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A practice-based exploration of therapeutic change in a charitable, community-based person-centred counselling service using routine outcome measures of anxiety and depression. I: Statistical and clinically significant change

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Abstract

Background: Establishing the value of differing treatments for depression and anxiety is crucial in a climate of delimited spending and increased demand. Drawing from a well-founded, diverse evidence base is salient to constructive evaluation and any subsequent recommendations being fit for purpose.

Design: This study employed a practice-based quantitative design to explore therapeutic gains in adult counselling clients attending person-centred therapy ($n = 301$), delivered in a charitable, community-based UK service.

Measures: Outcome measures PHQ-9 and GAD-7 were used from three time points: initial assessment (IA), first ongoing session and last or 6th ongoing appointment (whichever occurred first; T1, T2 and T3).

Analysis: Repeated measures ANOVA, CSI, RI and RCSI calculations were used to consider significant change in clients.

Findings: Reductions in PHQ-9 and GAD-7 outcome measures were observed over time (between T2 & T3 and T1 & T3) and were all statistically significant ($p = <0.001$). By T3: CSI was achieved by 48.1% of clients on PHQ-9 and 50.8% of clients on GAD-7, RI was achieved by 47.8% of clients on PHQ-9 and 60.5% of clients on GAD-7, and RCSI was achieved by 32.6% of clients on PHQ-9 and 41.2% of clients on GAD-7.

Conclusions: The treatment observed resulted in effective outcomes equivalent to other therapies reviewed in the literature for clients' symptoms of anxiety and depression as measured by GAD-7 and PHQ-9.

KEYWORDS
anxiety, counselling, depression, person-centred therapy, quantitative, routine practice

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1 | INTRODUCTION

1.1 | Framing the problem

The World Health Organization (WHO, 2023b) describes mental health as "integral to well-being, enabling people to realise their full potential," interrelated to "physical, psychological, social, cultural, spiritual and other" factors and "critically important" for both the individual and a well-functioning society.

Vigo et al. (2016) cite good mental health being disrupted in around one third of the population. However, they assess that currently used approaches underestimate the global burden of mental illness by more than a third, an oversight contributing to an inability to mitigate human, social and economic loss resulting from mental ill health. Their estimates place mental illness as "a distant first in global burden of disease," with those suffering severe mental illness having up to a 60% higher chance of dying prematurely.

Anxiety and depression are common disabling disorders with estimates of 301 million living with anxiety disorders and 280 million with depression in 2019 (WHO, 2023a). While regional prevalence is wide ranging (Baxter et al., 2013, 2014; Ferrari et al., 2013), Baxter et al. (2014) report global prevalence rates of 4% for anxiety disorders and 4.4% for major depressive disorders in 2010. Although Baxter et al. (2014) challenge the notion that these mental disorders became more prevalent between 1990 and 2010, the World Health Organization (WHO, 2023a) estimates conditions such as depression and anxiety rose by 28% and 26% in the first year of the COVID-19 pandemic, supported by findings from Schrempft et al. (2023). Mahmud et al.'s (2023) meta-analysis into the prevalence of depression, anxiety, stress and insomnia during the COVID-19 pandemic (December 2019 to June 2020) reported a global prevalence rate of 28.18% for depression and 29.57% for anxiety in the general population during this period.

Despite significant loss associated with mental illness and a range of effective pharmacological and psychological treatments being available for both depression and anxiety (Bandelow et al., 2017, 2022; Gaskell et al., 2022; Stiles et al., 2006, 2008), policymakers continue to fail to prioritise treatment and care for those with mental illness, with the global median of government spending on mental health below 2% (WHO, 2023c).

1.2 | Evidencing and recommending treatments

Identifying effective treatments with the potential to significantly mitigate distress, suffering and economic loss demands that legitimate and accessible sources of insight into what treatment options are helpful, for whom and under which circumstances are established (Clark, 2018; Layard, 2006; Moriana et al., 2017, 2022).

Despite wide agreement that research evidence, clinical expertise and patients' preferences inform evidence-based approaches, national and international unanimity in evaluating and applying these tenets within and across disciplines and practice remains a challenge (Satterfield et al., 2009). Moriana et al. (2017, 2022) reviewed evidence into psychological treatments for mental disorders, incorporating research, information and guidance from Division 12 of the American Psychological Association (clinical psychology branch of the APA), the Cochrane collaboration (collaboration of researchers, practitioners, patients and caregivers from over 130 countries), the Australian Psychological Society (APS) and the National Institution for Health and Care Excellence (NICE, providing evidence-based health and social care guidance to the NHS in the UK), all leading organisations legitimising treatments of choice for innumerable patients, practitioners and service providers around the world. They conclude that there is little agreement among organisations for most disorders (Moriana et al., 2017) and underline a lack of international consensus in evaluating available evidence, not only in how the "grade of evidence" is considered but also in resulting "treatments of choice" (Moriana et al., 2022).

Shaping medical knowledge and practice through rational scientific enquiry, randomised controlled trials (RCTs) are recognised as the gold standard of empiricism. Despite this, methodological limitations and the potential to overlook valuable alternative sources of evidence highlight a need for caution in generalising findings based primarily on RCT data to real-world practice (Bothwell et al., 2016; Frieden, 2017; Morrison et al., 2003). While Barkham et al.'s (2017) paper extolls the virtues of RCT, they propose that innate limitations to this design, such as controlling for comorbidity and selection of "willing" research participants, may result in conclusions that cannot be generalised to typical clinical populations. Gaskell et al. (2022) highlight some evidence indicating different treatment outcomes when comparing data from routine practice and clinical trials. Although "research participants" are randomly assigned treatment options as a methodological strategy for clinical

Implications for practice and policy

- These findings promote the value of person-centred counselling practice in the effective treatment of symptoms of anxiety and depression across all sectors.
- This study contributes to a relative paucity in third-sector (voluntary and community organisations), practice-based research into person-centred counselling, and enhances the value of such research, appealing to socio-economic rationale of decision makers.
- Findings emphasise a need to support and promote accessibility to a range of effective treatment options/therapies that can meet a range of client needs, carefully considering a wide range of sources of evidence.
- The findings also highlight the potential to challenge a paradigm in person-centred counselling training and practice that considers empirical/quantitative research extraneous.

RCTs, some evidence points to patient autonomy in treatment selection influencing treatment outcomes (Swift et al., 2018; Swift & Callahan, 2009).

A key development in research terms is large datasets made available through the implementation of programmes such as the Improving Access to Psychological Therapies (IAPT) programme in the UK. For example, in Stiles et al. (2006, 2008), data comprise natural or routine practice-based datasets of an "unprecedented size" (Barkham et al., 2017). The insights this practice-based evidence holds for efficacy in real-world settings are incomparable, and to overlook it would be remiss (Bate et al., 2016).

1.3 | Gaps in evidence

Meta-analysis and systematic reviews frequently highlight comparable paucity in available research into the clinical effectiveness of person-centred or nondirective counselling to that concerning cognitive behavioural therapy (CBT), with a long history of empiricism (Barkham et al., 2017; King et al., 2014; NICE, 2020, 2022). The concept of quantitative enquiry is at odds within an existing traditional person-centred paradigm that is sceptical of scientific approaches. Within this paradigm, only qualitative methods of research are considered appropriate for the field of counselling or psychotherapy and the human experience cannot, and should not, be quantified. McLeod (2003) provides an overview of quantitative methods with a dedicated chapter of his book on counselling research, considering the "limitations and issues arising from the quantification of the human experience" (McLeod, 2003, p. 41). Conversely, the British Association for Counselling and Psychotherapy (BACP) argue that "research is not only a scientific and an ethical endeavour, it is a political one which has at its root the desire to promote therapeutic plurality and choice of interventions for clients" (BACP, n.d., para. 2). Perhaps an additional insight into a deficient evidence base is Unsworth et al.'s (2012) research findings summarising that person-centred counsellors are anxious and resistant to employing outcome measures. Contrary to this resistance against "quantification," they conclude that outcome measures themselves can help "ground and integrate" the client/therapist relationship and are perceived as helpful by clients, validating their feelings and providing a visual representation of their issues and progress (Unsworth et al., 2012, p. 76). Further, Wilkins (2010, p. 215) postulates that quantitative approaches have the "most profound effect on the development of policy and funding." Although the virtues of qualitative research into the human experience are recognised, the validity of quantification, on both micro and macro levels, and the resultant potential benefits to clients, therapists and the wider community must be recognised.

Third sector (sometimes referred to as voluntary and community sector) organisations play an important role in supporting welfare or public services in western cultures (Hogg & Baines, 2011; O'Donnell et al., 2021). It is difficult to estimate the contribution the third sector makes to providing mental health support, though considering just one national charity in the UK, Mind (2021) report that in 2020–2021, their local branches and employee well-being programmes supported over 400,000 individuals, their online peer support reached almost 1.5 million people, and their online mental health information was accessed 20.7 million times. Despite smaller services and individuals without the capacity for data to be collated, analysed and delivered in a way that contributes to a peer-reviewed empirical evidence base (Broglia et al., 2021; O'Donnell et al., 2021), evidence considering the significant contribution third sector organisations make to effectively supporting those experiencing mental illness needs to be addressed.

Due to the way best evidence is currently considered, and in recognition of innate limitations to RCT design, the virtues of practice-based data and the wealth of knowledge they hold regarding efficacy in, and across available psychological interventions, both nationally and internationally, need recognition. Increasing the body of evidence for counselling is crucial to a range of evidence-based effective treatment options being accessible and available for those seeking treatment and those looking to deliver treatments to maximise the potential to mitigate the distress, suffering and economic loss resulting from mental ill health.

The themes outlined previously inform the circumstances within which this research has developed, providing a foundation for the adopted process of enquiry and the context within which it hopes to find a place.

The present article aims to contribute evidence through practice-based quantitative analysis of the therapeutic benefits of person-centred counselling and psychotherapy delivered in a community-based counselling service in the North-West of the UK.

2 | METHODS

2.1 | Design

A within-subjects design was adopted to analyse naturally occurring practice-based outcome data for adults attending person-centred counselling and psychotherapy delivered in a community-based counselling service in the North-West of the UK. In order to evaluate meaningful changes in self-reported symptoms of depression and anxiety, analysis considered the statistical significance of mean changes, in addition to clinical changes over the course of counselling (Jacobson & Truax, 1991).

2.2 | Participants

This study utilised retrospective opportunity sampling. There were 301 participants between 18 and 85 years of age suffering from symptoms of depression and/or anxiety. Participants had a mean age of 42.2 years ($SD = 13.9$). The sample was 61% female, with 83% of participants identifying as White English (Table 1).

TABLE 1 Participant demographics.

Gender (%)			Age		Ethnicity				
Male	Female	Not recorded	Mean (SD)	Range	White	Asian	Black	Mixed	Other/missing
109 (36%)	183 (61%)	9 (3%)	42.2 (13.9)	67 (18–85)	86%	2.8%	1%	2.9%	7.3%

2.3 | Outcome measures

2.3.1 | Patient health questionnaire-9 (PHQ-9)

The PHQ-9 is a nine-item self-report measure of depression based on the nine symptoms of major depressive disorder identified in the Diagnostic and Statistical Manual version 5 (DSM-5, 2013). Each of the nine items is rated on a 0–3 scale based on four responses, ranging from 0—"Not at all" to 3—"Nearly every day." Scores range between 0 and 27, with higher scores indicating greater severity of symptoms of depression. Clinical ranges are based on Griffiths & Griffiths (2015, p. 30) and Pybis et al. (2017) as follows: PHQ-9 = <10 = nonclinical, >9 = clinical. Kroenke et al. (2001) examined the validity of the PHQ-9 in its assessment of depression in a clinical population, concluding an excellent level of internal reliability or consistency as a measure of depression, determined by a Cronbach's α (a frequently used reliability coefficient, Cronbach, 1951; Cho & Kim, 2015) of 0.89 and a test–retest reliability of 0.84, and a PHQ-9 score > 10 having a sensitivity and specificity of 88% for major depression.

2.3.2 | Generalised anxiety disorder-7 (GAD-7)

The GAD-7 is a brief self-report measure of anxiety, developed from generalised anxiety disorder symptom criteria found in the DSM-5 (2013) and existing anxiety scales (Spitzer et al., 2006). Each of the seven items is rated on a scale of 0–3, based on four responses ranging from 0—"Not at all" to 3—"Nearly every day." Scores range between 0 and 27, with higher scores indicating greater severity of symptoms of anxiety. Clinical ranges are based on Griffiths and Griffiths (2015, p. 30) and Pybis et al. (2017) as follows: GAD-7 = <8 = nonclinical, >7 = clinical. Spitzer et al.'s (2006) research examined the validity of the GAD-7 in its assessment of anxiety in a clinical population, concluding GAD-7 has excellent internal reliability or consistency as a measure of GAD, determined by a Cronbach's α (a frequently used reliability coefficient, Cronbach, 1951; Cho & Kim, 2015) of 0.92 and a test–retest reliability of 0.83, and a GAD-7 score > 10 having sensitivity and specificity of >80%.

2.4 | Intervention

Counselling sessions were delivered within a person-centred framework (based on the work of Carl Rogers, 1967) by voluntary and paid qualified counsellors and counsellors-in-training, studying or having studied an accredited person-centred course. Initial assessment sessions were conducted by qualified counsellors, with a minimum of 200 practice hours, trained to conduct initial assessments by the organisation. Counsellors attended regular one-to-one and group supervision led by qualified person-centred supervisors employed by the organisation. Due to the retrospective nature of the study design, additional treatment fidelity measures such as therapy rating scales and video or audio recording rating were not employed as a standard part of service delivery.

Standard organisational parameters bearing upon fidelity to the person-centred approach include a requirement to deliver intervention within six sessions where possible, regular data collection by counsellors, standardised information gathering, sequence of session delivery and safeguarding procedures. Counsellors were well-informed through training, training manuals and proformas of expectations of adherence to standard client pathways for service delivery. Client pathways are provided via the flow chart in Figure 1.

2.5 | Procedure

2.5.1 | Ethical considerations

Ethics approval for this research was granted by the appropriate institutional panel, addressing issues relating to confidentiality, organisation and participant consent and risk assessment. Informed written consent was obtained from the organisation to carry out and report analysis of anonymised, naturally occurring data. Written informed consent from participants for the use of their anonymised data was obtained during the delivery of services. Client and counsellor work through a detailed "counselling agreement" at initial assessment and again at first ongoing appointments. The counselling agreement includes an explicit statement regarding the use of personal data and anonymised outcome measures for the purpose of research and service improvement.

2.5.2 | Setting

The service is a registered charity, providing a range of one-to-one, group and community counselling projects to adults and children. Projects delivered by this service included free, voluntary donation and private counselling, taking referrals from a range of sources, including self-referral. All clients attend by choice. The organisation and counsellors all hold relevant memberships with the BACP.

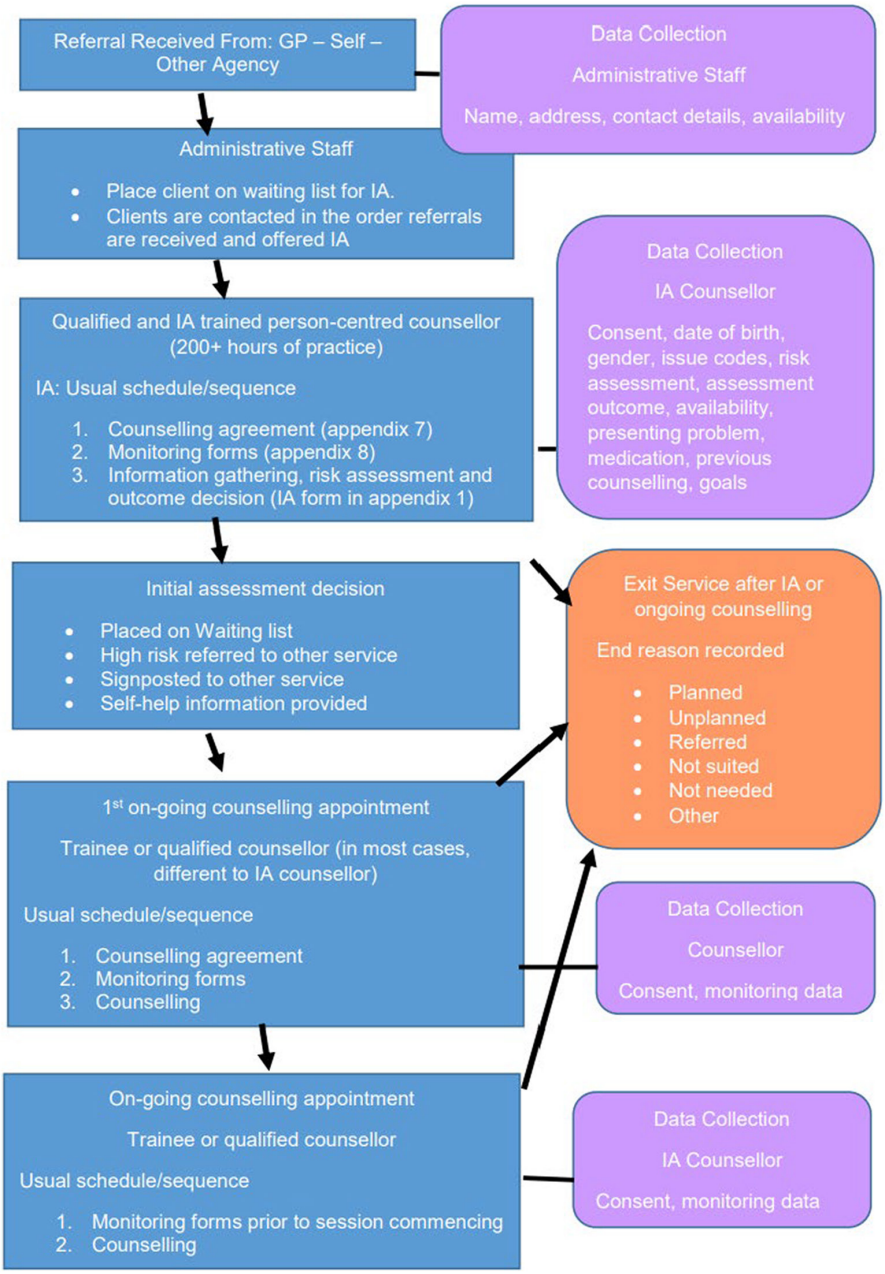

FIGURE 1 Flow chart—service/client pathway and data collection points.

2.5.3 | Data collection and inclusion and exclusion criteria

Client pathways, data collection points and full inclusion and exclusion criteria are detailed in Figures 1 and 2. All adult counselling activity within the service over a 12-month period (July 2015 to June 2016), which included 5025 appointments and 803 individual clients, was considered. Only clients returning outcome measures for all three time points, initial assessment session (T1), first counselling session (T2) and whichever came first of clients' sixth or final counselling session (T3) were included in the final analysis ($n = 301$). Due to limitations in the scope of this research project, the decision was made to exclude significant portions of data from the current analysis, listed in Figures 1 and 2.

2.6 | Data analysis

Statistical analyses were conducted using IBM SPSS version 24. Data were generated at each time point from two primary outcome instruments described in 2.3. Both employed measures inform diagnostic criteria and illustrate therapeutic movement and the efficacy of therapeutic services (Griffiths & Griffiths, 2015; Newman, 2022; Pybis et al., 2017). Data from the PHQ-9 and GAD-7 were collected at three time points: initial assessment/intake (T1), first follow-up counselling session (T2) and clients' sixth or final counselling session (T3). See Figure 1 for client pathway and data collection points.

Effect sizes were calculated using Cohen's *d* (mean pre-post change divided by prescore *SD*, Field, 2014) to give meaning to results in the wider context. A repeated measures ANOVA (analysis of

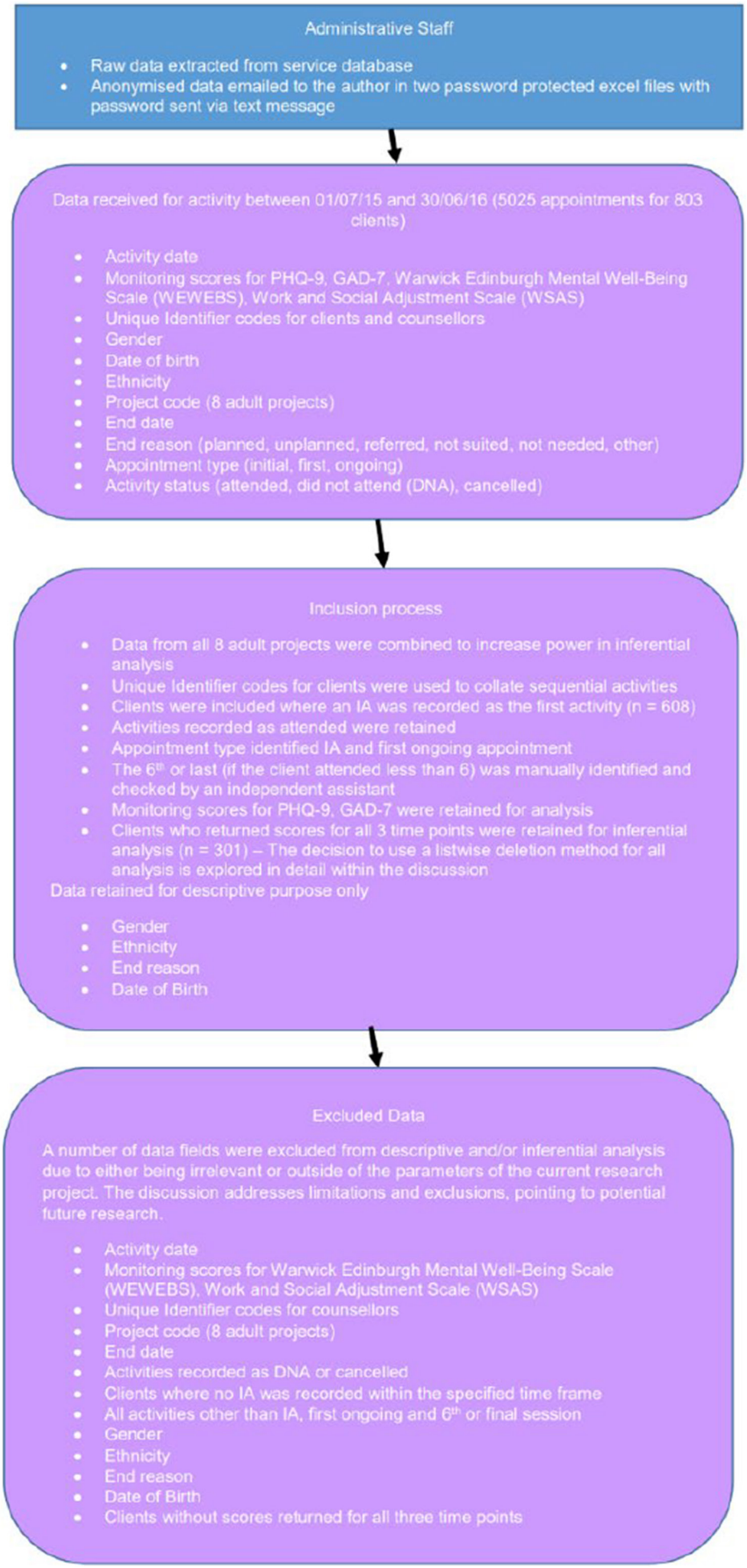

FIGURE 2 Flow chart—data collection, inclusion and exclusion criteria.

variance, Field, 2014) was used to explore clinical change between the three time points.

Post hoc analyses were employed to consider variability in treatment effects within the sample and the clinical significance of any observed treatment effects. Clinically significant improvement (CSI) between T1 and T3, reliable change (RC) between T1 and T3 and T2 and T3 and reliable and clinically significant improvement (RCSI) between T1 and T3 were all considered.

2.6.1 | Clinically significant improvement

Based on the work of Jacobson and Truax (1991), and following the lead of Griffiths and Griffiths (2015) and Pybis et al. (2017), the current study considers CSI to have taken place if a client entered at T1 in a dysfunctional state (i.e., PHQ-9 = >9 and GAD-7 = >7), and at a subsequent point in time returned to a functional state (i.e., PHQ-9 = <10 and GAD-7 = <8).

2.6.2 | Reliable change index (RCI) and reliable improvement (RI)

Based on the work of Jacobson and Truax (1991), reliable change was calculated by dividing the difference between the pretreatment and post-treatment scores by the standard error of the difference between the two scores to establish whether the magnitude of change observed for a given client is statistically reliable. An RCI above 1.96 indicates a statistically and clinically significant change unlikely due to chance ($p < 0.05$).

PHQ-9 RCI

The current study calculated an RCI of 5.54 for the PHQ-9 using listwise data ($n = 301$, mean at intake = 14.34, mean at T3 = 8.83, $SD = 6.03$, standard error of measurement = 2.00, standard difference = 2.83, mean pre-post change = 5.51 and effect size = 0.91). An RCI of 5.84 was also calculated using pairwise data ($n = 608$, mean at intake = 13.99, mean at T3 = 8.83, $SD = 6.355$, standard error of measurement = 2.11, standard difference = 2.98, mean pre-post change = 5.16 and effect size = 0.81). Reliability of Cronbach's $\alpha = 0.89$ was used, taken from Kroenke et al. (2001). In consideration of the RCI cited in previous literature, and the current RCI calculation, an RCI of 6 was selected for use in this research. Participants were considered to have reliably improved (RI) if their PHQ-9 score reduced by >5, reliably deteriorated if their PHQ-9 score increased by >5, and no reliable change was observed if their pre-post score fell within these thresholds.

GAD-7 RCI

An RCI of 3.88 using listwise data was calculated ($n = 301$, mean at intake = 13.14, mean at T3 = 7.68 $SD = 4.95$, standard error of measurement = 1.40, standard difference = 1.98, mean pre-post change = 5.46 and effect size = 1.10). An RCI of 4.21 was also calculated using pairwise data ($n = 608$, mean at intake = 13.08, mean at T3 = 7.68, $SD = 5.364$, standard error of measurement = 1.52, standard difference = 2.15, mean pre-post change 5.40 and effect size = 1.01). Reliability of Cronbach's $\alpha = 0.92$ was taken from Spitzer et al. (2006). In consideration of the RCI cited in the literature previously and the current research's RCI calculations, an RCI of 4 was selected for use in this research. Participants were considered to have RI if their GAD-7 score reduced by >4, reliably deteriorated if their GAD-7 score increased by >4, and no reliable change was observed if their pre-post score fell within these thresholds.

2.6.3 | Reliable and clinically significant improvement (RCSI)

Based on the work of Jacobson and Truax (1991), participants achieving RCSI were identified. RCSI captures those participants moving from clinical to nonclinical ranges, in addition to achieving RI based on the adopted RCI to illustrate the magnitude and reliability of that change.

3 | RESULTS

Table 2 displays descriptive statistics for scores observed on PHQ-9 and GAD-7 measures at each of the three time points (T1, T2 and T3), mean changes between time points and effect sizes.

TABLE 2 Summary of PHQ-9 and GAD-7 T1, T2 and T3 data and analysis ($n = 301$)—ANOVA post hoc Bonferroni.

	Time mean (SD)			Mean change (SD) – effect size Cohen's d		
Variable	Intake T1	First T2	Sixth or Last T3	T1-T2	T2-T3	T1-T3
PHQ-9	14.34 (6.03)	12.22 (6.35)	8.83 (6.69)	−2.12 (4.94) – $d = 0.35$*	−3.39 (6.21) – $d = 0.53$*	−5.51 (6.28) – $d = 0.91$*
GAD-7	13.14 (4.95)	11.95 (5.19)	7.68 (5.81)	−1.19 (4.25) – $d = 0.24$*	−4.26 (5.54) – $d = 0.82$*	−5.46 (5.6) – $d = 1.1$*

Note: Cohen's *d* effect size is calculated by dividing the mean pre-post change by prescore standard deviation (Field, 2014). 0.8 = Large, 0.5 = medium and 0.2 = small effect size.

Abbreviations: GAD-7, generalised anxiety disorder—7 item; PHQ-9, Patient Health Questionnaire—9 item; SD, standard deviation; *T*, time point.

*p-value <0.001 (95% confidence interval).

3.1 | Statistical significance

Repeated measures ANOVA was conducted, and analysis revealed a significant main effect over time. PHQ-9 = F (1.86, 558.2) = 136.39, $p = 0.000$, $\eta_p^2 = 0.313$. Partial eta squared indicated that 31.3% of the variation in PHQ-9 scores can be accounted for by progression through counselling/time. GAD-7 = F (1.82, 545.74) = 185.43, $p = 0.000$, $\eta_p^2 = 0.382$. Partial eta squared indicated that 38.2% of the variation in GAD-7 scores can be accounted for by progression through counselling/time. Post hoc analysis using Bonferroni corrections revealed that the observed improvements between T1 and T2, T1 and T3 and between T2 and T3 for both PHQ-9 and GAD-7 measures were statistically significant ($p = <0.001$; Table 2).

3.2 | Clinical significance

3.2.1 | Clinically significant change/recovery

As defined in 2.6.1., at T1, 77.4% (233) of participant PHQ-9 scores and 85% (256) of participant GAD-7 scores fell within a clinical range (PHQ-9 = >9 and GAD-7 = >7). Of the 233 participants considered to have PHQ-9 scores falling within a clinical range, 48.1% (112) had achieved CSI, moving into the nonclinical range (PHQ-9 = <10) by T3, and of the 256 participants considered to have GAD-7 scores falling within a clinical range, 50.8% (130) had achieved CSI, moving within the nonclinical range (GAD-7 = <8) by T3 (Table 3).

3.2.2 | Reliable change

Reliable change considers the magnitude of change and the statistical reliability of that change, and is defined in 2.6.2. Participants are considered to have achieved reliable change if scores change at or above the level of the calculated RCI. Results show that at T3, 144 (47.8%) of participants ($n = 301$) had achieved RI in self-report scores on PHQ-9 and 182 (60.5%) on GAD-7 (Table 3). Participants reliably deteriorating or making no reliable change at T3 are detailed in Table 3.

3.2.3 | Reliable and clinically significant improvement

Based on the work of Jacobson and Truax (1991), participants achieving RCSI at T3 were identified. Overall, 32.6% ($n = 98$) of participants achieved RCSI on the PHQ-9 measure and 41.2% ($n = 124$) on the GAD-7 measure (Table 3).

4 | DISCUSSION

Initial analysis reveals participant demographics and levels of initial distress to be comparable to those accessing clinical settings in reviewed literature (Wakefield et al., 2021 [60% female and majority white in those reporting gender and ethnicity], Pybis et al., 2017 [66% female, 84% white British, mean age 41 years], O'Donnell et al., 2021 [65% female, mean age 38 years], Kroenke et al., 2001 [66% female, 79% white, mean age 46 years] and Spitzer et al., 2006 [65% female, 80% white, mean age 47.4 years]).

Meaningful reductions in distress were observed over time. For both measures of anxiety and depression, average therapeutic gains and effect sizes were observed (T3, PHQ-9, −5.51 [$SD = 6.28$], $d = 0.91$; GAD-7, −5.46 [$SD = 5.6$], $d = 1.1$) and were all statistically significant ($p = <0.001$). Findings were comparable to reviewed literature from RCT and practice-based studies, meta-analyses

TABLE 3 Clinical change—clinical categories and movement, RCI movement, RCSI ($n = 301$).

		PHQ-9		GAD-7	
		n	%	*n*	%
T1	Clinical	233	77.4*	256	85*
	Nonclinical	68	41.5*	45	15*
T3	Clinical	125	41.5*	134	44.5*
	Nonclinical	176	58.5*	167	55.5*
T1 to T3	Achieved clinically significant improvement (CSI)	112	48.1**	130	50.8**
T1 to T3	Reliably improved (RI)	144	47.8*	182	60.5*
	Reliably deteriorated (RD)	8	2.7*	14	4.7*
	No reliable change (NC)	149	49.5*	105	34.9*
T1 to T3	Achieved reliable and clinically significant improvement (RCSI)	98	32.6*	124	41.2*

Note: % = *percentage of total participants $n = 301$; **percentage of T1 clinical population $n = 233$.

Abbreviations: GAD-7, generalised anxiety disorder—7 item; *n*, participant numbers; PHQ-9, Patient Health Questionnaire—9 item; *T*, time point.

and systematic reviews considering the effectiveness of psychological interventions in general, along with individual therapeutic formats (Gaskell et al., 2022 [depression $d=0.96$, $p=<0.001$ and anxiety, $d=0.8$, $p=0.001$]; Wakefield et al., 2021 [PHQ-9, $d=0.87$, $p=<0.001$; GAD-7, $d=0.88$, $p=<0.001$]; Pybis et al., 2017 [PHQ-9 – counselling, $d=0.95$; CBT, $d=0.94$]; Stiles et al., 2008 [CORE-OM, counselling $d=1.39$; CBT $d=1.38$]; Stiles et al., 2006 [CORE-OM, counselling $d=1.32$; CBT $d=1.27$]).

Recovery rates (PHQ-9 CSI = 48.1%, RI = 47.8%, RCSI = 32.6%; GAD-7 CSI = 50.8%, RI = 60.5% and RCSI = 41.2%), as measured using both RCI and movement from clinical to nonclinical assessment thresholds (CSI) at either sixth or last sessions (whichever came first), were also comparable to those observed in the reviewed literature (Pybis et al., 2017 [CBT RI = 50.4%, RCSI = 46.6%; counselling RI = 49.6%, RCSI = 44.3%]; Griffiths & Griffiths, 2015 [PHQ-9 RI = 50.2%; GAD-7 RI = 65.1%]; Stiles et al., 2006 [CBT RCSI = 62%; counselling RCSI = 57.6%; psychodynamic therapy RCSI = 48.1%]; Stiles et al., 2008 [CBT RCSI = 58.6%; counselling RCSI = 58.6%; psychodynamic therapy RCSI = 54.4%]).

Pybis et al.'s (2017, p. 10) research concludes that although side effects and effects related to the number of sessions attended were observed, in line with other research, CBT and generic counselling outcomes were "comparable and that model of therapy did not predict outcome." Barkham et al.'s (2021) RCT considered the clinical and cost-effectiveness of CBT and person-centred experiential therapy (PCET) for moderate and severe depression. They conclude that at 6-month follow-up, PCET is "noninferior" to CBT, although at 12 months it may become inferior. Barkham et al. (2017, p. 261) consider evidence from RCTs, routine datasets (IAPT) and qualitative research. Their conclusions are that "counselling [non-directive therapy] is as effective as CBT as an intervention for depression" and "may well be cheaper and therefore more cost-efficient than CBT." King et al. (2014, $n=134$) report their findings from an RCT, comparing nondirective counselling, based on the work of Carl Rogers (1967), and CBT, for patients experiencing a depressive episode entering primary care settings in the UK. Their findings also concluded that there was no significant difference, and very little clinical difference, between the outcomes of CBT and nondirective counselling on all three measures, regardless of depressive diagnosis at intake. Both treatment approaches performed significantly better than routine GP care at 4 months, but by 12 months, the difference was no longer significant. Stiles et al. (2008) concluded that "negligible differences in effectiveness among these alternate approaches" were observed (Stiles et al., 2008, p. 678) and that "theoretically different approaches tend to have equivalent outcomes" (Stiles et al., 2006, p. 555). However, Stiles et al. (2008) note that pre-post scores ranged widely from −29 to 40, indicating that significant individual differences between patients were observed, indicating "scope … for research on sources of variation" (Stiles et al., 2008, p. 683) beyond treatment modality.

Considering the reviewed literature, the current study observed outcomes for those receiving person-centred counselling in a charitable community-based service, which are broadly equivalent to outcomes from RCTs and routine practice, individual studies, meta-analyses, systematic reviews and real-world sources of data, including general psychological interventions and more specific modalities such as CBT and psychodynamic therapy.

These findings indicate that person-centred counselling, delivered in a charitable, community-based service in the UK, was effective in reducing symptoms of anxiety and depression as measured by the PHQ-9 and GAD-7. The observed outcomes were broadly comparable to benchmarks for the overarching effectiveness of psychological interventions for anxiety and depression and for reported outcomes for both counselling and CBT in routine practice reviewed in the literature, supporting the value of real-world, practice-based research and person-centred counselling as an effective intervention in mitigating distress, suffering and the wider burden of mental ill health.

5 | LIMITATIONS

There was a lack of experimental control group and random assignment to therapy, which increases the chance of selection bias and detection bias. However, psychotherapies often naturally lack standardisation due to therapist responsiveness to the emerging needs of clients and a requirement to adapt, including treatments with specific techniques and structure and perhaps particularly those that are client-led (Pybis et al., 2017; Stiles et al., 2006, 2008).

Significant portions of data were excluded due to the scope of this research project. It could be that some of the excluded data could help elucidate some of the challenges faced when delivering psychological therapies. Excluded data included average time span of sessions attended, waiting times, attrition rates and reason for prematurely ending therapy, additional assessment measure data, additional client and counsellor demographics, IA and continuing counsellor consistency, counsellor experience and project type. Despite similarities in outcomes across treatment modalities within the literature, variation in outcomes for participants leaves "scope … for research on sources of variation" (Stiles et al., 2008, p. 683), with further analysis of excluded data holding potentially valuable insight into variability.

6 | POTENTIAL FUTURE RESEARCH

There is a lack of gold standard RCTs within the current efficacy literature on PCT. Future research should aim to include methods that use clear measures of treatment fidelity and more rigorous controls. To further build an evidence base for the efficacy of PCT, future researchers should aim to investigate the effects of PCT on less common mental health disorders where the client's motivation to change can be extremely low (e.g., eating disorders). In order to establish effectiveness, it is also important to increase ecological validity by comparing PCT to other psychotherapies commonly used to treat mental health disorders in clinical and community settings where interventions are typically provided.

It is not currently clear how mechanisms of PCT best support change in individuals suffering from depression and anxiety. It is important to provide a clearer picture of the impact of PCT on mental health and greater insight into successful intervention delivery. Spontaneous remission, practitioner variance, patient history, diagnosis and comorbidities are all likely to impact the efficacy of PCT. Future research may elucidate such factors using mixed methods designs. Qualitative data can provide a rich source of data and by exploring the subjective experiences of individuals receiving PCT greater understanding can be gained into how this approach fosters change.

CONFLICT OF INTEREST STATEMENT

Jennifer Young declares there are no conflicts of interest, and she gained no financial benefit from this research. The research has not received funding from any source. As a predominantly person-centred practitioner, findings are supportive of her own orientation. Mark Widdowson declares there are no conflicts of interest, and he gained no financial benefit from this research. The research has not received funding from any source. He is a transactional analysis psychotherapist and, as such, has no personal allegiance bias relating to his own theoretical orientation. David Tate declares there are no conflicts of interest, and he gained no financial benefit from this research. The research has not received funding from any source.

ETHICAL APPROVAL

Ethics approval for this research was granted by the University of Salford's Joint School Approval Ethical Panel for Taught Programmes, on 19 January 2017. Written informed consent from participants for the use of their anonymised data is addressed during the delivery of services. Client and counsellor work through a detailed "counselling agreement" at IA and again at first ongoing appointments. The counselling agreement includes an explicit statement regarding the use of personal data and anonymised outcome measures for the purpose of research and service improvement.

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