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Defining and delivering effective counselling and psychotherapy

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Following a brief historical summary of three mainstream approaches, this paper addresses the similarities and differences between the terms counselling and psychotherapy. After settling on counselling as the default term, the paper then provides a comprehensive definition, explores counselling's essentially voluntary nature and examines the practice and research divide between individual, couples and family focused work. Though there is good evidence for the effectiveness of individual, as well as couples and family counselling, it is acknowledged that amassing the evidence with respect to couples and family work has proved to be a more challenging task. The finding that the strength of counselling effectiveness has altered little over the past 40 years is then linked to the question of how counselling works. The evidence points away from a medically grounded focus on differential effects of particular models of counselling, towards common factors—especially the nature of the counsellor–client alliance—that appear to be present in all successful counselling outcomes. The common factors findings, in turn, suggest the need for a shift in focus from the relative efficacy of differing models of counselling to research into counsellor training and the ongoing development of counsellor expertise. A key correlate of this continued development has been shown to be counsellors' capacity and willingness to seek and act upon client feedback. Moreover, the formalisation of a feedback-informed approach via validated, user-friendly client feedback protocols permits the monitoring of outcomes on both a case-by-case and aggregate basis. This in turn provides a way forward with respect to developing an ongoing accountability framework for counsellors, counselling agencies and their funders.

KEY MESSAGES

- Differences between counselling and psychotherapy are largely in the eye of the beholder; both are relatively recent, mainly personally focused approaches to centuries-old traditions of providing culturally appropriate responses to "problems of living".
- Medically informed models of how counselling and psychotherapy "work" continue to inform much theory and practice, and have prompted thousands of studies seeking evidence for and against the relative efficacy of different "treatment" approaches.
- Almost all well conducted studies of mainstream counselling interventions have concluded that regardless of the model used, the average effect size of counselling (discussed in the body of the paper) is substantial and compares well with effect sizes achieved in established medical practice.
- Unlike medical interventions however, the effect size has little if anything to do with the particular model of treatment employed; rather, effects are linked to factors found to be common to all counselling interventions.
- Somewhat counter-intuitively, there is no convincing evidence that counsellor gender, qualifications, theoretical orientation, professional discipline or even years of experience impact noticeably on outcome; there *is* evidence that effective counsellors tend to be consistently effective, while ineffective counsellors tend to be consistently ineffective.

- Counsellors (as well as commentators and researchers) continue to struggle to reconcile models of individual counselling, focused mainly on internal emotional and cognitive processes, with couples or family counselling models focused mainly on quality of interactions between individuals.
- In both individual as well as couples and family counselling however, the focus of practice and research is increasingly turning to how the common factors that drive successful counselling interact with each other, and how counsellors gain, retain and develop their therapeutic expertise; research comparing the efficacy of differing models of counselling is unlikely to yield useful results into the future.
- Counsellors' willingness to systematically elicit, record and make use of client feedback in the context of establishing a sound therapeutic alliance appears to be strongly associated with good outcomes;the use of validated client feedback protocols also allows for the routine monitoring of outcomes by counsellors themselves as well as by counselling organisations and funding bodies.

Counselling and psychotherapy in a contemporary context: What is it?

> All the (healing) precursors to psychotherapy … bear a resemblance to each other and to later forms of healing like psychotherapy. (Duncan, 2014, p. 15)

Federal, state and local governments throughout Australia support a large range of counselling services in the belief that they provide an effective means of improving the lives of individuals, couples and families. It will be seen that broadly speaking, this belief is justified. But what gives counselling its potency? Impressive effect sizes demonstrated by research need to be reconciled with the fact that since its development in Western countries at least 400 intervention models and at least 145 manualised treatments have been developed, while more than 10,000 "how to" books on the "talking cure"[1] have been published (Beutler et al., 2005, cited in Miller, 2013). Not surprisingly, this plethora of options has been accompanied by much ongoing debate about the true nature of counselling and psychotherapy.

Mainstream developments of counselling and psychotherapy during the first half of the 20th century are provided in Box 1 (page 4). After demonstrating that differences between counselling and psychotherapy are largely in the eye of the beholder, the paper provides a comprehensive definition of counselling, the word used as the default descriptor in the remainder of the paper.

The paper then summarises the evidence regarding whether or not individual, couple and family counselling "works" and how it works. Evidence about how counselling works leads to a brief discussion of the critical question of how counsellors develop and maintain expertise and how, as an essentially private process, counselling can nonetheless provide appropriate levels of accountability for clients, employers, funding bodies and of course for counsellors themselves. The paper concludes with a number of observations regarding future practice options.

Counselling and psychotherapy: same or different?

Before offering a definition of counselling, it is useful to address the ongoing issue of whether counselling and psychotherapy are significantly different or largely represent two sides of the same coin.

1 This description of the "talking cure" process was coined by Bertha Pappenheim, an early recipient of contemporary psychotherapy. A patient of Josef Breuer (more widely known as "Anna O"; see Breurer & Freud, 1895), Bertha was cured of a range of symptoms through a process of talking and hypnosis.

Box 1: Origins of the "talking cure"

The seeds of *contemporary* approaches to counselling were probably sown in the wake of the Industrial Revolution. Giddens (1991) has described how within the larger more urbanised societies emerging at that time, traditional rules of living were increasingly challenged, whilst norms governing personal relationships became less constrained. As power, responsibilities and protections supported by local knowledge and recognised reference points began to diminish, the capacity of traditional healers to influence individual and group behaviour also waned.

According to Albee (1977), the gradual shift from life in villages and small towns to life within larger more anonymous societies prompted increased attempts to seek direction from within. The focus on inner direction, accompanied by the weakening of old certainties hitherto buttressed by religion and a sense of social and geographical belonging, created a need for more personalised help, guidance and support.

Clients with personal problems: the counsellor as expert

In the culture that followed the science-led Industrial Revolution, it is perhaps not surprising that science-informed alternatives to traditional morally and religiously based responses to "problems of living" began to gain acceptance. Scull (1975) for example, has demonstrated how the medical model, resting on taxonomies of physical illnesses and diagnostic criteria, was recruited into also creating categories of *psychological* disturbance (see also Foucault, 1967).

Experiments with hypnosis in the late 19th century, famously elaborated upon and eventually reinterpreted by Freud, represented an early departure from physically focused treatments. Though still firmly located within the medical profession,[2] Freud's development of psychoanalysis contained two foundational insights that continue to inform much (though not all) contemporary counselling and psychotherapy. They are firstly, the importance of the relationship between therapists and their patients; and secondly, the idea that the origins of some psychological difficulties are not fully accessible to conscious rational thought.

At about this time, behaviourism, an overtly rational approach to counselling, grew out of Pavlov's experiments with classical conditioning. In the United States, Watson (1919) applied Pavlov's stimulus-response work with dogs to learning in human beings, while Skinner (1938) extended Watson's work by introducing the broader concept of operant conditioning.

Though behaviourists continue to argue that psychological interventions must be based on observable and measurable learning principles, most have accepted the limitations of attempting to explain complex behaviours (such as language) via linear chains of stimuli and responses (see for example Lashley, 1951). Most contemporary behaviourists acknowledge that the processing of emotions and/or cognitions must also be part of the learning equation. Hybrid models such as rational emotive therapy (Ellis, 1962) and cognitive behavioural therapy (e.g., Westbrook, Kennerley, & Kirk, 2011) have largely replaced earlier "purer" expressions of behaviourism.

The self-healing client: the counsellor as facilitator

Both psychoanalytic and behaviourist approaches to alleviating psychological distress have tended to support top-down, expert-driven interventions. Limitations of this presumed expertise began to reveal themselves towards the middle of the 20th century, especially in the context of attempts to make sense of the Holocaust and other ravages of war.

In the United States, the need to offer practical and emotional assistance to so many returned service men and women coincided with the development of new forms of counselling that were focused on paying close and empathic attention to the client.[3] In developing a "person centred" approach, Rogers (1957) did not rely on diagnostic categories or expert-based interpretations of possible reasons behind clients' behaviour or distress. Rather, the self-actualising underpinnings of Rogers' philosophy of human development led him to suggest that being deeply heard and accepted by the counsellor would provide space for clients to discover their own understandings about their distress and their own solutions to their problems. Later research (described below) suggests that while "deep listening" may not be enough, Rogers was quite prescient in his analysis of *how* counselling and psychotherapy work.

2 In its early days for example, the American Psychoanalytic Association spent considerable time debating whether non-medically qualified individuals were eligible for admission (see Gifford & Thomson, 2011).

3 Australian Indigenous people refer to this process as "Dadirri" or "deep listening" (Brearly, 2010).

National occupation data from the 2006 Australian Census suggest that of the almost 15,000 individuals who identified themselves as counsellors and psychotherapists, the proportion of those who saw themselves as counsellors was considerably greater than the proportion who identified as psychotherapists (Australian Institute of Health and Welfare [AIHW], 2009).[4] As Schofield and Roedel (2012) have pointed out however, these numbers probably included only a small proportion of individuals who identified primarily as members of related professions such as psychology and social work. For many of these individuals, counselling and/or psychotherapy would be an aspect of their normal duties.

In their non-randomised survey of 1,003 Australian counsellors and psychotherapists, Schofield and Roedel (2012) found that 70% identified as counsellors and 45% as psychotherapists. Though some clearly saw themselves as both, this survey, like the 2009 Census data did not explore the question of how respondents made the distinction between these two areas of activity.

McLeod (2013) has suggested that both psychotherapists and personal counsellors:

- provide people with a confidential space in which to explore difficulties;
- believe that effective practice depends to a great extent on the quality of the client–practitioner relationship; and
- believe that self-awareness and personal therapy are valuable if not essential elements of counsellor and psychotherapy training and ongoing development.[5]

In terms of perceived differences, McLeod (2013) noted that psychotherapy is more likely seen as a wholly professionalised occupation.[6] Though also provided by paid professionals in many (probably most) cases, personal counselling is more likely than psychotherapy to include para-professionals (such as "pastoral counsellors"), volunteers (such as "Lifeline" counsellors), as well as those whose practices are formally linked to occupational roles (such as employment counsellors) or to responses to a particular class of events (such as grief counsellors).

There is some evidence that those identifying as psychotherapists tend to conceptualise their clients as individuals with psychological disorders or with problems in psychological functioning (sometimes thought of as a deficit model), whereas personal counsellors' default views of clients are more likely to be that of functioning individuals who are experiencing difficulties in operating within the circumstances or social contexts in which they find themselves. Consistent with this, counselling agencies are thought to be more effective when they are embedded within their communities, more able to appreciate the context of their clients' difficulties and more able to cross-refer to other relevant agencies or practitioners. The location of psychotherapy agencies on the other hand is usually thought to have little bearing on the outcome of the psychotherapeutic process[7]—consistent with a public perception that psychotherapy is less accessible, more expensive and more "middle class" in its focus than counselling (McLeod, 2013).

Broadly speaking, psychotherapeutic treatments originating from behavioural approaches commonly involve the application of interventions guided by protocols and manuals.[8] Psychotherapeutic treatments originating from both behavioural and psychodynamic approaches are also more likely to be theory driven and attached to a brand name (e.g., cognitive behavioural therapy or Jungian therapy). Though theory is important, counselling is less likely to be *driven* by theory or delivered with the aid of a treatment manual.

4 For example of the 4,429 of these practitioners working in the health sector, 1,370 identified as psychotherapists, while the remainder identified as counsellors.

5 Yalom, who has written a great deal on the art and science of psychotherapy, is unequivocal about the need for personal therapy to be part of counsellor training (see Yalom, Shaughnessy, Main, & Madewell, 2007).

6 It should be noted that there are no Australian laws or other formal restrictions preventing an untrained individual from using the terms, counsellor, therapist or psychotherapist.

7 This suggestion finds some support in Schofield and Roedel's (2012) survey of Australian practitioners, which found that while 83% of individuals who described themselves as psychotherapists worked in private practice, only 41% of those who identified themselves as counsellors worked in a private setting.

8 Indeed adherence to protocols and manuals specified by the particular brand of therapy are an important part of the basis upon which claims of evidence-based practice are made.

In terms of practitioner recruitment, psychotherapists are generally required to have formal training or qualifications in the brand or *type* of therapy they offer.[9] Counsellors are more likely to be drawn from a wider variety of backgrounds. They may or may not be well qualified in the formal sense of the term. Typically, entrance requirements into the counselling profession place a high value on life experience and personal maturity and self-awareness. Entrance to both psychotherapy and counselling courses might also require experience of or willingness to participate in personal therapeutic work.

It is important to recognise that the similarities and differences noted above describe broad characteristics only. As McLeod noted:

> In reality, the domains of counselling and psychotherapy are fragmented and complex and embrace a multiplicity of forms and practice. It would not be hard to find examples of psychotherapy practice that corresponds to characteristics attributed … to counselling (and vice versa). (2013, p. 12)

Like McLeod, I have decided in the remainder of this document to use the words counsellor and counselling as the default terminology. However, because the literature uses words like "psychotherapy/psychotherapist" or "therapy/therapist" alongside counselling/counsellor and at times as a replacement for the latter terms,[10] I also use these words when the context demands it.

Defining personal counselling[11]

Within mainstream Western cultures, personal counselling involves *collaborative discussions* in a *supportive and confidential environment* aimed at arriving at an *account* (or accounts) of a *problem* (or set of problems) for the *purpose* of assisting the client(s) to reach a point at which the problem(s):

- no longer exist;
- are transformed into opportunities and/or better management of self, relationships or the wider environment; or
- continue, but in less debilitating, more manageable form[s].

The key elements of this core definition are elaborated below.

Collaborative discussions:

- imply a relational[12] rather than a top down advisory approach[13] to understanding the problem(s) and to engaging in therapeutic processes to address them;
- acknowledge need for a shared and contextual approach to understanding clients' problems and the use of diagnostic language;[14] and
- require, above all, the development and maintenance of a trusting relationship between client[s] and counsellor.

9 But see the rider to this noted in footnote 6.

10 For example, the most recent and perhaps most comprehensive analysis of the efficacy of "counselling" and the ingredients that contribute to its success (Wampold & Imel, 2015), has the title, *The Great Psychotherapy Debate*.

11 The definition has been derived from my own reading of the research and practice literature, combined with experience in the teaching and practice of counselling and "counselling psychology".

12 The term "relational" here implies collaboration between the client(s) and the counsellor. In individual counselling, the foci of that collaboration are typically issues and conflicts that are seen as internal to the client. When more than one client (typically a couple or a family) is involved in the counselling process, the foci of the work are more likely to be the relationships *between* those clients. In these situations, the relationship between the clients and the counselor nonetheless remains a very important aspect of the process.

13 As an intervention aimed at improving personal wellbeing and assisting with "problems of living", personal counselling in Western countries is frequently confused with more "common sense" uses of the concept of "counsel" or "counselling". Terms such as legal counsel and financial counselling for example, assume the delivery of advice arising out of an expert knowledge of content. Though personal counsellors typically have expertise in theories of human and social change, their core expertise lies in facilitating *processes* that will assist clients in arriving at outcomes that meet their particular needs. Personal counselling is essentially contextual and is informed by a default expectation that while they might be distressed, confused or emotionally labile, clients are experts in their own lives.

14 Consider the difference between, "I have an anxiety disorder" and "I feel anxious in the following situations".

Provision of a *supportive environment* is based on recognising:

- unconditional positive regard for the client(s) as a fundamental building block of the counsellor/client relationship;
- that making attitudinal and behavioural changes is usually experienced as a challenging process; and
- that through attention to constructing a therapeutic relationship, counsellors must "earn the right" to support and provide feedback on clients' attempts to change their attitudes and behaviours.

Provision of a *confidential environment* recognises:

- the importance of creating a sense of safety in the counselling setting and counselling relationship; and
- that confidentiality is always limited by the counsellor's duty of care to the client and duty to warn others of dangerous possibilities or dangerous intentions.

Account(s):

- are narratives that give meaning to client concerns or distress;[15]
- provide context for the identified problem(s); and
- must be congruent with (even if challenging of) the way the client(s) "see the world".

Problems are perceptions, behaviours or external forces that compromise individuals' quality of life and impact on their personal potential,productivity and enjoyment of life. Problems may be located or be seen to be located:

- internally;
- interpersonally;
- externally; or
- within two or more of the above domains.

In fulfilling any of its above "purposes", counselling aims to:

- relieve distress;
- enhance personal, interpersonal and social functioning; and
- enhance capacity to manage everyday affairs.

A glance at the counselling literature reveals a multitude of more succinct definitions than that suggested above. Though many share common elements, McLeod (2013) made the significant observation that definitions tend to be offered not from the perspective of the client, but from that of the counsellor or counselling profession. McLeod's implied criticism of such definitions stems from recognising a contemporary shift in focus away from counsellors having expertise in the content of a clients' concerns, to counsellors acting as a collaborators with their clients.[16]

An example of a professionally focused approach is as follows:

> [Counselling is] a principled relationship characterised by the application of one or more psychological theories and a recognised sense of communication skills, modified by experience, intuition and other interpersonal factors, to clients' intimate concerns problems or aspirations. (Feltham & Dryden, 1993, as cited by McLeod, 2013, p. 7)

From the perspective of the *client*, McLeod has offered the following definition:

> Counselling is a purposeful private conversation arising from the intention of one person, couple or family to reflect on and resolve a problem in living and the willingness of another person to assist in that endeavour. (McLeod, 2013, p. 7)

15 A form of counselling known as narrative therapy has clients' accounts or stories of their lives as its main focus of intervention. Narrative therapy aims to assist clients "re-author" stories that are "problem saturated" or "re-story" conversations associated with dysfunctional relationships.

16 The expanded definition of counselling in this document owes much to Rogers' (1957) person centred approach noted earlier. Of course when appropriate, effective counsellors draw on key insights from a broad range of orientations, including developments arising out of the psychodynamic and behaviourist approaches also summarised briefly above. Effective counsellors would for example recognise the now overwhelming neurological evidence that we are not always consciously aware of how we make decisions or of what motivates us towards certain behaviours (Lehrer, 2010; Atkinson, 2014). They would also recognise that the pairing of stimuli (expanded to include cognitions and emotions) with habitual responses can lead to either adaptive or non-adaptive behaviours.

Counselling as a voluntary process

In the above client-focused definition of counselling, McLeod (2013) speaks of the *intention* of clients to reflect on and resolve a problem. Clients who voluntarily seek counselling could generally be assumed to have an intention to change something in their lives for the better.[17] Amongst clients *referred* to a counsellor by a service or another professional, however, motivation to identify and "deal with" problems is likely to be more varied.

Referrals may be actively facilitated after consultation with the client (sometimes known as a "warm" or "facilitated" referral); or the person may be simply informed of the existence of a counselling service and left to his or her own devices regarding follow-up. In the case of facilitated referrals, client motivation to make use of counselling is likely to have been explored or at least considered as part of the referral process. In the case of non-facilitated referrals, this is less likely to be the case.

In either of the above situations, referrals may also involve elements of coercion. The client may be told for example that, "The conditions under which you can continue to parent your children include consulting with a counsellor."[18] The extent to which most researchers and commentators would regard what happens in these circumstances as an example of counselling would largely depend on what sort of alliance the counsellor was able to make with his or her client, notwithstanding the conditions under which the client had been referred.

Regardless of the original intention therefore, effective counselling requires that the person deemed to be seeking help (the client) is, or becomes, willing to engage. That is, counselling is a facilitated process rather than something a counsellor does *to* the client. The counsellor can invite—perhaps even persuade—but not force or "require" the client to take part.

Thus it is important to recognise that clients not ready or not willing to accept the invitation to participate in counselling may find themselves exposed to the best efforts of expert counsellors—perhaps even for long periods of time. They may be "seeing a counsellor" but counselling may not be occurring. Counselling as defined above can only occur when clients are *co*-participants in the process rather than passive recipients of counsellor interventions.[19]

McLeod's (2013) definition of counselling cited above also speaks of conversations between a counsellor and a "person, couple or family" (p. 7). The latter conversations between a counsellor and a couple or family are broadly defined as relationship counselling. But as noted below, the default presumption in most of the writing and most of the research on the subject is that "counselling" takes place with individual clients. Before proceeding to questions of whether and how counselling works therefore, it is important to address the paradoxical reality of the importance but relatively low status of relationship counselling.

The status of relationship counselling: a continuing conundrum

As the phrase suggests, relationship counselling aims to assist individuals to recognise and better manage or reconcile problematic differences and/or repeating patterns of stress in their

17 See Prochaska, Norcross, and DiClemente (2013) for a more in depth exploration of this assertion.

18 Johnston, Roseby, and Kuehnle (2009) have provided a good example of a comprehensive intervention by a judicial officer that included a requirement to attend counselling:

> Mr. R, what you have done to your wife is a criminal act under the laws of this state regardless of what you say she did or said to provoke you, and there are consequences that the court is bound to impose. What you did to your wife is also very harmful to your children, whether they actually witnessed the event or not. Living in a violent home is bad for the children. Mr. R, I hear you when you say you love your wife and children, that you are sorry for what you did, and that you have promised not to do that again. The court is going to help you keep that promise to yourself and your family by doing three things: first, by providing your family with protection until it can be sure that you are no longer a danger, and you can show that you are no longer a danger; second, by providing you an opportunity to manage your anger better and to resolve conflict in a non-violent way; and third, by providing you and your children a safe place to visit together, where they will not be afraid, and you will be given an opportunity to show that you have a loving relationship with your son and daughter. (Johnston et al., 2009, p. 27)

19 De Shazer (1984) identified three categories of clients—visitors, complainants and customers. In De Shazer's terms, the only true counselling clients are those who are or who can be recruited into becoming "customers".

relationships. Relationship counselling is typically conducted as: couples counselling/couples therapy; marriage counselling/marital therapy; or family counselling/family therapy. To distinguish itself from individual counselling, the research and practice literature uses the term, "Marital and Family Therapy" (MFT) or more recently (and perhaps more appropriately), "Couples and Family Therapy" (CFT).

About one in eight counsellors working in the Australian community sector identify as a "marriage and family counsellor". Substantial minorities of Australian counsellors have reported that they do *some* work with couples,[20] while overseas, Orlinsky and Ronnestad (2005) noted that in the largest study of psychotherapists conducted until that time, 70% reported that they did at least some work with couples. Lebow and his colleagues found this figure to be:

> [a] remarkable statistic, which may give some pause when one considers the limited training in couple therapy in professions other than marriage and family therapy and family psychology. (Lebow, Chambers, Christensen, & Johnson, 2012, p. 147)

These authors go on to suggest that although they believe there is good (if relatively recent) evidence to show that couple counselling is effective, lack of training may be the reason why couples counselling had one of the lowest ratings in terms of consumer satisfaction in the *Consumer Reports* study of psychotherapies (Seligman, 1995). There is an important presumption underpinning this statement—that training to work with individuals does not necessarily equip counsellors to work effectively with couples and families—that a somewhat different set of skills is needed to work with more than one client at the same time.

It is significant in this regard that McLeod's (2013) *Introduction to Counselling* devotes less than two of its 751 pages to counselling with couples and only one of its 26 chapters to the subject of working with families. Consistent with this, the most recent major review of counselling published by the American Psychological Association (APA) (Duncan, Miller, Wampold, & Hubble, 2014) devoted less than 10% of its content (one of 14 chapters) to research into "couples and family work"; while Wampold and Imel's (2015) impressive presentation of the evidence for "what makes psychotherapy work" makes no mention at all of interventions with couples or families.

Gurman and Fraenkel (2002), Johnson and Lebow (2000), Lebow et al. (2012) and Sprenkle (2002) have all observed that conjoint counselling[21] with couples and families has continued to struggle to establish its credibility. The relative lack of attention to this form of counselling is puzzling given that Gurman and Fraenkel also noted that as early as 1960, over 40% of all people seeking psychological help viewed the nature of their problem as "marital'. We have known for some time that being in a successful committed relationship is associated with a range of both physical and psychological benefits (Brannon & Feist 1997); and that on the other side of the coin, significant adverse physical and psychological consequences are associated with ongoing relationship conflict (Elridge & Baucom 2012; Noller 2012).

It is beyond the scope of this paper to provide a comprehensive review of why the skills and challenges associated with conjoint counselling have, comparatively speaking, received so little attention from training establishments and from researchers. One reason might be found in the fragmented and sometimes religiously focused beginnings of what was originally called marriage guidance or marriage counselling (Gurman & Fraenkel, 2002). Another may be the considerably

20 The 2009 Australian Census reported that of the nearly 10,500 counsellors who worked in the community service sector, roughly 1,300 (about 12%) identified as marriage and family counsellors (AIHW, 2009). At the same time, more than half the 1,003 Australian counsellors surveyed by Schofield and Roedel (2012) reported that at least some of their practice involved "work with couples"; and roughly a quarter reported "working with families" some of the time. Though more than two in five (44%) respondents listed helping clients to improve their relationships as one of their four most important goals, it is unclear how many would have included working exclusively with one individual or working sequentially with individuals in a relationship with each other as "couple" or "family" work.

21 The term "conjoint therapy", that is, working with more than one client at a time, was made popular by Satir (1964).

greater complexity involved in defining and then researching what makes for good outcomes and effective processes in couples and family work (Lebow et al., 2012).[22]

A third reason could be the difficulties experienced by many practitioners and commentators in incorporating systemic approaches into working with more than one person at a time. Underpinning systemic approaches, a key focus of many family therapists, is the core proposition that we are primarily *relational* beings, whose wellbeing and very existence is dependent on membership of a family, group or community. Systemic counselling grew out of a perception that individually focused attempts to assist in the resolution of marital/relationship problems and children's emotional and behavioural difficulties were inadequate. These perceptions were supported by credible, though largely anecdotal, observations of the occurrence of relapses after clients who had worked with individual counsellors returned to the "real world" of their partners and families, and observations (again largely anecdotal) that successful resolution of one family member's problems sometimes led to the emergence of problems in another family member (Carr, 2006).[23]

On the question of systemic approaches employed by many family therapists and some couple therapists, McLeod (2013) raised a key issue that continues to challenge much of the counselling profession:

> It is difficult to integrate traditional family therapy into "mainstream" models of counselling for a number of reasons, some philosophical, some practical. The emphasis of family therapists … on what goes on *between* people rather than what goes on *inside* them does not sit easily with counsellors trained to work with self, feelings and individual responsibility … The application of family therapy makes a range of demands that most counsellors could not countenance. (p. 273–274)

It could be argued that the individual focus of "mainstream" counselling is primarily attuned to the dominant culture in Western countries, which for at least the past 100 years has emphasised individual needs and individual rights. At the same time McLeod (2013) observed that:

> Systemic therapy has taken up the challenge of implementing a relational philosophy based on an understanding that in the end, individualism is not an adequate basis for living a good life. (p. 284)

McLeod's observation continues to present a challenge to counsellors. In the end however, it is likely that the most effective counsellors are those able to work with equal ease with the spaces (relationships) between individuals as well as with the internal emotions and cognitions of individuals themselves. Amongst other things, the expertise of these counsellors is likely to lie in making sound clinical judgments with respect to where the focus is best placed at any given moment.

The next section addresses the question of whether or not individual and relationship counselling actually "works".

22 In their recent work on effective principles for couples therapy, Gottman and Gottman (2015) have drawn attention to this problem by asking questions such as the following:
- How are you supposed to get at something as elusive as "a relationship"?
- How do you empathise with both clients if they have opposite points of view?
- Are you only successful if you keep couples together?
- If clients give different answers, who should you believe?
- What are you supposed to do with all the emotional and personal history that your clients stir up in you?
- How can you make your work research-based?

23 A concept that places systemic theory in some tension with individual counselling models is that of the "identified patient". The behavioural or emotional difficulties of a child, for example, might be seen by a systemic counsellor as indicative of or indeed a proxy for a stressed relationship between the child's parents or between other members of the family on whom the child depends. Rather than focusing exclusively on the child's distress, the counsellor would consider the possibility that the child's role in the family has become that of the "canary in the mine". The counsellor might therefore seek permission to explore a broader range of relationships in the family.

Does counselling "work"?

> Great doubt: great awakening. Little doubt: little awakening. No doubt: no awakening. (Zen Mantra, cited in Sparks and Duncan, 2014, p. 357)

Early controversies

Systematic research into the outcome of psychoanalysis in the 1930s and 1940s, came to the conclusion that about two thirds of the recipients benefited, while about a third showed no improvement or deteriorated (Rachman & Wilson, 1980). Though these were encouraging early findings for psychoanalysts as well as other practitioners of the "talking cure", we can recognise that by today's standards, they were methodologically naive. Amongst a range of other limitations, these studies made no attempt to compare outcomes for those who experienced psychoanalytic interventions, with outcomes for those who had similar problems but received no formal intervention.

This deficiency was brought forcefully to the attention of counsellors when Eysenck (1952) published a review of 24 studies that had compared recipients of psychotherapy, with those who had received no treatment for the same "condition". Finding that about 65% improved despite receiving no formal assistance, Eysenck claimed that the outcomes reported by the psychoanalytic studies as well as outcomes from other "eclectic" psychotherapeutic interventions, were no better than outcomes achieved via what he termed "spontaneous remission". Eysenck also suggested that some psychotherapeutic interventions were not only ineffective but were in fact harmful.

Throughout his lifetime, Eysenck also continued to argue that because its tenets were unable to be operationally defined and therefore unable to be proved or disproved, psychoanalysis and psychodynamic interventions did not conform to the principles of scientific inquiry. His research presented a challenge to counsellors that could only be answered by the employment of more sophisticated research designs than those that had been employed up to that point in time.

In particular, it was recognised that to be credible, outcome studies required comparison between counselling clients (generally referred to as the "treatment group") with a group of clients who were similar in other ways but were not recipients of a counselling or psychotherapeutic intervention (the control group).[24] In psychotherapy and counselling studies, the most usual and probably the most ethical method of conducting such studies became that of comparing the treatment group with individuals on waiting lists.[25] During much of this time, the efficacy of different "brands" of counselling has continued to be hotly contested. Therefore most of the studies (Sloan, Staples, Cristol, Yorkston, & Whipple, 1975, being recognised as one of the earliest) have also compared outcomes resulting from two or more types of interventions (such as psychodynamic and behaviourist approaches) with outcomes from control groups.

Counselling "works"

A large number of individual investigations conducted since the Sloan et al. (1975) study have arrived at minor variations on two key results. First, they have generally reported that counselling and psychotherapy result in benefits for a significant majority (usually between 70% and 80%) of clients who participate, while such benefits are enjoyed by about half of that proportion (30% to 40%) of subjects belonging to control groups. Second, attempts to compare different forms of

24 Similar criticisms were also levelled at early more conventionally scientific studies, including the original behaviourist study of "Little Albert" by Watson and Rayner (1920). Though it is now universally accepted that the efficacy of a treatment can only be reliably established if recipients are compared to a similar (control) group who do not receive the treatment, it is often not appreciated that this is a relatively recent methodological development. Even within medical research, the first randomised controlled trial was not conducted until 1948 (see Brown, 1998).

25 The use of waiting list clients is not of course without its methodological and sometimes ethical challenges. Assuming these have been attended to however, clients on waiting lists make potentially good control subjects. That is, the methodology assumes that they are as likely as the treatment group to have already recognised that they have a problem and to be as motivated as their treatment group counterparts to attempt to do something about it. Therefore the explanation for any superior improvement observed amongst recipients of counselling or psychotherapy is most likely to be the treatment itself.

intervention with each other have generally found no differences or only marginal differences between them.[26]

Results from these individual outcome studies have also been confirmed in key meta-analytic studies (APA, 2012; Elliot et al. 2013; Lambert & Ogles, 2004; Roth & Fonagy, 2005; Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Wampold et al., 1997).[27] The average effect size of these interventions has been found to be .80.[28] In reviewing a range of evidence-based practices in medicine, Wampold (2007) found that many did not achieve this effect size. And in a more recent review of treatments for emotional problems, Wampold (2014) found that psychotherapy was typically, "as effective as drug treatments for emotional problems and is more enduring and creates less resistance to multiple administration than drugs" (p. 55).

Though there have been criticisms of individual meta-analytic studies as well as criticisms of meta-analysis as a method (Eysenck, 1984; Wilson & Rachman, 1983), Miller, Hubble, Chow and Seidel (2014) have concluded that research over the past 40 years has put the efficacy[29] of psychotherapy and counselling as well as its effectiveness in real world clinical settings beyond any reasonable doubt.

A "real world" approach to the effectiveness of counselling and psychotherapy can be found in the *Consumer Reports* methodology noted earlier (Seligman, 1995), which surveyed responses from 22,000 readers. Amongst the key conclusions were that clients benefited very substantially from psychotherapy and that psychotherapy alone did not differ in effectiveness from medication plus psychotherapy.

In reviewing the strengths and limitations of the this study, Seligman (1995) noted that the methodology must be considered less robust than the methodology employed in randomly selected samples in which outcomes are measured against control subjects. On the other hand, a limitation of many of the controlled studies has been the formal conditions (such as university laboratories) in which they have taken place. Seligman therefore suggested that results from such a large sample of "real world" participants provide valuable complementary support for these more scientifically rigorous studies.

What of relationship counselling?

In considering whether or not relationship counselling "works", it is important to recognise the broad context in which these interventions take place. Families in Western countries are exposed to innumerable life stresses (Lebow, 2012) and rapidly changing expectations (Moloney & Weston, 2012; Weston, Qu, & Hayes, 2012)—typically leading to one third to half of all marriages ending in divorce. In Australia for example, Petch, Murray, Bickerdike, and Lewis (2014) found that relationship counselling clients reported rates of psychological distress that were four times those found in the general Australian population. Not surprisingly therefore, as Lebow et al. (2012) have pointed out, some couples and families seeking help are beyond the point at which remaining together would be considered a viable (or even a desirable) outcome.

26 Though not all studies have reached this conclusion, research such as that by Luborsky et al. (1999) has typically found that outcomes that favour a particular "brand" of therapy over another have almost invariably been authored by researchers who have investigated the therapeutic method in which they have been trained or to which they hold an allegiance. For a more recent perspective on this expectancy effect, see Wampold (2010).

27 In meta-analytic studies, the changes reported in single studies for treatments and no treatment controls are averaged out. This permits an overall estimate of the benefits of treatment vs non-treatment.

28 That is, the average score on the outcome measures used to assess functioning of those who receive the counselling intervention was 0.8 standard deviations better than those who were not recipients of the intervention.

29 A distinction is frequently made in the literature between efficacy studies, which arise out of randomised controlled trials involving careful selection of clients, control subjects and counsellors; and effectiveness studies, which report on treatment effects in routine practice (Nathan, Stuart, & Dolan, 2000). More specifically:

> In efficacy trials, participants usually are screened for meeting predefined inclusion and exclusion criteria, undertake systematic assessment before and after treatment, and provide informed consent to accept a particular treatment condition with specified goals and duration (Nezu & Nezu, 2008). In addition, treatment is usually described in written manuals, and therapists often are trained and supervised to ensure the integrity and quality of the treatment provided. In contrast, in effectiveness studies, there often is less selectivity than in efficacy trials about which clients are accepted into treatment, comprehensive assessment might or might not be undertaken, clients often negotiate the goals and type of treatment, and therapists can often operate more or less autonomously with limited or no supervision of their practice. (Halford, Pepping, & Petch, 2015, p. 1)

The question of what constitutes success in relationship counselling is therefore likely to be more difficult to determine than when the equivalent question is asked of work with individuals. This is probably why there is considerable variation in the methodologies employed within studies aimed at arriving at measures of effectiveness in this area (Halford et al., 2012). Notwithstanding these difficulties, several meta-analyses of couple counselling outcomes (e.g., Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Lebow & Gutman, 1995; Pinsof & Wynne, 1995; Shadish et al., 1993) have suggested that effectiveness is similar to that of counselling with individuals.

Another approach taken by researchers such as Sprenkle (2012) and Carr (2014a; 2014b; 2014c) has been to summarise research studies linking systemic and relationship counselling to outcomes for specific psychological problems. Though most of these studies have reported positive results, Evans, Turner, and Trotter's (2012) review of Australian and overseas literature on couples and family counselling over a recent 5-year period was more cautious in its conclusions. These authors found evidence to support the effectiveness of families and couples counselling, but noted:

> There are clear gaps in the available literature with a need for more methodologically rigorous research to be conducted with couples and families in general, and specifically, in an Australian context. (Evans et al., 2012, p. 17)

In a recent Child Family Community Australia paper, Hunter and Commerford (2015) reviewed the evidence for the effectiveness of relationship education and counselling. They found that relationship counselling had been reported to be not effective for approximately 25–30% of those who attended, regardless of the approach taken. They also came to the following somewhat cautious conclusions:

- Several approaches to relationship counselling have been found to be moderately effective in reducing relationship distress or increasing relationship satisfaction compared to no treatment, although there has been limited new research in the past decade.
- Few differences in effectiveness have been found between different theoretical approaches to relationship counselling.
- Initial levels of distress may be an important factor in the success or failure of counselling and it may be of value for practitioners to assess for this.
- Initial research suggests that moderately distressed couples should receive a full treatment model and that highly distressed couples may be less likely to experience positive outcomes from counselling (Hunter & Commerford, 2015, p. 17).

In summary, the evidence base for effectiveness of relationship counselling appears to be more complex and more mixed than the evidence base for the effectiveness of individual work. This may reflect higher levels of complexity in the work itself and in the methodologies required to assess outcomes. For a couple in a significantly dysfunctional or abusive relationship for example, separation may be seen as a good outcome by one partner and an unsatisfactory outcome by the other. Similarly, separation might be recorded as a failure by a relationship counselling organisation but recognised by the counsellor as an outcome that releases both individuals to "regroup" and seek happiness within a new set of life circumstances. In both cases, the impact of the separation on any children of the relationship raises complex practice and research questions that continue to present major challenges (Amato, 2010; Sweeper 2012).

How does counselling "work"?

> Psychotherapy does not work in the same way as medicine … Bluntly put, the existence of specific psychological treatments for specific disorders is a myth. (Hubble, Duncan, Miller, & Wampold, 2014, p. 28)

Over the years, a great deal of both practice and research energy has gone in to delivering counselling in a manner designed to parallel the delivery of medical services (Wampold & Imel, 2015). Typically, a medical model of intervention begins with careful systematic observation, the

purpose of which is to reach a diagnosis. As a result of the diagnosis, an intervention is prescribed that previous observations and previous studies have shown will cure or ameliorate the condition. Consistency demands that the intervention be delivered in a standardised manner. Careful attention is paid to issues such as dosage and to the conditions under which the dose is delivered. But questions such as who delivers the intervention are considered to be largely if not totally irrelevant.

For more than 40 years, a considerable amount of counselling research, inspired by medically focused models of intervention, has attempted to compare outcomes of one or more treatment models with a "no treatment" group. In this research model, clients and control subjects are carefully selected for evidence of a particular problem (e.g., depression).[30] Counsellors are then selected (and frequently trained) to deliver a standardised version of that particular counselling intervention. The assumption has been that, in a manner similar to improvements noted after a standardised medical intervention, improvements following counselling are primarily due to the efficacy of the standardised treatment.

It has been increasingly understood however, that the question of how counselling works is intimately linked the question of the *circumstances* in which it is delivered. In particular, evidence over more than 20 years (e.g., Blatt, Sanislo, Zuroff, & Pilkonis, 1996; Crits-Christof et al., 1991; Crits-Christof & Minta, 1991; Elkin, 1999; Huppert et al., 2001; Kim, Wampold, & Bolt, 2006) has suggested that the qualities possessed by particular counsellors are more likely to be responsible for the outcomes than the method of counselling employed.

More broadly there is now strong evidence that counselling works through the application of common factors—factors that are not only located in the counsellor, but also in the client, the counsellor–client alliance, the broader social environment, the client's and the counsellor's *belief* in the treatment model and the client's propensity or willingness to change.

A common factors explanation for the success of counselling was originally hypothesised almost 80 years ago (Rosenzweig, 1936).[31] The common factors likely *mechanisms* were most famously articulated by Lambert (1986; 1992). Though acknowledging he lacked strong empirical evidence for his assertion, Lambert had proposed four broad mechanisms of change, which he ranked in importance on the basis of their estimated contribution to outcome. These were: "extra therapeutic variables"—that is, all the factors that impact on improvement but are independent of the intervention (40%); common factors—especially the capacity to form a "therapeutic alliance" (30%); hope, expectancy and placebo—which are in turn influenced by the stance taken by the counsellor (15%); and model or technique (15%).

Further research (summarised in Duncan, Miller, Wampold, & Hubble, 2014; Hubble, Duncan, & Miller, 1999; Wampold, 2001; and Wampold & Imel, 2015) has led to significant revisions in the conceptualisation of these factors—now more commonly labelled "therapeutic factors" (Orlinsky & Ronnestad, 2005). According to Hubble at al. (2014), Wampold's (2001) investigation has been especially influential in:

> [Broadening] an appreciation of the potency of client, therapist, and alliance factors—while elucidating the limited impact of model difference. His analysis revealed that the differences among models accounted for only 1% of the variance of the outcome, dramatically reducing Lambert's (1986; 1992) estimate of the contribution of specific effects. (pp. 33–34)

30 An immediate ontological problem here is that like most psychological or psychiatric diagnoses, the term, "depression" is not a "thing in itself" (like a broken leg) but a construction arrived at after observing a series of behaviours or reports of behaviours. The feeling of "being depressed" may be experienced as mild through to severe. Its primary cause may be thought to be adverse life circumstances; or it may be thought to be the result of a neuro-chemical imbalance apparently unrelated to an existential cause; or it may be thought to be something in between. Some individuals who attract a diagnosis of depression appear to respond positively to physical interventions such as antidepressant medications or electroconvulsive therapy. Others do not respond, while yet others become worse—even suicidal—after medication is administered. In addition, some people report debilitating side effects that seemingly arise from the very physical interventions that are meant to improve the situation. Counsellors who support and/or challenge individuals with depressive symptoms appear to achieve results at least as good as those achieved by physical interventions but just as with physical interventions, counselling is not always successful. Such observations strongly suggest that there are many human experiences described by terms such as, "depression" and no certainty that *particular* response to "depression" will be effective.

31 In this and subsequent papers, Rosenzweig spoke of the "Dodo" effect, taken from Lewis Carroll's *Alice in Wonderland:* At last the Dodo said, "Everybody has won and all must have prizes" (cited in Rosenzweig, 1936, p. 412). See further references by Frank (1973) and Luborsky, Singer, and Luborsky (1975).

Of greater importance perhaps, subsequent research has also demonstrated that these factors cannot be rendered as discrete elements capable of being individually operationalised. As Hubble et al. put it:

> It is not surprising that over time, the unsubstantiated logic of specificity came to be applied to the common factors. It was as though they could be distilled into a treatment model, used to create techniques and then administered to the client … In reality, the common factors are not invariant, proportionally fixed or neatly additive. Far from it, they are independent, fluid and dynamic … Much like raw materials in nature, common factors exist in an unprocessed or minimally processed state. The eventual form a treatment assumes is thus entirely dependent on materials available; the skills of the artisan; and most important, the desires and preferences of the end user. (2014, p. 34)

In contrast to thinking of counselling as similar in structure to medical interventions, Wampold and Imel (2015) have labelled the results of their research into how counselling works as a *contextual model*. In their view, whereas the medical model is, "under-girded by materialism and specificity and existing within anatomy, physiology, microbiology and sciences" (Wampold & Imel, 2015, p. 7), the *contextual model*, grounded in the social sciences, posits that:

> The benefits of psychotherapy accrue through social processes and that the relationship, broadly defined, is the bedrock of psychotherapy effectiveness. (Wampold & Imel, 2015, p. 50)

Significantly, Wampold, and Imel (2015; see Table 3.2, p. 75) have presented research hypotheses that predict the outcomes of both the medical and the contextual models with respect to five core effects. These are:

- Absolute efficacy—studies that focus on the overall effectiveness of therapy. The hypothesis here is and there should be no expected difference between the predictions of both models.
- Relative efficacy—studies that deal with the effects of different treatments that can be operationally defined and implemented. The hypothesis for relative effects is that the medical model would predict that certain treatments would be superior to others. The contextual model makes no such prediction.
- Therapist effects—Therapist effects in the medical model are predicted to be small since therapists are required to comply with the requirements of a manualised program. The contextual model would predict large therapist differences because according to this model, the therapist–client relationship is a key component of the outcome.
- General effects—The contextual model would predict that relationship factors such as the therapeutic alliance, empathy, collaboration, client and counsellor expectations, therapist allegiance to a particular model of intervention and cultural issues would all impact appreciably on the outcome. The medical model would predict that these factors should have little or no effect.
- Specific effects—The medical model predicts that adherence to a specific treatment for a specific problem, and that demonstration of competence in that treatment, will impact positively on the outcome. The contextual model predicts that adherence to a specific treatment and demonstration of competence in that treatment will not impact on the outcome.[32]

Relying on meta-analyses of counselling outcomes, Wampold and Imel (2015) have examined the hypotheses generated with respect to the five effects noted above. They found no difference with respect to absolute and relative efficacy, large differences with respect to therapist effects and general effects, and little evidence with regard to the prediction of specific outcomes being tied to specific treatments. The authors concluded that the contextual model is compatible with these findings, while the medical model holds little explanatory power.

32 *Belief* in the model by both counsellor and client has been shown to be an important ingredient. This issue is discussed later.

Wampold and Imel (2015) have acknowledged that no theory is ultimately provable (see Lakatos & Musgrave, 1970).[33] In the future therefore, a more parsimonious theory may build on or even replace the contextual model. They suggest however, that the medically inspired practice of comparing differing brands of treatment holds no future promise for counselling research. Their further suggestion that clinical trials aimed at such comparisons should be discontinued is consistent with an earlier observation by Wampold (2014):

> Much money has been spent on clinical trials, with the same result. "Both treatments were more effective than no treatment, but there was no differences in outcomes between the two treatments." Continued research that looks at new variations of old treatments will yield little that can be transported to systems of care to improve the outcomes of clients. (p. 71)

A contextual, common therapeutic factors approach to counselling has a number of profound implications for counselling practice and research. Before discussing these, it is important to consider whether this approach holds equally for relationship counselling.

Families and couples counselling: does the contextual model hold?

Though there is no a priori reason to assume that relationship counselling would work in a radically different way to individual counselling, it is important to examine formally whether or not there is evidence that these outcomes are more reliant on the application of differential approaches. If this were to be the case, we would need to consider the possibility that there was something about relationship counselling processes that more closely resembled medical interventions. If not, it is likely that relationship counselling, though perhaps more challenging with respect to processes such as forming and maintaining a therapeutic alliance (Pinsof, 1994; Pinsof & Catherall, 1986; Pinsof, Zinbarg, & Knobloch-Fedders, 2008), also works largely through the application of common factors.

In their *Millennial Review* of couples counselling Gurman and Fraenkel (2002) divided the development of the field into four phases. They noted that a major thrust in the development of couples therapy in the most recent phase:

> [h]as been the "quiet revolution" (Lebow, 1997, p. 1) in the movement toward integrative clinical theory and practice, paralleling related developments in the world of individual psychotherapy (e.g., Norcross & Goldfried, 1992; Stricker & Gold, 1993), and exposing the reality that eclecticism and integration are probably the modal orientations of couple therapists (Rait, 1988). This movement, begun in response to the recognition of common factors that affect treatment outcomes, and the limited evidence of differential effectiveness of various psychotherapies, asserts that a broad base for understanding human behavior is necessary. Integrative treatment approaches allow greater treatment flexibility and increase treatment applicability, therefore potentially leading to more positive outcomes (Gurman, 1981; Lebow, 1984). (Gurman & Fraenkel, 2002, p. 235)

In summarising the multiple practices of and research support for family therapy, Carr (2012) also alluded to the importance of common factors:

> While the preceding review shows that there is good evidence now for the effectiveness of specific types of marital and family therapy and systemic interventions for specific problems, Sprenkle et al. (2009) argue that a set of common factors and mechanisms of change underpins most forms of successful psychotherapy in general and marital and family therapy in particular regardless of the theoretical orientations of the therapists or the specific techniques employed. (Carr, 2012, p. 452)

33 See also Popper (1963), who concluded that scientific theories can only be falsified, not proved. All scientific knowledge is therefore tentative and open to challenge.

Carr's considerable contribution to the field has included multiple reviews of the effectiveness of couples and family counselling with respect to specific problem areas (e.g., Carr, 2014a; 2014b; 2014c). The key question however, is whether such studies demonstrate a *necessary* relationship between a particular intervention and a particular outcome. In the above statement, Carr appears to be holding to a "both/and" position. He acknowledges the argument of Sprenkle and his colleagues that a set of common factors underpins "most forms" of successful marital and family therapy. At the same time, Carr appears reluctant to abandon the idea that specific couples and family counselling techniques may be responsible for successful outcomes in particular circumstances.

In reviewing the evidence on differential approaches to couples and family therapy, Sparks and Duncan (2014) are more definitive.

> Meta-analysis over the past 17 years and recent comparative investigations have not found evidence for differential efficacy nor the predicted advantage of models adhering to specific protocols. The Shadish et al. (1993) meta analysis of 163 randomised trials did not find significant differential effects of couple and family therapy over individual therapy or differences between various MFT orientations. In a later review of 20 meta analyses of MFT interventions Shadish and Baldwin (2002) similarly found few significant differences among various models. When comparing MFT approaches with alternative treatments, any differences were small and tended to get smaller overtime. Confirming this conclusion, a recent meta-analysis of differential efficacy in the treatment of youth disorders, including family therapy, found some differences in efficacy among treatments but the upper bound of the differences were small (Miller, Wampold, & Varhely, 2008) … Couple therapy follows suit … Chrisensen and Heavey's (1999) review of couples therapy noted that the few studies showing the superiority of one treatment over another favoured the investigator's treatment and had not been replicated. (Sparks & Duncan, 2014, p. 360)

Alluding to Rosenzweig's "dodo effect" noted earlier, Sparks and Duncan summarised their findings as follows:

> A critical review of the differential efficacy data demonstrates few exceptions to the dodo verdict when allegiance is considered, comparisons are fair, and bona fide treatments are contrasted, eroding claims of differential efficacy and giving credence to the claim that all have won prizes. (Sparks & Duncan, 2014, p. 365)

Though there appears to be little evidence that different models of couples and family counselling produce different results, a more important question may be whether working conjointly rather than individually with relationship issues is generally more likely to produce superior results. Crane and Christenson's (2014) reporting of cost-effectiveness studies of family therapy has provided some evidence that this might be the case. Gurman (2008), a highly respected researcher over many years, is clear about the appropriateness of working conjointly when the identified problem is the relationship. For Gurman for example, couple therapy is a qualitatively different process that should not be confused with individual therapy focused on improving a relationship with a person who is not participating in the process.[34]

As a family therapist and a family mediator, my intuitive sense is that relationship issues are generally best addressed by directly supporting those in the relationship to make bona fide attempts to improve the situation between them. As a researcher however, I need to acknowledge that the "jury is out" on the evidence for such an assertion and that the truth may lie somewhere in between. That is, it is likely to transpire that there are times when it is appropriate to work on relationships at an individual level but other times when those in relationship with each other are more fruitfully engaged in the therapeutic process together.[35]

34 It is of course legitimate (many would argue it is an ethical requirement) to see individual members of a couple or family during the assessment phase or if the counsellor develops concerns about the safety of one or more members of the group.

35 A contemporary conjoint vs individual counselling tension has been neatly summarised by Kottler (2015, pp. 15–17). His imaginary debate on this question between senior therapists demonstrates that the issues raised by this question remain complex and alive.

Common factors: advances in practice and research

> Most literature seeks to understand the general in terms of the unique, while contemporary psychology, like most "modern sciences", tries to explain the unique in terms of the general. (Stone & Stone, 1966, p. viii)

Though contemporary counselling shares many common elements with "tailored" healing practices that have gone before, in a scientific age there is also a legitimate expectation that counselling practices should be based on evidence (e.g., Howell, 2012). How then, can the tension between a legacy of culturally informed wisdoms and the results of scientific inquiry be reconciled? Addressing this issue almost a decade ago, the American Psychological Association made the following observation:

> [Evidenced based practice is] the integration of the best available research with clinical expertise in the context of patient characteristics of culture and preferences. (American Psychological Association Presidential Task Force on Evidence-Based Practice [APA Task Force], 2006, p. 273)

Elaborating on this observation, the American Psychological Association added:

> Psychotherapy is a collaborative enterprise in which patients and clinicians negotiate ways of working together that are mutually agreeable and likely to lead to positive outcomes. Thus, patient values and preferences (e.g., goals, beliefs, preferred modes of treatment) are a central component of [evidenced based practice]. (APA Task Force, 2006, p. 280)

The APA's reference to the client's preferred mode of treatment effectively acknowledges that because no single model of intervention can possibly account for the sum of human experience, effective counsellors need to recognise when and how to draw upon one or more of the core "truths" contained within each approach to counselling. In the field of couples counselling for example, consistent with Gurman & Fraenkel's (2002) observation that there has been a quiet revolution in integrative clinical theory and practice, Snyder and Balderrama-Durbin (2012) found that a mark of effective couple therapy is the frequency with which they are prepared to integrate different treatment approaches.

The APA's use of terms such as "collaborative enterprise" and "mutually agreeable ways" further suggests that choices concerning which "truths" to draw upon need to be iterative processes informed by careful attention to each client's construction of reality. In this regard, the APA also observed that:

> The application of research evidence to a given patient always involves probabilistic inference. Therefore ongoing monitoring of patient progress and adjustment of treatment as needed is essential (APA Task Force, 2006, p. 280).

Detailed research into precisely how good outcomes are facilitated by one or more common factors has continued (see for example Halford et al., 2012, with respect to couple therapy). Though it is beyond the scope of this paper to critique the advances being made, it is now possible to speak with some confidence about key practice implications that stem from a common factors approach that appear to be compatible with the principles suggested by the American Psychological Association.

Counsellors, client feedback and the development of expertise

Counsellors, and the ways in which counsellors adapt theories to the needs of each individual case, appear to be at the heart of effective practice. In a study of 81 clinicians, for example, Baldwin, Wampold, and Imel (2007) found that 97% of the difference in outcome between practitioners was attributable to counsellor variability in the alliance. By contrast, *client* variability was unrelated to outcome. The results showed that some counsellors were consistently better at establishing and maintaining helpful relationships than others.

A later study examined counsellor effects using a sample of 25 providers treating clients in a university counselling setting (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). In this study, the clinicians were asked to respond to a series of video simulations to test for facilitative interpersonal skills (FIS). Each simulation presented a difficult clinical situation, complicated by a client's anger, dependency, passivity, confusion, or need to control the interaction. The authors found that differences in outcome were attributable to counsellors' possession of deeper, domain-specific knowledge.

Importantly, differences in client outcomes between therapists were found to be unrelated to therapist gender, theoretical orientation, professional experience, or overall social skills. This was not in itself a new finding. Rather, the study added to our knowledge base the fact that the best results were obtained by counsellors who exhibited deeper, broader, more accessible and more interpersonally nuanced knowledge as measured on the FIS task. Regardless of the client's presenting problem or style of relating, top performers were able to respond collaboratively and empathically, and were far less likely to make remarks or comments that distanced themselves from or offended a client.

In the light of such findings, Miller et al.'s (2014) conclusion that the main focus of research must shift from the contributions to treatment outcomes made by different *counselling theories* to those made by individual *counsellors* leads logically to the question of how to promote and assess counsellor expertise. Unfortunately, counsellors themselves have been found to be generally poor at detecting lack of client progress (Halford et al., 2012), typically overrating their own effectiveness (Walfish, McAllister, O'Donnell, & Lambert, 2012).[36] In addition, not only do many counsellors' levels of effectiveness tend to plateau early in their careers (Ericsson, Charness, Feltovich, & Hoffman, 2006), but those counsellors found to be effective tend to be consistently effective while (unfortunately), ineffective counsellors tend to be consistently ineffective (Brown, Lambert, Jones, & Minami, 2005).

These findings appear to be in marked contrast to findings by researchers such as Ericsson (2009) and Holmes (2006), about the development of expertise in a wide range of other fields. According to Holmes (2006), for example:

> Years of investigation of elite performance or expertise across many domains of practice such as the airline industry, and emergency and health services (Salas & Klein, 2001), have demonstrated that expertise is the consequence of *persistent, highly engaged, deliberate practice, developed by a fine-grained practical and pragmatic feedback process, resulting in consistent refinement in the quality of practice*. The act of the practitioner grappling with the uncertainty and demands of real-world issues of practice, in contrast to repeatedly applying without reflection a fixed model or procedure, has been demonstrated across numerous domains of practice to contribute to the development of expertise. (p. 115, emphasis added)

In their review of the field Miller et al. (2014) contrasted such findings with much of what has occurred in the field of counselling and psychotherapy:

> The behaviours of world class musicians, athletes, mathematicians, chess players, pilots, medical diagnosticians and air traffic controllers have been and continue to be studied. Because of this work the performance of these professionals has consistently improved. In contrast, despite 30 years of feverish effort, the overall outcomes of therapy have remained unchanged. (p. 425)

In the light of this, Miller et al. (2014) have suggested that *expertise research can* provide a suitable platform to support the shift from research into "brands" of counselling to research into the counselling process and characteristics of the therapist. Drawing on such research, Miller and his colleagues identified three components that, working in tandem, appear to be critical to achieving superior performances as a counsellor. These are considered in turn.

36 These authors found that therapists on average rated their overall clinical skills and effectiveness at the 80th percentile, which as Bertolino, Bargmann, and Miller (2012) have pointed out is a statistical impossibility. In addition, fewer than 4% of therapists rated themselves as average, whilst nobody rated his or her performance below average.

1. Determining a baseline level of effectiveness

Though effectiveness measures are now widely available, it has been noted by several researchers that few clinicians actually use them in their day-to-day work. Paradoxically, though most counsellors express an interest in receiving regular reports of client progress, the routine collection of outcome data remains rare. Drawing on research by Hatfield and Ogles (2004), Miller et al. (2014) noted that despite their stated desire to make routine use of outcome data, counsellors provided two main categories of reasons for *not* doing so. The first category consisted of practical reasons such as considerations of cost and time. The second was "philosophical"—especially a questioning of the relevance of the information within the context of the presumed time-consuming nature of the data gathering.

There is no doubt that outcome measures such as Lambert's (2010) well validated 45 item "Outcome Questionnaire-45", designed to provide feedback after each session, add significantly to the time required by clients to complete a counselling program. Counsellors whose main concerns are about the extra costs and time are likely to be more attracted to the development of brief user-friendly scales such as the four-item *Outcome Rating Scale* (ORS) designed to assess client progress and, when aggregated, to gauge a therapist's overall effectiveness; and an equally brief four-item *Session Rating Scale* (SRS), designed to measure the quality of the therapeutic relationship, a key element of effective therapy (Bachelor & Horvath, 1999; Norcross, 2010). As part of the Partners for Change Management System (PCOMS), these validated scales are available in a large range of languages, are free of charge and take approximately a minute to administer (see Miller & Duncan, 2004).[37]

The other main concern about the routine use of outcome data reported by Hatfield and Olges (2004) was its relevance. Such a concern may suggest a continued commitment by these counsellors to the efficacy of their favoured model or technique. Whether or not this is the case, it would be useful to explore the reasons for the persistence of this view as such ongoing commitments are unsupported by research. Exclusive adherence to a particular model may have its origins in counsellors' sense of allegiance to the convictions associated with their earlier (or perhaps ongoing) counsellor training. This may in turn link to a sense of professional identity that such allegiances provide. But although there may be a range of emotional responses and vested interests involved in continuing to promote the "superiority" of one "brand" of counselling over another, the evidence suggests that a default use of "brand-focused" approaches will almost certainly result in a narrowing of possibilities and options for clients.[38]

2. The efficacy of systematic, ongoing feedback

A number of studies (e.g., Lambert & Shimokawa, 2011; Reese, Norsworthy, & Rowlands, 2009; Reese, Toland, Slone, & Norsworthy, 2010; see also summary of studies in Bertolino, Bargmann et al., 2012) have shown increased rates of reliable change in clients as well as reduced deterioration rates in both individual and couples counselling following the employment of routine client feedback using validated instruments. These studies point strongly to the efficacy of collaborative models of counselling that are supported rather than determined by theory and technique.[39]

In retrospect at least, these findings should not come as a surprise. The routine assessment of progress via a formal client feedback mechanism supports the most enduring finding of more than 40 years of outcome research in counselling—the importance of the quality of the client's participation and engagement (see Orlinsky, Ronnestad, & Willutzski, 2004). As Miller and his colleagues suggested:

37 For an interesting discussion regarding possible trade-offs between administrative time on the one hand, and reliability and predictive validity on the other, see Halford et al. (2012, p. 52).

38 For a recent analysis of couple and family therapists' ambivalent attitudes to including formalised client feedback in their work, see Oanes, Borg, and Karlsson (2015).

39 For example the ORS and SRS interpretive algorithms and normative database, collectively known as "Feedback Informed Treatment" (FIT), have been listed on the American Substance and Mental Health Services Administration National Registry of Evidence-based Programs and Practice (Miller et al, 2014) (see <www.samhsa.gov/nrepp>).

> It is as though they are being told, "Your input is crucial; your participation matters. We invite you to be a partner in your care. We respect what you have to say, so much so that we will modify the treatment to see that you get what you want". (Miller et al., 2010, p. 424)

The American Psychological Association also recommended routine assessment of client response to treatment (Ackerman et al., 2001; APA Task Force, 2006). At the same time however, it is important to recognise that the seemingly simple act of obtaining client feedback has not always been found to increase counsellor expertise (De Jong, van Sluis, Nugter, Heiser, & Spinhoven, 2012). Rather than being reduced (perhaps ironically) to a technique in its own right, Miller et al. (2014), like Holmes (2006), have suggested that increasing one's expertise via feedback requires the additional element of engaging in "deliberate practice".

3. Feedback and "deliberate practice"

The *mechanics* of deliberate practice consist of putting aside time for reflecting on the feedback received, identifying where performance is working and where it is falling short, seeking supervision from peers and recognised experts, then developing, rehearsing and evaluating a plan for improvement (see for example Ericsson, 2009; Ericsson, Krampe, & Tesch-Romer, 1993).

These practices, however, must be supported by *attitudes* that derive from understanding their purpose. The attitudes that drive deliberate practice include those of reflectiveness, respect for the wisdom of clients as well as the problems they bring to counselling, a determination to keep learning, a willingness to combine theoretical rigour with flexibility, a commitment to stay abreast of research and perhaps most of all, a sense of humility.

It is also important to recognise that the circumstances under which clinical expertise can grow and flourish provides a number of challenges to both organisations and their funding bodies. Clinical expertise, like good counselling outcomes, develops via an endless chain of corrective feedback. Paradoxically, in order to learn and make corrections, counsellors must make mistakes. For the sake of the client as well as for the sake of the counsellor however, mistakes and the correction of those mistakes must take place within a safe and supportive environment.

For this reason, a focus on effectiveness through the routine use of client feedback will enhance counselling practice and lead to better client outcomes, so long as the cooperative and iterative nature of the counselling task is appreciated and respected by all of those involved in delivering the service. Appreciation must therefore come not only from the counsellors themselves, but from their employers and their employers' funding bodies.

A potential difficulty here is that many counselling organisations support (or require) intake processes designed to result in a diagnosis or at least an initial formal statement of the problem. While this may be necessary from an organisational perspective, it is also the case that a feedback informed approach to counselling differs quite profoundly from a process that:

- determines the nature of the problem through the employment of diagnostic categories;
- prescribes relevant actions (treatment) that match the diagnoses;
- measures adherence to the treatment plan; and
- assumes it is the *plan* and adherence to the plan that is responsible for progress or lack of progress.[40]

40 I acknowledge that in what Kottler (2015) has described as therapy "in the real world", the process is rarely as mechanical as this statement might suggest. At the same time, it remains the dream of some who strongly support randomised controlled trials in the service of evidence based practice to "rule out the common factors" (Jackson, 2005, p. 18) or, via manualised treatments, to "reduce therapist variability and help ensure that treatment is delivered with integrity" (Charman & Barkham, 2005, p. 9).

Formalising feedback

A wide range of methods exists for monitoring outcomes and advancing clinical expertise through the employment of client feedback. There is much to be said however, for promoting a feedback-informed culture via the use of instruments that:

- are validated;
- are sufficiently brief for both clients and counsellors to be willing to use them every time they meet;
- are sufficiently brief for agencies and their funding bodies to be willing to endorse their everyday use;
- can be employed across a wide range of clients in a wide range of settings and languages; and
- are easily and freely available.

The International Centre for Clinical Excellence[41] has produced a series of six Manuals for counsellors who wish to formalise their use of client feedback in a manner that meets the above criteria. Using the SRS and ORS as key guiding instruments, each Manual addresses a key aspect of "Feedback Informed Therapy" (FIT).

Manuals 1 and 2 (Bargmann & Robinson, 2012; Bertolino, Bargmann et al., 2012) cover the evidence supporting the efficacy of FIT and the basics of clinical implementation. Manual 3 (Maeschalck, Bargmann, Miller, & Bertolino, 2012) addresses the issue of Feedback-Informed Supervision, a critical part of the FIT process. Manual 4 (Seidel & Miller, 2012) describes how change can be documented and measured using FIT, while Manual 6 (Bertolino, Axsen, Maeschalck, Miller, & Rabbins-Wagner, 2012) addresses the implementation of FIT in agencies and systems of care.

Finally, Manual 5 (Tilsen, Maeschalck, Seidel, Robinson, & Miller 2012) addresses the use of feedback-informed clinical work with respect to:

- specific populations:
  - people diagnosed as "severely and persistently mentally ill";
  - people with learning disabilities or cognitive impairment;
  - people mandated to treatment;
  - people who experience marginalisation; and
  - people who experience partner violence;
- specific service settings:
  - multi service and multi service providers;
  - outpatient services;
  - intensive day treatment, residential and inpatient treatment; and
  - outreach;
- group work; and
- long term therapy.

All six manuals propose the following definition of FIT:

> Feedback Informed Therapy is a pantheoretical 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 using the resulting information to inform and tailor service delivery. [It] is not only consistent with but operationalizes the American Psychological Association's (APA) definition of evidence-based practice. (Bargmann & Robinson, 2012; Bertolino, Bargmann et al., 2012; Bertolino, Axsen et al., 2012; Maeschalck et al., 2012; Seidel & Miller, 2012; Tilsenet al., 2012; p. 2)

41 See <www.centerforclinicalexcellence.com>.

Brief reflections on future training and practice

> It is, after all, a myth that any of us are applying any theoretical paradigm in its pure and unadulterated form; the reality is that each of us is unique in the ways we interpret and apply concepts, no matter what we call ourselves. (Kottler, 2015, p. 29)

The evidence that, broadly speaking, counselling "works" but that the mechanisms by which it works bear little if any relationship to a priori selection of one intervention model over another, has profound implications for future practice. Though these implications are yet to be sufficiently appreciated and implemented, it is also important to acknowledge that the common factors evidence does not mean that the many approaches to counselling that have been developed over more than a century have little or no value—quite the contrary.

There is considerable wisdom for example in the insights into our inner worlds and internal conflicts articulated by psychodynamic theory. The behaviourists and cognitive behaviourists have helped us to understand how we can become habituated to unhelpful responses or unproductive ways of thinking. In addition, the person centred approach has reminded us that most individuals are naturally resilient and respond positively when given non-judgmental support and the space to develop their own solutions. Narrative counsellors emphasise the power (for good or for bad) of the stories others tell us as well as the stories we tell ourselves. Existentialists focus on the broader joys, challenges and paradoxes of our finite existence as human beings, while systemic counsellors invite us to look beyond individual symptoms or behaviours and understand their meanings within our larger network of relationships. And so on.

In the end, the common factors evidence and the wisdom embedded in counselling theory must be reconciled with the moment-to-moment decisions made by the counsellor during the counselling process. Like other professionals committed to practising their craft to the best of their ability, a competent counsellor will at any given moment be attending to a large range of possibilities and simultaneously formulating a response. Many of these, summarised by Kottler (2015, p. 81), have been reproduced in a slightly adapted form in Box 2.

Box 2: What makes a difference in promoting change in counselling?

Positive expectations and hope	Relationship factors (trust, caring)	Disclosure/ processing of content
Permission to explore new areas	Telling personal story	Feeling understood and heard
Emotional arousal	Emotional regulation	Facing fears
Constructive risk taking	Reduction of stress	Honestly and directness
Rehearsal of new skills	Task facilitation	New insights and understandings
Sensitive confrontation	Challenging dysfunctional beliefs	Suggestions for problem solving
Focus on present, past and future	Modelling of new behaviours	Creation of meaning
Public commitment of intentions	Social support	Reframed narrative
New options and alternatives	Secondary gains eliminated	Responsibility for consequences
New resources accessed	New solutions generated	Understanding past behaviour
Future planning	Interpretation of behaviour	Tolerance of ambiguity
Tolerance of complexity	Inviting feedback	Responding to feedback
Flexible adjustments over time	Integrity and mutual respect	Follow up and accountability

Such a list returns us to the emphasis on ongoing development of counsellor expertise noted in the previous section. It reminds us that at any given moment, competent counsellors must be:

- responsive to the unique circumstances and issues their clients bring to counselling;
- informed, but not enslaved by theory;
- purposeful in their actions; and
- willing to suspend or even abandon a line of approach if it appears to be unhelpful and/or if another promising approach emerges.

Of course counsellors must begin their professional lives somewhere. Most counsellors begin their training by learning the theory and practice of one or maybe two of the mainstream approaches, while perhaps learning at least something about the *existence* of other models. This is a defensible approach (see Schofield & Roedel, 2012) so far as it goes. Sometimes however, the rationale for promoting only one or two methods and theories is that they are supported by superior "evidence". When this assumption underpins training, counsellors could be forgiven for concluding that there is no need to extend their knowledge, skills or even their life experiences beyond what those models tell them. They might in fact feel a sense of disloyalty for venturing into areas of counselling theory or practice not emphasised in their training—let alone for learning from other disciplines or drawing on the wisdom derived from those iconic stories and observations that have at key points in time, changed the way we think (Downs, 1983).

There has been little research on how counsellors select a particular training approach at the beginning of their careers or on how loyalty to a particular approach is developed or maintained. An important pedagogical challenge for trainers or training institutions is how to strike a realistic and responsible balance between the need to engender confidence by practising skills within a limited number of frameworks, and to expose students to a wider variety of approaches. What is being taught and practised at any given time needs to be seen not as the end goal but as the therapeutic equivalent to learning musical scales. Regardless of how the balance is struck, the evidence is now clear. The model or models being employed at any given time must always be subservient to close attention and close responses to what clients are communicating. This will be further enhanced as counsellors increase their knowledge of what clients themselves have found helpful (see Bowen, Brown, & Howat, 2004; Lambert & Shimokawa, 2011; Larsen & Stege, 2012; Manthei, 2007; Paulson, Turscot, & Stuart, 1999).

In the absence of a culture that endorses (and indeed celebrates) the routine practice of corrective feedback, counsellors will be tempted to apply their own or their organisation's dominant model(s) of counselling—knowledge of which they probably had to demonstrate as part of their training or at interview for their current position. An alternative is to employ clandestine methods of departing from such a model when a counsellor intuitively feels it is not serving the client's needs. In the absence of a feedback-informed culture, a conspiracy of silence can easily evolve in which the dominant therapeutic model(s) are assumed to be the major reason for client change.

As we have seen, the research points to two critical "quid pro quos" for encouraging—even requiring—organisations to support their counsellors in the routine taking of corrective actions through close attention to client feedback. They are that this approach a) has been shown to be associated with continued improvement in counsellor performance, and therefore better client outcomes; and b) sets up the conditions for routine accountability at the levels of both individual counsellor and organisational performance.

Finally, the reader will recall that in McLeod's (2014) assessment of the similarities and differences between counsellors and psychotherapists, one area of agreement was that both groups valued self-awareness and personal therapy as part of their training and ongoing development. Over the years, different training approaches to counselling have placed greater or less emphasis on self-awareness (through group process work for example) and on personal therapy as a key part of the learning. Given that the key ingredients of a common factors explanation for effective counselling include close attention to client needs and the development and maintenance of therapeutic alliance, it

would seem to be increasingly untenable to endorse future training regimes and ongoing counsellor development that did not emphasise such self-reflective elements.

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