

1 Brief Counselling

This chapter covers:

- Evidence-based counselling
- Brief therapy – what the research shows
- A definition of brief therapy
- Is counselling cost-effective?
- School counselling research
- Is brief counselling in school cost-effective?

Introduction

The effectiveness of therapy is first considered by examining counselling research generally, and then we take a look at the particular contribution of brief therapy. Finally, research on school counselling is reviewed. Headteachers and governors have a difficult task when deciding whether to finance a counselling provision in school or college. Their primary interest is in raising achievement, measured by examination results, and a principal concern will be whether or not counselling serves this purpose. If it is accepted that contented pupils learn better than when they are stressed, then the question is a case of whether counselling in school reduces anxiety.

Counselling is a costly provision, and although students consistently say through self-reporting surveys that they find therapy in school helpful, some stakeholders may require more objective evidence than subjective surveys. Objective research is beginning to show that school counselling is effective in reducing student anxiety.

Evidence-based Counselling

The massive research project carried out by Smith, Glass and Miller (1980) concluded that all psychotherapies – verbal or behavioural, psychodynamic, person-centred or systemic – were beneficial to clients, and were consistently effective. Mick Cooper's (Cooper, 2008) survey endorses earlier studies. In spite of this, counsellors are sometimes reluctant to consider the implications of research.

An American study showed that only 4 per cent of psychotherapists ranked research literature as the most useful source of information on how to practise compared with 48 per cent opting for 'ongoing experiences with clients', 10 per cent for 'theoretical literature' and 8 per cent for 'their own experiences as clients in therapy' (Morrow-Bradley and Elliott, 1986).

Pitfalls in Counselling Research

While stakeholders and funding managers may be wary of this reluctance when considering whether to resource counselling, there may be some partial justification for counsellors to dismiss research. Counselling informed by sound research, and no less school counselling, is imperative in these days of accountability, but research-based therapy is not as easy to achieve as might be imagined. There are systemic difficulties. For example, by its very nature research talks in generalities rather than specifics (Cooper and McLeod, 2011), and considers average outcomes for given approaches or techniques; it doesn't mean that one particular client will definitely improve with a given approach or technique (Cooper, 2008: 4). In addition, all research is essentially influenced by the researcher's assumptions and agendas.

It is known in the pharmaceutical industry that when research is commissioned by a particular drug company, it yields better results for its own product than for those of its competitors – what is 'found' is what has been 'looked for'. If cognitive behaviour therapy (CBT) researchers are testing their treatment programme for a given problem, say a panic disorder, and have found it objectively effective, they may claim success for an average number of clients with this difficulty but they cannot claim it to be better than other treatments if they have not conducted comparative tests (Cooper and McLeod, 2011).

Another limitation centres upon the particular tool a researcher is using to measure outcome. Researchers can come up with different conclusions when analysing the same data. If a therapist is seeking to reduce a physical symptom by a chosen intervention and this proves to be successful, the intervention may not be the best for producing other improvements, such as social well-being or alleviating stress. And, finally, approaches favouring some cultural groups may not be as effective with others (Cooper, 2008: 3–4).

In spite of these limitations, meta-analyses substantiate the claim that most counselling and psychotherapy is effective (Cooper, 2008, 2010), and that all counsellors and psychotherapists should have confidence in Carl Rogers' sentiment that *the facts are always friendly* (Rogers, 1961: 24). Cooper states that whether a client's feelings (i.e. their inner-subjective states) or more measurable behaviour changes (The Clinical Outcome in Routine Evaluation Outcome Measure (CORE-OM) scores, for

example) are assessed, the ‘findings from such studies show that participation in counselling and psychotherapy is associated with positive changes ...’ (2008: 16).

Even randomised controlled trials (RCTs) – where subjects are unwittingly selected and compared with a ‘control group’ (i.e. those receiving no intervention) – the facts do show that those who receive therapy tend to improve more than a control group over time (Lambert and Ogles, 2004). And even with clinical trials, which attempt to rule out the *expectancy* factor, known as the placebo effect, counsellors have every reason to celebrate that although the placebo effect does make a difference, the change is not as great as therapeutic interventions are (Cooper, 2008: 16–20).

Meta-analysis also demonstrates that therapeutic improvements continue to remain for periods of reasonable timescales for clients living in the real world outside therapy. Further, counselling and psychotherapy compares favourably with pharmacological treatments. There is evidence to substantiate the notion that many psychological therapies have a more enduring effect in time after treatment than drugs alone (Gould et al., 1995), but in respect of combined treatments of drugs and talking cures for particular conditions ‘immediately after therapy’, there is less certainty (Cooper, 2008: 33–4).

Pre-eminence of Approaches or Pluralism

From such findings, many counsellors reason that ‘all are winners’, following what has been termed as ‘the dodo effect’, from the dodo bird in *Alice in Wonderland* who declares that every competitor in the race should have a prize because everyone has won. But other psychotherapists contest this, arguing for the pre-eminence of particular approaches over others, and this has divided the world of psychological research.

Combined research shows that CBT has proved to be the most effective over a wide range of psychological difficulties, particularly anxiety disorders and depression, bulimia nervosa and sexual dysfunctions, and some researchers argue that resources should be put into ‘what we know works’. On the other hand, if there is evidence from RCTs, even if it is limited, to show that non-CBT therapies – psychodynamic therapy, experiential therapy, family therapy and interpersonal therapy – have been effective for some problems, they can be supported if ‘the ongoing experience’ of practitioners, supported by ‘client feedback’, claims they have been beneficial (Cooper, 2008).

From the accumulation of evidence-based therapy, the National Institute of Health and Clinical Excellence (NICE) has supported the superiority of CBT and has recommended from research (Shapiro and Shapiro, 1982) that

(Continued)

(Continued)

decisions over resources should favour this approach. Opposition from other theorists follows the reasoning that CBT – which lends itself more readily to objective measurement and which is privileged in receiving generous funding for clinical trials – is bound to come out on top, and, further, that just because there is no *evidence* to support an alternative therapy for a given problem, that does not mean that the particular approach does not work in practice (Cooper, 2008: 36–59).

In consequence, any given approach should not be ruled out on the basis of there being no extant evidence to support its efficacy, but then again neither should sound research be ignored which may indicate that, on average, a particular approach or technique has proven effective with a particular problem. Perhaps there is a balance to be struck where counsellors should recognise the common ground and be less concerned with promoting their own brand. Further opposition to ‘brand promotion’ has been voiced by advocates of pluralistic counselling, in light of psychological research that shows that ‘human functioning is multifaceted, multidetermined and multilayered’ (Cooper and McLeod, 2011: 153).

Common Factors with all Counselling

Given the biases and prejudices that are bound to exist (Cooper, 2010), purists should not dismiss the fact that common factors underlie most approaches to counselling, such as client variables and extra therapeutic events, expectancy and placebo effects, and the all-important therapeutic relationship, rather than place an over-reliance on an approach or techniques belonging to a particular psychotherapy.

With regard to ‘extra therapeutic events’, Lambert’s findings (Asay and Lambert, 1999; Lambert, 1992; see Figure 1.1), which several authors and practitioners draw upon (Cooper, 2008; Davis and Osborn, 2000), highlight the importance of factors outside of counselling that contribute towards a successful outcome. These personal and environmental resources for young people include friendships, family support and fortuitous events. They represent the largest influence for improvement (40 per cent), followed by psychotherapeutic factors, such as the therapist–client relationship (30 per cent),¹ expectancy of positive change (15 per cent) and the specific techniques employed (15 per cent).

The position adopted in this book is to favour those integrative approaches which have CBT leanings with regards to adolescent stress and social problems, and to give due credence to those non-directive and interpersonal approaches to problems that centre upon personal trauma and loss.

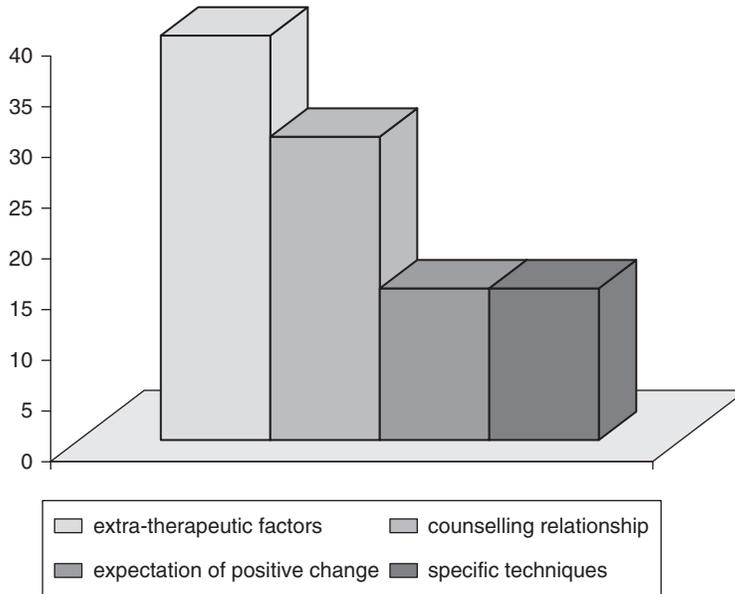


Figure 1.1 Factors influencing improvement (%) (Asay and Lambert, 1999; Lambert, 1992)

Brief Therapy – What the Research Shows

However counsellors view themselves, what is crystal clear is that a radical change is taking place through the changing requirements of the counselling profession and the pressing demand for brief methods that can be shown to work. Short-term counselling has developed in the public service institutions because of the pressure to become cost-effective and to reduce long waiting lists (Butler and Low, 1994).

A comprehensive review of brief therapy outcome research can be found in the literature for practitioners and teachers (Davis and Osborn, 2000; Feltham, 1997; O'Connell, 2005), with research regularly pointing to the preference of brief interventions for a particular problem range (Curwen et al., 2000).

The last decade saw a proliferation of research on the efficacy of brief therapy generally (Lambert and Bergin, 1994), particularly for less severe difficulties such as job-related stress, anxiety disorders, mild depression and grief reactions, and for incident stress situations, such as PTSD, earthquake experience and rape. Improvement through brief therapy for clients having poor interpersonal relations is also supported by research (Koss and Shiang, 1994).

Single Session Therapy

Moshe Talmon's (1990) study of the significance of 'one session' remains highly influential. He studied 10,000 outpatients of a psychiatric hospital over a period of

five years and found that the most common number of appointments for any orientation of psychotherapy was one. He found this the case for 30 per cent of patients for a given year, and that the majority of clients dropped out of counselling because they felt sufficiently helped and had no need of further support.

Two hundred clients of Talmon's were followed up and it was found that 78 per cent said they had got what they had wanted after one session, and that for those receiving planned single-treatment programmes, 88 per cent felt they had improved and had no need of further work – 79 per cent said that one session was sufficient (O'Connell, 2005).

Other research on short-term counselling indicates positive outcomes. Meta-analysis shows a 15 per cent improvement before the first session began, 50 per cent improvement after eight sessions, 75 per cent by session 26 and 83 per cent by session 52 (Howard et al., 1986). An early large percentage rise in improvement, therefore, is followed by a slower rate as the number of sessions increases.

Meta-analyses of the most rigorously controlled studies indicate that short-term psychodynamic psychotherapy appears moderately effective over a period of time for a broad range of common mental disorders (Abbass et al., 2006: 10), particularly for clients with depression (Leichsenring, 2001), which compares well with CBT. Clients suffering from anorexia nervosa have been shown to benefit from short-term psychodynamic therapies (Fonagy et al., 2005; The Sainsbury Centre for Mental Health, 2006), as well as cognitive analytic therapy (Treasure et al., 1995). There is also some evidence that short-term psychodynamic psychotherapy has benefited clients who misuse opiates, with the exception of cocaine (Fonagy et al., 2005), but there is no evidence to suggest that short-term psychodynamic therapy helps clients with anxiety difficulties (Cooper, 2008: 164).

Single sessions and short-term psychotherapy are not to be seen as failure, therefore, but as success. Some have pressed counsellors to assume that short-term counselling should be suitable for everyone until there is strong evidence to show that brief therapy simply does not work (Wolberg, 1968). When a client is aware of a time-limited period of counselling, she may better handle the disclosure of deeper feelings (Thorne, 1999). She may also cope with frequent and more intense sessions, knowing the time limitations of the work and her right to decide what to disclose and what to withhold. But what is meant by *brief* therapy?

A Definition of Brief Therapy

Brief therapy is not a specific approach, or model of distinctive theory and practice, but a descriptor of time-pressured counselling which utilises strengths, sees problems in context and concentrates on the future (McLeod, 2003: 435–7). It is a foreshortened practice of mother models (Feltham, 1997; Talmon, 1990; Thorne,

1994). Freud practised brief therapy when ‘curing’ Maler with only one session while walking in the woods. Although Freud was proud of his analysis of the psyche, he was disappointed that the process of therapy was so lengthy.

Time-limited Therapy

Brief therapy has a certain kinship with time-limited psychotherapy. Working briefly can mean anything up to 40 or 50 sessions, whereas time-limited counselling is not usually more than 20 at most, and can include single session therapy. Brief counselling may occur by design or by default, as determined by outside pressure rather than a planned meeting of a desired outcome (Feltham, 1997: 1).

For many practitioners, any contract of less than 25 sessions is brief therapy. Colin Feltham (1997) has worked in a number of counselling agencies, including some which had no time limit imposed. In one agency offering up to an initial contract of six sessions, the mean number actually used was 3.5–3.75. Feltham also found that many clients dropped out of therapy after the first session, not necessarily due to dissatisfaction or defensiveness, as is often assumed, but because ‘they had not expected to attend longer and do not feel a need to’ (Feltham, 1997: 22). He says we have to give consideration to client preferences.

In addressing the move towards brief therapy, Brian Thorne recognises a tension within himself between the person-centred virtue of establishing the time-essential counselling relationship as the process for change, and his feelings about the success of an experiment he carried out when offering early-morning, three-session focused work to university students (Thorne, 1999). The short-term counselling achieved a bonding with clients and a genuine commitment on their part to attend.

In consequence, given the priorities and pressures of time and resources in educational settings, all counselling in schools is likely to be brief.

Is Counselling Cost-effective?

At some point, the question has to be asked: *is counselling cost-effective?* The most influential report produced in the UK on mental health and counselling was the Layard Report (2004), which declared that mental illness costs the UK some 2 per cent of its gross domestic product, or around £25 billion per year, through time off work for depression, anxiety and stress, reduced opportunities for employment due to poor health, caring for the mentally ill and the costs of GP surgery time, drugs and social services support (Cooper, 2008: 34). The Report calculates that a saving of as much as £2000 per individual can be made if a patient is offered 16 sessions of CBT for depression, quite apart from increased happiness and social well-being.

The same applies in the USA, where compared to the costs of hospitalisation, lost days at work and other more tangible factors, counselling and psychotherapy research establishes that psychological treatments over a non-therapy control can produce savings of \$10,000 a year for every individual (Cooper, 2008: 32–3).

School Counselling Research

A large-scale review of research on effective therapy with young people was commissioned by BACP (Harris and Pattison, 2004), and Cooper's project (2009) has contributed to the growing evidence supporting the efficacy of school counselling (Cooper and McLeod, 2011: 125). Although some research evidence applies to younger children, we shall have cause to draw on this material for our client group in the pages that follow.

The systematic scoping review commissioned by BACP asked the question: *is counselling effective for children and young people?* The review covered behaviour and conduct problems, emotional problems, medical illness, school-related issues, self-harm and sexual abuse. Cooper's survey established that 88 per cent of participants wrote that they were 'satisfied' or 'very satisfied' with the counselling services, 74 per cent said that counselling had helped them 'a lot' or 'quite a lot', and 91 per cent said that they would 'definitely' or 'probably' use the counselling service again (Cooper, 2006; Cooper and McLeod, 2011: 125).

An earlier review of school counselling outcome research carried out between 1988 and 1995 showed that there was tentative support for career planning, group counselling, social skills training and peer counselling (Whiston and Sexton, 1998). Although the study focused more upon remediation activities than preventative interventions, the research validated peer counselling as being particularly cost-effective (Geldard, 2009). Skills learnt in peer mediation programmes assist in resolving conflicts at home, particularly for students facing family disruption (Whiston and Sexton, 1998: 424).

Four of the reviewed studies indicated that social skills training programmes were beneficial to students. Although it was claimed that students' self-esteem or self-concept had improved through counselling interventions, it was not clear how such a nebulous concept as self-esteem could be measured, and various studies used different measures which meant that no clear conclusions could be drawn.

One primary interest to stakeholders and fund managers is the relationship of school counselling to academic achievement, and again no fixed conclusions could be drawn owing to the complexities involved in designing a research programme to measure the 'counselling intervention' in isolation of other social and institutional factors surrounding students' lives in school. A study in Malta showed that school counselling using CBT helped dyslexic students progress through raised self-esteem (Falzon and Camilleri, 2010).

Random Control Trials in School Counselling Research

There has been a drive to conduct research into the effectiveness of school-based counselling using RCTs in the UK, as reported at the BACP Research Conference in 2010 (Hanley, 2010). This resurgence of interest follows Cooper's (2009) comprehensive

review of evaluation and audit findings from 30 studies, involving 10,830 clients, which brought together quantitative and qualitative outcome papers to give clear evidence of the effectiveness of school-based counselling according to self-evaluation reporting. In setting a platform for comprehensive research, Cooper et al. (2010) carried out a feasibility study, and although the findings consistently reported beneficial outcome through self-reporting, there was found to be little difference between the reduction in distress reported by those receiving humanistic counselling and those awaiting therapeutic intervention. It is possible, of course, that those on counselling waiting lists may have been anticipating recovery through the motivational power of hope, as Lambert's (1992) study, highlighted above, indicated, which is that hope represents 15 per cent of improvement for clients.

Hanley (2010) recognises that quantitative data using RCTs are required by fund-holders, since qualitative research on client feedback, although consistently positive, is prone to bias in the sense that most clients tend to report favourably on their therapy. There is a need to know, for example:

- that reported change would not have occurred anyway, or through other means than therapy
- that change is the result of counselling provided
- that those other than clients recognise change
- that change is sustainable over time.

Research-informed Counselling

Cooper and McLeod (2011: 117–33) press for counselling to be research-informed, rather than research-driven, and argue for a need to establish 'potential pathways of change rather than universal laws', to focus on 'micro-processes rather than global relationships' of factors. The question to ask is *what treatment* works, for *whom* is it effective and for *what* specific problem is it effective (Paul, 1967)? Sometimes the same clients, particularly in school, may need *different things* at *different times*. Such questions are beginning to be addressed in school counselling research through more comprehensive and objective measures than merely self-reporting questionnaires (Hanley, 2010).

In sum, the efficacy of school-based counselling remains largely dependent on self-reporting, not that this is insignificant. Brief therapy has proved beneficial for adults in many settings, and research using RCTs is currently under way to establish its benefits for teenagers in school settings for any approach, including those advocated in this book (see Appendix I).

Is Brief Counselling in School Cost-effective?

In spite of outcome studies and client-feedback surveys indicating favourable results, there is no research on the effectiveness of *brief counselling in school* using RCTs at this time. There is, however, anecdotal and inferential evidence. Although

no systematic study has been carried out to estimate the cost savings of putting a counsellor in every school or college, it stands to reason that any form of learning that draws heavily on focused cognitive attention will be impaired through stress, worry or social upheaval, whether or not it results in absent days.

The cost-effectiveness of school-based counselling is not easy to assess because decisions centre on values and on the role of education, values such as the importance of emotional literacy and personal well-being, and the educative role of developing the *whole person* in place of passing examinations (DfES, 2001, 2004). However, as mentioned earlier, the Layard Report (2004) validates the cost-effectiveness of counselling in terms of lost days from work, among other indicators. Student attendance figures are examined by Ofsted. Pupils absent from school because of emotional troubles cannot learn, and neither can those who though attending may be silently suffering. This rather suggests the question of cost-effectiveness answers itself.

Conclusion

This chapter has examined research on the effectiveness of brief therapy as an approach in school or college. Outcome research for briefer ways of working is fairly sound, and findings gathered through client feedback demonstrate the effectiveness of school-based counselling. Research using RCTs is currently being planned to establish unequivocally the benefits of counselling in educational settings, and I remain confident that continuing evaluation will carry the argument for school-based therapy.

Brief therapy appears to be supported by consumer choice, and by extension it does not seem unreasonable to conclude that if this is the case for adults it can equally apply for adolescents, even though their problems will be different.



Reflective Exercise

1. In reading this book, you must be considering using briefer ways of working in school or college, whatever your training has been. Suppose your agency manager, or the senior pastoral teacher in school or college who is managing you, had instructed you that owing to the rising demand of referrals you had no choice but to work with teenagers in a maximum of three sessions:
 - What would be your initial thoughts and feelings over such pressure?
 - How would it alter your practice?
 - What would have to be cut out or foreshortened?

(Continued)

(Continued)

2. How would briefer ways of working influence your ability to form a therapeutic relationship with your young student-client?
3. How would you argue the case for more provision of counselling in school? Present a bullet point list for the headteacher from research outlined above to argue the need for an extra day of counselling in school, supposing he has asked you to present a case for cost-effectiveness in learning outcomes to take to the governors for funding.

Key Points

- Outcome studies utilising randomised control trials (RCTs) support the claim that psychotherapy is effective for a range of social and emotional difficulties.
- CBT and non-directive therapies have been shown to be cost-effective in the UK and the USA. NICE supports therapy (principally CBT) in UK clinical settings.
- There is evidence to show that clients improve with brief therapy, that in practice most counselling is brief, and that in general time-limited support is what clients prefer.
- Brief therapy is not a particular model but a descriptor of a certain time-limited stance which utilises strengths, sees problems in context and concentrates on the future.
- Most school counselling is brief – there are fewer sessions than might occur in other settings.
- Evidence-based school counselling is beginning to show promise, and students in self-reporting surveys consistently claim they find it helpful, saying that it is a source of help to which they would return.
- Besides in-house testing and client feedback, RCTs are currently being planned to demonstrate the efficacy of school-based counselling.
- The cost-effectiveness of school counselling is through raised attendance, improved socialisation, reduced anxiety, less maladaptive behaviour and a higher focused attention to learning: although a direct link of school counselling and attainment would be difficult to establish, common sense suggests they are related.