CHARACTERISTICS AND BEHAVIOURS OF MORE (AND LESS) EFFECTIVE THERAPISTS

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Therapist studies (recruiting)

- Supervision intervention study (details at end of talk)
- Ned Dickeson’s M.Psych (Clin) study: “Investigating Issues Relevant to Professional Boundaries in Therapeutic Practice”
- Amelia Rieger’s M.Psych (Clin) study: “Managing therapists’ therapy-interfering beliefs in clinical practice.”

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Differences between therapists

- Account for ~7-8% of variance in client outcomes in routine settings, controlling for client severity (Barkham et al., 2017)
- Account for ~3% of variance in client outcomes in randomized controlled trials, controlling for client severity (Baldwin & Imel, 2013)
- Account for ~9% of variance in retention time in routine settings (Lutz et al., 2015)

All therapists are not equally effective...

- The top 10% therapists get 2-3x as much change in pre-post outcomes as bottom 10%, controlling for client severity (Barkham et al., 2017)
- Effective therapists achieve average effect sizes of $d = 1.00$ to $1.52$ v Ineffective therapists ($d = -.91$ to $-1.49$) (Kraus et al., 2011)
- Recovery rates (Saxon & Barkham, 2012):
<table>
<thead>
<tr>
<th>Most effective</th>
<th>Average</th>
<th>Least effective</th>
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<tr>
<td>76%</td>
<td>59%</td>
<td>40%</td>
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Therapist factors in context

Therapists may differ in being above-average in efficiency vs effectiveness (Okiishi et al., 2006)

Differences between high- and low-performing therapists increase over the course of therapy (Goldberg, Hoyt, et al., 2016)

Therapist effects are more evident with more severe clients:
- Explain 4% outcome variance when baseline OQ-45 ~80
- Explain 16% outcome variance when baseline OQ-45 ~120 (Barkham et al., 2017)

(OQ-45 range: 0-180)

Most effective therapists have more "rapid responders" (Erekson et al., 2018)

~15-20% therapists have above-average outcomes; ~15-20% therapists have below-average outcomes (Barkham et al., 2017)

Assignment to treatment vs waitlist accounts for 14% variance in outcomes (Wampold & Imel, 2013)

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...and our clients are not all equally easy to work with...

- ~50% of outcome variance due to client baseline distress (Wampold, 2015)
- ↑ Client severity & ↑ aggravated client risk associated with worse outcomes (Saxon & Barkham, 2012)
- Personality disorder associated with 1.5-2x worse response to CBT for anxiety and depression (Goddard et al., 2015; Huibers et al., 2015; Newton-Howes et al., 2013)
- Individuals who experience subclinical psychotic symptoms are 7.5x less likely to achieve remission from CBT for depression & nearly 4x as likely to relapse (Wigman et al., 2014)
- CBT for PTSD, OCD, substance use for individuals with psychosis → less improvement than non-psychotic populations
- Labile affect, interpersonal problems and self-harm are particularly predictive of poor outcome (van Noorden et al., 2012, Durham et al., 2006)
- PD consistently predicts greater likelihood of drop-out
Facilitative Interpersonal Skills

- Warmth, acceptance and understanding
- Verbal fluency
- Emotional expression
- Empathy
- Collaboration ("alliance-bond capacity")
- Hope and positive expectations
- Persuasiveness
- Alliance rupture-repair responsiveness
Facilitative Interpersonal Skills

• Accounted for 24% between-therapist variance in slope of client outcome change (Anderson et al., 2009)
• Clients allocated to High-FIS therapists achieved more change and faster than those of low-FIS therapists (Anderson et al., 2016)
• A similar set of skills in trainees – communication clarity, empathy, respect & warmth, management of criticism, willingness to cooperate – in a group interaction predicted client outcomes later (Schottke et al., 2016)

FIS: Warmth, acceptance & understanding

**Effective therapist**
Conveys concern and care for client

**Ineffective therapist**
• A*voids disclosing* own thoughts and feelings
• listens silently and fails to offer empathic or caring responses


• Judgmental
• Critical
Predicts early termination

Elkin et al (2014)
**FIS: Verbal fluency**

**Effective therapist**
Communicates in a relaxed manner without anxiety, easy to follow (may have “melodic, rhythmical” quality)

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**FIS: Emotional expression**

**Effective therapist**
Energy & emotion in therapist’s voice (not inc. hostility/demeaning)

[https://unisa.kanopy.com/playlist/5546818](https://unisa.kanopy.com/playlist/5546818)
FIS: Empathy

**Effective therapist**
Demonstrates accurate comprehension of what the client is saying, including inferences beyond explicit statements, from nonverbal expression

**Ineffective therapist**
Misunderstands and interrupts out of sync with client → Client responses: “confused”; client correcting therapist; dropping topic; and remaining silent

T: You never have to tell me things that are too difficult or painful—but this didn’t seem so drastic to talk about? Can you see that from the outside this looked like a fairly harmless affair compared to serious abuse? / C: For me this was a serious offense

FIS: Collaboration

**Effective therapist**
Creates a relationship where both therapist and client recognise the need to work together; “we-ness”

**Ineffective therapist**
Discourages client’s proactive involvement in change by dominating dialogue:
- Oblivious to client’s agenda
- Dismisses client contributions
- Misses signs of client disengagement and discord

FIS: Hope and positive expectations

Effective therapist
Expresses clear hope for client’s future &/or positive expectations about therapy, including *how client* can do something to move closer to goals (i.e., illustrates pathways to change)

FIS: Persuasiveness

Effective therapist
Ability to get the client to accept a different perspective via a rationale or reframe
• Clarity, cogency of message
• Credibility of source (confidence, certainty, authority)
• Tailored to recipient
**FIS: Alliance-repair responsiveness**

**Effective therapist**
- Sensitive to ruptures in the alliance
- Attempts to repair rupture

**Ineffective therapist**
- Insensitive to client signals of ambivalence, reactance or passive disagreement
- Defensiveness, anger in response to ruptures

von der Lippe et al (2017), Castonguay et al., (1996); Francis et al., (2005); Westra et al., 2012

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**Working Alliance**

[Diagram showing the working alliance with overlapping circles for agreement on goals of therapy, agreement that tasks of therapy will achieve goals, and bond.]

- Client-therapist alliance → outcome, $r = .28 \,[.25, .30]$
  - Horvath et al (2011)

- Client-therapist collaboration → outcome, $r = .29 \,[.24, .34]$
  - Tyron et al (2018)
A checklist for maintaining a collaborative alliance

Checklist for maintaining collaborative alliance

• Goal-consensus
• Feedback
  • Outcome tracking
  • Reactions to in-session activities
• Guided discovery
• Focus on client strengths
• Skilful interrupting
• Flexibility
• Noticing alliance ruptures
• Repairing alliance ruptures
**Working alliance**

**EXERCISE: REVIEW WORKING ALLIANCE (p.3-4 workbook)**

1. Choose 1 of your clients from your caseload (one not progressing so well).
2. Complete the Brief Alliance Inventory in your pack for the case.
3. If mean ≤ 3 for either scale, make a plan to renegotiate the goals or treatment plan for therapy (tasks/goals scale) or increase your feedback-seeking (bond).

**Goal consensus**

**Exercise:** Review goal statements of your caseload.

(see p.4-5 workbook)

Goal-consensus – outcome: $r = .24$ [.19, .28]  
($k = 54, N=7.278$) 
(Tyron et al., 2018)
Set goals in context

1. Short-term: achievable in 2-4 sessions
2. Medium-term: achievable by end of therapy (3-5 months)
3. Long-term: achievable in the next few years

How do we know our clients are improving or deteriorating?

- 5-10% adults get reliably worse in therapy (Hansen et al., 2002)
- Clinicians generally assume treatment is going well even when their cases are deteriorating (Hannan et al., 2005; Walfish et al., 2012)
- Adopting routine outcome monitoring can reduce the number of deteriorating cases on a caseload*
- Why weekly?
  - Non-response or deterioration is detectable quickly (i.e., within the first 3-5 sessions).
  - Track serious symptoms (e.g., suicidal ideation)
Complementary monitoring: Goal attainment scaling

For a concrete contract, you could have the client write a goal statement and use this as an outcome measure using the scale below.

*e.g.,* “By the 30th June, I will have caught public transport to and from town 3 times per week during peak hour. 3 weeks in a row”

<table>
<thead>
<tr>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>No progress</td>
<td>Slight progress (25% way towards completing goal)</td>
<td>Definite progress (50% way toward completing goal)</td>
<td>Marked progress (75% toward completing goal)</td>
<td>Completed goal</td>
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Homework suggestion: Behavioural Experiment – Introduce outcome monitoring

- Note any concerns or predictions you might have about what will happen (e.g., “I wont learn anything I didn’t already know”, “my clients will complain”, “it will take too long”)
- Use an outcome questionnaire at least 10 times
- Check your predictions. How accurate were they? What else did you learn?

(see p.6 workbook)
End-of-session feedback

• Formulation-driven
• Generic qualitative (*e.g.*, J. Beck)
• Standardised (SRS)

End-of-session feedback: Formulation-driven

Formulation of client (*example 1*):

• Beliefs about others: *e.g.*, “People are judgmental and harsh”
• Beliefs about therapy: *e.g.*, “It might work for some people but I’m too damaged”

“How might my questions or responses this session have been interpreted by this client?”

Ask:

“Did you feel like I was criticising you at any point today?”

“Did I ask you to do anything you didn’t think would work for you?”
End-of-session feedback: Formulation-driven
Formulation of client (example 2):
• Beliefs about others: e.g., “Other people are always trying to control me/tell me what to do”
• Beliefs about therapy: e.g., “I’m here to see what a professional says, but I’m not promising to make any changes”

“How might my questions or responses this session have been interpreted by this client?”
Ask:
“Did I seem too bossy at any point today?”
“Did you feel like I was telling you what to do?”

End-of-session feedback: generic qualitative feedback?
 e.g.,
• “How well do you feel like I understood your problem? Was there anything you felt I didn’t “get”?”
• “How satisfied were you with how we spent our time today?”
  • Was there anything you wanted to talk about or work on that we didn’t get to?
  • Did you feel we spent too long on anything that wasn’t so important?”
• “How satisfied are you with what we came up for you to do this week?”
  • Do you have any concerns about trying out the plan?”
• “Did I do or say anything that bothered you or confused you?”
  (J.Beck, 2011)
End-of-session feedback: Session Rating Scale (SRS)

1) On a scale of 0-10, to what degree did you feel heard and understood today, 10 being completely and 0 being not at all?

2) On a scale of 0-10, to what degree did we work on the issues that you wanted to work on today, 10 being completely and 0 being not at all?

3) On a scale of 0-10, how well did the approach, the way I/we worked, make sense and fit for you?

4) So, given your answers on these specific areas, how would you rate how things were in today’s session overall, with 10 meaning that the session was right for you and 0 meaning that something important was missing from the visit?

⇒ If any item < 10, ~“what would have made it higher?”


(Optional) homework suggestion

• Script some questions to ask for feedback

See p. 6 workbook
Guided discovery: staying together

- Frequency of Socratic questioning predicts subsequent BDI↓ controlling for alliance (Braun et al., 2015)
- Greater competence in Socratic questioning associated with greater reduction in PTSD symptoms (Farmer et al., 2017)
- Socratic > didactic information rated as more helpful, autonomy-supportive and likely to lead to engagement in therapeutic tasks (Heiniger et al., 2018)

Didactic conversion guide...

- “The flight or fight response occurs when we face a threat…”
- “Depression is a kind of ‘give up and go back to the cave’ response when persistence…”
- “If we keep exposing ourselves to situations that trigger fear…”
- “This week I’d like you to write down every time you notice yourself feeling lower than usual”
- “Have you heard of the fight or flight response?”
- “Why do you think the human race has the ability to become depressed?”
- “Have you heard of the saying ‘you just gotta get back on the horse’? What does it mean?”
- “Is it possible there are factors that do make your mood lower that you haven’t noticed? Would you want to know? How could we find out?”
Guided discovery: ending session

• What did you learn today?
• How will you apply what you learned today, this week?
• How will you remember?

Homework exercise: Guided discovery

• Video-record yourself.
• Make predictions about the ratio of questions you ask to statements you make.
• See how your prediction compares to your observations of your video.

(see p.5 workbook)

Cognitive therapy experts (video demonstrations):
Questions: statements = 1:1 (David M Clark) – 3.5: 1 (Padesky)
Statements mainly: introducing/structuring statements, instructions, some corrective information
Frequency of summaries = ~1 / 9 minutes
Focus on client strengths & resources

Characterised effective courses of therapy (von der Lippe et al., 2017)

C: I ... try to control the feeling of catastrophe by drinking, but it does not help at all, of course / T: but if you do it again and again, it must help for something?

C: I was asked to join an expert-group / T: An expert group!

Maintain attention to both positive changes and problems
• Assessment
• Reviewing events of week (inc. homework)
• Reflections
• Functional analyses of trigger situations in which coped

Skilful interrupting

Effective therapist
• Asks permission
• Invites client to focus
• Gives rationale if needed
• Monitors for client’s response
  • Apologises if need be
  • Seeks agreement on frequency of interruption

Ineffective therapist
Interrupts the client with distracting, closing or confronting questions, or premature conclusions


P: [My sister] was the kindest in our family, an angel. And she had ... by accident... bumped into [my cousin]. And my mother got hysterical. She grasped my sister and dragged her into the bathroom, and hit the life out of her, and shook her so that ... and locked the door. I remember so well, that I was in despair. I hammered on the door ... she couldn't do that to my sister! But then...
T: Are they twins? A boy and a girl?
P: No. Two girls.
**Flexibility**

**Effective therapist**
Therapist flexibility associated with stronger alliance (Kivlighan et al., 1993)

**Ineffective therapist**
- Dismisses client contributions
- Delays working on change
- “Linear” orientation


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**Noticing ruptures in the alliance**

Alliance ruptures **definitions:**

“disagreement in tasks or goals or deterioration in bond”
(Muran, 2019)

“tension or breakdown in the collaborative relationship
between patient and therapist” (Safran et al., 2011)

**Resistance** (Miller & Rollnick, 2002)
**Disengagement** (Miller & Rollnick, 2012)
- Sustain talk – i.e., disagreement about goals
- Discord* – i.e., esp. rupture in the bond.
Noticing ruptures in the alliance (client behaviours)

**Confrontation → Complaints about:**
- Therapist as a person
- Therapist’s competence
- Activities of therapy
- Being in therapy (doubts)
- Limits/requirements of therapy
- Progress in therapy

**Withdrawal (i.e., avoidant interpersonal coping):**
- Denial
- Minimal responding, going silent
- Shifting topics to unrelated matters, story-telling
- Overly (pseudo) compliant, appeasing
- Intellectualising, abstract/vague

Confrontation ruptures
Found in 12-69% of sessions (by observers)

Withdrawal ruptures
Found in 17-100% sessions (by observers)

*(Eubanks, Muran & Safran, 2018)*
Noticing ruptures in the alliance

• 25-68% **clients** report ruptures in their therapy (cf. Muran et al., 2019)
• Therapists notice more ruptures than clients (Eames & Roth, 2000; Muran et al., 2009)
• Observers identify more ruptures than therapists or clients (Muran et al., 2019)
• **When therapists recognise a rupture** (as experienced by the client), the **alliance improves next session** (Chen et al., 2018)
• **When therapists don’t recognise ruptures**, client **outcomes** (functioning) poorer at next session; when therapists do recognise ruptures, client outcomes are no poorer next session (Chen et al., 2018)
• Alliance worse next session when only **either** client or therapist rather than both notice (Rubel et al., 2018)
• Client distress higher session after both identify a rupture (Rubel et al., 2018)
• Therapists less likely to notice **withdrawal** ruptures than **confrontation** ruptures (Eubanks et al., 2018)

Noticing ruptures in the alliance

• Words alone not a good indicator; depends on context (tone, place in conversation, solicited/unsolicited)

*e.g.*, “I don’t know”

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<thead>
<tr>
<th>Tone/speed</th>
<th>Context</th>
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<tbody>
<tr>
<td>Earnest</td>
<td>Trying to answer therapist’s question but genuinely unsure</td>
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<tr>
<td>Monotone</td>
<td>Not trying; mentally detached attempting to fulfil a third party requirement to attend session</td>
</tr>
<tr>
<td>Irritated-dismissive</td>
<td>Perceives line of questioning as irrelevant to needs</td>
</tr>
<tr>
<td>Whispered</td>
<td>Frightened, dissociating; overwhelmed by preceding discussion</td>
</tr>
<tr>
<td>Pensive</td>
<td>Envisioning or thinking it over in order to cooperate &amp; answer therapist’s question</td>
</tr>
<tr>
<td>Angry-defiant</td>
<td>Does not want to answer the question; communicating “back off”</td>
</tr>
<tr>
<td>Sarcastic</td>
<td>Feels insulted that the therapist is checking their understanding</td>
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**Nb: What is not a rupture...**

- If you ask the client what they think or feel and you don’t like their answers: this is not resistance!

  *e.g.*, 
  
  *T:* “*How do you feel about the exposure exercise we have planned today?*” 
  
  *C:* “*I’ve been worrying about this all week. I’m not sure I can go through with it*”

(cooperating with therapist by answering question truthfully)

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**Identifying ruptures**

- Client behaviours
  - See Disengagement Checklist – p.* workbook

- Therapist reactions
  - “Who do I wish would cancel his/her session today?” (J.Beck, 2005). Exercise on p.* workbook

  *(Personal) Examples* 
  - Feeling anxious
  - Feeling pushed away
  - Feeling bored
  - Like “walking on eggshells”
  - Like trying to get blood out of a stone

  - Like the client is sneering at/mocking me
  - Like the client is guarded/suspicious of me
  - Like the client is clinging to me
  - Feeling irritated
  - Feeling hopeless
Repairing ruptures in the alliance

When time is limited & interpersonal problems not focal:

- Repeat rationales
- Change tasks or goals
- Clarify misunderstandings
- Balance validating what’s valid about status quo with encouraging clients to approach & solve problems
- Respond non-defensively to client negativity or hostility
- Accept responsibility & apologise for contributions to rupture
- Seek feedback

(Safran & Kraus, 2014; Safran et al., 2011)

Example alliance repair

T: And so, when I asked you to fill this thought record out, I get the feeling like, it’s almost kind of offensive? Therapist acknowledges that she has contributed to the rupture by saying something that offends the patient. Therapist invites patient’s thoughts and feelings about the rupture.

C: Yeah, well, it’s like you didn’t think how I was writing my anxiety down was good enough. You gave me this form like I was a child or something. It’s like something I did in elementary school. Like why would I have to write this form if I’m already writing it down? Patient complains about the activity and the therapist, patient defends self (confrontation markers).
Example alliance repair

T: So I guess I’m wondering, right, you know, we could talk about a couple different options. I mean, we could talk about—you could continue to do the kind of journaling you’ve been doing, we could modify the form in some way, we could try an experiment of trying the form. I mean, I know that you’re wary of it, you have concerns about it, reservations about it, but I am wondering if it would be worth an experiment to try it. Therapist introduces possibility of changing the task.

C: I mean, I guess I could try it again. I don’t know, I don’t think it’s really going to help, but if I have to try it again, I’ll try it again. Patient complains about activity (confrontation marker); patient is somewhat deferential and appeasing (withdrawal marker).

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Example alliance repair

T: Well, you don’t have to. I mean, many patients who have used it have found it very useful, and actually the fact that it’s so simple makes it easier to do quickly, which for many people is an advantage. But I can appreciate that maybe for you it’s different. Therapist provides a rationale for the task and validates the patient’s position.

C: I mean, yeah, I guess I could give it a go. I’ll try next time. Patient is deferential and appeasing (withdrawal marker).

T: But how are you feeling now? Because I don’t want you to, I don’t know, sort of give in to kind of get me off your back, you know? Therapist invites patient’s thoughts and feelings about the rupture.

C: I mean, I just don’t know this is going to go anywhere. And so sometimes it feels like I either have to do it your way, or I should just quit this treatment all together. Patient complains about the activity and the therapist; patient pressures the therapist (confrontation markers).
Example alliance repair

T: Do you have any thoughts or ideas about what you would like to be doing, or how you think we should be working together? Therapist invites patient’s thoughts and feelings.

C: I mean, what if I just give you my journal? What if I make copies of the pages in my journal each week, and you read that instead of these stupid forms you keep giving me? Patient complains about the activity (confrontation marker).

T: I’m willing to try that. I think that could be really useful. I’d be interested to see what you’ve been writing in your journal. Therapist changes the task.

Repairing ruptures in the alliance

When interpersonal problems clinically significant:

Invite client to explore how each of you contribute to recurring patterns that play out in therapy

- Communicate tentatively & emphasize your own subjectivity
- Don’t assume parallel with external relationships (risks sounding ‘blaming’)
- Accept responsibility
- Focus on here-and-now (e.g., “Right now...”, “As you’re speaking...”)
- Focus on concrete, specific behaviours
- Explore the client’s reactions to your communication; clarify/reflect as needed
- Establish “we-ness” (in the rupture together)
- Use judicious self-disclosure + invite client to hypothesize what therapist is feeling
**Repairing ruptures: Expert consensus**

For either withdrawal or confrontation, within the session it occurs:

- **Validate**
  Interventions that validate and legitimize the client’s position on an issue. *e.g.*, Explore and empathize with the client’s feelings of anger toward the therapist. Validate the client’s right to make her own choices about her treatment.

- **Rupture-bond repair**
  Interventions that include those used to identify and explore the events surrounding a rupture in the emotional bond between the client and therapist. *e.g.*, Explore and empathize with the client’s feelings of anger toward the therapist. Explore what about the therapist’s comment upset the client.

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**Rated as ineffective:**

- **Communicating personal/professional limits** to treatment during either type of rupture

- **Self-disclosure of own reactions** to client (e.g., that you care about the client; that will make mistakes and disappoint the client sometimes) or exploring changing interactions with loved ones (e.g., explore whether client is willing to change attitude to partner; refer for couple counselling) during withdrawal ruptures

- **Foster hope** (e.g., communicate there is hope for a better life in the future; explore and validate client’s strengths and achievements) during confrontation rupture

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Eubanks et al (2018)
Repairing ruptures: Expert consensus

For either withdrawal or confrontation, in a future session AFTER the one in which the rupture occurs:

- **Coping Strategies**
  Interventions that aim to help clients manage and cope with painful feelings and/or unpleasant thoughts. *e.g., Focus on ways the client can manage and cope with her feelings of anxiety. Encourage the client to increase her activity level to alleviate her depression.*

- **Patterns**
  Interventions that highlight patterns in the client’s relationships and/or patterns of behavior, thoughts, or emotions.
  *e.g., Explore the link between the client’s current feelings and the client’s unresolved feelings from her childhood experiences. Explore the link between the client’s anger and her depression.*

Eubanks et al (2018)

Repairing ruptures: Expert consensus

After confrontation, in a future session after the one in which the rupture occurs:

- **Emotion**
  Interventions focused on clarifying and exploring the client’s emotional experience. *e.g., Explore the link between the client’s anger and his depression. Explore the client’s feelings of guilt.*
Formulation skills

“...it is not talent or mastery of simple, observable skills that differentiates between good and expert performers in sport, music, medicine and other domains. Expert performers primarily excel in their superior thinking and cognitive representations”

Formulation

Recent research

• Competence in case conceptualisation accounted for 40% within-client variance and 19% between-client variance in depression symptom improvement (Easden & Fletcher, 2018)
• Therapists more competent in case conceptualization had more treatment-resistant depressed clients experience sudden gains (Abel et al., 2016)
• Written formulation letter quality predicted greater acceptance and reductions in eating disorder examination scores (Allen et al., 2016)

Skilful formulation

• Begins by describing presenting problem → explaining what causes problem & how client can reach goal
  • Triggers & maintaining factors
  • (If useful) Predisposing factors that explain client’s vulnerability & Protective factors that explain how the client can cope/heal
• Client and therapist work at developing formulation thru hypothesis-testing and refining (i.e., collaborate)
• Strengths-focused
“I’ve done all the dumb things”

• Cut and pasted client’s symptoms into an off-the-shelf model leaving important parts out
• Didn’t draw on any empirically-supported theory
• Formulated each comorbid problem separately (no integration)
• So complex looked like a circuit board
• Too complex too early in therapy
• Formulated without client’s collaboration
• Didn’t explain client’s main problem or how to achieve goals

(Kuyken et al., 2009)

Formulation exercise: 1-minute verbal summary

• Choose a client from your caseload who is not progressing as well as you would like
• Explain to the person next to you in 1 minute or less:
  • What the presenting problem is
  • What the client wants to achieve from therapy
  • What factors you think are causing the problem
  • Your plan to help the client achieve his/her goals
• Partner:
  • Ask up to 3 questions to help clarify anything you don’t understand about this summary
• Swap roles

No judgment for not knowing an answer: but make a note to find this out!
Increasing strength focus

• What do you like? What do you enjoy doing?
• What's going right in your life?
• How would you like to be? What would you like to do more of? (i.e., positive goals)
• What are you best at? What do others say you’re good at?
• What are some of your greatest accomplishments?
• What about you are you most proud of?
• What are some of the most difficult challenges you've overcome? How did you do that?
• What kind of abilities are called for to solve this problem? Have there been any times where you've done something like this?
• Functional analyses of situations where person coped or succeeded

(optional homework)
Formulation exercise: written

• Same client from your caseload who is not progressing as well as you would like
• List 3 strengths this client has.
• Try to describe in words or in an image how this client would ideally like to be.

If you’re not sure how to answer these questions → behavioural experiment homework: try to discover these next session!
Formulate resistance/ruptures

- Beliefs about treatment
  - Goals
  - Tasks
  - Format / length
  - Pace
  - Effectiveness (inc. hope)
- Beliefs about therapist
  - Specific to therapist
  - As an instance of beliefs about others
- Automatic thoughts perceiving threat to needs:
  - Autonomy
  - Competence
  - Relatedness

Example: Allan – formulation of presenting problems

<table>
<thead>
<tr>
<th>Top 3 clinical problems</th>
<th>Maintaining factors</th>
</tr>
</thead>
</table>
| Loneliness              | 1. refuses to forgive others when they offend him (← inflexible expectations e.g., “people should..x,y,z”) → he avoids others  
2. intrusive/domineering when meets people → others avoid him  
3. makes excessive demands on others early in relationship → others avoid him |
| Fear of infirmity       | rigid conviction in pessimistic assumptions:  
1. “old people are useless”  
2. “no one will socialize with an old, infirm person”  
3. “I’ll need help and no one will provide it” |
| Chronic pain            | 1. avoids movement (e.g., exercises) → stiffness, atrophy  
2. inflexible hopeless beliefs (“nothing can be done to improve it”) |
### Example: Allan – formulation of therapy-interfering behaviours

<table>
<thead>
<tr>
<th>Top 3 therapy-interfering behaviours</th>
<th>Maintaining factors</th>
</tr>
</thead>
</table>
| Not sticking to agenda topics        | 1. Therapist fails to interrupt and renegotiate agenda  
                                       | 2. Belief “therapy consists of me talking about whatever comes to mind for 55 minutes and the therapist telling me what to do in the last 5”  
                                       | 3. Automatic thought “I’m not even sure if I should come to therapy”  |
| Demanding that the therapist “tell me what to do” | 1. See #2 above  
                                              | 2. Belief “If I ask for help, others should do what I ask, my way. If I’m asking it means I can’t do it myself”  
                                              | 3. Belief “I’m too old to work things out”  |
| Dismissing ideas before testing them (← inflexible expectations) | 1. Belief “I know what will work best, I don’t have to try it out”  
                                                     | 2. Belief “you’re inexperienced: your ideas won’t help”  
                                                     | 3. Therapist abandons line of exploration when client dismisses idea and looks for new idea to suggest.  |

### Homework exercise: Formulate client attitude to therapy (as well as presenting problem)

**EXERCISE:**

1. Choose a client from your caseload (ideally, one not progressing so well)
2. List top 3 problems & top 3 therapy-interfering behaviours
3. For the above 6 items, list top 3 perpetuating/maintaining factors

See pp. 10-11 of workbook
Formulating interpersonal problems

- Autonomy
- Competence
- Meet needs
- Safety
- Belonging

**FIGHT**
(e.g., Argue, control [interrupt, talk continuously], complain, blame, accuse, belittle, threaten)

**SUBMIT**
(e.g., defer, comply, appease, wait)

**AVOID**
(e.g., avoid eye contact, minimal responding, intellectualise, procrastinate, evade, be cold, hypervigilant etc)

- Protect from Criticism
- Protect from Rejection
- Avoid pain
- Avoid from Physical Harm
- Protect from Financial/material loss
- Protect from Sexual harm
- Protect from Disappointment
- Meet needs
- Autonomy

Formulation-based empathic confrontation of therapy-interfering behaviour

**FORMULATE:**
- Working from the behaviour back in time: If my client is doing this, what beliefs about him/herself and other people might s/he hold?
- Working from origins forward: What might my client have learnt from his/her history about herself & others that would make this coping style understandable?

**(GENTLE) EMPATHIC CONFRONTATION**
- Share formulation & invite client feedback
- Validate the protective function of the coping strategy
- Elicit disadvantages of coping strategy
- (If needed) Highlight the adverse impact on therapy (& optionally, on therapist)
- Invite the client to collaboratively solve this problem (as behavioural experiment)
Homework skills

Homework research

- Homework compliance associated with better outcome from CBT (e.g., LeBeau et al., 2013)
- Competence in assigning homework predicts outcome in CT for cluster C PD (Ryum et al., 2010)
- Therapist higher adherence to using homework during CBT for depression predicts less dropout (Cooper et al., 2016)
Homework research: therapist behaviours

Competence associated with homework compliance:
- **Reviewing** previous homework
- **Eliciting reactions** to homework and **trouble shooting obstacles** (Bryant et al., 1999; Weck et al., 2013)

Greater early empathy associated with greater mid-therapy homework compliance (Hara et al., 2017)

*Compliance = proportion of assigned tasks completed*

---

Homework research: therapist behaviours

Therapist behaviours involved in...
- **assigning** homework predicted homework engagement
- **reviewing** homework did not (Conklin et al., 2018)

*Engagement = overall frequency/extent of homework activities*
Devising homework tasks

• Discuss rationale for task
• Describe how to do the task
• Practice the skills needed to do the task
• Ensured the client understands how to do the task
• Assigned a specific task and concrete goals
• Checked importance & usefulness of task (qualitatively & rating scales)
• Anticipate (& overcome) difficulties in execution
• Clarified which activities discussed in session were homework tasks
• Ensured the client had a written record of the assignment

These practices are associated with better outcomes in CT for depression (Detweiler-Bedell & Whisman, 2005)

Reviewing homework

• What was learnt?
  • About what maintains the problem?
  • About what solves the problem?

• What does this mean for life in the future?
  • How could more adaptive behaviour patterns be integrated and sustained?

• How should we change the planned assignment next time to learn more?
Setting homework

• Common obstacles:
  • Difficulty managing in-session time
  • Incomplete case formulation

EXERCISE: for a client on your caseload who does not have a homework task, think about the kind of behaviour changes you would like to see him/her make between sessions. Conceptualise what maintains status-quo behaviour, then develop a homework assignment. Discuss in 2s, 3s if unsure. See p.15 of your workbook

“How can I help the patient feel better by the end of the session?”

“How can I help the patient have a better week?”

J. Beck (2011, p. 134)
Skills in managing arousal to optimise learning

2 separate therapist errors

Under-activating arousal
Therapist focuses on neutral and general information and avoids emotional topics

*e.g., In response to client disclosing distressing intrusive images...*

Over-activating arousal
“flooding” client

T: Can it also be positive episodes? / C: Only bad ones / T: I have thought about—as I understand you generally, there is a gap between how others see you and how you see yourself in situations, but if you should describe yourself generally in relation to others ...
Importance of attention to client’s emotional arousal

- Clients seeking therapy to reduce alcohol use with comorbid depression
  ⇒ Better drinking outcomes when low therapist focus on emotion
  ⇒ Worse drinking outcomes when high therapist focus on emotion
  
  (Karno & Longabough, 2003)

Helping clients manage arousal

- Maintaining collaborative style minimises ruptures from pushing too far-too soon
  - Jointly formulate the problem requiring new learning
  - Brainstorm ways to discover new information. Include:
    - Researching educational materials
    - Surveys
    - Observation
  
  Until either client sees the “best way” or that the “next step” can only be gained by direct new client experience

- Ultimately all safety behaviours should be removed, but remember: a) this can be part of grading and b) not all safety behaviours interfere with new learning; some promote it.
Helping clients manage arousal

• Brainstorm and reiterate ways the client has/can have personal control over exercises before beginning: check their understanding before proceeding
• Equip with arousal-reduction strategies (e.g., safe place, breathing)
• “Don’t start something you can’t finish within the time” – either allow longer, or aim lower.
• If emotion arousal high after session:
  • allow client to remain on site if possible
  • follow-up soon after to check – esp:
    • Alliance
    • what was learnt
    • plans to cope

Therapist skills in managing own mental state
**Therapist “presence”**

- Therapist alertness associated with improved alliances (Hersoug et al., 2001; Saunders et al., 1999)
- Effective therapies: therapists prioritise attention to clients’ present-moment emotions (von der Lippe et al., 2017)

---

**Importance of therapist emotional management**

- Higher resilience among IAPT wellbeing practitioners $\rightarrow$ better outcomes (Green et al., 2014)
- Low psychodynamic therapist self-nurturance $\rightarrow$ client improvement (Henry et al., 1986, 1990)
- Therapists lower in emotional disturbance have more consistent client outcomes (Buetler et al., 1986)
- Therapists lower in experiential avoidance allocate more session time to exposure in hypothetical scenarios (Scherr et al., 2015)
- Lower adherence in competence in panic disorder CBT linked to client hostility (Boswell et al., 2013) $\Rightarrow$ resilience to client anger may $\uparrow$ competence $\rightarrow$ outcome
Trainee meditation time directly related to supervisors’ ratings of ability to manage adverse reactions to clients (Fatter & Hayes, 2013)

Clients’ perceptions of therapist presence strongly correlated with perceptions of therapist empathy and quality of session ($r > .8$) Vinca (2009)

**Time management skills**
Formulate your time-management

EXERCISE: Think of a session in which you were dissatisfied with your time management

• Action wish hadn’t taken:
• Why took that action:
• Evidence for/against rationale:
• Preferable action:
• How confident are you that you could carry this out next time? (0-10)
• If confidence < 7, identify any automatic thoughts associated with taking this new action. What could be done about these?

• Action wish had taken:
• Why didn’t take action:
• Evidence for/against rationale:
• What could do/day to self to help take this action next time
• How confident are you that you could carry this out next time? (0-10)
• If confidence < 7, identify any automatic thoughts associated with taking this new action. What could be done about these?

Barriers to best practice
Barriers to best practice

- Excessive focus on specific brands of therapy
- Organisational/setting factors
- Therapist factors

Excessive focus on specific brands of therapy

- > 500 brands psychotherapy
- Differences in efficacy between bona fide therapies in RCTs are rare
  - Differences in therapy brand language can be large
- Weak evidence base for matching therapy brand to client characteristics
- Strength of competence-outcome relationship varies between studies: some therapies are harder to do well than others
- RCTs train clinicians until expert-rated adherence and competence satisfactory; maintained by weekly supervision with video review
  - Workshop attendance, reading books and practice unsupervised don’t produce similar competence
  - How many brands of therapy do you have time to reach competence in?
**Organisational/setting factors**

- No financial reimbursement/ insufficient employer provision for preparation & reflection time
- Scheduling tasks that displace potentially aversive critical self- or supervisor- reflection
- Unscientifically-derived KPIs (client numbers, goals v client capacity)
- Peer supervision multiple relationship: friend v supervisor. Conflict in providing useful feedback
- Unrelated workplace stressors

**Therapist factors**
**Therapist factors**

- Professional self-doubt
- Anxiety
- Self-sacrificing schemas
- Demanding standards schema
- Special Superior person schema
- Burnout

---

**Professional Self-doubt**

- Humility, openness & courage -> Better outcomes
  (Nissen-Lie et al., 2013; McManus et al., 2012)

- Low confidence (anxiety interferes with performance) -> Worse outcomes
  (Green et al., 2014)

- Over-confidence & overestimation of abilities -> Worse outcomes
Therapist anxiety

• Associated with ↓use of CBT methods (Waller et al., 2012, Simpson-Southward et al., 2015)
• More likely to hold negative beliefs about exposure and not use exposure (Meyer et al., 2014)

Therapist anxiety-driven behaviour & therapy-interfering beliefs

<table>
<thead>
<tr>
<th>Antecedents</th>
<th>Behaviour pattern</th>
<th>Potential consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Fear of hurting or distressing clients</td>
<td>• Short-term anxiety ↓ for therapist &amp; client</td>
</tr>
<tr>
<td></td>
<td>• Fear of making mistakes</td>
<td>• Long-term: client does not improve sufficiently; therapist’s doubts about own competence &amp; inefficacy of EBTs reinforced</td>
</tr>
<tr>
<td></td>
<td>• “I’m an incompetent /inadequate therapist”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fear of client anger</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Therapist trait experiential avoidance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Avoid using strategies of proven efficacy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• “Under-dose”</td>
<td></td>
</tr>
</tbody>
</table>
Avoidance: client & therapist therapy-interfering behaviour

<table>
<thead>
<tr>
<th>Client</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Intellectualising”</td>
<td>Excessive psychoeducation</td>
</tr>
<tr>
<td>Excessive talking about events from the week that don’t relate to medium-term therapy goals</td>
<td>Allowing the client to talk about matters unrelated to therapy agenda without interrupting the client &amp; asking them to prioritise</td>
</tr>
<tr>
<td>Asking not to do behavioural tasks solely to avoid discomfort</td>
<td>Postponing behavioural tasks for fear of distressing the client</td>
</tr>
<tr>
<td>Talking about exercises rather than doing them</td>
<td>Talking about exercises rather than doing them</td>
</tr>
<tr>
<td>Agreeing to do homework tasks not intending to carry out (fear of assertiveness, confrontation)</td>
<td>Moving on to another agenda item immediately after a client reports has not done homework assignment</td>
</tr>
<tr>
<td>Finding flaws with exercises, discounting their value, changing goals (after previously agreeing with rationale for task, to avoid discomfort)</td>
<td>Abandoning exercises based on a solid assessment &amp; rationale when client shows signs of discomfort without discussion or re-grading</td>
</tr>
<tr>
<td>Withholding important opinions or questions about the rationale or methods of therapy</td>
<td>Not asking for feedback or collecting meaningful data re client progress</td>
</tr>
<tr>
<td>Seeking reassurance</td>
<td>Giving similar reassurance repeatedly</td>
</tr>
<tr>
<td>Prolonging therapy</td>
<td>Avoiding termination discussions</td>
</tr>
</tbody>
</table>

Identifying & reducing avoidance

- Invite mindfulness of present reactions
- Perform functional analysis together & summarise: invite client to identify function of behaviour
- Invite client to examine workability of behaviour:
  - “towards” values/goals or “away” from discomfort?
  - short-term v long-term consequences
- Ask client what behaviour would best serve goals of therapy
- Model identifying own avoidance & its antecedents & consequences
- Elicit agreement not to collude with each other’s avoidance
Therapist therapy-interfering behaviour

“Heroic disempowerment”
Well-meaning determination to take responsibility for client progress → undermining client’s ...
• Sense of personal agency
• Competence
• Confidence

“I need to give the client something”

“I’ve done all the dumb things”

Helicopter therapy-ing?

Therapist schemas: Excessive Self-Sacrifice (Leahy, 2001)

• “I should meet my clients’ needs”
• “I should make them feel better”
• “The clients’ needs take precedence over my own”
• “I would do almost anything to meet my clients’ needs”

Poor role-modelling for client
Blur professional boundaries

Possible schema-driven responses
• Waiving/reducing fees/unpaid work
• Extending sessions past usual time
• Providing extra work outside of sessions

See p.18 Limits statement exercise
Therapist schemas: 
Demanding Standards (Leahy, 2001)

(aka Perfectionistic or Obsessive-compulsive therapists)

• “I should be able to cure all my client”
• “I must always meet the highest standards”
• “My clients should do their homework”
• “We should never waste time”
• “I should know everything about the patient’s problems”
• “The session should go according to my plans”
• “The client should work harder”

? Overcompensation for fear of failure

“my client isn’t getting better”
“l’m not doing my job”
“I’ll be exposed as a fraud”
“I’m a failure”
“I can’t accept any failure in myself”

Possible schema-driven actions

• Avoid difficult cases
• Assume client cannot recover
• Demandingness, controlling behaviour
# Therapist therapy-interfering behaviours

<table>
<thead>
<tr>
<th>Antecedents</th>
<th>Behavioural pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demanding standards schemas &amp;/or Fear of inadequacy</td>
<td></td>
</tr>
<tr>
<td>• ?Culture of KPI-focus &amp;/or controlling supervision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pushing client for change too hard, too much, too soon</td>
</tr>
<tr>
<td>Possible consequences</td>
<td></td>
</tr>
<tr>
<td>• Therapist frustration/impatience → alliance rupture &amp;/or client deterioration</td>
<td></td>
</tr>
<tr>
<td>• Pseudo-compliance without sustained change</td>
<td></td>
</tr>
</tbody>
</table>

## Therapist therapy-interfering behaviour

### Playing the “expert” →
- Client passivity
- Client reactance
- over-looking data (from self and client)
- failure to improve as a therapist (avoidant of feedback)
Therapist schemas: Special Superior Person (Leahy, 2001)  
(aka Narcissistic therapist)

- “I am entitled to be successful”
- “My clients should appreciate all that I do for them”
- “I shouldn’t feel bored doing therapy”
- “Clients try to humiliate me”

Therapist therapy-interfering behaviour & beliefs

“Casting a magic spell”
insensitivity to client’s understanding, unique circumstances

→
- Encourages black/white thinking about value of interventions (either “works” or doesn’t)
- Disconnected from ongoing process of client testing own ideas, practising & learning from them
Free reassurance: You won’t “spoil” an exercise by interrupting it to check what sense the client is making of it; stay attuned.

Burnout

- 40% mental health professionals report Emotional Exhaustion
- 22% report Depersonalization
- 19% report low levels of personal accomplishment

(O’Connor et al., 2018)

- 18% clinical and counselling psychologists experience high emotional exhaustion (Simpson et al., 2018)
- Burnout (depersonalization/disengagement) explains ~30% of the variance in therapist effects (Delgadillo et al., 2018)
### Therapist therapy-interfering behaviour

<table>
<thead>
<tr>
<th>Antecedents</th>
<th>High complexity caseload with inadequate supervision, support, resources; helplessness assumptions; self-sacrifice &amp;/or perfectionism → effort imbalance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural pattern</td>
<td>Therapist “gives up” / “goes through the motions” / “runs down the clock”</td>
</tr>
</tbody>
</table>
| Consequences                                                               | • client demoralisation  
                                • Therapist demoralization/doubt/detachment/exhaustion  
                                • client passivity  
                                • Problem remains “stuck” |

### Identifying own therapy-interfering beliefs

**THERAPIST “HOOKS” – Examples:**

- “If I’m a good therapist I should be able to help everyone”
- “I have to have something new to offer the client”
- “It’s up to me”
- “I’m not doing it ‘right’!”
- “I need more knowledge, training, a new therapy framework”
- “Psychotherapy doesn’t really work”
- “It doesn’t matter what you do, everything is equally helpful and it’s all down to the client anyway”
Managing own therapy-interfering beliefs

*Exercise*

On *p.17* of your workbook, identify 1-3 of your own “therapist hooks”. Conceptualise.

Identify one or more “interventions” that you could apply to your therapist hook (*e.g.*, cognitive restructuring, defusion).

---

**How do I improve?**

*Specific therapy models*

- Account for ~1% outcome variance in meta-analyses (Wampold & Imel, 2013)
- Meta-analysis of dismantling studies showed no effect of removing ‘key’ component (Bell et al., 2013)
- Meta-analysis of additive designs showed ‘key’ components account for <2% outcome variance
What if the key to better outcomes is doing what we already know, better?

Intro: RCT v routine setting study

Gibbons et al (2013)
Potential differences - RCTs:
• Weekly supervision
• Sessions video-taped
• Expected to adhere to treatment model
• Time-limited (strictly enforced)
• Expectation of clear & single treatment focus (for both client and clinician!)
• Sessions twice/week first 4 weeks
More effective therapists work harder on their craft

Top 25% therapists spent 2.8x more time on deliberate practice alone than other therapists.

Reviewing therapy recordings alone was the only specific activity related to actual improved outcomes (Chow et al., 2015)

Homework task: Record & rate session

- What would it take to make this possible?
- What would be the potential benefits?
- What help would you need to overcome barriers to doing this more often?

Record notes on p.19 of workbook
Supervision intervention study

- 10-session (monthly FREE individual in-person or video-conference) supervision intervention aimed at common-factors:
  - Formulation
  - Managing alliance ruptures
  - Managing own therapy-interfering beliefs and behaviours
- Looking for 24 therapists
  - willing to be randomly assigned to immediate or delayed supervision intervention
  - Min. 8 hours direct client contact with adult outpatients per week
  - General registration not provisional registration
  - Willing to collect outcome questionnaires from clients

Email: matthew.smout@unisa.edu.au
Website: www.dcmatthewsmout.com

Recommended resource

Donald Meichenbaum’s Core Tasks of Psychotherapy
https://search.alexanderstreet.com/preview/work/bibliographic_entity%7Cvideo_work%7C1824833

The Melissa Institute for Violence Prevention and Treatment
https://melissainstitute.org/
Feedback?

I’d love to hear about your experiences reflecting on your practice in the areas covered by this workshop (today & after today).

Matthew.smout@unisa.edu.au