EFFECTIVE INGREDIENTS OF SUCCESSFUL PSYCHOTHERAPY: Implications of Forty Years of Process-Outcome Research [n1]

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Systematic research on psychotherapeutic processes began in the late 1940s and early 1950s, stimulated by the experimental use of phonographic recordings in counseling and therapy sessions. These recordings allowed samples of the delicate, subtle, ever-changing substance of therapeutic interaction to be fixed and examined in microscopic detail, for as long as desired and by any number of investigators. This technological development has had an impact in psychotherapy parallel to the introduction of the microscope in biology. What the patient said; how the patient said it; what the therapist did; when and how it was done; how the patient responded: these could now be pored over with sustained attention and theoretical discrimination. Significant nuances that might be too swift or subtle for a therapist to notice while conducting a session, or even to be heard at first when listening to a recording, could now -- in principle -- be mapped and measured.

Together with convergent developments that I will shortly describe, this technological factor initiated a quiet revolution in the body of expert knowledge on which psychotherapeutic practice is based. Previously, even to the present day, most direct knowledge of therapeutic processes was derived from impressionistic and individualistic (if not idiosyncratic) reports by therapists about cases they had treated. Although informative and sometimes brilliantly insightful, these case histories are inevitably unsystematic in their observations, selective in an uncontrolled manner, and not infrequently used for polemical purposes to illustrate their authors' favorite theories.

By way of contrast, newer empirical methods of study make systematic observations that, while necessarily selective, use a combination of statistical evaluation and research design to draw logically controlled conclusions. Two clear advantages are that inferences can be protected from the investigator's subjective biases, and the generalizability of findings beyond the cases observed can be determined. In the long run, theoretical conflicts between schools of therapy that are based primarily on

differences in terminology and selective emphasis on some of the many factors involved in psychotherapy can be resolved through the progress of systematic empirical research.

It would be misleading if I were to leave an impression that all modern research on psychotherapeutic processes has been based on the use of phonographic (and, more recently, of video) recordings. These recordings only make the externally observable events of therapy accessible to "objective" or non-participant observers. Important as that is, essential aspects of the therapeutic process consist of internally observable events that are only accessible to participant observers who are the subjects of therapy, that is, to the patient and the therapist directly. In fact, it would be ironic as well as misleading if I did not emphasize these, since I have been one of those in the field of therapy research who have most strongly argued that systematically observing the experiences of patients and therapists is crucial to understanding the process of therapy. Systematic observations of patients' and therapists' experiences in treatment have been conducted, without interrupting the flow of therapeutic work, most often through the use of post-session questionnaires. These usually brief, confidential questionnaires typically ask therapists about their perceptions, feelings, and evaluations of themselves and their patients in particular sessions, or ask patients about their perceptions, feelings, and evaluations of themselves and their therapists. Although the answers that participants can give to these questions are necessarily limited to what they consciously experience, analyses of concurrent and sequential patterns of responses to these questions -- like analyses of free-associations -- can reveal aspects of experience that are preconscious or even unconscious.

Historically then, the systematic study of therapeutic processes has followed these three main observational perspectives: the "objective" or non-participant perspective, based mainly on recordings of therapy sessions; the "experiential" or participant perspective of patients, based mainly on questionnaires and psychometric instruments; and the "experiential" or participant perspective of therapists, based on similar measures. The last-mentioned (that is, the therapist's perspective) is most similar to the traditional case historical method, but the crucial difference even here is that modern research is based on systematic observations and explicitly controlled inferences rather than impressionistic observations and intuitive or subjectively implicit inferences.

It is an interesting and important fact that the results of observations made from these three perspectives are not always highly correlated or parallel, although there are large areas of overlap between them. This means that, while interrelated, the three perspective are independent. What may be seen clearly from one perspective may be obscured or even invisible from another perspective. This is not so strange as it might first seem, if one considers the analogy of physical perspectives. Seated in the back of the room looking forward, one sees a different picture than standing in front of the room looking back, and indeed a different picture again when sitting in front of the room looking forward. Similarly, standing in the very same spot one sees a different view by looking north or south, east or west, up or down. These differences do not deny each other; they supplement and complement each other in defining the complex reality of space. In the same way, the three perspectives of patients, therapists, and non-participant observers define the complex reality of psychotherapy.

Clinicians often ask whether interventions made by researchers in order to observe the inner or outer events of psychotherapy do not change what are viewed by some as basic properties of therapeutic process. Psychoanalytically-oriented clinicians in particular typically express a concern that these observational procedures will change or distort the nature of the transference situation. Of course, observational methods vary in their intrusiveness. Studies have shown that the routine operation of recording apparatus is typically quickly forgotten by participants as they become adapted its presence. The psychological impact is not different, and often less, than recording sessions for supervisory purposes, which is a commonplace occurrences, or even the simple awareness that session notes will be reviewed and evaluated by a clinical supervisor. Evidence concerning more active observational interventions, such as the routine use of brief post-session questionnaires, suggests that their enhancement of self-reflectiveness and clarification of experiences are generally very compatible with the varied goals of insight, cognition, and realistic self-control that characterize different theoretical orientations. Moreover, transferences are robust phenomena when they occur and are typically expressed indirectly in relation to the manifest content of the situation no matter what that might be. Gentle probing often reveals that a therapist's concerns about observational interventions express a natural anxiety about having one's performance evaluated, but this is an anxiety that mature therapists typically learn to overcome when a trustworthy alliance is established between the therapist and researcher. Therapy

itself is a form of intervention, designed to change natural but disordered modes of experience and behavior.

In fact, evaluating the efficacy of therapeutic interventions has been another major focus of systematic empirical research. Historically, evaluations of efficacy or treatment outcome have also been based on multiple observational perspectives. The viewpoints relied on typically include those of patient and therapist, as well as relatively independent perspectives of expert clinical interviewers or diagnosticians, the use of assessment by psychometric methods, and also (but less often) the views of people involved in the patient's life, like family members or friends. Here again, as can be understood, evaluations of outcome from these separate perspectives as a rule overlap but do not exactly coincide. If, as a result of therapy, a patient quits a boring or highly stressful job, or leaves a destructive marriage, the outcome of treatment from the patient's or therapist's perspective might be viewed as an expression of healthy self-affirmation, but from the contrasting perspectives of the patient's employer or spouse the treatment outcome might seem quite negative. Different evaluators tend to apply different value criteria in rating outcome. Patients are inclined to rely on the natural criterion of subjective well-being, whereas therapists frequently hold their work to the high standard of ideal functioning dictated by their theories of personality, and social authorities (such as teachers, employers, or magistrates) tend to judge the outcome of therapy in terms of the patient's productivity and tendencies toward responsible or antisocial behaviors.

Granting the legitimacy and acceptability of systematic empirical research in this field, and appreciating the realistic complexity of such research, the next question -- the big question -- is what has been learned so far about psychotherapy that may be valuable to the clinical practitioner. It has taken many years of trial and error for researchers to learn how therapeutic processes and outcomes could be meaningfully mapped and measured. Early studies were necessarily preoccupied with the development of new research methods, and many clinicians who had hoped for validation and guidance in practice soon lost interest when substantial results were not quickly obtained. Nevertheless, a small but growing tribe of psychotherapy researchers that appeared to wander in the desert for 40 years, as in the Biblical legend of Moses, seems finally to have arrived at the gates of the promised land. Literally thousands of studies of therapeutic process and outcome have been done during the last half century, and recent integrations of this accumulated work, assisted by the

new statistical technique of meta-analysis, have greatly clarified their findings. [n2]

For example, there is massive evidence from a large and varied number of studies indicating that psychotherapy and counseling are indeed effective, from a variety of observational perspectives, when compared with no-treatment and placebo or minimal treatment controls. Research documentation [n3] for the efficacy of psychosocial treatments compares favorably, and is often more extensive, than the documentation for many generally accepted medical treatments. This fact should give psychotherapists and counselors a new sense of confidence about their work, especially when confronted by ill-informed colleagues, administrators, and legislators with the old, thoroughly discredited critique of psychotherapy made by Hans Eysenck in 1952.

Yet psychotherapists and counselors should not grow too confident. The picture is more complex. The findings I cited are based on group averages, and inspection of the data regularly shows that individual patients improve to varying degrees: some, very much; most, somewhat; some, not at all; and a small but significant number worsen or continue to deteriorate. Another fact that should temper the pride of therapists is that a significant minority of patients seem to improve with minimal contact, simply as a result of enhanced expectations of help and a restoration of their general morale. A related and very consistent finding of comparative outcome studies, in which different treatments are directly compared, is that different types of therapy -- behavioral, cognitive, humanistic, systemic, or psychodynamic -- produce basically similar results. At the least this suggests that, although psychotherapy is effective for many patients, the actual causes of its efficacy may differ from those cited by the partisans of various theoretical schools. One interpretation of these facts suggests that factors common to the various treatment approaches, such as a relationship with a caring authority figure and the enhancement of hopefulness or morale, are responsible for their similar efficacy. In contrast to this emphasis on common factors, another interpretation suggests that various treatment approaches have a specialized but limited efficacy, which will improve as we learn more about which patients benefit most from which treatments. These two interpretations are not logically incompatible, and at present it seems plausible to suppose that common factors and specific effects are both important.

In sum, the positive but complex situation revealed by research indicates a

general similarity of results across different therapies along with a substantial degree of variability in effectiveness within particular treatments. Further light is shed on the situation by a large body of studies known as process-outcome research. [n4] Process-outcome research represents an empirical strategy for determining which aspects of therapeutic process, separately or in combination, are particularly helpful (or, as it may be, harmful) to patients. To clarify the special nature of process-outcome research, one could say that clinical theories and case histories indicate what psychotherapy ought to be, pure process research seeks to determine what actually occurs in psychotherapy, and pure outcome research seeks to evaluate actual effects of therapy. Process-outcome studies seek to identify the effective ingredients of successful psychotherapy.

Overall, the crucial factors revealed by more than 40 years of process-outcome research are, first, the cohesive, communicative, collaborative quality of the therapeutic relationship experienced by the patient; second, the therapist's skillfulness in using relatively potent techniques such as paradoxical intention, experiential confrontation, and interpretation to further the patient's mastery of problematic experiences; third, the patient's genuine engagement in appropriate therapeutic tasks; fourth, the patient's inner openness or lack of defensiveness in assimilating the results of therapeutic work; and fifth, the patient's experience of session-by-session benefits such as insight and support.

These are factors that may be present or lacking in any case, in any treatment approach. When they are strongly present, and when therapy continues for a sufficient time, process-outcome research indicates a high probability of improvement for patients, whatever the formal treatment frame may be. On the other hand, poor treatment outcomes are likely when patients experience the therapeutic relationship as hostile or oppressive; when therapists use interventions without skill, or use only weak interventions such as giving advice; when patients are not genuinely engaged in therapeutic tasks or are highly defensive; and when patients routinely experience insecurity, distress, or confusion in sessions rather than support, relief, or insight.

It is important to emphasize the nuances of these findings. For example, it is the quality of the therapeutic relationship as experienced by the patient that forecasts a positive outcome, whereas the quality of the therapeutic relationship as experienced by the therapist is less richly

predictive of patient benefit. This fact implies that therapists cannot afford to rely solely on their own perceptions of the relationship, but must find ways to elicit the patient's view of it. The same is true regarding therapist skillfulness and the use of techniques such as experiential confrontation and interpretation, as well as the patient's experience of session-by-session benefits. When assessed from the perspectives of patients or objective raters these are clearly related to outcome, but not when they are assessed by therapists themselves. However, therapist's can be more confident in relying on their direct perceptions of the patient's engagement and openness as predictors of outcome. When you perceive your patients as genuinely engaged in therapeutic tasks and relatively open to dealing with problematic experiences, treatment is probably going well. However, when you perceive your patients as superficially engaged or avoidant of therapeutic work, and as consistently on the defensive, you may guess that treatment is going poorly and should probably reconsider what you are doing before risking long-term frustration or potential harm to the patient.

I hope it is clear by now that psychotherapy research does finally have something important to say to clinicians about effective practice. The time for exclusive reliance on impressionistic case histories and clinical theorizing is past. Therapists who are ignorant or neglectful of facts established by systematic empirical research will increasingly put their professional competence at risk. So too do the trainers, supervisors, administrators, and policy makers who determine the climate of psychotherapeutic work.

This does not mean that therapists should read every issue of the research journals, or focus unduly on the results of individual studies taken out of context. No single study in this field can be definitive. It is only when large numbers of studies are considered together and sifted for consistently significant findings that results of value to practitioners will be found. This in itself is a specialized job requiring clinical sophistication as well as research sophistication, and people with those qualifications need to devote more time to the urgent work of preparing sound, research-based texts and programs for educating counselors and psychotherapists.

Finally, clinical practitioners need not only to have this new, research-based knowledge of psychotherapy, but also need to understand how to use it. No treatment manual or recipe, however devised, can substitute for the therapist's individual clinical judgment. Research knowledge is always stated in terms of relevant conditions and resulting probabilities.

However, as therapists we generally practice in settings where it is impossible to control all relevant conditions, and where we must make definite interventions in the face of uncertainty.

To understand this, we should consider that research knowledge is like a weather forecast which indicates the probability of sunshine or rain in your area. You would probably be unwise to set out before checking the weather forecast, but it either will or will not rain in the specific place you are going, and you must somehow decide whether to take your umbrella and coat or leave them at home. How high must the probability of rain be before you decide to take them? Does it not depend on what else you have to carry, and on the consequences of getting wet for your state of health or your social presentability? As clinicians, too, we are certainly wise to keep well informed about forecasts that can be derived from research knowledge of psychotherapy; but, being as well informed as possible, it is our final responsibility to exercise good judgment on behalf of the patients who seek our help.

Notes

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2 - Readers interested in this literature should begin by examining the Handbook of Psychotherapy and Behavior Change (4th edition, 1994) edited by A. E. Bergin and S. L. Garfield (New York: John Wiley).

3 - See, for example, the chapters by M. J. Lambert and A. E. Bergin on "The Effectiveness of Psychotherapy" and I. E. Elkin on "The NIMH Treatment of Depression Collaborative Research Program" in the Handbook of Psychotherapy and Behavior Change (op. cit.), and the paper by M. W. Lipsey and D. B. Wilson on "The efficacy of psychological, educational, and behavioral treatment: Confirmations from meta-analysis" in the December 1993 issue of the American Psychologist (volume 48, pages 1181-1209).

4 - For further details, see the chapter by D. E. Orlinsky, K. Grawe, and B. K. Parks on "Process and Outcome in Psychotherapy" in the Handbook of Psychotherapy and Behavior Change (op. cit.).