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## Introduction: the Challenge of Research

### This chapter discusses:

- The value of applying research findings to practice.
- The limitations of applying research findings to practice.
- The aims of the book.
- The personal, theoretical and methodological perspective from which the book is written.
- What is in the book ... and what is not.
- How the book is structured.

### The Value of Research

Research findings can be like many things. They can be like dusty old library books hidden away, decomposing and seemingly irrelevant to everyday life. Or they can be like a mallet: something we get hit over the head with by people who want us to think like them. Research findings can also be like a deity: something we are in awe of and too afraid to question. This book hopes to convey another possibility – that research findings can be like good friends: something that can encourage, advise, stimulate and help us, but also something that we are not afraid to challenge and argue against.

#### **Research**

A systematic process of inquiry that leads to the development of new knowledge.

#### **Empirical**

Based on concrete experiences or observations, as opposed to purely theoretical conjecture.



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So how can research findings be of help? For a start, they can give counsellors and psychotherapists (as well as clients) some very good ideas about where to start from in the absence of other information. Research can only ever tell us about the likelihood of certain things happening, but that knowledge can be enormously valuable if we have virtually nothing else to go on. So, for instance, if a therapist is meeting a depressed client for the first time, it can be very useful to know that, in general, positive outcomes with depressed clients are associated with empathic, caring and warm ways of relating (Castonguay et al., 2006). Subsequently, a therapist may discover that this particular client actually prefers a more distant form of encounter, but until the therapist has a clear sense of what that individual client wants, the research evidence can provide a valuable source of guidance on what the default therapeutic stance should be.

Second, and related to this, research findings can help practitioners to understand therapy from the *client's* perspective. Of course, trainee or practising therapists may feel that they already have a good insight into their clients' experiences – whether through theory, their own experiences in therapy or through listening to, and observing, their own clients – but the evidence indicates that is not always the case (and particularly in the early stages of therapy or when the therapeutic relationship is poor; Timulak, 2008). For example:

- Therapists' ratings of the quality of the therapeutic relationship tend to show only moderate agreement with clients' ratings (e.g., Gurman, 1977; Tryon et al., 2007).
- In just 30 to 40 per cent of instances do therapists agree with clients on what was most significant in therapy sessions; with therapists tending to overestimate the importance of technical, as opposed to relational, aspects (Timulak, 2008).
- Therapists are often poor at predicting the outcomes of therapy (Kadden et al., 1989), with one study finding that therapists correctly predicted just one out of forty-two clients who ultimately deteriorated (Lambert and Ogles, 1997).
- Client and therapist reports of the same episode of therapy often reveal striking differences in perception. For instance:

Client: The counseling was worthwhile. It felt good ... because it was the first time in years I could talk with someone about what's on my mind.

Therapist: We were still in the beginning phases of treatment when she pulled out ... I didn't feel that we were making progress. (Maluccio, 1979: 107–8)

- Counsellors and psychotherapists tend to overestimate their effectiveness relative to other therapists, with one study finding that 90 per cent of therapists put themselves in the top 25 per cent in terms of service delivery (Dew and Reimer, 2003 cited in Worthen and Lambert, 2007).

So although it can be important for trainee and practising therapists to trust their own intuitive sense of what clients are experiencing, it is also important for them to know that they can sometimes get it completely and utterly wrong, and empirical research findings can be a useful way of helping them to understand what their clients might be really going through. For even if their clients are telling them how good the therapeutic work has been or how much they value a particular intervention, the tendency for

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clients to 'defer' to their therapists (Rennie, 1998 see Box 7.2) means that an anonymous, independent examination can sometimes give a more accurate and reliable picture.

In this respect, the value of empirical research findings may not be so much in what they *teach* therapists, but more the way in which they can *challenge* therapists to reconsider their implicit assumptions and expectations (Cooper, 2004): shaking them out of rigid belief systems so that they can be more responsive to the actual client in front of them. Here is a personal example: as someone trained in existential psychotherapy (something I've defined as 'similar to person-centred therapy ... only more miserable'; Cooper, 2003: 1), my tendency in initial sessions had always been to warn clients of the limits of therapeutic effectiveness. That is not to suggest that I would start off assessment sessions by saying: 'OK, so your life is meaningless, it has always been meaningless, you have no hope of change ... and how can I help you?' but I did tend to adopt a rather dour stance, emphasising to clients that therapy was not a magic pill and highlighting the challenges that it was likely to involve. Then I came across a research chapter by Snyder and colleagues (1999) which showed, fairly conclusively, that the more clients hoped and believed that their therapy would work the more helpful it tended to be. How did I react? Well, initially I discounted it; but once I'd had a chance to digest it and consider it in the light of some supervisory and client feedback, I came to the conclusion that, perhaps, beginning an episode of therapy with all the things that might not help was possibly not the best starting point for clients. So what do I do now? Well, I don't tell clients everything is going to be fine the moment that they walk through the door; but I definitely spend less time taking them through all the limitations of the therapeutic enterprise; and if I think that therapy can help a client, I make sure that I tell them that.

Within the world of contemporary healthcare practices, there is another very good reason, albeit a more pragmatic one, why counsellors and psychotherapists should be aware of the research findings: to communicate with others about their work, and to help consumers understand the value of what it is that they do. Today, it is rarely enough to say to a commissioning agency, 'I really think you should employ me because I know that what I do is helpful.' And why should it be? Snake-oil salespeople would say exactly the same thing. Funding bodies, whether large-scale corporations or private individuals, are becoming increasingly critical consumers, and want concrete evidence with which to justify their expenditures; so with so much high-quality evidence demonstrating the value that therapy can have (see Chapter 2), it would seem entirely self-defeating for therapists not to have a good working knowledge of this material. As the research itself shows, counsellors and psychotherapists tend to underestimate the strong research support for certain positive therapy findings (Boisvert and Faust, 2006), so knowing what the research really says can help therapists feel more confident in promoting their work.

## The Limitations of Research

The premise of this book, then, is that research findings can be like good friends but, as things stand today, it would seem as though many counsellors and psychotherapists are

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yet to get acquainted: research itself shows that many therapists have little interest in, or familiarity with, empirical research findings in their field (e.g., Boisvert and Faust, 2006). A study of American psychotherapists, for instance, found that only 4 per cent ranked research literature as the most useful source of information on how to practise; with 48 per cent giving top ranking to 'ongoing experiences with clients', 10 per cent ranking theoretical literature as the most useful source, and 8 per cent ranking their own experiences as clients most highly (Morrow-Bradley and Elliott, 1986).

There are many good reasons why counsellors and psychotherapists should be wary of research findings. For a start, by its very nature, research talks in generalities rather than specifics. So, for instance, the research might show that depressed clients, *on average*, will exhibit fewer psychiatric symptoms after participating in short-term **psychodynamic therapy** (Leichsenring, 2001), but this does not mean that the one client in front of a therapist will *definitely* improve if he or she uses that therapeutic approach. The probability is that he or she will, but on the other hand he or she may not, and it is also possible that he or she will feel a lot worse if the therapist works in that way. In this respect, to base therapeutic practice wholly on empirical research findings – to the exclusion of other factors, such as the expressed preference of the client – would be profoundly unethical. Counselling and psychotherapy research findings can only ever tell us about what is most *likely* to happen – they can not give us certainties.

Another limitation of research findings is that they will inevitably be influenced by the researchers' own assumptions and agendas (see Chapter 3). Take the following example: in a review of studies that compared the effectiveness of different anti-psychotic drugs, Heres and colleagues (2006) found that in 90 per cent of the studies the anti-psychotic drug that came out on top was the one manufactured by the drug company sponsoring the research. Hence, even when research is conducted in a highly rigorous way, biases still manage to creep in. This means that we should always read research findings in a critical way, paying attention to the background and context of whoever conducted the research and what their agendas might be.

Related to this is the fact that research findings are always arrived at through the use of some particular tool, measure or procedure, and these will inevitably influence the kinds of things that are 'found'. If psychological wellbeing is defined and measured in terms of a lack of 'mental illness', for instance, the kinds of therapies that are shown to be most effective may be very different to those if it is defined and measured in terms of a 'potential for growth'. Researchers can even come up with radically different conclusions with the same set of data if they use different tools of analysis (see, for instance, Elkin et al., 2006; Kim et al., 2006, Chapter 5). It is also important to bear in mind that research is always conducted with a particular sample of people, such that the generalisability of its findings will always be limited (see Chapter 3). We might know, for instance, that non-directive counselling is more effective than usual General Practitioner (GP) care for a predominantly white, UK-based sample (King et al., 2000), but does that mean it will also be more effective for clients from black and minority ethnic backgrounds, or for clients in Japan? Again, the point is that research does not give us absolute truths, but one particular perspective on a phenomenon.

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**Sample**

The collection of participants used in a study, from whom we want to make generalisations to a wider 'population'.

Even if it were possible for researchers and research tools to be entirely objective, value-free and comprehensive, we are still faced with the fact that the scientific method itself is not an assumption-free tool, but a particular way of understanding the world that is based on a specific set of assumptions (for instance, that events in the world are linked together by cause-and-effect relationships). So while, within the scientific framework, it may be possible to prove or disprove that certain things are true (though even that is questionable), it is never possible to prove that science itself is the 'truest' way of understanding the world.

**RECOMMENDED READING**

Slife, B.D. (2004) 'Theoretical challenges to therapy practice and research: the constraints of naturalism', in M.J. Lambert (ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change* (5th edn, pp.44–83). Chicago: John Wiley & Sons. In-depth and comprehensive critique of the assumptions behind traditional scientific research methods.

**A Research-Informed Approach to Therapy**

Given all these limitations, the basic premise of this book is that therapy should not be 'research-directed', but 'research-informed' (Westen et al., 2004). Here, research is seen as one very valuable source of information on how to practise counselling and psychotherapy, but it is not seen as a privileged or superior fount of knowledge – theory, personal experiences, supervisory input and many other factors are all seen as having a role to play too. Such a position may seem somewhat wishy-washy when compared with a harder-nosed, scientifically orientated approach, but it is worth noting that it is entirely consistent with the American Psychological Association's latest definition of 'evidence-based psychological practice': 'the integration of the best available research *with clinical expertise in the context of patient characteristics, culture, and preferences*' (APA, 2006: 273, italics added).

**Aims**

The principal aim of this book is to provide counsellors and psychotherapists with a user-friendly introduction to research findings in therapy. Accessibility is a key feature

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here: one of the main criticisms of therapy research is that it is seldom communicated in a 'clear and relevant fashion' (Morrow-Bradley and Elliott, 1986: 193). This book aims to be accessible to all, whatever their level of research-expertise or professional training. Another key feature of the book is its orientation towards practice: the aim of the book is not just to help therapists reflect on their work, but to concretely and practically develop the therapy that they do. To this end, 'Implications for practice' boxes are dispersed throughout the text, and it is my hope that practitioners will find many more implications for their work throughout the text.

The book also aims to help those in related fields – such as policy developers, service managers, social workers and general practitioners – to understand more about the impact of counselling and psychotherapy and the particular ways of working that may be most effective within specific contexts or with specific clients groups. It is also hoped that *users* (both actual and potential) of counselling and psychotherapy services will find this book a valuable resource: something that can help them to find the most appropriate therapist (see summary in Box 8.1), and to make the most of the counselling and psychotherapeutic services that they might participate in.

A third aim of this book is to act as a starting point for students or practitioners undertaking their own research in the counselling and psychotherapy field. Here, novice or experienced researchers can find out the kinds of questions that are being asked in particular areas of counselling and psychotherapy and the findings that have begun to emerge. To this end, recommendations for further reading are distributed throughout the book, and these are texts that I think researchers, or other interested readers, will find particularly useful or inspiring when wanting to follow up specific areas. The book also introduces readers to a number of key concepts in counselling and psychotherapy research. It should be emphasised, however, that the aim of this book is *not* to teach readers how to carry out their own research: for this, a number of excellent texts already exist, and I would particularly recommend McLeod's (2003) *Doing Counselling Research* (Sage, 2nd edn) and Barker, Pistrang and Elliott's (2002) *Research Methods in Clinical Psychology* (Wiley, 2nd ed).

Finally, and perhaps most importantly for me, what I hope this book can do is to convey something of my own passion and love for empirical inquiry. Without doubt, research findings can be dull, dreary and boring, but they also have the potential to be enormously stimulating, inspiring and challenging, and I would love for readers to experience something of that possibility when engaging with this text. My hope, when writing this book, was that it would be one of the first research texts that readers would want to keep by their bedside: that they will want to read and look forward to reading because they genuinely want to know what the research is saying.

### Trying to Achieve Balance

In *Essential Research Findings in Counselling and Psychotherapy*, I have tried, as hard as possible, to produce a book that is a balanced and non-partisan evaluation of counselling

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and psychotherapy research findings. It should be emphasised, however, that such a task is by no means easy. Like many of us in the field, I *am* partisan and committed to a set of beliefs and assumptions about how counselling and psychotherapy does, and should, work.

To counteract these tendencies, I have tried to be as aware of my biases as possible, and to put them to one side whenever I notice them emerging. I have also tried to look for, and be open to, evidence which specifically counteracts my assumptions. In addition to this, the book has been reviewed by readers from a range of orientations to try and ensure that the material presented is relatively balanced. Nevertheless, it is important to acknowledge that this book does not, in any way, claim to be a definitive and objective presentation of the data. It is my, subjective, reading of the 'essential' research findings, and another reviewer, with other personal agendas and experiences, would almost certainly present it in a different way.

In trying to present a balanced overview of the field, one other thing that I can do is tell you, the reader, about my own particular perspective, so that you are more able to put my biases and assumptions to one side for yourself. In recent years I have come to see that the touchstone for my therapeutic work is a progressive political outlook (Cooper, 2006b). This means that I am particularly drawn towards those orientations, such as person-centred, existential and relational therapies (Cooper, 2003; Cooper et al., 2007; Mearns and Cooper, 2005), which I perceive as advocating an egalitarian, relatively democratic client-therapist relationship: in which clients are engaged with as intelligent, choice-making individuals who are trying, just as hard as their therapists, to do their best within their given circumstances. This means that I have a particular wariness towards those therapies – in particular, the more authoritarian forms of psychodynamic and cognitive-behavioural practice – which I perceive as promoting a relatively hierarchical client-therapist relationship: therapist as 'expert' and client as 'patient'. Having said all that, I am by no means a person-centred or existential purist, and feel strongly that an authentic expression of progressive values lies in an appreciation of the many different forms that therapy can take. Indeed, most recently, I have been working closely with John McLeod at the University of Abertay to develop a 'pluralistic' therapeutic framework (Cooper and McLeod, 2007), which starts from the assumption that different clients are likely to want different things from therapy at different points in time, and that there is no, one, 'right' way of working with clients. You may therefore find in this book, then, that it is particularly challenging of therapeutic positions which suggest that one way of working is superior to every other, whether it is CBT or person-centred therapy.

This pluralistic bias, to some extent, also comes from my own experiences as a client. As someone who has been through some fairly severe episodes of psychological distress, I have experienced, and found helpful, a wide range of different therapies, including CBT, person-centred and psychodynamic; and I have also found anti-depressants an enormous help at a time of severe crisis. Concomitantly, I have come out of a few therapeutic relationships – two psychodynamic ones, in particular – feeling more traumatised than when I went in; and some of my experiences in existential, person-centred, cognitive and gestalt therapy have also been less than satisfying. In this respect, I really

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do believe that different therapies have lots to offer, and that what is generally most important is a therapist who is warm, respectful, non-defensive and willing to respond to a client's particular needs – though guidance, advice and structural interventions can also be very useful too.

Given that this book draws together research findings, it is also worth saying something about my biases in terms of what I consider valid methods of empirical inquiry. As might be expected from the above, I see different forms of research as having different contributions to make at different times, and do not feel that an 'either/or' split between quantitative and qualitative methods is either necessary or constructive.

### **Quantitative Research**

Number-based research, generally incorporating statistical analysis.

### **Qualitative Research**

Language-based research, in which experiences, perceptions, observations, etc., are not reduced to numerical form.

This preference for 'methodological pluralism' (see, for instance, Goss and Mearns, 1997) means that the present book draws on research findings from both the quantitative and qualitative realms. Quantitative findings are used to build up a picture of the typical outcomes of therapy and the kinds of factors that tend to be associated with positive changes; and, as with other reviews (e.g., Roth and Fonagy, 2005), there is a particular reliance on findings from studies with large numbers of participants, or where a large number of studies have been drawn together, because of the greater generalisability of such research. Also, the book draws primarily from those quantitative studies in which there is a high degree of methodological rigour and where efforts have been made to control bias, to minimise, as far as possible, the likelihood that the results are a product of the researchers' own prejudices (see hierarchy of evidence in the Glossary for more details of how different sources of evidence tend to be weighted in this, and other, research reviews, e.g., Roth and Fonagy, 2005). As stated above, however, this book also draws wherever possible from qualitative research, and this is used to try and understand some of the more complex processes and outcomes in therapy, as well as some of the ways in which clients might specifically experience the therapeutic process.

## **Content**

With respect to the content of this book, it might also be helpful to say a few words about statistics. Many people hate statistics, and I have tried, wherever possible, to

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report findings in a way that is accessible to even the most anxious statisticophobe. Having said that, there are some statistical concepts that are so useful for readers to know about that the book has not entirely dispensed with statistical terminology or analysis. This means that some of the writing (particularly the boxes in Chapter 2) might feel a bit tough going, but I would really encourage readers to stick with it and re-read sections, refer to the Glossary, 'Google' terms (the online encyclopaedia Wikipedia is a particularly useful and comprehensive source of information), or purchase a simple introductory text like Derek Rowntree's *Statistics Without Tears* (Penguin, 1991) to get a grasp of what is being discussed. I promise... it won't be for nothing: just understanding a few basic concepts like 'effect sizes' and 'significance' can make a world of difference to an understanding of counselling and psychotherapy research findings, and also to the confidence with which you will be able to communicate them to others.

In terms of the language used in this book, coming from a standpoint that wants to acknowledge the active role of service users, I have used the term 'client' throughout as opposed to 'patient'. I also tend to talk about clients 'participating' in therapy, rather than 'undergoing' it or having it done *to* them. I have tried to avoid the term 'treatment' because of its more medical connotations; and tend to write about psychological 'distress' rather than 'mental illness' or 'psychopathology' to avoid making judgements about what is or is not normal. The one exception to this is Box 3.1 on empirically supported treatments, where the research being discussed is very much framed within a medical outlook.

Given the lack of any reliable evidence indicating a difference between the practices of 'counselling' and 'psychotherapy' (Dunnett et al., 2007), I have tended to use the two terms interchangeably or used the generic terms 'therapy'. However, it should be noted that the vast majority of research findings discussed in this book are based on practices that are described as 'psychotherapy', so that the legitimacy of extrapolating from them to counselling could, conceivably, be challenged.

Finally, something about what is not in the book. A brief search on ISI Web of Knowledge (an internet journal search engine) reveals that around 60,000 academic papers have been published on counselling and psychotherapy research in the last thirty years. If each of these papers took one hour to read, a comprehensive reading of the literature would take about thirteen years. All that is a long way of saying that, inevitably, there are certain findings within the counselling and psychotherapy field that are not covered in this book. Most often this is because research in these areas is very limited, such that it is difficult to say anything with any degree of reliability. In other instances, however, I may have simply overlooked some important findings. If this is the case, I would be very happy to hear from readers about research that they think should be included for future editions (please email me via the publishers). Finally, for reasons of space I have focused primarily on the *outcomes* of *one-to-one*, person-to-person (i.e. not self-help) counselling and psychotherapy with *adults* (in the younger to middle-aged ranges). For research findings on aspects of counselling and psychotherapy not within this remit, see the suggestions for recommended reading below.

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**RECOMMENDED READING***The process of therapy*

Tryon, G.S. (ed.) (2002) *Counselling Based on Process Research: Applying What We Know*. Boston: Allyn & Bacon.

*Group therapy*

Burlingame, G.M., MacKenzie, K.R., and Strauss, B. (2004) 'Small group treatment: evidence for effectiveness and mechanisms of change', in M.J. Lambert (ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change* (5th edn). Chicago: John Wiley & Sons. pp. 647–96.

*Family and couple therapy*

Sprenkle, D.H. (ed.) (2002) *Effectiveness Research in Marriage and Family Therapy*. Alexandria, VA: American Association for Marriage and Family Therapy.

*Self-help materials*

den Boer, P., Wiersma, D. and van den Bosch, R. (2004) 'Why is self-help neglected in the treatment of emotional disorders? A meta-analysis', *Psychological Medicine*, 34 (6): 959–71.

*Children and young people*

Fonagy, P., Target, M., Cottrell, D., Phillips, J. and Kurtz, Z. (2002) *What Works for Whom? A Critical Review of Treatments for Children and Adolescence*. New York: Guilford Press.

Harris, B. and Pattison, S. (2004). *Research on Counselling Children and Young People: A Systematic Scoping Review*. Rugby: BACP.

*Older adults*

Hill, A. and Brettell, A. (2004) *Counselling Older People: A Systematic Review*. Rugby: BACP.

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Research findings on counselling within specific contexts are also not covered here. For systematic reviews of research within such areas as primary care (Hill and Brettell, in press), further and higher education (Connell et al., 2006) and the workplace (McLeod, 2008) see the BACP publication pages at [www.bacp.co.uk/publications/index.html](http://www.bacp.co.uk/publications/index.html).

In terms of structure, the book begins with a discussion of the overall outcomes of therapy (Chapter 2). Subsequent chapters then look at the relationship between therapeutic outcomes and different factors within counselling and psychotherapy: the therapist's orientation (Chapter 3), client factors (Chapter 4), therapist factors (Chapter 5), relational factors (Chapter 6) and techniques (Chapter 7). The concluding chapter (Chapter 8) draws together the research findings and points towards ways of taking this work forward. Finally, for those interested in the evidence for specific therapeutic orientations, there is a review of the relevant research (Appendix 1). A Glossary of key terms is also presented at the end of this book.

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## Conclusion

For all of us, whether practitioners, researchers, students and/or clients, the challenge of research is by no means easy. It makes things complex, it can be hard work, and it can force us to reconsider our assumptions and most cherished beliefs. Carl Rogers (1961: 24), founder of the person-centred approach and one of the first psychotherapy researchers, wrote, 'in our early investigations I can well remember the anxiety of waiting to see how the findings came out. Suppose our hypotheses were *dis*-proved! Suppose we were mistaken in our views! Suppose our opinions were not justified!' However, he goes on to write:

At such times, as I look back, it seems to me that I disregarded the facts as potential enemies, as possible bearers of disaster. I have perhaps been slow in coming to realize that the facts are *always* friendly. Every bit of evidence one can acquire, in any area, leads one that much closer to what is true. And being closer to the truth can never be a harmful or dangerous or unsatisfying thing. So while I still hate to readjust my thinking, still hate to give up old ways of perceiving and conceptualizing, yet at some deeper level I have, to a considerable degree, come to realize that these painful reorganizations are what is known as *learning*, and that though painful they always lead to a more satisfying because somewhat more accurate way of seeing life.

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## RECOMMENDED READING

Lebow, J. (2006). *Research for the Psychotherapist: From Science to Practice*. London: Routledge. Hugely readable collection of essays on psychotherapy research findings, controversies, and implications for practice.

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## QUESTIONS FOR REFLECTION

- 1 What images or phrases does the word 'research' conjure up for you?
  - Write or draw these down, without trying to consciously filter them.
  - What does this tell you about how you might respond to counselling and psychotherapy research findings?
- 2 What do you consider the particular (i) strengths and (ii) limitations of research evidence as a basis on which to develop therapeutic practice?
- 3 To what extent would you trust research findings as against information from the following sources?
  - theoretical models
  - your own personal experiences as a therapist
  - your own personal experiences as a client
  - ethical and philosophical principles

(Continued)

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*(Continued)*

- 4 Spend a few minutes listing the factors that you believe make therapy effective:
- How would you feel, and what would you do, if you came across research that challenged these assumptions?
  - How open do you think you are to being challenged by research evidence?

**Box 1.1 Research quiz**

The following multiple-choice quiz offers readers an opportunity to reflect on the kinds of questions asked by counselling and psychotherapy researchers and to try and predict what they have found. Contrary to counselling and psychotherapy lore, there *are* right answers, but the quiz is not intended to be a test of readers' knowledge or ability; rather, its aim is to stimulate interest and discussion in the field.

If used as part of a training programme, the quiz works well when undertaken in small groups of four and five. Groups should be given twenty minutes or so to try and come up with a *consensual* answer to each of the questions: i.e., students will need to discuss together which answers they think are right. With the input of a facilitator, the groups can then go through each of the answers (see end of book), discussing any issues, questions or surprises that emerge.

- 1 Compared with medical and surgical procedures, how would the effectiveness of counselling and psychotherapy, in general, be best described?
  - (A) It has a large positive effect.
  - (B) It has a small-to-medium positive effect.
  - (C) It has no effect.
  - (D) It has a small-to-medium negative effect.
- 2 Approximately how many sessions of therapy are needed to produce a 50 per cent rate of recovery among clients (i.e., about half of clients moving from a clinical, 'abnormal' level of psychological functioning to a non-clinical, 'normal' one)?
  - (A) 1–5
  - (B) 5–10
  - (C) 10–20
  - (D) 20–50
- 3 If therapists have personally experienced the same types of problems as their clients, are the outcomes of therapy, in general:
  - (A) Substantially enhanced?
  - (B) Slightly enhanced?
  - (C) Unaltered?
  - (D) Substantially worsened?
- 4 In a recent study, primary care patients for whom a brief therapeutic intervention was indicated were given the option of choosing between non-directive counselling and

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cognitive-behaviour therapy (CBT). In non-directive counselling, patients were told that the therapist would give them the opportunity to talk about what was troubling them so that they could explore their thoughts and feelings about it. In CBT, patients were told that the therapist would identify thoughts, feelings and behaviours that affected their mood and help them develop a more positive approach to them. Of those patients who specifically opted to choose one of these two therapies, what percentage chose the non-directive counselling and what percentage chose CBT?

- (A) 10 per cent opted for non-directive counselling and 90 per cent opted for CBT.
  - (B) 40 per cent opted for non-directive counselling and 60 per cent opted for CBT.
  - (C) 60 per cent opted for non-directive counselling and 40 per cent opted for CBT.
  - (D) 90 per cent opted for non-directive counselling and 10 per cent opted for CBT.
- 5 In general, what is the relationship between clients' levels of psychological functioning and the amount that they tend to get out of therapy?
- (A) Clients who have poorer levels of psychological functioning tend to get the most out of therapy.
  - (B) Clients who have higher levels of psychological functioning tend to get the most out of therapy.
  - (C) Clients who have higher levels of psychological functioning tend to get the most out of relational therapies (e.g., psychodynamic and humanistic approaches), while those who have lower levels of psychological functioning tend to get the most out of cognitive and behavioural therapies.
  - (D) Clients' initial levels of psychological functioning are unrelated to how much they get out of therapy.
- 6 Which of the following factors was described, in one of the most comprehensive reviews of the research ever conducted, as 'the most important determinant of outcome'?
- (A) The quality of the therapeutic relationship.
  - (B) The therapist's orientation.
  - (C) The quality of the client's participation in therapy.
  - (D) The quality of the therapist's interpretations.
- 7 Which one of the following statements is true?
- (A) More 'resistant' clients (i.e., those with greater tendencies to oppose their therapists) tend to do better in non-directive therapies, while less resistant clients tend to do better in directive therapies.
  - (B) Less resistant clients tend to do better in non-directive therapies, while more resistant clients tend to do better in directive therapies.
  - (C) The vast majority of clients do better in more directive therapies.
  - (D) The vast majority of clients do better in less directive therapies.
- 8 Which of the following events did clients, overall, describe as most important in forming and strengthening a positive therapeutic relationship with their therapists?
- (A) Technical activity (e.g., The therapist got me to make a list of my goals).
  - (B) Self-disclosure (e.g., The therapist's business card said he/she was a trauma survivor like me).

*(Continued)*

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(Continued)

- (C) Emphasising client expertness (e.g., The therapist said, 'You know yourself best').
  - (D) Active listening (e.g., The therapist remembered and repeated back to me things I had said in previous sessions).
- 9 For which of the following forms of psychological distress does psychotherapy appear to be most *cost-effective*?
- (A) Severe psychological distress (e.g., schizophrenia).
  - (B) Moderate psychological distress (e.g., moderate depression).
  - (C) Mild psychological distress (e.g., mild generalized anxiety disorder).
  - (D) None: it is never cost-effective.
- 10 Which one of the following statements is true?
- (A) On average, clients of female therapists tend do *much better* than clients of male therapists.
  - (B) On average, clients of female therapists tend do *a bit better* than clients of male therapists.
  - (C) On average, clients of male therapists tend do *a bit better* than clients of female therapists.
  - (D) On average, female clients tend to do better with female therapists and male clients tend to do better with male therapists.