

What Really Matters

The foundation of effective counselling and psychotherapy

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Preface

Until lions have their historians, tales of hunting will always glorify the hunter.

African proverb

Some years ago, when I first started reviewing psychotherapy and counselling outcome and process research, I must admit I was very surprised, even shocked. How could there be such a wide gap between what researchers were telling us and what practitioners, trainers, and professional organizations were actually *doing*? Counselling and psychotherapy practice and training were becoming ever more diverse and complex, emphasizing technique and therapist expertise, while the research evidence was mounting to indicate a simpler (but not simplistic) truth, emphasizing commonalities and client resources. Who were the real heroes of this paradoxical enterprise - therapy gurus, researchers, practitioners, or clients?^{71,30}

Time has passed and I now have a better understanding of the communication difficulties, time lags, politics and traditional inertia within the field. However, my core concern about the divergence of research and practice has been addressed only relatively recently in this country. Action has been stimulated by the growing demands from large service funders (particularly the National Health Service and other healthcare providers ^{93,87,49,16}) that therapies have proven effectiveness and efficiency. ^{97,14,87,74} Scientific method and costbenefit analysis are being applied more and more to counselling and psychotherapy whether practitioners are well-disposed to them or not. ^{97a}

Many practitioners remain wary of, or are even antagonistic towards, counselling and psychotherapy being studied and evaluated scientifically. Science, in itself, does not necessarily pose a threat to the "heart and soul" of therapy. In this enlightened day and age, surely we should value objectivity over mysticism and rationalism over dogmatism when we tinker with someone's psyche?¹⁰⁵ Of course, scientific evidence can be abused too and I am sure that few of us would relish the absurd reductionism of conducting "therapy by numbers". Perhaps drawing the analogy of music to therapy demonstrates why science need not be so feared: the physics of sound are precisely defined, yet the variety of music is exquisite and its effects on the listener are highly individual and often profound. Though, when appropriate, science can tolerate ambiguity, fuzzy thinking, and even chaos too.^{60,17} Evidence-based practice may be our goal, but research also confirms that flexibility, creativity, and our individual humanity must never be sacrificed in its pursuit.^{54,10,79}

This paper has been written as part of the project undertaken for the COSCA Fellowship 1999-2000, with its main aim being to highlight "what really matters" in effective counselling and psychotherapy. I hope that responsible practitioners will welcome the challenge of laying aside their differences, within the field and across disciplines, to focus more clearly on what works best from the *client's* viewpoint. A concerted effort to reconcile therapeutic research and practice could yield significant benefits to both the population of Scotland, particularly those in remote or rural areas where psychosocial services are scarce, and the profession itself. ^{99,87} Our professional integrity is increasingly being challenged by the public and rival professionals: let us make sure that we *are* wearing clothes!

This work could not have been achieved without many different sources of help. My acknowledgements and thanks particularly go to: the numerous researchers and reviewers whose original work I have so freely digested (and sometimes regurgitated!); the COSCA Management Committee for their award of the Fellowship; COSCA staff for their enthusiasm and practical assistance; my therapist colleagues for stimulating discussion and suggestions; therapy clients for regularly shaking us out of professional complacency; and finally, to my wife Christina, and children, Fiona and Finlay, for their tolerance and reminding me that the real therapy is living.

Introduction

A wise man proportions his belief to the evidence.

No testimony is sufficient to establish a miracle, unless the testimony be of such a kind, that its falsehood would be more miraculous than the fact which it endeavours to establish.

David Hume, 1758

Despite ancient origins, it is only fairly recently, over the last fifty years or so, that counselling and psychotherapy have been investigated scientifically. ^{10,97,49,85} In this time, the great boom in the availability and diversity of therapies has far outstripped the growth in our objective knowledge and its ability to influence practice and training. The unfortunate result now is a deeply entrenched schism between practice and research which leaves counselling and psychotherapy open to much criticism - some constructive, some downright hostile from both outwith ^{34,42,93a,68,89} and within ^{25,26,13,53,34,70} the field. Researchers have generally failed to communicate clinically practical findings and practitioners have shown little interest in research. ^{54,72,97a} Much more heat has been expended in fighting professional turf wars and defending theoretical standpoints than light shone on how we can best make therapy practice effective and efficient. The present situation is undoubtedly confusing and frustrating, for both practitioners and those whom they seek to serve. Current self-regulatory schemes and proposals for legislation in the United Kingdom ^{1,18,19,15,83} are unlikely to provide a valid simplification, as they are neither rooted in the evidence base from research nor unequivocally led by the public interest. ^{51,81,82,86} Ideology and dogmatism remain much more powerful influences on the field than science. ¹⁰⁵

In an era of increasing clinical and financial scrutiny, it is reasonable to first ask why we have such a multitude of different approaches to 'the talking cure' - an estimated 250 therapy models and over 400 techniques at present. ^{10,54,30} And especially, when many are based on little more than subjective opinion, personal belief, or a few selected case studies. ^{25,26} Does each of these therapies really have a unique contribution to make to our emotional and mental well-being? Is the field complex because human nature is or is it just responding through its diversity to a call for greater consumer choice? Should more public money be invested in counselling and psychotherapy services, even if few are scientifically evaluated? There are many questions which can be asked, and we will need much more informed debate and hard evidence to answer most of them convincingly. However, there are some robust conclusions (so well-confirmed that they might even be accorded the status of facts ¹⁰⁵) which do emerge from the accumulation of research to date:

1. Therapy has focused on pathology

"We know more today about how to treat mental illness effectively and appropriately than we know with certainty about how to prevent mental illness and promote mental health. Common sense and respect for our fellow humans tells us that a focus on the positive aspects of mental health demands our immediate attention." (US Surgeon General, 1999). 116 "Psychotherapy research and practice continue to be based on and guided by the assumption that what is wrong with the people who visit therapists ... is of more importance than what is right." "Since the Diagnostic and Statistical Manual of Mental Disorders [DSM] was first published in 1952, the number of diagnostic

categories included in the volume has increased a whopping 300%." (Miller, Duncan & Hubble, 1997)^{79,2,119}

2. Therapy works overall

"That psychotherapy is, in general, effective, efficient, and lasting has been empirically supported time and again." (Asay & Lambert, 1999).⁵ "Psychotherapy facilitates the remission of symptoms. It not only speeds up the natural healing process but also often provides additional coping strategies and methods for dealing with future problems." (Lambert & Bergin, 1994).⁶³ "There is more, and better quality, scientific evidence to support psychotherapy than for many other interventions in health care today." (Shapiro, 1996)⁹⁷

3. Different therapies produce similar results

"With some exceptions ... there is massive evidence that psychotherapeutic techniques do not have specific effects; yet there is tremendous resistance to accepting this finding as a legitimate one." (Bergin & Garfield, 1994). 10 "Head-to-head comparisons among treatments differing in the strengths of their respective evidential support show surprisingly modest differences. For most [disorders], there is little evidence to take us beyond the paradoxical 'Dodo bird verdict' of equivalent outcomes from very different treatment methods." (Shapiro, 1996) 97

4. The client's resources are paramount

"The data point to the inevitable conclusion that the primary agent of change, the 'engine' of change, is the client." "70% of why therapy works goes to the client and 30% to the therapist." "On the whole, there is little or no difference between therapists that is based on their training or experience, suggesting that specialized expertise on the part of the therapist is not a major contributor to effectiveness." (Tallman & Bohart, 1999). 113 "The quality of the patient's participation in therapy stands out as the most important determinant of outcome." (Orlinsky, Grawe & Parks, 1994) 92

Noting conclusions 1) and 2), this paper will explore 3) and 4) in more detail, with the aim of laying a foundation for effective and efficient therapeutic practice. Although there is already a substantial body of research literature concerning the key factors - "what really matters" - in therapy, the communication and dissemination of clinically important findings have evidently been very limited. The original literature on evidence-based integrative therapy ^{35,79,54,118,44} is not well-known in Scotland and the most comprehensive research reviews ^{10,54,97,85} are somewhat daunting to the reader without research training. By providing a brief, "practitioner-friendly" digest of our best research evidence to date, this paper will hopefully serve as a footbridge across the chasm between research and practice. It is certainly not intended to advocate yet another model of therapy. The search for a winner among therapies has been proven largely futile: outcome research has failed to identify one (or more) consistently superior therapy. ^{63,54,97} Rather, practitioners will be encouraged to thoughtfully optimize therapy for each individual client, guided by the proven principles of effective practice. While most of the research reviewed is quantitative and statistical in nature, to determine general features, the value of qualitative research, individual case studies and informed debate is also recognized. ^{75,34,53,42,29}

Fortunately, much of the ground we shall cover will already be familiar to many practitioners and trainers. Effective counsellors and psychotherapists will no doubt welcome validation of their existing ways of working and therapists in training should have a firmer, evidence-based, foundation on which to build their skills and practice. And most importantly, our clients, and society in general, will benefit.

Counselling or psychotherapy?

The perceived differences between counselling and psychotherapy have long been debated and it is inappropriate to examine them in detail here. 34,57 A fundamental problem is that these activities and any boundaries between them are poorly defined both in practice and in research. 97,49 None of the criteria often argued to differentiate counselling and psychotherapy (such as: type of problem; symptomatic relief or personality change; 'depth' of working; internal or external focus; working with the conscious or unconscious; directiveness or non-directiveness; duration of therapy; frequency of sessions; practitioner's job title or length of training) appear to be applied consistently or proven clinically reliable. Moreover, research on the rapeutic effectiveness does not support the relevance of these supposed distinctions to client outcome. 10,54 Commonalities between counselling and psychotherapy are, however, considerable and highly significant to outcome. We also note that the overwhelming bulk of outcome and process research uses 'psychotherapy' as the generic term for psychological helping. For these reasons, and for the sake of brevity, this digest will use the term 'therapy' to refer to both psychotherapy and counselling. Behavioural therapies will also be included in the digest, again since their commonalities with other therapies are significant. 10,56 Our improved understanding of the mind-body system confirms the importance of emotional, rational and behavioural processes to effective therapy. 92,64,78,44,43,102

While cosmetic differences between counselling and psychotherapy need not concern us for the purposes of this paper, it is interesting to note that counselling has received much harsher criticism than psychotherapy in some recent, highly influential, research reviews. (Psychotherapy may have fared better because of its quasi-medical connotations.) For example, Roth & Fonagy (1996) devote an entire chapter to drawing rather flimsy conclusions about the value of counselling while making special pleading for psychodynamic therapy elsewhere. The *Effective Health Care* (1997) review similarly dismisses generic counselling, from a very restricted range of studies. Although rebuttals of these and similar poorly substantiated conclusions have now been published, it illustrates how therapeutic factions and allegiances influence researchers' work too. Although rebuttals of these than true scientific objectivity in this field is still hard to achieve.

Research terms and concepts

Although we will avoid using jargon as far as possible, it is useful to have a familiarity with some of the terms and concepts often bandied around research work. Besides facilitating this paper, the summary below will perhaps encourage more practitioners to critically evaluate research articles for themselves:

Evidence-based practice is the conscientious, explicit, and judicious use of current best evidence in determining how to optimize therapy with individual clients. This means integrating the practitioner's own expertise and the individual client's resources and preferences with the best available external evidence from systematic research. Such evidence informs, but should never dictate, how therapy with an individual client proceeds. Evidence-based practice requires a "bottom-up" rather than a "top-down" approach. (Adapted from Sackett et al, 1996)^{98,97a}

We need to recognize the distinction between the *efficacy* of a therapy (the results it achieves in the strictly controlled environment of a research trial) and its *clinical effectiveness* (the outcome of the therapy in 'the real world' of everyday practice). Efficacy studies normally use the *randomized controlled trial* (RCT) design, where clients are randomly allocated to different therapy or control conditions. This permits two or more active therapies to be compared, or a therapy's effect to be contrasted with no therapy, a waiting list, or a plausible but dummy intervention. The RCT has become a yardstick for evidence of treatment efficacy, particularly in medicine, and an empirically validated treatment (EVT) usually refers to a treatment which has yielded positive results in an RCT efficacy study. ^{85,54} However, several significant problems arise when investigating psychological therapies (discussed by Seligman, 1995 ¹⁰³,1998 and others): ^{63,97,8,25,107,49,97a}

- Placebo factors the mobilisation of hope and expectancy of improvement play an
 active role in all types of therapy. However, in medical research, placebo substances
 and procedures can easily be used as controls because they are inert from a
 pharmacological or physiological standpoint. Placebo controls are much more difficult
 to implement in psychotherapy research since the effects of both psychotherapies and
 placebos depend upon psychological mechanisms.^{63,107,100,9}
- 2. An RCT of psychotherapy cannot be *double-blind* in the same way that an active drug versus a placebo pill can. The therapist knows what they are giving to clients and the client generally knows what they are receiving. Even a *single-blind* study, with the client unaware ('blind') of what they are receiving, is hard to achieve in therapy.
- Therapy in the field is generally not of fixed duration, but dependent on the client's improvement. In contrast, an efficacy study normally stops after a certain number of sessions, regardless of progress.
- 4. Therapy in the field tends to be self-correcting, with alternative techniques and modalities being tried to replace those that are not working. In contrast, the techniques and modalities used in efficacy studies are strictly defined and rigorously applied.
- 5. Therapy clients in the field often actively choose their therapist and their preferred therapeutic approach. In contrast, clients in an efficacy study are passively and randomly assigned to both the therapist and the approach.
- 6. Therapy clients in the field usually have multiple and interacting problems. Clients in efficacy studies are carefully selected to have but one or two well-defined diagnoses.

7. Therapy in the field is usually concerned with improving the general functioning of clients as well as relieving specific problems or symptoms. Efficacy studies usually focus only on specific problem resolution and symptom reduction.

Seligman remarks: "It is hard to imagine how one could ever do a scientifically compelling efficacy study of a [therapy] which had variable duration and self-correcting improvisations and was aimed at improved quality of life as well as symptom relief, with [clients] who were not randomly assigned and had multiple problems. But this does not mean that the effectiveness of [therapy] so delivered cannot be empirically validated." Parry (2000) concludes that, "research evidence of efficacy does not guarantee delivery of clinically effective therapies. We need both types of evidence - efficacy research and good clinical research on outcomes of therapies as delivered." Therefore, this review will consider the findings from both efficacy and effectiveness research to determine what works.

Researchers use a technque called *meta-analysis* to summarize a large number of research studies. Many of the reviews cited in this paper refer to meta-analyses. The basic unit of analysis is the *effect size* (ES) calculated from individual studies. Effect size provides a common measure across a variety of studies. Typically, it is calculated as the average difference between the experimental (for example, test therapy) and control (for example, no therapy) groups, measured in terms such as the clients' well-being or reduction in symptoms. Effect sizes may be expressed in standard deviation units, or in terms of percentiles. For example, when a therapy group is compared to a control group, an effect size of 1.0 (standard deviations) means that the average therapy client is better off than 84% of the control group. As a guide, an ES of zero indicates no difference; 0.2 suggests a small difference; 0.5 a medium-sized difference; and 0.8 a large difference.

Though insensitive to individual cases and speaking only for the average client, metaanalysis is a powerful research tool to examine the overall phenomenon and effect of therapy.^{58,97,63,25}

The similar outcomes phenomenon

Plus ça change, plus c'est la même chose.

The more things change, the more they are the same.

Alphonse Karr, 1849

Considerable evidence now exists to prove the superiority of therapy to both no-therapy and placebo control groups, at least in research settings. The advantage of therapy is summarized in Table 1, derived from meta-analyses of over a thousand outcome studies. ^{5,63,104} This shows that the average client who participates in therapy is better off than around 80% of those who do not. Though this result is clearly significant, we should not presume that we may generalize from therapy research to therapy in actual practice. There are numerous different conditions and variables, as discussed previously. Although relatively fewer rigorous effectiveness studies have been conducted, there is now tentative scientific evidence that therapy does work in the field too. ^{104,21,103,56} It has been estimated recently that the effect size of therapy in the field is similar to therapy in research settings, or at most, a tenth smaller. ¹⁰⁴

While we can be confident that the data does show overall benefit, it also indicates that the outcome of therapy is highly variable. There are significant differences between individual practitioners and even entire service delivery systems. Such differences cannot be explained by the nature of the cases being seen, the therapeutic approaches followed, or the outcome measures used. 16,10

Table 1
Summary of effect sizes from meta-analyses of therapy outcomes

Comparison	Size of effect	Percentile
Therapy vs. no therapy ^{5,63}	0.82	79%
Therapy vs. placebo ^{5,63}	0.48	68%
Placebo vs. no therapy ^{5,63}	0.42	66%
Differences between therapies 117	0.00 < ES < 0.21	50% < ES < 58%

Despite the large number of approaches to therapy, each with its own rationale and specific techniques, there is remarkably little evidence to support the superiority of one approach over another. 63,54,79 Much time and effort have been put into the search for a winner among therapies and professional passions have run high whenever a leader seemed to be emerging from the ever growing pack of also-rans. Leaving psychodynamic and humanistic therapies trailing, cognitive-behavioural therapy (CBT) has currently achieved official status (for example, in the National Health Service) as the "treatment of choice" for many common problems. 97,85 Undeterred, proponents of rival therapies continue to lure cost-conscious service providers with impressive claims of efficacy and efficiency. Among others, Eye Movement Desensitization and Reprocessing (EMDR), Neuro-Linguistic Programming

(NLP), Solution-Focused Brief Therapy (SFBT), and Thought Field Therapy (TFT) have recently been in vogue, promising easier and swifter results. (The latter even claims 80-97% success rates - in minutes!)⁵⁶ Research data on these and other under-researched therapies is accumulating, but current evidence and past trends suggest it is highly unlikely that early claims of superiority will be sustained. ^{56,97,88}

When data analyses have accounted for investigator allegiances, selectively reactive outcome measures, longer term follow-up, and dropout (attrition) rates, the differences in outcome among *all* therapies are found to be minimal. 63,54,79,56,103,117 Researchers have dubbed this phenomenon of similar outcomes the 'dodo bird verdict', borrowed from Lewis Carroll's Alice in Wonderland: "Everyone has won and so all must have prizes." This verdict has been reached time and again from numerous outcome studies and meta-analyses, many of which were originally expected to confirm the superiority of a particular therapy over another! Even a recent meta-analysis, conducted to answer objections to earlier ones, has once again reconfirmed the dodo bird verdict, finding the efficacy of bona fide therapies to be "roughly equivalent" - see Table 1. 117 It is also interesting to note that data comparing a variety of psychoactive medications with numerous psychotherapies indicates that they all achieve roughly equivalent results, at least in the short term (though therapy generally does better in the long term).³¹ Combining medication with psychotherapy is not usually more effective than either alone.^{41,56,10,3,23} Greenberg (1999) summarizes the research: "... therapeutic outcome appears to be most influenced by the interpersonal dimensions of the treatment process. No specific factors associated with either drug or psychotherapy treatments proved to be more important than the patient and practitioner personal qualities that interact to establish an effective therapeutic relationship ... there is more to practicing effective pharmacotherapy than simply choosing an appropriate drug and dosage level."41

Strenuous attempts have been made to dismiss or overturn the dodo bird verdict: "rationalizations that attempt to preserve the role of special theories, the status of leaders of such approaches, the technical training programs for therapists, the professional legitimacy of psychotherapy, and the rewards that come to those having supposedly curative powers." (Bergin & Garfield, 1994). ¹⁰ Perhaps unsurprisingly, often trying to keep up with medicine, some professional groups (particularly in psychology and psychiatry) have persisted in pursuing 'empirically validated treatments' (EVTs) - therapies approved for particular disorders. ^{97,85,54,102,56} However, in spite of the popular appeal of developing "psychological pills", the evidence that unique ingredients are responsible for the efficacy of these therapies is very weak indeed. ^{117,10,16,30} There are also significant problems concerning the utility and reliability of diagnostic schemes (such as DSM-IV and ICD-10) for psychological disorders in the first place. ^{30,41,26,2,119}

To summarize: whatever differences in therapy effectiveness exist (neither due to methodological artifacts nor chance), they appear to be extremely small, at best.

The common factors of effective therapy

Our foundation for effective practice starts with the similar outcomes phenomenon, since it is such a robust finding from research. It is clear that, in some way, the *similarities* rather than the differences between therapeutic approaches account for most of the effectiveness of therapy. While exploring how this may happen, we will also bear in mind other significant research findings which cut across therapeutic approaches and modalities:

- a) In response to distress or crisis in their lives, most people change or adapt adequately using their own resources, without requiring therapy. The rate for spontaneous (or 'extratherapeutic') improvement is approximately 40%, but with a wide variation depending on a diversity of client and problem factors. ^{5,63,97} People often overcome even severe problems on their own, despite pessimistic prognoses. Successful change does not hinge on therapist expertise. ^{113,29,115,26} Of those who do seek therapy, most attend only a handful of therapy sessions and spend a very small percentage (less than 1%) of their waking hours in sessions. It is estimated that less than a quarter of people with a diagnosable mental disorder ever participate in therapy and less than a tenth of people with health-threatening lifestyle problems ever seek professional assistance. Therapists' caseloads are therefore not truly representative of how entire populations change. ^{95,116,79,114}
- b) People in distress seek help from a wide variety of sources, both formal and informal. Perhaps up to a half of clients seeking therapy have also sought help from other sources. People are generally satisfied with the extratherapeutic assistance they obtain. The overall effectiveness of self-help is comparable to that of professionally provided therapy, for a wide range of problems and different modalities. For example, self-help books (bibliotherapy) and other media-based material, self-help groups, and computer-programmed therapy all tend to show similar benefits (another dodo bird verdict). Self-expression and self-disclosure have been found to be beneficial too. 113,63,61,77,84
- c) Therapists have become increasingly pragmatic, tending to select therapeutic procedures from any approach that appear to be the best ones for a particular client. Therapists identify themselves as 'eclectic', or the more systematic 'integrative', more frequently (around two-thirds) than any other orientation. ^{10,108,107,30} In private at least, therapists seem to agree with the overwhelming research evidence that clients make the larger contribution to therapy outcome. ^{113,56,92} Feltham (1999) asked: "Why is the open secret that many practitioners freely practise their own idiosyncratic version of what they were trained in, and do not teach what they practise kept so secret ...?" ³⁴

Diverse therapies may produce similar outcomes either by embodying common therapeutic factors or by achieving similar goals through different processes. The first alternative has received the most research attention and it is also consistent with the findings of placebo and dismantling studies (the latter aim to identify active therapeutic ingredients). A contribution to outcome from the second alternative and more unique variables should not be discounted, but "based on our review of the evidence, it appears that what can be firmly stated is that factors common across treatments are accounting for a substantial amount of improvement ... These so-called common factors may even account for most of the gains that result from

psychological interventions." (Lambert & Bergin, 1994). 63 Since common factors evidently contribute a great deal to positive outcome, it is crucial for therapists to intentionally empower them in their practice. But what are these common factors and how can we most usefully conceptualize them?

Various conceptualizations have been suggested for the common factors, for example, by Karasu (1986), Frank & Frank (1991), and Lambert & Bergin (1994). The latter, shown in Table 2, is a particularly practical example and was derived from the variables correlated with positive outcome in research studies. Most schemes based on empirical evidence recognize the importance of affective, cognitive and behavioural factors in providing effective therapy and assessing outcome. ^{63,35,56} Norcross (1999), having reviewed schemes for cataloguing therapy commonalities, concluded that the complex process of therapy has to be viewed inclusively, across theoretical boundaries. "Common factors are not located solely in the therapist, but also in the client; not solely in the intratherapy alliance, but also in the broader environmental context ... not solely in formal treatment, but also as part of clients' self-change." ⁵⁴

Table 2
Sequence of common factors associated with positive outcomes
(Lambert & Bergin, 1994)⁶³

Support factors	Learning factors	Action factors
Catharsis	Advice	Behavioural regulation
Identification with therapist	Affective experiencing	Cognitive mastery
Mitigation of isolation	Assimilation of problematic experiences	Encouragement of facing fears
Positive relationship	Changing expectations for personal effectiveness	Taking risks
Reassurance	Cognitive learning	Mastery efforts
Release of tension	Corrective emotional experience	Modelling
Structure	Exploration of internal frame of reference	Practice
Therapeutic alliance	Feedback	Reality testing
Therapist/client active participation	Insight	Success experience
Therapist expertness	Rationale	Working through
Therapist warmth, respect, empathy, acceptance, genuineness		
Trust		

Probably the most useful and respected overview of common therapeutic factors is the 'big four' proposed by Lambert (1992), from an extensive review of outcome research. ^{5,62,54} This classification has the advantages of inclusiveness and weighing the relative importance of the common factors on the basis of their estimated contributions to outcome. Figure 1 shows graphically how these factors contribute, on average, to client improvement.

Model/technique
factors
15%

Extratherapeutic
factors
40%

Therapeutic
relationship factors
30%

Figure 1
Factors influencing client improvement

Extratherapeutic factors comprise everything about the client (for example, personal qualities, history and motivation) and their environment (for example, social support and chance events) that helps, *regardless* of formal participation in therapy.

Therapeutic relationship factors reflect the quality of the therapeutic alliance between the client and the therapist (including for example, empathy, warmth and trust).

Placebo factors reflect the client's hope and expectancy that they will improve (for example, by simply coming to therapy and from its credibility).

Model/technique factors are the beliefs and procedures unique to specific therapies (providing for example, a rationale and a treatment protocol).

What is immediately striking about this breakdown is the great degree to which outcome is determined by the client and outside circumstances - not the therapist or the therapy. "Considering that placebo factors are client factors (client self-healing through hope and belief), and clients contribute at least as much to the therapeutic relationship as does the

therapist, Lambert's figures also imply that the client is responsible for 70% or more of the outcome variance." (Tallman & Bohart, 1999). ¹¹³ "Based on this, one could conclude that 85 per cent of clients would improve with the help of a good friend and 40 per cent without even that." (Dineen, 1999). ²⁶ Though we are talking averages, the extent of client efficacy obviously goes a long way to explaining the observations and findings a) to c) noted previously. People usually overcome problems on their own, but when self-change attempts fail, they seek assistance from a variety of sources, including therapists. ¹¹³

The dodo bird verdict has been addressed at an even more basic level than the 'big four' by Prochaska, DiClemente and colleagues. They have conducted research which shows convincingly that there are common pathways to change, inside and outside of therapy. Individuals who spontaneously overcome their problems use the same general change strategies used in therapy. 95,48 Many of the common factors across therapies are processes which occur naturally in everyday life. Indeed, most of the specialized techniques which therapists employ have everyday analogues too. Tallman & Bohart (1999) summarize: "What we call therapy is a special example of processes that occur outside of therapy." Therapy concentrates or distills the experiential and intellectual contexts of everyday life. Therapy then can be thought of as a prosthetic provision of contexts, experiences, and events which prompt, support, or facilitate clients' self-healing." Though various systems of change have been proposed, Prochaska et al's 'transtheoretical model' of change now has considerable empirical support, and has been successfully adopted for working with entire populations across many different problem behaviours and therapy modalities. Table 3 presents this model's stages of change and the processes of change which help people progress from one stage to the next. The stage of change has been proven to be highly predictive of client progress. 95,79,112,48

Stages of change

Precontemplation. People in this stage are not really intending to change, underestimating the benefits of changing and overestimating the costs. They may be unaware that a problem exists, or recognize the problem but not their part in it, or are demoralized at having failed to change previously.

Contemplation. People in this stage are starting to recognize that change is needed, but are unsure or ambivalent about its pros and cons.

Preparation. In this stage people are becoming committed to change. They explore their options for action and experiment with the desired change to experience its effects.

Action. Now people have a firm commitment to change and put their preferred plan for change into action. They look forward to reaping the benefits of change.

Maintenance. People in this stage are working to maintain or consolidate their gains, anticipating the challenges which might provoke regression or relapse.

Termination. In this final stage, people have no temptation to return to their old problematic ways, and are totally confident of handling contingencies. An ideal goal for most people; staying in maintenance is more likely.

Table 3

Stages and transitional processes of change
(Prochaska, 1999)⁹⁵

Stages of change							
Precontemplation	Contemplation	Preparation	Action	Maintenance	Termination		
		Processes of o	change				
Consciousne	ess raising						
Dramatio	relief						
Environmental	reevaluation						
	Self reev	aluation					
		Self-libe	ration				
			Continger	ncy management			
			Helping	g relationships			
			Counte	erconditioning			
			Stim	ulus control			

Processes of change

Consciousness raising involves increased awareness and information about the possible causes and consequences of, and cures for, the problem. Generally the pros of changing and the cons of not changing have to be increased.

Dramatic relief involves emotional arousal about the current predicament and relief that can come from changing. For example, fear, hope, guilt, and inspiration can move people to contemplate changing.

Environmental reevaluation involves assessing, both emotionally and cognitively, how one's social environment is affected by the problem and how changing would affect that environment.

Self-reevaluation involves assessing, both emotionally and cognitively, one's self-image free from the problem. The past image of a troubled individual is replaced by a future focus and imagination about how life will be free from the problem.

Self-liberation includes both the belief that one can change and the commitment to act on that belief. Willpower and motivation are enhanced by choosing one's own preferred plan of action.

Contingency management involves the systematic use of reinforcements (particularly those under self-control) and some punishments to handle temptations to regress and relapses.

Helping relationships provide social and professional support for maintaining change.

Counterconditioning requires the learning of more desirable behaviours to replace the problem behaviours.

Stimulus control involves modifying the environment to increase cues that prompt more desirable responses and decrease the cues that are tempting.

From the research evidence, we now have a good understanding of the common ties which lead to change in general and to therapeutic improvement in particular. Accepting that common factors account for most of the change in therapy does not mean, though, that "anything goes" or that therapy should be devoid of models and techniques. As members of the family of curative factors shared by all therapies, appropriate models and techniques do have an important contribution to make. However, an informed therapy needs to actively incorporate and empower all the common factors that facilitate change, with an emphasis which reflects their relative contributions. We will now explore how this may be done in evidence-based practice, using the 'big four' classification. Practice guidelines at foundation level which are particularly important are highlighted and ticked (\checkmark). A summary of suggested therapist actions follows each guideline. Obviously, several of these recommendations will overlap or be linked to others.

Extratherapeutic factors

People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the minds of others.

Blaise Pascal, 1623-1662

Although extratherapeutic factors make the largest contribution to client improvement, 40% on average, there is surprisingly little hard information on how therapy can best stimulate these factors. Much more work has been done on investigating the therapeutic relationship and developing treatment models and techniques.^{79,113,10}

However, substantial evidence supports the premise that the client is the major agent of change in therapy, largely explaining the similar outcomes phenomenon, the significant rate of spontaneous recovery, the effectiveness of self-help, and the limited contribution of therapist expertise. To this we can add data from research into what clients themselves find helpful in therapy (mostly relational aspects, not techniques) and how clients positively manipulate the course of their therapy. Clients actively gather and utilize their resources, including therapy, and tailor what each provides to address their goals. People come to therapy when their attempts at self-change falter, for a variety of personal, social, and circumstantial reasons. Though some clients may need considerable assistance to overcome their predicament, it is still their 'self-healing' abilities which are primarily responsible for change. ^{36,92,113,79,56,4}

The self-healing process has been usefully described by Tallman & Bohart (1999) as a repeated cycle of *thinking-exploring-experiencing-behaving*, which can be entered at any point to instigate change. Thinking differently about one's problems leads to new solutions and behavioural experimentation which provides experience to feed back into the next cycle. Different approaches to therapy may emphasize different points of entry to the cycle, but effective therapy will recognize the whole cycle and that it can happen inside or outside therapy, with or without a therapist's presence. [113] (See also the support, learning and action factors listed in Table 2.)

The findings on client agency and behaviour change strongly suggest that the pursuit of a medical-type model for therapy, with an expert (the therapist) diagnosing the problem and prescribing a standard treatment, is misguided. Active collaboration and client choice through a relational model, rather than passive compliance, are called for instead. By focusing predominately on pathology, homing on to presenting deficiencies and dysfunction, we can easily lose sight of wider client resources and everyday functioning outside therapy. Fortunately, there is now a growing recognition that a shift in emphasis from psychopathology to positive emotional and mental wellbeing is long overdue. 116,30,39,84,64 The above points lead to our first guideline:

✓ Therapy should be primarily facilitative: helping the client to make best use of whatever abilities and resources they already have.

This requires the therapist to view the client *as if* they are competent and resourceful enough to solve their problems, and to be particularly attentive to their functioning and

resources outside therapy. Therapy should capitalize on *anything* the client finds helpful in their life.

Findings from a variety of research areas (attribution, expectancy, acceptability and therapeutic alliance) indicate that mismatches in perception and language between the client and the therapist generally lead to poorer outcomes. 55,79,92,56,94 "Rather than squeezing the client's complaint into the language and theoretic bias of the therapist's, the data suggest the exact opposite. Therapists should consider elevating the client's perceptions above theory and allow the client to direct therapeutic choices." (Hubble, Duncan & Miller, 1999). As much as a third of outcome variance may be accounted for by how well therapy fits clients' views and expectations. Outcome is evidently enhanced when the client's perceptions of their presenting problem, its causes, and potential solutions are taken seriously by the therapist. By learning the client's informal *'theory of change'* and speaking and working within the client's language, the therapist increases the probability that any positive change will generalize to life outside therapy. This approach to empowering extratherapeutic (and other) factors appears to be significantly more effective than asserting the superiority of the therapist's theories and language over the client's. 55,79,29,47

Of course, the client's theory of change may initially be incomplete, impractical or otherwise flawed, but it forms a platform of belief which effective therapy needs to build on or gradually modify. Our next guideline is therefore:

✓ Therapy should evolve from the client's world view.

This requires the therapist to speak the client's language and to accommodate the client's beliefs about their problems and their ideas about how change will happen. Therapy should be tailored to fit the client, not vice versa.

Extratherapeutic change which leads to client improvement seems to be the rule rather than the exception, according to the research evidence. In addition to the work of Prochaska et al, several studies confirm the significant extent of change which takes place outside therapy. For example, perhaps as many as two-thirds of clients experience improvement in the presenting problem *prior* to their first session of therapy. Approximately 40% of clients improve enough not to need therapy while on a waiting list for services. The majority of clients who don't return after their first session believe they have received enough help. Around 70% of clients report problem-related improvement at the beginning of any given session. 113,79,114,46 Although some of these figures do vary between studies, it is clear that pre-therapy change and between-session change are important extratherapeutic factors for the therapist to take into consideration.

Positive change which the client experiences before, or early in, therapy appears to be a significant predictor of outcome. Several studies suggest that the client's self-report of improvement in the first few sessions provides a more accurate prediction than most current standardized measures of pathology. The majority of clients experience change earlier rather than later in therapy, *regardless* of the model or technique employed. Also, the longer the client goes without experiencing change, the greater the likelihood of a negative outcome. ^{63,79,16,56} Garfield (1994) summarizes: "Thus, it does appear as if the patients' subjective feeling of change may really be the essential variable. If one can view this as the

patient's feeling better or seeing himself or herself as improving early in therapy, then this early state of improvement may be indicative of positive outcome at termination." "Also, since some research findings indicate that improved predictions of outcome are possible by the third or fourth therapy session, therapists should be particularly attentive and sensitive to what takes place during these early sessions. The early perceptions and reactions of the client appear to be of great importance for both continuation and outcome in psychotherapy." ³⁶

Client improvement which bears no relationship to the processes and events within therapy can easily be overlooked or underestimated. However, research into self-efficacy indicates that extratherapeutic improvement can be enhanced by helping the client to see such change as a consequence of their own efforts. When clients view themselves as the agents of change, or at least capable of capitalizing on helpful chance events, improvements are more likely to be maintained. Actual agency is of less importance than the client's *perception* of it. By assigning appropriate "positive blame" to the client for successes, whenever and for whatever reason they occur, therapists can influence the client's view and further empower extratherapeutic factors. 63,113,79

To conclude extratherapeutic factors, our guideline about change is:

✓ Therapy should nurture any beneficial change.

This requires the therapist to be on the alert for any client improvement, no matter when, how or why it occurs in the client's life. The therapist should validate such change and highlight the client's part in achieving it or benefiting from it. Early change is especially significant: if no improvement is reported by the client within a few sessions, the therapeutic approach should be altered to better fit the client's 'theory of change'. Particular attention needs to be paid to change occuring before or outside of therapy.

Therapeutic relationship factors

No one is useless in this world who lightens the burden of another.

Charles Dickens, 1812-1870

The quality of the therapeutic relationship has been shown to be a highly significant determinant of outcome across a wide diversity of therapeutic approaches, contributing 30% on average. Over a thousand studies have confirmed the link between the alliance and outcome, with the client's perspective on the relationship holding particular significance. Even therapies which are strongly rooted in psychological theory or are predominately technique oriented (for example, psychodynamic and cognitive-behavioural therapies respectively) appear to depend on relationship factors for a large part of their effectiveness. In contrast to many therapists' attributions, *clients* consistently report a strong therapeutic relationship as being more important to outcome than particular therapeutic techniques or methods. ^{92,7,79,63,56,4}

From their comprehensive review of research into the relation of process to outcome in therapy, Orlinksky, Grawe & Parks (1994) concluded: "The quality of the patient's participation in therapy stands out as the most important determinant of outcome. The therapeutic bond, especially as perceived by the patient, is importantly involved in mediating the process-outcome link." More recently, Bachelor & Horvath (1999) highlighted the following findings from their review of research literature on the therapeutic relationship:

- A therapeutic relationship regarded positively by the client is a necessary (but probably not sufficient) component of all forms of effective psychotherapy.
- The therapeutic relationship is usually formed early in therapy, probably within the first few sessions.
- Therapists and clients tend to perceive the therapeutic relationship differently, and tend to attribute change to different factors. Clients' perceptions are generally more relevant to outcome than therapists'.
- Both participants' contributions are required to forge a productive therapeutic alliance. There has to be a commitment of the participants to each other and to the goal of the relationship. Most importantly, the therapist needs to establish "a climate of trust and safety through responsiveness; attentive listening; and the communication of understanding, liking, and respect." The client needs to commit to participate in therapy and to collaborate with the therapist in the work involved.
- The specific responses from the therapist that best foster a strong therapeutic relationship vary from client to client. The therapist has to be sensitive and responsive to the individual client's perceptions. Monitoring the client's satisfaction with the relationship and promptly addressing any concerns is important.
- Participating in the therapeutic relationship can in itself produce beneficial change.

- The participants' personal characteristics and relational styles can significantly influence the quality of the therapeutic relationship and its exchanges. (Though neither age, sex, nor ethnicity plays a major role in therapy outcome. 11,56)
- Therapy should accommodate the client's readiness for change and adjust the processes
 of change accordingly.

Ample research evidence confirms the general importance of the client perceiving therapist-provided warmth, empathy, respect and genuineness. For example, mutual affirmation between client and therapist is consistently associated with positive outcome. However, the more technical procedures and strategies often employed by therapists to promote therapeutic change have mixed empirical support. Findings from research into directiveness, self-disclosure, interpretation, questioning style, exploratory and supportive actions, and so on, indicate that individual clients may respond very differently to a standard intervention. Even empathy itself has been found to be perceived in significantly different ways by clients (notably as cognitive, affective, sharing or nurturant). From the client's perspective, there is no single, standard response which the therapist should use to facilitate empathy. Pop. 17,92,79,11 The essential conclusion we can draw is that the therapist should carefully match their attitudes and interventions to the individual client. Our first guideline for harnessing therapeutic relationship factors is therefore:

✓ Therapy should adopt the client's view of a therapeutic relationship.

This requires the therapist to tailor their provision of warmth, empathy, respect, genuineness, and so on, to the client's definition of these conditions. Right from the start of therapy, the therapist should monitor the client's satisfaction with the alliance and act swiftly to reconcile any divergent perceptions or to repair any relationship ruptures.

Understanding what the client really wants from therapy seems to be one of the most essential elements of effective therapy. Agreement and clarity between client and therapist on the goals of therapy have been found in studies to be important contributors to a successful outcome. P2,36,95 Research also indicates that therapy is more effective and efficient when the client's goals are accepted at face value and when they focus and structure the course of therapy. Standardized interventions which discount clients' personal goals and individual characteristics have been shown to lead to poorer outcomes (for example, in treating drug or alcohol problems). "Previous treatment failure is often caused by inattention to the client's desires and/or the theoretical imposition or assumption of goals. Successful outcome depends on the client's articulation of goals and therapy's commitment to those goals." (Duncan, Hubble & Miller, 1997) Again, fostering active collaboration is the most effective manner of helping in therapy. Pagain, fostering active collaboration is the most

Research from several fields indicates that beneficial change is more likely to come about when the goals for therapy are realistic and perceived by the client as being both desirable and attainable. ^{79,46} In particular, meaningful goals specified in small, concrete, specific, and behavioural terms may as much as double the likelihood of a successful outcome. ¹² Of course, many clients find difficulty in articulating their goals in such precise terms. But data

suggests that, by deliberately adopting a collaborative stance and inviting the client's participation, vague and broad ideas of outcome can be worked on to produce some tangible goals. This is especially important when there is a history of treatment failures or dismal prognoses. ^{113,29,71}

Our next two guidelines for empowering the therapeutic relationship are:

✓ Therapy should collaboratively address the client's goals.

This requires the therapist to collaborate with the client to determine what the client really wants from therapy, and to share a commitment to work towards this outcome. The therapist should help the client to find practical goals which they perceive as both desirable and attainable. As far as possible, goals should be described in the smallest, most specific, concrete and behavioural terms.

✓ Therapy should be geared to the client's readiness for change.

This requires the therapist to assess and accommodate the client's stage of change and to match the processes of change to it. The therapist and the client should collaborate to find corresponding therapeutic interventions which address the client's goals by utilizing the client's resources and ideas.

There is now very substantial evidence that a person's social relationships have a critical bearing on their mental and physical wellbeing. Studies show that people disconnected from life partners, family, friends, social groups, work colleagues and so on are significantly more at risk and have a poorer recovery from many common afflictions. For example, the degree of social relatedness influences cancer, coronary heart disease, viral infections (including HIV), depression and the likelihood of suicide. As a medical risk factor, social isolation is comparable to high blood pressure, obesity, lack of exercise, or smoking. "[Research] has established that social isolation is usually a cause of illness rather than a consequence." "With only minor variations, the link between social isolation and subsequent poor health holds true for both sexes, for all ages, for people living in large cities and small rural communities, and for several countries." (Martin, 1997) Interestingly, social relationships have also been found to have a significant bearing on the immune function and mental health of other primates and social species. ^{78,100,111,44,84}

Effective therapy therefore aims to help the client to improve their social support, either actually or perceptually. Significant though the therapeutic relationship is to outcome, it should not unduly detract from this essential *extratherapeutic* factor. (Helping the client to make best use of their existing resources generally has been recommended earlier.) Evidence from social support, dependency, and alliance studies suggests that once a "good enough" working relationship with the client has been established, it is more important to increase the client's sense of external social support than to try to further strengthen the alliance. Research does not show that the strength of the alliance is a function of the length of time the client has been in therapy. ^{76,92,7,79} Hence the following:

✓ Caveat: The therapeutic relationship should not detract from the client's social support.

This requires the therapist to temper their desire to build a strong therapeutic alliance with the greater need to help the client maximize their own social support.

Placebo factors

The doctors told me that if you could diagnose me, I'd get well, and so the minute you said, 'Moribundus', I knew I'd recover.

Previously dying hospital patient who did not understand Latin

(from G Allport, 1964)

Placebo factors contribute on average 15% to therapy outcome and refer to the increased hope and expectation of improvement experienced by clients simply by engaging in therapy. Often dismissed, almost as a nuisance, by physical therapies and paid scant attention in practitioner training, placebo factors are nonetheless very important to client outcome. Their intrinsic therapeutic value is also confirmed by the wealth of medical research which uses placebo substances or procedures as controls. To illustrate their significance, studies indicate that 75% to 90% of the effectiveness of antidepressant drugs (including the current best-seller Prozac) could be due to placebo effects. ^{100,41,13,107,31,9,67}

For a client to experience hope, studies suggest that the client needs to think they have the *agency* ("I *can* do it") and *pathways* ("how I can do it") to change. "People in psychotherapy become hopeful by finding any one of the following: a new goal, a new pathway, or a new sense of agency." (Snyder, Michael & Cheavens, 1999). In the main, the therapeutic relationship and setting foster the client's agency thinking, and the therapeutic rationale and ritual stimulate their pathways thinking. Frank & Frank (1991) concluded that these four therapeutic factors combat the client's demoralization in *all* approaches to therapy. ^{107,35} Research also indicates that the acceptability to the client of the particular therapeutic rationale and ritual is a major determinant of outcome. By deliberately tailoring the therapeutic approach to accommodate the client's current beliefs about their problem and possible ways forward, the therapist can kindle the client's enthusiasm for change and desire to participate. As noted previously, the quality of the client's participation is crucial to a positive outcome. ^{92,100,79}

In practice, the client's agency thinking and pathways thinking can be stimulated in a variety of ways. Research into how people attribute positive and negative events substantiates the importance of fostering optimism in the client. Positive and negative expectations about the future, including beliefs about the efficacy of therapy, one's self-efficacy, and the extent of personal control over events have all been linked to outcome. "Optimistic attitude, positive expectancy, belief in one's own power to promote recovery - these are 'what the patient brings to the table' that can influence treatment response." (Scovern, 1999)^{100,101,84} By providing clients with an opportunity to stand back from their problems and reappraise their attributions, therapy can help counter pessimism (which attributes negative events to internal, stable, and global factors - "it's my fault, it's going to last, and it affects everything"). Outcome has been found to be particularly sensitive to the client's perception of having a reasonable measure of personal control over events in their life. Therapists can help here by listening for and amplifying instances of client influence whenever and wherever they occur. Though the client's perception is central, the data also suggest that demonstrated self-efficacy is also important. For example, placebo effects have been found to be enhanced when therapy evokes previously successful experiences of the client. Also, as noted previously, outcome is more successful when the client actually experiences the

achievement of small, meaningful goals during the therapy process. 100,107,79 Finally, the powerful use of appropriate metaphors (such as stories, anecdotes, similes, music and images) to stimulate hope of change has been recognized throughout history and appears to be intrinsic to our emotional functioning. 43,44,64

Research has shown that a substantial portion (around two-thirds) of client improvement occurs early in therapy, and includes improvement which often occurs even before therapy begins. Results suggest that the client's expectation of positive change and the instillation of hope play a leading role in stimulating this improvement. As might be expected, the therapist's initial attitude towards the client and their ability to satisfy the client's expectations of therapy have considerable influence on placebo effects. Therapists who transmit enthusiasm and confidence about therapy working reasonably soon to alleviate the client's problems are more likely to mobilize hope and counteract demoralization in the client. "Effective therapists model both agency and pathways thinking through their confidence in and mastery of the techniques they use." (Snyder, Michael & Cheavens, 1999). Pessimistic attitudes which emphasize psychopathology, or stress that change is likely to be difficult and long-term, do little to harness placebo factors. Indeed, their net effect may often be harmful rather than healing. 107,36,79 This certainly applies to physical treatments too: "The finding that drug efficacy relates to prescribing physician attitudes has been replicated repeatedly." (Scovern, 1999) Therapists who demonstrate hope, interest and belief in the client's self-efficacy and potential to change may also enhance outcome significantly. 100

Each school of therapy has developed its own ideas about the causes and mechanisms of, and cures for, psychological troubles. Despite hundreds of theories and hypotheses, there is still remarkably little concensus and hard evidence to pinpoint the causes of many, perhaps most, of the problems which clients bring to therapy. Also, since clients entering therapy are generally more emotionally vulnerable than usual, and hence more suggestible, there have to be serious concerns about inducting clients into unsubstantiated clinical belief systems. Also, since clients entering therapy are generally more emotionally vulnerable than usual, and hence more suggestible, there have to be serious concerns about inducting clients into unsubstantiated clinical belief systems. Also, since clients entering therapy is increasingly showing that the factors which actually contribute to client improvement are frequently unrelated to the factors which are assumed to have caused the client's problems. So, as the therapeutic alliance still account for most of the improvement in cognitive therapy for anxiety and depression, despite its "validated" status and technical focus on modifying distorted thinking. Placebo factors are therefore more likely to be enhanced when therapy focuses on beneficial change in general, rather than on the specific changes required by a particular theory of problem causation.

From the above discussion, our guidelines to harness placebo factors are:

✓ The therapist should be enthusiastic and believe in the therapy and the client.

This requires the therapist to convey enthusiasm and confidence to the client, genuinely believing in the efficacy of the therapy and expecting that the client will improve. The therapist should also show continuing interest in the client's progress, demonstrating a real faith in the client's self-efficacy and potential to change.

✓ The therapeutic approach should gain the client's confidence and eagerness to participate.

This requires the therapist to have sufficient flexibility in their approach to accommodate the client's pre-existing beliefs about the problem and how improvement might come about. The therapeutic approach should be adjusted until the therapeutic rationale and ritual are found compelling by the client, and they show eagerness to participate and see therapy through.

✓ Therapy should stimulate the client's sense of agency and ability to find solutions.

This requires the therapist to help the client believe that change is possible for them and that they can find their own ways to achieve it. The client can be helped to develop more optimistic expectations for the future, and to develop a greater sense of control or influence over their own destiny. To see more possibilities, it is helpful for the client to separate themselves from their problem, gaining distance and perspective. The therapist can also assist the client by evoking past client successes and appropriate metaphors for change, and by agreeing small, specific goals, with concrete markers and substeps.

Model and technique factors

"Try to fly!" he said. "You can if you hold onto this magic feather!"

Timothy Mouse, to Walt Disney's Dumbo

Contributing on average 15% to client improvement, model and technique factors are obviously significant and essential to effective therapy. However, their importance has been constantly overstated by the many schools of therapy which vie for professional credibility and new adherents. Amidst the clamour of claims to therapeutic uniqueness and superiority, the underlying commonalities and real contribution of these factors have often gone unheard. Most practitioner training courses remain firmly rooted in one or two therapeutic traditions; even the increasingly popular 'eclectic' or 'integrative' courses normally use only a handful of the 400 plus therapeutic methods currently available. The major professional associations tend to propagate the reliance on established "brand name" therapies by insisting that accredited training, practice and supervision adhere to 'core theoretical models'. Also, with the current professional emphasis on diagnosis and the application of specific treatments for specific disorders (for example, EVTs), the high profile of model and technique factors remains undiminished. ^{79,34,97,85}

But the empirical evidence is clear: therapeutic models and techniques matter much more to *therapists* than clients. Clients consistently attribute the beneficial change they experience in therapy to the other, non-technical, common factors. Objective judges also correlate the non-technical aspects with positive outcome more than technical interventions. ^{62,110} As Miller, Duncan & Hubble (1997) commented, ironically: "'Empirically Validated Treatments' [are] *not* empirically valid." ⁵⁶ As this paper is concerned with the overall effectiveness of therapy, it would be inappropriate to investigate specific treatments in detail. However, it is worth noting that research evidence does indicate positive benefit from techniques used to treat some highly circumscribed problems (for example, specific behavioural methods for certain anxiety and sexual disorders). ^{91,30} "It may be that continued research in psychotherapy will show some treatments are slightly more effective than others ..." (Wampold et al, 1997)¹¹⁷ At a foundation level, though, "we have to face the fact that in a majority of studies, different approaches to the same symptoms show little difference in efficacy." (Bergin & Garfield, 1994)¹⁰

Evidence shows that clients are more likely to be satisfied with and benefit from therapy when the therapist takes a sufficiently flexible and collaborative approach. "Process-outcome findings amply document the importance of patient cooperation with therapist interventions." (Orlinsky, Grawe & Parks, 1994) Actual improvement should guide therapy with the individual client rather than strict conformity to theoretical belief or rigid adherence to technical procedure. 92,79,56 Our increasing knowledge of the mind-body link confirms that the therapist should have a wide and flexible range of therapeutic tools which utilize the client's own mental and physical abilities and life resources. An academic understanding of therapy models and techniques is of much less importance than a practical ability to customize therapeutic attitudes and methods to the individual client and enlist their active participation in change. 78,44,25,64,39

Our first guideline for harnessing model and technique factors is therefore:

✓ Therapeutic models and techniques should primarily empower the other common factors.

This requires the therapist to have a flexible attitude and a working knowledge of a variety of therapeutic models and techniques, including mind-body approaches. The therapist should select the approach which is most likely to maximize the client's benefit from the other common factors. In particular, the therapeutic approach should fit the client's informal 'theory of change', address their goals, utilize their own abilities and resources, stimulate their hope and expectancy of improvement, and maintain the therapeutic relationship.

Studies indicate that structure and focus are essential components of effective therapy. The therapist's ability to provide an adequate framework for change and a means of concentrating the collaborative effort has been found to be highly related to outcome. Indeed, the failure to structure or focus the therapy session is one of the most reliable predictors of a negative outcome. This deficiency can affect outcome even more than the personal qualities of either the client or the therapist. 63,79,56 Models and techniques can clearly help the therapist by serving as learnable and replicable templates to structure and activate change. They help the other common factors to converge by using change processes appropriate to the client's stage of change, utilizing the client's abilities and resources, and mobilizing placebo effects. "Therapeutic technique provides clinicians with something akin to a magnifying glass that brings together, focuses, and concentrates the forces of change, narrows them to a point in place and time, and causes them to ignite into action." (Miller, Duncan & Hubble, 1997)⁷⁹ Of course, being skilled in the use of a variety of techniques is necessary, but we should not confuse technical competence with therapeutic effectiveness. Useless or even harmful techniques can still be most diligently applied. For example, the Rorshach ink blot test has been administered by thousands of highly trained professionals though research evidence has increasingly discredited the technique. ^{25,106} Our next guideline follows:

✓ Therapy should have a structure and focus.

This requires the therapist to use an approach which systematically focuses effort on an agreed therapeutic objective. As far as is practicable, the therapist and client should jointly determine specific and realistic goals for each session, and measure its outcome by agreed criteria. The therapist can use therapeutic models and techniques to structure and focus change, provided that they empower the other common factors and are appropriate to the client's stage of change.

Studies of the therapeutic alliance, dropouts from therapy, and intractable cases indicate the hazards of the therapist persisting with a therapeutic approach which is not working for the client. "Doing more of the same" without monitoring its effect can result in client resistance, non-compliance, premature termination and generally poorer outcomes. ^{29,30,71} Also, despite their prevalence in practice, certain interventions carry a greater likelihood of outcome failure than others, though individual clients may find them helpful at times. For example, research findings indicate that transference interpretation raises the probability of damaging the therapeutic alliance and increasing the dropout rate. "Transference interpretations do not seem uniquely effective, may pose greater process risks, and may be countertherapeutic

under certain conditions." (Henry et al, 1994)^{50,94,96} Similarly, confrontational approaches may increase the likelihood of harm being caused to clients.⁷⁹ Diagnostic and strategic questioning and didactic feedback have been found to lead to poorer therapeutic alliances than supportive-reflective, collaborative and interactive approaches.^{45,28,95,79} Clearly, the clinical effectiveness of several traditional interventions cannot be assumed.

Rather than promoting particular interventions and dismissing others out of hand (they may well deserve a continuing therapeutic niche for certain clients), we need to ask a more fundamental question: "Is *this* approach actually working for *this* client at *this* time?" By gathering feedback from clients about the process and outcome of clinical work, therapists can better inform their subsequent practice. Several studies now confirm that providing therapists with such feedback improves the effectiveness and efficiency of therapy. ^{30,75,16} Self-help which provides interactive feedback via computer has also been shown to be more effective than passive approaches. ⁹⁵ Interventions which encourage greater client participation and influence over the process of therapy help harness the other, non-technical, common factors

The client's perceptions of progress and satisfaction are both important, but studies do show that levels of satisfaction and changes in feelings are rather poor indicators of the final clinical outcome. (Ratings of the therapeutic alliance and shifts in cognition are more reliable predictors.)113,65,40 Incorporating feedback about satisfaction is, however, particularly useful in strengthening the therapeutic alliance.^{7,75} There are now many formal and informal ways of assessing clinical progress and outcome, but a standardized clientcompleted measure is probably the most reliable and valid method of making this assessment. 58,16,30 (The CORE System tools and the Outcome Questionnaire 45 are examples of easily administered, clinically validated measures which are readily available.)^{22,30} Given data on the high dropout rate from therapy and the reluctance of clients to report dissatisfaction before terminating, it is inadvisable to restrict the opportunity for feedback to the planned end of therapy or sessions at certain intervals. By regularly incorporating feedback from the individual client into the process of their therapy, therapists can both help clients achieve better outcomes and prove their therapeutic effectiveness to service providers and funders. 16,56,30,7 But of course, the gathering of process and outcome data should not in itself have a counter-therapeutic effect, undermining the common factors such as the quality of the alliance.

The above discussion is summarized in our final guideline:

✓ Therapy should incorporate feedback about the client's progress.

This requires the therapist to gather feedback from the client about the process and outcome of therapy, and to modify their approach with that client accordingly. Information about the client's perceptions of progress and satisfaction should be gathered regularly and systematically so that therapy may be optimized for their individual needs, preferences, and circumstances.

Articles of faith, not evidence

Where the foundation is most flimsy, dogma is most firm.

Peter Breggin, 1993

This paper has highlighted the main, proven elements of effective therapy. However, it seems useful to briefly mention some variables generally assumed to lead to effectiveness, but for which supporting research evidence is conspicuously lacking.

Regarding therapist *training and experience*, Tallman & Bohart (1999) concluded that: "Results show little more than small differences in effectiveness between experienced, well-trained practitioners and less experienced, non-professional therapists ... Rather than professional training or experience, it looks as though differences in personal qualities make some therapists more helpful." Other reviewers summarize the research similarly: "The empirical evidence presently available is not supportive of any claim that high levels of academic training are important determinants of therapeutic effectiveness." (McLennan, 1999)⁷³ "There is only a modest relationship between training and outcome, or between experience and outcome, although the evidence for the latter is stronger than for the former." (Roth & Fonagy, 1996)⁹⁷ "The general failure ... to show unique therapeutic effectiveness for trained professionals is sobering ..." (Lambert & Bergin, 1994)⁶³

The empirical evidence for the importance of therapists participating in personal therapy and supervision is no more encouraging: "The absence of a clear relationship between personal therapy and therapist efficacy can be attributed to a variety of factors ... Because the reasons for entering therapy are so diverse and the effects so varied, the role of personal therapy on efficacy remains varied ..." (Beutler, Machado & Neufeldt, 1994)¹¹ "The research studies fail to demonstrate that having the experience of personal therapy produces more effective therapists. Indeed there is no evidence to support that some of the putative benefits of personal therapy claimed by its supporters are indeed necessary skills for effective therapists. Even in areas where some supportive evidence exists, such as in the development of empathy skills, there are other less expensive and demonstrably more effective ways of developing these skills." (Macaskill, 1999)⁶⁶ "The use of supervision or case consultation in relation to outcome was examined, with mixed results." (Orlinsky, Grawe & Parks, 1994)⁹² "While the evidence for the necessity of high levels of academic training to ensure therapeutic efficacy is largely negative, or at least well short of being compelling, the evidence for the positive contribution of supervision is almost non-existent!" (McLennan, 1999)^{73,69} Though commonly advocated for ethical practice, professional mandates for personal therapy and supervision do not have adequate empirical support.

We do know that the therapist's personal qualities, attitudes and skills can contribute significantly to a successful outcome (on average 30%), but primarily by stimulating the agency of the *client*. Also, how these therapeutic attributes and abilities come about, whether by aptitude or learning, is apparently complex and highly individual. Unlike most other professional disciplines where practitioner expertise is pivotal to outcome, psychotherapy is dominated by client, extratherapeutic and relationship factors. The influence of therapist training, experience, personal therapy and supervision is less direct and is confounded by more significant variables. ^{11,92,113} Hogan (1999), who has extensively researched therapy

regulation in the United States, remarks: "little evidence exists that current entrance requirements [to the profession] have any bearing on necessary skills or any relationship to performance. Even if it were, it seems clear that the requirements are way above what is minimally necessary to be competent." "... licensing laws should emphasise the regulation of *output*, not input. Hence, they should be concerned with a person's *actual* skills, not how those skills were obtained." (italics added)⁵¹

The conclusion from the research evidence that a therapist's competence should be assessed from actual client outcomes is in contrast with the professional accreditation and registration schemes currently operating in the United Kingdom. These have developed around input variables such as formal qualifications, lengths of training and experience, amounts of personal therapy and supervision, and so on. But as we have discussed, such criteria are too weakly linked to therapeutic effectiveness to provide a valid and reliable indicator of a therapist's competence. Moreover, the professional organisations involved have themselves not provided empirical evidence to substantiate their criteria. The divergence of research and practice in this area is particularly unfortunate and undermines the efficient use of resources and the credibility of professional standards offered to the public.

The gulf between established professional credentials and "what really matters" in therapy is perhaps best illustrated by the dominance of the psychiatric profession in the control of mental health services. For example, a consultant psychotherapist in the National Health Service has to be a fully qualified psychiatrist *foremost*. ⁵⁹ Modern psychiatry is predicated on biological and genetic models of human functioning. As a consequence, biochemical and physical treatments (notably psychotropic drugs, and to a lesser extent, electroshock and brain surgery) have dominated the psychiatric approach to mental health problems. This world-view is very different from that which the research evidence shows is necessary for successful psychotherapy. Whilst individual psychiatrists may well have effective psychotherapeutic attitudes and skills, there appears to be little cogent argument why the profession of psychiatry should be the gatekeeper of psychotherapy and counselling. ^{13,81,56}

It seems inevitable that professional turf wars in the field of therapy will continue until practice, training, and regulatory structures are better informed by empirical evidence and all concerned unequivocally share a common goal of putting the *client's* interests first. ^{25,30,51} Howard (1998) concluded, aptly: "The integrity route [to professionalization] requires patience, persistence, discipline and an underlying faith that the counselling enterprise will ultimately be able to prove its value. If truth and reality matter to counselling, then the integrity route is the only one available. It may not produce such rapid or financially rewarding results, but it will allow aspiring counsellors to sleep soundly in their beds, with a clear conscience." ^{53a}

Summary and conclusions

Whoever acquires knowledge and does not practice it resembles him who ploughs his land and leaves it unsown.

Sa'di, Gulistan, 1218

There is now a wealth of scientific data from therapy process and outcome research which can reliably guide our practice in the new millennium. The findings confirm the general efficacy of therapy, and they can be grouped and interpreted legitimately in a variety of ways. However, by appreciating the important role of the common factors in client improvement, and their relative contributions, therapists have a sound yet adaptable foundation on which to build an optimized therapy for each individual client.

The guidelines which constitute our evidence-based foundation for effective practice are summarized for convenience in Table 4.

From the research evidence, it is striking that achieving success in therapy seems to be very much a threshold effect for the client. Whether guided formally by a therapist, informally by family or friends, by self-help methods, or simply by taking advantage of chance events, a client can achieve lasting benefit from anything and everything which manages to carry them over the threshold of change and self-healing. Despite numerous obstacles, such as patriarchal therapeutic relationships, pathology-oriented treatments, and dubious therapeutic techniques, a great many clients *still* manage to improve! Tallman & Bohart (1999) concluded: "We believe the dodo bird verdict [the similar outcomes phenomenon] occurs because the client's abilities to use whatever is offered surpass any differences that might exist in techniques or approaches." The remark by Prochaska, Norcross & DiClemente (1994) that therapy may be "simply professionally coached self-change" seems uncannily accurate, according to our review of the research. 113

But this begs an important question: why *should* therapists change their practice to incorporate research findings when clients already seem to benefit adequately from the gamut of existing therapies? There are several points which can be made to answer this, and we will touch briefly on only a few. However, they indicate why the credibility and future survival of therapy as a distinct helping discipline is at stake in these (financially and professionally) competitive times. To illustrate:

- One of the major factors which prevents people from participating in therapy is low confidence in the outcome. If the confidence of potential clients and service funders is to be raised to more reasonable levels, therapists will need to focus much more on promoting the *outcome* of their services, rather than the services themselves. Professional credentials and "treatments of choice" mean nothing if they do not demonstrably lead to client improvement. By using reliable and valid measures of the individual client's response to therapy, therapists can adjust their approach to maximize the probability of a successful outcome. ^{16,30}
- High dropout rates are common in therapy (some studies suggest that as many as half
 of clients fail to return after their initial session).^{56,114} This represents a very

considerable waste of resources which could be mitigated by ensuring, for example, that therapy is better matched to the client's stage of change and truly addresses the client's goals. ⁹⁵ The inordinate drain on the National Health Service (and professionals' morale) by "heartsink patients" could be similarly reduced. ⁷¹

- Though estimates vary, we do know that a small, but certainly significant, percentage of clients are harmed by therapy conducted in good faith. For example, persisting with a particular intervention without monitoring its effect on, or acceptability to, the client is a common cause of negative outcome. Adopting evidence-based practice and incorporating feedback about clients' perceptions of process and outcome into therapy will help to minimize such risks. ^{63,27,51,81}
- The data clearly shows that para-professional therapists (such as volunteers) can play a major, and similarly effective, role alongside professional therapists. By sharpening up practitioner training to focus on effectiveness and efficiency, discarding archaic and redundant material, we should be able to improve the quality and availability of therapy services. Therapy can also be made more efficient by carefully monitoring client change, particularly over the first few sessions. When assessing therapist competence, shifting the emphasis from input to output variables should simplify the process and reduce overheads, particularly relieving the voluntary sector.
- Finally, this digest has raised a number of ethical issues for clients, therapists and trainers concerning some current practices and trends in the field.^{53a} We confirm that a reconcilliation between research and practice is long overdue, and would do much to restore the field's professional integrity. The underlying ethical principles of doing good, not doing harm, autonomy, and justice can all be more openly demonstrated to clients by heeding the best available evidence for what makes our work effective and efficient.

From the evidence, counselling and psychotherapy work pretty well. It seems that most of us are already doing most of the right things to help our clients. Now that we know "what really matters", we can make therapy work even better, for more people. We will let the last word go to the philosopher Francis Bacon (1561-1626):

"The end of our foundation is the knowledge of causes, and secret motions of things; and the enlarging of the bounds of human empire, to the effecting of all things possible."

Table 4 Foundation of effective practice

Extratherapeutic factors: 40%

- ✓ Therapy should be primarily facilitative: helping the client to make best use of whatever abilities and resources they already have.
- ✓ Therapy should evolve from the client's world view.
- ✓ Therapy should nurture any beneficial change.

Therapeutic relationship factors: 30%

- ✓ Therapy should adopt the client's view of a therapeutic relationship.
- ✓ Therapy should collaboratively address the client's goals.
- ✓ Therapy should be geared to the client's readiness for change.
- ✓ Caveat: The therapeutic relationship should not detract from the client's social support.

Placebo factors: 15%

- ✓ The therapist should be enthusiastic and believe in the therapy and the client.
- ✓ The therapeutic approach should gain the client's confidence and eagerness to participate.
- ✓ Therapy should stimulate the client's sense of agency and ability to find solutions.

Model and technique factors: 15%

- ✓ Therapeutic models and techniques should primarily empower the other common factors.
- ✓ Therapy should have a structure and focus.
- ✓ Therapy should incorporate feedback about the client's progress.

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