

# Measuring outcome in counselling: a brief exploration of the issues

'We shall not cease from exploration  
And the end of all our exploring  
Will be to arrive where we started  
And know the place for the first time.'

T S Eliot<sup>1</sup>

WHENEVER I visit my doctor I am conscious of a desire to be allowed more of that wise and kindly man's attention than the current problem seems to justify. I suppose that on those occasions I am experiencing what Balint called 'the drug, doctor' — that concentrated and dependent transference so cruelly curtailed by the 10-minute consultation and by awareness of the needs of so many others.<sup>2</sup>

Since the time of Balint's psychodynamic insights — a period that has seen the development of several alternative counselling perspectives, such as Rogers' humanistic psychology,<sup>3</sup> Beck's cognitive work,<sup>4</sup> and family systems theory deriving from the ideas of Bateson<sup>5</sup> — the importance of the quality of human interaction during therapeutic encounters has gradually become accepted. At the same time, concepts about what situations are appropriately medical have extended to include all kinds of psychosocial problems, particularly in the field of general practice.

In response to such an extension of responsibility it could be argued that general practitioners ought to acquire counselling skills and themselves offer extra time outside surgery hours; or else include some concentrated counselling in the 10-minute consultation that already accommodates history taking, examination, health promotion, computer operation, and the rest. An alternative solution might be to wean people from dependence upon 'the drug, doctor', while providing instead 'the drug, counsellor', represented by an additional clinician, professionally trained to focus upon emotional need and distress, and in certain circumstances to address psychological disturbance in the hope of facilitating its alleviation.

This debate has been intruded upon by a political and economic ideology of commoditization which perceives clinical relationships in terms of commerce and production. The expression of this ideology expects justification for the employment of professional counsellors through the measurement of outcomes that might be seen as analogous to the results of more concrete interventions like surgery or drug treatment. Nevertheless, the issue of outcomes has for some time concerned the related professions of counselling and psychology. In 1952, Eysenck published a study suggesting that the rate of improvement of symptoms following either psychodynamic or eclectic psychotherapy was no better than that of spontaneous improvement: about two-thirds.<sup>6</sup> His conclusions have been criticized on methodological grounds, Lambert<sup>7</sup> finding only a 43% rate of spontaneous improvement. The search continues for credible methodologies that might allow legitimate conclusions about counselling outcomes.

Smith and Glass developed a method of meta-analysis of previous outcome studies using a statistical measure called effect size, expressed in units of standard deviation, sometimes converted into percentages.<sup>8</sup> Assembling 375 studies they concluded that the average counselled client was 'better off than 75% of untreated controls'.<sup>9</sup> A replication meta-analysis using 475 controlled studies found the effect size to be 80%,<sup>10</sup> and Shapiro and

Shapiro found similar results.<sup>11</sup> Eysenck's position has, however, been supported by Rachman and Wilson.<sup>12</sup>

Counselling research poses particular difficulties, for example: what exactly should be measured when different theoretical perspectives may assess improvement in different ways? Should each form of counselling be tested on its own terms, or should they all compete against a common measure of success? Are some problems more responsive to specific orientations of psychotherapy? How should the wide extent of patients' problems be categorized? Is it important to include a placebo group, and if so, how? At what intervals from the end of counselling should follow-up measures be applied in case of relapse? Difficulties such as these have been addressed in different ways and have led to a lack of uniformity in the construction of outcome studies. It is debatable whether the blanket calculations of meta-analysis smooth out such incongruities or enhance their effect.

Glass and Kliegl's meta-analysis makes an attempt to compare the outcomes of different forms of counselling.<sup>10</sup> The results suggest the relative superiority of cognitive over psychodynamic therapy, and of both over undifferentiated counselling, measured by effect size.<sup>10</sup> In a review of research on individual therapy, Barkham offers some examples of more focused, prospective work.<sup>13</sup> He mentions studies of anorexia nervosa and bulimia by Hall and Crisp<sup>14</sup> and Freeman and colleagues,<sup>15</sup> comparing different therapeutic interventions. He also mentions the Sheffield psychotherapy project<sup>16</sup> in which a reverse cross-over trial of prescriptive (cognitive-behavioural) against explorative (experiential-psychodynamic) psychotherapy with 40 patients indicated a slight advantage in favour of prescriptive work. The efficacy of cognitive therapy in depression is supported by the work of Fennel and Teasdale,<sup>17</sup> and in anxiety by Butler and colleagues.<sup>18</sup>

King and colleagues propose a controlled trial of the outcomes of counselling in general practice, using a method of stratification to allow for differences in the severity of patients' disturbance.<sup>19</sup> A pilot study of 24 patients using three questionnaires and a clinical interview, with measurements at entry, 12 weeks and six months, appeared to indicate that further controlled work would be feasible.<sup>19</sup> The authors were impressed by the severity of distress they found among patients seeing a counsellor.

Orchard has pointed out some major conceptual difficulties in interpreting outcome measures applied to health care.<sup>20</sup> She lists some of the difficulties: 'Outcomes are multidimensional. Most outcomes are qualitative. Assessment... will be affected by timing. Subgroups of diseases may have different outcomes. Outcomes may not be attributable to specific treatments.'<sup>20</sup> If such difficulties exist in the area of mainstream, biomedical science, it is likely that interpretation of outcome measures will be even more complicated in the branch of applied psychology known as counselling. Counselling is a discipline whose objects of study are conceptual rather than natural, and its theoretical derivation is in social, rather than natural, science. After all, a counsellor is not really analogous to a drug acting with indifference upon somebody's biochemical nature.<sup>21</sup> Counselling is a social act, not a chemical behaviour. Politics and economics are also social sciences, yet often those very market theorists who exalt judgement by outcome are content to impose ideologically-driven changes in advance of empirical testing.

For some time now there has been a crisis of truth criteria in

the social sciences,<sup>22-31</sup> and new philosophies and methodologies are emerging. There is a whole philosophical movement, devoted to structures of human understanding, which has important relevance to the human meanings of scientific evidence.<sup>32</sup> The sociopolitical contexts of research projects, and the intentions, ideologies, traditions and interests of both researchers and interpreters, are all regarded as relevant data for an open process of interpretation that emphasizes plurality, uncertainty and philosophical critique.

This is not to say that outcome studies are not important — the ones that have been done have been immensely important in stimulating theoretical argument — only that they are unlikely to be conclusive. The one thing we do know is that people are increasingly asking for the kind of unhurried, skilled and compassionate attention that qualified counsellors are educated to provide, and it may be that this kind of attention deserves to be sufficient outcome in itself.

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## References

- Eliot TS. Little Gidding. In: *Four quartets*. London: Faber and Faber, 1944.
- Balint M. *The doctor, his patient and the illness*. 2nd edition. London: Pitman, 1957.
- Rogers CR. *On becoming a person*. Boston, MA: Houghton Mifflin, 1961.
- Beck AT, Rush AJ, Shaw BF, Emery G. *Cognitive therapy of depression*. New York, NY: Guildford Press, 1979.
- Bateson G. *Steps to an ecology of mind*. New York, NY: Ballantyne, 1972.
- Eysenck HJ. The effects of psychotherapy. *J Consult Psychol* 1952; **16**: 319-324.
- Lambert MJ. Spontaneous remission in adult neurotic disorders. *Psychol Bull* 1976; **83**: 107-119.
- Smith ML, Glass GV. Meta-analysis of psychotherapy outcome studies. *Am Psychol* 1977; **32**: 752-760.
- Smith ML, Glass GV, Miller TI. *The benefits of psychotherapy*. Baltimore, MD: Johns Hopkins University Press, 1980.
- Glass G, Kliegl R. An apology for research interpretation in the study of psychotherapy. *J Consult Clin Psychol* 1983; **31**: 28-41.
- Shapiro DA, Shapiro D. Meta-analysis of comparative therapy outcome studies: a replication and refinement. *Psychol Bull* 1982; **92**: 581-604.
- Rachman S, Wilson GT. *The effects of psychological therapy*. 2nd edition. New York, NY: Pergamon Press, 1980.
- Barkham M. Research in individual therapy. In: Dryden W (ed.) *Individual therapy*. Milton Keynes: Open University Press, 1990.
- Hall A, Crisp AH. Brief psychotherapy in the treatment of anorexia nervosa: outcome at one year. *Br J Psychiatry* 1987; **151**: 185-191.
- Freeman CPL, Barry F, Dunkeld-Turnbull J, Henderson A. Controlled trial of psychotherapy for bulimia nervosa. *BMJ* 1988; **296**: 521-525.
- Shapiro DA, Firth JA. Prescriptive versus exploratory psychotherapy: outcomes of the Sheffield psychotherapy project. *Br J Psychiatry* 1987; **151**: 790-799.
- Fennell MJV, Teasdale JD. Cognitive therapy for depression: individual difference and the process of change. *Cognitive Therapy Research* 1987; **11**: 235-271.
- Butler G, Cullington A, Hibbert G, et al. Anxiety management for persistent generalized anxiety. *Br J Psychiatry* 1987; **151**: 535-542.
- King M, Broster G, Lloyd M, Horder J. Controlled trials in the evaluation of counselling in general practice. *Br J Gen Pract* 1994; **44**: 229-232.
- Orchard C. Comparing healthcare outcomes. *BMJ* 1994; **308**: 1493-1496.
- Stiles WB, Shapiro DA. Abuse of the drug metaphor in psychotherapy process-outcome research. *Clin Psychol Rev* 1989; **9**: 521-543.
- Habermas J. *Knowledge and human interests*. Oxford: Polity Press, 1968.
- Harré R, Secord PF. *The explanation of social behaviour*. Oxford: Blackwell, 1972.
- Gadamer H-J. *Truth and method*. London: Sheed and Ward, 1975.
- Dilthey W. An introduction to the human studies (1883). In: Rickman HP (ed.) *Dilthey: selected writings*. Cambridge University Press, 1976.
- Feyerabend PK. *Problems of empiricism*. Cambridge University Press, 1981.
- Geuss R. *The idea of a critical theory: Habermas and the Frankfurt school*. Cambridge University Press, 1981.
- Ricoeur P. *Hermeneutics and the human sciences*. Cambridge University Press, 1981.
- Polkinghorne D. *Methodology for the human sciences*. Albany, NY: State University of New York Press, 1983.
- Outhwaite W. *New philosophies of social science: realism, hermeneutics and critical theory*. New York, NY: St Martin's Press, 1987.
- Kvale S (ed). *Psychology and postmodernism*. London: Sage Publications, 1992.
- Bleicher J. *Contemporary hermeneutics: hermeneutics as method, philosophy and critique*. London: Routledge, 1980.

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# General practice fundholding: time for a cool appraisal

THE subject of general practice fundholding arouses strong passions. Its proponents claim that giving general practitioners control over budgets has resulted in improved efficiency, greater responsiveness to patients' needs and enhanced quality of care. Critics of the scheme argue that it leads to widening inequalities, fragmentation of services and deterioration in relationships with patients. The government has hailed it as a great success, claiming that fundholders have proved to be better purchasers than district health authorities with the result that their patients receive more appropriate services.<sup>1</sup> In October 1994 the secretary of state for health announced a further extension of fundholding so that more patients might benefit. This underlined the government's confidence in the scheme, but how far is this confidence justified?

There is no doubt that fundholding is becoming more popular among general practitioners. Despite strong opposition when it

was initially introduced, the voluntary scheme has grown rapidly such that in England it now encompasses 1682 fundholding practices who between them control £2800 million of health service resources. Their combined practice populations make up 36% of the population of England<sup>2</sup> and this is set to rise again in April 1995. In some parts of England population coverage is already over 70%. New and even more radical developments include the 'total fundholding' experiments in which some practices hold budgets for all their patients' health care needs, including accident and emergency services, medical and psychiatric inpatient care, and maternity services, which are excluded from conventional fundholding.<sup>1</sup>

Surveys of general practitioners and anecdotal reports have shown that many fundholders are convinced that they have achieved major benefits through their involvement in the scheme.<sup>3-6</sup> However, reports from non-fundholding practices