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# Emerging Methods for Providing Clinicians With Timely Feedback on Treatment Effectiveness: An Introduction

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This article introduces the issue of *Journal of Clinical Psychology/In Session* devoted to the need for, and value of, providing psychotherapists with feedback about client progress during the course of treatment. After an introduction that sets articles in the series in the context of improving psychotherapy outcome, the seven articles in this special issue are briefly summarized. The articles that follow this introduction provide general principles for effective feedback, highlight therapist difficulties in predicting treatment failure, provide "lab tests" for recognition of poorly responding clients, and demonstrate the powerful effects of providing therapists with feedback on client progress. The articles argue that coupling of statistical modeling techniques with currently available information technology is an innovation to routine clinical practice that clinicians can ill afford to overlook. © 2004 Wiley Periodicals, Inc. *J Clin Psychol/In Session* 61: 141-144, 2005.

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Psychotherapy of various orientations and formats has been found to be effective in a variety of patient disorders. The extent and richness of this effect extend over decades of research, thousands of treated individuals, hundreds of settings, and multiple cultures. Psychotherapists should be encouraged by the mass and breadth of empirical results that clearly demonstrate that the treatments they provide reduce distressing symptoms, resolve interpersonal problems, restore work performance, and improve life quality for the majority of those who seek treatment.

Nevertheless, it is also clear that psychotherapy can occasionally be harmful or result in no detectable progress in a minority of patients. Estimates of the number of patients who deteriorate while in treatment are difficult to obtain, but a fair estimate is between

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5% and 10% (Lambert & Ogles, 2004). Just as positive therapy outcomes depend largely on patient characteristics, so too do the negative changes that occur in patients who are undergoing psychological treatments. Positive as well as negative patient change can be effected by therapist actions and inactions.

To the extent that *therapist's* behaviors and attitudes lead to patient worsening, it is typically not the misapplication of techniques or the failure to use a specific method that is to blame. It is more likely that negative changes result from empathic failures, ruptures in the therapeutic alliance, critical or hostile interactions directed to the patient by the psychotherapist, and related behaviors that are often perceived by the patient as a rejection (Lambert, Bergin, & Collins, 1977).

Despite the relatively small proportion of treatment failures, preventing negative outcomes is a topic of considerable importance. The current climate of enhancing patient outcomes has placed a primary emphasis on studying and documenting effective treatments for specific disorders and increasing the likelihood that an "empirically supported" or "evidence-based" treatment will be offered to the patient. Unfortunately, offering the right treatment for the right disorder is not a remedy that has a proven track record of reducing patient deterioration. Even in clinical research trials that support the value of a particular treatment for a particular disorder, a sizable minority of patients (approximately 40%; Hansen, Lambert, & Forman, 2002) derive no benefit and a small group deteriorate. Not all patients benefit from effective treatments offered by carefully selected and closely supervised therapists. And a portion of patients even in rigorously controlled research have a negative outcome.

Past research on negative outcomes has suggested many mechanisms of corrosive influence but has also produced a rather consistent finding, replicated over the past few decades: Psychotherapists are relatively poor judges of who will and who will not deteriorate at the end of treatment. Recall, for example, the classic study of members of encounter groups by Yalom, Lieberman, and Miles (1973). These researchers defined deterioration as a *casualty* of the encounter group. In order to be defined as a *casualty* the person had to be worse off at the end of the group and at least 6 months later (so the effect was not a temporary one) and deterioration had to be directly attributable to factors within the group (one participant who committed suicide during the study was not considered a casualty because his participation was minimal and nothing untoward occurred during any session that he attended). Of greatest interest in the present discussion is that little agreement was found between *therapist*-judged deterioration and self-nomination, whereas group members' judgments showed considerable agreement with self-nomination.

In general, the judgments of psychotherapists about outcome tend to be overly positive and rarely indicate that a patient has worsened while under their care. In many ways, the phenomenon at play is optimism; such judgments suggest considerable optimism and hope within the therapist, attitudes that have been shown to be related to positive patient outcome. This optimism allows therapists to work hard in the face of difficult patient behaviors and severe dysfunction and to remain determined in the face of slow or slight improvement. It also allows therapists to ignore, to some degree, patient worsening. Considerable clinical lore has built up around the idea that patients will worsen before they get better, although this road to recovery is rare and, in fact, is a good indicator of a final negative outcome.

#### Measuring, Monitoring, and Providing Feedback

This issue of *In Session* on feedback is based on the considerations described, namely, that deterioration occurs and can be reduced; that the use of empirically supported treatments

does not solve the deterioration problem; and that therapists remain underaware of the signs that can alert them to the possibility of a final negative change, reducing the likelihood that they will respond appropriately to those patients whose negative outcome can be predicted. The authors of the following articles focus generally on feedback and specifically on it as a possible solution to the problem of patient deterioration.

First, the contributors discuss general principles of effective feedback. As will be seen, the major emphasis is on patterns of patient treatment response over time and in reference to "expected response" on the basis of normative data. In this context, we propose that empirically based algorithms can assist clinical practice and aid practitioners. The articles argue that a monitoring system that employs decision support tools will benefit some portion of cases, describe how the systems can be implemented, and provide guidelines for effective use of such systems. In the end, we hope that clinicians will at least experiment with adding monitoring of patient treatment response in relation to expected response to their routine clinical activities.

In the first article, Jeffrey Sapyta, Manuel Riemer, and Leonard Bickman provide a rationale for feedback in clinical practice and then summarize a meta-analysis on the effects of feedback in general and in regard to health status in particular. They provide recommendations for implementing feedback in mental health practice. Their overview lays a conceptual foundation for the topic of feedback and its effective applications, providing guidelines for those who choose to make feedback a routine aspect of effective treatment.

In the second article, Corinne Hannan, Michael J. Lambert, Cory Harmon, Stevan Lars Nielsen, David W. Smart, Kenichi Shimokawa, and Scott W. Sutton discuss the need for and development of a "iab test" for use in routine practice. They present evidence that shows the degree to which clinicians seriously underpredict poor treatment progress and deterioration, along with evidence that illustrates the success of an actuarial method for identifying patients for whom positive outcome is in doubt. These authors argue that clinicians would be well served by availing themselves of effective monitoring and alerting techniques.

In the third article, Michael J. Lambert, Cory Harmon, Karstin Slade, Jason L. Whipple, and Eric J. Hawkins present compelling evidence that feedback to therapists about patient treatment progress enhances psychotherapy outcomes and reduces deterioration rates. The characteristics of a software program with built-in alarm-signal algorithms are described and the program's uses and limitations are illustrated.

In the fourth article Cory Harmon, Eric J. Hawkins, Michael J. Lambert, Karstin Slade, and Jason L. Whipple summarize clinical support tools consisting of a decision tree and several brief measures that can assist psychotherapists in problem solving with unresponsive clients. Information about giving *clients* feedback on their progress (in reference to expected progress) is also provided. This somewhat intrusive (to therapists) and controversial intervention can have highly positive effects and has been found to have high acceptance among clients and no observed negative consequences.

In the fifth article, George S. Brown and Edward Jones describe a feedback system used in a large managed behavioral health system to enhance the quality of patient care. The nature and effects of feedback are described from the point of view of an insurance company that aims to improve the quality of patient care by focusing on patient treatment response. Most surprisingly, their study of outcomes provides data that have led them to increase the psychotherapy offered to patients.

In the sixth article, Scott D. Miller, Barry L. Duncun, Ryan Sorrell, and George S. Brown present the use of highly efficient tools used to track patient treatment response and the therapeutic alliance. Their work, although somewhat preliminary, provides collaboration for the findings that are reported in the preceding articles—there are

substantial advantages of tracking patient treatment response. Their system requires less than 5 minutes of patient time and can be routinely used by clinicians in private practice.

In the final article, Charles D. Claiborn and Rodney K. Goodyear present an overview of the broad concept of feedback and of principles that make it more or less effective. They emphasize what research has taught us about feedback offered to clients who are in psychotherapy. This is a fitting article to complete this *In Session* issue because it emphasizes feedback to clients and means to maximize its beneficial effects. Assuming that therapists are convinced by the preceding articles that client outcomes can be enhanced by tracking treatment response, Claiborn and Goodyear make valuable suggestions about principles of client feedback (including test results).

All told, this issue presents the principles and pragmatics of providing feedback to clients. Sapyta, Riemer, and Bickman as well as Claiborn and Goodyear offer practice-friendly principles (and supporting evidence) that can be used by therapists as they consider adding feedback about client progress to their routine practice. Lambert and associates, Brown and Jones, and Miller and colleagues present three different systems of providing feedback to clients about their treatment response that can be used by therapists to implement the foregoing principles pragmatically.

As we move through the 21st century, psychotherapy is firmly entrenched as a highly effective treatment for many disorders that entail an extremely costly burden on those who suffer them and on those who pay for their amelioration. This issue highlights easy-to-apply and inexpensive feedback strategies that can enhance treatment effectiveness.

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