

PERSON-CENTRED QUARTERLY

**Person-Centred & Experiential Therapies are Highly
Effective:**

**Summary of the 2008
Meta-analysis**

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Among his various accomplishments, Carl Rogers was a pioneer in the field of psychotherapy research. Following in his footsteps, we have just completed a major project to integrate 60 years of research on the effectiveness of person-centred and related therapies. Our results have confirmed, strengthened and extended previous results, using much larger sample of more than 180 scientific outcome studies. With a few important exceptions, these results are good news for therapists and counsellors working within the person-centred approach, because they provide multiple lines of evidence demonstrating that these therapies are highly effective.

We presented our results this July at the Person-Centered/Experiential (PCE) therapies conference in Norwich, England. Although we used more rigorous methods than in previous analyses, we found some of the results so different from widely held beliefs in the mental health field that we felt compelled to go back and re-do them, just to ensure we had not made a mistake somewhere. The pace of research on PCE therapies continues to accelerate, making it difficult to keep up, and the data set we have assembled so far is rich enough to keep us busy for several years. Currently the main findings are clear and can be summarised as follows:

Conclusion 1: PCE therapies are associated with large pre-post client change. To establish this, we looked at 203 samples of clients, from 191 studies, amounting to more than 14,000 people. In these studies, the researchers had provided enough quantitative information about how the clients were doing before and after therapy that we could calculate a statistic called an effect size, which in this case was the difference between how the clients were doing on average before they started therapy and how they were doing on average after therapy. Because different researchers use different outcome measures, we converted all these pre-post differences to a common metric by dividing them by an estimate of the variability of the scores (a standard deviation, sd for short). This is a very abstract number but is necessary for this kind of study.

What did we find? Similar to previous analyses of smaller samples of clients, we obtained an average effect size of 1.01 standard deviation (sd) units. Social scientists consider this to be a very large effect, many times larger than effects typically found for common medical procedures or medications. In other words, on average, PCE therapies make a big difference for clients. Furthermore, contrary to what many PCE therapists believe, this is particularly true for symptom measures like the CORE-OM, as indicated by the two large UK-based studies by Stiles et al. (2006, 2007).

Conclusion 2: Clients' large post-therapy gains are maintained over early and late follow-ups. Next, we looked to see if clients retained the benefits of PCE therapy over time. The answer to this question is yes. Our analyses indicate that if anything clients in PCE therapies show slight further gains during the first year after therapy (effect size: .99 immediately after therapy vs. 1.12 sd for follow-ups less than a year after therapy). Furthermore, these gains are maintained beyond

the one-year mark (effect size 1.13 sd). This stability of post-therapy benefit is consistent with the PCE philosophy of enhancing client self-determination and empowerment, indicating that clients continue to develop on their own after they have left therapy.

Conclusion 3: Clients in PCE therapies show large gains relative to clients who receive no therapy. In order to show that there is causal relationship between PCE therapy and client change, it is necessary to compare clients who get therapy to those who don't. For example, some clients might be asked to wait before starting therapy, so researchers can see whether they would have changed on their own without therapy; this is called a 'waitlist control design'. These studies are most convincing when the assignment to therapy or no-therapy (or waitlist) is random (making it a 'Randomised Clinical Trial' or RCT). This is because randomisation tends to make the two groups of client roughly equivalent to start with.

We analysed data from 60 studies, involving more than 2,100 PCE clients compared to more than 1,900 controls. For each of these studies we first measured the amount of pre-post change in the PCE therapy clients, and then calculated how much people in the no-therapy or waitlist group changed in the absence of therapy. Finally, we measured how much more clients in PCE therapies changed in comparison to no-therapy clients. We found a controlled effect size of .81 sd, which is considered to be a large effect size. (Clients who received therapy showed very little change: .19 sd.)

About half of these controlled studies did not randomise clients to receive PCE therapy or not; these studies are generally dismissed by scientific review panels like those charged with developing and revising the NICE guidelines. For this reason, we ran the same analyses for the 31 Randomised Clinical Trials within our sample (some 550 PCE clients), and found that randomisation made almost no difference (controlled effect size: .78 sd). Scientists tend to believe that these kinds of careful results allow us to conclude that therapy causes client change. This provides the second main line of evidence for the effectiveness of PCE therapies.

Conclusion 4: PCE therapies in general are clinically and statistically equivalent to other therapies. How do PCE therapies stack up against other therapies? To answer this question, we first assembled a large collection of 109 studies, including 134 comparisons between PCE and other therapies, among them CBT; these studies contained data from more than 10,300 clients. As with the controlled studies just described, we first calculated how much clients changed in PCE therapy, then how clients seen in other therapies changed, and finally how much more or less PCE clients changed than the other clients. There was virtually no difference between PCE and other therapies (comparative effect size: .01 sd), indicated equally large amounts of change. That is, PCE therapies were neither more nor less effective than other therapies. Once again, we weeded out the non-randomised studies, leaving 91 so-called 'gold standard' RCTs, with virtually identical results.

Conclusion 5: PCE therapies in general might be trivially worse than CBT. It is commonly assumed by CBT therapists, government officials, and the general public that CBT has better outcomes than other therapies such as PCE therapies. The results we have just reviewed do not address this issue. Therefore, we looked at the 78 studies in which PCE therapies were compared to CBT, including 63 RCTs. When all these PCE therapies were pooled together they at first appeared to be slightly but trivially less effective than CBT (78 studies; effect size: -.18 sd = a small effect; for the 63 RCTs the effect size was -.16). However, this effect disappeared when we statistically controlled for the theoretical orientation of the researcher (referred to as researcher allegiance).

Conclusion 6: So-called 'Non-directive/Supportive' therapies have worse outcomes than CBT but other kinds of PCE therapy are as effective or more effective than CBT. Why should controlling for the researcher's theoretical allegiance make the trivial superiority of CBT go away? In order to understand what was going on, we divided the PCE therapies into four types:

1. Person-centred therapy, following Carl Rogers, the most common form of counselling in the UK
2. Therapies typically labelled by researchers as 'non-directive/ supportive'; further investigation of these revealed them to be watered-down, typically non-bona fide versions of PCE therapies, commonly used by CBT researchers, especially in the USA
3. Process-experiential (also known as emotion-focused therapy), developed by Greenberg, Rice and Elliott, and recently recognised as an empirically supported therapy in the USA
4. Other experiential therapies, including gestalt, focusing-oriented, expressive and so on

What we found when we did this was that the small effect in favour of CBT could be accounted for by the presence of the 'non-directive/supportive' therapies. That is, studies in which these therapies were used have substantially worse outcomes when compared (by CBT researchers) to CBT (38 studies; effect size: -.35 sd; for the 33 RCTs the effect size was -.29).

In contrast, once the non-directive/supportive therapies were removed, the effects of the bona fide PCE therapies could be seen more clearly: pure PCE appeared to be statistically equivalent in effectiveness to CBT (22 studies, including 18 RCTs, with identical effect sizes of -.09 sd), even without controlling for researcher allegiance. Furthermore, in a small number of studies, the newer process-experiential therapies for individuals or couples actually appeared to be more effective when compared to CBT (7 studies; effect size: .35 sd; for the 4 RCTs the effect size was

.55 sd). Other experiential therapies were also equivalent to CBT: 10 studies: -.14 sd; including 7 RCTs: -.07 sd.

These results were so striking that we wanted to make sure there was no error. Therefore, one of us went through the entire data set and reclassified all the studies from scratch, with the same result.

What are the implications of these analyses?

In fact, these results are uniformly good news for person-centred/experiential practitioners: clients use our therapies to make large changes in themselves; these changes are maintained over time and are much larger than our clients would have experienced without therapy. Furthermore, our clients show as much change as clients seen in other therapies, including CBT, but only if bona fide person-centred, process-experiential and other experiential therapies were involved.

From a policy point of view these data support the proposition that person-centred/experiential therapies are empirically supported by multiple lines of scientific evidence, including ‘gold standard’ RCTs and recent very large RCT-equivalent studies in the UK (e.g., Stiles et al., 2006, 2007). This body of research suggests that the NICE Guidelines need to be updated, and that PCE therapies should be offered to clients in primary care, NHS, and other mental health settings. Relying on multiple lines of evidence, such as provided in the present study, provides a sound basis for establishing public mental health policy. The shortfall in the availability of psychological therapy in the NHS could be instantly resolved if health authorities were to draw upon the large body of trained person-centred counsellors and psychotherapists throughout the UK.

For those of us in the PCE tradition, the moral of this story is that we do not need to be afraid of either quantitative outcome research or RCTs. However, if we let others define our reality by studying watered-down versions of what we do, we are going to be in trouble. For this reason, it is imperative that PCE therapists do our own outcome research—including RCTs—on legitimate versions of our therapies. As Carl Rogers said, ‘The facts are friendly.’

References

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