial to the progress of psychotherapy.

According to conventional wisdom, people enter therapy to actively resolve their problems, reduce their symptoms, and retool their lives. That's a dangerous assumption, say psychologists James Prochaska, Carlo DiClemente, and John Norcross (Prochaska, 2000; Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1995; Prochaska, Johnson, & Lee, 1998; Prochaska & Norcross, 2002). Their large-scale studies suggest that people progress through several predictable, well-defined stages on the way to change, and are apt to take resolute action only toward the tail end of the process. This means that

only a small percentage of new therapy clients are ready to actively resolve their difficulties—a reality that clinicians can't afford to ignore, the researchers say. They urge clinicians to assess each client's readiness to change and to tailor therapy accordingly, or risk alienating clients who may conclude that the therapist is clueless about their needs.

Prochaska, professor of psychology at the University of Rhode Island, and DiClemente, professor of psychology at the University of Maryland, have examined the stages of change that people traverse in dealing with such problems as depression, anxiety and panic disorders, marital discord, eating disorders, smoking, alcoholism, and delinquency. In cross-sectional studies involving more than 3,000 individuals, they asked people to identify their major problems, their plans for change, and the specific actions they were taking to bring change about. Most of these subjects came from household samples, while others were in treatment for medical or mental health problems. Regardless of their family and cultural background, the nature of the problem they faced, and whether they had enlisted professional help, Prochaska, DiClemente, and their colleagues (DiClemente, Prochaska, Fairhurst, & Velicer, 1991; Prochaska, 1999; Prochaska, DiClemente, & Norcross, 2003; Prochaska et al., 1994) found that, across studies, people negotiated five discrete stages as they progressed toward change.

PRECONTEMPLATION

In this initial stage, individuals are largely unaware of their problems and have no intention of changing their behavior. People who go into therapy at this stage typically do so in response to pressure from others—a spouse who threatens to leave them, an employer who threatens to fire them, a court that threatens to jail them, or parents who threaten severe consequences. Precontemplators often wish *other* people would change, as in, "How can I get my wife to quit nagging me?"

CONTEMPLATION

Contemplators are aware that they face problems and are seriously thinking about grappling with them within the next six months. But they have not yet made a commitment to take action, usually because they still feel daunted by the effort required to overcome the problem, or because they still feel positively about some aspect of their troublesome behavior. Bad habits die harder than we may realize: when Prochaska and DiClemente followed 200 contemplators who were considering quitting smoking, most of them were still "thinking about it" 2 years later (DiClemente et al., 1991).

PREPARATION

Individuals at this stage intend to take action within the next month. Preparers may have already made some small attempts to modify their behavior—such as trying relaxation exercises when they feel anxious—but these attempts typically have been sporadic and only partially effective. They may be developing strategies for a more committed program of change, such as mapping out an action plan, going public with their intention to behave differently, and getting social support. Most still feel twinges of ambivalence about taking the plunge.

ACTION

In this stage, individuals are taking concrete steps to change their behavior, experiences, or environment in order to overcome their problems. Actors endorse statements such as, "Anyone can talk about changing, but I am actually doing something about it." Because action often brings up feelings of guilt, failure, coercion, and yearning to resume the old behavior, clients typically need a lot of support during this period. A sobering statistic: at any given time, only 10%–15% of people in the process of change are engaged in the action stage (Prochaska, 2000).

MAINTENANCE

During this stage, people work to consolidate their gains and prevent relapse. For some problems, such as alcohol abuse or recurring depression, maintenance might last a lifetime. Remaining free of the problem and behaving in ways incompatible with the problem—such as engaging in positive self-talk or calling a friend when one begins to feel blue—are key signs that a person has reached this stage.

GUIDELINES FOR TREATMENT

Prochaska and DiClemente believe that any clinician, regardless of approach, can offer better-targeted and more effective therapy by observing the following principles:

Don't assume that all clients are at the action stage—or want to be. Therapists often design excellent action-oriented treatments only to discover that the client is not yet ready to embrace change. As a result, clinicians may label the client "resistant" and become quickly frustrated with the case. Remember, only 10%–15% of people are in the action stage.

Assess the client's stage of change. This need not be complicated. You might simply ask, "Do you think that any particular behavior is a problem for you now?" After the client has identified a behavior, follow up with, "When do you intend to change that?"

Go slowly. Rather than rushing straight toward action, help your clients to move only one stage further along the continuum—for example, from precontemplation to contemplation, from feeling it's someone else's problem to thinking about trying to do something about it themselves in the next few months. The researchers found that when people progressed from one stage to the next during the first month of treatment, they doubled their chances of taking action within the next six months.

Anticipate backsliding. Although the term "stages of change" suggests that change marches forward in a step-by-step, linear fashion, it actually occurs in a spiral pattern, which encompasses both forward and backward movement. Some people successfully move into action only to relapse and slide all the way back to the precontemplation stage. Therapists should educate clients about the spiraling nature of change to help counteract shame and discouragement about regressing to earlier stages. To minimize backsliding, relapse prevention should be a key part of any treatment plan.

Do the right thing at the right time. An intervention that is effective at one stage might not work at another. For example, precontemplators typically aren't prepared to take in a lot of information and are best helped by observations and interpretations that gently raise their awareness of their difficulties. By contrast, those in the action stage respond best to specific, behavior-change interventions coupled with steadfast support from the therapist.

Avoid inappropriate interventions. One of the most frequent mistakes therapists make is to deliver insight to an individual who is in the action stage—for example, devoting sessions to the impact of a client's family of origin on his marriage at a time when he is actually ready to change his spousal relationship. The likely result: a bored, frustrated client. Another common mismatch arises when clinicians offer action interventions to precontemplators or contemplators, which can leave them feeling inadequate and even hopeless. In both cases, clients are likely to feel deeply misunderstood—and misunderstood clients are more apt to drop out of therapy.

Honor every stage of change. Because the changes that clients make during the action stage tend to be the most visible and dramatic, clinicians often equate change with action. But Prochaska and DiClemente's research illuminates the fact that each stage is a critical element of the change process, and that negotiating each one requires substantial effort and courage on the part of clients. To help people make enduring change, we must be willing to invest considerable energy and patience in each stage—and to validate our clients as they take each small, significant step toward their goals.

Prochaska, DiClemente, and Norcross offer a view of therapy that can prove extremely valuable to all therapists regardless of their theoretical orientation or the kinds of clients treated in their practice. Ever since I first encountered their research, I have kept track of where each client falls in terms of their stages of change. Although tracking where clients are in their stage of change requires a little effort, few pieces of information have proven as valuable. Clients clearly find psychotherapy more engaging and make more progress when the approach is matched with their stage in the change process.

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8

BEYOND INTUITION: RESEARCH ON PSYCHOTHERAPEUTIC PROCESS

Psychotherapeutic process research examines how processes in therapy unfold either through direct observation of therapy or through asking clients and therapists to report on their experiences. This chapter looks at the vital role this kind of research can have for clinical practice, primarily focusing on the research of Leslie Greenberg, illuminating processes in experiential therapy.

Most research assessing psychotherapy follows a simple organization focused on treatment outcome. Clients are evaluated before and after receiving treatment, and the differences between how clients are before and after treatment are compared with the changes in others with similar difficulties who do not receive treatment. Therapy "process research" brings a much different lens to research, examining what clients and therapists actually do in treatment and the immediate impact of what is happening. Process research operates on the principle of smaller is better, intensely examining what occurs during important moments in therapy to provide clues to how therapists can

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11

IMPROVING OUR TRACK RECORD: HOW THERAPISTS CAN BETTER MEET THE NEEDS OF THE DISADVANTAGED

Psychotherapy research, much like most other research, traditionally has paid insufficient attention to highly salient variables such as ethnicity and social class. Treatments that are developed and tested with one population may or may not be effective with another. As mental health treatment research moves into the 21st century, we are seeing increasing attention to the question of how well results can be generalized to those from different ethnicities and social classes. And, as this chapter describes, we are also beginning to be able to learn from research centered on treatments that have been specially tailored to the needs of diverse populations and the economically disadvantaged.

Louise and her two children—Joseph, 10, and Anita, 6—live in one of Chicago's poorest housing projects, surrounded by high crime, drug dealers, and violence. Her job as a food service worker pays minimum

wage, barely enough to feed her kids. Joseph is in trouble at school constantly, fighting with other kids, talking back to teachers, and playing hooky. Just 25 years old, Louise already feels overwhelmed by life and hopeless that anything will ever change. She spends her evenings staring at the television, sinking deeper into depression. Her older sister, Sally, and their mother have tried without success to help Louise and the kids. Joseph's teachers have urged Louise to set firmer limits, but she just doesn't have the energy. She did go to a conference at the school with Joseph's teachers and school counselors, and after much discussion, they suggested she take the family to the local community mental health clinic for therapy.

Louise called the clinic to make an appointment for the family, as she'd been told to do. But after making the appointment, she began to have second thoughts: Where will she find an extra $5 to pay for the session, when she couldn't pay her bills last week? How will they find transportation to the clinic, and will she and the kids make it back home safely through the neighborhood? And lurking behind all those worries was the nagging fear that she would be blamed for Joseph's behavior. Her mother had told her about people who went to the clinic and lost custody of their children. Still, Louise is determined to be there for the appointment. But when she told the children about going for counseling, they flatly refused, and she had no idea how to get them to attend.

After Louise missed the appointment, the intake worker politely called and encouraged her to try again, but with no success. Louise became more lethargic and depressed, and Joseph spent more and more time in trouble.

The prevalence of stories such as Louise's is confirmed by clinical research, which has established that traditional psychotherapy has a less-than-impressive track record with people in poor communities (Bernal, Bonilla, & Bellido, 1995; Bernal & Scharro-del-Rio, 2001; Miranda et al., 2005). Fortunately, research is finally beginning to offer a picture of what works best for clients whose problems are entangled with dangerous neighborhoods, social isolation, and lack of economic opportunities. In recent years, we have also seen researchers move from asking how therapy works with the poor, a question too general to be useful, to the far more instructive study of how therapy can best have an impact on the specific kinds of problems most likely to affect those living in poverty.

In 1995, 11% of the families in America (36 million people) lived below the poverty level ($15,500 for a family of four) and more than 20% of children lived in poverty. Thirty percent of African Americans, 30% of Hispanics, and 50% of African-American children lived in poverty. Research shows that levels of stress, number of individual psychological problems, marital and family difficulties, and severe mental illness increase as socioeconomic status declines. For example, having a low income increases the likelihood of depression, schizophrenia, anxiety, and psychophysiological distress in adults and psychological distress in adolescents. In Leo Srole and associates' classic 1962 Midtown Manhattan Study, which examined the relationship between socioeconomic status and mental health, lower income individuals were overrepresented among those who had significant difficulties in coping, a finding consistently replicated over the years (Srole, 1962, 1975).

Despite the greater incidence of psychological stress, research assessing mental health treatment shows that poor clients are less likely to use psychotherapy, compared with those with more financial resources. And those who try therapy more frequently drop out before the treatment can be delivered. In a 1984 study, Paul Pilkonis and colleagues found that low-income clients seldom stayed in treatment more than six sessions (Pilkonis, Imber, & Rubinsky, 1984). At the same time, it is extremely important to emphasize that outcome research also shows that those who are able to develop positive alliances with therapists and remain sufficiently long in treatment do as well as higher income clients who stay in therapy (Orlinsky, Grawe, & Parks, 1994). Poverty does not affect clients' ability to benefit from therapy, but rather the likelihood that they will form the kind of therapeutic relationship that encourages them to stay with treatment. This finding is no doubt influenced by the fact that clients in poverty are typically treated by therapists who are beginning their careers and are inexperienced in building a therapeutic alliance. The research also shows that clinicians often expect therapy with poor clients to fail and the negative effect of low therapist expectations is a well-documented empirical finding.

Of course, one must be cautious about overgeneralizing about how poverty influences treatment outcome. Poor, well-educated clients have a much more positive view of therapy than less-educated poor people. Newly divorced mothers with low incomes frequently seek therapy for stress and depression and seem to benefit from it. Social and ethnic groups also differ in their response to psychotherapy, and within specific ethnic groups there is enormous diversity in attitudes. For example, a large-scale study conducted by Stanley Sue and colleagues from the Los Angeles Community Mental Health Services in 1991 found Asian Americans and Mexican Americans much less

likely to use services than African Americans or whites (Sue, Fujino, Hu, & Takeuchi, 1991). Other studies, including one conducted by Sue in 1974, have shown African Americans are more likely to drop out before treatment begins or after a few sessions than are poor whites (Sue, McKinney, Allen, & Hall, 1974). Yet researcher Raymond Lorion summarizes the overall finding, replicated again and again about work with low-income clients: "Low-income status contraindicates individual psychotherapy as an intervention" (Lorion, 1978, p. 910). To engage and retain most clients living below the poverty level, therapy needs to be different from traditional office practice.

Researchers have developed and tested approaches to therapy that overcome the most common obstacles to engaging poor clients. Some of their recommendations are

- Offering therapy in clients' homes or neighborhoods
- Reducing costs
- Offering treatments through well-respected community facilities
- Adapting therapy methods to the cultures within a given community

It has been shown that successful treatments for disadvantaged clients typically address multiple levels within the system. The most promising programs combine ingredients from family and individual therapies with ideas drawn from prevention programs, family preservation, and social work. Interventions are aimed at families, individuals, schools, and peer groups.

Howard Liddle, Jose Szapocznik, and Patrick Tolan head large, programmatic research projects that have established, tested, and revised therapy methods targeted at specific populations of economically disadvantaged youth. Liddle, a psychologist at the University of Miami, and his colleagues have developed an approach aimed at urban (largely African American) substance-abusing adolescents and their families (Liddle et al., 2001; Liddle & Diamond, 1991; Liddle & Hogue, 2001). This approach includes elements drawn from structural family therapy, family psycho-education, a developmental perspective on adolescence, and traditional drug abuse therapy. Sessions are typically held in the home. Some meetings are with the entire family, others are with the parents or with the adolescent alone. The therapy first seeks to restore the family's sense of hope through directly engaging their despair about the problem. Subsequent goals focus on helping the family learn about typical patterns in adolescence and drug abuse, on fostering constructive communication, on helping the parents set more

effective limits, and on improving the self-image of teenaged family members. Explicit attention is centered on relevant themes within the clients' cultural community, such as anger, rage and alienation. The powerful influence of the teenage peer groups is also addressed.

In a study comparing this approach with cognitive-behavior therapy in a primarily African-American sample in which 55% of the adolescents had been arrested in the previous year, the adolescents receiving multidimensional family therapy used considerably fewer drugs and alcohol and had many fewer symptoms at six-month follow-ups than those receiving cognitive-behavior therapy. Research has also shown that multidimensional family therapy is highly effective in helping parents work in concert in coping with their teenager (Liddle & Hogue, 2001).

Jose Szapocznik, a psychologist at the University of Miami Center for Family Studies, has developed a multisystemic approach combining structural and ecosystemic therapies for intervening with Hispanic families of adolescent delinquents (Beutler & Crago, 1991; Szapocznik et al., 1989; Szapocznik et al., 2002). He was particularly interested in therapeutic engagement tactics, such as in-home visits and using telephone calls to encourage family members to attend the first appointment. In one study, Szapocznik found that an aggressive approach to alliance building engaged 81% of clients, compared with 60% of families treated with a conventional intake process (Blaney et al., 1997; Santisteban et al., 1996; Szapocznik, Perez-Vidal, Brickman, & Foote, 1988; Szapocznik & Williams, 2000).

In their Metropolitan Area Child Study, Patrick Tolan and his colleagues at the University of Illinois at Chicago have developed an intervention for at-risk, inner-city, elementary schoolchildren, identifying those children showing early signs of acting out before these behaviors become major problems (Tolan & McKay, 1996). Tolan and colleagues begin their efforts with a range of interventions to gain the confidence of the children and their parents, including help in dealing with various bureaucracies. The program provides social skills training for the children, behavior-management and instructional-methods training for the teachers, a small-group program on social skills for high-risk children, and a variety of structural and psycho-educational interventions aimed at improving family management of internal and external stressors. The two-year program has been used in 16 urban schools with second- and fifth-grade children. Initial results after seven years of data collection indicate that the interventions reduce later aggression and lead to fewer arrests among the most aggressive group. These

results suggest that the engagement of the family is critical to treatment success, especially for high-risk kids in high-risk environments.

With solid data now proving both the relative ineffectiveness of office-bound, traditional therapy, and the success of multilevel interventions for the poor, such as those of Liddle, Szapocznik, and Tolan, the potential of therapy to successfully engage and treat low-income clients who face overwhelming obstacles to traditional participation in psychotherapy is not in doubt. The more that community mental health agencies, therapists, schools, and other local organizations take on the burden of making therapy user-friendly for low-income families, and the more that therapists break down the boundaries between individual, family, and community interventions, the more clients such as Louise and her son will stay in therapy and have successful outcomes.

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12

ADDICTIONS TREATMENT: MYTH VS. REALITY

Many of the most exciting findings in psychotherapy research today center on the treatment of those with specific difficulties or disorders. This chapter focuses on two recent landmark reviews of the research on the treatment of those with substance use disorders that suggest many useful understandings about these difficulties and guidelines for treatment. Highlighting the role that research can play in showing how realities can differ from commonly held beliefs, several of these findings and guidelines contrast with long-held myths about how the treatment of those with substance use disorders is best conducted.

Substance abuse treatment used to bring to mind a no-holds-barred, in-your-face engagement, such as the notoriously confrontational groups of the 1970s and 1980s, often led by tough former addicts, or the Johnson intervention, in which family members and close friends came together to overwhelm the abuser's denial with stories of the harm done and to insist on treatment. It was widely accepted that the best therapists for addicts were former addicts. Many thought intense,

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MINDFULNESS GOES MAINSTREAM: RESEARCH IS PROVING THE VALUE OF AWARENESS PROCESSES

Psychotherapy research has rarely examined interventions that lie outside of the mainstream of practice. And when research centers on these sorts of methods, it's rare that the findings about treatment effectiveness parallel the excitement of clinicians offering these interventions. The integration of mindfulness practice into psychotherapy is a major exception to this trend, with a solid base of research support accumulating. This chapter looks at some major recent trends in research on using mindfulness in psychotherapy.

It seems hard to believe that only about 20 years ago, meditation was still widely considered something practiced only by Zen students, yoga adepts, and New Age esoterics in Birkenstocks. True, in the 1970s, a few outlander physicians, led by Herbert Benson, began studying the power of meditation to evoke a relaxation response that lowered blood

pressure and alleviated stress. Still, for a long time, the scientific credibility of meditation as a legitimate healing approach was roughly on the same level as faith healing and exorcism.

Over the past 10 years, however, what began as the outre, even slightly disreputable idea that meditation might actually have a real and empirically measurable impact on mental and physical health has now become almost mainstream. Since the 1970s, dozens of research studies have demonstrated that meditation can reduce anxiety, stress, blood pressure, chronic pain, insomnia, posttraumatic stress disorder symptoms, and substance abuse. It also seems to improve the quality of life.

The practice of mindfulness has been part of many Asian traditions for thousands of years and part of some methods of psychotherapy since the pioneering work of Alan Watts (1963) and others brought Eastern ideas of consciousness into the world of psychotherapy in the 1950s and 1960s. Entire cultures have been profoundly affected by formal and informal exposure to ways of experiencing aimed at increasing mindfulness, such as meditation and yoga, and these methods are now also practiced by millions of Americans.

But, until the last few years, relatively few credentialed, respectable and standard-issue psychotherapists seemed to have discovered meditation for themselves, much less felt prepared to teach their clients how to do it. Hovering for years around the fringy edges of mental health care (along with crystals and aura readings), it is only now beginning to enter the mainstream of psychotherapy practice. These days, more and more workshops and conferences seem to have *mindfulness* or *meditation* in their titles and increasing numbers of therapists are not shy about admitting that, right along with their other favorite modalities, they also teach their clients to sit quietly and follow their breathing.

In spite of increasing support for meditation among practitioners and lots of anecdotal evidence that it works well for many different clients in a variety of circumstances, formal research on the value of incorporating it into the clinical practice of psychotherapy has been relatively sparse. Why should this be? Perhaps the philosophy of detachment, learning to accept and make peace with life as it is, which is often seen to accompany meditation traditions (e.g., Zen Buddhism) seems to conflict with the goal of endless improvement and progress that characterizes Western science and, probably, most psychotherapy models. It is wired into the fabric of our society, business, science, and health care that we aim to improve, to get better, to not be satisfied with the status quo. And the ever-present orienting word for most psychotherapies has been *change* rather than *acceptance*. Or, maybe meditation still seems tainted by its associations with religious and spiritual traditions, and exotic "foreign" traditions. Most likely, the research community is guilty of its own sort of myopia and difficulty thinking outside the box it has created for itself. The biggest, most stultifying box of all is the self-defeating assumption that there must already be some scientifically empirical evidence for the value of an intervention *before* there can be more exploration of its value as an intervention!

But this assumption is indeed nearsighted, because there is a growing body of very exciting research that demonstrates the extraordinary power of mindfulness practice on the way the mind works. Granted, much of this research has not been done in the realm of psychotherapy per se, but some of the evidence for the impact of meditation on the mind and brain is so convincing that even the hardest nosed psychotherapy researcher should be impressed.

In one of the most remarkable partnerships in the history of research, Richard Davidson, a neuroscientist at the University of Wisconsin, collaborated with the Dalai Lama on an astonishingly innovative piece of research investigating the impact of long-term meditation on the mind and brain (Davidson et al., 2003). For this project, the Dalai Lama sent eight of his monks, who had each meditated between 10,000 and 40,000 hours over the preceding 15 to 40 years, to Davidson's laboratory. In a randomized design, comparing the brain waves of these monks with those of novice meditators, Davidson and colleagues found that the monks had substantially higher levels of gamma brain waves, brain activity indicating higher levels of consciousness, than the novices. In addition, the monks' brain waves were also better organized and coordinated than in the controls, indicating that their consciousness seemed to more smoothly invoke a sense of familiarity and openness to experience. Brain activity in the monks was highest in the left prefrontal cortex, the area of the brain that has been associated with happiness. Furthermore, these differences in how the brain functioned remained present even when the monks were not meditating; the years of mindfulness practice seemed to have changed how the brain operated. And as with other dose-response effects, those who had practiced the longest showed the strongest effects.

Other major threads of research are more directly related to psychotherapy. Some studies, for example, have looked at the value of training in mindfulness techniques for increasing happiness and reducing levels of distress and psychopathology. The best known is a series of studies by Jon Kabat-Zinn of the University of Massachusetts Medical Center, who developed and evaluated a program for increasing mindfulness called "mindfulness-based stress reduction" (MBSR)

(Kabat-Zinn, 2003a, 2003b; Kabat-Zinn, Lipworth, & Burney, 1985). Developed originally in the context of exploring its impact on chronic pain, MBSR is an 8- to 10-week course for instruction and practice in mindfulness, which includes an all-day intensive mindfulness session. Participants practice at least 45 minutes per day, 6 days per week. A prominent feature of MBSR training is teaching participants to observe their emotions, sensations, and cognitions, even the unpleasant and painful ones, calmly, dispassionately, and without judgment. Kabat-Zinn's research showed that MBSR led to significant decreases in pain and in the number of medical symptoms reported and reduced psychological distress in participants (Kabat-Zinn, 1984; Kabat-Zinn et al., 1985). Similar findings have emerged in rigorously controlled studies done by Kabat-Zinn and colleagues examining the impact of MBSR on generalized anxiety disorder and depression (Kabat-Zinn, 2003a; Kabat-Zinn, et al., 1992).

What does it mean to be mindful or to do research on mindfulness? How do you take this deeply private, spiritual, and elusive experience and make it the focus of research aimed at studying how these experiences can become part of replicable psychotherapy treatments? Rather than analyzing what is perhaps unanalyzable, researchers studying mindfulness have focused more simply on two core aspects of mindfulness: the value of remaining in the moment and the development of one's ability to accept and go with what is occurring. These sum to maintaining a focus on the present rather than past or future, and on learning to observe and follow one's experience rather than to guide it. Typically, in these efforts, mindfulness is usually defined much the way Kabat-Zinn defines it, as paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally. Such mindful practice is consciously and purposely initiated, but allows experience to unfold without evaluation or criticism. Following from such definitions, researchers have developed a technology for assessing mindfulness, such as the Mindfulness Attention Awareness Scale, developed by Kirk Brown and Richard Ryan (2003) of University of Rochester, and the Kentucky Inventory of Mindfulness Skills, developed by Ruth Baer, Gregory Smith, and Kristen Allen (2004) of the University of Kentucky. Such scales track clients' self-report of their mindful experience such as their ability to remain nonjudgmental. Although such brain technologies as magnetic resonance imaging and electroencephalogram—as used in the Davidson research assessing the monks, described previously—have promise for indicating levels of mindfulness, to date research on the extent to which mindfulness is present remains principally the product of self-reports.

Particularly promising, and unexpected, is a surge in research on mindfulness from cognitive-behavioral therapists, a set of research/practitioners who often seem dismissive of all techniques outside their usual cognitive-behavior therapy (CBT) methodologies and particularly disdainful of so-called humanistic therapies. Yet, a growing number of the most prominent CBT researchers have become convinced of the value of these methods and have come to see them as consistent and complementary with CBT. How can it be that practitioners of such strict, empirically demonstrated, protocol-driven methods are being turned on by something as ephemerally mystical sounding as mindfulness? After all, CBT therapists are typically very concrete and focused on behavior and language, highly active and judgmental in questioning ideas explicitly labeled as "cognitive distortions," a zeitgeist far removed from mindfulness. And unlike the Zen archer, CBT therapists are typically trained to aim their arrows quite precisely.

However, it should be remembered that CBT and mindfulness practice aren't as foreign to each other as they might seem. CBT therapists have always employed techniques, such as relaxation and imagery, that had some overlap with mindfulness practice. Both CBT and mindfulness share the notion of directed awareness about one's inner processes and a focus on how we automatically react to situations and get carried away by our feelings. Furthermore, several decades of pursuing directed change has led some in the CBT movement to come to intimately understand the limits of directed efforts toward change, which does not help everyone and which even leads to active resistance on the part of some clients. Even highly successful CBT treatments such as cognitive therapy for depression do not succeed in helping many clients reach "normal" functioning at the end of treatment. Such findings have led leaders in the CBT movement, such as Steve Hayes (2002, 2004a, 2004b) of the University of Nevada and Andrew Christenson (Christensen, Sevier, Simpson, & Gattis, 2004) of the University of California Los Angeles, to write and speak extensively about the need for self-acceptance and acceptance of others as they are. And, yet another source of connection is that some CBT therapists such as Alan Marlatt and Marsha Linehan have for many years engaged in mindfulness practice in their own lives, long before they brought these methods into their practice of CBT.

One example is a closely related variant of Kabat-Zinn's MBSR developed by John Teasdale and his colleagues in Cambridge, England, that melds mindfulness with cognitive therapy called mindfulness-based cognitive therapy, which has been shown to help reduce recidivism in depression (Teasdale, 2004; Teasdale et al., 2000; Teasdale et al., 2002).

Teasdale and colleagues developed an eight-week program based on Kabat-Zinn's program aimed to help depressed people acquire a sense of detachment from the patterns of thoughts that tend to automatically trigger their depression. Mindfulness-based cognitive therapy includes simple breathing meditations and yoga stretches to help participants become more aware of the present moment, and learning mindfulness meditation that accents allowing distressing and depressive thoughts and feelings to come and go. Teasdale and colleagues found far lower rates of relapse (37%) in depressed patients who had major depressive disorder and received this intervention than those who did not receive this special treatment (who had a relapse rate of 66%). The effect was most pronounced in those who had three or more previous episodes of depression.

In another example of the potential uses of meditation in psychotherapy with a difficult population, Alan Marlatt of the University of Washington examined the impact of a mindfulness practice called Vipassana meditation on the behavior of a prison population (Marlatt, 2002; Marlatt et al., 2004). Prisoners in a minimum security facility in Washington either participated in a 10-day course or simply completed measures receiving the typical regimen in the prison. Marlatt found that even in this highly recidivist population, participating in this program instead of in treatment as usual resulted in reduced levels of arrest, less alcoholism, and less drug use. For example, alcohol use in the meditation group went from 50 days of the last 90 to only 10 days, far fewer days than the control group, and total alcohol and drug use was also much less frequent.

We are also beginning to see mindfulness practice incorporated as one component of multi-method treatments intended for clients with problems notoriously resistant to treatment. Dialectical Behavior Therapy (DBT), for example, originally developed for clients with borderline personality disorder by Martha Linehan of the University of Washington, incorporates mindfulness training as part of a complex treatment strategy. In DBT clients are taught mindfulness skills, such as observing their own emotions, to help them calm down and get some detachment from their own inner turmoil (Bagge & Linehan, 2000; Linehan, 1987, 1993). For this sensitive and very troubled group, the mindfulness training is taught in a more flexible way, with less-demanding expectations for practice than some other more-structured mindfulness instruction programs (Dimidjian & Linehan, 2003; Linehan, 1993). The training is structured in this way to mitigate the difficulties that these clients often have in responding to rigid structures and expectations for performance, as well as in response to the high levels of frustration and powerful troubling affects that these clients can quickly develop. The client is allowed to become comfortable with the techniques in a nondemanding environment so that they can experience the soothing effects and, in this way, gradually increase mindfulness practice. DBT, which makes this mindfulness practice one of several key interventions, has been the subject of several clinical trials that have established it as a well-established treatment for borderline personality disorder, and now the most widely circulated treatment for this difficulty (Linehan, 2000).

Enough research has emerged over the last few years that a meta-analysis of studies specifically testing the impact of mindfulness interventions has recently appeared in the prestigious research journal, *Clinical Psychology*. In that analysis, Ruth Baer (2003) assessed the impact of the summation of all the research on mindfulness on the kinds of problems frequently encountered in psychotherapy, such as depression and anxiety. She found a mean effect size for all these treatments of 0.74, meaning that 74% of those in the groups receiving mindfulness training did better than those receiving the alternative of no treatment or another treatment. This is what is statistically called a "large" effect for these interventions, signifying that in statistical terms the effect is considerable and that the vast majority of those receiving the treatment are helped compared with those not receiving it. And she found these treatments to be highly acceptable to clients: 85% of participants complete these programs.

So where is this research taking us? It seems clear that research has already demonstrated how powerful mindfulness techniques can be in the treatment of pain, anxiety, depression, and even more complex and difficult problems, such as borderline personality disorder. The impact of these methods on those not suffering from emotional problems is equally clear, and mindfulness techniques are increasingly becoming a staple of the movement toward accenting positive psychology led by psychologist Martin Seligman of the University of Pennsylvania (2002). Basic questions still remain about the most useful ways to incorporate these techniques into psychotherapy (particularly, how and when they should be integrated with other techniques) and for which clients these methods are most useful. Furthermore, as Sona Dimidjian of the University of Washington and Marsha Linehan have pointed out, research so far has focused only on the secular variations on mindfulness, leaving unexplored the role that spirituality has typically played in traditional mindfulness traditions (Dimidjian & Linehan, 2003; Hayes, Follette, & Linehan, 2004). To what extent, if at all, are the beneficial aspects of mindfulness connected to the spiritual or religious

meanings ascribed to these practices by traditional cultures? Over the next decade, it will be interesting to see research examining and comparing mindfulness practices both within and outside of the different native contexts in which they originally took root. For now, research has revealed that there is real value, if not fully explored or analyzed, in helping therapists learn mindfulness skills and teach them to their clients.

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14

REASSESSING SELECTIVE SEROTONIN REUPTAKE INHIBITORS: SEPARATING HYPE FROM FACT ABOUT ANTIDEPRESSANTS

Arguments about the efficacy of treatments sometimes play out in the marketplace as much as in clinical research and practice. Selective serotonin reuptake inhibitors (SSRIs) have been heavily marketed with extraordinary claims for effectiveness in treating all forms of depression. This chapter looks at the evidence for the impact of SSRIs compared with the evidence for the impact of psychotherapy. The findings discussed provide an example of how research can sometimes point to conclusions that widely differ from popular conceptions.

For the last decade, there's been a spectacularly successful advertising campaign to convince the public that the SSRIs, including Prozac, Zoloft, Celexa, Lexapro, Luvox, and Paxil, have revolutionized the treatment of depression. In response, antidepressant use has doubled and requests for antidepressant treatment have tripled in the last 10

years. Today, 74% of those seeking help with depression in the United States are treated with medication. Incredibly, 28 million Americans have taken an SSRI, including 500,000 children. A full 10% of the elderly now receive antidepressants at any point in time. Researcher James Coyne of the University of Pennsylvania has pointed out that more people fill prescriptions each year for antidepressants than research indicates fit the diagnosis of depression, suggesting the widespread use of these medications for other conditions, even though these uses remain wholly untested (Coyne, Thompson, Palmer, Kagee, & Maunsell, 2000).

Meanwhile, the remarkable growth in use of the SSRIs has paralleled a significant decrease in the use of psychotherapy to treat depression. The proportion of those being treated for major depressive disorder or dysthymic disorder with psychotherapy declined from 71% to 60% over a recent 10-year period.

DEPRESSION AS A DIAGNOSIS

Before exploring the impact of various treatments on depression, it is essential to understand the context for this research. There has been no testing of the impact of medications on the feelings such as sadness, upset, or irritation in the general population. All uses of medication to ameliorate such feelings extend beyond the purposes for which these medications were created and are without any research demonstrating an impact. Antidepressant medications have been tested only in relation to their effect on individuals who meet the criteria for the specific *Diagnostic and Statistical Manual–IV* diagnoses for depression, the conditions they were developed to treat.

The research on depression that we are considering focuses on the treatment of the two principal syndromes in which signs of depression predominate: major depressive disorder and dysthymic disorder. Both of these syndromes feature the presence of such symptoms as depressed mood, diminished pleasure, poor appetite, low energy, low self-esteem, and feelings of hopelessness (and the absence of manic symptoms that would result in a diagnosis of bipolar disorder). Major depressive disorder tends to be more acute and severe, whereas dysthymic disorder tends to be less intense and extend over a longer period. Individuals diagnosed with either syndrome experience something well beyond just feeling sad or reacting to an acute loss.

THE IMPACT OF SSRIs

Do these pills work as advertised for most people? SSRIs have fewer side effects than older generations of antidepressants (the tricyclics), and overdoses tend not to be lethal, making them safer for physicians to prescribe. However, the research provides little support for the notion that these drugs are a breakthrough in the treatment of depression. The key findings of the latest research ("Depressing Research," 2004; Whittington et al., 2004; Wilson & Mottram, 2004) indicate that:

- SSRIs are *no more effective* than the older tricyclic antidepressants, such as Elavil or Tofranil, which have been around for decades. For example, a meta-analysis by several researchers at the Evidence-Based Practice Center at the University of Texas at San Antonio found that the SSRIs help 63% of patients, compared to 60% for tricyclics. So, whereas SSRIs may have fewer side effects, they're no more effective than older generations of drugs, and they're more expensive.
- The impact of SSRIs on depression in children and adolescents is minimal. Recent surveys of treatment research indicate impact no better than placebo.
- Taking SSRIs increases the risk of suicide and suicidal ideation, especially in children and adolescents. Rates of suicidal ideation have been as high as 9% in a trial of Lustral, an SSRI manufactured by Pfizer. This rate is much higher than the rate of suicidal ideation among subjects receiving a placebo.
- Although lacking the side effects of the tricyclics, SSRIs often result in loss of libido, a side effect found in as much as 70% of those taking these medications. Many find this so distressing they discontinue use.
- SSRIs often lead to intense anxiety, lethargy, and distress when medication is discontinued. There's increasing evidence of at least a psychological dependency on these medications, which leads to considerable discomfort when clients stop taking them. This, in turn, makes discontinuing these medications more difficult.

Despite this research, the general public continues to overestimate the effects of the SSRIs. Because the pharmaceutical industry not only spends millions of dollars in advertising, but also funds much of the research on their products, it can largely control the flow of information to the public, which remains unaware of research findings. The *New York Times* recently reported Forest Laboratories' failure to release research showing low levels of impact on children and adolescents for

its SSRI Celexa. Under pressure, Forest then released data from a study showing a similar lack of impact for Lexapro, another Forest antidepressant, in children and adolescents. The data demonstrating the small impact and increased risk in children for all SSRIs recently led to a decision by Great Britain's Medicine and Health Care Products Regulatory Agency to warn against prescribing SSRIs for depressed children and adolescents.

Nevertheless, the combined results of all the studies on adults treated with SSRIs do indicate that, though these aren't "wonder drugs," they do help the majority of adult clients with major depressive disorder or dysthymic disorder. Therefore, many professionals and organizations, including the American Psychiatric Association and the American College of Neuropsychopharmacology, argue strongly for the efficacy of SSRIs.

SSRIs VS. PSYCHOTHERAPY

To put the effectiveness of SSRIs into perspective, it's also helpful to compare research on SSRIs with studies of psychotherapy as a treatment for depression. Several forms of brief therapy have been shown to have effects comparable to the SSRIs. The best-established treatment is Cognitive Therapy for Depression (Beck & Young, 1985), a therapy developed by psychiatrist Aaron Beck of the University of Pennsylvania, which focuses on challenging the accuracy of depressive thoughts and building a more optimistic worldview.

Considerable evidence also supports the success of Interpersonal Therapy for Depression (Klerman, Weissman, Rounsaville, & Chevron, 1996), a form of psychodynamic therapy developed by psychiatrist Gerald Klerman and psychologist Myrna Weissman. Behavioral approaches, centered on helping clients become more activated through self-monitoring, scheduling, and self-reward—such as the approach developed by University of Oregon psychologist Peter Lewinsohn (Lewinsohn, Clarke, & Hoberman, 1989)—have also proven effective. Research indicates that approximately 80% of depressed clients are typically helped by each of these therapies, without the side effects and increased risks that accompany medication.

Few studies have directly compared medication and psychotherapy. Such research is expensive and risky for both sides of the controversy. The best known comparative study is the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP), conducted in the 1980s by psychologist Irene Elkin, now a professor at the University of Chicago (Elkin, 1994; Elkin, Gibbons, Shea, & Sotsky, 1995; Elkin, Shea, Watkins, & Imber, 1989; Elkin, Parloff, Hadley, & Autry, 1985). This study compared short-term cognitive therapy, interpersonal therapy, and tricyclic medication. The research found all the treatments had comparable impact and concluded that medication and short-term psychotherapy worked equally well in treating dysthymia and depression.

However, the study used many measures and numerous ways of analyzing the sample of clients, leaving a wide range of possible interpretations of the results. Some prominent psychopharmacologists, including psychiatrist Donald Klein (1996, 1999; Klein & Ross, 1993), argue the study supports the superiority of medication, particularly in those with more severe depression. Proponents of psychotherapy, among them Robert DeRubeis of the University of Pennsylvania, rebut that conclusion (DeRubeis & Gelfand, 2000). What's most striking in the TDCRP is that the treatments were comparable in their effectiveness, and even the placebo group improved. Another factor to consider is that the time frame for treatment in these research studies—16 sessions—is more conducive to medication trials than to psychotherapy. The impact of psychotherapy is all the more impressive then, given that clients might still be in early stages of therapy treatment at the study's conclusion.

DEPRESSION AND RELATIONSHIPS

Recent studies of the treatment of depression have also suggested a special place for couple therapy. Typically, one-half to two-thirds of depressed individuals who are married also have distressed intimate relationships, pointing to these relationships as an obvious target for intervention. Two major studies have found couple therapy to have an impact comparable with individual therapy on depression, with the impact especially marked for those who are in distressed relationships (Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky 1991; O'Leary & Beach, 1990). And in these studies, only the couple therapy improves the distressed relationships. Based in these findings, psychologists Maya Gupta, James Coyne, and Steven Beach (Gupta, Coyne, & Beach, 2003) have suggested that for many people with depression what may be needed may be a new kind of couple therapy: one that deals with the difficulty of involving partners of depressed clients in therapy and possibly that does not depend on the participation of both partners.

CHRONIC DEPRESSION

Another research finding not generally publicized is the fact that a substantial number of depressed clients in these studies (20%–30%) don't improve, no matter what treatment they receive. And among those who do improve, there are high rates of recurrence. The risk of repeated episodes of depression exceeds 85% over a period of 10–15 years. Individuals who have one episode of major depressive disorder typically experience four major episodes of approximately 20 weeks' duration during their lifetime, in addition to other symptoms of depression, such as intense sadness and low energy, during the periods of remission (Westen, Novotny, & Thompson-Brenner, 2004)

Although some therapists and researchers think these findings about treatment failure suggest a need for better medications and more effective short-term psychotherapies, this ignores the data on the nature of depression itself. Others argue that high incidence of recurrence may simply be a risk of depression and that no treatment may fully eradicate the problem. In a landmark research study examining depressive symptoms over time, James Coyne and his colleagues Michael Klinkman and Thomas Schwenck found the patterns in depression to be more like chronic disorders, such as asthma, than like acute disorders that are amenable to targeted interventions, such as appendicitis (Coyne, Thompson, Klinkman, & Nease, 2002). Coyne and colleagues suggest depression is a chronic condition and that effective intervention should focus on the factors that bring on and intensify depression, much like the lifelong treatment of diabetes. However, the acute-disorder model is the one driving most psychopharmacological intervention for depression today.

CONCLUSION

Based on the recent research on the treatment of depression, it's clear that the health care establishment, the general population, and mental health providers need to broaden their view of depression and its treatment. This won't be easy, because short-term decisions provide immediate gratification. To the depressed client, taking a pill to feel better soon is easier than engaging in therapy. To the health care system, dispensing pills is cheaper, faster, and more profitable than therapy. What's missing from these approaches is the recognition of the long-term psychological and economical consequences of these short-term solutions. From a financial standpoint, the cost of taking an antidepressant over a lifetime is much greater than the cost of psychotherapy offered as needed to fit the ecology of depression. When the psychological benefits that result only from therapy, such as increased emotional maturity, improved relationships, and greater life skills, are added to the equation, the value of medication to the depressed patient and to society pales in comparison with the efficacy of psychotherapy.

The research on the treatment of depression is far out of keeping with the depictions in the ubiquitous advertisements we see for antidepressants. Even on the playing field of research designs which are better suited to drugs and which constrain psychotherapy, enough data have already accrued to argue strongly for psychotherapy as at least equally effective as medication even in simply accomplishing the goals of symptom reduction. And in children and adolescents, psychotherapy is clearly the safest and most effective treatment for depression. But, of course, who receives what treatment is a matter not just of what works but of other factors, such as the marketing of those treatments to the public. The pharmaceutical industry is powerful and has deep pockets. We can hope that this will be a place where the data triumphs and the trend toward using antidepressants as *the* primary treatment for depression will reverse course.

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16

THE MESSENGER IS THE MESSAGE: THE EFFECTIVENESS OF TREATMENT STILL DEPENDS ON WHO DELIVERS IT

Psychotherapy research typically focuses on the treatment and the clients, but rarely on the psychotherapist. Yet therapies are only delivered through a therapist and research shows that therapists differ in the relationships they are able to build with clients and in their effectiveness. This chapter centers on the largest and most comprehensive effort to study psychotherapists, an effort that helps us understand who therapists are and the ways they practice most effectively.

Psychotherapy researchers typically focus exclusively on different clinical interventions while ignoring the psychotherapists who make use of them. It's as if treatment methods were like pills, in no way affected by the person administering them. Too often researchers regard the skills, personality, and experience of the therapist as side issues, fea-

tures to control to ensure that different treatment groups receive comparable interventions.

However, studies that do take into account the therapists' relational skills and personal styles have found that these qualities have a greater impact on outcome than the treatments they offered. In fact, comparative studies of different treatments often show more variation within a group getting one kind of treatment than between groups getting two different kinds of treatment (Lambert & Barley, 2001). And the largest proportion of this outcome variance, it's now well known, stems from relationship factors (Wampold, 2001). In fact, the National Institute of Mental Health Treatment of Depression Collaborative Research Program found that even the effectiveness of psychopharmacology is significantly influenced by the "bedside manner" of the physician dispensing the medication (Krupnick, Elkin, Collins, & Simmens, 1994).

And yet, surprisingly, little research has been performed on psychotherapists themselves, even though their individual characteristics are probably the single most important factor in therapy's success or failure. Without having a clear idea of who and what psychotherapists are as a group—their personal traits, professional training, personal and professional experience of therapy, clinical orientations, and how they develop over time—it is difficult to fully understand their clinical impact.

Now, at last, there's some serious, long-range research being conducted on psychotherapists. David Orlinsky, a professor of psychology at the University of Chicago and a founder of the Society for Psychotherapy Research, has launched an international research project to determine what therapists bring to the therapeutic encounter, personally and professionally, and what their experience of the therapeutic process is at different stages in their careers (Ackerman et al., 2001; Ambühl, Orlinsky, Cierpka, & Buchheim, 1995; Smith & Orlinsky, 2004).

Long before there were narrative therapies, Orlinsky, along with long-time collaborator Ken Howard of Northwestern University, intensely studied the views of clients and therapists session by session over the course of therapy in a project described in the book, *Varieties of Psychotherapeutic Experience.* In that study, Orlinsky and Howard found a complex set of interactions between the way clients' and therapists' experience therapy. These interactions involved the clients' and therapists' sense of collaboration and shared positive experience, which determined the impact of the therapy (Howard, Orlinsky, & Hill, 1968; Orlinsky & Howard, 1967a, 1967b). Now, working on a shoestring budget outside the limits imposed by government funding and with an international group of coinvestigators that included

M. Helge Rønnestad of the University of Oslo, Hansruedi Ambühl of the University of Bern, Ulrike Willutzki of Ruhr-University of Bochum, Jean-Francois Botermans of Catholic University of Louvain, Manfred Cierpka of University of Heidelberg, John Davis of the University of Warwick, and Marcia Davis of North Warwickshire Health, Orlinsky developed an extensive questionnaire to assess how therapists experience therapy, training, and their own lives (Frank et al., 1992; Orlinsky, Ambühl et al., 1999; Orlinsky, Rønnestad et al., 1999). That questionnaire asked about such obvious factors as discipline, employment setting, years of experience, orientation and training, but also delved into therapists' self-perceptions at the beginning their careers and how they changed over time, the kinds of clients they saw, their degree of satisfaction in their work, their views of themselves as therapists, their coping strategies, their difficulties, and their degree of satisfaction in their own lives.

To date, 8,000 therapists from 30 countries have completed the questionnaire. The largest numbers of respondents are from the United States, Germany, South Korea, Norway, and Great Britain. The study provides the best snapshot we have of what therapists around the world are like. The clinical experience of this sample ranges from less than 1 year to more than 50 years, with therapists averaging 11 years in practice. Some 44% of the therapists have either a part-time or full-time private practice. Slightly more than 50% of the therapists are female. They range in age from 21 to 91 years old, with a mean age of 42.

In terms of preferred modality, nearly 60% of these therapists rely strongly on psychodynamic concepts in their work with patients, about 30% rely strongly on humanistic/existential orientations, 20% are strongly influenced by cognitive and cognitive-behavioral approaches, and 20% by systemic theories. More than 75% of the respondents had experienced therapy themselves at least once in their lives and more than 25% were in personal therapy.

PATTERNS OF PRACTICE

Examining how therapists generally experience the process of doing therapy themselves, Orlinsky and his colleagues identified two distinct states of mind and work: "healing involvement" and "stressful involvement." In healing involvement, therapists experience themselves as feeling personally committed, affirming, fully engaged with a high level of empathy, having good communication skills, and enjoying a sense of conscious "flow" during sessions. They feel effective, and they can deal with difficulties constructively when they arise. By contrast, in stress-

ful involvement, therapists experience themselves as feeling bored and anxious during sessions and as having difficulties with clients, which they tend to deal with unconstructively by avoiding engagement.

Most of us can recognize both these states in our own practices: we know that feeling of being alive, engaged, and productive, and we've also felt that other state, often expressed as the fervent wish, "I hope they don't make their session today!" But, clearly, if we're doing a good job and generally enjoy our work, we feel more dedicated than we do detached.

Although all therapists experience some proportion of each of these states, Orlinsky and his colleagues found that the amount of time therapists spend in each state produces four distinct practice patterns: effective practice (characterized by much healing involvement and little stressful involvement), challenging practice (with much healing involvement but also much stressful involvement), distressing practice (with high stressful involvement and little healing involvement), and disengaged practice (with little stressful involvement but also little healing involvement). Half the therapists in the study emerge as in "effective practice," a quarter in "challenging practice," and a small but significant minority described themselves in "disengaged" (1 in 6) and "distressed" practice (1 in 10). Thus most therapists have a predominantly positive experience of their clinical work, but nearly 30% experience themselves as stressed or disengaged in their work—a significant number by any standards.

In their recently published book, Orlinsky and his Norwegian colleague Helge Rønnestad (2005) also examine therapists over their professional life cycle. Their findings on this subject include the following:

- Therapists at all levels of experience value their continuing development and show high levels of current growth. For most therapists, growth is a lifetime task. And if therapists don't feel they're moving forward, they're susceptible to becoming disengaged or distressed practitioners.
- As they become more experienced, therapists come to feel increasing levels of healing involvement and lower levels of stressful involvement. Thus the number of therapists reporting effective practice grew from about 40% among novices to 65% among experienced therapists. The therapists reporting distressed and disengaged practice declined from 20%–25% percent among novices to 3%–11% among experienced therapists. Beginners experience the highest levels of stressful involvement.
- High levels of theoretical breadth, variety of caseloads, and current experiences of growth increase healing involvement and effectiveness. Clearly, remaining effective as a therapist is a function of renewal and change, not mere repetition of methods of practice over time. And a sense of improving over time also depends on the breadth and depth of case experiences.

DIRECTIONS

Based on the findings of what differentiates therapists who experience their careers positively from those who don't, Orlinsky and Rønnestad offer a number of suggestions for the training and development of therapists, including the following:

- Because the relationship between therapist and client is so important for effective therapy, therapists should be selected for academic programs, in part, because they have good interpersonal skills. This criterion is often ignored by training programs, which base their selection of candidates primarily on school performance.
- Therapists should receive a foundation of training in a clear method of practice. Such a foundation seems to reduce the levels of stressful practice for therapists, which is the bane of existence for many clinicians early in their careers.
- Therapists should broaden their own base of practice as their careers progress. Having a variety of different types of clients and professional experiences, as well as expanding one's repertoire of methods and interventions, promotes the sense of personal renewal and professional growth that's essential to building and maintaining effective practice.
- Therapists should be mindful of the stress that inevitably accompanies their career choice and monitor as well as limit the number of highly distressing clients in their caseloads. They also should always maintain strong personal and professional support networks among family, friends, and colleagues to mitigate stress and burnout.

Of course, the sources for these data are therapists themselves. Can we as therapists trust ourselves to report accurately about our experiences? The answer appears to be "yes." A long line of research studies of therapist, client, and observer reports about therapy is unambiguous on the subject. Research has also shown that therapists do see therapy somewhat differently than do clients and observers. Their perspective is unique, though typically honestly reported (Beutler, Machado, & Neufeldt, 1994).

In outcome studies, they also tend to be most pessimistic about outcomes of the three perspectives about progress in psychotherapy.

Orlinsky and colleagues have provided a unique view into the minds and experiences of psychotherapists, and clearly psychotherapists themselves are the best source of information about their own experiences, just as clients are. What emerges most strongly from their study is a reminder from the world of research that psychotherapy is most of all a human activity, and shouldn't be confused with that kind of treatment described by Alan Gurman as "technolotry"—the worship of technique over everything else. Orlinsky and Rønnestad say, "Therapists did not experience themselves as detached technicians dispassionately administering treatment procedures but rather as healers working with the heart as well as the mind" (Orlinsky & Rønnestad, 2005). The traditional image of the psychotherapist as neutral, recently further implied in the context of some technique-oriented evidence-based practice, is clearly at odds with how most therapists experience themselves, and is typical of only a minority who experience themselves as relatively ineffective.

RESOURCES

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23

NEW SCIENCE FOR PSYCHOTHERAPY: CAN WE PREDICT HOW THERAPY WILL PROGRESS?

Progress research looks at how clients change over the course of psychotherapy by assessing how they are doing on a session-by-session basis and whether their gains over time match those that might be expected. In contrast to most psychotherapy research, this form of research focuses on how individual clients change in relation to their own earlier levels of functioning (an example of what is called an ipsative measure) rather than how well kinds of treatment work for groups of clients. This chapter focuses on the research of Kenneth Howard, who was the principal architect of progress research.

Until recently, research examining psychotherapy offered only limited guidance to practicing therapists. The structure of the typical study—from its university setting, to its elaborate controls to assure validity, to its carefully qualified conclusions (e.g., "more research is necessary")—mitigated the opportunity for the direct application of research findings. Over the past few years, however, we have begun

to see the emergence of research that is intended to influence practice and is designed for consumption by care providers. A prime example has been the work of Kenneth Howard, a professor at Northwestern University before his untimely death in 2002.

Howard was forever on the cutting edge of practice-relevant psychotherapy research. In the 1960s, well before the interest in understanding the client's perspective and current discourse about the client's voice, Howard and his longtime colleague David Orlinsky asked clients and therapists directly about their experiences in psychotherapy. Their book on the results, *Varieties of Psychotherapeutic Experience,* remains an essential guide to the experience of psychotherapy. Howard then turned to investigate such vital questions as, What progress can be expected in therapy? What does an expected course of treatment for a particular problem look like? and When can we say a therapy has had a fair trial and is not working? This group of studies, which has important implications for clinicians, public-policy makers, and those involved in the funding of mental health care, earned Howard several awards, including the Distinguished Professional Contribution to Knowledge Award from the American Psychological Association.

Howard's work strongly supports the efficacy of psychotherapy. In his sample of 15,000 clients treated in a wide range of settings and modalities, most treatments emerge as highly effective in helping individuals, couples, and families resolve their difficulties and achieve their treatment goals (Howard, Moras, Brill, & Martinovich, 1996; Howard, Lueger, Martinovich, & Lutz, 1999; Sperry, Brill, Howard, & Grissom, 1996). Howard emphasized that a similar level of effectiveness has been found in numerous other samples (Lambert & Bergin, 1994; Smith & Glass, 1977), making psychotherapy among the most tested and empirically validated health interventions.

Howard developed what he terms the "Dosage-Response" Model for charting therapeutic progress (Kopta, Howard, Lowry, & Beutler, 1994). The concept behind the model is fairly simple: psychotherapy, as with other health care interventions, should be evaluated in relation to its effectiveness at various dosages. Just as milligrams are the most appropriate measures for most medications, Howard argued that the most appropriate measure of dose in psychotherapy is the number of sessions. In charting the relation of sessions to outcome, Howard uncovered a number of findings with important clinical implications.

FEELING BETTER WITHOUT TREATMENT

Many clients (5%–10%) feel significantly better even before treatment begins (Kopta et al., 1994; Lyons, Howard, O'Mahoney, & Lish, 1997). Change in these clients occurs between the time they make an appointment and the first session. As clinicians, we should remember to ask clients at the beginning of treatment, "How are you doing now?" rather than "What is the problem?" We should take care not to assume there is a current problem, even though there was one when the first appointment was scheduled. Clients who are no longer distressed may still wish to pursue psychotherapy for self-exploration or to improve their coping skills, but they do not require therapy to feel better. As therapists, we must be cautious about taking credit for these clients' improved feeling states (though scheduling a session may well have been critical in beginning the process of feeling better). Instead, these clients may best be thought of as candidates for interventions that help them to better understand and continue the positive steps they have already taken to improve their lives (e.g., using the "exception" question of solution-focused therapies that asks clients to focus on what is different at those times when they are able to resolve their problems).

For example, Connie had been significantly depressed for two months after the breakup of her relationship with her boyfriend. Setting up an appointment with a therapist meant overcoming her inertia and beginning to take constructive action, which she followed up by engaging more with friends in a variety of activities. By the time she met with a therapist a week later, she felt substantially better. Connie decided there was no need for further therapy, because she had already achieved her goal of feeling better. In their one meeting, Connie and her therapist discussed some of the vulnerabilities that may have made her subject to depression and focused on how she had marshaled her resources to resolve her difficulties. They parted with the agreement that Connie would come back if her depression returned.

Although, as mental health professionals, we know the wide range of benefits that psychotherapy can bring, we must bear in mind that clients are often simply interested in feeling better. Howard's data remind us that, for many, just starting treatment or even making an appointment is enough to ameliorate their distress without any additional interventions.

DIMINISHING RETURN WITH MORE SESSIONS

Although most clients experience significant change early in the treatment process, for those who do not initially respond to treatment,

more and more effort is required to produce change (Kopta, Lueger, Saunders, & Howard, 1999; Lyons et al., 1997). Therefore, the minority of clients who respond slowly consume a grossly disproportionate amount of the total number of treatment sessions offered by a typical therapist. According to Howard's research, about 50% of clients are improved after 8 weekly psychotherapy sessions, 75% after 26 weekly psychotherapy sessions, and 85% after 52 weekly sessions. Those who do not respond at this point require many more sessions to improve, if treatment is effective at all.

There are several implications of this finding. The achievement of treatment goals for those who have already received considerable therapy is likely to involve many more sessions. Therapists should plan accordingly, and directly discuss the likely need for longer term treatment, rather than suggesting change is just around the corner.

Howard also suggested that the small number of clients who enter long-term therapy can distort therapists' overall views of their caseloads. Because a small number of clients require most of the therapy sessions, it is likely that, over time, therapists will have cases that are primarily in long-term therapy, even if they do short-term treatment with most clients, leading them to conclude that most actually require long-term therapy.

THE SEQUENCE OF CHANGE

Howard found client change generally proceeds in a clear sequence (Kopta et al., 1994; Kopta, Newman, McGovern, & Sandrock, 1986; Lutz, Lowry, Kopta, Einstein, & Howard, 2001). First, clients feel better, experiencing the relief that comes with seeking help and beginning to face problems directly. This change, termed *remoralization*, usually occurs in the first few sessions. This stage is followed by a change in symptoms, *remediation*, that is the result of developing new coping skills and typically requires about 16 sessions. Finally, the third phase of treatment, *rehabilitation*, focuses on such tasks as unlearning maladaptive behaviors, establishing new ways of approaching one's life, dealing with interpersonal problems, and improving self-esteem, tasks most often conceived of as the essence of psychotherapy. The time needed for these changes depends on the severity of the individual's difficulties and the area of life on which the problem centers. Based on Howard's data, clinicians can expect most clients to feel better fairly quickly, to overcome their symptoms within four months, and to make changes in how they live more slowly—typically between six months and one year.

For example, Bob and Viv, like most couples entering therapy, began treatment feeling hopeless about their relationship. By the third session, their belief that the therapist had something to offer, along with a few glimmers generated in the meetings, left them feeling substantially better, even though none of their problems were resolved. By the eighth session, many of their specific complaints, such as the high level of mutual criticism and low level of support, were substantially ameliorated, and they no longer considered divorce. Nonetheless, they needed 30 sessions to make the kinds of changes that allowed for a close, connected relationship.

BAD BEGINNINGS OFTEN LEAD TO BAD ENDINGS

According to Howard's research (Kopta, Newman, McGovern, & Angle, 1989), if a positive change in the client's feeling state does not occur early in therapy (by the sixth session), change is not likely to occur in that therapy relationship. Feeling worse after beginning therapy is a sign that a change in therapist should strongly be considered. Feeling increasingly worse indicates treatment failure. Far from confirming the old tenet, never supported in research, that the client needs to feel worse to feel better, Howard found that once off on the wrong foot, therapy is unlikely to be productive. Although there are relatively few bad therapists who have consistently poor outcomes, bad matches of client and therapist are quite common.

Howard's work challenges the assumption that trying harder is a solution to a mismatch between client and therapist. If a client is responding poorly to treatment by the eighth session, Howard suggested it would be far better for the therapist to consider referring the client to someone else. Given the vital importance of the client–therapist alliance, it is striking how seldom such mismatches are remedied by this simple response. Howard's data demonstrate that we all need to acknowledge as soon as possible when our therapy is not helping our clients.

Tom initially felt quite uncomfortable with his behavioral therapist's distance and the homework tasks he assigned. In response, the therapist offered many more assignments, which were focused on overcoming anxiety and being more assertive. After one year of unproductive therapy, Tom tried another, more experiential therapist and almost immediately began to feel hopeful. Although the therapy ultimately proved productive, this does not mean that the second therapist was superior to the first, only that a good fit for Tom meant a therapist who was experiential and accepting.

CLIENTS WITH DIFFERENT SYMPTOMS AND PROFILES RESPOND TO TREATMENT AT DIFFERING RATES

Clients differ and can be expected to respond in ways and in amounts of time that are predictable given their characteristics. Those with symptoms of distress, such as anxiety and depression, show the fastest change, whereas those with broad difficulties in personality show the slowest. Using his data pool, Howard and colleagues developed patient profiles that enable therapists to anticipate what an expected course of treatment is likely to be, given such characteristics as the client's symptoms, amount of previous therapy, and overall level of functioning (Lutz et al., 2001). Actual progress is then compared with the expected course.

As an example, Mel began therapy in the average range of overall mental health. He had many depressive signs that were diagnosed as stemming from a dysthymic disorder. His clinical characteristics predicted that therapy would at least be moderately effective. However, even modest progress was not achieved after a year of treatment. Patient profiling showed treatment was much less effective than had been estimated. In contrast, Susan presented with multiple symptoms of anxiety and a diagnosis of panic disorder. After six months of treatment, patient profiling showed that she had profited as expected from psychotherapy.

LOOKING AT OUTCOME AS A PROCESS

Because some early changes predict the course of treatment, Howard emphasized that treatment evaluation should be an ongoing process, not something to be measured at termination. Consider the Smith family, who entered family therapy because of the substance-abuse problem of John, age 15. Assessing the effectiveness of this therapy inevitably includes a comparison of John's drug use before and after treatment, but should also contain interim signs of progress, such as the forming of a therapeutic alliance and the development of a parental coalition that can effectively cope with John's behavior. Knowing early in treatment that John's drug abuse was increasing and that the parents' alliance with the therapist was weak could have considerable value in shaping further intervention strategy. Clearly, just measuring treatment effects after termination has far less impact than using early evaluation data to enhance the treatment process. Evaluation is best conceptualized not as assessing the difference in status before and after treatment, but as the ongoing tracking of change.

AN X-RAY FOR THE CHANGE PROCESS

Howard's research has been extended into the development of a widely used method of outcomes assessment, principally used in managed care, but designed to provide feedback to clinicians in all settings. Howard emphasized the importance of this kind of measurement in managed care because, typically, managed mental health care uses only the number of sessions to measure the effectiveness of clinicians. He suggested that the question is no longer whether managed care will evaluate therapists, but what form the evaluation will take. His efforts moved the question in managed care from the simplistic, "How many sessions?" to the more useful, "What is likely to be accomplished with how many more sessions?" The measures he and his colleagues created intensively track progress along a number of dimensions in each case, and relate that progress to the expected levels of change for other, similar clients. Howard likened these measures to an X-ray that charts the progress of psychotherapeutic healing. The measures include subjective well-being, current symptoms, and current life functioning, summarized into an overall mental health index, along with measures that focus on the process of treatment. The forms are completed by the client and the therapist periodically, providing a profile of how the client is feeling, how symptoms are progressing, how well the client is functioning, and how such core elements of treatment process as the bond between client and therapist are progressing. These forms are sent by the therapist for scoring, leading to regular feedback about progress in the form of written reports, thus providing an additional source of information about treatment progress. Because clients often want to be kind to their therapists, the information from the report sometimes is quite revealing. The reports also compare progress in the individual case with that of other similar clients in the large database. This creates a context for assessing how well the treatment is going.

These reports provide direct feedback to the therapist, who can see how well the client is progressing compared to others like that client. If progress is not at the level expected, the report serves as a launching point for an inquiry about why this has occurred. Have there been special circumstances that would explain the lack of progress (e.g., job loss, death in the family), or is the treatment simply less effective than might have been expected? Grant Grissom, a colleague of Howard's, points out that this kind of feedback provided directly to therapists about their work without an ax to grind is typically found to be very helpful.

Robert Marcovitz, a clinician who has used the Howard measures for several years, has found its major value lies in correcting his own

misperceptions. Although 70% of reports from the measures are consistent with his expectations, in the other 30%, the measures identify clients as responding differently to therapy than he expects. For example, some clients who report feeling better in sessions indicate they are feeling no better than before treatment on the measures. He also finds that clients occasionally make disclosures on the forms that they have not shared with the therapist. When clients report better functioning on the measures than in session, Marcovitz uses the findings to discuss dependency and the possibility of termination. In the context of managed care, the use of the measures becomes more complex, serving to help case managers monitor treatment as well as directly helping the therapist learn about treatment. Although the case manager's access to the data creates the possibility that the results will be used to justify limits on service, Howard argues that without measurement of treatment process and outcome, the alternative is simple cost containment (i.e., the manager restricting the number of sessions). Using the patient profiling, client progress can be assessed compared to an expected norm, and in many cases a strong argument for more therapy can be made. Marcovitz finds that in dealing with managed care, the hard data about client progress and need for further treatment are far more convincing than clinician opinion. Of course, at times, the data also call on therapists to understand that therapy is no longer necessary.

Howard's efforts have led to other substantial projects centered on the ongoing assessment of client progress in psychotherapy. Michael Lambert and colleagues have used their measure, the OQ-45, on a client base as large as Howard's (Lambert & Barley, 2002; Lambert & Finch, 1999; Lambert, Hansen, & Finch, 2001). Lambert has also conducted research that has demonstrated the value of feedback to psychotherapists about client progress on the outcomes of psychotherapy (Lambert & Whipple, 2001). Barry Duncan and Scott Miller (2000) use a very simple session-by-session measure of client progress as the central core intervention in their outcome-informed therapy. And Bill Pinsof has extended the Howard paradigm to couple and family therapy in a system of tracking progress that includes feedback to therapists based in the Systemic Therapy Inventory of Change (Pinsof & Wynne, 2000).

In closing, the methods developed by Ken Howard and the evidence marshaled are powerful and convincing. This is good science brought to evaluate clinical practice. In the domain of managed care, measures such as Howard's appear to be enormously useful as an antidote for simplistic decision making. Of course, it remains to be seen whether they will be used in an informed way that includes careful feedback and consultation, as intended by Howard.

Given the strong evidence of psychotherapy's effectiveness, it is a reasonable expectation in most cases that it will yield positive results. It is our responsibility to carefully monitor treatment progress and take special measures if clients do not respond.

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LEARNING TO LOVE ASSESSMENT: TODAY'S RESEARCH TOOLS TO ASSESS PROGRESS CAN HELP YOU BE A BETTER THERAPIST

Therapists can readily study client progress during psychotherapy through employing measures that track change, client satisfaction, and therapy process. This chapter looks at how therapists can incorporate such sources of information to inform treatment.

Research still intimidates most therapists, who associate it with highly technical methodologies and arcane studies that are indecipherable except to a tiny group of experts. True, rigorous, large-scale research can be daunting to contemplate. A research design may involve hundreds of cases (even small treatment studies are based on 20–30 clients) and tough requirements, including undeviating treatment protocols, homogeneous treatment populations, and randomization of subjects to conditions.

But, research can be far simpler and more user-friendly than most therapists realize. In fact, it's now possible for competent clinicians to