The Effects of the Individual Psychotherapist and Implications for Future Research

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A body of research concerning psychotherapy outcome is reviewed with the intent of establishing the importance of the individual psychotherapist to treatment process and outcome. Although particular therapy techniques have not been shown to be especially important in therapy process and outcome, they have been the focus of most research and training for the past two decades. In the past, extensive study of the individual therapist was difficult, but the rising trend of managed health care organizations has created opportunities to conduct research on this topic. Hypothetical outcome data for individual clinicians are presented in graphical form. An attempt is made to show how patient typing can be used to adjust outcome by case-mix methods. Suggestions for future research are made.

Key words: **psychotherapy outcome, therapist effects, managed health care, Outcome Questionnaire, therapist variables.** ***[Clin Psychol Sci Prac 4:66–75, 1997]***

The empirical study of treatment effects has a long history of focusing on the theoretical and technical aspects of treatment. The tendency to examine therapy outcomes as a result of techniques has become even stronger over the last two decades as evidenced by the number of comparative studies that follow the assumptions of clinical drug trials in pharmacological studies.

Most of this research has gone to great lengths to eliminate the individual therapist (a unique individual) as a variable that might account for patient improvement. This tendency has been manifest in the form of training therapists with manuals that make therapy interventions explicit and often includes supervision aimed at enhancing competence and conformance to manual-guided treatment. The aim of these training methods is to "purify" psychological interventions so that the effects of specific therapies on specific problems can be investigated (Talley, Strupp, & Butler, 1994).

Another more contemporary force emphasizing techniques is the movement toward managed health care. Managed health care institutions manage or hire providers, develop or adapt treatment guidelines, and attempt to ensure that appropriate treatments, in the form of manual-based techniques, are offered for specific disorders. This emphasis is based on the assumption that there is a direct relationship between specific techniques and outcome.

Even more clear to the majority of the providers and clinical psychology faculty is the current controversy over the promotion of "empirically validated therapies" that are the focus of training in clinical programs and internship settings (Sanderson & Woody, 1995). Empirically validated therapies are advocated with little or no attention to the individual provider as a primary contributor to patient outcome. In this article, we review evidence that suggests the individual therapist is a salient force in producing positive and negative outcomes. We also call for the study of the individual therapist as a primary

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method for illuminating the curative components of effective therapy.

PAST RESEARCH HAS SUGGESTED SPECIFIC TECHNIQUES ARE NOT THE MOST IMPORTANT FACTOR

In a review of psychotherapy outcome, Lambert and Bergin (1994) summarized research on variables that seem to be contributing factors to patient change following psychotherapy. They highlighted many factors that are apparently associated with client improvement. Among these are patient characteristics, extraneous therapeutic events, specific intervention techniques, therapist characteristics, including experience, and factors that are common across divergent therapeutic modalities, such as the therapeutic alliance. This review, as well as many earlier reviews (e.g., Luborsky, Singer, & Luborsky, 1975; Meltzoff & Kornreich, 1970; Smith, Glass, & Miller, 1980), has not found strong evidence to support the idea that patient improvements are generally linked to therapeutic techniques. In fact, the most consistent finding of comparative studies of psychotherapy is the relative equivalence of therapies as stimulators of patient change. Despite this fact, the importance of psychotherapeutic techniques and their underlying theoretical explanations of change continue to be emphasized in graduate training, in professional and graduate level textbooks, and, to some extent, in clinical practice.

Among the alternative explanations for the changes that occur in psychotherapy is the hypothesis that the individual therapist's attributes, attitudes, and actions override the effects of particular techniques on patients. The possibility of this effect has received considerable attention in research. A good example is Gurman and Razin's (1977) edited text, which is devoted entirely to empirical evidence on the therapist's role in client change (e.g., gender, race, interpersonal skills, countertransference, personality, experience). Many other authors and researchers have explored this topic (e.g., Beutler, Machado, & Neufeldt, 1994; Crits-Christoph et al., 1991; Crits-Christoph & Mintz, 1991) and provided convincing evidence of the importance of the therapist's contribution to outcome.

All manner of therapist traits have been studied. Much of this research is useful in confirming and questioning what would seem to be correct from clinical intuition. For example, professional affiliation has not been shown to have an effect on therapeutic outcome, despite the obvious differences in theoretical perspective and training strategies among professions (Beutler et al., 1994). Similarly, experience has not been found to have a dramatic effect on patient change (Stien & Lambert, 1995) despite the common sense idea that greater clinical experience would facilitate patient improvement. While these findings run counter to clinical intuition, much of the research on process variables seems to support the link between therapist activities and psychotherapy outcome (e.g., Orlinsky, Grawe, & Parks, 1994).

The lack of consistent differences in the overall success rates of various therapies and the growing trend toward an eclectic approach among practitioners (Jensen, Bergin, & Greaves, 1990) have spurred research on factors found to be common across all therapies. It has been argued that the common factors in therapies are accounting for substantial degrees of improvement in psychotherapy patients (Lambert & Bergin, 1994). The common factors can be viewed as originating from three sources: the therapist, the credibility of therapy procedures, and the client. The therapeutic endeavor often results in the creation of a cooperative working endeavor. The patient's increased sense of trust, security, and safety, which is promoted by most therapists, results in decreases in tension, threat, and anxiety, leading directly to changes in patient conceptualizations of problems and ultimately in actions such as refacing fears, taking tasks, and working through problems in interpersonal relationships. Among the common factors most frequently studied have been those identified by the humanist or client-centered school: empathy, positive regard, nonpossessive warmth, and genuineness. Reviewers are virtually unanimous in their opinion that the therapist–patient relationship is critical for positive outcome and that at least some of the relationship is a function of therapist attitudes and behaviors (Weinberger, 1995).

More recently, psychodynamically oriented researchers have generated research on the importance of the therapeutic alliance, a measure of the degree to which a patient and therapist are able to develop a collaborative relationship. Some components that are typically measured include (a) the patient's affective relationship to the therapist, (b) the patient's capacity to work purposefully in therapy, (c) the therapist's empathic understanding and

involvement, and (d) patient-therapist agreement on the goals and tasks of therapy (Gaston, 1990). Although there are instances where the therapeutic alliance fails to predict or has little association with outcome, a strong therapeutic alliance appears to be one of the common factors leading to positive outcomes (Horvath, Gaston, & Luborsky, 1993). The common factors position has been well stated by Butler and Strupp (1986), who concluded, "The complexity and subtlety of psychotherapeutic processes cannot be reduced to a set of disembodied techniques because techniques gain their meaning and, in turn, their effectiveness from the particular interaction of individuals involved" (p. 33). Continued research on common variables among diverse treatments promises to be helpful in clarifying the factors that bring about positive change and will illuminate more clearly the therapist's role in promoting this change.

Although the research on general therapist attitudes is relevant and important to therapeutic outcome, this research is often of secondary importance to the researchers and the purpose for undertaking the research (e.g., therapeutic alliance is merely a moderator or control variable rather than the subject of the study itself).

In addition to this research, there is also a small body of research that has been concerned with the impact of specific therapists on outcome and the identification of these therapists for the purpose of understanding their role in therapeutic outcomes. The methodology used to study individual therapists is of necessity different and the assumptions directing this research are often radically different from traditional designs that focus on specific therapeutic techniques using clinical trials with homogeneous patient samples. The clinical trials studies, of necessity, select patients who are atypical of multiple-diagnosis patients seen in routine clinical practice. Clinical trials research provides the ideal situation to examine techniques, and in this context techniques can be expected to have their greatest impact. But results from clinical trials may not generalize to outpatient treatment, and it is in the naturalistic setting in which the effects of specific therapists can be expected to loom large.

In the context of routine clinical practice much can be gained from naturalistic studies that examine the outcomes of particular therapists coupled with an attempt to understand the therapist's contribution to the helping process. The following section is devoted to showing examples of studies that have focused on the individual therapist using a variety of research strategies, including clinic trials and naturalistic studies. By examining these studies, the breadth of applications and conclusions that can be attained from research on the individual therapist is highlighted. Following this brief review we turn our attention to future research on the individual therapist.

EXAMPLES OF THE IMPACT OF THE INDIVIDUAL THERAPIST

There are many studies that focus on the individual therapist and his/her impact on clients after analysis of the effects of specific techniques (e.g., Henry, Schacht, & Strupp, 1990; Miller, Taylor, & West, 1980; Nash et al., 1965; Pilkonis, Imber, Lewis, & Rubinsky, 1984; Strupp, Schacht, Henry, & Binder 1992). Some of these reports suggest a great deal of variability among therapists in the outcome of their clients. Other reports bring to light possible negative effects a single therapist may have on a large percentage of their clients. These studies suggest that understanding the individual therapist as a unique contributor to outcome is important. The following are some of the most dramatic cases demonstrating the effect of the individual therapist.

The Ricks Study

Ricks (1974) published a study that probably gives the most dramatic example of the individual therapist's effect on patients. In this study, a group of adolescent boys who had been experiencing severe problems of anxiety, vulnerability, and disassociation were examined as adults in a follow-up study. As teenagers, the boys were seen by either of two therapists in a child guidance clinic. Although less disturbed clients showed no significant long-term differences, there were marked differences in the therapeutic styles and outcomes of the therapists for the more distressed boys. The more successful of the two therapists (Therapist A) was labeled "supershrink" by one of the boys, and Ricks uses this label as well in contrasting techniques with the less successful of the two (Therapist B), who Bergin and Suinn (1975) labeled "pseudoshrink." The two therapists had staggering differences in their outcomes. For example, 84% of pseudoshrink's cases were diagnosed as schizophrenic as adults, whereas only 27% of supershrink's had the same result, even though the caseloads of the two therapists were equal in level of disturbance and other characteristics at the beginning of therapy.

In examining the differences in the two therapists' styles, it was determined that Therapist A invested far more time in his more disturbed clients while Therapist B did the opposite. In addition to simply spending more time, Therapist A made use of resources outside the immediate therapy situation, was firm and direct with parents, encouraged movement toward autonomy, and implemented problem-solving skills in patients' everyday lives, all encompassed by a strong therapeutic relationship. Concerning differences between the two therapists, Ricks states:

A's supportive ego strengthening methods produced much more profound changes than the methods of therapist B, who moved too precipitously into presumably deep material. . . . The children considered here were already experiencing nearly intolerable degrees of anxiety, vulnerability, feelings of unreality, and isolation. When the therapist increased those feelings, without helping the boy develop ways of coping with them, he may well have played a part in the subsequent psychotic developments. Therapy may lead one into health, but it may also be a part of the complex process that ends up driving one crazy. (p. 291)

In addition to his seemingly harmful style, case notes suggest that Therapist B was frightened by the boys' pathology and tended to withdraw from them. Therapist B often commented on the problems with the cases and seemed to become depressed when confronted with a particularly difficult one. There is one case in particular where Therapist B manifests this behavior. He says, "I tell him my impression that his spirit has been broken. . . ." Later he notes, "He is still very depressed and hardly said anything to me at all. This case certainly has an ominous aspect" (p. 282). This demonstrates how the therapist was caught up in the boy's depressed and hopeless feelings and as a result may have reinforced his client's sense of self-rejection and futility.

Careful examination of individual therapists so reported by Ricks supports traditional beliefs regarding the effects of therapist personality, adjustment, and countertransference on outcomes. The design of this naturalistic case study is rich in hypotheses about the elements that lead to negative and positive outcomes. These hypothesis easily justify further studies and examination. Despite its obvious value and relative simplicity, similar studies have not been widely published in the decades following this report.

Shapiro and Firth

The Second Sheffield Psychotherapy Project (Shapiro & Firth, 1987) looked at cognitive-behavioral treatment compared to interpersonal-psychodynamic treatment according to processes and outcome. The project used a crossover design, in which each patient was seen by a therapist in 8 weekly sessions using one treatment technique and 8 weeks using the second treatment technique. The study was designed to hold constant individual differences of clients and therapists while maximizing measurability of differences between the two treatments. There were four therapists treating 6–18 patients. All of the patients were referred by general practitioners and psychiatrists.

In their first article concerning this study, Shapiro and Firth (1987) focused mainly on the different therapy types and their effects, and found a slight advantage for cognitive-behavioral therapy over psychodynamic therapy. In a follow-up article (Shapiro, Firth-Cozens, & Stiles, 1989) they discussed how one of the therapists actually had significantly better results than the other therapists. Across all 16 sessions there was no significant difference among the therapists, but Therapist 1, in using cognitive-behavioral treatment, had much better results than the other therapists, even though they were all using the same treatment manual.

Although not as dramatic an example as the Ricks study, it is important to note that this study was designed specifically to minimize therapist effects. Despite this fact, individual differences among therapists surfaced and made a difference in therapeutic effectiveness. This adds further support to the idea that individual differences in therapists play a significant role in therapy outcome.

Orlinsky and Howard

Orlinsky and Howard (1980) reported the outcome ratings of 143 female cases seen by 23 therapists who offered a range of traditional verbal psychotherapy. Six of the 23 therapists were rated "+," which is given when 70% or more of their cases were improved and less than 10% deteriorated, or when 40% improved "considerably" with no cases getting worse. Five of the 23 therapists received an "x" rating, which is given when 50% or less of their cases were rated as improved while more that 10% were rated as worse. Using this method, Orlinsky and Howard gave each therapist a "consumer" rating. This rating, however, tells only part of the story.

In examining therapist factors that could be used to predict outcome, few relevant variables were discovered. Although professional degree and age were not related strongly to outcome, experience beyond 6 years was associated with better results. Retabulation of this data suggests the following estimates: 9% (2 of 23) of the therapists showed consistently low-level results, while 13% (3 of 23) showed mixed results. The improvement rate for the clients of these therapists was 44%. In contrast, just over 25% (6 of 23) of the therapists had excellent results, with their clients averaging a rate of improvement just over 81%. Some therapists did well with difficult cases, while others did not. Process data were not reported for individual therapists. D. Orlinsky (personal communication, April 15, 1985) suggested that therapists who produce poor average outcomes, however, do not perform poorly across all cases. The data clearly demonstrate that they did well with some clients. Thus, many of the therapists studied by Orlinsky and Howard (1980) were seen as being limited in the *range* of patients they dealt well with, rather than being poor therapists in the absolute sense.

If nothing else, the Orlinsky and Howard (1980) data demonstrate the feasibility of analyzing the effects of the individual therapists and providing consumer information that could be used in the referral process. In addition, it is reminiscent of some of the findings reported in the early process studies of client-centered therapy. This research strongly suggests that therapists whose process ratings average the lowest levels are more likely to receive even lower ratings when confronted with a difficult client. In contrast, those whose average ratings are relatively high maintain high ratings and a facilitative relationship even when dealing with the most difficult cases (Carkhuff, 1969).

Najavits and Strupp

A study by Najavits and Strupp (1994) also examined differences in individual therapists. The authors examined 16 therapists (eight psychologists and eight psychiatrists) who were recommended by previous supervisors as "caring empathetic clinicians" (Najavits and Strupp, 1994). The therapists were assigned five patients each and were given cases with similar difficulty levels. After 25 sessions, therapists were evaluated according to outcome, client length of stay, and therapist in-session behavior.

Using the data from these evaluations, therapists were placed into two groups: "most effective," which consisted of three therapists who had no negative outcome cases and had no patients leave before session 16, and another group that we will call "least effective," who had at least one negative outcome case and had two or more patients leave before session 16. Six of the 13 patients who had negative outcomes were seen by the least effective therapists.

Interestingly, training was shown to have a slightly negative effect on outcomes. There were also a number of variables that seemed to distinguish the more effective group from the less effective group. More effective therapists employed more positive behaviors and fewer negative behaviors than the less effective therapists. Warmth, understanding, and helping were considered positive and ignoring, neglecting, attacking, and rejecting were considered negative. More effective therapists were also more willing to look at themselves critically and admit when they had made mistakes. Although the top-rated therapists showed much less negative behavior than the lowest rated therapists, it is interesting to note that even the best therapists showed *some* negative behaviors.

The finding most relevant to this article was that the largest differences among therapists were found on "nonspecific" relationship variables rather than "specific" technical ones. This finding suggests that the individual therapist's personal traits (i.e., ability to be warm and genuine) were much more important in the therapeutic process than skills received via training in specific techniques. This supports the idea that the individual therapist is an integral part of the therapeutic process and has an effect on both positive and negative outcomes. Results similar to these have been reported by numerous investigators (e.g., Lafferty, Beutler, & Crago, 1991).

Additional evidence for the impact of the individual therapist can be found in a variety of types and kinds of psychotherapy. The work of Luborsky, McLellan, Woody, O'Brien, and Auerbach (1985) and Strupp (1980a, 1980b, 1980c, 1980d) is notable in this regard, as is the work of Lieberman, Yalom, and Miles (1973) on encounter group participants.

A "NEW" DIRECTION

It is clear that the individual therapist can play a key role in the outcome of therapy. Lambert (1989) suggested that

research on the individual therapist should be given high priority in future research, but was pessimistic that much research would be forthcoming. He gave several reasons.

(a) The field seems to be moving more toward the specific treatments for specific problems design. These designs are so intensively interested in technique that they cannot afford to spend primary attention (including random assignment) on particular therapists.

(b) It is more difficult to study therapists than therapies because of the number of patients needed for study and the burden of matching time schedules if there were enough patients.

(c) Therapists may want to withhold their permission for defensive and self-protective reasons.

(d) There is little theoretical appeal in studying the behavior of a selected set or random set of therapists. It is not until effective therapists are lumped together that you get back into theory-based (and therefore more interesting and appealing) research.

Certain changes in the delivery systems of psychological treatments have made this earlier appraisal seem pessimistic (Lambert, 1995). Currently, a huge number of patients are receiving care under the direction of managed health care. In this managed care environment, research on patient outcome is now beginning to flourish. Managed care companies have been quick to see the marketing advantages and financial implications of conducting outcome research. The quality assurance departments of such companies are encouraging data collection and data-based management of therapy on the basis of individual practitioner performance. This trend implies dramatic effects on both the number of therapists available for study and the number of patients seen by each therapist. In addition, because of the development of sophisticated data-based collection systems, data-based case management is becoming a routine practice. Data-based management allows for routine tracking of patient progress through session-by-session entry of patient status information. This outcome data will become available on thousands of patients and thousands of therapists. The sheer number of therapists and patients available for study in naturalistic investigations presents an opportunity not even conceived of in earlier decades.

In the data-based care management system in which we are most familiar, the outcome portion of the system works in the following way:

(a) Patient presents self for treatment and is assessed with the Outcome Questionnaire (OQ; Lambert et al., 1996), a 45-item self-report scale that taps patient symptoms, interpersonal problems, social role performance, and quality of life.

(b) These data are entered into a case file along with diagnostic, pretherapy level of functioning, treatment history, and demographic records.

(c) The therapist and patient identify focal problems from an extensive problem list, and select five problems with behavior-based anchor points on which improvement ratings are made. Problem data are already part of the computer software file, but become individualized for each patient.

(d) Each session the therapist rates progress on the ideographic problem record. The results of progress on each of the five problems are graphically available to the therapist prior to each therapy session and are also available for storage in a central data bank.

(e) The patient completes the OQ prior to each session, or at least every fifth session. These data are available to the therapist by graph, showing patient progress, and are stored with the individualized goal record.

(f) Therapists also record (from a menu) their intervention activities following every session.

The analysis of individual therapist performance in naturalistic studies of change requires "case-mix" adjustment since patients are not assigned to therapists at random or through some prearranged systematic matching strategy. Typing of patients based on variables that are expected to affect patient outcome is an essential component of studying the competence of the individual therapist. Post hoc typing allows us to see if therapists are especially effective (or ineffective) with certain types of patients. It offers a substitute for the absence of random assignment and a way of compensating for the frequent occurrence in clinical settings of more difficult clients being referred to therapists who have a reputation of being effective with them. Thus, it allows comparison of therapies within "difficult" and "easy" treatment cases.

Past research on client variables that could be used for case-mix adjustments because they are predictive of outcome are plentiful (e.g., Garfield, 1994; Lambert & Anderson, 1996; Lambert & Bergin, 1994). From this literature we selected patient variables and classified patients into types that differ in severity of current symptomatic

states, history of psychological problems, diagnosis, and degree of functional impairment. The patient classification system results in over a hundred possible types, allowing us to analyze the outcomes of therapists across the spectrum of patient difficulties as they occur in routine clinical practice.

Because this research is only in its initial stages, we do not have sufficient data to report outcome on individual therapists at this time. However, Figures 1 and 2 present *hypothetical* outcome data on two patient types for two therapists who work at the same outpatient clinic. Their results are presented in the context of the results of all therapists working at the same clinic and with the outcome for each patient type from the national database (which includes patients and therapists on the provider panel from across the nation).

Figure 1 presents the outcome of patients seen by hypothetical Therapists A and B, both of whom work at Clinic X. The national and clinic samples serve as normative samples with which Therapists A and B can be compared. In this illustration, outcome is reported only for patient type 3-2-1-3. Patients of the 3-2-1-3 type, prior to therapy, have a high level of symptomatic disturbance, a diagnosis of moderate severity, no history of prior illness, but a poor level of functioning over the past 3 months. As illustrated in Figure 1, Therapist A's patients improved more than those seen by Therapist B as well as the clinic therapists generally, and the patients seen in the national sample by a multitude of therapists. Therapist A seems to have unusually good results with the 3-2-1-3 patient type.

Figure 2 presents the hypothetical outcome for the

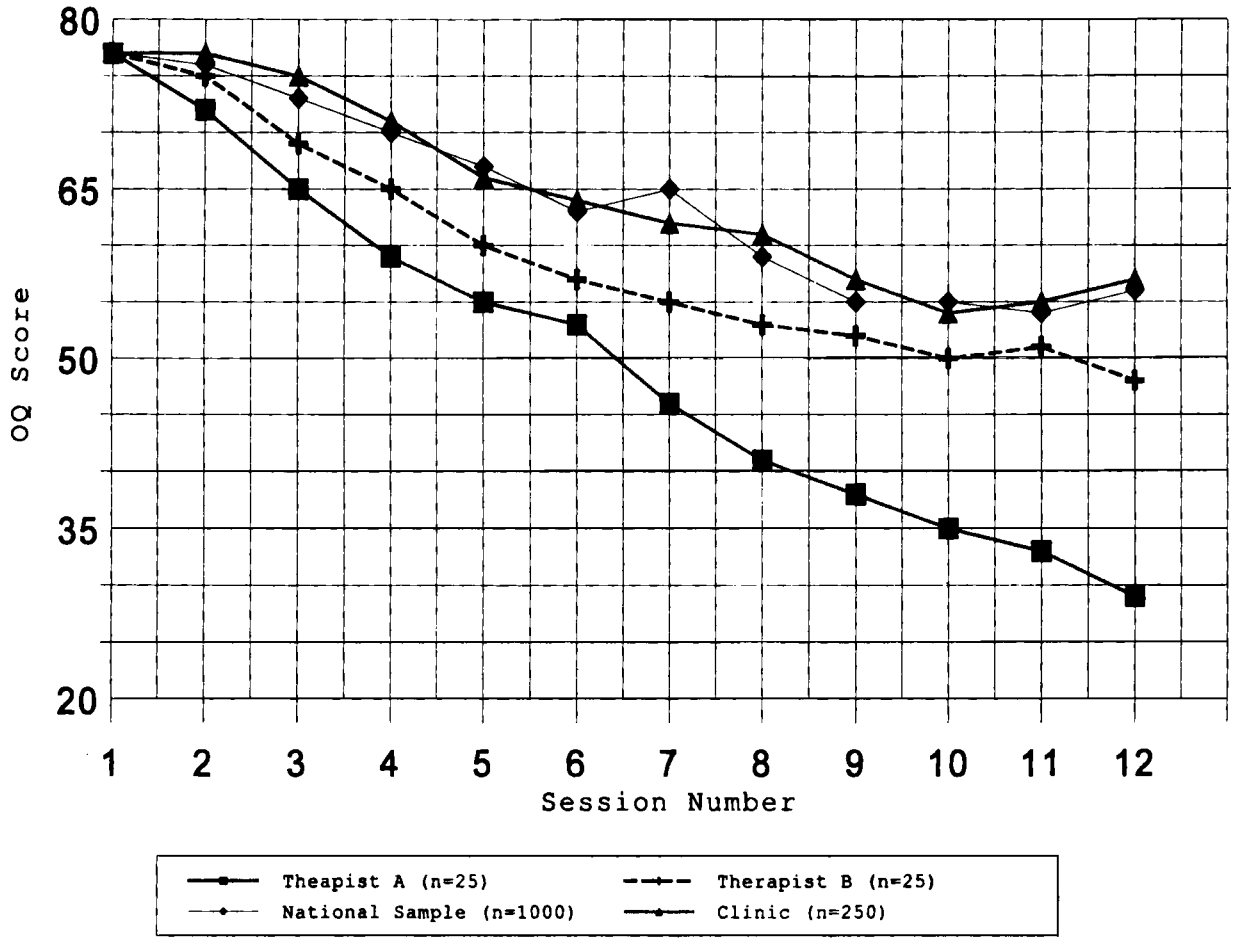

Figure 1. Outcome of Therapist A, Therapist B, national sample, and clinic sample for patient type 3-2-1-3 (high level of symptomatic distress, diagnosis of moderate severity, no history of prior illness, but poor level of functioning). Therapist A has significantly better outcomes based on OQ scores, indicating that Therapist A has unusually good results with this patient type.

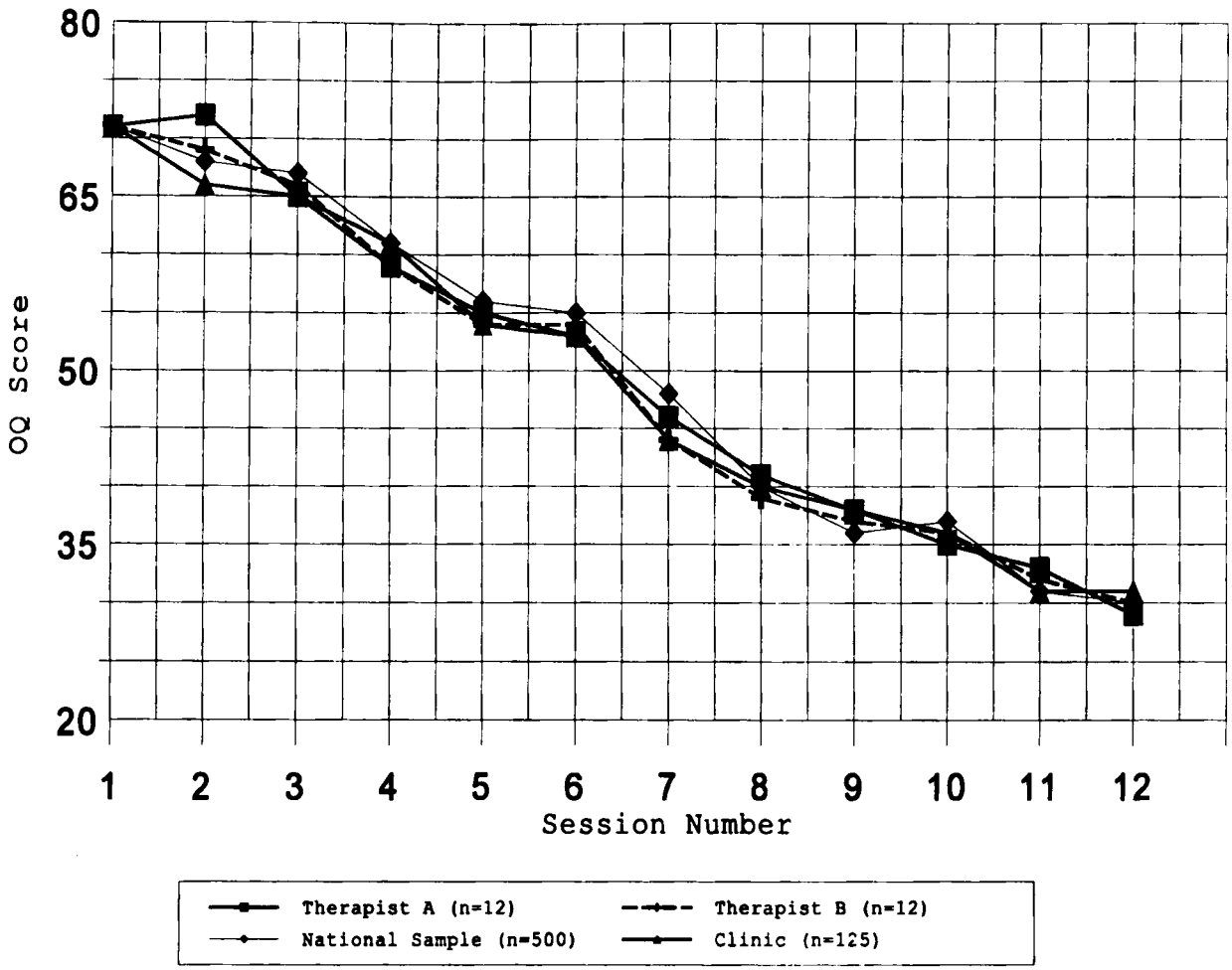

Figure 2. Outcome of Therapist A, Therapist B, national sample, and clinic sample for patient type 1-1-1-2 (low symptomatic distress, adjustment disorder diagnosis, no history of past problems, high level of functioning). There is little difference between the outcomes of the samples based on OQ scores.

same two therapists and clinics, but for a different patient type. This type, the 1-1-1-2 type, is characterized by a low level of symptomatic distress, adjustment disorder diagnosis, no history of past problems, and a relatively high level of functioning. As can be seen in Figure 2, there is no difference between the outcomes of Therapist A and B patients and clinic and national sample patients.

This methodology, if applied, over time has potential for informing therapists, clinics, practice groups, and managed care corporations about the efficacy of providers within the context of the clinic or settings in which they work. This is a research task that requires much larger *N*s than controlled clinical trials and the individual case reports of a specific therapist. Obviously it is only possible within the confines of a cooperative effort by large provider networks where patient outcomes are persistently tracked. Like the work of Orlinsky and Howard (1980), a consumer rating is possible, but because the rating is based on a large sample of cases it could be reliable enough to report back to therapists for their consideration. In fact, the next research task would be to identify therapists who are exceptionally effective and those who are exceptionally ineffective. The former could be studied to identify common characteristics, attitudes, practices, and the like. The latter, assuming they are not ineffective across all patient types, could undergo additional training or merely use the feedback to restrict their caseload by referring to practitioners who are more successful with particular types of clients. The data on both effective and ineffective providers could also prove useful

in selection and training of therapists by clinical training programs and managed care companies.

Of course, an essential part of collecting these data is the cooperation of the individual therapist. Will therapists be willing to undergo or initiate this type of scrutiny? General medicine has been using this kind of research for years in the form of physician audits (Barrable, 1992; Donabedian, 1988). This research allows hospitals and physician committees to identify death rates, rates of complications, cost effectiveness data, and the like linking these outcomes to specific physicians, and provides feedback that results in appropriate actions. It also allows physicians to receive more training in areas where they seem to need improvement (Davis, Thomson, Oxman, & Haynes, 1995). Although there has been and continues to be controversy concerning the methods used for evaluation in the medical field (Avis, Bond, & Arthur, 1995), much can be learned by examining the way this field has attempted to assess practitioners and intervene with them in order to help individual physicians improve the level of care they are providing.

A time for unparalleled opportunity for collaborative efforts awaits the field of clinical psychology and related professions. This opportunity will allow us to examine the curative factors on a scale that is remarkable. Research on the individual therapist can be conducted by each and every provider if measuring outcome becomes a part of routine clinical practice. It is hoped that our cooperative efforts will result in needed changes in training and practice patterns and ultimately in better treatment for those who suffer from psychological disorders.

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