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Scientific Foundations (Chapter 2 of Integrative Psychotherapy)

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Scientific Foundations

THERE IS AN OLD JOKE AMONG PSYCHOLOGISTS that you can ask three psychologists their views on how to treat a particular client, and you will get four opinions. There is a kernel of truth in this. Psychologists have offered many ideas, models, techniques and theories all of which were thought to help people. The bad news is that many of these techniques and theories lack scientific support for their claims (e.g., primal scream therapy or neurolinguistic programming); the good news is that psychologists keep testing new treatments in order to discover which treatments work best. Various approaches to psychological treatment are effective, which sometimes makes it difficult for students, therapists and clients to choose which approach they want to pursue.

Consider how widely accepted yet different theories can be applied to a case. Jim has grown increasingly impatient with his position as a warehouse supervisor. He has been in this position for eight years and sees it as a dead-end job. Particularly frustrating to him is his demanding and nonsupportive boss, who seems committed to making sure that Jim's job is unrewarding. Seeking to resolve his frustration, Jim consults with various counselors on ways to deal with his mounting anxiety and depression. He consults one therapist who focuses on the similarities between Jim's demanding boss and his unsupportive father; the therapist hopes Jim will benefit by gaining insight into his displaced reactions to his boss. Another therapist offers a structured eight-session program that focuses on the self-defeating thoughts that seem to predispose Jim to looking at the pessimistic and unrewarding aspects of his work. This therapist hopes that alterations in Jim's thinking will lead to changed feelings and behaviors. A third therapist advocates that Jim confront his boss and assertively insist on some major changes in his job assignment. This therapist believes that behavioral changes will promote changes in Jim's work environment and positively alter his feelings.

Which of these approaches will most help Jim? Will any of them help him? Or should he avoid counseling or psychotherapy altogether and focus on spiritual means of dealing with his situation—growing in prayer, seeking guidance,

fasting in order to experience the sufficiency of Christ, fostering an attitude of self-sacrifice and service?

In chapter one, we argued that doctrine provides an essential backdrop for understanding any Christian approach to psychotherapy. As clinical psychologists, we are also trained and committed to investigate and evaluate psychotherapy with scientific methods. Sometimes scientifically trained psychologists make disparaging comments about spiritual ways of knowing, as if science has deemed Scripture irrelevant. Conversely, Christian counselors sometimes devalue the importance of scientific investigation, as if the Bible answers every question so thoroughly that we no longer need to observe the world around us. We believe that both science and Scripture are important in establishing a credible Christian approach to counseling and psychotherapy. Christian faith provides an essential worldview for the Christian therapist, and scientific research on psychotherapy has the potential to tell us what works, when and why. Quantitative and qualitative research methodologies have been developed that can provide useful insights into the seemingly opaque world of psychotherapy.

Psychological scientists tend not to talk much about the integration of Christianity and psychology, and those interested in integration tend not to talk much about science. This is an unfortunate divide insofar as both science and Christian faith ought to have shared roots in the virtue of humility. Ironically, most people may not think of either scientists or Christian theologians as particularly humble, but both approaches are based on an intrinsically humble worldview. Christianity, as outlined in chapter one, assumes a pervasive state of human brokenness. The noetic effects of sin mean that we are naturally blinded, that we cannot trust our own inclinations in determining what is true. In humility we must test our frail human reasoning by comparing our beliefs and assumptions against the standard of special revelation. And this cannot be an individual enterprise because our personal interpretations of Scripture are easily distorted. So throughout history we see Christians coming together for dialogue so that a collective understanding of revealed truth can be established. The historic church councils (e.g., Nicea, Chalcedon, Trent and many more) illustrate this sort of collective process of identifying and affirming truth. The councils are born out of a theological humility—recognizing that none of us is holy or wise enough to discern truth correctly on our own. Similarly, science is based on the assumption that human ideas cannot be fully trusted unless they gain empirical validation. Ideas are tested under well-defined conditions, and conclusions derived based on statistical probabilities. As with theology, science is more than an individual endeavor. Ideally, scientific findings are replicated in more than one laboratory and evaluated within a scientific community. There is humility built into the process

of science, because the scientific method presumes individuals will come to faulty conclusions if not held to some external standards. Theologians assume the same.

Though both Christian theology and science call for humility, they rely on different external standards: special revelation for the theologian and general revelation for the scientist. But to the Christian, both are legitimate forms of revelation so we need not fear either the methods or findings of science.

Psychotherapy Effectiveness

The effectiveness of psychotherapy has been an object of attack by Christians who oppose psychological interventions. Sadly, much of this has been based on outdated and incorrect information. One of the first studies on the effectiveness of psychotherapy was conducted by Hans Eysenck in 1952. He published a review of twenty-four studies on psychotherapy and concluded that there was no research evidence to support the effectiveness of psychotherapy compared to no-treatment control groups. His conclusion was both provocative and controversial in the research community, and subsequently his findings were soundly criticized by numerous researchers on methodological grounds (see Bergin, 1971; Lambert, 1976). However questionable Eysenck's research may have been, a report by a respected psychologist on the ineffectiveness of psychotherapy was all the evidence some Christian writers needed to support their preconceived opinion that psychotherapy doesn't work. (See Bobgan & Bobgan [1987] for their perspective on Eysenck's [1952] study. Also see McMinn & Foster [1990] for a response.)

Following Eysenck's report, hundreds of outcome studies were conducted on psychotherapy in the ensuing decades. The application of a statistical procedure known as meta-analysis allowed findings of large numbers of studies to be analyzed together. In a landmark meta-analysis, Smith, Glass and Miller (1980) scoured the scientific literature—including journals, books, unpublished dissertations and other sources—to find and analyze 475 psychotherapy outcome studies. They concluded that psychotherapy is effective. It is not perfectly effective for everyone who seeks help, but the authors conclude that psychotherapy works at least as well as education works for our children, medicine works on our ailments or business turns a profit.

The beauty of meta-analysis is that it simultaneously evaluates the effects of many studies. In a large body of literature, there may be a few studies that do not support the effectiveness of psychotherapy and several others that provide outlandish success rates that are bigger than real life. Looking at studies from either extreme could easily skew our understanding of psychotherapy effectiveness.

This is what some Christian authors have done when they handpick a few studies and then conclude that psychotherapy never works. Meta-analysis controls our impulse to find only what we are looking for by comparing treatment groups from a large number of studies with the control groups from those same studies. The

COUNSELING TIP 2.1: A Confident Optimism

What should a therapist say if a client asks, "Are you sure this will help me?"

In most cases the proper answer is an optimistic one. Research strongly suggests effectiveness, but one cannot be absolutely sure that psychotherapy will help because therapy is not effective for every person or every problem. But still, there is good reason to be hopeful. Both efficacy and effectiveness studies suggest that psychotherapy is effective for most people and for a variety of problems.

results are reported as an effect size, which, roughly speaking, is the distance between the average of the treatment groups and the average of the control groups, expressed in a standard unit that is analogous to a standard deviation.

Accumulating research over sixty years involving hundreds of controlled studies, thousands of patients and therapists using various therapeutic approaches with many presenting problems has shown that psychotherapy is effective (Asay & Lambert, 1999). Meta-analytic reviews of numerous psychotherapy outcome studies have shown that the average effect size for psychotherapy is .82, indicating that the average treated person is less symptomatic than 80 percent of untreated persons.

The effect size for psychotherapy becomes more meaningful when compared to the effect size of commonly prescribed medications for psychological disorders. Faraone (2003) reported the following common effect sizes for these medications (the greater the number, the larger the effect): Immediate-release stimulants (e.g., Ritalin) for attention deficit hyperactivity disorder = .91; serotonin-specific reuptake inhibitors (e.g., Prozac) for depression and obsessive-compulsive disorder = .50; atypical antipsychotic medications (e.g., Risperidone) for schizophrenia = .25. Within this context, the average effect size for psychotherapy appears quite respectable.

Most research studies that evaluate psychotherapy outcomes are known as efficacy studies. These studies carefully control various factors such as client demographics, client diagnoses, therapist variables and intervention protocols so

that the outcomes can be attributed to the interventions only. Additionally, control and comparison groups are used to further substantiate the effect of the interventions. This model of evaluating psychotherapy outcome is the same model used in evaluating the effectiveness of medications. The strength of efficacy studies lies in their carefully controlled laboratory qualities. The weakness of this approach is that it may lack a "real world" quality. For example, few clients in the real world of psychotherapy practice are so carefully screened that they have only one diagnosis, have no previous history of psychological problems or have no history of abuse.

Another approach to measuring psychotherapy outcomes has been accomplished by surveying consumers of psychotherapy. These surveys are known as effectiveness studies. Although they lack the careful controls of efficacy studies, they do have the power of showing how typical clients respond to psychotherapy. Seligman (1995) described a *Consumer Reports* survey on the perceived effects of psychotherapy as reported by those who received the services. Patients

COUNSELING TIP 2.2: Collecting Data

Some therapists find it useful to keep track of their own therapy outcomes. By giving an anxiety, depression, spiritual well-being or relationship questionnaire at the beginning and end of treatment, or by administering a satisfaction survey during the final session, therapists can keep track of their success rate. This can sometimes be useful in negotiating contracts with health insurers or in obtaining other mental health credentials. For therapists who collect their own outcome data, it is important to get information from *every* client—not just those who do well in therapy. Otherwise, the integrity of the research is questionable. For more about keeping outcome records in clinical practice, see Paul W. Clement's (1999) book *Outcomes and Incomes*.

indicated that they "benefited very substantially from psychotherapy, that long-term treatment did considerably better than short-term treatment, and that psychotherapy alone did not differ in effectiveness from medication plus psychotherapy. Furthermore, no specific modality of psychotherapy did better than any other for any disorder" (p. 965). Thus, various research methods point to the clear effectiveness of psychotherapy as a way to relieve the suffering of psychological disorders.

With strong support from the research literature, professionals no longer question whether or not psychotherapy is an effective way to treat psychological disorders. Contemporary researchers are seeking answers to different questions now. For example, what kinds of psychotherapy are most effective with which disorders? How much psychotherapy is needed for positive results to be obtained? How long do the positive results last? What are the effective components of psychotherapy?

Psychotherapy Models

Traditionally graduate education in psychotherapy has revolved around various schools of thought. Students learn early that major systems of psychotherapy grew from grand theories of personality. Thus students are pushed to survey these theories, such as psychodynamic, client-centered, cognitive and behavioral models, and endorse one of these theoretical orientations prior to graduation. Students are asked to describe their theoretical orientation in internship interviews and later in state licensure evaluations. Most states require ongoing postdoctoral education for psychologists, and it is common for these continuing education workshops to focus on specific therapy models or techniques. Attending one of these workshops gives the impression that you have just learned the best (and perhaps the one and only) way to treat a specific disorder.

Some people become such ardent proponents of a particular psychological theory that they cling to it as a worldview. One of us was recently at a meeting of psychologists where an enthusiastic attendee proclaimed, "Psychoanalysis is my political party." Sometimes one gets the sense that a particular theory takes on such importance to some psychologists that it replaces political ideology, historical wisdom and spiritual understanding. As we argued in chapter one, sound doctrine provides a better center for one's worldview, not one's theoretical persuasions in psychology.

Interestingly, there is little evidence that one model or kind of psychotherapy is superior to another. Despite the zeal and fervor with which various psychologists promote their theoretical models, most approaches to therapy fare about the same in large meta-analytic studies (Wampold, Mondin, Moody, Stich, Benson & Ahn, 1997). Psychoanalytic, object-relations, behavioral, cognitive and family therapists may be ardent believers in their models and techniques, but none of these models has been shown to be more effective than another as a global model of psychotherapy. The finding of similar outcomes among psychotherapies was long ago dubbed the "dodo bird verdict" by Rozenzweig (1936) and elaborated upon by Luborsky, Singer and Luborsky (1975). This comes from Alice in Wonderland who proclaimed, "Everyone has won, and all must have prizes."

Despite the dodo bird verdict—which is held to be true by most psychotherapy researchers—cognitive and cognitive-behavioral therapies have gained momentum in recent years. Some of these therapies had only recently been developed when Smith, Glass and Miller reported their meta-analysis in 1980. Their analyses included Albert Ellis's Rational Emotive Therapy, now known as Rational-Emotive Behavior Therapy (REBT), but did not include the more recent developments of Aaron Beck, Judith Beck, Arthur Freeman, Jacqueline Persons, David Barlow, Donald Meichenbaum, Samuel Turner, Mark Reinecke, Christine Padesky, Michael Mahoney and others. There are several reasons for the rising prominence of the cognitive and cognitive-behavioral therapies: it is easier to research short-term treatments such as cognitive therapy than longer-term treatments; cognitive and behavior therapies lend themselves well to the symptom-based outcome measures used in research studies; and they have been shown to be effective with particular disorders such as depression, anxiety disorders, borderline personality disorder and a variety of other problems (Chambless et al., 1998).

Given the research evidence, it does not seem reasonable to proclaim superiority of one particular theoretical paradigm over any other. Recent developments within the field of psychotherapy support integration of psychotherapy models (Norcross & Goldfried, 2005), and IP demonstrates a similar integrative attempt. Integrative psychotherapy is integrative in two dimensions. First and foremost, it integrates Christian thought with psychological theory and practice. Second, it integrates various theoretical perspectives within psychology. IP draws heavily on cognitive therapy perspectives but also relies on the more relational theories in psychology, including interpersonal psychotherapy and family therapy.

Length of Psychotherapy

At the beginning of the animated movie *Antz*, a neurotic ant named Z who sounds just like Woody Allen is lying down exploring the various traumas of life: how he feels physically inadequate because he has never been able to lift more than ten times his body weight, how he struggles with abandonment issues because his father flew away when he was only a larva, and how he longs for attention because he was the middle child in a family of five million. One gets the sense that Z will be lying in the therapist's office for a very long time dealing with a long list of issues ranging from body image to birth order. How realistic is this portrayal of therapy?

Traditionally, psychotherapy has been conceptualized as a long-term process that can last for years. Although some forms of psychotherapy (e.g., psychoanal-

IN THE OFFICE 2.1: Setting a Time Limit

Some clients may be concerned that the therapist will recommend several years of intensive therapy. These fears are fueled by inaccurate media portrayals of therapy and stories the client may have heard from others. It is often wise to respond by suggesting a specific length for the therapy relationship.

Bill: How long is this going to take? I've heard of people going to a therapist for years, and I'm just not interested in that sort of thing.

Mark: Yes, that's an important question. Most often therapy lasts a matter of weeks or months rather than years, though there are times when therapy can last longer.

Bill: I don't want something that goes on forever.

Mark: Right. We agree on that. Perhaps it would be good for us to agree on a particular time frame—say eight sessions—and then at the end of the eight sessions we will have this conversation again. We may agree that it is time to stop, or perhaps we will still have some things to work on. In either case, it keeps us focused on making progress and it keeps us talking about how long you want to invest in this process.

Bill: That sounds like a good plan. I just don't want eight weeks to turn into eight years.

Mark: Yes, I hear your concern and I think you are wise to be asking these questions. We are talking about eight sessions, not eight years.

ysis) may require several years, the time frame of psychotherapy has been greatly reduced over the last twenty years. There are several reasons for the reduction in time to months or weeks, including the advent of managed health care; a better-informed, health-consuming public; development of short-term psychotherapy models; the development of more effective psychotropic medications and a focus on symptom relief rather than personality change. Regardless of the cause, most psychotherapy practiced today tends to be brief.

Lambert (2004) reports that most research on psychotherapy examines therapy that is conducted once per week for no more than fourteen weeks. Psychotherapy as practiced in actual treatment settings may average closer to five sessions. Among clients who persist beyond the first few sessions, approximately half show significant improvement by eight to ten sessions, and 75 per-

cent improve within twenty-six sessions (Kadera, Lambert & Andrews, 1996). Thus accumulating research indicates that most psychotherapy lasts for weeks or months rather than years.

IP is well suited for the relatively brief treatments that occur in the real world of psychotherapy practice, but it can also function as a longer-term therapy for clients who are seeking more extensive personal insight and change. The length of treatment is related to the domains-of-intervention approach we describe in chapter four.

Lasting Effects of Psychotherapy

Although psychotherapy should not be conceptualized as forever curing someone of emotional troubles, the effects of psychotherapy, in general, are long lasting. Follow-up studies indicate that most clients tend to maintain therapy gains for significant periods of time, especially if clients attribute changes to their own efforts (Lambert & Bergin, 1994). Additionally, clients tend to have more lasting gains when their problems are related to situational causes rather than longstanding difficulties and when they have substantial social support.

Of course there are particular conditions that are prone to relapse—substance abuse, eating disorders, some forms of depression, and personality disorders. Typically these disorders have multiple causes and may involve biochemical or neurological determinants. Although psychotherapy effects appear to be long lasting for many clients, some clients are prone to relapse and will require either ongoing care or subsequent episodes of psychotherapy treatment.

A caveat is in order. The long-term effectiveness of psychotherapy should not be determined by whether or not a therapist ever sees a client again after a course of therapy has been completed. This can be illustrated by considering two hypothetical therapists, both caricatures. Dr. Grossman is an obnoxious, in-your-face therapist who does not like his clients very much. He criticizes them, gives advice prematurely and has bad breath. He sees clients for an average of five sessions each and then they rarely return. Dr. Goodheart is a kind, sensitive therapist who listens well to her clients, offers them coffee at the beginning of each session, remembers the details of their lives and cares deeply about their healing. She sees clients for an average of fourteen sessions each, and they often return again at a later time in life for more therapy. From a pure research perspective, one could argue that Dr. Grossman is a better therapist than Dr. Goodheart because he requires fewer sessions with his clients, and once they improve they never again need his help. Of course we know better. Dr. Goodheart is a better therapist, which is why her clients stay in therapy longer and come back again when the need arises.

IN THE OFFICE 2.2: Back to Square One?

Therapy is usually effective and typically brings sustained, long-term benefits. But this doesn't mean that people never take steps backwards. Often-times therapists schedule booster sessions in order to check in with clients to see if they are maintaining their progress. Other times clients will call for some additional appointments after completing therapy. It is good to reassure a client at times such as these. Just because a person has taken a step backwards, it does not mean that all the previous work was for naught.

Consider the following telephone conversation.

Clark: Hello, Jean.

Jean: Hello. Thanks for calling me back. I'm not sure what happened. I was doing just great until a couple weeks ago, and then these feelings of depression just started up again. I thought I was all over this.

Clark: It can be so discouraging to have those feelings of depression come back. You're depressed, which is bad enough, and then you're also feeling depressed about being depressed.

Jean: Exactly. I feel like I'm back at square one, like I didn't really learn anything after six months of therapy.

Clark: It's natural for it to feel that way. Depression can be a very persistent thing. But this time you already know some of the tools to fight against it. Maybe we should plan to meet for a few more sessions, and we can also talk about whether it would be good to get you back in to see your physician.

Jean: That's encouraging to hear. I'm glad to know you are willing to see me again.

Clark: Oh, of course. I look forward to helping you figure this out.

Notice that a reassuring, matter-of-fact tone is calming and helpful in this situation.

IP represents an effort to balance relational and technical skills. If done properly, many clients will respond quickly to therapy and will make long-term changes. However, it is also important to realize that some clients will come back later for additional care. This should not be seen as a failure, but as a relational success.

Change Processes and Stages

Although psychotherapy models may use different terminology, there is mounting evidence that various models encourage similar change processes. Prochaska and DiClemente (1983) described some of the common psychotherapy change processes as consciousness raising, catharsis, self-reevaluation, counterconditioning and stimulus control. These processes may be implemented in different ways in various therapies, but all are quite likely to be facilitated in one way or another. For example, virtually all psychotherapies help clients become more aware of themselves (self-reevaluation) and specific foci of change (consciousness raising). Prochaska and Norcross (1994) indicated that psychotherapies differ more in the content of change rather than the change processes.

Prochaska and DiClemente (1983) further identified stages involved in personal changes. They presented some evidence indicating that stages of change are likely involved whether the change occurs in one's natural environment, a specific program designed for personal change or in individual psychotherapy. The stages identified include Precontemplation (no intention to change), Contemplation (intention to take action), Preparation (intention to take immediate action), Action (implementing specific modifications in behavior) and Maintenance (steps to avoid relapse).

Some enhanced successes in therapeutic interventions have been obtained when client stage level has been assessed prior to therapy beginning (Prochaska and DiClemente, 1983, 1984, 1985; Prochaska, DiClemente, Velicer & Rossi, 1993). Appropriate therapeutic strategies are then aimed at addressing client problems according to their stage of change. For example, it would not make sense to promote active implementation of new behaviors with a client who is in the Precontemplation stage. This client may benefit most from considering the negative consequences to self and family by remaining at the present status. Overall, the empirical evidence on this matching approach is encouraging, but it seems to be most useful for clients with various substance disorders such as smoking addiction.

Common Factors in Psychotherapy

Researchers are particularly interested in determining which components of psychotherapy are most effective. The results are humbling to ardent advocates of a specific theoretical approach because over the last couple of decades it has become increasingly clear that there are certain common elements in all psychotherapies that appear to be the primary components of change. We now know

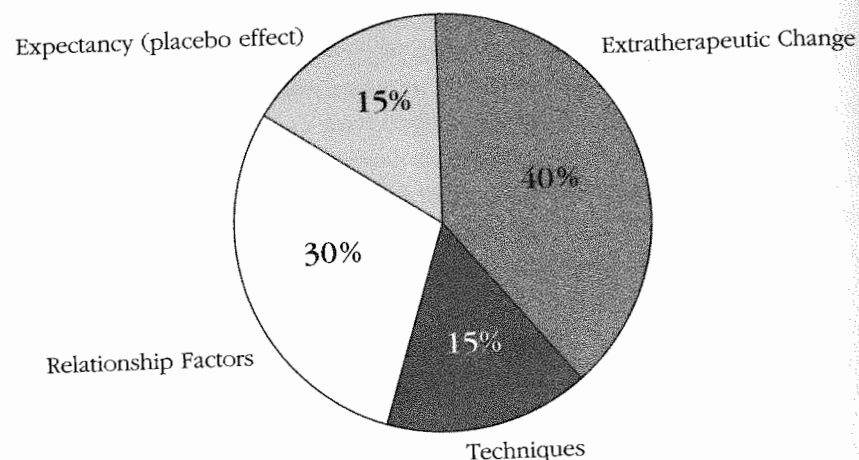


Figure 2.1. Psychotherapy outcome research

that the specific techniques or models of psychotherapy generally have a modest impact on the outcome. Although proponents continue to voice their convictions that psychodynamic, cognitive-behavioral, family and many other models are the source of psychotherapy outcome, the research indicates a different perspective.

What has emerged from the research literature is known as common factors. These are the factors present in all psychotherapies that seem to account for outcomes regardless of model or technique. Lambert (1992) persuasively described four common factors which have been elaborated by various authors (see Hubble, Duncan & Miller, 1999; Duncan, Hubble & Miller, 1997; Miller, Duncan & Hubble, 1997; Lambert, 2004). The four common factors are (1) client/extratherapeutic, (2) relationship, (3) hope/expectancy and (4) model/technique. Figure 2.1 shows these factors and Lambert's estimates of the degree to which each factor contributes to the outcome of psychotherapy.

Client/extratherapeutic factors. A recurring observation by supervisors in training beginning graduate students involves the attributions students make in their early clinical training. Trainees often feel like failures when clients do not make giant strides toward psychological health: progress is slow, symptoms intensify, or the client may drop out of treatment. It is quite natural for students to attribute these "failures" to a lack of counseling knowledge, skill or experience. While knowledge, skill and experience are all important, these client "failures" are often due to client factors rather than therapist factors.

Client/extratherapeutic factors involve both internal and external features that affect the client. Internal factors include strengths such as intelligence, motivation, persistence, faith, emotional management and so on. External factors include social, financial and community support. This includes involvement and support from a religious community, which appears to play a helpful role in providing clients with ongoing emotional and spiritual sustenance.

Some clients come to counseling having just faced a severe loss or transition, while others have dealt with multiple stressful issues for years. Some come from abusive families, while others were provided consistent love and security at home. Some believe they have emotional issues they need assistance in changing, and others see no problems in themselves and simply arrive at the psychologist's doorstep at the demand of a weary spouse. Traditionally psychologists have been aware of these significant client factors, but the magnitude of their effect on psychotherapy outcome has been underestimated. Lambert (1992) estimates these factors account for 40 percent of psychotherapy outcomes.

COUNSELING TIP 2.3: Church Is Good for Body and Soul

Social scientists are discovering various ways that church involvement promotes physical and mental health and protects people from premature death (Koenig, McCullough & Larson, 2001; Powell, Shahabi & Thoresen, 2003). In addition, church communities often promote spiritual hope and meaning in life, and provide social support in times of isolation and loss. For all these reasons, church involvement should be considered a significant client/extratherapeutic factor. It is not appropriate to coerce a client into attending church, but it is worth asking about church attendance and gently encouraging clients who are not currently involved in a church to consider the possibility.

The power of client factors, such as personal resiliency and social support to name a couple, is a likely reason why some people improve without psychotherapy. Asay and Lambert (1999) reported several studies indicating that on average 43 percent of people improved with little or no treatment. It is unclear how rapidly they improved or how long the improvement lasted, but it appears that people can recover from emotional difficulties through many of their own resources. The last couple decades have witnessed a huge rise in the availability of self-help literature and support groups, which provide needed help for clients

apart from formal psychotherapy. This also helps explain the powerful role of the church in helping people heal from emotional struggles. Not only does the church provide spiritual resources for help, it also provides a social support network and helps individuals gain a meaning or purpose for living. All of these factors bode well in recovering from psychological problems.

The importance of a client's diagnosis in determining the type of therapy is a research question that has garnered a good deal of attention. Many psychotherapists rely on an accurate diagnosis to assist in determining the nature of psychological treatment and the potential for improvement in psychotherapy. Although diagnosis is a client factor and is related to improvement, it appears to have relatively little impact on psychotherapy outcome. Thus, diagnosis is important for a variety of reasons (see chapter five), but of relatively little significance in determining psychotherapy outcome.

Relationship factors. Graduate students sometimes express disappointment at the start of clinical training when the focus is on developing basic relationship skills. Listening, empathy, reflection and self-awareness are common foundational relationship skills that psychotherapists use. Some students express concerns that these skills are elementary and that they need to focus on learning techniques such as *in vivo* exposure or cognitive restructuring. These same students may hold strong beliefs that psychotherapy is very complex and that they must adopt a specific theoretical orientation and master the related therapy techniques. The temptation is to see the therapeutic relationship as elementary.

Regardless of the therapist's theoretical orientation, the therapeutic relationship is an important factor in the success of the therapy. Although some models may place relatively less emphasis on the relationship (e.g., Rational-Emotive Behavior Therapy), most models emphasize the prominence of the alliance between therapist and client. Relationship factors include caring, empathy and emotional support to name a few. These factors account for 30 percent of the success in psychotherapy outcome research.

In 1957 Carl Rogers posited several necessary and sufficient conditions for change in psychotherapy. Among them were acceptance, empathy and genuineness. Acceptance promotes the feeling of being heard, respected and valued by another. Empathy facilitates the sense of being understood by the therapist—not just the words that are spoken but the underlying emotions and conflicts. Finally, genuineness or congruence on the part of the therapist communicates honesty and consistency. The client can then trust the therapist and discuss painful issues openly. Rogers believed these therapeutic attitudes were so powerful that they were the sufficient causes of therapeutic change. Decades of research

and reflection seem to support the necessity of these attitudes, but not the sufficiency of them. In other words, these therapist relational qualities are essential to successful psychotherapy, but in and of themselves they are not always enough to bring about change and growth.

Significantly, these factors need to be detected by the client to be effective. It is not enough for the therapist to believe that the attitudes have been present and communicated to the client. Rather, the client has to experience these qualities—to feel accepted, understood and safe.

Expectancy/hope factors. People do not come to a therapist's office expecting to spend an hour and a good deal of discretionary income each week to no avail. Fortunately, they come with hopes of feeling and functioning better. Their expectations of getting better are one of the reasons they do get better.

The expectancy effect—sometimes called the placebo effect—comes from the belief clients have that their condition is being treated effectively. People typically downplay the significance of the placebo effect, but it plays a substantial role in all kinds of change, including response to medications. Expectancy and hope factors include the belief that one is going to get better, that the therapist has the knowledge and skill to help, that there is hope in a brighter future. Lambert (1992) summarized these factors as accounting for 15

COUNSELING TIP 2.4: Beyond Technique

Many counseling texts give specific tips for how to express therapeutic warmth and compassion. A therapist may learn to lean forward when a client is encountering particularly troubling memories or to use a softer voice when a client is weeping. All these tips may be useful but they are no substitute for a caring and compassionate heart. Effective therapists do not simply learn tricks to express care—they truly care. Clients can tell the difference between genuine care and technique-based care.

If sincere compassion does not come naturally, it may be a reminder to listen more intently to the client's story, to consider the developmental and environmental factors that have contributed to the client's current difficulties, and to pray more fervently for the client outside of therapy sessions.

Therapists facing excessive stress and burn-out may find they are relying more on technique than genuine compassion day after day. In times such as these, it is important for therapists to seek spiritual and emotional support, to get the help of a supervisor and to consider taking a break from clinical work.

percent of the outcome variance in psychotherapy.

In 1973 Jerome Frank published a seminal book titled *Persuasion and Healing: A Comparative Study of Psychotherapy*. In this book Frank described a broad range of healing practices across various cultures, including religious practices, faith healings, shaman rituals and psychotherapy. He showed that many of these practices had common elements, including a healing ritual, an expert who provided some kind of treatment, a willing and hopeful person in need of treatment, and the expectation by all involved that healing would occur. These factors are common to a variety of healing practices and exert a powerful effect on the success of treatment.

Expectation, hope and belief are so powerful that these effects have been measured in improvement rates. Lambert, Weber and Sykes (1993) summarized findings of placebo effects in terms of effect size and showed that the average client receiving placebo treatment improved more than 66 percent of no-treatment control participants. This improvement rate should be viewed in the context of a variety of psychotherapy outcome studies which show that the average client receiving psychotherapy improves more than 80 percent of no-treatment control subjects. These reports point to the strong impact that hope, expectation and belief have on therapeutic outcomes.

COUNSELING TIP 2.5: Measuring Hope

For years psychologists have measured hopelessness. Now there are ways to measure hope. For a brief scale measuring one's current state of hope, C. R. Snyder and colleagues' State Hope Scale is worthwhile (Snyder, Sympson, Ybasco, Borders, Babyak & Higgins, 1996). The scale is available online at <<http://www.psych.ku.edu/faculty/rsnyder/state.htm#State%20Hope>>.

Snyder and his colleagues have also developed a dispositional hope scale for children (Snyder et al., 1997). The Children's Dispositional Hope Scale is also available online at <<http://www.psych.ku.edu/faculty/rsnyder/child.htm#Child%20Scale>>.

Model/technique factors. Like expectation/hope effects, Lambert (1992) reported that model and technique factors account for 15 percent of the outcome in psychotherapy. These factors include specific procedures used in various psychotherapies. Examples include progressive relaxation, hypnosis, bio-feedback, transference interpretation, dream analysis, behavioral contingency arrangements, thought stopping, tracking dysfunctional thinking, assertiveness

training and so on. These factors may also include the rationale, explanation or structure that specific therapies provide. It is these factors that psychotherapists have traditionally emphasized in training programs with the notion that the accurate application of techniques in a manner congruent with a particular therapy model would lead to behavior change.

It is sometimes discouraging to students to realize that they go through undergraduate training, then another five years of doctoral training, then a year or two of postdoctoral training, and much of their training pertains to something that accounts for only 15 percent of therapy outcome. But this may not be as dismal as it sounds at first. Although 15 percent of the change in psychotherapy may be seen as a modest contribution to the overall effectiveness of change, it is still a substantial contribution. Also, some specific techniques have been shown to be effective with particular disorders, so it is not as though the techniques are equally important. An example of an effective technique is exposure in the treatment of specific phobias (discussed in chapter seven). With this technique phobic clients are slowly and systematically exposed to the feared object or situation while maintaining minimal levels of anxiety. This procedure has been shown to be more effective than other techniques in the treatment of these sometimes debilitating disorders.

The nature of common factors that account for change in psychotherapy should not be too surprising to Christians. Scripture and Christian tradition seem to support a common-factors approach to understanding change. Change does not simply occur by understanding proper doctrine (though this is important), but also by a variety of factors that shape the direction and quality of one's life. For example, hope through re-interpretation of current circumstances was frequently taught by the apostles. Christ taught in the Sermon on the Mount that various personal spiritual qualities were important in leading a fulfilling life. Similarly, Christian community—filled with meaningful relationships—is necessary for support, encouragement and admonishment. Specific techniques such as prayer, confession, meditation and service are also described as necessary for growth. These common elements of life, available to everyone, are seen as helpful in withstanding the negative events we encounter and in promoting godly character.

Empirically Supported Treatments

Over the last two decades there has been a strong movement in health care to demonstrate the effectiveness of various interventions (Deegear & Lawson, 2003). Various referred to as evidence-based or empirically supported treatments (ESTs), these are medical or mental health interventions that have dem-

onstrated effectiveness (Nathan & Gorman, 2002). A task force created by Division 12 (Society of Clinical Psychology) of the American Psychological Association (APA) has been documenting mental health interventions that have empirical support for their effectiveness in treating specific disorders. A specific intervention must meet relatively strict criteria to be included on the list of effective treatments. Of these empirically supported treatments, most are cognitive-behavioral in nature. "The vast majority of ESTs identified to date—60% to 90% depending on the list—are cognitive-behavioral treatments" (Norcross, 2004, p. 13). Although techniques make only a modest contribution to the overall outcome of psychotherapy, the cognitive-behavioral techniques have the most research support.

Determining the effective components of all psychotherapies is different than determining the most effective treatments for a specific disorder. That is, showing that common factors in psychotherapy matter a great deal is not synonymous with showing that specific factors (techniques) don't matter. The Dodo Bird finding by Rozenzweig (1936)—that all psychotherapies are similarly effective—may be analogous to stating that medications are effective in treating illnesses. However, it is apparent that some medications are designed to specifically treat certain illnesses, and when we probe at this level it is evident that some medications are more effective than others for specified illnesses.

Various cognitive therapy interventions have been shown to be helpful with particular disorders (Butler & Beck, 2001), and several meta-analytic studies have shown that cognitive-behavioral methods yield slightly more favorable outcomes than other psychotherapy methods (cf. Shapiro & Shapiro, 1982; Robinson, Berman & Neimeyer, 1990). Admittedly, this finding may be partially due to the relative ease with which cognitive-behavioral treatments can be translated into research protocols, but it is unlikely that this can fully account for the magnitude of cognitive therapy's success in the research literature. Recent studies demonstrate that cognitive-behavioral therapy is more effective than supportive counseling for anxiety symptoms in older adults (Barrowclough et al., 2001), more effective than emotion-focused psychotherapy for patients with panic disorder (Shear, Houck, Greeno & Masters, 2001), more effective than supportive counseling for adult survivors of trauma (Ehlers & Clark, 2003), and more effective than medication for relapse prevention in depression (Butler & Beck, 2001). Christian approaches to cognitive therapy have not been proven superior to other nonreligious cognitive therapy approaches (Johnson, 1993; McCullough, 1999; Worthington & Sandage, 2001).

Cognitive-behavioral therapy has been studied extensively, and many meta-analyses have been conducted on the effectiveness of this form of psychother-

apy. Butler, Chapman, Forman and Beck (2006) recently reviewed sixteen meta-analyses that demonstrated methodological rigor. Their findings show that cognitive therapy is highly effective for adult and adolescent unipolar depression, generalized anxiety disorder, panic disorder, social phobia, posttraumatic stress disorder, and childhood depressive and anxiety disorders (grand mean effect size = .95). Additionally, cognitive-behavioral therapy is effective for bulimia (average effect size = 1.27) and as an adjunct to medication in treating schizophrenia (average effect size = 1.23). Cognitive therapy was moderately effective for marital distress, anger, childhood somatic disorders and symptoms of chronic pain (average effect size = .62). Cognitive therapy is relatively ineffective in treating sexual offenders (average effect size = .35).

Conclusion

At the beginning of this chapter we considered the situation of Jim who experienced anxiety and depression in the midst of a frustrating job. Which conceptualization of his problems is most appropriate? Although there is no formula to address such complex human problems, there is some guidance available from the psychological research literature. A careful assessment of Jim's background, resources and traits would likely yield information that would help a therapist identify Jim's expectations, hopes and beliefs about himself, the world and change processes. A wise therapist would use this information to facilitate a sound therapeutic relationship designed to further enhance Jim's personal resources at an appropriate change stage.

Regardless of the specific techniques used in therapy, Jim will probably improve. Factors that will increase his chances of a successful outcome include his psychological resources and social support system, a positive and trusting relationship with his therapist, his positive expectations for successful therapy, and the specific techniques used by his therapist. A cognitive-behavioral approach to Jim's anxiety and depression might be most helpful in alleviating his specific symptoms, though many other approaches to therapy could also be helpful. In the process of therapy, Jim may request further assistance with understanding how his distress is related to his job, family or faith—topics that go beyond the realm of standard cognitive therapy.

The integrative psychotherapy that we describe in this book is rooted in cognitive therapy techniques, but not exclusively so. The research literature allows us to be confident in cognitive therapy interventions, but it also requires humility because many different approaches to therapy are also effective. The domains-of-intervention approach described in chapter four integrates various theoretical approaches to psychotherapy, emphasizes the importance of a

healthy psychotherapy relationship, and requires therapists to be familiar with the various stages of change and to work collaboratively with clients in determining how much change is being requested.

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