

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

Part C of a Synopsis

From Pathology to Competence ...

So, where are we in our story to discover "what works" in therapy? Lambert gave us a General Framework for categorizing the factors associated with effective programming – and these are important, but they still beg the question about what makes them work. Common sense and our professional folklore tells us that it must be the *qualifications* (education & training) and *experience* of the individual counsellor. But research, as we saw, puts the kibosh on this fantasy. If clinical experiments eliminate the *therapist* as the active agent in therapeutic change, then what's left? The answer, of course – and as unlikely as it seems - is The Client! Could it *possibly* be that therapy is *all about the client*, not all about the therapist? Preposterous ...

But true: the research literature on therapy outcome shows over & over again that it is the *client's perceptions* (of the nature of the problem & its susceptibility to change, of the alliance, of the therapist, of the techniques, of the meaningfulness & progress of the therapeutic process, etc.), *actions*, and *expectations* that determine the outcome of therapy – *not the therapist's*.

Shifting from the therapist's perspective on therapy to the client's is another one of those *revolutionary* leaps that (a) pulls familiar clinical ground out from under us, and (b) a lot of people will not want to make. After all, how can one go about making sense of 'the client's perspective' if every client is *in some important respect* different from every other client? It boggles the mind. [Besides, why would any counsellor want to give up the illusion that s/he is in charge of programming? Why would they want to abdicate their "power"?)

It is possible to *generalize* some of the differences that such a shift in perspective from counsellor to client entails. We can then use these generalizations as a kind of guideline for re-thinking & improving our programming – and for getting a fresh understanding of what the counsellor's role might be. Let's approach this exercise using Lambert's framework [please note that all of these differences are elaborated in detail in the original article] ...

Client Factors:

From the traditional *therapist's perspective*, the client is a rather nasty piece of business: usually pictured as *pathological*, *dysfunctional*, or *disordered* – maybe even *mentally ill* (to say nothing of *delinquent*, *criminal*, or *incorrigible*). The emphasis is on *deficiency*.

In contrast, a switch to the *client's perspective* 're-humanizes' the client – granting to him or her the same respect and dignity we claim for ourselves (*there* but for the grace of God, etc.). Like all humans, the client is many-faceted: suffering in some ways, but proficient in others; failing spectacularly here, but succeeding gloriously there; up one minute, down the next. So, in this shift of perspectives, we move from a *deficiency*-based thinking to a *competency*-based thinking.

Therapeutic Alliance:

Our traditional perspective establishes the therapist as an 'expert' in dealing with the client's problems. Consequently, the therapist is believed to be in possession of superior wisdom & insight, *which the client must accept and comply with*. In contrast, the client's perspective establishes the client as the only 'expert' in his/her life.

Because the traditional view establishes the therapist as the expert, the focus of the client/therapist interaction is usually on what the therapist regards as important for solving the problem. This often involves a lot of work, worry, and discussion about issues that the client does not perceive as relevant. Research confirms, however, that it is *only* what the client regards as relevant that will be attended to and actualized in any change.

In the traditional view, the 'active' ingredients in therapy are the qualifications & experience of the therapist. We have seen, however, that there is no scientific support for this belief. Indeed, what the research shows is that it is the client's *perception* of certain *qualities* in the therapist that correlate with successful outcome – particularly qualities such as: *caring*, *genuineness*, *emotional responsiveness*, and *warmth*. [In terms of work with adolescents, then, the best thing a counsellor can be is 'cool' – i.e., someone 'in touch' with the real issues, willing to put the person before the rules, and worthy of emulation. 'Coolness' is kind of like "respect freely given" and based on something that makes the 'cool' person seem both 'different' and 'okay in my books'.]

Expectancy/Placebo:

In the traditional view, the 'expectation' of 'what works' in therapy is tied to the *specific factors* that define each model – these are seen as the 'active' ingredients of programming. Accordingly, change is measured by conformity with the *model's* prognosis – i.e., what the theory defines as "good for the client". In contrast, research shows us that the *client's* expectations should define the possibility of change – and these expectations are rooted not in academic theories, but in the real-life experiences & sensibilities of the client. It should be the *client* that sets: (a) the *limitations* on change, (b) the *goals* that are meaningful & possible to achieve, (c) the *criteria* by which progress is to be judged, and (d) the *methods* for measuring such progress.

Models & Techniques:

From the traditional perspective, one's therapy model & related techniques are one's bread & butter – they are conceived, as we've discussed, as the *real* reason that therapy works. Research, however, does not bear this assumption out: while not entirely insignificant, they account for only 15% of the successful outcome of therapy. From the new perspective, models & techniques are also important – but *not* because of their 'magic' (i.e., their unique insights); rather, because of the *structure* they provide for the therapeutic interaction with clients:

A way to view techniques is to see them as something akin to a magnifying glass. They bring together, focus, and concentrate the forces of change, narrow them to a point in place and time, and cause them to ignite into action. Not surprising, the literature indicates that focus and structure are essential elements of effective psychotherapy. In fact, one of the best predictors of negative outcome in psychotherapy is a lack of focus and structure. Failure to provide a structure or focus in therapeutic sessions can have a greater impact on treatment

outcome than the personal qualities of either the therapist or client. [Hubble et al. (1999)]

So, if we want to improve the effectiveness of our services and programs, we should make them more 'client-directed' (i.e., more in keeping with the new perspective coming from research) by:

- ▶ Focusing on the client's *competencies* and *resilience*, not deficits – which means interacting with the client as an *innovative, thinking, changing* human being capable of endlessly creating and re-creating *meaning* in his/her life;
 - ▶ Tapping into the natural change sources that occur in the life of the client *outside* the therapeutic process;
 - ▶ Tailoring programming & the client's goals/activities to the client's current *stage of change* (i.e., precontemplation, contemplation, preparation, action, or maintenance);
 - ▶ Accepting the client as the only true 'expert' in his/her life, and as the ultimate authority & judge of change;
 - ▶ Eliciting the client's perception of the counsellor and ensuring that such perception is *genuine, empathetic, caring, and 'cool'*;
 - ▶ Engaging the client in a *collaborative* relationship that focuses on goals & activities that the *client* sees as *relevant* and *achievable*;
 - ▶ Ensuring that the ideas & energy that inform and direct the programming come from the client, not the counsellor;
 - ▶ Being *solution-focused*, not problem-focused;
 - ▶ Fostering the client's *sense of control* over his/her life (and aligning *with*, not *against* the client) by *externalizing the problem*; and
 - ▶ Providing the kind of *structure & focus* (i.e., model & techniques) to the programming that is *flexible* and *responsive* to the changing needs of the client - and is compatible with the client's own *theory of change*.
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If your initial response to these recommendations for effective programming is anything like mine, then I suspect you are somewhat unsettled by pangs of doubt. Certainly, *some* of these things make sense (and we already do them) – but there are quite a few mountains here that don't look like they can be climbed. After all, our clientele is basically *involuntary* – they engage us not in *suffering* and *need*, but in *distrust, scorn, indifference, and hostility*. Worse, a lot of the time their goals & values are explicitly *anti-social* – ethically, we can neither tolerate nor reinforce such destructiveness. Worst of all, we are immersed in a system that is *compliance-based* by its very nature – it will never permit clients the kind of self-control necessary to develop 'responsibility' or 'personal accountability'. Indeed, from the system's perspective the client **is** the problem – and the solution is *compliance* and *external control*. [In case it hasn't been said enough, compliance-based programming and external control are antithetical to 'responsibility' and internal control (i.e., true 'self-control'). You can't teach responsibility by denying it (or, worse, by focusing it solely on *past* behaviour – the only type of behaviour that can't be changed or controlled). Neither can a child/youth learn self-control by being *forced* to comply with external demands. Permit me to torture another metaphor: you can make a puppet dance because the external strings take all the control & responsibility; but cut the strings and the puppet has not learned to dance. In fact, it's often worse when the 'puppet' is a real human being; not only has the kid's natural capacity for self-control atrophied (like muscles never exercised lose tone & strength), but – in some cases – *resentment*

turns what little self-control there might be in negative and anti-social directions. Still, the belief that compliance-based programming "teaches a lesson" persists – as does the myth that *punishment* works. Compliance & punishment – these are two sides of the same coin: they purchase the same consequences.] So, when we're professionally caught between the rock of 'safety & security' and the big fluffy pillow of 'treatment', it's fairly obvious what's going to win out.

Involuntariness, anti-social goals & values, compliance – these things begin to add up to the point where we might question the worth of the research. As its implications begin to build in our mind, we might go from "that sounds great" to "that sounds nice *in theory*, but how *practical* is it really?" to "this is nonsense – it doesn't apply to the kinds of kids we deal with at all!" Or does it?

Involuntary clients? Well, that really *isn't* so unusual – especially in working with children. I can't imagine a children's mental health residential treatment program or a child welfare residence that *would* describe their clients as *voluntary*. 'Involuntary' is really just a place to start a relationship with a client (especially a child or youth). **Anti-social goals?** Again, this is more a *pseudo*-problem than a real problem. [The article reveals the professional secrets behind converting the anti-social into the pro-social.] **Compliance-based programming?** Well, one of the oldest conundrums in social work is: are we therapists devoted exclusively to the interests of our client or are we agents of social control? What's supposed to be stronger: the bond of trust tying us to the individual client or the bond of duty tying us to the common good? Tough call. Anyway, the answer lies partly in how you set the ground rules with the client at the beginning of service (i.e., establishing the expectations and requirements of therapy *versus* compliance). Partly, it also lies in how you process information and interaction with the client on a daily basis (i.e., using your relationship to promote *both* personal change *and* compliance with social rules). Mostly, however, it depends on your skill in creating a 'therapeutic space' where you can align *with* – not against – the client in his struggle with compliance.

Involuntary clients and anti-social goals and compliance demands, *oh, my!* – *lions and tigers and bears* – we find them all over the children's services map, but life (and therapy) goes on. If we give in to our initial pangs of doubt, are we just being realists? Or do we simply misunderstand what the real challenges of therapy have been all along?

