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Leading Researchers' Consensus on Psychotherapy Research Findings: Implications for the Teaching and Conduct of Psychotherapy

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We examined leading international psychotherapy researchers' views on psychotherapy outcome research. Participants completed a questionnaire on which they rated level of research evidence for or against various assertions about psychotherapy processes and outcomes. Participants rated how confident they were that the assertions were supported by psychotherapy research. Strong, or relatively strong, consensus was achieved on several of the questionnaire items. Areas for which relative uniformity of opinion does or does not exist have potential implications for the teaching and conduct of psychotherapy and for the science–practice interface in psychotherapy. Additionally, consensus about psychotherapy findings can be used as a yardstick by which to measure practicing clinicians' knowledge of the research.

In 1949 at the Boulder Conference, the profession of clinical psychology declared its allegiance to the goal of integrating science and practice and cast the field in the “scientist–practitioner model,” or the Boulder Model (Raimy, 1950). Additionally, at the Vail Conference in 1973, the profession of clinical psychology addressed the science–practice interface but endorsed a “professional model” of training focused on practitioner training issues and psychologists as consumers and users of research (Korman, 1974). Both the Boulder and Vail Conferences emphasized the knowledge and use of psychological research in clinical practice. A central mission of the profession of psychology was to accumulate scientific knowledge in order to advance the understanding

of behavior and to guide practice. In theory, psychology had “recommitted” itself to science, juxtaposing the scientific method and clinical practice.

A goal of the Boulder Model was for research to drive practice such that clinicians would be the beneficiaries of research findings (Goldfried, 1984). Knowledge gained through research would be applied in clinical settings. That is, clinicians would ultimately strengthen clinical services by integrating research findings into practice. The science–practice debate over the ensuing years presents a mixed picture, which sometimes suggests adherence to and benefit from the Boulder Model (Beutler, Williams, & Wakefield, 1993; Beutler, Williams, Wakefield, & Entwistle, 1995; Morrow-Bradley & Elliott, 1986; O'Sullivan & Quevillon, 1992; Thelen & Ewing, 1970) and sometimes suggests otherwise (Barrom, Shadish, & Montgomery, 1988; Cohen, 1979; Cohen, Sargent, & Sechrest, 1986; Prochaska & Norcross, 1983).

The Boulder and Vail models require us to apply scientific know-how, but what we know scientifically is not always clear. There may be no ultimate way to determine unequivocally when a scientific assertion is “established” or “proven.” However, Division 12 (Society of Clinical Psychology) of the American Psychological Association (APA) has established a Committee on Science and Practice to identify psychological interventions that are scientifically supported and to design treatment guidelines for implementing these interventions. This, in some ways, is an attempt to bridge science and practice (a goal of the Boulder Model) by providing guidance to the scientist (i.e., establishing specific criteria for what constitutes a scientifically supported research finding—for instance, strength of evidence from controlled clinical trials; Chambless & Hollon, 1998; Nathan & Gorman, 2002) and to the practitioner about how to implement these empirically supported research findings (e.g., using treatment manuals; Barlow, Levitt, & Bufka, 1999; Davison, 1998). In essence, these efforts have begun to more closely merge science with clinical practice by establishing guidelines for the integration of science and practice in psychotherapy. These practical treatment guides could be seen as a potential reflection of knowledge guiding

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practice—a fundamental tenet of the Boulder Model. However, despite these efforts there is mixed acceptance of these practice guidelines, and more work needs to be done to identify scientifically sound clinical interventions (Chambless & Ollendick, 2001; Nathan, 1998).

Another probabilistic, although fallible, indicator of scientific soundness is consensus among leading researchers in an area. That is, one would expect a positive relationship between agreement among eminent scientists that a scientific proposition is sound and the soundness of that proposition. It is thus of considerable interest, in considering or applying the Boulder Model, to ask whether, or in what areas, leading psychotherapy outcome researchers agree on the state of knowledge in psychotherapy. Such agreement or disagreement offers another potential means of identifying what is known about psychotherapy and providing practical guidance to practitioners, ultimately strengthening the science–practice interface.

As an initial step in identifying the domain of knowledge in psychotherapy outcome, we surveyed leading researchers to ascertain their views on psychotherapy outcome research. We designed a survey containing assertions about psychotherapy findings that were rated for level of research support. Results were intended to provide some insight into areas of relative consensus or disagreement among leading researchers across various topics in psychotherapy research. Results could also serve as a potential yardstick for assessing practitioners' knowledge of psychotherapy outcome research, with such knowledge seemingly a necessary (and yet rarely studied) but not sufficient condition for proper application of the Boulder Model.

Survey of Psychotherapy Research Experts

We selected a group of experts in psychotherapy research by identifying the 25 most highly cited authors in the fourth edition of the *Handbook of Psychotherapy and Behavior Change* (Bergin & Garfield, 1994), which has been recognized as a highly influential text. As Bergin and Garfield (1994) noted, “One survey of psychologists ranked it first among books on psychotherapy, and a survey of psychology departments listed it as the second most frequently recommended book in departmental reading lists for graduate students” (p. xi). We also searched PsycINFO to calculate the authors' publication histories from 1970 to 2000. Publication count has been identified as an acceptable index of scholarship (G. S. Howard, Cole, & Maxwell, 1987). The mean number of publications for our group was 95, and the median number was 89. Considering that the mean number of publications for psychotherapists is approximately 7, the median number approximately 2, and the modal number zero (Norcross, Prochaska, & Farber, 1993; Prochaska & Norcross, 1983), our group as a whole represented very highly published psychologists, and as such, it is likely to be a robust sample of experts in psychotherapy outcome research.

The questionnaire contained a series of assertions about psychotherapy (the questionnaire is available upon request). The 20 questionnaire items were chosen on the basis of a comprehensive review of the psychotherapy literature, including research findings from seminal studies or meta-analyses of psychotherapy outcome; conclusions from psychotherapy outcome research that Bergin and Garfield identified (1994, pp. 180–182); and “equivocal findings” based on the authors' impressions of psychotherapy outcome re-

search. The questionnaire items were selected because they are, in our opinion, among the most frequently addressed issues and the focus of much research in psychotherapy outcome. We were most interested in experts' familiarity with general research findings, such as the percentage of clients who benefit from therapy, rather than their familiarity with specific research findings, such as whether, for example, cognitive–behavioral therapy compared with psychoanalysis alleviates panic attacks more quickly.

The experts rated their certainty regarding the assertions on a 7-point Likert scale. A rating of 1 reflected the judgment that the expert was *extremely certain that the assertion was incorrect*; a rating of 7 reflected the judgment that the expert was *extremely certain that the assertion was correct*. The scale also included a *Don't Know* (DK) response category, which participants were instructed to endorse only if they were not familiar with the research in that particular area. Endorsing the scale's midpoint indicated that the expert was familiar with the research but believed it was inconclusive or “equivocal.” It is unlikely that participants' DK responses reflected their belief that the research finding was equivocal because for most of the few experts who endorsed DK responses, they also endorsed the midpoint for other questionnaire items. This suggests that they were able to distinguish between a DK endorsement (i.e., having no knowledge of the research in that area) and a midpoint endorsement (i.e., having knowledge of the research but believing that the research was equivocal in that area).

We sought to solicit participants' knowledge about psychotherapy outcome research and not their personal beliefs about psychotherapy. Although there is no formal method for controlling for participants' response styles or interpretation of questions, we emphasized separation of personal belief from understanding of the literature in the cover letter and on the questionnaire (“please rate how certain you are that the following psychotherapy assertions are correct *based on psychotherapy outcome research*”).

The 25 psychotherapy researchers were sent a packet containing a cover letter explaining the purpose of the study, a confidentiality statement, and a questionnaire. After 2 weeks, a reminder postcard was sent to all 25 participants. One month following the first mailing, a second full mailing was sent. Within 2 months of the initial mailing, 12 of the 25 participants had returned completed questionnaires, yielding a return rate of 48%.

The experts' responses to the items were reviewed for level of agreement. “Agreement,” or relative consensus, was examined using two criteria. First, we identified items on which the majority of the experts endorsed the same rating. These items were deemed the “majority-response items.” Seven of the 20 questionnaire items satisfied the majority-response criterion (see Table 1; items in boldface in the table represent the majority-response items, and these items are followed by their majority-response endorsement). Second, we examined level of consensus by reviewing response trends for all of the items. As is probably evident, selecting criteria to identify consensus or relative consensus is partly arbitrary, and good arguments could be made for various choices.

The seven majority-response items covered important areas in psychotherapy outcome and comprised a relatively diverse set of frequently cited research findings. For four of the seven items, there was generally high certainty that research supported the particular finding. These findings included “therapy is helpful to the majority of clients,” “therapy is more effective than placebo,”

Table 1
Means and Standard Deviations for the Questionnaire Items

<i>M</i>	<i>SD</i>	Item
4.90	0.99	The client's social support system is a strong predictor of a client's ability to benefit from therapy (5).
5.70	1.34	The majority of terminations are client-initiated.
5.58	1.17	The relationship between the therapist and client is the best predictor of treatment outcome.
3.08	1.83	Long-term therapy is more effective than brief therapy for the majority of clients.
6.00	1.04	In general, therapies achieve similar outcome (6).
3.18	1.47	Insight is often necessary to achieve lasting change.
5.73	0.91	People change more due to "common factors" than to "specific factors" associated with therapies.
5.50	1.57	Most therapists learn more about effective therapy techniques from their experience than from the research.
2.67	1.16	Paraprofessionals achieve lower success rates in therapy compared with professionals.
5.92	0.67	Most people achieve some change relatively quickly in therapy (6).
3.40	0.97	Drop-out rates are equal for brief therapy and long-term therapy.
5.27	1.55	Most of the gains from therapy occur in the first 10 sessions.
2.42	1.31	Therapist experience is a strong predictor of outcome.
3.17	1.27	Many problems respond better to specific therapy techniques compared to nonspecific therapy techniques (3).
1.50	0.52	Placebo control groups and waitlist control groups are as effective as psychotherapy (1, 2).
3.58	1.51	For many clinical problems, outcome of psychotherapy is improved if medications are used.
5.08	1.68	The longer the therapy, the greater the change (5).
6.33	0.49	Therapy is helpful to the majority of clients (6).
4.40	1.27	Graduate school training does not make a therapist more effective.
5.67	1.23	Approximately 10% of clients get worse as a result of therapy.

Note. Items in boldface represent the majority-response items.

"therapies achieve similar outcomes," and "clients achieve some benefit relatively quickly from therapy." Additionally, for two items, the experts were moderately certain that the assertion was correct on the basis of the research. These items included "the longer the therapy, the greater the change," and "the client's social support system is a strong predictor of a client's ability to benefit from therapy." For the last majority-response item—"many problems respond better to specific therapy techniques compared to nonspecific therapy techniques"—the experts were moderately certain that the assertion was incorrect on the basis of the research.

We also examined all of the questionnaire items for response trends. Response trends provide further insight into strength of consensus, or lack thereof, not only on the seven majority-response items but also on the remaining items. For example, responses can fluctuate across a narrow range but fail to meet the majority-

response criterion. Also, level of agreement, although a predetermined criterion, was not necessarily uniform across the majority-response items (see Table 1 for standard deviations of the questionnaire items).

In examining response trends, we found high agreement for several items. For example, the majority of participants (i.e., at least 6 of the 12) were highly or extremely certain (i.e., the majority endorsed a 6 or a 7 for the item) that 7 of the 20 assertions were correct on the basis of the psychotherapy outcome research. The majority were also highly or extremely certain (i.e., the majority endorsed a 1 or 2 for the item) that 3 of the 20 assertions were incorrect on the basis of the psychotherapy outcome research (see Table 2 for items achieving strong expert agreement).

There were four items for which the majority of participants were at least moderately certain (i.e., the majority endorsed above

Table 2
Items for Which the Experts Showed Strong Trends of Agreement

<p>Experts showed <i>strong agreement</i> that research <i>did support</i> the following assertions:</p> <ul style="list-style-type: none"> • Therapy is helpful to the majority of clients. • Most people achieve some change relatively quickly in therapy. • People change more due to “common factors” than to “specific factors” associated with therapies. • In general, therapies achieve similar outcome. • The relationship between the therapist and client is the best predictor of treatment outcome. • Most therapists learn more about effective therapy techniques from their experience than from the research. • Approximately 10% of clients get worse as a result of therapy.
<hr/> <p>Experts showed <i>strong agreement</i> that research <i>did not support</i> the following assertions:</p> <ul style="list-style-type: none"> • Placebo control groups and waitlist control groups are as effective as psychotherapy. • Therapist experience is a strong predictor of outcome. • Long-term therapy is more effective than brief therapy for the majority of clients. <hr/>

the midpoint) that the assertions were correct on the basis of the psychotherapy research findings, and two items for which the majority were at least moderately certain (majority endorsed below the midpoint) that the assertions were incorrect on the basis of the psychotherapy research findings. Lastly, the remaining four questionnaire items included assertions for which participants showed little agreement (see Table 3 for items achieving moderate or low expert agreement).

Implications for the Conduct and Teaching of Psychotherapy

These findings can help increase our awareness of certain phenomena and possibilities that are not easily noticeable when we are deeply engaged in a therapy relationship. For example, knowledge of the association between treatment length and therapy outcome (e.g., K. I. Howard, Kopta, Krause, & Orlinsky, 1986) may lead us to terminate some clients earlier rather than later but to continue with others who may show gains only after many sessions. Research on negative treatment effects (Bergin, 1980; Lambert & Bergin, 1994; Mohr, 1995; Strupp, Hadley, & Gomes-Schwartz, 1977) may help us avoid making false attributions about a client's distress (e.g., attributing the distress to the client rather than to the therapy) and enable us to adjust the therapy when needed.

There was strong expert agreement that therapies achieve similar outcomes and that problems, in general, do not necessarily respond better to specific as opposed to nonspecific therapy techniques (Luborsky et al., 2002; Luborsky, Singer, & Luborsky, 1975; Shapiro & Shapiro, 1982; Smith & Glass, 1977). Thus, a clinician who insists on using a particular technique despite resistance from the client may wish to rethink his or her position, especially if such an intervention further increases the client's distress and jeopardizes the fundamental therapist–client relationship. Additionally, a therapist who is unaware of research findings indicating that paraprofessional therapists can achieve success rates similar to those of professional therapists (Berman & Norton, 1984; Christensen & Jacobson, 1994; Faust & Zlotnick, 1995; Strupp & Hadley, 1979) may overlook viable therapy options for clients who have limited funds or who experience obstacles that preclude them from securing professional treatment.

Although the results yielded strong agreement in several areas, there was less agreement in other areas. Such findings also have potential implications for other areas of therapy practice. For example, a third-party payer may have a strong opinion about, for example, the relationship between therapist experience or disciplinary background and outcome (e.g., they may approve therapy for the client only with certain credentialed therapists or with

Table 3
Items for Which the Experts Showed Moderate-to-Little Agreement

<p>Experts showed <i>moderate agreement</i> that research <i>did support</i> the following assertions:</p> <ul style="list-style-type: none"> • The majority of terminations are client-initiated. • The client's social support system is a strong predictor of a client's ability to benefit from therapy. • The longer the therapy, the greater the change. • Most of the gains from therapy occur in the first 10 sessions.
<hr/> <p>Experts showed <i>moderate agreement</i> that research <i>did not support</i> the following assertions:</p> <ul style="list-style-type: none"> • Paraprofessionals achieve lower success rates in therapy compared with professionals. • Many problems respond better to specific therapy techniques compared to nonspecific therapy techniques. <hr/>
<p>Experts showed <i>little agreement</i> that research supported the following assertions:</p> <ul style="list-style-type: none"> • Insight is often necessary to achieve lasting change. • Drop-out rates are equal for brief therapy and long-term therapy. • For many clinical problems, outcome of psychotherapy is improved if medications are used. • Graduate school training does not make a therapist more effective. <hr/>

therapists from a particular discipline). They may treat the matter as if it had been clearly decided (or was clearly supported by the research), not knowing that even experts in psychotherapy outcome research hold varying views in this area.

The findings from the study also provide possible guidance in the area of informed consent, at least to the extent that the study potentially elucidates a subsection of the domain of knowledge in psychotherapy outcome that may overlap with content areas typically covered in informed consent. The elements that constitute informed consent often include matters that are ultimately best determined through proper research, such as the risks and benefits of the treatment, the expected length of treatment, and the comparative risks and benefits of alternative treatments (Haas, 1991). Arguably, to obtain informed consent regarding therapy, clients should be provided with the best available knowledge about these matters.

If therapists are unfamiliar with the domain of knowledge in psychotherapy research, the information provided on these types of matters pertaining to informed consent is likely to be personal opinion and may not align with the research evidence. In some situations, it may be incumbent upon therapists to discuss with clients when they are offering their “personal opinion” as opposed to when they are offering an “opinion” that is more firmly grounded in research. For example, suppose a prospective client asks a therapist who prefers long-term therapy, “How long should therapy take?” It would seem important for that therapist to convey, despite personal orientation, the research findings suggesting that most people achieve change relatively quickly (despite the extent to which this statement may be antithetical to the therapist’s own experience and impressions, which may be based on years of providing long-term therapy, with the modal number of sessions being 50). If clinicians guide their decisions on the basis of their personal opinion about the need for longer term therapy, they may create dependency, restrict the client’s family and social activities, and negatively affect the client’s financial situation. Arguably, when the therapist’s views deviate from consensus opinion among experts, clients should be informed of both positions and the strength of the evidence on which each rests.

The experts’ strong consensus that therapy leads to negative effects in approximately 10% of cases has potential implications for informed consent. Informing clients about the risks and benefits of therapy is a fundamental component of obtaining informed consent, analogous to a physician’s informing a patient about the risks and benefits of a medication. Informing prospective clients that therapy does not work for all clients and that there is some risk, albeit small, in participating in therapy is not inconsistent with fundamental components of informed consent (APA, 2002).

Within the constraints of our small sample size, we found some consistency of support for or against certain propositions in psychotherapy outcome research. Also noteworthy was our finding that the experts only seemed to achieve high consensus on approximately 50% of the items. Various methodological factors may have accounted for this (e.g., the small sample and type of experts, inadequate sample of items, difficulties interpreting the items, and measurement error). Experts may have had difficulty achieving a higher level of consensus because some psychotherapy research findings are difficult to interpret, ambiguous, or insufficiently consistent. For example, the experts showed little agreement with the assertion that “insight is necessary to achieve lasting change.”

It may be that our current methodologies do not measure insight adequately, and as such, the research findings are equivocal. Also, it may be difficult to conceptualize the construct “insight” and, consequently, to interpret the research findings. Thus, perhaps the equivocal results for some items do not reflect methodological limitations but rather the very nonspecificity of some psychotherapy constructs, making measurement of them inherently slippery.

Lack of consensus on some items suggests that even experts struggle to discern trends in some areas of psychotherapy research. This has implications for the amount of research knowledge we can expect practitioners to possess. It would be unrealistic to expect practitioners to draw consistent conclusions about a body of literature, or a subsection of a body of literature, that does not necessarily lend itself to such conclusions. More powerful methods for testing theories and interpreting bodies of knowledge, such as the meta-scientific techniques proposed by Faust and Meehl (2002), may also help in an area as complex as psychotherapy outcome research.

Although fundamental differences may exist between the science and practice of psychology, and one would expect some disagreements and areas of contention, one would also expect a certain amount of agreement about the domain of knowledge in the field. Assessing experts’ agreement about the research, as this study sought to do, may be one component in working toward a more meaningful and productive science–practice dialogue.

The results may inform us about where to direct more research, such as in those areas where there was little expert agreement. For example, according to this study, experts could not agree on the extent to which graduate school training makes one a better therapist or, for example, if insight is needed to achieve lasting change. Additional research could be directed in these areas to help clarify the state of knowledge. The results from the study could also have potential policy implications—for example, in establishing better treatment guidelines for practitioners.

The results from this study also provide a means for measuring practitioners’ knowledge of psychotherapy outcome research. Measuring practitioners’ knowledge base could help identify areas in which there may be systematic errors or biases in practitioners’ impressions of the literature. Ultimately, to pursue questions concerning the application of science to practice in psychotherapy, it is important to determine the extent to which practitioners are familiar with research findings, and the extent to which practitioners agree about findings, particularly those findings that have potential practice applications. After identifying these potential areas, one could design continuing education programs or modify graduate school curricula or courses to strengthen the knowledge base of practitioners or aspiring practitioners.

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