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'Therapy outcome from the point of view of the client'

Introduction

Outcome research has always been hugely important for the counselling/ psychotherapy profession. The issue of 'does it work? ' lies at the heart of debates around the legitimacy and social role of therapy. For example, the findings of outcome studies have had major implications for policy and practice, in terms of supporting the use of counselling/psychotherapy alongside, or instead of, drug treatments, and in informing decisions about the form of therapy that is to be made available within health-care systems in the UK and elsewhere (see Roth and Fonagy, 2005).

Outcome Research Studies

Given the importance of outcome studies, it is essential to take a critical stance in relation to the research that has been carried out. It is not helpful for anyone, in the long run, merely to accept at face value the results of existing studies. In relation to outcome/effectiveness research, it is clear that the current knowledge base around outcome is built around studies in which clients complete symptom questionnaires (such as CORE or the Beck Depression Inventory) pre and post therapy, and at follow-up. There is a widely accepted implicit assumption within the profession that the knowledge yielded by outcome studies is 'objectively' true (notwithstanding the inevitable measurement error and uncertainty), as long as an outcome study has been conducted in a systematic and thorough fashion. Certainly, the knowledge generated by outcome studies is regarded as true and valid, in practical terms, by those who commission counselling and psychotherapy services in health care systems such as the NHS in Britain.

From a critical perspective, it can be argued that all knowledge is socially constructed. From such a standpoint, it is possible to see that the outcome of psychotherapy or

counselling consists of a very complex set of phenomena. To define therapy outcome as change on CORE or BDI scores is to construct it in a particular way. To be specific, it is a way of understanding outcome that reflects the assumptions of a research community that is dominated by psychological and medical discourses. This is not to argue that the construction of outcome that is derived from comparing pre- and post-therapy CORE scores is wrong. But what it is saying is that there may be some interest and value in giving some consideration to the idea that outcome might look different if constructed by other stakeholders. It is possible to imagine several other groups of relevant stakeholders (for example therapists, clients, the employers of those who seek therapy, the friends and relatives of those who seek therapy) each of whom might construct the outcomes of therapy in a slightly different fashion. The construction of outcome by therapist themselves, for instance, is itself a complex process that draws on several sources of evidence not utilised by researchers (Daniel and McLeod, 2006).

The voices of people within these groups are at a bit of a disadvantage, in relation to the accumulation of knowledge about psychotherapy outcome. This is because considerable effort and investment has been devoted, over many decades, to building up a credible and rigorous knowledge base grounded in a psycho-medical researcher's view of outcome. The aim of the present paper, is to make a small contribution toward expanding our understanding of the meaning of outcome, by considering the views of clients. The key question that has driven this research is: "how do clients evaluate the counselling they have received?"

The study that is reported here was carried out in a primary care counselling service that is based in the counselling research clinic at the University of Abertay Dundee. Clients were referred from an inner-city GP practice, and received open-ended counselling, using an integrative approach that we describe as a collaborative pluralistic framework for practice (Cooper and McLeod, 2007). Some of the counsellors are very experienced (tutors on the Abertay and Aberdeen courses), while others are Diploma students. Clients are interviewed before they begin counselling, about their social networks, problems, and goals for counselling, and complete a number of questionnaires both weekly and at the end of therapy. The material in the current paper is based on interviews carried out with clients approximately 12 months following the end of their counselling.

This research is on-going, and the preliminary findings presented here are taken from analysis of the first 6 interviews that we conducted. These interviews were carried out with people who had received between 8 and 12 sessions of counselling, had all been quite severely troubled on entering counselling (as assessed through CORE scores), and who all believed that counselling had been helpful for them. The interview schedule was influenced by Elliott's Change Interview method (Klein and Elliott, 2006), but adopted a more narrative approach (i.e., seeking to elicit the client's story) rather than focusing on specific domains of change.

Before moving to the findings of the study, it is useful to mention two very significant methodological challenges involved in this kind of investigation. First, it is clear that it is hard for clients to remember what they gained (or did not gain) from the counselling that they received. This is because the initial state of distress that they felt has been replaced by new emotions. Basically, as people overcome problems or

assimilate problematic experiences, they tend to forget them. To overcome this tendency, we carried out dialogical interviews, in which the interviewer reminded the person of what he or she had said about their problems before they commenced therapy. This technique proved to be reasonably effective in re-evoking the person's recollection of previous problems, and how these problems had been resolved.

The second methodological problem associated with the study is that this is a very difficult question or research topic for an interviewer who is a trained therapist. This is because it is not easy to de-centre oneself from professional assumptions and really hear what the person is saying. Beyond this, the interviewee is in turn trying to explain something in a particular context, which is that of a person who they know has a particular viewpoint and role. In order to try to overcome this factor, and enable participants to voice their own ideas, we have worked hard to try to eliminate assumptions from our interview questions, and listen very closely to the interview recordings, for what participants are really saying (rather than what we imagine they are saying).

The analysis of the interviews has made use of two analytic strategies, which have been pursued in parallel. First, we have tried to identify themes or meaning categories that appear across all the interviews. Second, we have analysed each interview as a separate case, with the aim of gradually building a model of discrete 'types' of cases, that represent different pathways through therapy (we are quite a long way from achieving this). Interviews have been transcribed, and then the transcript text is read carefully, and coded with a word or phrase that captures the possible meaning of what the participant has said. This process of 'open coding' is `carried out using simple WORD files, with coding labels and the statements to which they refer being copied into separate files. Once the transcript has been subjected to this kind of initial coding, all of the different codes are compared with each other, to allow more general meaning categories to emerge. Two researchers work on the material in parallel, and compare their analyses at regular intervals. The purpose of using two researchers is not to arrive at one 'true' analysis of the data, but to ensure that important meanings are not missed, and that as much of the significance of what the participant has said, is fully reflected in the eventual results. Throughout this work, the researchers keep diaries, in which they record their hunches and ideas about what their analysis might mean, in broader theoretical terms – this is helpful in keeping a disciplined focus, when actually analysing the text, on what the person said (rather than on what you imagine that he or she might have said). The findings that are eventually produced represent a 'construction' of the way that clients make sense of outcome – this construction inevitably reflects, to some extent, the interests and sensitivities of the researchers. This research procedure is based on the Grounded Theory approach to qualitative research (Rennie et al, 1988; Corbin and Strauss, 2008), and on the generic model of qualitative research in McLeod (2001). However, unlike a full-scale grounded theory study, there is no attempt to arrive at a single 'core category' that captures the overall meaning of the experience – the aim instead is to allow as many different threads of meaning (categories) to emerge as possible, in order to respect the complexity of what people say, and the diverse ways that different people respond to counselling. Qualitative research using grounded theory methods has been used in a range of studies of therapy, which have produced valuable insights (Rennie, 2002).

This research process is very time-consuming, but is also an interesting and rewarding experience. Qualitative research of this type forces the researcher to listen carefully to what the informant has said, and to be as sensitive as possible to what these words might mean. For a counsellor, there is always important learning in carrying out this form of research, because it inevitably challenges one's assumptions, and makes one think more deeply about what counselling is really all about. Further information about the research procedures used in the present study can be obtained from the author.

The analysis provided below gives some of the flavour of what we are finding, at this early stage of the study, by describing three central themes that have been present in all the interviews, in relation to the criteria that clients appear to use to decide whether or not counselling has been helpful for them. These themes are: (i) getting life back on track; (ii) learning; and (iii) explaining what happened.

Getting life back on track

The reasons that clients gave for seeking counselling (or for making the visit to their GP that eventually lead to a referral for counselling) were always framed in terms of a life that was troubled and stuck. When asked about what brought them to counselling, clients tended not to describe specific symptoms, but instead characterised their troubles in terms of a situation that troubled and preoccupied them. The troubling nature of the situation, in turn, could only be understood in relation to their life story as a whole: what was the matter, was that the course of their life had taken a wrong turning, or was not proceeding as it should. Typically, in the interviews, research participants explained what had been troubling them in terms of a concrete scenario, fleshed out with brief details of people and events, that was then summed it up by using phrases such as:

> "I was trapped"
>
> "I was so desperate to have this episode in my life finished that I was ready to try almost anything. Everything was so out of control. I was in a relationship that wasn't good but I had completely run of ideas on how to improve it"
>
> "I was absolutely overwhelmed, drowning in problems. It was like I couldn't get out of the house…arguments were regular, looking at the future of any sort was – its just gone….nothing good's ever going to come of this, and it'll gradually get worse and worse and worse. Things can't get any better"

There were certain characteristics that were associated with stuck lives. These included: a sense of hopelessness or absence of any future; an inability to control what was happening; and, having tried everything they knew to sort the situation out, but without success.

The effectiveness of counselling was assessed in relation to the extent to which it had enabled the person to resolve the troubled scenario that had brought them into therapy. Participants reported that their lives were "back on track", counselling had "turned things round", or that they had been able to "move on" in their lives. One

participant stated that “(counselling) made my future much brighter, instead of that feeling of being stuck, and having to put up and get on with it”.

The descriptions of what life was like following effective counselling were marked by a sense of expansiveness – the person was now purposeful, and doing new things. However, research participants took pains to explain that this did not mean that they were necessarily happy all the time, or untroubled. There might still be recurrences of previous tensions, but within an overall context of life being on track again and moving along in a generally satisfactory way. The new things that become possible were not regarded as criteria against which counselling was judged, and on the whole, participants did not always attribute an expanded life space as an outcome of counselling. The key criterion here was that they had been able to move on from a particular episode.

Learning

All of the participants evaluated the effectiveness of the counselling they had received in terms of things that they had learned, and had been able to use in order to make a positive difference to the difficult situation in which they had been in their life. There were many different types of learning that were described:

- standing up for oneself and saying “no”;
- stepping back during arguments with a spouse to make a space for reflection;
- memorable images or metaphors that provided an alternative perspective on a situation;
- strategies for self-soothing;
- talking about how one is feeling, to other members of a family;
- defusing panic situations;
- learning that counselling is a resource, if problems come up again in the future.

Research participants talked about their counselling as a space in which they were able to explore troubling aspects of their life, with someone who listened and cared, and also who was independent of their actual life situation. However, although counselling was regarded in general terms as an arena for personal learning, it was evaluated, in relation to its success, in terms of whether there were one or two key things that were learned that could clearly be traced back to conversations with the counsellor, could be directly applied to the troubling situation, which made a tangible difference, and which continued to be used on a regular basis even after the end of therapy. Informants were able to be quite specific about what they had learned in therapy. They were able to describe when and how they had learned it, what it was they had learned, how they used it at the time, and how they continued to use it. The things they had learned (for example: being able to say “no”) were not necessarily new to them, but they recognised that it was with their counsellor that they had been able for the first time to learn how to implement this new skill or strategy in a truly effective manner.

Explaining what happened

A third factor that seemed to be important for participants, in evaluating whether the counselling had been helpful, was whether they had been able to construct a coherent story of what had happened. This explanation encompassed a series of factors: how and why their troubles had developed; how the counselling had helped, and how things were different now. The existence of an explanatory account appeared to be important for participants as a means of gaining distance from what had been a difficult part of their lives. In some cases, the story also had a valuable role to play in terms of being able to hold different types of conversations with other people in their lives.

A case example: Daniel

One of the former clients interviewed in the study was Daniel, aged 38. At the time of entering counselling Daniel had been on disability benefit for 10 years, as a result of chronic Myalgic Encephalopathy (ME) a condition that is associated with on-going pain and fatigue, and difficulty in accomplishing basic life tasks. In many ways Daniel had made a successful adjustment to ME, in terms of pacing his life, attention to diet, and a combination of conventional and complementary therapies. He lived with his partner, Eva, who was also unemployed, and had suffered from depression for many years. Daniel sought counselling because of problems in his relationship with Eva, who demanded a high degree of care from him. At the intake interview, Daniel described himself as not coping, and engaging in self-harming behaviour. The counsellor who worked with Daniel used an integrative approach that was influenced by CBT and solution-focused methods. They had 8 sessions of counselling, at the end of which Daniel reported that the situation at home was much better. Daniel recounted in the follow-up interview that he and his therapist had been able to generate many ideas for new ways in which Daniel might approach his problems. He described most of these strategies as unworkable, because they were unacceptable to Eva, and made the relationship worse. However, he did learn two things in therapy. First, he learned a technique of pausing for a few seconds of reflection, when he and Eva were beginning to argue. And he learned a strategy of standing back and allowing Eva to do things for herself. The pausing technique had been successful in defusing the arguments. The standing back technique had resulted, over time, in Eva gradually becoming more independent. At the time of the follow-up interview, he still employed both learnings, on a routine basis. Although he acknowledges that other people had suggested these approaches to him, he is clear in his own mind that he really ‘learned’ how to apply them during the counselling sessions. Daniel did not appear to have developed much in the way of an explanatory account or narrative that allowed him to make sense of the problems that had resulted in entering counselling. Possibly as a result of this, he did not describe any examples of how the outcome of counselling had stretched to other domains of his life, beyond his relationship with Eva. In learning to accommodate ME into his life, Daniel had developed a rich array of self-care strategies, along with a sophisticated understanding of the nature of his illness, and it seemed as though he experienced counselling as another valuable self-care method, rather than as having any wider significance in terms of self-understanding. At the end of counselling, Daniel had resolved the problem that had brought him to counselling, and the situation was still good at one-year follow-up. Although he still experienced

many difficulties and restrictions in his life, in relation to the ME, he was clear that he had never expected counselling to address these issues.

Discussion: the meaning and implications of these findings

The findings of this study can be expressed in terms of a tentative summary statement of the criteria that clients use to evaluate counselling. Clients seem to use three main criteria to assess the value of the counselling they have received:

1. To what extent has counselling helped me to get my life back on track?
2. Did counselling enable me to acquire practical strategies and skills that I have been able to use to resolve the problems in living that drove me to seek help in the first place?
3. Have I come out of counselling with a credible explanation, or coherent story, about how and why my troubles developed, and how they have been addressed?

It seems likely that all three elements need to be present for a client to deem the outcome of therapy as satisfactory. For example, if a life is back on track, but criteria 2 and 3 have not been fulfilled, it would be probable that the person would attribute this change to other factors, and not to therapy.

It is essential to interpret the findings of this study with caution. The study is based on a small set of interviews, with clients who were largely satisfied with the counselling they had received. We need to do many more interviews, with a wider range of client outcomes, in order both to thicken and test out the themes that have been reported in this paper. It is important, when interpreting these findings, to keep in mind the context of this study – people in Scotland who had originally sought help from their GP at a point of crisis. A person who sought a specific form of private practice therapy, with the goal of personal development, or someone who was living in a different society, might well have quite a different type of story to tell. Nevertheless, despite the undoubted limitations of this analysis, it is possible to offer a preliminary and tentative exploration of what these findings might mean in terms of counselling practice and research.

The first thing to say is that it seems clear that clients evaluate the outcome of therapy in quite a different fashion than researchers. These clients did not talk about symptoms that they had experienced, but instead talked about their lives. They viewed counselling as effective in so far as it helped them to get on with their lives. Sometimes, getting on with life was associated with symptom reduction, but sometimes it was not. It seems likely, therefore, that further research, on larger numbers of clients, will reveal that estimates of effectiveness based on client criteria will differ from estimates based on researcher criteria, and will therefore allow a more comprehensive understanding of the outcomes of counselling and psychotherapy to be developed.

A further point that emerges in quite a striking fashion from this material is that there is a quite different *quality* to client accounts of outcome, compared to researcher accounts. Specifically, when clients evaluate outcome in their own terms, rather than through categories and questions supplied by researchers, they portray themselves as active agents, as purposeful actors within a life space. The researcher narrative can be condensed down into a story along the lines of “this person was depressed, they

received therapy X, and they got better". It is significant, in the context of this kind of narrative, that standard outcome evaluation tools do not allow the possibility for clients to express their agency, but instead ask the client to report on symptoms in a manner that positions them as observers of their own behaviour. The client's account, which is saturated with agency, is quite different, and proceeds along the lines of: "there was a difficult situation in my life; I tried A, B and C to sort it out, but nothing helped; I went into counselling, where I learned how to fix the situation; I still use what I learned". Client criteria for outcome can therefore be seen as extending the theory and research on client agency, developed by Bohart (2006), Rennie (2000) and others. It is possible to envisage the creation of research tools that are less time-consuming than the interviews carried out in the present study (or similar change interviews used by Elliott), but which provide opportunities for clients to report on their own personal accounts of outcome, which could be reliably scored. A similar approach has been used by Adler and McAdams (2007), who asked clients to write about the story of their therapy, using a structure suggested by the researcher. The present research suggests some ways in which the story structure used by Adler and McAdams could be altered, for example to accommodate an account of what was learned in therapy and how that learning was applied. In our own research at the Abertay counselling research clinic, we have been piloting a brief open-ended instrument that asks clients to write briefly each week about what they learned from counselling and how they used what they learned.

The results of this study are consistent with the findings of other studies that have explored client experiences and perceptions of the outcomes of therapy. Kuhnlein (1999) interviewed clients who had received in-patient CBT, and similarly found that they made sense of outcome in terms that were substantially different from their therapists' understandings. Specifically, she found that the 'central criterion' by which clients judged the effectiveness of their therapy was 'biographical continuity' – in other words that they have been able to construct an explanation that allows them to assimilate what happened in therapy into their account of their life as a whole. McKenna and Todd (1997) interviewed clients who had engaged in multiple episodes of therapy over the course of their lives, and, as in the present study, found that these informants evaluated the effectiveness of each episode in terms of the specific goals that had lead them into therapy at that time.

Finally, the findings of this study may have some implications for counselling and psychotherapy practice. On the basis of how clients evaluate the counselling they receive, it seems that they are pretty clear about what they want, which is to find some way of getting on with life. This idea has some relevance to issues around the length of therapy. The clients interviewed in the present study knew when their lives were getting back on track, and as a result were good judges of when to finish therapy. For example, one of them knew that the number of sessions she had been allowed was not enough, while another knew that it was time to finish because he had got what he needed, even though his therapist was still generating new ideas for areas to work on. Another implication for practice arises from the importance that clients place on learning. Currently, the concept of learning does not get much attention within the counselling and psychotherapy literature. What the clients in the study were talking about was not learning understood in terms of moments of insight or understanding. What they were referring to, instead, was learning as a form of practice, and learning that was situated in a specific concrete situation. The work done in the field of

education by Lave and Wenger (1991), and applied to psychotherapy by Dreier (2008), provides some valuable new ways of thinking about the learning process. These theorists talk about most learning as taking place not in schools and similar establishments, but within *communities of practice*, where someone wanting to learn to do something joins a community of people who already practice that activity. The list of "things that were learned" that was included earlier in this paper, will be familiar to any member of the audience who is a trained therapist – they are all practices that are part and parcel of the lives of anyone who is a fully paid-up member of the therapy community of practice. It may be that thinking about what is involved in this kind of 'situated learning' may generate new possibilities for ways that we can be helpful for clients.

Conclusion

It is hoped that the research that has been described in this paper will make a contribution to shifting the emphasis in counselling and psychotherapy outcome research, away from evaluation criteria specified by researchers and policy-makers (i.e., symptoms) and in the direction of trying to take seriously the ways that client themselves evaluate the therapy that they have received. The research reported here is only a beginning. There have been many hundreds of published outcome studies, based on quantitative analysis of questionnaires that clients have been asked to fill in. By contrast, there have been very few studies where clients have been given the time and space to explain the benefits (or otherwise) of counselling in their own terms. What is needed now, is for more researchers to carry out qualitative outcome studies, with different groups of clients in different situations, so that we can build up a detailed picture of what clients want from counselling, and how they evaluate what it is that they are offered. My belief and prediction is that this knowledge will have very significant implications for practice. For example, research into the effectiveness of counselling in the NHS in Britain has tended to show that the overall level of symptoms reported by clients is reduced by counselling, in the short term (i.e., by the end of therapy) regardless of the approach to counselling that is offered (CBT, psychodynamic or person-centred) (Stiles et al, 2006). What would be useful to know, however, would be what these clients have *learned* from counselling, and the extent to which they have been able to use this learning in the following years, to help them to deal with further crises and stresses in their lives.

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