

The Challenge of Counselling and Psychotherapy Research

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Slides available from www.strathclydecounselling.com
(features/presentations)

Towards a research-driven profession

- Research findings increasingly dominant force in therapy: e.g.,
 - IAPT programme: millions to be allocated to *empirically-supported* therapies alone

THE FACTS ARE ENEMIES

The problem with research evidence

- Only ever gives us generalities:
 - tells us nothing about *this* particular client
- Danger that we impose on client assumptions
- Why not just respond to unique, individual client?

The problem *without* research evidence

- But *all* of us hold particular assumptions about what is helpful
- Emphasis on orientation can make assumptions even more rigid

Research can help us to challenge our implicit assumptions

<< less likely to impose biases on clients

A challenge to (my) existential practice

- Used to start therapy by outlining its limitations
- Challenged by research on importance of client *hope*
- Now: stronger emphasis on positive possibilities for change

Aims

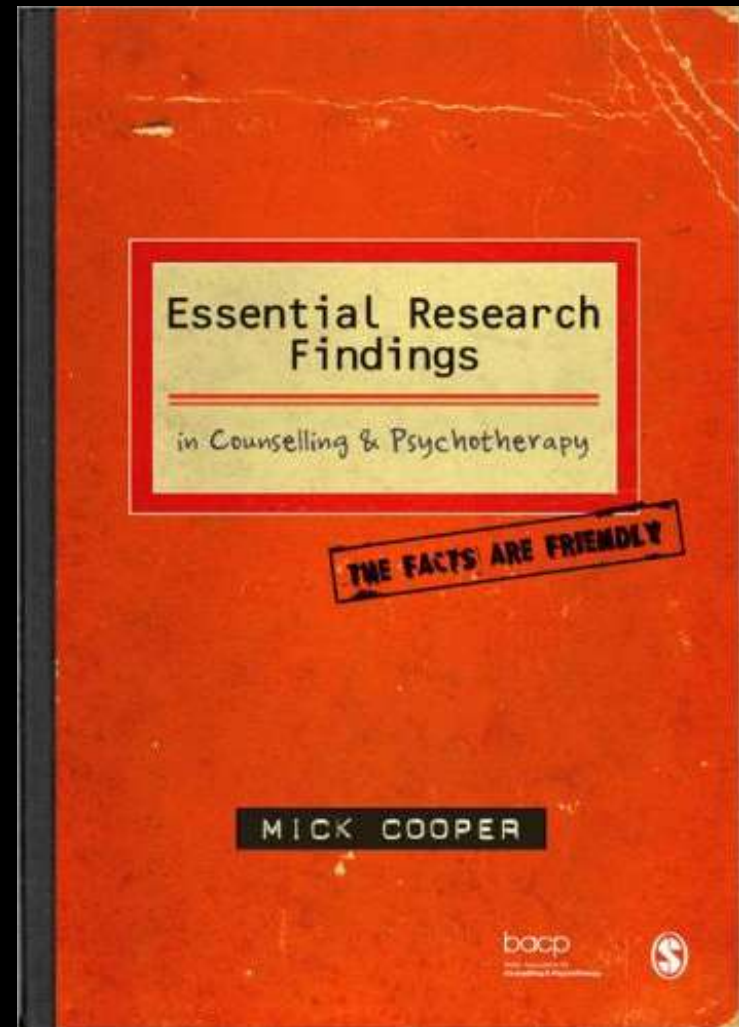
- To highlight the value of research findings
- Not because they tell us what to do – or give us definitive 'truths'
- But because they can challenge our assumptions about what we should be doing
 - and help us meet our clients from a stance of openness and responsivity

Content

- Look at eight key assumptions that many therapists hold
- Do they stand up to empirical scrutiny?

Essential Research Findings in Counselling and Psychotherapy

- Based on research for BACP-funded text (Sage, 2008)
- Extensive review of research findings in counselling and psychotherapy field



The voice of the client

- Research challenge us with how *clients* experience therapy
- May feel that we know, but research indicates that is not the case...

THE FACTS ARE FRIENDLY

Assumption 1

We know how our
clients experience
therapy

Contrasting evaluations of outcomes

Client: 'The counselling was worthwhile. It felt good... because it was the first time in years I could talk with someone about what's on my mind. She helped me to gain confidence. I began to get out more with people, to get along easier....'

Worker: 'Some important things got out on the table, but we didn't really deal with them... I wasn't happy, because we couldn't get in and deal with these issues.... I didn't feel that we were making progress....'

(Maluccio, 1979)

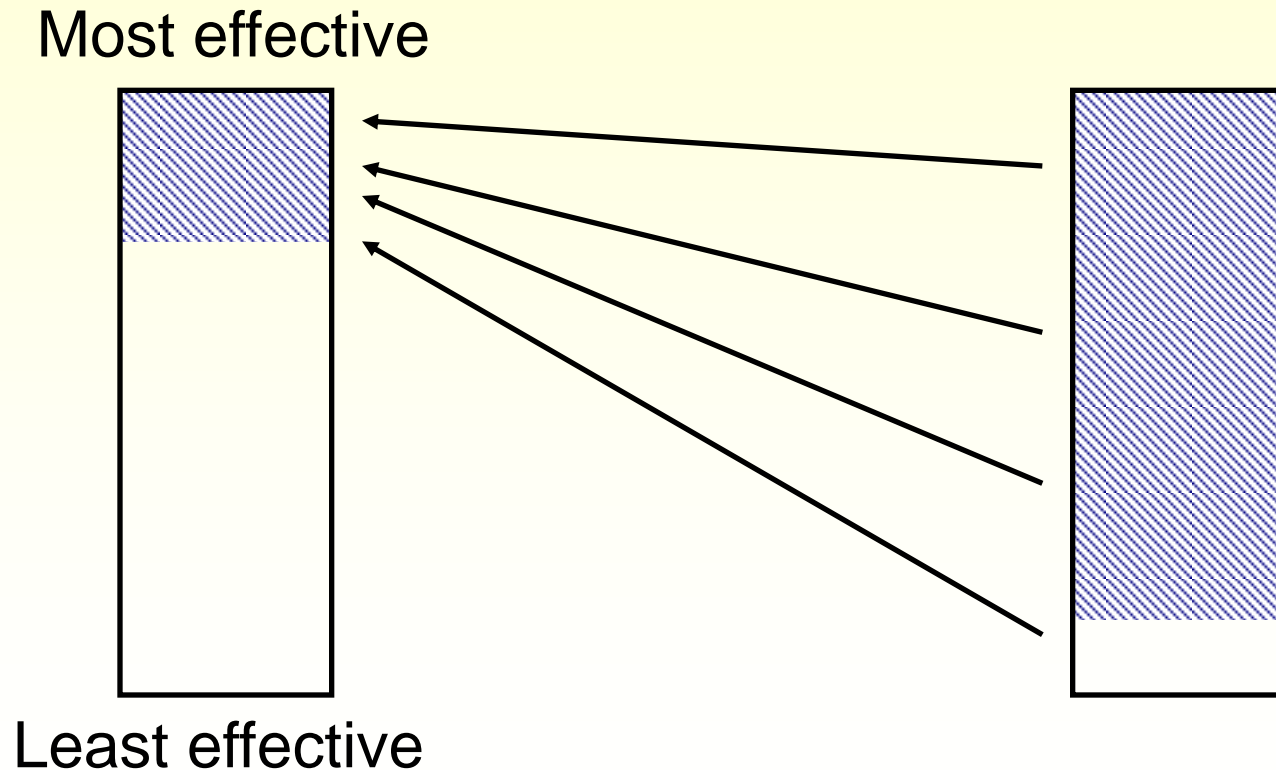
Contrasting ratings of process

'There is very little agreement between patients' and therapists' perceptions of the quality of the therapeutic relationship.... therapists tend to see themselves as creating a more facilitative therapeutic relationship than patients.'

(Gurman, 1977)

Therapists overestimate their effectiveness relative to others

90% put themselves in top 25%



Client non-disclosures

- 46 per cent of clients kept one or more secrets from their therapists
 - around half of these of a sexual nature (for instance, 'I am more sexually attracted to my therapist than I have let on')
- Clients particularly likely to conceal negative reactions to therapists ('deference')

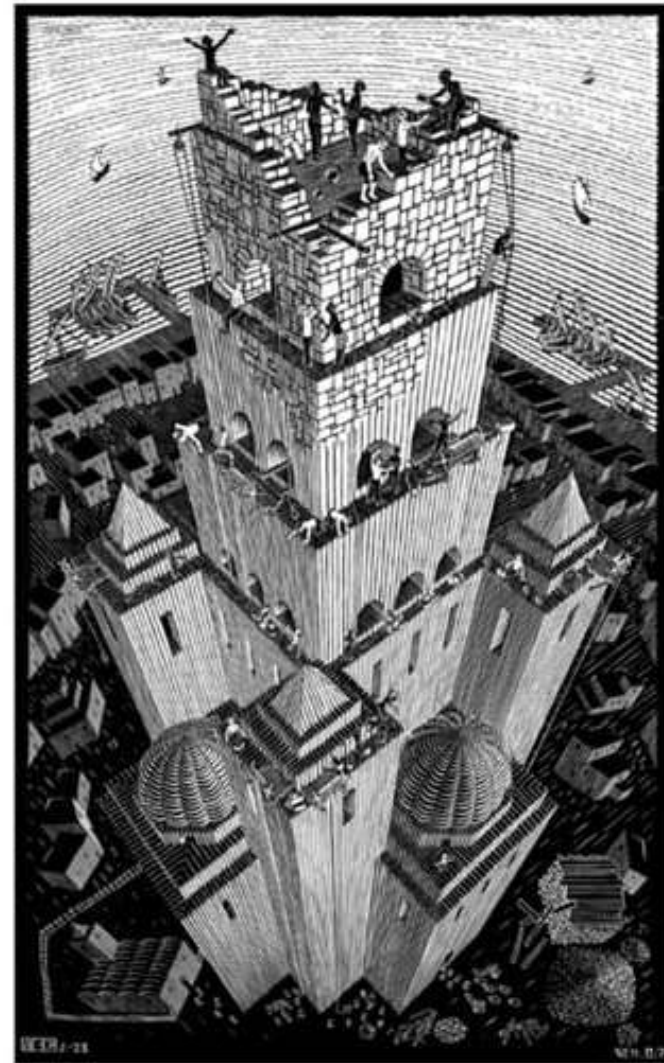
Summary 1

Do therapists know what their clients are experiencing?

Not really!

The challenge to our dogmas

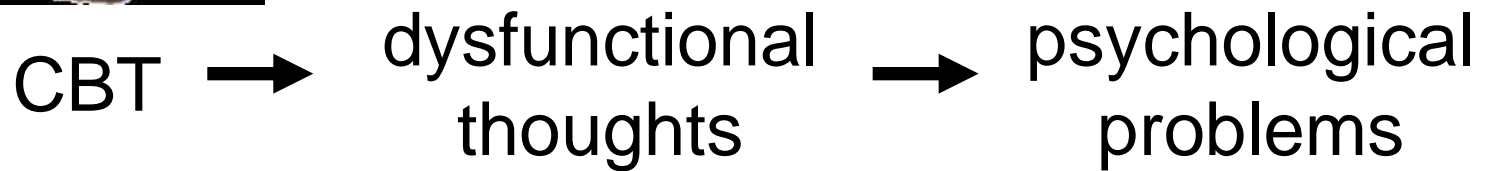
- Clients' experiences of therapy can be very different to what therapists assume
- Do 'sacred cows' of principle therapeutic orientations withstand empirical evaluation?



Assumption 2

Cognitive therapy
works by
improving the way
people think

The cognitive mediation hypothesis



How does CBT work?

- Many CBT clients *do* experience a reduction in dysfunctional thinking, but:
 1. So do many clients in other therapies, *and to a similar extent*
 2. Some clients improve in cognitive therapy without significant reductions in dysfunctional thinking
 3. Much improvements in CBT *prior to* implementation of cognitive techniques

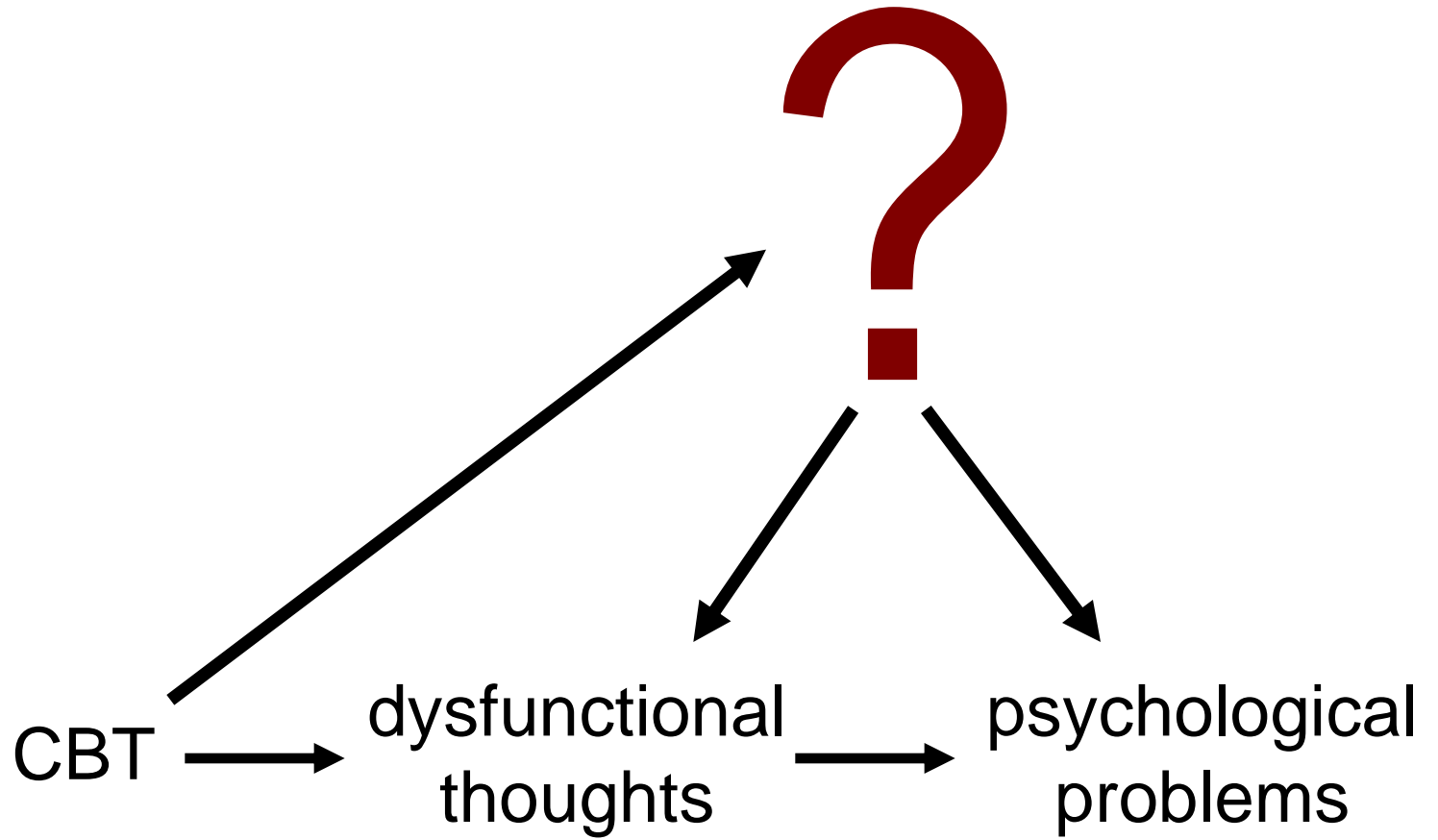
Clients' self-reports

- Review of studies where clients asked about most helpful aspects of their CBT:
 - *relationship* with therapist consistently considered more important than cognition-modifying *techniques*
 - For instance: most helpful aspect was 'the therapist's calm, sympathetic listening, support and approval, advice, and "faith"'.
THE FACTS ARE

Most recent analysis...

- Improvements in dysfunctional thinking do not cause improvements in mood in CBT
- Some third, 'unknown variable' – e.g., reduced feelings of hopelessness – brings about both improvements in mood and reductions in dysfunctional thinking

THE FACTS ARE FRIENDLY



Individual differences

- For some clients, at least, improvements in CBT *are* related to changes in thinking:
 - 'It's [CBT] helped me to have a more logical approach to my emotions, so that when horrible things happen I use the methods taught to sort of balance that out'
(Clarke et al., 2004)

Summary 2

Does CBT work in the way it is supposed to?

Perhaps for some clients, but
no strong evidence for all

ASSUMPTION 3

Transference
interpretations are
beneficial to clients
(psychodynamic)

More transference interpretations

→ worse outcomes

- Interpretations, *per se*, evidently helpful
- More accurate → more helpful
- But more *transference* interpretations associated with:
 - poorer outcomes
 - More dropout
- Clients who drop out more likely to be exploring transference issues in their final sessions

Pre-dropout pattern



1. The patient made his or her thoughts about dropping out clear, usually early in the session.
2. The patient expressed frustration about the therapy sessions. This often involved expectations that were not met and the therapist's repeated focus on painful feelings.
3. The therapist quickly addressed the difficulty by focusing on the patient-therapist relationship and the transference. Links were made to other relationships.
4. The patient resisted the focus on transference and engaged in little dynamic exploration (work). Resistance was often active, for example, verbal disagreement, and sometimes passive, for example, silence.

Pre-dropout pattern



5. The therapist persisted with transference interpretations.
6. The patient and therapist argued with each other. They seemed to be engaged in a power struggle. At times the therapist was drawn into being sharp, blunt, sarcastic, insistent, impatient, or condescending.
7. Although most of the interpretations were plausible, the patient responded to the persistence of the therapist with continued resistance.
8. The session ended with encouragement by the therapist to continue with therapy and a seemingly forced agreement by the patient to do so.
9. The patient never returned.' (Piper et al, 1999)

What causes what?

- Evidence of correlation does not *prove* causation:
 - e.g., clients threatening to drop out invite more transference interpretations
 - Controlled study comparing two forms of psychodynamic therapy:
 1. Therapists instructed to address relationship /make transference interpretations
 2. Therapists only refer to extra-therapeutic relational patterns
- Result: no differences in effectiveness

Individual differences

- Controlled study: transference interpretations more helpful when:
 - more severe psychopathology
 - more interpersonal problems
- Other studies have found opposite
- General agreement that most effective in context of strong therapeutic alliance

THE FACTS ARE FRIENDLY

Summary 3

Transference
interpretations are helpful?

Perhaps, for some clients, but
not clear for who; and too
many seem unhelpful

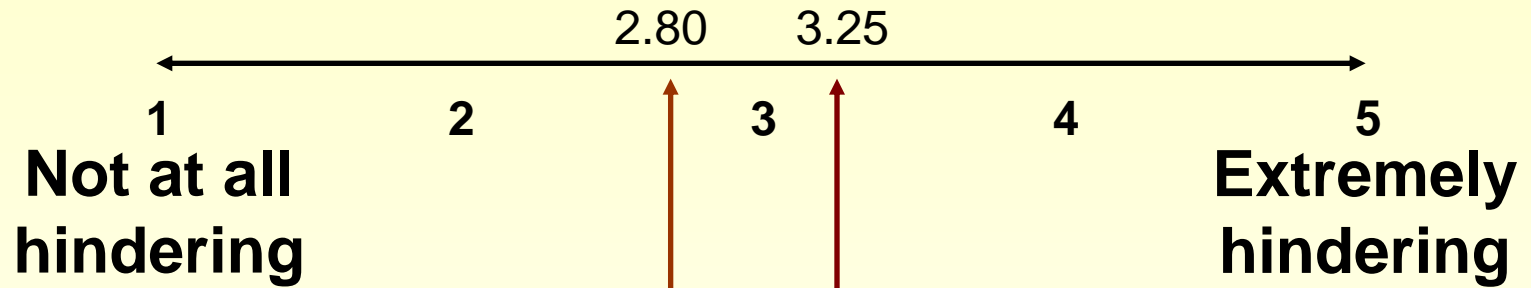
Assumption 4

Non-directivity is
beneficial to clients
(person-centred)

Support for non-directivity

- Some evidence that more directive interventions – e.g., guidance, advice, confrontation – lead to greater client resistance
- Highly directive behaviours rated as relatively hindering

THE FACTS ARE FRIENDLY

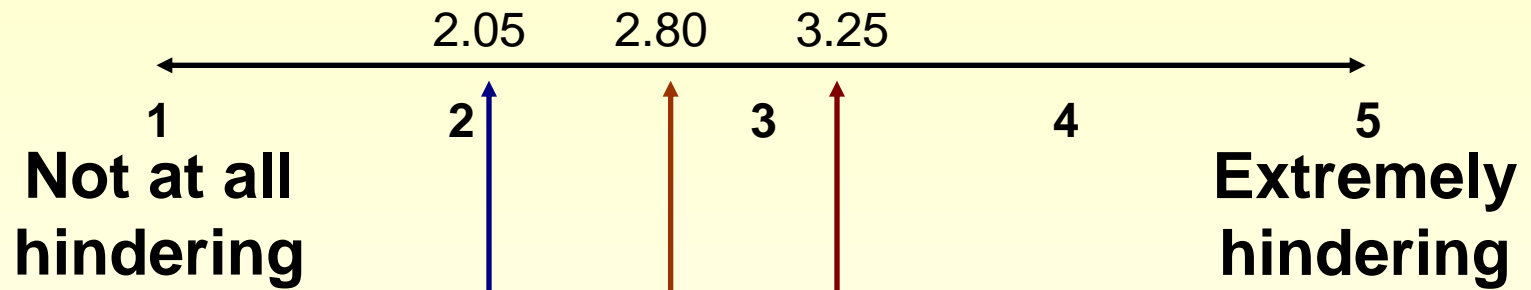


'The counsellor trying to tell me what to do'

'My counsellor being too directive'

Challenges to non-directivity

- Many highly directive interventions – e.g., flooding – associated with large positive change
 - Even in non-directive therapy, clients can rate 'suggestions and advice' as very helpful
- Non-directive behaviours can also be rated as unhelpful



'The counsellor trying to tell me what to do'

'My counsellor being too directive'

'My counsellor not telling me what to do'

Non-directivity as uncaring

- 'He just sat there while I was trying to save my marriage.... I didn't know if he really cared'
- 'She could at least say what she thought... Sometimes I felt like I was just another case as far as she was concerned'

(Maluccio, 1979)

Individual differences

- Non-directivity seem to be more helpful with:
 - Highly resistant clients
 - More mistrustful and suspicious clients
- Directivity seems to be more helpful with:
 - Non-defensive clients
 - Clients with anxiety disorders (possibly)
- In general: extreme directivity *and* extreme non-directivity seem least helpful

Summary 4

Is non-directivity
beneficial to clients?

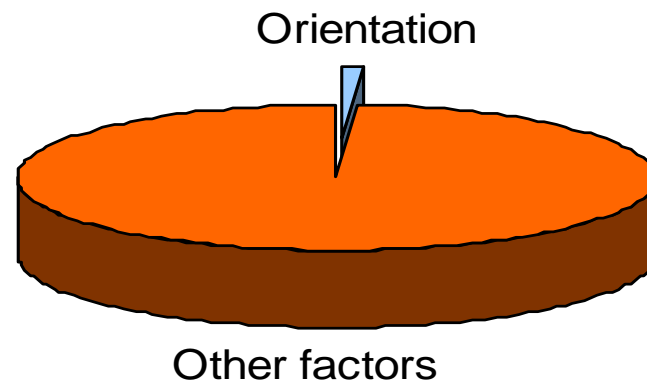
To some clients some of the
time, but not to all clients all of
the time

Assumption 5

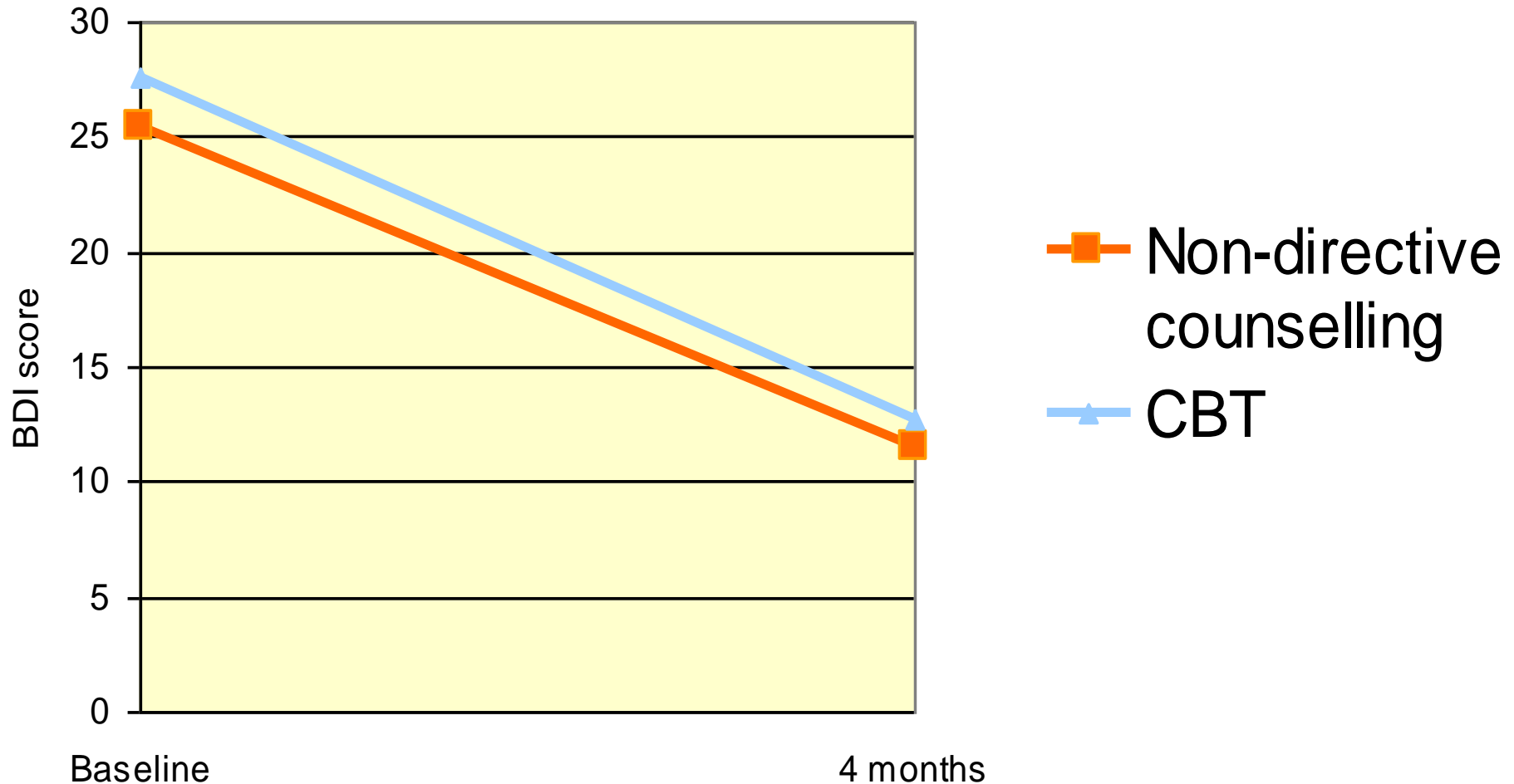
Oriéntation
matters

The 'dodo bird' finding

- Studies that directly compare (bona fide) therapies consistently find few differences in effectiveness
- Orientation calculated to account for as little as 1% of variance in outcomes

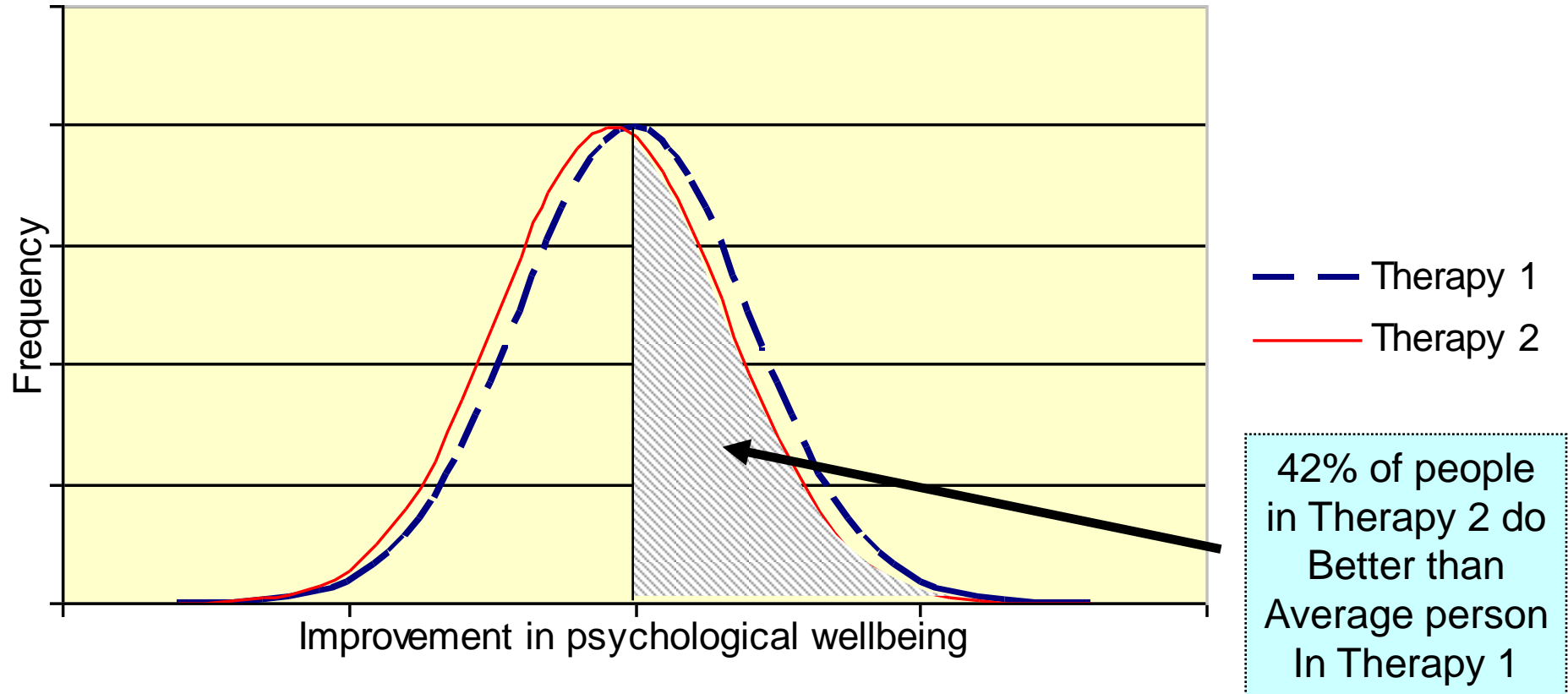


E.g., Comparison of CBT and non-directive counselling in primary care



Even if one orientation is marginally more effective overall, a large percentage of clients will do better in the other therapy

Comparison of two therapies with small (0.2) effect size difference in efficacy



Individual differences

- Cognitive behavioural approaches may be more helpful when:
 - Greater cognitive functioning
 - Ability to apply practical solutions
 - Problems manifested externally
- Non-CBT approaches may be more helpful when:
 - Greater interpersonal functioning
 - Problems inaccessible to consciousness
 - Problems manifested internally

Summary 5

Does orientation matter?

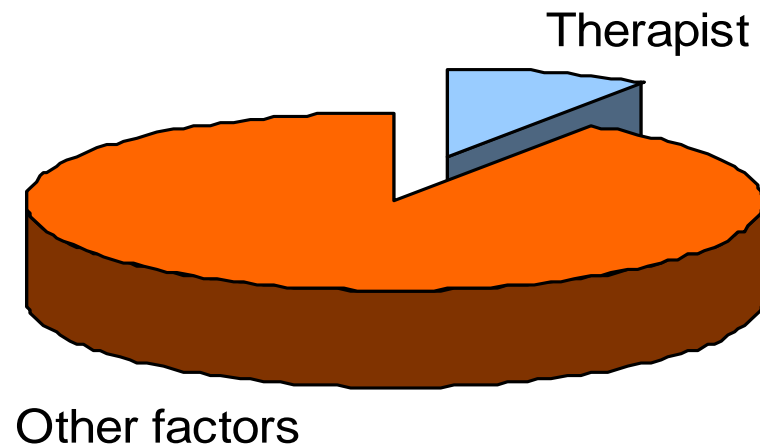
Perhaps, for some clients at some points in time, but not overall

Assumption 6

It's not what you
do, it's who you
are that counts

Some evidence of differences

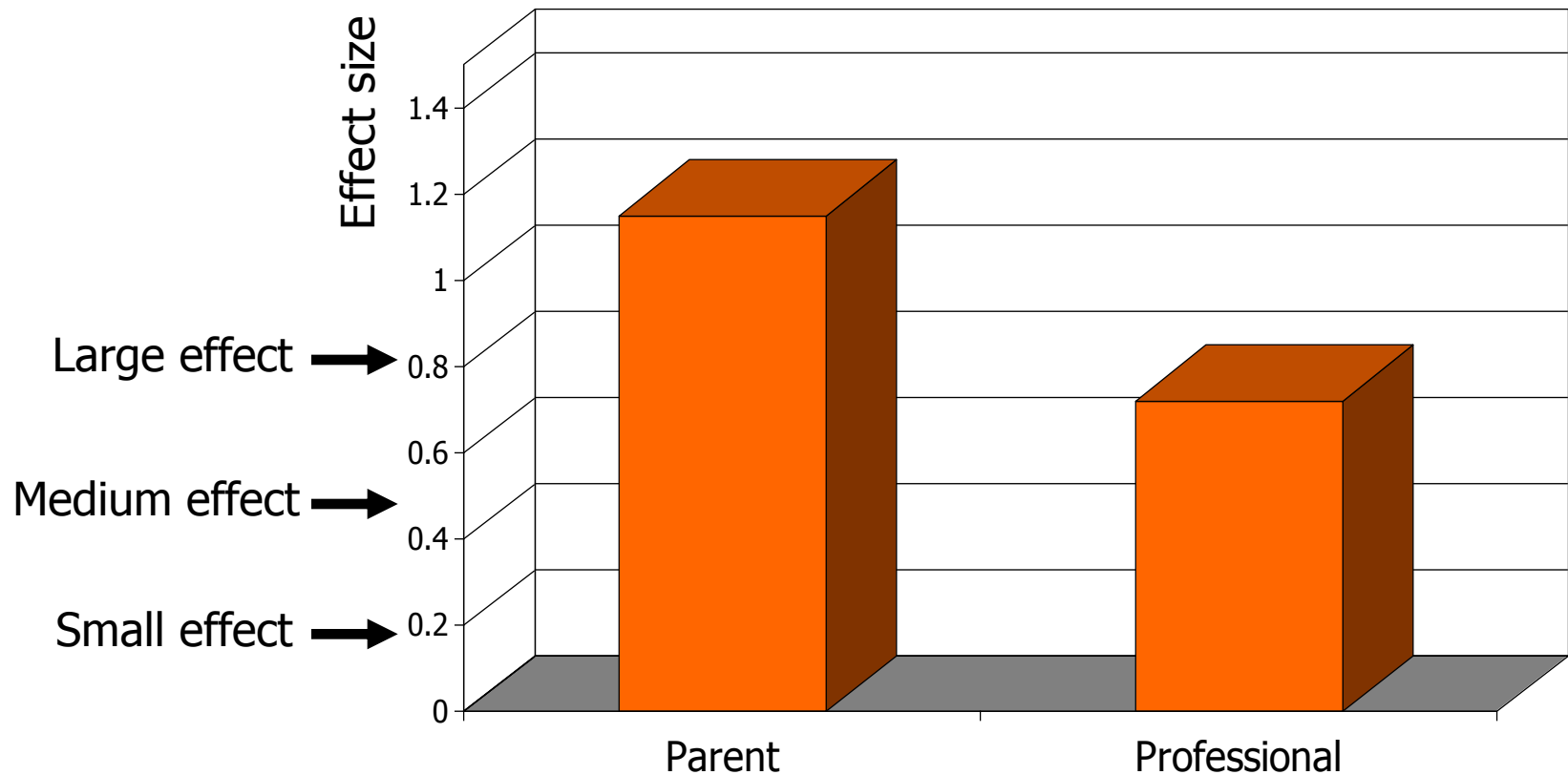
- Therapists can vary quite considerably in effectiveness:
 - ‘supershrinks’ and ‘pseudoshrinks’
- About 9% of variance in outcomes



But, minimal evidence that outcomes are related to therapists'...

- Personality
- Gender/age/orientation/ethnicity/sexuality
- Amount of supervision
- Life-experience
- Extent of personal therapy
- Amount of professional training
- Professional experience
- Professional vs. paraprofessional

E.g., parent-conducted vs. professional conducted play therapy



Summary 6

Is it who you are, as a therapist, that makes the difference?

To some extent, but not for the obvious reasons

Assumption 7

It's the
relationship that
heals

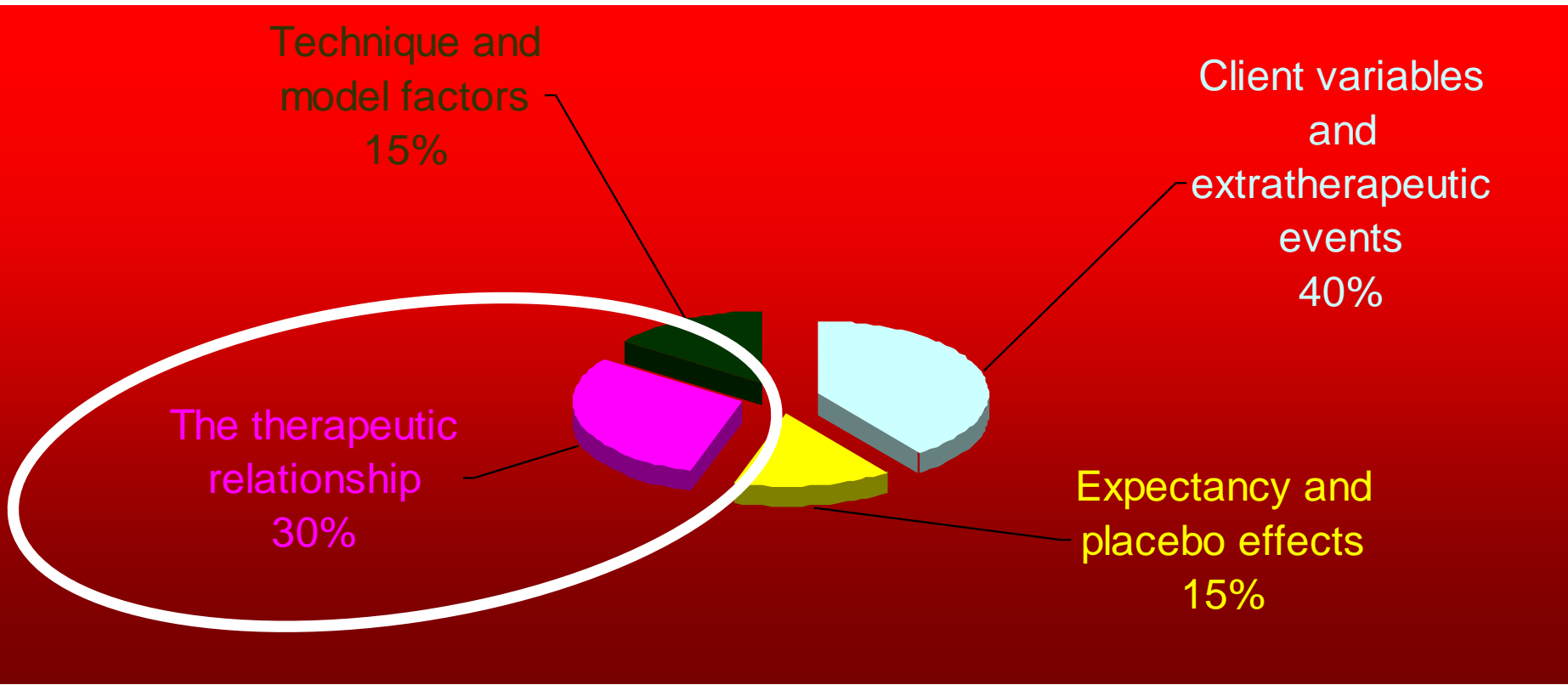
'Lambert's pie': Estimation of factors determining outcomes

Technique and
model factors
15%

Client variables
and
extratherapeutic
events
40%

The therapeutic
relationship
30%

Expectancy and
placebo effects
15%



'Except what the client brings to therapy, [relationship factors] are probably responsible for most of the gains resulting from psychotherapy interventions'
(Hubble, Duncan and Miller, 1999)

Challenges to relational emphasis I

1. More recent estimates: 7-17% of variance in outcomes
2. Relational processes inseparable from techniques: e.g.,
 - Study of events that led to the formation/strengthening of the alliance:
 - technical interventions most commonly cited

THE FACTS ARE FRIENDLY

Challenges to relational emphasis II

3. Correlation does not prove causation: improved relationship may be due to positive change
4. Relationship not just what *therapist* does, but large *client* contribution

THE FACTS ARE FRIENDS

Challenges to relational emphasis III

5. Entirely, or predominantly, 'non-interpersonal' therapies – e.g., self-help manuals – can be highly efficacious

<< Rogers' 'core conditions' are not *necessary* for therapeutic personality change (though may, for many clients, be sufficient)

Individual differences

- Clients with better interpersonal skills seem to be more responsive to relational focus in therapy
- But some clients benefit less from relational approach: e.g.,
 - clients 'who are highly sensitive, suspicious, poorly motivated, and reactive against authority perform relatively poorly with therapists who are particularly empathic'

(Bohart et al., 2002)

Summary 7

Is it the relationship that
heals?

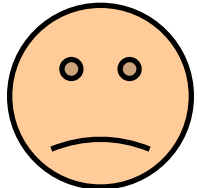
Perhaps for some clients, and may
be very important for others, but
can't be generalised to all

Assumption 8

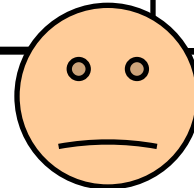
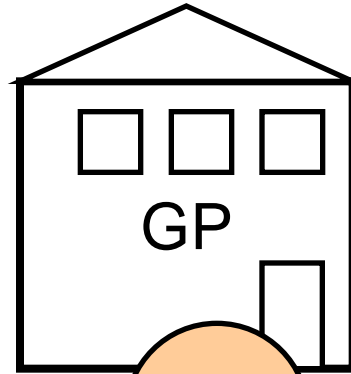
So is therapy
ineffective?

Amount of change

- 'Meta-analyses' (bringing together findings from different studies) indicate 'large' positive effects for counselling and psychotherapy
- Larger than average effect of medical or surgical procedures, such as sleeping pills for chronic insomnia
- Approximately 8 out of 10 people better off after therapy than average person who does not have therapy



Frank



Therapy

A large yellow rectangular area containing a group of nine faces with various expressions (happy, neutral, sad) and two sad faces to the right. The word "Therapy" is written diagonally across the center.

Summary 8

Is therapy ineffective?

No

Discussion

THE FACTS ARE FRIENDLY

What the research tell us

- Counselling and psychotherapy can be highly effective
 - Very beneficial, sometimes life-saving, to many people
- But we don't really know why
- Probably no one, single explanation
- Different individuals seem to change in different ways

THE FACTS ARE EVIDENT

An openness to our clients

- Research findings call into question many key therapeutic assumptions
- Disheartening...

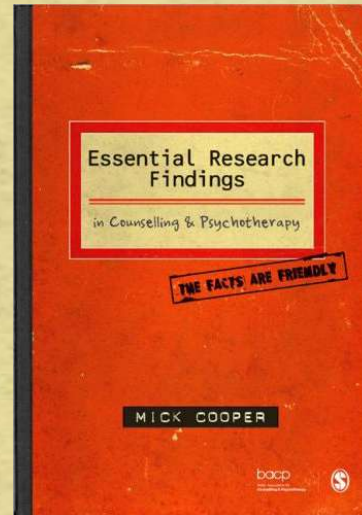
... or profoundly valuable:

- Research findings can stop us from falling into rigid, therapist-centred understanding and practices

THE FACTS ARE FRIENDLY

Research can
help us stay
open to the
fluid,
multifaceted,
complex, unique
mystery of each
client's
experiences

Thank you



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