Reducing reoffending: lessons from psychotherapy and counselling

Ros Burnett, Susan Batchelor and **Fergus McNeill** summarise some findings on the effectiveness of psychotherapy and counselling in reducing problematic behaviour and supporting the change process.

As part of a broader literature review to explore key practice skills in reducing reoffending, we identified findings from the psychotherapy and counselling literatures that are relevant to interventions with offenders. As in research on what works in criminal justice interventions, much psychotherapy research is concerned with identifying the efficacy of specific methods for particular problems and the relative effectiveness of the various components and principles. In carrying out investigations, distinctions are made between:

- **methods** (or interventions or approaches, e.g. cognitive behavioural methods)
- **process variables** (e.g. therapist style, the client-therapist relationship) and
- **extra-therapeutic factors** (e.g. client resources and chance factors).

Research investigating these has led to a long-term debate on whether any one method of intervention or technical approach is more effective than another in bringing about change, or whether the positive outcomes can be attributed to some common factors (the 'specificity versus commonality' debate). A recurring finding in much of the research is that no method is any more effective than the rest, and, instead, it is common aspects of each intervention that are primarily responsible for bringing about change.

What are these 'common factors' or 'core conditions'? There are alternative conceptualisations in answer to this question, but the following are consistently identified as critical to successful outcomes:

- accurate empathy, respect, or warmth, and therapeutic genuineness
- establishing a 'therapeutic relationship' or 'working alliance'
- an approach that is person-centred, or collaborative and client-driven.

Experts argue that this common factors model is widely applicable in the helping professions, including medicine, family therapy and individual therapy.

In addition to revealing these key factors, however, studies also identify their relative significance in producing effective outcomes. Here, the research 'brings home' the extent to which 'extra-therapeutic' factors also contribute to outcome. As the term implies, these are 'extra' to whatever is provided by the interventions and brought to the process by the therapist, and include chance factors, external factors and client factors. According to one meta-analytical review, the percentage of success that is attributable to the various factors is as follows:
40 percent: client and extra-therapeutic factors.
30 percent: therapeutic relationship.
15 percent: expectancy and placebo effects.
15 percent: techniques unique to specific therapies.
(Assay and Lambert, in Hubble *et al.*, 1999).

Though such analyses do not in any way contradict findings that some treatments work better than others for certain conditions, these percentage differences underscore the relatively small contribution of specific approaches. If successful outcomes are mostly attributable to practitioner and relationship variables in combination with the client's circumstances and own resources (extra-therapeutic factors) then careful attention must be given in practice to each of these aspects.

Therapist, relationship and client variables

The literature interchangeably refers to 'therapist' and 'relationship' variables, reflecting the difficulty in separating intrapersonal qualities from inter-personal expression. Similarly, there are limits to how far therapist qualities and skills can be treated as distinct from the way in which these are perceived by clients and modified in response to client variables. Therapist, client and relationship variables interact and ultimately must be understood in relation to each other.

Therapist factors

Subsequent research has confirmed the much cited finding of Patterson (1984: 437) that: "The evidence for the necessity, if not sufficiency, of the therapist conditions of accurate empathy, respect, or warmth, and therapeutic genuineness is incontrovertible". Variability in the extent to which therapists bring these and other appropriate qualities into their work has been identified, with some therapists appearing to cause harm rather than helping. According to contemporary assessments: "The therapist factor, as a contributor to outcome, is looming large in the

Sunita Patel

assessment of outcomes. Some therapists appear to be unusually effective" (Lambert and Ogles, 2004:181).

The relationship and working alliance

In its guideline for treatment choice in psychotherapy and counselling, the Department of Health for England and Wales (2001) identifies as a general principle that "Effectiveness in all types of therapy depends on the patient and the therapist forming a good working relationship". It gives this principle a higher weighting for reliability than any of its other listed principles. A growing body of evidence confirms that relationship factors are crucial to outcome, even in the more technical therapies in which technique is important.

Some studies of relationship factors in psychotherapy are organised around the related concepts of 'therapeutic alliance' and 'working alliance'. When a working alliance has been established, the therapist and client share:

- agreement on overall goals;
- agreement on the tasks that will lead to these goals;
- a bond of mutual respect and trust.

Client factors

The interaction of client factors in outcomes is a research domain in its own right. Motivation to work towards change is one of the most crucial client factors. A basic difference in working with psychotherapy clients as distinct from offenders is that the former are more typically in voluntary contact and therefore likely be more motivated to co-operate and change than those under legal duress. In practice, there are undoubtedly many exceptions to this 'rule'.

Another important client variable that is complementary to motivation, is 'expectancy'; that is, whether the client expects treatment to 'work' or to help them in achieving their goals. Clinical theorists have emphasised the importance of facilitating and utilising positive expectancies in psychotherapy (Weinberger and Eig, 1999).

Effective approaches and principles

It is worth highlighting some of the techniques, approaches and principles, that have been successfully applied in psychotherapy and counselling because of their obvious applicability to work with offenders. (This is already happening to some degree, particularly in the adoption of motivational interviewing in criminal justice settings, much advanced by the work of Mary McMurran and colleagues).

Motivational interviewing

The leading authorities on the concept of motivational interviewing (MI) define it as a directive, client-centred counselling style, helping clients to explore and resolve ambivalence (Miller and Rollnick, 2002). The adjective 'directive' here refers to the approach being problem-focused and goal-directed: it does not denote that the therapist should direct the client in an authoritarian or expert manner. On the

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contrary, a 'quiet and eliciting' counselling style is essential to MI, and the *spirit* of the approach is distinguished from the *techniques*. The rationale for the approach is that client ambivalence about the problem behaviour, and a lack of motivation to change it, is commonly at the root of treatment failure. It is this lack of resolve that is the principal obstacle to be overcome. Motivational interviewing works by shifting the balance between how the person perceives the pros and cons of their behaviour, with one or the more of these factors becoming dramatically more salient to them.

Non-directive, person-centred methods

A review of outcome research in psychotherapy concluded that a major operational variable in successful outcomes is the intentional utilisation of the client's frame of reference. The investigators produced a guide for working with 'impossible cases' (Duncan *et al.*, 1997): these are the long-term patients who do not respond to therapy and whose problems continue or get worse. The main message of this guide is that the key to making progress is for the therapist to identify and bring into play the client's way of thinking, worldview, and own informal 'theory of change', on the basis that clients themselves best know what needs to be done to address their problem and therapists should draw out these insights. Such an approach taps into what is broadly referred to as a 'person-centred therapy' (PCT).

PCT can be either directive or non-directive, though a non-directive approach may be more effective with reluctant, involuntary clients. This is particularly relevant to work with offenders who, as noted by Marshall and Serran (2004: 315), are typically a "difficult population to work with at least partly because they are often defensive and oppositional". PCT emphasises that therapists should find ways of challenging clients that do not involve criticising them or undermining their sense of self-worth. As in the criminal justice field, person-centred therapists have experience of working with some particularly difficult or fragile clients, including those who 'dissociate' or separate themselves from others, perhaps following abuse in childhood or traumatic adult experiences. One recent development in the field that has been influential has been the provision of 'pre-therapy' for 'contact-impaired' clients (Prouty et al., 2002).

Responsivity: adapting approach to client

Therapists need different skills for different clients and settings and many experts recommend a flexibility of approach that is tailored to client problems and characteristics. Generally, research indicates that highly resistant clients respond better if there is minimal therapist directiveness, whereas non-compliance increases when therapists use directive behaviours such as attempts to teach and confront. In some contrast to this, Marshall and Serran (2004) found that empathy, warmth, rewardingness *and directiveness* significantly influenced behaviour changes among sex offender clients – though they emphasise that 'directiveness' involved suggesting rather than telling the client what to do. The common ground here seems to be, as Norcross (2002) has observed, "seasoned therapists have learned to respond flexibly to patient qualities and to alter their relational stance".

Ros Burnett *is a Senior Research Fellow, Centre for Criminology, University of Oxford.* ***Susan Batchelor*** *is a Lecturer, Law School, University of Strathclyde.* ***Fergus McNeill*** *is a Senior Lecturer, Glasgow School of Social Work, Universities of Glasgow and Strathclyde.*

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