Platinum standard outcome studies do show therapy/counselling works BUT:

- Nearly two-thirds of the good effects are due to the worker/client relationship or alliance
- About a quarter of the benefits are due to the workers commitment to their approach

Wampold, B. 2001. *The Great Psychotherapy Debate*. New York. Lawrence Erbaum.
Carr, A. 2009. What works in Psychotherapy. Routledge

- In component/dismantling trials no specific technical operations have been shown to reliably produce a specific effect.

- So there is no evidence that particular aspects of an approach are critical to it's success
- And there is no evidence for requiring particular aspects to be completed

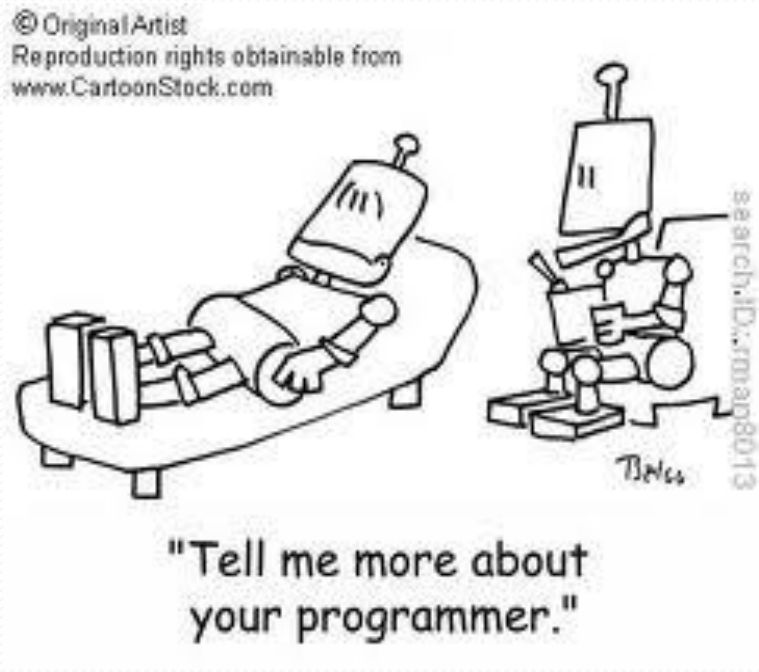
Duncan, B. & Miller, S. in Norcross, J. Levant, R. & Beutler, L. (Eds) (2006) Evidence-based practices in mental health. Washington, DC: APA Press.

Jacobson, N. et al (1996) A component analysis of CBT for depression. J of Clinical Psychology 64 295-304

Longmore, R. Worrell, M. (2007) Do we need to challenge thoughts in CBT? Clin Psychol Rev 27 173-187

Different therapeutic approaches do not have different outcomes.

- Research into277 different studies showed no approach to be reliably better than another.
- Another study of 2000 therapists 13 different approaches showed no differences



1. Brown, Dreis & Nace, 1999

2. Rosenburg, S. *Some implicit common factors in diverse methods in psychotherapy.* Journal of orthopsychiatry 6. 412 – 415.

3. Godley, S.H. Jones, N. Funk, R. Ives, M Passetti, L. 2004. *Comparing outcomes of best-practice and research-based outpatient treatment protocols for adolescents*. Journal of Psychoactive Drugs. 36 (1) 35-48.

The Therapeutic Relationship

This has been viewed as merely "setting the stage" for the "real" or "active" ingredients in treatment which have been thought to be:

- Confronting distorted thoughts;
- Recovering forgotten memories;
- Asking special questions;
- Tapping or waving fingers in front of the client's face.

Olinsky, Y. et al. 1994 *Process and Outcome in Psychotherapy*. In The Handbook of Psychotherapy and Behavioural Change. 4th edition. New York. Wiley.

How did we get so focused on models?

Partly through the influence of the medical model which offered release from:

- Demon possession
- Blame
- Moral flaws
- Being phlegmatic
- Having certain humours.
- Melancholy

- Instead it offered **diagnoses**. Symptoms were given a label that could provide a rationale for further action.

- A diagnosis suggests that, like medicine and science, certain responses work best for certain conditions.

- Like a pill, different approaches were thought to have different active ingredients

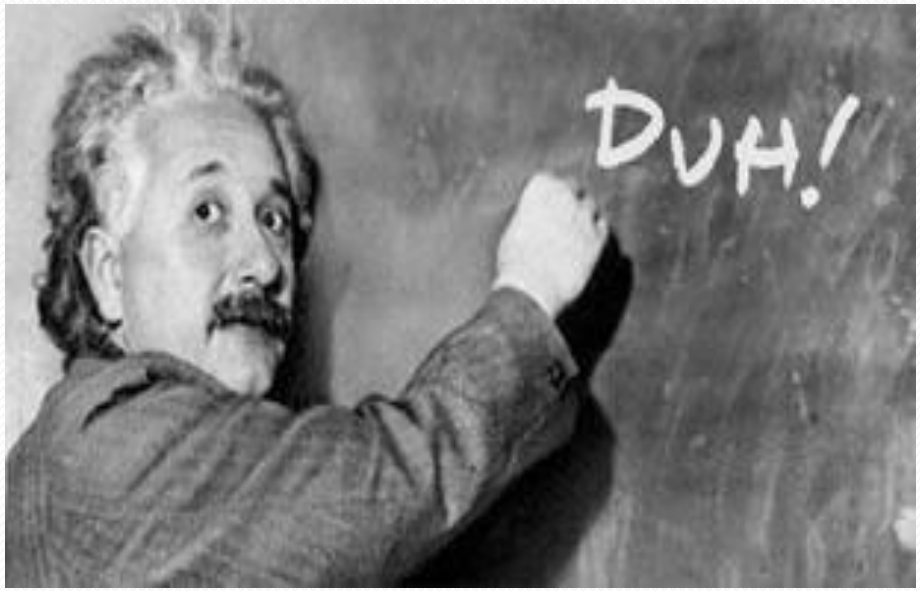
SO:

- If we call it anxiety or OCD, NICE recommend CBT.
- If we call it conduct disorder NICE recommend parent training.
- If we call it attachment disorder NICE recommend AFFT or PIP or ANT
- If we call it PTSD NICE recommend EMDR.
- If we call it anorexia NICE recommend Family Therapy.

Choosing what's best for you. CAMHS Publications, 2007

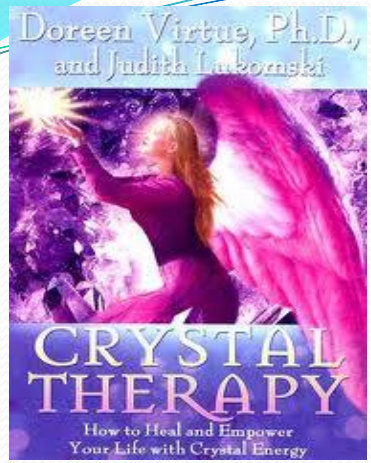
BUT

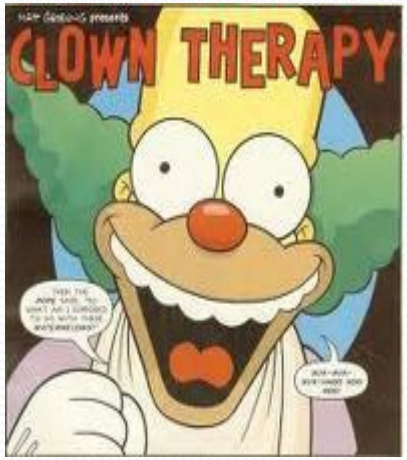
Data to support the value of using diagnoses for psychological problems simply doesn't exist.

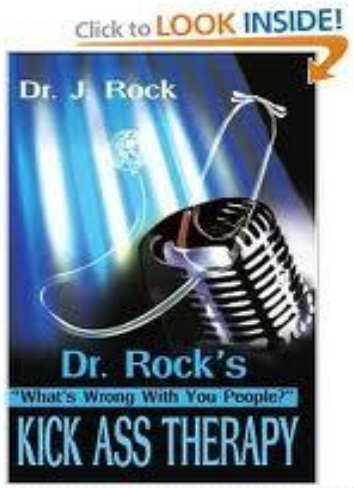


Wampold, B.E. et al. (1997) *A meta-analysis of outcome studies comparing bona fide psychotherapies. Empirically all must have prizes*. Psychological Bulletin 122(3). 203 – 215.

Miller, S. What works in Psychotherapy. www.talkingcure.com







If:

A) Diagnoses don't help and

B) There's nothing particular in an approach that has particular effects -

- then there is no good reason to have particular approaches for particular diagnostic categories

Duncan, B. & Miller, S. in Norcross, J. Levant, R. & Beutler, L. (Eds) (2006) Evidence-based practices in mental health. Washington, DC: APA Press.

- Those in control of the various professional groups …

- "not unlike the pigs in Orwell's *Animal Farm*, continue to assert that some therapies are more equal than others."

Duncan, B. Miller, S. & Sparks, J. (2004) *The Heroic Client: A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy* (Revised edition) Jossey Bass Wiley, San Francisco

Miller, S. Hubble, M. & Duncan, B. Supershrinks. (2007) Networker Oct/Dec issue p27-56

Outcomes from CBT

- 15 comparative studies have found an advantage for CBT – and there are about 3000 studies that show no difference.

- Wampold, B. (2001) *The Great Psychotherapy Debate: Models, Methods, and Findings*. Lawrence Erlbaum Associates, New Jersey

Outcomes from Prescribing

- In the largest ever study on depression that compared CBT, IPT, anti-depressants and placebo there was no significant difference in outcome between treatments.

- Wampold, B. & Brown, J (2006) Estimating variability in Outcomes attributable to therapists: A naturalistic study of outcomes in managed care. Journal of Consulting and ClinicalPsychology 73 (5) 914-923

- The three most effective clinician/prescribers achieved better outcomes when prescribing placebo than the three poorest did when prescribing anti-depressants.

Differences in outcome have little or nothing to do with the worker's:

- Age
- Gender
- Professional discipline
- Theoretical orientation
- Training undertaken
- Personal therapy
- Professional registration or certification

1. Bewter, L. Matik, M. Almohamed, S et al. 2002. *Therapist variables*. Handbook of Psychotherapy and Behaviour Change. New York. Wiley.
2. Brown, J. et al 2005
3. Garfield, S. 1997
4. Seligman, M. 1996
5. Atkins & Christenson, 2001. 6. Lambert & Bergin, 1994. 7. Lambert & Ogles, 2004; 8. Weisz, Weiss, Alicke & Klotz, 1987

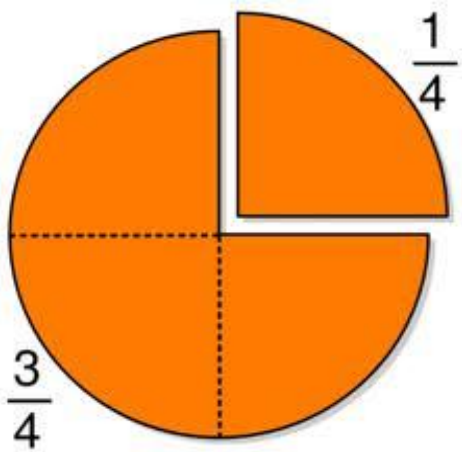
And yet,
25% of staff reliably achieve results that are twice as good as other staff.

Wampold, B., & Brown, J. (2006). 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.*

What do this 25% of workers do?

1. They encourage clients to use their own skills, knowledge, ideas and preferences

The probability of success is greater when the approach fits the clients theory.



- Frank, J.D. 1976. *Psychotherapy and the sense of Mastery*. In R.L. Spitzer Evaluation of Psychotherapies. Baltimore, MD. John Hopkins.
- Uberman, B. 1978. *The Maintenance and Persistence of Change*. In J.D. Frank et al (eds) Effective Ingredients of Effective Psychotherapy. New York. Brunner Mazel.
- Miller, S What works in Therapy. www.talkingcure.com

- **2**. They work to develop an understanding relationship with clients.

- Common practice may be to try to apply one or other therapy but the evidence says to just understand things from their point of view

- *Duncan, B. On Becoming a Better Therapist. Psychotherapy in Australia, Vol 16, 4. August 2010*

3. They work to achieve change in the shorter term.

In a study of 2000 therapists, no improvement by the third session generally resulted in no improvement by the end.

- Common understandings may suggest that some problems require long term work but the evidence suggests we should focus on short term change and clinician change when stuck

Brown et al, *What really makes a difference in psychotherapy in Hubble, Duncan & Miller (Eds) The Heart and Soul of Change Washington DC outcome1999)*
Bobar, T.F. Delboca F.F. 2003. *Treatment matching in Alcoholism*. UK, Cambridge 113

4. They are constantly extending their skills by deliberate practice

(Rather than by more academic qualifications, supervision, teaching, writing papers etc)

Brown, J. Lambert, M. Jones, E. & Minami, T. (2005) Identifying highly effective psychotherapists in a managed care setting. The American Journal of Managed Care. 11 513-520

Ericsson, K.A. Krampe, R. Tesch-Romer, C. (1993) The role of deliberate practice in the acquisition of expert performance. Psychological Reviw. 100 346-406

Collier, C. (2005). Finalword: The expert on experts. Fast Company. 116

5. Their primary focus is on preferred stories of “clarity, coping, endurance and desire”

“unsuccessful staff focused on problems whilst neglecting strengths . Successful staff focused on clients resources from the start

”

- Common practice is to focus on the problem and ‘problem solving’ but the evidence says to focus on what people value, what they’re clear about and their skills of living

Gassman, D. & Grawe, K. (2006).General change mechanisms: The relation between problem activation and resource activation in successful and unsuccessful therapeutic interactions. Clinical Psychology and Psychotherapy, 13, 1-11.

- 6. They track progress

- Keeping track on the problems and the worker/client relationship contributes directly to better outcomes

Lambert & Shimokawa, 2011
Anker, Duncan & Sparks, 2009

- **Western therapies focus on the worker, an** expert technician, schooled in the delivery of science based approaches.

- But…

- **The evidence values:**

  A focus on the clients theories skills and preferences,

But…

- Focusing on the client doesn't guarantee effectiveness

And…

- Focusing on the worker doesn't guarantee ineffectiveness

So…

How might we also orientate or position ourselves to:

1. Work effectively, even whilst focusing on the worker?

2. Reduce the chances of any ineffective work whilst focusing on the client?

Michael White identified the four positions that emerge from this:

1. Worker focused with an effective relationship

2. Worker focused with an ineffective relationship

3. Client focused with an effective relationship

4. Client focused with an ineffective relationship

A quadrant of positions

1. Worker focused / Effective relationship

2. Worker focused/ Ineffective relationship

3. Client focused /Effective relationship

4. Client focused / Ineffective relationship

1. Worker focused / Effective Relationship

When the client and worker both focus on the worker's knowledge and ideas

- GP consultation, car mechanics advice, plumbers recommendations etc are normally unproblematic examples of this position.

- However, in our work, implications that the client could or should have known better can be hard to avoid. This can sometimes restrict the clients collaboration and lead to an interaction that is:

2. Worker focused / Ineffective Relationship

When the client is less interested in the workers ideas than the worker is.

- A focus on the workers own ideas, judgements and preferences is often revealed in language like:

  “faulty thinking”,

  “inappropriate behaviour”,

  “unhealthy lifestyle”

  “inadequate boundaries” etc

3. Client focused / Effective Relationship

When the worker focuses on the client's resources, wishes and ideas to help achieve the clients goals.

- Potentially the hardest position, the worker attends carefully to client's ideas and preferences to support client's preferred outcomes and lifestyle.

- This also requires a short-term but empathic orientation that focuses on client resources more than client problems

4. Client focused / Ineffective Relationship

When the worker takes a marginal role in proceedings or does little that makes a difference

This may occur when:

- *The worker is listening but doing little else*
- *The worker is overly focusing on long problem descriptions*
- *It's hard to get a word in edgeways*
- *Clients are re-engaging in old arguments*
- *Clients seem to be positioning us as a judge of what's true or fair*