Improved Treatment Outcome Associated With the Shift to Empirically Supported Treatments in a Graduate Training Clinic

Kelly C. Cukrowicz, Bradley A. White, Lorraine R. Reitzel, Andrea B. Burns, Kimberly A. Driscoll, Therese S. Kemper, and Thomas E. Joiner
Florida State University

There has been an increase in recent years in the use of empirically supported treatments (ESTs) for a variety of mental disorders. This study was an investigation of the impact of standardized use of ESTs in an outpatient community clinic. Clients treated prior to and those treated after the implementation of this policy were compared. The results indicate significant group differences, with the improvement ratings of the group receiving ESTs surpassing those of the group receiving unsupported treatment. Support for the use of ESTs indicates that patients may be best served if therapists rely primarily on these treatments.

Keywords: empirically validated treatments, empirically supported treatments, treatment outcome, graduate training

Kelly C. Cukrowicz is completing her predoctoral internship in cognitive behavior therapy at Duke University Medical Center. She completed her doctoral work at Florida State University and will earn a PhD in clinical psychology in August 2005. She will begin a 2-year postdoctoral fellowship at the Duke University Center for Aging and Human Development, with an emphasis on suicide in older adults.

Bradley A. White is completing his predoctoral internship in clinical psychology at the Federal Correctional Complex in Butner, NC. He will receive his doctoral degree in clinical psychology from Florida State University in August 2005. His research and clinical interests include the development of conduct problems and the development and delivery of evidence-based treatment approaches to forensic and underserved populations.

Lorraine R. Reitzel received her MA in clinical psychology from East Carolina University. She is currently a doctoral candidate at Florida State University and is completing her clinical internship in Fort Worth, TX. Her areas of research interest include correctional psychology, treatment and recidivism of sexual offenders, and general treatment outcome.

Andrea B. Burns is a doctoral candidate in the clinical psychology doctoral program at Florida State University. Her primary research interests include the biological and interpersonal causes and correlates of the mood and eating disorders.

Kimberly A. Driscoll is completing her predoctoral internship in pediatric psychology at Children’s Hospitals and Clinics in Minneapolis, MN. She completed her doctoral work at Florida State University and will earn a PhD in clinical psychology in August 2005. She will begin 2 years of postdoctoral fellowship training in cystic fibrosis at Cincinnati Children’s Hospital Medical Center, Cincinnati, OH.

Therese S. Kemper is a clinical psychology doctoral student at Florida State University. Her research interests include treatment and risk prediction in juvenile sexual offenders, classification of juvenile sexual offenders, and comparisons between sexual offending and nonsexual offending delinquents.

Thomas E. Joiner is the Bright–Burton Professor of Psychology at Florida State University. His research is on the psychology, neurobiology, and treatment of suicidal behavior, mood disorders, and associated conditions.

Correspondence concerning this article should be addressed to Thomas E. Joiner, Department of Psychology, Florida State University, Tallahassee, FL 32306-1270. E-mail: joiner@psy.fsu.edu

The integration of science and practice in clinical psychology has attained a growing level of consensus among leaders in the field (Eysenck, 1952; Foa et al., 1995; Linehan, 1993; Nathan & Gorman, 2002; Rudd, Joiner, & Rajab, 2001). These values have led to changes in the way new generations of clinical psychologists are being trained. Training has begun to emphasize the use of empirically supported treatments (ESTs) as the most efficient way to reduce the symptoms of a variety of disorders. This shift has also led to a greater utilization of treatment manuals that have been developed for use in randomized clinical trials (RCTs). The purpose of this study was to investigate the effects of the shift to ESTs on therapy outcomes at a clinical psychology graduate training clinic.

In 1995, the Division 12 Task Force of the American Psychological Association (APA) published Training in and Dissemination of Empirically Supported Psychological Treatments: Reports and Recommendations as a preliminary guideline, along with a list of treatments meeting one of three categories of empirical support (Division 12 Task Force, 1995). These categories include well-established treatments, probably efficacious treatments, and experimental treatments.

Cognitive–behavioral, behavioral, and cognitive treatments are the most common psychological interventions listed in Nathan and Gorman’s (2002) summary of ESTs. For example, a substantial number of RCT studies have supported cognitive–behavioral therapy (CBT; e.g., exposure and response prevention) for the treatment of obsessive–compulsive disorder. The treatment of major depressive disorder using interventions consisting of behavioral, cognitive–behavioral, and interpersonal therapies has received support by RCT studies as well. Finally, numerous RCT clinical trials have supported dialectical behavior therapy (DBT) as an efficacious treatment for borderline personality disorder.

On the basis of their demonstrated efficacy, the scientific orientation of many academically based training programs, and the demands of managed care and ethical guidelines for therapist accountability, ESTs are now being used more widely in training.
programs. Treatment manuals provide guidelines for the implementation of EST. These manuals include clear session-by-session instructions that are easy to follow for trainees, and they facilitate data collection and evaluation of treatment fidelity. Another advantage of ESTs is the inclusion of choice parameters for patients with differing presenting symptoms or causes of the same disorder. For example, interpersonal psychotherapy (IPT) consists of four treatment options so that the therapist can choose whether the most important issue is role transition, grief, role disputes, or social skills training. This flexibility allows therapists to tailor treatment to the needs of the patient. Similar flexibility is inherent in the DBT model. Because of the heterogeneous nature of individuals with borderline personality disorder, the treatment of two patients may consist of somewhat different DBT skills. Finally, the proliferation of research in ESTs has sparked an increase in studies aimed at identifying the “active ingredients” in EST treatments (Barlow, Craske, Cerny, & Klosko, 1989; Elkin, Shea, Watkins, & Imber, 1989; Jacobson et al., 1996; Mattick, Peters, & Clark, 1989; Quinette, Finney, & Moos, 1997).

There is a lack of research on the effectiveness of ESTs when implemented by trainees in graduate training programs. Trainees are often learning new techniques at the same time that they are using them to treat patients. Also, compared with the originators of the treatment, trainees have a less comprehensive understanding of such topics as the rationale behind the treatment and the way that each session impacts specific symptoms of the disorder. They also have a smaller number of patient contact hours on which to base in-session decisions. The specific direction of their treatment at choice points (e.g., IPT for which of the four areas?) cannot be grounded on experience with a large range of clients. The present study sought to determine the clinical impact of a shift toward exclusive use of ESTs by graduate trainees. Because graduate trainees are relatively inexperienced therapists, the graduate training clinic arguably provides a rigorous setting for demonstrating the efficacy of ESTs in settings beyond those in which they were developed.

Most initial demonstrations of treatment efficacy come from highly controlled clinical trials, which are often limited to relatively homogeneous patient populations experiencing only one mental disorder; comorbid disorders and other patient variables are highly limited or excluded. The present study further extends the extant literature by examining the relative impact of ESTs on a demographically diverse sample of patients experiencing a broad range of psychopathology and the therapy provided by clinicians with as yet limited experience. To our knowledge, this is the first study to objectively evaluate the impact of ESTs on patient outcome across a wide variety of patients and mental conditions in a training clinic setting.

The purpose of this study was to examine differences in clinical outcome for a diverse population of patients treated with ESTs and those treated with unsupported treatments in a clinical psychology graduate training clinic. We hypothesized that the provision of ESTs by new therapists would result in higher treatment efficacy than the provision of non-ESTs. Thus, we predicted that greater improvement ratings by independent judges would occur for patients who received therapy after the change in clinic policy to a scientific approach and application of ESTs than among patients who received treatment prior to the strict application of ESTs.

One hundred and seventy-three patients were included in the present investigation. Sample size, demographic data, and diagnostic information for the two comparison groups are provided in Table 1. These comparisons indicate a strikingly higher rate of participants given a diagnosis in the sample of participants after September 1998. This is partly the result of diminished concerns about the stigma of labeling psychological disorders. The increased rates of other disorders (i.e., anxiety, mood, personality) are likely the result of the increase in labeling patients with the appropriate disorder classification. These two groups did not differ significantly with respect to either sex or age, ethnicity, or diagnostic category. All patients were seen at the Florida State University (FSU) Psychology Clinic, an outpatient community mental health center. Data were taken from randomly selected therapy cases from a total of approximately 2,250 adult patients admitted to the FSU Psychology Clinic between 1984 and 2001. By completing the application, patients agreed to the research and training nature of the clinic. Over the course of the time periods examined in this study, all therapists were trained in the prevailing nosology of the time (i.e., the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders [DSM-IV]; American Psychiatric Association, 1994) and conducted structured clinical interviews centered on the presenting problem to arrive at diagnoses based on the DSM-IV.

Although university-affiliated, the FSU Psychology Clinic primarily services nonstudents who present with clinical disorders typical of a community mental health outpatient clinic. The FSU Psychology Clinic uses minimal exclusionary criteria—it does not treat people with psychotic-spectrum disorders or bipolar disorder who are not stabilized on medications.

Treatment Before and After Change in Clinic Policy

Prior to the change in policy, an empirical basis for intervention was not emphasized or required, as it was after the change. Following this change in clinic policy in 1998, only those supervisors with appropriate knowledge to supervise the use of ESTs remained active supervisors. In addition, weekly training meetings focused on the mastery of the theories and techniques underlying ESTs for various disorders. The ESTs used consisted primarily of CBT approaches. For example, the Cognitive Behavioral Analysis System of Psychotherapy (McCullough, 2000) was used for the treatment of major depression and dysthymia, and Fairburn and Wilson’s (1993) CBT was used for bulimia nervosa. Therapists also received secondary training in other ESTs, including IPT for depression, DBT for borderline personality disorder, and motivational interviewing for substance use disorders.

Because of the limited focus of clinical trials on homogenous samples, the clinician is often left with no empirically supported approach to handling co-occurring disorders. When comorbid dis-

1 Research examining the effectiveness of tailoring treatment to specific patient needs has not yet shown that tailoring directly affects patient outcomes; however, tailoring may be beneficial for another reason—it may encourage therapists who are concerned about treatment flexibility to choose and implement ESTs.
orders are present, therapists are trained to first use an appropriate (empirically supported) treatment for the disorder that appears to be causing the most patient distress or functional impairment (focal disorder). Often this approach produces collateral amelioration of symptoms of comorbid conditions. However, in cases in which comorbid disorders persist, upon amelioration of the primary disorder, treatment focus shifts to an EST appropriate to treatment of the comorbid condition(s).

The concurrent change in clinic policy and clinic supervisors raises the possibility that patient improvement was partially the result of general factors associated with improved supervision. However, it should be noted that many of the previous supervisors remained at the clinic, changing to EST-based didactics following the change in clinic policy in 1998. Another potential confound, a shift in the quality of graduate students recruited with the change in clinic policy, was explicitly investigated. No significant differences were found in the student-quality variables examined (i.e., undergraduate grade point average and quantitative, verbal, and analytic Graduate Record Exam scores) among students admitted prior to and after the shift in training emphasis.  

It is important to consider the types of treatments used prior to the shift in clinic policy in 1998 in order to determine if change in policy affected treatments offered. Any EST use prior to the formal shift in training would arguably create a more stringent test of our hypotheses because patients occasionally receiving ESTs presumably would have benefited from their use, reducing the magnitude of group differences in our analyses. A qualitative review of files randomly selected from the pre-EST period suggests however that non-ESTs were indeed primarily emphasized prior to the change in directorship. In particular, psychodynamic and traditional humanistic (i.e., supportive–empathic but nondirective and non-CBT) approaches were dominant. Furthermore, these treatments were not applied to specific disorders in a systematic fashion, and EST-based treatment manuals were rarely used.

### Materials and Procedures

Therapy outcome was assessed through a retrospective chart review using the Clinical Global Impression (CGI) Scale—a face-valid, forced-choice, subjective measure that requires minimal training to use (Guy, 1976). The CGI was chosen as a therapist rating scale that could be used to assess improvement for all patients, regardless of diagnosis. Clinical psychology doctoral-level student therapists (students enrolled in their second year or higher in the FSU clinical psychology PhD program) were randomly selected and asked to independently assess the degree of patient improvement using the CGI. Raters had access only to information in the files and did not see the patients themselves. Treatment outcome was indexed by raters on a one-item “improvement following therapy” 7-point Likert scale: 1 (very much improved), 2 (moderately improved), 3 (minimally improved), 4 (no change), 5 (minimally worse), 6 (moderately worse), and 7 (very much worse).

The CGI has been shown to have acceptable internal consistency and concurrent validity in adults diagnosed with anxiety and depression (Leon, Shear, Klerman, & Portera, 1993), in severe patient populations (e.g., schizophrenic patients; Stern et al., 1998), and in children with severe emotional disturbance (Mattison, Bagnato, Mayes, & Felix, 1990). Though the CGI was originally used in medication treatment outcome studies, many other studies have supported the validity of the CGI as a psychotherapy outcome measure. In addition, the reliability and concurrent validity of the CGI Scale in our clinic has been supported (e.g., good agreement between CGI ratings, DSM–IV Axis V Global Assessment of Functioning [American Psychiatric Association, 1994], and patient progress ratings by therapist and patient [Lyons Rarndon, Cukrowicz, Reeves, & Joiner, 2003]).

Two to four therapists rated each patient file using the CGI. Therapists were instructed to independently review patient files, including session progress notes, diagnostic and treatment summaries, and objective treatment measures, in their assessment of treatment outcome: Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), Minnesota Multiphasic Personality Inventory (Hathaway & McKinley, 1942), and Minnesota Multiphasic Personality Inventory—2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). The policies and training regarding file and progress note content were not modified with the change in EST policy. Thus, raters had access to the same types of file information for patients seen before and after the change in policy regarding EST use. It is important to note that the patient’s therapist was not among the four raters assessing patient improvement.

Improvement in therapy was rated globally on the basis of the entire therapy outcome, rather than on session-by-session process of therapy. Treatment outcome was rated in terms of “total improvement.” Meetings were held weekly with the assistant director.

---

<sup>2</sup> Data were available and compared for students admitted between 1993–1997 and 1998–2003.
to ensure adherence to this protocol. To reduce the risk of demand characteristics, all therapists (and thus raters) were unaware of how the CGI ratings would be used, and all ratings were submitted to a data manager for entry into the database, not to the clinic director. It is also noteworthy that raters were not unanimously supportive of ESTs, well trained in ESTs, or working with well-known professors who knew ESTs. Indeed, at the time the ratings were conducted, an anonymous survey of raters revealed that approximately one third of the raters had expressed substantial skepticism regarding the virtue of ESTs.

Interrater reliability among therapists on CGI ratings was high (average intraclass correlation coefficient of .93, \( p < .001 \), standardized \( \alpha = .93 \)). Therefore, ratings for these patient files were averaged into a single CGI score to optimize stability. Ratings were completed at the rate of 10 patient files per week over the course of a 10-week period.

Following preliminary data screening, CGI improvement ratings were compared for the two time periods that reflected the periods before and after the FSU Psychology Clinic directorship and policy change to emphasize a scientific approach to assessment and therapy, including the required use of ESTs. Between-groups differences in CGI improvement ratings were examined using a \( t \) test for independent samples.

Results

Means, standard deviations, and bivariate correlations for all variables of interest are presented in Table 2. As this table illustrates, date of patient intake was significantly and negatively correlated with patient improvement rating at termination, indicating that those patients who began therapy at a later date improved to a greater extent than those patients who began therapy at an earlier point in time: Improvement ratings ranged from 1 (most improvement) to 7 (significant worsening).

Our primary question of interest was whether the implementation of a clinic policy in September 1998 requiring the use of a scientific approach and ESTs with all patients had a significant impact on patients’ improvement over the course of therapy. Accordingly, all patients were grouped dichotomously by their date of intake at the FSU Psychology Clinic, with those beginning treatment prior to September 1998 \( (n = 92) \) grouped separately from those beginning treatment in or after that month \( (n = 81) \).

Table 2
Means, Standard Deviations, and Bivariate Correlations for All Variables of Interest

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sex of client</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>2. Age of client</td>
<td>-.02</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>3. Date of intake</td>
<td>-.02</td>
<td>.10</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>4. Improvement rating</td>
<td>.12</td>
<td>-.10</td>
<td>-.49*</td>
<td>—</td>
</tr>
</tbody>
</table>

| \( M \) | .46  | 24.53 | 4.03  |
| \( SD \) | .50  | 11.40 | 1.40  |

Note. \( N = 173 \).

To investigate our primary question, we conducted a \( t \) test comparing the improvement ratings of the two subgroups of patients. Clients who began therapy during or after September 1998, when EST training was implemented, improved significantly more over the course of therapy \( (M = 3.12, SD = 1.29) \) than did those patients who began therapy prior to the implementation of ESTs \( (M = 4.82, SD = 0.93) \), \( t(171) = 10.07, p < .001 \). The effect size for this group difference was notably large at .77 (Cohen, 1988). Furthermore, the mean improvement rating for patients receiving ESTs was consistent with at least slight improvement, whereas the mean improvement rating for patients prior to EST training reflected slight worsening of symptoms.

The effect of the implementation of this policy on patient improvement is graphically illustrated in Figure 1. This figure shows data for most of the individuals in the sample (as can be clearly discerned from Figure 1) prior to and after the shift in clinic policy to training in ESTs. The majority of patients in the sample were rated at termination as having displayed no change or having worsened slightly with respect to their symptoms. However, a clear shift occurred in the fall of 1998, at which time patient improvement ratings sharply improved, despite a similar degree of variability among patients. The improvement in outcomes has been consistent over time since training in ESTs was implemented.

In addition to the primary analyses, several post hoc comparisons were conducted to rule out alternative explanations for patient improvement following the shift to ESTs. A significant difference was found when the two samples were compared with respect to the total number of therapy sessions attended. Patients beginning therapy during or after the fall of 1998 attended significantly fewer therapy sessions \( (M = 10.20, SD = 9.39) \) than those beginning therapy before this time \( (M = 19.63, SD = 16.13) \), \( t(169) = 4.59, p < .001 \). Thus, despite attending fewer therapy sessions, patients receiving ESTs demonstrated more improvement over the course of therapy. That is, those who received ESTs showed better and faster improvement.

A second possible alternative to explain the differences found was the severity of the presenting symptoms at intake. Notably, the FSU Psychology Clinic’s policy prior to the fall of 1998 excluded more severe cases of psychopathology from receiving treatment (e.g., suicidal patients, severely personality disordered patients, and others with extreme conditions). The clinic’s shift in policy in 1998 allowed for severely distressed patients to obtain treatment at the FSU Psychology Clinic, which appears to have increased the number of patients seen with severe psychopathology. Examination of Axis I and Axis II diagnostic information Table 1 supports this account. Thus, decreased severity or better prognostic status is probably not a viable explanation for improvement in EST-treated patients.

A third alternative explanation for our findings might be that the greater severity of patients postfall 1998 permitted a larger range of possible improvement than was possible for the pre-EST group. We were able to rule out this explanation by comparing CGI ratings only for patients with at most moderate CGI severity

3 The patients represented in this study were treated across several versions of the DSM; thus, an analysis was completed to determine if results differed when excluding patients treated prior to the shift to ESTs who were not diagnosed under the DSM–IV guidelines. These results indicated no significant difference, so all patients seen prior to 1998 were included in the main analysis.
ratings at intake in both groups. Results were unchanged when the analyses were restricted in this fashion. In general, then, it appears that the shift in clinic training to ESTs produced better outcomes, within fewer sessions, among a more symptomatic population of patients experiencing a wide range of psychopathology.

The results of this study indicate that patients who began therapy after the change in clinic policy showed significantly more improvement over the course of therapy than did those who were treated before the mandatory EST policy was in place. Specifically, patients in the EST-mandated group showed a reduction in symptomatology throughout treatment, whereas the same cannot be claimed for prepolicy patients. These results negate Luborsky et al.’s (2002) dodo bird verdict, which claims that factors common to all therapies result in nonsignificant difference in overall treatment outcome between them. We maintain that our pattern of results is supportive of the greater effectiveness of ESTs than non-ESTs in the amelioration of patient symptomatology. Therefore, we recommend that ESTs be implemented as frontline treatments whenever possible to be consistent with an ethical practice that emphasizes helping patients to get better as quickly as possible.

Limitations of the study primarily involve our lack of control over variables. One example of this lack of control concerns the prepolicy treatment utilized. Although we know that ESTs were not frequently used prior to the implementation of the mandatory EST policy, we cannot definitively draw the conclusion from this study that the prepolicy treatments were all nonempirically supported in nature. That is, in some cases, ESTs may have been used by therapists in training prior to the mandatory EST policy. However, given that we would expect that the use of ESTs to enhance, rather than detract from, treatment outcome, the inclusion of ESTs in the prepolicy group would function to mask only the effect of the clinic policy change. As a significant effect was nonetheless found in treatment outcome between the EST-mandated and the prepolicy patients, this limitation does not appear to have affected the study’s conclusions substantially.

Another limitation of this study is that patients could neither be randomly assigned to EST-mandated or prepolicy groups nor be fully matched on variables (e.g., diagnosis, age, sex) between groups for subsequent analysis of treatment outcome (i.e., improvement in functioning). However, post hoc comparisons revealed that differences between the groups with regard to treatment duration could not have masqueraded as the effect of the clinic policy change. That is, patients in the EST-mandated group actually attended fewer therapy sessions than those in the prepolicy group, and, therefore, an increased duration of treatment was ruled out as an explanation for the enhanced treatment outcome of the EST-mandated group. Likewise, differences between the EST-mandated patients and the prepolicy patients with regard to severity of symptomatology (and therefore better prognostic status) were ruled out in a post hoc comparison of groups. In fact, changes in the clinic policy have actually resulted in an increase in the acceptance of patients demonstrating severe symptomatology (e.g., suicidal patients or patients with psychosis). Finally, no significant differences were found between the groups as a whole with regard to age or sex. Thus, although these limitations should be considered, we have attempted to address them by ruling out various sources of discrepancy among groups that could have affected the study’s results.

Another limitation concerns the treatment outcome measure, the CGI improvement ratings. Although the CGI does provide a global measure of improvement in patient functioning (i.e., treatment outcome), it is somewhat subjective in nature as it is based primarily on the treating therapist’s conceptualization of patient progress as indicated in session notes and summary reports. In other words, it may be subject to therapist biases or demand characteristics. It is possible, for example, that therapists utilizing ESTs had greater expectations that their patients would improve simply by virtue of the fact that the treatment offered had been empirically supported, and thus were more likely to record/report improvement in their patient’s functioning. Therefore, the independent raters reviewing the records and generating the CGI improvement ratings for this study would have an inaccurate perception of the actual change in functioning that took place. While this might have been possible, the inclusion of objective data in clinical files (e.g., depression inventories, personality measures) helped to ensure that improvement ratings were not based entirely on subjective data.

Moreover, it is our anecdotal impression that therapists’ expectations for success did not differ pre- and post-1998. That is, some therapists in training and independent raters were skeptical about the effectiveness of ESTs in practice both before and after they were implemented at the clinic and, therefore, would not be susceptible to such biases or demand characteristics. Future research in this area may benefit from the inclusion of a patient-based global clinical measure, to complement clinician-based measures, in order to allow for more objective determination of clinical outcome.

Despite the limitations of the CGI improvement rating, its use is defensible as the outcome measure in this study. The CGI im-

Figure 1. Relationship between date of intake and improvement in therapy as indexed by therapist ratings on the Clinical Global Improvement Scale at termination. Under 4 indicates improvement, and above 4 indicates worsening of symptoms. ESTs = empirically supported treatments.
provement ratings have shown good levels of interrater agreement (alpha range: .84–.93) and have correlated with other improvement measures, such as other progress ratings (Lyons Reardon et al., 2003). Finally, the CGI improvement rating scale also was applicable across a diverse sampling of diagnoses, allowing for a direct comparison of improvement across patients with varying diagnoses and symptom severity.

A potential limitation of studies that encompass a substantial time period, as ours does, is that DSM diagnostic criteria change over time, quite radically for some disorders (e.g., generalized anxiety disorder). Such changes could influence the reliability of some diagnoses. However, DSM changes are unlikely to have systematically influenced the general treatment approach (empirical vs. nonempirical) in our training clinic during the two time periods, which were determined primarily by current clinic policy, supervision, and program training emphasis. Similarly, our ratings of patient improvement are likely to be fairly robust to changes in DSM nosology, as they were based not on diagnostics but on the patients’ global functioning. Another potential limitation of this study is that the medication status of all patients was not available. Among the more recent cases in our sample (all post-1998) for whom medication data were available, approximately 20% were taking psychotropic medications at the time of intake. When the analyses were rerun, excluding those post-1998 participants who we know were on psychotropics, the significance of the results was unchanged. Future prospective studies should include this information to test the impact of variable rates and types of medications on the effectiveness of treatments with different levels of empirical support.

Implications for Clinicians

Despite accumulating evidence of the efficacy of certain treatments, not all practicing clinicians choose to utilize ESTs as frontline treatments for their patients. The reasons cited for this decision are varied and should be examined for applicability to the present results. One reason cited for the failure to use ESTs in clinical practice is that efficacy in clinical trials does not necessarily translate to effectiveness in the real-world clinical setting because of issues such as comorbidity. It is widely recognized that diagnostic comorbidity, particularly comorbidity on both axes, typically results in a less favorable treatment response. However, results of this study support the assertion that ESTs can demonstrate effectiveness in an outpatient clinical setting where comorbidity is commonplace. In fact, our post hoc analyses indicate that ESTs were more effective than non-ESTs in the amelioration of symptomatology, even though the portion of the sample receiving ESTs had higher rates of diagnostic comorbidity and, thus, was less likely to be amenable to treatment.

Another reason cited for the failure to implement ESTs in clinical practice concerns treatment manuals. Some practitioners believe that manualized treatment, although intended to aid clinicians in the delivery of efficacious therapies, actually minimizes therapeutic flexibility and stifles innovation and have recommended that clinicians do not adhere strictly to such manuals in the delivery of services (cf. Serran, Fernandez, Marshall, & Mann, 2003). However, we maintain that there is flexibility inherent in manualized treatments and that they can and should be implemented in a way that accounts for unique patient needs. Therapists and patients can together choose a relevant problem area in IPT for depression, for example, and patients can select their own problematic interpersonal situations when using the Cognitive Behavioral Analysis System of Psychotherapy (for more examples, see Addis, Wade, & Hatgis, 1999).

It is also notable that our results provide evidence that a clinician need not be extensively experienced with manualized treatments in order to affect treatment outcome. The therapists in training in our study were in their second or third year of graduate training, with experience ranging from no previous experience to a few years of experience administering manualized treatment. Castonguay, Schut, Constantino, and Halperin (1999) have suggested that continued practice with manualized treatment is key to developing increased competence in its utilization, and we are inclined to agree. However, despite their relative inexperience, the therapists in training in this study nonetheless significantly affected treatment outcome. This is good news for seasoned therapists who may not have been exposed to manualized treatments during the course of their clinical training. Results of this study suggest that such therapists can gain skill in the implementation of these treatments relatively quickly, even as they first begin to apply them in practice.

A final criticism that had been historically wagered against ESTs was the dodo bird verdict, as mentioned previously, suggesting little difference overall in treatment outcome regardless of the psychotherapeutic approach used (Luborsky et al., 2002). The results of this study, however, lend more support to a growing literature indicating that ESTs do in fact demonstrate better treatment outcome than do non-ESTs. Moreover, in this sample, patients who received ESTs not only got better than those who did not but they also got better with comparatively less therapeutic contact. This is beneficial for patients because we expect that they would experience a quicker decrease in distress and an earlier improvement in functioning as the result of symptom amelioration from effective treatment. It is also beneficial for their therapists, who many times have limited sessions allowed by insurance and managed care in order to affect a change in their patients. Assisting patients to get better faster can be helpful to clinicians in independent practice who benefit from word-of-mouth referrals from previous patients. Also, as an unfortunately large number of patients prematurely terminate from therapy (Pekaris, 1983), it is important for clinicians to use treatments that not only work, but also work quickly, as some patients may be unilaterally terminating from therapy because of the absence of an effect early in treatment.

Critics, however, might reasonably argue that patient improvement is not just about getting patients better faster, but about helping them to stay better longer. Although we maintain that ESTs help patients to get better faster, we have not presented evidence that patients treated with ESTs stay better longer than those treated with non-ESTs. We were, in fact, unable to evaluate this with our patient sample as we did not collect long-term data.
follow-up data about functioning after the patients had terminated services with our clinic. However, there is extant literature indicating that some ESTs (e.g., CBT for the treatment of depression) have enduring treatment effects that persist beyond the termination of therapy (cf. Hollen, 2003).

In the case of depression, patients who had received CBT and bilaterally terminated treatment were not any more likely than those patients remaining on medications after treatment to suffer a relapse of symptomatology (Hollen, 2003). Similar findings have emerged with regard to the application of CBT to other disorders (e.g., panic disorder; cf. Hollen, 2003). These data indicate that patients who received CBT in the past were protected from relapse compared with patients being maintained on medication. To our knowledge, there are no similar research findings with respect to non-ESTs, suggesting that, in at least some cases, ESTs result in optimum treatment outcome—patients get better quicker and stay better longer.

Future research in this area should focus on illustrating the benefits of evidence-based treatments to practicing clinicians and those who can affect clinic policy regarding therapeutic approaches to treatment. Researchers espousing the need for the utilization of ESTs in practice have to establish that research efficacy does indeed translate into clinical effectiveness. They must also heed the concerns of those who fear that the use of manuals jeopardizes treatment (for examples, see Addis et al., 1999) and work toward making manuals more attractive and acceptable to the practicing clinician (see Rudd et al., 2001, for a manual that strives to balance rigor and flexibility). Finally, studies must continue to test the premise that the use of ESTs is worthwhile. In other words, researchers need to demonstrate that the use of empirically supported and efficacious therapies, in practice, results in better treatment outcomes than when nonempirically supported therapies are used.

In conclusion, results of this study support that a policy change in an outpatient community clinic mandating the exclusive use of ESTs was associated with enhanced treatment outcome for patients treated under this policy, compared with those treated before such a mandate was in place. Clients treated with ESTs as a group showed more global improvement in functioning over the course of therapy than did those patients treated before the EST mandate. The treatment deliverers in this study were therapists-in-training, suggesting that even minimal experience in the delivery of ESTs using treatment manuals can nonetheless affect treatment outcome for the better. Results of this study add to the growing body of empirical literature refuting the dodo bird verdict that all therapies are created equal—mostly. Clinical Psychology: Science and Practice, 13, 327–331.


References


