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Merton S. Krause
Northwestern University

Wolfgang Lutz
University of Trier

Stephen M. Saunders
Marquette University, stephen.saunders@marquette.edu

Marquette University

e-Publications@Marquette

Psychology Faculty Research and Publications/College of Arts and Sciences

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Empirically Certified Treatments or Therapists: The Issue of Separability

MERTON S. KRAUSE

Department of Psychology, Northwestern University;

WOLFGANG LUTZ

*Department of Clinical Psychology and **Psychotherapy**, University of Trier, Germany*

STEPHEN M. SAUNDERS

Department of Psychology, Marquette University

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When a person needs psychotherapeutic treatment, it obviously is effective treatment that is to be sought. The ability to find out how effective the available treatment alternatives will probably be for this person depends upon the existence of effectiveness data on these available alternatives, which are the various psychotherapists presently available to the person. For clinical purposes then, effectiveness data ought to be about the results obtained in similar cases by the therapists available to patients, whatever the forms of treatment these therapists provide.

The results of forms of therapy performed in randomized controlled trials (RCTs), in experiments that compare the outcomes for patients provided a very specific form of treatment against the outcomes from some control condition (such as being on a waiting list), demonstrate the efficacy these forms can achieve under the special conditions of an RCT. These demonstrations are, however, always made somewhat ambiguous because of the particular mix of (still inadequately known) outcome-relevant kinds of therapists and patients involved in these studies. The results do not demonstrate the effectiveness that can reasonably be expected when these forms of therapy are performed in ordinary practice by other therapists with other patients (see [Franklin & DeRubeis, 2006](#); [Stirman & DeRubeis, 2006](#); [Westen, 2006a, 2006b](#)). RCT efficacy studies may sometimes demonstrate the ideal, but local effectiveness studies of ordinary practice are essential for demonstrating the real. This is not a matter of a few demonstrations of transportability, that is, of some RCTs' results being replicated in a few ordinary practice settings for some form of treatment, some therapists, and some patients. Instead, what is needed is the routine study of the results of ordinary practice.

The empirically supported treatments movement has promoted our finding out how efficacious some therapists' behavioral emphasis on one or another form of **psychotherapy** can sometimes be for some patients. The effort to establish by means of RCTs which forms of **psychotherapy** should be empirically certified to be efficacious, and so most properly to be relied upon in practice, has stimulated new and better efficacy studies and the integration of published efficacy studies (e.g., [Chambless & Ollendick, 2001](#); also see [Boruch, Soydan, de Moya, & Campbell Collaboration Steering Committee, 2004](#)). However, such certification might easily become legally or administratively required for a form of **psychotherapy** to be justified for use in practice (see, e.g., [Tanenbaum, 2006](#), pp. 251–253), whereas the results obtained in ordinary practice are really what should be crucial (see [Wampold, 2006a](#)). Patients ought not be subjected to any treatment form that is inadequate for them at its truly best, which some efficacy RCTs may sometimes tell us, but neither should they be subjected to any treatment form that is inadequate for them in ordinary practice even if at its best it is adequate for some other patients. Only continuing comprehensive effectiveness studies of ordinary practice can tell us how adequate therapists' ordinary practice is, whatever treatment forms they emphasize. This should be the evidence on which evidence-based practice ultimately depends ([APA Presidential Task Force on Evidence-Based Practice, 2006](#)).

We shall explain why **psychotherapy** treatment forms cannot be studied purely independently of each other and are in practice not neatly separable from one another (see [Rosenzweig, 1936/2002](#)). Therapists, however, can be studied independently of one another, and it is they, not treatment forms, to whom patients in fact are attracted, referred, or assigned. Therefore, we shall argue that psychology's concern for the effectiveness of psychotherapeutic services would be more fundamentally served by having empirically certified psychotherapists (ECPs) rather than empirically certified treatments (ECTs) and having a publicly accessible data bank on these ECPs' practices and results.

Inseparability in Practice of the Forms of Psychotherapy

It is now widely accepted that there is convincing clinical and scientific evidence that some distinguishably different forms of **psychotherapy** can be on average somewhat effectively therapeutic. These forms of **psychotherapy** overtly differ in their behavioral emphasis on such matters as trying to

provide constructively reinforcing responses, expressions of unconditional positive regard (UPR), credible problem-relevant information, fruitful insight-evocative interpretations of problematic actions or experiences, and more (see, e.g., [Howard, Krause, Caburnay, Noel, & Saunders, 2001](#); [Lambert & Archer, 2006](#); [Lambert & Ogles, 2004](#); [Lipsey & Wilson, 1993](#); [Shadish et al., 1997, 2000](#)).

However, what a psychotherapist in effect does, rather than simply appears to be doing, is only what is manifest in the consequences of her or his actions in the patient. Thus, whatever reinforces constructive responses in a patient is in effect a therapeutic reinforcement. Whatever is experienced by a patient as the therapist's UPR for that patient is in effect UPR for that patient. Whatever persuades is in effect a persuasively credible presentation of information. Whatever evokes transformative insights is in effect an interpretation. Empathy requires not merely certain specific intentions or behaviors on the part of the therapist but that the patient experiences empathy from the therapist. It is the psychological process directly induced in the patient that ultimately defines what the therapist has actually accomplished rather than merely attempted, and this is what is ultimately causally relevant to the outcome of a course of treatment, not merely the shape of the therapist's behaviors.

Furthermore, what fraction of intended reinforcing or extinguishings, impressions of UPR, persuasive messages, interpretations, and expressions of empathy that are actually achieved in any episode of treatment can only be determined after the fact, after this intended direct effect has occurred. Of course, some unintended consequences of these sorts must also occur. A problem for research is that we do not presently know what fractions of therapists' actions are those of unachieved intended interventions or of achieved unintended interventions. In ordinary practice, sessions of **psychotherapy** are necessarily somewhat heterogeneous and inconstant with regard to form of **psychotherapy**. In part this is so quite advertently, where therapists are intentionally and effectively eclectic. In part this is so only inadvertently, where therapists are unintentionally eclectic in effect because the forms of **psychotherapy** are somewhat inseparable in practice. This means that therapists cannot reasonably be presumed to be practicing (or, for outcome-variance partitioning purposes, to be exclusively nested in) pure forms of **psychotherapy** no matter what form they believe they practice, what manual they are guided by (see [Kendall, Chu, Gifford, Hayes, & Nauta, 1998](#)), or whether they are objectively judged to be behaviorally conforming to a given treatment form.

Consequently, there can reasonably be expected to occur in every session some reinforcing of constructive and some extinguishing of maladaptive patient behaviors (and some of the opposites of these), some increasing (and some decreasing) of patients' unconditional positive self-regard, some persuading of patients to replace dysfunctional beliefs and attitudes with more functional ones (and of the opposite), some evoking of patients' fruitful insights into themselves that lead to their living more realistically (and of some decompensations), and so forth. More or less of all of these sorts of events are unavoidably happening from what a therapist does over a course of treatment. So there must be considerable overlap of the various forms of **psychotherapy** in ordinary practice. For some evidence relevant to this point, see, for example, [Fiedler \(1950\)](#); [Sloane, Staples, Cristol, Yorkston, and Whipple \(1975\)](#); [Brunink and Schroeder \(1979\)](#); [Hill, Thames, and Rardin \(1979\)](#); [Luborsky, Woody, McLellan, and O'Brien \(1982\)](#); [Borkovec and Costello \(1993\)](#); [Stiles et al. \(1996\)](#); [Malik, Beutler, Alimohamed, Gallagher-Thompson, and Thompson \(2003\)](#); and [Weisz and Addis \(2006\)](#).

Therefore it is impossible to guarantee that a therapist has achieved exclusively a specific pure treatment form unless there has been an extraordinarily close examination of what processes have been directly induced in the patient. Even the closest examination of what the therapist intends to do or appears to herself or himself, to the patient, or to an outside observer (as, e.g., in [Stiles et al., 1996](#)) to be behaviorally trying to do is not enough. There undoubtedly are many ways to evoke fruitful insights, to reinforce, to condition, to convince, to reframe, to induce unconditional positive self-regard, and to relate empathically, but there are also many ways to fail to do so even with the best of intentions and training and presently defined behavioral form. It will only be possible to discriminate what is actually causing the differences in outcomes between treatments when we routinely and demonstrably validly measure all of the variables that are contributing substantially to these outcomes (see, e.g., [Orlinsky & Rønnestad, 2005](#), pp. 41–99) and not just those that presently behaviorally define a treatment form to ensure that its defining features were truly performed.

So, it is premature to assume that any specified form of treatment is what is exclusively, reliably, and most influentially being provided in practice when its use is mandated (see [Franklin & DeRubeis, 2006](#)). The fact that all psychotherapeutic treatment is undoubtedly deeply affected by the natures of therapist and patient and their evolving and often unavoidably and repeatedly perturbed relationship as therapist and patient (see, e.g., [Orange, Atwood, & Stolorow, 1997](#), pp. 19–34; [Soldz & McCullough, 2000](#); [Stiles, Honos-Webb, & Surko, 1998](#)) must also contribute to this heterogeneity. All of which undoubtedly further adds to the difficulty of showing that one treatment form is notably better than another (e.g., [Wampold, 2001](#)) by contributing to the considerable between-patient within-comparison-group outcome variance in efficacy RCTs, which obstructs the finding of significant outcome differences between treatments, and by contributing to the variation in the results of such RCTs when they are attempted to be replicated or are meta-analyzed.

Separability in Practice of Psychotherapists

There is certainly no good reason to require an already effective enough therapist to practice only what may be the current ECTs. In fact, it may well be that having a good range of options and choosing from them what treatment form or mixture of treatment forms or techniques or adjunctive services to emphasize, and how and when to do so, is an important aspect of being an effective therapist ([Carter, 2006](#); [Holloway, 2003](#); [Persons & Silberschatz, 1998](#)). However, only therapists who have been adequately evidenced in actual practice to validly report on their cases and to be reliably effective enough with specific outcome-relevant sorts of cases are qualified to be ECPs for these latter sorts of cases. Therapists evidently do vary in how effective they are with various sorts of cases (e.g., see [Wampold, 2006a](#); [Lutz, Leon, Martinovich, Lyons, & Stiles, 2007](#); [Lutz et al., 2006](#)), but data are lacking on how therapists vary in the validity of their reporting.

At the beginning of therapists' careers, the accredited training institutions that graduate them can and variously do determine that they are or are likely to be adequately effective therapists (see [Hill & Lent, 2006](#)) and to be competent and honest reporters on how they work and with what apparent results. After that point, no adequate evidence is generally collected on therapists' effectiveness (although some clinics and third-party payers are now doing so; see, e.g., [Lutz et al., 2006](#); [Wampold & Brown, 2005](#)) or on the adequacy of their reporting. Such evidence should be quite helpful for deciding which therapists to put on one's staff, have in one's practice group, refer to, or be treated by. The forms of

treatment therapists profess to or actually do emphasize in their practices, even if these are ECTs, cannot reasonably be presumed to, by themselves, indicate these therapists' effectiveness. Only valid monitoring of therapists' effectiveness in ordinary practice can indicate this. However, the feasibility of obtaining valid data from such monitoring obviously depends upon therapists' and patients' motivation to manifestly provide and to actually obtain adequately effective psychotherapeutic services, as well as to validly report on what was done with what results. So the incentives for manifestly being and for being treated by an ECP and for validly reporting on one's case as a patient or one's cases as a therapist are critical. Because therapists' acquisition and maintenance of adequate caseloads of patients must depend in some part upon prospective patients', referral sources', and supervisors' expectations of them regarding their results and their reporting, and because being an ECP should contribute favorably to such expectations, therapists would have at least this incentive for being an ECP (see [Okiishi, Lambert, Nielsen, & Ogles, 2003](#)).

Certification of psychotherapists who wish to be ECPs would involve routinely evaluating the work and the reporting of such therapists on all the outcome-relevant sorts of cases those therapists will treat (and adequately monitoring the effectiveness of ECTs in ordinary practice would involve no less). Although this would be no easy or inexpensive thing to do, it could be done; but the details of just how it could be done must be meticulously and locally negotiated among the many parties to the mental health service system. Then there must be a database comprised of information on the progress of at least a fair representation of patients in therapy with every participating psychotherapist. This is the basis on which each therapist's effectiveness for the various outcome-relevant cases (the adequate definition of which is another big job of research that is yet to be finished, but motivation for treatment and ability to take a suitable patient-role in it are two obviously relevant variables; see [Orlinsky, Rønnestad, & Willutzki, 2004](#)) can be evaluated to certify and periodically recertify the currently good-enough therapists for each such sort of case. Reasonable opportunities and incentives for achieving certification and for preventing the provision of inadequate or uncertified services and of invalid reporting are necessary complements to this. The investment in such a system would be socially worthwhile only insofar as it actually improves services enough to more than cover its social costs, therefore it needs to be experimented with and to be evaluated on a continuing basis. Only the study of actual practice can tell if any service system, clinic, or hospital; behavioral emphasis on a treatment form; or therapist reliably produces sufficiently cost-effective results (see [Borkovec, Echemendia, Ragusea, & Ruiz, 2001](#); [Ollendick & King, 2006](#); [Wampold, 2006b](#)).

To obtain the information necessary for such a system, every psychotherapist who wishes to be an ECP would have to keep or somehow have kept for them some standard and evidently valid descriptive records of the nature and outcomes of her or his cases. Insofar as these records were kept in terms of ultimately outcome-relevant therapist variables (such as building a good working alliance, clarifying the patient's strengths, facilitating the patient's experiencing positive affect in sessions; see [Orlinsky et al., 2004](#)) and of relevant patient variables (such as the two previously noted and including that of mental health status, which still remains an unsettled matter; see [Krause, 2005](#)). The necessary record keeping would obviously require quite a change in the ethos of **psychotherapy**, because it amounts in fact to a redefinition of proper clinical practice: Proper clinical practice is done not just for the betterment of this patient in this episode of treatment but also for the better treatment of future similar patients as well, not just for present results but also for valid data. Every treated case is a potentially informative

(though not a controlled or randomized) clinical trial, and this needs to be taken seriously and respected as important by everyone. This is the very heart of the notion of the scientist-practitioner (see [Witmer, 1897](#)).

Inseparability of Research and Practice

The nature of and results for each case that is treated by a therapist who wishes to be an ECP are to be aggregated over these individual cases to the level of the individual therapist but aggregated separately for each single apparently outcome-relevant sort of case ([Krause & Lutz, 2006](#), and, e.g., [Lutz et al., 2005](#)). From this level, the data may then be aggregated over individual therapists to whatever may prove on the basis of these data to be outcome-relevant types of therapists, to clinics or practice groups, and then to whatever larger organizations incorporate these. A publicly accessible and meticulously updated data bank, which preserves patient anonymity, can then be created from this (see [Fisher, 2006](#); [Fishman, 2000](#)).

This data bank could then be searched by system administrators and researchers (as well as by potential clients) for the especially successful therapists for any specific sort of case. If a therapist sometimes gets remarkably good results by behaviorally emphasizing a particular tactic or form of **psychotherapy** or mix of these under certain circumstances, then the logical administrative and scientific response would be to try to find out what sorts of therapists doing what under what sorts of circumstances can in that same way get such results. If no therapist under any circumstances ever got adequate results from behaviorally emphasizing a given tactic or treatment form or mix of such, and an adequate variety of therapists had tried under an adequate variety of circumstances, then emphasis on that tactic or treatment form ought not be condoned. In the real world of **psychotherapy**, manifold innovation is undoubtedly taking place, and psychology needs to take full advantage of individual therapists' successes for the evolution of practice, just as psychology also needs to attend to the absence of innovation or success in ordinary practice.

Of course, what we want are robust treatment forms or tactics such that (nearly) any therapist under reasonable circumstances gets adequate results by emphasizing them, but that is a very high standard (which is not currently required to be met by ECTs). Something less robust would be quite acceptable as long as we knew under what conditions it was adequate. RCTs could be used to supplement, better define (see [Borkovec & Castonguay, 1998](#)), and more securely evidence any promising possibilities at the growing edges of progress toward optimal **psychotherapy** effectiveness (perhaps as in the special clinics suggested by [Klein & Smith, 1999](#)). The data bank on ordinary practice would then be a way to subsequently assess the impact of any innovations as they became assimilated into ordinary practice, to detect further promising innovative possibilities, and to indicate where innovation was currently most needed.

Footnotes

- ¹ The measurement validity issues are very serious ones. Therapists want to be and to appear effective. Patients want to be better in some ways, but they may also want not to seem to certain others to be better in some ways too (e.g., so that certain of their actions or inactions are responded to caringly or at least tolerantly by family, friends, employers, or courts because of their illness). Independent assessors would seem to be the only way to avoid or detect these bias problems; requiring this would destroy the

voluntary and private character of **psychotherapy**, and assessed effectiveness cannot reasonably be assumed to be unaffected by the standpoint from which it is assessed (see [Orlinsky et al., 2004](#)), so the therapists' and patients' standpoints *must* be represented. Measurement validity requires incentives for providing the most relevant and unbiased data, and so we must learn to identify those therapists and patients who have such incentives and those who do not. Therapists who lack such intrinsic incentives ought not be ECPs and cannot have their testimony relied upon regarding either themselves or ECTs. Patients who are not known to have the intrinsic incentives (to which their therapists can sometimes testify) and who also lack extrinsic incentives (as may happen when self-assessment is not an inherent aspect of therapy) for providing valid data cannot have their testimony relied upon regarding either ECPs or ECTs. These incentives may be manifest in such ways as, for example, therapists' and patients' admissions of and descriptions of lack of success, therapists' constructive responses to their noncertification for at least some sorts of patients, patients' constructive responses to felt lack of success (by dealing with it in therapy so as to either alter the work being done or to transfer to another therapist), and agreement between therapist and patient about what ends were and were not achieved. A great deal more needs to be worked out about how to safeguard measurement validity for determining who will be an ECP (or, equally, what will be an ECT), but the matter exceeds the limits of this article.

2 As it is, for example, by *Pragmatic Case Studies in Psychotherapy*. Available from <http://pcsp.libraries.rutgers.edu/about.php>

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