Response to Ian Murray's Paper 'Does the length of training determine the effectiveness of counselling practice?'

SUE BURNEY
JO BROOKER
JANE FLETCHER

First of all we would like to congratulate Ian Murray for raising this important and controversial issue and would like to pass on our sympathies in respect of his death to his family, friends and colleagues. It is a great pity that he was not able to complete his paper and address his last two aims.

Mental health issues are the largest single cause of disability in Australia accounting for 24% of the burden of disease and place a significant financial strain on the Australian health care system (Australian Bureau of Statistics, 2008). Therefore, understanding the minimal training needs of mental health workers to produce optimal client outcomes should inevitably lead to a containment of costs in this area (Atkins and Christensen, 2001). Another reason for addressing this issue is that it is important to determine the amount of training necessary for mental health care workers to achieve optimal outcomes so as to minimise the cost to clients for such services. This is all in the face of a decline in the volume of psychotherapy training in Australia, particularly in psychology (Voudouris and Hunter, 2011; Voudouris and Mrowinski, 2010).

Before we discuss our personal views on this topic we would firstly like to comment on the methodology used by Ian in his paper. We are of the opinion that it has not been adequate to answer his main argument. To provide convincing evidence that mental health paraprofessionals and professionals have similar client outcomes in psychotherapy we believe the search strategy should have been more rigorous. In fact, Ian's argument would have been more convincing if a systematic rather than an informal review had been undertaken. A systematic review entails the use of a process such as that outlined in the Transparent Reporting of Systematic Reviews and Analyses Statement (PRISMA) (2009). In this approach the search terms are clearly articulated, the sources (e.g., data bases, published and unpublished reports) provided, the inclusion and exclusion criteria of papers presented, and the number of papers accessed, included or eliminated, described. Given that such a process was not used, Ian could be accused of bias in the selection of the research papers included in his review. Further, we would disagree with his comment that 1500 papers were unwieldy in a review of this type. From our perspective this is not a large number of papers, and this number could have been quickly reduced by clearly articulating the search terms and inclusion and exclusion criteria prior to the start of the literature search.

On our review of the literature in this area we agree with Ian that there are many factors that need to be considered when determining client outcomes in psychotherapy. We are certainly in agreement that there is inconclusive evidence that length of training is directly related to client outcomes. However, moving to the main issue addressed in Ian's paper, the contention that paraprofessionals are able to achieve better outcomes in psychotherapy than professionals, there is no clear evidence of this. In fact the results are equivocal in many of the studies cited. Certainly, as Ian suggested, in the seminal meta-analytic paper by Durlak (1979), this conclusion was supported. In a number of subsequent studies (e.g., Akins and Christensen, 2001; Armstrong, 2010; Berman and Norton, 1985; Nietzel and Fisher, 1981), however, this contention was not supported. In one of the more recent studies cited by Ian, Nyman, Nafziger and Smith (2010) it was found that client outcome was much the same when clients were seen either by a licensed doctoral level counsellor, a pre-doctoral intern, or a practicum student. In our view these therapists are all professionals not paraprofessionals so we are not convinced the conclusions in this latest paper support Ian's argument.

We would certainly agree with Ian that variation in terminology regarding what constitutes a paraprofessional and professional makes a review in this area almost impossible. Further, comparing the training of mental health workers in Australia with that in other countries is fraught with difficulty given the considerable differences in the various educational systems. However, to ensure that Ian's research question about whether paraprofessionals and professionals in psychotherapy have similar client outcomes is answered we reiterate that a systematic approach could have been used. In such a review the inclusion/exclusion criteria would have been carefully considered at the outset, thus providing a clearer focus for the review. If such a search revealed no or few studies, then we could surmise that there was not sufficient evidence to answer the study question.

Another of our criticisms of Ian's paper is that most of the cited studies seem to be based on proxies for length of training. If carefully formulated research evidence is to be produced to support his contention, studies that explicitly record length of formal training, and then control for other relevant factors should be examined. Some of the factors that should be included are the amount, quality and relevance of continuing professional development training as well as the content of formal training. Other important issues to consider in such a review include the severity and type of mental health problems that are being addressed by mental health workers. For example, there is a vast difference in the skills and knowledge required to help a client manage an adjustment disorder versus major psychiatric illnesses such as schizophrenia. Furthermore, individual difference constructs such as personality, attitudes and life experiences of both client and the mental health worker will possibly have a substantial impact on outcomes of psychotherapy and these factors should be considered. Other important factors that should be controlled for in such studies are the sociodemographic profiles of clients and mental health workers, and the therapeutic paradigm in which the mental health worker practises. For example,

the degree of eclecticism and flexibility in the approach used by a mental health worker is known to impact on client outcomes in psychotherapy (Brooks-Harris, 2008).

Another concern about Ian's paper is that many of the citations included are quite dated. It would have been more pertinent to include papers examining changes in formal training course content over the last two decades. Apologising in advance for the many examples taken from psychology to illustrate our arguments, there have been major changes in the training of psychologists during this time. For example, master of psychology and doctor of psychology degrees by coursework that include 1000 hours and 1500 hours of clinical placement respectively were only introduced in Australia in the past 15 years. Prior to the introduction of such courses graduates in psychology with 'lengthy' training may have completed masters or PhD by research and been registered to practise with little or no practical experience included in these courses. However, PhD graduates in psychology are now required to undertake a field placement under supervision for one year (pro-rata) post-graduation before they can be registered as a psychologist with the Australian Health Professionals Regulation Authority (AHPRA).

In psychology the introduction of psychology masters and doctoral by coursework degrees in Australia has increased knowledge in specialist areas and provides a good example of how content of psychotherapy training may be more important than length of training. Using an example from our specialist area of practice, psycho-oncology, a cancer patient may find a psychologist with a health psychology qualification more helpful than a practitioner with a clinical psychology degree. Health psychologists are trained to assist clients who have mental health issues that are a direct cause of, or impacted by, physical health problems. A good example would be depression in a patient with cancer that might be caused by their diagnosis or the side effects of treatments such as chemotherapy and radiation. As a side issue, we would therefore refute Ian's claim that two of the studies referred to in his paper that dealt with weight reduction and anticipatory nausea (no references provided) were more oriented to physical-based problems rather than those very often encountered in oncology, as these are some of the very areas in which health psychologists can offer evidence-based psychotherapeutic interventions.

Given our professional view that it may be the content rather the length of psychotherapy training that provides for the best client outcomes, a study into the content of TAFE graduate certificates and diplomas in mental health, undergraduate degrees in counselling, psychology masters degrees by coursework, in social work, and other human services courses and client outcomes should be undertaken. The length, content and quality of the field placements, which are an integral aspect of training in all psychotherapy courses, also require careful scrutiny in terms of their ability to impact on client outcomes. We also believe that the amount, content and quality of ongoing continuing professional development post-graduation are probably more clinically useful concepts to examine rather that length of formal (institutional) training in terms of effectiveness of psychotherapy. Using psychology as an example once again, once registered with AHPRA all

psychologists must complete a minimum of 30 hours of continuing professional development (CPD) activities annually. This is mandatory if a psychologist is to maintain their registration. Further, if they also become a member of an Australian Psychological Society College they must complete an additional 30 CPD college points plus the base number of 30 required for membership. For each block of 30 hours a minimum of 10 hours must be 'peer consultation' and

10 hours must be 'active' CPD activities, which refers to training in which the psychologist must be engaged in activities such as role plays, case studies, and debates (AHPRA, 2012). This standard was enacted under the *Health Practitioner Regulation National Law* (2009) with approval taking effect from 1st July 2010. As we are not aware of contemporary studies with rigorous designs that have examined the effectiveness of ongoing professional development on client outcomes, we recommend that this be undertaken across all the disciplines mentioned in Ian's paper.

Another concern with Ian's paper is that it seems to consider the outcomes for clients in a single client to single mental health professional context. While we know that many mental health workers still practise in this context the trend in recent decades has been for multidisciplinary team involvement in the care of the client (e.g., General Practitioner, psychologist, social worker, psychiatrist) (Mitchell, Tieman and Shelby-James, 2008). Furthermore, many paraprofessionals work in conjunction with professionals, such that outcomes may best be considered as team outcomes. From our reading of Ian's paper it appears that this confounding factor has not been addressed in the studies reviewed.

While we have been very critical of Ian's review to date, we certainly agree that the strength of the therapeutic alliance should be considered a possible predictor of client outcome regardless of the health practitioner's training. This contention, however, should be subjected to careful research attention. Ian has cited a number of studies in which individual constructs such as warmth, optimism, and empathy were reported as responsible for positive outcomes from psychotherapy (e.g., Roussos, Waizmann and Echbarne, 2010; Strupp and Hadley, 1979; Thompson, Gallagher, Nies and Epstein, 1983). Ian has also quoted the conclusions of authors such as Schmolling et al. (1997) who were of the opinion that there are many paraprofessionals who outperform professional workers because of their strong therapeutic alliance. However, these studies do not appear to have strong scientific merit given the type of research designs used. The only way to be sure that the above conclusions are decisive factors in psychotherapy outcomes, more studies with baseline measures of therapeutic alliance and a comparison group composed of individuals who did not receive the particular psychotherapeutic intervention would need to be conducted.

Concluding Remarks

While we might agree with Ian's provocative statement that training length is not the key factor in determining the outcome of psychotherapy, and that therefore paraprofessionals and professionals achieve the same client outcomes in psychotherapy, our view is only from an uninformed standpoint based on our observations in the field. We therefore have no absolute evidence for making this claim. While Ian concluded that trained and untrained therapists achieve comparable levels of improvement, Berman and Norton (1985) after carefully reviewing the research evidence, found that it was not appropriate to compare the outcomes of the studies by professionals with those of paraprofessionals. This was because the mental health problems, treatments, and outcome

measures were not the same across the studies. In other words, Berman and Norton were not comparing 'apples with apples'. These are the very variables that need to be controlled for in a review of the evidence in this area. Therefore, the only way we will know if Ian is correct in his assertion, and that our informal view is sound, will be to undertake a systematic review of contemporary well-designed research studies that collect the necessary data. We therefore recommend that a more systematic approach to gathering the research evidence be undertaken, with more attention to the finer detail of the studies presented so that we are clear that the above concerns are taken into consideration. If the outcome of such a review supports Ian's contention that training length is not associated with client outcomes in psychotherapy then we will need to explore the factors that contribute to successful client outcomes that are inherent in some mental health training courses and/or in mental health workers using rigorous research designs. As a final comment we tend to agree with O'Donovan and Dyck (2002) who concluded that the push for an increase in training length in psychotherapy may largely be motivated by psychologists who wish to enhance the status and prestige of their profession. We are certainly not convinced that extending the length of training in our discipline will result in better client outcomes.

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Dr Sue Burney 1,2 Corresponding author, Sue.Burney@monash.edu
Dr Jo Brooker 1,2,3
Ms Jane Fletcher 1,2

1. ***School of Psychology and Psychiatry, Faculty of Medicine, Nursing and Health Sciences, Monash University***
2. ***Cabrini Monash Psycho-oncology, Cabrini Health***
3. ***Southern Synergy, School of Psychology and Psychiatry, Faculty of Medicine, Nursing and Health Sciences, Monash University***