‘We need more faith that therapy works’

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Therapy fads undermine our profession – we need to go back to basics and understand how counselling changes lives, say **Matt Wotton** and **Graham Johnston**

It’s hard to know where to start when describing just how effective therapy is. Maybe with the multiple studies showing that changes brought about by therapy are visible via brain imaging.[1] Or maybe with the fact that the overall effect size for therapy is larger than the success rate for flu vaccines and heart surgery.[2] Perhaps the most important fact of all is that more than three-quarters of people who have therapy are emotionally better off than those who don’t.[2]

Those findings have been established by thousands of clinical trials over more than four decades – trials using exactly the same methodology as that used to test medical treatments. So we can be absolutely categorical when we say that counselling and psychotherapy have a success rate just as high as the majority of treatments for physical illnesses[3] and often have a substantially larger effect size than many medical or surgical procedures.[4]

And, of course, behind the percentages and effect sizes are real people who feel better as a consequence of having therapy. Those improvements show up in the number of hours slept per night or the number of days spent panic free. In one study, clients with anorexia weighed, on average, 40kg before therapy. After 12 months of therapy, on average they weighed more than 48kg.[5] Therapy can literally be the difference between life and death.

We also know this from our own, often life-changing experience of therapy. And now, as therapists and counsellors ourselves, we see these same kinds of changes in our clients. Evidence of this sort is anecdotal, but is also borne out by large-scale surveys. Seventy-six per cent of those who’ve had therapy or counselling would recommend it to friends and family, according to a recent BACP survey.[6] An earlier large-scale consumer survey in the US found that, of the people feeling ‘fairly poor’ at the outset, an incredible 92% reported feeling ‘very good’, ‘good’ or at least ‘so-so’ at the end of therapy.[7]

So therapy works. Indeed, that’s the reason for the radical expansion of mental health provision in the UK. Whatever you think of the limitations of the Improving Access to Psychological Therapies (IAPT) NHS initiative, Britain now leads the world in spending on psychological services. And the number of people receiving treatment each year will reach 1.9 million by 2024. Before we get too carried away, that is still only a quarter of the number of people suffering from anxiety or depression.[8] But the key point is this – services have been expanded because therapy is proved to reduce distress. Therapy works.

And it’s not just CBT that works. As the architects of IAPT say, ‘CBT may be the most widely researched form of psychological therapy... but there are many others, which have proved equally effective for some conditions’.[3] That’s why the National Institute for Health and Care Excellence (NICE), which produces evidence-based guidance for the NHS, also recommends family and couples therapy, short-term psychodynamic therapy, person-centred experiential therapy for mild to moderate depression, motivational interviewing for substance dependency, and interpersonal therapy, alongside CBT.

So how does therapy work?

The reason all these different types of therapy are effective is due, in part, to what all good therapy has in common.[9] Drawing on this finding, and summing up 40 years of research, Goldfried suggests that all effective therapy works according to five evidence-based, broad principles of change, listed below:[10]

- Promoting clients’ hope and expectation that therapy can help – most of the time, for most people, with most problems, therapy is effective at relieving distress.
- Establishing a good working relationship – a good therapeutic alliance is the foundation for change, which means agreement on the goals and methods of therapy.
- Helping clients become more aware of what causes their difficulties – standing back to see the wood for the trees, and/or zooming in to see the detail, as it really is.
- Encouraging clients to engage in ‘corrective experiences’ – helping them connect with thoughts and feelings they tend to avoid, and encouraging them to do things differently to learn something new or unexpected.
- Practising ongoing reality testing by putting all of the above together to create a virtuous circle to help clients notice when they’re on autopilot; pause and reflect; do something differently; note the results, and apply that learning.

Using a framework like this allows clients to begin to change the thoughts, feelings and habits of a lifetime. As we know, even small but consistent changes can make a remarkable difference over time. At its best, therapy helps us experience more meaning, more contentment and more fulfilment – to self-actualise, in the language of the humanistic tradition. In short, counselling changes lives.

Knowing the research

BACP’s *Ethical Framework* requires practitioners to ‘work to professional standards’ by keeping knowledge up to date and ourselves informed of relevant research (‘Our commitment to clients’, point 2b; ‘Working to professional standards’, point 14b).[11] Knowing how, why and to what extent therapy works is a requirement for one simple reason – it protects and benefits our clients. You wouldn’t give people with diabetes a medicine that hadn’t been tested and proven to be effective. By the same logic, we shouldn’t give people with depression or anxiety psychological treatments that are of no proven value.

And the problem is we have so many models of therapy – the most common estimate is ▶

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nearly 500![12] Some are short-lived fads - past-life therapy, rebirthing and primal scream therapy to name a few. Nevertheless, we still have far too many therapies that are unsubstantiated by research and therefore have no proven value. Even some incredibly well-known therapies have very limited academic support.

Let's take a look at two of the most popular - EMDR and polyvagal theory. The evidence base for each may surprise you.

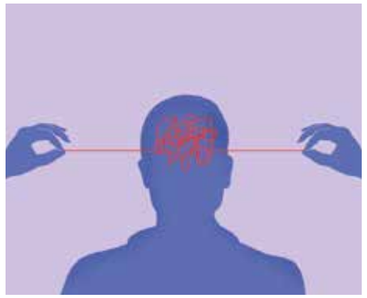
EMDR

Eye movement desensitisation and reprocessing therapy (EMDR) invites clients to focus on traumatic memories while simultaneously moving their eyes from side to side. Proponents of the treatment argue that bilateral eye movement stimulation while thinking about the traumatic memory somehow changes the way that the memory is stored in the brain, and thereby reduces or eliminates distress.

However, long-standing criticisms of EMDR have now settled into an academic consensus that eye movements are unnecessary, and that the effect obtained is solely the result of exposure, a technique borrowed from CBT. In CBT-based exposure, the client is invited to gradually confront the feared stimulus in order to learn that trauma reminders, however unpleasant, are not harmful, and that we are quite capable of tolerating the temporary distress they cause.

Head-to-head clinical trials consistently show exposure-based CBT to be more effective than EMDR. This isn't new information either. The data indicating 'no significant benefit because of eye movements' is 20 years old.[13] This same finding was also reported by Mick Cooper in 2008, in his excellent book, *Essential Research Findings in Counselling and Psychotherapy: the facts are friendly*, where he sums up the evidence for therapy more generally.[14]

There is some nuance here because research has found that EMDR works better than doing nothing and is probably better than just supportive listening.[15] The creators of IAPT conclude that this is because EMDR is actually a form of CBT by another name, albeit in



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slightly less effective form.[9] But the key point is this - NICE recommends exposure-based CBT, and only suggests providers 'consider' EMDR, if the client has a preference for it. In truth, this is a modest-to-weak endorsement. And the scientific status of EMDR is still best summarised by McNally, who wrote more than 20 years ago: 'What is effective in EMDR is not new, and what is new is not effective.'[16]

Polyvagal theory

Polyvagal theory describes the way trauma supposedly affects the autonomic nervous system - the part of the nervous system that regulates heart rate, blood pressure, respiration, digestion and sexual arousal. Polyvagal theory has been lauded by big-name therapists. Despite this, mainstream neuroscientific research suggests that some of its main premises are unlikely to be true. For example, research has found that the dorsal branch of the vagus has little effect on heart rate, and that the ventral vagal system is not a unique adaptation in mammals. There is an excellent summary of the research in a short, non-technical blog post by US psychologist Dr Shin Shin Tang.[17]

But perhaps the main criticism is this - while the vagus nerve, which extends from the brainstem to the heart, lungs and stomach, plays a role in transmitting signals between the brain and the rest of the body (a fact established long before the emergence of polyvagal theory), there is no evidence to suggest that it has any control over fear responses. Critics therefore suggest that polyvagal theory has not been able to shed additional light on what is already better explained by attachment theory, research on emotional self-regulation or existing psychological stress models.

Inevitably, this is a technical subject, and most therapists will need to defer to experts in this area. Paul Grossman, Research Director at the University Hospital Basel, says he debunked polyvagal theory more than a decade ago.[18] By 2017 his paper had been cited more than 500 times, without 'a single serious attempt to rebut his argument'.[19] He has since invited proponents of polyvagal theory to defend the idea on a prominent academic forum. Despite being viewed more than 17,000 times, there has been no serious defence of polyvagal theory. Grossman concludes that polyvagal theory is simply not seen as worthy of serious debate by those working in academic psychology.

For some, that information will be bitterly disappointing, perhaps even shocking. Others may prefer not to believe it. Dr Tang, summarising the evidence in this area, wrote that she felt like the Grinch who stole Christmas.[17] But we need to be clear that practising and promoting ideas that are untested or lack evidence can and do produce harm, not least by depriving clients of scarce time and money, and by diverting them from evidence-based treatments that do exist.

And before we get too downcast, we should remind ourselves of the sheer weight of evidence in support of therapy practised according to the well-established principles of change, outlined above. We already have a solution that works.

The slow road

So what accounts for the continued popularity of untested and novel therapies? First, not enough of us know the research. Second, publishers and training providers aggressively promote new ideas - they are lucrative, after all. And third, and perhaps most importantly, therapy is hard and slow, and we are seduced by promises to make it quicker. We look for breakthrough treatments because we care about our clients' distress and because therapy can often feel like a trudge. Freud first bemoaned how time-consuming therapy was nearly 100 years ago, and therapists have been echoing that sentiment ever since.

In truth, we are, in part, looking for a miracle cure. But we've got to curb that impulse. As behavioural scientist Professor Katy Milkman outlines in her recent bestselling book on habit change,[20] change is possible but not easy, and the barriers to change have to be overcome via tailored strategies and interventions.

So we've got to accept that therapy is often hard and sometimes slow, just as we've got to accept that it doesn't always work for everybody. If 76% of people would recommend therapy to family and friends, that means 24% wouldn't. If nearly eight in 10 people feel better after therapy, two in 10 don't. Research also suggests that significant numbers of clients drop out of therapy[21] and a small number even deteriorate.[22]

But most of the time, for most people, with most problems, therapy helps. That's by far the most likely outcome. Nearly 80% of people get better, and the numbers are even higher for those treated for specific conditions such as panic and social phobia.[23]

Seven keys of effective work

So, with that in mind, let's conclude with seven practical ways to sharpen our practice and avoid magical thinking:

1. Stick to the basics - we have decades of consistent research findings that underpin the basic principles of therapy. Goldfried's framework[11] is simple, memorable and underpinned by research. Don't be seduced by new ideas. If it sounds too good to be true, it probably is.

2. Use supervision to be honest about the clinical problems you face and get to the heart of the issue. Be honest and ensure supervision isn't too comfortable or cosy. Bring what you routinely struggle with or where you get stuck.

3. When considering CPD, don't be afraid to go back to basics. Chances are you don't need a new technique. When athletes plateau or suffer a loss of form, they deconstruct and refine existing techniques and/or they seek marginal gains. They seldom try a brand new technique or switch sports!

4. Consider CPD that goes further into your existing way of working. Going deeper may be more beneficial than qualifying in the latest 'add-on', which may well be difficult to incorporate into your practice. Chopping and changing styles, techniques or approaches is confusing - for you and your clients.

5. Match CPD to your actual clinical problems. Take a reflective approach and use supervision to identify any knowledge gaps or development needs, then choose your CPD accordingly.

6. Accommodate your clients' preferences. Rather than adding on a new technique, you may need to shift your approach to suit your client. You can't reinvent yourself, but we can all be ourselves with more skill. If you can't accommodate their preference, then refer on.

7. Change happens slowly - there is no miracle pill or magic cure. Expect the work to be hard sometimes; stay the course and work it through. Shortcuts and hacks are mostly overhyped fads; don't feel you have to follow the crowd just because others are training in or promoting them.

Therapy has never been more important in public life. Roughly a third of families in the UK include someone who is mentally ill. A third of us are expected to experience mental illness at some point in our lives. In developed countries, the World Health Organisation estimates that mental illness accounts for nearly 40% of all illness (stroke, cancer, heart disease, lung disease and diabetes together account for less than 20%).[24] Mental ill health is arguably Britain's biggest social problem.

Our work is critical. Practitioners need to be able to describe the core principles of change and keep clients safe from the harm inherent in 'miracle' cures or unevidenced therapies. We should be sceptical of anything inconsistent with mainstream scientific knowledge, and we shouldn't practise anything we don't understand or can't explain. We don't need to. Therapy is a powerful solution to human distress. It is backed by decades of research. It is enough. ■

About the authors

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