‘What Works in Psychotherapy & Counselling’

Author’s Affiliations:
Courtenay Young,
UKCP Registered Psychotherapist,
BPS Member,
EABP Honorary Member
EAP Individual Member
NHS Counsellor
Editor: International Journal of Psychotherapy

Courtenay Young is a well-known UKCP Psychotherapist, NHS Counsellor, author and editor. He currently lives and works in and around the Edinburgh area, working both in the NHS and privately. He is the author of several books (and edited books) and many published articles. He is currently also the Editor of the International Journal of Psychotherapy (www.ijp.org.uk). He has been involved in the several professional ‘projects’: the latest one being the 2012 EAP Project to Establish the Professional Competencies of a European Psychotherapist (www.psychotherapy-competency.eu). Most of his published articles are available as PDF downloads from his personal website: www.courtenay-young.com.

Contact Details:
Postal Address: 60 Earlston Road, Stow, Galashiels, Scottish Borders, TD1 2QT
Mobile: 07730-422800
E-mail: courtenay@courtenay-young.com

Clinical and Methodological Significance of this Article:
This article is quite a radical in-depth look at what actually works in psychotherapy and counselling, irrespective of the numerous methods and modalities, as well as therapies or treatments for different ‘conditions’, focussing instead on research evidence of what has actually been found to ‘work’ i.e. to be beneficial to the clients / patients.

Disclosure Statement:
There have been no financial inputs; there are no known conflicts of interest; no financial interest or benefit has arisen (or is intended) from publishing this article.

Total Word Count: 17,402

First Page:	130 words
Article: Part 1:	6,083 words
Article: Part 2:	8,770 words
References:	2,314 words
Endnotes:	3,013 words

What Works in Psychotherapy & Counselling: Part 1

COURTENAY YOUNG

Abstract
This is an extended article (in two parts) that was developed from an original PowerPoint presentation, first given at the Strathclyde University to a gathering of counsellors in Sept. 2015. It focuses on 'What Works' in Psychotherapy and Counselling - and therefore also, by default, what doesn't seem to work. It is contemporary, as well as being both researched and also very pragmatic.
Key Words: Psychotherapy, Counselling, Efficacy, Effectiveness, Pragmatism, Contra-indications.

Introduction

This article is not about any particular method or modality of psychotherapy being better than any other: especially, as the "Dodo Bird" verdict implies that all therapies are equally effective as they can all be seen to produce equally effective outcomes (Barlow, 2010; Benthall, 2009; Luborsky, 1999; Luborsky *et al.*, 1975; Luborsky *et al.*, 2002; Luborsky *et al.*, 2006; Rosenzweig, 1936; Wampold, 2001); **and** this article is not about developing a good therapeutic relationship – as that is a necessary part of one's training as a counsellor or psychotherapist; **and** it is also not about any 'artificial' distinctions between … psychotherapy, counselling, psychological therapy (IAPT), guided self-help, coaching, etc.; **and** it isn't about **any** randomized controlled trials, empirically supported therapies, evidence-based practice, effect-sizes, risk-factors, etc. (Nathan & Gorman, 2007; Castonguay, 2010; Dimidjian & Hollon, 2010; Young, 2014). [1]

It also is **not** about professional competencies (or National Occupational Standards) – which is what everyone is supposed to be able to do (EAP, 2012; Mind, 2009; ENTO, 2007; ESCO, 2009); **and** it isn't about anyone's views about 'mental illness': i.e. the 'medical model', etc. versus the more humanistic view, client-centred, or context-based, practice; and it has nothing at all to do with ethics and professional behaviour – which is about how one ought to be working – or how one ought **not** to be working; **neither** has it anything to do with BACP, or UKCP, or COSCA, or BPS, or APA, or EAP, … and all their different Ethical Principles and Codes of Practice, etc.; and, finally, it isn't about (or is only very partially about) what I do – because what works for me with this person, probably won't work for you with that person (and visa versa).

So, therefore, what this article is about is a sort-of pragmatic 'hotch-potch' of various ingredients that include: "The Common Factors Theory"; "Some 'Therapists' Are Better (than others) and Some 'Treatments' Are Better (for some things) – STAB"; "The Four Magic Words"; "WOOPS"; "The Great Divide => CPRN"; "Critical Psychotherapy & Counselling"; "Real Therapy & 'The Big Issues'"; "Mindfulness"; "Feedback Informed Treatment"; "What Doesn't Work"; "Myths about Counselling & Psychotherapy"; the concept of Collaborative Practice or "With-ness";

and … (hopefully) also some good ideas – in due course – that will come from a number of other professional people, like yourselves!

The Common Factors Theory

The 'Common Factors Theory' proposes that different approaches and evidence-based practices in psychotherapy and counselling share various 'common factors' that account for much of the effectiveness of a psychological treatment. This is in contrast to the view that the effectiveness of psychotherapy and counseling is best explained by specific or unique factors (notably, particular methods or procedures) that are suited to treatment of particular problems. It is also a way of 'integrating' aspects from the various forms of psychotherapy.

The 'Common Factors Theory' has – as its basis – an article by Saul Rosenzweig (1936), carried forward by Garfield & Bergin (1957), and was then developed further by Goldfried (1982). The theory has since been advanced by various meta-analyses [2], however there are also certain advantages and disadvantages to this theory – and there have also been some significant developments since its origin (Martin *et al.*, 2000; Wampold, 2001; Horvath & Bedi, 2002). Most "common factor" theories reduce the 'common factors' down to about five, which are: **(i)** client characteristics; **(ii)** therapist qualities; **(iii)** change processes; **(iv)** the treatment structure; and **(v)** the therapeutic relationship (Grencavage & Norcross, 1990).

Lambert (1992) identified four factors, which are: **(a)** extra-therapeutic change factors – qualities in the client or their environment; **(b)** common factors, such as empathy and the therapeutic relationship; **(c)** expectancies – from the client's belief in the rationale or effectiveness of the therapy; and **(d)** special techniques – unique to the particular therapy or tailored to a particular problem: and these concepts have been developed into the APA book by Duncan, Miller & Wampold (2nd Ed., 2009), *The Heart and Soul of Change.*

DeFife & Hilsenroth (2011) identified three 'common factors' or 'core' psychotherapeutic principles (see Table 1, below):

- **(A) Fostering positive expectancies** (first by identifying symptoms, then developing an understanding or rationale for these, and then using the therapeutic relationship to normalize concerns and communicate realistic confidence in the treatment process);
- **(B) Role preparation** involves 'educating the patient/client' in the therapeutic process (by using videos, socialization interviews, key questions and answers, the use of various strategies, and information about the therapist's role); and
- **(C) Collaborative goal formation** (again using the therapeutic relationship to agree on goals, assign tasks, and develop the therapist-client bond). Although the 'common factors' differ, depending on the orientation and the choice of studies, they also indicate concepts and processes that seem to work, despite the various types of psychotherapy or counselling involved.

Unfortunately, in the 1990s, the debate became overtaken by the increased emphasis – mainly from US insurance companies – on empirically supported treatments (EST) for various particular problems, emphasizing randomized controlled trials (RCT) as the – necessary – 'gold standard', and the American Psychological Association (Div. 12: Clinical Psychology) even developed 'lists' of ESTs – and also ('black') lists of what was not 'supported'; however this approach was criticized by Wampold (2001) as an over-emphasis on ESTs, and the debate reverted – more properly – back towards the significance of the Common Factors.

Summary of Early Treatment Stage Principles and Techniques Contributing to Positive Therapeutic Outcomes

(A) Fostering positive expectancies
Develop a plausible rationale or conceptual scheme for symptoms
Utilize qualities and techniques designed to enhance the therapeutic relationship (e.g., flexibility, alertness, honesty, accurate interpretation, and fostering affective expression)
Identify an explicit treatment course geared at alleviation of problems
Engender confidence in the treatment process (e.g., invoke evidence and experience for treating patient concerns)
Identify commitment to the therapeutic relationship and process Normalize patient concerns

(B) Role preparation
What is the treatment frame? (e.g., length, duration, frequency, fee)
What is the patient's role in treatment?
What activities are they suggested completing?
What types of content should they expect to focus on?
What will the therapist contribute to the process? (e.g., What is the treatment rationale for how techniques will contribute to treatment change?)

(C) Collaborative goal formation
Clarify concerns leading patients to seek treatment
Identify short-term and long-term goals
Identify goals across a range of functioning
Develop a method for assessing treatment changes over time
Regularly review progress towards treatment goals
Highlight adaptive changes
Identify areas for continued growth
Compare and contrast current and past functioning

DeFife & Hilsenroth (2011)

Table 1.

This culminated in a 'special edition' of the APA's journal: *Psychotherapy,* which attempted to: *"provide [not only] a perspective as an additional evidence-based approach for understanding how therapy works, but also as a basis for improving the quality of mental health services."*

This listed "ten things to remember" (Laska & Wampold, 2014) which were that: **(1)** Common Factors Theory (CFT) *is* imbedded in a scientific theory; **(2)** The 'mechanisms of change' in ESTs are ill-specified; **(3)** Common Factors models are not a 'closed' system; **(4)** There is no such thing as a "Common Factor" treatment – and this brings up the issue of whether a 'treatment' has any particular structure; **(5)** There are always anomalies: as a professional, you just have to

'deal with them!'; **(6)** What are the basic 'conjectures' underlying EST theory that make it seem so significant?; **(7)** Common Factors does not imply *'One Size Fits All'*; **(8)** What is omitted is just as important as what is presented; **(9)** RCTs are not the 'only' path to knowledge; and **(10)** "Different Thinks for Different Shrinks". This article, and a similar article (Laska, Gurman & Wampold, 2014) thus posit, both a refutation of the EST-model as well as a defence of the CFT-model.

So, the whole point of the "common factor theory" (CFT) is that there are some distinct 'common factors' within empirically-demonstrated or 'successful' therapies; and an examination of these 'common factors' can improve the quality of any practitioner's therapeutic practices. A sub-section of the Common Factors model includes the Recovery Model (RM) of therapeutic change (Reisner, 2005), which tries to differentiate slightly between the CFT, the ESTs and the RMs and yet find a balance between these: its conclusion is well worth reading.

Scott Miller, a pupil of Mike Lambert, presented in an excellent interview (2013), *'Why Most Therapists are Average (And How We Can Improve)'*, how he has developed – out of the Common Factors Theory – what he calls 'Solution Focused Therapy" in which he emphasizes that we, as therapists, really need to keep learning, growing, and becoming more effective with our clients by: **(a)** systematically monitoring our therapeutic outcomes; **(b)** inviting negative feedback, where appropriate; and **(c)** asking the simple question that seems often too difficult for therapists to ask: "How is 'this' [therapy] working for you?"

This involves taking a number of systematic measurements, as well as using some deep contextual knowledge in order to develop one's practice. This is not just a development from studying the Common Factors effects of psychotherapy, but it is actually a process of implementing their findings: *"The difference between the 'best' and the 'rest' is what they do before they meet a client, and what they do after they've met them, not what they're doing when they're with them."*

Daryl Chow is – another member of the International Center for Clinical Excellence – and author of (2014) *The Study of Supershrinks: Development and Deliberate Practices of Highly Effective Psychotherapists*, and his research indicates that, within their first eight years of practice, therapists with the best outcomes spend approximately more than seven times the number of hours on study and contemplation than the bottom two-thirds of clinicians engaged in these kinds of activities. One can conclude – just from this one piece of research – that 'training' itself is not enough; neither is the (usual) two years, or 150 hours (or 400 hours), of supervised practice: we – as apprentices and newly qualified practitioners – need to keep on practising and developing our professional activities and/or 'honing' our craft: we may be able to 'do' therapy, but we are not yet 'master' therapists, just 'crafts-persons' developing our 'craft' (Young & Heller, 2000).

There are – however – several critiques of the Common Factors Theory that should – in all fairness – be mentioned: **(a)** that it is tautological, untestable and therefore not subject to the same 'scientific' rules as ESTs; **(b)** that it dismisses the need for any specific or 'specialist' therapeutic

techniques; **(c)** that these 'common factors' are simply just a part of a good therapeutic relationship; and **(d)** that it relies *"on reverse engineering ... [as] it attempts to extract core therapeutic strategies by inferring and inducting them from a heterogeneous set of outcomes gathered across innumerable studies, patient groups, intervention intensities and durations"* (Baker & McFall, 2014). All these critiques are, of course, also able to be refuted (Imel & Wampold, 2008; Laska & Wampold, 2014).

The next major topic looks more at the therapist, himself and/or herself, and what they are trying to achieve: this topic can be looked at from (at least) two different directions: the effectiveness of the therapist; and the effectiveness of the change process. Patricia Coughlin (2016) claims that there are:

> Six factors … associated with brain change in adults: (1) focus and repetition; (2) creating and maintaining a collaborative alliance; (3) ensure moderate levels of anxiety – not too much, not too little; (4) facilitating multiple levels of emotional activation; (5) creating "profound moments of meeting"; and (6) developing a coherent life narrative.

She identifies these specific factors that are responsible for transformational change and she also links this process of change to extensive clinical research, and to theories of memory reconsolidation in neuroscience. Yet, this set of 'values' doesn't progress the discussion of 'What Works' very much further.

STAB – Some Therapists Are Better (than others) and Some Therapies Are Better (for some things)

'Therapeutic effectiveness' is a term whose definition is also debatable. A patient can achieve simple symptom relief, possibly without addressing any of their underlying issues: the charismatic spiritual healer may be instantly effective, and the person seems 'healed' – of their symptoms, but then the underlying issues may surface again later, and these can take longer to process and we don't hear so much about these somewhat 'un-glamourous' aspects. Sometimes, addressing those underlying issues is a much longer, more painful and challenging course, but this can ultimately result in a more meaningful conclusion. By which definition would either of those outcomes be considered as 'effective'?

The concept of therapeutic effectiveness (which uses the unfortunate acronym, 'STAB') is contentious, and yet research also indicates that there is something 'there', as well. Published by the APA Education Directorate, Bruce Wampold's short paper (2011), *The Qualities and Actions of An Effective Therapist*, was supposed to give a definitive answer, unfortunately it provoked quite a lot of controversy as well.

According to Wampold, there are 14 characteristics of qualities and actions that help to identify effective therapists: **(1)** Effective therapists have a sophisticated set of interpersonal skills including: verbal fluency; interpersonal perception; affective modulation and expressiveness;

warmth and acceptance; empathy; and a focus on the other person; **(2)** Clients of effective therapists feel understood, trust the therapist, and believe the therapist can help him or her; **(3)** Effective therapists are able to form a working alliance with a broad range of clients; **(4)** Effective therapists provide an acceptable and adaptive explanation for the client's distress; **(5)** The effective therapist provides a treatment plan that is consistent with the explanation provided to the client; **(6)** The effective therapist is influential, persuasive, and convincing; **(7)** The effective therapist continually monitors their client's progress in an authentic way; **(8)** The effective therapist is flexible and will adjust the therapy if resistance to the treatment is apparent, or if the client is not making adequate progress; **(9)** The effective therapist does not avoid difficult material in therapy and uses such difficulties therapeutically; **(10)** The effective therapist communicates hope and optimism; **(11)** Effective therapists are aware of the client's characteristics and context; **(12)** The effective therapist is aware of his or her own psychological process and does not inject his or her own material into the therapy process, unless such actions are deliberate and [likely to be] therapeutic; **(13)** The effective therapist is aware of the best research evidence related to the particular client, in terms of treatment, problems, social context, and so forth; and **(14)** The effective therapist continually seeks to improve him- or her-self

However, Whitbourne (2011) 'dumbed down' (somewhat plagiaristically) these to 13 characteristics, and Gladding (2015), in a presentation at a conference in Singapore, identifies just 8 **'H'** characteristics for effective counsellors: (i) '**H**eart' (feelings, affect); (ii) '**H**ead' (quick thinking, observing, listening); (iii) '**H**urt' (that has been healed or resolved); (iv) '**H**olistic' (seeing another person in their entirety); (v) '**H**ope' (optimism, life can be better); (vi) '**H**old' (insight, tongue, advice: be patient); (vii) '**H**umanity' (a genuine love for people; altruism, selfishness); and (viii) '**H**umour' (an ability to see the absurd, the lighter side of life). I am sure that there are many other such presentations (with or without the alliteration) that are also based on some sort of research findings – so, maybe you can find something of what you are looking for!

When we consider the other main aspects of 'STAB', i.e. that Some Treatments (or therapies) Are Better … for some things, we find an even greater controversy and many differences of opinion. There is absolutely no "One Size Fits All", especially if you take the most common reason for going into therapy: mild to moderate depression; mild to moderate anxieties; different life stresses; bereavements; relationship difficulties; work stress and/or an imbalance in the 'Work', 'Home' and 'Self' triune; etc.

For some people, anti-depressants are – essentially – a "life-saver"; for others, an anathema; and for others (probably about 60%), a combination of SSRIs and counselling **actually works best**. My 'therapeutic analogy' – that SSRIs are a bit like life-jackets (as they stop you from drowning, but they don't get you out of the water) – often provokes a positive response from clients. There is some hope that people with recurrent episodes of depression, or heightened levels of anxiety, might

need some psycho-pharmacological help in order to be able to stabilise, so as to look at and start to resolve, their deeper psychological issues.

In addition to this level of pragmatism, there was a fairly definitive statement from the APA (2012) on the 'Recognition of Psychotherapy Effectiveness':

> These large effects of psychotherapy are quite constant across most diagnostic conditions, with variations being more influenced by general severity than by particular diagnoses—That is, variations in outcome are more heavily influenced by patient characteristics e.g., chronicity, complexity, social support, and intensity—and by clinician and context factors—than by particular diagnoses or specific treatment "brands".
> … the results of psychotherapy tend to last longer and be less likely to require additional treatment courses than psychopharmacological treatments.
> … for most psychological disorders, the evidence from rigorous clinical research studies has shown that a variety of psychotherapies are effective with children, adults, and older adults. Generally, these studies show what experts in the field consider large beneficial effects for psychotherapy (in comparison to no treatment), confirming the efficacy of psychotherapy across diverse conditions and settings.
> … comparisons of different forms of psychotherapy most often result in relatively non-significant difference, and contextual and relationship factors often mediate or moderate outcomes. These findings suggest that: (1) most valid and structured psychotherapies are roughly equivalent in effectiveness; and (2) patient and therapist characteristics, which are not usually captured by a patient's diagnosis or by the therapist's use of a specific psychotherapy, affect the results.
> … in studies measuring psychotherapy effectiveness, clients often report the benefits of treatment not only endure but continue to improve following therapy completion as seen in larger effect sizes found at follow-up.
> … the research evidence shows that psychotherapy is an effective treatment, with most clients/patients who are experiencing such conditions as depression and anxiety disorders attaining or returning to a level of functioning, after a relatively short course of treatment, that is typical of well-functioning individuals in the general population.

However, it has also been shown that some therapies are (in fact) better than others – for some things: e.g. 'CBT' is (apparently) better than 'psychoanalysis' for … (say) bulimic eating disorders (Poulson *et al.*, 2014); and there are many such 'comparative' research studies, setting one therapy against another.

At this point, we probably need to mention something about the distinction between research on the ***efficacy*** of psychotherapies (which tries to maintain the internal validity of studies, by keeping conditions – like random assignments, control conditions, therapists' training, and vetting participants – as similar as possible) and research on the ***effectiveness*** of psychotherapies (which tries to maintain the external validity of different studies, by locating the treatment studies in similar clinics, for example, or whether the beneficial effects are sustained). Ideally, both apply.

> Data from both efficacy and effectiveness studies are key to a full understanding of the potential impact of a treatment. Once a treatment has been shown to be efficacious through multiple replications, the next step is to determine how well the treatment works in typical clinical practice. Evidence demonstrating that treatments evaluated under highly controlled research conditions (i.e., efficacy studies) can have a comparable clinical impact when delivered in regular clinical settings (i.e., effectiveness studies) provides essential support for the routine clinical use of such treatments. (Hunsley, Elliot & Therrien, 2013, p. 5)

Again and again, several different therapies (or 'treatments') seem to be 'better' than various others for certain disorders, and – in certain cases – a combination of medication and psychological therapy seems to be more effective and/or efficacious than just one or the other. The above study compared both 'efficacy' studies and 'effectiveness' studies for: depression, bipolar disorder, generalized anxiety disorder, social anxiety disorder, obsessive compulsive disorder, post-traumatic stress disorder, specific phobias, panic disorder, as well as coronary heart disease.

Somewhat less interesting in this respect is the fourth edition of a fairly definitive tome that calls itself, *A Guide to Treatments that Work*, (Nathan & Gorman, 2015). This considers a mass of research: outcome data and clinical trials, on both psychological and pharmaceutical treatments – again condition by condition – and this volume uses various different parameters in order to ascertain their efficacy and effectiveness. Unfortunately, this is not much use to an individual psychotherapist, as … it is very weighty, quite limited in its approach, and very oriented towards the 'medical model' (Young, 2017):

> "Another … reviewer states that, in their opinion, the biggest problem facing psychotherapy is that by far the biggest determinant of the effectiveness of any psychological treatment is how the treatment is delivered and not which treatment is delivered, and I am afraid that I have to concur – and most outcome research also points that way as well: that it is the therapist-client relationship that works, not the manualised treatment." (p. 67)

This concludes the section of this article on '**S**ome' '**T**herapies' (or '**T**herapists') **A**re **B**etter (STAB) than others.

WOOP-ing along successfully!

Another fairly pragmatic technique that seems to be quite successful in many different domains – interpersonal, academic, health, professional, etc. – which used to be called 'Mental Contrasting with Implementation Intentions (MCII) and that has been reasonably well-researched (Oettingen, 2015; Oettingen *et al.*, 2015), has now been given the unfortunate acronym, 'WOOP': standing for 'Wish – Outcome – Obstacle – Plan'.

Health professionals who are trying to help people to make effective changes in their lives might be interested to know the basics of this approach. To read the various literature makes this 'technique' (or approach) sound a little bit like a magic bullet: but – apparently – it just helps to identify some of the various issues involved along the way – these are: '**W**ish' (where the person identifies where they want to go, or how they want to be); the perceived present reality and thus the beginnings of the pathway to the desired … '**O**utcome'; and there is then the … '**O**pportunity' to clarify – and improve – one's perceptions and expectations, especially about overcoming any … '**O**bstacles' in the way; and then that leads – apparently – to the '**P**lan'! Were it just this easy!

There are many similar techniques (and acronyms) that abound in corporate management and motivational trainings, so it is not particularly surprising to see something like this finding its way into the field of psychology and psychotherapy. What is quite interesting – and possibly pertinent – is that Gabrielle Oettingen – the proponent of this theory – is a Professor of Psychology at New York University, as well as at the University of Hamburg, and that she also works with colleagues in the Department of Management in the prestigious London School of Economics. This is therefore a – potentially – practical – pragmatic tool, coming from both these disciplines, and hence this – perhaps – adds to its appeal.

The Great Divide

However, as one investigates further into the arena of 'What Works' (and what doesn't) in psychotherapy and counselling, one becomes more and more aware of a 'Grand Canyon' or a 'Great Divide' that exists between the academic researchers – on the one side – and the clinical practitioners – on the other. This "Great Divide" (as it is known: Stiefel *et al.*, 2014) is between two quite different realities: the so-called 'evidence-based practice' (EB) and 'clinical practice' (CP).

> [The negative reactions to EB] … are indicating that the people who use this word have no idea of the real-life issues [that] a busy … therapist encounters! What do these clean, artificial, randomly controlled trials with placebos tell us about the messiness only we as therapists see? *Nothing!* Such trials feel like rhetoric; bureaucratic exercises that don't add anything of importance. Further, they ignore context, they don't reflect multiple issues, they are not reproducible in our consulting rooms, and they reflect first-order, out-dated practices in both therapy and research. (Ibid, p. 49)

So, there are four basic types of 'evidence' implicit here: **(1) High-quality scientific research**, which is replicable and which can provide: *"practice advice and guidelines on the most effective ways of diagnosing and treating problems of a similar nature in carefully selected groups of people who meet certain criteria"* (Ibid) – essentially a controlled trial. Unfortunately, this is almost impossible to achieve, replicate or work with for most clinicians; **(2) Multiple-source information**, which goes towards producing more (hopefully better) general practice guidelines and protocols, assisting *"health care agencies to discharge their responsibilities in cost-effective ways and manage their liabilities …"* (Ibid) – but who decides? Are these people researchers, managers, or clinicians?; **(3) Practical clinical experience** – built up and improved on through supervision, honest self-examination and informed by reading and research – where there is little or no contact with any type of informative research; and **(4) 'Evidence' stemming from client feedback and outcome research** (Williams, 1999, 2002), which would then have to be co-ordinated and studied.

These four categories are quite broad and somewhat overlapping, and they are also fundamentally different, and yet they also complement and contend with each other. Much of science and research – especially in the field of psychology ('study' of the *psyche*) – falls into the first two categories; yet the people doing 'hands-on' therapy (*therapia* – 'healing'), who are

working every day in the field of psychotherapy & counselling, have a totally different set of experiences, and also a very different 'evidence-base'. We all have to decide which – and which combinations – actually work – both for us and for our clients. This brings us to a whole area of 'critique' (a word that I prefer to 'critical') within the field of psychotherapy and counselling.

What Works for Whom? A critical view of psychotherapy research, was the title of a (1996) book by Anthony Roth and Peter Fonagy (of University College, London): a second edition came out in 2006. This was one of the first of many attempts to enter into – and sort out – the (almost deliberately created) confusion of what (actually) is 'evidenced-based practice' (EB), which has been so controlled – for research purposes – that it is now largely irrelevant to everyday clinical practice (CP). The authors were very mindful of this gulf between research conditions and clinical therapy in the real world: *"The challenge is to achieve practice that is rooted in empirical findings, but not circumscribed by them."*

However, what we want (and desperately need) is to discover the ways that these "two houses divided" [3] can come together – and complement (rather than contradict) each other. There is a recent movement, on both sides of the Atlantic, towards establishing Clinical Practitioners Research Networks (CPRN) or Practice-based Research Networks (PBRN): both 'official' (like the UK's National Institute for Health Research: Clinical Research Network, Mental Health [4] and the US Department of Health & Human Sciences' Agency for Healthcare Research and Quality [5]) and there are also many more 'unofficial' collaborations between (say) universities and professional associations that are collecting therapeutic outcome and feedback studies in primary care and community settings. These are largely un-coordinated.

However, these latter groupings face a number of fundamental challenges – including a basic lack of funding; furthermore, such 'practitioner networks' must also: (**a)** make greater use of relevant health information technology in order to solicit the involvement of their involved clinicians; **(b)** identify and recruit potential participants (clinicians) – probably through the professional associations – that can be significantly involved in such 'practitioner-based' research. They may have to offer incentives, such as CPD credits; and **(c)** disseminate their key findings in a meaningful way to those who matter.

Unfortunately, this probably involves a lot of extra work for already over-burdened individual health professionals (Calmbach *et al.*, 2012). This therefore suggests that the various national and European-wide 'professional associations' within psychotherapy and counselling probably should be — could be doing a whole lot more to stimulate such 'practitioner networks' and also significantly 'invest' much more in education for, and involvement of, their current and potentially future members in clinical / practitioner-based research. This could then become a reasonably effective 'cutting-edge' strategy, which would still need a lot of hard work – and resources – to implement.

Critical Psychotherapy & Counselling

All of these idealistic dreams and ideations then lead us into a different arena that is commonly known as **'Critical'** Psychotherapy and Counselling. In June 2015, at the Anna Freud Centre in London, there was a one-day conference or 'event'. Speakers from several different countries, and different theoretical perspectives, addressed questions about the provision of the so-called 'talking therapies' in contemporary society, and how therapeutic practice is being affected – or not. They addressed various questions like:

- Is it important for psychotherapy & counselling to be 'critical', socially engaged, and/or even political?
- Do psychotherapists & counsellors do a disservice to their clients by not challenging present professional parameters?
- Do current psychotherapy & counselling trainings actually discourage critical thought and free-thinking, or are they just churning out 'clones'?
- Do present professional parameters promote an other-worldly sense of (or divide between) psychotherapy and the patient/client's 'inner world'?
- What models of 'mental illness' and (especially) 'mental health' are appropriate for psychotherapy and counselling in the 21st century?

These are all fairly fundamental questions – and will all probably need to be answered at some point in time. A previous (2014) conference, *The Limbus Critical Psychotherapy Conference:* – "Challenging Cognitive Behavioural Therapies: The Overselling of CBT's evidence-base" – has a post-conference website with download-able papers [6].

I would like to posit that – as a profession, or as an area of health provision – we probably need much more of this sort of critique from this sort of perspective – instead of being inundated with 'research studies' that 'prove' the efficacy or effectiveness of this method, or that modality; or professional associations offering seminars and conferences that – to an extent – 'preach to the converted'.

There is also much more about 'critical' psychotherapy out there - if you really want to find it. Yet, I am also not yet quite sure how useful the answers may be – to some of the legitimate questions that have been raised – for us, as clinical practitioners. So, what can we do differently, and what might the effects be of some of these 'answers'? It is difficult for individuals to redefine structural parameters, or to 'think outside the box'. It is also quite difficult – using different metaphors – to change canoes in mid-stream, or to fix the car whilst driving along the motorway. I think that we ('clinicians' – psychotherapists, psychologists, counsellors and other 'therapists') all need to develop more of a 'critical' attitude to what is "out there"; to what we have "been told"; and to what we are actually doing. This means, therefore, to engage with, and interact with, the various relevant professional 'dialogues' - via professional journals, conferences, seminars, webinars, CPD

events, committees, etc. in our own professional 'arenas', as well as on websites for similar professionals, like: Linked-In, ResearchGate, Academia.edu, etc.

Another spin-off of this Critical Therapy 'movement' is the increasingly pertinent question of: not only, *What is 'Real Therapy'?*, but what do 'real' therapists 'really' need to be doing. Apparently, there seems to be an increasing number of 'threats' to 'real therapy' (see Slaney, 2015) coming from:

* Governmental 'initiatives' like IAPT [7]; and recently employment 'therapists' (or similar) being placed in Job Centres with the sole intention of getting people back to work, irrespective of (or despite) any of their emotional or 'psychological' difficulties;
* The current volunteering system for trainees (in order to gain experience) and the 'intern' system for new graduates (ditto), which extends into a sort of exploitation of the innocent and a 'brain-washing' of the creative;
* The increasing state 'regulation' of the professions of psychotherapy & counselling, which may (or may not) develop into a 'decision-making' process about who can work and who cannot work, and with whom, and for how long, and for how much, etc.;
* Professional associations in psychotherapy and counselling who may be 'ducking' the quite serious social issues of 'diversity' and 'inequality', 'post-code lottery', and 'age-ism', etc. – despite the increasingly strong evidence that wider issues like: 'poverty', 'ethnic minorities', the demographics of numbers of therapists from similar cultures, and 'age differences' can all impact significantly on the state of mental health;
* Professional associations not being sure of their role: what 'costs' and what 'benefits' are they offering? Members have to pay, but what do they get in return? In a de-regulated country, this means there is no way of knowing, checking or controlling what is happening in the provision of 'good' mental health services;
* Professional associations being relatively 'blind' to the whole 'construct' of 'who judges whom' and 'who supports whom', especially concerning any accusations of unethical behaviour and /or unprofessional conduct against a member of such an association – professional practitioners are encouraged (or required) to be a member, are supposed to receive support … from the very people who are going to adjudicate the accusation;
* The people (probably clients) who make the complaints need much more support, access to resources, and understanding some of the issues involved. Organisations that support clients (people) who make complaints are not well funded and not well-known, so clients are more inclined to succumb to "no-win, no-cost" lawyers, who just escalate the whole complaint and liability process. The frameworks around provision of legal aid have been dramatically constrained and reduced.
* In addition, most of the smaller professional associations, employers, etc. do not have a very good idea of what "due and proper process" is when 'investigating' or 'adjudicating' complaints against their members – according to national and international professional standards. Some of these problems can be resolved by having a more centralised complaints or universal across-the-board process.
* There is often an dissonance within psychotherapy and counselling to the pragmatic impact of political, social or financial (austerity) programmes on individuals and communities, and the 'blind-spots' about the actually significant levels of psychological and social damage that some of these 'social', 'political' and/or 'financial' policies can incur. We, the professionals, are just left to, or have to, 'pick up the pieces'.
* The impact of innovative (quick fix?) therapies that deliberately question some of the traditional ideas of expertise and containment, and – instead – produce 'quick-fix solutions' (often with acronyms) that supposedly 'cure' several conditions in just a few sessions (the

modern version of "snake-oil". It is often difficult (if not professionally unethical to 'critique' another professional's practice.

* The unacknowledged extent of bullying, harassment and intimidation that is frequently found in a surprising number of both training and service organisations within the field of psychotherapy and counselling.
* The 'rigidity' of modality-based professional associations, training institutes, practitioner groups, etc. that can – all too easily – stifle innovation; require compliance to 'The Method'; not rock the boat; decry anything outside of the 'norm'; etc. – in order to 'stay safe'; maintain respectability; achieve political goals, rather than support practice-based development; etc.

I have tried not to give any specific examples as the 'mental health' care system is incredibly diverse, and what works for one person may not work for another and may also not be researched, scrutinised, proved or approved in any way. These sorts of issues can all be categorised into "What Doesn't Work" – or, at least, "What doesn't work very well". If 'ordinary' psychotherapists and counsellors, who are trying to work within such confinements and limitations, can ask – "What Works For Whom"; then this is – perhaps – a very legitimate question: or rather the question is – "What is supposed to work (and doesn't seem to) … for Them".

It is therefore the role, the duty, perhaps even the responsibility, of the various professional associations and training organisations in psychotherapy and counselling to establish – properly – the efficacy of their particular methods and modalities – especially when dealing with the various 'conditions' and 'issues' that the clients actually bring; and also to ensure that their trainees and member practitioners have the 'proper' tools and resources to deal with the reality of the situations that they are going to 'face' – out there!

This brings us to a final 'critique', which is almost unanswerable. The modern, urban Westernised 'human' animal was just not 'designed' (or did not evolve) to cope with the pressures and stresses of 21st century modern society. There is a conspiracy of (relative) silence about the Western (protestant) "work ethic", which tends to denigrates any time spent on looking after one's Self. It is not 'just' about a see-saw of a 'Work-Life' balance: there is, instead, a 'Work–Home–Self' (triangular tripod) model, with the 'Self' getting very short shrift: "There is no time to stand and stare" **[8]**.

Work responsibilities are ever-increasing and companies pay lip-service to the welfare of their employees, until something cracks or breaks down; and then they pass the 'problem' employee who is having difficulties onto the Employee Assistance Providers (EAP) companies, without properly acknowledging that many of the problems come from (other) people in the company being 'promoted to the level of their incompetence' (the Peter Principle); poor training of middle management; or ignorance of the factors behind employee stress (poor work stress risk assessment procedures) are probably more at fault. This takes us into the second part of this extended article.

Please note: *Books and Article references and Endnotes are given at the end of the 2nd article.*

What Works in Psychotherapy & Counselling: Part 2

COURTENAY YOUNG

Abstract
This is an extended article (in two parts) that was developed from an original PowerPoint presentation, first given at the Strathclyde University to a gathering of counsellors in Sept. 2015. It focuses on 'What Works' in Psychotherapy and Counselling - and therefore also, by default, what doesn't seem to work. It is contemporary, as well as being both researched and also very pragmatic.
Key Words: Psychotherapy, Counselling, Efficacy, Effectiveness, Pragmatism, Contra-indications.

Social, Cultural, Political and Historical Issues

In a 2015 letter [9] in *The Guardian*, 442 psychotherapists, counsellors and academics wrote condemning the UK Conservative government plans, as their 'proposed' 2015 budget included plans to provide online cognitive behavioural therapy to 40,000 claimants (for employment and/or support and/or jobseeker's allowance, as well as people on the Fit for Work programme), and to put minimally-trained IAPT therapists in more than 350 Jobcentres. This plan was originally proposed by a Labour economist, who had been advising the newly opened-up Russian government, so it has little to do with better mental health. [10]

Counsellors and psychotherapists in both the public and private sectors would therefore find themselves 'at the coal-face', responding to the effects of the current 'austerity politics' on the emotional state of the nation. The previous years (2007-2015) had already seen a radical shift in the kinds of issues that generated distress in clients coming into therapy: increasing inequality and outright poverty; families forced to move against their wishes; and – perhaps most importantly – benefits claimants (including disabled and ill people and those seeking work) being subjected to quite new and intimidating kinds of disciplinary regimes: being coerced into having "Get Back to Work" 'therapy' is manifestly not therapy at all … it is actually damaging and possibly even professionally unethical. Yet, it is also governmentally-sponsored: so … *"Where is the debate?'*

Private psychotherapists and counsellors, rather than health-service therapists, probably see slightly less impacts of these social pressures, as such 'benefit-claimants' cannot usually afford to pay for therapy, yet these people may be (or are) those who are the most in need.

Similar strictures often apply to therapy work with asylum seekers, refugees, economic migrants, and illegal immigrants: these people have often been severely traumatised as well, both in their country-of-origin, and also (possibly) by the rigours of the journey to relative 'safety' itself. They are then confronted with potentially hostile immigration officials, etc. They therefore need a special 'type' of therapy and (often) from someone who is familiar with their issues and who is

conversant with their culture and language of origin. These combinations are very rarely found and this type of therapy work is also quite 'telling' on the therapist, as well (Azar, 2006).

Transgenerational Trauma & PTSD

From this point, we can move on – albeit briefly – into the whole and very difficult (yet not so different) field of trans-generational trauma and how, who, and when, one can work with this topic.

Most of the work in this field was done originally with Holocaust survivors and their children (Erlich, 2002; Fromm, 2012; Connolly, 2011; Braga *et al.*, 2012) and there are now many such programmes [11]. There are more than enough instances of transgenerational trauma (Coyle, 2014), and it is difficult to know how to work with such cases unless one has received some specific specialist training, probably post-graduate or post-training. [12]

Psychotherapists and counsellors have historically been quite reticent in looking at some of these bigger cultural issues: as mentioned, Freud did not want to look at the possibility of familial sexual abuse; in the 1930s, the German and Austrian analysts (bar one: Wilhelm Reich (1933)) did not want to threaten their new-found status by taking-on the psychopathological issues of Fascism; many did not know how to work with survivors of the Holocaust, and many survivors did not consider using psychotherapy to try to heal their trauma; in the 1970s and 1980s, it took psychotherapists, counsellors and social workers quite a long time to realise the enormity of the problems around childhood sexual abuse, even to the point of becoming over-enthusiastic and creating (possible) 'false memory' syndromes. Equally, there are many cultural 'norms' – as well as psychological inhibitions – that prevent people in need from seeking psychotherapy or counselling (Mojaverian *et al.*, 2012; Sheikh & Furnham, 2000; Vogel *et al.*, 2007).

Trauma is an increasingly common experience – either from a single event, or from an accumulation of difficult experiences – and is (rather) an emotional response to a very difficult experience. With regards to what is now called 'Post-Traumatic Stress Disorder' (PTSD), even though it was described by Herodotus in 500 BCE, and even after the pioneering work of W.H.R. Rivers had identified 'shell shock' in WWI soldiers, it was not really until the needs / demands of the Vietnam War veterans, 50 years later, that 'post-traumatic stress' became properly identified and therapists began to find ways to work with this 'syndrome' quite successfully.

Even so, it is becoming clear that PTSD is often very 'embodied', and therefore any 'treatment' should be (or needs to be) 'body-oriented' (Levine, 1997, 2008; Rothschild, 2000; van der Kolk, 2015; Ogden *et al.*, 2006). Other, less specific, techniques, such as combinations of guided imagery, soft-belly breathing, drawing exercises, shaking & dancing,[13] are also claimed to be reasonably effective.

There are other reasonably effective techniques that can also be utilised – with skill and experience, and if seen as appropriate – such as: **(a)** removing the association between the original

sensory event and its metadata (emotions & meanings); **(b)** altering the 'sequence' of trauma and deconstructing the sensory memory; **(c)** altering the sensory memory of the trauma; **(d)** changing the 'meaning' of the experience, etc. [14]

Even though somewhat extravagant claims are also made for several other techniques that are supposed to resolve many different sorts of trauma, (such as EMDR), the evidence-base is still quite controversial and a debate persists as to whether the aspects of such novel 'eye movement' elements are actually an active ingredient in improved patient outcomes, but there is no real 'evidence' as to **how** or **why** such techniques might work.

There is now a massive amount of work being produced on working with trauma, much from a body-oriented perspective, like: Peter Levine's 'Somatic Experiencing'; Jack Cornfield's 'RAIN'; Daniel Stern's 'SIFTing'; 'Eriksonian' hypnotherapy; Bessel van der Kolk's *'The Body Keeps the Score'*; Babette Rothschild's *'The Body Remembers'* & *'Trauma Essentials'*; Steven Porges' *'Polyvagal System'*; etc. But there is not much point in examining anything much further in these areas, as I want to get back to the main theme: What Actually Works!

Mindfulness Practice

One of the new phenomena in counselling & psychotherapy is the recent introduction of various forms of 'mindfulness' practice, which have been shown to be reasonably efficacious and effective – particularly for mild-to-moderate anxiety & depression. There are several different forms of mindfulness practice (body scan meditation; movement meditation; breathing space meditation; expanding awareness meditation; etc.) – and no one particular form seems to be better than any other (Alidina & Marshall, 2013). Certainly, since anxiety is mostly about what might happen next (and the consequences of what has just happened), the focussing on what you are both experiencing and feeling in this present moment creates an anxious-free space, and the practice of reconnecting with your body and feelings can also create a sense of peace and calm, possibly enhanced by greater insight, less digestive problems, better sleep, etc.

Mindfulness is also a 2,500-year old Buddhist practice, with a whole ethical system (right way of living) embedded into it (Hahn, 2008). Essentially, both forms are the practice of focussed self-awareness – of one's full (embodied & feeling) 'Self' – in the present moment (Bishop *et al.*, 2004). And it seems to work reasonably well for both therapist and client (Carmody & Baer, 2008; Davis & Hayes, 2011). However, there are also some criticisms that the type of mindfulness practice that is being touted as the 'technique of the month' is in reality a very 'lite' form of the proper (and much deeper) Buddhist meditational practice.

> Does the contemporary notion of mindfulness have the same meaning as it does in the Buddhist Vipassana meditation I learned so long ago? It seems apparent from an examination of the mindfulness approaches, it does not. … The Buddhist approach to mindfulness is founded upon personal practice of meditation – not intellectual

> knowledge. When researchers and clinicians attempt to use the concepts without the foundation of personal practice, there are bound to be problems with their work. (Hendlin, 2016, pp. 36-37)

However, there is little doubt from both researchers and clinicians – as well as feedback from the clients – that the use of mindfulness in psychotherapy is both efficacious and effective, as well as being helpful. I find that a very good book that is often useful for clients who are starting out in mindfulness is Thich Naht Hahn's (1991) little book, *Peace is Every Step.*

Why & How Therapy Works

We have been considering 'what' works in therapy, but we also might want to consider very briefly 'why' and 'how' therapy works: so, this is just one perspective derived from neuroscience.

> The story of why psychotherapy works begins with the brain. We must understand how it evolved to learn, unlearn, and relearn. We have to understand the power of human relationships to regulate anxiety and stimulate learning, and that the way we interact with the world physically, emotionally, psychologically, and spiritually, has been woven into our social brains. Finally, we must understand the role of stories and our ability to edit our own stories to change the patterns of our lives for the better. (Cozolino, 2015)

Actually, Cozolino (2015) as well as other neuroscientists, are now able to inform us not only 'why' psychotherapy works, but we are also discovering much more about 'how' it works. It is not just a matter of: *"expressing the unexpressed, making the unconscious conscious and integrating thoughts and feelings."* … because … *"Language serves the integration of neural networks of emotion and cognition that supports emotional regulation and attachment. Putting feelings into words and constructing narratives of our experience make an invaluable contribution to a coherent sense of self.* (Ibid, p. 14).

We can therefore start to use techniques and interventions that assist this undoing process and re-doing, unlearning and re-learning, and the de-programming of the trauma process and hyper-alert response. Cozolino also describes how ancient physiological responses, when confronted with high states of internal arousal, actually shut down the brain areas for expressive speech (i.e. we become 'tongue-tied' when talking to the boss; or 'speechless' with terror), in the same way that adrenaline (the main stress hormone) shuts down our digestive system (as you don't want to be digesting your own lunch when under the threat of becoming something else's lunch). Whilst this may have been a really good primitive survival technique for our precursors in the African bush, our subsequent developments in language mean that this can now become a difficulty. As therapists, we cannot challenge the client's 'hyper-arousal' or their 'shut-down' into silence' – as that may tip the balance and the client may flee. We need to accept their inhibitions and allow their arousal to calm down, back into what Pat Ogden (Ogden *et al.,* 2006) calls the "comfort zone",

when the client relaxes a little and then can speak again (usually about the trauma), before we can continue with the 'talking therapy'. There has to be a 'dance' between therapist and client, and also a dance between arousal and relaxation within the client, that the therapist needs to be exquisitely aware of and work with this, rather than against it.

Porges (2009, 2011), Wagner (2016) and Dana (2018) all describe, quite effectively, how different 'systems' within the body can be affected by states of arousal and also about how to work with these effectively. Porges' [Polyvagal] theory specifies the functioning of two distinct branches of the vagus (or tenth cranial) nerve: this is a significant part (longest nerve) of the sympathetic half of the ANS and also forms part of the motor aspects of the parasympathetic part of the autonomic nervous system. These two branches of the vagal nerve serve different evolutionary stress responses in mammals: the more primitive branch elicits immobilization (e.g., the 'freeze' response, or 'feigning' death), whereas the more evolved branch is linked to social communication and self-soothing behaviours. These functions follow a phylogenetic hierarchy, where the most primitive systems are activated only when the more evolved functions fail. These neural pathways regulate autonomic states and the expression of emotional and social behaviour. Thus, according to this theory, one's physiological state dictates the range of behaviours and psychological experience.

The Polyvagal theory has many implications for the study of stress, emotion, and social behaviour, which has traditionally utilized more peripheral indices of arousal, such as heart rate and cortisol level. The measurement of vagal tonus in humans has become a novel index of stress vulnerability and reactivity in many studies of populations with affective disorders, such as children with behavioural problems, and even those suffering from borderline personality disorder.

However, what health professionals often overlook is that 'anxiety' and/or 'depression' are not necessary "illnesses". In (perhaps) 95% of clients/patients who present with anxiety and/or depression, these are **"symptoms"** of almost over-whelming life stress. There is actually nothing 'wrong' with the person; and they have not done anything 'wrong'. What has happened it that this 'wrong' (stressful) thing happened; and then that; and then this; and so on. When this is put to a client, they almost immediately: **(a)** agree and are able to identify the 'this' and 'that' and all the 'other' stressful life events; and **(b)** they experience a massive sense of relief.

This is – of course – the pragmatic application of Holmes & Rahe's (1967) research. They demonstrated that an accumulation of different stressful life events within a relatively short period (2 years) was a fairly reliable predicator of illness: often mental health issues, as well as psychosomatic symptoms. Working from the patient/client's 'lived experience' is – of course – much more effective than a 'label' or a 'diagnosis', as the 'problem is more accurately identified and then a variety of appropriate psychotherapeutic techniques can be applied – hopefully more successfully than 'just' medication and/or a step-by-step therapy.

The physiological component – an overload of the stress reaction system ('fight-flight-fright'), the sympathetic half of the person's autonomic nervous system (ANS) – then impacts on a person's natural ANS 'balance' which – for most animals – is in a ratio of about 1:5 (level of Sympathetic to Parasympathetic activity); however, the human 'animal' (especially in Western countries) is operating on a (something like) 5:1 ratio: the wrong way round, so that we are about 25 times more stressed than any other animal on the planet, which puts us very close to the 'edge' of our evolutionary potential (Young, 2008). We can see what happens to other species when they get ober-stressed, but we can't seem to see this in ourselves.

Another significant part of these physiological interactions is the stimulation of a number of chemical (peptide) receptors – peptides are single molecules made up of strings of amino acids, arranged rather like beads on a necklace. About 85-95% of the neuropeptide receptors are found in the emotional centres of the brain's limbic system.

> Emotional states or moods are produced by the various neuropeptide ligands, and what we experience as an emotion or a feeling is also a mechanism for activating a particular neuronal circuit—simultaneously throughout the brain and body—which generates a behavior. (Pert, 1997, p. 201).

Pert believes that there is probably one kind of peptide (and there are about 660 'peptides') for each possible emotion: just as endorphins are the mechanisms for bliss, and oxytocin is a part of the hormonal mechanism for bonding, as well as breast-feeding (Moberg, 2003). Emotional states or moods are therefore also produced by the various neuropeptides, and what we experience as an emotion or a feeling is also a chemical mechanism for activating a particular neuronal circuit—simultaneously throughout the brain and body – which then generates a particular behaviour. Endorphins, a group of opioid hormones that produce an analgesic effect, are quite well-known. Oxytocin is the hormone involved in bonding, sex, childbirth, and breast-feeding, as well as in relaxation and feelings of calm. It is the virtual mirror image of the stress hormone (adrenaline / epinephrine), which triggers the "fight or flight" systems in the body. New research findings, as well as the potentially beneficial applications of this hormone in reducing anxiety states, stress, addictions, and problems of childbirth, are not only fascinating, but of great significance to all our lives – and especially to our work as therapists. We can thus – potentially – influence what happens in the client's body in various ways: e.g. by visualising an increased flow of blood into a body part to increase the flow of nutrients to that area; or using some form of therapeutic massage, or encouraging self-massage by the client in certain ways that can help stabilise the client's emotions.

All this indicates that a 'good' therapist needs – not only to have a considerable level of knowledge – but also a considerable level of 'skill', in order to be aware of these somewhat more subtle aspects of the client's physiology, as well as their psychology, during the continually moving moments of a therapy session. Psychotherapy is therefore much more perhaps of a craft, than an

academic science (Young & Heller, 2000) – and these skills need to be developed and 'honed' to a fine degree through: professional practice; good line-management & supervision; proper & individual 'outcome' monitoring & research; a 'required' level of continuing professional development (CPD); regular re-accreditation; and a culture of 'life-long learning'.

Feedback Informed Treatment (FIT)

Scott Miller (see above) and others set up the 'International Center for Clinical Excellence' (ICCE) to discover 'What Works in Therapy'. Their manual consists of a guide (in six parts) covering the most important information for practitioners and agencies implementing FIT. This is a pan-theoretical approach for evaluating and improving the quality and effectiveness of behavioural health services. It involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery. It also involves the integration of the best available research … and monitoring of patient progress (and of changes in the patient's circumstances – e.g. job, loss, major illness) that may suggest the need to adjust the type or course of treatment (APA, 2006).

1. Significant Research Findings in Behavioural Health Outcomes: They look first at Behavioural Health Outcomes, which includes: **(a)** the average treated person is better off than 80% of those without the benefit of treatment; **(b)** psychotherapy is cost-effective; **(c)** therapy works largely because of general factors that are expressed in variable proportions through the interactions between clinicians and consumers; **(d)** there are 'client / extra-therapeutic factors', which account for about 80-87% of the variability in scores between treated and untreated clients; and then **(e)** a much smaller proportion of therapeutic factors that include: 'treatment effects' which represent a broad class of factors that are considered relevant to the influence of treatment. It is estimated that 'treatment' in total only contributes about 13-20% to the overall outcome: these include alliance effects (5-8%); model/technique effects (1%); expectancy, placebo and allegiance effects (4%); and therapist effects (4-9%).

The next two areas that form the foundation of what works in therapy are: **(A)** evidence of the role of routine and on-going client feedback in improving outcomes; and **(B)** predictors of outcome. Each area is central not only to improving outcomes, but also in elevating consumer confidence, ensuring the long-term viability of psychotherapy as a treatment option and creating greater accountability, stewardship and return on mental health service investments. There is a worldwide shift toward outcomes that are not specific to mental health. It is essential that clinicians follow this lead and demonstrate – through reliable and valid methods – a greater degree of accountability for the value of psychotherapy.

A. Evidence of the Role of Routine and Ongoing Feedback in Improving Outcomes

The best available research reveals that the use of routine and on-going client feedback provides practitioners, and the field, with a simple, practical, and meaningful method for documenting the usefulness of treatment. Seeking and obtaining valid, reliable, and feasible feedback from clients (consumers) regarding the therapeutic alliance and outcome, as much as doubles the effect size of treatment; cuts dropout rates in half; and decreases the risk of deterioration by about 33%; reduces hospitalization and shortens length of stay by about 66%; and significantly reduces the cost of care (compared to non-feedback groups, which increased in cost). Additional evidence indicates that regular, session-by-session feedback (as opposed to less frequent intervals, i.e., every third session, pre- and post-services, etc.; Warren *et al.*, 2010) is more effective in improving outcome and reducing dropouts. As the APA Task Force on Evidence-Based Practice (2006) concludes, "providing clinicians with real-time patient feedback to benchmark progress in treatment and clinical support tools to adjust treatment as needed" is one of the "most pressing research needs" (p. 278).

B. Predicators of Outcome

The following factors have been shown to be consistent, robust predicators of an eventual positive outcome: **(a) Short duration of therapy**, with some positive changes; **(b) Early client change** – the 'dose-effect relationship' (whereby 30% of clients experience an improvement by 2nd session and 60-65% by session seven; 70-75% within 6 months; and about 85% by one year [15]); **(c) Consumer / client rating of the therapeutic alliance** is a better predictor of positive outcome than the therapist's; **(d) Level of consumer / client engagement** is one of the most determinant predictors of outcomes [16]; **(e) Improvement in the alliance over the course of treatment:** Client-therapist alliances that strengthen and improve from intake to termination tend to yield better outcomes [17]; **(f) The client's level of distress at the start of therapy** - More so than diagnosis, the severity of the client's distress at intake predicts eventual outcome. Clients with higher levels of distress are more likely to show measured benefit from treatment than those with lower levels or those who present as non-distressed [18]; **(g) Clinician's allegiance to their choice of treatment approach**: While research shows that there are few, if any, meaningful differences in outcome among treatment approaches, research documents that clinicians must have faith in the restorative power of therapy as a healing ritual. Further, it is important that clinicians have therapeutic rationales, employ strategies consistent with those rationales, and believe in their approaches. [19]

2. The Therapeutic Alliance

The therapeutic alliance is one of the main factors that does seem to 'work' in psychotherapy and counselling. This 'alliance' refers to the quality and strength of the collaborative relationship between the client and the therapist (Norcross, 2010).

The alliance is comprised of four empirically established components: **(1)** Agreement on the goals, meaning, or purpose of the treatment; **(2)** Agreement on the means and methods used; **(3)** Agreement on the therapist's role (including being perceived as warm, empathic, and genuine; and **(4)** Accommodating the client's preferences. Over 1,100 separate research findings document the importance of the therapeutic alliance in any successful therapy, making it one of the most evidence-based concepts in psychotherapy (Norcross, 2011; Orlinsky, Rønnestad & Willutzki, 2004). Significant findings from this area of research are detailed in this section:

a) **The therapeutic alliance makes substantial and consistent contributions to client success across nearly all different types of psychotherapy.** Over 20 meta-analyses have demonstrated the impact of the therapeutic alliance on treatment outcome [20]. The relationship and alliance act in concert with treatment methods, client characteristics, and clinician qualities in determining effectiveness. The alliance accounts for between five to nine times more of the outcome of treatment than the model or technique.

b) **Next to the level of client's functioning at intake, the client's rating of the alliance is the best predictor of treatment outcome and is more highly correlated with outcome than clinician ratings.** The partnership between the therapist and client, as rated by the client, is a consistent predictor of eventual treatment outcome and more reliable than therapist ratings [21]. Some therapists form better alliances with clients and achieve better outcomes. In contrast, clients of therapists with weaker alliances tend to drop out at higher rates and experience poorer outcomes. [22]

c) **A significant portion of the variability in outcome between clinicians is due to differences in the therapeutic alliance.** Variability between clients is to be expected with regard to client ratings of the alliance. However, some therapists consistently form better alliances with clients and variability in the alliance accounts for a large portion of the differences in outcomes between therapists. [23]

d) **Monitoring the alliance allows clinicians to identify and correct problems with engagement and reduce early dropout or risk of negative outcome.** Routine and ongoing monitoring of the alliance through real-time client feedback processes helps to both identify potential ruptures and create opportunities for clinicians to take corrective steps. [24] In addition, improvements in the alliance (intake to termination) are associated with better outcomes and lower dropout rates. [25]

All these points indicate areas of possible improvement, but – in reality – 'improvements' in the therapeutic alliance are totally in the hands of the therapist, or rather in the personality of the therapist.

As in all heart-felt relationships, there needs to be a range of 'good' human qualities such as: compassion, openness, empathy, genuineness, understanding, equality, compatibility, teamwork, good communication, patience, honesty, trust, responsibility, humour, respect, love, etc. If these are not already inherent in the therapist, then they can be learnt and then modelled, however these qualities do not usually form any part of any psychotherapeutic assessment or of any training programme, irrespective of the modality. These are essentially human qualities; they can possibly be measured; maybe they can also be acquired; they are not easily 'taught'.

How A Therapist Can Get Better

Most therapists aspire to get better at what they do. However, research has shown that indulging in personal therapy has very little or even nothing to do with the therapist's outcomes; therapist outcomes do not depend on the number or frequency of sessions that they have had, or that they have given; there are no therapeutic approaches, strategies or interventions that have been shown to be better than any other; professional training and discipline do not seem to matter much to outcomes; there is no evidence to show that continuing professional education will actually improve therapeutic effectiveness; and (although it defies common sense) the amount of clinical experience does not necessarily improve outcomes either. So, what does 'professional development' really mean and how can we accomplish it?

Barry Duncan (2014) asserts that 'getting better' at psychotherapy requires therapists to dedicate themselves to two key tasks: **(a)** obtaining systematic client feedback and **(b)** taking charge of their own development as a therapist. He describes his 'Partners for Change Outcome Management System' (PCOMS), which provides systematic feedback from clients, thereby enabling therapists to identify and target those clients who aren't responding to traditional treatment before they drop out. He examines the common factors inherent to all successful therapies, and details the importance of the therapeutic alliance as the foundation of effective therapy. He encourages all therapists to expand their theoretical breadth, think deeply about the lessons that they learn from their clients, and then integrate these lessons into their performance.

Barry Duncan and Scott Miller are the co-founders of the *Institute for the Study of Therapeutic Change.* And so, we come back right to the 'common factors' theory. They developed the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) as clinical tools to encourage therapists to discuss openly the benefits and 'fit' of their services with clients. The whole purpose of all this – of course – is to improve one's actual therapeutic work, as much as is possible for a busy clinician. This means 'assuming' – contrary perhaps to what you were told – that your original training had certain significant deficits and also that the 'field' of psychotherapy and counselling is constantly changing and evolving: so, if you don't "go with the current flow", you might just end up in an inconsequential back-water with stagnant concepts and techniques – irrespective of the 'quality' (or limitations) of your original training.

Some of this implies that therapists (should or do) keep a regular track of the 'outcomes' of their therapy with their clients. There are a variety of outcome measures (the UK National Health Service (NHS) and the various Employee Assistant Provider (EAP) companies tend to use the CORE-IMS system).[26] However, in order to be a success, it means that the therapist must administer the outcome measure and record the results regularly.

What Does Not Work

It is fairly well-known and accepted that 'normal' one-to-one counselling & psychotherapy does not work very well for:

- People with a severe mental condition that affects their ability to make relationships, concentrate and attend regularly. Examples can include: severe depression, psychotic illness, personality disorders, etc.
- People who are currently engaged in: self-destructive behaviours, prolonged substance abuse, alcohol abuse, eating disorders, etc.
- People with severe mental disabilities or learning disorders\People with a history of violence, or with severe post-traumatic stress disorders, etc.
- People with a poor understanding of the therapist's language, etc.
- People from a very different background or culture, etc.

These types of client usually do much better working within a specialized team approach, or in residential setting, or with specialist facilities, or working with a therapist who has had specialized training and /or developed specialized expertise – and then counselling and psychotherapy *in those circumstances* can be appropriate for them. It is therefore very important to know – and to work within – one's own personal & professional limitations.

So, what else doesn't work? There are also several things that really don't work very well in counselling and psychotherapy:

- **Sticking** too rigidly to the method that you have been taught: this is – no doubt – a very good basis for therapeutic work, but it probably (almost certainly) isn't enough, or suitable for every situation, or for every client;
- **Not:** … keeping proper notes and records; … getting enough supervision; … obtaining enough CPD; … doing additional reading; … attending conferences; … writing papers; … engaging with other peer professionals; etc., etc.
- **Your Personal Needs** getting in the way of the client's needs or process: your regular hours, holiday times, frequency of sessions, fee structure, etc. all need to be (possibly) a bit flexible if you are dealing with a fairly mixed population of 'people';
- **Counter-transference:** if something in the client work "triggers" *your* 'stuff', you need to take care of it separately; so, beware the 'daemon' of beware counter-transference – it can sneak up on you and bite (!);
- **Professional attitudes** … of pride or superiority or arrogance; of thinking that you know better; of thinking you can 'help' or 'save' this person; of thinking that your 'way' (method, style) is good, better, best; of thinking that just because you have been trained, qualified, accredited, then that is **It**; etc. and so forth – Beware "hubris";
- **A Lack of Introspection:** you could do worse than remember Socrates: *"The unexamined life is not worth living"*

What also potentially doesn't work – and therefore we need to be particularly cautious about these possibilities – are:

- **Working with clients in areas that we are not personally familiar with**: e.g. (possibly) trans-gender issues; trans-cultural issues; childhood sexual abuse; etc.

- **Working with clients from backgrounds that we are not personally familiar with:** e.g. language differences; social & cultural differences; ethnic differences; prisoners; refugee & asylum seekers; etc.
- **Trying to be "helpful"** – because this is possibly more of ***your*** agenda than the client's – and it often doesn't work anyway (Casement, 2014).
- **<u>Not</u> doing a proper 'risk assessment'** – especially if there is at least one 'red light'. [27]
- **<u>Not</u> reading books of client experience like:** *The Mirror Crack'd - When Good Enough Therapy Goes Wrong and other cautionary tales for humanistic practitioners* **(**Kerns, 2007); or *The Gift of Therapy: An Open Letter to a New Generation of Therapists and Their Patients* (Yalom, 2003).
- **<u>Not</u> being aware of any possible adverse effects:** e.g. AdEPT –> Supporting Safe Therapy [28] (also see: Barlow, 2010);
- **Ignoring / overlooking a particular client's particular needs or vulnerabilities:** [29] as you can – sometimes – actually do harm by <u>not</u> responding to them properly, or ignoring their sensibilities (Ungar, 2015; Wolfson *et al.*, 2009).

What Else Does Not Work in Therapy

This section focuses on what else does not work in therapy by addressing two primary areas: **(1)** the lack of overall improvement in therapy outcomes, dating back to the first meta-analytic studies in the 1970s; and **(2)** a list of non-predictors and weak predictors of outcome.

1. The Lack of Overall Improvement in the Effectiveness of Therapy

Available research points to the reasons why the effectiveness of psychological treatments has not improved appreciably over the last three decades.

- **The emphasis on treatment models in professional discourse and training:** Though popular, there are actually few if any meaningful differences in outcomes between different competing approaches – especially when the following factors are taken into account:

  Equal comparison conditions between bona fide approaches intended to be therapeutic. Bona-fide approaches are defined as treatments that are: **(1)** intended to be therapeutic (having a theoretical base and associated techniques); **(2)** considered viable by the psychotherapeutic community (e.g., through professional books or manuals); **(3)** delivered by trained therapists; and (4) containing ingredients common to all legitimate psychotherapies (e.g., a therapeutic relationship) [30]. In sum, when treatment conditions are equal, there are no discernible differences between bona-fide treatment approaches.

  The statistical strength of meta-analytic studies as compared to single studies: Meta-analyses are a method of pooling together numerous studies with varying methodologies, sample sizes, and treatment approaches, all of which improves statistical power, flexibility, and generalizability compared to single studies. Numerous meta-analyses find no difference in effect between bona fide treatment approaches. To date, no differences in outcome have been found between different treatment approaches for psychotherapy in general [31]; depression [32]; PTSD [33]; alcohol use disorders [34]; and the four most common diagnoses in children and youth (depression, ADHD, anxiety, and conduct disorder) [35]. Despite claims that certain methods are superior to others, or that evidence-based practice is defined by specific treatments for specific diagnoses, meta-analytic studies fail to support such claims. Furthermore, any

differences between approaches reported in specific studies do not exceed what would be expected by chance. The failure to find any difference in effect between competing treatment is referred to as "The Dodo Verdict," an expression first coined by psychologist, Saul Rozenzweig, who borrowed a line of text from *Alice's Adventures in Wonderland* to summarize the evidence regarding differential efficacy: "All have won, and therefore all deserve prizes." [36]

- **The failure to address dropouts in psychotherapy:** Research to date suggests that premature termination or dropout – the unilateral decision by clients to end therapy – averages about 47%. [37] For children and adolescents, the range varies from 28% to 85%. [38] Clinicians, it turns out, achieve solid outcomes with clients who stay, but too many decide early to discontinue services.

- **The failure to identify which consumers of behavioural health services will not benefit and which will deteriorate while in care:** Even with well-trained and supervised clinicians, a significant percentage (30% to 50%) of clients do not benefit from therapy. Deterioration rates among adult clients range between 5% and 10%. [39] Regarding children and adolescents, rates of deterioration vary between 12% and 20%. [40] It is estimated that the clients who do not benefit or deteriorate while in psychotherapy are responsible for 60-70% of the total expenditures in the health care system. [41] Moreover, clinicians routinely fail to identify clients who are not progressing, deteriorating, and at most risk of dropout and negative outcome. [42] Conversely, clinicians who have access to outcomes data can better identify clients who are not improving or getting worse and respond to those clients, thereby reducing the risk of dropout and negative outcome. [43]

- **Substantial variations in outcomes between clinicians with similar training and experience:** In practice settings, some psychotherapists consistently achieve better outcomes than others, regardless of the psychiatric diagnoses, age, developmental stage, medication status, or severity of the people they work with, across a range of patients. [44] Findings indicate that clients of the most effective therapists improve at a rate at least 50% higher and drop out at a rate at least 50% lower than clients who work with less effective therapists. [45] The latest research indicates that 97% of the difference in outcome between therapists is attributable to differences in their ability to form alliances with clients. [46] Such findings indicate that the most effective therapists work harder than their counterparts at seeking and maintaining client engagement, as well as invest more time, energy, and resources into improving their craft. [47] Research consistently shows that the best predictor of engagement in psychological services is the client's rating of the therapeutic alliance. [48]

- **Therapists' lack of knowledge regarding their overall rate of effectiveness and the tendency of average clinicians to overestimate:** The majority of therapists have never measured and do not know how effective they are. [49] Naturally, it is impossible for clinicians to know if they are improving if they do not know their level of effectiveness. Additionally, therapists are not immune to a self-assessment bias in terms of comparing their own skills with those of their colleagues and in estimating the improvement or deterioration rates likely to occur with their clients. [50] Others found that therapists on average rated their overall clinical skills and effectiveness at the 80th percentile – a statistical impossibility. [51] Even worse, less than 4% considered themselves average and not a single person in the study rated his or her performance below average. The issue of therapists overestimating their personal effectiveness puts clients at risk for higher rates of dropout and negative outcome.

- **Clinician effectiveness tends to plateau over time in the absence of concerted efforts to improve it:** During their careers, clinicians acclimate to their settings, rely more on specific methods and strategies with which they are trained or are more comfortable, and become more confident in what they believe to be true about their clientele. Although these and other clinician factors may benefit specific clients in specific situations, they more often contribute to

a plateauing of clinician effectiveness. Clinicians need to establish personal baselines of effectiveness and employ reliable and valid methods to monitor and track client feedback in relation to outcomes and the alliance to improve on those baselines.

2. Non-predictors and weak/absent predictors of outcome

Myriad studies over the last three decades have identified a number of other variables that have little or no correlation with the actual outcome of treatment, including:

- **Clients' age, gender, diagnosis, and previous treatment history;** [52]
- **Clinician age, gender, years of experience, professional discipline, degree, training, licensure, theoretical orientation, amount of supervision, personal therapy, specific or general competence, and use of evidence-based practices;** [53]
- **Model/technique of therapy;** [54]
- **Matching therapy to diagnosis;** [55]
- **Adherence/fidelity/competence to a particular treatment approach.** [56]

There are also – some – valid reasons why someone in therapy might not get better – despite the therapist's best efforts. However, some of these critiques tend to put part of the onus for the failure of the therapy on to the patient / client and should therefore be considered only very cautiously: [57]

1. Being the wrong therapist for that particular client.
2. Not identifying clearly enough the goals of therapy.
3. Are our interventions accessible to the patient / client – or are we "going over their heads", or not being realistic about their personal situation?
4. Is there something about the patient / client that we don't really like?
5. Are we being patient enough with the patient / client? Maybe *they* don't fit into *our* model of being a 'good enough' client, or making 'good enough' progress.
6. The patient has: … a fear of judgment; … a fear of rejection; … a fear of assuming greater responsibility; … or a fear of intimacy: that may prevent *them* responding to *our* particular style of therapy, or *us* as a person.

There are however some therapists who unconsciously do harm, and we – as therapists – need to make sure that we are not one of them (Jarrett, 2008; Rhule, 2005). In a study (Boisvert & Faust, 2006), 28% of psychologists were unaware that there were any negative effects in psychotherapy. "Theoretically, it makes sense that if we're going to look at a list of treatments that are effective, then it makes sense to look at treatments that could potentially be harmful."

Therapist 'Drift'

Professor Glenn Waller, Head of Psychology at the University of Sheffield, presented a talk for the Scottish Division of Clinical Psychology about *Therapist Drift: Why well-meaning clinicians mess up therapy (and how not to).* [58] Therapist 'drift' is a topic that forces therapists to ask difficult

questions like, “Am I truly helping people? Am I practising what I was taught (or learned) to be effective?”

There is evidence, he says, that high levels of empathy can be linked to poorer outcomes for patients; however, evidence also shows that therapist resilience leads to better patient outcomes; therefore, the therapeutic alliance is necessary, but not sufficient for patients’ progress. Prof. Waller also pointed out that behavioural change builds the therapeutic alliance, and not visa-versa, as – apparently – patients value therapists’ technical skills more than – or at least as well as – their interpersonal qualities. Therapists’ anxiety about possibly distressing people and making things worse leads to their engagement in safety behaviours, such as avoidance of applying proven therapeutic techniques (e.g. exposure behavioural activation). Apparently only about 10% of clinicians routinely consult and read evidence-based manuals; and there is evidence that clinical judgement, length of times since qualification, experience and training do not lead to better predictions about what to do clinically. Some of the things that he recommended for therapists are:

- **Reflect and review** what they know works and what doesn’t.
- **Psychological Education:** i.e. read the evidence-based manuals.
- **Monitor Progress:** making a check-list of techniques, skills and meta-competencies that are used, looking at and comparing outcomes over time periods.
- **Challenging Thought Forms:** Being aware of our own beliefs, schemas, and assumptions and examining them critically.
- **Changing Behaviours:** Testing out your beliefs using behavioural experiments: engaging in exposure; practising with supervision.
- **Reviewing:** using the outcomes; getting feedback; both when therapy has gone well and when it hasn’t.

However, all this could be applied to any situation; to any level of clinical psychology, psychotherapy and counselling; and to any therapeutic modality; essentially, it boils down to ensuring that one keeps up to date, reviewing one’s practice, doing some outcome research, and using acceptable (evidence-based) methods.

There are – as well – a number of psychological techniques or interventions that some therapists use, from time to time, with some patients or clients, but not necessarily with all. Some of these come from different methods or modalities; and different (often well-qualified) ‘experts’ promote others; but there is also little compelling evidence that these interventions always “work”.

Amongst these interventions, some of the better known ones can be mentioned here: ‘a relational object’; ‘paradoxical intervention’ or ‘reverse psychology’ [59]; Gestalt’s ‘empty chair’ [60]; the ‘miracle question’ [61]; ‘voice dialogue’ [62]; ‘hunger illusion’ [63]; ‘head-on collision’ [64]; ‘transference interpretation’ [65]; ‘sand-play’ for children [66]; and so forth.

Whilst some of these techniques come from well-established and well-evidenced psychotherapies and counselling modalities, the techniques themselves can often be quite successful with some patients / clients on some occasions; a lot will also depend on the skill of the therapist as to know how, and when, and if, these might work. We know that these can work with some people, some of the time: but, really, that's all. Of course, some of the effectiveness of the functioning depends on the client as well: they should be encouraged to say whether this or that techniques works for them, or not.

Therapies That Can Harm

There have also been a number of studies that 'claim' to have identified types of psychotherapy and counselling that either **do not work**, or that may even **cause harm**:

- A recent national survey of UK NHS patients (Crawford, 2016), who had all received psychological treatment found that about 1 in 20 (5.2%) of people responding to the large survey [n = 14,587] reported experiencing lasting bad effects.
- Scott Lilienfeld (2002; 2007) (see also Lilienfeld *et al.*, 2005), a professor of psychology at Emory University, has done a number of studies, especially some for the APA, on treatments that *"should be avoided ... or only implemented only with caution".*
  This (in effect) is a 'black list' – a somewhat worrying development in itself – which includes: critical incident stress debriefing; facilitated communication; recovered-memory techniques; boot camps for conduct disorder; attachment therapy; dissociative identity disorder-oriented psychotherapy; grief counselling for normal bereavement; and expressive-experiential psychotherapies. However, Roth & Fonagy (2004) have questioned some of these results.
- There are also severe 'reservations' – from several studies (Thompson, 2005) – about: Eye Movement Desensitization and Reprocessing (EMDR); Thought Field Therapy (TFT); Adolescent (Gender) Transition Programmes (APT); as well as Encounter Groups, Grief counselling for normal bereavement, Energy psychotherapy, Angel therapy, Crystal healing, Past life therapy, Re-birthing, Primal scream therapy, Erhard Seminars Training (EST), Neuro-Linguistic Programming (NLP), DARE programs, Re-parenting, etc. – almost, unfortunately, *ad infinitum*.

Different 'Myths' About Counselling & Psychotherapy

There are a large number of myths about Counselling and Psychotherapy: **(1)*'The Myth of the Untroubled Therapist'*** (Adams, 2013); **(2) *'20 Myths about Counselling & Psychotherapy'*** (Stephens, 2012), which includes: 'Counselling /Psychotherapy never works'; 'Counselling /Psychotherapy always works'; 'Counselling /Psychotherapy is no good for Depression'; 'Counselling /Psychotherapy is always good for Depression'; 'Only Psychiatrists can do Counselling /Psychotherapy'; 'Only Psychologists can do Counselling /Psychotherapy'; and so on; **(3) *"Top Ten Myths about Counselling and Therapy"*** (Jacobsen, 2012), which includes: "(1) My therapist will know what I am thinking and/or can read my mind", "(2) I will have to lie on a sofa";

"(3) I will be encouraged to blame my parents for everything"; "(4) Therapy can go on for years and years"; "(5) Therapy just isn't as effective as medication"; "(6) My therapist is only interested because they are getting paid"; "(7) Therapy is only for those who can't deal with their problems and are weak or 'crazy'; "(8) Therapy will quickly fix all my problems"; "(9) Being with my therapist face-to-face is the only way of doing therapy"; "(10) Talking to someone who doesn't know me won't help and they might judge me"; **(4)** ***"5 myths about counselling – debunked!"*** (Klearminds, 2018), which includes: "(1) – Counselling is only for people with serious mental health issues"; "(2) – It's easier to talk to friends and family about my problems"; "(3) – Counselling is nothing about endless talk about my childhood"; "(4) – Counselling takes ages: It's like writing a blank cheque"; "(5) – I tried it once and it didn't work, so counselling is not for me"; **(5)** ***"The Myths about Counselling"*** (Martin, 2012), which include: "Only mad people need counselling"; "Counsellors just sit there and say nothing"; "Counselling takes forever"; "Everyone will know you are seeing a Counsellor"; "Counselling will change the person you are"; and so on.

All of these myths are just – quite literally - myths: that means they are not true. The only reality is that counselling or psychotherapy won't necessarily be what you expect; and it often works just to have another person listen to you talking about your life and issues.

Collaborative Practice (With-ness)

What is usually meant by "collaborative practice" is that the mental health practitioners work together with other professionals and with the service users and their families and support groups to "connect, collaborate and construct" with each other. (Ness *et al.*, 2014; Shotter, 2012; Anderson, 2009). Each member of the 'team' then has a sense of participation, belonging and ownership, which combines to promote (much more) effective and sustainable outcomes. This is not the usual situation, where theory is put into practice and techniques employed in a way that the service user becomes a 'patient' – often a disempowered one, who is then 'treated' by 'professionals'. The collaborative practice model invites all of those involved into a shared engagement, a mutual inquiry, and a joint action – by the process of generative and transforming dialogue – making collaborative therapy and other such endeavours much more of a "with-ness" practice.

Much of mental health practices involve thinking about the problem from the 'outside' and observing what is happening 'over there'. Collaborative practice is a form of engaged and responsive thinking, acting and talking ***with*** those involved. What can be gained from such 'understandings-from-within' is a *subsidiary awareness* of certain 'action-guided-feelings' that help to play a role in an ongoing process in which all are involved (in their different ways), all are responding differently, and there is then a sense or feeling of a collective and mutual process – a structure of tacit knowing – rather than just a clinical 'focus' on the person with mental health issues (Polanyi, 1958, 2015).

There have been a number of attempts to work "collectively" with people in mental health situations – sometimes referred to as 'therapeutic communities' – however, these have largely been inspired by somewhat radical professionals (R.D. Laing[67], E. Podvoll[68], L. Mosher[69], J. Berke[70], M. Barnett[71], etc.) and – unfortunately – their (often very successful) work has not lasted much beyond their lives. Yet, we can still let them inspire us.

So … How Can We – as Therapists - Improve?

We have discovered some ways already – as indicated above. There are also certain significant factors – and some of these can be remedied by keeping meticulous outcome data: e.g. 25% of the least helpful therapists produced effect sizes of 0.2 (Green *et al.*, 2014). If it is possible to imagine the possibilities of one's improved effectiveness – then the least 'helpful' therapists can still become much better.

Getting both objective and supportive feedback on our actual day-to-day practice (routine outcome monitoring) is **now considered as absolutely necessary** – as this leads to a form of practice-based evidence (Drapeau, 2012); therefore, the use of outcome measures like: CORE, OQ[72] and/or PCOMS[73]; as well as engaging patients with these "Clinical Support Tools"; and cutting down the number of 'unnecessary' sessions – i.e. 6-8 sessions is often at the point of peak improvement (Lambert *et al.*, 2005).

One should also try also to reduce drop-out rates (often around 25-35%) (Wierzbicki & Pekarik, 1993) – possibly by improving referral criteria, or by using a drop-out, feed-back form. There are a number of ways of 'being' with a client that can help: **(i)** don't interpret too much; and **(ii)** not focus on the seemingly 'inaccurate' or 'out-of-order' methodologies; and **(iii)** question (or explore) any confusing or anxiety-provoking moments (Rousmaniere, 2012): – these can all help to improve one's personal professional practice as a therapist.

Lambert (2007) recommends building-in a system of client feed-back – almost as an essential, as the baseline is that (he claims), on average, 20% of patients will (apparently) be worse off when they leave treatment than when they started. Such a feedback system can have a really dramatic effect:

> "… before each session, ask clients a few brief questions about how they are feeling and how they feel the course of therapy is going. These days, it can even be done on a palmtop at reception while they are waiting to see their therapist. By comparing a client's answers to the average progress made by similar clients at that stage – that is, clients who had similar problems, of similar severity, at treatment outset – Lambert's algorithms are able to say whether a client is 'on track' or 'off track'. This information can then be fed back to the therapist." (Jarrett, 2008)

However, this feedback & comparison system predicates a rather over-formalised way of overseeing a clinician's practice: this wouldn't necessarily work for the individual, (independently

working), 'private' psychotherapist or counsellor. Whilst, there are, of course, reasonably accurate levels of self-monitoring, maybe (just maybe), this should be done much more systematically – promoted by the psychotherapists' and counsellors' professional associations (if not by their employers), especially in any 5-yearly re-accreditation process. But/and, it is also true that clinicians generally react with resistance to such client feedback systems, even though these have been proved to be effective. People, especially those who consider themselves as 'professionals', quite naturally don't like to be 'shown up' or 'put on the spot' by producing poor outcome measures!

A Personal Professional Practical Note

Finally, on a more personal note, what I have found very effective are methods to increase: the client's empowerment; their sense of agency; and their self-esteem. Most (about 85-95%) of the people referred to me (as a GP or an EAP Counsellor) have **absolutely nothing wrong with them**: they **do not have a diagnosable 'condition'**; and they may (or may not) be taking anti-depressants, which is irrelevant. They have also **not done anything 'wrong'**, even though they may carry levels of guilt (often about not doing enough or doing well-enough).

What they are really suffering from is an overload of stressful life events (*as per:* Holmes & Rahe, 1967) and they mainly present with symptoms of (reactive, exogenous) stress, anxiety, depression, grief and loss. Therefore, a compassionate and empathic approach, as well as a fairly forthright matter-of-fact manner, is somewhat essential. Such a 'normalisation' of their present situation thus helps to put the rest of the 'things' (issues) around them into some sort of proper and re-balanced context and therefore actually de-pathologizes their symptoms.

If one then (as a therapist) adds in some gentle explanations about the functioning of their Autonomic Nervous System (ANS) (which can help them to understand how they get unbalanced and what they can do about re-balancing it – exercise, relaxation, etc. (Young, 2008)); and then I offer them the 'Four Magic Words', as well as a few other self-help, self-empowerment, strategies.

You have to understand, here – at this point, that I practice in a GP surgery just down the road from where the well-known author of the *'Harry Potter'* books lives. So, I quite often say:

> *"We don't have any 'magic wands' I am afraid, we leave that to J.K. Rowling down the road. What I do have is 'Four Magic Words', and – if you want them – you can write them on the inside of your forehead, in letters of gold, so that they are then the first thing that you think of."*

They usually agree, and so I then say, *"The Four Magic Words are: 'What – Works – For – Me?' And, if whatever it is that **doesn't** work for you, then all you have to say is: "That doesn't work for me"*. So, then, it is up to the other person to suggest something else. This is totally non-scientific,

not researched, with no RCTs, but – empirically – many people report very positively, often in the next session, that: *"That worked like magic!"*

There are several other fairly straight-forward, self-help, self-empowerment techniques that can also help: perhaps, the best sort is providing this sort of basic, accurate and non-jargon (or non-'pseudo-scientific') information (Young, 2010). Such self-help practices that promote the client's empowerment are also reported to be very effective by other therapists and researchers (McWhirter, 2011; Stosny, 2012; Pickett, 2014; etc.). Another form of empowerment is to encourage the person to claim back their 'power of choice' (Prochaska & Norcross, 2013; O'Morain, 2012).

This sort of somewhat 'forthright' intervention is also quite essential – especially if the client is in a narcissistic (or 'coercive control') type of relationship, or if they have 'learnt' – at an early age – to devalue themselves. The power of such simple self-help techniques is quite amazing, but there is very little of this sort of 'stuff' taught in psychotherapy and counselling trainings, or is used in practice, as it essentially disempowers the 'therapist': Oh, dear!

It is such a great pity that current UK mental health services are only really designed to respond (somewhat basically) to people with existing and identified mental health problems.

However, what should probably be considered – instead – are: widely (nationally) applied structures and strategies that are designed to be more effective in preventing people actually developing mental health problems.

This needs to be done in a great number of different ways, as with: **(a)** better parental education in the pragmatics of child psychology (especially for new parents); **(b)** the teaching of 'emotional intelligence' and self-empowerment, especially in primary schools; **(c)** many more – properly funded – interventions from social work departments (and the like) helping with 'problem' families; **(d)** many more healthy 'youth' and 'after school' activities for secondary school pupils to give them a sense of identity; **(e)** better 'policing' and other social strategies to prevent children getting supplied with drugs, or joining gangs; **(f)** much more successful – and many more strongly enforced – (anti-)'stress@work' policies; **(g)** much better and more easily accessed 'couples' counselling' facilities; **(h)** better awareness from GPs (and other 'medical' professionals) that many of their patients' problems are not actually 'medical' or (possibly) 'psychological', but instead are probably 'social', or 'emotional', or 'existential'; **(i)** much more easily accessed (and less socially discriminative) resources for people with symptoms of anxiety and/or depression, usually from a quite serious accumulation of 'life-stress' events and issues; etc.

Here is the final word: Prevention is always better than treatment; and it is usually much more effective; and it is often cheaper – in the long run. Working actively to prevent (or reduce) the next generation (and the next) getting 'mental health problems' is probably and actually 'What Works' **best** in psychotherapy and counselling.

* * * * *

Author

Courtenay Young is a well-known UKCP Psychotherapist, NHS Counsellor, author and editor. He currently lives and works in and around the Edinburgh area, working both in the NHS and privately. He is the author of several books (and has edited several books) as well as many published articles.

Over the years, he has been involved in the several professional 'projects': the latest one being the (2012) EAP's 'Project to Establish the Professional Competencies of a European Psychotherapist' (www.psychotherapy-competency.eu), as well as trying to establish the European Certificate of Psychotherapy (ECP) as an equivalent to EQF-7: the 7th level (at Master's degree) in the European Qualifications Framework. There is also a parallel project to get 'psychotherapy' in Europe established as an independent profession, equivalent to psychology.

He is currently also the Editor of the International Journal of Psychotherapy (www.ijp.org.uk). Most of his published articles are available as PDF downloads from his personal website: www.courtenay-young.com

E-mail: courtenay@courtenay-young.com

References

Adams, M. (2013). *The Myth of the Untroubled Therapist.* London: Routledge.

Aldina, S. & Marshall, J.J. (2013). *Mindfulness Workbook for Dummies.* New York: Wiley.

American Psychological Association (2012). *Recognition of Psychotherapy Effectiveness*. Accessed 5-Apr, 2016: http://www.apa.org/about/policy/resolution-psychotherapy.aspxBarlow, D.H. (2010), "The dodo bird– again– and again", *The Behavior Therapist, 33, pp. 15–16.*

Anderson, H. (2009). Collaborative practice: Relationships and conversations that make a difference. In: J.H. Bray & M. Stanton (Eds.), *The Wiley-Blackwell Handbook of Family Psychology*, (pp. 300-313). London: Wiley-Blackwell.

APA (2006). APA Task Force on Evidence-Based Practice, 2006, pp. 273, 276-277).

Azar, S.A. (2006). Working with Refugees: A personal experience. *International Journal of Psychotherapy, Vol. 10, No. 3, pp. 54-61.*

Baker, T.B. & McFall, R.M. (2014). The promise of science-based training and application in psychological clinical science. *Psychotherapy, 51, pp. 482– 486.*

Barlow, D.H. (2010). Negative Effects from Psychological Treatments: A perspective. *American Psychologist, Vol. 65, No. 1, pp. 13-20.*

Bassey E. & Davis, L. (1988, 1994, 2008). *The Courage to Heal: A guide for women survivors of child sexual abuse.* New York: Collins.

Bentall, R.P. (2009). *Doctoring the mind: Is our current treatment of mental illness really any good?* New York: New York University Press.

Bishop, S.R., Lau, M., Shapiro, S., Carlson, L., Anderson, N.D., Carmody, J., Segal, Z.V., Abbey, S., Speca, M., Velting, D. & Devins, G. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice: Vol. 11, No. 3, pp. 230.*

Braga, L.L., Mello, M.F. & Fiks, J.P. (2012). Transgenerational transmission of trauma and resilience: a qualitative study with Brazilian offspring of Holocaust survivors. *BMC Psychiatry, 12, p.134.*

Calmbach, W.L., Ryan, J.G., Baldwin, L.M. & Knox, L. (2012). Practice-based research networks (PBRNs): Meeting the challenges of the future. *Journal of American Family Medicine, Vol. 25, No. 2, pp. 572-576.* doi: 10.3122/jabfm.2012.05.120064.

Carmody, J. & Baer, R.A. (2008). Relationships between mindfulness practice and levels of mindfulness, medical and psychological symptoms and well-being in a mindfulness-based stress reduction program. *Journal of Behavioral Medicine, Vol. 31, pp. 23-33.* doi: 10.1007/s10865-007-9130-7.

Casement, P. (2014). Some hazards in being helpful in psychotherapy. *Psychotherapy Section Review, No. 53, pp. 15-25.*

Castonguay, G.L., Boswell, F.J., Constantino, J.M., Goldfried, R.M. & Hill, E.C. (2010). Training implications of harmful effects of psychological treatments. *American Psychologist, 65, pp. 34–49.*

Chow, D. (2014). *The Study of Supershrinks: Development and Deliberate Practices of Highly Effective Psychotherapists*. (Ph.D. thesis: Curtin University). Accessed: 21/7/17: www.academia.edu/9355521/

Connolly, A. (2011). Healing the wounds of our fathers: Intergenerational trauma, memory, symbolization and narrative. *Journal of Analytical Psychology, Vol. 56, No. 6, pp. 607-626.*

Cozolino, L. (2015). *Why Therapy Works: Using our minds to change our brains.* New York: W.W. Norton.

Coughlin, P. (2016). *Maximising Effectiveness in Dynamic Psychotherapy.* Hove, UK: Routledge.

Coyle, S. (2014). Intergenerational Trauma – Legacies of Loss. *Social Work Today, 14, 3, p. 18.*

Crawford, M.J., Thana, L. Farquharson, L., Hancock, E., Clarke, J. & Parry, G.D. (2016). Patient experience of negative effects of psychological treatment: results of a national survey. *British Journal of Psychiatry, 208 (3), pp. 260-265:* doi: 10.1192/bjp.bp.114.162628

Dana, D. (2018). *The Polyvagal Theory in Therapy: Engaging the rhythm of regulation.* New York: W.W. Norton & Co.

Davis, D.M. & Hayes, J.A. (2011). What are the benefits of mindfulness? A practice review of psychotherapy-related research. *Psychotherapy, Vol. 48, No. 2, pp. 198-208.* doi: 10.1037/a0022062.

Defife, J.A. & Hisenroth, M.J. (2011). Starting off on the Right Foot: Common factor elements in early psychotherapy process. *Journal of Psychotherapeutic Integration, Vol. 21, No. 2, pp. 172-191.* Accessed 5-April, 2016: https://www.psychologytoday.com/sites/default/files/attachments/2259/2011jpicommonfactorsearlyprocessdefifehilsenroth.pdf

Dimidjian, S. & Hollon, D.S. (2010). How would we know if psychotherapy were harmful? *American Psychologist, 65, pp. 34–49.*

Drapeau, M. (2012). The Value of Progress Tracking in Psychotherapy. *Integrating Science and Practice: 10 Tools for Progress Monitoring in Psychotherapy:* www.ordrepsy.qc.ca/en

Duncan, B.L. (2014). *On Becoming a Better Therapist: Evidence-based practice: One client at a time (2nd Ed.).* Washington, DC: American Psychology Association.

Duncan, B.L., Miller, S.D. & Wampold, B.E. (Eds.) (2009). *The Heart and Soul of Change: Delivering what works in therapy.* Washington, DC: American Psychology Association.

Erlich, S. (2002). Short-term Group Therapy with Holocaust Survivors and the Second Generation. *Eastern Group Psychotherapy Society, 'Group', 26, 2, pp. 163-171.*

EAP (2012). The EAP's Project to Establish the Professional Competencies of a European Psychotherapist: http://www.psychotherapy-competency.eu

ENTO (2007). National Occupational Standards for Counselling: http://ipnosis.postle.net/PDFS/CounsellingNOSFULLSuiteApprovedSept07.pdf

ESCO (2009). European Classification of Skills, Competencies, Qualifications and Occupations: https://ec.europa.eu/esco/portal/home

Fromm, M.G. (Ed.) (2011). *Lost in Transmission: Studies of Trauma Across Generations.* London: Karnac Books.

Gladding, S.T. (2015). Characteristics of Effective Counselors: The 8 H Qualities. Accessed 05-Apr: https://www.counseling.org/docs/default-source/2015-singapore-conference/keynote-sam-gladding.pps

Garfield, S. & Bergin, A. (Eds.) (1957). *Handbook of Psychotherapy and Behavior Change.* (1st Ed.) New York: Wiley.

Goldfried, M.R, (Ed.) (1982). *Converging Themes in Psychotherapy: trends in psychodynamic, humanistic, and behavioral practice*. New York: Springer.

Green, H., Barkham, M., Kellet, S. & Saxon, D. (2014). Therapist effects and IAPT Psychological Wellbeing Practitioners (PWPs): A multilevel modelling and mixed methods analysis. *Behaviour Research and Therapy, Vol. 63, pp. 43-54.*

Grencavage, L.M. & Norcross, J.C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 21 (5), pp. 372–378.*

Hahn, T.N. (1991). *Peace is Every Step: The path of mindfulness in everyday life.* New York: Bantam.

Hahn, T.N. (2008). *The Miracle of Mindfulness: The classic guide.* New York: Rider.

Hendlin, S.J. (2016). Meditation and the mindfulness trend in psychotherapy: Reflections through the prism of a 50-year meditator. *Psychotherapy Bulletin, 51 (3), pp. 34-43.*

Holmes, T.H. & Rahe, R.H. (1967). The Social Readjustment Rating Scale. *Journal of Psychosomatic Research, Vol. 11, 2, pp. 213-218.*

Horvath, A.O. & Bedi, R.P. (2002). The alliance. In: J.C. Norcross (Ed.), *Psychotherapy relationships that work: therapist contributions and responsiveness to patients*, (pp. 37–70). New York: Oxford University Press.

Hunsley, J., Elliot, K. & Therrien, Z. (2013). *The Efficacy and Effectiveness of Psychological Treatments.* Ottowa, Canada: Canadian Psychology Association. Accessed 5-Apr, 2016: http://www.cpa.ca/docs/File/Practice/TheEfficacyAndEffectivenessOfPsychologicalTreatments_web.pdf

Imel, Z.E. & Wampold, B.E. (2008). The importance of treatment and the science of common factors in psychotherapy. In: S.D. Brown & W. Robert (Eds.), *Handbook of Counselling Psychology (4th Ed.)*, (pp. 249-262). Hoboken, NJ: J. Wiley & Sons.

Jacobsen, S. (2012). T*op Ten Myths about Counselling and Therapy.* Retrieved 4-Aug., 2019: https://www.harleytherapy.co.uk/counselling/ten-myths-about-therapy-counselling.htm

Jarrett, C. (2008). When Therapy Causes Harm. *The Psychologist, Vol. 21, pp. 10-12.*

Kearns A. (Ed.). (2007). *The Mirror Crack'd: When good enough therapy goes wrong and other cautionary tales for humanistic practitioners.* London: Karnac Books.

Lambert, M.J. (1992). Psychotherapy outcome research: implications for integrative and eclectic therapists". In: J.C. Norcross & M.R. Goldfried (Eds.), *Handbook of Psychotherapy Integration*, (pp. 94–129). New York: Basic Books.

Lambert, M.J., Harmon, C., Slade, K., Whipple, J.L. & Hawkins, E.J. (2005). Providing feedback to psychotherapists on their patients' progress: Clinical results and practice suggestions. *Journal of Clinical Psychology, 61, pp. 165–174.*

Laska, K.M. & Wampold, B.E. (2014). Ten Things to Remember About Common Factors Theory. *Psychotherapy, Vol. 51, No. 4, pp. 519-524.* Accessed 4-Apr, 2016: https://www.apa.org/pubs/journals/features/pst-a0038245.pdf

Laska, K.M; Gurman, A.S. & Wampold, B.E. (2014). "Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective". *Psychotherapy: Theory, Research, Practice, Training, 51, 4, pp. 467-481.*

Levine, P. (1997). *Waking the Tiger: Healing Trauma.* Berkeley, CA: North Atlantic Books.

Levine, P. (2008). *Healing Trauma: A pioneering program for restoring the wisdom of your body.* Boulder, CO: Sounds True.

Luborsky, L. (1999). The researcher's own therapeutic allegiances: a 'wild card' in comparisons of treatment efficacy. *Clinical Psychology: Science & Practice, 6, pp. 49–62.*

Luborsky, L, Singer, B. & Luborsky, L. (1975). Is it true that 'everyone has won and all must have prizes?'", *Archives of General Psychiatry, 32, pp. 995–1008.*

Luborsky, L., Rosenthal, R., Diguer, L., Andrusyna, T.P., Berman, J.S., Levitt, J.T., Seligman, J.S. & Krause, E.D. (2006). The Dodo Bird Verdict is Alive and Well – Mostly. *Clinical Psychology: Science and Practice, Vol. 9, No. 1, pp. 2-12.*

Martin, A. (2012). *The Myths about Counselling*: Retrieved 04-Aug. 2-19: http://www.thecounsellorsguide.co.uk/myths-about-counselling.html

Martin, D.J., Garske, J.P. & Davis, M.K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review, *Journal of Consulting and Clinical Psychology, pp. 438–50.*

Masson, J.M. (1984). *The Assault on Truth: Freud's Suppression of the Seduction Theory.* New York: Farrar, Strauss & Giroux.

Masson, J.M. (1988). *Against Therapy: Emotional Tyranny and the Myth of Psychological Healing.* Common Courage Press.

McWhirter, E.H. (2011). Empowerment in Counselling. *Journal of Counselling & Development, Vol. 69, No. 3, pp. 222-227.*

Miller, S.D. (2013). *Why Most Therapists are Average (and how can we improve):* an interview with T. Rousmaniere. Accessed 4-Apr, 2016: https://www.psychotherapy.net/interview/scott-miller-interview

Miller, S.D. (2015). *The Heart and Soul of Change: What Works in Therapy.* Washington, DC: American Psychological Association.

Mind (2009). The regulation of psychotherapy and counsellors. BACP: 2008-2009.

Moberg, K.U. (2003). *The Oxytocin Factor: Tapping the hormone of calm, love and healing.* Cambridge, MA: De Capo Press.

Mojaverian, T., Hashimoto, T. & Kim, H.S. (2012). Cultural differences in professional help seeking: A comparison of Japan and the U.S. *Frontiers in Psychology, Vol. 3, pp. 615* doi: 10.3389/fpsyg.2012.00615

Nathan, P.E. & Gorman, J.M. (Eds.) (2015). *A Guide to Treatments that Work (4rd Ed.).* Oxford: Oxford University Press.

Ness, O., Borg, M., Semb, R & Karlsson, B. (2014). "Walking alongside": Collaborative practices in mental health and substance use care. *International Journal of Mental Health Care Systems, Vol. 8, No. 1, p. 55.* doi: 10.1186/1752-4458-8-55.

Norcross, J. C. (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- 141). Washington, DC: American Psychological Association.

Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work: Evidence-based responsiveness (2nd ed.).* New York: Oxford.

Oettingen, G. (2015). *"Rethinking positive thinking: Inside the new science of motivation."* New York: Current, Penguin Random House.

Oettingen, G., Kappes, H.B., Guttenberg, K.B. & Gollwitzer, P.M. (2015). Self-regulation of time management: Mental contrasting with implementation intentions. *European Journal of Social Psychology, 45, pp. 218-229.* Accessed: 6-Apr, 2016: http://www.psych.nyu.edu/oettingen/Oettingen,%20et%20al.%20(2015).%20EJSP.pdf

Ogden, P., Minton, K. & Pain, C. (2006). *Trauma and the Body: A sensorimotor approach to psychotherapy.* New York: W.W. Norton.

O'Morain, P. (2012). *Little Guide to Reality Therapy and Choice Theory.* Accessed 5-Apr, 2016: http://www.padraigomorain.com/concise-guide-to-choice-theoryreality-therapy.html

Orlinsky, D.E., Rønnestad, M.H. & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In: M J. Lambert (Ed.), *Bergin & Garfield's Handbook of Psychotherapy and Behavior Change (5th Ed.),* (pp. 307-390). New York: Wiley.

Pert, C. (1997). *The Molecules of Emotion: Why you feel the way you feel.* New York: Touchstone.

Pickett, S. (2014). Promoting Empowerment in Clinical Practice. Accessed 5-Apr, 2016: http://www.carlatbehavioralhealth.com/free_articles/promoting-empowerment-clinical-practice-free-article

Polanyi, M. (1958, 2015). *Personal Knowledge: Towards a post-critical philosophy.* Chicago, Il: University of Chicago Press.

Porges, S. (2009). The Polyvagal Theory: New insights into adaptive reactions of the autonomic nervous system. *Cleveland Clinical Journal of Medicine, 76, pp. 86-90.*

Porges, S. (2011). *The Polyvagal Theory: Neurophysiological foundations of emotions, attachment, communication and self-regulation.* New York: W.W. Norton.

Poullson, S., Lunn, S., Daniel, S.I.F., Folke, S., Mathiesen, B.B., Katznelson, H. & Fairburn, C.G. (2014). A randomized controlled trial of psychoanalytic psychotherapy or cognitive behavioural therapy for bulimia nervosa. *American Journal of Psychiatry, Vol. 171, No 1, pp. 109-116.* Accessed 5-Apr, 2016: http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2013.12121511

Prochaska, J.O. & Norcross, J.C. (2013). *Systems of Psychotherapy: A Trans-theoretical Analysis* (8th ed.). Stamford, CT: Cengage Advantage Books.

Reich, W. (1933, 1980). *Die Massenpsychologie des Faschismus [The Mass Psychology of Fascism]*. Copenhagen: Sexpol. Re-published in 1980, in English (3rd Ed.): New York: Farrar, Strauss & Giroux.

Reisner, A.D. (2005). The Common Factors, Empirically Valid Treatments and Recovery Models of Therapeutic Change. *The Psychological Record, Vol. 55, pp. 377-399.* Accessed 4-April, 2016: http://opensiuc.lib.siu.edu/cgi/viewcontent.cgi?article=1192&context=tpr

Rhule, D. (2005). Take care to do no harm. *Professional Psychology, 36, pp. 618–625.*

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6 (3), pp. 412–415.*

Roth, A. & Fonagy, P. (2004). *What Works for Whom?* New York: Guilford Press.

Rothschild, B. (2000). *The Body Remembers: The psychophysiology of trauma and trauma treatment.* New York: W.W. Norton.

Sheikh, S. & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology, Vol. 35, No. 7, pp. 326-334.*

Slaney, C. (2015). Linked-In discussion group: https://www.linkedin.com/grp/post/2154299-6026820190442975236

Stein, H.F. (2007). *Insight & Imagination: A study of knowing and not-knowing in organizational life.* Ney York: University Press of America.

Stephens, E. (2012). 20 Myths about Counselling & Psychotherapy. Retrieved 04-Aug. 2019: https://www.ironmill.co.uk/article/20-myths-about-counselling-and-psychotherapy

Stiefel, I., Renner, P. & Riordan, D. (2014). Evidence Based: Crossing the Great Divide between Research and Clinical Practice. *Australia & New Zealand Journal of Family Therapy, Vol. 24, No. 1, pp. 49-50.* Accessed: 6-Apr, 2016: http://www.researchgate.net/publication/264736541_Evidence_Based_Crossing_the_Great_Divide_Between_Research_and_Clinical_Practice?ev=auth_pub

Stosny, S. (2012). Validation and Empowerment: The necessary balance for self-help. https://www.psychologytoday.com/blog/anger-in-the-age-entitlement/201208/validation-and-empowerment

Shotter, J. (2012). More than Cool Reason: 'Withness-thinking' or 'systemic thinking' and 'thinking about systems. *International Journal of Collaborative Practices, 3 (1), pp. 1-13.*

Tracey, T.J.G. (2003). Concept mapping of therapeutic common factors. *Psychotherapy Research, 13 (4), pp. 401–413.*

Ungar, M. (2015). *Working with Children and Youth with Complex Needs: 20 skills to build resilience.* Hove, UK: Routledge.

van der Kolk, B. (2015). *The Body Keeps the Score: Mind, Brain and Body in the transformation of trauma.* London & New York: Penguin.

Vogel, D.L., Wester, S.R. & Larson, L.M. (2007). Avoidance of Counselling: Psychological factors that inhibit seeking help. *Journal of Counselling & Development, Vol. 85, pp. 410-423.*

Wagner, D. (2016). Polyvagal theory in practice. *Counselling Today.* Accessed 20-July, 2018: https://ct.counseling.org/2016/06/polyvagal-theory-practice/#

Wampold, B.E (2001). *The Great Psychotherapy Debate: models, methods, and findings.* Mahwah, NJ: L. Erlbaum.

Wampold, B.E. (2011). *The Qualities and Actions of An Effective Therapist.* Washington, DC: APA. Accessed 5-Apr, 2016: https://www.apa.org/education/ce/effective-therapists.pdf

Whitbourne, S.K. (2011). 13 Qualities to look for in an Effective Psychotherapist. *Psychology Today.* Accessed 5-Apr, 2016: https://www.psychologytoday.com/blog/fulfillment-any-age/201108/13-qualities-look-in-effective-psychotherapist

Wolfson, P., Holloway, F. & Killaspy, H. (Eds.) (2009). *Enabling recovery for people with complex mental health needs: A template for rehabilitation services. Faculty Report FR/RS/1:* London: Royal College of Psychiatrists. Accessed 7-Apr, 2016: http://www.rcpsych.ac.uk/pdf/fr_rs_1_forwebsite.pdf

Yalom, I. (2003). *The Gift of Therapy: An open letter to a new generation of therapists and their patients: Reflections on Being a Therapist.* London: Piatkus.

Young, C. (2008). Re-balancing the Autonomic Nervous System. *International Journal of Psychotherapy, Vol. 12, No. 2, July 2008, p. 24-35.*

Young, C. (2010). *Help Yourself Towards Mental Health.* London: Karnac Books.

Young, C. (2014). The possible harmful side-effects of psychotherapy. *International Journal of Psychotherapy, Vol. 18, No. 2, pp. 63-82.*

Young, C. (2017). Book Review: *A Guide to Treatments that Work (4th Ed.)* Peter E. Nathan & Jack M. Gorman (Eds.) New York: OUP. *BPS Psychotherapy Section Review, 59, Spring 2017, pp.65-68.*

Young, C. & Heller, M.C. (2000). The Scientific 'What' of Psychotherapy: Psychotherapy is a craft, not a science. *International Journal of Psychotherapy, Vol. 5, No. 2, pp. 113-131.*

Endnotes:

[1] Many of these 'controls' are 'supposed' to ensure that we "do no harm"! - i.e. If psychotherapy is powerful enough to do good, it may be powerful enough to do harm: (See: Dimidjian, S. & Hollon, D.S. (2010). "How would we know if psychotherapy were harmful?" *American Psychologist, 65, pp. 34–49*; Young, C. (2014). "The possible harmful side-effects of psychotherapy." *International Journal of Psychotherapy, Vol. 18, No. 2, pp. 63-82:* Castonguay, G.L., Boswell, F.J., Constantino, J.M., Goldfried, R.M. & Hill, E.C. (2010). "Training implications of harmful effects of psychological treatments". *American Psychologist, 65, pp. 34–49.*)

[2] **Meta-Analysis:** See Hilda Bastian (2014): PLOS Blogs: 5 Key Things to Know about Meta-analysis: - http://blogs.plos.org/absolutely-maybe/2014/01/20/5-key-things-to-know-about-meta-analysis. And also: Hilda Bastian (2015) Another 5 things to Know about Meta-analysis: - http://blogs.plos.org/absolutely-maybe/2015/06/30/another-5-things-to-know-about-meta-analysis

[3] **Shakespeare, W.** *Romeo & Juliet: Prologue:* "Two households, both alike in dignity, In fair Verona, where we lay our scene, From ancient grudge break to new mutiny, Where civil blood makes civil hands unclean."

[4] **NIHR-CRN:** https://www.crn.nihr.ac.uk/mentalhealth/

[5] **AHRQ-PBRN:** https://pbrn.ahrq.gov/about

[6] **Limbus Conference website: Downloadable papers:** Shedler (2010). The Efficacy of Psychodynamic Psychotherapy**;** Longmore & Worrell (2007). Do we need to challenge thoughts in Cognitive Behavioural Therapy?**;** Adams (2008). Naughty not N.I.C.E.: Implications for therapy and services; Ferraro (2015). Torture, Psychology & the Neoliberal State; Henrich, Heine & Norenzayan (2008). The Weirdest People in the World; Richardson (1997). Fields of Play: Constructing an academic life; Greenhalgh (2014). Evidence based medicine: a movement in crisis?**;** Samuels & Veale (2007). Improving Access to Psychological Therapies: For and Against; Westen, Novotny & Thompson-Brenner (2004). The Empirical Status of Empirically Supported Psychotherapies: Assumptions, Findings, and Reporting in Controlled Clinical Trials. http://www.limbus.org.uk/cbt/papers.html

[7] **IAPT:** Increased Access to Psychological Therapists.

[8] **"… no time to stand and stare":** Davies, W.H. (1911). "Leisure". In: *Collected Poems".* London: A.C. Fifield.

[9] **Letter to *The Guardian*:** http://www.theguardian.com/society/2015/apr/17/austerity-and-a-malign-benefits-regime-are-profoundly-damaging-mental-health

[10] **Lord Layard, a UK government economist,** was one of the drivers behind Improving Access to Psychological Therapies, an initiative to widen access to psychological treatments: "… treating someone for depression or anxiety disorders costs on average £650. The success rate is 50 per cent. If they then come off Employment Support Allowance as a result, the saving to the taxpayer is £650 a month. So, a single outlay of £650 can save £650 a month." … "People with mental health problems cost the NHS an extra £2,000 each in their physical

healthcare (in trips to A&E, for example), or £10bn in total. Spend more on psychotherapy and the cost would be covered by the saving on physical healthcare." … "Around seven million people are afflicted by a mental health condition, but only 15 per cent of that total are being treated. 'It's too low, it's outrageous,' fumes Layard." … "his passion is happiness and, in particular, mental health. 'I've always been interested in happiness. I became aware of evidence-based psychotherapy, which meant that for the first time, results could be measured – it was possible for instance to measure happiness of the old people in an old peoples' home.'"

[11] **Resources for Children of Holocaust Survivors**: Therapy: www.coshresources.org/coshtherapy.htm

[12] **Psychotherapeutic Work with Intergenerational Trauma:** Confer on-line programmes: www.confer.uk.com/module-intergenerational.html

[13] **Gordon, J.S. (2015**). 4 techniques used around the world to heal trauma. www.mindbodygreen.com/wc/dr-james-s-gordon

[14] **Living Well NLP**: 25 techniques for treating emotional trauma and PTSD: http://www.livingwellnlp.com/25-techniques-for-treating-emotional-trauma-and-ptsd/2010/

[15] **Dose-Response relationship:** Howard, K.I., Kopte, S.M., Krause, M.S. & Orlinsky, D.E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41 (2), pp. 159–164.*

[16] **Consumer determinant of outcome:** Orlinsky, D.E., Rønnestad, M.H. & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In: M.J. Lambert (Ed.), *Bergin & Garfield's Handbook of Psychotherapy and Behavior Change (5th ed.),* (pp. 307-390). New York: Wiley.

[17] **Improvement in the alliance over the course of treatment:** Anker, M.G., Duncan, B.L., Owen, J. & Sparks, J.A. (2010). The alliance in couple therapy: Partner influence, early change, and alliance patterns in a naturalistic sample. *Journal Consulting and Clinical Psychology, 78 (5), pp. 635-645.*

[18] **Level of client's distress:** Duncan, B.L., Miller, S.D., Wampold, B.E. & Hubble, M.A. (Eds.). (2010). *The heart and soul* of change: Delivering what works in therapy (2nd ed.). Washington, DC: American Psychological Association.

[19] **Clinician's Allegiance:** Hubble, M.A., Duncan, B.L., Miller, S.D. & Wampold, B.E. (2010). Introduction. 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. 23- 46). Washington, DC: American Psychological Association.

[20] **Therapeutic Alliance (a):** Norcross, J.C. (Ed.). (2011). *Psychotherapy relationships that work: Evidence-based responsiveness (2nd Ed.)*. New York: Oxford.

[21] **Therapeutic Alliance (b):**

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

(ii) Martin, D.J., Garske, J.P. & Davis, M.K. (2000). Relationship of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68 (3), pp. 438–450.*

[22] **Therapeutic Alliance (b):** Norcross, J.C. (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- 141). Washington, DC: American Psychological Association.

[23] **Difference in Therapeutic Alliance:** Baldwin, S.A., Wampold, B.E. & Imel, Z.E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75(6), pp. 842–852.*

[24] **Differences in therapeutic alliance:**

(i) 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), pp. 693-704.*

(ii) Anker, M.G., Duncan, B.L. & Owen, J. & Sparks, J.A. (2010). The alliance in couple therapy: Partner influence, early change, and alliance patterns in a naturalistic sample. *Journal Consulting and Clinical Psychology, 78 (5), pp. 635-645.*

[25] **Monitoring the Alliance:**

(i) Duncan, B.L., Miller, S.D., Wampold, B.E. & Hubble, M.A. (Eds.). (2010). *The Heart and Soul of Change: Delivering what works in therapy (2nd ed.).* Washington, DC: American Psychological Association.

(ii) Harmon, C., Hawkins, E.J., Lambert, M.J., Slade, K. & Whipple, J.L. (2005). Improving outcomes for poorly responding clients: The use of clinical support tools and feedback to clients. *Journal of Clinical Psychology, 61 (2), pp. 175–185.*

(iii) Lambert, M.J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice.* Washington, DC: American Psychological Association.

(iv) Miller, S.D., Duncan, B.L. & Hubble, M.A. (2007). Supershrinks. *Psychotherapy Networker, 31(6), pp. 26-35, 56.*

[26] **CORE-IMS (Information Management System):** www.coreims.co.uk. This is a system of client self-report questionnaire that is designed to be administered before, during and after therapy. The client is asked to respond to 34 questions about how they have been feeling over the last week, using a 5-point scale ranging from 'not at all' to 'most or all of the time'. The 34 items of the measure cover four dimensions: * Subjective well-being; * Problems/symptoms; * Life functioning; * Risk/harm. There is also a **Therapy Assessment Form** and an **End of Therapy** form. There are currently over 250 CORE PC Users including: • over 40 Primary care services • 40 Secondary & Tertiary Care services•30 Workplace services • 80 Voluntary sector services • 30 University services • 10 Private services. Using this system can (a) measure the outcome of a particular therapist's clients; or (b) compare therapists within the same service.

[27] **Therapeutic Risk Assessments:** http://www.bacp.co.uk/ethical_framework/good_standard.php; http://www.lifeforce-centre.co.uk/downloads/level4_yr2/session11/suicidal_client.pdf; http://www.therapytoday.net/article/show/1016/personal-safety-do-counsellors-care/

[28] **University of Sheffield**: https://www.sheffield.ac.uk/news/nr/preventing-adverse-effects-of-psychological-therapies-1.376074 => Supporting Safe Therapy: http://www.supportingsafetherapy.org/

[29] **Populations with Special Needs:** http://emc.ornl.gov/publications/PDF/Population_Special_Needs.pdf

[30] **Bona-fide Treatments:**

(i) Anderson, T., Lunnen, K.M. & Ogles, B.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, DC: American Psychological Association;

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

(iii) Frank, J.D. & Frank, J.B. (1991). *Persuasion and Healing: A comparative study of psychotherapy (3rd Ed.)* Baltimore: Johns Hopkins University Press;

(iv) Imel, Z.E. & Wampold, B.E. (2008). The common factors of psychotherapy. In: S.D. Brown & R.W. Lent (Eds.), *Handbook of Counseling Psychology (4th Ed.)*, (pp. 249-266). New York: Wiley;

(v) Wampold, B.E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist, 62, pp. 857-873*;

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

[31] **No difference in different treatment approaches for psychotherapy**: Wampold, B.E., Mondin, G.W., Moody, M., Stich, F., Benson, K. & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes." *Psychological Bulletin, 122 (3), pp. 203-215.*

[32] **No difference in different treatment approaches for Depression**: 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, pp. 159-165.*

[33] **No difference in different treatment approaches for PTSD:** Benish, S., Imel, Z.E. & Wampold, B.E. (2008). The relative efficacy of bona fide psychotherapies of post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review, 28, pp. 746-758.*

[34] **No difference in different treatment approaches for Alcohol Issues:** Imel, Z.E. & Wampold, B.E. (2008). The common factors of psychotherapy. In: S.D. Brown & R.W. Lent (Eds.), *Handbook of Counseling Psychology (4th Ed.)*, (pp. 249-266). New York: Wiley.

[35] **No difference in different treatment approaches for Common Issues in Children & Youth:** Miller, S.D., Wampold, B.E. & Varhely, K. (2008). Direct comparisons of treatment modalities for youth disorders: A meta-analysis. *Psychotherapy Research, 18, pp. 5-14.*

[36] "**All Should Have Prizes":** Wampold, B.E. (2001). *The Great Psychotherapy Debate: Models, methods, and findings.* Mahwah, NJ: Lawrence Erlbaum.

[37] **Drop-Out Rates:** Wierzbicki, M. & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24 (2), pp. 190-195.*

[38] **Drop-Out Rates for Children & Adolescents:**

(i) Garcia, J.A. & Weisz, J.R. (2002). When youth mental health care stops: Therapeutic relationships problems and other reasons for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology, 70 (2), pp. 439-443*;

(ii) Kazdin, A.E. (1996). Dropping out of child psychotherapy: Issues for research and implications for practice. *Child Clinical Psychology, 1, pp. 133-156.*

[39] **Deterioration Rates:**

(i) Hansen, N., Lambert, M.J. & Forman, E.M. (2002). The psychotherapy dose-response effect and its implication for treatment delivery services. *Clinical Psychology: Science and Practice, 9 (3), pp. 329–343*;

(ii) Lambert, M.J. & Ogles, B.M. (2004). The efficacy and effectiveness of psychotherapy. In: M.J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change (5th ed.)*, (pp. 139–193). New York: Wiley.

[40] **Deterioration Rates with Children:** Warren, J.S., Nelson, P.L., Mondragon, S.A., Baldwin, S.A. & Burlingame, G.A. (2010). Youth psychotherapy change trajectories and outcomes in usual care: Community mental health versus managed care settings. *Journal of Consulting and Clinical Psychology, 78 (2), pp. 144-155.*

[41] **Costs of Drop-Outs:** Miller, S.D. (2011). Psychometrics of the ORS and SRS. Results from RCTs and Meta-analyses of Routine Outcome Monitoring & Feedback. The Available Evidence. Chicago, IL. http://www.slideshare.net/scottdmiller/measures-and-feedback-january-2011.

[42] **Clients at risk of treatment failure:** Hannan, C., Lambert, M.J., Harmon, C., Nielsen, S.L., Smart, D.W., Shimokawa, K., *et al.* (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology: In Session, 61, pp. 155-163.*

[43] **Prevention of Treatment Failure:**

(i) Lambert, M.J. (2010). Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice. Washington, DC: American Psychological Association.;

(ii) Miller, S.D., Duncan, B.L., Sorrell, R. & Brown, G.S. (2004). The Partners for Change Outcome Management System. *Journal of Clinical Psychology, 6 (12), pp. 199-208.*

[44] **Variations between Clinicians:**

(i) Brown, G.S., Lambert, M.J., Jones, E.R., & Minami, T. (2005). Identifying highly effective psychotherapists in a managed care environment. *American Journal of Managed Care, 11 (8), pp. 513-520;*

(ii) 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), pp. 914–923.*

[45] **Improvements in Clients of Effective Therapists:** 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), pp. 914–923.*

[46] **Ability to form Alliances with Clients:** Baldwin, S.A., Wampold, B.E. & Imel, Z.E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75 (6), pp. 842–852.*

[47] **Effective therapists work harder:** Hubble, M.A., Duncan, B.L., Miller, S.D. & Wampold, B.E. (2010). Introduction. 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. 23- 46). Washington, DC: American Psychological Association.

[48] **Client's rating of Therapist:** Bachelor, A. & Horvath, A. (1999). The therapeutic relationship. In: S.D. Miller (Ed.), *The Heart and Soul of Change: What works in therapy*, (pp. 133– 178). Washington, DC: American Psychological Association.

[49] **Most Therapists Haven't Assessed Themselves:**

(i) Hansen, N., Lambert, M.J. & Forman, E.M. (2002). The psychotherapy dose-response effect and its implication for treatment delivery services. *Clinical Psychology: Science and Practice, 9(3), pp. 329–343.*

(ii) Sapyta, J., Reimer, M. & Bickman, L. (2005). Feedback to clinicians: Theory, research, and practice. *Journal of Clinical Psychology, 62, pp. 145-153.*

[50] **Therapists unable to self-assess accurately:**

(i) Dew, S. & Reimer, M. (2003). Why inaccurate self-evaluation of performance justifies feedback interventions. In: L. Bickman (Chair), *Improving outcomes through feedback intervention. Symposium conducted at the 16th Annual Research Conference, A System of Care for Children's Mental Health: Expanding the Research Base*, Tampa, University of South Florida, The Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

(ii) Lambert, M.J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice.* Washington, DC: American Psychological Association.

[51] **Therapists over-rate their effectiveness:** Walfish, S., McAllister, B., & Lambert, M. J. (unpublished manuscript, 2010). *Are all therapists from Lake Wobegon*? An investigation of self-assessment bias in health providers.

[52] **Therapists can affect outcome:** 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), pp. 914–923.*

[53] **Factors that don't affect outcome:**

(i) Beutler, L.E., Malik, M., Alimohamed, S., Harwood, T.M., Talebi, H., & Noble, S. (2004). Therapist variables. In: M.J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (5th ed.), (pp. 227-306). New York: Wiley., 2004;

(ii) Hubble, M.A., Duncan, B.L., Miller, S.D. & Wampold, B.E. (2010). Introduction. 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. 23- 46). Washington, DC: American Psychological Association.;

(iii) Nyman, S.J., Nafziger, M.A. & Smith, T.B. (2010). Client outcomes across counselor training level within a multi-tiered supervision model. *Journal of Counseling and Development, 88, pp. 204-209.*

(iv) Miller, S.D., Duncan, B.L. & Hubble, M.A. (2007). Supershrinks. *Psychotherapy Networker, 31 (6), 26-35, p. 56*;

(v) 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), pp. 914–923.*

[54] **Modalities that don't affect outcome:**

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

(ii) Imel, Z.E. & Wampold, B.E. (2008). The common factors of psychotherapy. In: S.D. Brown & R.W. Lent (Eds.), *Handbook of Counseling Psychology (4th ed.),* (pp. 249-266). New York: Wiley.

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

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

(v) 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, pp. 159-165.*

[55] **Matching therapy to diagnosis:** Wampold, B.E. (2001). *The Great Psychotherapy Debate: Models, methods, and findings.* Mahwah, NJ: Lawrence Erlbaum. NJ: Lawrence Erlbaum.

[56] **Adherence to a particular treatment approach:**

(i) Duncan, B.L. & Miller, S.D. (2005). Treatment manuals do not improve outcomes. 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. 140-160). Washington, DC: American Psychological Association

(ii) Webb, C.A., DeRubeis, R.J. & Barber, J.P. (2010). Therapist adherence/competence and treatment outcome: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78 (2), pp. 200-211.*

[57] **Elvira G. Aletta blog:** http://psychcentral.com/blog/archives/2011/03/16/10-reasons-why-someone-in-therapy-may-not-be-getting-better/

[58] **Wall, Ann-Marie** reported on this talk by Professor Waller at Kirklands Hospital, NHS Lanarkshire in May 2017: *Are we too nice to be effective therapists?* reported in *DCP-S Review, No. 16, pp. 50-53.*

[59] **Paradoxical Intervention:** Corey, G. (2012). *Theory and Practice of Counselling and Psychotherapy: 9th Ed.* Belmont, CA: Brooks/Cole.

[60] **Empty Chair:** Perls, F.S. (1992). *Gestalt Therapy Verbatim: 2nd Ed.* Gouldsboro, ME: Gestalt Journal Press.

[61] **The Miracle Question:** Metcalf, L. (2007). *The Miracle Question: Answer it and change your life.* Carmarthen, Wales, UK: Crown House Publishing.

[62] **Voice Dialogue:** Stone, H. & Winkelman, S. (1988). *Embracing Our Selves: Voice Dialogue Manual.* Novato, CA: Nataraj Publishing.

[63] **Hunger Illusion:** Weinberg, G. (1996). *The Heart of Psychotherapy: The most honest, revealing, fascinating account of what goes on in therapy.* New York: St Martin's Press.

[64] **Head-On Collision:** Johansson, R., Town, J.M. & Abbass, A. (2014). Davanloo's Intensive Short-Term Dynamic Psychotherapy in a tertiary psychotherapy service: overall effectiveness and association between unlocking the unconscious and outcome. *Peer Journal, 2. p. 548.*

[65] **Transference Interpretation:** Gabbard, G.O. (2010). *Long-term Psychodynamic Psychotherapy: A basic text. 2nd Ed.* Washington: American Psychiatric Publishing.

[66] **Sand-Play for Children:** Kalff, D.M. (1980). *Sandplay: A psychotheraputic approach to the psyche.* Cloverdale, CA: Temenos Press.

[67] **R.D. Laing:** A British 'radical' psychiatrist who founded Kingsley Hall. (see: T. Itten & C. Young (Eds.), *R.D. Laing: 50 years after 'The Divided Self'.* Ross-on-Wye, UK: PCCS Books.

[68] **Edward Podvoll**: author of "The Seduction of Madness: Revolutionary insights into the world of psychosis and a compassionate approach to recovery at home" (1990) and "Recovering Sanity: A compassionate approach to understanding and treating psychosis" (2003) and medical director and founder of the Windhorse Community in Boulder, Colorado and the Windhorse model of treatment.

[69] **Loren Mosher** was an American psychiatrist, who – when he was in London in the 1960s – became interested in alternative treatments for schizophrenia. He founded 'Soteria' (originally in San Jose, CA), as he believed that the violent and controlling atmosphere of psychiatric hospitals and the over-use of psychotropic drugs hindered recovery. Despite its success (it achieved superior results than the standard medical treatment with drugs), the original house closed in 1983 as further funding was denied because of the politics of psychiatry that were controlled by the pharmaceutical companies. Since then, other 'Soteria' community houses have been established in Switzerland, Sweden, Israel, Finland, Germany, Hungary and the USA. A 2008 systemic review analysed the success of the model.

[70] **Joseph Berke** was an American psychotherapist who worked with R.D. Laing at Kingsley Hall in the 1960s. He then co-founded the Arbours Association in north London (on a similar 'community' psychiatric/mental health model: www.arboursassociation.org). He is the author of several books including: *I Haven't Had To Go Mad Here"* (1979: Pelican) and *"Beyond Madness: Psychosocial interventions in psychosis.* (2001: Jessica Kingsley).

[71] **Michael Barnett** was the founder of "People, Not Psychiatry" a radical anti-psychiatry movement in London in the late 1960s and early 1970s. He had been active in radical alternatives to psychiatry for some time, offering a programme based not on drugs, repression and a 'questionable' expertise, but on human caring, greater awareness of the body, deeper communication between persons, and a willingness to let the emotions flow. It was a challenging alternative, which came at a time when the viability of scientific, theoretical and chemical approaches to distress were being questioned at all levels of society. The alternative methods included some of the new direct methods of healing (making whole) such as Encounter, Gestalt, Bioenergetics, Psycho-fantasy – methods that do not ***do*** things to people but allow them to feel their way into change through experimentation, experience, flow and choice.

[72] **OQ: Outcome Questionnaire (-45.2):** Available here, was devised by M.J. Lambert (and others) in 1996: it was designed to assess outcomes in the routine practice of psychotherapy and counselling for the purpose of enhancing the quality of treatment: such aims require that any outcome measure: **(a)** be easy to administer and score; **(b)** have high sensitivity to changes in psychological distress over short periods of time; **(c)** have low cost per administration; and **(d)** have the ability to tap into a wide array of characteristics associated with mental health functioning. It is not a diagnostic tool.

[73] **PCOMS: Partners for Change Outcome Management System:** PCOMS is a simple, evidence-based method for improving the quality and outcome of behavioural health services. It includes two evidence-based, trans-theoretical scales (the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS)) for monitoring the quality and outcomes of behavioural services, data from which is then integrated into clinical practice through Feedback-Informed Treatment (FIT). Randomized Controlled Trials (RCTs) have 'shown' that PCOMS as much as doubles the effectiveness of treatment, while simultaneously reducing dropout, deterioration rates and service delivery costs.