# Therapist Effects on Treatment Outcome in Psychotherapy: A Multilevel Modelling Analysis

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**Abstract**

**Objectives:** This study investigated specific and nonspecific therapeutic factors by focusing on therapist effects on treatment outcome.

**Methods:** Psychotherapists (n = 68) from 10 types of psychotherapy treating 237 patients in an effectiveness study were investigated with regard to their contribution to treatment outcome. Factor scores from a factor analysis of the change scores in all outcome measures were cluster analysed in order to generate clusters of differently effective therapists.

**Results:** Two clusters of differently effective therapists emerged. A fixed effects model revealed a significant impact of differential therapist effectiveness on treatment outcome. In addition to therapists' differential effectiveness, also nonspecific factors such as patients' severity of psychological problems predicted treatment outcome significantly. Treatment concepts did not impact therapists' effectiveness.

**Conclusions:** The results of this study support the view that there are differently effective therapists, but that patient characteristics also contribute significantly to the course of a psychotherapeutic treatment, independently of therapist.

**Keywords:** effects of psychotherapists; process-outcome research; treatment outcome in psychotherapy

**Points for Practitioners:**

1) The results of this study support the importance of the differential effectiveness of psychotherapists but they are tentatively valid for those treatment approaches only that were studied: psychodynamic, humanistic, body oriented, and integrative approaches.
2) The more effective psychotherapists are those with more professional experience.
3) The more experienced therapists seem to be more effective the more severe their patient's psychological problems are.
4) The amount of professional experience is not fully identical with therapists' effectiveness.
5) The results of this study support major parts of the research literature, in that there are differently effective therapists, but professional experience is not the only explanation. We were not able to identify sufficiently the reasons for the differences between the two clusters in our study.
6) Therapy concept and treatment adherence do not seem to contribute to these differences.

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The role of the therapist in psychotherapy has been a neglected variable for a long time and did not become a focus until the 1990s: see the special sections of the *Journal of Consulting and Clinical Psychology* (Kendall & Chambless, 1998) and *Clinical Psychology: Science and Practice* (Kazdin, 1997). There are several reasons for this. Research overemphasized the form or type of psychotherapy because many researchers "... tended to get emotionally involved and identified with a particular orientation" (Garfield, 1997, p. 41), which led to a predominance of research on specific types of psychotherapy relying predominantly on the paradigm of the randomized trial (RCT). This led to a supposed homogeneity of therapists, and thus the therapist was taken as a constant in psychotherapeutic interventions in order to exclude unwanted variance in randomized-controlled studies. As a consequence, therapists became a neglected variable in the therapeutic change process.

In addition, for a long time, psychotherapy has been under pressure to legitimatize its existence and its genuine effects and has had to compete with other forms of intervention (e.g. such as medication); it was therefore primarily concerned with legitimization (Willutzki *et al.*, 2013).

There is a growing body of literature aimed at having a closer look at therapeutic factors, which makes it necessary to concentrate more on process-outcome research in psychotherapy (Crits-Christoph *et al.,* 2013). Today, it is widely accepted that – besides the specific factor of treatment adherence to the treatment protocol – non-specific, common therapeutic factors such as the quality of the therapeutic alliance, the therapist's competence, the personality of the patient/client, the experience of the therapist, the length of treatment, and other factors – may play a more or less important role in the change process in different psychotherapies.

Baldwin and Imel (2013) summarized the available empirical evidence from studies on therapists' effects to date and concluded that the bulk of the research literature shows that some therapists are more effective than others. They assume that approximately 5% to 7% of the outcome variance in therapies might be due to the personality of the therapist. Baldwin and Imel consider that a certain difference in therapists' effects between efficacy studies (5% of the outcome variance) and naturalistic/effectiveness studies (7% of the outcome variance) may be due to the highly structured therapist activity in randomized controlled trial studies, which increases the homogeneity of therapists and lessens their individuality, creativity, and spontaneity. Wampold and Brown (2005) discuss the crucial role of statistical analysis in finding a proper average value to assign to the variability attributable to therapists. They assume that if therapists were treated as random and the appropriate statistical model used, about 8% of the variability of outcomes could be attributed to them. Compared to the minor influence of the treatment concept itself (see role of treatment adherence below), the personality of the therapist should be considered as a variable of major importance in psychotherapy. It is assumed that it should be most important that a therapist carries out the therapeutic approach in a skilful fashion (Shaw *et al.,* 1999).

Overall, the current discussion in the literature leaves no doubt about the existence of differently effective psychotherapists and, thus confirms the long-held conclusions by Frank (1959) and Luborsky *et al.*, 1986) that there are considerable differences between therapists in their success rates (Anderson *et al.*, 2009; Baldwin & Imel, 2013; Blatt *et al.*, 1996; Firth *et al.*, 2015; Huppert *et al.*, 2001; Jung *et al.*, 2015; Kaplowitz *et al.*, 2011; Kuyken & Tsivrikos, 2009; Tschuschke & Greene, 2002; Wampold & Brown, 2005; Willutzki *et al.*, 2013). The key question is: What are the differences between the therapists?

Treatment adherence and the competence of the therapists are supposed to be key concepts for approaching the differential effectiveness of therapists. Yet studies on treatment adherence and therapists' competence have yielded highly mixed results, ranging from

no impact on treatment outcome to a significant relationship with therapy outcome, from quadratic effects to curvilinear relationships (Baldwin & Imel, 2013; Barber *et al.*, 1996; Barber *et al.,* 2004; Barber *et al.,* 2006; Boswell *et al.,* 2013; Hogue *et al.,* 2008; Imel *et al.,* 2011; Strunk *et al.,* 2010; Webb *et al.,* 2010). More recent meta-analyses conclude that therapists' adherence to their treatment protocol or therapists' competence do not significantly impact outcomes (Baldwin & Imel, 2013; Webb *et al.,* 2010). As Barber *et al.* (2004) and Perepletchikova *et al.* (2007) comment, adherence to specific techniques does not necessarily ensure that the treatment is delivered appropriately, thus leaving much room for speculations about the role of therapists' competence or skilfulness. Barber *et al.*, (2006) found an interaction between therapeutic alliance, a curvilinear relationship between adherence and outcome, suggesting that the alliance can moderate the influence of treatment adherence on outcome. Our own results support this finding: Experienced therapists lowered their degree of treatment adherence in therapies with patients with a higher initial severity of psychological problems, who stressed the working alliance from the beginning of treatment (Tschuschke *et al.*, 2015).

Whereas most studies have failed to find an important contribution of variables such as age, gender, gender-matching, diagnosis, professional identity, length of treatment, and therapist experience (Brown *et al.,* 2005; Beutler, 1997; Vocisano *et al.,* 2004), some studies have found that professional experience discriminates between more and less successful therapists (Huppert *et al.,* 2001; Willutzki *et al.,* 2013).

There is also evidence that the therapeutic alliance serves as a mediator of change that depends on the therapist's and patient's personality, presumably on the patient's motivation and ability to bond and to cooperate, and on the therapist's skilfulness to adapt to a weakened or stressful working alliance (Barber *et al.,* 2006; Beutler, 1997; Meyer *et al.*, 2002; Tschuschke *et al.*, 2015; Zeeck *et al.*, 2012).

Another finding is that more effective therapists are "more" effective – but not with all their patients – and vice versa: less effective therapists are not unsuccessful with all of their patients. No psychotherapist seems to be continuously effective or ineffective, no matter what the patient. There is often a broad *within-therapist variability* in outcomes from case to case (Baldwin & Imel, 2013).

In the present study, we wanted to examine process variables as well as person-related characteristics of both therapists and patients, in order to find evidence of possible contributions of therapist variables to treatment outcome. We investigated 68 therapists working with ten types of psychotherapies, treating 237 patients, in a naturalistic outpatient setting. Referring to a most recent major meta-analysis by Baldwin and Imel (2013), the primary hypothesis was that there would be significant differences in therapist effectiveness between therapists. Additionally, with respect to therapists' effectiveness, we were also interested in looking at the role of therapists' theoretical orientation, the quality of the therapeutic alliance, therapists' professional experience, and patients' initial severity of psychological problems.

## Methods

### *A Naturalistic Study*

This study reports data from a naturalistic study, which has been described in detail by von Wyl *et al.* (2015). Patients chose their therapists themselves and were not matched with therapists based on any features. The study was a naturalistic study; the research had no influence on the practices of the cooperating therapists.

There was no restriction with regard to diagnosis; we were interested in the typical patient clientele that therapists encounter in their daily practice. This resulted in a sample of patients with a broad range of psychological problems and diagnoses. There was also no influence on length of treatment or therapeutic interventions.

The participating institutes were interested in empirical investigations that did not impact on everyday practice (frequency of sessions, duration of treatment, patient selection, therapists' interventions, and so on) other than the necessary audio-recording and testing of patients. The institutes agreed to have no influence on the scientific utilization of all project data.

At pre- and post-therapy, a battery of outcomes was administered by independent trained therapists, who cooperated in the study as independent assessors. The assessors first administered the Structural Clinical Interview for DSM-IV Axis 1 Disorders (SCID-I) and for DSM-IV Axis II Personality Disorders (SCID-II), and made their ICD-10 and DSM-IV diagnoses, and then administered three tests (see Measures). All therapy sessions with all patients enrolled in the study were audio-recorded, and therapists' technical interventions were objectively rated to investigate the therapists' degree of treatment adherence. To track the quality of the therapeutic alliance, after each fifth session, patients filled out a session questionnaire (see Measures).

All of the data was coded (ID number) by the therapists, so that the researchers worked with anonymous data and had no access to patient identification. Therapists had no access to patient session ratings (the patients' ratings were sealed in an envelope by the patients) or the outcome battery test results, because the patients were tested by independent testers and raters, outside of the therapists' practices. Psychotherapists practicing behaviour therapy, client-centred therapy, and system therapy approaches were invited to take part in the study, but declined. From March 2007 to June 2011, co-operating psychotherapists at all of the participating institutes/approaches asked new patients if they would participate in the study on a voluntary basis.

Participants were all out-patients, ranging in age from 17 to 72 years. Each participating patient signed a written informed consent that included the warranty that all participants were free to withdraw from the study at any time and without any justification. Also, each patient was assured of having their right not to participate in the study and yet to receive therapeutic treatment from the same therapist. Prior to the start of the project, a research application for the study was submitted to the local ethical committees of each of the Swiss states involved; these committees approved all of the applications.

The co-operating psychotherapists all work in private practices throughout major cities in Switzerland. This was an effectiveness/naturalistic study of psychotherapies without controlling for therapists' technical interventions (i.e. no manualization).

***Measures***

Independent and trained psychotherapists (i.e. not involved in the study as therapists) administered the three tests in the outcome battery.

**(1)** Patients completed the Global Severity Index (GSI) of the Brief Symptom Inventory (BSI) (Franke, 2000): it comprises 53 items and nine sub-scales covering a broad range of psychological symptoms. This short version of the Symptom Check-List (SCL-90-R) has a satisfactorily high internal consistencies of its scales, ranging from .70 to .89, and .96 for the GSI (Cronbach's alpha). Concurrent or convergent validity was estimated by high positive correlations with a number of clinical self-rating scales (Geisheim *et al.*, 2002). It is an overall measure of general symptom load.

**(2)** The Outcome Questionnaire (OQ-45.2) (Lambert *et al.*, 2002) was also completed by the patients: it is a measure for capturing symptom load, interpersonal relationship functioning, and quality of social integration. The internal consistency of the German version ranges from .59 to .93 for the different scales (Cronbach's alpha), and the convergent or concurrent validity was estimated by positive correlations between .45 (German version of the SCL-90-R) and .76 (German version of the Inventory of Interpersonal Problems – IIP).

**(3)** Finally, we used Beck's Depression Inventory (BDI-II) (Hautzinger *et al.*, 2006). The internal consistencies of the BDI-II scales in several studies vary from .84 to .94; the retest reliability for a time range of one week was .93. Correlations with other tests measuring anxiety or similar cognitive constructs ranged from .68 to .89, thus proving the validity of the measure (Kühner *et al.*, 2007).

The three tests were employed within the first probationary sessions before the start of treatment (t 1) and again immediately after the last therapy session (t 2). Approximately two to three probationary sessions are normal and serve as the basis on either side – patient and therapist – for a pro or con decision to start psychotherapeutic treatment together or not.

Patients rated the therapeutic relationship (therapeutic alliance) after each fifth session using Luborsky's Helping Alliance Questionnaire (HAQ) (De Weert-Van Oene *et al.*, 1999). Internal consistencies (Cronbach's alpha) of the two subscales (Scale 1 ["Cooperation Scale"] with six items, and Scale 2 ["Helpfulness Scale"] with five items) range from .79 to .90, which provides evidence for a sufficient reliability of the measure. Satisfying positive correlations with several outcome measures indicate the validity of the measure. We used the Cooperation Scale as a measure for patients' experience of the quality of the therapeutic relationship.

**Statistical Analyses**

T-tests, crosstabs, factor analysis, hierarchical cluster analysis, and linear mixed model calculations with random effect analysis were calculated (SPSS, version 21).

Therapists' effectiveness clustering was determined by following the procedure described in Figure 1. T-Tests were calculated for the pre-post comparison of the outcome measures. The factor analysis of the change scores of the three outcome measures from pre to post was carried out as in the Blatt *et al.* (1996) study to gain factor scores that served as a composite measure of therapist efficacy (eigenvalue > 1). Factor scores were averaged across all patients of each therapist. The resulting 68 scores (68 therapists) were then subjected to a hierarchical cluster analysis in order to find distinctive clusters of therapists.

Finally, we used a linear mixed model with random effects analysis to estimate the therapist effect (Baldwin & Imel, 2013; Saxon & Barkham, 2012). Outcomes for each of the 237 therapies were operationalized using the "strategy of multiple outcome criteria" (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1980). Rather than use a single outcome criterion, we combined several outcomes from the three outcome measures to measure up to the complexity of therapeutic effects. For this, T-score transformations for each score of each outcome measure (BSI-GSI, BDI-II, and OQ-45.2) at each measurement point were made. T-scores were then summed up across the three outcome measures each at pre (t 1) and post (t 2), and the total at t 2 was subtracted from the total at t 1, resulting in a final "T-score" (outcome score). T-score sum at pre-measurement (t 1) served also as a measure of the patient's initial severity of psychological problems prior to treatment.

**Results**

***Participants***

A total of 362 patients were enrolled in the X study. Complete data were available for 237 of the patients on a pre-post basis. Of these 237 patients, 161 (67.9%) were women and 76 (32.1%) men. Their average age was 39.8 years and ranged from 17 to 72 years, with a median of 40.0 years (s = 11.3 years). Participants' marital status was as follows: 127 patients (53.6%) were single; 60 (25.3%) married; 44 (18.6%) separated or divorced; and five (2.1%) widowed; (there was one missing value). As to their highest attained education level: two (0.8%) were unclear; three (1.3%) had no education; 14 (5.9%) had only completed elementary school; 78 (32.9%) had an apprenticeship certificate; 36 (15.2%) had a high school diploma; 45 (19.0%) had a degree from the university of applied sciences; and 59 (24.9%) a university degree; so, on average, the total sample is thus relatively highly educated.

A total of 305 DSM-IV diagnoses (first and second diagnoses) (American Psychiatric Association, 2000) were given for the 237 patients, including:

| Axis I diagnoses | Axis II diagnoses |
|---|---|
| • Affective disorders: 95 (40.1%)<br>• Anxiety disorders: 55 (23.2%)<br>• Adjustment disorders: 39 (16.5%)<br>• Others: 20 (8.4%)<br>• None: 28 (11.8%) | • Cluster A: 6 (2.5%)<br>• Cluster B: 24 (10.1%)<br>• Cluster C: 56 (23.6%)<br>• None: 151 (63.7%) |

Prior to enrolment in the study, 160 patients (67.5%) had had no psychiatric or psychotherapeutic treatment, and 73 patients (30.8%) had had one or more psychiatric/psychotherapeutic treatments in outpatient or inpatient settings, once or more times.

Only 237 patients/clients out of the total sample (N = 362) could be included in this report because of missing values in outcome tests of 125 patients. Of these 125 patients, complete data in outcome measures were available for 86 patients regarding their severity of psychological problems at treatment entry (pre-measurement). There were no differences in the outcome measures compared to the 237 patients in this report (T-score = - 1.100; df = 319; p < .272), nor were there marked differences in any demographic variable.

The average length of all 237 treatments was 43 sessions, varying widely from 10 sessions up to 235 sessions, depending on the clients' problems, and therapist-client agreements regarding treatment continuation or ending. Sixty-eight therapists from 10 different conceptual approaches treated 237 clients. The number of clients per therapist varied from one to nine clients (see list below).

| Number of clients per therapist | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|---|
| Therapists with number of treated patients | 15 | 8 | 13 | 10 | 13 | 4 | 3 | 1 | 1 |

Twenty-three (15+8) therapists treated one or two clients (33.9%), also 23 (13+10) therapists (33.9%) treated three or four clients, 17 (13+4) therapists (25%) treated five or six clients, and five (3+1+1) therapists (7.4%) treated seven to nine clients.

***Therapists***

86 therapists (in total) treated the 362 patients, however the 237 patients remaining in this study were treated by 68 psychotherapists, of whom 48 (70.6%) were women and 20 (29.4%)

men. Therapists had an average age of 54.0 years (range from 35 to 79; median = 55.0). Their professional experience of 12.7 years on average was very high (median = 10.0 years; range from 0 to 32 years; s = 7.4): fourty therapists (58.8%) were psychologists, nine (13.2%) were physicians, and 19 (27.9%) had university degrees in fields other than psychology or medicine.

All of the therapists were licensed by their institute and had been awarded state recognition, after having successfully completed their psychotherapy training.

Ten types of psychotherapy, all connected with the "Swiss Charta for Psychotherapy", agreed to cooperate in the study (the participating organisations and the founders of the method are shown in parentheses):

- Analytical Psychology (SGAP): Main orientation: Psychodynamic (Jung)
- Art and Expression-Oriented Psychotherapy (EGIS): Main orientation: Integrative (Knill)
- Bioenergetic analysis (SGBAT/DÖK): Main orientation: Body-oriented (Lowen)
- Existential analysis and logotherapy (GES): Main orientation: Humanistic (Frankl)
- Gestalt Therapy (SVG): Main orientation: Humanistic (Perls)
- Integrative Body Psychotherapy (IBP): Main orientation: Body-oriented (Rosenberg)
- Logotherapy and existential analysis (ILE): Main orientation: Humanistic (Frankl)
- Process Oriented Psychotherapy (IPA): Main orientation: Psychodynamic (Mindell)
- Psychoanalysis (???): Main orientation: Psychoanalytic (Freud)
- Transactional Analysis (SGTA/ASAT): Main orientation: Humanistic (Berne)

**Assignment of Therapists to Effectiveness Groups**

As mentioned, 68 different therapists treated a total of 237 patients (with complete data). The factor analysis of the pre-post differences of the three outcome measures revealed a one factor solution with an eigen-value of the first factor = 2.699 [explained variance = 81.1%] and consecutive factors < 1.00. The resulting 237 factor scores were averaged across all patients of each therapist resulting in 68 scores (as Figure 1 shows, 15 therapists treated only one patient, while the rest of the 68 therapists treated from between 2 to 9 patients). These 68 scores were subjected to a hierarchical cluster analysis. Two clusters emerged: 43 significantly more effective therapists (Group A) and 25 less effective therapists (Group B). The two groups did not differ with regard to the therapists' theoretical orientations, nor did they differ with regard to therapists' sex, age, or professional experience.

Patients treated by Group A therapists were significantly younger than patients treated by Group B therapists (4 years younger on average). Besides this, there were no meaningful differences regarding other demographic variables.

**Table 1** shows basic data for the two groups of differently effective therapists.

**Table 2** provides information on diagnoses. There were no differences in diagnoses between patients seen by Group A and Group B therapists.

**Table 3** shows traditional T-tests, describing pre-and post- outcomes for the three outcome measures for the total sample. All pre-post differences were on average significantly different between entering treatment and discharge. The effect sizes were roughly compatible with those found in most psychotherapy outcome studies.

**Table 4** shows correlations between therapist variables (age, sex, professional experience, and main theoretical orientation) and the three outcome measures. None of these correlations were significant.

**Table 5** shows the treatment response of the total patient sample for the two groups of

differently effective therapists in the three outcome measures by using the reliable change index procedure (dropout and missing value information was available for N = 350). Responders were patients who showed significant change through therapy, with a reliable change index score of at least 1.96 (reliable change scores using Jacobson and Truax's (1991) reliable change index). Non-responders were patients who did not fulfil this criterion: they did not change, or they even deteriorated. Dropouts were those patients who dropped out of treatment prematurely, without being tested again. Group A therapists had considerably more treatment responders in any outcome measure than Group B therapists did. They also had clearly fewer non-responders and fewer dropout patients compared to Group B therapists. It is clear from this overview that successful therapists differed from less effective therapists in all three outcome measures.

**Table 6** shows that compared to patients of Group B therapists, patients of Group A therapists had significantly more severe psychological problems when they entered and significantly less severe psychological problems when they finished psychotherapeutic treatment in each outcome measure. Thus, patients of Group A therapists benefited significantly more from their treatments than patients of Group B therapists did.

**Table 7** shows that the effect sizes of patients treated by Group A therapists ranged on a high level, whereas the effect sizes of patients seen by Group B therapists ranged on rather low levels.

**Prediction of treatment outcome**

Length of treatment (number of therapy sessions) did not differ statistically between the two groups of therapists' effectiveness.

Therapists' treatment approaches (using the four main theoretical orientations psychodynamic, humanistic, body oriented, and integrative approaches); patients' initial severity of psychological problems when entering therapy; therapists' professional experience; the therapeutic alliance; clusters of therapists' effectiveness; and interactions between some of these variables; were taken as independent variables and tested with regard to treatment outcome (dependent variable) in a linear mixed model (**Table 8**).

Although pre-treatment severity of psychological problems was distributed to control for regression to the mean, it still significantly predicted treatment outcome. Other significant predictors were: the therapists' effectiveness grouping; the therapists' amount of professional experience (in years); the quality of the therapeutic alliance; and the interactions between therapists' level of effectiveness and the degree of the patients' severity of psychological problems; as well as the level of therapists' professional experience, and the patients' severity of psychological problems.

The therapists' level of effectiveness, in interaction with their level of professional experience, was also not statistically significant, thus proving that the two variables are not identical. The four clusters of main theoretical orientations also did not predict treatment outcome. A test of random effects (237 cases) found no significant influence of the person of the therapist on treatment outcome (Wald = 0.609; $p < 0.542$). Thus, the fact that some therapists were represented repeatedly in the analysis because they treated more patients than other therapists did not influence the variables significantly predicting treatment outcome.

The analysis of the variance components revealed that the impact of the overall therapist's personality explained 3.4% of the outcome variance (test of random effects).

**Figure 2** shows the relationship between patients' psychological severity of problems and therapists' effects. At patients' lower levels of psychological severity therapists' effects were lower compared to higher levels of patients' psychological problems. Therapists treating

patients within the first percentile of psychological severity at treatment entry (0% – 25%) had an effect size of 2%, therapists' effect size increased to 8% when patients psychological problems were within the second percentile (26% - 50%), again the effect size increased to 14% when psychological problems were within the third percentile (51% - 75%), and finally increased to 17% when patients' severity of psychological problems was within the fourth percentile (76% - 100%).

Although therapists' impact on treatment outcome increased *in general* with higher severity of patients' psychological problems, more effective therapists significantly worked even more effectively with patients with higher levels of psychological severity (crosstabs with variables "therapists' effectiveness grouping" and "quartiles of psychological severity"; $\chi = 13.073$; $df = 3$; $p < .004$).

**Discussion**

Our aim was to investigate the degree to which psychotherapist characteristics contribute to treatment outcome. We investigated the role of the professional experience of 68 therapists using 10 different types of psychotherapy with four different main theoretical orientations, their age, their sex, and the impact of other, non-specific factors.

The results show that therapists differ in effectiveness, thus confirming our hypothesis. Our results are in line with other studies and a recent review (Baldwin & Imel, 2013; Blatt *et al*., 1996; Heinonen *et al*, 2012; Huppert *et al*., 2001; Kuyken & Tsivrikos, 2009; Luborsky *et al*., 1986; Luborsky *et al*, 1997; Saxon & Barkham, 2012; Wampold & Brown, 2005).

We found two clusters of differently effective therapists. Overall, the person of the therapist explained 3.4% of the outcome variance (Test of Random Effects). Thus, our results are slightly below the margin of the explained outcome variance reported by other studies (Baldwin & Imel, 2013; Firth *et al*, 2015; Wampold & Brown, 2005).

Our results suggest that two aspects are of major importance. The therapists' effectiveness predicted the treatment outcome, as did the severity of the patients' psychological problems at treatment intake. Both variables contributed to the psychotherapy outcomes independently of each other. The patients' severity of the psychological problems were statistically distributed out, and still predicted significantly treatment outcome, thus proving that a regression to the mean effect can be excluded. The therapists' effectiveness in our study was not identical with therapists' level of professional experience. As in the Saxon and Barkham (2012) study, our data confirm the conclusions drawn by those authors in that the more severe patients' psychological problems are, the more they benefit from a more effective psychotherapist.

A more effective, skilful therapist does not guarantee treatment success *per se*. This result also holds for the other side: A less effective psychotherapist can be very successful with patients with a high or low psychological burden, but to a much lower degree of probability. Patients treated by Group A therapists had an approximately 50% to 70% chance to be treated successfully, whereas patients of Group B therapists had an approximately 30% chance to benefit significantly from their therapy.

The more effective therapists clearly have higher treatment response rates and lower non-response and lower dropout rates in all outcome measures. Differences between both groups of therapists were not due to: their main theoretical orientation; their age; their professional experience, and the sex of the therapist did not play a significant role, either. Also, patient demographic variables did not significantly contribute to these differences.

The role of their professional experience in a therapist's effectiveness is controversial. A few studies found more experienced therapists to work more effectively with patients (Huppert *et al*., 2001), but most studies negate that relationship (Brown *et al.*, 2005; Vocisano

*et al.*, 2004; Willutzki *et al.*, 2013), and looked at rather inexperienced therapists (Willutzki *et al.*, 2013).

Therapists cannot be seen independently of the patients with whom they work. The sometimes extreme, within-therapist variability (Baldwin & Imel, 2013) appears to point to the personality of the patient as another major determining factor in the psychotherapeutic process. There is a widely held view that patients' personality and problems impact on the therapists' effectiveness. Beutler (1997) refers to a large body of literature that indicates that, whereas demographics and professional styles do not appear to exert main effects, differences emerge when the patients' personality and their coping style collide with the therapists' personality and professional style.

In our study, the amount of professional experience of the therapists was a significant predictor of treatment outcome; as was the quality of the therapeutic alliance. More severe initial psychological problems were significantly correlated with better treatment outcomes, but more severe psychological problems, in combination with more experienced therapists, were an even better predictor. We found that a higher effectiveness of a therapist combined with a higher severity of patient's psychological problems was the best predictor of treatment outcome.

We were not able to identify those characteristics that would explain the therapist effects satisfactorily. Although the therapists' amount of professional experiences contributed to treatment outcome in psychotherapy in our study, the therapists' effectiveness is not fully explained by their level of professional experience.

There are other variables in the psychotherapeutic process that are likely to affect treatment outcome as well. Therapist competence might be a crucial factor that mediates between patients' needs and abilities and a possibly hampered therapeutic alliance (Muran & Barber, 2010). It appears that the very complex interdependency exists between" patient's variables (chronicity, severity of problems), patients' ability and their motivation to bond with the therapist; the personality of the therapist, the therapist's professional experience, the timing of an intervention, the quality of an intervention, and the fit between the therapist's treatment concept and the patient's problems and possibilities or motivations add substantially to a successful psychotherapeutic treatment. There are a great many other variables impacting the course of psychotherapeutic treatment (Beutler, 1997; Brown *et al.*, 2005; Crits-Christoph & Mintz, 1991; Orlinsky *et al*, 2004).

## Conclusions

All in all, we were able to distinguish among therapists with regards to their effectiveness. Therapist effects appear to be very important and should be investigated with regard to specific treatment effects (Luborsky *et al.*, 1986). Patients' severity of psychological problems seems to be dealt with best in psychotherapy when psychotherapists are more effective. In general, the study showed that therapists' impact on treatment outcomes increased when patients' initial psychological problems at treatment entry were more severe. If the degree of patients' severity of psychological problems was taken into account, therapists' importance increased.

Research in this area appears to be in its beginnings; studies should examine large samples (patients and therapists) and should be designed from the outset to be therapist effect studies (Baldwin & Imel, 2013) and should have extensive process-outcome designs that include relevant variables such as patient characteristics, treatment adherence, therapist competence, quality of therapeutic alliance and the timing and content of interventions.

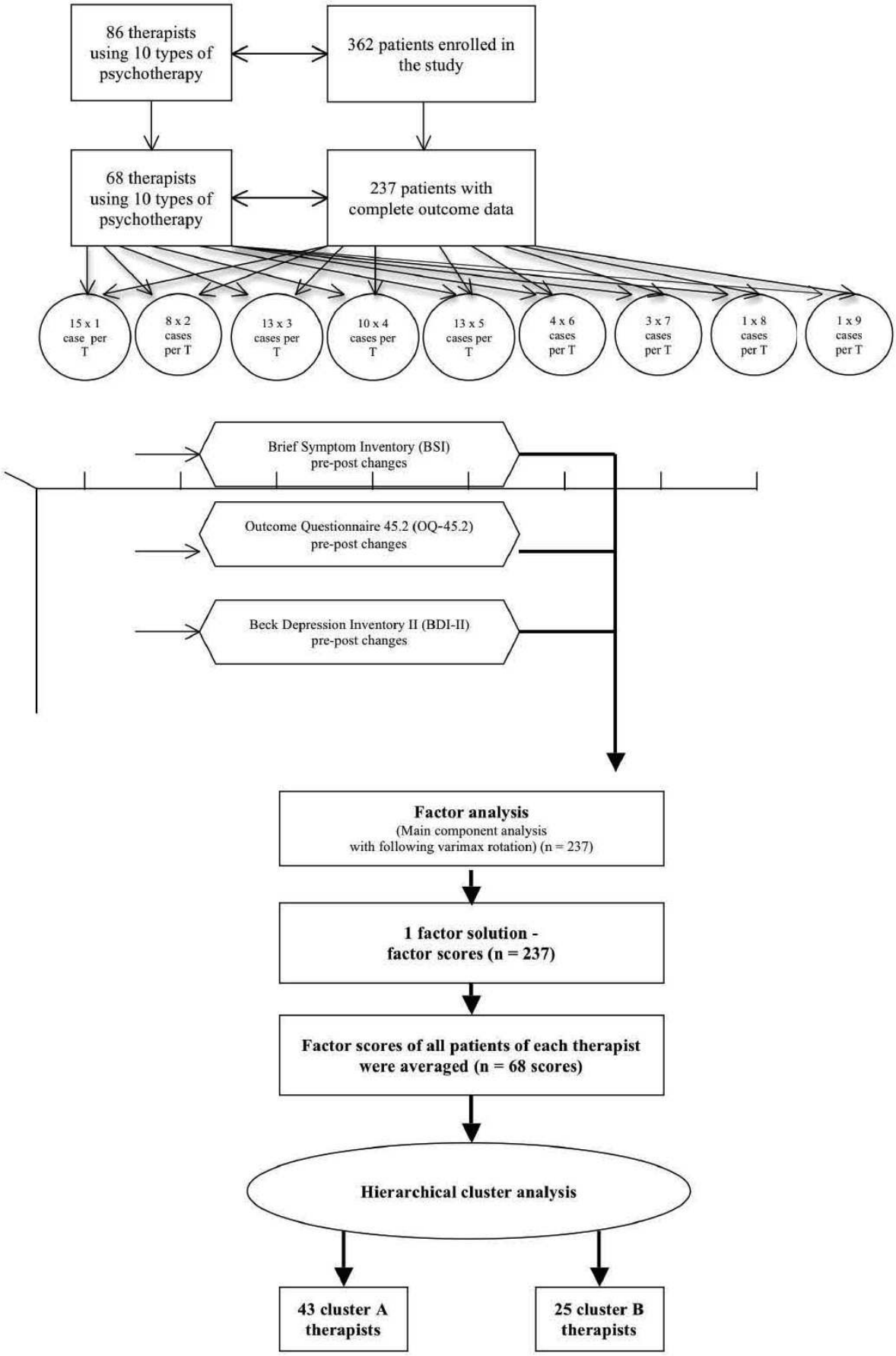


**Figure 1.** Flowchart of assigning therapists to different effect clusters

**Table 1.**

*Therapists' Grouping Characteristics (Age and Experience in Years)*

| Effect Groups | Age | N | Sex | | | Professional experience | Theoretical Orientations (N) | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *M* | | female | male | percent | *M* | Body Oriented | Humanistic | Psychodynamic | Integrative |
| A | 54.5 | 43 | 30 | 13 | 70:30 | 12.9 | 20 | 13 | 8 | 2 |
| B | 53.2 | 25 | 18 | 7 | 75:25 | 12.2 | 10 | 9 | 5 | 1 |
| Total | | 68 | 48 | 20 | | | 30 | 22 | 13 | 3 |

**Table 2.**

*Patients: DSM-IV Diagnoses (N = 237)*

| | Patients of group A therapists *n (%)* | Patients of group B therapists *n (%)* | $\chi$ *p* |
|---|---|---|---|
| Axis I | | | |
| Affective disorder | 66 (41.0) | 29 (38.2) | 1.105 |
| Anxiety disorder | 39 (24.2) | 16 (21.1) | .894 (df = 4) |
| Adjustment disorder | 26 (16.1) | 13 (17.1) | |
| Others | 12 (7.5) | 8 (10.5) | |
| None | 18 (11.2) | 10 (13.2) | |
| Total | 161 (100.0) | 70 (100.0) | |
| Axis II | | | |
| Cluster A | 3 (1.9) | 3 (3.9) | 1.499 |
| Cluster B | 17 (10.6) | 7 (9.2) | .683 (df = 3) |
| Cluster C | 36 (22.4) | 20 (26.3) | |
| None | 105 (65.2) | 46 (60.5) | |
| Total | 161 (100.0) | 76 (99.9) | |

**Table 3.**

*Treatment Outcome (Pre-Post T-test) of the Total Sample (N = 237)*

| | *M* | *N* | *SD* | *t* | *sig. p (2-tailed)* | *Effect size* |
|---|---|---|---|---|---|---|
| BSI-GSI pre | .81 | 237 | .52 | 11.60 | .000 | .79 |
| BSI-GSI post | .43 | 237 | .43 | | | |
| OQ-45 pre | 61.81 | 237 | 21.64 | 15.45 | .000 | .92 |
| OQ-45 post | 41.56 | 237 | 22.28 | | | |
| BDI pre | 14.50 | 237 | 9.53 | 12.42 | .000 | .85 |
| BDI post | 6.97 | 237 | 8.19 | | | |

*Note.* BSI-GSI = Global Severity Index; OQ-45.2 = Outcome Questionnaire 45.2; BDI-II = Beck Depression Inventory II.

**Table 4.**

*Correlations Between Therapist Variables and Average Change in Therapist Caseloads on Each Outcome Measure (N = 68)*

| Therapist variable / Tests | *GSI* | *OQ-45* | *BDI* |
|---|---|---|---|
| Age (years) | .104 | .041 | - .071 |
| Sex | - .009 | .002 | .061 |
| Theoretical orientation | .064 | - .016 | .009 |
| Professional experience (years) | .109 | .061 | - .002 |

**Table 5.**

*Responding, Non-Responding (Reliable Change Index), and Dropout Patients of Group A and Group B Therapists*

| | Responders *n (%)* | Non-responders *n (%)* | Dropouts *n (%)* | Non-responders and dropouts *n (%)* | *N* |
|---|---|---|---|---|---|
| BSI-GSI | | | | | |
| A therapists | 99 (50.0) | 58 (29.3) | 41 (20.7) | 99 (50.0) | 198 |
| B therapists | 26 (26.3) | 50 (50.5) | 23 (23.2) | 73 (73.7) | 99 |
| OQ-45-2 | | | | | |
| A therapists | 94 (47.5) | 63 (31.8) | 41 (20.7) | 104 (52.5) | 198 |
| B therapists | 20 (20.2) | 56 (56.6) | 23 (23.2) | 79 (79.8) | 99 |
| BDI-II | | | | | |
| A therapists | 122 (61.6) | 35 (17.7) | 41 (20.7) | 76 (38.4) | 198 |
| B therapists | 32 (32.3) | 44 (44.4) | 23 (23.2) | 67 (67.7) | 99 |

**Table 6.**

*Treatment Effects in Patients Treated by Group A and Group B Therapists (Group Comparisons at Pre and Post)*

| Therapist clusters / Patients' test scores (mean) | N | BSI | | OQ-45.2 | | BDI-II | |
|---|---|---|---|---|---|---|---|
| | | pre | post | pre | post | pre | post |
| Patients of group A therapists | 161 | 0.88 | 0.37 | 64.53 | 38.61 | 15.62 | 5.88 |
| Patients of group B therapists | 76 | 0.65 | 0.54 | 56.03 | 47.82 | 12.12 | 9.29 |
| T-score | | 3.22 | -2.88 | 2.87 | -3.02 | 2.68 | -3.05 |
| p | | .000 | .013 | .005 | .003 | .008 | .009 |

**Table 7.**

*Treatment Effects in Patients Treated by Group A and Group B Therapists (Pre-Post Comparison)*

| Patients of Group A therapists | *n* | *M* | *SD* | *t* | *df* | *p* | *Effect size (ES)* |
|---|---|---|---|---|---|---|---|
| BSI pre | 161 | .88 | .55 | | | | |
| BSI post | 161 | .37 | .36 | 13.075 | 160 | .000 | 1.10 |
| OQ-45 pre | 161 | 64.53 | 22.04 | | | | |
| OQ-45 post | 161 | 38.61 | 21.34 | 17.572 | 160 | .000 | 1.20 |
| BDI pre | 161 | 15.62 | 9.57 | | | | |
| BDI post | 161 | 5.88 | 6.86 | 14.388 | 160 | .000 | 1.17 |
| Mean ES | | | | | | | 1.16 |
| Patients of Group B therapists | *n* | *M* | *SD* | *t* | *df* | *p* | *Effect size (ES)* |
| BSI pre | 76 | .65 | .40 | | | | |
| BSI post | 76 | .54 | .54 | 2.293 | 75 | .025 | .23 |
| OQ-45 pre | 76 | 56.03 | 19.68 | | | | |
| OQ-45 post | 76 | 47.82 | 23.07 | 4.017 | 75 | .000 | .38 |
| BDI pre | 76 | 12.12 | 9.05 | | | | |
| BDI post | 76 | 9.29 | 10.14 | 2.7.02 | 75 | .009 | .29 |
| Mean ES | | | | | | | .30 |

**Table 8.**
*Dependent Variable: Treatment Outcome. Linear Mixed Model (N = 68) With Test of Random Effects (N = 237)*

Estimates of fixed effects

| *Parameter* | *Estimate* | *SE* | *df* | *t* | *p* | 95% confidence interval lower bound | upper bound |
|---|---|---|---|---|---|---|---|
| Intercept | - 55.27 | 36.22 | 56 | - 1.526 | .133 | - 127.82 | 17.28 |
| Psychological problems | - .33 | .15 | 56 | - 2.310 | .025* | - .63 | - .04 |
| Therapists' effectiveness | - 54.47 | 24.71 | 56 | - 2.204 | .032* | - 103.98 | - 4.97 |
| Main orientation 1 (humanistic) | 7.28 | 9.73 | 56 | .749 | .457 | - 12.20 | 26.77 |
| Main orientation 2 (body oriented) | 2.85 | 9.54 | 56 | .299 | .766 | - 16.26 | 21.98 |
| Main orientation 3 (psychodynamic) | .52 | 10.18 | 56 | .051 | .960 | - 19.88 | 20.91 |
| Main orientation 4 (integrative) | 0[a] | | | | | | |
| Professional experience | - 2.79 | 1.32 | 56 | - 2.107 | .040* | - 5.44 | - .14 |
| Therapeutic alliance | 12.22 | 4.84 | 56 | 2.525 | .014* | 2.53 | 21.92 |
| Therapists' effectiveness * Severity of psychological problems | .66 | .15 | 56 | 4.364 | .000*** | .36 | .96 |
| Professional experience and psychological problems | .02 | .01 | 56 | 2.728 | .008** | .01 | .04 |
| Therapists' effectiveness * Professional experience | - .82 | - .62 | 56 | - 1.322 | .192 | - 2.05 | .42 |

[a] This parameter is set to zero because it is redundant  * p < .05  ** p < .01  *** p < .001

Test of random effects

| Parameters | Estimate | *SE* | Wald Z | *p* | Explained variance |
|---|---|---|---|---|---|
| Residual | 722.15 | 75.87 | 9.519 | .000 | 25.41 / 747.14 = .034 |
| Therapist | 25.41 | 41.70 | .609 | .542 | 3.4% |

Variance of dependent variable (treatment outcome) = 747.14

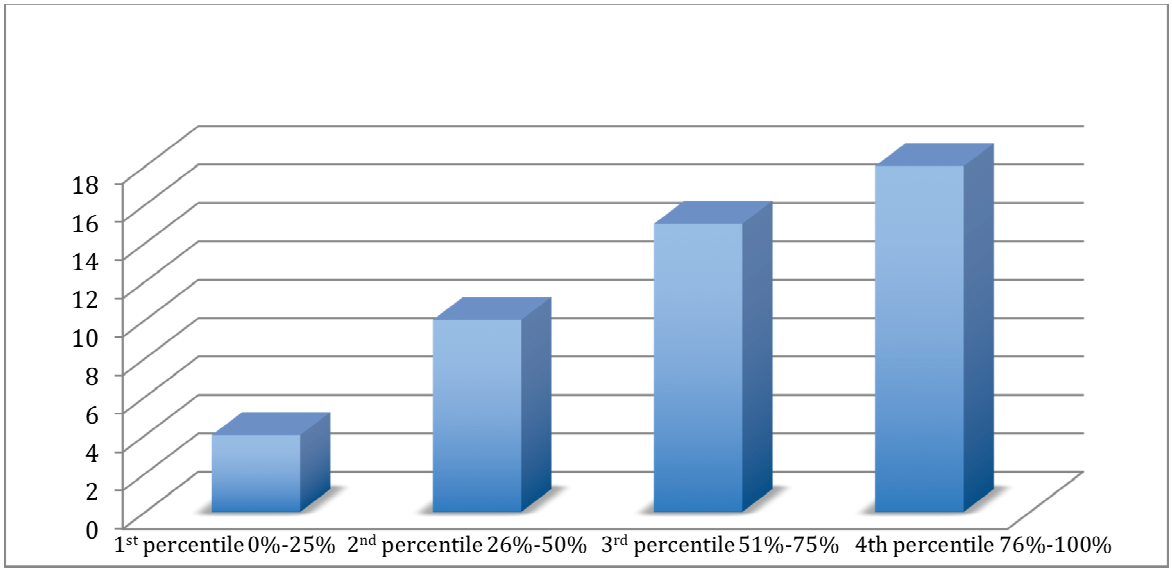


**Figure 2.**
***Patients' severity of psychological problems and therapists' effects***
***(percentiles of severity of psychological problems at treatment entry with the first percentile the lowest and the fourth percentile the highest severity level)***

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