Therapist Effects: Facilitative Interpersonal Skills as a Predictor of Therapist Success

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This study examined sources of therapist effects in a sample of 25 therapists who saw 1,141 clients at a university counseling center. Clients completed the Outcome Questionnaire-45 (OQ-45) at each session. Therapists' facilitative interpersonal skills (FIS) were assessed with a performance task that measures therapists' interpersonal skills by rating therapist responses to video simulations of challenging client—therapist interactions. Therapists completed the Social Skills Inventory (SSI) and therapist demographic data (e.g., age, theoretical orientation) were available. To test for the presence of therapist effects and to examine the source(s) of these effects, data were analyzed with multilevel modeling. Of demographic predictor variables, only age accounted for therapist effects. The analysis with age, FIS, and SSI as predictors indicated that only FIS accounted for variance in outcomes suggesting that a portion of the variance in outcome between therapists is due to their ability to handle interpersonally challenging encounters with clients. © 2009 Wiley Periodicals, Inc. J Clin Psychol 65: 755–768, 2009.

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Numerous studies demonstrate that therapist characteristics are a unique predictor of therapy outcome (e.g., Crits-Christoph & Mintz, 1991; Dinger, Strack, Leichsenring,

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Wilmers, & Schauenbirg, 2008; Luborsky, McClellan, Woody, O'Brien, & Auerbach, 1985; Okiishi, Lambert, Nielsen, & Ogles, 2003; Wampold & Bolt, 2006). Frequently this finding has emerged in the context of clinical trials where the researchers implemented interventions designed to eliminate nuisance variables (e.g., therapist effects or variability) through the careful selection of therapists and rigorous training and supervision in the provision of a manualized treatment (Wampold, 2001). For example, Luborsky et al. (1985) found significant differences among therapists on client outcomes despite strict adherence to manuals. Similarly, Shapiro, Firth-Cozens, and Stiles (1989) found that one therapist in the Sheffield II psychotherapy study had significantly better outcomes than other therapists in the study. Finally, Crits-Christoph and Mintz (1991) found therapist effects in a meta-analysis of 10 clinical trials. Taken together, these findings indicate that even in highly controlled interventions where researchers attempt to suppress or control the effects of individual therapists, client outcomes vary by participating therapists.

Advances in the application of statistical analyses (i.e., multilevel or hierarchical modeling) have yielded mixed results about the effect of individual therapists on client outcomes. For example, two recent re-analyses of the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (TDCRP) resulted in mixed findings with regards to therapist effects. Wampold and Bolt (2006) found significant therapist effects using hierarchical linear analysis, whereas Elkin, Falconnier, Martinovich, and Mahoney (2006) did not find therapist effects using the same data and a similar data analytic approach. Estimation of the model and the different treatment of outliers appear to be partly responsible for the emergence of these differences (Elkin, Falconnier, & Martinovich, 2007; Wampold & Bolt, 2007). Regardless, the majority of therapist effects research with clinical trials data supports the hypothesis that individual therapists differentially impact client outcomes.

Naturalistic studies of therapist effects using hierarchical linear modeling are relatively rare and thus little is known about the existence or quality of therapist effects in real-world practice settings. Okiishi, Lambert, Nielsen, and Ogles (2003) found significant variability among therapists for the outcomes of 1,841 clients seen in a university counseling center. In further analyses on a larger version of this dataset, Okiishi et al. (2006) found that therapist effects continued to account for variance in client outcomes. However, attempts to identify the source of these therapist effects were not informative. Results indicate that therapist effects were not attributable to a variety of therapist traits, such as sex, type of training, or theoretical orientation. Thus, the source of therapist effects in these naturalistic studies remains unknown.

Although therapist effects fairly consistently account for variance in clinical outcomes, to a large extent these effects remain a neglected variable in psychotherapy research (e.g., Garfield, 1997) and little is known about the sources that underlie these effects. Generally, demographic characteristics such as therapist age, sex, and ethnicity have failed to emerge as predictors of outcome (Beutler et al., 2004). Conversely, research demonstrates that variables such as therapist emotional adjustment and certain aspects of therapist personality (e.g., dominance) predict outcome with moderate effects (e.g., Beutler et al., 2004). These empirical findings highlight the need for studies that move beyond measuring therapists' demographic characteristics and general traits to include measures of therapist characteristics that have a more solid theoretical and empirical link to client outcomes. In other words, there is a need for therapist effects research that includes the measurement of constructs that are grounded in findings from psychotherapy research. For example, numerous studies support the presence of relationships between psychotherapy

process variables, such as empathy and the alliance, with clinical outcomes (Norcross, 2002; Wampold, 2001). Therefore, a potentially promising approach for identifying the sources of therapist effects would be to operationalize and examine therapists' skills in facilitating therapy processes (e.g., empathy and the alliance) that are theoretically and empirically related to therapy outcome.

In theory, indicators of the therapist's contribution to therapy processes can be identified through somewhat subtle *interpersonal* messages (Strupp & Anderson, 1997). For example, cases in which therapists communicated subtle interpersonally disaffiliative messages were shown to result in worse clinical outcomes than when there was an absence of such communication (Henry, Schacht, & Strupp, 1990). Another illustration involves the therapeutic alliance, which has commonly been viewed as partly a therapist's skill in *facilitating* a collaborative relationship with his or her client (e.g., Safran & Muran, 2000; Norcross, 2002). Another process variable, empathy, refers to the therapist's skill in accurately understanding and reflecting a client's thoughts and emotional experience (Bohart, Elliott, Greenberg, & Watson, 2002). Because the therapist is by definition a major contributor to the facilitation of the processes of therapy, we operationalized and examined the relationship between therapists' facilitative interpersonal skills (FIS; Anderson, Ogles, & Weis, 1999; Anderson, Patterson, & Weis, 2007) and clinical outcomes in this investigation of clients and therapists in a naturalistic setting.

The present study aims to further understanding about the sources of therapist effects. We extended previous research (i.e., Okiishi et al., 2006; Okiishi et al., 2003) by drawing from the same client population as these studies, but examining a broader spectrum of therapist characteristics, which included therapists' demographic characteristics (i.e., age, level of training, and gender) and theoretical orientation. However, our main hypotheses centered around interpersonal skills, which we theorized to be better reflections of the therapist qualities that would likely influence therapeutic processes, such as the therapeutic alliance, and which heretofore have not received significant attention as a possible explanation for therapist effects (see above). Specifically, these variables included a self-report measure of social skills and a performance-based measure of FIS (Anderson et al., 1999, 2007). We examined whether FIS predicts outcome in this sample because the sample used by Okiishi and colleagues, drawn from the same pool, found that therapist effects accounted for variability in client outcomes but traditionally studied therapist characteristics (e.g., demographic variables and general traits) did not explain the therapist effects identified in their sample.

We invited therapists who participated in Okiishi and colleagues' research to complete a self-report social skills measure and a performance task that consisted of responding to video-recorded analogue therapy segments. Ratings of therapists' responses to the performance task constituted the measure of FIS. We predicted that individual therapists would account for a significant amount of variability in outcome and we predicted that therapists' interpersonal skills (i.e., FIS) would account for a significant amount of variance in client outcomes in this large sample of clients and therapists in a naturalistic setting.

Method

Participants

Clients. An archival database of clients seen in a university counseling center was available for this study. Clients were included in the analyses if they completed at

least three therapy sessions and their therapist agreed to complete the therapist measures. Clients in the analyses were seen prior to the therapist assessment; 1,141 clients were included in the final sample.

Clients had a mean age of 23.0 years ($SD = 4.1$ years; range = 18 to 56 years). The majority of the clients were women (62.8%) and most of the clients were Caucasian (85.5%). All of the clients attended or were associated or employed with the university where the counseling center was located. Clients in the sample attended therapy for a range of 3 to 72 sessions, with a mean attendance of 9.09 sessions ($SD = 8.79$).

Therapists. Thirty-two therapists working in the counseling center at a large private university were invited to participate in the study. Twenty-eight therapists agreed to participate in the study and completed self-report measures and an FIS performance task. One of these therapists was excluded because of incomplete FIS performance assessment data. Two additional therapists were excluded because data for fewer than 10 clients were available in the archival dataset. Thus, 25 therapists (16 men; 9 women) were initially included in the analyses. Therapists treated a mean of 45.6 clients (ranging from 13 to 141 clients) for whom data were available in the archival dataset. Therapists had a mean age of 43.9 years ($SD = 10.9$ years) and were predominantly Caucasian (96%). Therapists self-identified their theoretical orientation as primarily cognitive–behavioral (CBT: $n = 8$), humanistic ($n = 8$), eclectic ($n = 5$), and psychodynamic ($n = 4$).

With regards to level of training, the 25 therapists who completed the performance assessment included 17 licensed doctoral level therapists; 2 postdoctoral but not fully licensed therapists; 3 predoctoral interns, and 3 graduate trainees. Therapists had 11.5 mean years ($SD = 10.1$) of clinical experience. Therapists estimated that they spent 42.9% of their professional hours in direct clinical practice (ranging from 8% to 70%).

Client Measures

Outcome Questionnaire-45. The Outcome Questionnaire-45 (OQ-45; Lambert et al., 2004) is a 45-item self-report general symptom measure with a total score that is the sum of three subscales that measure the subjective, interpersonal, and social role components of global psychological distress. Response options range from 0 (*never*) to 4 (*almost always*). This measure has good internal consistency (alphas range from .70 to .93) and test-retest reliability over 3 weeks of .84 (Ogles, 1996). The OQ was administered routinely at the beginning of each therapy session at this counseling center. A cutoff score of 64 or above is used to indicate a significant likelihood that the participant's score belongs to a clinical sample and reliable change is set at 14 OQ points (Lambert et al., 2004).

Therapist Measures

Social Skills Inventory. The Social Skills Inventory (SSI; Riggio, 1986) is a 90-item self-report questionnaire that assesses self-reported social skills. Items are scored using a 5-point Likert scale, with response options ranging from 1 = *not at all like me* to 5 = *exactly like me*. The SSI measures skills in expressivity, sensitivity, and control in verbal (social) and nonverbal (emotional) domains. The SSI yields a global score and six subscales with 15 items each, though subscale scores are highly correlated with each other and the total score. Thus, for the sake of parsimony, only

the global score was used in this study. Coefficient alphas range from .62 to .87 for each of the subscales and test-retest correlations range from .81 to .96 for a 2-week interval (Riggio, 1989). In the present study, the SSI was administered to therapists after they completed treatment with the clients in this study.

Facilitative Interpersonal Skills (FIS) Performance Task. The Facilitative Interpersonal Skills (FIS) Performance Task (Anderson et al., 2007) is designed to elicit responses that are indicants of a person's ability to perceive, understand, and communicate a wide range of interpersonal messages, as well as a person's ability to persuade others with personal problems to apply suggested solutions to their problems and abandon maladaptive patterns. A performance task was designed as a means of measuring therapists' abilities to respond to challenging interpersonal situations in a therapy setting. The development and use of a performance task, as opposed to self-report measures of FIS, is advantageous in that this task has a high level of ecological face validity.

Four problematic therapy process segments were selected from the videotaped archives of a study that focused on problematic interpersonal interactions between patients and therapists (Strupp, 1993). In addition, unique interpersonal patient styles were selected to represent a range of interpersonal patterns, including (a) a confrontational and angry patient ("You can't help me"); (b) a passive, silent, and withdrawn patient ("I don't know what to talk about"); (c) a confused and yielding patient (only the therapist's opinion matters); and (d) a controlling and blaming patient (implies that others, including the therapist, are not worthy of him). Thus, two cases were designed to include patients who were highly self-focused, negative, and self-effacing, and the remaining two cases were designed to be highly other-focused, friendly, but highly dependent clients. Two brief segments (approximately 2 minutes each) were selected for each problematic patient–therapist interaction, and hence the final performance task consists of eight of these brief segments. Actors were hired to re-enact the eight scenarios. These actors memorized the transcripts from the sessions and were coached on how to capture the interpersonal style of the patients they were enacting. Using therapy transcripts, actors re-enacted the scenarios and practiced for multiple sessions before the re-enactments were video-recorded.

Therapists from the present study were presented with these eight brief situations and were prompted to respond to the patient–actors (who were filmed directly facing the camera) at predefined moments "as if" they were the therapist in the situation. The video clips were presented via a computer program that allowed therapists to make their responses in the privacy of their offices at the counseling center. Therapists were asked to leave the audio recorder running to capture the therapists' initial, nonpracticed responses to the video scenarios.

FIS ratings and scoring. FIS item content was selected from the clinical and research literature (e.g., Norcross, 2002) on common therapist interpersonal skills and facilitative conditions. Specifically, the 10 FIS items included ratings of verbal fluency, emotional expression, persuasiveness, hopefulness, warmth, empathy, alliance-bond capacity, and problem focus. Each item was scored using a 5-point Likert type scale, where ratings of 1 or 2 represent deficiencies in the skill, 3 indicates a neutral level, and ratings of 4 and 5 denote proficiencies of the skill being rated.

Two licensed PhD research clinicians rated each of the eight recorded responses for each therapist. Raters were provided with a manual for rating the FIS items. After studying the manual, the two raters (one of which developed the manual) met

for 2 days to discuss and practice ratings with sample responses, none of which included therapist responses from the present study. Then from two separate locations, the PhD research clinicians rated all participating therapists' responses to each of the 10 items. The mean score for the two raters on each item were then summed to obtain one FIS performance rating for each therapist. Hence, possible scores ranged from 5 to 50 and the mean total FIS rating was 29.8 ($SD = 4.52$) and ranged from 19.8 to 36.8. Replicating previous research involving the FIS rating system (e.g., Anderson, Crowley, & Carson, 2001), each of the FIS items had acceptable interrater reliabilities (all were $r > .70$).

FIS in previous research. In a prior research study (Anderson et al., 2001), therapists' FIS served as an independent variable. Doctoral students from a range of graduate programs (e.g., psychology, biology, history) were the therapists in this prior study on FIS. These trained (psychology doctoral students) and untrained (doctoral students in disciplines that do not relate to clinical therapeutic work) therapists were selected based on their performance on the FIS task and based on their social skills, empathy, and sociability. This screening process allowed for a group of high-FIS therapists and a group of low-FIS therapists to participate in the study. Therapists met with clients for seven sessions. Results indicate that clients of high-FIS therapists had significantly better outcomes (OQ-45; Lambert et al., 2004) relative to clients seen by low-FIS therapists. This difference was evident at both termination and at 3 months posttreatment.

Procedures

Outcome data were collected at a university counseling center and portions of the outcome data presented in this sample have been published in other studies (e.g., Okiishi et al., 2003, 2006). However, the assessment of therapists' FIS occurred specifically for this study. Clients receiving services at the center were instructed to complete the OQ-45 prior to each session. Data collected at the same time as the OQ-45 included the client identification number, date of session, and the client's therapist.

Therapists were assessed with the self-report FIS and the FIS performance task, both of which were collected in the privacy of an onsite research office (the researcher was not present). To protect therapist identities, a nontherapist research assistant used randomly assigned therapist identification numbers so that identifying individual therapists would not be possible when viewing the data set. After therapists completed their assessment, they placed their questionnaires and tape-recorded responses to the performance analysis in an envelope, which they were instructed to seal and sign before returning the envelope to the onsite researcher.

Client OQ session data for this study occurred over a 45-month period. All therapist assessments were collected over a 4-month period, beginning in the 40th month and ending in the 44th month of client OQ data collection (most being collected in the 40th month). More specifically, 76.6% of OQ session data were collected prior to the date of the assessment, 23.1% of OQ data were collected after the assessment, and 0.3% occurred on the therapist-reported date of the assessment. The majority of clients (63.1%; $SD = 28.2$) had completed all of their sessions by the time the therapist completed their individualized FIS assessment. At the extremes, one therapist had not completed therapy with any clients at the center while four therapists had terminated all clients prior to the FIS assessment.

Once therapist assessments were completed, all therapist data were sent to a second university site. The two raters of the therapist performance task were also located at different university sites, neither of which was where the client data was collected. Thus, raters were blind to the identities of the therapists being rated and client outcome data was forwarded only after completion of the therapist ratings.

Results

Plan of Analysis

Data were analyzed using hierarchical linear modeling (HLM). Hierarchical linear modeling has a number of advantages over other multivariate methods of analysis (Bryk & Raudenbush, 1992; Singer, 1998) and is especially useful for naturalistic data in which there are variable lengths of data collection and missing data. An initial HLM was examined using an unconditional model with sessions nested within clients and clients nested within therapists. Although the first session intake was sometimes conducted by a different therapist, this intake was attributed to the treating therapist. After examining the unconditional model, a second analysis was conducted taking into account therapist variables (level of training, primary theoretical orientation, type of training, and gender). This analysis focused on the perennial question of therapist variables that may influence outcome (Beutler et al., 2004). A final analysis examined the influence of therapist facilitative interpersonal skills on client outcome. These analyses were followed with further exploration of differences in outcome among therapists and their relationship to therapist characteristics.

Unconditional Model

An examination of the unconditional model with sessions nested within clients and clients nested within therapists indicated that on average clients started treatment with an OQ-45 score of 68.24 ($SE = 0.68$) and that the average slope across therapists was approximately one OQ-45 point of improvement per session, $avg. = -.96$ ($SE = 0.10$). There were no significant differences among therapists in terms of initial OQ-45 scores (intercepts) prior to treatment onset, $p > .05$. However, there were differences among therapists in terms of average outcomes (slope) across clients, $\chi^2(24) = 42.80$, $p = .011$. Estimated intercepts and slopes for the 25 participating therapists are displayed in Table 1. As can be seen, one therapist (therapist I) was a significant outlier with a slope across 50 clients that was significantly lower than all other therapists. Because this case happened to be such a substantial outlier, further analyses were conducted without this therapist. An additional qualitative assessment of this unique therapist is included in the discussion.

Traditional Therapist Variables

The next HLM analysis of therapist data was conducted to see if any of the four traditional therapist variables (age, sex, theoretical orientation, and percentage of work time conducting therapy) might account for differences in outcomes among therapists. The results of this analysis indicated that the sex, theoretical orientation (CBT, humanistic, eclectic, dynamic), and percentage of time conducting treatment did not significantly account for variation in outcomes among therapists

Table 1
Therapist Hierarchical Linear Modeling (HLM) Estimated Intercepts and Slopes Across Clients

Therapist	Estimated intercept	Estimated slope (Empirical Bayes)
A	68.18	−1.29
B	68.21	−1.15
C	68.22	−1.08
D	68.20	−1.19
E	68.24	−0.95
F	68.23	−1.03
G	68.18	−1.29
H	68.26	−0.85
I	68.37	−0.27
J	68.23	−1.03
K	68.25	−0.93
L	68.19	−1.25
M	68.27	−0.82
N	68.21	−1.12
O	68.24	−1.00
P	68.29	−0.67
Q	68.25	−0.92
R	68.27	−0.83
S	68.27	−0.82
T	68.22	−1.09
U	68.27	−0.83
V	68.28	−0.75
W	68.22	−1.10
X	68.24	−0.97
Y	68.27	−0.79

Table 2
Hierarchical Linear Modeling (HLM) With Age, Sex, Percentage of Work Time Conducting Treatment, and Theoretical Orientation as Predictors of Outcome (Slope)

Predictor	Coefficient	SE	T-Ratio
Age	−0.02	0.01	−2.77*
Sex	0.06	0.13	0.46
Percentage of time conducting treatment	0.00	0.00	0.74
Theoretical orientation	0.01	0.08	0.17

*$p < .05$.

(see Table 2). In contrast, the age of the therapist did account for differences in outcome, with older therapists having better outcomes than younger therapists.

FIS as a Predictor

To examine the variable of interest, FIS, a third HLM analysis was conducted with age, self-report of social skills (SSI), and the FIS performance assessment ratings as predictors of outcome (see Table 3). Age was included because it was a significant predictor in the first stage of the analysis. As can be seen in Table 3, FIS was the lone predictor of variation in outcome slope among therapists. In the context of SSI and FIS, age was no longer a significant predictor of therapist slope.

Table 3

Hierarchical Linear Modeling (HLM) With Age, SSI, and FIS as Predictors of Outcome (Slope)

Predictor	Coefficient	SE	T-Ratio
Age	−0.01	0.01	−1.70
SSI	0.00	0.00	0.66
FIS	−0.03	0.01	−2.16*

Note: SSI = Social Skills Inventory; FIS = facilitative interpersonal skills. *$p < .05$.
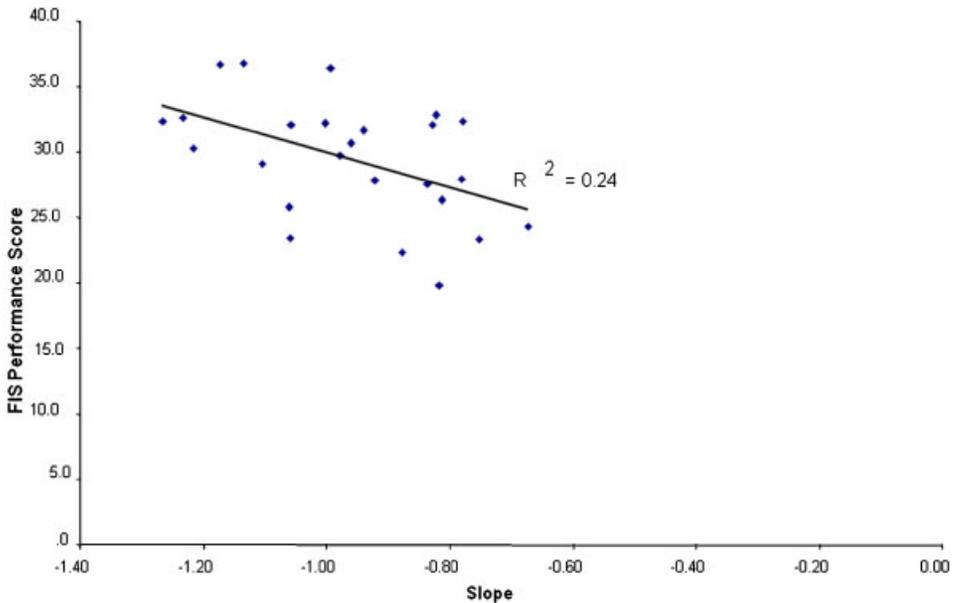

Figure 1. Scatterplot of facilitative interpersonal skills (FIS) by outcome slope.

Additional Analyses

To further explore the relationship between therapist characteristics and client outcome in this naturalistic setting, we examined the scatter plot of, and calculated the simple correlation between, the FIS total score for each therapist and the HLM estimated outcome slope for each therapist's caseload of clients. Although this analysis is somewhat counterintuitive to the HLM design in that the hierarchical nature of the data is lost when aggregating at the therapist level, it does allow for another perspective on the relationship between slopes and FIS. As can be seen in Figure 1, therapists with higher facilitative interpersonal skills had clients with greater change rates (slopes). The simple correlation between therapist FIS sum and outcome slope was significant, $r = .47$ ($n = 24$).

Because age initially emerged as a significant predictor of outcome, only to be displaced by FIS, we were interested in other associations with age in our dataset. Most notable was that age and FIS were significantly associated, $r(27) = .45$, $p < .02$. In addition, because the OQ data were collected over a prolonged period, it seemed possible that older therapists may have had a disproportionately large number of cases completed prior to the assessment (e.g., OQ scores could have been influenced

by the FIS assessment). Thus, we explored whether older therapists may have had a greater number of completed cases prior to their FIS assessments. Therapist mean percentage of cases completed prior to the FIS assessment was not significantly correlated with demographic variables, including therapist age, $r(27) = .24$, *ns*. Also, the percentage of completed cases prior to the therapist assessment was not associated with the mean estimated slope of OQ scores from the above HLM analysis, $r(27) = .11$, *ns*. Although not all therapists estimated their hours of clinical experience, there was, not surprisingly, a strong and significant relationships with age for those who did, $r(21) = .81$, $p < .001$.

Discussion

A substantial body of research suggests that the variance in therapy outcomes is explained in part by individual therapists. In a meta-analysis of therapist effects, Crits-Christoph and Mintz (1991) found that approximately 9% of the variance in therapy outcomes was due to differences among therapists. However, little is known about the specific characteristics that underlie these therapist effects. The current study sought to understand not only the impact of traditional therapist variables (e.g., age, theoretical orientation, sex of the therapist) on clinical outcomes, but also to understand the role of therapists' facilitative interpersonal skills (FIS) on outcome. To investigate these characteristics, HLM analyses were conducted on a subset of the sample from Okiishi and colleagues' (2003, 2006) studies. Therapists in the current study's sample completed self-report measures and a performance task designed to measure one's level of facilitative interpersonal skills.

As predicted, there were considerable differences among therapists with regards to average outcomes across clients. In other words, therapist effects were present in the current study. To investigate the potential sources for these effects, the traditional therapist variables of therapist age, therapist sex, percentage of work time conducting treatment, and therapist theoretical orientation were analyzed with HLM analysis. Of these four variables, only the age of the therapist accounted for differences in therapy outcome, specifically, that older therapists produced superior outcomes. This was an unexpected finding because most of the previous literature on therapist characteristics has not found age to be a predictor of outcome. (e.g., Beutler et al., 2004). However, when the therapist's age, self-reported social skills, and FIS were examined with HLM analysis, age no longer predicted outcome. It seems reasonable to infer that age serves as an indicator of the accumulation of clinical experience needed to master the interpersonal qualities inherent in FIS. We believe that the collection of interpersonal qualities needed to optimize the therapeutic relationship, as measured in the current study through the use of vignettes that are therapeutically challenging, likely requires considerable effort and more practice than typically afforded in standard clinical training (e.g., see Strupp & Anderson, 1997). Indeed, our study found that age and FIS were significantly correlated. Even though age no longer predicted outcome when accounting for FIS in our hierarchical analysis, we suspect that the relationship of experience, practice, and life experience deserve future study as significant aspects of constructs such as FIS, which attempt to test the limits of therapists' interpersonal abilities. An important finding from this study is that FIS emerged as a significant predictor of outcome (slope). This finding indicates that the therapist characteristic of facilitative interpersonal skills (e.g., emotional expression and persuasiveness) represents a quality of the therapist that impacts clinical outcomes.

Correlational analyses were conducted in an effort to better understand the relationship between FIS and outcome. These analyses further illuminated the importance of FIS in terms of clients' outcomes. Results indicated that larger rates of improvement were reported by clients whose therapists had higher levels of facilitative interpersonal skills, as compared to clients of therapists with lower levels of facilitative interpersonal skills. The finding that therapists' interpersonal skills predicted outcome is congruent with the literature surrounding empirically supported relationships (Norcross, 2002). In essence, this study sheds light on one of the factors that underlie therapist effects and the findings from this study support the notion that the person of the therapist is a key ingredient of psychotherapy. Although the finding regarding therapists' facilitative interpersonal skills is the most striking result from this study, analyses yielded additional interesting results.

The unconditional HLM analysis of the entire sample indicated that therapists' clients did not differ substantially from one another in terms of their initial symptom severity (measured by the OQ-45 prior to intake). One strength of this study is that clients completed the OQ-45 at each session, so that session-by-session change was available for analyses. Across therapists, clients in the current study improved an average of approximately 1-point per session. This rate of change indicates that 14 sessions were needed for clients, as a group, to make reliable change. Thus, clients in the naturalistic setting had change rates that were consistent with findings from Lambert, Hansen, and Finch's (2001) study on the number of sessions needed for clients to make reliable change in therapy.

One noteworthy finding relates to a unique therapist that was treated as an outlier in the current study. The slope across clients for this therapist revealed a much lower rate of change in client symptoms. Of the total 25 therapists in the present study, this one distinct therapist represents 4% of the sample of therapists. It could be said that this therapist is similar to therapists identified in other studies who have significantly poorer outcomes (Bergin & Suinn, 1975). This finding has important implications for future studies. Not only should researchers examine therapist effects in terms of therapist factors that enhance outcome, such as facilitative interpersonal skills, but also researchers must examine therapist factors that lead to or are related to client deterioration. Both sets of factors have the potential to lead to methods for improving the effectiveness/efficacy of psychotherapy.

Limitations

This study contains several limitations that must be addressed. The primary limitations of this study include the following: (a) selection and timing of therapist assessments; (b) outcome was assessed with a single measure, as opposed to multiple measures; and (3) limitations typically associated with naturalistic studies. The details and implications of these limitations are described below.

As described earlier, this study's sample is composed of a subset of clients and therapists from the sample of therapists and clients that participated in Okiishi and colleagues' (2006, 2003) studies. Therapists from these previous studies were invited to participate in the current study and their participation required that they complete self-report measures and a performance assessment of facilitative interpersonal skills. To reduce possible biases, two independent raters that were located at two separate universities from the data collection site completed ratings of the FIS performance task. Although this rating procedure reflects a strength of this research, it is unclear whether the volunteer selection process affected the results of this study. In addition,

therapists completed the self-report measures and the FIS performance task after their clients terminated from therapy. It seems likely that social and facilitative interpersonal skills represent stable constructs; thus, the timing of measurement may not have impacted the study's results. However, because the stability of these constructs has not been formally researched, we cannot make definitive conclusions about the effects that the timing of assessment had on the findings from this investigation.

The second limitation of this study is the fact that clinical outcomes were measured by only one self-report instrument (OQ-45). Unfortunately, no single outcome measure can depict a complete picture of a client's gains or declines. To fully capture therapy outcomes, a wide range of measures with multiple target areas and sources are necessary. Nevertheless, the OQ-45 is an outcome instrument that is highly correlated with a variety of other self-report instruments typically used in outcome research and with psychometric properties that allowed for repeated assessments of outcome over the course of numerous sessions.

Lastly, inherent in the present research is the set of limitations found in any study of psychotherapy (i.e., an imbalance of internal and external validity). The lack of control in naturalistic studies leads to decreased internal validity. For example, the current study did not have a control condition or random assignment. However, the strength of this study lies in its external validity. Because this study did not have stringent criteria for inclusion/exclusion of clients and the setting was not highly controlled, its findings may be generalized to other clinical service-oriented settings that treat similar clinical samples.

Conclusion

There is variability in psychotherapy outcome that can be linked to individual therapists and it appears that a portion of this variability can be linked specifically to therapists' interpersonal skills rather than to other variables. Because therapists' facilitative interpersonal skills explain a significant proportion of therapist variability in client outcomes, future research in this area has the potential to improve both clinical trials research and evidence-based practice in naturalistic settings. By selecting therapists who have equivalent FIS scores, clinical trials researchers may be better able to control therapist variability and thus, be better able to determine the effects of the specific techniques or treatments being studied. Further examination and consideration of therapists' FIS have the potential to enhance client outcomes in real-world practice settings, such as the counseling center where our data was collected. The FIS construct is broad-based and is more similar to general therapist competencies than to specific techniques. Our findings suggest that emphasis should be placed on facilitative interpersonal skills similar to those examined in this study in the selection and training of therapists. In addition, from the point of view of the consumers of services it would be an advantage to know beforehand which therapists are high in such skills. Future research will help clinicians understand the situations in which the therapists' interpersonal skills influence the progress of therapy and whether interpersonal skills reflect a stable or dynamic characteristic that may be influenced by therapeutic process and interactions with different clients. Additionally, further research in this area would help clinical supervisors understand and identify the relative importance of competencies for therapist training. The current study reaffirms the notion that many psychotherapies, as routinely practiced, are

evidence-based when delivered by therapists who can offer high levels of interpersonal skills on a performance-based measure.

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