Psychotherapy Pre-Season
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University of South Australia

* Before the workshop: List the initials of as many clients from your current caseload as you can remember on p.2 of the workbook provided

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Supervisors v Supervisees

<table>
<thead>
<tr>
<th>“they’re defensive”</th>
<th>“they’re critical”</th>
</tr>
</thead>
<tbody>
<tr>
<td>“they need to hear this”</td>
<td>“they need to listen more”</td>
</tr>
<tr>
<td>“I need to guide their discovery”</td>
<td>“I wish you’d just get to the point and tell me”</td>
</tr>
<tr>
<td>“they’re fine, they’ve got this”</td>
<td>“I need some direction!”</td>
</tr>
<tr>
<td>“they don’t know what they don’t know”</td>
<td>“They don’t know how much I know”</td>
</tr>
<tr>
<td>“I’ve seen where this can go wrong”</td>
<td>“They haven’t seen a real client for ages”</td>
</tr>
<tr>
<td>“They’re not getting it”</td>
<td>“They’re not explaining it”</td>
</tr>
<tr>
<td>“The only way they’ll learn is by doing”</td>
<td>“I’m not ready to do this”</td>
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</table>
### 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

<table>
<thead>
<tr>
<th></th>
<th>CCT N = 23</th>
<th>RCT N = 18</th>
<th>Comparison</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td></td>
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</tr>
<tr>
<td>Female (%)</td>
<td>52</td>
<td>50</td>
<td>0.01, 0.89</td>
<td>0.02</td>
</tr>
<tr>
<td>White (%)</td>
<td>83</td>
<td>83</td>
<td>0.00, 0.95</td>
<td>0.00</td>
</tr>
<tr>
<td>Married (%)</td>
<td>55</td>
<td>44</td>
<td>0.10, 0.73</td>
<td>0.05</td>
</tr>
<tr>
<td>Unemployed (%)</td>
<td>15</td>
<td>13</td>
<td>0.11, 0.74</td>
<td>0.05</td>
</tr>
<tr>
<td>Anxiety disorders (%)</td>
<td>44</td>
<td>44</td>
<td>0.54, 0.46</td>
<td>0.11</td>
</tr>
<tr>
<td>Substance disorders (%)</td>
<td>33</td>
<td>17</td>
<td>0.66, 0.42</td>
<td>0.13</td>
</tr>
<tr>
<td>Double depression (%)</td>
<td>6</td>
<td>4</td>
<td>0.03, 0.86</td>
<td>0.03</td>
</tr>
<tr>
<td>Recurrent depression (%)</td>
<td>61</td>
<td>70</td>
<td>0.06, 0.81</td>
<td>0.04</td>
</tr>
<tr>
<td>Axis II comorbidity (%)</td>
<td>24</td>
<td>39</td>
<td>3.76, 0.05</td>
<td>0.30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>t, p</th>
<th>d</th>
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<tbody>
<tr>
<td>Symptom and treatment factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake BDI, mean (SD)</td>
<td>27.2 (7.8)</td>
<td>30.7 (10.5)</td>
</tr>
<tr>
<td>Number of sessions, mean (SD)</td>
<td>18.4 (18.7)</td>
<td>18.7 (6.9)</td>
</tr>
<tr>
<td>Posttreatment BDI, mean (SD)</td>
<td>20.5 (14.0)</td>
<td>8.2 (17.9)</td>
</tr>
</tbody>
</table>

### Supervisors

- **Create safety / trust**
  - Share own responses
  - Normalise normal; validate valid
- **Use questions > statements**
  - Aim for > 2 questions/statement
- **Help supervisees operationalise & explain their reasoning & concerns**
- “Are they likely to know this?” (how could I find out?)
  - Don’t enable avoidance
  - Don’t fish in a dry lake
- **Facilitate all group members’ involvement**
Use supervision like this, not ↓

Characteristics of more (and less) effective therapists
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></th>
<th>Most effective</th>
<th>Average</th>
<th>Least effective</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>76%</td>
<td>59%</td>
<td>40%</td>
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</table>
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 wait-list accounts for 14% variance in outcomes (Wampold & Imel, 2013)

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

…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., 2004)
• 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

<table>
<thead>
<tr>
<th>Effective therapist</th>
<th>Ineffective therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conveys concern and care for client</td>
<td>• Avoids disclosing own thoughts and feelings</td>
</tr>
<tr>
<td></td>
<td>• listens silently and fails to offer empathic or caring responses</td>
</tr>
</tbody>
</table>

**von der Lippe et al (2017)**

|                     | • Judgmental  |
|                     | • Critical    |
|                     | Predicts early termination |

**Elkin et al (2014)**

### FIS: Verbal fluency

<table>
<thead>
<tr>
<th>Effective therapist</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicates in a relaxed manner without anxiety, easy to follow (may have “melodic, rhythmical” quality)</td>
<td></td>
</tr>
<tr>
<td>Clear, easily understood questions &amp; statements</td>
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</tbody>
</table>

maybe this is just a depressed thought.' Right... 'Maybe this isn't true.' Okay. So one of the
**FIS: Emotional expression**

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

**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

<table>
<thead>
<tr>
<th>Effective therapist</th>
<th>Ineffective therapist</th>
</tr>
</thead>
</table>
| Creates a relationship where both therapist and client recognise the need to work together; “we-ness” | 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 |

*von der Lippe et al (2017)*

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### FIS: Hope and positive expectations

<table>
<thead>
<tr>
<th>Effective therapist</th>
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</table>
| 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

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# FIS: Alliance-repair responsiveness

<table>
<thead>
<tr>
<th>Effective therapist</th>
<th>Ineffective therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sensitive to ruptures in the alliance</td>
<td></td>
</tr>
<tr>
<td>• Attempts to repair rupture</td>
<td></td>
</tr>
<tr>
<td>• Insensitive to client signals of ambivalence, reactance or passive disagreement</td>
<td></td>
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<tr>
<td>• Defensiveness, anger in response to ruptures</td>
<td></td>
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von der Lippe et al (2017), Castonguay et al., (1996); Francis et al., (2005); Westra et al., 2012
**Working Alliance**

- Agreement on Goals of therapy
- Agreement that tasks of therapy will achieve goals
- 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)

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**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
Goal consensus

Goal-consensus – outcome: $r = .24$ [.19, .28]
($k = 54, N=7,278$)
(Tyron et al., 2018)

Exercise: Review goal statements of your caseload.
(see p.4-5 workbook)

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

**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

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

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

*Only confrontation ruptures predict outcome (medium effect)*

(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)

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

e.g., “I don’t know”

<table>
<thead>
<tr>
<th>Tone/speed</th>
<th>Context</th>
</tr>
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<tbody>
<tr>
<td>Earnest</td>
<td>Trying to answer therapist’s question but genuinely unsure</td>
</tr>
<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>
</tr>
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</table>
 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)

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).
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.
Repairing ruptures: Expert consensus

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

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.
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.*

Identifying ruptures

...VIA Therapist reactions

- “Who do I wish would cancel his/her session today?” (J. Beck, 2005). Exercise on p.8 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
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 drop-out (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)

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!

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. |
EXERCISE: Formulate client attitude to therapy (as well as presenting problem)

EXERCISE (See pp. 10-11 of workbook):
1. Choose a client from your caseload (ideally, one not progressing so well)
2. List top 3 problems & top 3 therapy-interfering behaviours (1st column in table on p.11)

Formulating interpersonal problems

- Autonomy
- Competence
- Meet needs
- Physiological
- 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)

Avoid pain

- Protect from Criticism
- Protect from Rejection
- Protect from Disappointment
- Protect from Financial/material loss
- Protect from Sexual harm
- Protect from Physical Harm
EXERCISE: Identify the function of client’s therapy-interfering behaviour

FORMULATE:
- How might this behaviour have been a strength in another place and time?
- 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?

Formulation-based empathic confrontation of therapy-interfering behaviour

(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)
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?

Increasing strength focus

- 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
- How might the therapy-interfering behaviours identified earlier be seen as a strength in another context?
- What skills or qualities were needed to commit crimes? How could these be harnessed toward prosocial goals?
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↑ competence $\rightarrow$ outcome
Formulate your time-management

EXERCISE: Think of a session in which you were dissatisfied with your time management (EX 15 workbook, p.19)

• Was it because you did something that wasn’t useful?
• Was it because you spent too long on something that would have been useful had you spent less time on it?
• Was it because you didn’t do something that would have been useful?
• Is hindsight bias affecting your judgement? What evidence did you have available at the time?
• How will you decide differently next time?
Barriers to best practice

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
- Schemas and other beliefs
- 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-driven behaviour & therapy-interfering beliefs

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

Antidote: “Can the client do this themselves?”
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
Blurs 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 clients”
- “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”
Therapist schemas: 
Demanding Standards (Leahy, 2001)

<table>
<thead>
<tr>
<th>Overcompensation for fear of failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>“my client isn’t getting better”</td>
</tr>
<tr>
<td>“I’m not doing my job”</td>
</tr>
<tr>
<td>“I’ll be exposed as a fraud”</td>
</tr>
<tr>
<td>“I’m a failure”</td>
</tr>
<tr>
<td>“I can’t accept any failure in myself”</td>
</tr>
</tbody>
</table>

Possible schema-driven actions
- Avoid difficult cases
- Assume client cannot recover
- Demandingness, controlling behaviour

Therapist therapy-interfering behaviours

<table>
<thead>
<tr>
<th>Antecedents</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demanding standards schemas &amp;/or Fear of inadequacy</td>
</tr>
<tr>
<td>• ?Culture of KPI-focus &amp;/or controlling supervision</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioural pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pushing client for change too hard, too much, too soon</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Possible consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Therapist frustration/impatience</td>
</tr>
<tr>
<td>→ alliance rupture &amp;/or client deterioration</td>
</tr>
<tr>
<td>• Pseudo-compliance without sustained change</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>?Hi 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”                                                                                                                                 |

- 87
- 88
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).
“Therapeutic outcome in a CBT group is determined by both the formal CBT strategies and the small-group process present in the group context. The group leader plays a pivotal role in determining whether the treatment proceeds essentially as individual therapy within a group setting or from the perspective of enhancing the CBT by recognising and building in group process factors”

(Burlingame et al., 2004)
**Group therapy: Therapeutic factors**

- Instillation of hope – inspiration - optimism
- Universality – normalising - not alone
- Imparting information
- Altruism (helping others)
- Corrective emotional experiences
- Development of social skills
- Imitative behaviour
- Interpersonal learning (group elicits members’ interpersonal patterns)
- Shifting self-focus
- Group cohesiveness
  - therapeutic group alliance: comfort & belonging; valuing the group; unconditional acceptance by group members
- Catharsis

(Bieling et al., 2006; Yalom, 2006)

**Increasing group cohesiveness**

- ↑ Group homogeneity in pre-group selection
- Encourage consistent attendance
- Provide a safe environment for self-disclosure
  - Model acceptance, empathy and feedback
- Promote sharing information
- Make connections between two or more group members’ experiences
- Attend to group process in the here and now
Therapist’s in-session tasks

**Balancing:**
- “air time” between therapists and group members
- each member getting a similar amount of attention from the group
- Focusing on the individual and taking topics back to the group for general feedback
- Interaction between co-therapists and supporting one another’s interventions
- Working on agenda content v group members’ reactions in the here-and-now (+ questions)

**Addressing:**
- Effect of drop-outs/non-attendance on group cohesion

---

**Group Therapy**

*Group member profiles*

<table>
<thead>
<tr>
<th>Prototype</th>
<th>Description</th>
<th>Therapeutic Management</th>
</tr>
</thead>
</table>
| Quiet and silent type   | • Group participation is minimal  
                         | • Prefers to sit in silence               | • Use group to help draw out  
                         |                                                                                         | • Ask direct questions to help facilitate interaction  
                         |                                                                                         | • Try to link experiences to other group members’ experiences  
                         |                                                                                         | • When appropriate, process thoughts and feelings about being in the group |
### Group Therapy

#### Group member profiles

<table>
<thead>
<tr>
<th>Prototype</th>
<th>Description</th>
<th>Therapeutic Management</th>
</tr>
</thead>
</table>
| Overbearing Type   | • Monopolises group time  
                     • Has no difficulty sharing information | **Use containment strategies to help balance group time**  
                     • Start with subtle (not reinforcing continued talking with questions or nonverbal encouragers)  
                     • Escalate to overt: stopping the person midstream (e.g. “I am going to stop you there so we can hear from others”) |
|                    | You’ve raised a great point, let’s see how others have managed             |                                                              |
|                    | I need to jump in here. These are interesting ideas…I’m just aware of time and we have a few more things to get through |                                                              |

#### The helper

<table>
<thead>
<tr>
<th>Prototype</th>
<th>Description</th>
<th>Therapeutic Management</th>
</tr>
</thead>
</table>
| The helper         | • Always giving advice that may or may not be helpful  
                     • May talk in generalities using “we” and not “I”  
                     • May focus on others and not own issues | • Encourage the person to reflect upon personal experience and speak in the first person.  
                     • If advice is helpful, then reinforce and direct the person to how he or she can focus on his or her own issues  
                     • If advice is not helpful (e.g. “If you are anxious about going, then don’t go”) then process within the group (e.g. “What do group members think about that idea?”) |
|                    | How does this fit with what we’ve learnt in the group so far?               |                                                              |
|                    | What do you think the advantages and disadvantages of taking this advice would be? |                                                              |
### Group Therapy

**Group member profiles**

<table>
<thead>
<tr>
<th>Prototype</th>
<th>Description</th>
<th>Therapeutic Management</th>
</tr>
</thead>
</table>
| The disbeliever | • A pessimistic person who doesn’t really buy into treatment.  
|               | • May have already tried CBT a number of times.  
|               | • May challenge the therapist and the therapy. | • “Roll with resistance”: Do not engage in argument, agree/validate member’s feelings, then shift direction to emphasize personal responsibility and choice.  
|               |                                                                              | • Return group’s attention back to planned tasks                                           |

It makes sense that you’re feeling frustrated if you’re not finding this group helpful. We know that although this group is effective for many people, it doesn’t work for everyone. We’d completely understand if you decided not to continue with the group.

---

<table>
<thead>
<tr>
<th>Prototype</th>
<th>Description</th>
<th>Therapeutic Management</th>
</tr>
</thead>
</table>
| The drifter  | • Sometimes shows up and sometimes does not  
|              | • Does not appear to be committed to the group. | • Individual pre-group meetings: problem-solve barriers to attendance  
|              |                                                                              | • Set group norms to attend  
|              |                                                                              | • Address in group  
|              |                                                                              | (When going around circle, ask how coping with difficulties attending; use group to problem-solve practical barriers)  
|              |                                                                              | • May need to have an individual meeting (empathic confrontation)                         |
## Group Therapy

### Group member profiles

<table>
<thead>
<tr>
<th>Prototype</th>
<th>Description</th>
<th>Therapeutic Management</th>
</tr>
</thead>
</table>
| The not-appropriate-for-group member | • Somehow this member made it through screening  
• Problematic in group because his or her issues may be different from those of the rest of the group  
• Often due to problematic features (e.g. paranoia) or other conditions that require immediate treatment | • Use management and containment strategies  
• Acknowledge that his or her needs may be different from those of the group and shift the focus to what the individual may gain from group participation  
• May need to discontinue group and find alternative treatment option if the person is too disruptive or treatment needs have shifted. |

---

## Co-leading

- Plan talk time before sessions: agree to balance of questions/sections
- Agree - beforehand - on how disruptive group members will be handled
- If a more-experienced leader is paired with a less-experienced leader, agree that there will be circumstances under which the more-experienced leader might “take the wheel” and specify these
- Agree – beforehand – on how to handle “epic fails” + “rescue signals”
- Avoid communicating conflict to group members at all costs
Adaptations for low-functioning clients

- ↑ Repetition
  - Make all points concrete and personally-relevant through helping members find specific examples in their own lives
- ↑ rehearsal
  - Present info in multiple formats: verbally, video, diagrams, exercises, handouts
- Provide snacks!
- Use simple, closed questions
- Balance member participation
- Group norms/guidelines on walls when group operates

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?

More effective therapists work harder on their craft

<table>
<thead>
<tr>
<th>Activity</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clinical clinical supervision as a supervisee (without review of individual recordings of sessions)</td>
<td>13</td>
<td>2.02</td>
<td>2.83</td>
<td>5.14</td>
<td>2.63</td>
<td>7.63</td>
</tr>
<tr>
<td>2. Clinical supervision as a supervisee (with review of individual recordings of sessions)</td>
<td>10</td>
<td>2.04</td>
<td>2.85</td>
<td>5.10</td>
<td>4.00</td>
<td>8.40</td>
</tr>
<tr>
<td>3. Clinical supervision as a supervisee (with review of difficult/challenging cases and cases of help)</td>
<td>12</td>
<td>2.06</td>
<td>2.87</td>
<td>5.10</td>
<td>4.00</td>
<td>6.40</td>
</tr>
<tr>
<td>4. Live supervision provided during sessions (e.g., supervisor in both sessions, one-way mirror/reflection team)</td>
<td>10</td>
<td>2.04</td>
<td>2.85</td>
<td>5.10</td>
<td>4.00</td>
<td>6.40</td>
</tr>
<tr>
<td>5. Reading of relevant readings pertaining to psychotherapy and counseling</td>
<td>14</td>
<td>2.06</td>
<td>2.87</td>
<td>5.10</td>
<td>4.00</td>
<td>6.40</td>
</tr>
<tr>
<td>6. Reading and reviewing particular materials, alone</td>
<td>11</td>
<td>2.65</td>
<td>2.92</td>
<td>5.10</td>
<td>4.00</td>
<td>6.40</td>
</tr>
<tr>
<td>7. Applying practical knowledge and strategies to psychotherapy problems</td>
<td>10</td>
<td>2.72</td>
<td>2.87</td>
<td>5.10</td>
<td>4.00</td>
<td>6.40</td>
</tr>
<tr>
<td>8. Reviewing therapy recordings, alone</td>
<td>10</td>
<td>2.70</td>
<td>2.83</td>
<td>5.10</td>
<td>4.00</td>
<td>6.40</td>
</tr>
<tr>
<td>9. Reviewing therapy and literature, alone</td>
<td>10</td>
<td>2.72</td>
<td>2.83</td>
<td>5.10</td>
<td>4.00</td>
<td>6.40</td>
</tr>
<tr>
<td>10. Reviewing therapy and literature, with peers</td>
<td>10</td>
<td>2.70</td>
<td>2.83</td>
<td>5.10</td>
<td>4.00</td>
<td>6.40</td>
</tr>
<tr>
<td>11. Reviewing therapy and literature, with peers</td>
<td>10</td>
<td>2.70</td>
<td>2.83</td>
<td>5.10</td>
<td>4.00</td>
<td>6.40</td>
</tr>
<tr>
<td>12. Reviewing therapy and literature, with peers</td>
<td>10</td>
<td>2.70</td>
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<td>4.00</td>
<td>6.40</td>
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⇒ 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

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