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# What do we know about the effectiveness of counselling and psychotherapy?

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# Background I

- Increasing demands for counselling and psychotherapy to be rooted in a body of research evidence, e.g.
  - HPC criteria for new professions
  - IAPT
- No longer sufficient to say, 'I think this therapy is effective...'
- Therapists *do* get it wrong: e.g.,
  - 90% of therapists think they are in the top 25% of practitioners

# Background II

- Vast body of empirical evidence, built up over last 50+ years, *does* exist...
- But many therapists not aware of it or drawing on it: e.g.,
  - Most useful source of information on how to practise
    - 48%: Ongoing experiences with clients
    - 10%: Theoretical literature
    - 4%: Research literature
- Why not? Research findings seldom communicated in a 'clear and relevant' fashion

THE FACTS ARE FRIENDLY

# Essential Research Findings

*in Counselling & Psychotherapy*

**THE FACTS ARE FRIENDLY**

**MICK COOPER**

bacp  
British Association for  
Counselling & Psychotherapy



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# Overall Effectiveness

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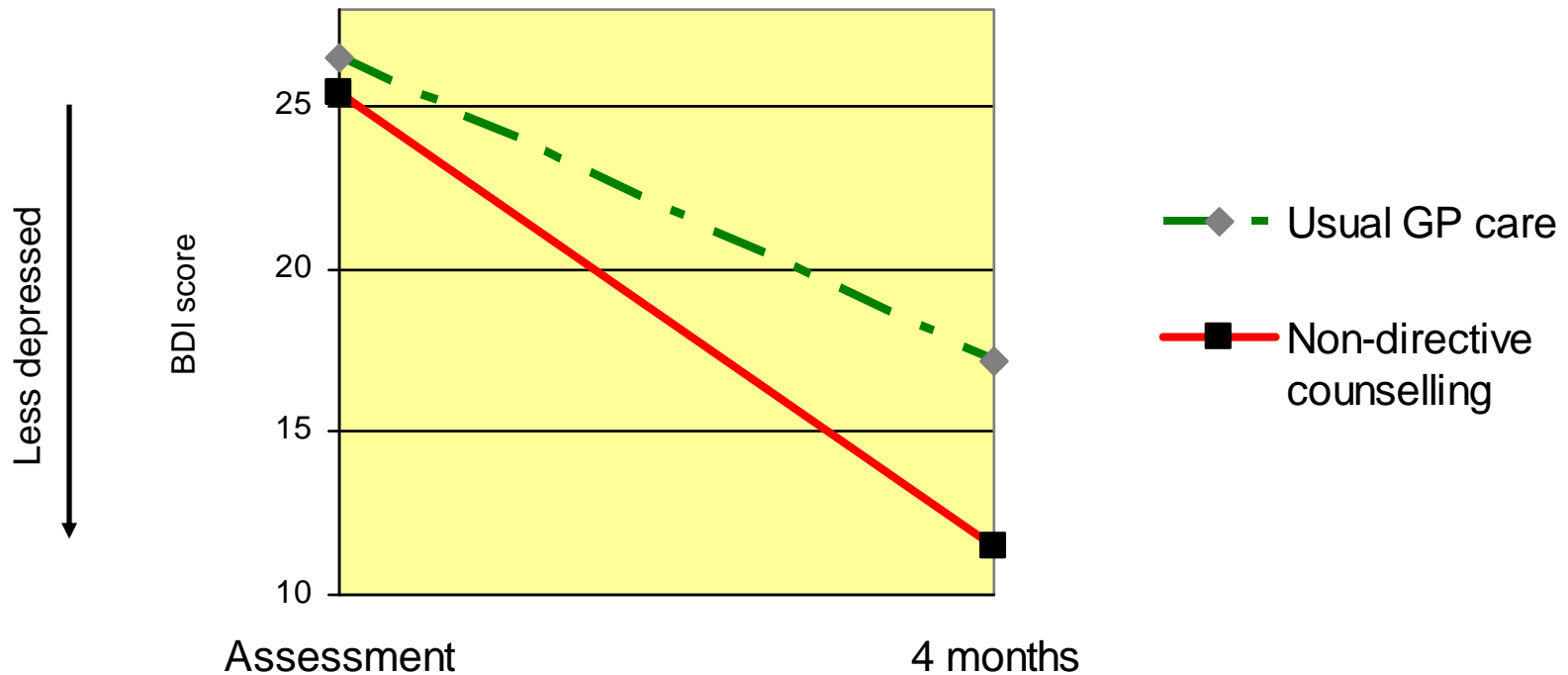
Does therapy work?

**Yes**

(on average)

# How do we know?

- Can compare changes in individuals who *do* have therapy with those who *do not*: e.g.,
- King et al., (2000): Rigorous RCT of therapy in primary care
  - Clients: depression & mixed anxiety/depression (n=464)





# Amount of change

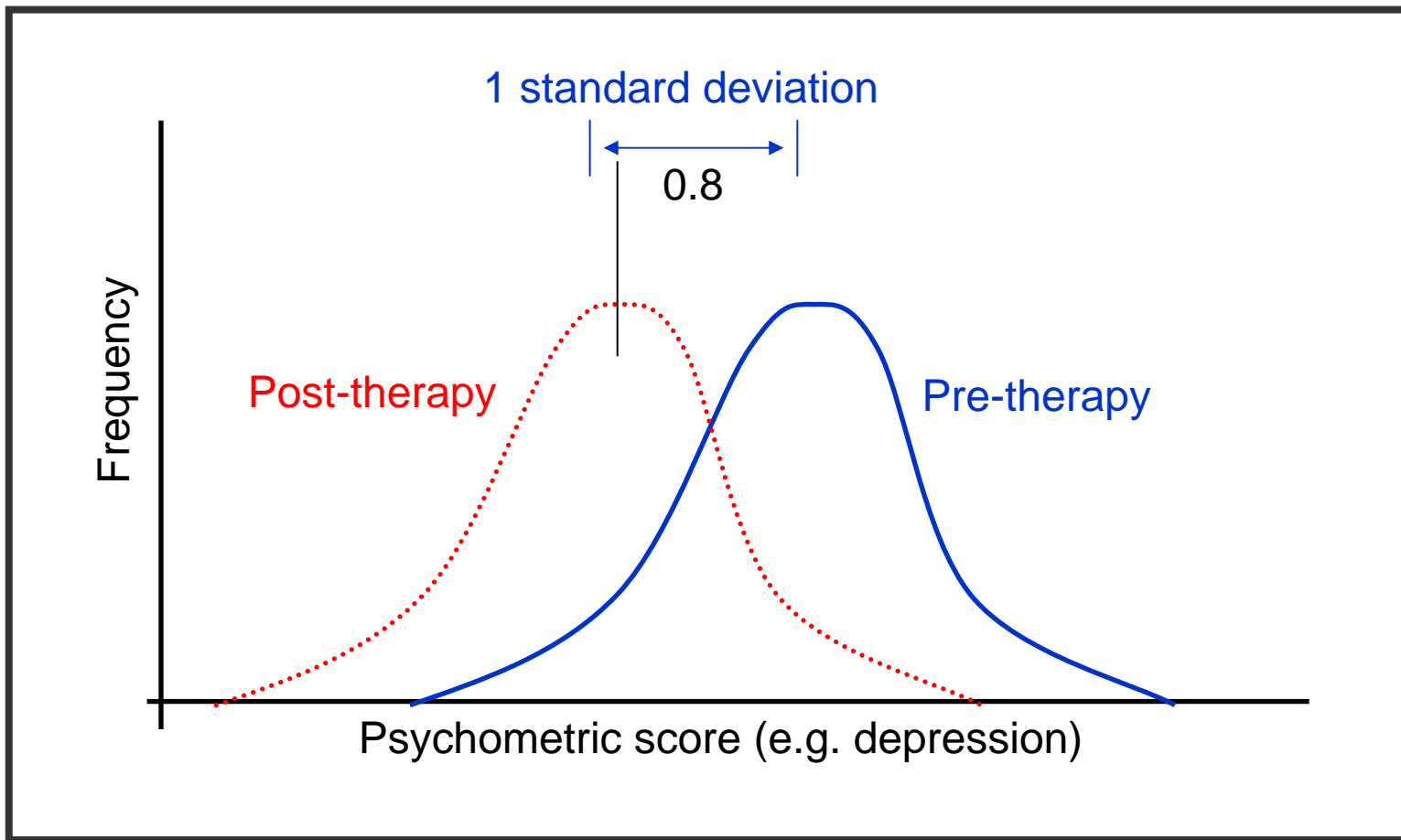
- 'Meta-analyses' (bringing together findings from different studies) indicate 'large' positive effects for counselling and psychotherapy
  - 'Effect size' ( $d$ ) against control groups approximately 0.7 – 0.8 = 'large'

ES 0.2 = small

ES 0.5 = medium

ES 0.8 = large

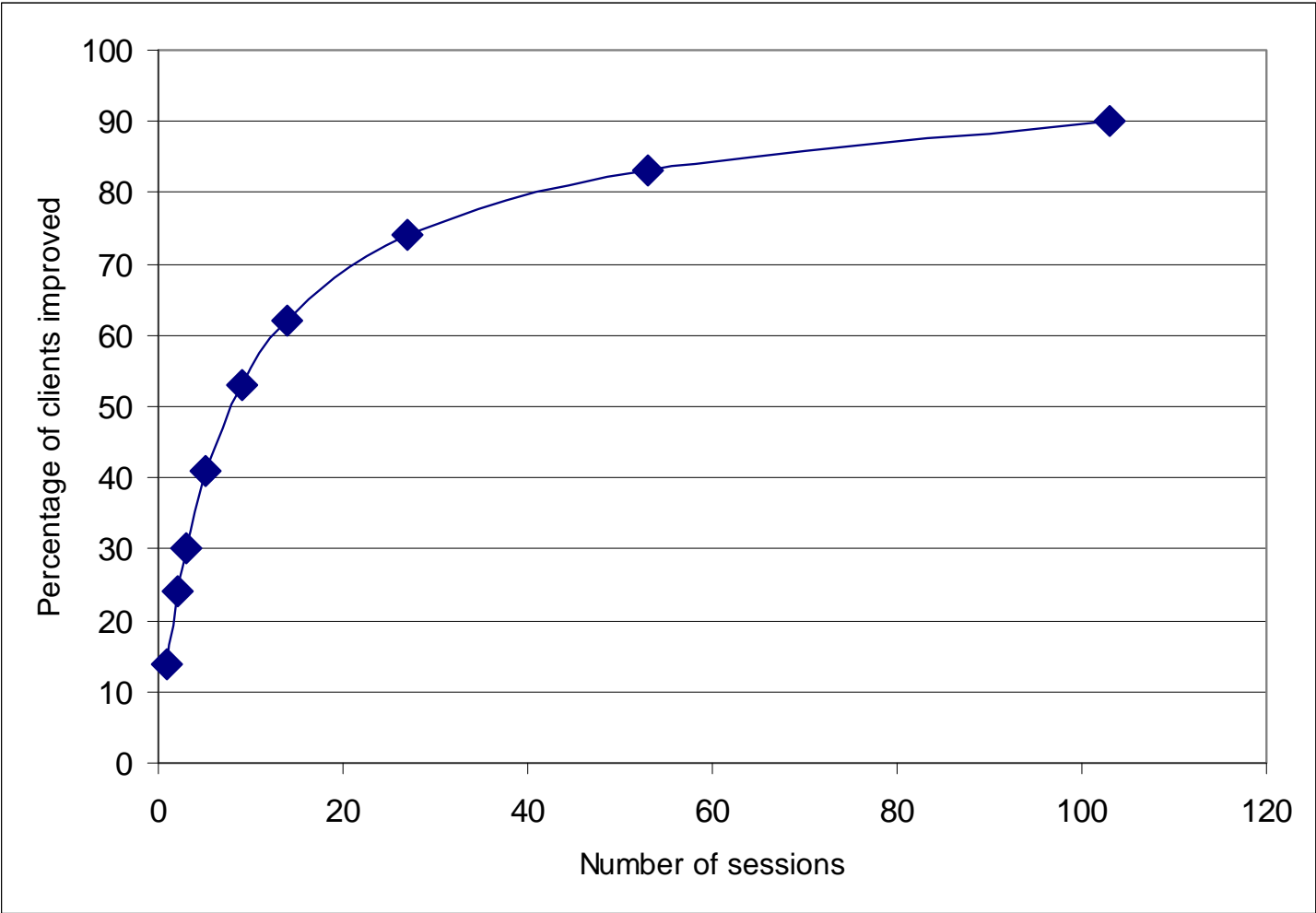
# Effect Sizes



# Amount of change

- ES of 0.8 > average effect of medical or surgical procedures, such as sleeping pills for chronic insomnia
- Approximately 8 out of 10 people better off after therapy than average person who does not have therapy

# More therapy makes it more effective



# And...

- Therapeutic gains generally maintained over time
- People who do well tend to continue doing well, and vice versa
- Generally as effective as medication, often with less drop-out and relapse
- Cost effective – particularly where savings on in-patient costs (e.g., schizophrenia, older people)
- Approximately five to ten per cent of clients deteriorate as a result of therapy

**What  
makes  
therapy  
effective?**

②

Orientation  
and Technique  
Factors

THE FACTS AND TRENDS



# Does orientation matter?

- Perhaps most controversial question in field
- Depends how you 'cut the cake'?



# Empirically supported therapies perspective

- 'Which psychological therapies/  
techniques are of proven efficacy for  
particular psychological problems?'  
(i.e., proven through at least one or  
two rigorously conducted  
randomised controlled trials)

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<b>Selected psychological problems</b>	<b>Empirically Supported Treatments</b>
<b>Depression</b>	CBT Behavioural marital therapy Problem-solving therapy Mindfulness-based cognitive therapy Interpersonal therapy Psychodynamic therapy Counselling Process-experiential therapy
<b>Specific phobias</b>	Cognitive therapy Exposure Applied muscle tension
<b>Post-traumatic stress disorder</b>	Exposure EMDR
<b>Bulimia</b>	CBT Interpersonal therapy
<b>Pathological gambling</b>	CBT

# Empirically-supported perspective

- Much more evidence for effectiveness of CBT compared with other therapies

But  
more evidence  
≠  
evidence of greater effectiveness

'Perhaps the best predictors of whether a treatment finds its way to the empirically supported list are whether anyone has been motivated (and funded) to test it and whether it is readily testable in a brief manner' (Westen et al., 2004, p.640)

# Comparative outcomes

- Most studies comparing different orientations, or orientation-specific techniques, show no differences
- Especially where:
  - *bona fide* practices
  - 'allegiance effects' controlled for

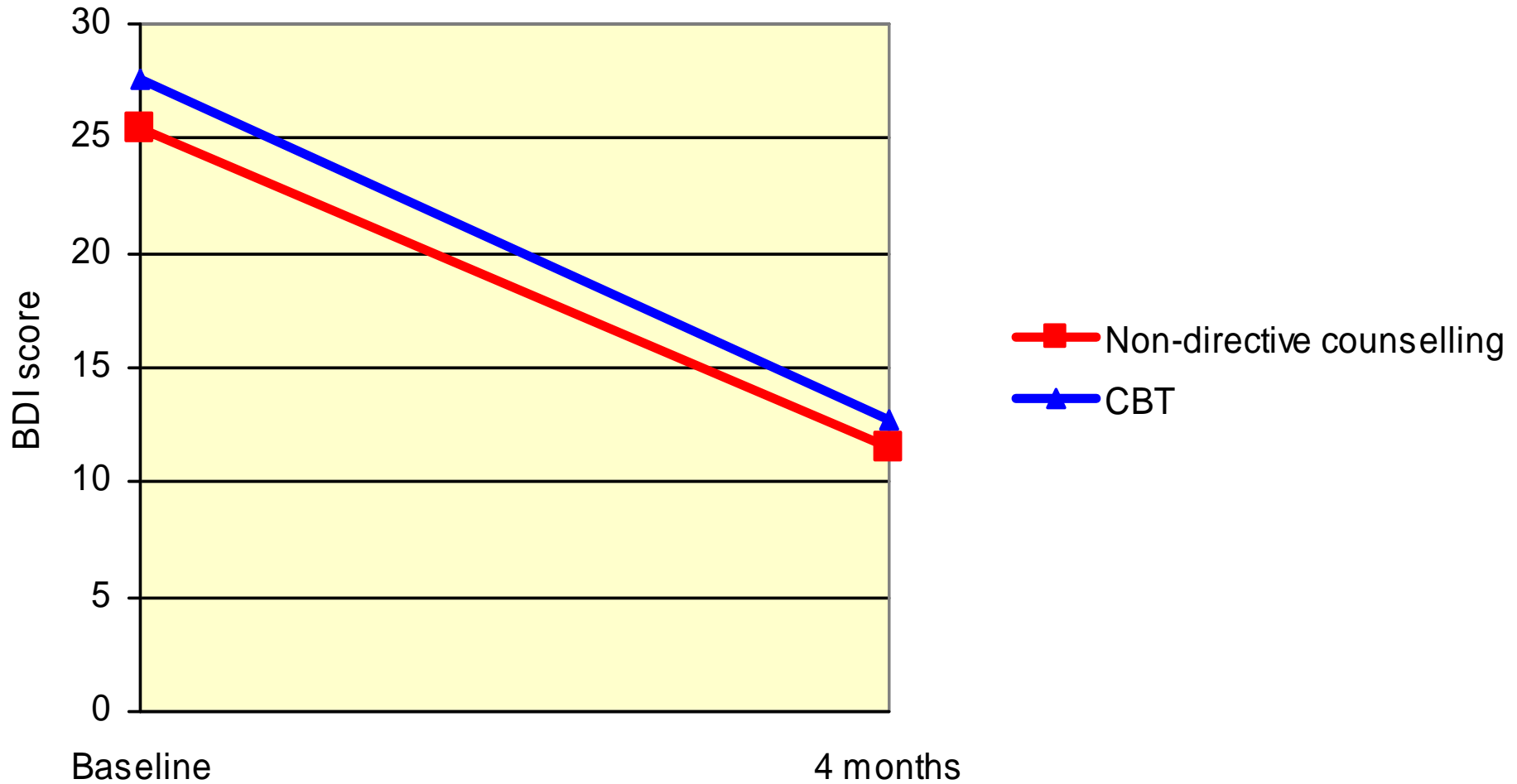
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# Allegiance effects

1. 'File drawer problem': 'null' results don't get published
2. Distorted analysis of data (esp. therapist factors not taken into account)
3. Use of outcome measures that are more responsive to particular therapies (e.g. cognitive slant of BDI)
4. Control 'counselling' is nothing like real counselling: (e.g. 'counsellors' instructed to change topic if client mentions assault [Foa et al., 1991])
5. 'Counselling' delivered by practitioners aligned to experimental treatment ⇒ questionable commitment to, or belief in, 'counselling'

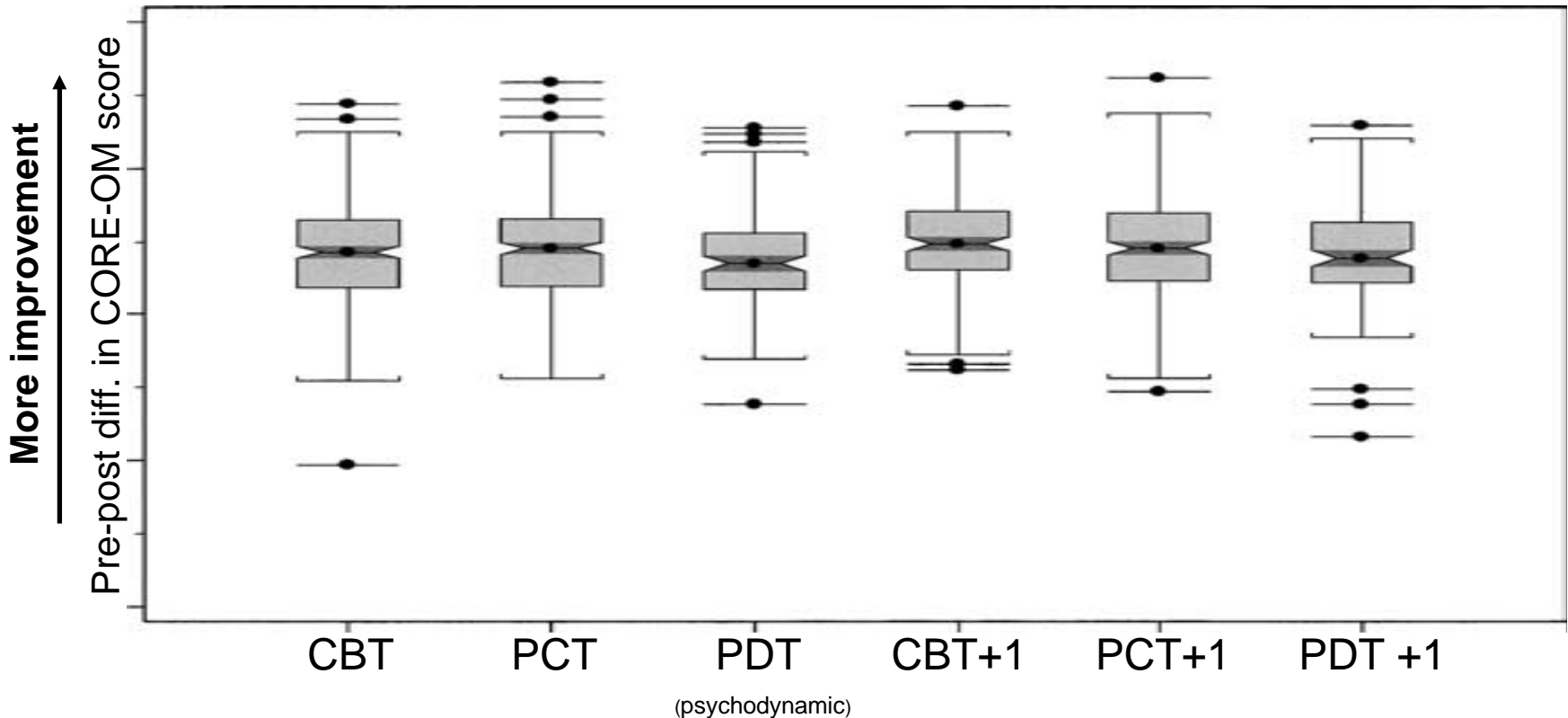


# Independent study: e.g., King et al. 2000



# Stiles et al., 2006

- 1309 clients at 58 primary and secondary care NHS sites





# ... 'Dodo bird' verdict

- Wampold (2001) meta-analysis: less than 1% of variance in outcomes due to therapists' particular orientation/ techniques
- Dodo bird rules across:
  - Group vs. Individual
  - 'Complete' therapies vs. Components
  - Professional vs. Paraprofessional
  - Self-help vs. Therapist-directed

③

# Therapist factors

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# 'Supershrinks' and 'pseudoshrinks'

- Strong indications that some therapists have better outcomes than others
- In one study:
  - clients of *most effective* therapist: average rate of change 10 times greater than normal
  - clients of *least effective* therapist: worsening of symptoms
- 5-10% of variance in outcomes seems due to specific therapist
- But why?

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# Professional characteristics

- Most professional characteristics only minimally related to effectiveness:  
e.g.,
  - Professional training
  - Professional status (profession)
  - Experience (as therapist)
  - Life-experience
  - Amount of supervision

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# Personal characteristics I

- Effectiveness also not strongly linked to:
  - Particular personality characteristics
  - Level of psychological wellbeing (including amount of personal therapy)
  - Gender
  - Ethnicity
  - Age
  - Sexual orientation

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# Personal characteristics II

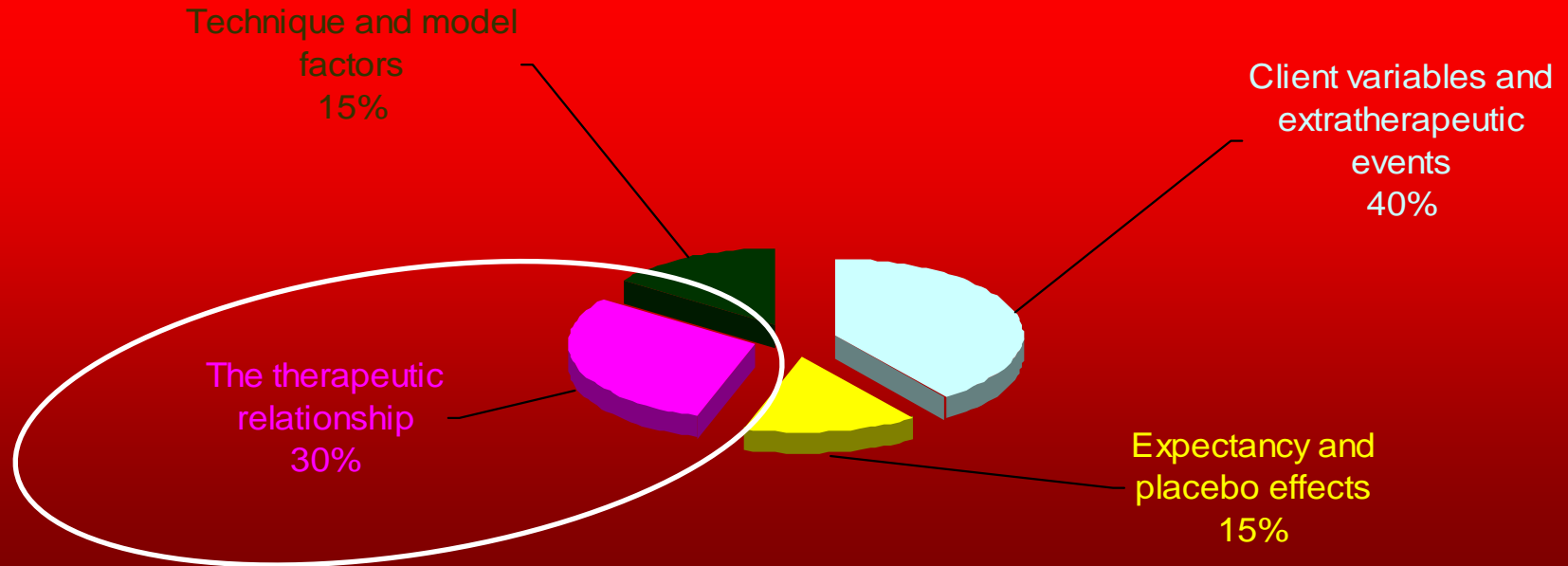
- Some clients from marginalised social groups, and/or with strong values (e.g., highly religious), do seem to do better with matching therapists
- But seems more to do with therapists' actual/expected relational qualities than characteristics *per se*: e.g.,
  - Study of Orthodox Jews:
    - some expressed preference for Orthodox therapist as feared non-Orthodox might judge
    - some expressed preference for non-Orthodox therapist as feared Orthodox might judge

④

# Relational factors

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# 'Lambert's pie': Estimation of what determines outcomes



- Others give more modest estimates of relational contributions: e.g., 7% to 17 (Equally important in less relationally-oriented therapies)



# 'Demonstrably effective' elements of the relationship

(in descending order of magnitude)

- Goal consensus and collaboration
- Cohesion in group therapy
- Therapeutic alliance
- Empathy

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# 'Promising and probably effective' elements

- Management of countertransference
- Feedback
- Positive regard
- Congruence
- Self-disclosure
- Relational interpretations
- Repair of alliance ruptures

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For clients who dropped out of psychodynamic therapy where there was a high transference focus, Piper and colleagues (1999) identified a consistent pattern of interactions in the pre-termination sessions:

1. The patient made his or her thoughts about dropping out clear, usually early in the session.
2. The patient expressed frustration about the therapy sessions. This often involved expectations that were not met and the therapist's repeated focus on painful feelings.
3. The therapist quickly addressed the difficulty by focusing on the patient-therapist relationship and the transference. Links were made to other relationships.
4. The patient resisted the focus on transference and engaged in little dynamic exploration (work). Resistance was often active, for example, verbal disagreement, and sometimes passive, for example, silence.
5. The therapist persisted with transference interpretations.
6. The patient and therapist argued with each other. They seemed to be engaged in a power struggle. At times the therapist was drawn into being sharp, blunt, sarcastic, insistent, impatient, or condescending.
7. Although most of the interpretations were plausible, the patient responded to the persistence of the therapist with continued resistance.
8. The session ended with encouragement by the therapist to continue with therapy and a seemingly forced agreement by the patient to do so.
9. The patient never returned.'

## But...

- *Associations* between relational (or any other) factors and outcomes not evidence that former *causes* latter
- Evidence for self-help therapies indicates that relationship not always necessary
- Quality of therapeutic relationship not determined by therapist alone...

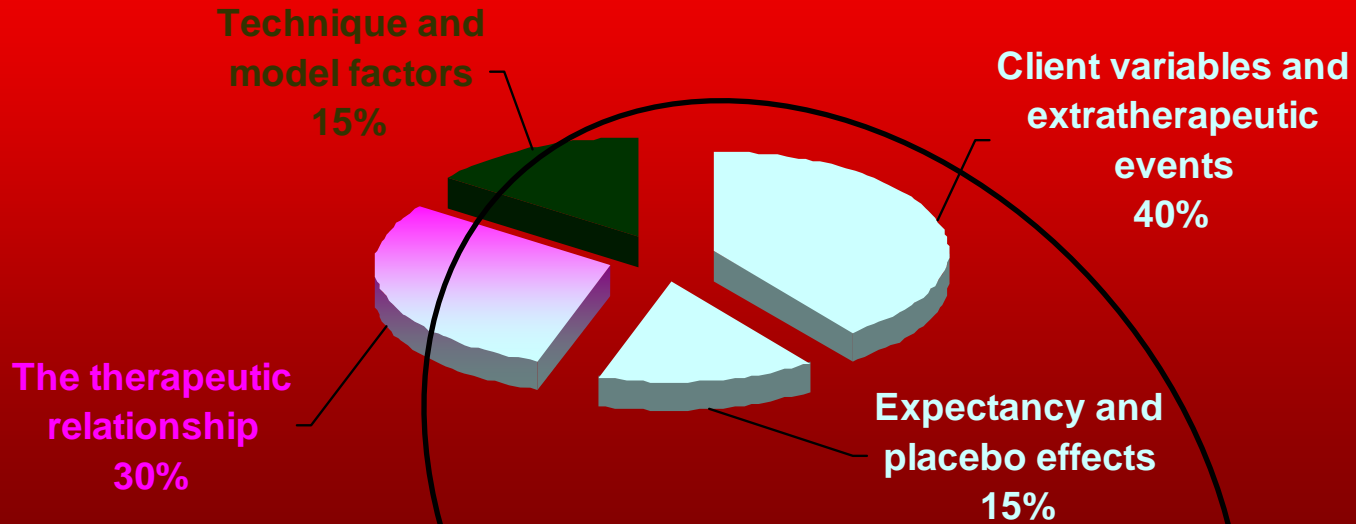
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# Client factors

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# 'Lambert's pie'

Estimate of Percentage of Improvement in Psychotherapy Clients as a Function of Therapeutic Factors



Client factors  
= 70% +

# Clients' participation in therapy

- Possibly 'the most important determinant' of outcome (> 20%)
- Positive outcomes associated with clients...
  - Motivation
  - Involvement
  - Active choosing of therapy
  - Realistic expectations

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# Capacity to 'use' therapy

- Better outcomes associated with higher levels of psycho-social functioning:
  - Secure attachment style (can form strong therapeutic alliance)
  - Higher psychological mindedness
  - Absence of 'personality disorders'
  - Lower perfectionism
  - More advanced stage of change
  - Greater social support

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... 'capitalisation hypothesis'  
VS.  
'compensation hypothesis'

- Does therapy primarily work by:
  1. helping clients *compensate* for deficiencies, or
  2. *capitalise* on strengths?
- Research tends to support latter hypothesis
- Clients do better in therapies aligned with strengths: e.g.,
  - Clients with higher cognitive abilities did better in CBT, those with higher levels of social functioning did better in IPT

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# Discussion

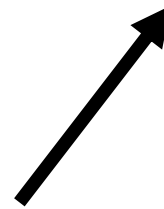
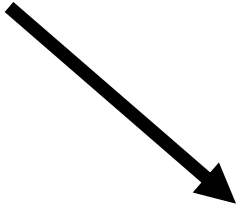
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# Summarising the evidence

- Extent to which outcomes determined by specific practices and techniques still not clear
  - Need for more independently-conducted comparative studies
- Emerging indications that client motivation, involvement and capacity to engage with therapy is at heart of effective change process



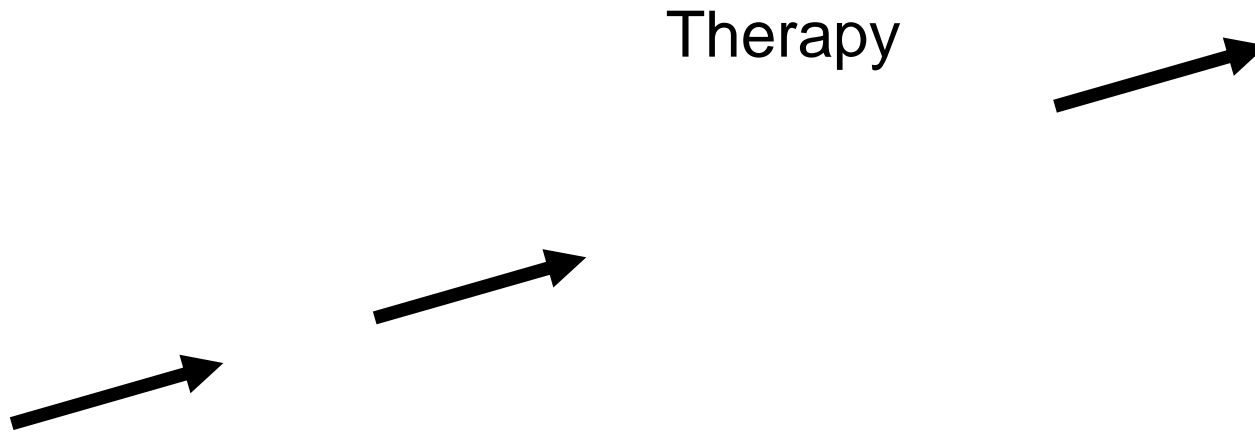
# Therapist as healer



# Therapy

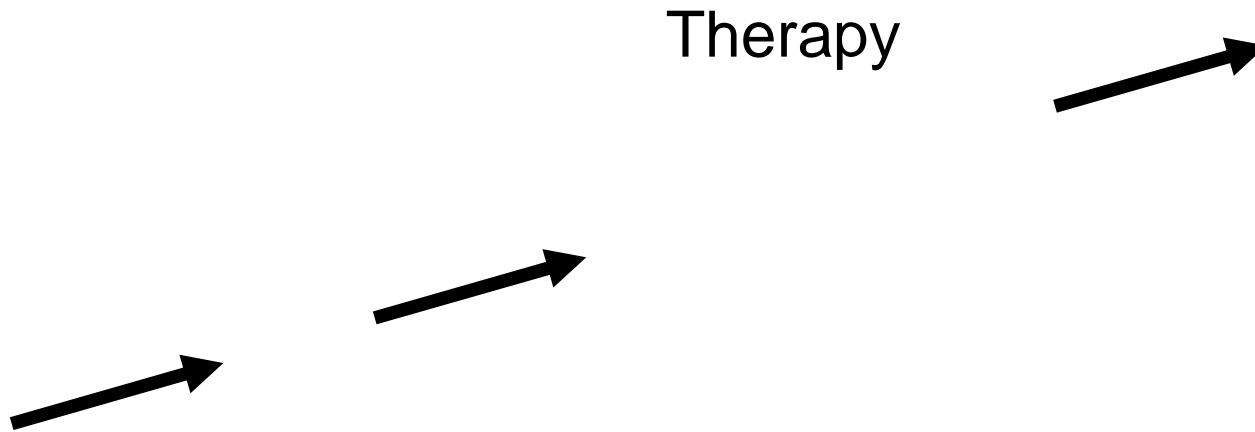


# Therapist as catalyst



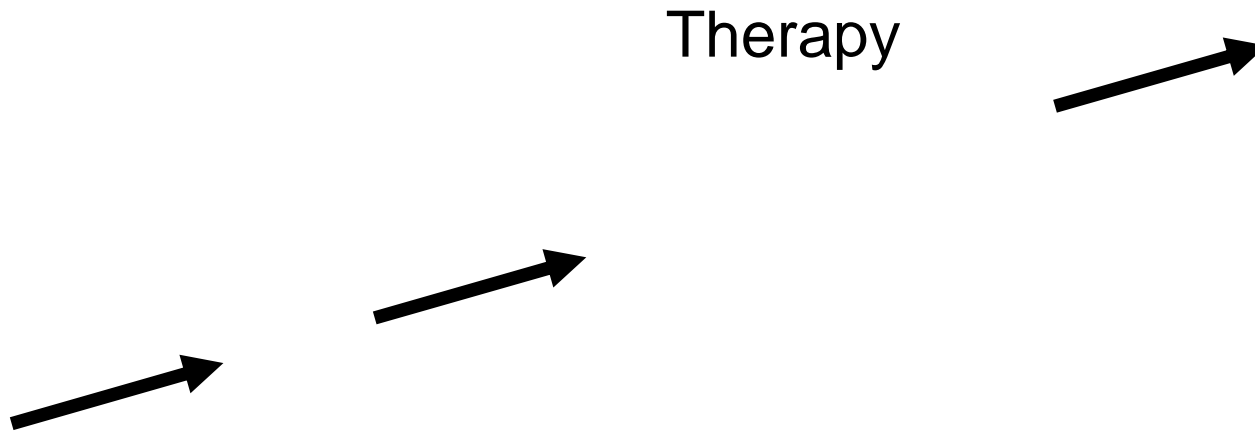


But clients may be more able to capitalise on some therapies than others: Is it consistent with their trajectory?



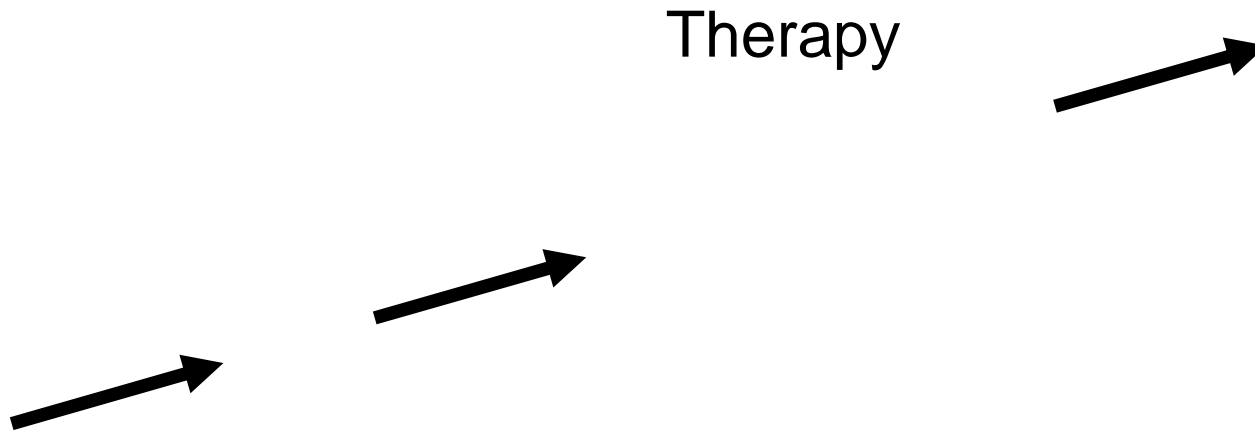


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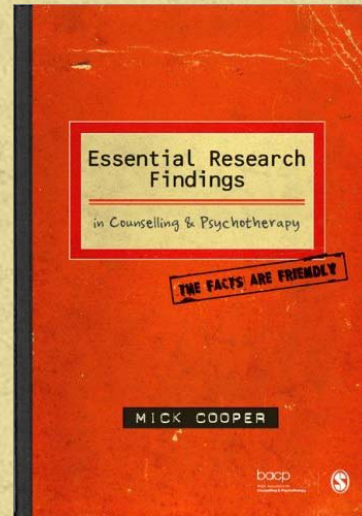


'at the heart of most successful therapies, is a client who is willing and able to become involved in making changes to her or his life. If that client then encounters a therapist who she or he trusts, likes and feels able to collaborate with, the client can make use of a wide range of techniques and practices to move closer towards her or his goals. For different clients, different kinds of therapist input may be more or less helpful; and there may be certain kinds of input that are particularly helpful for clients with specific psychological difficulties; but the evidence suggests that the key predictor of outcomes remains the extent to which the client is willing and able to make use of whatever the therapist provides'

Q. 'How many therapists does it take to change a lightbulb?'

A. 'One, but the lightbulb has really got to want to change.'

# Thank you



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