

What Works [Who Works], *Talking Incoherently I/I 2002*

## Part A of a Synopsis

All things being equal, it's a fairly safe bet that we would choose to do "what works" rather than wasting our time & effort on "what doesn't work". Still, it's sometimes hard to tell the difference between these two, especially when we are dealing with behaviour that is exceedingly complex & demanding – as is the case with Child & Youth Counselling [CYC] in the criminal justice system. To help us sort out the facts from the fantasies, we need to rely on **research**. So what is it that research says about our field? What works?

In order to know what research says about a particular area of study (in our case, this would be 'programming for young offenders'), we have to locate it in a relevant research tradition. I propose that the relevant research tradition for us is the field of research on 'therapy'. Activities researched in this field go by a lot of different names, including: treatment, intervention, counselling, clinical work, psychotherapy, psychosocial treatments, rehabilitation, and sometimes just programming. What is common to all these activities is that they are characterized by three elements:

- (1) a *professional helper* (therapist, counsellor, "my worker") socially sanctioned (certified, trained) to deal with behaviours, emotions, and/or cognitions;
- (2) a *person* (client, patient) *in need of help* with his/her behaviours, emotions, and/or cognitions; and
- (3) a *helping relationship* (contract, service, plan of care) between them.

Certainly, there are many things in working with young offenders that make us different from other types of therapy, for example: the distinctive behavioural aspects of the *criminal act*; the necessity to be an agent of *social control* while encouraging personal change; *externally imposed* time-limits (i.e., length of sentence or disposition); the reluctant, *non-voluntary* nature of the clientele; the use of '*recidivism*' (rather than 'personal growth') as the most important outcome of service; etc. Still, there is more we share with these other therapies than what makes us different. So, again: What does the research say? What works?

The first important conclusion coming from scientific research on work with criminals (including young offenders) was that "Nothing Works!" Although this conclusion was first made in the 1970s and it was wrong, it continues to haunt our field as a myth that is still believed by many people. "Nothing Works!" Could it be that simple? [Might as well put 'em in a hole and forget about 'em.] Certainly, nearly fifty years of sound, credible research on the efficacy of therapy (in general) does not agree with such a conclusion. Quite the opposite: the issue of whether therapy works is really no longer an issue. Whether we are talking about *statistical change* (i.e., measures that try to determine *how much better* a client is *after* service as compared to *before* service) or *clinically significant change* (i.e., measures that indicate whether a client is functioning like a "normal" person thanks to program interventions), the message is clear: **therapy works!**

Of course, once people realized that therapy was indeed effective, they immediately set about trying to determine which kind of therapy

was the **most** effective. Naturally, everyone believes that their own particular brand (or "school") of programming is the best (why else would they bother spending the time, money, & effort learning it?). The rush was on: *psychoanalytic* versus *behavioural* versus *humanistic* versus *cognitive*, etc., etc. In the article, I refer to this competition between types of therapy as the Great Therapy Derby. This race started way back in the mid-1950s and it continues today. [At the moment, *cognitive-behavioural* therapy is ahead by a nose and *psychoanalysis* appears to have broken a leg. Many are suggesting that the only humane thing to do is shoot it.] In large part, this desire to prove one therapy better than all the others remains the single most important motivation for doing research.

The reason why the Great Therapy Derby is still going on after nearly fifty years of research to discover a winner is because *no particular school of therapy can prove that it is indeed the best*. Trial after trial, study after study seems to show that the major schools of therapy are equally effective (and the more valid and accurate the measurements, the truer this conclusion seems). [The best we can say for the time being is that for *some* clients with *certain specific* problems, there are *specific* techniques that do appear to work better than others – e.g., cognitive-behavioural techniques seem to be the most effective for dealing with phobias and panics. However, you should keep in mind that even these kinds of results are just *statistical* victories: they don't mean that other approaches don't work (or that the "winning" technique *always* works) – they just mean that *on average* the preferred technique seems more effective.]

The fact that all major therapies appear to be equally effective has been such a consistent finding in research over the past fifty years that it has been given a name – the **Dodo Bird Verdict**. [The Dodo Bird reference is from Lewis Carroll's *Alice in Wonderland*. Asked to judge a race in which all contestants ran off in different directions, the Dodo Bird thought for a moment, then declared: "Everyone has won and all must have prizes!"] The Dodo Bird Verdict has been so important that it has defined (and continues to define) the agenda for research in therapeutic programming – in other words, most research either (a) *accepts* the Dodo Bird Verdict and tries to figure out what causes it, or (b) *rejects* it and continues to look for the magic therapy that beats all others. [For reasons I detail in the article, the vast majority of researchers – the mainstream – *reject* the Dodo Bird Verdict. I, however, tend to cautiously accept it. *Making a choice here is not a trivial matter*. Whether we believe the Dodo Bird or not will determine how it is we think about programming – how we understand what is truly effective & what we can do to improve our professional practice.]

By rejecting the Dodo Bird Verdict, researchers cling to the belief that "what works" in a therapy is "that special something" that makes the therapy *different* from all others – its unique aspect, essence, or fundamental insight on human behaviour. This is called the **Specific Factors** theory. [For example, psychoanalysts believe it is "unconscious conflict"; behaviourists believe it is "reinforced habits"; and cognitivists believe it is "belief & value systems". So, if a counsellor wants to be effective, he/she should – respectively – "root

out the hidden conflict”, “change the consequences”, or “challenge the faulty thinking” that supports the client’s problem.]

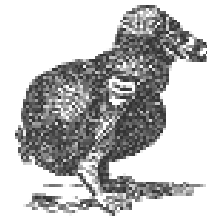
In contrast, if we *accept* the Dodo Bird Verdict, we have to ask: “If it’s *not* the unique *difference* of a therapy (i.e., its Specific Factors) that helps a client change, *then what is it?!*” It turns out that the answer is: *it’s what the therapies share*. This is called the **Common Factors** theory.

The evidence supporting the Dodo Bird Verdict – i.e., the Common Factors theory – has been so ‘robust’ (as the statisticians like to put it) and so convincing that it appears that these Common Factors virtually overwhelm the therapeutic process, making *differences* between therapies almost insignificant. To help picture the relative influence of the Common versus the Specific Factors, one psychiatrist resorted to a rather colorful metaphor:

*There is an old Spanish recipe for making horse-and-canary pie: Take one horse, add one canary, mix thoroughly, and bake. This also turns out to be the recipe for successful psychotherapy, with the horse represented by the basic components of psychotherapy [i.e., the Common Factors] and the canary represented by specific techniques of the various schools or brands [i.e., the Specific Factors]. It is not to say that the canary adds nothing to the pie – to a highly discerning palate it may make the difference between a mediocre and a really tasty pie. Rather what this recipe implies is that for most clients it is fatuous to spend long hours arguing about what specific type of canary would go best in the pie. [Torrey (1986)]*

Where should we look for the nourishment our clients need to change – in the meat & potatoes of our practice (the Horse), or the seasoning of our theories (the Canary)?

It seems *evident* (despite what the ‘evidence-based’ gurus often claim) that if we want to increase our helpfulness as therapists, or to improve the effectiveness of our programs, we need to resist our fascination with the ‘bells & whistles’ of our trade – *or, at least, put them in proper perspective*. Instead, we would do much better to concentrate on the fundamentals of the helping profession – i.e., those things that are shared across the various schools. So what are these Common Factors? Well, that’s a story that will have to wait until our next edition.



*Everyone has won and all must have prizes!*

#### 📌 The Argument (So Far) In A Nutshell (Part I) ...

- ▶ Young Offender Programming (i.e., *what we do*) is a type of ‘therapy’ (or intervention, treatment, rehabilitation, counselling, etc.).
- ▶ Despite persistent rumors and claims to the contrary, five decades of outcome research have conclusively proven that **therapy** (of all kinds, *including ours*) **works** – i.e., that it produces change in the client’s behaviours, attitudes, and/or emotions.
- ▶ The overall effectiveness of therapy, whether understood *statistically* (i.e., as a ‘numbers exercise’) or *clinically* (i.e., as ‘real world’ differences), is real and significant.
- ▶ Researchers originally (and persistently) assumed that what makes therapy work are its Specific Factors – i.e., those things that make one type (or model) of therapy *different* from all others.
- ▶ Therapy outcome research, however, has failed to confirm this assumption. With very few exceptions, the research shows over & over again that the difference in effectiveness between all types of ‘established’ therapies is insignificantly small. This is called the Dodo Bird Verdict 🐦.
- ▶ If it’s not the *difference* between therapies that explains effectiveness, then it must be *what they share* – i.e., the things they have in common. This is the Common Factors hypothesis of therapeutic effectiveness.
- ▶ Of course, not everyone is happy with the Common Factors conclusion. In fact, the continued search for (and assumption of) Specific Factors remains the dominant strategy in outcome research – even that refurbished and much ballyhooed outcome research going by the name ‘empirically-validated’ or ‘evidence-based’.