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COMMENTARY

What Have We Learned About Treatment Failure in Empirically Supported Treatments? Some Suggestions for Practice

Michael J. Lambert, *Brigham Young University*

The examination of treatment failure has substantial value in advancing psychological practice as illustrated by the articles in this special issue. Treatment failure is not well defined and includes at least two independent phenomena: nonresponse and deterioration. After discussing the important distinction between nonresponse to treatment and client worsening, some general findings are highlighted. These include client, therapy, and therapist dimensions. The retrospective study of nonresponse to treatment can lead to important modifications in treatment protocols and can influence theory as well as clinical intervention. However, there is a need for methods suitable for routine care that monitor treatment response and make suggestions for changes in real time. A system for accomplishing this task in routine care is briefly described.

It is a mark of maturity of a field of study when researchers and clinicians turn their attention from validating treatments to fine-tuning them for the purpose of maximizing their effectiveness. Dimidjian and Hollon (2010) noted the advantages to the field of studying client worsening for the purpose of maximizing benefits to clients. In the current special series, a unique collection of papers examining treatment failures, as well as a structure for doing so provided by the editors, is an extension of their 2010 article on client worsening. It is an important step forward in understanding the limits of treatments and the ways in which such limits might be reduced. As Dimidjian and Hollon (2011) note, it has proved easier to call for the study of treatment failures than to actually present data on the topic. I join them in congratulating the authors of this series, who present rich examples of treatments that failed in their intended impact and who explore the reasons for failures and propose viable solutions.

Before discussing this body of work, it may prove useful to note that the focus in this series is on "treatment failure," not client *worsening*. The treatment failure problem is examined in the context of providing *empirically supported treatments* (which, in this case, means a specific manualized treatment delivered to a client who met criteria for the disorder that the treatment was tailored to address). Often this meant that the treatments were delivered within a research protocol, not within routine clinical care where a somewhat different set of problems may emerge. This is an important topic because some of the reasons for treatment failure discussed in this issue are possibly related to the constraints imposed by research designs. In routine care, cost constraints, treatment dosage, offering treatments that vary from those for which empirical support exists, therapist training and expertise, and other practical matters may contribute to treatment failure but are not necessarily examined in these reviews. I will return to this topic in the final section of this discussion when I offer practical solutions for reducing treatment failure in routine care.

Definition of Treatment Failure

As noted above, "treatment failure" can have multiple definitions, with client *worsening* being a more specific and unique type of "failure." Unfortunately, there is no generally agreed upon definition of treatment failure and this is reflected in the diversity of definitions used by the authors in this issue. Most often authors interpreted treatment failure to mean that the patient did not seem to respond to treatment by the time it was terminated. The typical treatment failure was identified through the use of standardized scales reflecting a variety of raters as unchanged at termination (e.g., Cooper & Fairburn, 2011; Echiverri, Jaeger, Chen, Moore, & Zoellner, 2011; McCauley, Schloredt, Gudmundsen, Martell, & Dimidjian, 2011). However, in the case examples that were provided, treatment failure cases ranged from patients who actually

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had a good outcome by termination (but whose course of therapy was marked by very rough progress and a need to modify usual procedures; Newman, 2011; Eisendrath, Chartier, & McLane, 2011); or who had a positive outcome at termination only to relapse later (Arch & Craske, 2011). Besides "treatment failure," terms such as "suboptimal outcome" (George, Taylor, Goldstein, & Miklowitz, 2011), "treatment refractory" (Brozovich & Heimberg, 2011), or "premature termination" (Boswell et al., 2011) were used as well. It appears that the cases under study were not all treatment failures and were quite variable in their outcome, with perhaps only one experiencing deterioration sufficient to lead the therapist to unilaterally initiate referral (Rizvi, 2011) and another in which the patient attempted suicide (George et al., 2011).

Historically little effort has been expended on understanding treatment nonresponse, while deterioration has been of interest since the 1960s when Bergin (1963) hypothesized that patients in treatment both worsened and improved, and that this fact suggested that therapies were quite powerful, if not always effective. The topic of failing to benefit was not addressed. Lambert, Bergin, and Collins (1977), after reviewing the treatment literature on deterioration and its causes, identified interpersonal factors as the largest contributors to negative effects. Specifically, events related to therapist countertransference, rejection (e.g., poor handling of termination and referral), disinterest, low levels of empathic responding, lack of regard, therapist hostility, and the like, were seen as central causative factors. Very little evidence could be found for deterioration tied to the misuse of therapeutic techniques or the inadequacy of theoretically based treatments, or assignment of clients to the "wrong" psychotherapy (with the exception of assigning patients with borderline personality disorder to highly ambiguous/low-structure treatments). These early studies mainly examined psychodynamic psychotherapy, but the review considered person-centered, behavior therapies, and cognitive behavior therapies as well. At the time, there were few manual-guided treatment protocols. The review also addressed treatments delivered in a variety of modalities (e.g., group, couple, individual) where the rate of negative effects appeared similar, with the exception of some group therapies. But even here higher rates of deterioration in some group formats were most often linked with the attitudes and behavior of specific group leaders who were overly aggressive.

Having looked across so much of the past literature on deterioration did not prepare me for the broader focus on "treatment failure" as conceptualized in the important contributions by the authors in this series. This reinforces the importance of clarity in definitions. One important distinction between the early deterioration literature and many of the papers in the current series is that the former includes clients who end treatment worse off (and possibly injured by their therapist) while the latter includes clients who have more or less been untouched by the treatment delivered in a highly structured and time-limited format.

Nonresponse and negative change are not the same problem and do not have the same implications for improving practice. Drawing conclusions across all the studies in this series is made difficult by the imprecision or inconsistent phenomena under study. It probably matters whether we are trying to learn something about how to maximize follow-up adjustment, or deal with cases that actually worsen while in treatment, versus those clients who do not change. Since each article dealt with a different disorder and treatment, finding general processes that can account for treatment failures is further complicated. Despite these difficulties and the use of single cases for almost all the treatments under consideration, the material is rich with possibilities for discussion and actions, specifically with regard to treatment nonresponse.

The Scope of the Problem of Treatment Failure

Most articles did a service to the field by estimating the frequency of treatment failure in the specific disorders and treatments under consideration. When the various articles are seen as a whole, and when treatment failure is highlighted, it becomes obvious that as effective as these treatments are, there is still plenty of room for improvement. This is true even where we have had the greatest success in returning patients to a state of normal functioning (e.g., 50% to 70% in panic; Arch & Craske, 2011), but especially true for the more difficult disorders (e.g., at best less than 50% of eating disordered patients gain a full recovery; Cooper & Fairburn, 2011). Deterioration rates (a special subset of treatment failure) in psychotherapy have been estimated at 5% to 10% for adults (Lambert & Ogles, 2004). Hansen, Lambert, and Forman (2002) examined a representative sample of clinical trial outcomes based on 89 treatment comparisons (mostly CBT) and reported an average of 57% to 67% recovered or improved after receiving an average of 12 to 13 sessions of treatment, figures that are similar to those reported in this issue. These outcomes were contrasted with those found in over 6,000 clients who participated in routine care that lasted an average of 4 sessions, with patients ranging from those treated in community mental health centers to those being seen in employee assistance programs. Rates of improvement/recovery averaged 35% and deterioration varied from a low of 3.2% to a high of 14%, with an average rate of 8%.

Treatment failure and deterioration among youth is even more problematic. Warren et al. (2010) found that deterioration rates varied from 15% to 24% depending on the sample and treatment setting (managed care versus community mental health). If these results are replicated it would suggest that one in four child patients seen in the

public sector are worse off after treatment. This is a much larger problem and a different problem than nonresponse (the rates of which are also very high) and one that begs for immediate attention in routine care. Both clinical trial outcomes and routine care context outcomes offer up many instances of treatment failure and deterioration that need to be addressed. Unfortunately, we have an abundance of cases to learn from.

Some Substantive Findings

In contrast to Dimidjian and Hollon (2010), who emphasized deterioration, many of the papers in this series focus largely on nonresponse. The editors guided authors to consider the full range of reasons for nonresponse—including client factors, treatment model factors (the wrong treatment, applying treatments that do not cover a full range of client problems, inadequate conceptualization), as well as poor delivery of treatment. This helped focus the series and give it some uniformity with regard to analyzing how and why treatment failed. Authors were free to emphasize what seemed most important to them, what they learned from retrospectively examining the failure of some clients to change, and what to do about it. I have tried to distill some of the most important conclusions.

Patient Factors

With regard to causes, it is abundantly clear that client factors loom large as possible explanations for treatment failure, despite the fact that the authors went out of their way to not place "blame" on the clients. Those who did not respond to treatment provided special challenges to practitioners and these tended to take three general forms: poor motivation, complicated problems, and resistance. Motivational difficulties were abundant in many of the cases, perhaps best illustrated by McCauley et al.'s (2011) case study of a depressed adolescent who agreed that he needed help but did not think the specific help that was offered was going to be useful to him. Boswell et al.'s (2011) example of premature termination in the treatment of GAD illustrated many motivational problems. Despite many indications that the patient thought that her worries were problematic, she at times defended them as normal and reasonable. Evidence of not complying with homework assignments and similar failures to follow through were apparent across phases of treatment until she unilaterally terminated treatment. In many cases patients were highly motivated and complied with treatment requirements, but appeared to "prefer" their problematic problem behaviors as a means of coping with difficult affect (Cooper & Fairburn, 2011).

Several examples of complicated presentations make obvious the difficulties that arise when comorbidities exist, including when substance abuse or personality disorders are present. For example, in the case of PTSD (Echiverri et al., 2011) the client appeared to have grief problems and the need to think repeatedly about the traumatic death of her husband rather than moving forward, indicating perhaps that she was not at a point in her life to profit from the CBT interventions offered (or any therapy?). While explicitly forbidding therapists from attributing failure to clients undergoing DBT, one can't read the case example presented by Rizvi (2011) without sensing that a major goal of the patient was to defeat the therapist at every turn. In the case of family-focused treatment for bipolar disorder, the therapist appeared to side too much with the adolescent (and father) while seeing the mother as overinvolved and needing to give up control—but here there was also the problem of substance abuse, which the adolescent kept hidden from the parents and the therapist. The sheer multitude of problems in the family dynamics, in addition to bipolar disorder, appeared to doom the treatment.

Clearly, client contributions to treatment failure are central in explaining its occurrence, but often we are not blessed with the knowledge to know beforehand if client problems will prove too difficult to overcome in specific cases, even when patients are selected to be a good match for the intended population of the empirically supported treatment. Even though there are ideal candidates for specific treatments, we cannot refuse treatment to less-than-ideal clients, and one of the functions of this series is to push the field to consider the treatment of patients presenting with complexity and comorbidity. Fortunately, the best predictor of final treatment outcome is early response to treatment (Haas, Hill, Lambert, & Morrell, 2002), and if we identify cases that are having a poor response to treatment, we can modify treatments in a timely fashion, an important topic to which we will return shortly.

Technique Factors

The papers in this issue place considerable emphasis on the modification of treatment protocols to increase and broaden their impact. This practice stands in contrast to the bulk of recommendations that have been emphasized in the deterioration literature. Perhaps the clearest example of this trend is Cooper and Fairburn (2011), who provide an enhanced CBT for eating disorders based on examination of nonresponders. They propose one to four elements to be added to treatment *in particular cases*: increased focus on clinical perfectionism, mood intolerance, low self-esteem, or interpersonal difficulties. Addition of these treatment foci increases the basic protocol to 20 sessions delivered over 20 weeks in order to broaden treatment.

Another example can be found in adapting adult behavioral activation interventions to depressed adolescents (McCauley et al., 2011). Pilot testing the adaptation with a small number of cases, including the one presented, suggested that with youth the therapist needed to be more flexible, including putting aside worksheets and other preprepared material if responded to negatively by the adolescent. This flexibility included adapting the order of presenting core skills. While a fixed order was satisfying to the majority of patients, it needed to be modified for some in relation to feedback from them. There appeared to be a need to make greater attempts to strike a balance between insistence on following a preset structure and individualization based on patient reactions. They also added weekly assessment of suicide to the assessment that was already in place and tapering of sessions to make the end of treatment more responsive to individual cases. Ongoing flexible contact with families was another innovation that would enhance treatment for particular clients. In general, it appears that in order to enhance treatment outcomes, treatment protocols needed to cover more aspects of dysfunction and more treatment targets tailored to specific clients. In routine practice clinicians may already make such accommodations because they do not feel compelled to follow manuals, whereas in research protocols the treatments are being tested for efficacy and need to be more well defined—including being offered in a standard dosage.

Some treatments already show an impressive history of treatment modifications based on treatment failures (e.g., Brozovich & Heimberg, 2011). When such treatments already emphasize making the treatment flexible and individually tailored within a broad principle-based and alliance-heavy treatment, this series makes clear that interventions can still fail. In such cases, the authors turned to client characteristics such as low motivation, unwillingness to engage in treatment activities, comorbidity (with the possible need for additional treatments), and implementation issues. The treatment of social anxiety provided by Brozovich and Heimberg provides an excellent example. It appears that the warning signs of poor motivation, low expectations for treatment success, avoidance of engaging in prescribed treatment activities, and the complications of depression and substance abuse were recognized early on by the therapist, who also addressed them, for the most part, in a timely manner. Nevertheless, the patient could not face the demands of treatment and withdrew when he was confronted by the discrepancies between what he had to do to achieve success and what he was able to bring himself to do. The suggestion here is that the therapist might have been more direct or creative in approaching the client's lack of improvement by better addressing motivation and comorbid depression. Newman (2011; morbid avoidance and anger) provides a similar example of where the client could not tolerate experiential aspects of treatment.

Poor Treatment Delivery

Each article in the series found instances where therapist mistakes in delivery may have interfered with patient outcome. Supervision of ongoing treatment can go a long way toward reducing these contributions to nonresponse, provided that sessions are recorded and analyzed. This is most likely to be helpful if the supervision of cases is focused on cases that are having a poor response to treatment.

Routine Monitoring With Alarm Signals and Feedback for Prevention of Treatment Failure

Attempts to modify EST protocols for the sake of reducing treatment failure can benefit from the broad literature on methods applied in routine care to reduce failure in ongoing treatment in real time (Lambert, 2010). Here the focus is not so much on theory and intervention development as in changing the course of treatment for specific clients whose recovery is in doubt. Such an endeavor is based on identification of cases that are at risk of negative change rather than nonresponse. Accurate identification of such cases depends largely on predictive models. Although the papers in this series suggest that ongoing monitoring of client outcomes was used, it is possible that the clients and therapists may have benefitted from tools and processes to make optimal use of this information in real time.

Prediction/Identification

In this series on treatment failure, some of the cases challenged the therapist early on in treatment; in other cases, the treatment failure was not evident until after termination. We do not know what percent of challenging cases would be predicted by their therapist to be among those who were final nonresponders or deteriorators. If general research on the topic is any indication, it is likely that few of these clients would be identified in real time, in the absence of systematic monitoring methods. Hatfield, McCullough, Plucinski, and Krieger (2010), for example, reported that clinicians seldom noted client deterioration in treatment based on mentioning any worsening in their weekly case notes, even when the negative change clients reported on self-report measures was extreme. For example, of the most severe negative change that occurred, only 30% of case notes recorded any worsening. Hannan et al. (2005) reported, in a study intended to pit clinical trainees against experienced clinicians and against a statistical method's ability to predict negative change, that out of 550 clients whose progress was evaluated, only 1 was predicted to fail—even though 40

clients actually deteriorated *and* clinicians were informed that the baseline expectancy for deterioration was 8%. In contrast, the statistical method identified 36 of the 40 before the clients left treatment. Of the 20 licensed professionals who participated in the study, none accurately predicted a single case of deterioration (as reported by patients). It appears that therapists are likely to overestimate the benefits of therapy for their clients and see themselves as superior to their peers in producing good outcomes, with 90% of therapists seeing themselves as above the 74th percentile (i.e., almost all therapists see their personal impact on clients as better than a substantial majority of their peers; Walfish, McCallister, O'Donnell, & Lambert, 2010).

Nevertheless, client worsening can be predicted through several statistical methods, most of which simply take into account how disturbed a patient is at intake and what kind of progress they make early in treatment. This requires that clients' self-reported level of mental health functioning be evaluated consistently throughout treatment and compared with the progress of similarly disturbed patients (i.e., actual progress is compared with expected progress) with an off-track signal generated for cases who are significantly deviating from an expected course of recovery. Given clinicians' tendency and need to be optimistic about their client's future progress, the task of identifying treatment failure is best left in the hands of actuarial methods with hard and fast rules of identification.

Finch, Lambert, and Schaalje (2001), for example, found that they could identify 100% of clients who were deteriorated at termination using longitudinal predictive models. But, for every correct identification of a deteriorated case, two cases predicted to deteriorate did not. Such inaccuracy on the side of overprediction has some advantages, especially when one considers that many false-alarm cases go on to be nonresponders.

Lutz et al. (2006), borrowing from statistical models used in avalanche research, has found prediction of negative outcomes (combined deteriorated cases with nonresponders) more difficult than predicting deterioration but still quite successful. These actuarial models provide a kind of "lab test" result like those used in medicine for decision making and management of chronic illnesses, such as heart disease and diabetes. Without vital sign lab tests, physicians would have to guess at the degree to which treatments were succeeding or in need of modification. As the cases presented in this series make clear, clinicians did not have specific markers for indicating that their treatments were failing and therefore (at least in some cases) acted too slowly on their impressions to benefit those particular clients. Without warnings based on standardized data, each clinician develops her or his own system for identifying problematic cases and modifying treatment, an approach the data suggest is substantially flawed.

Providing Feedback

Once patient mental health is monitored in real-time with standardized self-report scales and this information is subjected to algorithms for identifying potential treatment failures, this information can be provided to therapists as feedback so as to alert them to the possible need to alter treatment. Such a feedback system is critical. In addition, we have developed clinical support tools to assist clinicians in problem solving with these poorly responding clients. The clinical support tools consist of a brief 40-item self-report measure—Assessment for Signal Clients (ASC), a decision tree that organizes problem solving hierarchically, and intervention lists that suggest actions a therapist may consider taking (Lambert, Whipple, et al., 2004). At this point in time the OQ-Analyst computer software can provide an organizing framework for problem-solving treatment failure and possible courses of action, but it is up to each individual clinician and possibly supervision to narrow down the possibilities and decide on a course of action.

The feedback intervention is consistent with Bickman's Contextualized Feedback Intervention Theory, which suggests that clinicians (and professionals, generally) will benefit from feedback if they are committed to the goal of improving their performance and are aware of a discrepancy between the goal and reality (particularly if the goal is attractive and the clinician believes it can be accomplished), and if the feedback is from a credible source, is immediate, frequent, systematic, unambiguous, cognitively simple (such as graphic in nature), and provides clinicians with concrete suggestions of how to improve. Feedback is most helpful when the therapist has the goal of being maximally helpful and client progress is discrepant from this goal (Reimer, Rosof-Williams, Bickman, 2005; Sapyta, Riemer, & Bickman, 2005).

Research evidence from six clinical trials suggests that for *off-track* cases, simply providing feedback about progress alone (i.e., just providing therapists the information that their patient is predicted to fail treatment) will result in substantial benefit for these clients. Somehow, if therapists are made aware that the client is not improving, they find ways to intervene that improves outcome. In addition, when the therapist administers the ASC and uses the Clinical Support Tool manual, further progress is made (Shimokawa, Lambert, & Smart, 2010).

Germane to the discussion at hand, the decision-tree component of the Clinical Support Tool manual organizes likely reasons for failure along the same lines as the problems highlighted by the authors in this series. The therapist is first directed to assess the quality of the therapeutic alliance using 11 of the 40 items in the ASC. We provide therapists with a general score on the alliance

but have found they benefit more when specific item feedback is also provided. For example, we alert therapists if the overall alliance is problematic (1.5 standard deviations below average) and also if there is a problem with the bond, task agreement, and goal agreement, as well as specific item feedback that is below average (e.g., a low score on a specific item, such as "My therapist seems glad to see me"). Specific suggestions for repairing a ruptured alliance are drawn from the work on rupture repair researched by Safran and Muran and (2000).

After considering the patient's perception of the alliance, items from the ASC measuring motivational problems are considered. Such items would appear to be especially important with regards to CBT treatments (and prevention of nonresponse versus deterioration) with their emphasis on completion of out-of-office assignments. Many case studies in this issue contained challenges with regard to motivation and noncompliance. At the same time, the motivational items in the ASC were not chosen based on CBT treatment or homework specifically, and a more suitable marker may be if a client reports doing homework or not, information readily available to the therapist at each session of CBT. There may still be a place for the motivation scale in CBT in that CBT clinicians have no systematic standard for dealing with homework noncompliance as a marker for treatment failure.

Another dimension tapped by the ASC is social support. Here the assumption is that intimate relationships outside of therapy can be so disturbed or dysfunctional that the client does not have the external support and interpersonal stability to keep them functioning at a high level. Negative interpersonal interactions, changes in relationships, and losses can be at the root of deterioration during psychotherapy, and bringing this to the therapist's attention through the use of a series of formal questions can help with problem solving. Poor and worsening social support may lead to dramatic changes in the treatment—changes that are not a part of the treatment protocol or original case conceptualization/treatment plan. One sees the possibility for this being helpful in several of the cases within this series. For example, in McCauley et al.'s (2011) article on behavioral activation, it became obvious that "Tim's" parents were contributing to his difficulties and that it may have been more helpful for them to briefly participate more directly in his treatment. His therapist realized this was a problem and the treatment protocol was changed accordingly without the help of social support items from the ASC. However, such measurement with poorly responding cases may bring this problem to awareness sooner, or serve as a marker for when parent or spouse involvement might be an essential part of treatment. In some settings, realization of poor social supports can trigger other changes in the treatment, such as adding on adjunct group psychotherapy or social skills training.

The decision tree and ASC next assesses stressful life events that may be affecting treatment. The especially important life events that can trigger deterioration include losses in the patient's life through death or other causes such as being fired. Another important factor is physical illness, especially where physical pain plays a role. While it is difficult to assess the presence of all the life events that may significantly impact therapeutic progress, therapists are well aware of instances where therapy appears to be progressing satisfactorily only to suddenly have a life event occur that has special importance for a patient.

The final areas of the decision tree draw the therapist's attention to the possibility of a missed diagnosis and the possible value of a medication referral. Unlike the treatment failure examples provided in this issue that emphasized modifying treatment protocols as a solution to treatment failure, the CST approach begins with failures of the interpersonal aspects of treatments and finally directs attention to modifying diagnostic judgments and treatment plans (administration of tests, Clinical Support Tool, and related material is imbedded within the OQ-Analyst).

Consequences of Feedback

Shimokawa et al. (2010) summarized the results of six clinical trials aimed at testing the effects of various experimental feedback conditions through the use of meta- and mega-analytic statistical procedures. The studies under consideration compared the outcome of 8,859 clients who received treatment as usual or a version of feedback, with the same therapists providing comparative treatments. Thus, the general question was: Do patients fare better when therapists (and in some cases clients) receive feedback than when they don't? The focus of the feedback intervention was on the outcome of clients who were predicted to be treatment failures (deteriorated cases), as the interventions were presumed to reduce deterioration rates.

Table 1 provides a summary of results across studies and treatment conditions with the not-on-track (about 19% of cases) and on-track cases (about 81% of cases). The results are presented for clinically significant change based on Jacobson and Truax (1991). The interventions as applied to the intent-to-treat sample were all superior to treatment-as-usual outcomes. The use of progress feedback with alarm signals lowered deterioration rates from 20% in treatment as usual to 11% in the progress feedback plus CST condition. When the efficacy sample, who actually stayed around long enough to have their therapist receive and act on the CST information was considered, the deterioration rate was only 5.5%.

Table 1
Clinical Significance Classification of Not-on-Track Patients by Treatment Conditions

Treatment Conditions (Intent-to-Treat Sample)							
Clinical Significance	CST Fb	NOT P/T Fb	NOT Fb	NOT TAU	OT P/T Fb	OT Fb	OT TAU
Worsened/Deteriorated	47 (11.3%)	35 (15.8%)	58 (13.6%)	64 (20.1%)	20 (2.1%)	45 (1.9%)	43 (3.0%)
No Change	212 (51.1%)	101 (45.5%)	237 (55.5%)	183 (57.5%)	507 (54.2%)	1485 (62.1%)	940 (65.1%)
Improved/Recovered	156 (37.6%)	86 (38.7%)	132 (30.9%)	71 (22.3%)	408 (43.6%)	860 (36.0%)	461 (31.9%)
Treatment Conditions (Efficacy Sample)							
Clinical Significance	CST Fb	NOT P/T Fb	NOT Fb	NOT TAU	OT P/T Fb	OT Fb	OT TAU
Worsened/Deteriorated	12 (5.5%)	26 (14.7%)	24 (9.1%)	-	20 (2.6%)	40 (2.4%)	-
No Change	91 (41.9%)	71 (40.1%)	140 (53.2%)	-	349 (44.9%)	794 (48.1%)	-
Improved/Recovered	114 (52.5%)	80 (45.2%)	99 (37.6%)	-	408 (52.5%)	817 (49.5%)	-

Note. CST = Clinical Support Tool; Fb = feedback; NOT = not on track; P/T = patient/therapist; TAU = treatment as usual; OT = on track. Reprinted with permission of the American Psychological Association (Shimokawa et al., 2010).

This research endeavor clearly showed that deterioration could be lowered (it was four times more likely in the treatment as usual cases) and that for clients who were never predicted to be at risk for treatment failure, it substantially improved the proportion of cases that had a positive outcome.

Summary and Conclusions

This special series on treatment failure makes it clear that a portion of patients fail to benefit from a variety of psychotherapies that have been found to be helpful to the majority of those who enter treatment. The emphasis on what can be learned from clients who fail to benefit proved useful, leading to many suggestions for improving treatment across diverse patient populations and problems. The different cases provided examples of instances when failure to benefit could be placed at the door of clients who were unable or unwilling to participate in therapy as offered and therapists and treatments that did not effectively engage them. In some instances, important expansions to treatment protocols were developed or suggested, in others it appeared that the protocols were sufficient but their flexibility was not—thus leading to recommendations for proceeding with some clients in a more flexible manner. Failure to progress in treatment rarely appeared to be due to therapist interpersonal skills (e.g., therapeutic alliance, respect, etc.) but instead seemed to center around their failure to respond appropriately when they sensed the therapy was not going well. Perhaps there was a tendency to wait too long to address treatment problems with more challenging cases with the hope that sticking with the treatment program would eventually work out. Overall, we see patients who did not progress (or relapsed rapidly) but therapists who were highly invested in helping and made gallant efforts to do the best things for their patients. It was a pleasure to read the case studies and see the degree to which therapists were committed to the well-being of their patients.

This series focused on improving treatments and treatment protocols for the further testing of enhanced treatment delivery. This can go a long way in maximizing positive treatment outcome in future patients. Although many of the therapists and clinical protocols discussed in this series used consistent outcome monitoring, there appeared to be a deficiency in the models for structuring how to best utilize that information. It is suggested here that more immediate good could come from systematically monitoring patient treatment response using statistical modeling to estimate an expected treatment response for specific patients and then alerting therapists in real time to actual response. The key aspect of monitoring patient progress is providing alarm-signals—providing therapists with "precise" information that patient responding is not consistent with a positive outcome, a task clinicians do not do well if left on their own. Further assessment of certain client factors can assist therapists in their attempts to turn a failing patient on a new positive course. At this time, it appears that general characteristics of the client, such as motivation, social supports, and their working relationship with the therapist, are sufficient to help therapists move the treatment forward. This series clarifies that we can make continual progress in enhancing treatments and broadening their effects through the examination of treatment failures and that effective methods exist for recognizing off-track progress and remedying it in real time to improve outcome.

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Address correspondence to Michael J. Lambert, Ph.D., Department of Psychology 272 TLRB, Brigham Young University, Provo, UT 84602; e-mail: michael_lambert@byu.edu.

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