Efficacy vs. Effectiveness Research in Psychotherapy: Implications for Clinical Hypnosis

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Empirically supported therapy (EST) has become a major focus and trend for mental health practice. When hypnosis is involved, this may mean satisfying a standard that is entirely too narrow in its emphasis. In this article “efficacy”-based research in clinical practice is contrasted with “effectiveness”-focused research, and they are discussed from the perspective of hypnosis. When clinicians can consider trans-theoretical factors as well as those that are treatment-enhancing, possibilities for improved treatment outcome increase. The “effectiveness” perspective also serves as a counter point for hypnosis in contrast with the dubious efficacy-based gold standard currently proposed for therapy in general, and hypnosis in particular.

Keywords: Hypnosis, EMDR, effectiveness, efficacy, research, standards, symptom removal, therapeutic alliance, trans-theoretical

Introduction

Perennially, clinical hypnosis has sought to increase its effectiveness in treating patients, to explicate underlying mechanisms, and to satisfy criteria associated with standards of efficacy (Nash, 2000). In this article these issues of explicating hypnotic underpinnings and pursuing efficacy through clinical trials is contrasted with the concept of clinical effectiveness (Cone, 2001; Beutler, 1998, 2000; Seligman, 1996; Luborsky, McClen, Dugger, Woody, & Seligman, 1997). The distinction in the professional clinical literature between efficacy and effectiveness in psychotherapy is no trivial matter (Clarke, 1995; Hoagwood, Hibbs, Brent, & Jensen, 1995; Jacobson & Christensen, 1996; Seligman, 1996; Goldfried & Wolf 1996; Hunsley, Dobson, Johnson, & Mikail, 1998). In an age of managed care, manual-based therapies, empirically supported/evidence-based treatment, and especially increased emphasis upon treatment guidelines (Reed,
Mclaughlin, & Newman, 2002), hypnosis may be in danger of falling short of these numerous emerging standards.

The authors will examine the currently emphasised efficacy research and contrast it with effectiveness research. **Efficacy-focused research** seeks to evaluate specific models and specific therapeutic protocols with the criteria/goals of achieving *empirically supported therapy* status. **Effectiveness-focused research** attempts to understand not only the ways therapy is practised in the real world, but also to identify those factors and dynamics that influence therapy. It also strives to increase the effectiveness of therapy, regardless of models, protocols, or specific techniques used. Effectiveness has specific implications for hypnosis.

**Background**

Nathan (1998) has provided an excellent overview of the history of research into *Empirically Supported Treatments* (EST’s). Since the 1960s, increasingly focused, controlled, and exacting standards have been applied to evaluations of psychotherapeutic methods (Chambless & Hollon, 1998). Clinical trials have as their purpose what researchers refer to as the determination of “efficacy”—evidence that a particular treatment works. This particular scientific approach arises from the “medical model” (Walmpold, 2001, pp. 8-19).

The rationale for this pursuit of scientifically determined clinical practice is important to consider. The desire for guidelines, manuals, and even standards of practice is driven by a variety of motives. These motives include the wish to ground treatment in practices that are based more upon specified evidence rather than passion or rhetoric (Beutler, Williams, & Entwhistle, 1995; Elliot & Morrow-Bradley, 1994; Havens, 1994; Garb, 1998). Guidelines or manuals arise as antidotes to therapy that is driven by theory, ideology, or strong belief (Norcross & Prochaska, 1988; Messer, 1992).

An additional and no less important motivation, however, is economic (Aaron, 1996; Fraser, 1996). Third party funding seeks efficacy and economy. Most empirically based treatments are short as compared with other traditional treatments such as long-term uncovering therapies. Finally, efficacy indexed therapies, mostly cognitive-behavioral in nature, are relatively easy to teach, practice, and propagate. Hence they have become a major focus in graduate training (Peterson, 1991; Dobson, 2002).

**Efficacy Research and Hypnosis**

For hypnosis, the pursuit of efficacy—empirically supported or evidenced-based practice—has been no less an issue. Ranging from the deep psychologically visionary hypotheses of Rossi (2003) to social learning and cognitive models (Kirsch & Lynn, 1998), hypnosis has sought to plant itself upon efficacious grounds. Experimental and research-based endeavours attempt to define not only what hypnosis is and how it works, but also how it ought be applied generally, if not case to case. While research on hypnosis has ranged from case studies to biologically focused speculation, increasingly the “gold standard” for treatment has become empirically supported efficacy.

A special issue of the *International Journal of Clinical and Experimental Hypnosis* (Nash, 2000) assessed the status of hypnosis as an empirically supported clinical intervention. The guidelines developed by the American Psychological Association (Chambless & Hollon, 1998) were chosen as the yardstick to assess the
clinical efficacy of hypnosis. The editor of the special issue (Nash, 2000) stated that the “advantage of adopting these general guidelines for this report is that it enables us to compare hypnosis’ empirical record of efficacy with that of other therapeutic interventions” (p. 109). Six articles catalogued and critiqued the research literature on clinical hypnosis with children (Milling & Costantino, 2000), hypnotic analgesia (Montgomery, DuHamel & Redd, 2000), hypnosis as an adjunct to cognitive-behavioural therapy (Schoenberger, 2000), hypnosis in medicine (Pinnell & Covino, 2000), hypnosis and smoking cessation (Green & Lynn, 2000), and hypnosis in the treatment of Posttraumatic Stress Disorder (Cardena, 2000). A seventh article by Lynn et al. (2000) summarised the findings across the articles and made recommendations for future research. The authors of these articles operated from diverse theoretical orientations, but they were mandated to “adhere to the notion that, in the final analysis, the field and our patients are best served by examining the evidence carefully, thoughtfully, and dispassionately” (Nash, 2000, p. 108).

In the light of these standards, concerns have arisen concerning hypnosis and empirically indexed endorsement. For example, specifically with children (Milling and Costantino, 2000) and smoking cessation (Green & Lynn, 2000), hypnosis requires “further investigation” at best, or (with smoking specifically) “cannot yet be regarded as a well established treatment” (Green & Lynn, 2000, p. 195). An absence of systematic studies with post-traumatic conditions (Cardena, 2000, p. 225) raises further questions about efficacy. Though studies demonstrating the efficacy of hypnosis in the treatment of pain exist, it may be difficult, in the light of the yoking of hypnosis as “adjunct” or collateral treatment (Kirsch, Montgomery & Saperstein, 1995; Schoenberger, 2000; Pinnell & Covino 2000) to determine the specific effect for hypnosis per se.

If EST and efficacy-focused research becomes the exclusive fulcrum for treatment judgement, it is possible that hypnosis could be at risk as clinical practice. While such scientific emphasis—whether a particular therapeutic orientation/model produces results—remains a proper focus for all clinicians, the concept of clinical effectiveness emerges as a second research-based emphasis of perhaps greater significance for the field of clinical hypnosis. Effectiveness differs from efficacy in that the focus is on the process of psychotherapy at a macro-level and the investigation of trans-theoretical dynamics or principles of change—not a particular model or approach, per se (Beutler & Harwood, 2000; Prochaska & DiClemente, 1984; Walmpold, 2001). In the literature, effectiveness is the study, generally, of whether psychotherapy actually works and what it is in “psychotherapy” generically that can make most models successful, at least some of the time. Luborsky and colleagues (1976) have quoted the Red Queen from Alice in Wonderland in describing this more inclusive attitude toward diverse models of therapy: “. . . everyone has won, and all must have prizes!” (p. 106). With this approach most therapies can boast of effectiveness, at least some of the time.

**Effectiveness Research in Clinical Practice**

Effectiveness is that vein of research that emphasizes the discovery and explanation of what makes any treatment (as practiced in the field) work (Persons & Silberschatz, 1998). Effectiveness studies place greater emphasis on external validity and on how consumer benefit or gain is achieved. Effectiveness in this sense includes process, and process-outcome research (Borkovec & Castonguay, 1998).
Identical Treatment Models Vary in Effects

The benefit of emphasizing effectiveness is illustrated by the Luborsky et al. (1997) study that demonstrates that a treatment applied under tightly controlled conditions—for example, adhering strictly to a treatment manual—will still vary widely in its effects. Processes and mechanisms of change that are not accounted for by a given treatment model may nevertheless play an important role in the effects achieved by that treatment.

Investigations designed to answer the overarching research question of how treatment achieves desirable effects are obligated to examine any factors that might contribute to effects such as reported by Luborsky et al. (1997) study. This obligation stands whether the effects observed be in-session, post-session, or post-treatment, and whether the effects observed result from hypnosis that is based in cognitive-behavioural, psychodynamic, utilitarian, or even certain bizarre approaches. Impressive strides have been made in answering this question.

The Centrality of the Therapeutic Alliance

Safran and colleagues (Safran, Cocker, McMain, & Murray, 1990; Safran & Muran, 1996; Safran, Muran, & Samstag, 1994) have been investigating ruptures and repairs of the therapeutic alliance, for example, and have developed a working model to help map processes of alliance rupture, alliance repair, and failed attempts to repair the alliance. Other authors have investigated how the interpersonal behaviour of clients and therapists within sessions influences therapeutic processes and outcomes (Henry, Schacht, & Strupp, 1990; Najavits & Strupp, 1994). These results may benefit all practitioners. Henry, Schacht, and Strupp (1990) found that therapists in their poor outcome group emitted significantly more responses of a “belittling and blaming” style or an “ignoring and neglecting” interpersonal style. Najavits and Strupp (1994) divided therapists into more effective and less effective groups than the “good outcome” group. They found that the more effective therapists displayed significantly more affirmation, understood and protected interpersonal behaviour, and were more nurturing than less effective therapists. Less effective therapists displayed more “watch and manage”, “belittle and blame”, and “ignore and neglect” interpersonal behaviours than more effective therapists.

Common Factor Approaches

Several investigators have been innovating and tweaking methods of inquiry to help gain understanding and provide explanations of how therapy works. These methods include task analysis (Rice & Saperia, 1984), comprehensive process analysis (Elliott, 1989), a definitive emphasis on the analysis of significant events occurring within treatment (Greenberg, 1986, 1991), and operating within a discovery-oriented paradigm (Mahrer, 1992, 1999). These advances represent only a small sample of the work being conducted to examine the effectiveness of psychological treatment: how treatments, components of treatment, and processes within treatment function to achieve effects. Nonetheless, they all represent attempts to elaborate the processes and discover the mechanisms at work in treatment that are responsible for the effects achieved. More encompassing reviews of the evolution of this psychotherapy research can be found in Hill (1994), Hill and Corbett (1993), and Russell and Orlinsky (1996).
The expanding literature on common factors that facilitate beneficial therapy in diverse theoretical approaches is able to liberate mental health practitioners from the arena of dueling theories and models. “Effectiveness” is prepared to consider that even a bad model may, through no fault nor credit of its own, produce a good piece of work to the extent that it operationalizes effectiveness factors (Walmpold, 2001). This “common factor” approach offers broader considerations in thinking of clinical practice proper as well as planning how to teach therapeutic skills. Beutler (1998), Buettler and Harwood (2000), Walmpold (2001), and Fishman (1999) have provided perhaps the closest template of what an emphasis upon effectiveness (general things that help people change), in treatment or teaching, over efficacy (a specified model and set of techniques) might look like. They are not, however, the first to try to do so.

In 1961 Frank and Frank published the classic text, *Persuasion and Healing*, within which were discussed dynamics of change that appeared to be transcendent to models and techniques per se. Later Luborsky, Singer, and Luborsky (1976), and more recently, Lambert (1998), Beutler (1998) and Roth and Fonagy (1996) have attempted to locate change in the process of psychotherapy (i.e., dynamic variables within and between therapist and patient) not in its format (model). Discussions about what are common or shared dynamics appears to involve some fairly intuitive notions. Fishman (1999) has described these as

. . . an emotionally charged, confiding relationship between patients and therapist; warmth, support, and attention from the therapist in a healing setting; a positive therapeutic alliance between therapist and patient; a new rationale or conceptual scheme offered with confidence by the therapist, ritual; and the passage of time (p. 216).

Following this same theme, Hubble, Duncan, and Miller (1999) have stated that four factors seem to govern the process:

- extra-therapeutic consideration
- relationship or “alliance” factors
- hope and expectancy, and
- techniques consistent with patient expectation, and efficacy.

### The Failure of Technique to Explain Transcending Models

Ironically, it appears that “technique” accounts for, at most, 12-15% of the “success” of therapy (Lambert, 1992). In a similar vein Beutler (2000) has listed 18 principles that he and his colleagues feel should guide any process of consultation. These range from consideration of problem chronicity, to the best way to administer, calibrate, or define treatment with a given patient. These researchers are not alone in their identification of dynamic and static variables that effect change, or benefit psychotherapy (Garfield, 1996; Frank & Frank, 1991; Horvath & Luborsky, 1993; Lambert, 1998).

These effectiveness factors seem to transcend models. Shaw et al. (1999) examined “between therapist” differences in a study of efficacy-focused research in cognitive behavioural therapy. “Better” therapists, using the same model, were those
who actualised more of the “common factors”. Appreciation of contextual and process related variables that influence change are apparently significant regardless of model or approach (Peterson, 1991).

**Hypnosis in the Light of Effectiveness Consideration**

Emphasizing effectiveness—common factors and those process and dynamic variables that increase outcome—in clinical hypnosis can by-pass much of the conflictual, if not useless, speculation about specific mechanism or the “real” reason something works. However, efficacy studies and theoretical speculations should not be disparaged or dismissed. In fact effectiveness approaches complement efficacy. The application of effectiveness inquiry in a dynamic context of critical attention to variables that make efficacious methods more likely to succeed, adds an important dimension to them.

In order to illustrate the connection between particular clinical method and effectiveness we have elected to discuss Eye Movement Desensitization Reprocessing (EMDR; Shapiro, 1995, 1996), a controversial treatment much discussed and embraced by members of the professional hypnosis community (Frischholz, Kowall & Hammond, 2001).

**EMDR as a Prototype for the Effectiveness Model**

EMDR and hypnosis both have limited or controversial efficacy (McNeal, 2001), but both are substantially embraced by clinicians and defended for their effectiveness. Critics of EMDR, like critics of hypnosis, attempt to dismiss its clinical efficacy or to liken the treatment to other, similar forms of therapy—specifically cognitive behavioural approaches involving exposure techniques and restructuring (Carrigan & Lew, 1999; Devilly, Spence & Rapee, 1998; Lohr, Kleinecht, Tolin, & Barret, 1995; Lohr, Tolin, & Lilienfeld, 1998; McNally, 1999; Rosen, Lohr, McNally, & Herbert, 1998; Rosen, McNally, Lohr. et al., 1998). However given the growing body of research on effectiveness factors (Amundson & Gill, 2001a, 2001b), EMDR and hypnosis need not seek gold standard efficacy, nor be reduced to another form of specific therapy to retain their effectiveness.

For example, Shapiro (1996) describes EMDR fidelity as involving several discrete phases of treatment:

- Preparation, readiness, and assessment which involves the development of rapport—involving confidence, stability and appreciation of history and current social, medical, and related circumstances in a patient’s life (pp. 89-117).
- In addition to this larger patient contextual emphasis, the clinician ought to “form a bond with the client” (p. 119), which involves “respect and accommodation and creation of a safe place” (p. 122). In these phases of treatment the model is explained, and therapist and patient collaborate regarding readiness, expectations and reassurance (p. 129).
- Treatment proper involves identifying as clearly as possible “what happens when (the patient) thinks about or reacts to the problem” (pp.129-130). There is a focus upon the feelings and thoughts about the particular issue being addressed.
A structured process then ensues that involves discretely identifying cognitive, emotive and sensate aspects of the problem, in the light of the patient’s experience (pp. 131-139).

Then a process of “desensitization” (p. 146) is introduced and a specified process followed. This step seems to involve accepting the patient’s experience without interpretation as it emerges (pp. 144-145). There is apparently little imposition of insight by the therapist (pp. 151-153).

Finally the building of “positive cognition” (i.e., skillful new thoughts) in light of problems: specific thoughts or feelings seem central to the therapeutic goals (pp.133-134; 157-158).

In juxtaposing EMDR protocol(s) with effectiveness factors it is possible to account as much for its effect based upon trans-theoretical “common factors” (Hubble, Duncan & Miller, 1999) as specific hypothesized dynamics related to neuro-networks or accelerated information processing (Shapiro, 1995). Lambert (1992) feels that empirically supported evidence for the role of relationships, alliance or interpersonal process (Horvath & Luborsky 1993; Norcross, 1993; Norcross, 2002) accounts for 30% of any effective therapy. Walmpold (2001) describes a .45 correlation between such alliance and outcome. EMDR as described above, clearly operationalizes not only the extra-therapeutic factors associated with effectiveness research—i.e., “stability”, “confidence”, and “history” of the patient—but focuses considerable attention as well on relationship or alliance issues. Emphasis in EMDR upon skill building rather than deficit or blame has, as well, been demonstrated to increase the likelihood of beneficial outcome in any therapy (Beutler & Harwood, 2000). In another parallel to common factors, Beutler (2000) has demonstrated empirically that therapies that seek to “disrupt symptoms” or “remove symptoms”, and do so in in-vitro techniques, (p. 1005) fare much better than those therapies less inclined to do so.

**Extra-theoretical Considerations and Hypnosis**

These extra-theoretical considerations of EMDR apply equally to hypnosis. For example, Evans (2000) has described hypnosis as consisting of four stages, one of which is “expectation” and what he calls “placebo variables” (p. 2). In discussing this stage he refers to rituals of therapeutic relationship and confidence, a process he states accounts for “about 60% of the magnitude of the treatment variables being investigated” (p. 6). In the light of effectiveness research this expectant faith in the benefit of treatment has been extensively discussed and empirically investigated (Frank & Frank, 1991; Fishman, 1999; Lambert, 1992; Walmpold, 2001). Similarly, Toothman and Phillips (1998) in their discussion of Ego State Therapy methodology emphasize alliance, respect, empathy, positive connotation, and the need to respect the status of the patient relative to any working alliance. They go so far as to suggest that “sometimes the therapeutic alliance may seem to develop automatically, though at other times its development may need to be the main focus of treatment” (p. 177). In more formal applications of hypnosis, within an analytic frame of reference for example, attention to factors that increase or decrease the likelihood of success are the hallmark of “screening” at the initiation of treatment (Crasilneck & Hall, 1975). Such screening represents what the effectiveness literature would describe as attention to extra-therapeutic factors, i.e., aspects of the...
patient that may enhance or limit therapeutic responsiveness (Lambert, 1992; Hubble et al., 1999). Beutler (2000) and others (Beutler & Harwood 2000; Beutler & Clarkin, 1990) outline research-based considerations which, when attended at the initiation of treatment, increase the likelihood of effective therapy. Perhaps most representative of this focus upon dynamic and historical features—the centrality of the patient in treatment—in hypnosis are the Ericksonian or utilization-based models (Erickson & Rossi, 1979; O’Hanlon & Hexum, 1990; Gilligan, 1987; O’Hanlon, 1987). Acceptance, “partnering”, collaborating, and using what the patient brings are hallmarks of trans-theoretical factors found in more effective therapy (Cummings & Cummings, 2000) that are certainly reflected in Ericksonian approaches.

To initiate a discussion on efficacy and effectiveness research in the light of clinical hypnosis, a case example is provided. There is an old saying that there is a difference between a “report” and a “story,” and this same difference ought to define a case study or a case example. A case study or report represents the most minimal form of efficacy-focused research. The intent of a case study or report is to provide support for a given approach, to provide new insight, to define a technique, or to provide new directions for future more elaborate efficacy-indexed research (Mott, 1986). In contrast, the following case example serves as vehicle for exposition beyond the specific, a vehicle to explicate effectiveness variables or common factors research.

Case Example

Alexis suffered a traumatic event at her place of work. As a result of this event she became incapable of returning to work, and in fact was unable to leave her home except for brief, task-oriented forays. She was accompanied by a family member to her first appointment with me (JA), and this individual had driven almost 3 hours in order to transport Alexis for a brief 15 minute trip across town.

In order to help with the presenting complaint, a focused hypnotic procedure to reduce specific anxiety related to the event was used in the initial consultation. The patient had shared that in addition to the immobilizing anxiety associated with the event, she was also suffering intermittently from what she termed panic attacks. The precipitating “fears” were often non-contingent in her mind, and consequently she was afraid to drive or go too far from home lest she be triggered into an attack. The costs of these fears included the inability to return to work, the loss of any social/recreational life, and feelings of hopelessness and self-disparagement.

In the initial session we discussed what Alexis would want from therapy, and how we would know we had achieved her goals. Reduction in general and specific anxiety, and absence of “panic attacks” (as she defined them) were her subjective goals. Secondarily, she wanted to be able to go out, to “not be afraid to see people from her work,” and, most importantly, to “be able to return to work.” The hypnosis used in the first session utilised ego-strengthening “relaxation”, “light trance”, and “desensitisation”.

Alexis presented for the next session on her own. She described an immediate reduction in distress following the first session. She had regained enough confidence to at least be able to come to the session on her own. Our focus then moved to symptoms, i.e., “fears” and her experience of them. The procedures of the first session were continued progressively through the next 3 sessions. What would have been
seen as ego strengthening, desensitisation, and continual emphasis upon “fears” as the issue/"enemy” characterised each of these sessions.

Between the fourth and fifth session (again her progressive sense of confidence, increased function, and “feeling better” lending itself to very little change in emphasis in therapy) Alexis took a holiday. She had gained enough freedom of movement to go away for a long weekend. Prior to and upon return she had engaged in particular therapy-directed acts of “fearlessness”: visiting her place of work out of hours and speaking on the phone as well as face to face with some of her colleagues, using the hypnosis skills from our sessions to hold on to or engage her sense of courage or fearlessness.

Nonetheless, the thought of return to work still evoked the feeling of panic and overpowering anxiety. However, she initiated the fifth session by describing how she had “had the strangest dream.” Alexis had dreamt that she was cleaning her house and that as she put her house in order, she discovered a doorway. This door led to a set of immense rooms and additions to her house which had become a grand mansion of sorts that she hadn’t known existed.

I (JA) sought to incorporate the dream’s contents into what Ericksonian hypnotherapists would have considered a “‘utilization-based”, conversational trance. The “interpretation” of the dream became an induction that involved a grateful reassurance by the therapist that “at last” the case was coming clear. The dream told us that the therapy was really only to re-order her house, to put things back right, not to undo, redo, or overdo anything about her life—and what a life indeed! What she hadn’t found or understood about herself was what lay behind the door, a personal richness as yet unrealized. This was something Alexis ought never forget!

The sixth session was cancelled because Alexis had “gone back to work”. Six months later while the therapist’s (JA) wife was using a credit card in a business transaction, the person taking the card (who was Alexis) asked if the name on the card were connected to the name of the therapist. A cautious acknowledgement was met with Alexis’ broad smile and bold declaration that “he had really helped (her) a little while ago,” and she went on with her work.

Alexis has not had to return to therapy for help with her presenting complaints. Very occasionally, and over many months, I (JA) have had the opportunity to observe Alexis from a distance as she carried out the functions of her employment.

Details of treatment regarding initial symptoms reduction and details of the dream beyond the minimal needed for a good example or "story" are excluded here because the case example is not about a particular approach. It is not presented to demonstrate efficacy of a particular method of symptom reduction, or dream analysis as induction in hypnosis. Nor is it presented to demonstrate a particular hypnotic model of rapid reduction of trauma. It is instead offered to highlight the ways in which efficacy research versus effectiveness trans-theoretical, or common factors consideration can be viewed.

Rapid symptom reduction techniques (Bjick, 2001) or utilization approaches (O’Hanlon & Martin, 1992) represent “specific effects” in relation to outcome in this case. Specific effects can arise from application of theory, the experience of a given therapist, anecdotal or case reports, or empirical investigation. However, in the light of
effectiveness research, with this or any case, the therapist understands that specific effects—the role one or another approach or technique in therapy plays—account for a relatively small amount of the variance. As mentioned above, Lambert (1992), describes how “techniques” per se account for about 15% of a given therapy. Walmpold (2001) and Garfield (1996) however have determined that the role of specific technique may account for perhaps as little as 8%, and no more than 13% of the outcome. This research would suggest a model of therapy then is secondary to a process of therapy. In fact this kind of effectiveness research explains why many methods or theoretical conceptualisations in clinical hypnosis, often seemingly incompatible, may actually achieve good outcomes. In the light of effectiveness considerations, it is not the technique but the nesting of the technique within the broader, or more general effects that will determine the course of treatment. This perspective—a shift from theoretical content to process orientation—may seem counter-intuitive, and especially runs against the grain of model propagation.

For most mental health professionals, going to graduate school and learning about mental health treatment was a lot like going to an Arthur Murray dance studio and learning the foxtrot. In fact most students recall that in order to graduate they had to be able to demonstrate mastery of a particular model. The difference between an emphasis upon model efficacy and an emphasis upon effectiveness is, however, akin to the difference between a particular dance and rhythm. Most would agree that it is probably better to have rhythm than to simply be good at doing the polka.

Consequently, from an effectiveness point of view, what would require consideration with the case of Alexis? What are the research-based factors that are part of the general or non-specific effects related to positive outcome in psychotherapy generally, and clinical hypnosis in particular? What would guide or potentiate the application of particular interventions involved?

In the first place, the patient arrived with a significant level of distress. Beutler (2000) has demonstrated that level of distress, as well as chronicity, complexity, and patient receptivity, in the light of competency, chronicity, and distress, are general effects that play a significant role in outcome. Too much arousal, for too long, and of a more enduring and pervasive nature, or the opposite, i.e., acute and circumscribed distress, are determinant factors in the application of specific clinical skills (Beutler & Clarkin, 1990). With this patient then, the issues of chronicity, pervasiveness, “level of distress”, etc. would calibrate the application of any specific technique. Beutler (2000) has shown that too much arousal (crisis) or too little arousal (compensation relative to distress) bode less well for outcome.

Secondly, two additional effectiveness-based considerations appear useful at the onset of any therapeutic endeavour, but especially so in this case. Better therapies—therapies more likely to produce results—involves three general procedures:

- enhancing the agency of the patient
- increasing tolerance for emotional experience, and
- teaching techniques to resolve conflict (Wolfe, 1989).

For this patient the definition of the problem as “just fears”, engineering ways to relate to the “fears” cognitively or in action, and teaching her to fight or reduce the fears through hypnotic or quasi-hypnotic means all served this general effect requirement. For patients in an effectiveness guided therapy the issue is always to reduce the demand characteristics of the therapeutic encounter and increase personal agency or competency.
(Orne, 1962; Kihlstrom, 2002).

Specific in-session reduction of the “fears” was vital to the patient’s improvement. Trans-theoretical research has shown that therapies (from whatever theoretical justification) that provide dramatic relief, counter-conditioning, restoration of some immediate self-efficacy, extinction of problematic arousal, etc. lead to greater benefit (Walmpold, 2001; Prochaska & Clemente, 1984; Beutler, 2000). Hence the goal in the initial sessions for a clinician invested in effectiveness as opposed to facile model application would be to make it simple (enhance agency), make it effective (provide relief), and to do so under the dictates of the receptivity/responsiveness (consolidation of history, chronicity, personal resource, etc.) of the patient.

Alexis had to be “assessed” in terms of how quickly and how respectfully a process of fear-reduction could be introduced. In this regard—patient resource, history, and those static and dynamic factors patients bring to therapy—it is possible to see again an emphasis upon what the effectiveness research has shown to be a significant non-specific or general factor. Tallman and Bohort (1999) as well as Lambert, Shapiro, and Bergin (1986) have shown that attention to the unique resource or experience of the patient and the “extra-therapeutic” (Hubble et al., 1999 pp. 1-16) constitutes perhaps the greatest single variable relevant to outcome. Attention to the extra-therapeutic means not only the status of patients and their histories at arrival (Beutler & Clarkin, 1990; Beutler, 2000; Beutler & Harwood, 2000), but also events or contextual features collateral to therapy that can be expropriated as useful. With this patient, then, the dream and its enfoldment in therapy reflects less a clever clinical manoeuvre than simply the application of research-based principles arising from effectiveness considerations. Frank and Frank (1991) state that it

…is not that technique is irrelevant to outcome. Rather the success of all techniques depends on the patient’s sense of alliance with an actual or symbolic healer. This position implies that ideally therapists should select for each patient the therapy that accords, or can be brought to accord, with the patient’s personal characteristics and view of the problem. Also implied is that therapists should seek to learn as many approaches as they find congenial and convincing. Creating a good therapeutic match may involve both educating the patient about the therapist’s conceptual scheme and if necessary, modifying the scheme to take into account the concepts the patient brings to therapy (p. 217).

Creating “a good therapeutic match”, in general, and this case in particular, requires an additional feature associated with outcome regardless of specific approach: the ability to awaken or mobilize expectant faith (Lambert, 1992; Hubble et al., 1999). Walmpold (2001) and others (Luborsky et al., 1986; Crits-Cristoph et al., 1991) have referred to this as the therapist effect. It is the ability of the therapist to appreciate the patient; to consider the extra-therapeutic issues related to effectiveness, to form an alliance, to conceptualise the therapy in enabling ways and in so doing, to raise the patient’s sense of competence (Wilkins, 1984; Ilardi & Craighead, 1994). This process is referred to in the effectiveness literature as propagation of hope, involving confidence, patience, enthusiasm, or any one of a number of dynamics that model to patients the
expectation for relief (Snyder, Michael & Cheavens, 1999). Snyder et al. (1999) have spoken of hope as the opening of a pathway, so to speak, wherein the patient clearly feels both comforted and “pulled” toward an attainable goal (p. 193). With Alexis the issue of “fears” and confident, rapid, symptom-reducing actions that were consistent with problem conceptualisation, invited hope. The provision of early relief and hope are not inconsequential. Cummings and Cummings (2000) have summarized the research on the effect of hope or expectancy in early sessions on latter outcome by stating that therapists need to “hit the deck running” (pg. 89).

Finally, creating a “good therapeutic match” (Frank & Frank, 1991) returns the discussion of the case of Alexis to the issue of alliance. Relationship, alliance, collaboration, and related themes cannot be omitted from any consideration of effectiveness-based therapy. While it is beyond the scope of this discussion to review current research on the therapeutic relationship, it is important to understand that relationship emerges as the most consistent and enduring variable, or general effect in treatment. For clinical hypnosis, this may mean that this general factor trumps or at least is essential in the potentiating of specific factors, i.e., activation of unconscious resource, ego strengthening, insight; catharsis, etc. Walmpold (2001) has said, “proponents of most treatments recognize that the relationship between the therapist and the client is critical but not sufficient. However, it appears that the relationship accounts for dramatically more of the variability in outcomes than does the totality of specific ingredients” (p. 158).

Considering the case of Alexis, we would generalize to clinical practice under common or trans-theoretical factors, and suggest an analogy that psychotherapy generally, and hypnotherapy in particular, is to mental health practice what oncology is to medicine. In the treatment of cancer there are a few well-established and highly proportionate successful cures. Cervical and skin cancer evoke more secure images of cure than other forms of the disease. There are similarities in psychotherapy. Systematic desensitization, for example, has earned its keep with receptive patients regarding simple phobia and anxiety related concerns. Nonetheless most cancers and their treatment, and most therapies, have an experimental quality to them. In treatment of cancer there are cure rates determined by type, time of diagnosis, response to applied treatment and demographic/epidemiological assessment of morbidity. In mental health treatment there may be factors that qualify even the more specified treatments we have, i.e., desensitization, in the light of character or personality disorder, or factors that in truth leave clinicians on the same tentative ground oncologists walk.

Conclusion

Alexis’ outcome—her subjective report of symptom reduction, her return to work, and the enduring objective restoration of adaptive function—ought be attributed as much to general, effectiveness factors as to specific treatment factors per se. It is not that treatment models are unimportant. They are important to the degree models are set within the context of the broader dynamics and principles described above. This approach to therapy may be experienced as somewhat irregular, for it has been the history of the mental health profession to pursue efficacy through the medical model, i.e., specified treatment.

At this time the pursuit of efficacy has become no less a part of clinical hypnosis.
Models, protocols and specified clinical procedures reflect not only the influence of the medical model, but the pursuit of efficacy in the most narrow sense. To suggest that models or specified practices are not the place to seek outcome appears to run contrary to what clinicians have been inclined to believe. On the other hand, effectiveness variables and attention upon these broader, trans-theoretical considerations seems to the experienced clinician simply intuitive. Of course we know a patient’s history and status at arrival is important; that rapport or relationship needs to be established; that patients need to feel confident or believe in what is taking place. Respect is clearly essential, as is the need to motivate and enhance self-esteem/strengthen the ego in order to achieve our goals. However, what we haven’t considered is how apparently vital these “intuitive” factors are.

Clinical hypnosis will do well to take these “intuitive”, general factors seriously. This will allow treatment to be conducted with the understanding that perhaps as little as 8% of outcome is attributed to a model and 70% accounted for by general features common in all good therapies (Walmpold, 2001). While teaching and practicing what all experienced clinicians understand as clinical intuition—really the core of effectiveness based research—may supersede model propagation and development, it is important to also appreciate that an 8% specific and a 70% general effect leaves more than 20% of the outcome in therapy unexplained (Walmpold 2001, p. 211). This 22% may be the intangible dimension in a given clinician or a given therapy. Efficacy research will continue, as will research on effectiveness and the specific and general effects associated with better outcome. With clinical hypnosis this 22% factor might continue to be a bastion of some mystery and uncertainty. It may perhaps be the reason we can’t all get it right, all of the time, regardless.

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Efficacy vs. Effectiveness Research in Psychotherapy


