When therapist variables and the client’s theory of change meet

BILL ROBINSON

Recent research confirms the importance of the client’s theory of change (CTC)—perceptions and views the client has about the nature of the problem they bring to therapy and its possible resolution. If the theory of the client is primary, what then does the therapist bring to the encounter? BILL ROBINSON argues that the study of therapeutic effectiveness needs to focus on the interplay between therapist variables (the person of the therapist) and the client’s theory of change. When these two vital factors meet, something new is created. It is crucial that the therapist becomes aware of, and manages, the effect of therapist variables on the alliance. This can be monitored through eliciting client feedback on perceived progress and strength of alliance. Case studies drawn from the author’s practice illustrate this process.

‘It is not death that a man should fear, but he should fear never beginning to live.’ Marcus Aurelius (2006).

The term ‘the client’s theory of change’ was first coined by Duncan, Solovey and Rusk (1992). It was used to refer to the ‘informal’ theory of the client in contrast to the ‘formal’ theories that can dominate professional discussions in counselling and psychotherapy. This concept was developed further in subsequent papers (Duncan & Moynihan, 1994; Duncan, Hubble & Miller, 1997; Duncan & Miller, 2000; Duncan, Miller & Sparks, 2004).

The client’s theory of change (CTC) refers to the perceptions and views the client has about the nature of the problem they bring to therapy and its possible resolution. Rather than the client having to accommodate the therapist’s theory of how change occurs, or risk being labelled resistant, the views of the client are central and therapy is tailored to their views about what is helpful or unhelpful.

In the light of recent research, a change in emphasis from what the counsellor perceives and does, to what the client perceives and does, makes good sense. According to Assay and Lambert (1999), client and extra-

therapeutic factors account for 40 per cent of outcome variance, while the results of a later meta-analysis by Wampold (2001) put the figure at 87 per cent. The concept of the client’s theory of change does not imply that clients live with a clearly defined theory of how change happens and how problems can be overcome in their lives. As Duncan and Sparks (2004) point out, ‘the client’s theory of change is not an anatomical structure in the client’s head to be discovered by your expert questioning. Rather, it is a plan that co-evolves via the conversational unfolding of the client’s experience, fuelled by your caring curiosity’ (p.31).

When prompted to reflect on what has led to positive change in their lives on previous occasions, or how difficult problems have been overcome, clients will often recall internal and external resources they have used to resolve problems in the past. In fact, what may bring people to therapy is that they have forgotten or lost faith in these abilities. The CTC refers to the process by which clients experience change, and so encompasses more than just goals and expectations. A good way to understand this is to reflect on significant issues in our own lives. Did we take time out to work through the issue on our own, or did we talk to a friend or a professional? If we talked to another person, were we looking for empathy, advice or challenge? When the change happened, did we act impulsively or did we plan every step carefully? If we connect with how the client experiences this process, and adapt the therapeutic approach accordingly, we are more likely to be helpful than if we impose a therapist constructed model of problem resolution.

If the theory of the client is primary, what then does the therapist bring to the encounter? In some instances, all that may be needed is a non-directive person-centred approach where the counsellor responds to the client’s lead with empathy, respect and acceptance. For other clients, their theory of change may include a part for a counsellor who challenges, gives advice or designs strategies. As Bachelor and Horvath (2000) point out, ‘Effective responses are attitudes and interventions that are appropriate to the
The concept of the client’s theory of change does not imply that clients live with a clearly defined theory of how change happens and how problems can be overcome in their lives.

Miller, Hubble and Duncan (2007) suggest that ‘Who provides the treatment is a much more important determinant of success than what treatment is provided’ (p. 15). These therapist variables include observable traits such as the therapist’s age, gender and race, and observable states such as professional discipline, training and experience. They also include inferred traits such as personality and coping patterns, level of emotional well-being, values and beliefs, and cultural attitudes (Bergin & Garfield, 2004). Despite this, the focus of research in recent years has moved from discrete therapist characteristics to randomised clinical trials that evaluate the type or model of therapy offered (Bergin & Garfield, 2004).

Research further suggests the most important aspect of therapy that involves the therapist is the therapeutic alliance. According to Assay and Lambert (1999), the therapeutic alliance accounts for 30 per cent of outcome variance. For Wampold (2001), the alliance accounts for more than half of the 13 per cent attributed to therapeutic factors, rather than client and extra-therapeutic factors. Put another way, the alliance accounts for seven times as much outcome variation as the model or technique being used by the therapist. In a subsequent paper, Wampold and Brown (2005) suggest that five per cent of outcome variance can be attributed to therapist effects. Beutler et al (2004), in their study of therapist variables, emphasise the importance of both therapist effects and the therapeutic relationship: ‘Despite the concerted effort to control, reduce or eliminate the effects of both therapist variability and extradiagnostic patient variables, research has not been able to escape the need to recognize either the roles of the clinician or the reciprocal influence of patient and therapist qualities on one another’ (p. 227). Both therapist factors and alliance factors are of major importance in client outcome and there is significant overlap. In seeking to understand what makes therapy successful, a fruitful focus could be to consider how therapist effects meet the client’s theory of change, and build and maintain the therapeutic alliance.

Recently, having tracked my own clinical outcomes for the last seven years, I started to look at this data with a focus on clients who I had not helped successfully. Was there a particular presenting problem, age group, gender, ethnic or socioeconomic group, that I did not seem to help because of variables associated with me as a therapist? This is a work still in progress that, to date, has yielded no clear answers. However, what has been reinforced is the finding that each therapeutic encounter is a one-off encounter between a unique client with their unique theory of change, and a unique therapist with their unique response.

From their overview of research into therapist variables Bergin and Garfield (2004) find little evidence that the personal characteristics of the therapist have any marked significance in therapeutic outcomes. However, they emphasise that there is a lack of recent studies, and probably too few, to enable any clear conclusions to be drawn. Since it has been shown repeatedly that the therapeutic model or technique used by the therapist is of minor importance, what then are the therapist variables that have the effect on outcomes?

Miller, Hubble and Duncan (2007) address this question in their study of ‘Supershinks’. The term ‘supershink’ was first coined by D. F. Ricks in 1974.
and refers to the growing evidence that there are wide differences between the most effective and the most ineffective therapists in the field. Okiishi, Lambert, Nielson and Ogles (2003) analysed data from fifty–six therapists in a university counselling setting and showed that, ‘The therapists whose clients showed the fastest rate of improvement had an average rate of change 10 times greater than the mean for the sample. The therapists whose clients showed the slowest rate of improvement actually showed an average increase in symptoms among their clients’ (p.361). Wampold and Brown (2005), in their study of therapists from a managed care company, also report wide variation in outcomes achieved by different therapists.

In an article that not only draws on an analysis of therapeutic outcomes, but also on excellence in any field of human endeavour, Miller, Hubble and Duncan (2007) conclude that the person who achieves superior performance is the person who works hardest and in a directed and feedback-informed way to improve performance of their task. The supershrinks in their study are hypervigilant to threats to the alliance with the client and check out even minor concerns. They are alert to anything that may sabotage the success of the joint endeavour with the client.

We may hypothesise from this that what is crucial is how the therapist becomes aware of therapist variables and manages their effect on the alliance. The most effective therapist will be the one who recognises problems in the alliance due to differences in background or outlook between therapist and client, or to the therapeutic approach used by the therapist, or simply due to the therapist having a bad day. As a first priority, the effective therapist will aim not to get in the way of the client’s theory of change. As a first priority, the therapist, or simply due to the therapist having a bad day. As a first priority, the effective therapist will aim not to get in the way of the client’s theory of change. As a first priority, the therapist, or simply due to the therapist having a bad day. As a first priority, the effective therapist will aim not to get in the way of the client’s theory of change.

Carl Jung (1945) used the alchemical term ‘coniunctio’ in his exploration of the process of psychotherapy. In alchemy this refers to combining two chemicals to make a different third chemical, but was used by Jung as a symbol for intrapsychic processes and the encounter between therapist and client. Using this metaphor, we can see the therapeutic encounter as a place where therapist variables (who we are and how we relate) and the client’s theory of change meet, and out of the resulting ‘coniunctio’ something new is created that is unique to that particular pairing.

Growing evidence is emerging that the provision of ongoing feedback to the therapist can significantly improve the outcomes achieved by their clients (Harmon, Hawkins, Lambert, Slade & Whipple, 2005; Harmon, Lambert, Smart, Hawkins, Nielson, Slade & Lutz, 2007; Anker, Duncan & Sparks, 2009). The last ten years have seen the development of user-friendly measures that enable us to monitor the client’s experience of improvement, or lack of it, and their experience of the therapeutic alliance. They can enable us to monitor whether we are working with the client’s theory of change or getting in the way of it. While the use of these measures may not turn every therapist into a supershrink, they can make a major contribution towards improving therapist performance.

There are a number of reliable and valid measures available. Two of the most brief and user friendly are the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS).

The ORS was developed by Miller and Duncan (2000), validated by Miller, Duncan, Brown, Sparks and Claud (2003) and is available at www.talkingcure.com. This is also a four item questionnaire that asks the client to assess the alliance according to: the degree to which they feel understood and respected; how seriously their agenda is being followed; how seriously their ideas for change are being considered; and whether the relationship with the therapist is a good fit. The SRS is given to the client at the conclusion of every session. Any ‘less-than-enthusiastic’ responses are explored with the client with the aim of adjusting the direction of future work so that the client can experience it as more helpful.

The case of Jack

Jack is a retired man in his sixties. He suffered a brutal childhood and experienced further trauma as a member of the armed forces. He also suffers chronic pain from injuries received in active service. Initially, he came to therapy for help to deal with his stress and outbursts of anger. His anger was of particular concern. Given his military training, he knew that if he ‘totally lost it’ he had the ability to do somebody serious harm.

In early sessions Jack talked a great deal about his experience in his family of origin and in the military. We explored how and why he had become the person he was, where his anger was...
coming from and what was likely to
trigger it. This seemed to be going well
and Jack’s scores were moving slowly
upwards on the ORS when I noticed
a slight dip in the SRS score. I took
this up with Jack who said that while
understanding himself and the triggers
for his stress and anger was important,
he felt it was now more urgent to be
able to manage his anger when it was
triggered. I adjusted my approach
to our sessions in the light of this
feedback and subsequent scores on the
ORS and SRS confirmed we were on
the right track. Later, with strategies in
place to manage the stress and anger,
Jack initiated further discussion on
the origins of his anger and what it
was that had led to his father being so
brutal to him. He found this now to be
helpful and healing, as was confirmed
by his ORS and SRS scores.

As it unfolded, Jack’s theory of
change was that he needed strategies
to manage his emotions and a degree
of understanding of himself and his
family. In the person of his therapist
he had someone who was willing and
able to work in a directive cognitive
way to address the former, and in a
psychodynamic way to address the
latter. Nevertheless, the alliance
between us threatened to derail. Unlike
a supershrink, I was unaware when
my responses to him emphasised the
wrong area. It was fortunate for us both
that I made use of formal measurement
tools (ORS and SRS) to check that
we were on track and alert me to the
danger.

As our work progressed, I became
aware that our beliefs and opinions
on some political, social and religious
questions were quite different. This
did not hinder our ability to work
together because his theory of change
did not include winning the therapist
and everyone else over to his way of
thinking. Another therapist factor
was that I had no difficulty relating
to someone who held different views.
Whatever our differences, it was clear
that we shared a primary concern for
honesty and fairness, and a passionate
belief in the right of children to safety,
acceptance and love.

If Jack had worked with another
therapist it is probable that the
path trodden would have been very
different, but could have been just as

When the two vital factors of therapist
variables and the client’s theory of
change meet, real therapy begins...

Initially, as she recounted her story, I
was left speechless. It was not an action
that Jane had spoken of pursuing at
our previous session. If she had, I was
aware that I would have urged her to
reconsider, or at least have some idea of
the response she may get before taking
such bold action. While expressing
my admiration for her courage, I told
her it was probable that this is how I
would have responded had she run it
past me first. As we discussed this,
emerged that our discussion in the
previous session had communicated a
concern for her physical and emotional
safety, while affirming her in following
her own thoughts and feelings to
decide on the appropriate course of
action. This had not been a ‘therapeutic
strategy’, but rather an expression of
my assumptions that people had a right
to control the direction of their own
lives and, at the same time, to be safe
and secure. While we did not discuss
her eventual action, our discussion had
helped to empower her. At the same
time, my expressed concern that she
protect herself against further harm
led to her taking her husband with
her rather than acting alone. She may
not have done this had we not had
that discussion. It is possible also that
the faith that we shared was a factor,
as she felt she was able to do what she
did with the aid of a higher power.
She knew that her counsellor, while
being concerned for her safety, would
understand and accept this and that
her action would not sabotage further
therapeutic work. Her ORS and SRS
scores confirmed that her sense of
personal well-being was improving
and that she was comfortable with the
relationship with her counsellor.

For Jack, who had been a victim
of the abuse of power in his family
of origin and adult life, having his
experience validated and his ideas for
change taken seriously, strengthened
the alliance between us. The initiation
of formal feedback, and the message
anger and stress levels, and improve the quality of his life and his relationships with others. The fact that in Jack’s case we did not share the same beliefs, but could accept and respect each other’s views, turned what could have been a negative into a positive.

For Jane, the experience of someone who questioned and challenged, but affirmed her right to trust her own judgment enabled her to take the action she did. The message that her therapist trusted her to back her own judgement, even though at the time he might have had doubts about the course of action she had chosen, helped her to trust herself and to trust the therapeutic process to address other problems in her life.

The use of the formal feedback tools is constantly surprising and humbling on various dimensions; how much I can learn from my clients, how wrong I can be in my initial estimates of their capability, and how wrong I can be in my opinion about what is helpful to them. This is not to say that I avoid initiating ideas and possible solutions. However, I do not pursue them if the message from the client is that they are not helpful. The therapy room is not a place where people come to be given a diagnostic label and the manualised treatment that is supposed to go with it. As a therapist, it is a place where I come with my personality, beliefs, cultural background, theories, techniques and everything else that makes me a unique person and unique counsellor. As Duncan and Sparks (2004) point out, ‘You are multidimensional—you are already many things to many people (friend, partner, parent, sibling). Use your complexity to fit clients’ (p.22).

The client comes to therapy with their presenting problem(s), their solutions, their internal and external resources and, arising out of all of this, their own unique theory of change. The many variables that contribute to ‘me’ as a therapist then come into play as I endeavour to meet the challenge to connect with this person and their theory. Jack needed both understanding of how he had become the person he was and strategies to deal with potential dangers this gave rise to. To have said that I could not respond to either one of these needs because I did not have the skill and training, or because my model of therapy did not include giving strategies or understanding, would have obstructed the working out of his theory of change. Ethically, all I could have done would have been to get out of the way and refer him to a colleague who was able and willing to help him do both of those things. Jane needed someone who would collaborate with her and respect her judgement, rather than someone who would direct her. This is not to say that direction cannot ever be the right way to go, but in this case, at this time, it would not have been helpful. A therapist variable here was that it did not bother me that a client had used her own judgement to decide on a major course of action without running it past me first. As Miller and Duncan (2000) state, ‘Accommodating the client’s theory, therefore builds a strong alliance. The therapist attends to what the client considers important, addresses what the client indicates is relevant, and tailors both in and out of session intervention to accomplish goals specified by the client. The therapist and client work to construct interventions that fit with the client’s experience and interpretation of the problem’ (p.17).

To return to the alchemical metaphor, who I am and who Jack and Jane are met in a particular time and place, and were able to interact with, affect and change each other. This created something that neither on their own, or with anyone else, could have created. It produced an outcome that was unique to that particular pairing. This is not to say that either could not have achieved a successful resolution of their problems with anyone else, but the path to achieving this would not have been the same. Every therapeutic encounter, like every other human relationship, results in a particular ‘coniunctio’ that could not be produced by any other combination.

When the two vital factors of therapist variables and the client’s theory of change meet, real therapy begins as we connect with who the client is and allow clients to connect with who we are. It is then we can recognise their strength and true heroism. Sometimes because of us, sometimes regardless of us, and sometimes in spite of us, they just do it.

References


BILL ROBINSON is a counsellor with twenty five years experience who has worked with individuals, couples and families in a number of settings in Australia and the UK. He is now a manager, counsellor and a senior supervisor with Relationships Australia based in Mandurah, Western Australia. He is a certified CDOI (Client Directed Outcome Informed) trainer.

Comments: bill.robinson@wa.relationships.com.au

Make a difference in the lives of people who need people.

There are unique callings that attract unique people. Those who want to inspire others and help them learn. Those who want to offer spiritual help and counsel, who’ll empower, support and encourage. People who care about social justice, equity and inclusion as they relate to individuals, families, communities and regions.

People who choose to develop leadership skills based on emotional, social and ethical intelligence.


FOR MORE INFORMATION:
Associate Professor Barbara Pamphilon
T (02) 6201 2323
F (02) 6201 2263
E Barbara.Pamphilon@canberra.edu.au

Postgraduate and non-school leavers apply online at: www.canberra.edu.au