

Introduction to the contemporary research that informs the CPCAB model of practitioner development and proficiency.

Note:

This paper should be read in conjunction with the following CPCAB documents available for free download from the CPCAB website (www.cpcab.co.uk):

1. Overview of the CPCAB model of practitioner development and proficiency
2. The CPCAB Service Levels Framework

Abstract:

The paper begins by examining the question 'which research for what purpose?' and suggests that, although the diversity of research methods is useful to the field, research resources focussed on policy questions have often been wasted in that they have led to little useful policy or clinical outcomes. The paper continues with an examination of the question 'what contributes to what kinds of therapeutic change?' and concludes that the the best available current research does not support the established medical model. Contemporary research paints, in contrast, a sophisticated picture of therapeutic change in which the 'treatment' plays only a supporting role to the lead character: the client, together with the therapeutic relationship s/he forms with the practitioner. The research therefore challenges policy-makers to make radical changes to their policies: currently some of these are undermining forms of counselling and psychotherapy, such as Person-Centred and Experiential, that emphasise the importance of the client as the primary contributor to therapeutic change and this needs, therefore, to be reversed. In the third section, the paper describes the 'seven processes framework' - which forms part of the CPCAB model - and demonstrates how the framework is underpinned by both the latest research and research-informed recommendations for structuring training. The paper concludes that practitioners trained within the CPCAB model integrate the best available research with clinical expertise in the context of client characteristics, culture, and preferences and their practice can be viewed, therefore, as 'evidence-based'.

© Dr. Anthony Crouch, C.Psychol. (Couns.), PhD (2010)

This paper is published by the Counselling and Psychotherapy Central Awarding Body (CPCAB): www.cpcab.co.uk

Copyright © and Moral Rights for this paper are retained by the individual author(s) and/or other copyright owners. You may not engage in further distribution of the material for any profitmaking activities or any commercial gain. You may freely distribute both the url (www.cpcab.co.uk/research-informed-cpcab-model) and the content of this paper for research or study, educational, or not-for-profit purposes without prior permission or charge.

Any correspondence concerning this copyright should be sent to:
Counselling and Psychotherapy Central Awarding Body (CPCAB)
PO Box 1768, Glastonbury, Somerset BA6 8YP United Kingdom
Phone: +44 (0)1458 850350 Fax: +44 (0)1458 852055 Email: admin@cpcab.co.uk

1. Which research for what purpose?

In the field of counselling and psychotherapy there are many different approaches to practice which fit into three or four broad modalities. This diversity of approaches can seem very confusing to the novice client or trainee, especially since none of them represent the 'absolute truth' but rather a range of useful perspectives and practices. In a similar way, within the research field there are many different approaches to research which fit into two broad methodologies - one is based on numbers/measurement (quantitative) and the other on language/meaning (qualitative). This diversity of approaches can also seem very confusing to anyone engaging with the research literature for the first time, especially since none of them represent the 'absolute truth' but rather a range of useful research perspectives and practices.

Both forms of research can enrich our understanding of counselling and psychotherapy but, to add to the confusion, research can often be divided into two broad categories: policy-orientated and practice-orientated. Policy-orientated research is primarily designed to play a part in the broader medical and mental health world, whereas practice-orientated research is primarily designed to extend knowledge and understanding. The most influential types of research with policy makers are quantitative 'meta-analyses' that summarise the results of all the available relevant quantitative research papers¹. Quantitative meta-analysis projects are able to produce their summaries because the individual research studies all use standard ways of *measuring the magnitude of therapeutic change* in terms of small, medium or large *effect sizes*. For example, a meta-analytic study of the effectiveness of cognitive therapy for depression can summarise the results of all the available research papers on this topic in terms of the *average effect size*. Such a meta-analysis might produce a large averaged effect size for cognitive therapy for depression and therefore conclude that the best available research demonstrates that it is an effective intervention.

Examining the great swathes of, often quite expensive, policy-orientated research it is, unfortunately, rather easy to conclude that there could have been much better ways of focussing those research resources. Wampold (2008, p.254), for example, in a review of the findings from policy-orientated outcome research concludes that:

“Hundreds of clinical trials have failed to document that any psychotherapy is consistently superior to any other psychotherapy, both generally and for specific disorders. What evidence that does exist is problematic and has not been consistently replicated. As a result, little treatment-specific understanding has emerged from empirical research... Finally, the degree to which a therapist adheres to a treatment protocol has, at best, a mixed relationship with treatment outcome.”

In a similar vein, the recent World Association for Person-Centred and Experiential Psychotherapy and Counselling (WAPCEPC) Task Force report laments the fact that the most influential types of research with policy makers is of a highly controlled, quantitative nature which excludes other research methods that are more useful for extending understanding of their modality's practice:

¹ Particularly of randomized controlled trials (RCTs): “on the basis of randomization and experimental control, changes in the independent variable (the client's state) are attributed to the independent variable (psychotherapy).” Timulak (2008)

“The PCE² approach is under severe threat in many parts of the world... the question of how to respond to this situation creates a real dilemma for the PCE community... on the one hand to go down the route of ever more controlled, quantitative... research may seem, to some, like a betrayal of the very principles of the PCE approach... On the other hand, however, if the PCE community is not willing to... provide the kind of evidence that is being asked for, will there be any PCE community left in a few years time?”

Conclusions to the WAPCEPC Task Force (Cooper et al. 2010)

» For further reading on research methodologies see, for example, Sanders and Wilkins (2010), Timulak (2008) and McLeod (2003, 2010, 2011). For a very different approach to research, see “Becoming a reflexive researcher” which describes a form of research that emphasises the role of self in the research process and which has similarities to the process of counselling and psychotherapy (Etherington, 2004).

2. What contributes to what kinds of therapeutic change?

“The question to which I wish to address myself is this: Is it possible to state, in terms which are clearly definable and measurable, the psychological conditions which are both necessary and sufficient to bring about constructive personality change? Do we, in other words, know with any precision those elements which are essential if psychotherapeutic change is to ensue?”

Carl Rogers (1957)

» *In this seminal 1957 paper Rogers goes on to lay out the six conditions that formed the basis of counselling. See also chapter 2 in Castonguay et al. (2010) for a detailed account of Rogers founding contribution to the field of counselling and psychotherapy research.*

The reason that quantitative meta-analyses are so influential is that in recent years policy-makers within the medical world, including the governments and organisations that fund medicine, have decided that medical interventions must be ‘evidence-based’: that they must be founded on what they consider to be the *best available research*. The quantitative meta-analytic studies that provide average measures of the magnitude of therapeutic change are viewed as the best source of such evidence.

» Evidence-based practice is often viewed as simply the application of research evidence to practice but it is worth noting that the American Psychological Association (APA) defines evidence-based practice within psychology (including counselling and psychotherapy) as ‘*the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences*’ (American Psychologist, 2006).

A recent APA publication ‘Bringing psychotherapy research to life: understanding change through the work of leading clinical researchers’ (Castonguay et al. 2010) describes the contributions of what it considers are 28 of the most influential researchers. Of the 28, 25 are from North America, 2 are German and 1 is from the UK. As this distribution indicates, most research in counselling and psychotherapy is conducted in the USA and although some research takes place within the UK, its influence on the field as a whole is limited.

Research carried out within the USA has, therefore, had a major impact on the field internationally, especially with regard to the question of what constitutes evidence-based medicine and what forms of treatment should therefore be fundable by medical insurers. This question has fed an intense debate between the proponents of the established

² Person-centred and experiential (PCE)

medical model and those who have argued for a more sophisticated approach to understanding therapeutic change.

On the medical model side of this debate lies a key international standard³ for the classification and diagnosis of mental disorders in the form of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. In recent years psychiatry has tended to be dominated by pharmaceutical interventions and, within the USA, this has also led to very serious conflicts of interest⁴. In response to the growing demand by policy-makers for evidence-based medicine, however, clinical psychologists set out to develop an evidence-based alternative to pharmaceutical interventions in the form of 'empirically supported treatments' (ESTs). The EST movement is primarily driven by Division 12 (Clinical Psychology) of the APA which organised a Task Force to conduct a major review of the research evidence and published its conclusions in 1998. This report, currently in its third edition, catalysed the development of the EST movement⁵ (Nathan and Gorman, 2007).

The medical model defines (i) medical research as the identification of specific medical interventions to treat specific illnesses and (ii) medical practice as the competence of the doctor in accurately diagnosing the medical problem and then applying a treatment based on the best available research evidence. Proponents of the medical model have argued that the only bona fide therapy is a standard mental health diagnosis and an associated '*empirically supported treatment*' (EST) in the form of a *manualised treatment protocol* (the medical intervention). From this perspective, all other treatments are not evidence-based and should therefore be excluded from medical insurance coverage. From within this perspective, the particular characteristics of the individual doctor and patient, together with their relationship, are seen as irrelevant to the outcome of the medical intervention. In much of the highly controlled research on counselling and psychotherapy, therefore, these 'variables' are specifically, and carefully, excluded from the studies. This is, however, a rather simplistic approach to understanding therapeutic change that is, perhaps, based more on the desire to fit counselling and psychotherapy into the policy-makers established medical model framework, rather than a genuine attempt to develop a clinically-useful science of therapeutic change. Cooper and McLeod (2007) point out, for example, that

“... psychological difficulties may have multiple causes and that there is unlikely to be one, 'right' therapeutic method that will be appropriate in all situations – different people are helped by different processes at different times.”

while Sawyer, (2006, pp. 577) quoting Edmund Wilson points out that:

"We usually refer to natural sciences like physics and biology as the 'hard' sciences, and social sciences like psychology, education, and sociology as the 'soft' sciences... in fact, the

³ The other key international standard is the World Health Organisation's (WHO) International Statistical Classification of Diseases and Related Health Problems (ICD)

⁴ The American Psychiatric Association has recently come under intense congressional scrutiny for its intimate relationship with the pharmaceutical industry. The current president, for example, was principal investigator on a US government study into a drug being developed by a company that he had himself set up and within which he had several million dollars invested.

⁵ The EST movement also includes an earlier, very influential *UK study* that led to the publication of the book "What works for whom?" (Roth and Fonagy, 2005).

social sciences are much harder than the natural sciences, because the systems they study are infinitely more complex."

Proponents of the more sophisticated perspective have argued that the many specific forms of therapy have roughly equal benefits because they share a common core of non-specific therapeutic factors such as the relationship. Partly in response to the growing influence of the EST movement, the APA Division 29 (Psychotherapy) organised a second Task Force to investigate the importance of the therapeutic relationship and published its conclusions in 2002 (Norcross, 2002). This report on '*empirically supported relationships*' provided extensive evidence for the importance of the relationship as a major contributor to therapeutic change.

In response to the growing conflict between the two opposing sides in this debate, a third Task Force was organised by the APA's Division 12 and the Society for Psychotherapy Research (SPR) to investigate the evidence for *both* common factors and specific treatments. Once again the report, published in 2006, had a major influence on the debate (see Castonguay and Buetler 2006).

Recently a fourth Task Force, *jointly sponsored* by both the APA's Divisions 12 and 29, has been re-examining contemporary research on the relationship together with 'client factors'. This huge meta-analysis, which encompasses approx. 100,000 clients across 400+ research studies, will report in Spring 2011 but its provisional conclusions were presented at a recent conference of the Society for the Exploration of Psychotherapy Integration (Norcross, May 2010). One of the conclusions in this conference presentation was that the combined effect size for the various common factors is considerably larger than the effect size for specific treatment factors and that the most important factors concern the client. In other words, according to the best available research, therapeutic change is primarily the result of the common factors whilst the treatment per se - independent of the overly researched question of *which* treatment - makes a much smaller contribution to the process of therapeutic change. This report, given its status within the profession, will have profound and far-reaching effects on the field and necessitates the development of a more sophisticated medical model for the field of mental health.

Much of the quantitative research described above is based on various measures of traditional mental health categorisations in which therapeutic change is most often conceptualised in terms of symptom diagnosis and symptom reduction. This has been extensively criticised, not least because within the wider medical field it is assumed that different underlying medical problems can display the same or similar symptoms. Different modalities also define therapeutic change in different ways and many approaches are opposed to the traditional mental health diagnosis. Given, however, the importance of client factors, perhaps the most *scientific* way forward is to research how clients actually experience, and define for themselves, therapeutic change. Timulak and Creaner (2010) have, for example, begun this process with a *qualitative* meta-analysis⁶ of *qualitative* outcome research. The results paint a rich picture of participant-defined therapeutic change that bears only a very minor relationship to the symptom-based measures of the current mental health model. This meta-analysis uncovered eleven categories of participant-defined therapeutic change, only one of which was 'mastering symptoms'. The various other forms of therapeutic change included 'smoother and healthier emotional experiencing', 'experience of self-compassion', 'self-insight and/or self-awareness',

⁶ This was a relatively small meta-analysis: encompassing 106 clients across 9 research studies.

'changed view of others' and 'appreciating vulnerability'. This latter category is particularly interesting because it actually contradicts the current medical model's goal of symptom reduction: clients described the benefit of, for example, having 'permission to feel the pain' or, in other words, accepting and feeling the symptoms rather than simply trying to reduce them.

In concluding this section, therefore, the best available current research does not support the established medical model. Contemporary research paints, in contrast, a sophisticated picture of therapeutic change in which the 'treatment' plays only a supporting role to the lead character: the client, together with the therapeutic relationship s/he forms with the practitioner. The research therefore challenges policy-makers to make radical changes to their policies: currently some of these are undermining forms of counselling and psychotherapy, such as PCE, that emphasise the importance of the client as the primary contributor to therapeutic change and this needs, therefore, to be reversed as soon as possible. Policy-makers also need to encourage the development of a sophisticated medical model for mental health that focuses on, rather than excludes, the particular characteristics of the client and the relationship s/he forms with his/her practitioner. They also need to provide the associated research funding, not for studies that simply seek to fit into their established frameworks and ways of thinking about mental health, but for genuinely scientific and clinically-useful research that can lead to challenging insights and understandings.

» *For further reading see, for example, "The Great Psychotherapy Debate: Models, Methods, and Findings" (Wampold, 2010), "Re-thinking the DSM" (Beutler and Malik, 2002) and Timulak's work on qualitative meta-analysis (for example: Timulak and Creaner, 2010)*

3. The seven processes framework

This third and final section outlines some of the key research that informs the CPCAB model⁷ of practitioner development and proficiency. The model has itself been developed through a process of 'educational design research' over a twenty year period⁸.

Contemporary research in counselling and psychotherapy has identified four factors that represent the broad processes that contribute to therapeutic change:

1. **Relationship:** the research identifies various factors within the therapeutic relationship that contribute to, and impact on, therapeutic change. The fourth APA Task Force (Norcross 2011) has concluded that the alliance, empathy, goal consensus/collaboration and positive regard are 'demonstrably effective' whilst congruence/genuineness, collecting client feedback, repairing alliance ruptures, self-disclosure, counter-transference management and the quality of relational interpretations are 'probably effective'.
2. **Client:** the research demonstrates that the client is the primary source of therapeutic change and that customising the counselling/therapy to take account of client factors can enhance therapeutic change. The third APA Task Force sub-divides client factors⁹ into observed and inferred characteristics. Inferred characteristics either contribute to, or impact on, therapeutic change and include motivation for counselling, expectations of process and outcome, stage of change, psycho-social functioning, attachment style and social support. Observed characteristics, on the other hand, impact on the relationship, practitioner and technique/'treatment' factors and include gender, culture, sexual orientation, age, socio-economic and employment status. The fourth APA Task Force has concluded that customising the relationship to take account of the individual client's functional impairment, reactance/resistance level, stage of change, coping style and preferences are 'demonstrably effective' whilst customising to take account of attachment style and expectations are 'probably effective'. The established medical model makes key assumptions about therapeutic change that can conflict with the client's beliefs and assumptions - see, for example, the work of Timulak and others (Timulak and Creaner, 2010). The CPCAB model enables the practitioner to both engage with the established medical model and work with both the alternative approaches of different modalities and the perspectives of clients. It does this through defining a 'service levels framework'¹⁰ that references both the symptom-based categories of the established mental health model and 'levels of therapeutic change'. These levels of therapeutic change refer to, not symptoms, but the relational, developmental and intrapersonal aspects of the client's self¹¹.
3. **Practitioner:** these factors contribute to, or impact on, therapeutic change and include the practitioner's (a) observed/professional characteristics: gender, ethnicity, age and professional training/experience and (b) inferred characteristics: own well-being and

⁷ See 'Overview of the CPCAB model of practitioner development and proficiency' (CPCAB, 2010)

⁸ For further information on this research methodology see, for example, Akker et al. (2006)

⁹ The third Task Force also sub-divides practitioner factors into these two categories.

¹⁰ See 'The CPCAB Service Levels Framework' (CPCAB, 2010b)

¹¹ See also the 'three perspectives' framework of the CPCAB model (CPCAB, 2010a)

psychological functioning, personality, beliefs and values. Through self-awareness the practitioner can develop more effective ways of working with clients including, for example, working with counter-transference.

» See, for example, Woskett's (1999) book on the 'therapeutic use of the self'.

4. Technique/'treatment': this category refers to the practitioner's coherent use of theory-based skills and techniques to facilitate therapeutic change. Within the established medical model this has been viewed as the primary source of therapeutic change and the thrust of much research has therefore been to identify the most effective treatments. Contemporary research, however, has demonstrated that the use of techniques and treatments play only a supporting role to the other common factors with the client being the primary source of therapeutic change. Given these research conclusions, Wampold (2008) argues that (i) an important *common factor* is the practitioner's use of a coherent, bona fide theoretical framework in the provision of a coherent treatment and that (ii) the potency of that treatment is dependent on the extent to which it is congruent with the client's cultural framework, belief system and the explanation s/he currently holds of her/his distress. In other words, the practitioner's use of a theoretical framework and associated skills/techniques is important but the practitioner should also listen carefully to the client's explanations and beliefs relating to their distress together their potential for healing their distress or, in other words, the client's understanding of the process of therapeutic change. Perhaps most importantly, however, it implies that the range of modalities and sub-modalities that have developed meet the diverse needs of clients and that service providers should, therefore, seek to ensure that clients are able to access a range of *different* bona fide modalities.

» Together with the seven processes framework, the CPCAB model also includes a framework of three therapeutic perspectives¹² which enables trainees, training within the broad range of bona fide modalities and sub-modalities, to be working towards, and assessed against, a common set of standards. This aspect of the model provides, therefore, an integrative common framework that embraces both the diversity of modalities and the diversity within modalities whilst also meeting the needs for integration, including the need for common standards and associated common assessment criteria. Over the past two decades this aspect of the model has been tested and honed within thousands of individual training programmes at hundreds of training centres utilising a diverse range of modalities and sub-modalities including Humanistic, Cognitive Behavioural, Psychodynamic, Transpersonal and Integrative together with religion-orientated approaches such as Islamic, Jewish, Christian and Buddhist. The ability of the model to encompass such a diverse range of training programmes and modalities is a testament to its applicability and flexibility.

Alongside this consensus with respect to these four factors, there is also a growing agreement that the field needs to move beyond the long-standing conflicts between proponents of particular factors and modalities¹³ in order to develop an inclusive and integrative approach to all four. In the preface to the third APA Task Force report, for example, Castonguay and Beutler remark on the fragmentary and contradictory nature of much of the research which they see as due to:

¹² The relational, developmental and intrapersonal perspectives (CPCAB, 2010a). This aspect of the CPCAB model is itself informed by research on self and identity including, for example, Blatt (2008) and Leary and Tangney (2005) together with research on complex systems (see, for example, Cilliers, 1998).

¹³ Often based on researcher allegiances to particular modalities.

“the ‘either/or’ position that many researchers and clinicians seem to take with regard to the variable(s) responsible for change. While some authors seemed to emphasise the importance of relationship above all, others focused on the effects of participant (therapist or patient) factors, and still others drew attention to the salience of certain treatment procedures and models. It struck us that all of these groups of scholars had lost sight of the possibility that relationship, participant factors, and treatment procedures were effective and interactive; that the conjunction should be ‘and’ not ‘or’ when describing the things that produce change.”
Castonguay and Beutler (2006)

Recently, Jacques Barber in his 2009 presidential address to the Society for Psychotherapy Research (SPR) also identified similar “core conflicts” between relationship and technique factors and between client and practitioner factors. In his address Barber also argued that both researchers and practitioners need to replace the either/or conflicts that currently dominate the profession with an inclusive approach.

The evidence from recent research, however, suggests that, of the four groups of factors, client factors are the most important. The fourth APA Task Force compares the relative effectiveness of the various factors and one of its broad conclusions is that client factors are the most important. Cooper (2008) also points out that although ‘for many counsellors and psychotherapists, a basic assumption may be that it is what *they* do - or the conditions that they create - that is the principle factor in determining therapeutic change... 75 per cent¹⁴ or more of the change in psychotherapy may be directly attributable to client factors’ and quotes Duncan et al. (2004) that ‘clients, not therapists, make therapy work’ while Emmerling and Whelton (2009) point out that ‘one client characteristic that has received considerable attention in recent years is the motivation to change. It has come to be regarded as a vital component of the entire change process’.

The CPCAB model embeds, within its seven processes framework of practice and training, an integrative approach to the four factors together with a special emphasis on client factors through (i) separating out the observed and inferred client characteristics into two processes and (ii) placing the client at the very centre of the work.

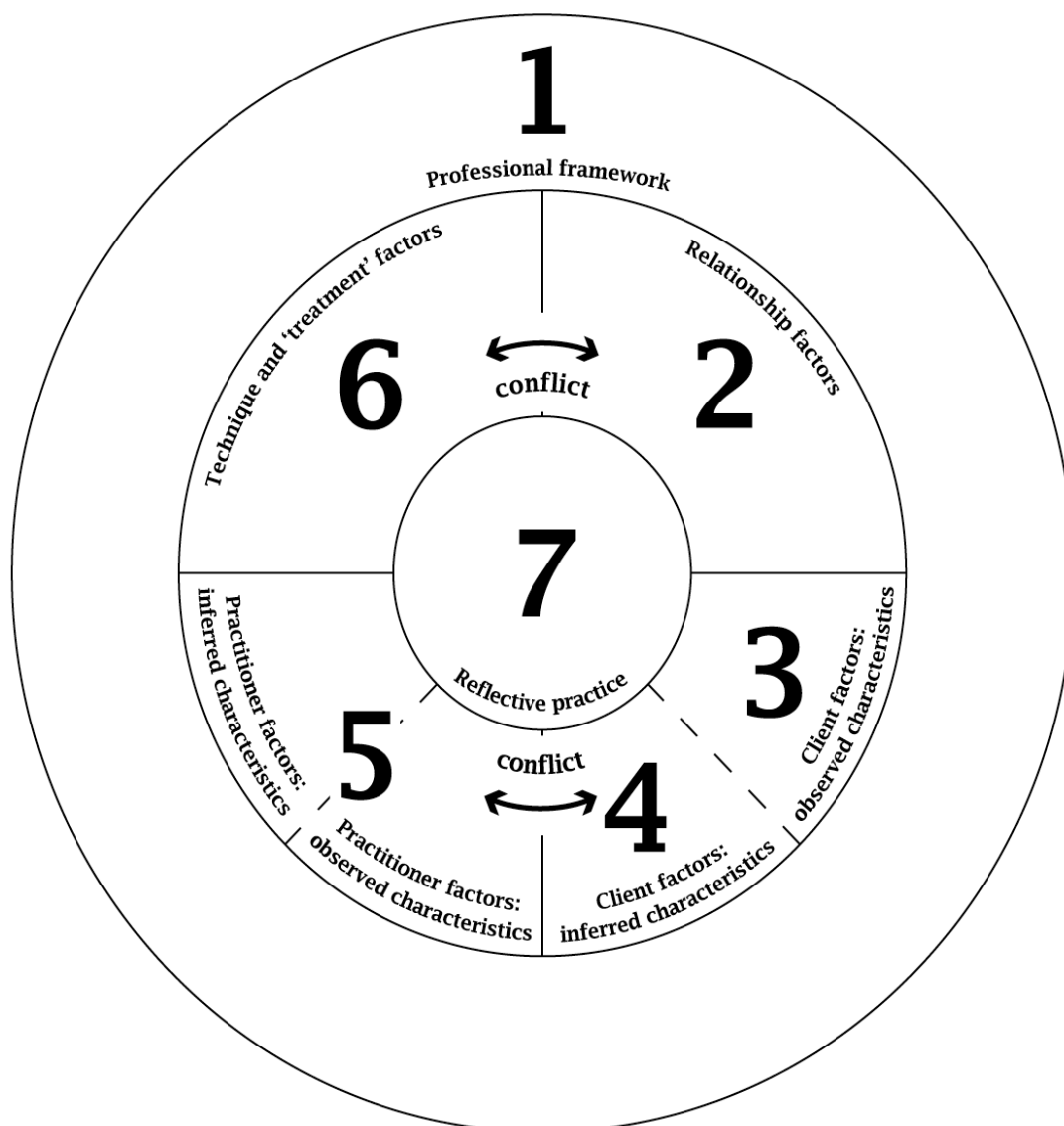
These five processes may be necessary for effective practice but they are *not*, however, sufficient. Practitioners also need to be working within a ‘professional framework’ of knowledge, skills, rules and guiding principles concerning legal, ethical and safe practice. Just as effective practice involves attending to the nature and quality of the relationship, it also involves attending to the nature and quality of the professional framework. Practitioners also need to be skillfully reflecting on their work - both in and out of session and within clinical supervision. The ability to reflect, *in an integrative way*, on not only the relationship or the use of a technique but also on the *interactions* between these parallel processes - between, for example, the effect of a particular technique on both the working alliance and the client’s motivation - are an important aspect of effective practice. These two processes are therefore added onto the previous five to form the CPCAB’s seven process framework of practice and training:

1. Skillfully attending to the nature and quality of the professional framework.
2. Skillfully attending to the nature and quality of the relationship.
3. Skillfully identifying and responding to the client’s observed characteristics.

¹⁴ This percentage may be too high - the provisional conclusions of the fourth APA Task Force suggest that they represent just under 50% of the explained variance (with unexplained variance at 45% of total variance).

4. Centering the counselling on the client: skillfully identifying and responding to client goals, agenda, motivations, expectations, world view and other inferred characteristics.
5. Developing awareness of, and integrating within the work, the practitioner's own self.
6. Using techniques and interventions coherently, knowledgeably and skillfully.
7. Skillfully reflecting on the work.

Practice is seen, therefore, to involve the use of these seven integrated and parallel processes¹⁵: the practitioner should be able, during both a session and the work as a whole, to identify how their work involves these seven processes. All the CPCAB qualifications embed the seven process framework through seven units or seven learning outcomes in order that, from the beginning and throughout their training, the learner is learning within an overarching framework of these seven integrative, parallel processes.



A number of researchers have also argued that there are clear advantages to founding practice and training on a limited number of core concepts. Thirty years ago, in a seminal paper, Marvin Goldfried initiated what he described as the “principles-based” approach to

¹⁵ This aspect of the model is also informed by research in cognitive science on standard working memory and the development of expert working memory.

understanding therapeutic change (Goldfried, 1980). Thirty years on, in a 2009 research journal special issue devoted to his 1980 paper, he identified a key advantage of this approach:

“One of the advantages of having at one's disposal a handful of principles that contribute to the change process is that it can afford a more manageable list of therapeutic guidelines to practicing clinicians, as opposed to the very large array of potential specific treatment interventions that currently exist... having this more manageable set of principles can also help beginning clinicians to learn how to proceed therapeutically, so as to make a more reasonable decision on what specific intervention to then select.”
Goldfried (2009)

In a recent APA Division 29 journal special edition devoted to training, Fauth et al. have also recommended that:

“Based on extant research... Binder (2004) proposed that psychotherapy training should focus on a limited number of ‘big ideas’. We would add that these ‘big ideas’ should be geared to trainees’ developmental level. Focusing on a limited number of ‘big ideas’ provides a useful means for structuring the training and tracking trainee skill development over time. Furthermore, increased structure has been found to improve the effectiveness of psychotherapy training.”
Fauth et al. (2007, p.385)

CPCAB qualifications are designed in exactly this way: embedding the seven processes within all the qualifications and gearing them to each developmental level of training. The model does this through applying the seven processes to a set of CPCAB service levels in the definition of a coherent series of progressively more in-depth learning outcomes and associated assessment criteria.

Well over 100,000 helpers and counsellors have trained - within a broad range of modalities¹⁶ - within the framework of the CPCAB model. They have learnt, and been assessed within, a framework that is informed by, and embeds within the training, the best available contemporary research - a framework that also emphasises the importance of taking full account of the client's characteristics. As these practitioners develop their clinical expertise, and integrate it with the learnings from their training, they meet the APA definition of *‘the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences’* (American Psychologist, 2006) and their practice can be viewed, therefore, as truly ‘evidence-based’.

¹⁶ The CPCAB model's ‘three perspectives’ framework is able to encompass the broad range of modalities.

About the author:

Dr. Anthony Crouch, C.Psychol. (Couns.), PhD has a long-standing research background in counselling and psychotherapy competence¹⁷, having first published (Crouch, 1992) and presented¹⁸ on this subject during the early 1990's. He established CPCAB at that time and has overseen its growth into the largest awarding body in the UK within this sector whilst his radically subjective book 'Inside Counselling' (Crouch, 1997) is widely used as a student 'textbook' on a range of counselling training courses. A chartered and state-registered Counselling Psychologist, he originally trained at a leading cognitive psychology department before undertaking a doctoral programme examining the creative process. After completing his doctorate, and partly as a result of a personal crisis, Anthony became interested in counselling and psychotherapy where he also noticed similarities between the processes of creative and therapeutic change. He went on to undertake a range of humanistic and psychodynamic training and supervision relationships and has also been in his own long-term psychotherapy relationship. His long-term cross-cultural marriage has provided him with in-depth insights into difference and diversity and he has also studied a range of religions and meditative practices.

Annotated references and suggestions for further reading

Akker, J.V. Den, Gravemeijer, K., McKenny, S., Nieveen, N. (2006) *Educational Design Research* Oxford: Routledge

» *The CPCAB model has been developed through a process of educational design research over a twenty year period. This book examines this type of research.*

American Psychological Association (2006) Evidence-based practice in psychology. *American Psychologist*, 61:4, 271-285

» *The APA definition of evidence-based practice: www.apa.org/practice/ebp.html*

Barber, J. (2009) Toward a working through of some core conflicts in psychotherapy research. *Psychotherapy Research*, 19: 1, 1-12

» *Presidential address to the Society for Psychotherapy Research (SPR) arguing that both researchers and practitioners need to replace the either/or conflicts that currently dominate the profession with an inclusive approach.*

Binder, J.L. (2004) *Key competencies in brief dynamic psychotherapy: Clinical practice beyond the manual*. New York: Guilford

» *Binder proposes that training should focus on a limited number of "big ideas".*

Beutler, L.E. and Malik, M.L. (2002) *Rethinking the DSM: A psychological perspective*. Washington: American Psychological Association

» *Excellent critique of the DSM and the established medical model together with a consideration of alternative approaches to mental health*

Blatt, S.J. (2008) *Polarities of Experience* Washington: American Psychological Association

» *Sets out Blatt's research-informed theory on the development of identity through interaction with others across the life span*

¹⁷ and educational design research (see, for example, Akker et al., 2006)

¹⁸ Presentations at a series of British Psychological Society (BPS) Division of Counselling Psychology (DCoP), European Association for Counselling (EAC) and Society for the Exploration of Psychotherapy Integration (SEPI) conferences during the 1990's.

- Castonguay, L.G. & Buetler, L.E. (eds.) (2006) *Principles of therapeutic change that work*. Oxford: Oxford University Press.
- » *The third APA Task Force: integrates common factors with specific treatments/techniques*
- Castonguay, L.G., Muran, J.C., Angus, L., Hayes, J.A., Ladany, N. and Anderson, T (eds.) (2010) *Bringing psychotherapy research to life: Understanding change through the work of leading clinical researchers*. Washington: American Psychological Association
- » *Excellent introduction to the lives and work of 28 leading researchers*
- Cilliers, P. (1998) *Complexity and Postmodernism* London: Routledge
- » *The 'three perspectives' framework of the CPCAB model is informed by work on complex systems. This book explores how complex systems develop over time in interaction with their environment.*
- Cooper, M., and McLeod, J. (2007) A pluralistic framework for counselling and psychotherapy: Implications for research. *Counselling and Psychotherapy Research*, 7:3 135-143
- » *Sets out the author's 'pluralistic framework' in which psychological difficulties are seen to have potentially multiple causes where 'different people are helped by different processes at different times'. See also their forthcoming publication: 'Pluralistic Counselling and Psychotherapy' (2010) London: Sage*
- Cooper, M. (2008) *Essential research findings in counselling and psychotherapy: The facts are friendly*. London: Sage.
- » *Commissioned by the British Association for Counselling and Psychotherapy (BACP) and possibly the best introduction to, and overview of, the research findings that were available prior to its publication in 2008.*
- Cooper, M., Watson, J.C. and Holldampf, D. (eds.) (2010) *Person-Centered and Experiential therapies work: A review of the research on counselling, psychotherapy and related practices*. Ross-On-Wye: PCCS Books
- » *The WAPCECP Task Force report*
- CPCAB (2010a) *Overview of the CPCAB model of practitioner development and proficiency* Somerset: CPCAB (www.cpcab.co.uk)
- » *Outlines the CPCAB model and should be read in conjunction with this paper.*
- CPCAB (2010b) *The CPCAB Service Levels Framework* Somerset: CPCAB (www.cpcab.co.uk)
- » *Outlines the CPCAB service levels model and should be read in conjunction with this paper.*
- Crouch, A. (1992). The Competent Counsellor. *Self and Society: European Journal of Humanistic Psychology*, 20:3, 22-25
- » *Describes the author's early model of counsellor competence.*
- Crouch, A., (1997) *Inside Counselling: Becoming and Being a Professional Counsellor* London: Sage.
- » *A radically subjective and emotional 'textbook' for counselling and psychotherapy students designed to compliment the rational, theory-based approach of the majority of such books.*
- Duncan, B.L., Miller, S.D., Sparks, J.A. (2004) *The Heroic Client: A Revolutionary Way to Improve Effectiveness Through Client Directed, Outcome Informed Therapy*. San Francisco: John Wiley & Sons
- » *One of a very small number of texts that examine the contribution of the client to the therapeutic process.*
- Emmerling, M.E.; Whelton, W.J. (2009) Stages of change and the working alliance in psychotherapy, *Psychotherapy Research*, 19: 6, 687-698
- » *Interesting article that examines client's motivation to change and its relationship to the working alliance.*

- Etherington, K. (2004) *Becoming a reflexive researcher: Using our selves in research*. London: Jessica Kingsley
 » *An approach to research that emphasises the role of self in the research process and which has similarities with the process of counselling and psychotherapy: the book describes how reflexive research works in practice.*
- Fauth, J., Gates, S., Vinca, M.A., Boles, S., and Hayes, J.A., (2007) Big ideas for psychotherapy training. *Psychotherapy: Theory, Research, Practice, Training*, 44, 384-391
 » *One of six papers in a recent (December 2007) special section of this APA Division 29 journal devoted to 'Psychotherapy training: effective elements and new directions'.*
- Goldfried, M.R. (1980) Toward the delineation of therapeutic change principles. *American Psychologist*. Vol 35(11), 991–999
 » *Seminal, and highly influential, paper that sets out common therapeutic change principles.*
- Goldfried, M.R. (2009) Searching for therapy change principles: Are we there yet? *Applied and Preventive Psychology* 13, 32–34
 » *Goldfried's review of progress over the past 30 years including the advantages for practice of a manageable list of therapeutic guidelines.*
- Leary, M.R. and Tangney, J.P. (2005) *Handbook of Self and Identity* New York: Guilford
 » *Inter-disciplinary handbook examining the structure and organisation of the self within interpersonal relationships and across the lifespan.*
- McLeod, J. (2003) *Doing counselling research*. London: Sage
 » *Excellent introduction to the research process.*
- McLeod, J. (2010) *Case Study Research in Counselling and Psychotherapy*. London: Sage
 » *New book on case study research by one of the UK's leading counselling researchers.*
- McLeod, J. (2011) *Qualitative Research in Counselling and Psychotherapy*. London: Sage
 » *Excellent introduction to qualitative research - second edition published 2011.*
- Nathan, P.E. and Gorman, J.M. (eds.) (2007) *Treatments that work*. New York: Oxford University Press
 » *The first APA Task Force: devoted to empirically supported treatments (ESTs).*
- Norcross, J. C. (ed.) (2002) *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press
 » *The second APA Task Force: devoted to empirically supported relationships (ESRs)*
- Norcross, J. C. (May 2010) Psychotherapy relationships that work II: Evidence-based practice & practice-based evidence. *Annual conference of the Society for the Exploration of Psychotherapy Integration (SEPI)* Unpublished presentation: norcross@scranton.edu
 » *Presentation on the initial findings of the fourth APA Task Force (to be published in Spring 2011) on the nature and importance of common relationship and client factors: has major implications for the field including the nature of the medical model within mental health.*
- Rogers, C.R. (1957) The Necessary and Sufficient Conditions of Therapeutic Personality Change. *Journal of Consulting Psychology* 21: 2, 95-103
 » *In this seminal 1957 paper Rogers goes on to lay out the six conditions that formed the basis of counselling.*
- Roth, A. and Fonagy, P. (2005) *What works for whom?: A critical review of psychotherapy research*. New York: Guilford
 » *Influential early UK study (originally published in 1996) devoted to empirically supported treatments (ESTs)*
- Sanders, P. and Wilkins, P. (2010) *First Steps in Practitioner Research: A guide to understanding and doing research in counselling and health and social care*. Ross-On-Wye: PCCS Books

» *Excellent introduction to research methods published by the Person-Centred book publisher PCCS Books*

Sawyer, R.K. (2006) *The Cambridge Handbook of the Learning Sciences* Cambridge: Cambridge University Press

» *Cutting edge handbook exploring the new inter-disciplinary science of learning*

Timulak, M. (2008) *Research in psychotherapy and counselling*. London: Sage

» *Excellent in-depth introduction to research methods*

Timulak, M. and Creaner, M. (2010) Qualitative meta-analysis of outcomes of Person-Centred and Experiential psychotherapies in Cooper, M., Watson, J.C. and Holldampf, D. (eds.) (2010) *Person-Centered and Experiential therapies work: A review of the research on counselling, psychotherapy and related practices*. Ross-On-Wye: PCCS Books

» *A qualitative meta-analysis of qualitative outcome research. The results paint a rich picture of participant-defined therapeutic change that bears only a minor relationship to the traditional symptom-based measures of the current mental health research model.*

Wampold, B.E. (2008) The importance of treatment and the science of common factors in psychotherapy. In Brown, D.B. and Lent, R.W. (eds.) (2008) *Handbook of Counselling Psychology*. New Jersey: Wiley

» *Excellent review of the treatment/common factors debate: concludes that the provision of a coherent technique/treatment is actually an important 'common factor'.*

Wampold, B.E. (2010) *The great psychotherapy debate: Models, methods, and findings*. 2nd ed. to be published summer 2010: Routledge

» *Wampold has been one of the most vocal and long-term advocates of the potency of common factors relative to specific treatments and techniques.*

Woskett, V. (1999) *The Therapeutic Use of Self: Counselling Practice, Research and Supervision* London: Routledge

» *One of a small number of texts examining counsellor self-awareness and the process of reflecting on practice. Woskett argues that the 'counsellor's evaluation of their own practice [is] the main vehicle for the development of insight and awareness into individual therapeutic characteristics'.*