Great Debates
Evidence-Based Practice:
Specific Methods and/or Therapeutic Relationship?

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Counterpoints from Psychotherapy Research
1. When bona fide treatments are directly compared, typically modest or no clinically meaningful outcome differences are found

The Dodo Bird Verdict
Everyone has won and all must have prizes
But do you really believe that:
No specific treatment is better than any other?
It doesn’t matter what we do?

The Mesa Grande Review
Weight of Evidence for Treatments
Included all (N=361) comparative clinical trials of treatments for alcohol use disorders with 71,936 participants
For 46 specific treatments with ≥3 trials:
- Computed a cumulative evidence index (CEI)
- With each study weighted for:
  1. Methodological quality of research (1-17)
  2. Strength of causal imputation (1-2)
  3. Direction of finding (+ or -)
- Each study contributes + or – score to CEI

And sometimes there are differences between specific treatments

130 concerned family members randomly assigned to one of three interventions (all 12 hrs of contact)
To engage “unmotivated” drinkers in treatment
- Al-Anon Facilitation Therapy (AFT)
- Johnson Institute Intervention (JII)
- Community Reinforcement (CRAFT)


Engagement Rates: Alcohol Study

Average time to treatment entry: 47 days

Engagement Rates: Drug Study

- P<.0006
- CRAFT = CRAFT+
- CRAFT > Alabon

Replications of CRAFT Treatment Engagement Rates
Counterpoints from Psychotherapy Research

1. Few outcome differences for specific methods
2. Overall psychotherapy outcomes are good

Retraining Staff in EBTs?

- Treatment-as-usual is a high standard to beat
- Re-training can be challenging and expensive
- Specific treatment effect size often shrinks with dissemination into clinical practice
- Therapist belief / enthusiasm / style matters
- Testable question: Is it cost effective to re-train staff in an EBT?

Average Alcohol Treatment Outcomes

- 7 multisite U.S. trials over 40 years (N=8,389) with 12 months of follow-up
- Remission Status:
  - Continuous abstinence for 12 months: 24.1%
  - Continuous moderation for 12 months: 10.4%
  - Overall % days abstinent: 81.4%
- For all clients with any drinking:
  - Abstaining on 75% of days
  - Alcohol use decreased by 87%


Counterpoints from Psychotherapy Research

1. Few outcome differences for specific methods
2. Overall psychotherapy outcomes are good
3. Average psychotherapy outcomes have not improved much for 50 years

Alcohol Treatment Outcomes

*Armor et al. (1978)*

- 8 U.S. Program sites
- N = 1,340
- Uncontrolled treatment as usual
- 12-month outcomes
- 69% follow-up rate
- S.O. confirmation

*Project MATCH (1997)*

- 5 U.S. Outpatient sites
- N = 952
- Manual-guided and closely supervised treatment
- 12-month outcomes
- 94% follow-up rate
- S.O. confirmation

Rand (1976) vs. MATCH (1997)

- % Abstinent at 12 Months: 16.7% vs. 11.6%
- % Moderate at 12 Months: 19.1% vs. 12.4%
- Drinks/Drinking Day: 5.5 vs. 5.17
**Counterpoints from Psychotherapy Research**

1. Few outcome differences for specific methods  
2. Overall psychotherapy outcomes are good  
3. Outcomes have not improved for 50 years  
4. High variability of outcomes for therapists

**Do you really believe that . . .**

- All therapists are equally effective?  
- It doesn’t matter who provides treatment?  
- Treatment success is attributable to factors that are “common” to all therapists?

**Miller, Taylor & West (1980)**

- Nine counselors trained and supervised together, all delivering the same manual-guided behavior therapy for clients with alcohol use disorders  
- Independently rated by three supervisors for level of *accurate empathy* (using observation scale developed by Truax & Carkhuff, 1967)
Delivering a manual-guided 16-week Combined Behavioral Intervention for alcohol use disorders


The COMBINE Study
- 22 experienced therapists who treated at least 10 clients
- Delivering a manual-guided 16-week Combined Behavioral Intervention for alcohol use disorders
- All trained together and closely supervised

Outcome: Average percent days abstinent for each therapist’s clients through 12 months of follow-up


Predictors of Benefit from Treatment on the COMBINE Trial
- Exposure to pharmacotherapy (naltrexone)
- Exposure to psychotherapy (CBI)
- Exposure to specific treatment modules in CBI
  - Mood Management
  - Coping with Craving
  - Social and Recreational Counseling
- Above-average therapist empathy (independent of specific treatment modules)

Looking for Evidence-Based Treatments

Therapist Factors
- Therapists have a large effect on outcome
  - Whether in manual-guided specific treatment or uncontrolled treatment as usual
- Example therapist factors:
  - Accurate empathy
  - Positive expectancy/hope
  - Compassion / warmth / unconditional regard
- In fact, “evidence-based psychotherapies” are inseparable from therapists who provide them


In Search of Therapeutic Factors
- What therapist factors (skills / behaviors / attitudes) predict positive client outcomes?
- Such factors are not “common” to all therapists, but highly variable
- Calling them “non-specific” just means that we have not done our homework
- Specifiable, reliably measurable, learnable
- This is what Carl Rogers was searching for more than 60 years ago

Accurate Empathy is an EBT
- Well specified “attitude” and skill
- Reliably measurable
- Learnable – skill improves with training
- Initial (at hiring or post-training) level of empathy predicts subsequent in-session level
- High in-session empathy predicts better client outcomes (e.g., in behavior therapy)
- Low empathy worse than no therapy
- Hire empathic therapists!