

CHILD AND YOUTH THERAPY IN BC

by

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Abstract

The study of what conditions are most effective in child and adolescent therapy is one that is growing but much work has yet to be done. This work is a review of two current approaches to psychotherapy, evidence based practice and the common factors and then suggestions from each to combine the two in an attempt to provide effective child and adolescent therapy. This is done by first exploring evidence based practice, then common factors and merging the two with the use of outcome measures. These are applied to children and adolescents in literature findings and the research specific to working with the specific diagnosis children and adolescents face in British Columbia are explored and summarized.

Keywords: Evidence base, evidence based practice, evidence based research, practice based evidence, medical model, practitioner as scientist, common factors, monitoring outcomes, child and adolescent therapy

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CHAPTER 1 INTRODUCTION

The current state of psychotherapy for children and adolescents in Canada has been presented as bleak by prominent researchers. Waddell, McEwan, & Shepherd, et al., (2005) have called for a total restructuring of how mental health services are provided to children and adolescents in Canada. The Mental Health Commission of Canada found that 1.2 million children are affected by mental illness and only 20 per cent of those receive appropriate treatment (n.d.). In a study out of Simon Fraser University, they found that of children and adolescents with mental health disorders who require specialized treatment, a full 67 per cent do not receive the help they require (Waddell, Shepherd, Schwartz, et al., 2013). Yet, 70 per cent of mental health problems begin to appear in the adolescence years (Physical and Health Education Canada). More pertinent was the finding that 70 per cent of mental health cases appearing in adolescents can be addressed through early intervention (Physical and Health Education Canada, n.d.). Without the necessary intervention, children and adolescents suffer unnecessarily, at home, in their schools and in the community (Waddell, et al., 2005). That suffering continues and worsens for many into their adult years; causing significant strain on both the individual and society (Waddell, Shepherd, Schwartz, et al., 2013).

In response to the identified need, British Columbia's Ministry of Children and Family Development, with the support of the Ministry of Health, began a process to develop and improve their systems to better meet the needs of children and youth in BC. They identified in The Child and Youth Mental Health Plan that the mental health system in BC had become a complex network of "poorly coordinated and insufficient" services, ill equipped to meet the mental health needs of children and adolescent (Auditor General, 2007, pg. 1). As a result, a plan was created to make organizational changes to better integrate child and youth mental health

services. The main goals of that plan were to provide timely and effective treatment; reduce, prevent and mitigate the effects of mental disorders; put effort into prevention of mental health disorders in children and youth; and to coordinate services, monitor outcomes and ensure public accountability for policies and programs (Auditor General, 2007). Further expectations for the plan included that it be appropriately supported by research, expert opinion, stakeholder consultation and include “value-for-money” (Auditor General, 2007, pg. 3). The focus of the plan was to improve performance in the government system, a goal that included hiring clinical staff, incorporating a computerized clinical intake screening tool and using evidence based treatments.

The need for improved approaches to meeting the mental health needs of children and adolescents is clear. Even the government bodies providing mental health services have acknowledged the issue. If unaddressed, these preventable mental health issues can evolve into mental health disorders in the adult years that remain through the lifespan (Waddell, Sheppard, Chen, et al., 2013). There are many life limitations that can accompany pervasive mental health issues, including reduced educational and occupational opportunities through to increased mortality (Waddell, Sheppard, Chen, et al., 2013). The economic impact of which has been estimated at over \$51 billion annually in Canada (Waddell, Sheppard, Chen, et al., 2013). Several different approaches to change have been proposed. Some suggest structural changes need to occur on the government level (Auditor General, 2007). Some suggest a comprehensive health approach that monitors the entire population of Canada’s health (Waddell, Sheppard, Chen, et al., 2013).

The need for more effective provision of services is clear, what form that takes however has been a source of debate. In the treatment of mental health, limited resources mixed with a

demand that far exceeds the capacity to provide it has also impacted the provision of individual treatment of clients. While the government agencies have moved toward greater accountability and evidence based practice, not all therapists have embraced the shift. Evidence based practice is one approach to counselling. Another can be described as a common factors approach. The common factors are the elements found in all effective therapy techniques and models. There are a variety of models with different factors included, however it is generally agreed that these include four categories of factors: 1) *Client factors* those elements of change that are attributed to the client and their commitment and capacity for change, 2) *relationship factors*; the therapeutic alliance, 3) *placebo, hope and expectancy factors*; all of which envelope the client's belief that the work they are engaging in will impact them, and 4) *model or technique factors*; which includes that the therapeutic approach is appropriate to address the client's issues, a fit for the client and takes into consideration the therapist's competency with the model they chose. Another growing area of psychotherapy is monitoring outcomes. All have all been proposed as the best approach to therapeutic practice.

About the Author

I am currently pursuing a Master of Counselling Degree from City University. This manuscript style thesis has been undertaken in pursuit of the completion of that degree. I also work as a Social Worker Assistant with the British Columbia Ministry of Children and Family Development and have been in that role for eight years. Additionally, I have been working with Child and Youth Mental Health in the role of practicum student toward the completion of said degree. As a result, the clear policy requiring the use of EBP is a relevant and current issue for me.

I previously worked for half a decade with high risk foster children as the primary caregiver in a government contracted resource. That experience has been supplemented with my current work on a youth team. In these I developed a significant curiosity about what elements were needed to create healthy transformation for youth. It seemed clear to me that the relationship with somebody who was invested in the youth was a significant contributing factor; however, it seemed that there was more involved than what was simple or obvious. I am curious to know more about what the communities who engage professionally with youth have found so that I can integrate more of what works into my own engagement with youth.

Personal Bias

I work within the provincial government and am aware of the competing priorities between need and resources yet see that people do amazing work with families. The tension between the expectations that we work with accountability, best practice and build relationships in a client centered environment all exist in my work place. In the middle of that, whatever their ideologies, I witness coworkers striving to do the best they can for families. Personally, I am torn between feeling a deep connection with a person centered approach and a belief that there is more to effective interventions than a healthy connection. I believe the acknowledgement and inclusion of evidence based practice is vital, however I do not believe it to be sufficient. I believe there are common factors that underlie all effective therapy and I have been monitoring my outcomes with the use of session rating scales in my own sessions and am learning how to integrate feedback into my work with clients.

Thesis statement

What are considered the best approaches to psychotherapeutic interventions with youth?

Intended Audience

The findings of this research are intended to provide an overview for therapeutic practitioners working with children and youth. There seems to be a conflict between evidence based practice and common practice. Through exploring evidence based practice and the common factors, we then review what aspects of practice are valuable to therapeutic interaction with youth. There has been an identified need for therapists to build the awareness and capacity to provide early interventions with youth. Early intervention for adolescents requires therapists to be equipped to provide the support that could address and prevent the damaging effects of mental health issues. In order to do so, the elements of psychotherapy that contribute to best practice need to be clarified. I seek to develop my own conceptual and theoretical framework as well as provide a review of the academic literature of current practice with children and adolescents.

Definitions

Evidence based practice was defined by the Canadian Psychological Association's task force of psychological treatment to incorporate the following ideals: peer-reviewed research evidence, psychologists employing both general knowledge of the evidence-based, understanding the hierarchy of the evidence and application in their session-by-session work in collaboration with the client or patient.

Evidence based treatment is providing treatment that is guided by the best available evidence (Canadian Psychological Association).

Common Factors are the elements found in all effective therapy techniques and models. There are a variety of approaches to which factors should be included, however it is generally agreed that these include four categories of factors: 1) *Client factors* those elements of change that are

attributed to the client and their commitment and capacity for change, 2) *relationship factors*; the therapeutic alliance, 3) *placebo, hope and expectancy factors*; all of which envelope the client's belief that the work they are engaging in will impact them, and 4) *model or technique factors*; which includes that the therapeutic approach is a fit for the client and their presentation as well as the therapist's competency with the model they chose.

Scientist practitioner is a clinical psychologist who works with clients and also applies training as a scientist in collecting statistical data.

Evidence based guidelines are manualized approaches to a specific presenting issue that bases the prescribed intervention on the best available evidence; randomized control trials, Meta analysis and systematic reviews.

Children are 0 to 12 years old.

Adolescents or youth are 13 to 18 years old (and 19 in BC).

Methodology

A manuscript approach will be used to explore and summarize the academic literature pertaining to current therapeutic approaches to children and adolescents and then focus on what are considered effective therapeutic interventions with the main mental health issues children and adolescents experience. This will begin with a look at evidence based practice, then the common factors model, what children and adolescents want in therapy, monitoring outcomes and then focus in on specific interventions for the most significant mental health issues faced by children and adolescents in British Columbia. This will provide an overview of significant trends in approaching therapeutic work with children and adolescents before highlighting the research significant to specific mental health disorders. These will be explored using electronic

databases, keyword searches, and a review of current practice and then the approaches specific to working with the issues currently prevalent face youth in BC.

Structure of the thesis

Chapter one placed the issue of child and youth mental health issues in the context of the state of psychotherapy in British Columbia. In chapter two the evidence based practice is explored and issues with resistance to implementation are highlighted with a look at outcome measurement as a means to overcome the issues and integrate clinical practice more effectively into psychotherapy through the use of outcome measures. In chapter three, the common factors of effective therapy are explained and again, suggestions for integrating these into outcome measures are suggested. In chapter four, we explore how a database could expand the evidence base and incorporate practice with the evidence. In chapter five, the focus shifts to the specific mental health issues faced by children and adolescents in BC and the evidence based practice approaches suggested to address each.

CHAPTER 2 EVIDENCE BASED PRACTISE

In order to more effectively meet the mental health needs of child and youth in British Columbia, interventions are to be rooted in evidence based practice. The Auditor General (2007) recommendation the Child and Youth Mental Health Plan developed by the Ministry of Children and Family Development include an initiative to ensure that all clinicians receive training in evidence based practice, that supervisors consistently review the application of these concepts with staff and ensure that evidence based practice be integrated into services. This was followed by a reminder that “significant resources” were provided to the ministry to implement this plan and a reminder of accountability to report the progress and results of the implementation and follow through of that plan (Auditor General, 2007, p.12). The need for transparency, accountability, and cost effective results are accepted as being consistent with evidence based approaches (Buckley, Tonmyr, and Lewig, et al. 2014; Greenheart, 2011).

What is evidence based practise?

Evidence Based Research (EBR) was established during the 1990s in the field of medicine as a multidisciplinary approach to developing a scientific base for how to best address specific medical issues (Katsikis, 2014). The drive toward using EBR spread from medical care into other disciplines, including psychotherapy and has been adopted as the most reliable and cost effective means of providing services in Canada (Canadian Psychological Association, 2012). The research collection includes clinical trials that have shown both effectiveness and the efficacy of various treatments through experimentation (Katsikis, 2014). EBR became a “cornerstone” in the evidence for best approaches and randomized controlled trials (RCTs) were established as the most reliable source of evidence (Katsikis, 2014, Wampold, 2010). These

empirically supported treatments are used to generate treatment guidelines and manuals (Miller, Hubble, Chow et. al., 2013).

When the guidelines and manuals are applied in working with clients, EBR translates into evidence based practice (EBP). Only approaches that have been through a rigorous review process and validated with consistent results in randomized control trials are included in the body of EBR (Katsikis, 2014; Test, Kemp-Inman, & Diegelmann, et al., 2015). The underpinning idea of EBP is that the specific ingredients of these clinically validated therapies are more effective than other treatments (Miller, et al., 2013). According to the Canadian Psychological Association (CPA), using EBP includes identifying and selecting interventions and treatment strategies that maximize the chance of benefit, minimize the risk of harm and deliver the most cost-effective treatment (2012).

EBP includes monitoring and evaluating all aspects of the intervention provided to clients from the intake to the termination of treatment (CPA, 2012). EBP also includes a commitment to professional development on the part of the evidence based practitioner. To provide EBP, a therapist must seek relevant and effective interventions as EBR is an evolving and growing body (CPA, 2012). EBR led to a body of evidence that has shown that psycho-therapeutic interventions, like cognitive behavioural therapy (CBT), are effective for a wide variety of people across a wide range of psychological problems (Test et al., 2015, & Dozois, 2012). Research evidence has also shown these psychological practices can be safe, effective, efficacious, and can lead to increased productivity and life satisfaction; with effects potentially enduring over time (Katsikis, 2014; Dozois, 2012; CPA, 2012).

The problem with the evidence

Opponents of EBP claim that the rationale that makes EBP such a good fit in medicine and other disciplines, does not fit in social sciences and psychotherapy (Katsikis, 2014). This critique may be based on the view that humans are not uniform and personal variations appear in psychotherapy that does not fit within the parameters of testing with the scientific method (Katsikis, 2014). Complicated circumstances and histories can be convoluted, which makes the application of cause and effect solutions found in medicine more difficult to apply to the fluid and unpredictable social sciences (Buckley, et al., 2014). This has been specifically relevant for the populations who present for service at government funded agencies, the exact agencies that have purported the use of EBP (Buckley, et al., 2014). To further complicate the issue, the research has not always been readily transferable into practice and can be hard for practitioners to interpret (Buckley et al., 2014; CPA, 2012; Dozois, 2013). Also, not all research results are reliable; some can be poor quality, costly, and mistaken in the conclusions as well as potentially having flaws in the methodology (Buckley, et al., 2014). For example, in a systematic review of 32 EBP guidelines on substance misuse among adolescents, the researchers found that evidence to support the recommendations was sparse; many were based on expert consensus or on studies among adults instead of results from RCTs, and the link between evidence and recommendations was often unclear (Bekkering, et al., 2014). The researchers concluded that although there are a substantial number of guidelines addressing substance misuse in adolescents, the level of evidence underpinning the recommendations were low, despite these being considered high-quality guidelines (Bekkering, et al., 2014).

Criticisms of EBP include utilizing a medical model in therapeutic situations (Miller, et al., 2013). There are some who associate EBP with a model of intervention belonging to a

medical model and an “illness ideology” that emphasizes the therapist’s actions and technique to create a certain effect (Aigen, 2015, p. 22; Miller et al., 2013). In a medical model, treatment comes from a concept of illness and intervention instead of an approach in which people are presumed to be competent and equal (Aigen, 2015). Rather than working with clients strengths and resources, the medical model directs treatment "toward a disorder, problem, or complaint" (Rolvjord, 2010, p. 24). The medicalization of psychotherapy has been interpreted by some as a threat to established successes in the field (Aigen, 2015, Miller, et al., 2013). Forcing therapists to adopt condensed and regulatory approaches associated with manuals of how to perform therapy based on treatment guidelines associated with EBP may strip the interpersonal aspects from therapeutic process and remove the relational elements critical to successful change in clients (Miller, Hubble, and Chow, et al., 2013).

There are established approaches to therapeutic practice that are perceived as being threatened by the use of EBP. Some types of treatments, like CBT have received extensive funding for research and a large number of studies exist on CBT with RCT to derive results from. The criteria set by the CPA for treatments to become a part of the research base were controversial (Dozois et al., 2014). Evidence from therapeutic approaches that have not met those criteria has been deemed unscientific and marginalized to the point that important data derived from those studies have been overlooked (Laska & Gurman, 2014). Aigen (2015) expressed fear that the application of EBP principles in a firmly scientific manner can threaten the welfare of clients and the future of therapeutic approaches that have historically been diverse and pluralistic, like the approaches used in music therapy. The many issues with EBR and the potential application to EBP have not been bridged. Even those who ascribe to EBP are clear that clinical practice should be evidence-informed, but does not need to be narrowly evidence-driven

(Dozois, et al., 2014). There are many suggestions of how to more effectively integrate EBR into EBP and bridge the gap between the scientist and practitioner.

Local Clinical Scientist (LCS)

The potential for integration of clinical experience into EBR can be seen in the idea of adopting a local clinical scientist practice or scientist practitioner (SP). In this approach, counselling psychology practitioners would bring science into their day to day professional roles by collecting data in each interaction with clients (Hiebert, 2011). Therapists who take on the role of SP act as scientists in their daily work and treat each session as a scientific investigation (Hiebert, 2011). They observe, track, document, and look for patterns in the various factors that might influence client change; documenting the process and outcomes of each session (Hiebert, 2011). If many therapists engaged in the process, then clinical practice would provide examples of all the various approaches. Data from all of the therapists engaging in the role of SP would accumulate, providing a body of evidence based in practice instead of a controlled clinical environment (Hiebert, 2011). The data could then be synthesized to find patterns, build predictions and explore treatment viability from real world sessions (Hiebert, 2011). Although this would provide a rich and diverse amount of data, it is but one suggestion of how to bridge the gap between the clinical trials and real world therapy as well as between scientist and practitioners. Even the president of the CPA acknowledged that psychotherapy needs the experience and expertise of practitioners (Dozois, 2013). By capitalizing on clinician's knowledge and experiences, many of the gaps in EBR can be bridged (Dozois, 2013 & CPA, 2012). In an attempt to decrease the scientist-practitioner gap, clinicians systematically recording their experiences contribute not only to the body of EBR but would provide important information to the next generation of psychotherapists (Dozois, 2013).

Suggestions for Scientist and Practitioner

In an attempt to overcome the barriers between EBR and EBP, the Canadian Psychological Association (CPA) created a task force that was focused on the integration of EBR into practice. The taskforce was established to disseminate psychological treatments that are most likely to be successful (CPA, 2014). The taskforce acknowledged that although the majority of therapists acknowledge and favour the idea of practicing in a manner that was evidence based, many lean more heavily on clinical judgment than evidence (CPA, 2014). The CPA have provided the following suggestions for the scientist and for the practitioner to work together to increase the integration of EBR into EBP (Dozois, 2013). The president of the CPA acknowledged that EBR needs to be further rooted in practice (Dozois, 2013). In order to accomplish that, infrastructure would have to be adapted and developed for more efficient and effective translation of clinical research into information relevant to practice (Dozois, 2013). To further this, it would be beneficial for increased and direct collaboration between psychologists who identify primarily as researchers and those who primarily identify themselves as therapists (Dozois, 2013).

Dozois (2013) went on to explain that because human judgment and memory are fallible, more science was needed in therapeutic practice. By training psychologists to think in an evidence-based manner they would be better equipped to apply EBR in their day-to-day practices (Dozois, 2013). He also suggested students coming into the field trained on how to think critically, respect, and understand scientific knowledge and empirical methodologies, as well as learning how to integrate this information into the context of client's needs and circumstance (Dozois, 2013). He suggested students be trained and develop awareness of when it would be beneficial to adhere to a particular approach, when to modify it, and when to abandon it (Dozois,

2013). By teaching students how to think in an evidence-based manner, future generations of therapists could then adapt to individual circumstances and effectively integrate research into their practices (Dozois, 2013).

Another recommendation was to increase research on what the specific mechanisms of change are (Dozois, 2013). While we have many studies that have shown that psychological interventions are effective for a host of conditions, why has yet to be understood (Dozois, 2013). This could help clinicians to determine which therapeutic ingredients to emphasize (Dozois, 2013). Knowing how psychotherapy works would result in more efficient and effective treatment (Miller, et al., 2013). Dozois (2013) also suggested a type of SP to monitor outcomes as another method to narrow the gap between research and practice. By measuring treatment progress in a way that was systematic, routinely using scientifically reliable indicators of clients' functioning, they would better determine whether a particular intervention were effective and make informed treatment decisions (Dozois, 2013)

Integrating EBR and EBP

Whether or not therapists embrace EBR; government, health care, and education are moving toward this as the standard. It is clear that in British Columbia the plan has already been made and government funded mental health services are implementing and monitoring the adherence to EBP. Goodheart (2011) stated that the future of psychotherapeutic practice will be heavily impacted by EBR. She predicted that only evidence based interventions will be supported by government funding and that counselling education programs will increasingly focus on interventions that are based in EBR (2011). Goodheart (2011) called for an integration of EBR and EBP, however, like Dozois, was able to identify that EBP must be based in not only evidence from the best available research but also in clinical expertise, client characteristics,

culture, and the client's preferences (Goodheart, 2011). The therapeutic encounter cannot be purely scientific as there are too many elements that must be considered. The complex interaction between a therapist and client includes a dynamic back and forth. Each client brings a unique combination of fears, hopes, strengths, limitations, attitudes, and personal characteristics and the therapist engages with clinical training, flexibility, focus on the patient's goals and the therapeutic alliance to bring about internal and external changes (Goodheart, 2011). To know whether or not an intervention was effective for the client, the therapist must assess the outcomes for the client (Goodheart, 2011 & Duncan, Miller and Hubble, 2007). The client can provide an accurate depiction of the effectiveness of therapy by rating important factors, thereby gauging how clients are responding to treatment and their degree of improvement (Duncan, et al., 2007).

Conclusion

Practice in the province of BC is moving toward integrating EBP into the services they offer to children and youth with mental health issues through the Ministry of Children and Family Development. The use of EBP works well within their need for accountability and transparency. EBP is derived from EBR, a body of evidence based on clinical research that has been validated with consistent results and meets the standard for treatments. The intention of focusing on EBP is to maximize the chance of benefit, minimize the risk of harm and deliver the most cost-effective treatments that have been shown to have positive results.

There are, however, limitations to the implementation of EBP as the standard of treatment. There are opponents to EBP that include those who associate EBP with a medical model. They explained that a medical model approach comes from an illness ideology that identifies a person as ill, diagnoses them and then the therapist directs the cure for the ailment.

Those who view the medical model of psychotherapy as problematic point out that a person centered approach does not identify a person as ill, but facing circumstances that they are seeking therapeutic support to overcome. The person centered approach, instead of a focus on illness, focuses on the strengths and resources of a client and positions them as the greatest resource in therapy. Some struggle with the body of evidence including; translating the specific cause and effect solutions to the convoluted circumstances found in individual lives, links between evidence and practice, and the quality of guidelines associate with EBP. Others express fear that EBP will limit what evidence is included in the accepted approaches and worry that moving toward EBP may threaten the viability of more fluid approaches like music therapy.

The CPA, however, has identified these concerns and has provided a variety of suggestions to address them. One of those suggestions is the integration of clinical experience into the evidence base through a greater contribution of scientist practitioners. By using outcome measures in day to day sessions with clients, data can be compiled and integrated into the evidence base by these practitioners who also act as scientists. The more therapists who participate in the collection of data, the greater the influence will be of clinical practice on EBP.

Another suggestion was a greater focus from the scientific community on translating research into forms that are consistent with and applicable to clinical practice. The shift toward EBP for children and adolescents services in BC is underway. Some work remains to be done however, to bridge the gap between scientist and practitioner of psychotherapy.

CHAPTER 3 COMMON FACTORS

In 1936, Rosenzweig claimed that there are commonalities between all effective therapy approaches. This was confirmed over time as researchers noticed that some factors appeared in many practice models; some researchers hypothesized that certain factors were present no matter what practice model was used (Cameron & Keenan, 2010). This was confirmed in the classic review of comparative clinical trials in 1975 by Luborsky, Singer, and Luborsky (as cited in Duncan, Miller & Sparks, 2007). Lambert elaborated on this in 1992 with an extensive qualitative review of decades of outcome research. Based on that review, he categorized these factors into four categories and provided percentages of what amount of change could be accounted for with each (Sexton, Ridley, & Kleiner, 2004). Those common factors and their respective percentages were client factors (40 per cent), relationship factors (30 per cent), placebo, hope, and expectancy factors (15 per cent), and model or technique factors (15 per cent) (Sexton, et al., 2004, Miller, Duncan & Hubble, 1997). The common factors have been further studied through meta-analyses (Cameron et al., 2010). The results of those studies have consistently shown that clients make changes in response to a wide variety of practice models and approaches when the common factors are present (Cameron & Keenan, 2010, Wampold, Mondin, Moddy, Stich, Benson, & Ahn, 2001, Miller et al., 1997). As Wampold, et al., (2001) explored in detail, study after study has been performed comparing various therapeutic models and approaches through clinical trials and with very few exceptions, the differences are not attributed to the specific models (Miller, et al., 1997). Instead, this body of evidence has shown that the common factors of effective therapy account for positive outcomes in psychotherapy; a fact that has been shown by “the most replicated finding in psychological literature” (Duncan et al., 2007, p. 37). Meta-analyses of child and adolescent therapeutic models as well as family

therapy approaches yielded the same results (Duncan et al., 2007). A significant study of 2000 therapists and 20000 clients revealed that there were no significant differences in therapeutic outcomes between 13 different approaches to children and adolescents, including medication and family therapy (Duncan, Miller & Sparks, 2007).

Lampart's Common Factors

The common factors have been interpreted by many over the years and included various classifications. Lampart (1992) included; client factors, relationship factors, placebo, hope, and expectancy factors, and model or technique factors. Client factors are everything in a client's life and world (Miller et al., 1997). These are the supports, connections, and strengths clients have in themselves and their lives. More importantly, this includes the quality of a client's participation in treatment, "the single best predictor of psychotherapy outcome" (Miller et al., 1997, p. 33). Relationship factors include the therapeutic alliance (Miller et al., 1997). This therapeutic alliance includes a Rogerian style that is characterized by empathy, genuineness, respect, positive regard, and warmth (Miller et al., 1997, Shirk, Karver & Brown, 2011). Placebo, hope, and expectancy factors are a curative or destructive factor in therapy (Miller et al., 1997). Facilitating hope and a positive expectation for change with clients is an important factor in therapy (Miller, et al., 1997). Model, approach, or technique factors are vital parts of the therapeutic process, it is not, however, the particular model that is important but that the therapist is proficient in using it, the client believes it will help move toward their goals and is consistent with their world view (Duncan, et. al., 2007). A therapist using the common factors takes into account the values, meanings, and beliefs of each client when selecting therapeutic strategies (Cameron & Keenan, 2010). Research has shown that the treatment is not the catalyst of change but the combination of therapist, client, and their work together that is critical to the

successful outcomes in psychotherapy (Wampold, 2010). Having a focus that orients the interaction and that works toward agreed upon goals and acts to structure the interaction however is a vital aspect of therapy (Miller, et al., 1997). The competence of a therapist in working with an approach is also an important element in this factor (Miller et al., 1997).

The Contextual Model

Wampold (2015) recently summarized the common factors within the contextual model. This model incorporates the factors of Lampart's (1992) model but there are some theoretical variations that simplify the common factors into three categories. Wampold (2015) emphasized the importance and foundation of establishing the initial therapeutic relationship. He explained that the majority of premature terminations of therapy happen after the first session and are likely based on the first impression of whether the therapist is trustworthy, has the necessary expertise, and will take the time and effort to understand the client's context and problem (Wampold, 2015). If the therapeutic alliance can be established then the contextual model factors can be applied. These consist of a real relationship, the creation of expectations through explanation of disorder and the treatment involved, and the client's performing actions toward the goals or treatment (Wampold, 2015).

Although the common factors have been discussed for almost a century and clearly supported in the body of research, the focus of psychotherapy is not on those fundamental elements of effective therapy but on evidence based practice (EBP). In the current environment, with the development and dissemination of treatment models being the focus, the common factors are often discounted and when they are not, they have been dismissed as perhaps necessary, but not sufficient (Wampold, 2015). The evidence, however, strongly suggests that the common factors must be considered therapeutic and attention must be given to them, in terms

of theory, research and practice (Wampold, 2015). Especially because all elements of the approach account for approximately 15 per cent of the outcome variance and the client and therapist relationship account for closer to 40 per cent (Duncan et al., 2007). The special ingredients that account for the effective outcomes and change are not primarily the EBP models and guidelines but the practice of psychotherapy that has been occurring for over a half a century (Dewell & Owen, 2015).

Common factors with children and adolescents

The common factors approach also aligns with what adolescents want from their experience in therapy. A recent qualitative study of adolescent priorities in psychological services produced a list of factors that are important to them. Considering the consistently high rates of adolescents who fail to attend after their first session, their input may more actively sought for future studies (Wampold, 2015). The priorities of adolescents in therapy include the need to keep control, not have their parents involved, have more of a friendship type of relationship with the therapist than a professional one, to talk freely and be listened to and to have accessible and flexible access to services (Gibson, Cartwright, Kerrisk, Campbell & Seymour, 2015).

This finding is supported in other literature pertaining to adolescents, particularly the need to establish a therapeutic alliance and work with the client to establish goals. Shirk, Karver and Brown (2011) pointed out that the bond between therapist and child or adolescent is not in itself “curative, but rather a catalyst for promoting therapeutic work” (p. 17). Similar to Wampold’s (2015) explanation of the foundational importance of establishing a bond in therapy, Shirk et al. (2011) agreed that the bond is the foundation to child and adolescent involvement in therapy, as well as in any tasks, including in session and between sessions home work (Shirk, et

al., 2011). Campbell and Simmonds (2011) pointed out that empirical evidence supports the connection between therapeutic alliance and treatment outcomes and acknowledged that the importance of these in the child and adolescent literature as widely recognized. Children and adolescents are known to detect insincerity and trustworthiness in a therapist; they are described as “having their own radar” to detect the therapists level of sincerity, honesty, and authenticity (Campbell, & Simmonds, 2011, p. 205).

Another important aspect predominant in the adolescent literature is agreement on the goals of therapy. Like adults, an agreement on goals that are the client’s is a priority in child and adolescent therapy. With adolescents, however, this seems to be an even more significant issue. Without judgment on their validity, the client’s goals must be accepted at face value as working with the goals of the child or adolescent is what excites and motivates them toward action on their own behalf (Duncan et al., 2007). This is essential for positive outcomes in psychotherapy (Duncan, et al., 2007). The therapist and client work together to construct the tasks of therapy within the context of the therapeutic alliance toward the client’s goals of therapy (Duncan et al., 2007).

How does a therapist know that she or he is attending to the child or adolescent and continuing to move toward their goals and working well within the therapeutic alliance? Children and adolescent have less power in relation to adults and often are brought to therapy by their parents (Shirk, Karver & Brown, 2011). As a result, they may not feel as free to provide feedback, especially when it is negative in nature. In addition, therapeutic services may be located in a professional office that could be intimidating for children and adolescents. Duncan et al. (2007) point out that the voice of adolescents in both their treatment and the literature has

been neglected. To remedy this, they suggest that therapists seek feedback from clients to measure the therapeutic alliance, the goals, and tasks, and all other aspects of practice.

Measuring Outcomes

Duncan et al. (2007) coined the term practice based evidence (PBE) to describe the value of outcome informed psychotherapy (Goodheart, 2011). They proposed that assessing known predictors of change would provide an “accurate snapshot” of how the client has responded in each stage of treatment (Duncan et al., 2007). They explained that systematically assessing treatment with the client filling out a simple questionnaire before and after each session could introduce a simple, scientific element into practice (Duncan et al., 2007). This evaluation of the outcome of each session would inform practice and demonstrate the effectiveness of treatment (Duncan, et al., 2007). The use of this simple outcome measure would act to monitor relevant changes in the client and allow the therapist to build PBE that would act as a gauge of each stage of treatment (Duncan et al., 2007). This practice provides an immediate opportunity for therapists to process and measure whether each of the elements are a fit for the clients, there is an opportunity to adjust the individual elements accordingly (Duncan et al., 2007).

According to Duncan et al. (2007), there are clinicians who have consistently superior results with their clients. Studies have shown that some therapists are able to form stronger alliances no matter the circumstance or presentation of the clients, have a higher level of interpersonal skills, consistently seek feedback from clients, express more professional self doubt, and spend vastly more time outside of therapy practicing various therapeutic skills (Wampold, 2015; Miller, 2010). These “top guns” of psychotherapy consistently do three things that result in more effective outcomes. First, they are willing to step outside of what they are comfortable doing (Duncan et al., 2007). The most effective therapists strive to be more

effective in their practice by identifying clients who are not progressing and proactively re-engaging those clients to collaboratively seek a new direction for the treatment (Duncan, et al., 2007). Talking to clients about what is not working for them can be a challenge for the therapist but can strengthen the therapeutic alliance (Duncan et al., 2007). Second, they use reliable measures to determine as clearly as possible how clients are responding to treatment and their degree of improvement through feedback (Duncan, et al., 2007). They start asking the client at the beginning of therapy how things are going and continue to be systematic in assessing the client's degree of improvement (Duncan, et al., 2007). Third, they establish and maintain the highest level of engagement they can within the therapeutic alliance (Duncan et al., 2007; Wampold, 2015). The main reasons for early attrition in therapy are either the therapy was not helping, or the alliance was problematic (Duncan et al., 2007). By seeking outcome results with clients, the therapist gains PBE and measures of both the client's progress with the intervention and the therapeutic alliance with each session (Duncan, et al., 2007). This application of evidence in to day to day practice can act to incorporate best results for clients, more effective practice for therapists and some results to contribute to the evidence base; all with a simple questionnaire. It would be a small contribution to the larger practice, a continuous measure for both the client and therapist and possibly a small step toward the future of psychotherapy.

Using PBE could potentially provide a bridge between EBP and the common factors as well as between scientists and practitioners. Although there is a significant body of data supporting EBP, there is also a significant body of data that supports the common factors in psychotherapy. The evidence for the common factors has been excluded thus far from the evidence based literature. The president of the CPA acknowledged that many therapists keep up with recent literature, including EBP; yet clinical experience, not the evidence based literature

continues to have the strongest affect on treatment decisions in Canada (Dozois, 2013). The Canadian Psychological Association (CPA) found that attitudes toward EBP were the largest barrier to implementation of EBP (Dozois, 2013). According to the Willow Tree Counselling website, most practicing therapists in the Vancouver area have a Master's degree with a minority having a Bachelor's degree and a few with other qualifications (Sutherland, 2012). With such a highly educated and informed demographic could it be that there may be valid reasons that they are not adhering to EBP? Could that be that EBP is not all that it has been presented to be and the common factors actually account for positive outcomes in therapy? Research on common factors shows that the model, the therapist proficiency in working with it, the model's relevance to the client's particular problem and the client's belief that using it will better their lives all together account for about 15 per cent of change in psychotherapy (Miller et al., 1997). If Miller et al. (1997) are correct, then the model that is used is significant, however, an additional 85 per cent of therapeutic interventions involve factors not accounted for with a model.

According to Miller (2010), the majority of therapists are effective and efficient most of the time. Yet, in British Columbia, government funded mental health services are implementing and monitoring the adherence to EBP. Goodheart (2011) predicted that in the future, only evidence based interventions will be supported by government funding and that counselling education programs will increasingly focus on interventions that are based in EBR (2011). In fact, the primary goal of many clinical psychology graduate programs in Canada is to train scientist-practitioners who are skilled in developing both scientific research and clinical practice skills (Peluso, Carleton, & Asmundson, 2010). Also, the CPA guidelines for accreditation and ethical conduct require a balance between research and clinical training in education programs in order for them to receive accreditation (Peluso, et al., 2010). If EBP is the direction that

psychotherapeutic practice in Canada is moving, and it seems clear that there is significant pressure in that direction, then it would be worthwhile for those who do not adhere to EBP models to contribute to the body of literature and work to enhance the EBR so that it includes the modalities and approaches they use.

Conclusion

Although clinicians in Canada value clinical evidence over scientific evidence, according to Miller, neither has made statistically significant gains in practice outcomes (Dozois, 2013, Miller, Duncan, & Hubble, 2007). Miller et al. (2007) explained that there are 145 officially approved and manualized EBTs in addition to the proliferation of knowledge through international sharing of studies in the field of psychology. Yet the combination of all of the shared knowledge and research, “no measurable improvement in the effectiveness of psychotherapy has occurred in the last 30 years” (Miller, et al., 2007). Miller et al. (2007) explained that our attempts as a field to improve our practice as a whole has failed. Remembering of course that therapy has a high rate of success, the idea is to strive for better results than the status quo, not to diminish the therapy that has approximately a 70 per cent success rate (Miller et al., 2007). In order to achieve better outcomes for clients than the current rate, therapists would need to engage on a professional level at improving their practice. The largest barrier to this, surprisingly, is competence (Miller et al., 2007). After the noticeable mistakes of the first weeks and months of practice start to disappear, people starting getting comfortable in their professional activities. At that point, the cost in time, effort, and resources into intentional improvement becomes high and that is where those who are the “experts” in the field are separated by the rest by intentional practice (Miller et al., 2007).

The call for monitoring outcomes is widespread. The president of the CPA said that to improve psychotherapy outcome, it is important to gain a clearer understanding of how therapy works and what may account for when it fails to work (Dozois, 2014). He explained that not only is it recommend to monitor outcomes when treatment is initiated, but suggest monitoring the ongoing reactions, symptoms and functioning of each client and using that data to inform treatment (Dozois, 2014). Goodheart (2011) was specific in stating that outcome measurement was the best way to demonstrate the effectiveness of psychological services and specifically called for PBE as part of her design toward an improved vision for psychotherapeutic services.

Although “most clinicians do good work most of the time, and do so while working with complex, difficult cases” there is room for improvement and even more space for excellence (Miller et al., 2007, p. n.d.). To do so, those who purport EBP as well as those who purport the common factors are asking for a higher standard of therapy and all sides have stated that outcome measurement is a significant part of that. Engaging in outcome ratings has been shown to improve practice (Miller et al., 2007).

CHAPTER 4, A SHIFT IN PSYCHOTHERAPY

I believe a shift in psychotherapy has begun to occur. Miller, Hubble, & Duncan (2007) showed that despite significant research completed in the advancement of evidence based practice (EBP) and the mass amount of research promoting new models in psychotherapy, there have actually been very little improvements in the overall outcomes for clients over the past three decades. Miller, et al. (2007) pointed out that for the average therapist, which is the majority, of every ten clients, three do not benefit from the counselling they receive. Worse, Waddell, McEwan, & Shepherd, et al., (2005) found that most children in Canada with mental health disorders do not receive effective treatments. They attributed this shortfall to issues with individual practice and the fragmentation of the mental health services available (Waddell, et al., 2005). Waddell (2013) declared the solution to the lack of effective treatment for youth to be strict adherence to EBP and brought forward the suggestion from Health Canada to implement a comprehensive system to provide ongoing monitoring of the entire population, which would enable the collection of data on the indicators of children's mental health (Waddell, 2013). To facilitate the momentous task of improving the outcomes for children and youth in need of mental health services, Waddell (2013) asked that provincial and territorial ministries and agencies responsible for the mental health of children and youth as well as federal services like the Canadian Institute for Health Information and Statistics Canada invest the time and resources to partner together and either enhance current high quality data sources or create new systems to facilitate a monitoring system.

A Mental Health Database

If a project to coordinate federal and provincial mental health services were created, I believe that system should be used to synthesis data in a way that could be used to advance

clinical practice and improve the mental health outcomes for Canadians. Instead of limiting an information system to monitoring the implementation and results of EBP, it could be used to further it. Despite the “significant” local and global resources put toward the dissemination of EBP, mental health “clinicians do not consistently use the information available to them” (Dadich, 2010, pg. 197). There are many reasons for this including; disagreement around the criteria for inclusion in the evidence base (EB), common treatments that were excluded from the EB being deemed unscientific and the resulting marginalization of those treatments, and/or aversion to imposed expectations contrary to years of clinical experience, issues with the evidence base, the cost of retraining practicing therapists in EB treatments, and the translation of research into practice (Dozois et al., 2014, Laska & Gurman, 2014, Aigen, 2015). Whatever the reason for resistance to EBP, the fact is that in the province of British Columbia, the country of Canada and many countries in the world, EBP guide government policy and funding priorities (Dadich, 2010, Auditor General, 2007).

Therefore, I do not see the solution as resistance to the implementation of EBP but significant expansion of the information to be included in the evidence base. The creation of a system to store and synthesis data from day to day real world sessions could create the bridge needed to expand EBP. The EB has been primarily derived from randomized clinical trials (RTC)(Laska & Gurman, 2014). The data from this type of research, however, limits as many variables as possible in order to test a single element of therapy and in doing so, vital elements that significantly impact the therapy such as; the therapeutic alliance, client variables and the level of adherence to the model used, are accounted for by the control condition to address the unmeasured variables (Crits-Christoph, 2014). The very nature of a controlled clinical trial is to control for different variables, a limitation that excludes understanding and learning from the

complexities experienced in clinical practice settings. If information from day to day sessions were uploaded to a system, the complexities of actual sessions with clients could be analyzed and provide data for exploring all aspects of therapy. If this were a national database and a variety of clinicians from diverse settings across the country uploaded sessions to be synthesized, the information gathered would be rich, relevant and applicable to daily practice.

Several issues would have to be addressed in order for a database of clinical sessions to provide effective information. The first issue would be the isolation of variables. In RCT, the researchers attempt to control and filter out as many variables as possible in order to isolate the effect of the one variable being tested. While there can be some control of the environment in an RCT, there are many variables that are actually present. Instead of working to control the environments, researchers would apply alternate research methodology to synthesize the data allowing for less control of the variables but representing real world results. Research results could be filtered based on factors such as age, presenting issue, model or approach used to address the issue, and results can be broken down to greater detail and limited by similar variables such as the number of sessions. If research was tracked in a manner similar to PharmaNet, then researchers could have access to detailed information such as what the presenting issue was, the method used to treat it, the number of sessions, as well as the baseline assessment prior to and following therapy. Then when studies are done to show the efficacy of an intervention, researchers can search for the actual results answering question such as whether children who attend a CBT group for anxiety between the ages of 13 and 15 seek further mental health support later in life and the results would not be limited to those willing to participate in the research. The implications of access to this type of information would be immense as every

aspect of therapy would be available to explore, including those pertaining to client demographics, therapeutic approach, adherence to a model and details of the therapeutic alliance.

Clinicians submitting information to the database would bring science into their day to day professional roles by collecting data in each interaction with clients (Hiebert, Domene, & Buchanan, 2011) These scientist practitioners would observe, track, document the process and outcomes of each session (Hiebert, et al., 2011). The data could then be synthesized to find patterns, build predictions and explore treatment viability with the benefit and insight of practitioners and draw on their experience and expertise (Hiebert, et al., 2011). This could be an easy transition in Canada if implemented through the education system. In fact, in order to receive accreditation for their program, universities require a balance between research and clinical training in their education programs (Peluso, et al., 2010). Clinical psychology graduate programs include the training of scientist-practitioners as one of their primary goals, and all graduates are learning the skills relevant to both scientific research and clinical practice (Peluso, Carleton, & Asmundson, 2010).

Individual Practice

Waddell, et al., (2005) identified issues with individual practice as another reason most children in Canada with mental health disorders do not receive effective treatments. Miller, Duncan, & Hubble (2007), major proponents of the common factors model, supported the assertion that practice issues do exist. They found that for the average therapist, which is the majority, at least three of every ten clients do not benefit from the counselling they receive (Duncan, 2010). That leaves 70 per cent as the common success rate of psychotherapy; this is higher than the success rate for well accepted medical procedures like coronary artery bypass surgery but clearly there is room for improvement (Miller, Duncan, & Hubble, 2007). While

Waddell (2013) offered the use of EBP as the solution to practice issues, the common factors model attributes only 15 per cent of what happens in therapy to the model or approach used begging the question, what else needs to be improved.

Miller & Hubble (2011), in exploring the differences between average clinicians and those who were top performers found that the best results were obtained by clinicians who “exhibited deeper, broader, more accessible, interpersonally nuanced knowledge” (pg. 30). They also found that they were more collaborative and empathetic and had acquired understanding, perception and sensitivity (Miller & Hubble, 2011). These top performing psychotherapists not only had a grasp on psychotherapeutic strategies, but also knew when to use them. Although research shows that almost all psychotherapists strive for these qualities, there are no shortcuts to achieving them (Miller & Hubble, 2011). The deliberate practice required to be above the average becomes less and less rewarding once a person is practicing and proficient in their career (Miller, Hubble, & Duncan, 2007). This is why it is vital for universities to implement and emphasis training in the skills specific to positive outcomes for clients with students in their programs. This cannot be limited to the focus on the scientific research or that of implementing EBP but must also include the skills to work with a client from the initiation to termination of therapy.

Common Factors

The common factors model explores the elements present in all effective psychotherapy including; client factors; relationship factors; placebo, hope, and expectancy factors; and the model or technique factors (Miller, Scott, & Hubble, 1997). In sessions the therapist discusses and highlights the elements of each factor relevant to their client; however there are some skills involved in the use of these elements that can be learned in standardized learning environments.

The skills specific to building and maintaining the therapeutic alliance include responding to the client with empathy, genuineness, respect, positive regard, and warmth (Miller et al., 1997, Shirk, Karver & Brown, 2011). These may seem self evident, however, Duff & Beti (2010) found in their research on factors that strengthen the therapeutic alliance that counsellor behaviour like making encouraging statements and comments about the client and greeting them with a smile accounted for the majority of difference in the ratings of alliance from clients. Duff & Beti (2010) described these as micro behaviours and found in their research that the therapist's small, strengths based micro-behaviours are a significant factor contributing to establishing and strengthening the therapeutic alliances (Duff & Beti, 2010). Micro behaviours are verbal and physical cues of communication and are skills that are relatively easy to adopt¹. Sul Ross State University (n.d) describes these micro skills as the foundational tools that are used to create successful interventions with clients. These micro skills create the alliance building environment and include; showing empathy, understanding, genuineness and acceptance (Sul Ross State University). I believe it is important in an environment of increasing pressured from government and stakeholders to adhere to EBP that these skills, integral to the craft of psychotherapy, whether they are broken down into micro skills or included in an umbrella term like the therapeutic alliance, be clearly included side by side with EBP in all policy relevant to psychotherapy. It has been shown in vast studies and is currently well documented and accepted that a healthy therapeutic alliance not only contributes to clients remaining through the course of therapy but is a clear predictor of positive outcomes (Duncan, 2010).

The development of practice skills necessary in all aspects of therapy can be monitored throughout the educational and practicum experience. In order to graduate from Canadian

¹ A tracking sheet of microskills is attached as appendix one and a description of each is attached as appendix 2, form created by Kevin Slingerland from Yorkville University.

master's level graduate program, students are required to demonstrate competence in theoretical and practice areas. To gain registration with the regulatory bodies that oversee counsellors, a practice element is usually included. Students seeking to meet the requirements for registration with the BC Association of Clinical Counsellors (n.d.) are required to have 100 hours of clinical supervision with 25 of those directly observed by the supervisor. The Canadian Counselling and Psychotherapy Association require applicants to have 150 hours of practice supervision. In these supervision hours, it could be specified by either the educational institution or the regulatory bodies that skills specific to EBP, building a therapeutic alliance, session monitoring and the incorporation of feedback into practice all be monitored and developed during the supervised experience. Other skills attributed to excellence that could be included are; tracking client progress and alliance, identifying at-risk cases, developing alternate strategies, seeking permission to record treatment sessions, ensuring ethical compliance and confidentiality, systematically reviewing the recordings, evaluating and refining the use of specific strategies, and pursuing consultation, training, or coaching specific to particular skill sets (Miller, Duncan, & Hubble, 2007). These skills are all in addition to the skills involved in following EBP manuals and I believe need to be developed and maintained in the field. Expanding not only what is taught to students but how specific aspects of practice are incorporated into individual practice to ensure each therapist has the skills to continue to evolve is important.

Developing understanding and student investment in outcome rating scales can create long term benefit for clients, therapists and potentially provide information relevant to a mental health database; if it were created. Especially with the awareness that 30 per cent of clients and many of the Canadian youth with mental health issues do not benefit from psychotherapy, these clients need to be identified. Teaching the use of outcome rating scales to students would

familiarize them with their use and instill in the next generation of psychotherapists a value in the benefits of using outcome measures. Using a session rating scale can indicate which aspects of sessions to focus on improving. Outcome rating scales can also be short and unobtrusive, for example, the Session Rating Scale is only four questions.² It is very easy to fill out, does not add undue paperwork to already busy clinicians but provides the information needed about each session. The four question scale is based on the known predictors of change and informs how the session fit for a client in those four domains (Duncan et al., 2007).

This quick and easy addition to each session builds in a systematic assessment of treatment from the client, providing the opportunity to not only inform your practice but also to demonstrate the effectiveness of treatment, measure whether each of the elements of treatment are a fit for the clients, and the opportunity to adjust treatment accordingly (Duncan, et al., 2007). The results can then be imputed to the automated system. One currently is provided by the creators of the Session Rating Scale;³ however, one could be incorporated into a Canadian database if it were created (Duncan, 2010).

This is one of many options for outcome monitoring; however, this was chosen as an example of how simple incorporating the important element of feedback into your practice can be. When results are entered into the website, it automatically tracks the outcomes, establishes a baseline, and compares performance to national norms (Duncan, 2010). These elements may seem intimidating to some; establishing a baseline of your individual performance in comparison to the norm. However, Miller, Hubble & Duncan (2007) have found that providing therapists with real-time feedback improved client outcomes by almost 65 percent! With a system that provides feedback to therapists when clients are at risk for deteriorating or dropping out and

² An example of this rating scale is attached as appendix 3

³ The automated system can be found at www.myoutcomes.com

improves client outcomes by such a significant level, clearly the use of outcome ratings would benefit clinicians. Outcome ratings provide feedback that can improve clinical practice and more significantly, can identify the issues in session that lead to poor outcomes for clients and provide the opportunity to remedy the situation. This type of information and feedback already exists and could be incorporated into the proposed mental health system.

Conclusion

A shift in practice has begun; it is led by a cry to assist the children and youth who are not provided with the mental health support they require. This cry, at least from some, calls for greater monitoring of services and the use of EBP. I suggest, however, that the time and effort put into changing practice should not be limited to the EBP agenda but should include a shift in practice that incorporates practice evidence from individual practitioners across Canada. That information could be synthesized and used as raw data to provide evidence for research derived from and relevant to clinical practice. Individual practice has been pushed in the direction of EBP through shifts in university accreditation and government policy. I have pointed out that students should also be learning the psychotherapy skills in developing a therapeutic alliance and all aspects of therapy that are the foundation of positive therapeutic outcomes. I believe that these should be intentionally incorporated into policy alongside EBP in order to preserve and advance them. In the advancement of those skills, I have also proposed that outcome rating scales be incorporated into psychotherapeutic learning. By doing so, the clients such as the children and youth who do not receive the services they require, can be identified and supported. Therapists also improve their overall practice and outcomes by implementing feedback into their sessions with outcome measures. All of which can be monitored with an information system that incorporates all the relevant data around mental health.

The present era in psychotherapy has been referred to by many leading thinkers as the "age of accountability." Everyone wants to know what they're getting for their money. But it's no longer a simple matter of cost and the bottom line. People are looking for value. As a field, we have the means at our disposal to demonstrate the worth of psychotherapy in eyes of consumers and payers, and markedly increase its value. The question is, will we? Miller, Hubble, & Duncan (2007).

CHAPTER 5, PUTTING IT ALL TOGETHER

Psychotherapy is an intricate interaction between therapists and clients aimed at increasing an individual's sense of wellbeing and relationships (Ontario Society of psychotherapists, 2016). Psychotherapists are sensitive to the client's needs and employ a wide range of skills to facilitate the client's goals through developing a therapeutic relationship, communicating and creating a dialogue, and working to overcome problematic thoughts, feelings or behaviours with clients (Ontario Society of psychotherapists, 2016). The process is not simple because people are complex and the interactions between people are complex. In the individualized process between therapists and individuals, each encounter is unique. There are however, some approaches that have proven to be effective.

The common factors of effective therapy, evidence based practice (EBP) and outcome measures can be incorporated into the therapeutic process to create more effective outcomes for children and youth. By keeping an awareness of the common factors at the forefront of interactions with children and youth and monitoring these through outcome measures, clinicians can strive to meet their mental health needs, one client at a time. Instead of dismissing therapist and client factors as a nuisance to be filtered out of therapy, these contextual influences that impact methodology can be incorporated into measures as EBP continues to be integrated into the Canadian psychotherapeutic field (Miller, Hubble, Chow & Seidel, 2013). By using the elements of effective therapy, therapists can guide their practice and interactions into directions that have proven effective no matter what model is used and apply a degree of adherence to an EBP model (Wampold, Mondin, Moody, Stich, Benson, & Ahn, 2001, Miller, Duncan, & Hubble, 1997). By utilizing outcome measures, therapists working with children and youth monitor the ongoing impact of the approach, therapeutic alliance and the fit of these for the client

(Duncan, Miller, & Sparks, 2004). In developing the practise of measuring outcomes and using that information to hone one's skills, therapists can increase their mastery in psychotherapy; providing better outcomes for future clients and decreasing the rate of attrition with the current ones (Miller & Duncan, 2007).

Practice specific to Children and Youth

The outstanding element to be addressed is the integration of EBP and the common factors as well as an application of outcome measures relevant to working with children and youth. There are clear benefits for therapists to use both the common factors and EBP in their practice. The common factors are found in all effective therapy; however, EBP is a growing body of evidence showing the efficacy of various approaches with specific presentations. The question remaining would be which approaches to implement with various presentations. The body of evidence based research has begun accumulating indicating which models seem most effective in working therapeutically with children and youth.

Simon Fraser University's Children's Health Policy Centre in British Columbia published information about the prevalence and recommendations for interventions with children and youth in British Columbia (Waddell, Shepherd, Schwartz, & Barican, 2013). According to Waddell et al. (2013), an estimated 12.6 per cent of children and youth in British Columbia (BC) experience symptoms of mental health disorders considered significant at any given time. Also pointed out in this study was the 67 per cent of children and youth who fail to receive the specialized mental health services they require (Waddell, Shepherd, Schwartz, & Barican, 2013). When left unaddressed, these symptoms result in unnecessary suffering for the children and adolescents and may result in pervasive issues that can persist into adulthood (Waddell, Shepherd, Schwartz, & Barican, 2013). In addressing this need, the government of BC has included in policy an

expectation that EBP be the treatments of choice for services provided funded through tax dollars in BC (Auditor General of British Columbia, 2007). Therefore, a look at the specific mental health issues that are prevalent in BC and the accepted EBP to treat them are worth exploring.

Of the mental health issues faced by children and youth in BC, the following are found to require intervention to address their symptoms: the most prevalent were anxiety disorders, attention deficit/hyperactivity disorder (ADHD), substance use disorders, conduct disorders, major depressive disorders, bipolar disorder, and eating disorders (Waddell, Shepherd, Schwartz, & Barican, 2013). It is important to note that autism was also included, however in BC there is a specialized arrangement with the province through which funding and resources specific to autism are addressed. Schizophrenia was also included at a prevalence of less than 1 per cent and was based on a previous review that was more than 10 years old and therefore has been excluded from the following results. Also, although Waddell, et al., (2013) found that some children and youth had concurrent disorders, if both were considered significant enough to require treatment, both diagnoses were included.

Anxiety Disorders

Anxiety disorders account for the highest prevalence, accounting for 30 per cent of mental health disorders in children and youth in BC. Anxiety disorders included; generalized anxiety disorder, post traumatic stress disorder, and obsessive compulsive disorder. Of the three recommendations for treatment, cognitive behavioural therapy (CBT) was recommended for both prevention and treatment with mention of the FRIENDS program that has been introduced in some schools in BC. Medication was also among the recommendations with the antidepressant fluoxetine for the reduction of anxiety symptoms in children and youth (Waddell, Shepherd, Schwartz, & Barican, 2013).

These recommendations were verified by Podell, et al., (2013) with research findings that are consistent with both EBP and the common factors. They found that in using CBT with children and adolescents to treat anxiety, therapists who were collaborative and empathic, using a coaching style had better outcomes (Podell, et. al., 2013). Podell's, et al., (2013) evidence supports the importance of relationship factors in the use of CBT. They also found that therapists who followed the treatment manual, and implemented the treatment with development of the child in mind had children and adolescents with better outcomes. This effectiveness in tailoring the intervention for the youth can be explored through the use of outcome measures before and after each session as well as by checking in with the client in session to ensure the model is a fit for the youth. Also pointed out was the finding that although all therapists used the same manual-guided treatment, the therapist's style, experience, and clinical skills were related to differences in therapeutic outcome (Podell, et. al., 2013). This difference could be adjusted, according to Miller et al., (2013) with the use of outcome measures and feedback to assist therapists; providing the feedback and information to continuously develop their skills.

Southam-Gerow, Weisz, Chu, McLeod, Gordis, and Connor-Smith (2010) used a randomized controlled trial methodology to compare a CBT manualized program called the Coping Cat and a common factors approach to treatment. They found no significant difference between the two approaches; however, at the end of treatment more than half the children and adolescents no longer met criteria for their primary anxiety disorder. It is important to note, however that children and adolescents receiving CBT used fewer additional services than those who received the common factors treatment (Southam-Gerow, 2010).

ADHD

Attention Deficit/ Hyperactivity disorder accounted for 20 per cent of mental health disorders in children and youth in BC. The recommended EBP treatments include psychosocial treatment including behavioural therapy, CBT and parent training to reduce symptoms (Waddell, et al., 2013). Medication was also recommended with three stimulants being recommended: methylphenidate, dextroamphetamine, and atomoxetine to reduce symptoms (Waddell, et. al, 2013). Antshel, Faraone, and Gordon (2014) confirmed these findings in assessing CBT for managing adolescent ADHD. A manualized CBT treatment protocol intervention was used and adolescents with ADHD and comorbid anxiety/depression were rated by parents and teachers as benefiting from the intervention (Antshel, Faraone, & Gordon, 2014).

Alternately, attachment based approaches that include parenting training that have been popular in BC. Included among those is Bruce Perry, the senior consultant to Alberta's Minister of Child and Youth Services in that province, who does not agree with ADHD as a diagnosis but instead refers to it as a description of presentation (Boffey). Perry's approach includes training an adult who is able to regulate themselves and build success in assisting the child who is dysregulated and acting out (Boffey). Gordon Neufeld has developed a training through the Vancouver based Neufeld Institute. The various trainings through them utilize an attachment based developmental approach which also works with the adults in relationships central to a child or youth who has some challenging behaviours (Neufeld Institute). Another approach that is currently popular in British Columbia is Ross Greene's Collaborative Problem Solving. His model advocates for working directly with behavioural challenged children and to seek solutions collaboratively with them (Lives in the Balance). His premise is that there are lagging skills and unsolved problems that result in challenging behaviours to arise in children and trains the

involved adults to work with the child or youth to alleviate the pressure of those issues (Lives in the Balance).

Substance Use Disorder

Substance use disorders accounted for 19 per cent of mental health disorders in children and youth in BC. The recommended EBP treatments include prevention with psychosocial treatment including CBT and family therapy to reduce symptoms in children and youth as well as motivational training. According to the Society of Clinical Psychology (n.d.), motivational interviewing is an EBP used to address substance misuse. This brief person-centered clinical method is consistent with the common factors. The motivational interviewing approach is used for strengthening clients' motivation and commitment to change. It was found to be particularly effective with clients who are reluctant, ambivalent, or defensive about change with a style that is collaborative and empathic (Society of Clinical Psychology, n.d.). Motivational interviewing finds and works with the client's motivations, strengths and resources. The therapist works with the client's goals for change within an atmosphere of acceptance to minimize resistance and defensiveness (Society of Clinical Psychology, n.d.). It was noted that the common factors based approach of motivational interviewing had more enduring results than CBT or 12 step interventions, however, both could be used in conjunction with this approach (Society of Clinical Psychology, n.d.). Using outcome measures can be used in substance related interventions to gauge the effectiveness of the therapeutic approach would be highly relevant with this type of approach as it assists in measuring the therapeutic process, the relationship between the client and therapist as well as guide treatment planning (Bickman, Rosof-Williams & Salzer, et. al., 2000)

Conduct Disorder

Conduct disorder accounted for 17 per cent of mental health disorders in children and youth in BC. The recommended EBP treatments include CBT combined with parent training and family therapy to reduce symptoms in children and youth. According to Gardner (2012), parent training interventions significantly reduced child conduct problems, improved positive parenting practices and reduced negative parental practices. He concluded that behavioural and CBT group-based parenting intervention programs were effective for improving early-onset child conduct problems, parental mental health issues and parenting skills in the short term (Gardner, 2012).

Henggeler & Sheidow (2012) explained that the family based treatments recommended in EBP have been difficult to translate into real world practice settings. Whether a common factors approach, an EBP approach or a hybrid of the two are used to address conduct disorders in children and youth, the benefit of access to a body of findings from community practice settings is clear in this example.

Also applicable to the presentation of conduct disorders are the approaches of Gordon Neufeld, Ross Greene and Bruce Perry, working with the parents to create increased parent and adult regulation and skills creates a healing environment for the children and youth. These approaches are consistent with the common factors approach of focusing on the client factors, tailoring therapy to the specific child while prioritizing the therapeutic alliance, drawing on the existing strengths of the family and building the hope and belief in a favorable future while applying an approach that suits the situation and skills and experience of the therapist.

Major Depressive Disorder

Major depressive disorder accounted for 13 per cent of mental health disorders in children and youth in BC. The recommended EBP treatments include CBT, interpersonal psychotherapy to reduce symptoms in children and youth. Interpersonal psychotherapy is the use of the effective elements of therapy which are those that made up by the common factors. Webb, Auerback, and DeRubeis (2012) reviewed the support for CBT in addressing depression in children and adolescents and confirmed the effectiveness in reducing negative cognitions. Several studies confirmed that CBT was more effective than medication in many cases in therapy for adolescent depression (Webb, Auerback, and DeRubeis).

Outcome measures can be used with depressive clients to measure progress, therapeutic alliance, and client-family satisfaction as elements known to predict successful treatment (Bickman, et al., 2000). Therapists may then use the results of outcome measures to modify treatment, compare interventions and determine the effective ingredients of change for different client groups (Bickman, et al., 2000). When many therapists follow these types of measures with follow ups at regular intervals, a body of data can be accumulated indicating the long term effects of treatment for different groups of clients or clinicians (Bickman, et al., 2000).

Bipolar Disorder

Bipolar disorder accounted for 5 per cent of mental health disorders in children and youth in BC. The recommended EBP treatments include medication and the specific medication suggested is Risperidone to reduce manic symptoms (Waddell, et. al., 2013). Masi, Milone, Stawinoga, Veltri, and Pisano (2015), in an RCT with a diagnosis of both bipolar disorder and conduct disorder were compared to test the efficacy and safety of the medications, Risperidone and Quetiapine. Both were found to have positive outcomes with adolescents, however, it was

noticed that there was significant weight gain as one of the side effects of Risperidone, a potential deterrent for adherence to medication protocol (Masi, et. al., 2013).

Interestingly, Goldstein, Axelson, Birmaher, and Brent (2007) also explored dialectical behavior therapy (DBT) for adolescents with bipolar disorder. DBT was delivered over one year and included both family skills training and individual therapy. The open pilot was designed to work in conjunction with pharmacological management. The results included high treatment satisfaction ratings, significant reduction in suicidal behavior, nonsuicidal self-injurious behavior, emotional dysregulation, and depressive symptoms (Goldstein et. al., 2007). DBT was found to be promising as an EBP approach to the psychosocial treatment of adolescent bipolar disorder.

According to Dimeff and Linehan 2001, DBT was developed due to several difficulties that were commonly faced in working with chronically suicidal clients with borderline personality disorder. These struggles included the separation in goals as the therapist's focus on changing the suicidal behaviour was found to be invalidating by the clients and often resulted in anything from withdrawal from therapy to attacks on the therapist. The second barrier was the therapist's attempts to teach and strengthen new skills to a client with therapy interfering behaviours like their motivation to die and resulting suicidal behaviours between sessions (Dimeff and Linehan 2001). The third issue was the nature of working with suicidal clients who became aggressive or punishing in the nature of their communication with the therapist when the therapy was effective and pleasant when therapists were more neutral and less effective at addressing the behaviours with them (Dimeff and Linehan 2001).

Due to the chronic struggles in working with this client group, DBT was created as a result and has been shown, as indicated above, to be effective in working with clients diagnosed

with borderline personality disorder. This EBP includes radical acceptance of the client's capabilities and behavioural functioning and synthesized that with change within each weekly session; was split into highly structured individual and group sessions, includes between session phone calls and is supplemented with team and consultation meetings for the therapists to keep them focused and motivated (Dimeff and Linehan 2001).

Eating Disorders

Eating disorders accounted for 1.5 per cent of mental health disorders in children and youth in BC. The recommended EBP treatments include family therapy (Waddell, et. al., 2013). Family-Based Treatment (FBT) for bulimia nervosa and anorexia nervosa was designed for adolescents (Society of Clinical Psychology, n.d.). FBT consists of three phases. In the first phase, parents are placed in charge of helping their child reestablish healthy eating patterns and preventing binge eating and purging episodes (Society of Clinical Psychology, n.d.). This is a collaborative process aimed at increasing parental authority in response to the health crisis of the eating disorder (Society of Clinical Psychology, n.d.). The adolescent's independence and connections with friends and school are maintained (Society of Clinical Psychology). In the second phase of treatment, once the symptoms have decreased and regular eating of a variety of foods is established, control over eating is returned to the adolescent (Society of Clinical Psychology, n.d.). The third phase of treatment moves toward termination and seeks to increase the strength of the family without focusing on what caused the eating disorder but instead on what can be done to resolve the issues (Society of Clinical Psychology).

Wilson, Grilo, & Vitousek (2007) agree with the approach suggested by the Society of Clinical Psychology. They also point out that there have been significant advancements in psychological treatments for eating disorders that have resulted in the evidence to support this

approach; however, they also found that important challenges remain. They point out that the overall efficacy of CBT with family therapy is low (Wilson, Grilo, & Vitousek, 2007). They also pointed out that the treatments have not been applied as often with those diagnosed with an eating order not otherwise specified or to the higher risk and more chronic cases of anorexia nervosa (Wilson, Grilo, & Vitousek, 2007). Wilson, Grilo, & Vitousek (2007) also called for the development of new models to address eating disorders and expressed some criticism of modifying treatments for disorders with similar characteristics to fit other eating disorders, extending training opportunities for therapists and learning more about the psychobiological sources of the issue as well as identifying the mechanisms that contribute to therapeutic change for those who it occurs in.

Limitations

There are many limitations of this review. The scope and depth of this work have been shallow on topics of importance. As a result, this is but a summary of broad topics at a pivotal point in the course of psychotherapy. The summary of the state of EBP and EBR has been a glimpse into a very well documented evolution in the development of the evidence base in both research and practice. This evolution and the various pressures that drive the move are worthy of in-depth consideration, especially in light of the potential impact on the future of therapy. Second, the common factors are important elements of all therapy. This is a topic worth exploring to provide a foundation for those new to the profession and to refresh those with experience. Many articles and books have been written on the topic and are worthy of review in much greater depth. Also, outcome measures and session rating scales are introduced here but are a growing field. These measures have the potential to transform an individual's therapeutic

practice with feedback from those they serve. I have introduced them as a tool but not delved into the various measures available or the characteristics of any specific tool.

In addition to limitations of exploring broad topics in summary, the issues are presented in the context of how they have evolved in BC. Presenting the local context provides a perspective for the issues presented; however, this limited the scope of the work.

Future research

The government mandate and funding provided for clinical work in BC is clearly biased to those who using the evidence based approaches. I believe this push toward prioritizing models that are supported by the research will have an immense impact on therapeutic practice. The mandate to only accredit educational programs that focus on EBP will likely have significantly higher impact. Educational opportunities will incorporate elements of EBR and it remains to be seen what, if any weight will be given to the common factors as the elements that are present in all effective therapy. It is my hope that in order to merge EBP with the common factors that a strong alliance or merger develops between those who practice and those who study psychotherapy. I hope many clinical therapists develop the skills to gather data and incorporate that into a knowledge base that can be synthesized into research data that includes not only the elements of a clinical approach but also captures the human element of the common factors. I believe the divide between RCT and clinical practice can only be bridged by including day to day clinical findings into the research base. With the ease of access to information and technology, this may be as simple as developing the software and platform for sharing information.

Implications

Implications for the common factors, EBP and outcome measures are profound. If these are merged then clinicians and clients would benefit from the presence of elements used in all effective therapy, the best evidence available as well as an approach that is tailored to the specific needs of the individual client in each session. If a platform were created to document and share this merger, then the research base could be expanded to include not only the results of controlled trials but evidence duplicated and proven in practice. If this were done on a global level, then the interplay of the various elements of therapy could be synthesized into data to be researched and explored to the benefit of both clients and therapists.

Conclusion

The mental health issues faced by children and adolescents are significant. With the understanding that the common factors are present in all effective therapies, therapists can embrace the use of EBP by incorporating their style with both the elements present in all effective therapy and the application of approaches validated by research. There are some mental health issues that respond better to a more personalized common factors based approach is more effective, substance abuse being an example, and others where a more formalized and structured EBP approach clearly results in better outcomes for clients, like those with bipolar disorder. In exploring the mental health issues most commonly found in children and adolescents in BC, one can see that the common factors and EBP are both incorporated in most of the proven and suggested approaches to the presenting mental health issues. The approaches to the specific mental health issues faced by children and adolescents in BC have been summarized along with some suggestions for EBP approaches that are inclusive of the common factors. In every approach, the goal is to work with the client and family toward a positive

outcome for children and youth regardless of the approach. By incorporating outcome measures and session rating scales, the therapist can apply both their clinical skills and the EBR to interventions with children and youth and add the additional element of being responsive to the specific response of that client to the treatment. In using outcome measures, the therapist has a session by session gauge indicating the degree that the intervention is impacting the child or youth.

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Appendix 1

Session Rating Scale (SRS V.3.0)

Name _____	Age (Yrs): _____
ID# _____	Sex: M / F _____
Session # _____	Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected.

I-----I

I felt heard, understood, and respected.

Goals and Topics

We did not work on or talk about what I wanted to work on and talk about.

I-----I

We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me.

I-----I

The therapist's approach is a good fit for me.

Overall

There was something missing in the session today.

I-----I

Overall, today's session was right for me.

The Heart and Soul of Change Project

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Appendix 3

Counseling Microskills (Sulross university)

- Microskills are the basic foundational skills involved in effective helping relationships.
- They are the foundational tools on which the success of interventions with clients may depend
- They help to create the necessary conditions from which positive change can take place
- They provide the client with such alliance building constructs as empathic understanding, genuineness and acceptance, and will greatly facilitate the development of a safe therapeutic environment
- They will aid in establishing rapport with clients

Essential Counseling Microskills

- Rapport** can be understood as a harmonious or empathic relationship.
- The development of rapport starts with the initial contact and continues throughout the counseling process.
- Effective rapport is crucial for individuals seeking counseling, as this may be the first encounter with a professional counselor and this interaction may either encourage or discourage the client from seeking counseling in the future or following up for subsequent counseling sessions.
- The microskills are a set of verbal and behavioral responses that facilitate the process of counseling and alliance formation regardless of the professional counselors' theoretical orientation.
- These skills are presented as a hierarchy that is organized within a systematic framework.
- At the bottom of the hierarchy are the basic attending skills such as patterns of eye contact, body language, and tone of voice
- A bit farther up the skills hierarchy is the basic listening sequence, which includes questioning, paraphrasing, summarizing, and reflection of feelings

Attending Skills

- Good communication involves more than just verbal content—much communication takes place non-verbally.
- Following validation and education, clients ranked nonverbal gestures and presentation and body language as the most important alliance building factors.
- Non-verbal attending behaviors communicate a counselor's interest, warmth and understanding to the client, and include such behaviors as eye contact, body position, and tone of voice.

Eye Contact

- Maintaining good eye contact is how a professional counselor conveys interest, confidence, and involvement in the client's story.
- For those clients who have difficulty with closeness, making eye contact can be an

important vehicle of change.

-There should be natural breaks in eye contact; eye contact should be more of an “ebb and flow” as you collect your thoughts and listen to your client’s story.

-It is essential to be sensitive to differences in how eye contact is expressed across cultures.

Body Position

-Your body position should convey to the client your interest and involvement.

-Face the client and adopt an open, relaxed, and attentive body posture, as this will assist in putting your client at ease

-Do not cross arms and legs

-Do not sit behind a desk or other barrier

-Slightly lean in the upper body toward the client

-Let your clients decide the physical distance between you and them by offering to let them arrange the chairs at an individual comfort level, but make sure to set up your own personal space boundaries, too

Vocal Tone

-Emotions are frequently conveyed via tone of voice. The pitch, pacing, and volume can all have an effect on how a client responds emotionally to a professional counselor.

-Your voice can do much to help create a soothing and anxiety-regulating atmosphere for the client.

-Learn to use your voice as a therapeutic tool

Verbal underlining—giving increased vocal emphasis to certain words or short phrases—helps convey a sense of empathic understanding.

The Basic Listening Sequence

-The basic listening sequence represents a set of interrelated skills used to achieve three overarching goals:

.To obtain an overall summary and understanding of the client’s presenting issue

.To identify the key facts of the client’s situation

.To identify the core emotions and feelings the client is experiencing

-The skills involved in the basic listening sequence are: open and closed questions, paraphrasing, reflection of feelings, and summarizing.

Open and Closed Questions

Questioning is a primary skill that allows professional counselors to gather important and specific information about clients.

-Questions allow us to make an accurate assessment of the client’s issues and guide and focus our clients so we can make the most effective use of the counseling session.

-But, used inappropriately, questioning can impede communication and block client disclosure (e.g., drilling clients with questions).

Open Questions

Open questions usually elicit fuller and more meaningful responses by encouraging

the client to talk at greater length.

- Open questions typically begin with what, how, could, would, or why, and are useful to help begin an interview, to help elaborate the client's story, and to help bring out specific details.

- With open questions, the client can choose the content and direction of the session.

- Be careful when using *why* questions and questions that are leading in nature.

Questions that begin with "why" often:

- Cause the client to intellectualize and can lead to a discussion of reasons

- Cause a client to begin to rationalize or intellectualize their problems, when what we really want them to do is to explore the deeper meaning and feelings behind their issues

- Cause the client to become defensive and to feel "put on the spot"

Leading questions often contain a hidden agenda because the answer or expectation is already *imbedded* within the question.

- Although well intentioned, these types of questions place too much power into the hands of the professional counselor and tend to push the client into a preconceived direction

Closed Questions

Closed questions can be used when professional counselors need to obtain very specific concrete information and get all the facts straight.

- Closed questions typically elicit either a "yes/no" type of response or provide specific factual information.

- The use of too many closed questions can cause the client to shut down and become passive because in essence you are training the client to simply sit back and wait for the next question to answer.

- Begin with open questions (i.e., general), and as you gather information and hear the client's story, move to more closed questions (i.e., specific) to obtain the specific details important for the assessment and subsequent intervention plan

Open Vs. Closed Questions

- Professional counselors often need to use closed questions to identify and bring out specific details to aid in assessment and treatment planning.

- However, one can often obtain the same information by asking open questions; so try to refrain from moving too quickly into a closed questioning approach unless you are unable to obtain the information otherwise.

The Reflecting Skills

The reflecting skills represent a set of interventions used to help stimulate clients' exploration of their thoughts and feelings related to the presenting problems.

- These skills will also stimulate a deeper understanding of the problem so that the client can examine the issues more objectively.

- Reflecting skills include: paraphrasing, reflecting feelings, and summarizing.

Paraphrase

A paraphrase is how we feed back to the client the essence of what has just been spoken in our own words.

- By paraphrasing, one reflects the *content and thoughts* of the client's message.
- A counselor is mirroring back to the client, in a nonjudgmental way, an accurate understanding of the client's communication and the implied meaning of that communication
- It is important that the paraphrased information is accurate by checking in with the client.
- This "checking in" also allows for the building of a collaborative relationship with your clients and conveys your interest and care in accurately understanding their message

Reflecting Feelings

- By reflecting feelings a professional counselor can help the client become aware of the emotions experienced in relation to the issue at hand.
- Reflecting feelings can promote the development of accurate empathy and help to create a safe environment for the client.
 - To reflect feelings one must be able to recognize and put words to those feeling states observed in the client.
 - To aid in identifying a client's feelings:
 - Pay attention to the affective component of the client's communication
 - Pay attention to the client's behavior (e.g., posture, tone of voice, facial expression)
 - Use a broad range of words to correctly identify the client's emotions
 - Silently name the client's feeling(s) to yourself
 - When reflecting feelings to your client:
 - Use an appropriate introductory phrase (e.g., *sounds like...., you feel...., it seems...etc*)
 - Add a feeling word or emotional label to the stem
 - Add a context or brief paraphrase to anchor or broaden the reflection
 - Pay attention to the tense (present tense reflections can often be more powerful)
 - Do not repeat the client's exact words
 - Reflect mixed emotions
 - Check out the accuracy of the reflection of feeling with the client

Summarizing

- By summarizing, a professional counselor can begin to put together the key themes, feelings, and issues the client has presented.
- By distilling the key issues and themes and reflecting this back to the client, counselors can begin to help clients make sense of what may have originally seemed to be an overwhelming and confusing experience.
 - A summary is not only to be used at the end of the session or begin a new session by re-capping the previous session, but can be used periodically throughout the session, helping to keep a focus and putting together the pertinent issues at hand for the client.
 - A summary may be appropriate when:
 - Your client is rambling, confused, or overly lengthy in comments
 - When your client presents a number of unrelated ideas
 - To provide direction to the interview
 - To help move from one phase of the interview to the next
 - To end the interview
 - To provide an opening to the interview by summing up the prior interview

-There are three common types of summaries:

- **Focusing summaries** are often used at the beginning of the session to pull together prior information the client has given and to provide a focus to the session
- **Signal summaries** are used to “signal” to the client that you have captured the essence of their topic and that the session can move on to the next area of concern
- **Planning summaries** help to provide closure and are used to recap the progress, plans, and any recommendations/agreements made