Effectiveness of Psychotherapeutic Treatment

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Abstract: Effectiveness of Psychotherapeutic Treatment

Decades of research compellingly demonstrate that when aligned with a wise, skillful, sound provider, clients entering psychotherapeutic treatments can expect to reduce symptoms, accelerate natural healing processes, improve life functioning, and learn additional coping strategies. Those who seek therapy consistently have better outcomes than those who do not receive treatment (or who are on a waitlist) and a broad range of therapies have been shown to assist patients make changes that are both statistically and clinically meaningful in relatively short periods of time. For many clinical disorders, about 50% of all patients return to normal functioning in 10 to 20 sessions. An additional 25 percent of patients experience substantial improvement when dosage levels are increased to 30 to 50 sessions. With the exception of disorders that tend to recur (e. g., addiction disorders), the benefits from treatment appear to be durable as the results of follow-up studies suggest that the effects of treatment last for at least one to five years subsequent to treatment. These results seem at least partially attributable to the emphasis and efforts that psychotherapists make to provide more than support. Personality changes and re-organization of the self often occur.

Changes appear to be due to factors common across theory-based treatments rather than to specific unique treatment methods.

Keywords: common factors, psychotherapeutic treatments, psychotherapy outcome, psychotherapy process, treatment effects

Introduction

In general, psychotherapy is a collaborative enterprise (between a trained professional clinician and patient) developed to provide relief from problematic symptoms and help prevent future relapses, support desired personality change, enhance adaptive role functioning in relationships and at work/school, increase the ability to make healthy life choices, and promote overall quality of life through helping patients to negotiate challenges and make changes in their behaviors, emotions, cognitions, and/or other characteristics. Approaches to psychotherapy are numerous and diverse including orientations such as cognitive, behavioral, psychodynamic, humanistic, and eclectic combinations of these theory-based orientations. Training programs are also highly diverse with little agreement across the world about type and amount of training necessary for effective practice.

Over the past 40 years, a myriad of research designs, methodologies, and meta-analytic investigations have combined to create a sizeable body of scientific evidence that attests to the effectiveness of psychotherapy across diverse settings (hospitals, counseling centers, clinics, military, public health, primary care, etc.), conditions (diagnoses, addictive, health, psychological and relational problems), and populations (adults, children, adolescents, older adults). Overall, research has demonstrated that psychotherapy interventions are efficient, safe, demonstrate efficacy across most diagnostic conditions, and have far-reaching effects. Assessments (via self-report, therapist/expert evaluations, evaluations of significant others, and/or societal records) of the benefits of psychotherapy have focused on such domains as reduction in symptoms, increase in problem-solving skills, enhanced health, and improvements in interpersonal/social functioning. Reviews of this literature have confirmed the beneficial effects of therapy concluding that treated patients consistently fare better than untreated patients; in fact, research reveals based on effect size estimates that 65% of treated patients can expect to have a positive outcome as compared to only 35% of patients who receive no treatment during the same period of time (Lambert, 2013).

Furthermore, when compared with interventions like psychopharmacology, the results of psychotherapy tend to last for longer periods of time with much lower relapse rates in many cases. Moreover, given that patients often acquire new knowledge and a variety of useful skills during the course of treatment that they continue to utilize after the treatment has ended, it is common for patients to experience further improvement following treatment termination. Psychotherapy has proven to be very cost-effective as it often pays for itself in terms of medical cost offset (as patients engaged in psychotherapy are less likely to use inpatient medical services, tend to have significantly shorter hospital stays, etc.), life satisfaction, and increased productivity in work and home roles (e. g., Chiles, Lambert & Hatch, 1999; Crane, 2008).

Treatment Duration and Lasting Effects

In contrast to the length of treatment associated with psychoanalytic psychotherapy (which often lasted years with multiple visits per week), the extant literature suggests that substantial benefits from treatment occur in relatively short durations (e. g., 14 weekly sessions), and equally important, these gains are maintained over substantial periods of time. Examinations of changes over weeks of treatment have confirmed a positive response to treatment as the dose (i. e., number of sessions) increases, with diminishing returns at higher dosage levels. Studies from the dose-effect literature suggest that, for many clinical disorders, a range of 10 to 20 sessions is sufficient for 50 percent of patients to return to normal functioning (Harnett, O'Donovan & Lambert, 2010). Moreover, promising results occur as the dosage level is increased to the extent that 75 percent of patients can be expected to recover substantially after 26 to 50 sessions (Hansen, Lambert & Forman, 2002). The recovery of the remaining portion (25%) of patients has not been well documented and they must be considered nonresponders.

Although a majority of patients experience significant benefits from psychotherapy, there is also evidence that the more disturbed (and comorbid) a person is at the outset of therapy, the longer (more sessions) it will take for them to return to a normal state (Lambert, Hansen & Finch, 2001). Observed trends in patient improvement have led some researchers to propose a phase model of recovery in which morale, symptoms, and characterological problems (personality structure) improve in sequence (Kopta, Howard, Lowry & Beutler, 1994). However, replication of this work casts doubt on this formulation.

In addition to results supporting relatively short recovery periods for a majority of patients, there is evidence that beneficial gains from psychotherapy are enduring. Although adjustment from psychotherapy treatment does not prevent recurrences of psychological disturbance, it appears that many patients maintain healthy functioning for prolonged periods of time subsequent to treatment (Dugas et al, 2010). However, exceptions to the notion of lasting treatment gains are noted in work with patients who are obese, have substance abuse, eating disorders or who are suffering from symptoms of recurrent depression or personality disorders. Conversely, research has also detected a large minority of patients, perhaps 30%, who are able to attain benefit from therapy after a surprisingly small number of sessions (3 - 5); these clients are said to have "sudden gains" or "early dramatic treatment response" and approximately 80% have been found to maintain gains and remain improved one year later (Haas, Hill, Lambert & Morrell, 2002).

Factors Important to Psychotherapy Outcome

In addition to the research focused on examining the effectiveness of psychotherapy, considerable emphasis has been placed on the factors that contribute to positive patient outcome. Findings from this research fall into three general categories: patient variables, common variables, and specific intervention variables.

Patient Variables

The patient rather than the treatment or therapists is most likely to determine successful outcome. The literature focusing on the study of patient variables is too voluminous to repeat, and thus only a few of the most important findings are reported here. Each patient entering treatment brings a diverse array of factors when presenting to the clinician. These include different psychological disorders, historical backgrounds, stresses, coping habits, and the quality of their social support networks, to name just a few. Patient variables found to have relationships with outcome are severity of disturbance, motivation and positive expectancy for treatment to be effective, capacity to relate, integration, psychological mindedness, and ability to recognize relevant problems (Bohart & Wade, 2013). Therefore, patients suffering from challenging symptoms as well as relative deficits in numerous patient variable categories are likely to experience negligible improvement during treatment. For example, the borderline, alcoholic patient with suicidal tendencies who is forced into treatment, believing that most marital problems are a result of an insensitive spouse, is likely to benefit less from treatment than the depressed patient who voluntarily begins treatment and is determined to make personal changes that will lead to marital harmony (Sexton, Datchi, Evans, LaFollette & Wright, 2013).

Although patient variables have been conveniently categorized, the impact each has on the outcome of therapy is not equal. In general, the severity of disturbance is the patient variable that is most related to the outcome of the treatment (Garfield, 1994). Patients with serious mental disorders, such as the schizophrenic, schizoaffective, and bipolar disorders are typically treated primarily with psychopharmacological management, suggesting the challenge these disturbances provide for psychotherapy alone (Forand, DeRubeis & Amsterdam, 2013). Personality disturbances also appear resistant to change in the short term use of psychotherapy (i. e., 12 sessions).

Common Factors

Because outcome researchers have consistently failed to find sufficient evidence indicating superior improvement of patients as a consequence of receiving a particular kind of psychotherapy, some have concluded that psychotherapy equivalence is a result of factors common to all

psychotherapy (Cuijpers et al., 2012; Grawe, 2002). Common factors explanations for treatment effects suggest the possibility that there are components utilized in therapy that are curative and universal - regardless of specific school or theory of change - include support, learning, and action elements (Lambert, 2013). The developmental nature of the support-learning-action sequence presumes that the supportive elements precede modifications in attitudes and beliefs which, consequently, precede the clinician's attempts to encourage client action. It is presupposed that all therapies provide for a collaborative working enterprise wherein the client's sense of safety, trust, and security (along with resultant decreases in anxiety, threat, and tension) lead to changes in conceptualizing problems and, ultimately, in behaving differently by taking informed risks to talk about a sensitive concern, experiment with new coping skills, problem-solve through purposely exposing oneself to anxiety-producing situations, and/or engage in other growth-promoting behaviors that are commonly challenging and distressing.

More specifically, it has been proposed that the therapist-client relationship is a common factor crucial to positive treatment outcomes that has multidimensional and substantial research base (Wampold, 2001).While specific techniques may occasionally be influential, the extent to which unique methods can be used to effect change is largely determined by the nature of the relational context in which they are employed. In clinical trial studies comparing multiple treatments for particular psychological disorders, patients' positive assessment of the therapeutic alliance is one of the best predictors of psychotherapy outcome. If factors like acceptance, trust, kindness, understanding, warmth, and human consideration are not present, it is likely that the interventions utilized will have diminished effects. Furthermore, a systematic review of psychotherapy research by Norcross and Lambert (2011) on the role of relationship factors in therapy revealed that empathy, alliance, and collecting client feedback were all "demonstrably effective" in facilitating positive therapy outcomes while positive regard, goal consensus, and collaboration were found to be "probably effective" components of therapy.

However, although a significant amount of evidence points to common factors as mediators of patient change, the notion of beneficial techniques unique to specific therapies cannot be ruled out, as occasionally such interventions can be shown to contribute to successful outcomes in patients independent of common factors.

Specific Interventions

The American Psychological Association and other professional associations in other countries (e. g., Germany and England) are constantly in the process of developing clinical treatment guidelines (e. g., NICE guidelines in the UK) that can help identify particular treatments and procedures that research has demonstrated to be most effective with specific problems and/or patients. The evidence for treatments is usually judged to be strongly supported or moderately

supported based on the kind and amount of evidence that has accumulated (see Chambliss & Hollon, 1998, for an example of one rating system). One should keep in mind, however, when reviewing the following sections that denote specific therapeutic approaches that the empirically supported treatments that are summarized are not necessarily uniquely effective nor are the outcomes in most cases so superior to other forms of therapy to justify their sole promotion or use. In fact, as stated prior, differences in outcome when comparing various forms of therapy are most often not as distinct as expected, hoped for, or insinuated.

Moreover, other significant obstacles to this type of specificity and approach arise including the sheer number of therapeutic approaches/theories that exist (which is in the hundreds if not the thousands), the constant evolution of therapies subsequent to research and in its absence, and the emergence of new methodologies that appear promising. In addition, some would argue that it is not reasonable to expect a single therapist to sufficiently master the number of therapies it would require to serve a general clientele given that the number of discrete disorders surpasses 300. The expense, impracticality, and lack of research evidence on so many therapies with so many disorders may prove insurmountable. Furthermore, most often clients present with a myriad of complex symptoms and circumstances of life that do not easily fall into definite categories to be matched up with a single clear-cut treatment.

Lastly, as mentioned before, while technical proficiency undoubtedly makes a unique contribution to therapy, any efforts to propagate a best practice or an empirically supported psychotherapy while dismissing the impact and importance of the therapeutic relationship is potentially misleading and incomplete (Norcross & Wampold, 2011) as it is this positive interpersonal affective environment that often stimulates patient improvement in the therapeutic encounter. Nevertheless, at least empirically supported treatments have been rigorously tested and undergone the peer review necessary for publication and we have some information about their comparative effects. The clinical use of empirically supported treatments over treatments with no empirical evidence is a wise decision on the part of a practitioner, but not a guarantee of success.

Anxiety Specific disorders within the anxiety spectrum for which particular techniques have been researched include Generalized Anxiety Disorder, Panic Disorder, and Posttraumatic Stress Disorder.

Generalized Anxiety Disorder (GAD): The basic premise of Cognitive Behavioral Therapy (CBT) for GAD is that thoughts, behaviors, and feelings are interconnected and so using an intervention to change one aspect (e. g., behavior) can lessen difficulties in the others (e. g., thoughts and feelings). Cognitive Behavioral Therapy typically refers to a treatment wherein combinations of cognitive and behavioral techniques are utilized in the same course of treatment. In CBT for GAD these interventions might include modifying negative thinking (e. g., the thought that

worrying is beneficial in some way), taking part in relaxation training, planning pleasurable activities, and/or intentional exposure to avoided situations that are objectively safe, to learn that anticipated, feared outcomes do not occur. CBT for GAD typically encompasses 16 – 20 sessions over a 4 month period.

Panic Disorder: CBT has strong research support for treating panic disorder. Most frequently the therapist utilizes a combination of psychoeducation (about panic/fear and the body's physiological response), cognitive techniques (helping the patient identify, evaluate, and modify problematic thoughts related to panic such as perceived catastrophic consequences of specific places, people, bodily sensations, feelings, etc.), and exposures that incorporate in vivo (e. g., intentional approach of real-world, trauma-related situations that are objectively safe yet have been avoided previously due to trauma-related fear) and/or interoceptive (e. g., inducing bodily sensations like a racing heart, trouble breathing, dizziness, sweating, etc.) aspects. CBT for panic is typically 12 – 16 sessions and can be delivered in either an individual or group format.

Posttraumatic Stress Disorder (PTSD): Prolonged Exposure (PE) for PTSD is a specific cognitive behavioral approach for PTSD that includes education regarding common reactions to trauma and PTSD, breathing retraining (for relaxation), repeated recounting and recording of trauma memory(ies) during therapy sessions, and homework assignments that include listening to the recorded trauma account daily and engaging in in-vivo exposure (confronting trauma-related, real-world situations that are objectively safe yet have been avoided previously due to trauma-related fear). This treatment typically takes between 10 – 16 sessions.

Depression: This section will review the individual/group as well as specific couple approaches that have been researched for treating depression.

Individual and/or group approaches: CBT for Depression includes interventions such as identifying and modifying negative thinking (e. g., all/nothing or catastrophic thinking, jumping to conclusion, etc.) and simultaneously incorporating behavioral interventions like exercise, planning pleasurable activities, etc. It should be noted that Behavioral Therapy (BT) and Cognitive Therapy (CT) have been utilized individually and independently (as BT and CT rather than in combination as in CBT), each with strong support for efficacy; hence, a brief review of each will follow. Behavioral Therapy (BT)/Behavioral Activation (BA) is a short-term approach (approximately 12 sessions) that utilizes strategies that focus on increasing the quality and frequency of pleasant activities so that patients can increase their sense of mastery, decrease aversive consequences (e. g., of withdrawal, escape behaviors, and disrupted routines), and improve mood. Behavioral activation uses graded exercises to systematically increase contact with sources of reward (e. g., pleasant activities), to identify barriers to activation, teach problem solving skills, and improve quality of life. It is believed that no modification of thoughts or insight is necessary for change

to occur. Likewise, Cognitive Therapy (CT) and Mindfulness-Based Cognitive Therapy (MBCT) focus almost solely on awareness and modification of thoughts for improving depression. CT is a time-limited, problem-focused, structured therapy that emphasizes the identifying, monitoring, recording, and modification of maladaptive thoughts and beliefs (e. g., catastrophic thinking, all/nothing thinking, emotional reasoning, jumping to conclusions, personalization, etc.); this challenging and altering of unhelpful cognitions and beliefs is often called cognitive restructuring. Problem-solving and development of adaptive coping skills is also a frequent focus. CT for depression can be delivered in both group and individual formats and is typically 14 – 16 sessions in length. In Interpersonal Psychotherapy for Depression (IPT) it is proposed that, as psychiatric difficulties most often occur within an interpersonal/social context, that teaching patients to identify and understand the relationship between the onset and fluctuation of symptoms and interpersonal problems is essential. Specific interpersonal domains include grief, role transitions, interpersonal role disputes, and interpersonal deficits. The therapist (using techniques that often include clarification, encouragement of affect, communication analysis, and supportive listening) helps to motivate the patient to work towards change in the area of interpersonal difficulties which, consequently, alleviates symptoms. This treatment is typically 12 – 16 sessions and can be delivered in both individual and group formats. Emotion-Focused Therapy (EFT) [MS] is built on a process-experiential approach designed to facilitate patient identification, utilization, and processing of emotion in the environment of a safe, secure, therapeutic relationship. Three specific phases (Emotion Awareness, Emotion Regulation, and Emotion Utilization/Transformation) assist patients to increase awareness of emotions, deepen emotional experiences, recognize / regulate unhealthy emotional responses, and utilize healthy emotions to guide behavior. This approach is typically delivered in an individual format and is 16 – 20 sessions in length.

Couple therapy approaches for depression. Behavioral Couples Therapy (BCT) [MS] is designed for couples wherein one of the partners is depressed. BCT focuses on problem, solving, communication, and the exchanges that occur between partners to improve relationship functioning, support, and to decrease conflict which, consequently, decrease depressive symptoms in the affected partner. This treatment typically takes between 12 – 20 couple sessions. Emotionally Focused Couples Therapy (EFT) [MS] focuses on the here-and-now construction of the emotional experience and interpersonal patterns of interactions of a distressed couple. Psychoeducation regarding adult love and bonding processes is provided and the EFT therapist aids the couple in reshaping interactions so that a more secure attachment can be formed. Through reorganizing interactions, reprocessing about experience, and increasing safety, trust, and contact, the couple is able to create a more secure bond that benefits both. Treatment typically comprises 8 – 20 couples sessions.

Eating Disorders and Obesity: Empirically supported interventions for anorexia nervosa, bulimia nervosa, binge eating disorder, and obesity have been proffered, several of which include family components.

Anorexia Nervosa: Family-Based Treatment (FBT) for anorexia nervosa is a 3-phase treatment that may follow a brief stay in an inpatient unit (if medical concerns are present) or can begin on an outpatient basis. In the first phase the parents collaborate with the therapist to assume responsibility for weight restoration and nutritional rehabilitation (while the adolescent maintains autonomy in other areas of life as developmentally appropriate). In the second phase (after acute starvation is reversed), control over eating is returned to the adolescent. The third phase includes addressing issues of family structure, normal adolescent development, and termination. This approach typically takes place in 20 sessions over the course of 12 months. CBT for anorexia nervosa is a post-hospitalization relapse intervention designed to prevent a return of symptoms following the completion of inpatient treatment and subsequent weight gain. It is typically conducted in individual sessions that occur over one year wherein behavioral strategies (regular pattern of eating, systematic exposure to “forbidden” foods) and attending to cognitive features of the disorder (disturbances in perception of weight/shape, motivation for changing) are utilized in order to accomplish the explicit goals of achieving and maintaining a healthy weight.

Bulimia Nervosa: CBT for bulimia nervosa is a present-centered treatment that targets the current symptom cycle rather than attempting to determine etiology. It includes three phases of treatment over approximately 20 weekly sessions. If the first phase, psychoeducational information regarding adverse physiological consequences of extreme dieting, binging, purging, and weight is shared and the aim is to establish a regular pattern of eating as well as developing an appropriate schedule for monitoring weight. Phase two is designed to reducing diet behaviors as well as weight/shape concerns and identification of relapse warning signs is also a focus. In the third phase the focal point is maintenance of progress and relapse prevention. CBT is utilized throughout the phases to disrupt variables (e. g., cognitive distortions) that perpetuate the binge-purge cycle and then to achieve and maintain abstinence from binging and purging behaviors. IPT has also been modified for treating bulimia nervosa. While the connection between bulimia nervosa and interpersonal difficulties is identified at the beginning of therapy, the symptoms of bulimia nervosa are never an explicit focus. Rather, an interpersonal problem domain is identified (grief, role transitions, interpersonal role disputes, and interpersonal deficits) and interpersonal precipitants are identified. The focus then shifts to facilitating change in the interpersonal realm with the third phase focused on progress made and relapse prevention. Treatment typically takes 20 weekly sessions and can be delivered in individual or group format. While strong research support for IPT for bulimia nervosa exists it has been noted that these gains tend to be made more slowly than in CBT. Family-Based Treatment (FBT) for bulimia nervosa was adapted from FBT for anorexia nervosa and, consequently, also has three phases of treatment. This treatment typically encompasses 20 sessions over six months.

Binge Eating Disorder: CBT for binge eating disorder is a 3-phase treatment that primarily focuses on the maladaptive eating patterns, feelings of distress, and felt loss of control that precipitate binge eating behaviors. In the first phase, the approach is dependent upon whether the individual is obese or not; if obesity is an issue the aim is to persuade the patient to prioritize termination of binge eating over immediate weight loss so that an appropriate weight monitoring and eating schedule can be established (if the person is not obese this step is not necessary). Psychoeducational information regarding nutrition is supplied and a regular exercise program is encouraged. Phase two encompasses identification of problematic beliefs ("food addiction", self-esteem based solely on appearance, etc.) and a goal of reducing weight/shape concerns and increasing the definition of self-worth ensues. The last phase is devoted to maintenance and relapse prevention planning. CBT techniques are used throughout and aimed at the disruption of and cessation from factors (thoughts, emotions, behaviors, etc.) that perpetuate binge eating. This treatment typically takes place over approximately 20 weekly sessions in either individual or group formats. IPT has also been adapted for binge eating disorder [SS]. Typically, IPT for binge eating disorder takes place over 20 weekly sessions in a group or individual format.

Obesity and Pediatric Overweight: Behavioral Weight Loss (BWL) Treatment is a short-term approach aimed at establishing new behavioral patterns to achieve acute weight loss and maintain weight reductions attained. The LEARN (Lifestyle, Exercise, Attitudes, Relationships ,and Nutrition) Program is a 12-session holistic approach for adults that encourages small lifestyle changes that, along with reasonable weight goals and moderation in food choices, yields weight loss. Adaptations of BWL for children have also been developed.

The Negative Effects of Psychotherapy

While research overwhelmingly suggests that psychotherapy facilitates reductions in symptomatology, improves everyday functioning, and results in appreciable gains and clinically meaningful change, contrary to the intent of psychotherapy, research also shows that there are some clients who actually worsen during the course of treatment. Similar to client improvement, research shows the phenomenon of deterioration to be equivalent across theoretical orientations (Lambert, Bergin & Collins, 1977). Likewise, negative outcomes have been observed across all client populations, treatment interventions, and family and group therapies. In fact, research shows a relatively consistent proportion of adults (5% to 10%) and an alarmingly high portion of children (14% to 24%) deteriorate when participating in treatment (Lambert, 2013; Warren, Nelson, Mondragon, Baldwin & Burlingame, 2010). While therapy factors (inadequate conceptualization, applying treatments that do not cover the full range of patient problems, unsuitable treatment) may be liable, this finding does not mean that all instances of worsening are attributable to therapy itself as a myriad of other factors may be present.

Instances that are independent from treatment can occur such as an inevitable negative life event (e. g., loss of loved one, medical condition, etc.) or a progressive decline that is inescapable (such as dementia). Unfortunately, as mentioned prior, severity of mental illness alone is predictive of unsuccessful outcome. Higher levels of interpersonal problems and a higher degree of seriousness in presenting problems also predict poor results. In addition, certain diagnoses and symptoms (e. g., Borderline Personality Disorder, Obsessive Compulsive Disorder, psychotic, schizophrenic, bipolar) seem less amenable to psychotherapeutic intervention. Client, setting, and therapist factors related directly to treatment might also help account for treatment failure (e. g., the inability of therapists to repair ruptures in the therapeutic alliance; Muran & Barber, 2006). Just as some client characteristics help maximize gains, other clients factors such as poor motivation, sporadic attendance, hostility, resistance to therapist suggestions and prescriptions, complicated problems, negative expectations of treatment, dysfunctional relationship dynamics or environment, and/or unreported problems/issues predict poor outcomes (Bohart & Wade, 2013). The setting in which the client is seen also seems to play an important role in whether clients improve or deteriorate (Warren et al., 2010). Lastly, specific therapist behaviors have also been found to lead to treatment failure. Clinician competence and mastery vary and, not surprisingly, some therapists respond better to challenging patient presentations than others. Studies focused on deterioration have found lack of empathy, underestimation of the severity of client concerns, and/or overestimation of client progress to be detrimental; multiple studies also underscore the destructiveness of therapist negative reactions towards the client that reflect irritation, hostility, and disappointment (Henry, Schacht & Strupp, 1986).

Fortunately, innovative resources have been developed to help reduce rates of deterioration in psychotherapy. Routine monitoring of outcome measures taken at each contact with the client can provide real-time clinically relevant feedback to the therapist that provides a benchmark for the client's progress in therapy (Boswell, Kraus, Miller & Lambert, 2013). One such resource has created software that employs score-specific algorithms that track progress, detect "off track cases", sends alarm signals to the therapist for those predicted to have a negative outcome (e. g., deterioration, premature termination) so that ameliorative action can be taken; the result of such an intervention resulted in reducing deterioration rates from 20% to 13%. When clinical support tools were incorporated that helped to identify possible causes of negative response and provide possible solutions/ideas for corrective interventions, the deterioration rate dropped to approximately 8% while positive outcomes doubled (Lambert, 2010; Shimokawa, Lambert & Smart, 2010).

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