

# Psychotherapy Research, the Recovery Movement and Practice-Based Evidence in Psychiatric Rehabilitation

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**ABSTRACT.** This article reviews the literature on psychotherapy outcome research and discusses the relationship between those findings and the tenets of the consumer-driven recovery model. The research provides compelling evidence for practitioners to abandon the current emphasis on diagnosis and theory, model, and technique in favor of a partnership with clients that leverages the common factors and places emphasis on the alliance. Empirical support of the shortcomings of evidence-based practices is provided. Use of outcome and alliance feedback to inform the work and shift to practice-based evidence is offered as a practice that is informed by the research and honors the recovery model's call for consumer-driven mental health services.

**KEYWORDS.** Consumer driven, outcome rating scale, practice-based evidence, session rating scale, therapeutic alliance

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There has been a recent push by mental health consumer advocacy groups for an alternative to the medical model of care. Individuals who have experienced services that they believe render them hopeless and voiceless have been motivated to seek a service delivery model that would position them in collaboration with service providers to focus on client empowerment, leverage hope, and encourage personal agency within a nonpathologizing framework (Jacobson & Greenley, 2001). The recovery model, with origins in the “consumer-survivor movement” (Anthony, 1993; Frese & Davis, 1997) and community support systems models (Anthony, 1993), has emerged as a viable solution to this problem.

Whereas consumers of mental health services have been advocating for a move toward a more people-centered system, therapists have been moving away from partnership with people toward a product orientation with their embrace of evidence-based practices (EBPs). The acceptance of EBPs, although predicated on the belief of enhanced effectiveness, comes despite overwhelming empirical evidence that effective clinical work is not made from the stuff of EBPs.

This article reviews the basic tenets of the recovery movement, followed by a summary of psychotherapy research that provides empirical grounds for the kind of shift in mental health services articulated by the supporters of the recovery movement. The limitations of EBPs is discussed, introducing in contrast an alternative approach that answers the call for a consumer-driven approach and satisfies providers’ desire for empirical evidence of effectiveness.

### ***THE RECOVERY MODEL***

The recovery model advocates for a system where consumers are positioned in collaboration with providers in an effort to leverage consumer competency and privilege individual self-determination. This “doing with” versus the “doing to” of traditional mental health services destabilizes the dominance of the medical model, the guiding narrative of contemporary psychiatry and psychology. This destabilization is accomplished by decentering the assumed “experts” (professional service providers), shifting the focus from pathology to competency, instilling and mobilizing hope and belief in recovery

(vs. symptom management), and rejecting the view of a person's identity based on his or her diagnosis. Part and parcel of these changes is the shift from *patient* or *client*—a role that suggests vulnerability and lack of agency (Farone, 2004)—to that of consumer—a position of increased control and choice. Relying on the consumer metaphor embedded within the recovery model is a radical, grassroots departure from the authoritarian hegemony of the medical industry, but it leverages the currency of the language of the marketplace to support its philosophy of capitalism as a driving force in today's health care delivery.

The cornerstones of the recovery model include hope, empowerment, destigmatization, partnership with providers, personal agency, consumer rights, and community involvement (Anthony, 1993; Jacobson & Greenley, 2001). Less an actual model of treatment and more a philosophy (Reisner, 2005), the recovery model has been bolstered by legislation on the national and state levels. The President's New Freedom Commission on Mental Health (2003) and subsequent report call for consumer-driven systems in which the values of the recovery model receive a governmental mandate. In the United States, some iteration of the recovery model is in place at various state and county levels, including in California, Ohio, and Wisconsin.

Some, including recovery advocates, have voiced concern that the recovery model has not been sufficiently researched to determine its empirical soundness (Anthony, 1993; Peyser, 2001). Yet the heart and soul of the recovery movement—consumer-helper collaboration, hopefulness, self-determination, and competency—have received robust empirical support, as a review of the literature indicates.

### **THE RESEARCH**

In an attempt to determine the superiority of one therapy model over another, study after study has set out to discover the best way of doing therapy for any particular diagnosis or identified problem (Duncan, Miller, & Sparks, 2004). The thrust of these studies has involved demonstrating that a specific ingredient unique to a particular model is responsible for clinical effect, or change. This belief in the significance of a specific, active ingredient is central to the

medical model and serves as the foundation of the quest for the supreme treatment method. As Wampold (2001) concluded in his analysis of the literature, “decades of psychotherapy research have failed to find a scintilla of evidence that any specific ingredient is necessary for therapeutic change” (p. 204).

The research also has consistently demonstrated that there is no difference in effectiveness between treatments (Luborsky, Singer, & Luborsky, 1975). This finding has since been replicated time and time again in some of the largest and most well-respected studies (e.g., Treatment of Depression Collaborative Research Project [Elkin et al., 1989], Project MATCH [Conners, DiClemente, Carroll, Longabaugh, & Donovan, 1997], Human Affairs International Study [Brown, Dreis, & Nace, 1999], Cannabis Youth Treatment Study [Dennis et al., 2004]). In all of these studies, all forms of treatment (including those that have been granted status as EBPs) have demonstrated their equivalent effectiveness, leading Wampold et al. (1997) to query: “Why, [do] researchers persist in attempts to find treatment differences, when they know that these effects are small?” (p. 211).

The implicit good news in all of this is that therapy works (Asay & Lambert, 1999; Bergin & Lambert, 1978; Lambert & Bergin, 1994; Smith, Glass, & Miller, 1980), demonstrating an effect size between .7 and .8 (Wampold, 2001). Despite the financial and political muscle of the pharmaceutical industry, medications have proven only to be more effective than placebo and, importantly, therapy has been shown to outperform medication (Duncan, Miller, & Sparks, 2000; Elkin et al., 1989; Shea et al., 1992).

If therapy is effective yet there exists no evidence that one model is superior to others, to what can we attribute change? This is precisely the question for which Rosenzweig (1936) provided an answer for in his pioneering work, “Some Implicit Common Factors in Diverse Methods of Psychotherapy.” In this oft-cited work, Rosenzweig invoked the dodo bird from *Alice’s Adventures in Wonderland*, the Lewis Carroll (1865) classic, for his explanation. In the story, the dodo bird was asked to declare the winner of a race held by the cast of Wonderland characters. The dodo exclaimed that “everyone has won and all must have prizes.” Duncan (2002) pointed out that the dodo bird’s declaration has become a metaphor for psychotherapy outcome research: Clinical trials are the contests in which hopeful winners find themselves just as useful as the rest of the pack—but no better than the pack.

Since Rosenzweig's initial work, the wisdom of the dodo has been reaffirmed time and time again. Luborsky et al. (1975) confirmed the dodo's tenacity through a review of comparative clinical trials. Since the empirical validation of Rosenzweig's work, the "dodo bird verdict" as it is now often referred to, has become the most robust and repeated finding in psychotherapy outcome literature (Duncan et al., 2004; Wampold, 2001). Wampold et al. (1997) and Wampold (2001) provided meta-analysis that lends further credence to these findings, as do subsequent meta-analyses such as Miller, Wampold, and Varhely (2008). What makes the dodo bird verdict an even more compelling argument for common factors (and, hence, against specific effects) "is that it emerged by accident—when researchers were trying to prove the superiority of their own models . . . it is a finding remarkably free of researcher bias" (Duncan et al., 2004, p. 33).

What are these common factors, the pantheoretical components of change that exist across theoretical orientations and professional disciplines? Asay and Lambert (1999) articulated four factors: client, relationship, hope or placebo, and model or technique.

## ***The Common Factors***

### *Client Factors*

Originally termed *extratherapeutic factors* (Lambert, 1992) and now more commonly known as *client factors*, this set of variables is the "single most potent contributor to outcome in psychotherapy" (Duncan et al., 2004, p. 34). Client factors constitute everything that does not have to do with therapy itself: client resources; contextual considerations; chance events; characteristics such as optimism, persistence, and curiosity; support systems; and religious or spiritual beliefs and practices. Asay and Lambert (1999) found that 40% of improvement during psychotherapy is attributable to client factors. In his comprehensive meta-analysis, Wampold (2001) attributed 87% of improvement to client factors, leaving only 13% of change due to effects of therapy.

These findings stand in stark contrast to the routine characterization of mental health consumers as ill, incapable, and in need of expert intervention. As Duncan et al. (2004) pointed out, "Rarely is the client cast in the role of the chief agent of change or even mentioned in advertisements announcing the newest line of fashions

in the therapy boutique of techniques” (p. 34). These findings also support the recovery model’s emphasis for consumers to be in charge of their own care, working in partnership with providers. The research suggests that the recovery model’s focus on empowerment is not without foundation; indeed, the data would suggest that empowerment has received empirical validation.

### *Therapeutic Alliance Factors*

Support for the recovery model’s focus on consumer–provider collaboration is strengthened by the next most significant contributing factor to improvement in therapy: the alliance. Accounting for 30% of change in the original common factors studies (Lambert, 1992), Wampold’s (2001) meta-analysis attributes 54% of the variance in therapy due to the alliance (i.e., 54% of the 13% of outcome variance that is due to therapy effects, not client factors). This makes the amount of variance from the alliance about seven times that of model or technique factors (Duncan et al., 2004).

The alliance factor has received a fair amount of attention from researchers (Bachelor, 1995; Bachelor & Horvath, 1999; Krupnick et al., 1996). Among the most salient and repeated findings to directly inform practice is that the client’s perception of the alliance—not the therapist’s—is predictive of outcome (Bachelor & Horvath, 1999). Duncan et al. (2004) underscored the implications of this finding, stating, “from the client’s perspective, there is no single, invariably facilitative, type of relationship” (p. 35) that accounts for a positive outcome. Consequently, practitioners must attend to the client’s perspective and preferences to position themselves for a successful outcome. The recovery model suggests this kind of privileging of the consumer’s perspective and emphasis on collaboration that the research supports.

### *Placebo Factors: Hope, Expectancy, and Allegiance*

Accounting for 15% of the influence on outcome is expectancy, hope, and placebo (Lambert, 1992). These are factors that have to do with a client’s expectation that change will occur, instillation of hope, and the client’s belief in the therapist’s credibility and techniques. Frank and Frank (1991) found that even the client’s assumption that therapy will be helpful contributes to a positive

outcome. Wampold (2001) added to this discussion by noting the effects also of therapist allegiance—those effects resulting in the therapist's belief in his or her treatment model or technique—thus indicating that it is the hope held by both the client and the helper that proves consequential.

### *Model and Technique*

Despite the field's heavy emphasis on theories, models, and the current push for EBPs (which privilege certain models based on the assumption that their specific components are the active ingredients of change), Lambert (1992) found that only 15% of improvement during psychotherapy is attributable to model or technique—the same amount for which placebo factors account. Beyond the graduate classroom, models and techniques are privileged by regulating bodies, whose requirements and licensure tests typically focus on testing one's knowledge of theory and competence in performing the specific tasks of various models. The many solicitations mental health professionals receive for their continuing education dollar are overwhelmingly focused on models and techniques and often focused on a prevailing few.

Allegiance to the medical model also serves to privilege techniques. Wampold's (2001) meta-analysis calls into question the special stature models and techniques receive: Of the 13% of variance that can be accounted for by the impact of therapy, only 8% is due to model effects. Moreover, only 1% of the total variance of change is portioned to a specific technique.

Models are important because they lend structure to the work and provide the proverbial toolbox from which to select approaches to address a range of concerns. With the push toward EBPs, however, it is easy to impose an approach on a client without any regard for individual preferences or contextual factors such as social location or culture. This concurs with the Nylund and Tilsen (2006) assertion that traditional psychological theories reflect Western hegemony and as such are neither objective nor benign and tend to reify modernist notions of universality. The recovery model rejects this and calls for culturally relevant services and culturally competent practitioners (Anthony, 2000) as part of a focused shift away from traditional Western European concepts of therapy to more indigenous and postmodern client-centered ones.

## ***EVIDENCE-BASED PRACTICES***

Although currently thought of as the gold standard of psychotherapeutic intervention, the evidence for mandating EBPs is not convincing. Some researchers have begun to argue that such mandates are “gross misinterpretations of the data and blatant misuse of the evidence” (Murphy & Duncan, 2007, p. 171). Because of this prevalent schism, clarifying what constitutes an EBP is important.

An EBP is an approach that has been established as better than placebo or treatment as usual (TAU) in two clinical trials. If the approach is better than placebo, however, this does not translate to differential efficacy over other treatments. Indeed, almost any intervention has been found to be superior to placebo in 50 years of psychotherapy research. The marketing of EBPs, however, has led most people—professionals and the public alike—to believe that they have often been demonstrated to be more effective than other treatments.

EBPs are based on the assumption that a unique, active ingredient is responsible for the effect of an intervention. Three empirical arguments exist that challenge this core assumption. The dodo bird verdict is the first. As discussed previously, an enormous amount of data exist from comparative reviews of clinical trials as well as meta-analyses demonstrating that specific technical operations are not responsible for specific effects or relative efficacy. As such, the dodo bird verdict provides compelling support against specific models.

Second, the data point to how little impact on the outcome variance is due to technical factors. Recall that Lambert (1992) originally estimated that 15% of outcome is due to model, whereas Wampold’s (2001) meta-analysis assigned only 1% of the total variance to technique. Therefore, EBP—which highlights model specifics and techniques—is effectively marginalizing between 85% and 99% of the factors that account for change. Those factors, the client, the therapist, and their relationship, are considered interchangeable in this product view of treatment.

Third, component studies have verified that there is little evidence to support specific effects (Duncan & Miller, 2000). Ahn and Wampold’s (2001) meta-analysis on component studies lends veracity to these findings, effectively demonstrating that a model still works no matter what component is left out.

There are also, not surprisingly, political agendas involved with the promotion of EBPs. In contrast to the recovery model's grassroots advocacy and consumer-centric origins, there is often a developer of a model who stands to gain prestige and financial reward with the success of that model. Most EBP research is done by the founders of the model being studied, thus raising legitimate concerns for what is known as *allegiance effects*—researcher bias. Messer and Wampold (2002) put allegiance effects at up to 70% of outcome in such studies.

In the search for greater effectiveness, the research shows that EBPs fail to live up to the promises of their proponents. This is not to say that any particular model that has gained the status of EBP is itself not effective; on the contrary, the research tells us that any treatment can be useful for a particular client. It is the privileging of EBPs over other treatments that lacks empirical support, as EBPs fail to acknowledge the idiographic nature of psychotherapy.

### ***PRACTICE-BASED EVIDENCE***

If EBP is premised on the least salient factor that accounts for change, what options exist for effective and accountable practice? Is there a way to deliver mental health services that (a) satisfy consumers' demands for consumer-driven service, (b) meet practitioners' demand for empirical support, and (c) harness the wealth of knowledge about what works in psychotherapy by heeding the call of the dodo bird and honoring the cogency of the research on the alliance?

Practitioners can answer “yes” to these questions by shifting from EBP to practice-based evidence. Rather than choosing a priori a specific treatment based on diagnostic criteria, clinicians rely on formal feedback from their clients to determine collaboratively if their relationship and work together are effective. Client feedback is collected for both outcome and alliance. Two critical findings inform this shift.

First, the client's subjective experience of change within the first three visits is most predictive of success (Haas, Hill, Lambert, & Morrell, 2002; Lambert et al., 2001). This suggests that measuring outcome—from the client's perspective—is key to effectiveness. Most change occurs earlier in treatment (up to 65% of clients improve within seven visits) and clients reporting an absence of improvement early were less likely to experience change later in treatment

(Howard, Lueger, Maling, & Martinovich, 1993). Brown et al. (1999) also found that clients who reported no improvement by the third visit were not likely to report any progress by the end of their care. In addition, those who got worse within three sessions were twice as likely to drop out of treatment as compared to people reporting improvement. Furthermore, Brown et al. found that factors such as diagnosis, severity, and type of treatment were not as predictive of outcome as was the client's self-report of improvement.

The second important finding that supports the use of formal client feedback is the predictive nature of the client's rating of the alliance. As noted earlier, it is the client's rating of the alliance that is more predictive of outcome (Bachelor & Horvath, 1999; Horvath & Symonds, 1991). Furthermore, the Treatment of Depression Collaborative Research Project, Project MATCH, and Cannabis Youth Treatment studies all found that it was the client's rating of the alliance early in treatment that was predictive of outcome. These findings stand in support of seeking feedback on the alliance. Seeking client feedback on the alliance amplifies their voice, underscores collaboration, and provides the practitioner with the necessary information to make adjustments to the process to ensure success.

By utilizing client feedback to measure change (outcome) and the strength of the alliance, therapists can organize their work around the common factors that are empirically known to matter. It also answers the recovery movement's call for consumer-driven evaluation (Anthony, 2000). Rather than choosing an EBP for a particular diagnosis or presenting problem (thus reifying the fallacious premise that therapy operates in a nomothetic manner), clinicians engage in a process of "work, measure, work, measure," making adjustments as needed based on client feedback. By creating a milieu where client input is honored and acted on, therapists position themselves in partnership with both clients and the research on what works in therapy. Furthermore, they privilege client preferences and assume accountability for their work.

Although there are a variety of tools to assist in monitoring outcomes, we have integrated into our clinical practices the Outcome Rating Scale (ORS; Miller & Duncan, 2000) and Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2001). These two valid and reliable ultrabrief tools (for a complete explication of the psychometric properties of the ORS and SRS the reader is referred to *The Outcome and Session Rating Scales Administration and Scoring*

*Manual*] [Miller & Duncan, 2004]; for a thorough explanation of their use and implementation the reader is referred to *The Heroic Client* [Duncan et al., 2004]) have the added dimension of *feasibility*, a feature previously lacking in other outcome monitoring tools. Lack of feasibility led to poor compliance on the part of practitioners and consumers. It has been our experience that clients and practitioners alike are willing to take the minute or two to complete the forms when they understand their purpose and see that the information provided immediately informs the process in meaningful ways.

The ORS and SRS supply real-time feedback. The ORS is given at the beginning of each session and the client discusses with the therapist the implications of his or her marks. This collaboration is a departure from traditional assessment processes and is key to privileging the client's voice and nurturing the alliance. As noted previously, the research is clear about early change; consequently, it is critical that we begin measuring right away and at every session.

The SRS is administered near the end of the session. It is during this feedback process that the practitioner continues to "open space for the client's voice about the alliance" (Duncan et al., 2004, p. 101). What is of greatest importance during the discussion of the SRS is the exploration of any negative responses. By responding to client concerns about the alliance with appreciation and action (i.e., token invitations for client input will damage the alliance and potential for a positive outcome), clinicians nurture the alliance and improve the likelihood of a good outcome.

Outcome and alliance feedback taken together are greater than the sum of their parts. Although the research has shown that early change is predictive of a good outcome, it has also shown that the client's perception of the alliance is a strong predictor of outcome as well. Furthermore, one of the interesting nuances of outcome measurement is that alliance scores that are only poor or fair, but then improve, are even more predictive of a positive outcome than scores that start good and stay there.

## CONCLUSION

Clinicians do not have to choose between standing with their clients or standing with the research. For some, this has been an ethical

dilemma, as they struggled to mediate the tension between wanting to do what would be best for their clients (being led to believe that research-based EBPs were best) and responding to the recovery model's call to listen to client preferences. Research on what works in therapy indicates that the guiding principles of the recovery model (privileging consumer voices, focusing on competency, underscoring belief in recovery, destigmatization, collaboration with professionals, personal agency, consumer rights, and community involvement) are very much in line with the research's emphasis on the client and the alliance as the most salient factors contributing to change.

As a consumer movement, the recovery model seems well suited to embrace a consumer-driven outcome management system such as the ORS and SRS described earlier. This psychometrically sound system utilizes client perspectives and client meanings to inform the work, keeping the wisdom of the client and the research at the center. Our hope is that clinicians will see the wisdom of partnering with their clients and engage in consumer-driven research to provide effective and accountable service.

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