Research Commentary

The Challenge of Counselling and Psychotherapy

Research

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1

THE CHALLENGE OF COUNSELLING AND PSYCHOTHERAPY RESEARCH

Abstract:

Aims: The purpose of this commentary is to argue that the value of counselling and psychotherapy research lies, not only in what it teaches us as therapists, but also in its ability to *challenge* us and our assumptions. *Method:* The paper identifies eight beliefs that may be prevalent in sections of the counselling and psychotherapy community, and presents evidence that challenges them. *Findings:* While many of our beliefs may hold true for some clients some of the time, the research evidence suggests that they are unlikely to be true for all clients all of the time. *Discussion*: By questioning and challenging therapists' *a priori* assumptions, research findings can help counsellors and psychotherapists to be less set in their beliefs; and more open to the unique experiences, characteristics and wants of each individual client.

Keywords: psychotherapy research, process-outcome research, research methods, humanistic psychology,

In recent years the professions of counselling and psychotherapy have seen a dramatic rise in the importance attributed to research evidence. Where once this was a relatively neglected backwater of the field, research findings are now being given a central role in decisions about the commissioning of psychological therapy services. In the UK for instance, the Improving Access to Psychological Therapies (IAPT) programme, intended to offer psychological therapies in primary care for clients with anxiety and depression, is committed to supporting the delivery of only those therapies that are considered by the National Institute for Health and Clinical Excellence (NICE) to be evidence-based. Similarly, within the field of training, research awareness is also taking a more central role. In the draft Standards of Proficiencies for Psychotherapists and Counsellors developed by the UK's Health Professions Council (2009) for instance, therapists will need to be able to engage in evidence-based practice, be aware of a range of research methodologies, and be able to evaluate research and other evidence to inform their own practice.

Not all counsellors and psychotherapists, however, are happy with this shift towards a more research-orientated profession (e.g., Rowan, 2001), and one of the main reasons for this – particularly for humanistic and existential therapists like myself – may be a fear that an increased reliance on research evidence will lead to a greater dehumanisation of our clients (Cooper, 2007). This is not just because research often reduces down people to abstract, inhuman numbers, it is the fact that research, by its very nature, talks in generalities about clients' experiences – whereas what therapists like myself want to do is to engage with our clients' in all their individuality and uniqueness.

3

What use is it, for instance, to know that anxious clients, *on average*, respond

well to cognitive restructuring techniques? This tells us nothing about what might be

helpful for the one individual client in front of me? Indeed, from this standpoint, the

more that we use generalised research evidence to determine how we relate to

individual clients, the more we may end up imposing on them particular techniques or

interventions that are unhelpful or harmful. Rather, what we should be doing is

tailoring practices to the specific clients we are encountering, and this requires a

bracketing of *a priori* assumptions (e.g., Spinelli, 1997) – including those derived

from research -- rather than the imposition of them.

The aim of this paper, however, is to offer an alternative way of thinking about

the role that research findings can have – and this is one that comes from an equally

deep commitment to humanistic values and practices (see, for instance, Cooper, 2003,

2006, 2008). The basic assumption underlying this perspective is that, while it might

be ideal to encounter clients from a stance of 'unknowing' (e.g., Spinelli, 1997), the

reality is that we will always, already, meet our clients through particular beliefs and

biases. While it is true, then, that research findings could simply create one more layer

of assumptions that get imposed onto clients, this paper argues that they also have the

potential to help strip off some of these previous layers.

Here is a personal example that I have written about in my recent book

Essential research findings in counselling and psychotherapy: The facts are friendly

(Sage, 2008):

As someone trained in existential psychotherapy (something I've defined as

'similar to person-centred therapy… only more miserable' (Cooper, 2003, p.

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1) my tendency in initial sessions had always been to warn clients of the limits

of therapeutic effectiveness. That is not to suggest that I would start off

assessment sessions by saying: 'OK, so your life is meaningless, it has always

been meaningless, you have no hope of change… and how can I help you?'

but I did tend to adopt a rather dour stance, emphasising to clients that therapy

was not a magic pill and highlighting the challenges that it was likely to

involve. Then I came across a research chapter by Snyder and colleagues

(1999) which showed, fairly conclusively, that the more clients hoped and

believed that their therapy would work the more helpful it tended to be. How

did I react? Well, initially I discounted it; but once I'd had a chance to digest it

and consider it in the light of some supervisory and client feedback, I came to

the conclusion that, perhaps, beginning an episode of therapy with all the

things that might not help was possibly not the best starting point for clients.

So what do I do now? Well, I don't tell clients everything is going to be fine

the moment that they walk through the door; but I definitely spend less time

taking them through all the limitations of the therapeutic enterprise; and if I

think that therapy can help a client, I make sure that I tell them that. (Cooper,

2008, p. 3)

In attempting to demonstrate the value of research findings in challenging our

assumptions then, this paper will look at some of the beliefs that, to me, seem

particularly prevalent in certain sections of the counselling and psychotherapy

community, and show how they are called into question by the evidence. Of course, in

a paper such as this, it is impossible to review all the evidence with respect to each

5

particular assumption; but what I hope to show is that there is enough counter-

evidence to the belief to make its unquestioning acceptance, *for all clients*,

problematic. What also needs emphasising is that there are, undoubtedly, many other

assumptions in the counselling and psychotherapy field that could be called into

question through the empirical research (see, for instance, Bickman, 1999). The aim

here then is not to provide a comprehensive, critical review of evidence in the field,

but to highlight how *certain* assumptions encounter *certain* challenges from *certain*

empirical findings – thus illustrating the deconstructive potential of empirical

research.

One reason why research findings may be a particularly valuable challenge to

therapists' assumptions is because they articulate, albeit in a relatively structured and

mediated form, *clients'* experiences of therapy and the therapeutic change process. As

a trainer and a supervisor, my perception is that therapists' often feel that they already

have a good grasp of what clients are experiencing – indeed, humanistic and

psychodynamic courses often encourage students to learn to draw on their intuitive

felt-responses to clients. But while such feelings can, at times, give great insight into

clients' experiences, the research evidence actually indicates that therapists are often

very poor at judging what clients are experiencing.

Belief 1: Therapists have good insight into their clients' experiences of therapy

For a start, research indicates that clients and therapists often perceive the same

episode of therapy in very different ways (Cooper, 2008). The following example, for

instance, comes from a classic qualitative study of clients' experiences of therapy:

6

Client: 'The counseling was worthwhile. It felt good…. because it was

the first time in years I could talk with someone about what's

on my mind.'

Therapist: 'We were still in the beginning phases of treatment when she

pulled out…. I didn't feel that we were making progress.'

(Maluccio, 1979, pp. 107-108)

Research also indicates that there is very little agreement in how clients and therapists

perceive the quality of the therapeutic relationship (Cooper, 2008). Here is a personal

example of a significant mismatch:

[S]ome years ago, not long after I had qualified as a practitioner, a female

clinical psychologist was referred to me for counseling. I was somewhat

daunted by the prospect, feeling relatively inexperienced, but, by the end of

the first session, felt that I had begun to experience some feelings of warmth

and empathy towards her, and simply assumed that she had, in some way,

perceived these core conditions in me. At the beginning of the second session,

then, I was shocked when she presented me with a picture she had drawn of

me earlier in the week, in which I was depicted as a cold, aloof and

unwelcoming figure, dressed entirely in black. (Cooper, 2005, p. 62)

Similarly, counsellors and psychotherapists tend to overestimate their effectiveness

relative to other therapists, with one study finding that 90 per cent of therapists put

7

themselves in the top 25 per cent in terms of service delivery (Dew and Reimer, 2003 cited in Worthen & Lambert, 2007).

Consistent with this evidence, research indicates that around 50 per cent of clients have kept one or more secrets from their therapists, around half of these being of a sexual nature (for instance, 'I am more sexually attracted to my therapist than I have let on') (Hill, Thompson, Cogar, & Denman, 1993).

Research such as this indicates that clients' experiences of therapy may be very different from what therapists' – both as individuals and as representatives of particular orientations – imagine them to be.

Belief 2: Cognitive therapy works by improving the way people think

Cognitive therapy is based on the assumption that psychological problems are a consequence of maladaptive thinking (the 'cognitive mediation hypothesis'), such that 'Correction of these faulty dysfunctional constructs can lead to clinical improvement' (Beck, John, Shaw, & Emery, 1979, p. 8). Consistent with this hypothesis, many cognitive therapy clients do experience a reduction in dysfunctional thinking. However, so do many clients in other therapies, *and* to a similar extent (Oei & Free, 1995). Some clients have also been found to improve in cognitive therapy without significant reductions in levels of dysfunctional thinking (e.g., Serfaty, Turkington, Heap, Ledsham, & Jolley, 1999). What also provides a strong challenge to the cognitive mediation hypothesis is the fact that when CBT clients are asked about the most helpful aspects of their therapy, they often indicate that the relationship with their therapist is more helpful than the cognitive-behavioural techniques employed (Keijsers, Schaap, & Hoogduin, 2000).

In one of the most sophisticated analyses to date, Burns and Spangler (2001)

came to the conclusion that reductions in dysfunctional thinking did not cause

improvements in mood. Rather, some third factor, such as reduced feelings of

hopelessness, seemed to be responsible for both of these improvements. However,

such an analysis is based on the assumption that all clients in cognitive therapy

change in the same way, and a qualitative interview study by Clarke and colleagues

(2004) suggests that, for some clients at least, the correction of dysfunctional thoughts

is a key part of the cognitive therapeutic process. 'Barbara,' for instance, states: 'Once

I started looking at my beliefs about myself I could see a lot of it was nonsense'

(Clarke et al., 2004, p. 87); and for 'Carmen': 'It's 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, p. 85).

In summary, then, some clients do seem to improve in cognitive therapy as a

result of developing more functional thinking patterns, but there is very little evidence

to indicate that this is true for all.

Belief 3: Transference interpretations are a key ingredient of effective therapy

The use of transference interpretations – statements that help the patient to understand

the link between their interactions with the therapist and the interactions they

experience with others – is a cornerstone of much psychodynamic practice (Wolitzky,

2003). However, research over the last twenty years (primarily conducted by

psychodynamically-orientated researchers) has indicated that higher frequencies of

transference interpretations are actually associated with *poorer* outcomes in therapy.

In the most extensive study of this type, for instance, Piper and colleagues (1991) found a medium sized correlation of .37 between proportion of transference interpretations and general symptoms and distress at outcome, and a similarly negative relationship with quality of the therapeutic alliance.

There is also evidence that greater focus on transference is associated with higher rates of drop out, with clients who drop out more likely to be exploring transference issues in their final sessions than completers. Piper and colleagues (1999) identified a consistent pattern of interactions in these pre-termination sessions, with the client making their frustrations and thoughts about dropping out clear, the therapist attempting to analyse this in terms of transference, the client and therapist arguing, and the client not returning.

Of course, evidence of correlation does not prove causation, and it may be that clients who are more likely to drop out invoke more transference interpretation from their therapists, and indeed, in a direct contrast of two forms of psychodynamic therapy – one in which transference interpretations were mandated and another in which they were prohibited – outcomes were approximately the same (Høglend, Johansson, Marble, Bogwald, & Amlo, 2007). Interestingly, however, those clients with more severe forms of pathology did better in the transference condition than in the non-transference condition, while the reverse was true for those with less severe forms of pathology (though other studies have found the reverse relationship, Connolly et al., 1999).

In summary then, while the use of transference interpretations does not seem, in general, to reduce the effectiveness of therapy, there is very little evidence to support the assumption that they are a key ingredient of effective therapy.

Transference interpretations seem particularly contraindicated where the therapeutic

alliance is weak, in short-term work, and may be particularly counterproductive if

used frequently (Cooper, 2008). Research does suggest that transference

interpretations may be particularly useful for some groups of clients but, at present,

the evidence is entirely contradictory as to whom.

Belief 4: Non-directivity is beneficial to clients

At the heart of much humanistic practice – particularly in its classical, client-centred

form (e.g., Merry, 2004) – is the belief that therapists should refrain from directing

their clients in any particular way. Consistent with this hypothesis, research shows

that more directive therapist behaviours tend to lead to greater client resistance (e.g.,

Bischoff & Tracey, 1995), and that relatively directive therapist response modes –

such as guidance, advice and closed questions – tend to receive mixed responses from

clients (Williams, 2002). Similarly, a questionnaire study by Paulson and colleagues

(2001) found that clients rated both 'The counsellor trying to tell me what to do' and

'My counsellor being too directive' as relatively hindering, with means ratings of 3.25

and 2.80, respectively, on a 5-point scale of unhelpfulness (1 = *not at all hindering,* 5

= *extremely hindering*).

At the same time, most of the therapies that have been empirically validated

are based on highly directive therapeutic procedures (e.g., Chambless & Ollendick,

2001), and there is clear evidence that many directive interventions, such as exposure

techniques, have positive therapeutic effects (Orlinsky, Rønnestad, & Willutzki,

2004). What is equally evident from the research is that non-directive therapist

behaviours can also be rated by clients as relatively hindering: for instance, 'My

11

counsellor *not* telling me what to do' received a mean rating of 2.05 on the 5-point

scale in the Paulson and colleagues' (2001) questionnaire. Along similar lines,

Maluccio (1979, pp. 76-77), in his classic study of clients' experiences of therapy,

reports one non-directive client as saying, 'He just sat there while I was trying to save

my marriage…. I didn't know if he really cared,' and another, 'She could at least say

what she thought…. Sometimes I felt like I was just another case as far as she was

concerned.'

In general, what the evidence seems to indicate is that a rigidly non-directive

approach is as unhelpful as a rigidly directive one. However, what the research also

seems to indicate is that some clients do better in non-directive ways of working than

others. In particular, clients with high levels of resistance (i.e., who have a tendency to

behave in oppositional ways), tend to benefit more from non-directive practices,

whereas those who are judged to be non-defensive benefit more from directive

therapeutic procedures (Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2006).

Furthermore, there are some indications that clients who are particularly

mistrustful and suspicious may become more so when faced with a therapist who

actively tries to structure a session (Kolb, Davis, Beutler, Crago, & Shanfield, 1985).

At the same time, data from a range of sources suggest that directive practices may be

particularly useful for clients who are experiencing anxiety disorders (Woody &

Ollendick, 2006).

Belief 5: Orientation matters

Research evidence calls into question some of the key assumptions underlying the

principal therapeutic orientations. More than that, though, it calls into question the

12

assumption that orientation matters in the first place – a belief that is pervasive

throughout the counselling and psychotherapy field (whether, for instance, in

evidence-based treatment guidelines or in orientation-specific trainings). Studies that

compare the outcomes of different therapies, for instance, almost invariably find that

there are of about equal efficacy. In a classic example of this, for instance, King and

colleagues (2000) found that CBT reduced clients' levels of depression on the Beck's

Depression Inventory by 14.9 points after four months, while non-directive

counselling reduced it by 13.9 points – a non-significant difference. Within the

counselling and psychotherapy research literature, this finding of equivalence across

the different therapies has come to be known as the 'dodo bird' verdict (Rosenzweig,

1936). This is after the dodo bird in *Alice in Wonderland* who, having judging a race

around a lake, declares that 'everyone has won and so all must have prizes.'

Drawing together findings from hundreds of studies, some researchers have

estimated that therapist orientation accounts for just one per cent of the variance in

outcomes (Luborsky et al., 2002; Wampold, 2001). Furthermore, Wampold (2001)

calculates that, if the therapies being compared are *bona fide* ones and researchers'

allegiances are controlled for, this figure is reduced to zero. Even without this

recalculation, a contribution of one per cent means that 42 per cent of clients in a 'less

effective' therapy will actually do better than the average client in a 'more effective'

therapy. This means that, even if marginal differences do exist between the overall

effectiveness of different therapies, this actually tell us very little about the kind of

therapy that may be most helpful for a particular individual client.

However, there is some evidence to suggest that different kinds of clients may

benefits from different kinds of therapy. In particular, cognitive behavioural

13

approaches may be more helpful when clients have greater cognitive functioning, are able to apply practical solutions to their lives and tend to manifest their problems externally. On the other hand, non-CBT approaches may be more helpful when clients have greater relational and interpersonal functioning, where problems appear inaccessible to consciousness, and where difficulties appear to be expressed in an internal way (for instance, through somatisation) (Cooper, 2008).

In summary, then, while many therapists remain closely identified with a particular therapeutic orientation, there is little evidence to suggest that this affects the effectiveness of their work. Some clients do seem to do better in some kinds of therapies, but it is no means clear who does best in which ones.

Belief 6: It's not what you do, it's who you are that counts

If therapists' orientations do not seem to be the principal determinant of therapeutic effectiveness, what is? One possibility is that it is something to do with the person of the therapist: for instance, their levels of self-awareness, or the extent of their professional training. Certainly, this assumption is at the heart of many therapy trainings, particularly person-centred, humanistic and psychodynamic ones, where there is a particular emphasis on the personal development of the trainee (Mearns, 1997). In support of this, research does show substantial differences in outcomes across therapists. One study, for instance, found that the clients of the most effective therapist in a university counselling centre showed a rate of improvement ten times that of the average, while the clients of the least effective therapist showed an average worsening of problems (Okiishi, Lambert, Nielsen, & Ogles, 2003). Across a range of studies, research suggests that around 5 to 10 per cent of the variance in outcomes is

14

related to differences across therapists (Crits-Christoph et al., 1991), meaning that the differences in effectiveness from one CBT practitioner to another, or from one psychodynamic therapist to another, is considerably greater than the differences in effectiveness between *all* CBT practitioners and *all* psychodynamic therapists, or all therapists of any other orientation.

However, many of the therapist factors that might be assumed to be key predictors of outcomes appear only marginally related to the success of the therapeutic work. For instance, there is little evidence to suggest that any particular type of personality or demographic characteristics are related to outcomes, and outcomes also do not appear strongly related to therapists' levels of training, the amount of supervision they receive, their personal development work, or whether or not they have experienced the same personal difficulties as their clients (see Cooper, 2008). Even therapists' status as professionals or paraprofessionals does not appear to be a major determinant of outcomes; one research review found that play therapy was significantly more effective when conducted by a parent as compared to being conducted by a mental health professional (Bratton, Ray, Rhine, & Jones, 2005).

Part of the reason why specific therapist factors may make only a marginal difference to client outcomes is because this relationship may be more distal (i.e. far away) than therapists might imagine. From a therapist's stance, for instance, it may seem that changes at a professional or psychological level will have a direct impact on their clients. However, to begin with, intrapersonal changes in the therapist must first be manifest at an overt level. They must then be perceived by the client, and only when these perceptions have been interpreted and understood in a particular way can they make a difference to the client's psychological functioning and wellbeing.

Hence, by the time it impacts upon a client's intrapersonal world, a big change in the

therapists' internal world may make only a very small difference to the client's

internal world – with much of the magnitude and meaning of the change dissipated

along the way.

Belief 7: It is the relationship that heals

If therapists vary quite markedly in their effectiveness, but this is not strongly related

to any particular personal or professional characteristics, could this be because the key

factor is not *who* the therapist is, but *how* they relate to their clients? Certainly, this is

the view of many therapists (e.g., Yalom, 2001), including the present author, who see

the quality of the therapeutic relationship as the key curative agent in counselling and

psychotherapy. Consistent with this, Michael Lambert, one of the world's leading

psychotherapy researchers, estimates that the quality of the therapeutic relationship

accounts for as much as 30 per cent of the variance in outcomes (Asay & Lambert,

1999): 'Except what the client brings to therapy,' write Hubble, Duncan and Miller

(1999, p. 9), relationship factors 'are probably responsible for most of the gains

resulting from psychotherapy interventions'.

But is this actually true? In fact, there are a number of empirical and

methodological reasons why such a conclusion is almost certainly premature. For a

start, 'The collection of meta-analytic findings over the past 10 years indicates that

relationship quality accounts for a far more modest proportion of the variance in

outcome than the 30 per cent suggested by Lambert' – probably somewhere nearer 7

to 17 per cent (Beutler et al., 2004, p. 282). Second, the quality of the therapeutic

relationship, as experienced by clients, may be much more tied in with the particular

techniques that the therapist uses than practitioners imagine. For instance, in their study of the events that led to the formation and strengthening of the therapeutic alliance, Bedi and colleagues (2005) found that the most commonly cited incidents were technical interventions, such as clients being asked to undertake homework. Third, the fact that relational factors are *related* to outcomes does not prove that the former *caused* the latter. It may be, for instance, that clients who feel they are doing well in therapy then start to feel more positive about their therapists.

Fourth, while a good therapeutic relationship is predictive of good therapeutic outcomes, it is essential to remember that this is not something that therapists 'provide' for clients, but something that emerges in the client--therapist interaction. Indeed, there is actually more evidence that clients' contributions to the therapeutic relationship predict outcomes than there is for therapists' contribution (Orlinsky et al., 2004). Fifth, and perhaps most importantly, there is clear evidence that many non-person-to-person therapies, such as web-based therapeutic programmes and self-help manuals, can be highly efficacious (Gould, 1993). Contrary to Rogers' (1957) hypotheses, then, it would seem that certain relational conditions are not necessary (though they may be sufficient) for therapeutic personality development to occur.

Again, however, what the research seems to indicate is that different clients may be differentially impacted upon by the quality of the therapeutic relationship. In particular, while clients with better interpersonal skills, as suggested above, may be particularly responsive to high quality therapeutic interactions, others may be only marginally affected by such factors, and some may even experience high quality relationships as hindering. Bohart and colleagues (2002, p. 100), for instance, report that clients 'who are highly sensitive, suspicious, poorly motivated, and reactive

against authority perform relatively poorly with therapists who are particularly

empathic.'

In summary, then, while the relationship may be the key healing agent for

many clients, it can not be assumed that it will be necessary or important for all.

Belief 8: Therapy is ineffective

So if it is not the orientation, or the therapist, or even the relationship, does this mean

that therapy is actually ineffective? There are certainly those in the wider community

who have argued that the costs of therapy outweigh its benefits (e.g. Furedi, 2003);

but the answer to this question seems to be a resounding 'no'. In fact, combined

findings from a wide range of controlled trials suggest that, on average, counselling

and psychotherapy has a *large* positive effect (e.g., Wampold, 2001) – greater, indeed,

than the average surgical or medical procedure (Caspi, 2004). Put more precisely,

what the research shows is that approximately 80 per cent of people will do better

after therapy than the average person who has not had therapy.

To illustrate this, imagine 'Frank,' going to his GP with depression, and being

encouraged to wait and see how things improve:

Now imagine Frank two months down the line: possibly feeling a little better,

but still relatively depressed. And now imagine another ten people going to

their GP, but this time being referred to therapy. So what the research is saying

is that, in two months time, approximately eight of these people will be feeling

better than Frank, while two of them will be feeling worse. (Cooper, 2008, pp.

22-23)

Discussion

What the research indicates is that psychological therapy can be highly effective and almost certainly 'life-saving' for some individuals. But while we know many of the factors *associated* with positive therapeutic outcomes – in particular, relational factors, as discussed above, and also client factors like levels of motivation and participation (Cooper, 2008), we do not know *why* these outcomes come about. Almost certainly, however, there is no one, single explanation for this process. What the research indicates is that different clients change in different ways, and being open to a multiplicity of explanatory frameworks may, ultimately, prove more useful than attempting to identify a single 'silver bullet' that accounts for it all.

In this respect, research findings call into question some of the key underlying assumptions of our principal therapeutic orientations. They do not indicate that these hypotheses are wrong, merely that, in postmodern terms, they cannot claim to be 'grand narratives'. That is, they may be true for some clients some of the time, but they are not universal truths for all clients all of the time, and in this respect they need to be held lightly rather than as self-evident givens.

For some counsellors and psychotherapists, such a conclusion may seem disheartening: What is the point of research if all it tells us is what is *not* the case? Yet if our aim is to engage with, and relate to, our clients as the unique human beings that they are, then the process of constantly questioning our a priori assumptions is a profoundly important one. Doctrines and dogmas flourish in the absence of empirical evidence – research findings have the potential to call us back to the lived-reality of our clients' lives, in all their complexity and diversity. In this respect, research

findings can help us stay open to the multifaceted and ever-changing nature of our

clients' experiences – attuned, not to any one set of assumptions, but to the unique,

unpredictable, indefinable individuals that we meet in the therapeutic encounter.

Biographical note

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21

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