What can we learn from what works across therapies?

By Nathan Beel 2011

Abstract

The recent trend in Evidence Based Treatment (EBT) has made counselling more prescriptive about what treatments should and should not be offered to whom. Although evidence suggests that EBT does not necessarily improve treatment effectiveness or client outcomes, it is assumed that evidence-based counselling models and techniques have intrinsic potency, and are more effective than other models in the treatment of certain disorders. The assumption is largely derived from the success of the Medical Model. A number of studies have found that there is little variation in outcomes between models of counselling including EBT. Research suggests that what is important is not what distinguishes one model from another, but rather the commonalities between them. This paper examines the common factors that have been found to have a more positive impact on counselling outcomes than selecting prescribed evidence based treatment approaches. These factors do not constitute an alternative modality but rather highlight potent ingredients common to all modalities. Being aware of what these factors are and integrating them more intentionally into practice has the potential for improving outcomes.

Since the 1990s, there has been a growing international trend towards Evidence Based Practice (J. C. Norcross, Beutler, & Levant, 2006). This has occurred as a result of increasing pressure for financial accountability within the mental health profession, particularly by governments and private funds, and the need to legitimise alternatives to medical interventions in the treatment of psychological disturbances. Psychological associations in Australia and the United States have published a list of treatments that research has validated for use in specific disorders (American Psychological Association Division 12; Lovelock, Matthews, & Murphy, 2010).

In the quest to legitimise and identify effective and superior counselling interventions, the EBT movement has adopted many of the underlying premises of the medical model. The medical model operates on the premise that to successfully treat a patient, the practitioner must first correctly diagnose the disorder, and then, apply the most effective treatment for the condition. Additionally, the model predicts that some treatments are more effective or potent than others. For example, in a counselling context, EBT suggests that applying Cognitive Behavioural Therapy to a client with depression is more likely to lead to better results than a less specific alternative therapy.

While the EBT movement has strong appeal and promises superior treatment to approaches which have not been tested, there are, nonetheless, some critical deficiencies. The first challenge is that clients often present with multiple and complex issues which complicate treatment choice and

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application. Another challenge is that applying the treatment to the client requires that one must gain the client's compliance to submit to the treatment. Not all clients feel comfortable with the mode of treatment on offer. In addition, it can diminish the client's own preferences. These are the same challenges faced in medicine.

Two of the most vexatious questions are: Are there some counselling models that are superior to others, and is interpreting evidence in the treatment modality the most relevant in aiming to improve outcomes? Wampold *et al* (1997) and other researchers (Benish, Imel, & Wampold, 2008; Scott D. Miller, Wampold, & Varhely, 2008; Spielmans, Pasek, & McFall, 2007; Wampold, 2001, 2006; Wampold, Minami, Baskin, & Tierney, 2002), have found that all bona fide therapies are roughly equivalent in terms of effectiveness. Wampold (2010) suggested research design was the primary cause of discrepancy. He found the following to bias research design:

1. **Are they comparing like with like?** If one compares a bone fide therapy against a therapy not intended to be therapeutic, it will win every time.
2. **Researcher allegiance.** Often the researcher has an allegiance to a particular model of therapy being tested. Typically the researcher's therapy wins.
3. **Therapist allegiance.** Therapists who believe in a therapy will gain better results than if they are asked to deliver a therapy that they do not believe in. This is known as the *allegiance effect*.
4. **Unequal therapist preparation.** Often the preferred therapy of the researcher will receive more intense training and supervision than the therapists who will utilise the comparison therapy.

When these confounding factors are accounted for, or if studies that have these are eliminated, the results show negligible difference in treatment.

The second major challenge focuses on the actual evidence. EBT assumes that the primary healing ingredients is the psychotherapeutic model itself. The assumption is that if one applies the right model to the right client issue it will increase the likelihood of positive outcomes. However Wampold (2001) highlighted that 13% of the impact of client outcomes results from psychotherapy. Of this psychotherapy impact, he found 70% had to do with factors common to all therapies, 8% due to the variability between treatments, and 22% due to client variability. He highlights "it must be clearly noted that the 1% of the variability in outcomes due to specific effects is likely to be the upper bound" (Wampold, 2001, p. 209). It seems absurd to focus so much attention on counselling model *superiority* when the variance between is 1% at most, and the factors common to all treatments have more than seven times the impact of distinguishing factors on outcomes.

The quest for improvement by looking to identify models that have most, albeit a marginal, effect on outcomes diverts attention away from factors that make the largest contribution to client change. Rather than attempting to find specific approaches to treatment which contribute little to outcome, the aim ought to be to understand better the common factors of successful therapy regardless of therapeutic school. How might this understanding guide what practitioners think and do?

The most commonly accepted common factor is the therapeutic alliance. Although the alliance is a significant predictor of the outcomes (Horvath & Symonds, 1991) little attention is typically given to it in therapy texts or supervision other than highlighting its importance. When clients are asked

about what is helpful in therapy, they typically point to the relationship more than techniques (J. Norcross, 2010). It is the client's perception of the alliance that is correlated with outcome and counsellors are typically unaware of any alliance problems (Cecero, Fenton, Frankforter, Nich, & Carroll, 2001; Safran, Muran, Samstag, & Stevens, 2001; Tryon & Kane, 1990; Zuroff et al., 2000).

Research into the constituents of helpful therapeutic relationships point to two broad salient factors (Hatcher & Barends, 2006). One is support generated from a connection or bond with the counsellor. The other is actual rather than merely perceived agreement about tasks and goals. The counsellor needs to be perceived as both caring and helpful. More specific qualities that support a strong therapeutic alliance are unconditional positive regard, empathy, goal consensus, and inviting a collaborative relationship. By the same token, blaming, criticising, confronting or rigid behaviour are unhelpful, if not harmful, to the alliance (Norcross, 2010).

Another significant factor in treatment success is the counsellor. Traditionally, the client is deemed the predictor of treatment outcomes, and counsellors have tended to hold clients responsible for poor results. However, success is predicated more on the therapist than the client. Research has found that some therapists are able to get better results in less time than others (Okiishi, Lambert, Nielsen, & Ogles, 2003). This performance is not contingent on therapist characteristics such as age, gender, qualifications or experience (Okiishi *et al*., 2006; Wampold & Brown, 2005). Rather than learning new models, counsellors might focus on improving counselling performance by monitoring their outcomes and utilising this feedback to adjust their approach (Miller, Hubble & Duncan, (2008). Note that improvement does not occur with experience alone. It requires sustained and intentional practice. It also requires obtaining valid feedback about performance from clients about the quality of the therapeutic alliance and progress towards well-defined outcome measures (Lambert, Hansen, & Finch, 2001).

Counsellors are social influencers. They are in the business of influencing clients towards constructive change. The more credible the counsellor from the client's point of view, the more open clients will be to counselling (Anderson & Lunnen, 2010). Credibility entails being seen as experts, attractive and trustworthy (Hoyt, 1996). A corollary is that the counsellor genuinely believes in what they are offering to clients. This is known as the allegiance effect (Toska, Neimeyer, Taylor, Kavas, & Rice, 2010). Counsellors who deliver a therapeutic model they believe in will get better results than those they consider incredulous (McLeod, 2009). What is important is not the particular model they subscribe to *per se*, but their belief in its benefits (Anderson & Lunnen, 2010).

As mentioned previously, Wampold (2001) found that much of the change in clients results from the client and their environmental influences, and only 13% is attributable directly to the therapy. The reasons for change have relatively little to do with therapy itself. Clients' resourcefulness makes a considerable contribution to therapeutic success. Clients are neither passive nor incompetent. Most will change and improve without the help of counselling. Counsellors primarily support the process of change (Bohart & Tallman, 2010). That is not to say that counselling is largely unhelpful. It does, however, suggest that if therapeutic benefit is to be maximised, more effort needs to be invested in helping clients activate resources outside of the confines of therapy. Efforts might be focussed on how to enhance clients' personal and social resources. These include utilising and enhancing the client's own motivations, capacity for change, strengths, resilience, participation in

therapy and participation in their change efforts. Rather than ignore this potential, or worse, pathologise the client, it needs to be realised.

It is important to ensure therapeutic efforts fit in with the client's own values and perceptions; otherwise there is a grave risk of alienating them. One way to enhance client participation is to base treatment on the client's own theory of change. What does the client want to focus on? How does the client perceive their problem and its cause? What are their ideas on how to change? Rather than assuming clients do not have a theory at all, or at least one that is not workable, the counsellor can inquire from the client what they believe will be helpful for them (Duncan & Miller, 2000; Philips, Werbart, Wennberg, & Schubert, 2007). Counsellors who are receptive to the answers to these questions are better positioned to adjust the model of therapy to suit the client's needs. Giving the clients' theories a chance does not mean uncritically accepting them. Rather the counsellor can explore the ideas with the client and help them evaluate whether or not their desired solutions are likely to be helpful. The benefit of adjusting to the client's theory is that the client is more likely to cooperate with treatment, particularly if it is the client who primarily develops the treatment plan.

EBT is about applying treatment which evidence suggest will be helpful based on extrapolating sample population norms to individuals. An alternative to EBT is Practice Based Evidence (PBE), which is about ongoing monitoring of treatment fit and response to each client. Rather than assuming treatment works because one is using the recommended modality, the therapist regularly monitors whether the treatment he or she is providing is actually helping the client to improve. If the client is not improving or has flagged alliance problems, the counsellor can discuss this with the client and adjust treatment accordingly.

Practice based evidence is most successful when applying a system of formal ongoing feedback. In fact, gathering feedback and adjusting therapy accordingly is believed to be the single best way to improve therapy outcomes. When counsellors using feedback measures are compared against counsellors not using feedback, the former showed advantage over treatment as usual (Anker, Duncan, & Sparks, 2009; Lambert, Whipple, Smart, Vermeersch, & Nielsen, 2001; Reese, Norsworthy, & Rowlands, 2009; Reese, Toland, Slone, & Norsworthy, 2010; Shimokawa, Lambert, & Smart, 2010; Slade, Lambert, Harmon, Smart, & Bailey, 2008; Whipple et al., 2003). The bottom line is that for most counsellors, feedback will help their clients gain better results quicker, and will also help them identify where treatment is not working.

Implications for Counselling

Intentionally using Common Factors knowledge in counselling has a number of implications for practice. Among the most salient are:

- Counsellors are advised to be versatile in their treatment of clients so as to accommodate their many and varied expectations and values.
- Counsellors need to listen to their clients and value their ideas. Part of this is attending to the client wishes, goals, perceptions, preferences and theories of change, rather than privileging their own and attempting to impose them on clients.
- Counsellors are advised to deliver treatments that they believe in. Both the therapist and the client must believe that the approach is likely to result in change.

- Counsellors must be viewed as credible by their clients, i.e., as an effective agent of change.
- Counsellors need to gather feedback from clients to assess satisfaction and progress rather than simply rely on clinical intuition and judgment. In contrast to EBP, this procedure provides Practice Based Evidence. (The Outcome Rating Scale and the Session Rating Scale developed by Scott Miller and his associates are useful for doing so because they are easy to use, quick to administer, empirically validated, outcomes can be easily tracked over time and there is free access to individual users. Another very popular and validated alternative is the longer OQ-45, however its length also has benefits in that it provides more specific data about the client's progress and areas to address in treatment.)

Conclusion

The medical model and evidence based treatment philosophy is seductive in its appeal when applied to psychological therapies. They offer hope that a correct diagnosis leads to a treatment that will result in a cure or, at the very least, remission. What makes any counselling modality effective is not the difference between, but what is common to all, therapies. The overemphasis on attempting to identify superior treatment modalities has drawn attention away from factors that have been shown to have a significantly stronger correlation with positive client outcomes. Acquiring and practising various counselling models is still necessary. However, attention should be directed at understanding how to enhance the common factors that invariably lead to therapeutic change.

Counsellors might begin by asking the following questions:

- How can I foster and maintain an effective working alliance with this client?
- How can I choose interventions and explanations that support the client's theory of change?
- How can I help the client gain awareness of their own strengths and utilise this towards their own solutions?
- How can I utilise and increase client expectation and hope of improvement?
- How can I ensure I am on track with this client, both in our relationship and in helping them towards better outcomes?
- How can I reliably check if I am effective with my clients?

These questions are more likely to lead to improved outcomes more so than by selecting and applying the recommended brand of therapy.

References

American Psychological Association Division 12. Website on Research-Supported Psychological Treatments Retrieved Sep 10, 2011, from http://www.div12.org/PsychologicalTreatments/index.html

Anderson, T., & Lunnen, K. M. (2010). Putting models and techniques in context. In B. L. Duncan, S. D. Miller, B. E. Wampold & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 143-166). Washington: American Psychological Association.

Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology, 77*(4), 693-704. doi: 10.1037/a0016062

Beel, N. (2011). *What can we learn from what works across therapies?* Paper presented at the Australian Counselling Association National Conference, Melbourne.

Benish, S. G., Imel, Z. E., & Wampold, B. E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review, 28*(5), 746-758.

Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor. In B. L. Duncan, S. D. Miller, B. E. Wampold & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 83-112). Washington: American Psychological Association.

Cecero, J. J., Fenton, L. R., Frankforter, T. L., Nich, C., & Carroll, K. M. (2001). Focus on therapeutic alliance: The psychometric properties of six measures across three treatments. *Psychotherapy: Theory, Research, Practice, Training, 38*(1), 1-11. doi: 10.1037/0033-3204.38.1.1

Duncan, B. L., & Miller, S. D. (2000). The client's theory of change: Consulting the client in the integrative process. *Journal of Psychotherapy Integration, 10*(2), 169-187.

Hatcher, R. L., & Barends, A. W. (2006). How a return to theory could help alliance research. *Psychotherapy: Theory, Research, Practice, Training, 43*(3), 292-299. doi: 10.1037/0033-3204.43.3.292

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: a meta-analysis. *Journal of Counseling Psychology, 38*(2), 139-149.

Hoyt, W. T. (1996). Antecedents and effects of perceived therapist credibility: A meta-analysis. *Journal of Counseling Psychology, 43*(4), 430-447. doi: 10.1037/0022-0167.43.4.430

Lambert, M. J., Hansen, N. B., & Finch, A. E. (2001). Patient-focused research: using patient outcome data to enhance treatment effects. *Journal of Consulting and Clinical Psychology, 69*(2), 159-172.

Lambert, M. J., Whipple, J., Smart, D., Vermeersch, D., & Nielsen, S. L. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research, 11*(1), 49-68.

Lovelock, H., Matthews, R., & Murphy, K. (2010). *Evidenced-based psychological interventions in the treatment of mental disorders: A literature review* (3rd ed.): The Australian Psychological Society Ltd.

McLeod, B. D. (2009). Understanding why therapy allegiance is linked to clinical outcomes. *Clinical Psychology: Science and Practice, 16*(1), 69-72. doi: 10.1111/j.1468-2850.2009.01145.x

Miller, S. D., Hubble, M. A., & Duncan, B. L. (2008). Supershrinks: What is the secret of their success? *Psychotherapy in Australia, 14*(4), 14-22.

Miller, S. D., Wampold, B., & Varhely, K. (2008). Direct comparisons of treatment modalities for youth disorders: A meta-analysis. *Psychotherapy Research, 18*(1), 5-14. doi: 10.1080/10503300701472131

Norcross, J. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 113-142). Washington: American Psychological Association.

Norcross, J. C., Beutler, L. E., & Levant, R. F. (Eds.). (2006). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions*. Washington: American Psychological Society.

Okiishi, J. C., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D., & Vermeersch, D. A. (Writers). (2006). An analysis of therapist treatment effects: Toward providing feedback to individual therapists on their clients' psychotherapy outcome [Article], *Journal of Clinical Psychology*: John Wiley & Sons Inc.

Okiishi, J. C., Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003). Waiting for supershrink: an empirical analysis of therapist effects. [Article]. *Clinical Psychology & Psychotherapy, 10*(6), 361-373. doi: 10.1002/cpp.383

Philips, B., Werbart, A., Wennberg, P., & Schubert, J. (2007). Young adults' ideas of cure prior to psychoanalytic psychotherapy. [Article]. *Journal of Clinical Psychology, 63*(3), 213-232. doi: 10.1002/jclp.20342

Reese, R. J., Norsworthy, L. A., & Rowlands, S. R. (2009). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy: Theory, Research, Practice, Training, 46*(4), 418-431. doi: 10.1037/a0017901

Reese, R. J., Toland, M. D., Slone, N. C., & Norsworthy, L. A. (2010). Effect of client feedback on couple psychotherapy outcomes. *Psychotherapy: Theory, Research, Practice, Training, 47*(4), 616-630. doi: 10.1037/a0021182

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2001). Repairing alliance ruptures. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 406-412. doi: 10.1037/0033-3204.38.4.406

Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting and Clinical Psychology, 78*(3), 298-311. doi: 10.1037/a0019247

Slade, K., Lambert, M. J., Harmon, S. C., Smart, D. W., & Bailey, R. (2008). Improving psychotherapy outcome: the use of immediate electronic feedback and revised clinical support tools. *Clinical Psychology & Psychotherapy, 15*(5), 287-303.

Spielmans, G. I., Pasek, L. F., & McFall, J. P. (2007). What are the active ingrediants in cognitive and behavioral psychotherapy for anxious and depressed children? A meta-analytic review. *Clinical Psychology Review, 27*, 642-654.

Toska, G. A., Neimeyer, G. J., Taylor, J. M., Kavas, A. B., & Rice, K. G. (2010). Epistemology and allegiance: Exploring the role of therapists' epistemic commitments on psychotherapy outcomes. [Article]. *European Journal of Psychotherapy & Counselling, 12*(1), 65-75. doi: 10.1080/13642531003637783

Tryon, G. S., & Kane, A. S. (1990). The helping alliance and premature termination. [Article]. *Counselling Psychology Quarterly, 3*(3), 233.

Wampold, B. E. (2001). *The great psychotherapy debate: models, methods, and findings*. Hillsdale, New Jersey: Lawrence Erlbaum.

Wampold, B. E. (2006). The psychotherapist. In J. C. Norcross, L. E. Beutler & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 200-208). Washington: American Psychological Society.

Wampold, B. E. (2010). The research evidence for common factors models: A historically situated perspective. In B. L. Duncan, S. D. Miller, B. E. Wampold & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 49-82). Washington: American Psychological Association.

Wampold, B. E., & Brown, G. S. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73*(5), 914-923. doi: 10.1037/0022-006x.73.5.914

Wampold, B. E., Minami, T., Baskin, T. W., & Tierney, S. C. (2002). A meta-(re)analysis of the effects of cognitive therapy versus "other therapies" for depression. *Journal of Affective Disorders, 68*, 159-165.

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H.-n. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empiricially, 'all must have prizes.'. *Psychological Bulletin, 122*(3), 203-215.

Whipple, J. L., Lambert, M. J., Vermeersch, D. A., Smart, D. W., Nielsen, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment and problem-solving strategies in routine practice. *Journal of Counseling Psychology, 50*(1), 59-68.

Zuroff, D. C., Blatt, S. J., Sotsky, S. M., Krupnick, J. L., Martin, D. J., Sanislow, C. A., III, & Simmens, S. (2000). Relation of therapeutic alliance and perfectionism to outcome in brief outpatient treatment of depression. *Journal of Consulting and Clinical Psychology, 68*(1), 114-124. doi: 10.1037/0022-006x.68.1.114

Beel, N. (2011). *What can we learn from what works across therapies?* Paper presented at the Australian Counselling Association National Conference, Melbourne.

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