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The Effectiveness of a Brief, Nondirective Person-Centered Practice

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Abstract

This study serves as a replication of earlier findings on the effectiveness of client-centered therapy and a refutation of the need for specificity and directiveness in brief, efficacious treatment. It also provides a quality low cost model for individual therapists to address the single most stressful aspect of their work, the perception of lack of therapeutic success (Farber & Heifetz, 1982). Using four global indexes, results showed consistent improvement across clients in a college counseling center throughout the weeks of brief therapy, with the most dramatic gains seen within the first four weeks of therapy with virtually every client (97%). The average effect size across outcome measures was 0.97. The research found significant correlations between the various measures, adding to its validity.

Background

Meta-analytic studies have clearly shown that psychotherapy is usually effective (Consumer Reports, 1995; Howard, et. al., 1996; Smith, et al., 1980). However, most therapists are not aware of empirical findings that demonstrate how clients improve from therapy. In fact, the single most stressful aspect of a psychotherapist's work has been found to be the perceived lack of therapeutic success (Farber & Heifetz, 1982). The present research served as a cost and time effective means for this therapist to become more aware of his effectiveness and may be helpful as a model for others.

Additionally, no particular therapy has been found to be superior to any other. Common or non-specific factors are often cited as the agents of change (Ahn & Wampold, 2001; Lambert, 1992). Comparisons have been made between the common factors and the client-centered attitudes (Patterson, 1984). Nevertheless, there has been a trend towards Empirically Validated Treatments (EVTs) by the American Psychological Association, or specific treatments for specific diagnoses.

These EVTs have involved directive cognitive-behavioral therapies. This trend has been described as the "specificity myth" (Bozarth, 1998) and has been challenged by meta-analytic study (Ahn & Wampold, 2001). There is also a trend toward directiveness in brief therapy (Rudolph, 1996). This study provides a refutation to the popular perceived need of specificity and directiveness in brief therapy.

Methods

Procedures

All therapy clients who were seen by the author at a college-counseling center were invited to participate in the study. (Clients who were provided services exclusively in the context of 1-2 crisis management sessions were excluded.) The setting mandated that clients had a maximum of 16 sessions if they began in the first half of the year and 12 if they began in the second. Clients who had not reached their maximum were simply considered ended for the purpose of the research at the end of the data collection period. All participants had the nature of the research, their freedom to refuse or withdraw participation, as well as factors related to willingness explained to them; they signed consent forms.

The data consisted of scores from two measures administered in the first week of therapy and final week of therapy. Additionally, two measures were administered weekly as both progress and outcome ratings.

Participants

The therapist was myself, a psychology intern with a Master of Arts Degree in Clinical Psychology and six years of clinical experience. Additionally, I graduated with a Psychology Doctorate a month after the completion of the study and became licensed as a clinical professional counselor in a midwestern state six months after completion of the study. I am a nondirective client-centered therapist, which is one who believes in an unconditional trust of clients as the central component of client-centered therapy. The "client-centeredness" of the therapist's practice was empirically shown through a systematic review of 101 therapy tapes (Cornelius-White, 2003, this issue). The overall nondirectivity score was 97% with 91% of responses categorized as empathic following responses. Using a sub-sample of sessions, 28% of the total spoken words came from the therapist. Hence, while I have studied, been influenced by, and like several other approaches to therapy, including other humanistic therapies, cognitive behaviorism, psychoanalysis, and systems theory, in practice my behavior and attitudes are quite client-centered (White, 1997).

There were 22 participating clients, students at a large community college in suburban Chicago, 17 of whom took part in all phases of the research. They ranged in age from 18 to 38 with two modes being at 19 and 26. The mean age was 22. There were 17 females and 10 males. The sexual orientations included one gay male and one bisexual woman, while the others identified as heterosexual. The race of the participants included 15 White people, 2 African-Americans, 3 Asian-Americans, and 2 Latinos. Students intelligence and educational achievement varied widely as

seen be an ACT score range of 15 to 35, and the fact that some people had not graduated from high school while others had previously attended and graduated from prestigious universities. (The ACT is a national college entrance exam with a range of 0-36.)

Measures

Three measures were used in the outcome and progress portions of the study. Two, the Derogatis Psychiatric Rating Scale (DPRS) and the Quality of Life Inventory (QOLI), were used as outcome measures. They were chosen because they showed strong reliability and validity data, were quick to administer (4-10 minutes), and had been approved for outcome use by the Joint Commission on Accreditation of Health Care Organizations (JCHACO). The Global Pathology Index (GPI from the DPRS) along with the third measure, the Global Assessment Scale (GAS), was used for weekly progress ratings.

The therapist made the ratings when ratings were required beyond those made by the clients. Steps were taken to prevent the obvious, well-documented bias from significantly affecting the validity of the research. All ratings, which presented a significant difficulty in how to be scored, involved consultation with Barbara Brodley, Ph.D., a senior clinician and researcher. These consultations resulted in unanimous agreements before a score was entered into the data pool. The therapist rated measures were then correlated with the client self-report measure to help observe and explain potential bias that was not prevented through consultation.

The Derogatis Psychiatric Rating Scale (DPRS) contains 17 distinct symptomatic dimensions on a rating scale of 0 (Health)-6 (Severe Disturbance) with extensive behavioral anchors. Examples are Depression, Phobic, Sleep Disturbance, and Euphoria. The DPRS also has a Global Pathology Index (GPI) with scale of 0(Health)- 8 (Pathology). The Sum of the scores on the 17 dimensions was also used as an overall measure of outcome. The DPRS reports strong inter-rater reliability and criterion validity.

The Quality of Life Inventory (QOLI) rates a client's satisfaction in 16 different life areas. Examples include Love, Home, Friends, and Work. The QOLI consists of 32 client-answered questions. This measure has an emphasis on health as opposed to pathology. The inventory yields a score of –6 to +6 in each life area, a Total Raw Score, a T-score, a percentile, and an Overall Quality of Life range from 1 Very Low, 2 Low, 3 Average, to 4 Above Average. Seventy percent of the standardization population scored within the average range. The QOLI reports high validity, especially at predicting the likelihood of contracting physical health problems in the near future.

The Global Assessment Scale (GAS), a close relative to the DSM-IV Global Assessment of Functioning (GAF), provides a score between 0 (no functioning)-100 (perfect functioning) using behavioral and impressionistic anchors along social, emotional, occupational, and behavioral dimensions. The score of 61 provides a natural dividing line, as this is the point above which it is intended that "most

untrained people would not consider the client 'sick.'" While this scale's validity data was the worst of the tests administered, it is also the most widely used, especially in its roughly equivalent form in Axis of V of DSM-IV diagnoses, and is the quickest to administer.

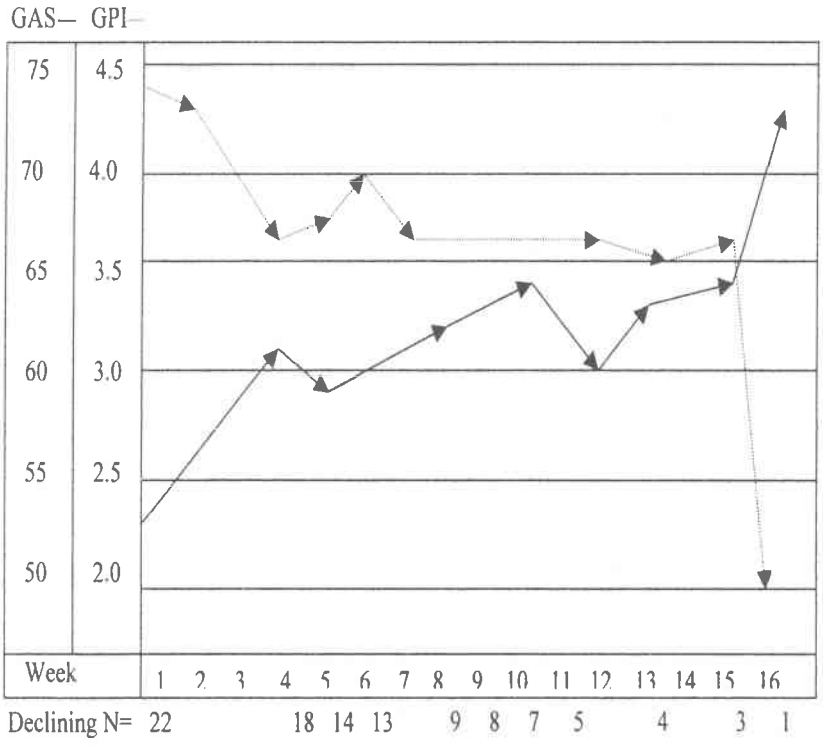
Results

Progress Data

As seen in Figure 1, the clients began therapy with an average GAS score of 53.4. and an average GPI score of 4.38. Throughout the weeks of therapy, there was a general trend towards improvement. The average scores at week 4 stood out within this general picture. At week 4, the GAS score was 60.9, and the average GPI score was 3.61 reflect a significant progress point. Clients terminated therapy at different times. Thirteen (59%) clients had three to seven sessions. Five (23%) clients had 11 or more sessions. The mode number of sessions was 7, and the mean was 7.72 sessions.

Figure 1

Weekly Progress in Average GPI and GAS Scores with Declining N



Outcome Data

Both the GAS and the GPI average scores began between the Moderate and Severe ranges and finished in the Mild range. From first to last session for each client, there was a change of 11 points on average with the GAS and 1.35 points on the GPI. Of those studied, 81% of people began therapy with a score below the GAS division point of 61, a level at which "most untrained people would consider the client 'sick.'" In contrast, 74% finished therapy with a GAS score >61. Hence, 87% of those starting with a score <61 met this criterion for clinically significant change.

On the QOLI, clients' percentiles moved from a starting score of 23.6 to a finish of 32.8. The Overall Quality of Life moved from 2.1 to 2.6. Hence, when using rounded scores, the average client began with Low Satisfaction in Life Classification and moved to the Average Satisfaction range. The clients showed an average increase of 5.9 points using QOLI T scores. The QOLI manual suggests that change from one Life Category to a higher category and/or a change of 5 T score points represent clinically significant change. Using these benchmarks, the mean score showed clinically significant change. In looking at individual scores, 50% of clients met these criteria.

There were five of the 17 Dimensions on the DPRS that were elevated beyond a mean of 2.0 on the first administration. These symptom dimensions were obsessive-compulsive, interpersonal sensitivity, depression, anxiety, and phobias. Hence, the diagnostic characteristics of the sample were diverse, though disoriented and psychotic clients were not seen. All clients showed improvement at the final administration. Mean DPRS Sums changed from 20.5 to 14.6, which represents an average 34% improvement on the five highest dimensions.

Effect sizes, a measure of the magnitude of change, offer a means to compare results across studies using a common metric. Effect sizes for this uncontrolled study were calculated by dividing the pre-post differences by the pooled standard deviations for each of the four measures. The effect sizes on the GAS, GPI, DPRS Sum, and QOLI were 1.44, 1.43, 0.65, and 0.37, respectively. The overall average effect size was 0.97.

Discussion

Progress Data

The changes seen within the first 4 weeks are the most significant. In fact, all clients who stayed in therapy for four weeks saw at least minimal improvement. This finding replicates the findings of Howard, et al. (1986) who found a "dose dependent" effect of therapy. In the first four sessions of therapy, people typically experience a "remoralization" phase where feelings of hopelessness and desperation respond quickly to therapy. Howard also found evidence of a "remediation" phase,

where clients typically experience symptomatic relief within 16 sessions, the longest period in the present study.

Outcome Data

A significant aspect of this study is that using four global measures of change, statistically significant results were found ($p<.001$) and virtually all clients showed at least minimal positive change (97%). No clients showed negative change on any of the measures. In terms of effect sizes, the overall effect size of 0.97 is clearly comparable to that reported by Elliot's (2002) meta-analysis where the overall effect size from 357 measures involving 5,030 clients receiving humanistic therapy was 1.06. However, the average treatment length in Elliot's review was 21.9 sessions whereas there was an average of 7.72 sessions in the current study, indicating similar effectiveness between humanistic therapy and nondirective brief therapy.

Additionally, the association of measure type with size of effect is similar in the present study as compared to this recent meta-analysis. Clinician-rated symptom reductions, as seen with the GAS, GPI, and the DPRS, had a mean effect size of 1.52 and a standard deviation of 0.75 (Elliot, 2002). The effect sizes of 1.44 (GAS) and 1.43 (GPI) are very close to this mean. However, the effect size of 0.65 (DPRS Sum) is more than one standard deviation below the mean. Coping, health, and personality measures, like the QOLI, showed an average effect size of 0.59 and a standard deviation of 0.45. The effect size seen on the QOLI was 0.37, indicating a result within 0.5 standard deviations.

Effect sizes are generally considered small, medium, or large at 0.2, 0.5, or 0.8 (Kazdin, 1992). Hence, the overall effect size of this study would be considered large. The effect sizes with the GAS and GPI would be considered large while that with DPRS Sum would fall midway between medium and large; and the client-rated life satisfaction of the QOLI would fall mid-way between a small and medium effect size. These results replicate earlier findings on the overall effectiveness of client-centered therapy (Elliot, 2002) and further refute the notions that efficacious brief therapy must be directive and tailored according to the specific diagnoses of the clients (Cornelius-White, in press).

Correlation Data

Table 1

Correlations Between Outcome Measures

Measure	GPI	GAS	QOLI	DPRS Sum
GPI	-	0.66**	-0.28	0.85**
GAS	0.66**	-	0.52*	0.39
QOLI	-0.28	0.52*	-	0.51*
DPRS Sum	0.85**	0.51*	0.51*	-

* $p<.01$ ** $p<.002$

Scores on the therapist ranked measures, especially the GAS scores, seemed to show larger increases in functioning as opposed to client self-report. This evidence of bias in the therapist as rater or researcher is well documented in the literature. Also, the GAS is the only measure that did not have strong validity levels as reported by the literature.

A multi-modal approach to assessment strengthens the study. These statistics represent the amount of consistency there is between the various measures of mental health that were used. They also serve to detect and explain any bias in the therapist rated measures as opposed to the client self-report, which was not prevented through the methodology of outside consultation explained above. Table 1 reports the correlations between measures that were conducted. Four of the six potential correlations between the major indices of outcome were statistically significant. The client self-report measure was significantly correlated with both therapist-rated instruments with a $p<.01$. Hence, the positive progress and outcome findings appear to be valid.

Conclusion

Clients showed consistent progress throughout therapy with the most obvious positive change occurring within the first four weeks. There were moderate to dramatic gains on various indices, and an overall large effect size of 0.97. Significant correlations were found between most progress and outcome measures, including correlations between therapist ratings and client self-reports. Hence, the results appear to be valid that a brief, nondirective person-centered practice was generally effective.

Author's Note

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