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

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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*

individual client. To develop an effective therapeutic relationship, sensitivity to client's differential phenomenological worlds, as well as to relational needs and expectations, seems important' (p.146). Therapeutic models and techniques may play their part as they give us different ways to consider the issue and suggest different responses.

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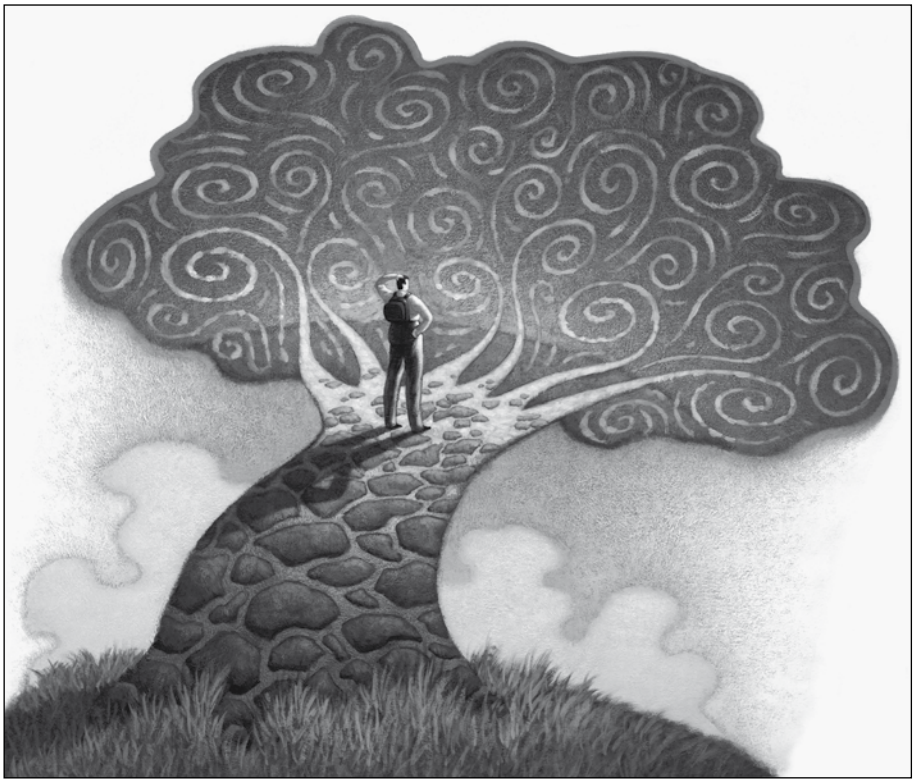
Miller, Hubble and Duncan (2007) suggest that *'Who provides the treatment is a much more important determinant of success than what treatment is provided'* (p. 15). These therapist variables include observable traits such as the therapist's age, gender and race, and observable states such as professional 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 'Supershrinks'. The term *'supershrink'* was first coined by D. F. Ricks in 1974



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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. They will ask '*what part does my client's theory expect me to play?'* They will then ask *'Is this a part I have the skills to play and am capable of playing, and is it a part that ethically I am willing to play?'* In examining the effectiveness or otherwise of counselling, a focus is needed on the interaction between therapist variables and 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. The ORS monitors the client's estimation of the level of improvement. This is a four item questionnaire that asks the client to rate themselves in the areas of personal well-being, close relationships, work and social activity. It is given at the start of every session. The session by session results are tracked, and the results are shared with the client and used to inform the direction of future work.

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The client's experience of the therapeutic alliance is measured on the SRS developed by Duncan, Miller and Johnson (2002), validated by Duncan, Miller, Reynolds, Sparks, Claud, Brown and Johnson (2003) and is also 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 well 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 effective provided therapist factors did not prevent them connecting with his theory of change.

The case of Jane

Jane is a woman in her thirties. A practicing Christian, she asked to see a counsellor who shared this faith. She had come to discuss some current issues in her life. However, between the first two sessions Jane talked with a friend who was dealing with the effects of childhood sexual abuse. This conversation evoked memories of abuse that Jane herself had suffered years before. She felt these issues had never been dealt with and were affecting her life still. She had considered making a formal report and pursuing the legal route. I discussed with her the pros and cons of taking this path. I pointed out the challenges this would entail and stressed the need to ensure her own physical and emotional safety. At the same time, I assured her that I would support whatever decision she chose to make.

When Jane arrived for the next session she told me that she had traced the perpetrator. She had knocked on his door and, when he answered, told him she had come to confront him with the past and to get an apology. After a tense conversation, she was able to elicit an apology. This action resolved the issue for Jane.

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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, it 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 share 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 that this was listened to and acted upon, assured him that, whether or not his therapist agreed with him, his ideas of what he needed at this particular time were given priority. The experience of the therapeutic relationship stood in sharp contrast to the invalidation and abuse he had experienced so often in his childhood and adult life. It demonstrated the type of relationship he was looking for with other people in his life. Having his views taken seriously and acted upon helped him to connect with his own considerable strength of character. In turn, this enabled him to manage his

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.

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