Feedback Informed Treatment: Historical and Empirical Foundations

Eeuwe Schuckard, PGDipChFamPsyc, Scott D. Miller, Ph.D, Mark A. Hubble, Ph.D

From Prescott, D.S., Maeschalck, C.M., & Miller, S.D. (2017). Feedback Informed Treatment in clinical practice: reaching for excellence. Washington, DC: American Psychological Association.

"After climbing a great hill, one only finds that there are many more hills to climb."

– Nelson Mandela

More than a century has passed since the professionalization of psychotherapy. The discipline is now an integral element of healthcare and an extensive body of literature exists demonstrating it to be effective for addressing psychological distress and dysfunction. Nonetheless, practitioners face many challenges. For example, wages are stagnant and have been for more than a decade. Competition is increasing. Bureaucratic procedures have become more time consuming, and professional autonomy is under siege. In the meantime, use of psychotropic medications has increased four-fold since the early nineties while the demand for talk therapies has remained stagnant (Brown & Minami, 2010).

This chapter begins with a review of efforts to establish psychotherapy as a profession. Despite the time, energy, and money expended, research shows the majority of such initiatives have failed to improve either the quality or outcome of care. Feedback Informed Therapy (FIT) offers an evidence-based alternative for therapists—no matter their therapeutic discipline—to advance the field of psychotherapy in both its legitimacy and effectiveness.

The Effectiveness of Psychotherapy

For close to 100 years, the effectiveness of psychotherapy was repeatedly questioned. Ironically, much of the criticism came from within the field (Wampold, 2013). Intense and often acrimonious rivalry between the various theoretical schools complicated efforts to establish overall efficacy (Norcross & Newman, 1992; Rosenzweig, 1936). In 1952, Eysenck reviewed the extant scientific literature, concluding that recovery rates of patients receiving psychoanalytic and eclectic psychotherapies were no better than no treatment at all. Considerable controversy followed, with some advocating that psychologists inform potential clients that psychotherapy was no more effective than a placebo ("Psychotherapy Caveat," 1974).

In time, the empirical support for psychotherapy grew (DeLeon, Kenkel, Garcia-Shelton, & Vandenbos, 2011). Largely responsible for this development was the application of two specific research methods: the clinical trial (CT) and meta-analysis. CT's, as the name implies, involved assignment of patients to either an active treatment condition, wait list or control group (Wampold, 2013). Hundreds of such studies had been conducted by the early 1970's, documenting the beneficial effects of psychotherapy regardless of the type or approach (Bergin, 1971).

Meta-analysis allowed researchers to combine the results of these disparate studies to demonstrate the overall efficacy of psychologically informed treatments (Wampold & Imel, 2015). In what became a landmark study, Smith and Glass (1977) subjected 375 research reports to this statistical method, finding that the average individual in psychotherapy was better off than 60-82% of those not receiving treatment (Wampold, 2001). Subsequent meta-analyses confirmed these early findings, documenting that the effects of psychotherapy are both robust and equivalent to or better than results obtained in medicine (e.g., chemotherapy for breast cancer, heart bypass surgery [Lipsey & Wilson, 1993; Wampold, 2007]).

Psychotherapy Grows

Consistent with historical trends evident in earlier decades, the number of models and related methods continued to proliferate (Miller, Duncan, & Hubble, 1995). In 1975, a task force convened by the National Institute of Mental Health (NIMH)—a government agency responsible for managing one of the largest psychotherapy research budgets in the world—raised concerns about the large and growing number of therapies, each claiming success with a wide range of problems, in the absence of empirical support (Segal, 1975). At that time, more than 130 different approaches were in play. A challenging economic environment and dramatic changes in healthcare reimbursement policy only served to intensify such worries.

In an effort to reign in healthcare costs, the U.S. congress passed the Health Maintenance Organization Act in 1973 (Ellwood, 1988). Psychotherapists were now subject to external oversight and competed with one another for contracts offered by managed healthcare organizations (MHCO). The struggle to earn a living intensified as the numbers of practitioners doubled between 1970 and 1980 (Cummings & O'Donohue, 2008; DeLeon, Kenkel, Garcia-Shelton et al., 2011).

NIMH acted, advocating the use of the randomized controlled trial (RCT) to determine which therapies provided the best outcomes and thus, were deserving of reimbursement (Segal, 1975). By the 1990s, the RCT had become the primary methodology used in psychotherapy research (Goldfried & Wolfe, 1998). Previously, the method was most often used in medicine and pharmacology. In those fields, the efficacy of a given procedure or medication was thought to be proven by comparing it to a presumably inert or alternative intervention (Thaul, 2012; Wampold & Imel, 2015). Psychotherapy researchers employed similar comparisons in their RCTs but controversy arose about their use. For example, it is simply not possible to blind participants in trials of psychotherapy (O'Leary & Borkovec, 1978; Seligman, 1995; Wampold, 2001). In medicine, the active treatment (e.g., pill) can be made to appear the same as the placebo, even to the point that some placebo substances

mimic side effects of experimental substances (Moncrieff, Wesseley & Hardy (2004). The result is that neither the person administering the drug or the one receiving it can tell the difference between the real and sham treatment. In sharp contrast, it is nearly impossible to blind therapists to the fact that they are delivering less than the complete therapy (Wampold, Minami, Tierney, Baskin, & Bhati, 2005).

Despite concerns about the use of RCTs in the investigation of psychotherapy, in 1995, a task force within Division 12 (Clinical Psychology) of the American Psychological Association (APA), reviewed the evidence obtained in RCTs and then created a list of treatments that, in their estimation, had achieved an acceptable level of scientific support (Task Force on the Promotion and Dissemination of Psychological Procedures, 1995, Pg. 3). Adopting these "empirically-validated" or supported methods, the Task Force argued, would place the field on an equal footing with psychiatry—psychotherapy's major competitor. At that time, the political and social milieu favored a biological view of mental illness (Barlow, 2002). As such, the largest share of funding for research and training budgets, including contracts with MCHO's, went to psychiatrists (Crits-Christoph, Frank, Chambless, Brody & Karp, 1995; Goldfried & Wolfe, 1998; Olfsen, Marcus, Duss, Elison, Tanielian, & Pincus, 2002).

In the end, the Task Force's initiative did little to create an advantage for therapists in the mental healthcare market. First, psychiatry had two major advantages that allowed it to maintain its dominance. To begin, it had far more influence within the NIMH (Goldfried & Wolfe, 1998). It also had the full financial support and backing of the pharmaceutical industry (Crits-Christoph, et al., 1995). Second, within psychology, rather than unifying the profession, the list of treatments created by the Task Force, proved highly divisive (Persons & Silberschatz, 1998). Cognitive and behavioral approaches predominated, leaving out methods employed by the majority of practitioners. Furthermore, no evidence existed

documenting that the approaches included on the list were actually superior in their effects to any other treatments in use (Wampold, 1997). Not surprisingly, the fortunes of psychiatry continued to improve as incomes earned by psychotherapists steadily declined (APA Monitor, 2010; Brown & Minami, 2010; Cummings & O'Donohue, 2008).

Unanswered Questions

Setting aside the political and economic influences just discussed, a fundamental question remained. It is one that dogged the field since its inception and is central to improving outcomes: what makes psychotherapy work? Two major points of view have emerged. The first, and arguably the most popular, holds that psychotherapy is similar to medical treatments (Barlow, 2004). Known as the "specific factors" approach, proponents believe psychological treatments work like penicillin, containing ingredients remedial to a particular disorder. The second, the "common factors" perspective, maintains that the efficacy of psychotherapy is explained by curative factors shared by all (Hubble, Duncan, & Miller, 1999; Lambert, 1992; Wampold & Imel, 2015).

The two positions offer strikingly different visions for improving effectiveness. If one believes that specific factors account for change, then attention must be directed to selecting the right method for a given diagnosis and ensuring that clinicians deliver the interventions with fidelity (Chambless & Ollendick, 2001; Huppert, Fabbro, & Barlow, 2006; Siev, Huppert, & Chambless, 2009). In contrast, according to the common factors position, success depends on activating, by whatever means possible, the transtheoretical curative elements, including a strong working relationship, believable explanation for the presenting problem, a healing setting, and credible therapeutic ritual (Frank & Frank, 1993; Lambert, 1992; Miller, Hubble, & Duncan, 1995).

If the success of these factors, be they specific or common, was based on the number of studies and scholarly works published, one would have expected major improvements in

the outcome of psychotherapy. Nothing could be further from the truth. Psychotherapy's beneficial effects have remained flat, largely unchanged since the 1970s (Cuijpers, Smit, Bohlmeijer, Hollon & Anderson, 2010; Lipsey & Wilson, 1993; Smith & Glass, 1977; Wampold, Mondin, Moody et al., 1997). Over time, the reasons why neither the specific or common factors perspective made a difference became clear.

To begin, while common factors most certainly account for why psychotherapy works (Wampold & Imel, 2015), they have not proven particularly attractive to practitioners, nor helpful in improving their effectiveness. Clinicians both want and need to know what to say and do to assist their clients. In sharp contrast to the models and techniques that characterize the specific factors approach, the common factors position offers neither (Lambert & Ogles, 2014). Logically, it cannot (Goldfried, 1980). Indeed, as soon as the shared curative elements are translated into specific strategies and techniques, they cease being common (Seidel, Miller, Chow, 2013). With regard to outcome, available research is devoid of studies showing that common factors can be employed proactively or prescriptively to enhance effectiveness (Crits-Christoph, Chambless & Markell, 2014). It turns out, the empirical foundation for specific factors is equally weak (Laska, Gurman & Wampold, 2013; Wampold & Imel, 2015). The underlying critical argument is that different therapies are differentially effective, and efficacy is dependent on the reliable delivery of the specific healing ingredient contained in a particular approach. For all that, therapist adherence to, and competence in a special method or technique has not been found to improve outcome (Haas, Hill, Lambert, & Morrell, 2002; Webb, DeRubeis & Barber, 2010). In addition, when specific approaches are directly compared, typically no differences are found—results which have been replicated across numerous populations and diagnostic groups (Munder, Brutsch, Leonhart et al., 2013). Evidence obtained in what are known as dismantling studies is even more damning. In this

type of research, the supposed active ingredient in a particular therapy is removed. Contrary to expectations, such modifications have no impact on efficacy (Ahn & Wampold, 2001).

The failure to reach agreement about what makes psychotherapy work was not without consequence. If the two major explanatory paradigms were in dispute and the causal variables defied consensus, howcould effectiveness be improved ? Fortunately, work on an alternative means of quality improvement had begun during the 1980s.

From Process to Outcome

Patient-focused research, as it was called, involved the monitoring of an individual's progress over the course of treatment. In 1986, researchers Howard, Kopta, Kraus and Orlinksy demonstrated that change in therapy followed a highly predictable trajectory. Referred to as the "dose-response," it highlighted the relationship between progress and the amount of time spent in therapy. By examining thousands of sessions, and a score of previous studies, the authors found that the lion's share of change occurred earlier rather than later in treatment. Such findings had major implications for improving outcomes. As Howard et al. (1986) suggested at the time, such evidence could be used "to mark a point in treatment at which cases that have not shown any measurable improvement should be subjected to clinical review" (pp. 163-164).

Coincidently, this type of research was developing at the very same time MHCO's were increasing their cost containment efforts, chiefly by limiting the amount and types of treatments reimbursed (Brown, Dreis, & Nase, 1999). Such practices proved controversial as consumers were forced to seek care from segments of the medical system ill-equipped to work with mental health difficulties ([e.g., general practitioners, emergency room, etc.] Castner, Wu, Mehrok, Gadre & Hewner, 2015; Lechnyr, 1992;]. Patient-focused research would eventually provide a means for insuring quality, accountability, and effectiveness

within this climate of cost-attainment (Brown, Burlingame, Lambert, Jones & Vaccaro, 2001).

Along with patient-focused research, interest in *continuous quality improvement* grew ([CQI] Johnson & Shaha, 1996;). Briefly, CQI involves routinely gathering objective data and using the information for assessing and then, improving the quality of a product or service (Eckert, 1994). The field of medicine had already implemented such procedures with good results (e.g., Barrable, 1992; Donabedian, 1988). Together, CQI and patient-focused research formed the foundation for the emergence of a new paradigm. Termed *practice-based evidence*, emphasis shifted from identifying "best treatments" for particular disorders to determining whether a given course of therapy was working for the individual client (Barkham, Hardy, & Mellor-Clark, 2010; Duncan, Miller, Wampold, & Hubble, 2010; Lambert, 2010;).

Researchers who embraced the new paradigm began developing measures that practitioners could use in real time to assess the outcome with each and every client (Miller, Hubble, Chow, & Seidel, 2013). Howard, Brill, Lueger and O'Mahoney (1992, 1993, 1995) designed the first system, Integra Outpatient Tracking Assessment, later renamed COMPASS (Lueger, 2012). Lambert, Lunnen, Umphress, Hansen and Burlingame (1994) soon followed with the Outcome Questionnaire 45 (OQ-45). Both were psychometrically sound, sensitive to change, easy to administer and score, and applicable across a wide range of clients and presenting problems (Lambert, Hansen & Finch, 2001). Regardless of the measure employed, this line of research offered the chance of improving the overall effectiveness of psychotherapy by identifying clients at risk of a poor treatment outcome.

Improving Outcome One Case at a Time

Once more, Howard and colleagues led the way (Howard, Moras, Brill, Martinovich and Lutz, 1996). Their work on the dose-effect relationship offered an actuarial method for

determining when a particular client's course of progress deviated significantly from cases that achieved a successful outcome. This model for predicting outcomes required the analysis of considerable amounts of data, and only became possible with increasing access to powerful computers and the development of sophisticated statistical methods ([hierarchical linear regression]; Bryk & Raudenbush, 2002). Howard and colleagues (1996) asserted, and Lutz, Martinovich, and Howard (1999) confirmed, the chance of success dropped from 65% to 46% when clients' scores on their measure (COMPASS) varied a single time from the established norm. With two instances, the probability of success dropped to 36%. At this point, the stage was set for therapists to receive valid and reliable feedback about whether their clients were benefiting, or likely to benefit, from a given course of psychotherapy.

Lambert, Whipple, Smart, Vermeersch, Nielsen, and Hawkins (2001) were the first to investigate whether providing therapists with ongoing feedback actually improved outcomes. In those therapies most at risk of failure, feedback resulted in better retention, improved outcomes and reduced rates of deterioration. Clients benefitting from care ended treatment sooner, with no negative impact on the overall result. The following year, Lambert, Whipple, Vermeersch, Smart, Hawkins, Nielsen, and Goates and colleagues (2002) confirmed these initial findings.

Later research would document the importance of the availability, frequency and immediacy of feedback. Studies showed, for example, that without access to a formal system for assessing progress, therapists failed to predict or identify deterioration in their clients (Hannan, Lambert, Harmon, Nielsen, Smart, Shimokawa, & Sutton, 2005; Hatfield, McCullough, Frantz, Plucinski, & Krieger, 2010). Slade, Lambert, Harmon and colleagues (2008) further found that feedback delivered at the time of service had a considerably larger impact on outcomes than feedback delayed by two weeks. Sharing outcome data with clients

and engaging them in a discussion about their progress further enhanced its impact (Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004).

Alerting clinicians to the possibility of treatment failure was a major development. What was missing, however, was practical information for altering the course of treatment. Whipple, Lambert, Vermeersch, Smart, Nielsen, and Hawkins (2003) developed and tested a package of clinical support tools (CST) designed to complement feedback. When a case was deemed "off track," therapists received information from client-completed questionnaires regarding the strength of the working alliance, existing social support network, and readiness for change. This additional information yielded dramatic effects. Clients of therapists who received the CST data were much more likely to experience a good outcome, far less likely to deteriorate, and to achieve these benefits in fewer sessions. In fact, nearly 50% more realized these gains relative to clients whose therapists received progress feedback alone.

From Research to Practice

Despite the clear advantages documented by research, difficulties quickly emerged once efforts turned to implementing feedback shifted from the "laboratory" to real world practice. In particular, Miller, Duncan, Brown, Sparks, & Claud (2003) observed that the "methodological complexity, length of administration, and cost often rendered … [available outcome tools] infeasible for many service providers and settings" (p. 92). In an effort to overcome these obstacles, Miller and Duncan (2000) developed, tested, and disseminated two brief, four-item measures (Duncan et al., 2003; Miller, Duncan, Brown, Sparks, & Claud, 2003)[i]. The first, the *Outcome Rating Scale* (ORS), assesses client progress. The second, the *Session Rating Scale* (SRS), measures the quality of the therapeutic relationship, a key element of effective therapy (Bachelor & Horvath, 1999; Norcross, 2010).[1] Both scales take

[1] Both the ORS and SRS were developed following the second author's experience with using longer scales in clinical practice: (1) the *Outcome Questionnaire 45* (OQ) and (2) a 10-

less than a minute to complete and score. Owing to their brevity and simplicity, adoption and usage rates among therapists was found to be dramatically higher as compared to other assessment tools ([ORS: 89% versus 20-25%; SRS: 96% versus 29%] Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Miller et al., 2003).

As had been done with other outcome measures, Miller and colleagues (2006) developed norms for interpreting data derived from the ORS and SRS. Known as PCOMS (Partners for Change Outcome Management System [Miller, Duncan, Sorrell, & Brown, 2005), these norms were programmed into a computerized system (SIGNAL) and used to provide feedback to therapists working in an employee assistance program (EAP).[2] As the

---

item measure of the therapeutic alliance. The first was developed by his professor, Michael J. Lambert, Ph.D., the latter, by a mentor and supervisor, Lynn Johnson, Ph.D., [Johnson, 1995]). At a workshop Miller was conducting on routine outcome measurement, he mentioned the time the measures took to administer including the difficulty many of his clients reported completing the tools. Haim Omer, Ph.D., who was in attendance, suggested using a short, visual analogue format to capture the major domains assessed by the tools. Miller's experience with the *Line*

Bissection Test (Schenkenberg, Bradford, & Ajax, 1980) during his neuropsychology internship and subsequent work on the development of scaling questions at the *Brief Family Therapy Center* (Berg & Miller, 1992; Miller & Berg, 1995) led him to create measures with four lines, each 10 centimeters in length, representing domains of client functioning assessed by the OQ 45 (Miller, 2010) and the therapeutic alliance as defined by Bordin (1979). Together with his colleague, Barry Duncan, Psy.D., measures for adults, children, young children, and groups were developed and tested for reliability, validity, and feasibility.

[2] The SIGNAL software was used exclusively by the EAP program during the period the aforementioned study was conducted. At that time, Miller and colleagues planned to launch a

name implies, software used a traffic light graphic to provide "real-time" warnings to therapists when an individual client's ratings of either the alliance or outcome were on track (green), at risk (yellow), or fell significantly outside of the established norms (red).

During an 18-month study, outcomes of 5000 clients were monitored (Miller et al. 2006). In the initial phase, lasting three months, progress of all clients was measured but no feedback was provided to therapists. Later, when feedback regarding progress and the alliance was provided, outcomes improved by 27% (34% to 47%) while deterioration was cut in half (19% to 8%). This study not only confirmed the impact of feedback established in prior studies, but showed that shorter, more user-friendly scales, could perform as well as longer, more complex measures. A later meta-analysis comparing a longer system with the ORS and SRS would affirm these results (Lambert & Shimokawa, 2011).

During the same period as efforts were directed toward making feedback more feasible and accessible to practicing clinicians, other studies evaluated its applicability and effects in various treatment settings and populations. Positive results were found in outpatient and inpatient settings, counseling and university training centers, individual and group therapies, and specialized treatment programs (Gondeck, Edbrooke-Child, Fink, Deighton & Wolpert, 2016). By 2011, four meta-analytic reviews had been conducted underscoring the consistently favorable impact of providing progress feedback to therapists

---

web-based system known as PCOMS "for both monitoring and improving the effectiveness of treatment" (p. 2, Miller et al., 2005). The project did not go forward. Despite that fact, PCOMS remained in use as a shorthand for the ORS and SRS. Miller (2011) continued work on norms and interpretive algorithms that have been since incorporated into several, independently-owned, web-based systems providing electronic administration, scoring, plotting, data aggregation and interpretation services, including fit-outcomes.com, myoutcomes.com, and acehealth.com.

(Knaup, Koesters, Schoefer, et al., 2009; Lambert, Whipple, Hawkins, et al., 2003; Shimokawa, Lambert & Smart, 2010; Lambert & Shimokawa, 2011). Two systems (OQ 45 and the ORS and SRS) were vetted and then listed on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence Based Programs and Practices (OQ analyst, 2014, PCOMS: ICCE, 2013).

The "Wild Card" of Psychotherapy

If obtaining feedback were merely a matter of combining available research support with a feasible methodology, then adoption by practitioners should have been quick and straightforward. After all, whenever asked, a large percentage of practitioners consistently express interest in receiving regular reports of client progress (Bickman, 2000; Hatfield & Ogles, 2004). Curiously, while many measures are available, the same body of evidence documents that few actually use measures in their day-to-day work (Gilbody, House, & Sheldon, 2002; Hatfield & Ogles, 2004; Zimmerman & McGlinchey, 2008). Even more troubling, among those who do, research reveals the impact of feedback varies significantly. Indeed, some use the systems to considerable effect, while others experience little improvement in client outcomes whatsoever (de Jong, van Sluis, Nugter, Heiser, & Spinhoven, 2012; Sapyta, Riemer & Bickman, 2005). Put bluntly, success depends on *who* uses the feedback.

While disappointing to those invested in the development and promotion of measurement and feedback, such findings should not have been all that surprising. The impact of the individual therapist on clinical progress has long been known to exceed the effects of whatever intervention is in vogue or under study. In point of fact, the variance in outcomes attributable to therapists (5%–9%) is larger than the variability among treatments (0%–1%), the therapeutic relationship (5%), and the supposed superiority of an empirically-

validated or supported treatment over placebo (0%–4%) (Duncan et al., 2010; Kim, Wampold, & Bolt, 2006; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007).

In effect, up to and including the development of feedback systems, efforts to improve the efficacy of psychotherapy overlooked the contribution made by the therapist. As early as 1997, Okiishi and Lambert proposed investigating therapist effects using results gathered in real world settings. Together, patient-focused research studies and MCHO's were generating vast amounts of outcome data that could be used for such analyses. Among the first to compare clinicians directly, Miller et al., (2005) showed just how important the individual therapist was to outcome. Figure 1 plots the effectiveness of 30 therapists against the agency average (represented by the solid black line). An individual clinician is statistically above average at the 90% confidence level when the bottom end of their range falls above the agency average and below average when the top end falls below. As can be seen, practitioners varied significantly in their effectiveness, with some being consistently more helpful on average than others. Indeed, being seen by one of the most effective therapists improved the chance of success by almost 20%.

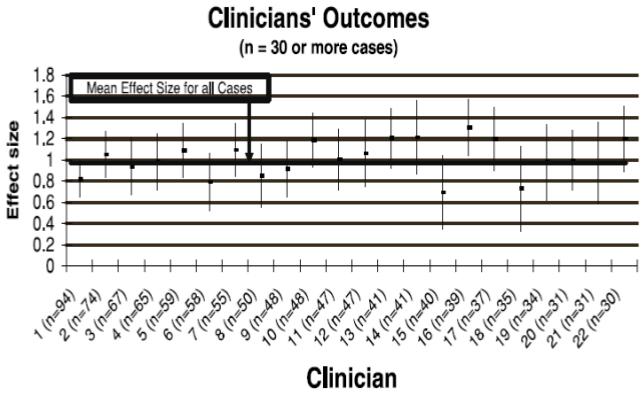

Figure 1: Average Outcomes of 22 Clinicians compared with the agency average

Used with permission

Okiishi and colleagues (2006) confirmed and extended these initial findings in a much larger sample with even more striking results. In their study, clients of the top 10% of

practitioners were twice as likely to recover and 50% less likely to deteriorate than clients seen by the least effective therapists. Unfortunately, the size of the difference was only surpassed by its inexplicability. The researchers considered a host of variables traditionally believed essential to the development of an effective therapist. None proved important, including professional discipline (e.g., counselling psychology, clinical psychology, marriage and family therapy, social work), years of training and experience, or the preferred theoretical orientation or approach (behavioral, cognitive–behavioral, humanistic, psychodynamic, etc.). Subsequent studies were equally unsuccessful in accounting for the differences in outcome between therapists (Baldwin, Wampold & Imel, 2007; Kim, Wampold & Bolt, 2006; Lutz, Leon, Martinovich et al., 2007; Wampold & Brown, 2005). As Miller et al. (2005) observed:

> "…little is known at present about the cause(s) of the difference…Nor do we know whether anything can be done to close the gap between more and less effective clinicians (e.g., distillation of effective practices by studying the most effective therapists, additional training or supervision)….If confirmed [however]…perhaps instead of empirically supported *therapies*, consumers should have access to empirically supported *therapists*…" (pp. 6-7).

The challenge was first to understand why therapists varied in their effectiveness and then, with that understanding at hand, proceed to improve the outcome of psychotherapy by making better therapists.

Taming the "Wild Card"

In 1974, psychologist David Ricks coined the term "supershrink" to describe a class of exceptional therapists—practitioners who stood head and shoulders above the rest. In a little-known study, published as a book chapter rather than a peer-reviewed journal article, he examined the long-term outcomes of a cohort of "highly disturbed" adolescents. When the research participants were later examined as adults, he found that a select group, treated by

one provider, fared notably better. On the other hand, boys treated by another clinician, termed the "pseudoshrink," had very poor adjustments later in life.

While Rick's (1974) report was cited occasionally over the next three decades, Okiishi, Lambert, Nielsen, & Ogles (2003) were the first to confirm the existence of exceptional therapists with a large sample and sophisticated statistical procedures. As in other studies, gender identification, level and type of training, and theoretical orientation did not explain the difference in outcome between the most and least effective. As Okiishi and colleagues (2003) noted, "Unfortunately, what... therapists *did* to be 'supershrinks' and pseudoshrinks' remains a mystery" (emphasis added, p. 372). At the end of their report, they asserted, "There is an urgent need to take account of the effectiveness of the individual therapist and it is time for clinicians to welcome such research" (p. 372).

Ultimately, understanding the variability in performance of individual clinicians—the "highs" and "lows"—did not come from within the profession. Instead, guidance was found in an extensive scientific literature bearing on the subjects of expertise and expert performance (Colvin, 2008; Ericsson, 2009a; Ericsson, Charness, Feltovich, & Hoffman, 2006). Across a wide variety of endeavors (including sports, chess, music, medicine, mathematics, teaching, and computer programming, and more), researchers had identified a *universal set of processes* that both accounted for superior performance and provided direction for cultivating individual development (Ericsson, 2006). In 2007, Miller, Hubble, and Duncan began applying these findings to the study of highly effective clinicians, identifying and describing three essential steps, including: (1) determining a baseline level of effectiveness; (2) obtaining systematic, ongoing feedback; and (3) engaging in deliberate practice.

With the steps identified and understood, the reason measurement and feedback (steps 1 and 2) failed to improve outcomes, on their own, became obvious. Together, they operated

much like a GPS. The measures alerted therapists when the therapy was off track and at risk for getting lost. Feedback then provided guidance for resuming progress, thereby improving the chance of arriving at the desired destination. Notwithstanding, no matter how accurate the information provided, success was completely dependent on the advice being followed. A later study published in *Psychotherapy Research* confirmed as much. With a sample of 57 therapists and over 400 clients, de Jong, van Sluis, Nugter, Heiser, and Spinhoven (2012) showed that one could not count on therapists to ask for feedback or use it productively when provided. Despite measuring progress at every session, half of the practitioners in the study indicated they did not use the feedback, whatsoever. Of those who did, only half showed any benefit from doing so. This state of affairs recalls the stereotypic, comical example of the "guy" who won't ask for directions when lost and then won't follow them once given.

There is more. Research from the field of expertise and expert performance also helped explain another troubling finding that had emerged early on in evaluations of measurement and feedback systems. Namely, even when fully committed to the process, therapists did *not* learn from the information the systems generated. Lambert observed, for example, that practitioners did not get better at detecting when they were off track with their cases or when their clients were at risk for drop out or deterioration. This happened despite being exposed to "feedback on half their cases for over 3 years" (Miller et al., 2005, p. 7). To realize the full potential of measurement and feedback, the third step—deliberate practice—was required (Ericsson, 2006; Ericsson, 2009a, 2009b; Ericsson, Krampe, & Tesch-Romer, 1993).

In brief, deliberate practice entails setting aside time for reflecting on one's performance, receiving guidance on how to improve specific aspects of therapeutic practice, considering any feedback received, identifying errors, and developing, rehearsing, executing, and evaluating a plan for improvement. Elite performers across a variety of professions and

endeavors had been shown to devote significantly more time to deliberate practice than their more average counterparts (Ericsson, 2006). For example, in a seminal study of violinists, Ericsson, Krampe, and Tesch-Romer (1993) found those rated "best" and "good" spent three times longer than the other performers in deliberate practice, averaging 3.5 hours per day for each day of the week including weekends, compared with 1.3 hours per day for the less highly rated.

In 2015, Chow, Miller, Seidel, Kane, Thornton & Andrews published the first study on the role of deliberate practice in the development of highly effective therapists. The research examined the relationship between outcome and a variety of practitioner variables, including demographics, work practices, participation in professional development activities, beliefs regarding learning and development, and personal appraisals of therapeutic effectiveness. As in previous studies, gender, qualifications, professional discipline, years of experience, time spent conducting therapy, and clinician self-assessment of effectiveness were not related to effectiveness (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Malouf, 2012; Walfish, McAllister, O'Donnell, & Lambert, 2012; Wampold & Brown, 2005). Consistent with findings reported in the expert performance literature, the amount of time therapists spent in activities intended to improve their ability was a significant predictor of outcome. In the first eight years of their professional work, the top quartile of practitioners spent, on average, nearly 2.8 times more time engaged in deliberate practice than those in the bottom three.

The three steps—establishing one's baseline performance via ongoing measurement, receiving critical feedback on the quality and effectiveness of one's work, and using that information to identify targets for improvement through deliberate practice—are challenging and demanding. Few, if any practitioners, left to their own devices, can be expected to integrate the steps into their daily work. Experience in the field, and available evidence,

indicate that superior performance does not occur in a social vacuum. Taming the "wild card" depends on creating a "culture of excellence," a community of practice containing an interlocking network of people, places, resources, and circumstances devoted to helping each therapist be the best they can be (Miller & Hubble, 2011). The combination of the steps practiced in a supportive context form the basis of and define Feedback-Informed Therapy (FIT).

References

Ahn, H., & Wampold, B. E. (2001). Where Oh Where Are the Specific Ingredients ? A Meta-Analysis of Component Studies in Counseling and Psychotherapy. *Journal of Counselling Psychology*, *48*(3), 251–257. doi:10.1037//O022-OI67.48.3.251

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 success. *Journal of Clinical Psychology*, *65*(7), 755–768.

APA Monitor. (2010, April). Psychology salaries decline. *Monitor on Psychology, 41*, 11.

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In S. D. Miller (Ed.), *The heart and soul of change: What works in therapy* (pp. 133– 178). Washington, DC: American Psychological Association.

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), 842–52. doi:10.1037/0022-006X.75.6.842

Barlow, D. H. (2002). Health Care Policy, Psychotherapy Research, and the Future of Psychotherapy. *American Psychologist, 51*, 1050–1058.

Barlow, D. H. (2004). Psychological treatments. *American Psychologist, 59,* 869–879.

Barrable, B. (1992). A survey of medical quality assurance program in Ontario hospitals. *Canadian Medical Association Journal, 146*, 153-160

Bergin, A. E. (1971). The evaluation of therapeutic outcomes. In: S. L. Garfield & A. E. Bergin (Eds.), *The handbook of psychotherapy and behavior change.* New York, NY: Wiley.

Barkham, M., Hardy, G. & Mellor-Clark, J. [eds.] (2010). *Developing and delivering practice-based evidence.* Chichester: JohnWiley & Sons Ltd.

Berg, I. K., & Miller, S. D. (1992). *Working with the problem drinker: A solution-oriented approach.* New York: Norton.

Bickman, L. (2000). Summing up program theory. *New Directions for Evaluation, 2000,* 103–112. doi:10.1002/ev.1186.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16,* 252-260.

Brown, G. S., Burlingame, G. M., Lambert, M. J., Jones, E., & Vaccaro, J. (2001). Pushing the quality envelope: a new outcomes management system. *Psychiatric Services*, *52*(7), 925–934. doi:10.1176/appi.ps.52.7.925

Brown, G. S., & Minami, T. (2010). Outcomes management, reimbursement, and the future of psychotherapy. In B. Duncan, S. Miller, B. Wampold, & M. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 267–297). Washington, DC: APA Press. doi:10.1037/12075-009

Bryk, A. S., & Raudenbush, S. W. (1992). *Hierarchical linear models: Applications and data analysis methods.* Newbury Park, CA: Sage.

Castner, J., Wu, Y. W. B., Mehrok, N., Gadre, A., & Hewner, S. (2015). Frequent Emergency Department Utilization and Behavioral Health Diagnoses. *Nursing research*, *64*(1), 3-12.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: controversies and evidence. *Annual Review of Psychology, 52*, 685–716. doi:10.1146/annurev.psych.52.1.685

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 the Development of Highly Effective Psychotherapists. *Psychotherapy, 52*(3), 337–345. doi:10.1037/pst0000015

Colvin, G. (2008). *Talent is overrated: What really separates world-class performers from everybody else.* New York: Penguin.

Crits-Christoph, P., Chambless, D. L., & Markell, H. M. (2014). Moving evidence-based practice forward successfully: Commentary on Laska, Gurman, and Wampold. *Psychotherapy, 51*(4), 491–5. doi:10.1037/a0036508

Crits-Christoph, P., Frank, E., Chambless, D. L., Brody, C., & Karp, J. F. (1995). Training in empirically validated treatments: What are clinical psychology students learning? *Professional Psychology: Research and Practice, 26*(5), 514–522. doi:10.1037/0735-7028.26.5.514

Cuijpers, P., van Straten, A., Bohlmeijer, E., Hollon, S. D., & Andersson, G. (2010). The effects of psychotherapy for adult depression are overestimated: A meta- analysis of study quality and effect size. *Psychological Medicine, 40,* 211–223. Doi:10.1017/S0033291709006114.

Cummings, N., & O'Donohue, W. (2008). *Eleven blunders that cripple psychotherapy in America: A remedial unblundering.* New York, US: Routledge.

de Jong, K., van Sluis, P., Nugter, M. A., Heiser, W. J., & Spinhoven, P. (2012). Understanding the differential impact of outcome monitoring: Therapist variables that moderate feedback effects in a randomized clinical trial. *Psychotherapy Research, 22,* 464–474. doi:10.1080/10503307.2012.673023

DeLeon, P. H., Kenkel, M. B., Garcia-Shelton, L., VandenBos, G. R. (2011). Psychotherapy, 1960 to the present. In J. C. Norcross, G. R. Vandenbos, & D. K. Freedheim (Eds.), *History of psychotherapy: Continuity and change* (2nd ed.) (pp. 39-62). Washington, DC, US: American Psychological Association. doi:10.1037/12353-002

Donabedian, A. (1988). The quality of care: How it can be assessed. *Journal of the American Medical Association, 260,* 1743-1748

Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Beach, P., Reynolds, L. R., & Johnson, L. D. (2003). The Session Rating Scale: Preliminary Psychometric Properties of a " Working" Alliance Measure. *Journal of Brief Therapy, 3*(1), 3–12.

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.

Eckert, P. A. (1994). Cost control through quality improvement: The new challenge for psychology. *Professional Psychology: Research and Practice*. *25*(1), 3-8. doi:10.1037/0735-7028.25.1.3

Ellwood, P. M. (1988). Shattuck Lecture - Outcomes Management. *New England Journal of Medicine, 318*(23), 1549–1556.

Ericsson, K. A. (2006). The Influence of experience and deliberate practice on the development of superior expert performance. In K. A. Ericsson, N. Charness, P. J. Feltovich & R. R. Hoffman (Eds.), *The Cambridge handbook of expertise and expert performance* (pp. 683–703). Cambridge: Cambridge University Press. doi:10.1017/CBO9780511816796 .038

Ericsson, K. A. (Ed.). (2009a). *Development of professional expertise: Toward measurement of expert performance and design of optimal learning environments.* New York: Cambridge University Press. doi: 10.1017/CBO9780511609817

Ericsson, K. A. (2009b). Enhancing the development of professional performance: Implications from the study of deliberate practice. In *Development of professional expertise: Toward measurement of expert performance and design of optimal learning environments* (pp. 405–431). New York: Cambridge University Press.

Ericsson, K. A., Charness, N., Feltovich, P. J., & Hoffman, R. R. (2006). *The Cambridge handbook of expertise and expert performance.* Cambridge: Cambridge University Press. doi:10.1017/CBO9780511816796

Ericsson, K. A., Krampe, R. T., & Tesch-Römer, C. (1993). The role of deliberate practice in the acquisition of expert performance. *Psychological Review, 100*(3), 363–406. doi:10.1037//0033-295X.100.3.363

Eysenck, Hans, J. (1952). The effects of psychotherapy: an evaluation. *Journal of Consulting and Clinical Psychology*, *16*, 319–324.

Frank, J. D.,&Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Gilbody, S., House, A., & Sheldon, T. (2002). Psychiatrists in the United Kingdom do not use outcomes measures. *British Journal of Psychiatry, 180,* 101-103. doi:10.1192/bjp.180.2.101

Goldfried, M. R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist, 35*, 991–999.

Goldfried, M. R., & Wolfe, B. E. (1998). Toward a more clinically valid approach to therapy research. *Journal of Consulting and Clinical Psychology*, *66*, 143–150. doi:10.1037/0022-006X.66.1.143

Gondek, D., Edbrooke-Childs, J., Fink, E., Deighton, J., & Wolpert, M. (2016). Feedback from Outcome Measures and Treatment Effectiveness, Treatment Efficiency, and

Collaborative Practice: A Systematic Review. *Administration and Policy in Mental Health and Mental Health Services Research*, 1–19. doi:10.1007/s10488-015-0710-5

Haas, E., Hill, R. D., Lambert, M. J., & Morrell, B. (2002). Do early responders to psychotherapy maintain treatment gains? *Journal of Clinical Psychology, 58,* 1157-1172.

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology*, *61*(2), 155–63. doi:10.1002/jclp.20108

Hatfield, D., McCullough, L., Frantz, S. H. B., & Krieger, K. (2010). Do we know when our clients get worse? an investigation of therapists' ability to detect negative client change. *Clinical Psychology Psychotherapy*, *17*(1), 25–32.

Hatfield, D. R., & Ogles, B. M. (2004). The Use of Outcome Measures by Psychologists in Clinical Practice. *Professional Psychology: Research and Practice*, *35*(5), 485–491. doi:10.1037/0735-7028.35.5.485

Hawkins, E. J., Lambert, M. J., Vermeersch, D. A., Slade, K. L., & Tuttle, K. C. (2004). The therapeutic effects of providing patient progress information to therapists and patients. *Psychotherapy Research*, *14*(3), 308–327.

Horvath, A. O. (2001). The alliance. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 365-372. doi:10.1037/0033-3204.38.4.365

Howard, K.I., Brill, P., Lueger, R.J., & O'Mahoney, M. (1992, 1993, 1995). *The Integra Outpatient Tracking Assessment.* Radnor, PA: Integra, Inc.

Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. *The American Psychologist*, *41*(2), 159–64.

Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy. Efficacy, effectiveness, and patient progress. *The American Psychologist*, *51*(10), 1059–1064. doi:10.1037/0003-066X.51.10.1059

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999), *The heart and soul of change: What works in therapy.* Washington, DC: American Psychological Association.

Huppert, J. D., Fabbro, A., & Barlow, D. H. (2006). Evidence based practice and psychological treatments. In C. Goodheart, A. Kazdin, & R. J. Sternberg (Eds.), *The evidence for psychotherapy: Where practice and research meet* (pp. 131–152). Washington, DC: American Psychological Association. doi:10.1037/11423-006

Johnson, L.D. (1995). *Psychotherapy in the Age of Accountability*. New York: Norton.

Johnson, L. D., & Shaha, S. (1996). Improving quality in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *33*(2), 225–236. doi:10.1037/0033-3204.33.2.225

Kim, D. M., Wampold, B. E., & Bolt, D. M. (2006). Therapist effects in psychotherapy: A random-effects modeling of the National Institute of Mental Health Treatment of Depression Collaborative Research Program data. *Psychotherapy Research*, *16*(2), 161–172. doi:10.1080/10503300500264911

Knaup, C., Koesters, M., Schoefer, D., Becker, T., & Puschner, B. (2009). Effect of feedback of treatment outcome in specialist mental healthcare: Meta-analysis. *British Journal of Psychiatry*, *195*(1), 15–22. doi:10.1192/bjp.bp.108.053967

Lambert, M. J. (1992). Implications of outcome research for psychotherapy integration. In J. C. Norcross & M. R. Goldstein (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). New York: Basic Books.

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

Lambert, M. J., Hansen, N. B., & Finch, A. E. (2001). Patient-Focused Research: Using Patient Outcome Data to Enhance Treatment Effects. *Journal of Consulting and Clinical Psychology*, *69*, 159–172.

Lambert, M. J., Lunnen, K., Umphress, V., Hansen, N.. & Burlingame, G. M. (1994). *Administration and scoring manual for the Outcome Questionnaire (OQ-45. 1).* Salt Lake City: IHC Center for Behavioral Healthcare Efficacy

Lambert, M. J., & Ogles, B. M. (2014). Common factors: Post hoc explanation or empirically based therapy approach? *Psychotherapy, 51*(4), 500–504. doi:10.1037/a0036580

Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy, 48*(1), 72–79. doi:10.1037/a0022238

Lambert, M., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is It Time for Clinicians to Routinely Track Patient Outcome? A Meta-Analysis. *Clinical Psychology: Science and Practice*, *10*(3), 288–301.

Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D. A., Nielsen, S. L., & Hawkins, E. J. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research*, *11*(2), 49–68.

Lambert, M. J., Whipple, J. L., Vermeersch, D. A., Smart, D. W., Hawkins, E. J., Nielsen, S. L., & Goates, M. (2002). Enhancing psychotherapy outcomes via providing feedback on client progress: a replication. *Clinical Psychology & Psychotherapy*, *9*(2), 91–103. doi:10.1002/cpp.324

Laska, K. M., Gurman, A. S., & Wampold, B. E. (2013). Expanding the Lens of Evidence-Based Practice in Psychotherapy: A Common Factors Perspective. *Psychotherapy, 51*(4), 467–481. doi:10.1037/a0034332

Lechnyr, R. (1992). Cost savings and effectiveness of mental health services. *Journal of the Oregon Psychological Association, 38,* 8-12.

Lipsey, M., & Wilson, D. (1993). The efficacy of psychological, educational, and behavioral treatment: Confirmation from meta-analyses. *American Psychologist, 48,* 1181-1209.

Lueger, R. J. (2012). The Integra / COMPASS tracking assessment system. *Integrating Science and Practice*, *2*(2), 20–23.

Lutz, W., Leon, S. C., Martinovich, Z., Lyons, J. S., & Stiles, W. B. (2007). Therapist effects in outpatient psychotherapy: A three-level growth curve approach. *Journal of Counseling Psychology*, *54*(1), 32–39. doi:10.1037/0022-0167.54.1.32

Lutz, W., Martinovich, Z., & Howard, K. I. (1999). Patient profiling: an application of random coefficient regression models to depicting the response of a patient to outpatient psychotherapy. *Journal of Consulting and Clinical Psychology, 67*(4), 571–577. doi:10.1037/0022-006X.67.4.571

Malouff, J. (2012). The need for empirically supported psychology training standards. *Psychotherapy in Australia, 18*(3), 28-32.

Meinert C. L. (1986). *Clinical Trials: Design, Conduct and Analysis.* Oxford, UK: Oxford University Press.

Miller, S. D. (2010). Finding feasible measures for practice-based evidence. Top Performance Blog. Retrieved from http://www.scottdmiller.com/?qtaxonomy/term/70

Miller, S. D. (2011). Cutting edge feedback. Top Performance Blog. Retrieved from http://www.scottdmiller.com/feedback-informed-treatment-fit/cutting-edge-feedback/

Miller. S. D., & Berg, 1. K. (1995). *The miracle method: A radically new approach to problem drinking.* New York: W.W, Norton.

Miller, S. D., & Duncan, B. L. (2000). *The Outcome Rating Scale.* Chicago: Author.

Miller, S. D., Duncan, B. L., Brown, J., Sorrell, R., & Chalk, M. B. (2006). Using formal client feedback to improve retention and outcome: Making ongoing, real-time assessment feasible. *Journal of Brief Therapy, 5*(1), 5–22.

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J. A., & Claud, D. A. (2003). The Outcome Rating Scale: A Preliminary Study of the Reliability, Validity, and Feasibility of a Brief Analogue Measure. *Journal of Brief Therapy, 2*(2), 91–100.

Miller, S. D., Duncan, B. L., Sorell, R., & Brown, G. S. (2005). The partners for change outcome management system. *Journal of Clinical Psychology, 61*(2), 199–208. doi:10.1002/jclp.20111

Miller, S. D., & Hubble, M. (2011). The road to mastery. *Psychotherapy Networker, 35*, 22–31.

Miller, S. D., Hubble, M., Chow, D. L., & Seidel, J. A. (2013). The outcome of psychotherapy: yesterday, today, and tomorrow. *Psychotherapy, 50*(1), 88–97. doi:10.1037/a0031097

Miller, S.D., Hubble, M.A., & Duncan, B.L.(1995). No more bells and whistles. *Family Therapy Networker, 19,* 23-31.

Miller, S. D., Hubble, M. A., & Duncan, B. L. (2007). Supershrinks. *Psychotherapy Networker, 31,* 26–35, 56.

Miller, S. D., Hubble, M. A., Duncan, B. L., & Wampold, B. (2010). Delivering what works. 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* (pp. 421–429). Washington, DC: APA Press. doi: 10.1037/12075-014

Moncrieff, J., Wessely, S., Hardy, R. (2004). Active placebos versus antidepressants for depression. *Cochrane Database of Systematic Reviews* 2004, Issue 1. Art. No.: CD003012. DOI: 10.1002/14651858.CD003012.pub2.Munder, T., Brütsch, O., Leonhart, R., Gerger, H., & Barth, J. (2013). Researcher allegiance in psychotherapy outcome research: An overview of reviews. *Clinical Psychology Review, 33*(4), 501–511. doi:10.1016/j.cpr.2013.02.002

Nathan, P. E. (1997). Fiddling while psychology burns? *Register Report*, *23*(2), 1,4-5, 10.

Norcross, J. C. (2010). The therapeutic relationship. 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. 113- 141). Washington, DC: American Psychological Association.

Norcross, J.C., & Newman, C.F. (1992). Psychotherapy integration: Setting the context. In J.C. Norcross, & M.R. Goldfried (eds.). *Handbook of Psychotherapy Integration.* New York: Basic, 3-45.

Okiishi, J. C., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D., & Vermeersch, D. A. (2006). An analysis of therapist treatment effects: Toward providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology*, *62*(9), 1157–1172. doi:10.1002/jclp.20272

Okiishi, Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology and Psychotherapy, 10,* 361-373.

O'Leary, K. D., & Borkovec, T. D. (1978). Conceptual, methodological, and ethical problems of placebo groups in psychotherapy research. *American Psychologist, 33,* 821–830.

Olfson, M., Marcus, S. C., Duss, B., Elison, L., Tanielian, T., & Pincus, H. A. (2002). National trends in the outpatient treatment of depression. *Journal of the American Medical Association*, *9*, 203-209.

Persons, J. B., & Silberschatz, G. (1998). Are results of randomized controlled trials useful to psychotherapists? *Journal of Consulting and Clinical Psychology, 66,* 126–135. doi:10.1037//0022-006X.66.1.126

Psychotherapy caveat. APA Monitor, December 1974, p. 7.

Ricks, D. F. (1974). Supershrink: Methods of a therapist judged successful on the basis of adult outcomes of adolescent patients. In D. F. Ricks, M. F. Roff, A. Thomas, D. F. Ricks, M. F. Roff, & A. Thomas (Eds.), *Life history research in psychopathology* (Vol. 3, pp. 275-297). Minneapolis, MN: University of Minneapolis.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6*, 412–415.

Schenkenberg, T., Bradford, D. C., & Ajax, E. T. (1980). Line bisection and unilateral visual neglect in patients with neurologic impairment. *Neurology*, *30*(5), 509-509.

Segal, J. (Ed.). (1975). *Research in the service of mental health, report of the research task force of the National Institute of Mental Health* (DHEW Publication No. ADM 75-236). Washington, DC: U.S. Government Printing Office.

Sapyta, J., Riemer, M., & Bickman, L. (2005). Feedback to clinicians: theory, research, and practice. *Journal of Clinical Psychology*, *61*(2), 145–53. doi:10.1002/jclp.20107

Seidel, J. A., Miller, S. D., & Chow, D. L. (2013). Effect size calculations for the clinician: Methods and comparability. *Psychotherapy Research*, *24*, 470–484. doi:10.1080/10503307.2013.840812

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist, 50,* 965–974.

Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting and Clinical Psychology, 78*(3), 298–311. doi:10.1037/a0019247

Siev, J., Huppert, J. D., & Chambless, D. L. (2009). The Dodo Bird, Treatment Technique, and Disseminating Emperically Supported Treatments. *The Behavior Therapist*, *32*(4), 69–76.

Slade, K., Lambert, M. J., Harmon, S. C., Smart, D. W., & Bailey, R. (2008). Improving psychotherapy outcome: The use of immediate electronic feedback and revised clinical support tools. *Clinical Psychology and Psychotherapy*, *15*(5), 287–303. doi:10.1002/cpp.594

Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, *32*(9), 752–760. Retrieved from 10.1037/0003-066X.32.9.752

Sorrell, R. (2007). Application of an Outcome-Directed Behavioral Modification Model for Obesity on a Telephonic/Web-Based Platform. *Disease Management*, *10*(1), 23–26. doi:10.1089/dis.2007.7716

Swartzman, L. C., & Burkell, J. (1998). Expectations and the placebo effect in clinical drug trials: why we should not turn a blind eye to unblinding, and other cautionary notes. *Clinical Pharmacology & Therapeutics*, *64*(1), 1-7.

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically-validated psychological treatments. *The Clinical Psychologist*, *48*(1), 3-23.

Thaul, S. (2012). *How FDA Approves Drugs and Regulates Their Safety and Effectiveness.* Congressional Research Service.

Tracey, T. J. G., Wampold, B. E., Lichtenberg, J. W., & Goodyear, R. K. (2014). Expertise in psychotherapy: an elusive goal? *The American Psychologist*, *69*(3), 218–29. doi:10.1037/a0035099

VandenBos, G. R. (1993). U.S. mental health policy. Proactive evolution in the midst of health care reform. *American Psychologist*, *48*(3), 283–290. doi:10.1037/0003-066X.48.3.283

Walfish, S., McAlister, B., O'Donnell, P., & Lambert, M. J. (2012). An investigation of self-assessment bias in mental health providers. *Psychological Reports, 110*(2), 1–6. doi:10.2466/02.07.17.PR0.110.2.2

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist, 62*, 857–873. doi:10.1037/0003- 066X.62.8.857

Wampold, B. E. (2013). The good, the bad, and the ugly: A 50-year perspective on the outcome problem. *Psychotherapy, 50*, 16–24. doi:10.1037/a0030570

Wampold, B. E., & Brown, G. S. J. (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. doi:10.1037/0022-006X.73.5.914

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: Research evidence for what works in psychotherapy* (2nd ed.). New York, US: Routledge.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ, US: Lawrence Erlbaum Associates.

Wampold, B. E., Minami, T., Tierney, S. C., Baskin, T. W., & Bhati, K. S. (2005). The placebo is powerful: Estimating placebo effects in medicine and psychotherapy from randomized clinical trials. *Journal of Clinical Psychology*, *61*(7), 835–854. doi:10.1002/jclp.20129Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes." *Psychological Bulletin*, *122*(3), 203–215. doi:10.1037/0033-2909.122.3.203

Webb, C. A., Derubeis, R. J., & Barber, J. P. (2010). Therapist adherence/competence and treatment outcome: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *78*(2), 200–11. doi:10.1037/a0018912

Whipple, J. L., Lambert, M. J., Vermeersch, D. a., Smart, D. W., Nielsen, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment and problem-solving strategies in routine practice. *Journal of Counseling Psychology*, *50*(1), 59–68. doi:10.1037/0022-0167.50.1.59

Zimmerman, M., & McGlinchey, J. B. (2008). Why don't psychiatrists use scales to measure outcome when treating depressed patients? *Journal of Clinical Psychiatry, 69,* 1916-1919.

i