Risk Management

Is counselling and psychotherapy of proven benefit with justifiable risks?

by Kathy Spooner

That is the question the Professional Standards Authority is asking of all the professional counselling and psychotherapy bodies that hold an accredited register, as part of the revised standards (2021).

It's a good question! Whether you are currently in training or have been practising for some time, there exists an ethical imperative to undertake the work in order to benefit and not to harm others. So how do we as practitioners assess the vast body of evidence that might lead us towards some answers?

The Great Psychotherapy Debate by Bruce Wampold and Zac Imel is a good place to start as it sets out the historic development of different models of therapy, it details how research is formulated in various contexts, and it highlights some of the shortfalls that occur in the design and process of many research projects. Wampold and Imel make a helpful distinction between research supporting the 'medical model' paradigm for counselling and psychotherapy, and what the authors refer to as a 'contextual model' in assessing research evidence regarding the benefits and risks of counselling and psychotherapy practice.

In what are perhaps overly simplistic terms, the 'medical model' approach to formulating and testing the benefits of therapy focuses on particular interventions aimed at treating specific psychological problem states. A supportive therapeutic relationship is taken into account, but is not in itself the significant factor in psychological change. Rather, the therapist's obligation is to deliver the appropriate intervention at the intensity and for the duration calculated to produce the most effective result for their client's specific presenting concern. All other things being equal, it is ***the intervention*** that produces the result. Moreover, some interventions are proven to be more effective than others. It follows also that an intervention needs to be targeted; one that is proven to treat condition A, for example, may be less effective in treating condition B.

The process follows a classic scientific premise in that when a testable hypothesis is proposed regarding treatment for an aspect of mental ill health, controlled clinical trials are undertaken to test that hypothesis. Evidence is then collated regarding which interventions are effective for different conditions, building up a manual of approved treatments. A good example is the *Improving Access to Psychological Therapies Manual* (IAPT) operational within the UK, which is built on a body of evidence from approved randomised control trials and which advocates *specific* training for specific treatments for specific depression and anxiety disorders. It follows that in the delivery of an IAPT service there are guidelines in place, relevant to clinical protocols, including specifying the requisite 'dose' for any type of intervention, and the expected duration and intensity of treatment to treat specific conditions. Most counselling available within the NHS is delivered through the IAPT model.

A 'contextual model' approach according to Wampold and Imel, draws more from a social science perspective, explicitly 'what is known about humans and human healing' (p.50), and is based on a different scientific approach: observational analysis. Again in overly simplified terms the contextual model is drawn from and supported by a body of research evidence (mainly meta-analyses) suggesting that therapies bearing specific characteristics tend to be effective for a variety of different conditions. The characteristics (called pathways in this model) are:

1. A real relationship exists (the establishment and sustenance of a therapeutic bond between therapist and client).
2. The therapeutic approach

makes sense to all parties: there is a rationale that explains why the client is experiencing mental ill health, and an expectation that it can be alleviated if certain actions take place. This means that the therapist articulates a cogent rationale for the client's experience of distress which makes sense to the client, and there is a con-commitment willingness by the client to undertake the tasks of therapy in the belief they will be helpful. These actions and tasks do not have to be specific interventions. They can, for example, be attending to the relational qualities and theories of psychological change that make person-centred counselling in the Rogerian tradition effective.

3 The client consents to and co-operates with the interventions offered by the therapist: the client has a belief in, and willingness to undergo, therapeutic actions or interventions consistent with the rationale / approach of the therapist.

In other words it does not matter who is coming to therapy, or with what. What matters is that a therapeutic relationship is established and therapist and client believe the model or approach will bear fruit, and the client undertakes the work associated with that approach as advised and offered by the therapist. Variations of similar research outcomes have been known as the 'dodo bird effect' and common factors studies to a large extent confirm this homogenising in the effectiveness of therapy.

Speculation that all forms of therapy are effective was first voiced in 1936 by Rosenzweig and evidence from the last fifty years of research in the field 'unfailingly produced evidence that demonstrated that there were small, if not zero differences amongst treatments' (p.156).

A CHALLENGE FOR THE PROFESSION

Most counsellors will be aware of the tension caused by the privileging of the medical model over the contextual model, especially in relation to the funding of practitioner training and research, and in employment opportunities in state-funded mental health services e.g. within the NHS. Above and beyond what we believe as individual practitioners concerning this macro bias, we are obliged to give solid assurance to clients that the way we practice is justified by a body of knowledge and research – which somewhat loses its appeal when generalised to the so-called dodo bird effect. Helpfully, Wampold and Imel also collate distinct research evidence for the main theoretical approaches to augment our philosophical and psychological rationales.

Notwithstanding the evident value of the two research foci outlined above, the goals of therapy go beyond the relief of symptoms of mental ill health in order to touch on what it is that will assist someone to live a more fulfilling life. We know that in that deeper work clients may not always leave a therapy session able to tick a box that says that their mood has improved. Sometimes clients will feel worse as they undertake the hard work of self-discovery, reflection and enacting change – this can be a tough and challenging experience and it is as well to remind clients of this reality.

WHAT CAUSES HARM IN THERAPY?

We know that harm can be caused in therapy by therapists engaging in certain behaviours that are generally outlawed by the various ethical codes. Here, though, this question concerns whether there is evidence of particular approaches or interventions appearing to cause harm in therapy, and if so, whether that the harm is attributable to the therapy rather than unrelated ongoing or new external factors in the client's life.

The most notable studies pointing to evidence of harm are centred around recovered memories (via hypnosis or suggestion), psychological debriefing (PD) immediately after a traumatic event, grief counselling that happens early in a bereavement, and 'boot camp' like residential programmes for adolescents. Evidence that recovered memories seem to cause harm to clients stands up and indeed most ethical codes warn against this strand of therapy. Similarly the 'boot camp' model of psychological change does appear to produce negative results in relation to participant's mental health and wellbeing.

The evidence for negative effects for PD (= more likely to cause PTSD) and grief support, however, has been challenged. PD is less counselling and more a preventative intervention offered whether or not someone has reported symptoms of trauma – so it's not in itself evidence of harm caused by therapy. Similarly the 'boot camps' mentioned above are not therapy per se. Grief counselling when available soon after bereavement, and when the bereavement has been complex, has in more recent research been experienced as helpful, and the original studies showing marked negative effects have been disputed.

Other research suggests that there is a risk of inducing panic attacks in some guided relaxation meditations, and that exposure therapy in treating phobias can exacerbate experiences of fear and terror. Some 'focused expressive' psychotherapy, (e.g. anger inducing gestalt type interventions) have been found to be harmful, but again the evidence is not sufficient to be a firm contra-indication. Finally some attachment therapies (for example, 're-birthing' and holding therapies) can result in physical harm through suffocation – but again the argument is that

these types of activity do not fall into a definition of counselling / psychotherapy.

This leads Wampold and Imel to conclude that there is little reliable evidence that counselling / psychotherapy, when practised by trained competent people with clients experiencing some degree of mental health problems, is harmful.

A NOTE ON CONVERSION THERAPY

Although not included in the Wampold and Imel research, there is a general acknowledgment amongst all professional counselling bodies in the UK and US that attempts at conversion therapy for LGBTQ++ people are largely unethical and ineffective, producing at best a suppression in sexual feelings through aversion techniques, rather than any lasting change in sexual orientation. *The 2018 National Faith and Sexuality Survey* conducted in the UK by the Ozanne Foundation, reports on some of the harmful experiences and effects of CT, with 61% of respondents reporting adverse effects on their mental health (of which a third had attempted suicide and two-thirds had entertained suicidal thoughts), with 40% having self-harmed and 25% suffering eating disorders.

Again, many attempts at conversion therapy are undertaken by non-counsellors / psychotherapists in churches or other religious settings. All counsellors on UK registers, including those affiliated with the ACC, are prohibited from engaging in conversion therapy and from demonstrating a preference with regard to heteronormative sexuality and gender identity.

WHAT ABOUT RELIGION?

Research in the area of religion, mental health and therapy adds another complex dimension to an already challenging research field, and as Koenig explains in his comprehensive review (2018), the multifaceted inter-relational dynamic between alterations in mental health and wellbeing and changes in religious beliefs and behaviours affects research findings, especially in observational studies.

Overall he suggests that:

> ***'The evidence base is growing for religion's positive effects on wellbeing, life satisfaction, happiness, hope, optimism and purpose / meaning in life and now exceeds that for studies finding positive effects on negative emotional states and chronic mental disorders' (p.148).***

So religion is generally regarded as a force for individual good that also impacts positively on family and society. It makes sense then to consider the value of integrating religion and therapy.

In relation to specific religious interventions, Koenig's extensive review of the evidence, finds that they 'have a moderate effect size in the treatment of depression, anxiety and other emotional disorders' and are most effective (as we might suspect) with religiously-orientated clients (pp.273/274).

These research findings suggest that religion has a valuable role in maintaining or restoring mental health and wellbeing, and especially for religious clients, it would be contra-indicated to not integrate the client's faith into the therapeutic frame at a foundational level (that is to say, all therapists should have a basic understanding of religious faith and the resource that it represents for the client).

Koenig argues, however, for specific training regarding religious interventions in counselling and psychotherapy (prayer, meditation, utilising religious resources and wisdom literature), and for their use only when certain conditions apply. He helpfully summarises this as having the 'right client' at the 'right time' with the 'right therapist' (p.291)!

By the 'right client' he means that clients need to explicitly want to explore their religious beliefs in therapy. By 'right time' he means that clients suffering from trauma and moral injury as a result of adverse life events, especially when these arise out of religious settings, need to be offered sufficient time and space initially in therapy in order to work through their psychological recovery, before any religious interventions are introduced. Finally by the 'right therapist' he means a therapist who has specialist training and who does not experience internal conflicts about their own faith and / or the faith of the client that gives rise to negative transference. Interestingly, religiously-integrated therapy seems to work equally well when clients and counsellors share a religious faith as when the faiths differ – although religious interventions have to have meaning for the client's religious outlook (discussions about Jesus, for example, will carry a very different significance for Christian and Muslim clients).

We might conclude that religiously-integrated therapy fits within Wampold and Zac's contextual model of therapeutic effectiveness – so where a real relationship exists between the therapist and client, and where the client's religion has a bearing on their wellbeing and there is a clear rationale for using religiously-integrated therapy, with the client participating in the activities of that therapy, then there is likely to be a good outcome.

WHAT CAUSES HARM IN RELIGIOUSLY-INTEGRATED THERAPY?

Koenig finds very little research evidence of direct harm. He states, however, the risk that when

conducted with the wrong client at the wrong time with the wrong therapist then 'at best it will have little effect or at worse cause further trauma' (p.291).

The Churchill Framework (2021) gives us a helpful set of competencies and a set of principles to guide therapists who want to work in this way, and includes the important first step of undertaking some form of spiritual / religious assessment to help gauge whether a religiously-integrated approach will be relevant and / or beneficial for the client.

Although not research evidence, we can extrapolate some lessons from the small volume of complaints that ACC receive about their counsellors. Reassuringly, not many complaints relate directly to religiously-integrated therapy, although in nearly all cases complainants do trust in the Christian identity of their counsellor and can therefore experience some dissonance when they feel a therapist has acted in an 'unchristian' way.

It seems that harm is experienced when a counsellor:

- Assumes a shared understanding of what being a Christian implies and / or directive interventions which results in the closing down of options and risks, inducing shame in the client, an example of which might be a gender bias as in an expectation about a woman's role in marriage.
- Is hesitant in accepting or affirming a client where aspects of the client's being or life choices conflict with the counsellor's religious values, an example might be in choices made around pregnancy.
- Is part of a wider shared community with clients (for example part of the same church fellowship) and in that context takes a position of spiritual / religious authority over current or former clients

CLOSING THOUGHTS

Counsellors and psychotherapists can be reassured that on balance the benefits of therapy are tangible and far outweigh the risks. Similarly, the fact that religion is a salient aspect of some clients' experience, when put together with evidence that religion is most commonly associated with positive mental health states, suggests that there is clear therapeutic rationale for religiously-integrative therapy. This is further supported by evidence that religious interventions relieve depression and anxiety disorders. Caveats, though include the advice that it is delivered by appropriately trained counsellors, at the right point in therapy, and that clients give informed consent for it to take place.

Of course the thirty-plus years of ACC's existence also suggests that we may be onto something good when we work with faith in counselling!

Notes

1 Wampold, E. and Imel, Z. (2015) *The Great Psychotherapy Debate*, Second Edition, What Makes Psychotherapy work, Routledge: Hove

2 Available online at https://www.ozanne.foundation/project/faith-sexuality-survey-2018/

3 Koenig, H. G. (2018) *Religion and Mental Health, Research and Clinical Applications*, Academic Press: London

4 A shorthand term used in this article for any therapy that integrates standard counselling approaches with interventions informed by religious and spiritual practices meaningful to the client and/or includes affirming and respectful exploration of the clients religious and spiritual understanding and resources in resolving mental ill health.

5 Available at https://www.acc-uk.org/publications/strategic-documents.html

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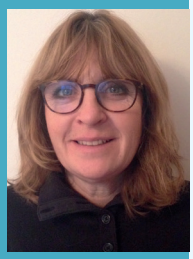
About the author



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