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Teaching Counselling Amid the Evolving Evidentiary Landscape
L'enseignement du counseling dans un contexte probant en pleine évolution

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ABSTRACT
Historically, professional counselling has been mired by "theory wars" involving proponents going to great lengths to prove (either through research or through rhetoric) that their approach was superior to others. This, not surprisingly, led to rancour and division within professional counselling and a form of camp mentality among model adherents. This paper offers an innovative approach to teaching models of counselling that counters such tendencies. The impetus for this approach stems from a robust and growing body of research indicating that counselling models, although often revered among model adherents and assumed to be the *sine qua non* of effective counselling, now appear to play a smaller role within the therapeutic enterprise. While few (including the present authors) would argue that counselling models are unnecessary, the various lines of research outlined in this paper compel counsellor educators to rethink how counselling models ought to be taught to graduate-level counselling students.

RÉSUMÉ
Par le passé, le counseling professionnel a été mis à mal par les « querelles de positions théoriques » dans lesquelles les partisans d'une approche donnée s'efforçaient de prouver (par la recherche ou par la rhétorique) que celle-ci était supérieure à toutes les autres. Sans surprise, ce contexte a nourri de la rancœur et de la division au sein de la profession du counseling et favorisa une mentalité de clan parmi les adhérents aux différents modèles. Le présent article propose une approche novatrice d'enseignement des modèles théoriques du counseling qui permet de contrer ces tendances. Cette approche est particulièrement attrayante, car elle se fonde sur de solides recherches croissantes qui indiquent que les modèles de counseling, bien que souvent vénérés par leurs partisans et conçus comme étant indispensables à l'efficacité

du counseling, semblent dorénavant jouer un rôle moins prépondérant dans la démarche thérapeutique. Certes, peu de personnes (y compris les auteurs de cet article) ne soutiendraient que les modèles de counseling sont inutiles, mais les diverses voies de recherche soulignées dans l'article incitent les formateurs de conseillers à revoir leur façon d'enseigner les modèles théoriques aux étudiants universitaires en counseling.

No graduate-level counsellor education program is complete without a course that addresses counselling models. Such a course, often scheduled early within counsellor education programs, is considered foundational to the skills and competencies that prepare students for eventual practice. This belief is affirmed by regulatory bodies that routinely list a course in counselling models within their credential requirements. Despite the stature and the purported importance of such a course within counsellor education, remarkably little has been written about counselling models from a pedagogical perspective. This is especially surprising given the historical and ongoing debate surrounding the evidentiary status of counselling models.

To be certain, important yet unsettled questions abound regarding how our profession ought to define, research, and implement evidence to support our practice. Yet, these questions often remain obscured within the confines of the well-trodden path of the traditional counselling models course, where each week a theory is covered, bookended by topics such as the person of the counsellor, cultural implications, and psychotherapy integration. Such fare has served students well across decades of training, offering apt road maps for how to engineer a successful therapy outcome. We contend, however, that research evidence should be fully integrated into counselling model course work, though not within a narrow version of the evidence that, as will be explained later, aligns with the original empirically supported treatment (EST) perspective.

Whether involving the teaching of counselling models via the traditional approach, EST models only, or a combination of the two approaches, educational success might be tempered by unintended and undesirable pedagogical side effects that foster competition and rigidity. We believe that the current zeitgeist of counsellor education, fuelled by new and exciting lines of evidence, has opened a welcoming door through which novel approaches can and should be developed for teaching counselling models. In this paper, we present one such approach.

We assert that teaching counselling models at the graduate level should include areas of research that (perhaps counterintuitively) diminishes the centrality of models within the therapeutic enterprise. A course that showcases this research while incorporating a novel approach to critical reflection can help counsellors harness the utility of counselling models without encumbering them with more importance than they ought to bear.

Limitations to Traditional Ways of Teaching Counselling Models

How counsellors come to choose the model(s) that informs and guides their work is of no small consequence, for it is from such models that all therapeutic intentions arise. Counsellors do not just enact whatever random interventive thought comes to mind (or at least they should not); rather, they do things that are taken from or align with models or schools of therapy. How, then, do counsellors come upon their chosen models? We believe that in many instances, this choice can be traced back to counsellors' graduate course in counselling models. If a traditional approach was offered, the student would have surveyed several models across consecutive weeks, culminating in a choose-and-defend paper at course end. Implicit with this approach is the assumption that the chosen (and ostensibly favoured) approach ought to prevail over all others.

While students are often encouraged to reflect on the strengths and weaknesses of all models, they are nonetheless enjoined to amplify the strengths of theirs at the expense of others, thus enabling the preconditions for rigidity and rivalry. Indeed, student investment in their chosen model is amplified through personal attachment. Models are not selected because of the purported strengths or evidentiary status, but because they align with an individual's personality, values, and personal predilections (Ogunfowora & Drapeau, 2008; Tartakovsky, 2016).

Though perhaps uncommon within dedicated counselling programs, an alternative to the model-each-week approach is to teach models according to a narrow version of evidence-based practice (EBP). This version, which can also be considered the original version of EBP in psychology and counselling, dates back to the mid-1990s. At this time, Division 12 of the American Psychological Association (APA; i.e., clinical psychology) published a list of "empirically supported treatments" or ESTs. To make this list, the treatments, as they were called, had to be supported by "at least two good between group design experiments demonstrating efficacy" or by "a large series of single case design experiments ($n > 9$) demonstrating efficacy" (Chambless et al., 1998, p. 4); in either case, treatments had to be conducted using manuals and client populations had to be specified clearly (i.e., diagnosed with a "mental disorder").

Publication of the original EST list was met with swift, concerted, and sustained opposition that over the past 25 years has slowly, although not entirely, eroded its import. Much of this opposition centres on the use of random controlled trial (RCT) research, a design borrowed from the biomedical model of research. The RCT approach's core tenets ascribe to a medical analogy where specific treatments applied to specific physical illnesses result in specific outcomes. To be viable as an evidence base for psychological research, the RCT approach relies on the following assumptions:

1. That homogenous, static, and accurately identified psychological disorders exist independently of shifting nosology or client presentation.

2. That standardized treatment protocols can be reliably and prescriptively delivered to a single diagnostic symptom cluster within a specified period (e.g., 12 sessions).
3. That tightly controlled research can be conducted on representative samples that generalize to typical practice contexts.
4. That a "cure" or an outcome can be reliably defined and measured.

Although space does not permit a thorough critique of these assumptions, suffice to say that numerous authors have challenged them roundly (e.g., Shean, 2015; Wampold, 2013).

The appropriation of RCT research for use in psychology and counselling served as an attempt to standardize counselling in a way that elevated the empirical status of some models (i.e., those most amenable to RCT research) at the expense of others. A review of Division 12's current list of evidence-based therapies (now referred to on the Division 12 website simply as "treatments") betrays a list dominated by cognitive and behavioural approaches, with many other mainstream models (e.g., narrative therapy, solution-focused brief therapy, Gestalt therapy, existentialist therapy, humanistic therapy, feminist therapy, Adlerian therapy, reality therapy, and Jungian therapy) not making the cut. From this perspective, teaching counselling models according to the narrow version of EBP makes for an incomplete offering and one that cannot be defended empirically given that meta-analytic outcome research finds few meaningful differences repeatedly across bona fide therapies. While exceptions to these equivalency findings can be found, in most instances there are no discernable outcome differences across the various models of counselling (Wampold, 2013).

Equivalency findings, along with an unrelenting critique of the RCT paradigm, led to the inevitable widening of the evidentiary approach originally proffered by APA's Division 12. A landmark moment in this endeavour came in 2005, when the APA published a policy statement on EBP in psychology that, while still intimating that RCTs ought to be housed on top of the evidence hierarchy, greatly expanded and strengthened the empirical range of what counts as evidence. A significant statement within the new policy reads as follows: "It is important not to assume that interventions that have not yet been studied in controlled trials are ineffective" (APA, 2006, p. 274). Such inclusiveness served as a striking counterpoint to those who promoted the narrow EBP tradition and who were quick to dismiss all therapies that did not fit easily into the RCT mould. The policy statement clearly departed from the narrow version of EBP by including a host of non-specific therapeutic features typically edited out from RCT research, such as therapist characteristics, client characteristics, the therapeutic relationship, and client feedback; notably, all of these features have indeed been shown to influence therapeutic outcomes significantly, regardless of the particular counselling model being used (Laska et al., 2014).

The rising interest in non-specific features of therapy that contribute greatly to therapeutic outcome regardless of the model being used, along with shortcomings associated with the choose-and-defend pedagogical approach outlined earlier, instantiates the need to veer from typical ways of teaching counselling models. We believe that the role of counselling models can justifiably be demoted within the therapeutic enterprise and hence be treated less deferentially within our counselling models coursework. Models are not constitutive of the entire therapeutic show; rather, evidence suggests that they are one relatively small part of the show. Although they are important, their significance is often inadvertently inflated (relative to other aspects of effective counselling) due to how they are taught or how they are viewed through the lens of EBP. In what follows, we present three bodies of research, each of which casts doubt on the primacy of counselling models within the therapeutic enterprise and figures prominently within the counselling models course presented in this paper.

Common Factors of Change

Equivalency findings, although a thorn in the side for some, have led others to look deeper into the features of counselling known to positively influence the outcome, regardless of the specific theory or model being used. Support for the "common factors" position comes via meta-analytic studies that highlight how counselling is undoubtedly effective in general terms (e.g., Munder et al., 2019), while in specific terms no single bona fide counselling model consistently outperforms others (Laska et al., 2014; Wampold et al., 2017; Wampold & Imel, 2015). A logical conclusion that arises from equivalency findings is that most models will do equally well, so long as they possess factors that cut across all "effective" therapies.

The roots of common factors can be traced back to a publication by Saul Rosenzweig (1936), who proclaimed that

> it is justifiable to wonder (1) whether the factors alleged to be operating in a given therapy are identical with the factors that actually are operating and (2) whether the factors that are actually operating in several different therapies may not have much more in common that have the factors alleged to be operating. (p. x)

To capture the essence of his argument, Rosenzweig (1936) drew upon a quotation from *Alice's Adventures in Wonderland*, in which the Dodo bird exclaims, "Everybody has won, and all must have prizes" (p. 412). This pronouncement foreshadowed what would become the clarion call of scholars and practitioners leery of ESTs and model-driven counselling. However, it was not until Luborsky

et al. (1975) reused this quote in their equally compelling paper that the notion of common factors surfaced again as a phenomenon of interest.

Initial renderings of the common factors position were, admittedly, oversimplifications of a complex phenomenon. Authors such as Duncan (2010) and de Felice et al. (2019) contended that rather than discreet, invariant variables that account quantifiably for a percentage of client change, common factors might be viewed more accurately and usefully as contextual variables that operate in "interdependent, fluid, and dynamic" ways (Duncan, 2010, p. 19). Despite this, evidence indicates that common factors play a significant role in sponsoring client change. Some estimates suggest that common factors could account for as much as 70% of therapeutic outcome variance, compared to between 1% and 1.6% for specific counselling models (Imel & Wampold, 2008; Laska et al., 2014).

While scholars continue to debate the number and functional properties of common factors, four have earned considerable empirical support and scholarly consensus: the therapeutic alliance, a genuine empathetic connection between the client and the counsellor, client outcome expectation, and therapist expertise (Leibert, 2011; Wampold & Imel, 2015).

Therapeutic Alliance

This term refers to the collaborative working relationship between the client and the counsellor (McClintock et al., 2017). Based on Bordin's (1994) original framework, the therapeutic alliance is commonly viewed as composed of three components: the agreement between the client and the counsellor of the objectives or goals of counselling, an agreement on the techniques the counsellor will use to attain the goals, and a strong bond or emotional connection between the client and the counsellor (McClintock et al., 2017; Wampold, 2013; Wampold & Imel, 2015). Research suggests that the summative effect of all three components accounts for 28% of therapeutic outcome variance (Laska et al., 2014).

The Empathetic Connection

A key ingredient of common factors is client perception of the counsellor's degree of empathy (McClintock et al., 2017). Empathy is a multi-faceted process by which an individual is affected by and shares the emotional state of another, assesses the reasons for that emotional state, and identifies with an individual by trying to embrace their perspective (Wampold, 2013). Research supports the importance of a warm, caring, and empathetic interaction with a counsellor, and there have been numerous studies associating perceived therapist empathy with a positive therapeutic outcome (Wampold, 2013; Wampold & Imel, 2015).

Outcome Expectation

Of equal importance is the anticipatory belief that a treatment will be effective (Constantino et al., 2012). Outcome expectation is a fluid process, where the

client's expectations are influenced by the developing client–counsellor relationship, the credibility of the treatment rationale for the client, and the effectiveness of early therapeutic actions (McClintock et al., 2017; Wampold, 2013; Wampold & Imel, 2015). Constantino et al.'s (2012) meta-analysis of the association between outcome expectations and the therapeutic outcome resulted in a small yet significant positive effect. A follow-up meta-analysis by Constantino et al. (2018) yielded similar results, thus solidifying the importance of outcome expectations as a common therapeutic factor.

Routine Outcome Monitoring

Routine outcome monitoring (ROM) refers to the practice of formally assessing client outcomes after each session to identify therapeutic progress and potential treatment alterations (Boswell et al., 2015). Although this practice dates to the pioneering work of Howard et al. (1996), only in the past 15 years has it gained the scholarly attention it deserves. Today, a compelling and growing body of research attests to the significant role that ROM plays in fostering a positive therapeutic outcome regardless of the model being used. ROM benefits counselling by increasing the proportion of clients who make clinically significant changes, lowering dropout rates, reducing the risk of therapeutic alliance rupture, shortening treatment length, and decreasing the cost of care (Goodman et al., 2013; Schuckard et al., 2017). Much of this is likely achieved through enabling counsellors to respond warmly, empathically, and collaboratively with clients, thus strengthening the therapeutic alliance (Schuckard et al., 2017). Effective use of ROM also increases the probability of a positive outcome by providing counsellors with a more accurate assessment of the strength of the therapeutic alliance (Schuckard et al., 2017).

Benefits of ROM

Evidence indicates that with proper training and implementation, ROM improves patient outcomes, helps prevent client dropout, and inhibits alliance deterioration (Lambert et al., 2018; Roe et al., 2015; Schuckard et al., 2017; Solstad et al., 2019; Wolpert, 2014). Of central importance to our arguments, ROM appears to achieve its benefits across all counselling models and purportedly has a greater influence on counselling outcomes than does the particular model being used (Schuckard et al., 2017). We suggest that the utilization of a ROM system will help to quell concerns by more skeptical clients that measurable changes are occurring throughout their counselling experience.

Challenges of ROM

Despite ROM's promise, certain challenges continue to require applied and empirical attention. For example, severely distressed clients may struggle to engage in the ROM process, perhaps preferring incisive advice over reflecting

and discussing feedback (van Oenen et al., 2016). Similarly, Østergård et al. (2020) commented that some ROM practices are completed with the therapist present, thus engendering the potential for social desirability effects (i.e., a desire to please one's counsellor). Researcher allegiance effects also undercut the empirical strength of ROM. A meta-analysis of all previous meta-analyses found a substantial association between researcher alliance and outcome across diverse settings, thus signalling the need for greater experimental controls if ROM is to strengthen its evidentiary base (Munder et al., 2019).

Transferring the tenets of ROM into one's counselling practice can also be challenging. To be effective, counsellors need to be adequately trained in using ROM, feedback needs to be carefully designed for the client, and assessments must be concise, easy to complete, reliable, valid, and useful to different stakeholders (Boswell et al., 2015; Roe et al., 2015). Solstad et al. (2019) recommended a client-centred approach to ROM characterized by a flexible, adaptive, and individualized style that empowers clients through fostering a positive therapeutic alliance, clear communication, and continual collaboration. Finally, the financial cost, the time, and the support (training) required to implement ROM also need to be considered (Boswell et al., 2015; Wampold, 2013; Wolpert, 2014).

Therapist Expertise

The efficacy of any given counselling model—even those deemed empirically supported by APA's Division 12—cannot be divorced from the skilfulness of the counsellor using the model. The RCT assumption (noted earlier) that a model can be administered reliably and prescriptively to a specific diagnosis belies the significant and irreducible influence of the individual practitioner. Research indicates that therapist expertise, as it has come to be known, accounts for a greater amount of outcome variance than the model employed (Schuckard et al., 2017). As the therapeutic community undergoes a paradigm shift toward understanding and maximizing non-specific factors, not surprisingly, notions of therapeutic expertise are also in flux. A review of the existing literature, as outlined below, highlights this shift, and the connection between "therapist" and "expertise" is complicated and defies singular encapsulation. Therefore, a discussion of therapist expertise requires an appropriate entry point and explanation; a recent series of events provides such a platform.

In June 2015, as the moderator of a discussion at the International Meeting of the Society for Psychotherapy Research, Clara Hill asked the group, "What is expertise?" This question surfaced after a recent publication (Tracey et al., 2014) that proposed that the field lacks a singular encapsulation of expertise. The crux of Tracey et al.'s (2014) concern was that more research is devoted to what *does not* contribute to therapeutic expertise than to *what does*. The therapeutic community's reaction was swift and insightful, evident from a series of peer-reviewed publications in the January 2017 issue of *Counseling Psychologist*. What follows

is an effort to locate this discussion in the recent history and present state of therapist expertise and possibilities for future efforts in this realm.

History of Therapist Expertise

A significant body of research suggests that there is much variance in the level of therapist effectiveness (e.g., Lambert, 2013; Miller et al., 2013). Further, there is a lack of empirical support highlighting how competent therapists develop their skill sets (e.g., Kohrt et al., 2015). This is concerning given the importance of tracking how highly effective psychotherapists develop their therapeutic skills and to what extent allegiance to a particular therapeutic stance increases performance and outcomes. Since the 1970s, there are three significant contributions to scholarship on therapist expertise: the work of David F. Ricks (1974) and his coining of the term *supershrinks*, the various works leading to the construction of the term "master therapists" (e.g., Miller et al., 2008; Jennings & Skovholt, 2016), and the early studies informing the therapeutic community of "deliberate practice" (Chow et al., 2015; Ericsson et al., 1993; Miller et al., 2013).

Supershrinks. Ricks (1974) found that the longitudinal outcome of mentally ill adolescents varied considerably between the two therapists in charge of their treatment. For example, 84% of the clients under the care of the first therapist were diagnosed with schizophrenia as adults. In comparison, only 27% of the clients attached to the second therapist received the same diagnosis. Further, although the caseloads, the client severity at presentation, and other socio-economic variables were equal, most of the clients of the first therapist were better socially adjusted compared to those of the second therapist. This longitudinal study of random and fixed therapist effects referred later to the effective therapist as a supershrink and to the less effective therapist as a pseudoshrink.

Ricks (1974) found that many factors contributed to the discrepancy in outcomes, but two are particularly relevant: The supershrinks strove to foster deeper, lasting relationships with their clients and sought direct client feedback. While the debate around therapist expertise continues, this study highlighted a second need to examine the skill sets of highly effective therapists further, and to acknowledge the "person of the therapist" (Wampold, 2001, p. 200) as a significant contributing factor in client outcomes.

Master Therapists. A review of the related literature suggests that past studies were able to identify qualities of highly effective therapists, such as being more psychologically minded (Blatt et al., 1996), having a flexible interpersonal style, and having the ability to develop strong working alliances (Laska et al., 2013). As Chow et al. (2015) suggested, however, no peer-reviewed studies have examined how these superior performing therapists develop and maintain their professional competencies.

Rather than focus on specific therapeutic skills, Jennings and Skovholt (1999) attempted to identify key personality characteristics of peer-nominated "master"

therapists. The study yielded rich descriptions of what *makes* a "master" therapist in terms of their cognitive, emotional, and relational expertise. Of the nine[1] personality characteristics described, the findings highlighted that mastery rests on how one does therapy—improving skills, gleaning new knowledge, and building on what Ricks (1974) suggested about soliciting immediate client feedback. While the study had discernable weaknesses (see Orlinsky et al., 1999) and does not clearly define the term master therapist, it did solidify the notion that therapeutic expertise extends beyond theoretical orientation and is not solely about accumulated experience; rather, the study results suggested that relationship skills and therapeutic alliance are the core building blocks for client outcomes.

Deliberate Practice. Within the field of counselling, research suggests that expertise accrues through the amount of time specifically dedicated to improving therapeutic skills, rather than merely to the amount of time one has been in practice. Ericsson et al. (1993) detailed the activities found to be most effective in improving performance across a vast array of professions. They problematized the widely held belief that expert performers have characteristics that extend beyond the range of normal performers. Outside of a few exceptions, such as those genetically prescribed (e.g., height), they argued that "the differences between expert performers and normal adults reflect a life-long period of deliberate effort to improve performance in a specific domain" (Ericsson et al., 1993, p. 400). Said differently, rather than reflect an innate talent, highly effective therapists are those whose skill sets rely less on EBP and more on other factors such as dedication to practice and to hard work.

In recent years, the concept of expertise has received considerable attention in counselling. Hill's (2015) question "What is expertise?" catalyzed significant debate within the community. For example, Tracey et al. (2014) argued that there is limited evidence of expertise in the professional practice of psychotherapy. Specifically, there is little evidence to suggest a correlation between time "in" practice with "improved" practice, and that longer practice does not improve clinical decision-making skills or client outcomes. Tracey et al. (2014) dismissed the evidence for commonly used markers (reputation, experience, credentials, and performance skills) and suggested that these are not connected seamlessly to treatment outcomes. Instead, the authors promoted a model that used reflective feedback to structure responsive treatment as the primary factor in developing therapist expertise.

1 Jennings and Skovholt (1999) found that there are nine personality characteristics of master therapists, who in their view "(a) are voracious learners; (b) draw heavily on accumulated experiences; (c) value cognitive complexity and ambiguity; (d) are emotionally receptive; (e) are mentally healthy and mature and attend to their own emotional well-being; (f) are aware of how their emotional health impacts their work; (g) possess strong relationship skills; (h) believe in the working alliance; and (i) are experts at using their exceptional relational skills in therapy" (p. 3).

Tracey et al.'s (2014) position did not go uncontested. Hill et al. (2017) countered, indicating that research suggests eight criteria define therapeutic expertise: performance, cognitive functioning, client outcomes, experience, personal and relational qualities of the therapist, credentials, reputation, and therapist self-assessment. While this list is comprehensive, others (e.g., O'Shaughnessy et al., 2017) found it too broad to apprehend the nuances of expertise in session and how such knowledge can be integrated with supervision.

Norcross and Karpiak (2017) respectfully acknowledged the efforts of Hill et al. (2017) to account and define expertise in therapy, noting, "We trust that our collegial points of convergence and contention may contribute in some small measure to that urgent dialogue and promote additional research on how best to grow expert therapists" (p. 74). Rather than discontinue further dialogue, the authors embraced further debate to be in the best interest of the profession.

Goodyear et al. (2017) took this further when they suggested that psychotherapy is a field in which expertise does not exist. Historically, expertise in psychotherapy has been measured by a practitioner's performance, reputation, and client outcomes, but the system is flawed. "Expertise" is more of a dynamic concept, one that involves a focus on skill improvement, lying outside of adherence to a singular theory. This is in line with Schuckard et al.'s (2017) position that ROM has underperformed because associated benefits tend to accrue only if used by skilled therapists who are dedicated to deliberate practice. Perhaps it is not that expertise is missing from the field of psychotherapy, but rather, it does not "fit" into a constricted form of EBP.

Therapist Expertise and Counselling Models

In line with many of the authors whose work is outlined in this paper, we believe that expertise can be both accounted for and developed in various ways. The key issue, in line with arguments by Tracey et al. (2014) and Miller et al. (2013), is that regrettably, most research tends to focus on what *does not* contribute to therapeutic expertise rather than on what *does*. Considering the significant debate that took place between 2014 and 2017, we can see some light at the end of the tunnel—a way forward.

Definitional shortcomings and lingering conceptual questions aside, evidence suggests that counsellor skill plays an important—and larger—role in counselling outcomes than the model being used. For example, while treatment outcome variance typically ranges from 1% to 3%, a recent review found that therapist effect sizes account on average for 5% of outcome variance (Johns et al., 2019). Acknowledging differential counselling outcomes associated with counsellor prowess is important insofar that doing so "redresses the over-attention paid to comparing 'brands' of therapy" (Johns et al., 2019, p. 79). This, of course, is the central concern addressed in this paper and one that has inspired us to chart a

different pedagogical path. Moving forward, research efforts should attempt to build on the existing literature that highlights these nuanced aspects of therapeutic expertise while at the same time ensuring that this body of evidence finds its way into counsellor education curricula.

An Example Course

In the preceding discussion, we argued that typical approaches to teaching counselling models might inadvertently foster elements of rigidity and competition that run counter to evidence regarding what contributes to successful counselling outcomes. We argued further that promoting counselling models according to the narrow version of EBP could foster untoward competition and rigidity. We suggested that a salve to such shortcomings can be found within three areas of research that independently and in sum signal the need to change how we think about and teach counselling models. In what follows, we present a graduate-level course in counselling models that incorporates areas of scholarship and research that promote an open, flexible, and inquisitive approach to learning this subject matter. This course's broad intent is to serve as a countermeasure to the rigidity and competition that, in too many instances, soils the professional discourse surrounding counselling models.

Course Structure

Models of Counselling and Client Change, offered through Athabasca University, is a 13-week course designed to provide a dynamic and interactive learning process in an online format. In broad strokes, the structure involves learning the constituent elements of critical analysis in the first half of the course and applying these to specific counselling models in the second half. The structure and the process of the weekly online lessons require all students to progress at a similar rate across the duration of the course. Each week, students are expected to respond to thought-provoking questions and prompts that are posted in weekly discussion forums.

Week 1

The 1st week introduces students to the course while setting the tone for critical reflection embedded within all weeks that follow. Students are enjoined to view critical reflection not as disapproval or condemnation but in the spirit of submitting all ideas contained within counselling models to careful and purposeful scrutiny. Given the propensity of students for choosing counselling models according to personal beliefs and values, this lesson requires them to reflect critically on what Truscott (2010) referred to as their "assumptive world views" (p. 9). Using an exercise borrowed from Truscott, students identify their assumptive world views and match them with assumptions embedded within "major systems of psychotherapy" (p. 9). Students undertake this in order to resist choosing and

committing to their favoured model and instead to foster awareness of the presence and influence of personal assumptions on model choice. This leads students to directly confront covert personal biases that influence their affinity for certain models over others.

Week 2

The 2nd week invites students to reflect on how therapeutic ideas arise and evolve through particular socio-historical or socio-political contexts. In this respect, the truthfulness of such ideas comes to be viewed by students, somewhat provocatively, as more akin to what is contextually fashionable than as what is universally correct or accurate. This week's emphasis differs from a typical history of a psychology course in that it is not about learning facts associated with a particular model or originator. Instead, the intent is to foster an understanding and appreciation of how socio-historical forces give rise to and shape the emergence of particular ideas at particular times. Such an appreciation helps dismantle the notion of essential "truths" that somehow stand outside historical and social context. This desire to relativize assumed truths can be viewed as part of a broader social constructionist agenda, which asserts that all knowledge is local, provisional, and political (Gergen, 1994).

Although it may be tempting to view historical events as quaint and perhaps interesting stories from the past with little relevance to the present, there is good reason to dust off those pages of antiquity. Our counselling models came into existence within identifiable social epochs and therefore inevitably reflect their contemporary zeitgeist. The fact that zeitgeist shapes the formation of our disciplinary ideas suggests that it is wrong to elevate their epistemological status to that of truths perched outside of historical context. Once this is conceded, rigidity gives way to flexibility and dogmatism gives way to pragmatism.

Week 3

The 3rd week's content requires students to reflect critically on counselling models through the lens of culture, which, once again, helps destabilize their status as universal truths while also exposing and challenging concealed expressions of power and inequity. Students learn that the social context that gave rise to prevailing counselling theories and models reflects, in many instances, the beliefs and values of White men who lived or are living in Europe or North America; the underlying assumption that is brought under scrutiny is that North American and European counselling models and theories are relevant to all and can be rightfully viewed as universal in their scope and application. Culture is presented as a crack in the foundation of Euro–North American universalism that opens space to view theories and models as cultural products rather than as universal truths; in this light, the idea of one model ascending to the top of the therapeutic echelon, peering down upon all others, becomes suspect.

Week 4

The learning gained from the previous three weeks contributes to the central focus of the 4th week's lesson, which involves teaching students a process of critical reflection that they apply to counselling models later in the course. The approach to critical reflection used for this lesson is derived from renowned adult educator Stephen Brookfield (2013). The key task associated with Brookfield's approach involves "hunting" for three types of assumptions: paradigmatic assumptions (i.e., structuring world view assumptions), causality assumptions, and prescriptive assumptions. If one were to apply Brookfield's model to psychoanalytic therapy, for example, a causal inference would be that an infant who is inadequately breast-fed will, as an adult, engage in excessive oral-based activities, such as smoking, eating, and chewing on objects. A prescriptive assumption would be that a counsellor or a psychotherapist working from this model should remain very neutral and concealed when working with a client. A paradigmatic assumption would be that irrational, unconscious impulses strongly influence human behaviour.

After learning about the assumption hunting process, students apply it to a counselling model of their choice. They are asked to annotate a full PDF version of an article or a book chapter on their model and to indicate all instances of Brookfield's (2013) three types of assumptions. Their annotated PDFs are then used to "problematize" the found assumption through the following means:

1. *Prescriptive assumptions*. Students compare three to five prescriptive assumptions from two of their peers' annotated articles that, when stated using plain language, are the same or very similar. It often happens that when stripped of the brand's jargon, the prescriptive assumptions from different counselling models come to resemble one another.
2. *Causal assumptions*. Students choose two of their peers' annotated articles and identify five causal assumptions for each. Students then identify two alternative causal assumptions for each of the five they noted. This exercise intends to demonstrate that even though proponents of various counselling models often strongly assert the veracity of their model's causal assumptions, almost always viable alternative assumptions can be proposed.
3. *Paradigmatic assumptions*. Students complete an exercise that requires them to identify subtle (and in some cases not so subtle) instances of power and hegemony embedded within our prevailing counselling models' assumptions.

Critical reflection, ultimately, involves asking questions: It is about stepping back from our preferred ideas in order to identify and consider the assumptions on which they are based. Thus, "hunting assumptions" might profitably be considered the foundation of all critical activities, both professional and personal. Unearthing assumptions does not necessarily mean that the found assumptions ought to be abandoned. Indeed, as Brookfield (2013) stated, "Assumptions are

rarely universally right or wrong, but . . . they are more or less contextually appropriate" (p. 1).

Indeed, a great degree of utility is attached to many of our assumptions, especially in supporting our counselling and therapeutic ambitions. The simple act of exposing assumptions embedded within our counselling models allows students to examine their constituent parts in a manner that strips them of their theoretical jargon. Laying assumptions bare in this fashion accomplishes two things. First, there is a certain humility associated with being naked. When disrobed of their jargon, counselling models become less arcane and hence more easily understood and more amenable to critique; for good effect, abstractions are pushed aside by parsimony.

Second, it often happens that models that appear quite different upon surface inspection operate according to similar assumptions. For example, narrative therapy and cognitive behavioural therapy are rarely viewed as comparable approaches. Yet when stated in plain language, the prescriptive assumptions embedded within relative influence questioning, in some instances, come to resemble the process of identifying cognitive distortions associated with CBT. One might even speculate that when stripped of jargon, there exists a finite set of interventive activities that are common to all successful models.

Week 5

In the 5th week's lesson, students are introduced to EBP, which, in keeping with our discussion earlier in this paper, is based on the premise that competing evidentiary approaches leads to very different functional conclusions regarding counselling models. Consequently, learning activities for this week centre on helping students understand the practical implications associated with the narrow versus broad version of EBP, *narrow* meaning that students would only choose counselling models that show up on lists such as those promoted by Division 12 of the APA and *broad* meaning that there are non-specific "ingredients" that greatly impact therapy outcomes, irrespective of the model being used.

To facilitate their learning in this regard, students survey articles from a special 2014 issue of the journal *Psychotherapy* that highlights current perspectives on EBP. The authors of the lead article (Laska et al., 2014) argued that the very meaning of EBP had been misconstrued as a synonym for empirically supported treatments (ESTs); this, they contended, has led to an unnecessary conflation of the randomized control trial methodology and a disregard for alternative types of research that undermine the inevitable results of RCT research (i.e., that specific therapies are more effective for specific problems). This week's learnings afford an apt segue to Weeks 6 and 7, which address the three bodies of research presented earlier in this paper.

Weeks 6 and 7

For these 2 weeks, students are immersed in current literature and associated learning activities that address common factors, ROM, and therapist expertise. In each instance, students are tasked with understanding and appreciating how an expanded view of empirical evidence (i.e., one that includes these areas of inquiry) shifts, in proportion, the relevance of counselling models vis-à-vis positive therapeutic outcomes. Example learning activities for these lessons include a role-play conversation between an advocate for common factors and an advocate for ESTs, creating a "conceptual quilt" of factors that will help students move toward expertise in their careers, and critically assessing the strengths and limitations of various ROM tools.

Weeks 8 to 12

Students take a week off from formal postings in Week 8 to prepare for the busy four weeks that follow. During Weeks 9 to 12, students engage in wiki-based group work that requires them to use what they have learned during Weeks 1 to 7 to deconstruct and critically analyze the major tenets of counselling models across four domains of human functioning: thoughts/beliefs, behaviours, emotions, and relationships. Each week, students are required to engage in a comprehensive critical examination of a counselling model that targets change in the domain of human functioning focused on that week (e.g., thoughts/beliefs, behaviours). Student groups add content to their wiki that addresses

1. Their model's macro context (historical/cultural).
2. Their model's underlying assumptions (paradigmatic, causal, prescriptive).
3. Their model's evidentiary base (types of research conducted on their model and outcomes).
4. Their model's alignment with common factors research and literature.

The content provided across the group wikis is then used within discussion forums to reflect critically on the following topics:

Assumptive Underpinnings. Critically analyze and reflect on the three types of assumptions, set across the various models presented in the wikis. What do you see as the major similarities and differences across the models? Reflect on the degree to which the assumptions identified within the models correspond with your assumptive world views. Comment on whether you would be drawn to use one or more of the models presented in this week's wikis.

Evidentiary Base. Critically reflect on the amount and quality of evidence found to support the various models presented in the wikis. Do some models seem to be better suited to certain types of research (e.g., process-outcome, qualitative, RCTs)? Do the research findings across the different models tend to support or contradict the dodo bird hypothesis? After considering the relative merits of the research for the different models, which model, if any, would you be inclined to use?

Common Factors. Critically reflect on how the models presented in the wikis can harness common factors in supporting client change. Identify any assumptions that potentially could impede the positive influence of common factors. Finally, reflect on the degree to which the models' assumptions, when stripped of their theoretical jargon, might come to resemble one another. Consider the results of this reflection considering the specific ingredients versus common factors debate.

The 4-week exercise in critical deconstruction is extensive and demanding, but students typically emerge from it with a new and profound appreciation of commonalities that bind seemingly diverse models together rather than set them apart. This resembles a levelling process of sorts in which no single model can lay claim to superiority and all effective interventive procedures merit attention. We contend that this increases therapeutic dexterity and creativity, an apt antidote to the sort of inflexibility known to undermine effectiveness.

Week 13

The final week in the course is dedicated to psychotherapy integration. Surveys of practising counsellors indicate that most engage in some form of integrative practice (Cook et al., 2010). Counsellors likely come to this stance, intuiting the inherent limitations associated with learning a few select manualized models, which would then be applied across all clients. Intuition aside, we think that the research evidence supports the viability, if not the superiority, of adopting a more integrative stance where branded models take a back seat to research-supported therapeutic processes (Hofmann & Hayes, 2019) or treatment interventions (Beutler, 2014).

Conclusion

Given our arguments thus far, it is reasonable to ask if we are advocating for the demise of counselling models altogether. Although we think any such pronouncement is premature, it appears that a change in thinking is imminent. Counselling models have always helped orient counsellors pragmatically to the therapeutic landscape. The embedded mix of paradigmatic, causal, and prescriptive assumptions provides a metaphorical map of sorts to tell us where we ought to go and how we ought to get there in service of collaboratively helping clients arrive at their preferred outcomes. Notice has been given, however, that it may be both helpful and desirable to find new ways to approach our therapeutic work devoid of the "brand name" model baggage that ostensibly has hindered progress due to years of "theory wars." Carl R. Rogers was prophetic in this regard, commenting 60 years ago on the questions "Where does this lead? To what end is all this research?":

> Its major significance, it seems to me, is that a growing body of objectively verified knowledge of psychotherapy will bring about the gradual demise of "schools" of psychotherapy, including this one. As solid knowledge increases as to the conditions which facilitate therapeutic change, the nature of the therapeutic process, the conditions which block or inhibit therapy, the characteristic outcomes of therapy in terms of personality or behavioral change, then there will be less and less emphasis upon dogmatic and purely theoretical formulations. (Rogers, 1961, p. 268)

Similar sentiments are being expressed today by leading figures in counselling and psychology. For example, Hofmann and Hayes (2019) argued that researching specific brands of therapy for specific diagnoses should be replaced by studies that focus on "theoretically derived" processes, linked to procedures that address client-generated change targets. These authors contend that a "process-based therapy" (as they called it) would lead eventually to the demise of branded therapies: "We believe that named therapies that are defined by sets of techniques will become much less dominant as packages and protocols are broken down into procedures linked to processes" (p. 43).

Similarly, Beutler (2014) argued for the end of named therapies, suggesting instead that generically named treatment procedures ought to be matched to client characteristics and adjusted according to relationship factors. Beutler provocatively quipped that "psychotherapy of the future may look at how principles of change interface with one another rather than being consolidated around horse races among different brands of intervention" (p. 499). Finally, Melchert (2013) contended that "theoretical orientations" should be discarded in favour of a single unified biopsychosocial metatheory, according to which generically labeled "therapies and other interventions" could be used to "address individuals' problems and improve their biopsychosocial functioning" (p. 17).

Of course, those familiar with the psychotherapy integration movement, which has existed at least since the 1960s (Goldfried et al., 2011), could readily assign the alternative propositions mentioned earlier to existing versions of psychotherapy integration. Indeed, psychotherapy integration proponents have undoubtedly been most vocal in denouncing model hegemony in counselling and psychology. The integration movement sputtered in the 1980s, however, as national funders like the National Institute for Mental Health in the United States committed their resources to research programs modelled after the medical sciences (i.e., RCT research). It remains to be seen how the trajectory of therapeutic research will shift now that funding priorities have changed from RCTs to a more translational approach (i.e., an approach aimed directly at improving specific human concerns; Goldfried, 2016).

Despite its shortcomings, the narrow version of EBP remains strong in some sectors. There is an obvious economic appeal to a version of EBP that neatly

packages discrete therapies for discrete, diagnosable problems. Yet, the neatness of this clinical tapestry begins to fray when confronted by an imposing body of research that undermines the dominion and viability of the narrow EBP initiative. It is thus enlivening to consider the fruits of the broad version that we have discussed and that increasingly seems to hold sway in many spheres, for example the APA definition of EBP, which, while showing its ancestral indebtedness to the original APA Division 12 proclamation, nonetheless had broadened considerably. What happens in our view when this broad perspective is taken is that it inevitably diminished the centrality of the counselling model, thus opening new ways of conceptualizing evidence while also magnifying the need to teach counselling models in ways that depart from the timeworn “one theory per week” approach that currently prevails.

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