The Milton H. Erickson Foundation
2018 Brief Therapy Conference

Time Passages

Honoring the Past to be Effective in the Present and Future

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brieftherapy
Burlingame, California | December 6 - 9, 2018

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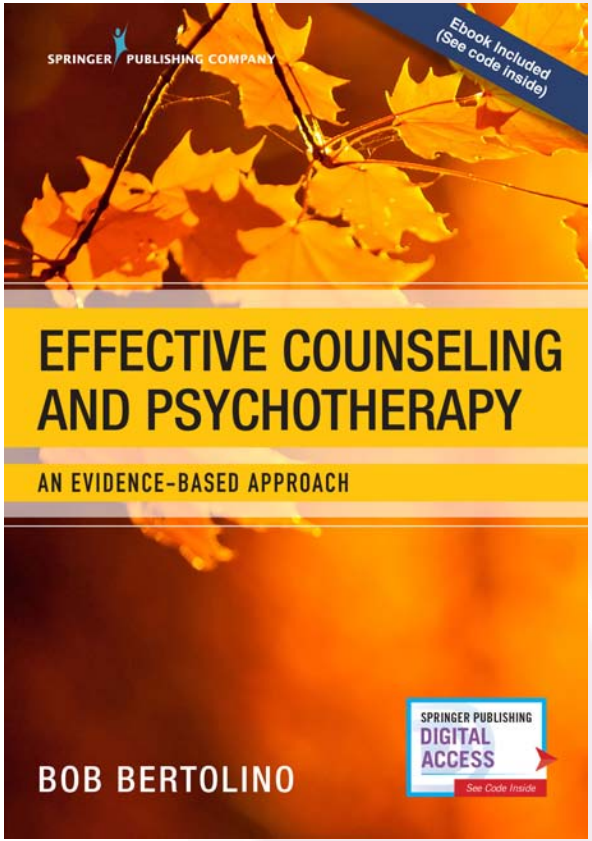
Resources

- Articles
- PowerPoint Slides
- Handouts
- Audio
- Video
- Imagine OMS

Slides for today's workshop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EFFECTIVE COUNSELING
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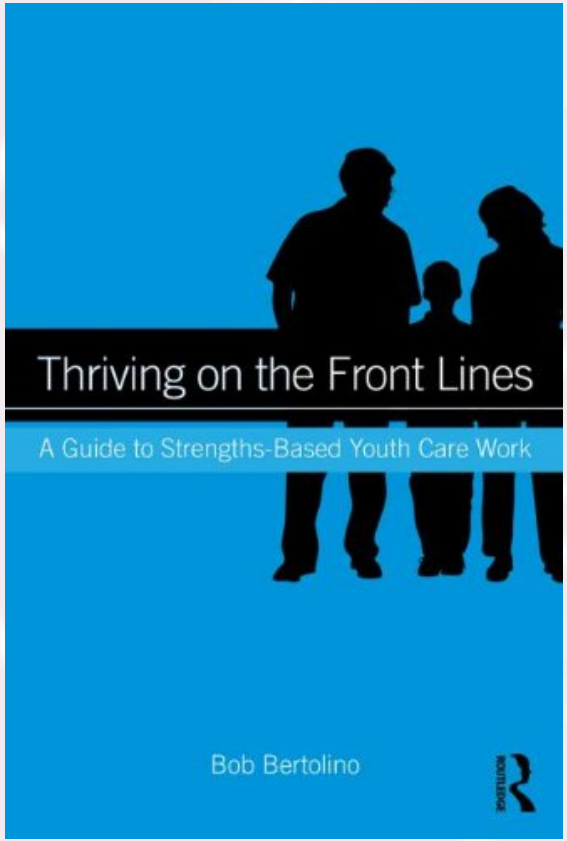
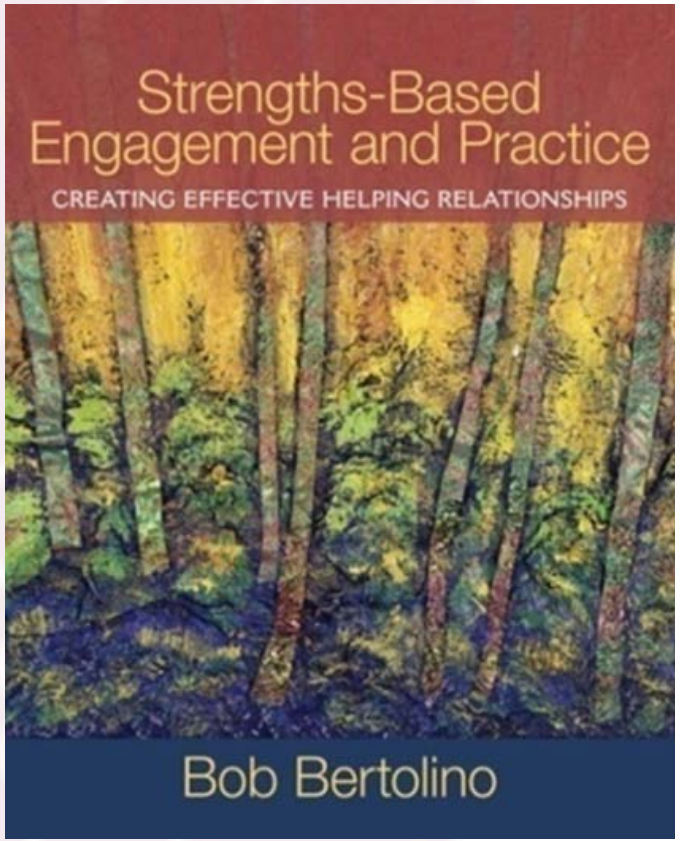

Thriving on the Front Lines
A Guide to Strengths-Based Youth Care Work
Bob Bertolino


Strengths-Based
Engagement and Practice
CREATING EFFECTIVE HELPING RELATIONSHIPS
Bob Bertolino

The Evolution of Psychotherapy (1985)
The Convocation

"We are here to speak to commonalities that underlie successful clinical work…. In the evolution of the infant discipline of psychotherapy, the first 100 years have been divergent. It has been a period of growth, consisting of flowers and weeds. Especially in the last 40 years, there has been a proliferation of discrete schools. Perhaps we can begin this second century in a way that is more convergent (Zeig, 1987, p. xxvii).

Zeig, J. K. (1987). Introduction. In J. K. Zeig (Ed.), *The evolution of psychotherapy* (pp. xv-xxviii). New York: Brunner/Mazel.

The Evolution of Psychotherapy (1985)
The Experience

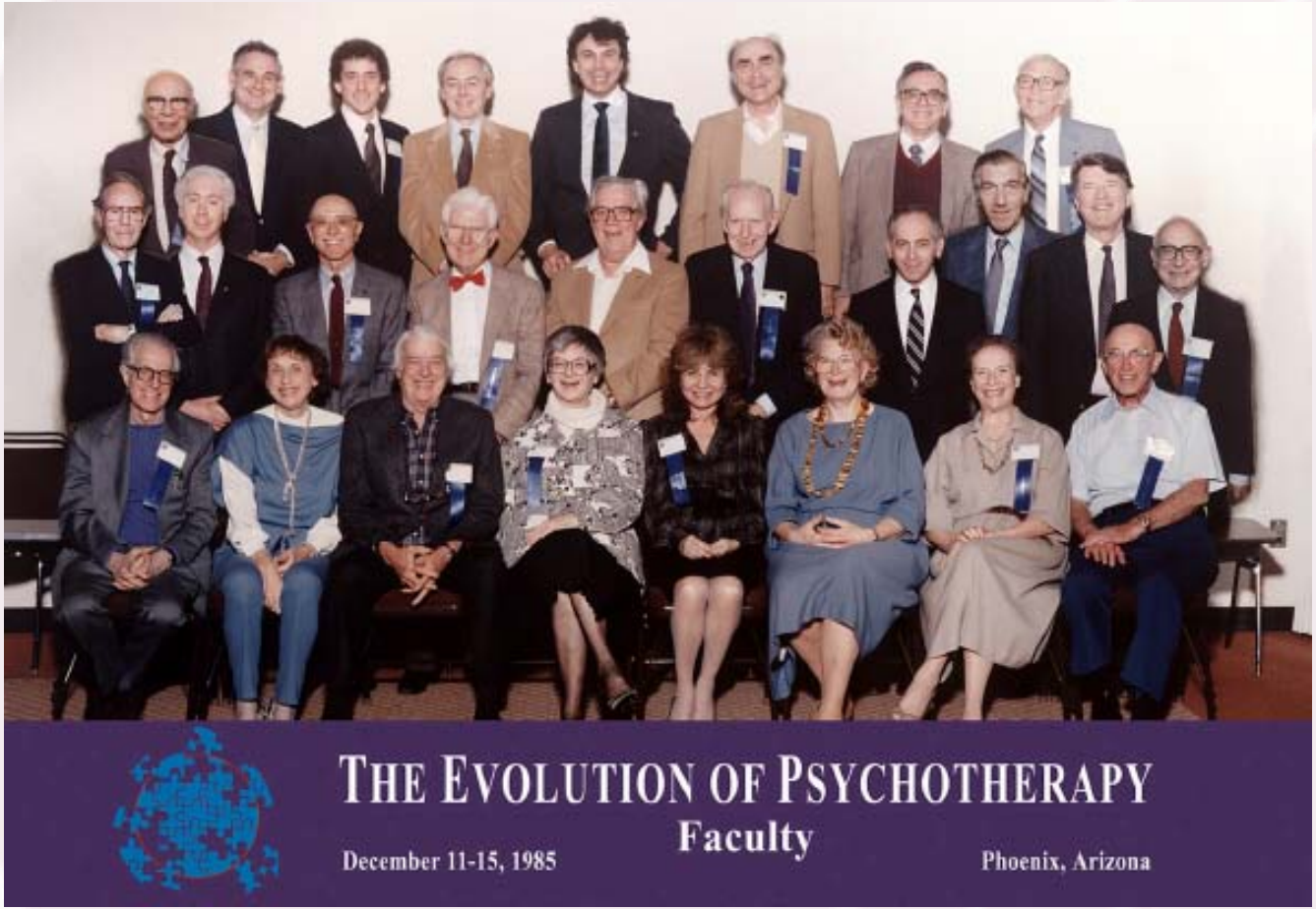
- Joseph Wolpe referred to the conference as a “babble of conflicting voices” (Leo, 1985, p. 59).
- In a review by *Time* magazine, one attendee commented, "All the experts are here, and none of them agree" (p. 59).
- In attempting to present their own position in its clearest, least complicated, and most elementary form for the large audience, the speakers created and subsequently demolished caricatures of opposing viewpoints…. (Shapiro, 1987, p. 66)

Leo, J. (1985). A therapist in every corner: Harmony was the goal, but participants seemed out of tune. *Time, 126*(25), 59.
Shapiro, J. L. (1987). Message from the master on breaking old ground. The evolution of psychotherapy conference. *Psychotherapy in Private Practice, 5*(3), 65-72.

The Evolution of Psychotherapy (1985)
The Conclusion

"Here were the reigning experts on psychotherapy and I could see no way they could agree on defining the territory. Can anyone dispute, then, that the field is in disarray?" (Zeig, 1987, pp. xviii-xix).

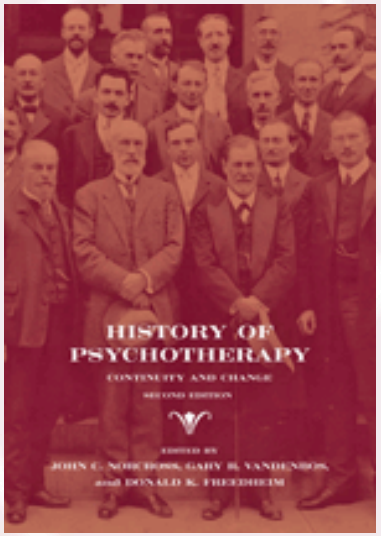
Zeig, J. K. (1987). Introduction. In J. K. Zeig (Ed.), *The evolution of psychotherapy* (pp. xv-xxviii). New York: Brunner/Mazel.

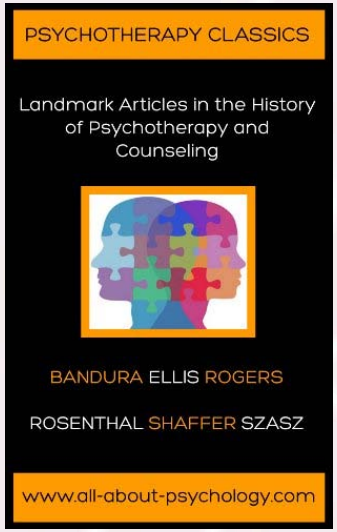

THE EVOLUTION OF PSYCHOTHERAPY
Faculty
December 11-15, 1985
Phoenix, Arizona

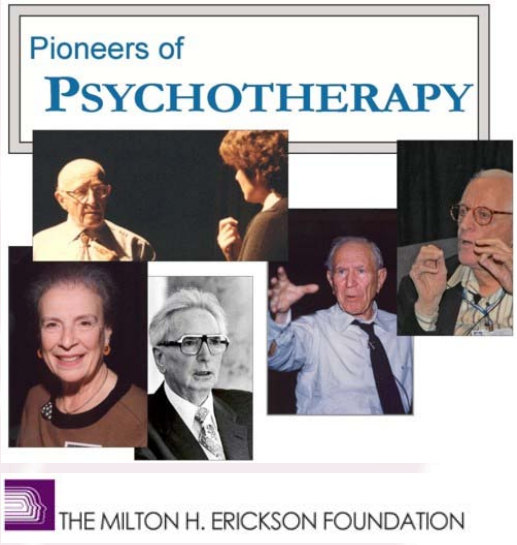
A

The History of Psychotherapy

- Sigmund Freud
- Carl Jung
- Alfred Adler
- Ivan Pavlov
- B.F. Skinner
- Fritz Perls
- Carl Rogers
- A.T. Beck
- Albert Ellis
- William Glasser
- Viktor Frankl
- Milton Erickson
- Virginia Satir
- Jay Haley







https://catalog.erickson-foundation.org/page/pioneers-psychotherapy-2604

Honoring the Past

What historical ideas, approaches, or methods from psychotherapy inform how you practice? How so?

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Fast Forward

From 1987 to 2018

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An Initial Consideration

Comparative Analyses in Psychotherapy

APA Resolution on the Recognition of Psychotherapy Effectiveness:

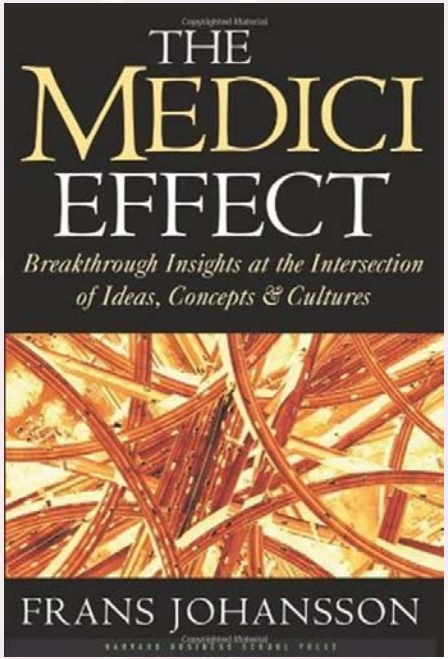
Comparisons of different forms of psychotherapy most often result in relatively nonsignificant difference, and contextual and relationship factors often mediate or moderate outcomes. These findings suggest that (1) most valid and structured psychotherapies are roughly equivalent in effectiveness and (2) patient and therapist characteristics, which are not usually captured by a patient's diagnosis or by the therapist's use of a specific psychotherapy, affect the results. (APA, 2012)

American Psychological Association (APA) (2012). Resolution on the Recognition of Psychotherapy Effectiveness. http://www.apa.org/about/policy/resolution-psychotherapy.aspx

Further Considerations

Intersections in Health and Behavioral Health

- Intersections between health and behavioral health continue to emerge.
- These intersections have contributed to a series of evidence-based principles that emphasize *hope, client contributions, the therapeutic alliance, culture*, *health and well-being (growth)*, *outcomes*, and *provider effectiveness and accountability*.



Evidence-Based Practice (EBP)

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Empirically-Supported Treatments (ESTs) vs. Evidence-Based Practice (EBP)

- ESTs: “Clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population" (Chambless & Holon, 1998, p. 7).
- EBP is inclusive of meta-analyses, naturalistic, process-outcome, and correlational studies and delved into a broad array of factors such as the therapeutic relationship, client and therapist effects, and other elements thought to influence therapeutic outcomes.
- Professionals often cannot distinguish between the ESTs and EBP.
- In a survey of clinical psychology graduate students, the majority identified EBP as synonymous with empirically supported treatments (Luebbe, Radcliffe, Callands, Green, & Thorn, 2007).
- This confusion is easily corroborated through an internet search of the terms “empirical-supported treatments” and “evidence-based practice.” Many sites either inaccurately define the terms, describe them as the same, or use the terms interchangeably. (Bertolino, 2018)

Bertolino, B. (2018). *Effective counseling and psychotherapy: An evidence-based approach.* New York: Springer.
Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*, 7–18.
Luebbe, A. M., Radcliffe, A. M., Callands, T. A., Green, D., & Thorn, B. E. (2007). Evidence-based practice in psychology: Perceptions of graduate students in scientist practitioner programs. *Journal of Clinical Psychology, 63*, 643–655.

Evidence-Based Practice
Intersections in Health & Behavioral Health

- APA: "The integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." (1)
- SAMHSA: "EBPs integrate clinical expertise; expert opinion; external scientific evidence; and client, patient, and caregiver perspectives so that providers can offer high-quality services that reflect the interests, values, needs, and choices of the individuals served." (3)
- IOM: "Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research." (2)

(1) APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285.
(2) Sackett, D. L., Rosenberg, W. M. C., Muir Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't: It's about integrating individual clinical expertise and the best external evidence. BMJ: British Medical Journal, 312(7023), 71-72.
(3) SAMHSA. (2016, January 6). Evidence-based practices web guide. https://www.samhsa.gov/ebp-web-Guide

Evidence-Based Practice (EBP)

"The integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." (p. 273)

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285.

Principles of Change

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Principles of Change

Castonguay and Beutler (2006), “We think that psychotherapy research has produced enough knowledge to begin to define the basic principles that govern therapeutic change in a way that is not tied to any specific theory, treatment model, or narrowly defined set of concepts” (p. 5).

Castonguay, L. G., & Beutler, L. E. (2006). Common and unique principles of therapeutic change: What do we know and what do we need to know? In L. G. Castonguay & L. E. Beutler (Eds.), *Principles of therapeutic change that work* (pp. 353–369). New York: Oxford University Press.

Best Available Research
The Variance in Psychotherapy Outcome

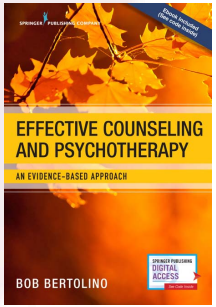
- Client/Extratherapeutic Factors = 80-87%
- Treatment Effects = 13-20%
  - Therapist Effects = 4-9%
  - The Alliance = 5-8%
  - Expectancy, Placebo, and Allegiance = 4%
  - Model/Technique = 1%

Bertolino, B., Bargmann, S., & Miller, S. D. (2013). *Manual 1: What works in therapy: A primer. The ICCE manuals of feedback informed treatment*. Chicago, IL: International Center for .Clinical Excellence.

Wampold, B. E., & Brown, G. S. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73*(5), 914-923.

Intersecting Principles in Behavioral Health

1. Expectancy and hope are catalysts of change.
2. Clients are the most significant contributors to outcome.
3. The therapeutic alliance makes substantial and consistent contributions to outcome.
4. Culture influences and shapes all aspects of human life.
5. Effective services promote growth, development, well-being, and functioning.



Bertolino, B. (2018). *Effective counseling and psychotherapy: An evidence-based approach*. New York: Springer.

Expectancy and Hope are Catalysts of Change

Primary Competency

Demonstrate Faith in Restorative Effects of Services

- Derived from clients' knowledge of being helped, the instillation of hope, recognition of therapist confidence, enthusiasm, and use of credible methods and techniques.
- Expectancy also includes the belief of both the client and therapist in the restorative power of the treatment, including its procedures.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins Press.

Hope as a Catalyst

Dr. Emil "Jay" Freireich, who helped discover effective treatment, and in many cases, what has been a cure, for childhood leukemia before he was 40. He became the champion of clinical research to alleviate the suffering of thousands of cancer victims. Dr. Freireich is outspoken about pessimism and hope:

"There's no possibility of being pessimistic when people are dependent on you for their only optimism. On Tuesday morning, I make teaching rounds, and sometimes medical fellows say, 'This patient is eighty years old. It's hopeless.' Absolutely not! It's challenging. It's not hopeless. You have to come up with something. You have to figure out a way to help them, because people must have hope to live." (quoted in Gladwell, 2013, p. 139)

Gladwell, M. (2013). *David and Goliath: Underdogs, misfits, and the art of battling giants*. New York: Little, Brown.

Clients are the Most Significant Contributors to Outcome

Primary Competency

Evoke and Utilize Client Contributions to Change

- Estimated as 80-87% of the variance in outcome. Includes qualities of the client or qualities of his or her environment that aid in recovery regardless of his or her participation in therapy. Examples include:
  - *Internal strengths* including character strengths, resilience, protective factors, coping skills, and abilities utilized in vocational, educational, and social settings.
  - *External resources* including relationships, social networks, and systems that provide support and opportunities. Examples are family, friends, employment, educational, community, and religious supports. Also involve affiliation or membership in groups or associations that provide connection and stability.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. New York: Routledge.

From Disease to Strengths

"What we have learned over 50 years is that the disease model does not move us closer to the prevention of these serious problems. Indeed the major strides in prevention have largely come from a perspective focused on systematically building competency, not correcting weakness. Prevention researchers have discovered that there are human strengths that act as buffers against mental illness: courage, future-mindedness, optimism, interpersonal skill, faith, work ethic, hope, honesty, perseverance, the capacity for flow and insight, to name several… We need now to call for massive research on human strength and virtue. We need to ask practitioners to recognize that much of the best work they already do in the consulting room is to amplify strengths rather than repair the weaknesses of their clients." (p. 6-7)

Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*(1), 5–14.

The Therapeutic Alliance Makes Substantial and Consistent Contributions to Outcome

Primary Competency

Engage Clients Through the Working Alliance

- Key concepts: empathy, positive regard, and congruence (Norcross, 2011)
- Clients who are more engaged and involved in therapeutic processes are likely to receive greater benefit from therapy.
- Next to the level of functioning at intake, the consumer's rating of the alliance is the best predictor of outcome and is more highly correlated with outcome than clinician ratings.
- Better client-therapist alliances lead to better outcomes whereas clients of therapists with weaker alliances tend to drop out at higher rates and experience poorer outcomes (Hubble et al., 2010; Lambert, 2010).

Hubble, M. A., Duncan, B. L., Miller, S. D., & Wampold, B. E. (2010). Introduction. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed.)(pp. 23-46). Washington, DC: American Psychological Association.

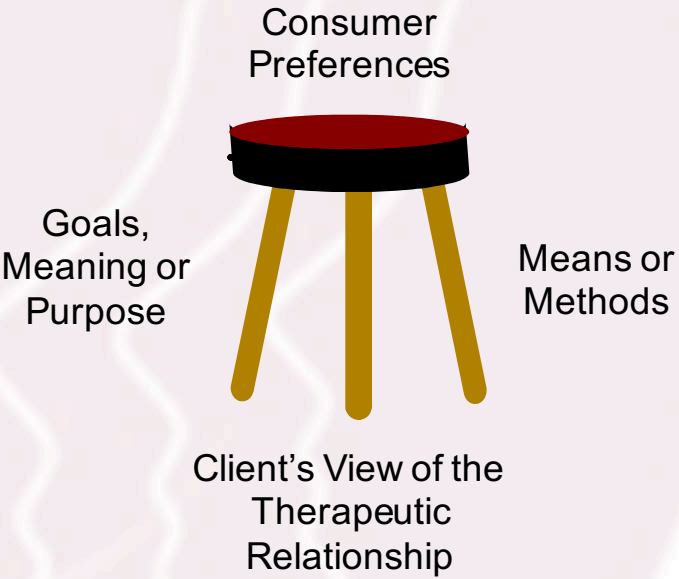
Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. Washington, DC: American Psychological Association.

Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.). New York: Oxford.

What is the Therapeutic Alliance?

The therapeutic alliance refers to the quality and strength of the collaborative relationship between the client and therapist and is comprised of four empirically established components:

1) agreement on the goals, meaning or purpose of the treatment;
2) agreement on the means and methods used;
3) the client's view of the relationship (including the therapist being perceived as warm, empathic, and genuine); and,
4) accommodating the client's preferences.



Culture Influences and Shapes All Aspects of Human Life

Primary Competency

Communicate Respect for Clients and Their Cultures

- Involves identification and inclusion of different aspects of culture: age, developmental and acquired disability, religion, ethnicity, social class, sexual orientation, indigenous heritage, national origin, gender/sex, social locations as vocational and recreational choices, partnership status, parenthood (or not), attractiveness, body size and shape, and state of physical health. (Brown, 2008; Hays, 2007)

Brown, L. S. (2008). *Cultural competence in trauma therapy: Beyond the flashback*. Washington, DC: American Psychological Association.

Hays, P. A. (2007). *Addressing cultural complexities in practice: Assessment diagnosis and therapy* (2nd ed.). Washington, DC: American Psychological Association.

Effective Services Promote Growth, Development, Well-being, and Functioning

Primary Competency

Utilize Strategies that Support and Empower Clients to Achieve Meaningful Improvement

- Involves identification and inclusion of different aspects of culture: age, developmental and acquired disability, religion, ethnicity, social class, sexual orientation, indigenous heritage, national origin, gender/sex, social locations as vocational and recreational choices, partnership status, parenthood (or not), attractiveness, body size and shape, and state of physical health. (Brown, 2008; Hays, 2007)

Brown, L. S. (2008). *Cultural competence in trauma therapy: Beyond the flashback*. Washington, DC: American Psychological Association.
Hays, P. A. (2007). *Addressing cultural complexities in practice: Assessment diagnosis and therapy* (2nd ed.). Washington, DC: American Psychological Association.

Intersections: Health & Well-Being

- Health: Prevention of disease and chronic conditions which increases life satisfaction and longevity.
- Early Childhood Education: Ensuring children have their basic needs are happier and learn more.
- Psychotherapy and Family Therapy: Prevention of and/or improved coping with depression, anxiety, substance abuse, family conflict, etc.
- Each trend promises to improve functioning in three domains: individual, interpersonal, and social, *and* decrease long-term expenditures.

Intersections: Health & Well-Being (cont.)

- High subjective well-being correlates with lower risk of anxiety, depression, and risk-taking behavior (Lopez, Teramoto Pedrotti, & Snyder, 2015).
- Shown to reduce inpatient stays, consultations with primary-care physicians, use of medications, care provided by relatives, and general health care expenditures by 60% to 90% (Chiles, Lambert, & Hatch, 1999; Kraft, Puschner, Lambert, & Kordy, 2006).
- Findings demonstrated with persons with high-utilization rates of medical and health-related services (Cummings, 2007; Law, Crane, & Berge, 2003).

Chiles, J., Lambert, M. J., & Hatch, A. L. (1999). The impact of psychological interventions on medical cost offset: A meta-analytic review. *Clinical Psychology*, *6*(2), 204–220.

Cummings, N. A. (2007). Treatment and assessment take place in an economic context, always. In S. O. Lilienfeld & W. T. O'Donohue (Eds.), *The great ideas of clinical science: 17 principles that every mental health professional should understand* (pp. 163–184). New York: Routledge.

Kraft, S., Puschner, B., Lambert, M. J., & Kordy, H. (2006). Medical utilization and treatment outcome in mid- and long-term outpatient psychotherapy. *Psychotherapy Research, 16*(2), 241–249.

Law, D. D., Crane, D. R., & Berge, D. M. (2003). The influence of individual, marital, and family therapy on high utilizers of health care. *Journal of Marital and Family Therapy, 29*(3), 353–363.

Lopez, S. J., Teramoto Pedrotti, J., & Snyder, C. R. (2015). *Positive psychology: The scientific and practical explorations of human strengths*. Thousand Oaks, CA: Sage.

Outcomes

A

Why Measure Outcome?

Providers routinely fail to identify which consumers of behavioral health will not benefit and which will deteriorate while in services.

- 30% to 50% of clients do not benefit from therapy (Lambert, 2010).
- Deterioration rates among adult clients: 5%-10% (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004); Children/adolescents:12%-20% (Warren et al., 2010).
  - It is estimated that the clients who do not benefit or deteriorate while in psychotherapy are responsible for 60-70% of the total expenditures in the health care system (Miller, 2010).
  - Clinicians routinely fail to identify clients who are not progressing, deteriorating, and at most risk of dropout and negative outcome (Hannan et al., 2005)

Hannan, C., Lambert, M. J.,Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., et al. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology: In Session, 61*, 155-163.

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

Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. Washington, DC: American Psychological Association.

Miller, S. D. (2010). Psychometrics of the ORS and SRS. Results from RCT's and Meta-analyses of Routine Outcome Monitoring & Feedback. The Available Evidence. Chicago, IL. http://www.slideshare.net/scottdmiller/measures-and-feedback-january-2011.

Warren, J. S., Nelson, P. L., Mondragon, S. A., Baldwin, S. A., & Burlingame, G. A. (2010). Youth psychotherapy change trajectories and outcomes in usual care: Community mental health versus managed care settings. *Journal of Consulting and Clinical Psychology, 78*(2), 144-155.

Why Measure Outcome? (cont.)

- Accrediting bodies including The Joint Commission, Council on Accreditation (COA), and the Commission on Accreditation of Rehabilitation Facilities (CARF) have employed standards related to reliable and valid measurement of outcomes.
- For example, The Joint Commission state: “Organizations will be required to assess outcomes through the use of a standardized tool or instrument. Results of these assessments would then be used to inform goal, and objectives identified in individual plans of care, treatment, or services as needed, and evaluate outcomes of care, treatment, or services provided to the population(s) served.”

Why Measure Outcome? (cont.)

Seeking and obtaining valid, reliable, and feasible feedback though routine outcome measurement (ROM) regarding the alliance and outcome:

- As much as doubles the effect size of treatment, cuts dropout rates in half, and decreases risk of deterioration.
- Assists with both identification of potential alliance ruptures and creates opportunities for clinicians to take corrective steps (Anker, Duncan, & Sparks, 2009; Anker et al., 2010).
- Improvements in the alliance (intake to termination) are associated with better outcomes and lower dropout rates (Duncan, Miller, Wampold, & Hubble, 2010; Harmon et al., 2007; Lambert, 2010, Miller, Hubble, & Duncan, 2007).

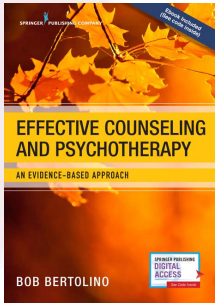
APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M.A. (Eds.), (2010). *The heart and soul of change: Delivering what works in therapy* (2nd. Ed.). Washington, DC: American Psychological Association.

Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*.. Washington, DC: American Psychological Association.

Why Measure Outcome? (cont.)

- Overprediction
  - Clinicians tend to overpredict client improvement.
  - Therapists require independent data to accurately assess improvement.
- Failure to identify client deterioration
  - Therapists often fail to recognize clients who worsen during treatment.
- Self-assessment bias
  - Clinicians tend to overestimate their effectiveness.
  - Studies suggest that individuals' self-judgments often surpass their abilities.



Routine Outcome Measurement (ROM) (cont.)

- Outcome Questionnaire (OQ) 45 (64 questions for youth); OQ/Y-OQ 30.2 (briefer version)
- Clinical Outcomes in Routine Management (CORE): Multiple versions
- Revised Helping Alliance Questionnaire (Haq-II)
- Working Alliance Inventory (WAI)
- Package: Partners of Change Outcomes Management System (PCOMS): Outcome Rating Scale (ORS) and Session Rating Scale (SRS)

Fit and Effect

- *Fit*: The degree to which a way of working with a client matches his or her worldview, culture, and ideas about change.
  - Consider assessment processes, diagnosis, the use of interventions, etc.
  - Feedback that focuses on the alliance assists with increasing fit.
- *Effect*: Did the intervention, at minimum, benefit the client, and at best contribute to a positive, measurable outcome?
  - Feedback that focuses on the client's subjective interpretation of the benefit of services assists with increasing effect.

Fit: Engagement is Critical to Outcome

Most providers do not actively address the risk of dropout in services.

Dropout: the unilateral decision by clients to end therapy—averages are between 20% to 47% (Swift et al., 2012; Wierzbicki & Pekarik, 1993). For children and adolescents the range varies from 28% to 85% (Garcia & Weisz, 2002).

Garcia, J. A., & Weisz, J. R. (2002). When youth mental health care stops: Therapeutic relationships problems and other reasons for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology, 70*(2), 439-443.

Swift, J. K., Greenberg, R. P., Whipple, J. L., & Kominiak, N. (2012). Practice recommendations for reducing premature termination in therapy. Professional Psychology: Research and Practice, 43(4), 379-387.

Wierzbicki, M., & Pekarik, G. (2002). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice,* *24*(2), 190-195.

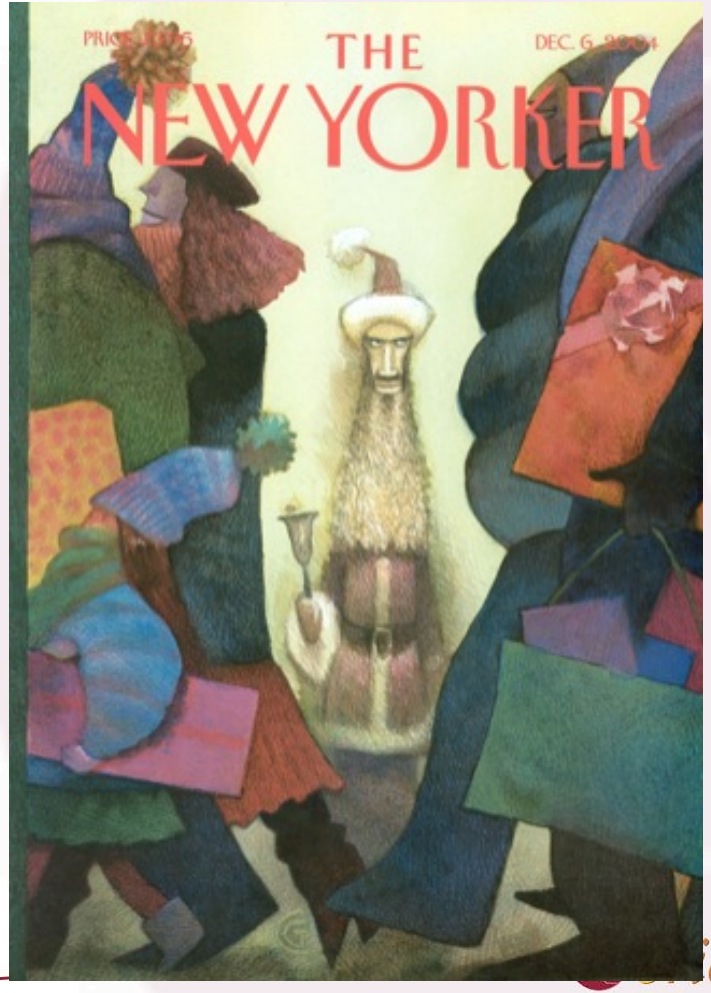
Effect: Focus on Early Change and Respond to Lack of Progress

The dose-effect relationship in psychotherapy; approximately 30% of clients improve by the second session, 60% to 65% by session seven, 70% to 75% by six months, and 85% by one year (Howard, Kopta, Krause, & Orlinksy, 1986). Early response in therapy is strong indicator of eventual outcome, making the monitoring of improvement from the start of therapy essential. The longer clients attend therapy without experiencing a positive change the greater the likelihood that they will experience a negative or null outcome or drop out. (Duncan, Miller, Wampold, & Hubble, 2010)

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M.A. (Eds.), (2010). *The heart and soul of change: Delivering what works in therapy* (2nd, Ed.). Washington, DC: American Psychological Association.

Howard, K. I., Kopte, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41*(2), 159–164.

Provider Effectiveness



ANNALS OF MEDICINE

THE BELL CURVE

What happens when patients find out how good their doctors really are?

BY ATUL GAWANDE

Every illness is a story, and Annie Page's began with the kinds of small, unexceptional details that mean nothing until seen in hindsight. Like the fact that, when she was a baby, her father sometimes called her Little Potato Chip, because her skin tasted salty when he kissed her. Or that Annie's mother noticed that her breathing was sometimes a little wheezy, though the pediatrician heard nothing through his stethoscope.

The detail that finally mattered was Annie's size. For a while, Annie's fine-boned petiteness seemed to be just a family trait. Her sister, Lauryn, four years older, had always been at the bottom end of the pediatrician's growth chart for girls her age. By the time Annie was three years old, however, she had fallen off the chart. She stood an acceptable thirty-four inches tall but weighed only twenty-three pounds—less than ninety-eight per cent of girls her age. She did not look malnourished, but she didn't look quite healthy, either.

"Failure to thrive" is what it's called, and there can be scores of explanations: pituitary disorders, hypothyroidism, genetic defects in metabolism, inflammatory-bowel disease, lead poisoning, H.I.V., tapeworm infection. In textbooks, the complete list is at least a page long. Annie's doctor did a thorough workup. Then, at four o'clock on July 27, 1997—"I'll never forget that day," her mother, Honor, says—the pediatrician called the Pages at home with the results of a sweat test.

It's a strange little test. The skin on the inside surface of a child's forearm is cleaned and dried. Two small gauze pads are applied—one soaked with pilocarpine, a medicine that makes skin sweat, and the other with a salt solution. Electrodes are hooked up. Then a mild electric current is turned on for five minutes, driving the pilocarpine into the skin. A reddened, sweaty area about an inch in diameter appears on the skin, and a collection pad of dry filter paper is taped over it to absorb the sweat for half an hour. A technician then measures the concentration of chloride in the pad.

Over the phone, the doctor told Honor that her daughter's chloride level was far higher than normal. Honor is a hospital pharmacist, and she had come across children with abnormal results like this. "All I knew was that it meant she was going to die," she said quietly when I visited the Pages' home, in the Cincinnati suburb of Loveland. The test showed that Annie had cystic fibrosis.

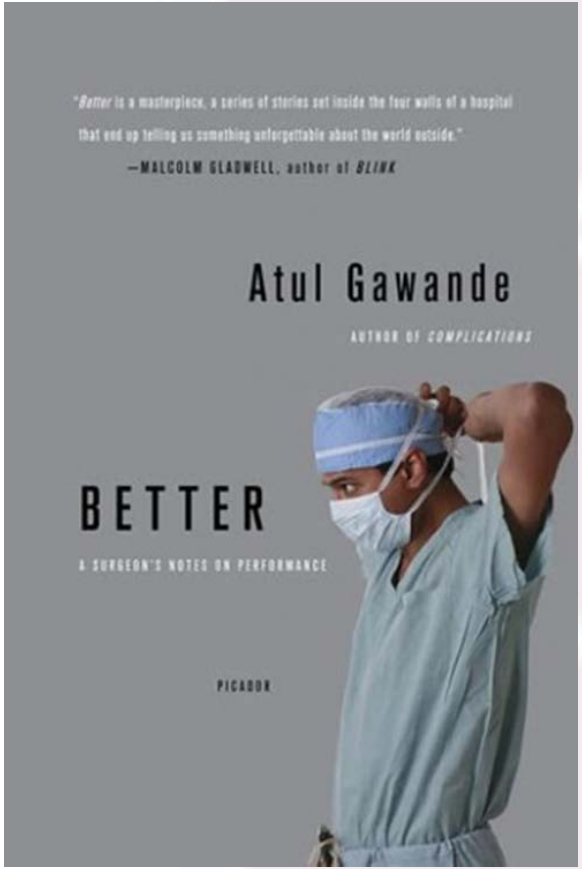
Cystic fibrosis is a genetic disease. Only a thousand American children per year are diagnosed as having it. Some ten million people in the United States carry the defective gene, but the disorder is recessive: a child will develop the condition only if both parents are carriers and both pass on a copy. The gene—which was discovered, in 1989, sitting out on the long arm of chromosome No. 7—produces a mutant protein that interferes with cells' ability to manage chloride. This is what makes sweat from people with CF so salty. (Salt is sodium chloride, after all.) The chloride defect thickens secretions throughout the body, turning them dry and gluey. In the ducts of the pancreas, the flow of digestive enzymes becomes blocked, making a child less and less able to absorb food. This was why Annie had all but stopped growing. The effects on the lungs, however, are what make the disease lethal. Thickened mucus slowly fills the small airways and hardens, shrinking lung capacity. Over time, the disease leaves a child with the equivalent of just one functioning lung. Then half a lung. Then none at all.

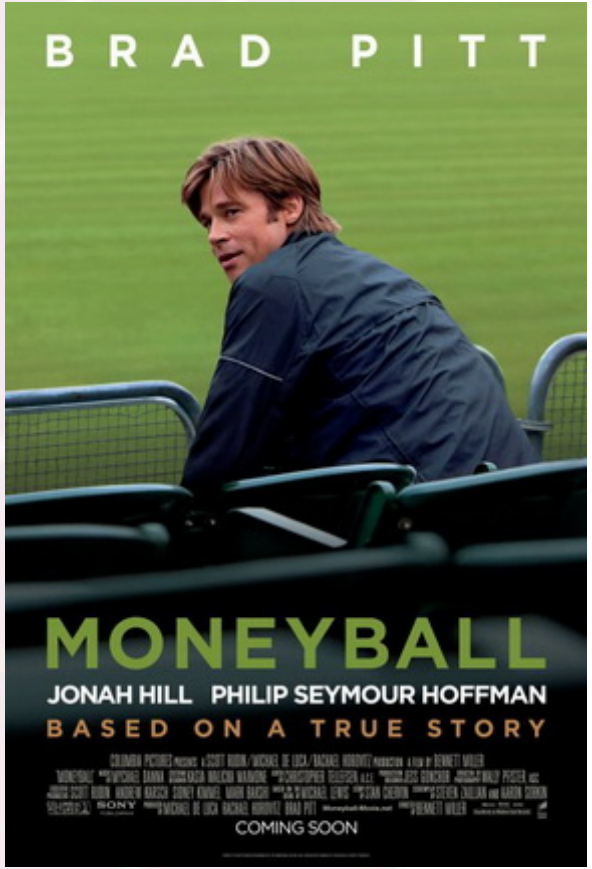
The one overwhelming thought in the minds of Honor and Don Page was: We need to get to Children's. Cincinnati Children's Hospital is among the most respected pediatric hospitals in the country. It was where Albert Sabin invented the oral polio vaccine. The chapter on cystic fibrosis in the "Nelson Textbook of Pediatrics"—the bible of the specialty—was written by one of the hospital's pediatricians. The Pages called and were given an appointment for the next morning.

"We were there for hours, meeting with all the different members of the team," Honor recalled. "They took Annie's blood pressure, measured her oxygen saturation, did some other tests. Then they put us in a room, and the pediatrician sat down with us. He was very kind, but frank, too. He said, 'Do you understand it's a genetic disease? That it's nothing you did, nothing you can catch?' He told us the median survival for patients was thirty years. In Annie's lifetime, he said, we could see that go to forty. For him, he was sharing a great accomplishment in CF care. And the news was better than our worst fears. But only forty! That's not what we wanted to hear."

The team members reviewed the treatments. The Pages were told that they would have to give Annie pancreatic-enzyme pills with the first bite of every meal. They would have to give her supplemental vitamins. They also had to add calories wherever they could—putting tablespoons of butter on everything, giving her ice cream whenever she wanted, and then putting chocolate sauce on it.

A respiratory therapist explained that they would need to do manual chest therapy at least twice a day, half-hour sessions in which they would strike—"percuss"—their daughter's torso with a cupped hand at each of fourteen specific locations on the front, back, and sides in order to loosen the thick secretions and help her to cough them up. They were given prescriptions for inhaled medicines. The doctor told them that Annie would need to come back once every three months for extended checkups. And then they went home to start their new life. They had been told almost everything they needed to know in order to give Annie





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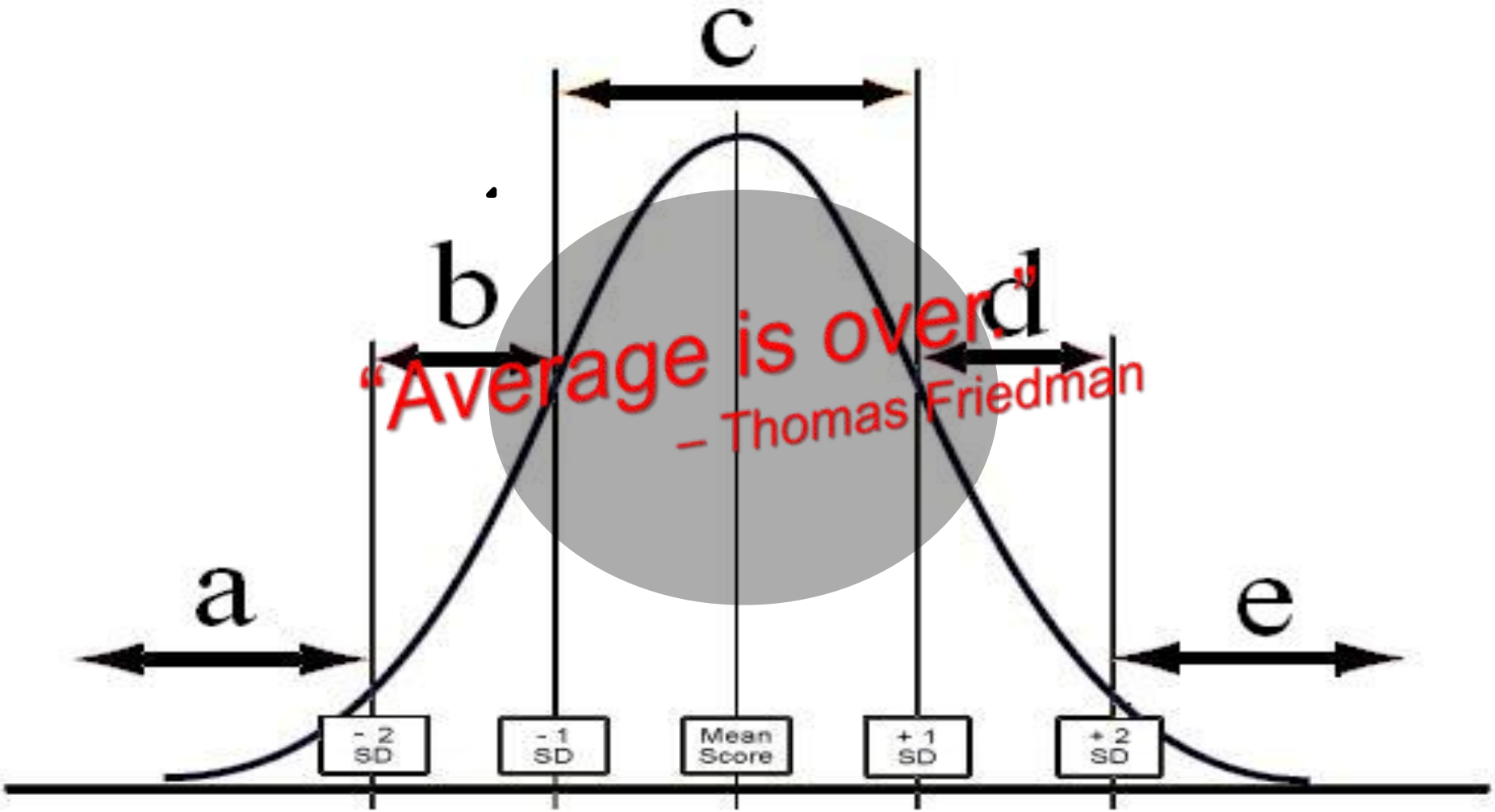
Burlingame, California | December 6 - 9, 2018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– Thomas Friedman
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Provider Effects

No improvement in treatment outcomes in nearly 40 years. Despite a substantial increase in diagnostic categories and a proliferation of treatment approaches and specialized techniques, the effect size of psychotherapy has not improved since the first meta-analytic studies in 1977 (Bertolino, Bargmann, & Miller, 2013).

Bertolino, B., Bargmann, S., & Miller, S. D. (2013). Manual 1: *What works in therapy: A primer. The ICCE manuals of feedback informed treatment*. Chicago, IL: International Center for .Clinical Excellence.

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

Provider Effects (cont.)

Providers lack knowledge regarding their rate of effectiveness and the tendency of average providers to overestimate.

- The majority of therapists have never measured their effectiveness (Hansen, Lambert, & Forman, 2002; Sapyta, Riemer, & Bickman, 2005). It is impossible to improve without this knowledge.
- Therapists are subject to self-assessment bias in terms of comparing their own skills with those of colleagues and in estimating improvement or deterioration rates (Lambert, 2010; Walfish, McAllister, O'Donnell & Lambert, 2012).

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

Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice.* Washington, DC: American Psychological Association.

Sapyta, J., Reimer, M., & Bickman, L. (2005). Feedback to clinicians: Theory, research, and practice. Journal of Clinical Psychology, *62*, 145-153.

Walfish. S., McAlister, B., O'Donnnell., & Lambert, M. J. (2012). An assessment of self-assessment bias in mental health providers. *Psychological Reports, 110*(2), 639-644.

Provider Effects (cont.)

There is substantial variation in outcomes *between* providers with similar training and experience.

- Some therapists consistently have better outcomes, regardless of the diagnoses, age, developmental stage, medication status, or severity of their clients. (Wampold & Brown, 2005)
- Clients of the most effective therapists improve at a rate at least 50% higher and drop out at a rate at least 50% lower than those of less effective therapists. (Wampold & Brown, 2005)
- 97% of the difference in outcome between therapists is attributable to differences in their ability to form alliances with clients. (Anderson et al., 2009; Baldwin, Wampold, & Imel, 2007)

Anderson, T. Ogles, B. M., Patterson, C. L., Lambert, M. J., & Vermeersch, D. A. (2009). Therapist effects: Facilitative interpersonal skills as a predictor of therapist effects. *Journal of Clinical Psychology, 65*(7), 755-768.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*(6), 842–852.

Wampold, B. E., & Brown, G. S. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *J Journal of Consulting and Clinical Psychology, 73*(5), 914–923.

Provider Effects (cont.)

- **Provider effectiveness tends to plateau over time in the absence of concerted efforts to improve it.**
  - The effectiveness of the "average" helper plateaus very early (Hubble et al., 2010).
  - The amount of time spent targeted at improving therapeutic skills was a significant predictor of client outcomes
  - Highly effective therapists indicate requiring more effort in reviewing therapy recordings alone than did the rest of the cohort (Chow, Miller, Seidel, Kane, Thornton, & Andrews, 2015).
  - Working hard at overcoming "automaticity."
  - Planning, strategizing, tracking, reviewing, and adjusting plan and steps.
  - Consistently measuring and then comparing performance to a known baseline or national standard or norm.

Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., & Andrews, W. P. (2015). The role of deliberate practice in development of highly effective psychotherapists. *Psychotherapy, 52*(3), 337-345.

Hubble, M. A., Duncan, B. L., Miller, S. D., & Wampold, B. E. (2010). Introduction. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed.)(pp. 23-46). Washington, DC: American Psychological Association.

Therapist Improvement with Time and Experience

- The largest study to date on the effect of experience on outcome.
- 75 therapists followed for 17 years.
- Question: Do therapists improve over time in terms of effectiveness with more experience and training?
- The answer: No.
- On average therapists' outcomes declined over time.

Journal of Counseling Psychology
2016, Vol. 63, No. 1, 1–11

0022-0167/16/$12.00 http://dx.doi.org/10.1037/cou0000131

Do Psychotherapists Improve With Time and Experience? A Longitudinal Analysis of Outcomes in a Clinical Setting

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examined both as chronological time and cumulative patients seen. ***Results:*** Therapists achieved outcomes comparable with benchmarks from clinical trials. However, a very small but statistically significant change in outcome was detected indicating that on the whole, therapists' patient prepost *d* tended to diminish as experience (time or cases) increases. This small reduction remained when controlling for several patient-level, caseload-level, and therapist-level characteristics, as well as when excluding several types of outliers. Further, therapists were shown to vary significantly across time, with some therapists showing improvement despite the overall tendency for outcomes to decline. In contrast, therapists showed lower rates of early termination as experience increased. ***Conclusions:*** Implications of these findings for the development of expertise in psychotherapy are explored.

Building Error-Centric Cultures
Investing in Failure

- Maintain aware that failure to execute ideas is the greatest failure.
- Everyone learns from past failures; do not reward the same mistakes over and over again.
- If people show low failure rates, be suspicious. Maybe they are not taking enough risks, or maybe they are hiding their mistakes, rather than allowing others in the organization to learn from them.
- Hire people who have had intelligent failures and let others in the organization know that's one reason they were hired.
- Develop *creative capital* – creative thinkers whose ideas and processes can be cultivated to improve services.

Closing Thoughts

- Make sure people are aware that failure to execute ideas is the greatest failure.
- Make sure everyone learns from past failures; do not reward the same mistakes over and over again.
- If people show low failure rates, be suspicious. Maybe they are not taking enough risks, or maybe they are hiding their mistakes, rather than allowing others in the organization to learn from them.
- Hire people who have had intelligent failures and let others in the organization know that's one reason they were hired.