THE DANCE OF CHANGE: STAGES, RESEARCH HISTORY, THE CLIENT-THERAPIST RELATIONSHIP, AND IMPLICATIONS FOR TRAINING

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Abstract

The need for change is all around us. Failure to make healthy lifestyle changes has led to a compromised quality of life for many individuals. Why do some people find change so difficult? This study, through a recursive process of examining the literature, writing, and reflecting on personal experiences, investigates the process of self-initiated change, and the role that psychotherapy plays in this process. Four topics are highlighted: The Stage of Change model is used to explore the blocks and challenges to change; the history of psychotherapy research is viewed, surveying the effectiveness of counselling and therapy; the client-therapist relationship is discussed, emphasizing the important part it plays in facilitating change; and the implications of this relationship for training are considered.

The Dance of Therapy: Personal Reflections

I come to you in trouble. You tell me your life is wonderful, and I should live my life like yours. But I am different from you.

I come to you confused. You tell me I should be strong. But I am needy.

I come to you upset. You tell me I am looking for an easy way out. You do not see my fear.

I come to you lonely. You see the truth. But I am not ready for it. I panic.

I come to you scared. You size me up: Orientation times three: time, place, and person. I pass. I am cautiously curious.

I come to you hopeful. But you do not stay.

I come to you wanting more. You are an illusion.

I come to you asking for help. You tell me what to do. You get trapped in the game.

I come to you depressed. You, chain-smoking, drinking your 15th cup of coffee, diagnose me "obsessive compulsive." I take your pills.

I come to you ambivalent. You judge me: sometimes I measure up, sometimes I fail.

I come to you willing to experiment. You try to put your words in my mouth.

I come to you discouraged. You want to be my friend. I try to give *you* what *I* need.

I come to you needy. You are unpredictable. Sometimes you make disparaging comments. But sometimes you recognize and validate my struggles.

I come to you in grief. You make soothing noises. But the pain does not go away.

I come to you determined. You tell me I am wrong to trust myself.

I come to you exhausted. You let me rest and show me how to listen inside.

I come to you guarded, but hopeful. You are solid. I experience contact.

I come to you with questions. You understand. Sometimes I cry. You are not afraid of my despair. You have faith in me.

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Chapter 1: Introduction

The motivation for writing this thesis came out of a desire to answer a question that has puzzled me for years: Why do some people find it easy to change, whereas others struggle for years, both in, and out of counselling, with varying degrees of success?

The need for change is all around us. Failure to make healthy lifestyle changes has led to a compromised quality of life for many individuals. Current research (Yusuf et al., 2004) into the causes of heart disease, for example, has indicated that 90% of all heart attacks are preventable with healthy lifestyle choices. Heart disease is the leading cause of death in Canada, with Newfoundlanders and Labradorians having the highest rate of all Canadians (Roebothan, 2003). In spite of this knowledge, many people find it difficult, if not impossible, to make the necessary lasting changes to their lifestyle (Prochaska, 1992).

Counselling is a viable option for those struggling to change, but the effectiveness of it is often called into question (Cushman, 1995; Dawes, 1994; Hillman & Ventura, 1993). A major emphasis (Hunsley, 2003) has been placed on research and implementation of Empirically Supported Treatments (ESTs) in order to ensure that those who provide counselling (as well as those who pay for it) are giving (and receiving) the best possible service. The establishment of ESTs is seen by many (Hunsley, 2003; Lambert & Barley, 2002) as a step in the right direction for setting standards of practice; this approach however, fails to recognize the importance of the relationship that must be formed between the client and the counsellor for successful counselling (Norcross, 2002b). Although the importance of this connection has been repeatedly validated for several decades (Orlinsky, Ronnestad, & Willutzki, 2004), counsellors are still trained primarily as technique specialists (Norcross, 2002a). Techniques may be just as efficacious as medication

for a variety of psychological disorders, however, both are more effective when there is a working alliance (Krupnick et al., 1996).

This thesis research explores the process of change, focusing on the client-counsellor relationship. The study also examines how therapist training needs to change to reflect the critical role played by the client-therapist relationship in the process of change. (In this thesis, the terms *counsellor* and *therapist* will be used synonymously, as will the terms *client* and *patient*). The thesis concludes with some thoughts and personal reflections on the process of change.

Several questions guide this thesis: What does it take to make a personal change? How do others influence (help or hinder) in this process? What are the blocks to change and how can they be overcome? What role do those in the helping professions play in this process? What light has research been able to shed on the process of change, whether self-initiated or counsellor guided, and how can counsellors be trained to be more effective in this endeavor?

In order to answer these questions I have chosen to immerse myself in the research literature, engage in conversations with anyone willing to discuss the issues, and reflect on my own experiences as a client, teacher, parent, grandparent, student, counsellor, and an individual engaged in a life-long quest to understand the process of change. Richardson (2000) talks about writing as a way of doing research, rather than as an activity that happens at the end of the research process. She suggests that it is a way of learning about and reaching a new understanding of self and the world. Writing provides the opportunity for the creation of new meanings through reflection on experiences. The result of this process has been the creation of four theoretical papers formatted as chapters in this thesis. Each is based on an analysis and synthesis of the material derived from this recursive process of engagement, reflection, and re-engagement with the issues (Barker, Pistrang, & Elliott, 2002; Elliott, Fischer, & Rennie, 1999;

Fadiman & Frager, 2002; Hill, Thompson, & Williams, 1997; McLeod, 1999; Polkinghorne, 1988, 1999; Rennie, 1998; Richardson, 2000).

The first paper explores the process of change using a model that has been well-researched and applied across a variety of areas including smoking, drinking, and exercise (Norcross, 2005; Prochaska & Norcross, 1999). Research (Prochaska & DiClemente, 1983) indicates that successful self-changers proceed through a set of stages using the same techniques that are used in counselling. The paper concludes with a description of the blocks and challenges to change.

The second paper traces the history of psychotherapy research, addressing the questions of whether or not therapy is effective (Eysenck, 1952; Smith & Glass, 1977), which theoretical approach provides the best client outcomes (Luborsky, Singer, & Luborsky, 1975; Wampold et al., 1997), and what are the effective ingredients that all approaches to therapy have in common (Lambert & Bergin, 1994; Lambert & Ogles, 2004). Lambert and Barley (2002) in their meta-analytic research review conclude that the largest variable affecting therapy outcome is the client at (40%), followed by the client-therapist relationship at (30%), and then hope and theoretical techniques, each at 15%.

The third paper examines how the client–therapist relationship has been described, analyzed, and measured both quantitatively and qualitatively, from a variety of perspectives. Research provides clear evidence that the best predictor of therapy outcome is the client's evaluation of the quality of the counselling relationship (Bachelor, 1988; Bachelor & Horvath, 1999; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Norcross, 2005). Key therapist variables that are proven to facilitate the establishment of this relationship are described.

The fourth paper explores ways of infusing current research knowledge about the relationship into the training curriculum. Theory, skills practice, internship experience, and personal growth processes are examined. Respecting and valuing the client's perspective reflects a major paradigm shift in the counselling profession (McLeod, 2003; Whiston & Coker, 2000). Has this change been reflected in the training of counsellors? The challenge for the profession continues to be how to integrate information generated from research into training and practice.

Chapter 2: Why Do Some People Find It Easier To Change than Others?

Stages, Processes, and Blocks

2.1 Theories of Change

What is change and what is known about the process of self-initiated behavior change? One way to understand change is to look at the theories that have been used to describe how people change their health-related behaviors. Festinger (1962) in his Cognitive Consistency Theory, suggests that cognitive dissonance is created when people realize they hold two conflicting beliefs, or they become aware of information that challenges their ideas or values. Change is motivated by a drive to resolve this discrepancy. Ajzen and Fishbein developed their model of Reasoned Action/Theory of Planned behavior in 1980. They assume that humans behave rationally and make use of information available to them when making decisions regarding their behavior. Bandura's (1986) Social Cognitive Theory evolved out of his observations that learning can occur vicariously, and that behavior, and behavior change is a function of what a person believes about reality.

Prochaska and DiClemente (1983) in their Stages of Change model, suggest that there are five stages that people go through in making a lifestyle change. Based on their observations of successful self-changers, these stages include: 1) precontemplation - not considering change in the near future, or have given up trying to change; 2) contemplation - aware of the problem, but no commitment to take action yet; 3) preparation - some small steps have been made towards changing, but not seriously dedicated to change yet; 4) action - doing it, change at this stage is most obvious to others; and 5) maintenance - working at preventing relapse. A sixth stage, termination, is reached when there is no longer any temptation to re-engage in the problem behavior.

The progression through the stages is seen as a spiral: people cycle through the stages several times before they reach the point where the behavior change is permanent. Different processes and behaviours are used depending on whether they are just contemplating making a change, or are actively in the middle of the change (see Appendix A). Prochaska, Norcross and DiClemente (1994) define these processes of change as activities that are used to 'help alter cognitions, affect, or behavior' (p. 25). These would include self-awareness exercises, consciousness-raising, and behavior modification techniques, and are the same processes used in psychotherapy, depending on the theoretical orientation of the therapist. Prochaska and Norcross's (1999) Transtheoretical approach provides a way to integrate all the different, and at times, conflicting theories on how to facilitate change (cf. Wilber, 2000).

Research (e.g., Miller & Rollnick, 2002; Norcross, 2002a, 2005; Prochaska, 1992; Prochaska & Norcross, 1999) indicates that the Stages of Change approach works; the model has been used to help people make successful changes in a variety of areas including smoking cessation, dealing with panic disorder, diabetes management, depression, weight loss, anxiety, and cardiac counselling. To what extent are counsellors and therapists using this model as a guide to help people change in their clinical practices?

Establishing the client's stage of change seems like a critical first step in the process of therapy, yet this model of change seems to receive scant attention in theories and models of therapy. If clients are pre-contemplative, and not sure whether or not they are ready to make a change even the best therapist will obtain poor results (Rochlen, Rude, & Baron, 2001). Many therapists assume that clients come to therapy because they want to change; however, researchers (Prochaska & Norcross, 2002) suggest that only 10% to 20% are ready for action. Between 30% and 40% are still thinking about what they want to do, and 50% to 60% are not even sure what

the problem is, or if they want to change. If clients are at stage one, success may be helping them to decide to move to stage two where they can actively start thinking about how to change, or, come to terms with the fact they really do not want to change.

Not everyone, however, turns to counselling when they decide to initiate a personal change. Some are successful on their own. They make up their mind to change and just do it, perhaps finding it difficult to understand why others are not able to do the same. What has to happen at each stage in order to successfully implement a new behavior? What causes some people to have difficulties? To try and answer these questions I have systematically applied the Stage of Change model to my own journey. At times I feel that I have generated more questions than answers. This model, however, does provide one way of conceptualizing some of the fundamental mechanics of change, and it facilitates the identification of the themes underlying the blocks to change.

2.1.1 Stages of Change

1. Precontemplation. This stage frustrates doctors, friends, and relatives of those who have serious health problems. Individuals in this first stage do not plan on changing in the foreseeable future. They may have tried to change in the past and failed, so have given up hope of ever changing. Alternatively, they may deny that there is problem, arguing the only problem is that others are making an issue about something that does not exist. Hubble, Duncan and Miller (1999) suggest:

> People in precontemplation underestimate the benefits of changing and overestimate the costs. They typically are not aware that they are making such mistakes. If they are not conscious of making such mistakes, it will be difficult for them to change. Many remain mired in the

precontemplation stage for years, doing considerable damage to their bodies, themselves, and others. (p. 229)

People might think that others need to change, but until and unless they are ready to face responsibility and accept ownership of the problem, it is unlikely that change will occur. These are the clients that are dragged into couple's therapy with the spouse demanding that the therapist do something to make the other person change. Trying to force others to behave differently when they are denying blame for a problem only leads to frustration (Lerner, 1986).

The other difficult situation occurs when clients who have no desire to change, and do not want to come to counselling, are court mandated to attend because of a drug arrest, or a drunk-driving charge for example. In such cases, therapists have a challenging job ahead of them. Motivating unwilling clients involves specific skills and a non-confrontational stance. When clients have an underlying addiction problem, the issue of low motivation is really one of "unresolved ambivalence" (Miller & Rollnick, 2002, p. 14). Each side of the argument, for and against change, has advantages and disadvantages, making it difficult to choose. Miller and Rollnick go on to suggest these risks and benefits may shift over time, with context and mood, and must be viewed within the person's life space.

So what does it take to move individuals to decide they do have a problem that they need to address? There are a variety of possibilities. Sometimes it can be a developmental event, like a 40th birthday, or a child leaving home. Sometimes it will take the death of a friend, spouse, or a parent to motivate a change in health behaviour (Prochaska et al., 1994).

The primary change process used at this stage is consciousness-raising (Prochaska & Norcross, 1999). Used alone, it is often not very effective - if it were, the scare tactics of the anti-

smoking campaigns would have put an end to smoking. Information however, may move people a step closer to deciding to make the effort to change.

The goal for counsellors working with those in the precontemplation stage is to raise their level of awareness of the problem. Sensitizing clients to the seriousness of a problem is not easy in an alcoholic family where denial is something the whole family covertly agrees with as a way of maintaining stability. But, until the negative consequences for drinking outweigh the immediate relief provided by the alcohol, individuals are unlikely to consider changing.

The potential benefits of changing behavior also need to be addressed. Part of this discussion should focus on how society views the behavior, and how the environment has changed regarding tolerance for things like alcohol consumption, smoking, and physical abuse. Prochaska et al. (1994) assert "The process of social liberation involves creating more alternatives and choices for individuals, providing more information about problem behaviors, and offering public support for those who want to change" (p. 100). The move to go smokeless in public places is one such example. Self-help groups are another. The change in attitude towards drinking and driving has made it easier to refuse alcohol at a party without fear of stigmatism.

When people realize their behavior is a problem for others, they may start to think about the possibility of change. The effectiveness of any technique that raises personal awareness of the impact of a problem behavior on self and others will be enhanced if it also triggers the individual's emotions. The goal is contemplation of change, not to overwhelm the individual, who may then tune out the message (Hubble et al., 1999).

The challenges present at this stage include defense mechanisms such as rationalization, minimalization, and the previously mentioned denial. Low self-efficacy is also a major issue for

some people. These are the precontemplators that have tried before to change their behaviors, but have failed. Exploring what worked in the past, what did not work, and why, may be necessary. Change does not happen just because it is desired. It is a complex process, and the more prepared people are, the better their chances will be of succeeding. By reviewing past experiences, it may be possible to anticipate what strategies will be necessary to help people succeed this time. It is also necessary to instill a sense of hope that change is possible. This is more likely to happen if people can understand why they did not achieve their goals in the past (Kottler, 2001; Prochaska et al., 1994).

In order for people to move from precontemplation to contemplation, three events have to happen: a) they have to become aware that there is a problem; b) they have to want to change; and c) they have to believe that it possible for them to change.

2. Contemplation stage. 'I have a problem that I would like to change, and I plan on doing something about it within the next six months. I am not sure what I am going to do yet, but I know I need to do something.' This is the objective measure for determining if the person has reached the second step of change, the contemplation stage (Prochaska et al., 1994). At any given point in time, approximately 40% of the population is at this stage for any specific behavior that needs to be changed (Norcross, 2005).

Ambivalence is the hallmark of this stage: People know they need to change, but they are not sure how to go about it. They may believe they need to find the perfect solution, the ideal treatment, or wait until the right time to make the change. Fear of failure can also inhibit action (Bandura, 1997). Inadequate preparation may result in a lack of success that sets them back to where they started, except now they have less reason to be optimistic about success. Such low self-efficacy can be viewed as a loss of a "belief in our abilities to change behavior, and a

decision to act on that belief" (Prochaska et al., 1994, p. 61). Prochaska et al. define willpower as commitment, but it is only one of the processes needed to change, and is not sufficient on its own. Those who claim that 'it just takes willpower to change' are overlooking the details. Further questioning indicates that other processes are usually involved in helping these self-changers progress through the stages (Kottler, 2001).

The subjective experience of someone stuck in this stage, otherwise known as chronic contemplation, can be one of prolonged agony (Prochaska et al., 1994). People can become stalled here for years (Kottler, 2001; Prochaska & Norcross, 1999). There are a number of reasons for this unfortunate situation. These relate to an ability to answer two difficult, but key questions: What exactly is the problem and to what extent is the change desired? The goal for those contemplating a change is to shift the decisional balance so the advantages of change outweigh the disadvantages, and a serious commitment to change can be made.

Which processes of change are the most appropriate to generate movement in this stage? Consciousness-raising continues to be critical – not just gaining factual information about the problem, but learning about the personal intricacies of the behavior pattern. To really assess the advantages and disadvantages of changing a behavior, so individuals can feel confident deciding to change, they need to know as much as possible about the behavior. Einstein is reported to have said that asking the right question is the key to solving the problem (Prochaska et al., 1994). While the cure might not happen that quickly, focusing a magnifying glass on the problem often turns up some surprises that can provide clues to a solution, or at least an understanding of why the behavior is so intractable.

One of the easiest places to start is with detailed observation: What is known about this behavior? When does it occur? Many behaviors happen automatically, so it will take a concerted

effort to stop and think about what might have triggered the response. What is the meaning or function of the behavior? Is it just habit, or does it meet a need?

The second part of this process includes identifying the triggers, and is referred to as the ABC analysis: Antecedent event, Behavior, Consequences (Prochaska et al., 1994). This step is critical in understanding what is reinforcing the problem behavior. If the problem is the absence of a desired behavior, then what is inhibiting action? When considering the impact of the behavior, what are the immediate consequences, as well as the long-term results? This ABC technique is useful for understanding what motivates and maintains behavior. The **A**ntecedents are any events that cause the undesired **B**ehavior to happen. The **C**onsequences are what reward the behavior, making it difficult to change. Part of the strategy of making a successful change lies in eliminating (or neutralizing) the triggers. A second part is the creation of new behavioral options in response to those triggers that can not be avoided. The third strategy involves changing the consequences for the undesired behavior.

Taking time to make these observations, and analyze the meaning of the behavior will be beneficial in helping establish the goal and developing the motivation to achieve it. Too often the desire to change leads people to take action before they have gained an in-depth understanding of the behavior. Without the knowledge of the triggers, it is almost impossible to prepare adequately to deal with temptation. Sometimes much soul-searching is needed to uncover the advantages of a seemingly destructive behavior. In order to find a more personally acceptable means to meet a need, it is necessary to be fully aware of the need. The difficulty arises when the problem behavior is automatic. It is a struggle to slow down the reaction enough to discover what is driving the behavior. Often, there is a good reason to avoid learning the truth, as the truth can be painful. Eating when stressed is a prime example; instead of thinking about something

upsetting, the focus is shifted to thinking about the eating problem. Exploring and learning as much as possible about the behavior, including the context in which it occurs is critical.

The other key issue that needs to be addressed is the nature of the goal. If the stated objective is to increase self-confidence, what exactly does that mean, and how will individuals know when they have succeeded? Part of the process of describing the behavior is figuring out what to change. What does low self-confidence look like? What makes it low? How would life be different if self-confidence were higher? What behavior would change? While this may seem like a mechanistic way to approach the problem, it can provide insight into some basic issues underlying the desire to change. What will successful change look like? Self-changers stand a better chance of achieving their objectives if they define them in terms of the process rather than the outcome: exercise for 30 minutes each day, rather than 'get fit'. Motivation is increased significantly if the focus is on learning a new behavior rather than passing or failing to achieve a goal (Bandura, 1997; Caprara & Cervone, 2000; Dweck, 2000; Heyman & Dweck, 1992).

When individuals desiring change have a clear idea of their goal, they can start the process of self re-evaluation. This involves reflecting on thoughts and feelings about the problem. Is the behavior consistent with their values (Prochaska et al., 1994)? This is the time to list the advantages and disadvantages of change. Working towards commitment is one of the critical steps necessary to move forward. The danger in looking at the negatives of the current behavior is the risk of feeling overwhelmed and depressed by the amount of change that the person feels is necessary.

When the effort required to change becomes greater than the perceived benefits, motivation suffers. The suggestion that people who do not change are lacking motivation is misleading; they are just not motivated by the potential gains to be had by changing. The

outcome does not compensate sufficiently for the energy required. The challenge then, is to increase the benefits for changing, and the penalties or negative consequences for maintaining the behavior. Interestingly, it takes twice as much movement on the positive side of the balance as it does on the negative side for change to occur. (Prochaska et al., 1994). Wanting to be fit and worrying about the health consequences resulting from a lack of exercise may not be sufficient motivators for a walk when it is freezing drizzle outside, or the work load leaves no time for extra activities. Negative factors can easily overpower a host of potential benefits.

Again, honesty and detail are essential. By spending time at the contemplation stage the person may realize that they do not really want to change after all. The costs may be too high. The motivation to change may be outweighed by the motivation to avoid the perceived pain and suffering that will ensue. Difficult choices will have to be made. Decision-making skills will be needed, as well as confidence to move forward even if all the questions have not been answered (Gelatt, 1989).

To resolve ambivalence it is necessary to increase the benefits of change, as well as the disadvantages of not changing. This can be done by obtaining more information (consciousness-raising) as well as by emotional arousal. The latter was mentioned in the context of precontemplation, but in the contemplation stage, the assumption is that individuals desiring to change will set out to deliberately scare themselves with the negative consequences of not changing. How effective is this? Does internal coercion work any more effectively than external coercion? Or, will people rebel against their own efforts to change – an internal version of psychological reactance? When people feel that their personal freedom is constrained, they tend to persist in their current behavior and resist pressure to change (Miller & Rollnick, 2002).

The impact of emotional arousal is cited as the reason for change after experiencing a disturbing or painful event (Kottler, 2001). It also forms the basis for many approaches to therapy (Engle, Beutler, & Daldrup, 1991; Greenberg, 2002; Johnson & Lee, 2000; Perls, 1973; Safran & Greenberg, 1991). It is possible to trigger emotions through the use of scare tactics as Prochaska et al. (1994) suggest, but the danger then becomes one of feeling compelled to act before the preparations for change are completed. A balance needs to be struck between getting bogged down in contemplation and moving too quickly.

A final task for the contemplation stage is to clarify and address fears of change. This seems to receive little attention in discussions about change. Especially when the change is perceived to be 'for the better', it may be difficult to understand and accept that it is normal to experience trepidation about making a change. This apprehension does not mean there is a problem, or a lack of willpower, just that change is scary. The hardest part about change is saying good-bye to the familiar. Some individuals find that process more difficult than others (Matthews, Deary, & Whiteman, 2003).

Many of the road blocks to change at the contemplation stage are internal. Besides not spending enough time analyzing the behavior to gain an in-depth understanding of the motivation behind it, there is also the danger of spending too much time at this stage. Resolving the advantages and disadvantages of a behavior is a normal and necessary part of the process of change. "It is when people get stuck in ambivalence that problems can persist and intensify. Ambivalence is a reasonable place to visit, but you wouldn't want to live there" (Miller & Rollnick, 2002, p. 14). What causes some people to ruminate endlessly, thinking about a problem instead of doing something about it?

Perfectionists are often reluctant to take action until they have enough information to solve the problem (Flett & Hewitt, 2002). They need to read as much as possible on the subject, talk to a wide variety of people, check out the internet, and watch TV shows on the topic. A variation on this form of procrastination is the need for the right equipment to start exercising, or the best diet, or the perfect stress free time to give up drinking. All these forms of rationalization help deal with the anxiety that is aroused by the thought of making a change.

Another way of coping with this anxiety is to engage in wishful thinking. This can take the form of a search for the special drug that will melt the pounds away while sleeping. This fantasy of a quick and painless solution is fed by the endless media offerings that keep consumers trapped in the belief that change should happen just because it is desired. The steps to change - stopping to explore and reflect on the triggers for a negative behavior (or the decision not to engage in a positive behavior) - take time, involve soul searching, and feel uncomfortable. Wishful thinking is constructive when it motivates action, not when it displaces it.

3. The preparation stage. This stage is distinguished by another shift in thinking. Those entering the third stage "focus on the solution rather than the problem… they begin to think more about the future than the past. The end of the contemplation stage is a time of anticipation, activity, anxiety and excitement" (Prochaska et al., 1994, p. 43). Ideally, people reach the end of the contemplation stage when they have resolved their ambivalence about making the change. They have a clear idea of what their goal is, and the nature of the behavior they are trying to change. Their ambivalence may resurface once they start making changes, but right now they are ready to take action.

If the danger of the contemplation stage is in spending too much time there, the danger of the preparation stage lies in skipping it completely. Kottler (2001) suggests it is necessary to

think of change as a marathon, not a sprint, and prepare accordingly. The goal is to develop a detailed action plan based on research – books, internet, consulting with others, and previous personal experience. It is important to anticipate and figure out how to deal with problem areas. What options are there when feeling tense at a social gathering and there are high-calorie snack foods available? What changes will be needed in the environment to enhance the likelihood of success? Will putting a clock beside the TV, and setting a timer help with the bedtime routine? While there will always be unexpected situations, rehearsing how to handle the inevitable triggers will contribute significantly to successful change (Kottler, 2001).

Strategy development is critical. What are self-changers going to do, and how are they going to accomplish it? They need to have a clear idea of what they want to change, a **SMART** goal (cf. University of Victoria BC Counselling Services, 2003). The goal should be stated in **S**pecific terms, it should be **M**easurable, and **A**chievable – within the realm of possibility, it should be **R**ealistic – they have the skills needed to accomplish the task, and the goal should have a stipulated **T**ime frame to completion. Using this approach, "lose weight" becomes "stop eating when full", "get more sleep" means "be in bed with the lights out at 10 o'clock six nights out of seven", to "increase level of fitness" means "raise heart rate to 120 beats per minute for 30 minutes at least four times a week", and "improve self-confidence" means "reframe negative self-statements." When self-changers know *what* they plan on doing, they are in a better position to figure out *how*.

How will self-changers deal with the triggers? The ABC analysis should provide them with the information they need to devise strategies to deal with the problems. What are the reasons for not having changed before now? Instead of reaching for the ice cream when stressed, what behavior will they substitute? If 'foolish freedom' (Prochaska et al., 1994, p. 281) is an

issue, hopefully, in the contemplation stage people will have identified and started to work on their need to feel in control, no matter what the consequences of their choices. When it is raining outside and too wet to go for a walk, how will individuals respond differently? What is their motivation for doing something that in the short run feels unpleasant, or down right dreadful? Will new rain pants make it easier? Will having the list of the advantages and disadvantages regarding exercise tacked on the door be a sufficient motivator for action? Or, perhaps having a piggy bank and a pile of loonies; deposit one dollar for every thirty minutes of exercise. While some might cringe at the thought of bribing themselves to change, behavior modification principles suggest that actions that are rewarded will increase in frequency (Evans, 1976).

In order to formulate an action plan that has a SMART goal and addresses how to deal with triggers, it is necessary to make change a priority by setting aside time to work on it. Again, this is may be a problem for those who are busy, need a quick solution, or were not expecting to spend time focusing on the details of the goal. Making a change involves more than just motivation and willpower. It takes time and commitment, and an awareness of how difficult a challenge it can be. Prochaska et al. (1994) suggest that preparing for change is like preparing for a major operation and it is important to acknowledge the challenge:

> Many changes – quitting smoking or drinking, losing weight, reducing stress, or becoming active - involve a psychic surgery that is as serious as many life-saving operations…change is powerful and real…you and those who support you put the operation first and everything else second…Changes in your mood, in your relationships, in your work performance, and other areas should be accepted as consequences of the all important work that will soon enhance your life. (pp. 156-7)

This description is quite melodramatic, but it serves to highlight the contrast between the effort required and the wish for painless change. At the same time, it underestimates the amount of time and effort required to deal with psychological issues such as the need for control, self-soothing, and nurturance underling a variety of health-related behaviors.

The preparation stage requires overcoming several psychological hurdles. Change involves saying goodbye to the familiar, something that is not often recognized. Letting go of the past is 'disorienting' (Prochaska et al., 1994). Anxiety and fear of failure can lead to the avoidance of spending the time needed to develop an action plan. Because of the level of stress involved, having a supportive person can make a substantial difference at this stage (Kottler, 2001; Prochaska et al.).

4. The Action Stage. This is the phase that most people identify with when they think of change, the 'doing it' part. The goal at this fourth stage is to make the behavior change a reality. There are a number of strategies that can be used, and these are taught by most programs aimed at changes such as stopping smoking and weight loss. They are highly effective – but only for those who are *prepared* for action (Prochaska & Norcross, 2002; Prochaska et al., 1994). Only 10-20% of the population who need to change are at this stage at any point in time (Norcross, 2005; Prochaska & Norcross).

Prochaska et al. (1994) suggest "most problem behaviors represent elaborate and indirect means of achieving relaxation and assertion" (p. 135), indicating the need for stress management skills. *Countering* is a strategy that involves finding more appropriate and less destructive ways of satisfying needs as well as confronting irrational thinking. The challenge then becomes implementing these stress reducing behaviors – such as exercise, meditation, and taking time off

to relax and play. All efforts to change will be severely compromised unless a way can be found to deal effectively with stress (Norcross, 2005).

Another strategy, *environmental control*, means rearranging surroundings, removing triggers, dealing with the antecedents. While it is not possible to change the weather for walking, finding out the swim schedule would provide a different exercise option. What can be changed in the surroundings to reduce the level of stress? Is it possible to cut down the number of hectic social functions that have to be attended? In some situations, the environment in which people find themselves may be a major limiting factor.

A third useful strategy in the action stage is *rewarding the desired behavior*. Sometimes, it is helpful to provide small incentives along the way for baby steps, a process of 'shaping', or successive approximation (Bandura, 1997). For example, instead of waiting until six days of exercising for thirty minutes have passed before receiving a big reward, people could give themselves something smaller for every day that they do exercise. The easiest way to do this is by positive self-talk, a form of internal coaching. But this idea will not work if they do not know how. Some are expert critics of their own short comings, and often fail to acknowledge their accomplishments. If individuals (or others around them) do not believe they need or deserve praise for making such a simple change, they will resist contracting for a treat, and change may be more difficult.

The Action stage is when personal change is most obvious to others. It is the easiest stage in some ways for positive behaviour changes like quitting smoking, dieting, or running. Friends and family cheer the person on. But change is not so easy when others are undermining the individual's efforts and are subversively discouraging him or her from changing for a variety of reasons. A change in one member, if it is successful, will force others to change and adapt to the

new relationship structure. The family as a system has a strong drive to preserve equilibrium; when one of its members tries to change, the others will often resist this change (Curtis & Stricker, 1991; Kottler, 2001; McLeod, 2003; Minuchin & Nichols, 1998; Napier & Whitaker, 1988; Nichols, 1999; Wachtel, 1991).

Helping relationships can make all the difference in the action stage (Kottler, 2001). For example: both people changing at the same time (quitting smoking, exercising together, changing eating habits), not tempting the individual, helping to rearrange the environment, cheering, sympathy, and realism about expectations for change. Those making a change need to recognize what a good support person looks like, and how to find one. Finding a support group is especially important if family or friends are not helpful, or are sabotaging change.

Many of the challenges at this stage are external and self-changers need to be well prepared to deal with the actual triggers and the temptations from others. There is no magic solution for long-term change. No single method or technique will fix things; planning is essential. Success at this stage makes the hard work worth it. The results will often provide an incentive to contnue with the change.

5. The Maintenance stage. This stage is reached when the new behavior has been maintained for a minimum of three to six months without any major slips (Norcross, 2005). The goal now is to prevent relapse and deal with it if, and when, it does happen. In this fifth stage, the focus continues to be on behavior change and modifying old habits and ways of life. Once the euphoria of accomplishing the change has worn off, it is easy to slip into complacency. Some people are successful at losing weight, but unable to keep it off. For example, after two years only 19% of those who had made New Years resolutions were still keeping them (Prochaska et al., 1994).

One of the dangers in the maintenance stage lies in changing some behaviors while continuing to engage in other behaviors that may lead to temptation. Rationalizations such as 'just one cigarette or one beer will not hurt' need to be challenged. For some habits, it is necessary to always be on guard. The most difficult part may be saying good-bye to the 'self' that behaves in a certain way – the 'insecure self', or the 'drinking self' (Caprara & Cervone, 2000; Cross & Markus, 1991). It also requires acknowledging the hazards of maintaining the old circle of friends. Building new friendships may be ultimately rewarding, but can be a difficult and stressful process. Finding or creating a support group will help facilitate the development of the 'healthy self' (Prochaska et al., 1994).

Another maintenance stage danger is denial or distortion of the extent of the problem. Remembering how bad it really was is an important strategy in this stage. But it is difficult: most people do not want to remember how unpleasant things were. Life is good now, and that is all that matters. Because the thrill of accomplishment has faded, along with outside reinforcement for observable behaviour changes, it is important for people to congratulate themselves for actually achieving the goal. This recognition is critical and serves to maintain commitment by acknowledging the effort that was required. Giving positive self-feedback needs to be an on-going process, along with remembering the positive benefits of changing.

2.1.2 Learning from Relapses

Complacency and overconfidence are the antithesis of low self-esteem and low self-efficacy. Both circumstances are equally hazardous. It takes a certain amount of humility to admit that something might always be a problem, especially if individuals have done a good job of convincing themselves of why they need to make the change. Kottler (2001) suggests a relapse prevention plan be developed as part of the change strategy. Assessing self-efficacy by

listing possible temptations and how confident people feel dealing with them is a good way to pinpoint problem areas and potential difficulties. Preparation for every possible temptation is challenging as there will always be unanticipated social situations and unforeseen events (Prochaska et al., 1994). It is how people respond to these unusual circumstances that determines whether a slip becomes a permanent downfall, or just a temporary state of affairs.

Relapse is inevitable. The danger lies in excessive self-criticism when a slip-up occurs. Setbacks often result from social pressure, extreme stress, or inadequate strategies for managing stress (Prochaska et al., 1994). The challenge lies in learning how to accept that relapses do not mean failure. Too often people use slips as a reason to give up instead of seeing them as an opportunity for learning what they need to do differently next time. For those who tend to have unrealistically high expectations, and are quick to criticize themselves when those expectations are not met, this may necessitate a major mental shift (Flett & Hewitt, 2002; Millon, 1999).

Change is not a one-time event; it requires continuous vigilance to guard against mistakes. It is still necessary to avoid dangerous situations, and monitor thinking patterns for distortions, denials, and defenses that might lead to relapses. These setbacks have to be viewed as knowledge opportunities, rather than as excuses to give up. The challenges to permanent change in the maintenance stage can be internal, and external; the process may never be complete. Change needs to be viewed as a cyclical process (Norcross, 2005).

Research by Prochaska et al. (1994) indicates that most people can and do learn from relapses. They cycle back to contemplation or preparation again, unless they give up on themselves completely. It is necessary to evaluate what was learned before proceeding again; what worked and did not work, and what to do differently. Only 20% achieve success the first

time they try to change a behavior (Prochaska et al., 1994). Many fail to realize how much time and effort is needed to succeed, assuming that willpower or motivation is sufficient.

The most common cause of relapse is distress (Norcross, 2005; Prochaska et al., 1994) that leads to intense emotions people have not yet learned how to deal with effectively. Do some individuals learn to cope better while others become more effective at blocking these emotions from awareness? People often deal with upsetting emotions by engaging in self-soothing behaviors. Some are beneficial, such as going for a walk, or meditating; others are potentially harmful or addictive, such as smoking, overeating, drinking, watching TV, or surfing the internet. The problem of not knowing how to deal with intense emotions effectively reinforces the need in the preparation stage for developing alternative strategies for dealing with the inevitable stresses of daily living.

The second major reason for relapsing is social pressure (Prochaska et al., 1994) Many feel threatened by change; the status quo has been challenged. Kottler (2001) gives the example of the husband bringing home fattening food that he did not usually eat, and leaving it around the house even though his wife was on a diet. His defense was that he did not need to lose the weight. He failed to recognize he was undermining her efforts. Families (and friends) can exert incredible pressure in their interactions with each other to remain the same, even when the change is viewed as an improvement. They will resist any change that disrupts the status quo, preferring to hang onto what is known, familiar and comfortable (Wachtel, 1991).

6. The Termination stage. This stage is attained when self-changers no longer need to be watchful; the change has become integrated into their personality, their habits and lifestyles. This sixth and final stage may not be possible with some behaviors. At termination there are no goals or tasks, just an ideal stage to be reached. Some never attain this, but have to content themselves

with constant vigilance for possible slips and back-sliding. Prochaska et al. (1994) list four essential features of the termination stage: a "new self-image… solid self-efficacy…a healthier life style…and no temptation in any situation " (pp. 276-7). The sense of self has changed and the new behavior has become internalized.

2.1.3 Stages of Change: Review

Why do some people struggle with changing their behavior, whereas others seem to do so effortlessly? Part of the answer is those who succeed have the motivation to act and the commitment, or willpower to carry through with their intentions.

Where does motivation come from? It flows from the resolution of ambivalence. Information stimulates awareness, providing the reasons for change. When there are sufficient perceived benefits of change, motivation to change will emerge. When the balance has shifted sufficiently, action will ensue if there is commitment. What determines commitment? It is a belief in the ability to succeed at change and a decision to act on those beliefs. When people have faith in their ability to succeed, self-efficacy exists (Bandura, 1997; Caprara & Cervone, 2000). A commitment is made, a decision to act, and the process of change is set in motion.

I *want* to do it, I *can* do it, and therefore I *will* do it. Whether or not the action is successful, depends on internal preparation, external circumstances, and the nature of the action taken. Before examining the barriers to change in more detail, it would be useful to review the goals and challenges to be met at each stage:

In the precontemplation stage, the goal is to increase the level of awareness and consequences of problem behavior. The challenges to overcome are low self-efficacy (due perhaps to previous failures), and defense mechanisms (e.g. cognitive distortions).

In the contemplation stage, the goal is to overcome ambivalence, and shift the decisional balance in favour of change. Part of this process will involve increasing knowledge about the behavior (triggers), and defining the change desired (benefits). The challenges at this stage include: inadequate analysis versus chronic contemplation, maladaptive perfectionism, fear of change, low self-efficacy, wishful thinking, and psychological reactance (internal rebellion).

In the preparation stage, the goal is to develop a SMART, detailed action plan. The danger at this point lies in not taking the time to complete the plan. In the action stage, the goal is to make the change. The challenges to be met may be a result of inadequate preparation, lack of support, or dysfunctional beliefs about self and the process of change.

In the maintenance stage the goal is to prevent relapse, and deal with it effectively when it occurs. The challenges at this stage can include overconfidence, complacency, lack of support, denial, distortion, and a negative view of relapse. In the termination stage, no more effort is required; the goal of change has been achieved.

2.2 Challenges to Change

If individuals have the motivation to change (sufficient perceived benefits) and believe that they will succeed (self-efficacy), why else might they have trouble changing? Some people seem to have a number of barriers to overcome at each stage. As a result they, either get stuck somewhere in the process, or continuously relapse. Some of these obstacles exist in the environment (external), some are related to not having sufficient information about the process of change itself and how to prepare for it (knowledge), and some of the challenges arise from personality and behavioral disposition (internal psychological issues).

2.2.1 External

In trying to understand why some people seem to have difficulty making changes it is useful to see where the difficulties exist, and then utilize the appropriate remedial strategy. Some environmental factors such as temptations in the workplace, with friends, or family are often difficult to avoid, hence the importance of health policies such as smoke free environments, and HeartSmart menus. A high stress job, recent loss of job, chronic unemployment or underemployment, poverty or low income, and inadequate housing all stress a person's (and family's) coping skills, making it more difficult to change behaviors that provide comfort in the short term, but have negative long-term health effects. Even simple things like inclement weather or having a safe place to walk can limit a person's ability to exercise. While the government cannot influence the weather, it can provide sidewalks and adequate snowclearing, and money for the construction and maintenance of hiking trails. Workplaces can incorporate exercise spaces, relaxation areas, and fitness memberships (e.g., Memorial University of Newfoundland's Wellness and Active Living policy (*Wellness and active living*, 2005)). Being surrounded by supportive people may make a significant difference (Brown & Tirril, 1978; Kottler, 2001), whether it is for baby-sitting during an exercise session, or to have someone to call when the temptation to smoke feels overwhelming.

2.2.2 Knowledge

While a supportive environment is important, it is also critical for individuals to have the behavioral, technical, and practical knowledge needed for change. Behavioral knowledge refers to personal knowledge about triggers, purposes, and consequences (both positive and negative) of the behavior they want to change. Knowledge about the process of change is also vital. Self-changers often do not realize how much time and effort is required, or the inevitability of stress,

and relapse. Social support is critical. Practical knowledge about strategies - such as developing goals and modifying behavior through contingency management, rewards, and countering - is often available through groups such as Weight watchers, Alcoholics Anonymous, and The Lung Association's Help Line. These groups also provide a social support network.

2.2.3 Internal

If individuals are in a supportive environment, have the requisite knowledge about the process of change, and incentives to do so, what stops them from succeeding? The last of the challenges to be addressed are the internal psychological factors. These seem to appear mainly at the contemplation stage, but they are also evident in the other stages: defense mechanisms, cognitive distortions, dysfunctional beliefs, overconfidence, fear of change, pessimism, maladaptive perfectionism, negative view of relapse, wishful thinking, psychological reactance, low self-efficacy, procrastination, rumination, inadequate coping skills, anxiety, and depression. This group of factors are probably the most difficult to deal with and modify, but if change is going to occur, the underlying psychological issues will have to be addressed. The question is, how?

Prochaska & Norcross (1999) in their Transtheoretical model of psychotherapy, categorize these issues into five levels of complexity: a) symptom/situational problems, b) maladaptive cognitions, c) interpersonal conflicts, d) family systems conflicts, or e) intrapersonal conflicts. They suggest starting with the most recent, easily accessible level, and then working downwards, utilizing the various processes of change (consciousness-raising, catharsis, contingency control and so forth). Some of the blocks identified such as rumination, low self-efficacy, low self-esteem, negative self-talk, maladaptive perfectionism, and procrastination, are habits and beliefs that will have to be addressed before other behaviors can be changed. These

second-order, or structural changes, may be more difficult to attain, but when they do occur – whether through therapy or a significant life event - the effects are usually more enduring (Dawes, 1994; Kottler, 2001; Miller & C'debaca, 1994). More attention needs to be paid to these issues in self-help groups and in health promotion programs.

2.3 Conclusion

The answer to the question "why do some people find self-initiated changes easy, while others struggle for years to change?" is that people have differential success in overcoming three major groups of barriers. Self- initiated behavior change is a complex and difficult process. Some people seem to make up their mind to change and then just do it. Others seem to have a never ending succession of hurdles to overcome, and often end up stuck somewhere along the way. Returning to the observation that the high costs of health care are related to diseases caused by lifestyle choices, the next question is: "Can counselling help people remove the blocks to change?" Does therapy work?

Chapter 3: A Brief History Of Psychotherapy Research: How the Changing View of the Client Has Been Accompanied by a Changing Research Methodology

3.1 Question One: Does Therapy Work?

The process and outcome of therapy are concerns for those who pay for psychotherapy, not only clients, but health-care agencies who are now deciding which problems will be eligible for treatment and which therapies will be reimbursed. Therapists want to know which techniques to use for various problems, and therapists-in-training need to know what the latest trends are in psychotherapy. Researchers are under a lot of pressure to come up with the answers (Duncan & Miller, 2000b; Kottler, 2001). In fact, psychotherapy is more heavily researched than medical treatments (Todd & Bohart, 1999).

In order to understand the obstacles to be overcome to answer this question, it is necessary to look at the history of psychotherapy research. Although psychotherapy has been practiced in one form or another for over a hundred years, research into its effectiveness did not begin seriously until the 1950's. At that time Hans Eysenck (1952) reviewed the literature on people with neurotic disorders, comparing those who had received psychotherapy with those who had not, and concluded that psychotherapy was ineffective. His research findings suggested "most people with neurotic disorders… would improve within two years, regardless of whether they were treated by psychotherapy" (Marshall & Firestone, 1999, p. 411). In other words, it was a waste of time and money. This declaration sparked a furious round of research activity into proving that psychotherapy was indeed effective, more effective than not doing anything at all. There was considerable debate over Eysenck's methods of analysis and lack of

control groups (Marshall & Firestone, 1999), but the net effect was to generate interest in using scientific methods to assess the effectiveness of therapy and counselling. The question researchers were intent on answering was: "Does psychotherapy work?"

In the early 1950's, there were three main schools of thought on psychotherapy: the Psychoanalysts, the Client-Centered therapists, and the Behaviorists. Each developed their own theories of human nature, offering different perspectives on problem development, how therapy should be conducted, and how to prove the efficacy of their approach to therapy.

3.1.1 Psychoanalytic Therapy

Psychoanalysis was developed by Freud on the basis of observations he made of his patients who were suffering from nervous disorders. He was trained as a medical doctor, and discovered that many of his patients could be cured of their illnesses by allowing them to work through traumatic emotional experiences from their childhood. While he has been severely criticized for many of his misogynist views, much of what he theorized underlies the views of human nature today. Most individuals are familiar with idea of a super-ego that sends a reminder to stop for red lights. Defense mechanisms such as rationalization are used to postpone an undesirable activity, or denial to avoid anxiety that might be caused by expressing anger.

Freud's view of how therapy should be conducted was to have the patient free associate to whatever thoughts came into his or her mind, telling the therapist everything. The therapist would expertly analyze the meaning of the patient's problems. This insight into the unconscious motivations of the patient would then have to be 'worked through' by the patient. When this was successful, emotions would be released, and the symptoms

of the problem would disappear. Therapy might last for several years, as it would often take a long time to overcome all the patient's resistances to the revelation of the repressed material. While Freud viewed the therapist as the final authority on what was in the patient's mind, and hence held ultimate control over what happened during a therapy session, he did stress the importance of the relationship between the therapist and the patient (Breuer, Freud, Strachey, & Bernays, 2000). For Freud, it was critical that the patient put his or her faith in the therapist, and trust the therapist completely. The real work of therapy could begin when the patient came to view the therapist as the most important person in his or her life (Karen, 1994). When this happened, the patient would then transfer his or her unresolved issues from important relationships in the past onto the therapist (Freud, 1912). The therapist would then help the patient work through and resolve them. Many of Freud's ideas, including the importance of the therapy relationship, transference, and catharsis of emotions, are reappearing in current therapies and showing up in research as significant variables to outcome results (Kahn, 1997; Lambert, 2004; Norcross, 2005). When asked for proof that psychoanalysis was effective, Freud relied on case studies, and suggested that the only way to really understand the unconscious was to experience it through psychoanalysis (Kahn, 1997). That, however, did not satisfy the skeptics.

3.1.2 Client-Centred Therapy

This school of therapy was created by Carl Rogers, a man who was very concerned with providing experimental proof that his new therapy worked. While his growth-oriented view of human nature and approach to therapy were in direct contrast to Freud's theory of dangerous drives and methods of analysis, he also focused on the

nature of the relationship that he was able to establish with the client. He preferred the term client to patient as he felt it was more respectful (Rogers, 1961). Rogers (1957) postulated that if he provided the right conditions (congruence, unconditional positive regard, and empathy) during therapy, then the client would grow into the person that he or she was meant to be.

Congruence has been variously described as genuineness (Kahn, 1997; Rogers, 1957; Sachse & Elliott, 2002), authenticity (McLeod, 2003; Tolan, 2003), transparency (Rennie, 1998), "realness, …willingness to be known" (McLeod, 2003, p. 174), and integrity, honesty and openness (Klein, Kolden, Michels, & Chisholm-Stockard, 2002). The therapist must be aware of his or her own inner experiences, and be in touch and comfortable with personal feelings in the moment in order for the client to learn how to do the same. Part of this quality of congruence depends on the therapist's comfort level with emotions. When therapists are genuine, they are open to exploring struggles: clients', as well as their own. Rogers (Rogers & Stevens, 1967) felt that a client would benefit from a relationship with someone who is open and honest, but he also came to realize that while congruence was critical, it was probably the most difficult skill to achieve. In their work with schizophrenics, Rogers and his colleagues (1967) found therapists experienced the most success with their patients when they were open, honest, and direct.

Empathy, the second core condition, and perhaps the best known, was described by Rogers as the ability to perceive and understand the client's experience, as if it were your own experience, but without ever losing the 'as if' quality (Bohart, Elliott, & Greenberg, 2002; Bohart & Greenberg, 1997; Farber & Lane, 2002; Kahn, 1997; Rogers

& Stevens, 1967; Watson, 2002). The therapist needs to grasp what it feels like to wear the client's shoes (Nerdrum & Ronnestad, 2003), but "without tripping over the laces" (N. Garlie, personal communication, February 11th, 2005). This cognitive and affective understanding of the client's experience must be communicated in a sensitive manner enabling the client to hear it (Bachelor, 1988).

Empathy is also probably the most misunderstood condition. At its worst, therapist empathy has been satirized as 'parroting' (Bohart et al., 2002), but at its best, empathy allows a therapist to reflect back to the client, things the client is only vaguely aware of, things that are on the edge of knowing (Gendlin, 1969; Greenberg, 2002; Norcross, 2005; Rogers, 1957). By making the implicit explicit, the therapist provides the client with new knowledge. This frees the client to see new possibilities and different choices.

In order to achieve a deep empathic understanding of the client, the therapist has to be able to see the world the way the client sees it. Entering into the client's experience opens up the possibility for the therapist to be changed as well (Myers, 2002; Yalom, 1999). This, as Rogers points out, is a risk all therapists tend to resist (Rogers & Stevens, 1967).

Unconditional Positive Regard, the final component of Roger's theory of counselling, reflects his philosophical faith in the inherent goodness and potential of all humans. Also known as acceptance (Farber & Lane, 2002), prizing (Rogers & Stevens, 1967), and agape (Kahn, 1997), Rogers believed that everyone was worthy of warmth and respect without reservation or judgment. In his view, the therapist's attitude towards

the client is the key to facilitating change (Hill & Nakayama, 2000; Rogers & Stevens, 1967).

Rogers (1961) noted these core attitudes must be conveyed to, and understood by the client without any ambiguity. For example, warmth may come across as an invasion of one's privacy, and unconditional positive regard may be interpreted as a lack of concern (Rogers & Stevens, 1967). Therapists must be sensitive to how the client experiences the relationship, and be prepared to modify their behavior accordingly (Norcross, 2005). Rogers (1957) also pointed out that the three conditions do not exist independently of each other; rather, they are mutually synergistic. It is difficult to imagine how a client could experience the therapist as empathic if the client thought that the therapist was not honest, or accepting (Watson, 2002).

Research on Client-Centred Therapy: While Rogers was focused on empathy and tuning into the subjective experience of the client in the therapy session, he also wanted to understand objectively what he was doing to help people get better. In order to test the validity of the hypothesized core conditions, he developed an extensive research program (Rogers & Dymond, 1954) and was one of the first therapists to analyze tape recordings of therapy sessions. He developed techniques to measure change and to quantify the behaviours of the therapists who were training in his approach (Hill & Nakayama, 2000). Several of the measures developed to assess the presence of these conditions are still in use today (usually a revised and updated version): the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1986), the Truax-Carkhuff Relationship Questionnaire (Truax & Carkhuff, 1967), and the Klein Depth of Experiencing Scale (Klein, Mathieu-Coughlan, & Kiesler, 1986; Rogers, 1967).

Roger's (1957) concept of necessary and sufficient conditions of therapy formed the core of his philosophical belief in the healing power of the relationship (Hill & Nakayama, 2000; Todd & Bohart, 1999). While there has been criticism of the methodology of some of the client-centered research (Lambert, DeJulio, & Stein, 1978), Rogers felt confident that these conditions, when present in therapy, would lead to a productive change in personality. Furthermore, it was the client's perception of these psychological conditions, provided by the therapist, which was the most accurate predictor of change. Outcomes measures included objective 'blind' MMPI scores, anxiety, and self- consciousness scores (Rogers & Stevens, 1967).

Although research on congruence, empathy, and positive regard has dwindled (Norcross, 2002b), several training programs have been developed based on Roger's principles and techniques (Egan, 2002; Ivey, 1988; Truax & Carkhuff, 1967), and many of his ideas were adapted and accepted into other forms of therapy (Bohart & Tallman, 1999; Bugental, 1978; Corey & Corey 1998; Cormier & Hackney, 1993; Duncan & Miller, 2000b; Elliott, Watson, Goldman, & Greenberg, 2004; Gendlin, 1969, 1981; Gladding, 2002; Hill & O'Brien, 1999; Kahn, 1997; Miller & Rollnick, 2002; Muran, 2002; Rennie, 1998; Safran, 1998; Teyber, 2000; Yalom, 1980).

3.1.3 Behavior Therapy

The third major school of psychotherapy was a direct contrast to both Freud and Rogers; their followers suggested that what could not be seen (i.e. the unconscious) did not exist. Changing behaviour was a matter of changing the reinforcement schedule. The relationship between the therapist and the client was not an issue. There was no need for empathy, or unconditional positive regard. If anything, positive attention should be

contingent on good behaviour. The behaviorist model of psychotherapy was developed from the work of Pavlov in Europe, and Watson, Hull, and Skinner in North America (Hill & Nakayama, 2000). These researchers developed their learning theories and behaviour modification principles through experiments. They were very familiar with the scientific model of doing research, including the need to randomize subjects and treatments, and control for all variables. Hypotheses were either supported by the evidence, or rejected. Their view of how to do therapy, and how therapy worked, fit well with the quest to prove that therapy is effective. They were able to do this with ease.

By the late 1950's and early 1960's, research into the effectiveness of psychotherapy had blossomed into a major undertaking. Study after study appeared proving the effectiveness of the different approaches, and laying to rest the challenge that Eysenck had posed in 1952 (Horvath, 2000; Kottler, 2001; Lambert & Bergin, 1994; Lambert & Ogles, 2004; Wampold, 2001). The question then became "which method of psychotherapy works the best?" This represented the start of the therapy wars.

3.2 Question Two: Which Therapy Is The Most Effective?

Not everyone involved in psychotherapy believed in the importance, or value of research. The late 1960's not only saw a phenomenal increase in the amount of research conducted, but also an increase in the variety of therapy experiences offered. This was the era of encounter groups, T–groups and marathon nude weekend sessions. The attitude in some of these groups was 'anything goes', and 'if it feels good, do it' (Lieberman, Yalom, & Miles, 1973). The organizers of some of the approaches mentioned had a decidedly anti-intellectual stance (Horvath, 2000). Fritz Perls (1969b), co-founder of Gestalt therapy, frequently admonished his followers to "lose their minds and come to

their senses." Although he was trained in psychoanalysis (Perls, 1945), he believed that the goal of therapy was to enable people to become more aware of the here-and-now. His focus was on living in the present, rather than dwelling on the past. Thinking and analyzing were an escape. The only way to prove Gestalt therapy worked was to experience it firsthand (Perls, 1973).

It is worthwhile noting the political and cultural climate of the era and the effect it had on attitudes regarding what was permissible in therapy. According to Kahn (1997), "To the radical consciousness of the 1960's the undemocratic psychoanalytic relationship was anathema, relying as it did on a severe power imbalance between therapist and client" (p. 10). This era also saw the emergence of existentialist views in the public forum. Writers such as Moustakas (1956), May (1969), and Heidegger (1962) were influencing therapists such as Laing (1967), and Yalom (1980), who were forming part of the humanistic approach. Victor Frankl (1963) based Logotherapy on his experiences in a German concentration camp. His focus was on examining the choices individuals make in their daily lives. Humanists view people "holistically…as self-aware…hav[ing] a need to make sense of their experiences and find meaning in their lives… People have the right, desire, and ability to determine what is best for them and how they will achieve it" (Cain & Seeman, 2002, p. 4). The existentialist perspective represents a view of people and of reality rather than being a specific type of therapy; it has had a profound influence on the process of research as well (Kuhn, 1970; Polkinghorne, 1988; Schneider, Bugental, & Pierson, 2001; Wilber, 2000).

The Feminist movement was another social force to have a profound effect on the practice of therapy. The research work by Gilligan (1982) on moral development was

instrumental in bringing into awareness the possibility of a different view of what it meant to be a mature person. Writers at the Stone Centre (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) proposed a relational perspective of people, rather than a focus on independence as the criterion of growth. They described therapy as a process of collaboration between the therapist and the client, and emphasized the importance of listening to the voice of women (Gilligan, Spencer, Weinberg, & Bertsch, 2003).

In the midst of this period of social upheaval, the question of which therapy was most effective seemed to be answered in 1975 by Luborsky, Singer, and Luborsky. Their review of literature confirmed the dodo bird verdict: "Everyone has won and all must have prizes" (p. 995). All approaches to therapy are equally effective. It was about as well received in 1975 as it had been when first declared by Rosenzweig in 1936. The expression came from the race in *Alice in Wonderland* (Carroll, 1946) where all the participants started from different places, ran in different directions, and ended at different times. The officiating dodo bird awarded prizes to all who had participated. The analogy was used to describe psychotherapy research since it reflected the difficulties encountered in comparing results due to the variety of definitions and measures used to assess different psychotherapy outcomes.

During the 1970's, researchers developed the technique of meta-analysis in order to make sense of the large number of outcome studies that contained different methods of comparison, different effect sizes, and different outcome measures. Smith and Glass published the first definitive meta-analysis in 1977. They looked at all the studies that compared some kind of therapy to a control group and concluded that all therapies were

more or less equally effective. It did not seem to matter what the problem was, or whether the treatment was therapy, psychotherapy or counselling. The dodo bird verdict still held.

The findings were repeated by a number of researchers in the 1980's (Stiles, Shapiro, & Elliott, 1986) and 1990's (Assay & Lambert, 1999; Bohart, 2000b; Wampold et al., 1997), but the debate continued over the meta-analysis reviews, and the validity of the dodo bird verdict. The results indicated that there was no one best type of therapy. Even the general public agreed that there was no difference between brand X and brand Y. A consumer survey, reported in *American Psychologist* (Seligman, 1995), revealed that while "longer was better" there were no differences in effectiveness among the different approaches to therapy.

Several assumptions underlie the question of which therapy is the best: 1) There is a "simple linear mechanistic relationship between a 'treatment' and an 'output'" (Bohart, 2000b, p. 132); 2) clients receive therapy and are cured; and 3) there is only one way of looking at things, the logical way. "Research is research. Rigorous, controlled, empirical, experimental research is the only scientific way of contributing to knowledge about psychotherapy" (Mahrer, 1999, p.1426). It should be noted that not all researchers agreed with these assumptions (cf. Bachelor, 1988; Bohart, 2001a; Hill et al., 1997; Mahrer & Boulet, 1999; Polkinghorne, 1994; Toukmanian & Rennie, 1992).

The quest for answers then expanded in several directions. Some researchers were convinced that one therapy had to be better than the rest and thought that increasing control of the variables would help. The problem of having to sacrifice external validity for the sake of increased internal validity appeared to have been ignored. Manualization of therapy allowed the treatments to be standardized. Precise steps describing how to do

specific kinds of therapies were set out in treatment manuals (Todd & Bohart, 1999). Scales of adherence were drawn up so therapists could be rated on how well they followed the protocol for administering therapy X. Only those patients who had one set of symptoms according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) of the American Psychiatric Association (1994) were recruited to test the efficacy of these treatments (Bohart, 2001b).

A variation on this research theme was to search for connections between type of treatment, type of individual, and the type of problem (Beutler, Mohr, Grawe, Engle, & MacDonald, 1991). The theory of Systematic Treatment Selection attempted to address the question posed by Paul in 1967: "What treatment, by whom, is the most effective for this individual with that specific problem, and under which set of circumstances?" (p. 111). Answering this question has involved the manipulation of a vast number of variables, but some patterns are emerging. It is the theory underlying the American Psychological Association's search for Empirically Supported Treatments (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Other researchers have looked at matching the personality of the therapist with the client (Marshall & Firestone, 1999), or the personality of the client with the type of therapy (Millon, 1999).

Another group of researchers decided to focus on finding the factors all therapies shared. This led to the third iteration of the original research question:

3.3 Question Three: What Factors Do All Therapies Have in Common? (Or, What Makes Therapy Effective?)

If all therapies are equally effective (Stiles, 2003), then what is it about therapy that enables people to change, to get better? What happens during the therapy session that

facilitates change? With such concerns, the search began for specific versus common factors. In 1992, after reviewing several decades of outcome research, Lambert concluded (as shown in figure 1) the main factor influencing outcome in therapy was "Client Variables" (40% of the outcome variance). "Hope" and "Techniques" (brand of therapy) accounted for 15% each. The "Client-Therapist" relationship accounted for the final 30%.

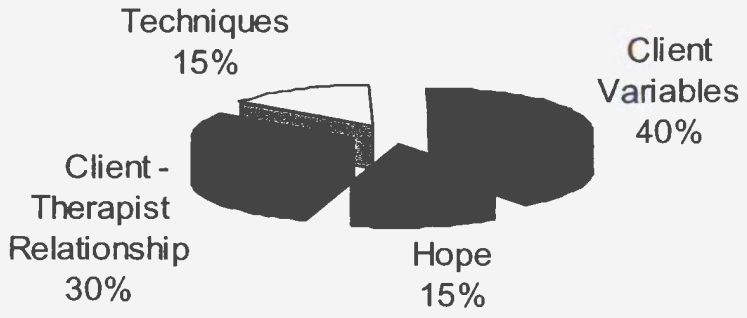

Figure 1. Factors that contribute to psychotherapy outcome

Note. Adapted from M.J. Lambert, & D. E. Barley (2002). Research summary on the therapeutic relationship and psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 17-32). New York: Oxford University Press.

These results seem to have come as a surprise to some, and were completely ignored by others. They did not fit the medical model of therapy that suggested people were passive recipients of therapy techniques applied by expert therapists. Those who were open to the idea of the client as active participant in therapy were discovering the power of that influence on outcome (Rennie, 1992).

3.3.1 Client variables

These are what clients bring into therapy, the issues identified in the chapter on the Stages of Change. They include the nature of the problem – its complexity, how long-standing the problem is, as well as whether or not clients have other equally pressing problems (Lambert & Barley, 2002; Norcross, 2005). What stage of change are they at (Prochaska & Norcross, 2002)? What else is going on in their life? Their coping skills and problem solving abilities, as well as the availability of support from friends and/or family will have a major impact on their ability to change (Bohart & Tallman, 1999; Caprara & Cervone, 2000; Duncan & Miller, 2000b; Kottler, 2001; Prochaska, 1992).

Although the idea of collaborating with the client as an equal partner was already a major value in feminist approaches, this shift in awareness of the role of the client becomes more evident in the development of postmodern and constructivist therapies. Here, the emphasis is placed on understanding the client's construction of reality, not as something that is distorted and needs to be challenged, but as an equally valid view (Duncan, Hubble, & Miller, 1997b; McLeod, 1997; Neimeyer, 1993; Peavy, 1996a).

Researchers (Bohart & Wugalter, 1991; Elliott et al., 2004; Gendlin, 1969, 1981; Greenberg & Paivio, 1998; Safran & Greenberg, 1991) had discovered that one important variable correlating with successful outcomes was the client's ability to get in touch with internal emotional experiences during the session. Some clients are able to engage at an emotional level fairly easily from the start. For others, that was never to happen, and therapy was less effective. Was this ability to experience and express emotion something that could be learned, or facilitated by the therapist?

It would take another twenty years before the importance of emotional experiencing by the client in therapy would return to the research agenda. The emphasis on cognitions and training clients to control negative feelings by changing their thoughts dominated psychotherapy theories and techniques for most of the 1980's and early 1990's (Safran & Greenberg, 1991). Only when researchers (Greenberg, Rice, & Elliott, 1993) were able to prove 'scientifically' that emotions did exist, and could be measured, did they turn their attention to this critical dimension of the change process in therapy.

Analysis of client factors leads into the tangled mess of personality theories, attachment issues, motivation, self-efficacy, self-esteem, and a cornucopia of possible problems that are in essence the reason clients come to therapy in the first place (Bartholomew & Horowitz, 1991; Blatt, Shahar, & Zurhoff, 2002; Caprara & Cervone, 2000; DiClemente, 1994; Eames & Roth, 2000; Matthews et al., 2003; McAdams, 1994; McCrae & Costa, 2003). Categorizing a client as resistant, needy, or obsessive compulsive may give the therapist a sense of control, but it can lead to therapy countertransference (Duncan et al., 1997b). 'Now that I know what is wrong with you, here is what (insert therapist's favorite theory-based technique) I am going to do to fix you.' Knowing about client factors and their correlation with outcome is interesting and useful information, but these factors are often outside of therapy; they represent the other 167 hours of the week in the client's life. The therapist only has direct impact during the one hour a week of therapy (Kottler, 2001).

3.3.2 Hope

Knowing outcomes may be poor when clients have many factors going against them in their life may also make it difficult for therapists to instill hope. Therapists need

to have faith in their clients' ability to change, and in their own ability to facilitate this process. This faith is based on knowledge about human nature, the process of change, and an understanding of how therapy works. Hope as a factor was first discussed by Frank in early 1970's when he talked about how clients often come to therapy feeling demoralized (Frank & Frank, 1991). The role of the therapist is to instill hope that change is possible, and, that clients will be able to achieve their desired goals (Duncan et al., 1997b).

While placebo effects are often viewed as potential confounding factors in medical research, they appear to play an important role in most helping relationships. When the patient has faith in the healer, and believes in the process, therapy works more effectively. There has to be a shared belief about the cause and cure, a common frame of reference for the client's reason for seeking therapy (Bohart, 2000b; Torrey, 1972).

3.3.3 Techniques

These are the specific in-session activities that characterize different forms of therapy: Psychodynamic therapists analyze dreams; Cognitive-Behaviorists challenge negative thoughts; Solution-Focused therapists ask miracle questions; Narrative therapists collaborate with the clients in the re-authoring of stories; and Gestalt therapists use dramatic enactments.

Although there are over 400 different brands of therapy (and special techniques) (Beutler et al., 1998; Prochaska et al., 1994), these processes include the same ones used by people who are successful in changing their behavior outside of therapy (Prochaska et al., 1994). Instead of comparing brands of therapy, perhaps researchers should focus on identifying what processes are appropriate for various problems (Rosen & Davison, 2003).

3.3.4 The Client-Therapist Relationship

If what the client brings to therapy represents the largest portion of variance in outcome (up to 40%), then the therapeutic relationship is a close second at 30% (Lambert, 1992; Lambert & Barley, 2002). The importance of the relationship between the patient and the therapist had been introduced by Freud, and highlighted again by Rogers. It was Bordin (1979, 2000), a student of Rogers, who developed the relationship concept into the construct of the 'working alliance.' He further divided the working alliance into three components: the bond, the task, and the goals. There was a need for agreement on all three aspects for a therapy relationship to be successful.

The challenge of measuring the strength of this alliance was taken up by Horvath (1986) who developed the *Working Alliance Inventory* (WAI). What had been preventing researchers from proving the importance of this relationship as hypothesized by Freud, and studied extensively by Rogers and others, was their insistence on objective, neutral observers to measure the strength of the alliance. In their quest to adhere to stringent scientific guidelines, they managed to eliminate a key variable. When researchers asked the client to rate the relationship with the therapist, it was the client's perception of the relationship that correlated with outcome (Horvath, 2000). The better the relationship between client and therapist, the better the outcome.

The ability to form a relationship is a function of the therapists' personal qualities: their interpersonal style, their character traits and behaviors, and what they do to make that crucial connection with the client. How good are they at establishing working alliances with their clients? It is the relationship that provides the context for the techniques.

The research evidence seems clear: the relationship is the most important factor in therapy affecting outcomes (Lambert, 2004; Norcross, 2002b). Therapists' abilities to facilitate change are affected primarily by the nature of the relationship they are able to create with their clients. Only after that has been established will their techniques be of value (Norcross, 2005). Before exploring the nature of the relationship in depth, it is necessary to focus attention on the research methods that have been used to understand this connection.

3.4 Question Four: How Does Therapy Work?

Accompanying this shift in focus to the relationship has been a renewal of interest in 'process-oriented' research. In some ways this is a return to the methods used by Carl Rogers when he first started analyzing counselling session audiotapes in the 1940's and 1950's. By listening repeatedly to what the therapist said, and how the client reacted, he and his team of researchers hoped to understand exactly what was happening during the interview that led the client to change. Rice (1992) describes how "the attitude in listening to the tapes together was highly naturalistic, and discovery oriented…. Categories were tentatively derived from the observations rather than being imposed on them. …emphasis was primarily on the style of functioning rather than on content categories" (pp. 2-3).

Working with Greenberg and his research team at York University, Rice went on to develop a process known as 'Task Analysis' to look at the moment-by-moment events in the therapy session. Through this process, they identified 'markers' that could be used by therapists as indicators for using specific types of interaction. These directives would guide the client to a deepened emotional experience, leading to a shift in cognitions

(Greenberg & Pinsof, 1986; Greenberg et al., 1993). Some of the interventions that they tested were based on Gestalt therapy techniques such as the empty-chair dialogue for resolving unfinished business. One cannot help but wonder what Fritz Perls would have thought about the publication of such research in respectable mainstream scientific journals.

While Greenberg and his associates were researching change 'moment-by-moment' in therapy, others such as Mahrer (Mahrer & Nadler, 1986) at the University of Ottawa were developing a method of locating and categorizing 'Good Moments' in therapy to see what these sessions had in common. Safran and his colleagues (Safran, Muran, & Samstag, 1994) looked more specifically at the dynamics of the client-therapist relationship and focused on breakdowns in the alliance. They were interested in understanding what led to these 'ruptures,' and how these could be negotiated and resolved. Using a variety of approaches from both qualitative and quantitative methodologies, their research has evolved to focus increasingly on the subjective experience of the therapist (Muran, 2002).

One of the methods used to explore in detail the experience of therapy is Interpersonal Process Recall. This technique involves the researcher and the client viewing a therapy session and stopping the tape at significant moments to discuss their meaning. As Elliot and Shapiro (1992) point out, "we see significant events as a [*sic*] windows into the process of change in psychotherapy" (p. 164). They observe that "therapy researchers have been particularly guilty of ignoring the role of context in understanding change processes. Careful, open-ended description of significant events is one way of generating knowledge about therapeutic change processes" (p. 164).

One of the problems encountered by all of these researchers is that they are often engaged in exploratory research where they are not really sure what they expect to find. While working with Rogers, Rice (1992) describes how "investigators were in the difficult position of trying to use standard hypothetico-deductive methods to study phenomena of tremendous complexity, often attempting to use a theoretical base for which there was little hard evidence" (p. 3). The scientific methods that they had been trained in were not providing answers to their questions. Warwar and Greenberg (2000) echo these sentiments, suggesting that research involves several stages: exploration of the phenomena, building a hypothesis and a model, then testing it, and finally revising it to match what is discovered.

Qualitative research is particularly suited to this phase of research. In the same year that Bergin and Garfield (1994) noted the critical role played by the client in therapy (after looking at 2,000 process-outcome studies), David Rennie (1994a) published his seminal paper on Client Deference. He began his research project by interviewing clients about their experiences after having completed an hour of therapy. To stimulate their recall of the process he played back a video or audiotape of the counselling session, asking clients to stop the tape whenever something significant happened and comment on the incident. This process is a variation of the technique of Interpersonal Process Recall originally developed for training counsellors (Kagan (Klein) & Kagan, 1997).

Using Grounded Theory, a qualitative research methodology, Rennie (1994a) analyzed the transcripts of the interview sessions, looking for themes and patterns to emerge from the responses that would provide an understanding of the therapy experience. What he discovered was that therapists were often not aware of when clients

were feeling negatively towards them. Rennie describes deference as 'negative politeness:' clients do not say what they are thinking for fear of offending the expert therapist. This deference includes whether or not they are in agreement with the therapist's approach, and their fear of putting the relationship at risk if they openly criticize the therapist. They feel pressured to go along with what the therapist suggests as they want to be seen as good clients.

Rennie (1992) discovered that clients attempted to communicate their discomfort in a way that was non-confrontational, but had great difficulty doing so, even when the therapist explicitly invited such metacommunication. They chose to remain silent if their nonverbal attempts at disclosure were not recognized by the therapist. This observation highlights the importance of establishing a good strong solid relationship early on with the client, one that feels safe enough for the client to reveal when things are not going well between the two of them.

Therapists are dependent on verbal and nonverbal feedback from clients. As Rennie (2000) points out "When clients do not reveal in either words or gesture what they are thinking and feeling, they keep for themselves their power" (p. 152). Further analysis of these tapes has revealed that clients are often covertly directing what is, or is not discussed during the session. This finding challenges the commonly held assumption that it is the therapist who is in charge of therapy.

The implications for research have been to stimulate more interest in studies focusing on illuminating the client's subjective experience of therapy (Bachelor, 1995; Bedi, Davis, & Arvay, 2005; Gutheit, 2001; Howe, 1993; Jack, 1991; Myers, 2000; Paulson, Everall, & Stuart, 2001; Singer, 1999; Wiebe, 2002; Yalom & Elkin, 1974).

Other topics that have been examined include the relationship between silences and the therapeutic alliance (Levitt, 2001), and misunderstandings between client and therapist (Rhodes, Hill, Thompson, & Elliott, 1994). The problem of deference and openness still remains: how much will the client be willing to reveal to the researcher? In some cases clients report having found "the research interview about the session to be more therapeutic than the therapy session being studied" (Hart & Crawford-Wright, 1999, p. 211). This raises a host of ethical issues regarding research of this nature (West, 2002).

Rennie's (1992, 1994a, 1994b, 2000, 2001, 2002) research highlights the shift in the view of the client from a passive recipient of therapy to a collaborator with the therapist in the process. This view is "an alternative that privileges the client's voice as the source of wisdom" (Duncan & Miller, 2000a, p. 170). The shift of attitude towards the client mirrors the shift that has taken place in research: Researchers have moved from seeing the client as a subject in an experiment to a co-researcher engaged in exploring the phenomena of therapy (Morrow & Smith, 2000; Rennie, 2002; Rhodes et al., 1994; Watson, 2002).

Since it is the client's experience of therapy and the relationship with the therapist that predicts outcome (Bachelor, 1991, 1995; Bachelor & Horvath, 1999; Horvath, 2000, 2001; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Norcross, 2005), it is necessary to use a research methodology that provides a glimpse of the client's reality. Only when therapists understand this experience will they be able to maximize the opportunities for change within and beyond the therapy hour. Qualitative research is particularly suited to this endeavor because of "the accessibility and similarity to practice of the underlying premises (client/participant constructions are central), method (interview), and the

communication of results (often narrative, or at least supported with participants' words)" (Morrow & Smith, 2000, p. 225).

It has been suggested that very few practicing therapists read or make use of current research (Boisvert, 2000; Norcross, 2005; Norcross & Beutler, 2000; Polkinghorne, 1999). Therefore, it is necessary to increase accessibility to research findings if the field is to change (Hill & Nakayama, 2000). Rennie and his colleagues (Elliott et al., 1999) have proposed guidelines for critically evaluating qualitative research that have been influential in having the value of this approach to psychotherapy research recognized. This has led to a re-evaluation of the assumptions underlying quantitative research, a challenge that has finally been addressed in Bergin and Garfield's most recent handbook of psychotherapy research - *the* guidebook for researchers in the profession (Lambert, Garfield, & Bergin, 2004; Slife, 2004).

3.5 Unfinished Business: The Politics of Change

Two issues that have not been dealt with directly that need to be addressed are the concept of change and how it is assessed, and how research interacts with the political process to affect policy formation. What is change and how should it be measured? Warwar and Greenberg (2000) suggest that if change is defined as "to make or become different…the elusive nature of the concept … is evident" (p. 571). How should the process and outcome of therapy be identified in order to improve upon them?

When measuring change, the time frame needs to be specified: Is it change from the start to the end of therapy? From one session to the next, or from one moment to the next within a session? Or, is it whether or not change is maintained for a year after the completion of therapy? And how will change be measured? By observable behaviours?

By subjective feelings? From whose perspective should change be assessed? If therapists are asked how they know the client has changed as a result of therapy, their philosophical orientation will determine their choice of measure. A psychoanalyst might choose a personality measure, a client-centered therapist would use self-esteem scales, and a behaviorist would look at observable behavioral measures. A humanist would prefer to ask the client directly. Different therapies focus on different levels as well, from symptom removal to changing thinking styles to reworking the personality (Prochaska & Norcross, 1999).

Who will receive feedback about the assessment of change? The efficacy of therapy improves when both client and therapist are given information about the client's progress (Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004). But who will make the assessment of change, the client or the therapist? Have they been able to agree on what the goals of therapy are? Or, should the question of whether or not the client has changed be addressed to the client's family, friends, co-workers, or employers to seek their evaluations?

What kinds of change are sought? Changing habits, improving coping skills (Blatt et al., 2002), or changing the quality of life? How can the long-term impact on others of one person's giving up an addiction (for example) be assessed? What value should be put on the changes? Certain qualities - assertiveness comes to mind - may be desired by the client, but when achieved can have a negative impact on other relationships (Kramer, 1993). When researchers report that a certain kind of therapeutic intervention is successful, what is their definition of success? Whose values are being used, those of clients, therapists or researchers?

This draws attention to the issue of how to measure change for health insurance purposes. Health Maintenance Organizations are only willing to pay for therapies that have been tested scientifically and proven effective for specific kinds of problems. They are "loathe to pay off completed gestalts and do not see incomplete gestalts as mental health problems" (James & Gilliland, 2003, p. 64).

In 1995, in response to this pressure for accountability in the profession, the American Psychological Association (APA) Task Force on Promotion and Dissemination of Psychological Procedures published the criteria for Empirically Supported Treatments (see Appendix B). While this might seem a laudable step, it has proven to be a controversial one because of the complexities of research in psychotherapy (Norcross, 2005). The researchers' allegiance to their brand of therapy exerts a significant effect on outcome results (Luborsky et al., 1999). Certain approaches are more amenable to randomized controlled trials than others. Humanistic and existential therapies are directed more towards improving relationships than removing symptoms (Cain & Seeman, 2002). Not all problems can be neatly categorized for insurance purposes. Certain approaches have stronger lobby groups than others (Todd & Bohart, 1999). Diagnosing and labeling people with specific disorders may fit in with the concept of using treatment manuals, but it is based on a medical model of psychotherapy. There is conflicting research (Lambert, 2004; Marshall & Firestone, 1999; Norcross, 2005) suggesting that certain treatments might be more appropriate for specific problems, such as cognitive and behavioral methods for compulsions and phobias. Designing and researching outcomes, however, is a daunting process when one considers the sheer size of the problems versus treatments matrix (Orlinsky et al., 2004). The 'diagnose and prescribe' method that treats the client

with brand x therapy, tends to ignore the role of the therapeutic relationship. Theoretical perspectives valuing a collaborative approach between the client and therapist are increasingly rejecting this medical model (Hill & Nakayama, 2000).

Fortunately, the importance of the relationship has been sufficiently documented over a long enough period of time such that the APA has released a set of guidelines that recognize the value of giving it priority for further research (Ackerman et al., 2001). And more significantly, it has recommended that more non-experimental and qualitative research studies be included into the template for evaluation of therapies. It remains to be seen whether or not this change is reflected in what is taught at graduate schools where the emphasis has been on teaching Empirically Supported Treatments (Todd & Bohart, 1999). Perhaps, this is because relationship skills are so difficult to teach (Horvath, 2000; Summers & Barber, 2003).

3.6 Conclusion

Research is about finding answers to questions. In this chapter the following questions have been addressed:

1. Does therapy work? Yes: Between 70% and 80% of clients are better off than those not receiving treatment (Lambert & Barley, 2002; Norcross, 2005).

2. Which therapy is the most effective? All therapy treatments are equally effective at helping clients change, hence the dodo bird verdict: "Everyone has won, and all must have prizes" (Luborsky et al., 1975, p. 995).

3. What factors do all therapies have in common that contribute to outcome (i.e., what makes therapy effective)? The client as an active participant (40%), hope and belief in the process (15%), specific theory-guided techniques (15%), and a positive

relationship between the client and therapist (30%). The client's perspective of this relationship is the strongest predictor of therapy outcomes (Lambert & Barley, 2002; Norcross, 2005).

4. How does therapy work? This question remains unanswered. The research cited in this chapter indicates why the therapy process can not be fully understood within a positivist framework. Clients' voices are ignored. If (as Freud and Perls suggested) it is necessary to experience therapy to understand it, then researchers should be engaging clients as collaborators. Quantitative research (Bachelor, 1991; Muran, 2002; Sachse & Elliott, 2002; Safran & Muran, 2000c, 2001) suggests clients' subjective experiences of therapy and the therapeutic relationship determine outcome. Qualitative research (Bachelor, 1995; Bedi et al., 2005; Hill & Williams, 2000; Horvath, 2001; Myers, 2000; Paulson et al., 2001; Rennie, 2001; Wiebe, 2002) sheds light on this experience by studying clients' voices.

5. What is known about the client-therapist relationship? The next chapter will explore this issue in detail.

Chapter 4: The Nature and Nurturing of the Client-Therapist Relationship

The previous chapter examined research evidence for the effectiveness of therapy, giving consideration to the factors all schools have in common. In this chapter the focus will be on one factor in particular, the client-therapist relationship. What does research have to say about it? How is it defined and measured? What qualities does a therapist need to build a relationship?

The relationship in therapy is the main technique or tool a therapist can use to influence the outcome of therapy, yet few give more than lip service to this fact in spite of the accumulation of evidence supporting the finding (Ackerman et al., 2001; Ackerman & Hilsenroth, 2003; Bachelor & Horvath, 1999; Bergin & Garfield, 1994; Horvath & Bedi, 2002; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Lambert, 1992; Lambert & Barley, 2001; Norcross, 2005; Orlinsky, Grawe, & Parks, 1994; Orlinsky et al., 2004). Is this a consequence of the belief that therapy is a treatment patients 'receive' from expert therapists? Patients come to therapy to be fixed, and therapists do the fixing. The patients' role is understood to be passive, hopefully co-operative. Research shows however, that one of the key factors relating to outcome in therapy is active client engagement in the process. (Arnkoff, Glass, & Shapiro, 2002; Elkin et al., 1999; Orlinsky et al., 1994).

During one of my many struggles in writing this paper, I went for a walk with a friend and had an interesting chat. I described the troubles I was having writing about what makes therapy work. He said:

> It's all about the personality of the therapist isn't it? If you like them and feel comfortable with them, and you kinda connect with them, they create a comfort zone

> for you, and then you develop trust with them, and things just take off from there. That trust thing is really important isn't it? You can talk about what is really bothering you and get it sorted out. (Christopher, age 52, licensed mechanic)

That is the art of good therapy, developing a good working relationship with the client. The science is in the techniques used, *after* the relationship has been solidified. Although some might argue that the relationship *is* the technique (Hubble et al., 1999; Kahn, 1997; Kohut, Goldberg, & Stepansky, 1984; Rogers, 1961; Watson, 2002; Yalom & Yalom, 1998), the fact remains, the therapist has to form a connection with the client in order to understand what the client wants from therapy. But what is a good relationship and what does it take to develop one?

4.1 Research on the Relationship – What Are the Facts?

4.1.1 The Return of the Dodo Bird Verdict and the Search for Common Factors

By 1975, psychotherapy outcome research was increasingly indicating that no one theory, school of therapy, method, or set of techniques was superior to another (Luborsky et al., 1975; Smith & Glass, 1977). In spite of what each of the proponents were claiming, they all had won in the therapy wars – essentially, they were all equally effective.

4.1.2 Working Alliance

If all therapies work equally well, what is it about therapy that leads to positive change? What aspects do all therapies share that contribute to successful outcomes in therapy? Recognizing the need for a common language, Bordin (1979, 2000) introduced the concept of the working alliance based on an integration of the ideas from both psychodynamic and client-centred schools of thought. He argued that the outcome of all therapies was tied to the successful negotiation of an agreement on what the purpose of

therapy was, and how to achieve this objective. As previously discussed, the working alliance consisted of three critical elements: goals, tasks, and a bond.

Bordin (1979, 2000) noted that the relationship among these three components was reciprocal; successful negotiation of the goals and tasks of therapy would enhance the bond, while a strong bond would facilitate the process of reaching an agreement on the tasks and goals. Different types of therapies will vary in the amount of emphasis put on these components; the most important factor is whether or not the client and therapist agree on the overall approach (Arnkoff et al., 2002; Elkin et al., 1999).

Goals refer to the outcomes desired from therapy, in other words, what clients hope to achieve. This might be symptom reduction, for example, gaining control over angry outbursts at roommates, alleviating depression, or ending rumination about a failed relationship. Or it might be something less concrete, like finding more meaning and a sense of purpose in life. While therapists might think they know what clients *should* focus on, if it is not what clients want to change, they will be working at cross-purposes.

Tasks refer to the methods and techniques used to attain the goal(s). These include the in-session activities such as free association, experiential processing, as well as homework assignments (e.g., keeping track of and challenging cognitive distortions). These tasks will vary with the theoretical orientation of the therapist, and will need to be negotiated either implicitly or explicitly with the client. Tasks also consist of the roles and expectations that both therapist and client have for each other. These include level of formality, distance and activity level desired (Norcross, 2005). The client might expect advice and direction on 'how to get better' while the therapist is more comfortable using self disclosure, and a here-and-now processing approach to therapy. They will find each

other and the process frustrating, unless they can reach agreement on their respective tasks, and responsibilities (Arnkoff et al., 2002; Elkin et al., 1999).

Bond refers to the affective dimension, whereas the goals and tasks capture the cognitive components of the alliance. The bond includes the associated thoughts and feelings therapists and clients have about each other and the manner in which these are acted upon in the relationship (Binder & Strupp, 1997; Kahn, 1997; Norcross, 2002a). This interpersonal factor assesses the quality of the connection between clients and therapists (Orlinsky et al., 2004). How do they feel about each other? Is there mutual respect and care? Is there a shared sense of collaboration and trust? What is the here-and-now space between them like?

More than the facilitative conditions contributed by therapists, the concept of the therapeutic alliance suggests a broader perspective by looking at clients' participation in, and perception of the relationship (Lambert & Barley, 2001). By conceptualizing the relationship construct so others could recognize it consistently, Bordin (1979, 2000) made it possible for researchers to reach agreement on what was meant by a 'good' therapy relationship. Rogers (1957) had defined helpful therapeutic conditions, but only from the therapists' perspectives. Bordin (1979, 2000) included clients in the equation by inquiring about their views on what they hoped to accomplish in therapy. What tasks did clients expect therapists to fulfill? What kind of a relationship did clients want? Bordin shifted the focus of attention onto how clients and therapists actively negotiated with each other to form a working relationship that led to positive therapy outcomes for both.

Several different measures have been developed to assess the alliance for research purposes. Four of the most commonly used measures are described below.

4.1.3 Measuring the Alliance

Horvath's Working Alliance Inventory (WAI) (Horvath & Greenberg, 1986) was developed to specifically measure each of Bordin's concepts from both the client's and the therapist's perspectives. The inventory also has an observer-rated measure. Typical questions include: 'My therapist and I trust one another,' 'We have established a good understanding of the kinds of changes that would be good for me,' and 'I feel that the things I do in therapy will help me to accomplish the changes that I want' (Duncan & Miller, 2000b). This inventory is particularly appropriate for measuring the alliance in the beginning phase of therapy (Eames & Roth, 2000).

Luborsky's Penn Helping Alliance (Alexander & Luborsky, 1986) scales are based on his observation that there is a critical first stage to be negotiated before the real work of therapy begins. Type I alliance is the first step when a trusting safe relationship is established with the client; this is followed by a Type II alliance which occurs when the client is engaged in the discovery work of therapy (Horvath & Bedi, 2002; Horvath & Luborsky, 1993).

The California Psychotherapy Alliance Scales (CALPAS) and the California Therapeutic Alliance Rating Scale (CALTARS) (Marmar, Horowitz, Weiss, & Marziali, 1986) draw upon Bordin's concepts as well. Some of the aspects examined include the patient's ability to engage constructively in therapy (ego strength), and the therapist's skills at empathy (Horvath & Bedi, 2002; Horvath & Greenberg, 1994).

The Vanderbilt Therapeutic Alliance Scale (Suh, Strupp, & O'Malley, 1986) is a product of the original Vanderbilt I project that looked at the relationships between several variables (client, therapist, techniques, training) and their effects on outcome. It is

used primarily for assessment purposes in short-term or time-limited dynamic therapies (Binder & Strupp, 1997; Henry & Strupp, 1994; Henry, Strupp, Butler, Schacht, & Binder, 1993).

Most of the research on the alliance has been done by researchers working from either a psychodynamic or humanistic perspective, where the relationship has been traditionally valued. More recently, therapists from a cognitive-behavioral orientation have started to focus on the relationship and have discovered that outcomes are correlated with the therapeutic alliance (Beck, 1995). Having a way to measure the relationship between client and therapist allows researchers to verify that the quality of the therapeutic relationship is important to outcome, something known intuitively all along. It provides a common link among all therapies and helps further understanding of how and why therapy works.

4.2 The Research Results: The Alliance as a Predictor of Therapy Outcome

4.2.1 Quantitative Research

In 1991, Horvath and Symons conducted a meta-analysis of 24 psychotherapy outcome studies and concluded that the strength of the alliance was a good indicator of how successful therapy would be, regardless of the type of therapy or type of client population. They discovered the best predictor of outcome was the client's perception of the relationship, and this connection to results could be discerned as early as the third session of therapy (Horvath & Bedi, 2002; Horvath & Greenberg, 1994; Horvath & Symonds, 1991; Krupnick et al., 1996). Quantitative research indicated that the client's experience of the relationship and involvement in the therapy process - fostered by the relationship – had a direct impact on the outcome of therapy.

In spite of the empirically validated evidence that the therapeutic relationship had about twice the impact on outcomes as technique did, in the 1990's, the emphasis remained on proving which technique was superior, or at least scientifically proven, to produce results. In 1995, the APA Task Force on Promotion and Dissemination of Psychological Procedures published the first of their Empirically Supported Treatment guidelines and pushed for the manualization of all therapies. The guidelines are based on the assumption that the therapist behaves in a standardized fashion with every client, in spite of research results to the contrary (Luborsky, McClellan, Woody, O'Brien, & Auerbach, 1985; Norcross, 2002a).

In deference to voices of dissent, however, the APA acknowledged there might be merit in examining relationship factors, and set up a task force to do so. The APA Division 29's Task Force review (Norcross, 2002b) sets out to provide specific evidence-based guidelines for therapists. This list of Empirically Supported (therapy) Relationships consists of practices that would improve the quality of the therapy relationship, allowing therapists to tailor the relationship to meet the needs of individual clients (Norcross, 2002a).

The chapter on the alliance in Division 29's final report begins with an examination of the link between the alliance and outcome. Horvath and Bedi (2002) define this connection as the "quality and strength of the collaborative relationship between client and therapist in therapy" (p. 41). They recognize that, while this relationship may be affected by previous relationships, there are also elements unique to the context of therapy. These include the feelings (positive and negative) that clients and

therapists have toward each other, as well as agreement about, and a commitment to the tasks and goals of therapy (Horvath & Bedi, 2002).

The meta-analysis covered 90 studies completed between 1976 and 2000. The number of sessions in each study varied, as did type of treatment (in- or outpatient, cognitive behavioral, gestalt, dynamic, interpersonal, and so forth). A variety of alliance measures were used, and assessed from different perspectives, over a range of time periods. Outcome measures were also examined from a variety of perspectives, and used (among others), the Symptom Checklist 90, Beck Depression Inventory, Global Assessment Scale, Dysfunctional Attitudes Scale, and Hamilton Rating Scale for Anxiety. After calculating an individual effect size, and then an overall median effect size, Horvath and Bedi (2002) concluded that "the overarching message from this body of research is deceptively simple: The quality of the alliance is an important element in successful, effective therapy" (p. 61).

More recent analyses (Ackerman & Hilsenroth, 2003; Martin, Garske, & Davis, 2000; Norcross, 2002a; Orlinsky et al., 1994; Orlinsky et al., 2004; Wampold, 2001) continue to demonstrate the same results: it is the relationship that makes the difference (Norcross, 2002a). Having a good working relationship with the client is a scientifically proven method of increasing the likelihood of achieving a successful outcome to psychotherapy (Ackerman et al., 2001; Norcross, 2005).

4.2.2. Mediators and Moderators

Beyond the general conclusion about the relationship between alliance and outcome, what factors might have affected the results they found? The type of measure used for rating the alliance or outcome did not seem to matter. Nor did previous client

relationship difficulties, attachment style, level of disturbance or type of disorder. These latter factors, however, appear to be mediated by the therapist's level of training and experience (Horvath & Bedi, 2002; Horvath & Luborsky, 1993).

Client perspective. The analysis of various studies indicated that of the three perspectives of the alliance (therapist, client, objective observer), the client's rating was the best predictor of outcome. This confirms the findings from earlier research (Bachelor, 1991; Horvath & Symonds, 1991). More recent studies suggest that when therapist and client ratings of the alliance converge over the course of therapy, this convergence of ratings also appears to be a good predictor of outcome (R. Bedi, personal communication, June 10th, 2005). The concept of 'experiential congruence' has been used to describe the extent to which the client and therapist "*experience the same relational reality*" (Orlinsky et al., 2004, p. 354).

Timing. This observation points to the other critical factor that sheds light on outcomes: the timing of the measurement of the alliance (Eames & Roth, 2000; Horvath & Bedi, 2002; Horvath & Symonds, 1991). If the alliance has not been established by the third session (Horvath, 2001), the prospects for a good outcome diminish rapidly, reinforcing the idea that the relationship is crucial. This highlights the importance of giving precedence to the establishment of a good relationship with the client early on in therapy (Horvath & Bedi, 2002; Krupnick et al., 1996; Norcross, 2005).

These results seem self-evident: if both clients and therapists feel the focus in therapy is on goals they have chosen, using techniques they are in agreement with, and they are working with a person they like and have respect for, then the outcome is likely to be positive. Conversely, if clients do not feel therapy is going to help them achieve

their goals, or if they feel their therapists do not understand them, or are pushing them to do things they are uncomfortable with, they will resist, forget to do homework, or just drop out.

Interactive elements. Horvath and Bedi (2002) in their comprehensive review also examined two interactive elements: therapist-client matching and complementarity. They noted that while these do not seem to be critical, what is important is that clients and therapists are not engaged in competitive, aggressive or antagonist behaviors toward each other. Collaboration has been defined as 'patient cooperation,' and when that is observed to be high, outcomes are positive (Tryon & Winograd, 2002). Investigation continues into whether or not in-session transactions between clients and therapists can be observed and rated as having a sense of 'we-ness' (Nerdrum & Ronnestad, 2002), and if this stance correlates with outcome (Samstag, Muran, & Safran, 2004). What has been demonstrated is that the client's perception, or 'felt sense' of collaboration, does correlate with outcome (Bachelor, 1995).

4.2.3 Task Force Conclusions in Brief

The remainder of the volume published describing the work of the Task Force consists of a collection of meta-analyses looking at the variables that affect therapy relationships and outcomes, either directly or indirectly. The findings of the Task Force indicated that the following elements are "demonstrably effective:" therapeutic alliance, empathy, and goal consensus and collaboration (Ackerman et al., 2001, p. 495). A second grouping - positive regard, congruence/genuineness, feedback, repair of alliance ruptures, self-disclosure, management of countertransference, and quality of relational interpretations are considered "promising and probably effective" (Ackerman et al., 2001,

p. 495). For this second cluster, the research evidence pointed in a positive direction. More recent research (Norcross, 2005) indicates that several elements (client-therapist real-time feedback, quality of relational interpretations, and repair of alliance ruptures) are now 'proven' to be effective at improving the quality of psychotherapy relationships.

How do these elements translate into practice? The Task Force pointed out that the relationship does not exist in a vacuum; it must be tailored to fit the client. To accomplish this, the therapist needs to ascertain the client's level of resistance and functional impairment, as well as coping style, stage of change, and expectations (Ackerman et al., 2001). What therapists do must be understood within the context of therapy with each individual client and needs to be tailored to the client's preferences (Norcross, 2005).

In their recommendations for practice, Horvath and Bedi (2002) suggested therapists be "cautiously curious" about how clients experience the therapist's intentions in action (p. 60). In other words, the message sent (either verbally or non-verbally) does not always equal the message received (Bachelor & Horvath, 1999). It is essential that therapists develop appropriate behaviors that will allow them to respond to the needs and abilities of their clients, and to negotiate good working relationships. In order to accomplish this task, therapists need to be able to see the world through their clients' eyes.

4.2.4 Qualitative Research: Understanding the Client's Perspective.

Knowing that clients' perspectives on therapy relationships predict outcomes is not enough to enable therapists to improve their practices. It is necessary to expand and deepen the understanding of this perspective in order for change to be possible.

Qualitative research, as discussed in the previous chapter, provides an opening for such exploration.

The importance of the clients' views of the relationship were first noted during Roger's research in the 1960's and 1970's (Rogers & Stevens, 1967). Yet this important consideration does not appear again in the literature until the late 1980's (Horvath & Symonds, 1991) when the climate became more conducive perhaps due to a postmodern view that valued a variety of perspectives. While Rogers looked at conditions provided by therapists that enhanced the process of therapy, the focus in the 1980's shifted to examining the nature of relationships between therapists and clients. What do clients contribute? What is the quality of the interaction? And more importantly, how do clients view the therapy process? Since it is clients' perspectives that matter, it is important to understand firsthand how they experience the therapy encounter.

Bachelor's (1988, 1991, 1995) qualitative research at Laval University has been part of the movement towards recognizing the importance of understanding clients' experiences in therapy. Using a phenomenological approach, she has explored students' perceptions of empathy in helping relationships. She discovered that the experience of empathy is critical to the success of therapy relationships, and that empathy expressed is not always empathy received (Bachelor, 1988). Further research (Bachelor, 1995) has indicated that what clients perceive to be important in their therapists varies considerably. More research is needed to help clarify what clients value and need in order to establish a good working relationship with their therapists (R. Bedi, personal communication, May 26th, 2005).

According to Bachelor (1995), clients have preferences for three different types of relationships. Those preferring an *insight-oriented* alliance wanted therapists to probe and help them discover connections they might not otherwise make on their own. These clients needed someone to help them understand what happens in different situations to trigger upsetting reactions with others, and to explore different possible solutions.

In a *nurturing* alliance therapists were described as nonjudgmental and good listeners. Clients trusted their therapists and felt safe to explore a variety of issues. Clients valuing this kind of relationship described their therapists as patient, comforting, friendly, warm, attentive, understanding, and accepting – even welcoming of their emotions.

The clients who emphasized the *collaborative* nature of the alliance described their active participation in the therapy process. These clients seemed to be more focused on roles and responsibilities. While all clients in the study valued their therapists' ability to be empathic, non-judgmental, respectful, and to create a trusting safe environment, these qualities seemed to vary in importance and salience to different clients.

Bachelor's research is significant as it not only represents an acknowledgement of the value of the client's perspective on the process of therapy, it also highlights the shift towards a view that recognizes the active role played by the client in therapy. As discussed in the previous chapter, Rennie's research (1992, 1994a, 2000, 2001, 2002) at York University has led to increase in awareness about the level of processing at which a client is engaged in during therapy. Since the client's level of involvement in the therapy process is a critical factor in successful therapy outcomes (Orlinsky et al., 1994), it would appear that a therapeutic attitude recognizing and valuing the client as an active partner would be one of the keys to this success.

Bachelor's (1995) research suggests that because different clients value different approaches in a therapist, therapists need to adapt their style accordingly. This is only possible if they have correctly understood the client's frame of reference. This research does not negate the importance of techniques; rather, it emphasizes the need to engage with the client first if techniques are to be effective (Norcross, 2005).

The research is clear: In order to have a good therapeutic relationship with clients, therapists need more than basic relationship skills. Effective therapists recognize and value clients as active participants in the counselling process (Tryon & Winograd, 2002). Therapists work continuously at understanding and appreciating their clients' experiences in and out of therapy, and conveying that understanding to them (Bohart et al., 2002). Good therapists also recognize when they have erred, and are able to repair their mistakes (Safran, Muran, Samstag, & Stevens, 2002).

4.2.5 Therapist Qualities Needed to Build a Relationship with the Client

Researchers (Ackerman & Hilsenroth, 2003; Asay & Lambert, 2002; Beutler, Machado, & Neufeldt, 1994; Blatt et al., 2002; Corey, 2001; Daniels, 2003; Gladding, 2002; Hill & O'Brien, 1999; Horvath, 2001; Horvath & Bedi, 2002; Hubble et al., 1999; Jennings & Skovholt, 1999; Lambert & Bergin, 1994; Luborsky et al., 1985; McLeod, 2003; Miller & Binder, 2002; Najavits & Strupp, 1994; Norcross, 2002a; Rennie, 1998; Rogers, 1957; Safran & Muran, 2000b; Teyber & McClure, 2000; Viscott, 1972; Yalom, 2002b) have suggested that there are a variety of attributes and characteristics that contribute to successful alliances and outcomes. How should these variables be translated into practice? After reviewing the APA Task Force report (Norcross, 2002b), listening to an update on current relationship research (Norcross, 2005), examining the studies on

master therapists and therapists' expertise (Jennings & Skovholt, 1999; O'Byrne, Clark, & Malakuti, 1997; Skovholt & Jennings, 2004; Skovholt, Ronnestad, & Jennings, 1997), and reflecting on personal experiences, I have identified five key areas for further analysis: basic relationship skills, collaboration, empathy, metacommunication, and rupture recognition and resolution. Therapists need to be familiar with, and be able to function competently within these domains.

Basic relationship skills: This is what usually comes to mind when describing competent therapists: they are 'good listeners', and possess 'good communication skills'. These basic skills were identified during the efforts to define and teach Carl Roger's approach to counselling (Truax & Carkhuff, 1967), and form the basis for most approaches to therapy (Corey, 2001). They include attending behaviors (establishing appropriate eye contact, open receptive posture), restatement, reflection, and asking open-ended questions (Baker, Daniels, & Greeley, 1990; Daniels, 2003; Egan, 2002; Hill & O'Brien, 1999). These will be discussed further in the chapter on training.

Collaboration: Reaching agreement on the goals and tasks of therapy is an essential requirement for both therapists and clients (Norcross, 2005; Tryon & Winograd, 2002). While collaboration may seem like a straight-forward process, it requires a fundamental change in how therapy has been traditionally carried out. Valuing the client's perspective means making paradigm shift from: 'let me tell you what is wrong with you…' to: 'let us work together to figure out what needs to happen here in order for you to make the changes you want.' This shift away from a medical model of how therapy should work necessitates a belief and faith in clients' self-healing abilities as well

as a shift in the balance of power in the therapy relationship (Horvath & Bedi, 2002; Teyber & McClure, 2000).

Bohart (2000b) describes this self-healing potential as something that exists in all individuals, but becomes blocked for a variety of reasons. Self-healing is not just a cognitive process; it arises from an increased or heightened awareness of inner knowledge and experiences (Bohart, 2001b). The therapists' role is to re-activate the clients' capacities to attend to, and act upon, their inner wisdom. Therapists do this through the provision of safe 'working spaces' for their clients (Bohart & Tallman, 1999).

This shift to the view of clients as active participants in the therapy process means refraining from taking control of the sessions (Henry et al., 1993; Horvath & Bedi, 2002). Instead, clients' views and opinions are given top priority and respect (Duncan, Hubble, & Miller, 1997a; Duncan et al., 1997b; Duncan & Miller, 2000a, 2000b; Norcross, 2005). This may be a challenge for therapists who have been trained in the art and science of diagnosis and treatment. Taking a collaborative stance can also be difficult when working with clients who want the therapist to provide the solutions to their problems (Smiles, 1929), or who are antagonistic and uncooperative (Binder & Strupp, 1997; Najavits & Strupp, 1994; Teyber & McClure, 2000).

Theorists in Feminist therapy, recognizing the problems inherent in the power differential in therapy relationships, have made redressing the balance of power one of their key guiding principles (Ballou & Brown, 2002; Brown, 1994; Chaplin, 1988). Writers at the Stone Centre such as Miller & Stiver (1997) and others (Jordan et al.,

1991) describe how, in the feminist relational perspective, all connections have the potential to be healing, or growth promoting, when collaboration and equality are valued.

Nowhere has the paradigm shift towards a valuing of the client's perspective been more evident than in postmodern and constructivist therapies. The possibility that there is more than one view of reality, and the lack of an ultimate authority on truth, requires a therapist to adopt a 'not-knowing' stance towards the client's experience (Hoyt, 1998; McLeod, 2003). Whether it is co-authoring new stories, or focusing on what already works in the client's life, collaboration with the client is valued (Mahoney, 1991; Neimeyer, 1993; Peavy, 1997).

In order to engage in collaboration, it is necessary that therapists not only believe in the value of this stance as a pre-requisite of successful therapy, but to have an attitude of openness and respect towards their clients. Therapists have to actively seek feedback from their clients (Miller & Duncan, 2005; Norcross, 2005), indicating to them that their opinions are equally valued, and that what happens in therapy is a shared decision. Therapists also need the skills required for collaboration: negotiation techniques, metacommunication, patience, and empathy, that is, an ability to understand the other person's point of view.

Empathy Revisited: While empathy was studied heavily in the 1950's and 1960's after it was first introduced by Rogers (1957), the topic fell from the research agenda, probably because it was so misunderstood and misused. Current research indicates empathy is a complex concept and is one of the fundamental skills needed to establish a therapeutic relationship, no matter what theoretical framework is used (Bachelor, 1988; Bohart et al., 2002; Bohart & Greenberg, 1997; Burns & Nolen-Hoeksema, 1992;

Johnson & Whiffen, 2003; Margulies, 1989; Miller & Stiver, 1997; Nerdrum & Ronnestad, 2002; Norcross, 2005; Watson, 2002).

One of the difficulties in discussing empathy is coming up with a definition. Is it a skill, an attitude, a trait, or a state of mind? How therapists choose to respond to a client will depend on beliefs about their role, and the value of empathy in the therapeutic process. If therapists intend to give advice based on their 'empathic' understanding of what the client has said, then a simple reflection will suffice: 'You are feeling _____, and this is what I think you should do.' Empathy used this way may indicate the therapist has heard the client's words correctly, but it does not deepen the client's level of awareness.

On the other hand, empathy involves more complex skills if the therapist's goal is to fully know and understand the client as a means of establishing the tasks, goals, and bond in therapy. Affirmative expressions such as 'sounds like…' are intended to validate the client's experience (Bohart et al., 2002). Empathy becomes a way of helping clients gain a better understanding of themselves in order to allow them to decide what they need to do (Bohart & Greenberg, 1997; Watson, 2002). Evocative empathy is aimed at enriching the client's emotional experience, often through the use of exploratory metaphors: 'You feel as if you are putting all your eggs in one basket?' Emotions can then be used to inform action (Elliott et al., 2004; Greenberg, 2002; Johnson, 2003a).

The focus of empathy can be directed towards the content – either cognitive or affective – of what the client has revealed, or towards the process (Bohart et al., 2002; Bohart & Greenberg, 1997; Watson, 2002). The latter requires the therapist to pay attention to both the verbal and non-verbal messages about what the client is experiencing as a result of the previous interactions. The client may be engaged in a

cognitive reflection: 'what has just transpired does not fit, or make sense,' in other words, a 'rupture'. Or, the client may be suffused in affect, and emotionally overwhelmed by the impact of the connections that are surfacing in therapy.

Empathic conjectures focus on the implicit, leading edge of the client's experience (Bohart et al., 2002; Bohart & Greenberg, 1997; Watson, 2002). Such conjectures are offered in a tentative fashion: 'does this fit with your experience?' (Yalom, 2002b). The goal is to make the unconscious conscious, so therapists have to be prepared to be wrong. 'Wrong' can be a matter of timing as well as meaning. These conjectures are similar to interpretations, and they bear the same caveats. Yalom (Yalom & Elkin, 1974) discusses offering his client 'brilliant interpretations, like orchids on a platter', only to have them rejected and then presented as if they were new by the client a few weeks later.

Therapists have to be patient and willing to take the time to make sure clients feel understood (Myers, 2000). This struggle to put words to 'felt' experiences by both clients and therapists is part of the process of enlarging clients' awareness and knowledge of their inner worlds. When empathy is expressed in a non-judgmental way, the message is that 'therapy is a safe place' and 'you can trust me.' If clients are going to risk exploring emotions, they need to be sure their therapists will deal with them in a caring and respectful way (Bohart, 2000b; Gordon, 2000).

Empathy also involves knowing how to reflect the clients' experiences back to them in a way that is contextually sensitive. Sometimes the best empathic response is silence. Therapists have to be able to monitor the non-verbal signals that clients send, and respond appropriately to the signals and not according to theory. Part of this ability to

respond appropriately relies on therapists having an awareness of their own inner feelings, of any countertransference issues, and perhaps, even intuition (Bugental, 1992; Watson, 2002).

Metacommunication: Since therapists are not always accurate judges of their empathic abilities (Lafferty, Beutler, & Crago, 1989; Watson, 2002), it is crucial they learn how to engage in a discussion of clients' 'in-session' experiences with them. Kiesler (1982, 1996) and others (McLeod, 2003; Rennie, 1998) describe this as 'communicating about how we are communicating.' It is a way to highlight the relationship dynamics by exploring how the client might be feeling towards the therapist in light of what the therapist has been saying. Metacommunication brings a sense of immediacy to the session (Egan, 2002). Yalom (2002) talks about "the space between us" (p. 12) with the client, whereas Norcross (Norcross, 2005) suggests asking the client "How are you and I doing?" as a way of the monitoring psychotherapy process.

Metacommunication involves talking about any problems that might be going on in the relationship between the client and therapist, rather than focusing on the content of what the client is saying. It is a way of discussing what is often implicit or only hinted at in a conversation, or suggested by a tone of voice. Rennie (1998) suggests that metacommunication can take a variety of forms depending on whose experience is explored. These forms include discussing the impact of a client's comment on the therapist, assessing the client's opinion of the techniques the therapist has been using, or even exploring the intent behind the client's remarks to the therapist. The challenge for the therapist is to invite this level of disclosure without intimidating the client (Kiesler, 1988).

The results from Rennie's (1994a) work on deference stress the need for metacommunication since clients are not always forthcoming about their feelings towards their therapists. Even Freud (1912) noted that therapists cannot assume that no news is good news. This suggests it is critical for therapists to be aware of subtle indications that the alliance may be at risk for a rupture, and know how to metacommunicate appropriately (Muran, 2002).

Other researchers (Levitt, 2001; Rhodes et al., 1994), looking at clients' experiences of therapy, have discovered similar results: clients are reluctant to openly criticize their therapists. Yet not doing so risks rupturing the alliance. Rhodes et al. (1994) found that when clients were willing to share their concerns about upsetting things therapists had done, and therapists were able to respond non-defensively and empathically, that the difficulty could be resolved. When this did not happen, or the therapists did not pick up on the problem, clients would drop out of therapy. This finding highlights the importance of therapists creating a trusting relationship where clients feel safe to share their concerns.

Ruptures: If a good working alliance is at the heart of the change process, then recognizing problems in this connection would appear to be a critical therapy skill. Safran and Muran (2000a) describe ruptures as "negative fluctuations in the quality of the relationship between the therapist and the client" (p. 160), and suggest these strains are an inevitable part of the ebb and flow of human relationships. A research analysis of clients' descriptions of these events suggests that ruptures occur when clients mistrust therapists' intentions, or feel unable to measure up to therapists' expectations. An impasse may also

be created if clients feel pressured to accept their therapists' goals or techniques, or if they do not feel understood by their therapists (Muran, 2002; Norcross, 2005).

Originally, Safran and Muran (1994) focused most of their research on developing a model based on the assumption that it is the client's maladaptive cognitive schemas (dysfunctional relationship patterns) that evoke negative responses from the therapist (rather than something the therapist might have done to 'start it'). Currently, these researchers are now exploring ruptures from the perspective of the subjective experience of the therapist, and how the therapist may be negatively contributing to this rupture process (Muran, 2002; Safran & Muran, 2001; Samstag et al., 2004).

A post-session questionnaire (Muran, 2002) was developed to help further understand the nature of ruptures. One of the key factors that researchers (Binder & Strupp, 1997; Kiesler, 1996; Rennie, 1998; Safran & Muran, 2000b; Samstag et al., 2004) have identified contributing to rupture resolution is the therapist's ability to metacommunicate about the therapy relationship. This research demonstrates the need to train therapists to become more aware of the status of the relationship in order to recognize when these tears and strains are occurring, and to take reparative action.

The suggestion that therapists might be contributing to problems in the relationship is highlighted in a study by Henry et al. (1993). The researchers looked at the effectiveness of using manuals for training therapists in short-term dynamic therapy. They discovered that, even after a year of training, the alliance ratings of some experienced therapists (due to their own unresolved family of origin issues) were deteriorating (Henry & Strupp, 1994).

Binder and Strupp (1997) point out that therapists are often unaware of when they are engaging in covert struggles with their clients. Even when they are aware, well-trained therapists may have difficulty extracting themselves from interpersonal conflict (Binder & Strupp, 1997). Most therapists know how they should behave but, with some clients, this ideal standard of empathy, unconditional positive regard, and acceptance seems particularly unattainable. A theoretical understanding of the dangers of countertransference is not sufficient to avoid engaging in what Binder and Strupp (1997) describe as a destructive cycle of 'negative processes' (p. 134). As Kiesler (1982) explains it, the therapist becomes "hooked" into the client's "pattern of interpersonal engagement" (p. 274).

4.3 Conclusion

The research evidence appears conclusive (Norcross, 2005; Orlinsky et al., 1994; Orlinsky et al., 2004): The client-therapist relationship is a key factor in successful therapy outcomes. Indicators of a functional working alliance, from therapists' perspectives, include their ability to collaborate with their clients on the goals and tasks of therapy, and their successes at gaining and maintaining the trust of their clients.

As one practicing clinician noted, (K. Hadden, personal communication, March 2003), "The client is the expert of the content; the therapist is the expert on the process." Through their empathic presence therapists earn the trust of their clients. When clients feel safe with their therapists, they are free to explore their problems. Therapists are responsible for keeping the relationship working smoothly and helping clients work toward mutually agreed upon goals.

Are therapists born with this set of relationship skills, or can these skills and attitudes be taught and developed? This issue will be the focus of discussion in the next chapter.

Chapter 5: The Implications for Counsellor Training and Practice

5.1 Introduction

In describing the therapeutic alliance and its influence on therapy outcomes, it is important to explore relationship issues in the context of training and professional development. In this chapter, the therapeutic alliance and its relationship to various elements of a training program - theory, skills, supervision, process groups, and personal work - will be examined. Three research-based training programs that focus on the importance of the relationship will be described.

5.2 Training Programs

As suggested by Hill and Nakayama (2000), the terms *counsellor* and *therapist* have been used interchangeably throughout these chapters as most people do not usually distinguish between various members of helping professions. Training, however, differs considerably for counsellors, clinical psychologists, social workers, school counsellors, and psychiatrists in terms of length, breadth, and depth. Most programs will cover the individual theories of counselling, some skills and techniques training, and a practicum experience. Courses on human behavior and development, family, career, and cultural issues, ethics, assessment and diagnosis, and a research experience may be required or optional, depending on the level of training.

The goals of training are to enable students to achieve a certain minimal level in core competencies. The list of these competencies varies somewhat, but usually includes interpersonal skills in individual and group counselling, assessment and diagnosis, research skills, ethics, and legal and professional skills. Doctoral level programs will also include supervision and administration in their list of competencies (Canadian

Counselling Association, 2005; Charman, 2004; Collins et al., 2005; Doyle, 2005; McLeod, 2003).

In order to achieve these goals, training programs generally consist of three elements: theory (didactic instruction), skills training, and supervised practice (practicum or an internship). A fourth component, personal work (either individual therapy or a process-experiential group), may or may not be present depending on the philosophy of the training institution.

Generally, programs focus either on the theory of one particular model (e.g., Psychodynamic, Cognitive-Behavioral), or give a broad overview of all the approaches to therapy, using a generic model for teaching skills. Programs also vary in the degree of emphasis put on the therapy relationship. At one end of the continuum are those that view therapy as something delivered in a standardized format by uniform therapists to passive clients (Bohart, 2000a; Duncan & Miller, 2000a). At the other end are the programs with a humanistic perspective (e.g., Experiential, Person-Centred), which has traditionally highlighted the client-therapist relationship. The focus is on how the relationship develops, the role it plays, and how to maintain it. The previous chapter demonstrates why a focus on the relationship needs to be present in the theory, practice, and supervision components of every program.

5.2.1 Theory

Theories can be thought of as languages for describing a common phenomenon (McLeod, 2003). Counselling theories are usually based on a set of philosophical assumptions about the nature of human beings and their problems, and thus play a role in maintaining the values and attitudes of therapists towards their clients and the process of

change. The broader the theoretical background, the broader the range of clients with whom therapists will be able to connect. Whether therapists choose to frame clients' relationship problems as cognitive distortions, or transference, is not as important as gaining an understanding about how clients view their problems. Therapists have to learn how to speak the language of their clients in order to understand their perspectives (Bohart, 2000b; Duncan & Miller, 2000a, 2000b; Hubble et al., 1999).

Therapists in training are more likely to be open to a variety of viewpoints if an individual counselling theory is presented as one of many possible ways of understanding a situation or behavior (Neimeyer, 1993). Students and practicing therapists should realize that, no matter which theoretical orientation they choose, the relationship with the client is critical and must be monitored closely. One of the implications of the dodo bird verdict is to suggest there are factors that all theoretical approaches have in common, hence the value of an integrationist approach (Norcross, 2005; Norcross & Beutler, 2000; Norcross & Goldfried, 1992).

Students should be introduced to the history of, and research on, the therapeutic relationship in order to understand why relationship skills are crucial. This perspective should include how different schools of therapy have conceptualized the relationship in the past as well as how they view it now. The role of the therapist continues to evolve as the result of research highlighting the active role played by the client in therapy (Arnkoff et al., 2002; Bohart, 2000b; Cain & Seeman, 2002; Duncan & Miller, 2000b; Elkin et al., 1999; Gendlin, 1981; Greenberg et al., 1993; Hill & Nakayama, 2000; Horvath & Bedi, 2002; Hubble et al., 1999; McLeod, 2003; Rennie, 2001).

There has been a paradigm shift from seeing therapists as experts on 'what is wrong with clients and how they are going to fix them,' to seeing clients as having the potential resources to solve their own problems. Therapists then assume a more consultative role in the process (Bohart & Tallman, 1999; Hoyt, 1998; Hubble et al., 1999; Schneider et al., 2001). This changing view of the process of therapy can be facilitated by becoming aware of the research on the therapy relationship and how it relates to outcomes. Students must be critical consumers of this research, especially in view of the heavy emphasis placed on practicing 'outcome informed' methods of therapy (Hunsley, 2003; Norcross, 2002b, 2005; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). It is necessary for students to become skilled at distinguishing solid from inferior research (Norcross & Beutler, 2000).

Students should become familiar with techniques associated with different theories and how they measure up in research and practice (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Therapists are in a better position to decide (with clients) when and how to use a technique if they understand the underlying theoretical rationale. One of the guidelines previously discussed is the research indicating a match between techniques and a client's stage of change and how that provides an effective way of customizing therapy (Miller & Rollnick, 2002; Norcross, 2002b; Prochaska & Norcross, 1999, 2002; Rochlen et al., 2001).

When students and clinicians have grasped the historical and research significance of the therapy relationship, as well as the different theoretical perspectives on therapy, they will be in a better position to make use of training aimed at helping them develop

relationship skills (Kagan (Klein) & Kagan, 1997). They are also more likely to continue using these skills in the field (Nerdrum & Ronnestad, 2002, 2003).

5.2.2 Lower and Higher Order Skills Training: Learning How to Do Therapy.

Theory explains what therapists do and why, and provides the background context for the skills taught (Nerdrum & Ronnestad, 2002; Safran & Muran, 2000b). The skills section of the training program usually captures students' interest as it teaches them what to say after clients have shared their stories.

Skills training became popular during the 1950's when efforts were made to take Carl Roger's approach to therapy, break it down into discernable steps, and then teach these steps to others (Truax & Carkhuff, 1967). Several programs were developed that are still in use today, each having a slightly different emphasis. For example, Carkhuff's (1967) Human Relations Training courses focus on creating the core conditions needed for therapy; Ivey's (1988) Microskills program develops communication skills; and Egan's (2002) Skilled Helper model draws on a cognitive-oriented problem solving approach while using skills from a variety of theoretical perspectives. Similarly, Prochaska and Norcross's (1999) Transtheoretical Model suggests that the choice of technique should depend on the client's stage of change. Each school of therapy has developed its own set of techniques (e.g., interpretation, challenging distorted cognitions, two-chair work, and the miracle question).

No matter which approach or model is used, all training programs start with the fundamental skills of communication (e.g., using open-ended questions, minimal encouragers, paraphrasing) and attending behaviors (e.g., open body posture, leaning slightly forward, making appropriate eye contact with the client). These are the basics, or

what Baker, Daniels, and Greeley (1990) refer to as 'lower order' skills, and they can be readily taught to most students. In fact some universities (e.g., University of Victoria, British Columbia) require mastery of these helping relationship skills as a pre-requisite for entry into their graduate counselling programs (c.f. Uhlemann, 2005). Research (Daniels, 2003; Daniels & Uhlemann, 2004) indicates these basic relationship skills are positively correlated with increased client-talk time and satisfaction with their therapists, among other client measures. Whether or not counsellors continue to use these skills if they do not have follow-up training sessions is not so clear (Daniels, Rigazio-Digilio, & Ivey, 1997).

Training usually involves listening to an explanation of the skill, watching a demonstration video, and then practicing the skill in class. Some programs use workbooks with exercises that students complete and hand in to be marked. The goal is to demonstrate competence in listening to what clients say, and then accurately reflect it to them. This accuracy is usually assessed by the instructor, particularly in the case of workbook exercises. The assumption underlying this approach is that effective counselling consists mainly of listening empathically while clients talk about their problems (Bohart & Greenberg, 1997), and that empathy can be accurately measured by an independent observer (Truax & Carkhuff, 1967; Watson, 2002).

These basic reflective techniques can also be used as a form of 'anesthesia.' It has been suggested by some cognitive-behaviorists (Raue & Goldfried, 1994) that empathic listening is necessary, but only as a means of enlisting clients' compliance with techniques. Raue and Goldfried note that even if a therapist has excellent skills, they will not have anyone to apply these skills to if they do not first establish an alliance. In this

respect they do regard the relationship to be important. They go on to suggest however, that "the task of therapists with clients who are not friendly submissive (and therefore not responsive to praise and approval, at least in the desired direction) is to bring them into this type of stance" (p. 135). Given this interpretation of empathy, it seems as if they might be missing the core of what a relationship should be, and needs to be, in order for therapy to be effective. A healthy therapeutic working alliance involves trust, not manipulation (Bachelor, 1995; Bachelor & Horvath, 1999; Horvath & Bedi, 2002).

Higher-order skills such as collaboration, appropriate and timely feedback, self-disclosure, relational interpretations, and metacommunication involve complex interpersonal processes that cannot be broken down into pieces and taught. Yet, they are potentially just as critical to the therapy relationship (Ackerman et al., 2001; Lambert & Barley, 2002; Norcross, 2005; Orlinsky et al., 1994) and depend on a thorough understanding of the intentions behind these actions.

Empathy is a case in point. As outlined in the previous chapter, it has been defined and measured in a variety of ways. Empathy can be a simple reflection of the client's words that indicates an intellectual understanding of the content of what has been said, to a way of being with the client that emphasizes felt experience (Bohart et al., 2002; Bohart & Greenberg, 1997; Burns & Nolen-Hoeksema, 1992; Duan & Hill, 1996; Kahn, 1997; Margulies, 1989; Nerdrum & Ronnestad, 2002; Rogers, 1961; Rubino, Barker, Roth, & Fearon, 2000; Watson, 2002). Tolan (2003) explains that "at its richest [empathy] involves a fearless exploration of another's inner world, a sensing of meanings unspoken, a compassionate naming of pain, suffering and humiliation, and of mischievousness and joy" (p. 18). Tolan stresses that empathy is a 'two-way' process,

with therapists constantly vigilant about how accurately they are connecting with the client's experience, both in the telling of past experiences and in the present moment of therapy.

How can something as complex as empathy, that involves both interpersonal and intrapersonal skills, be taught? Empathy involves an attitude towards self and others, as well as set of skills, which is not something that is easily memorized from a book (Rogers & Stevens, 1967). Given the important role of empathy in helping to establish the working alliance and monitoring the relationship, it is surprising so little research has been devoted to teaching therapists how to be empathic (Bohart et al., 2002). This is particularly disturbing since some therapists appear to be poor judges of their empathy skills (Horvath & Bedi, 2002; Lafferty et al., 1989; Watson, 2002).

While the first level of empathy (active listening) was heavily researched during the 1960's and 1970's (Bohart et al., 2002; Duan & Hill, 1996), there are few studies that explore the impact of empathy training on a therapist's ability to enter into the client's experience. Nerdrum and Ronnestad's (2003) recent work in Norway indicates that, when the focus of training is on affective (co-experiencing) as well as cognitive (role taking) aspects, trainees develop an "ability and willingness to decenter...and let go of ambitions to control and to change the other person's experience" (p. 55).

Whether or not this type of empathy training translates into improved client outcomes remains to be demonstrated. Ideally, research analyses such as these should include an outcome measure (Orlinsky et al., 2004). What the results from Nerdrum and Ronnestad's (2002, 2003) research highlight is that methods of teaching higher-order empathy skills should be based on an approach that also values empathy in the trainer.

5.2.3 Supervision

Working with real clients under the guidance of an experienced therapist can provide trainees with the opportunity to develop more complex skills such as empathy and metacommunication (Safran & Muran, 2000b). Supervision of the trainee's work can take place in a variety of formats, from the discussion of their case notes to co-counselling where the supervisor and trainee work together with the client. During the 1950's, Carl Rogers (Rogers & Dymond, 1978) initiated the process of using audiotapes to monitor and evaluate counselling sessions. With changing technology, audiotapes have given way to video recordings as well as one-way mirrors for 'real time' observations. In family counselling, such methods have been supplemented with supervisors (or a team of observers) calling in suggestions to the trainee (Hoyt, 1998).

Some supervisors also allow their trainees to observe them with clients, either live or on video (Norcross & Beutler, 2000). The latter format provides the opportunity to stop the recording at various points and have supervisors explain what their underlying thoughts and feelings were at the time (Safran & Muran, 2000b). It also allows supervisors to describe the rationale for the interventions they are using with clients. This process of reflecting on the subjective experience of therapists (Interpersonal Process Recall, or IPR) in response to what is happening in the session was developed by Kagan (Kagan (Klein) & Kagan, 1997) during the 1960's. The IPR process evolved out of a program aimed at helping mental health workers improve their interviewing skills. Students using the IPR process (when training with clients) become more aware of the impact that the counselling session has had on them. This increased awareness, in turn, affects the students' ability to be present with clients.

These different supervision strategies or techniques are similar to the task component of the working alliance. They strengthen the bond and are used to achieve a goal. If the purpose of supervision is to provide guidance and instruction on how to do therapy, then the primary focus for supervisors is to create an atmosphere where trainees feel safe enough to bring forward issues that are causing difficulty. When there is fear of hearing disparaging remarks made about their abilities to succeed, trainees will often withhold any information that might cast them in a negative light (Falender & Shafranske, 2004; Safran & Muran, 2000b). Rather than only discussing cases that will earn good grades, students need to be able to talk with their supervisors about difficult cases without fear of destructive criticism (Alonso & Rutan, 1988; Hill & O'Brien, 1999).

When trainees feel their concerns have been understood, they are then free to explore their anxieties. They need to have their struggles acknowledged and validated as normal. While supervision is not therapy, it shares many similarities with the process. Supervisors have to create an environment similar to the one created by therapists for clients – a safe working space to explore problems. In this case the problems revolve around trainees' work with their clients; hence, it is not therapy. Techniques such as IPR will only be effective if they take place in a relationship where trainees feel safe enough to expose personal vulnerabilities and shortcomings (Safran & Muran, 2000b).

Neufeldt (2004) and others (Falender & Shafranske, 2004) suggest that supervisors and students need to forge a training alliance, similar to the alliance that occurs in therapy. Researchers such as Patton and Kivlighan (1997) have indicated that, when there is a good relationship between supervisors and trainees, this is mirrored in the relationships between trainees and clients as well. Given the impact of that relationship

on outcome, it would seem crucial to make the establishment of a good working alliance between supervisors and supervisees a priority. Surprisingly, this has not been the case. Very little research has been carried out on the development and maintenance of this relationship (Ellis & Ladany, 1997). Supervisor training seems to be a forgotten element in counsellor training pedagogy (Goodyear & Guzzardo, 2000).

Safran and Muran (2000b) suggest that the lack of attention to training and supervision is not a major problem when the goal is to learn a 'narrowly defined set of technical skills' for the remediation of specific complaints. But if therapists are going to work with difficult clients, or those who present with multiple issues, they need to be capable of forming meaningful interpersonal relationships. Empathic attunement to clients is one of the key ways therapists establish this connection, but it is a complex skill to master.

As researchers (Bachelor, 1991; Bachelor & Horvath, 1999; Horvath & Bedi, 2002) have pointed out, the best judge of a therapist's ability to be empathic is the client, not the therapist, or an outside observer. Even supervisors tend to have their own filters that can bias their judgment of trainees' skills (Goodyear & Guzzardo, 2000). One way of providing trainees with feedback on their relationship skills is through the use of a process-experiential group. Some programs include this type of group experience, either in the form of an ongoing personal and professional development group, or as a requirement for a group counselling course (Merta & Sisson, 1991; O'Leary, Crowley, & Keane, 1994).

5.2.4 Process-Experiential Groups

Carl Rogers adopted the ideas from Kurt Lewin's human relations training seminars and developed experiential groups for the purpose of fostering the personal qualities of trainees (Marrow, 1969; McLeod, 2003; Rogers, 1971). He recognized the value of experiencing first-hand the core conditions he hypothesized were necessary for a good therapy relationship. These encounter groups became extremely popular during the late 1960's and throughout the 1970's, not only for training purposes, but also for the general public (Schutz, 1971). Unfortunately, there were no guidelines or standards to ensure participants were treated respectfully, or that leaders would act responsibly (Lieberman et al., 1973; Rogers, 1971). As a result these encounter groups received negative publicity, much of it deserved, and experiential groups disappeared from many training programs.

Several programs do require trainees to have a group experience in order to develop competency in leading a counselling group. The type of experience however, varies considerably. Participation in a psycho-educational group for the management of test anxiety, a self-help group for quitting smoking, or a support group for cancer survivors, are considered to be group experiences, yet none of these groups concentrate specifically on the development of personal relationship skills.

In contrast, the focus of a process-experiential group is on exploring the here-and-now with group members. The group provides the opportunity to practice empathy, collaboration, metacommunication, and giving and receiving feedback in a format that encourages respectful openness and honesty. Trainees learn how their communication style is experienced by others, and have the chance to explore different ways of

connecting, as well as dealing with problems in maintaining these connections. There are several options for organizing this kind of group, depending on the goals and philosophy of the program as well as the developmental stage of the students (Cohen, 2004; Merta & Sisson, 1991; O'Leary et al., 1998; Yalom, 1995).

Some examples of the ways groups vary include: the structure or format of the sessions; who discusses what and when; the relative emphasis on content versus process; the depth of material explored; the intensity of emotions aroused; and perhaps most importantly, the instructor's presence and/or level of involvement (Cohen, 2004; Elliott et al., 2004; Rosenbaum, 1996). Because of the potential for experiencing upsetting emotions, involvement in a process-experiential group is always voluntary. Students are advised not to join if they are not willing to participate fully.

While confidentiality is stressed in group sessions, students learn things about each other they will carry over into their daily lives. This information has the potential to affect their relationships outside the group. It is for this reason that some training faculty recommend students participate in process-experiential groups outside the training institution (K. Hadden, personal communication, March 12th, 2003). If students realize they are having difficulties mastering relationship skills because of personal problems, they should consider seeking counselling help (Canadian Counselling Association, 2001; McLeod, 2003).

5.2.5 Personal Therapy

Process group experiences, while appearing to be desirable as a means of improving interpersonal skills, are not always feasible or available. This is one reason personal therapy is recommended for students. Another is that while supervision can feel

like therapy at times, that is not its function. Since supervisors are the gatekeepers of the profession, it is incumbent upon them to identify trainees who, because of their own unresolved issues, are struggling with clients, and may be in need of personal therapy (Schulz, 2000).

Personal counselling also provides trainees with an opportunity to see what it feels like to be a client (Asay & Lambert, 2002). This can be a humbling and frightening experience for some. Receiving personal therapy ranks as one of the most important variables having a positive impact on therapists' abilities to connect with their clients (Jennings & Skovholt, 1999; Norcross, 2005; Norcross & Halgin, 2005; Orlinsky, Botermans, & Ronnestad, 2001; Yalom, 2002a). Research meta-analyses continue to indicate that the emotional health of therapists is associated with positive client outcomes, yet it is rarely assessed as a moderator variable in psychotherapy outcome research (Beutler et al., 1994; Beutler et al., 2004).

Personal counselling is not a requirement of most programs because of the ethics of requiring individuals to attend counselling (McLeod, 2003). Psychoanalytic training institutions are the exception: here the expectation is that personal therapy is an integral part of the training process (Goldfried, 2001). Other opportunities for personal growth besides individual therapy include retreats, self-help activities (Norcross & Beutler, 2000), meditation (Norcross & Beutler, 2000; Safran & Muran, 2000b), and journaling (Pennebaker, 1997; Rico, 1991).

5.2.6 Self-Care Strategies

The ability of therapists to look after their mental, emotional, spiritual and physical health should be incorporated into the curriculum. These skills maintain the

attitude of therapists and their ability to forge and maintain working alliances with their clients. The following is a list of self-care suggestions:

1. Personal therapy is highly recommended for therapists throughout their career (Mahoney, 1991; Yalom, 2002b). Listening to the problems of others is stressful; burnout is an inherent risk in the profession (Corey & Corey, 1998; Egan, 2002).

2. Therapists should seek out good listeners they can rely on when they need to debrief after difficult clients or situations (Norcross, 2000).

3. Therapists also need to be constantly monitoring their level of stress in order to take action before their clients are affected (Gladding, 2002; Manning, 1994).

4. Therapists need a repertoire of self-care strategies that they practice regularly (Mahoney, 1991; Norcross, 2000).

5. As part of their on-going development, therapists should seek out opportunities such as process groups to explore and reflect on their relationship skills with other professionals (Emerson, 1995; Yalom, 1999).

5.3 Three Training Examples

Three training programs will be described in order to explore training issues in a practical context. These are programs led by those who value empathy and collaboration as an attitude, and recognize the challenge of learning the complex skills of metacommunication, and rupture recognition and resolution. The first example is Process-Experiential therapy (PE therapy), offered at York University; the second is Person-Centred Counselling, taught by David Rennie (also at York University); and the third is Brief Relational Therapy as practiced at Beth Israel Medical Center in New York City.

5.3.1 Process-Experiential (PE) Therapy

Process-Experiential (PE) therapy, developed during the late 1980's, has been researched extensively for its effectiveness in helping clients deal with depression, the aftermath of abuse, and interpersonal difficulties (Elliott et al., 2004; Greenberg, 2002; Greenberg & Paivio, 1997, 1998; Greenberg & Watson, 1998; Johnson, 2003b; Sachse & Elliott, 2002; Wiebe, 2002).

In training students to practice PE therapy, Greenberg and his colleagues (Elliott et al., 2004) focus on teaching students to recognize 'markers' or indicators that a particular type of intervention would be appropriate to use with a client in order to allow the client to fully enter into the experience in the here-and-now. They use detailed techniques based on the Gestalt concept of experiments (Zinker, 1977), while their philosophical stance is clearly humanistic with its emphasis on the values of client–centred therapy: collaboration, empathic attunement, acceptance and prizing, and genuineness (Elliott et al., 2004; Greenberg et al., 1993).

PE therapists view the emotion system as a source of information and guidance in directing behavior, and thus an area for exploration in therapy. In order to access this information, clients need a safe working space. Empathy is important, not only to validate their feelings, but as a way of deepening their experiences, thereby leading to new understanding and meaning-making. Research (Bohart & Wugalter, 1991; Greenberg, 2002) indicates that when clients enter more fully into an emotional experience, therapy outcomes are improved.

Training in a PE program involves didactic and experiential activities (observation and modeling, both as therapist and client) with an emphasis on learning the

overall treatment approach first and then the specific techniques. Elliot et al. (2004) note that students find PE training to be a difficult, complex and stressful process, involving much soul-searching. The program necessitates both the development of skills and personal growth. Elliot et al. point out that trainers and supervisors need to tailor programs to meet the individual needs of students as there is considerable variation in their abilities and the speed with which they are able to master the processes.

The focus in the didactic course is on theory, illustrated with videos of clients in PE therapy, followed by a discussion of the principles. Students begin to practice empathic listening, as well as some specific Gestalt techniques in this class, but the main portion of the skills learning takes place in a two-hour long experiential training workshop held weekly throughout the program. During these sessions students engage in role playing exercises as clients and as therapists. Confidentiality is stressed as students are encouraged to use genuine, but not overwhelming problems, and to see themselves as 'psychotherapy training associates,' with the trainers available as consultants if needed (Elliott et al., 2004).

The attitude of the therapist is critical in PE therapy; therefore, it is important that trainees engage in learning activities (including individual growth experiences) that build on their existing abilities to be empathic, non-judgmental, and genuine. Especially critical is their ability to 'stay with' a client who is experiencing intense emotions. The process of learning PE therapy takes time, and is not suitable for everyone. "Forcing people into molds is antithetical to a humanistic therapy, even when the molds are humanistic ones!" (Elliott et al., 2004, p. 315). Elliot and his colleagues suggest more emphasis should be placed on selecting trainees who possess appropriate skills and abilities for the

profession. Some of these variables include "curiosity, creativity, high tolerance for ambiguity and complexity, as well as warmth and compassion, social awareness, openness and self-awareness" (p. 316).

5.3.2 Person-Centred Counselling

The second example (also from York University) is David Rennie's person-centred experiential approach to counselling, which is based on Carl Roger's (1957) philosophy of core relationship provisions. Rennie's (1992, 1994a, 1998, 2000, 2001, 2002) qualitative research has focused on client reflexivity, shedding light on how clients think about the process of therapy, and the critical importance of what they do *not* share with their therapists.

Rennie (1998) also uses role-playing in his training courses to explore a variety of experiential approaches to person-centred counselling, but with scripted roles. Rennie notes that the disadvantages of bringing real problems into a training situation outweigh the advantages. He argues that the danger is trainers will become drawn into rescuing the situation if the problem turns out to be deeper than either 'clients' or trainees anticipated. Working with imaginary clients also allows trainees more room to practice different ways of responding to clients without fear of causing serious harm.

The class size is restricted to eight as one student acts as a client each week, with the other students taking turns counselling. The trainer acts as a coach, working with the strengths and weaknesses of each student, helping him or her develop skills in four key areas: empathic work, transparency and metacommunication, process identification and direction, and the working alliance (Rennie, 1998, p. 132). Rennie suggests that while he is collaborating with students on how content will be taught, he is also modeling various

techniques (transparency, metacommunication, and empathy) and a philosophy of respect for the individual that he expects students to use in their practices.

During role-plays, trainees practice empathic listening, while focusing on finding the 'leading edge' of the client's experience. Feedback from the 'client' as well as the audience is invited to guide trainees in the process. Transparency about thoughts and feelings that trainees and clients have about each other involves an element of risk: the challenge for supervisors is working with students to maintain a safe, supportive learning environment.

The third skill Rennie (1998) identifies is process identification, and as appropriate with each client, process directives. He discusses how difficult this can be for some trainees because it requires paying attention to the tone of voice and body language along with the meaning of words. The goal is to gain a 'felt-sense' of the client's experience. Learning how to comment tentatively on what might be going on for clients in the moment will become easier as trainees learn how to use metacommunication to explore the impact of their interventions on clients.

For those not able to access a practice group, Rennie (1998) suggests replaying tapes of counselling sessions, using the ideas from his book as inspiration for alternative ways of responding to clients. Unfortunately, this method does not provide feedback, the critical piece needed for the establishment and maintenance of the working alliance (Norcross, 2005). It is essential that therapists learn the skill of metacommunication in order to monitor the relationship. As Rennie's (1994a) work on deference, and Hill and her colleague's (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996) work on

'things unsaid' indicate, therapists need to be acutely aware of how clients experience the process of therapy, making the necessary adjustments to safeguard the relationship.

5.3.3 Brief Relational Therapy

The third example is from Beth Israel Medical Center in New York City where Brief Relational Therapy has evolved out of a marriage between interpersonal, psychodynamic, and cognitive-behavioral approaches to therapy. The research program (Muran, 2002; Muran & Safran, 2002; Safran & Muran, 2000b, 2000c, 2001; Safran et al., 2002; Samstag et al., 2004) is aimed at understanding the variables contributing to ruptures in the alliance, and how to train therapists to recognize and repair these tears and strains.

Safran and Muran (2000b) put the relationship at the top of the training agenda. They stress the importance of basic interpersonal skills including "interpersonal sensitivity, perceptiveness, and tact" (p. 205), adding that therapists also require a "capacity for self-acceptance…as well as the willingness and courage to face their own demons" (p. 205). Therapists have to be prepared to have their biases exposed, and their assumptions challenged and changed through their interactions and relationships with their clients.

To be an expert practitioner in the field entails more than procedural knowledge; it necessitates the development of tacit skills, one of which has been described as 'reflection-in-action' (Neufeldt, 2004; Schèon, 1983). This involves responding in the moment to a situation by using feedback from a variety of sources, both at a conscious and an unconscious level, including 'gut feelings' and intuition (Bugental, 1992). This is not an easily developed ability and relies heavily on self-exploration, personal growth

work, mentorship, role-modeling, and socializing in a culture that values an intuitive approach to therapy. This stands in contrast to a system that uses manuals to guide techniques (Elliott et al., 2004; Safran & Muran, 2000b).

Going beyond imparting knowledge and teaching skills, Safran and Muran (2000b) view the process of training as setting up the 'preconditions for learning' (p. 207). They establish the importance of an experiential focus through the use of a series of exercises aimed at encouraging a 'beginners mind', a stance that is curious, questioning, open, and receptive to all possibilities. These exercises include techniques borrowed from Gestalt therapy (Perls, Hefferline, & Goodman, 1965), and mindfulness training (Peavy, 1997), where the intention is to stay focused on the here-and-now. The goal for students is to become more aware of the subliminal information they are taking in from interactions with clients, as well as their own thoughts and reactions (Safran & Muran).

These awareness skills form the foundation for the attending skills referred to earlier, but with the added focus on understanding the meaning of the information absorbed. For example, what does the body language say? Does the tone of voice seem contradictory to the content? Is there a sense of passive agreement to what the counsellor has suggested, indicating covert disagreement? This information can provide the therapist with feedback on the state of the relationship, as well as grist for process work (Yalom, 1989, 2002b).

Therapists constantly have to make decisions on what action to take and how to respond to clients. Should they use a form of empathy to deepen clients' emotional explorations? When therapists notice "you sighed as you said that," it invites clients to

reflect further on their experience (Rennie, 1998). Or, perhaps therapists should offer clients a reflection on what is happening between the two of them. For example:

> I noticed that you went quiet when I said that. Maybe I misunderstood what you meant? Were you feeling angry when he left? Or was it more like: Now I can get on with my life? Or, perhaps you were thinking that I [the therapist] really do not understand how upset you are about this.

Like Rennie (1998), Safran and Muran (2000b) suggest therapists have to be constantly aware of what clients are experiencing, and be ready to shift between focusing on process, content, or on the relationship between the two of them.

In their research program, Safran, Muran and others (Muran, 2002; Muran & Safran, 2002; Safran & Muran, 2000c, 2001; Safran et al., 1994; Safran et al., 2002) have looked at the nature of ruptures in the alliance and suggest a large part of the work of therapy is accomplished during the successful repair of these ruptures. In order to do this, therapists need to be able to metacommunicate about the relationship with their clients.

One of the best ways to learn about the process of rupture resolution is for students to practice the technique of metacommunication with each other. Safran and Muran (2000b) use trainees' internship experiences with difficult clients as content for role-plays in supervision groups. Trainees either play themselves or clients, with other students taking turns in both roles. The supervisor then acts as a role-model while helping students in their efforts to work through their internship training experiences.

5.4 Training Program Implications

The therapeutic alliance is the starting point for therapy: have the client and therapist been able to connect and agree on the tasks and goals of therapy (Norcross,

2005)? Training has to ensure that therapists are able to do this successfully. One suggestion is using therapeutic alliance assessment measures with trainee's clients as a way of assessing the competency of trainees (Summers & Barber, 2003).

Training programs need to reflect the importance of the client-therapist relationship by increasing their focus on the complex skills needed to develop and maintain the relationship with a diverse selection of clients. Experiential learning strategies can provide the opportunity for trainees to practice these skills and receive valuable feedback from those with whom they practice (Safran & Muran, 2000b).

Trainees need to become familiar with alliance and outcome measures and be prepared to use them in their work (Duncan & Miller, 2000b; Hawkins et al., 2004; Horvath, 2001; Lambert & Asay, 2004). Even experienced therapists are not always able to accurately judge how clients perceive the alliance (Hersoug, Hoglend, Monsen, & Havik, 2001), or when clients are displeased with their therapists (Rennie, 1994a).

Trainees also need to learn how to keep abreast of current research that clarifies the factors that affect the formation of the alliance, as well as learning ways to customize the relationship to each client (Norcross, 2002b, 2005). Along with intellectual knowledge and relationship skills, trainees need to ensure they learn how to care for their own mental health. Self-care strategies can play an important role in this endeavour (Norcross, 2000).

The following chapters will draw together the themes discussed in this thesis research, and explore personal reflections emerging out of the thesis writing process.

Chapter 6: Concluding Thoughts

6.1 Why is Behavior Change so Difficult for Some Individuals?

Why do some people struggle with self-initiated change while others just 'do it'? Most people do eventually succeed by trial and error, some faster or more efficiently than others (Bohart & Tallman, 1999; Kiecolt, 1994; Kottler, 2001; Prochaska et al., 1994). Those experiencing difficulties may have run into obstacles, or become entangled in the mechanical aspects of change. The impediments to change can take a variety of forms, from external problems in the environment, to internal psychological issues. A lack of awareness, knowledge, or understanding of the process of change itself and how difficult it can be may also lengthen the road to successful change. Some individuals have many blocks; others may have a combination of barriers. Can counselling or therapy help remove these blocks to change?

6.2 Counselling and Psychotherapy: Can They Help?

Research (Luborsky et al., 1975; Orlinsky et al., 2004; Wampold, 2001; Wampold et al., 1997) evidence indicates that therapy is effective, and that different varieties all work about the same (the dodo bird verdict) (Norcross, 2005). There is a greater difference between the performances of individual therapists within each theoretical orientation than between competing approaches (Krupnick et al., 1996). All therapists do not behave the same way with each and every client. Efforts to standardize the behavior of therapists have been a qualified success (Henry et al., 1993).

This myth of uniformity does not apply to clients and their problems (Hill & Corbett, 1993; Kiesler, 1995; Teyber & McClure, 2000). There are more differences than similarities between clients with the same problem. Clients often present with more than

one problem. The same set of symptoms (e.g., anxiety or depression) can be the end result of different factors for different individuals. Similarly, the same set of precipitating factors can lead to different outcomes in different people (Marshall & Firestone, 1999). Research is providing some answers about which techniques may be useful for different symptoms (Beutler et al., 1991), but a trusting relationship between therapist and client must be established first for techniques to be effective (Lambert & Ogles, 2004; Norcross, 2005).

6.3 What Does a Good Therapy Relationship Look Like?

What kind of therapy works the best? The kind that prioritizes the establishment of the client-therapist relationship (Norcross, 2005; Orlinsky et al., 2004). The client's perspective on this relationship is what matters (Bachelor, 1991). Therapy has to start with what the client wants – not with what the therapist thinks the client needs. A therapist must be able to collaborate with the client to reach agreement on the goal(s) and tasks of therapy (Horvath & Bedi, 2002). What does the therapist need to do in order for the client to feel safe and understood? Through empathic attunement and metacommunication the therapist establishes and maintains a bond (Bohart et al., 2002; Rennie, 1998; Safran et al., 2002). This connection between the client and therapist should be established as early as possible, preferably by the end of the first session, and no later than the third (Horvath & Bedi, 2002; Norcross, 2005).

6.4 What Does a Good Relationship-Focused Training Program Look Like?

Training programs need to focus on relationship skills as the foundation for techniques and strategies to be used with clients. Therapists need to understand how the relationship contributes to outcome, and how to monitor and maintain it (Horvath, 2001).

When therapists have a good working alliance with clients, they are in a better position to use their process expertise to work with their clients to help identify and remove the blocks to change (Norcross, 2005).

6.5 Summary

Most of the time people are able to change on their own, but there are times when they become blocked and need help (Prochaska et al., 1994). Therapists and counsellors can provide such help, but they will be more effective in this process if they make the relationship with the client their top priority (Norcross, 2002b; Orlinsky et al., 2004). Counsellors and therapists need to change their perspective on psychotherapy from a medical model where therapists diagnose client problems, and apply techniques to fix them, to a more collaborative model (Bohart & Tallman, 1999). In this postmodern paradigm, clients are seen as experts on the content of their experiences, and therapists as facilitators of the change process (Duncan & Miller, 2000b). The relationship that forms between them provides the bridge leading to successful outcomes.

Chapter 7: Personal Reflections

7.1 Change

Seventy percent of life-threatening diseases such as obesity, cancer, diabetes, and hypertension, are affected by life style choices (Prochaska & Norcross, 1999; Prochaska et al., 1994). My decision to do a thesis was based in part on the desire to understand my struggles with change. I have a family history of heart disease and high blood pressure, yet have been unable to make aerobic exercise a regular activity. I decided to take the stages of change model and use it as a framework to help analyze where in the process of change I was encountering difficulties, and hopefully discover what was preventing me from reaching the maintenance stage.

This was not an easy task, and took much soul searching. The stages of change model does not capture the sense of frustration that comes from knowing that change is essential, and yet continually having to fight with myself to make and maintain that change. In doing the research for this chapter, I became aware I was further along in the change process than I originally thought. I also realized why it has been so difficult for me to make and maintain certain changes in my life. It still does not make change any easier, but at least I now have a better understanding of the obstacles, and I am more accepting of the nature of my struggle.

7.2 Research

Growing up in a family that put a premium on logical thinking led me to the belief that there is an answer to every question. All I have to do is look long enough and hard enough and eventually I will find 'the' answer. No problem is insoluble; I just have to break it down into small enough components to understand how each piece functions, and

then fit it all back together again. I thought it should be possible to create a matrix that would predict what kind of therapy would work with specific kinds of people having specific kinds of problems. This seemed like a straightforward research question, easily amenable to study using a rigorously controlled experimental design.

Theoretically, researchers should be able to figure out the way to help people change, just as they should be able to count the number of angels that might fit on the head of a pin. The problem lies in specifying all the variables that define angels (and pins) – and people (and problems). So far, that has not been achieved. Searching for 'The way' reflects our desire for 'fast food therapy' (Gutheit, 2001), for a quick (and preferably painless) fix for all our personal problems

The research chapter was interesting to write for two reasons. First, it was exciting to follow the evolution of the research questions; and second, during the process I became aware of my reluctance to accept the legitimacy of qualitative research - in spite of my resonance with Rennie's results (1994a, 2000, 2001). The results were challenging me to rethink my view of what research should look like. As it turns out, an objective 'unbiased' perspective is not always the appropriate one for understanding complex human phenomena. To comprehend some of the variables that lead to successful therapy, it is necessary to talk with clients to appreciate what affects their experience.

7.3 The Therapy Relationship

The relationship chapter was the most difficult to write - much to my surprise - as it was the one I was looking forward to the most. I have kept a journal for many years, often as a way to process and work through difficult experiences, both in and out of therapy (Pennebaker, 1997; Progoff, 1977; Rico, 1991). I decided to use the therapy

experiences I had written about as a 'truth' gauge to assess the research I was reading (Allport, 1942). This could be described as a form of member checking, commonly used in qualitative research as one of the criteria for evaluating of the validity of the research (Barker et al., 2002; Camic, Rhodes, & Yardley, 2003; Elliott et al., 1999; Morrow & Smith, 2000).

As I worked on this chapter, I puzzled over what I thought were the key variables that were important in a successful therapy relationship. Every time I came across what appeared to be a significant or critical piece of research, I would check it against my own experiences, as well as those of friends and family members. I reflected on the relationships that I had formed with the clients I had seen while doing my internship at the University Counselling Centre at Memorial University of Newfoundland. I thought extensively about what my supervisors had said. Even what I had discussed with classmates, watched in videos, and read in books was subject to intense scrutiny. But what I did was more than intellectual reflection; it also involved emotional processing. In order to check the fit of my conclusions, I had to re-enter the helping situations at an affective level. It meant remembering the reasons for which I had sought the help, what my feelings were at the time, and how the other person had responded. The poem "The Dance of Therapy" (p. iii) emerged out of this lengthy and difficult process.

Reflexivity is the process of doing and then reflecting on the 'doing' (Rennie, 2001). We are continually moving back and forth between these two states. The reflection, or the sense we make of what we have done, is informed by our current knowledge. My understanding of the therapy process has been influenced not only by my previous experiences but by my new knowledge that has in turn affected perception of

my past experiences. Kolb (1984) refers to this knowledge as a "transformation process" as it is "continuously created and recreated" (p. 38).

What I have come to believe is that therapists have to realize that only clients can find their own answers (Kopp, 1982). The therapist are helpers - not to help clients get better by doing something to them, but by helping them sort things out. Good therapists listen to what clients say, and convey a sense of 'understanding at a gut level' what clients are feeling. When therapists' reflections are inaccurate, clients need to know it is safe to say something like "no, it's not quite like that, it's more like this." Therapists have to have faith that clients have the wisdom to know what is 'true.' Together they are engaged on a journey to help clients clarify thoughts and feelings, and discover their own solutions. This view of therapy as a collaborative undertaking represents a major paradigm shift – both personally and for the helping profession (Lambert, 2004).

7.4 Training

In the training chapter I had hoped to gain a clearer understanding of what an effective training program should look like, given the importance of the client-therapist relationship. I was surprised to discover there was a lack of research examining the impact of different types of training and supervision on the therapeutic alliance, and even less research examining the effect of therapist training on client outcomes (Lambert & Ogles, 1997; Norcross & Beutler, 2000). Perhaps this is because much of the research on the associations between the therapist's level of training (and/or experience) and client outcomes has turned up mixed results (Bachelor & Horvath, 1999; Bohart et al., 2002; Dawes, 1994; Lambert & Ogles, 2004; Orlinsky et al., 2004; Smith & Glass, 1977). One emerging observation is that experienced therapists appear to be better at monitoring the

relationship, and better able to take remedial action to strengthen the bond when necessary. This is particularly critical with clients who have difficulty in forming close relationships (Horvath & Bedi, 2002; Norcross & Halgin, 2005; Skovholt et al., 1997).

The second disturbing fact I uncovered was that little attention is given in training to addressing the therapist's ability to accurately monitor the relationship (Duncan & Miller, 2000b; Horvath, 2001). This is a critical skill, and the ability to assess the health of the therapeutic alliance - both formally and informally - should be included as part of every therapist's training program.

Doing the research on training has reinforced the value of a process I had observed during my internship experience: the need to be conscious of and comfortable with my own emotions. In order for therapists to enter into a client's experience they not only have to be able to name the client's emotion (M. Doyle, personal communication, September 18th, 2003), but also be at ease with the range of emotions that may be evoked when they do so. I have discovered that learning how to sit with, and contain emotions with a client takes more than book knowledge. It takes experiential practice in a supportive safe environment. Knowing the relationship is important is not enough if a therapist is not able to form one satisfactorily with the client. Training should provide the opportunity to develop and refine this ability.

If the hardest part of change is saying goodbye to the familiar, then having a travel companion (Yalom, 2002b) will make it easier to overcome the obstacles and leave the past behind. A therapist is in the position to provide such company on the journey.

7.5 Final Thoughts

What have I learned from the process of researching and writing this thesis? Therapists should make *sure* they connect with their clients, and they need to keep that as their top priority. Clients should like, respect, and trust their therapists. If they do not, they need to switch therapists. Finding a good fit is essential for good therapy.

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Appendix A

Ways of Analyzing Change (from Prochaska & Norcross, 1999, pp. 492 - 508)

Processes of change:

Consciousness-raising	Self-liberation	Contingency management
Catharsis	Counter conditioning	Environment reevaluation
Dramatic relief	Stimulus control	
Self re-evaluation	Helping relationship	

Stages of change:

1. Precontemplation: Not considering change in near future, need to 'own' problem to move on.
2. Contemplation: Aware of problem, but no commitment to take action yet.
3. Preparation: Have made some small steps in changing, not seriously dedicated to change yet.
4. Action: Doing it. Most obvious to others, investing time and effort in making changes.
5. Maintenance: Working at preventing relapse.
6. Termination: No longer have a problem

Levels of change:

Symptom/situational problems

Maladaptive cognitions

Current interpersonal conflicts

Family/systems conflicts

Intrapersonal conflicts

Appendix B

Criteria for Designation as an Empirically Supported Treatment

(From Marshall & Firestone, 1999, p. 418)

One of two sets of studies are [*sic*] necessary. Any previous studies not meeting these criteria are considered "null and void" (Todd & Bohart, 1999, p. 460):

I. At least two group design studies (that is, randomized clinical trials), demonstrating efficacy by being:

   A Superior to pill, psychological placebo, or another treatment

   B Equivalent to an already established treatment, in studies with adequate statistical power (that is, at least 30 participants per group)

II. At least ten single-case-design studies demonstrating efficacy. These studies must have:

   A Used good experimental designs

   B Compared the intervention to another treatment, as in I (A)

Furthermore, for both criterion I and II:

A. Studies must be conducted with treatment manuals.

B. The characteristics of the participants must be clearly described (using DSM-IV criteria)

Treatment effects must have been found by at least two different researchers or research teams.