

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

## Part B of a Synopsis

**A General Framework for Understanding Therapy ...**

Just because the evidence of outcome research points to the 'common' and the 'shared' factors, that doesn't mean that these factors are *obvious* – or even clearly understood or agreed-upon. To put these factors into perspective – and to show their relation to the Specific Factors – I rely on the work of **Michael Lambert**. Lambert proposes that the effective elements of therapy (i.e., 'what works') can be grouped into **four general categories**. Three of these categories describe elements that all therapies have in common [i.e., the Common Factors or 'Horse']. The fourth defines what makes therapies different from each other [i.e., it is the Specific Factors or 'Canary']. Lambert is even able to provide a relative measure of the impact that each category has on the effectiveness of therapy. So, by his calculation, Common Factors account for 85% of 'what works', while the Specific Factors account for only 15% - so our Effective Therapy Recipe calls for almost six cups of Horse for every 1 cup of Canary.

Lambert's general categories are:

- (1) **Client Factors.** Accounting for a whopping **40%** of the successful outcome in treatment are those factors that are an inherent part of the client or of the client's life context. Lambert also refers to them as **Extratherapeutic Change Factors** because they exist 'outside' the (normal) therapeutic process. [This is an extremely important point – and I will return to it shortly.] They include such things as:
  - ♦ *social supports & resources* (e.g., family relations, employment, friends, religious affiliations, faith & spirituality, cultural ties, hobbies, sports, recreation, etc., etc.);
  - ♦ *fortuitous events* (e.g., moves, deaths, injuries, illness, inheritances, etc.);
  - ♦ *client history* (e.g., divorce, abuse, racism, prejudice, drug use, etc.);
  - ♦ *client psychology* (e.g., motivation, temperament, persistence, resilience, character, etc.);
  - ♦ *client's stage of change-readiness* (i.e., pre-contemplation, contemplation, preparation, action, maintenance); and
  - ♦ *the client's theory of change* (i.e., the client's perception of 'what the problem is' and 'how change happens').
- (2) **Therapeutic Alliance (or Relationship) Factors.** Accounting for **30%** of the impact, these are factors related to the connection (bond, or alliance) that is formed between the client and his or her worker (counsellor, or therapist). This set includes such things as:
  - ♦ *appropriate therapist empathy* (i.e., matching clients cognitively, affectively, or nurturing);
  - ♦ *positive regard* (i.e., acceptance of the value of the client as a *human being*, not a "case");
- (3) **Expectancy (or Placebo) Factors.** The third set of Common Factors influencing therapy outcome – to a modest but not insignificant **15%** - relates to the fact that the client 'knows' he is in treatment and, consequently, has certain expectations for improvement – or failure - and these expectations become self-fulfilling prophecies. The dimensions of this set include:
  - ♦ *expectation of improvement* (i.e., degree to which the client and/or therapist believes treatment to be efficacious, including the presence of acknowledged 'rituals', 'socially-defined spaces', and 'symbols' – e.g., diplomas, offices, forms, jargon, etc.);
  - ♦ *placebo* (i.e., the extent to which the client is motivated to please the therapist or to meet the therapist's expectations);
  - ♦ *pathways thinking* (i.e., the extent to which the client and/or therapist believes a solution to be possible);
  - ♦ *agency thinking* (i.e., the extent to which the client and/or therapist believes the client has the ability to reach the possible solution);
  - ♦ *hope* (i.e., having a *goal*, with the *determination* to meet it, and the capacity to envision different *ways to meet it*).
- (4) **Models & Techniques.** Accounting for the remaining **15%** of therapeutic effect are the various beliefs and procedures unique to specific treatments – e.g., 'exploring exceptions' in narrative therapy, 'transference' in psychoanalysis, 'scaling' in solution-focused therapy, 'cognitive restructuring' in cognitive-behavioural therapy, 'identifying triggers' in anger management, 'role-modeling' in Child & Youth work, 'role-playing' in Gestalt therapy, 'defusing' in Non-Violent Crisis Intervention®, 'approach tactics' in PMAB, and on and on.

Finally, there is the Canary:

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So, what are the implications of this General Framework – especially concerning the message it contains for improving service?

Well, first & foremost, the Framework highlights a huge dilemma in our professional development (i.e., ‘staff development & training’) process. Think for a moment about where most of your post-graduation training has been concentrated. Has it been in learning to assess & adapt to the client’s *readiness for change*, or in engaging his *spirituality* or *social networks*? Has it been in learning the intricacies of the different types of *empathy*, or in developing the skills needed to be seen as ‘cool’ to a client? Have you ever taken training in enhancing the *placebo* or *expectancy effects*? Or – like the vast majority of us – has your staff development focused mostly on learning some model of intervention (e.g., PMAB, Anger Management, etc.) and its various (manualized) techniques? Models and techniques account for only 15% of our impact as professionals, but we spend nearly 100% of our training time and dollars on them? Does this seem efficient – let alone worthwhile?

A second implication of this Framework for improving service is that it suggests a useful direction for our professional efforts – i.e., *spend more time on the Common Factors than on the Specific Factors*. If 85% of ‘what works’ is horsepower, go with it – learning to fly (like a Canary) doesn’t have a comparable payoff.

Finally, the Framework makes a useful distinction between:

- (A) things we *can* control in therapy (i.e., Relationship, Placebo, and Models & Techniques) and
- (B) things we (supposedly) *can’t* control in therapy (i.e., Client Factors – the Extratherapeutic Change Factors identified above).

This distinction is important because it highlights one incredible strength and advantage that CYCs have over other child-serving professionals – namely: CYC professionals often (a) go places with clients that other professionals don’t (e.g., the school, home, neighbourhood, community, camping trips, court, hospital, etc.) and (b) interact with clients for longer periods of time (e.g., shifts, overnights, weekends, outings, etc.). In short, what is often considered ‘extratherapeutic’ for most helping professionals is not for CYC professionals. We need, as a profession, to learn to capitalize on this advantage.

### ***Skill, Experience, & Qualifications ...***

If you think about it for a minute, there seems to be something missing from this General Framework. True, all the things identified in it are important – in a sense, they are the nuts & bolts of programming. But don’t nuts & bolts need a *mechanic* to put them together? After all, they can’t do this by themselves. Isn’t it really the *therapist* that makes programming work, not ‘factors’? What, indeed, could relationships, expectations, and techniques accomplish without a skilled professional making them work?

There are two major dimensions by which we measure the *skill* (i.e., the presumed *effectiveness*) of a therapist. Each of these is based upon a belief so obvious that we cannot imagine how it could ever be questioned.

The first – and most important – dimension of skill is *qualifications* – as represented by the therapist’s accumulated level of education & training. The more qualifications one has, the greater one’s effectiveness in helping clients change. In fact, this belief allows us to create a “pecking order” of all the helping professions: the *psychiatrist* is more qualified than the *psychologist*; the *psychologist* is more qualified than the *social worker*; the *social worker* is more qualified than the *child & youth worker*, etc. It requires an

increasing investment of time & money to move up in this order (i.e., from CYC to Psychiatrist). In return for this investment, one is rewarded with increasing status, salary, credibility, and responsibility – *and one becomes more knowledgeable and more effective!* At least, that’s what we are led to believe.

The second dimension of skill is *experience* – as represented by the years a therapist has under her belt and by the types of problems she has worked with. While *experience* can’t, in general, overrule *qualifications*, it is still the most credible method for demanding greater respect, and maybe slightly higher pay, than one’s *peers*. Thus, we have another fundamental belief of our professional field: *the longer one practices, the better one gets – i.e., the more effective one is as a therapist*.

Qualifications & experience – aren’t these the real reasons why therapy works? It’s hard to imagine how such apparently unquestionable beliefs ever became the object of research, but they did. I personally suspect that researchers started looking at them because of the Dodo Bird Verdict (see previous Bulletin) – i.e., when all therapies started to show roughly equal outcomes, rather than look at Common Factors, most researchers still clung to the idea that *differentiating* factors could be found. Since it obviously wasn’t the difference between *therapy models/techniques*, maybe it was the difference between *therapists* themselves! The research strategy devised from this perspective was summed up as follows:

*If the therapist is the primary agent of change in therapy, then the therapist’s experience and training should make a difference. Furthermore, as with electricians and brain surgeons, experience and training should make a real difference. Experienced therapists should be much more effective than inexperienced therapists, and more highly trained therapists should be more effective than less trained therapists.*

[Tallman & Bohart, 1999]

With this research strategy, we start a new race – a race between the more qualified and the less qualified, the more experienced and the less experienced. So, who wins? Well, to get a judgement, we have to turn once more to the Dodo Bird ... *Tell us, O Great Feathered One, what’s the News?* Resplendent in his statistically significant robes, he peers down over his half-moon cheaters and declares: *“Everyone has won and all must have prizes!”*

Huh? Psychiatrists aren’t more effective than Social Workers? CYCs are just as good at therapy as Psychologists? In fact, it looks like *all* levels of professionals (from CYCs to Psychiatrists, from novices to scarred veterans, from the wet-eared to the grey-haired – even the bald) are all about equally effective. Heresy!

What *are* we to make of all this? [Of course, you know that all the juicy details and supporting research for this sacrilege are contained in the original article (plus a rather extensive & growing bibliography I keep in my office).]

[A few important caveats: (1) Although the *net* effectiveness of the professions is roughly equal, there is one slight identifiable trend – that is, psychiatrists/psychologists tend to be more effective with clients that have ‘internalizing’ disorders (e.g., depression, anxiety, phobias, OCD), while CYCs tend to be more effective with clients that have ‘externalizing’ disorders (e.g., conduct disorder, behavioural problems, non-compliance, hyperactivity). (2) While the research is far from extensive, there does seem to be an indication that in order to be effective, a therapist must have *some level of experience* (i.e., at least a *basic* training in the field). This would suggest an entry-threshold for competence. (3) Since therapists can be positively effective, they can also cause harm. Therapy is not all in one direction: clients *can* and *do* get worse in treatment. Like physicians, our cardinal principle is “*do no harm*”. We are, therefore, ethically obliged to understand and act upon all potential sources of harm in our relation with clients.]