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The effectiveness of counselling: COSCA's review and commentary

*Prepared for COSCA by
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Paper summary

The use of counselling as a way of responding to people in distress has grown rapidly in recent years. While it has proven popular with many people, the rapid growth of counselling has also generated some disquiet and numerous questions. Confusion abounds in many quarters about what counselling is and to what extent it works. The position is complicated by the fact that there is considerable debate about how the effects of counselling should be measured. Nevertheless, robust and consistent evidence about the effectiveness of counselling is now accumulating. This paper provides a brief introduction to debates about effectiveness before summarising the results of some of the most influential bodies of research. It also identifies important limitations of existing findings.

Controlled trials conducted in health care settings indicate that counselling is an effective intervention, clinically and economically. Its costs and benefits are broadly comparable to those of antidepressant medication. It is, moreover, a popular choice with many patients. Caution is sometimes attached to the results of these trials because, compared to trials of medication, the numbers of patients are relatively small. However, this paper argues that medical trials are, in fact, more likely to underestimate than overestimate the impacts and effectiveness of counselling. Studies of counselling in other settings indicate a high level of satisfaction among clients. Moreover, there is good evidence to suggest that counselling has an important preventative role in relation to mental illness: counselling has the capacity to reduce demand on psychiatric services by preventing less serious problems from becoming more serious, and by helping people to maintain reasonably good levels of mental health.

Sceptics often doubt the effectiveness of counselling because it appears to involve nothing other than one (or two) people "chatting" to another who is called a counsellor. Appearances are, however, deceptive. The communication that takes place within counselling is conducted within a very special kind of relationship. Practitioners are trained to be able to offer this special kind of relationship using appropriate techniques, but, above all else, using *themselves*. Human beings are social creatures who need at least some connections with others. What all approaches to counselling share is a commitment to apply insights and understandings about the importance of these connections to offer therapeutically effective relationships.

If you wish to see the complete article on the above research, this can be found on COSCA's website: www.cosca.org.uk (this complete article is on the following pages).

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Introduction

The use of counselling as a way of responding to people in distress has grown rapidly in recent years. While it has proven popular with many people, the rapid growth of counselling has also generated some disquiet and numerous questions (Feltham 1999, 2002). Confusion abounds in many quarters about what counselling is and to what extent it works. The position is complicated by the fact that there is considerable debate about how the effects of counselling should be measured. Nevertheless, robust and consistent evidence about the effectiveness of counselling is now accumulating. This paper provides a brief introduction to debates about effectiveness before summarising the results of some of the most influential bodies of research. It also identifies important limitations of existing findings.

What is meant by effectiveness?

Does counselling deliver benefits or improvements to its clients? Does it produce positive outcomes or effects? These apparently simple questions about the effectiveness of counselling belie a wide variety of perspectives on what constitutes a benefit or improvement, and on how best to measure effects or outcomes. For example, should effectiveness be evaluated in terms of changes in objectively defined symptoms (like standardised scores for anxiety or depression), or in terms of the subjective statements made by clients (that is how they say they feel)? Is it possible, and, if so, is it important to differentiate between changes caused directly by what happens in the counselling room and changes attributable to other factors? At what moment in time should outcomes be measured: when clients finish counselling, six months later, a year later or when?

In this context it is also important to note that counselling services are offered in a wide range of settings, which influences the kind of outcomes or effects considered relevant. For example, where counselling is available within the National Health Service it tends to be thought of as a form of (non-medical) health care and its outcomes are likely to be evaluated in relation to mental health symptoms. Counselling services provided "in house" by large organisations – for example by employers for employees, or by educational institutions for students – are usually classified as "support services", and relevant effects might be related to fitness to work or study. Other organisations that offer counselling to the general public around issues such as relationships or bereavement are likely to think of their services as contributing to non-statutory forms of "social care". In such contexts relevant outcomes or effects might include the well-being of others, such as children, as well as the social functioning and well-being of clients themselves, creating further complexities in relation to the measurement of effectiveness.

This paper does not attempt to offer a comprehensive overview of research across all approaches to the question of effectiveness. Instead, in the next section it focuses on research undertaken within a (broadly defined) medical model of effectiveness, which is widely regarded as the most significant and robust. It then turns to findings emerging from studies conducted within other perspectives. Lastly it discusses evidence about the relative merits of different approaches to counselling.

Studies conducted within a medical model of effectiveness

In medical research, the “gold standard” for measuring the effectiveness (and the side-effects) of medical interventions is the double-blind trial. This method takes the idea of scientific objectivity to its logical conclusion in excluding both patients and practitioners from knowledge about which individuals are (and are not) receiving the medication that is being. Such methods are impossible to apply to counselling (and to numerous other health-related practices) which cannot be administered without the knowledge of the patients or the practitioners. However, many features of the double-blind trial are used in randomised or randomised controlled trials through which the effectiveness of counselling in health care settings has been investigated. Within these studies, counselling is conceptualised as a form of medical treatment that can be compared with others (such as anti-depressant medication) or with doing nothing.

Early medical studies investigating the effectiveness of counselling were hampered by serious confusion about counsellors and counselling (Mellor-Clark 2000). The “counselling” tested often failed to meet the standards established by the professional bodies for counselling. For example, in some studies it was assumed that doctors or nurses could deliver “counselling” without any dedicated training in counselling. The results of such studies were, obviously, unreliable and unhelpful.

More recent medical trials have overcome these problems and are based on tests administered to clients who have received counselling from qualified counsellors. As results from a number of such studies have become available it is clear that counselling achieves results comparable to anti-depressant medication with patients suffering from clinically defined depression (Chilvers *et al.* 2001; Rowland *et al.* 2001; Ward *et al.* 2000). When the effects of medication and counselling are compared over time (after the end of “treatment”) results regarding longer-term effectiveness (prevention of relapse) are also broadly comparable (Chilvers *et al.* 2001; Rowland *et al.* 2001; Ward *et al.* 2000).

Cost effectiveness as well as clinical effectiveness attracts considerable attention within medical research. This too is a field full of complexities and disputes. However, the available evidence suggests that the costs of counselling and medication are probably fairly similar (Bower *et al.* 2000, 2003; Friedli *et al.* 2000; Simpson *et al.* 2000).

The issue of patient choice in relation to forms of treatment is accorded increasing significance within health care, and highlights the need to consider factors other than clinical and cost effectiveness. In an important recent study (Chilvers *et al.* 2001), counselling proved to be a popular choice among patients, as well as proving as effective as anti-depressant

medication. The researchers concluded that general practitioners should allow patients to have their preferred treatment. Counselling attaches a great deal of importance to the autonomy, and therefore the choices, of patients/clients. It cannot be administered to the unwilling, and the ability to say "no" may, in some circumstances, be indicative of the success of counselling.

In considering evidence from medical trials it is also important to note that counselling is predicated on ideas that are in tension, if not direct conflict, with the ideas about treating illness or disease or alleviating symptoms that inform medical interventions. In contrast to these assumptions, counselling is often understood as a way of *reframing* issues. For example, instead of thinking about depression or anxiety as illnesses that need to be cured, counselling may encourage clients to reflect on, and lessen, prohibitions against feelings of grief, fear or disgust. Consequently, clients may become more accepting of their feelings, rather than cured of their symptoms. This is one reason why the variables selected to measure outcomes are contentious. Some methodologies incorporate sufficient flexibility to allow for a diverse range of variables to be accorded importance in the measurement of outcomes (for example the CORE system) (<http://www.core-systems>). However, these still require the identification of discrete variables on which clients can report. The idea that counselling leads to issues being reframed suggests that changes are holistic and cannot easily be broken down into a series of measurable components.

The conclusion to be drawn from these various considerations is that medical trials, however well-designed, are more likely to underestimate than overestimate the impacts and effectiveness of counselling. Moreover, it is also clearly important to consider studies conducted outside the domain of health care settings.

Other studies about the effectiveness of counselling

Studies of the effectiveness of counselling conducted in settings other than health care do not generally conform to the strictures of the randomised trial. A great deal of evidence is gathered by services providers themselves, not least because of funding requirements. However, the results of routine in-house evaluation of client satisfaction are problematic as research evidence. Return rates from instruments such as postal questionnaires are too low to provide statistically robust evidence. Any attempt to "capture" client feedback before clients finish is equally problematic in terms of its capacity to provide independent and statistically representative evidence. While service providers have much to learn about their own services from routine monitoring and evaluation, this is not an appropriate means by which to gather generalisable evidence about the effectiveness of counselling *per se*.

Numerous small-scale studies about client experiences of counselling have also been conducted. Some of these employ quantitative methods, others employ qualitative methods. In their totality, these studies provide important evidence about the subjective impacts of counselling, and about how clients and practitioners think about the practice. However, evidence of this kind requires careful and thorough analysis to distinguish between generalisable findings about impacts and insights of other kinds. No attempt is made to undertake such a task in this paper, although this body of research does have an important contribution to make to debate about many aspects of counselling provision.

A major study of clients attending Relate Centres was conducted in the mid-1990s (McCarthy, Walker and Kain 1998). Clients completed questionnaires at the beginning and the end of counselling contracts, and again six months and twelve months after the end of counselling. Two-thirds of clients reported that they were glad they had gone and only 3 per cent said that they regretted having gone. Those who completed counselling contracts (and therefore did not withdraw without discussing the matter with their counsellor) reported the highest levels of satisfaction. A more recent study commissioned by ACCORD Catholic Marriage Care Service generated very similar results (McKeown *et al.* 2002). About two-thirds of respondents reported that counselling was beneficial to themselves and their children, and six out of ten reported it was beneficial to their relationship. This study also found dramatic reductions in stress levels both at the end of counselling and six months later.

Some robust quantitative evidence is available about the mental health status of clients when they first present for counselling to university and college counselling services. Statistics compiled by the British Association for Counselling and Psychotherapy indicate very high rates of mental distress among students in general (<http://www.studentcounselling.org/>). A recent survey quoted by BACP found that 64 per cent of female students and 46 per cent of male students showed significant symptoms of mental illness; another found that 82 per cent of students attending a large university counselling service presented with levels of distress exceeding the cut-off for patients treated with NHS mental health services (Potter 2002). While these surveys do not provide direct evidence of effectiveness, they indicate that the availability of counselling services is likely to reduce demand for NHS mental health services. Several small-scale studies of counselling delivered specific groups in specific settings provide further evidence that this intervention diverts demand away from psychiatric services, and reduces demand for other health services (such as GP care).

How counselling works and the issue of different counselling orientations

As well as medical studies that compare counselling to medication, there have been numerous studies that compare the effectiveness of different counselling orientations (for example psychodynamic, person-centred, and cognitive-behavioural therapy (CBT)). Although some studies point to modest variations in the effectiveness of different approaches for different conditions, the overwhelming message from these studies is that orientation is not a significant factor in relation to effectiveness. This claim may appear to contradict statements made by the Department of Health about the proven effectiveness of particular approaches for particular conditions, for

example CBT for specific phobias (Department of Health 2001; also see Roth and Fonagay 1996). However, there is no real contradiction: these statements about the effectiveness of particular approaches are made primarily because of the availability of evidence that is highly valued within a medical model of effectiveness, especially findings from controlled trials, which have been conducted far more with CBT than with other kinds of counselling. Thus, statements about the proven effectiveness of particular approaches arise more from the different histories, philosophies and trajectories of institutionalisation of different approaches, rather than from any intrinsic differences in effectiveness.

The similar effects achieved by different counselling orientations is entirely consistent with the argument that it is the quality of the therapeutic relationships counsellors are able to offer to clients that is the crucial factor in determining the effectiveness of counselling (Roth and Parry 1997). Consequently specific techniques matter only in the context of the quality of the therapeutic relationship available. It is also important to note that counselling clients (whether satisfied or dissatisfied overall) identify what are sometimes called non-specific factors as the most important features of counselling. These non-specific factors are invariably ways of describing the capacity to provide a therapeutic relationship – feeling understood, accepted etc. This evidence also suggests that the relevance of counselling orientation operates via the person of the counsellor: one orientation is better or worse than another only insofar as it supports a counsellor in their capacity to use themselves effectively. In other words, orientations need to match with the preferences and values of practitioners, not with the qualities or conditions of clients.

Conclusion

In summary, controlled trials conducted in health care settings indicate that counselling is an effective intervention, clinically and economically. Its costs and benefits are broadly comparable to those of antidepressant medication. It is, moreover, a popular choice with many patients. Caution is sometimes attached to the results of these trials because, compared to trials of medication, the numbers of patients are relatively small. However, this paper has argued that medical trials are, in fact, more likely to underestimate than overestimate the impacts and effectiveness of counselling. Studies of counselling in other settings indicate a high level of satisfaction among clients. Moreover, there is good evidence to suggest that counselling has an important preventative role in relation to mental illness: counselling has the capacity to reduce demand on psychiatric services by preventing less serious problems from becoming more serious, and by helping people to maintain reasonably good levels of mental health.

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About COSCA

COSCA is the professional body for counselling and psychotherapy in Scotland. It seeks to advance all forms of counselling and psychotherapy and the use of counselling skills by promoting best practice and through the delivery of a range of sustainable services.

About the author

This paper has been prepared by Professor Liz Bondi for COSCA. In addition to her previous voluntary commitment as a member of COSCA's Board, Liz is Professor of Social Geography at the University of Edinburgh and Co-Director of Social Studies, School of Health at the University of Edinburgh. Liz was leader of the Counselling and Society Research Group at the University of Edinburgh. She is also a COSCA Accredited Counsellor.

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