Humanistic and Integrative Therapies for Anxiety and Depression
Practice based evaluation of Transactional Analysis, Gestalt and Integrative
Psychotherapies and Person Centred Counselling

Abstract

The research was a naturalistic, non-randomised, evaluation of Transactional Analysis (TA) and Gestalt psychotherapies, Integrative Counselling Psychology and Person Centred counselling within a medium term, community based service. Routine outcome evaluation used standardised measures to assess treatment outcomes and working alliance. Adherence to the model was evaluated in clinical supervision. The outcomes showed that clients who engaged in treatment made statistically significant improvements and that Transactional Analysis and Gestalt psychotherapies, Integrative Counselling psychology and Person Centred counselling could be used effectively in treatment of anxiety and depression within a community setting. Clients had a choice about the duration of therapy and used different numbers of sessions within the framework of the service. They were also able to change a therapist. Both choices had clinical implications in terms of attrition and outcomes and require further research.

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Introduction

Depression and anxiety are some of the most common difficulties which bring people into therapy. Type, duration and the cost of therapy they receive depends largely on the setting. Within the UK, therapy takes place in a variety of settings: statutory, including educational and National Health Services (NHS), private sector and voluntary agencies.

NHS is by far the largest provider of psychological therapies. This service is funded by the health departments and highly impacted by the government policies. Therapy is provided free of charge to the patients.

Voluntary agencies are not-for profit or charitable organisation. They are frequently grant funded by the statutory agencies to provide a range of counselling and psychotherapy services. Therapists in these organisations operate from a variety of theoretical orientations. Many are students who work free of charge and gain experience required by their training. These organisations tend to respond to the needs of their local communities and fill the gaps statutory services have been unable to meet. Clients usually refer themselves through recommendations by their doctors, friends or family. Therapy is offered at low cost, or free of charge and the length of therapy varies. Even though they are largely independent, because of their reliance on grants by the statutory sector they have also been affected by the Government health policies in the last ten years.

Private sector is broadly regulated by the professional umbrella bodies. Therapists practice independently and charge for the service. Even within this sector, a number of therapists are contracted by organisations such as Employee Assistance Schemes and private health insurers, which are guided by the national health policies.

This structure of services means that government policies impact all sectors of counselling and psychotherapy, and this influence has grown substantially over the last decade.

Department of Health (DoH, 2002) recognition of prevalence of depression and anxiety in the population emphasised that treatments had to be based on research evidence. Within the UK, this is primarily Cognitive-Behavioural therapy. Research evidence in this climate has become essential in recognition of therapeutic approaches and treatments, and more difficult to develop within the non statutory sector, which has historically provided a wider range of approaches and choices for the client. The lack of research has impacted the voluntary agencies and devalued the work which takes place within them (Moore, 2006).

Transactional Analysis and other approaches, practiced more frequently in private practice and outside of the health system in the UK, have been impacted by this reliance on research evidence. In order to address this, the research clinic was developed at Metanoia Institute

The research clinic at Metanoia Institute (MCPS) has many features of a voluntary agency. It is a low cost counselling and psychotherapy service serving a multicultural, multiethnic, inner city community. The service has become a research clinic in 2010, following an evaluation project in primary care (van Rijn, Wild, & Moran, 2011). This paper focuses on the research clinic outcomes between 2010 and 2011.

Theoretical approaches taught within this academic setting are also practiced within the clinic and evaluated in this project. Transactional Analysis psychotherapy training within the Metanoia Institute leads to a Masters Degree level of academic training and EATA and ITAA recognised qualification. Therapists use the Relational model within TA (Fowlie & Sills, 2011b; Hargaden & Sills, 2001).

Integrative Psychotherapy and Counselling Psychology training departments use the same (integrative) theoretical orientation in their training, which leads to a Masters or a Doctoral Degree. The Integrative theoretical framework is based on the work of (Gilbert & Orlans, 2010) and uses psychodynamic and humanistic theories as well as research, in developing an individualised approach to integration. In this paper this approach is referred to as Integrative Counselling Psychology and integrative psychotherapy.

Gestalt Psychotherapy and Person Centred Counselling also lead to academic and national qualifications.

All the approaches are based on relational principles(Fowlie & Sills, 2011a) and share the emphasis on the centrality of the therapeutic relationship and co-creation in the therapeutic process(Summers & Tudor, 2000).

The aims of this paper are to present the outcomes of Transactional Analysis, Gestalt psychotherapies, Integrative Counselling Psychology and Person Centred counselling in the treatment of anxiety and depression in routine practice, and differences in outcomes between clients who engaged in therapy and those that did not

Literature
There is a wealth of research evidence for the efficacy and effectiveness of psychotherapy in general, although some approaches are better represented than

others. Efficacy research, based on randomised control trials focuses on the effect of treatments on specific diagnostic categories. A research body of evidence for efficacy of cognitive behavioural therapies for depression and anxiety has lead to it becoming recognised by the clinical guidelines in the UK (NICE). The policy of Increasing Access to Psychological Therapies (IAPT) within the UK, evaluated cognitive-behavioural therapy for depression and anxiety within the NHS (D.M. Clark et al., 2009), using large scale routine outcome evaluation, which shows positive outcomes for just over 50% of patients.

Generic counselling has also been evaluated in primary care in individual studies (Mellor-Clark, Connell, Barkham, & Cummins, 2001; W.B. Stiles, Barkham, Mellor-Clark, & Connell, 2008; W. B. Stiles, Barkham, Twigg, Mellor-Clark , & Cooper, 2006) and systematic reviews (Bower, Rowland, & Hardy, 2003; Hill, Brettle, Jenkins, & Hulme, 2008). All demonstrated its effectiveness in primary care. However, approaches such as TA, Gestalt and Integrative psychotherapies have had very limited evaluation even though they are practiced in a variety of settings and taught in higher education. In the recent years there has been more research into the general effectiveness of Transactional Analysis, by quantitative evaluation(van Rijn, et al., 2011) and case study research into effectiveness for depression (Widdowson, 2012) and long term health problems(McLeod, 2012).

Despite these new research developments, therapeutic practice outside of the health sector has had a very limited level of evaluation even though the existing research shows it to be as effective as the NHS with similar clinical presentations(Moore, 2006).

Research Methodology and Aims

Broadly speaking, quantitative research into psychotherapy outcomes relies on two main types of methodology, which both use standardised questionnaires to evaluate outcomes:

- 'efficacy' research, based on experimental design and used in Randomised Control Trials (RCT), and
- 'effectiveness' evaluation which focuses on evaluation in naturalistic practice

RCT designs aim to achieve a high degree of variable control. In psychotherapy research that means that therapists practice within a defined treatment manual, there are a clearly defined inclusion and exclusion criteria for the clients, usually based on

single diagnostic categories, and a randomised allocation of clients to experimental and control groups. These trials have a high level of internal validity and are used as examples of rigorous research by the health authorities. Their critics suggest that they have a limited level of generalisability to practice, and therefore a low level of external validity.

Effectiveness research is conducted in naturalistic, practice settings. Therapists practice in their usual way and the clients are accepted within the normal parameters of the service. Evaluation is conducted routinely, during practice, and referred to as 'routine outcomes evaluation'. The critics of this methodology question the fact that the way the therapists' practice is not clearly defined or monitored and that validity if often limited, because there is often a large percentage of missing questionnaires, due to unplanned endings of therapy(D. M. Clark, Fairburn, & Wessely, 2008). These questions about the methodological or internal validity of naturalistic evaluation have to extent been counterbalanced by the external validity of these studies (Stirman, DeRubeis, Crits-Christoph, & Brody, 2003), which give a true picture of how therapies perform in real clinical practice. The findings of these types of research therefore have a potential to develop clinical practice (Rao, Hendry, & Watson, 2010).

Because of its applicability to clinical practice, the researchers decided to use naturalistic evaluation, whilst taking measures to address the methodological limitations by using the design developed by (Nathan, Stuart, & Dolan, 2000) in integrating the features of effectiveness and efficacy designs. This approach was first used by the research team in the evaluation of a brief Transactional Analysis and Integrative Counselling Psychology in primary care (van Rijn, et al., 2011).

The following is the summary of the methodology:

- The project was a naturalistic, non-randomised, evaluation of routine outcomes of Transactional Analysis and Gestalt psychotherapies, Integrative Counselling Psychology and Gestalt and Person Centred counselling. Routine outcomes evaluation combined pre, mid and post therapy questionnaires with sessional evaluation, in order to increase validity. The research aimed to investigate the effectiveness of these different theoretical approaches and variables which accounted for change. The design involved monitoring and evaluation of the approaches therapists practiced, by developing and using questionnaires about the adherence to the theoretical model.

The hypotheses of the research team, based on the 'common factors' research outcomes were that:

- Transactional Analysis and Gestalt psychotherapies, Integrative Counselling psychology and Person Centred counselling would demonstrate effectiveness and lead to the statistically significant reduction in the symptoms of depression and anxiety

The Research Setting

The counselling and psychotherapy service where the research clinic was established has been operating since 1995. Metanoia Institute Counselling and Psychotherapy Service (MCPS) provides low cost, counselling and psychotherapy to the general public. Therapy can be extended to up to year, depending on the client's need and availability.

Therapists

Therapists were second year students at Metanoia Institute who were just starting to practice within their approach? They had regular clinical supervision at a ratio of one hour of supervision per four hours of clinical practice.

There were 67 practitioners during the year. Table 1 shows the theoretical approaches within the group.

Table 1 Therapists

	Practitioners	Whole Group %
Orientation		
TA	7	10.9
Gestalt	9	12.8
Person-Centred	23	34.6
Integrative Couns. Psychology	28	41.7
Total	67	

Clients

Clients self referred to the service. There were 321 clients during the year. The profile of the clients reflected the expected gender ratio and the age span within a community service. The ethnic mix reflected the local area.

72% of clients were female; 67% white British and 16.25% Asian and Black; average age was 38. The majority of clients were between the ages of 20 and 49 (82.17%); 15.29% were over 50 and 1.27% under 20.

In order to assess levels of anxiety and depression within the clinic clients were given standardised questionnaires at the assessment session (PHQ9 and GAD7). Research clinic used a clinical cut off point of 9 for PHQ9 and 7 for GAD 7, in the same way it was used within the health service, as a measure of severity of depression and anxiety. Prior to the assessment:

- 57.9% of clients were above the clinical cut off for depression (PHQ9)
- 74.9 % of clients were above the clinical cut off for anxiety (GAD 7)
- 89.5% of clients were above the clinical cut off for anxiety and depression

The clinic did not take clients who has psychotic disorders, fully developed personality disorders of active addition

Treatment

After the initial contact, clients had an assessment session with a trained clinical assessor. The assessment format has previously been developed for the service by the Head of Clinical and Research Services at Metanoia Institute(Bager-Charleson & Van Rijn, 2011) and highlighted presenting issues (such as current symptoms and functioning), developmental history and risk.

Following the assessment session, clients were referred to practitioners for the initial four exploratory sessions. Assessors usually talked to clients about their preferences for a way of working or the person of the therapist (mostly gender and ethnicity).   If clients decided to change a therapist at this stage, they would be referred to another practitioner. Practitioners could also decide if they were unable to meet the needs of a particular client. A client would then be referred on. The reason for the exploratory sessions was to offer additional safety to clients and therapists, taking into account the relative inexperience of the therapists. The exploratory period was an opportunity for the therapist to reflect on his/her levels of competency. For a client, it was an opportunity to have a trial period of therapy and decide whether the therapist and their way of working were suitable for them. When clients asked to change therapists they sometimes expressed preferences for a different way of working, or just asked for a change of day and time.

Based on the research into importance of feedback and therapist responsiveness (Horvath, Del Re, Fluckiger, & Symonds, 2011; M.J. Lambert & Shimokawa, 2011; Miller, Duncan, Brown, Sorrel, & Chalk, 2006) therapists were instructed to use the

outcome measures as a part of therapy, as well as for research. Questionnaires were treated as an important part of the therapeutic dialogue. When clients handed measures in, therapists inquired into them and used them to inform a contract for the session. They always addressed deterioration, risk, and any ruptures and misattunements, evident in the Working Alliance questionnaires.

Questionnaires

Adherence to the theoretical approaches

All sessions were audio-recorded. Clinical supervisors listened to segments of the recordings for each client once every six sessions and assessed whether the approach matched the theoretical approach. The role of the supervisor was to both assess and support the student in developing their adherence to the model. This role was formalised by the use of adherence questionnaires.

Adherence questionnaires have been designed by the tutor teams for each theoretical approach. The adherence to the model was evaluated using a five point scale ranging from 'No adherence' (1) to 'Full adherence' (5)

Clinical Questionnaires

At the assessment, sixth session and the end of therapy:
- Beck's Depression Inventory(Beck, 1996):a 21 item questionnaire measuring depression.

Questionnaires given after each session:
- Patient Health Questionnaire,PHQ-9, (K. Kroenke, Spitzer, & Williams, 2001): a nine item questionnaire which distinguished between clinical and non clinical populations
- General Anxiety Measure, GAD -7(Spitzer, Kroenke, Williams, & Lowe, 2006): a seven item questionnaire, which was initially developed for the Generalized Anxiety Disorder, and found to have sensitivity for other anxiety disorders (K. Kroenke, Spitzer, Williams, Monahan, & Lowe, 2007)

Therapeutic Alliance Questionnaire
After each session:

- Working Alliance Inventory, short form (Horvath, 1986): a 12 item questionnaire developed to measure working alliance as defined by Bordin (Bordin, 1979)

Ethical Considerations

Assessors gave written information about the research to clients, answered further questions about the research and sought consent. Clients who decided not to take part, or withdraw from research during treatment continued to receive the service.

Outcomes of questionnaires were discussed transparently between the therapists and the clients and became a part of the therapeutic dialogue. All the data was confidential and anonymised before analysis.

The Metanoia Institute Ethics Committee (an independent body approved by the Middlesex University) had given an ethical consent to the project.

Research Sample

Table 2 shows that there were altogether 346 cases during the year. The number of cases included clients who had been reallocated within the assessment period, which is why a number of cases is higher than the overall number of clients (321).

A proportion of clients were not accepted into the service. Some clients opted out of research but continued in therapy. Outcomes were divided into three groups.

Group 1 represented clients who engaged in therapy after the assessment period (assessment session and the four exploratory sessions).

Group 2 represented clients did not engage in therapy past the assessment period.

Group 3 was not analysed, because of the lack of the adherence questionnaires for the therapeutic approach

There is a full analysis of outcomes and adherence to the model for the group 1. Outcomes for group 2 were analysed as far as possible, to determine the outcomes for clients who did not engage passed the assessment period.

Table 2 Research Sample

Research Cases SPSS	Cases not accepted into the service	Cases Opted out	Group 1 5 sessions or more	Group 2 4 or less sessions	Group 3 7 or more sessions without adherence

No	346	16	45	138	110	37
%	100	4.6	13	40	32	10.7

Number of Sessions

Average number of sessions for Group 1 was 17.48 sessions. There was a difference in the length of therapy, as shown in Table 3.

The average number of sessions for Group 2 was 2.5 sessions. However, 62.8% of clients in Group 2 asked to be reallocated to another practitioner. After reallocation, their average number of sessions rose to 12.

Table 3. Group 1 Number of Sessions

		Frequency	Percent	Cumulative Percent
Valid	1-12 weeks	51	37.0	37.0
	13-24 weeks	57	41.3	78.3
	25 plus weeks	30	21.7	100.0
	Total	138	100.0	

Data completeness

Data completeness outcomes have implications for the validity of evaluation. Table 4 shows a percentage of completed questionnaires for groups 1 and 2. There was a higher percentage of data completeness for questionnaires given each session (PHQ9, GAD7 and WAI), then the questionnaires given at the beginning, middle and end of therapy. Data completeness for group 2 was lower

Table 4 Data completeness

DATA COMPLETENESS %	PHQ-9	GAD-7	BDI-II	WAI
GROUP 1	99.3	99.3	74.5	95.8
GROUP 2	57.2	59.2	12.6	49.5

Outcomes

The tables 5 and 6 below show the descriptive statistics for groups 1 and 2. The measures of central tendency were close in value suggesting that few or no outliers were affecting the sample. However, the standard deviations for all the measures were large in comparison to the mean. This demonstrated a wide spread of scores from the mean in the sample on all of the measures and across all the groups. It inferred that clients were entering therapy with a wide range of levels of distress, ending at different levels, and achieved change differently from each other. The wide spread of scores has been examined statistically using Kolmogrov-Smirnov test to establish whether the sample had a normal distribution of scores. The test showed a mixture of distributions for all the measures. This would be expected in this type of sample, where clients usually had higher scores at the beginning than at the end. These figures illustrated a negative skew in scores for all measures except the WAI which had a positive skew in scores, or floor and ceiling effects respectively. This showed that by the end of therapy the majority of the clients were reporting less distress on the measures. This was different for the working alliance showing high scores at the end of therapy.

Table 5 Descriptive Statistics Group1

	Group 1											
	BDI			PHQ-9			GAD-7			WAI		
					Pos			Pos				
	Pre	Post	Diff	S1	t	Diff	S1	t	Diff	S1	Post	Diff
Mean	24.44	11.56	12.43	11.08	5.89	4.91	10.57	5.75	4.86	63.18	70.42	8.55
Median	22.0	8.50	12.0	10.0	4.5	4.0	10.0	5.0	5.0	64.50	72.0	7.00
Mode	20	4	12[a]	8	0[a]	5	7	0	5	67[a]	84	0
Sd	10.83	10.32	10.58	5.91	5.01	6.33	4.76	4.76	5.63	12.71	13.11	12.02

a. Multiple modes exist. The smallest value is shown

Table 6 Descriptive Statistics Group 2

Group 2

	BDI			PHQ-9			GAD-7			WAI		
	Pre	Post	Diff	S1	Post	Diff	S1	Post	Diff	S1	Post	Diff
Mean	23.27	22.55	7.33	9.73	7.79	1.42	9.05	8.90	.52	55.44	63.31	3.22
Median	25.0	24.0	5.0	9.0	6.0	1.0	8.0	9.0	.00	58.0	64.5	2.00
Mode	26[a]	4	0[a]	9	4[a]	0[a]	7[a]	6	0	57	60[a]	0
Sd	10.84	14.4	7.74	5.88	5.7	4.42	5.5	5.7	5.13	17.40	14.62	11.50

a. Multiple modes exist. The smallest value is shown

Improvement rates

Criteria for improvement were calculated it by the difference between scores at the start of therapy and at the end of therapy using the percentage Improvement, No Change and Deterioration. The descriptive statistics showed that post-therapy scores were mainly low with the exception of the WAI which is high. Tables 7and 8 contain the percentage improvement scores for Groups 1 and 2.

Table 7Improvement Rates Group 1

%	BDI-II	PHQ-9	GAD-7	WAI
Improve	59.9	77.5	77.5	71.7
No Change	2.9	6.9	5.1	7.2
Deteriorate	3.6	15.9	17.4	19.6
No Data	33.6			1.4

Table 8 Improvement Rates Group 2

%	BDI-II	PHQ-9	GAD-7	WAI
Improve	4.6	34.6	28.4	14.8
No Change	0.9	9.3	10.1	4.6
Deteriorate	0.9	16.8	22.9	9.3
No Data	93.6	39.3	38.5	71.3

The percentage improvement clearly supported the descriptive statistics. Large percentages of improvement showed low scores at the end of therapy in comparison to the start of therapy. To examine this further, the data was tested to establish if these improvements rates were significant. As there was Mixture of normal and non-normal distributions in the sample a Wilcoxon Signed Ranks test has been used to examine the difference between pre and post-therapy scores. They showed that the difference between pre and post scores for all measures was significant at P<0.01 for Group 1 and the direction of the difference was represented by the negative Z score and effect size in Table 9 where scores were decreasing from pre to post therapy. All the changes show large effect sizes as they have a value greater than 0.5. Group 2 did not achieve a statistically significant change.

Tables 9 and Table 10 show the Z scores for groups 1 and 2

Table 9 Z Scores for Group 1

	Test Statistics[c]			
	PostBDI1 - PreBDI	PostScore1 - PHQ9S1	PostScore2 - GAD7S1	PostScoreTotal - WAS1Total
Z	-7.433[a]	-7.136[a]	-7.345[a]	-5.088[b]
Asymp. Sig. (2-tailed)	.000	.000	.000	.000
Effect Size	-0.83	-0.64	-0.65	-0.58

a. Based on positive ranks.
b. Based on negative ranks.
c. WilcoXon Signed Ranks Test

Table 10 Z Scores for Group 2

	PostBDI1 - PreBDI	PostScore1 - PHQ9S1	PostScore2 - GAD7S1	PostScoreTotal - WAS1Total
Z	-1.428[a]	-2.702[a]	-3.364[a]	-3.232[b]
Asymp. Sig. (2-tailed)	.153	.007	.001	.001
Effect Size	-0.45	-0.62	-0.6	-0.67

a. Based on positive ranks.
b. Based on negative ranks.
c. Wilcoxon Signed Ranks Test

Which Variables Accounted for Change?

A regression was been carried out to investigate which of the variables accounted for the greatest change in clients' scores from pre to post therapy and which variable had the greatest impact on post-therapy scores. Total Attendance, Pre score

(Severity), Adherence Score and WAI total score were entered stepwise into the regression.   A regression could only be performed on Group 1 data as Group 2 had too many missing cases. The regression showed that Severity (Pre Scores) and WAI accounted for a significant proportion of the variation in the regression model for post scores and change scores on all measures, as follows:

- BDI-II Post - $\square$ = .47, t= (142) =4.71, severity and $\square$ = -.29, t= (142) =-2.96, WAI explained a significant proportion of the variance in scores, where adjusted R^2 = .252, F (2, 75) =13.96 which is a large effect.

- BDI-II Change - $\square$ = .42, t= (142) =4.16, severity and $\square$ = .2.16, t= (142) =2.16 WAI explained a significant proportion of the variance in scores, adjusted R^2 = .227, F (4, 77) =12.63 which is a large effect.

- PHQ-9 Post - $\square$ = .29, t= (142) =3.4, severity and $\square$ = .29, t= (142) =-3.43 WAI explained a significant proportion of the variance in scores, adjusted R^2 = .149, F (2, 115) =11.24 which is a large effect.

- PHQ-9 Change - $\square$ = .682, t= (142) =10.68, severity and $\square$ = .231, t= (142) =3.62 WAI explained a significant proportion of the variance in scores, adjusted R^2 = .523, F (2, 115) =65.1 which is a large effect.

- GAD Post - $\square$ = .232, t= (142) =2.69, severity and $\square$ = -.307, t= (142) =-3.56 WAI explained a significant proportion of the variance in scores, adjusted R^2 = .125, F (2, 116) =9.47 which is a large effect.

- GAD Change - $\square$ = .6, t= (142) =8.5, severity and $\square$ = 0.25, t= (142) =3.5 WAI explained a significant proportion of the variance in scores, adjusted R^2 = .423, F (2, 116) =44.18 which is a large effect.

These results suggested that severity of depression and anxiety at the outset accounted for the greatest variation in scores. Those with the highest scores pre therapy showed the greatest difference on the outcome measures between pre and post therapy or the greatest amount of change during therapy. The regression model indicated that severity and working alliance were good predictors of clients' therapy outcomes.

Theoretical orientation

The absence of normal distribution warranted that the pre-therapy scores were checked to see if there were any differences between the theoretical orientations that would impact the analysis. A Kruskal Wallis test was carried out. It is a non-

parametric test that does not assume a normal distribution and can be used with large variations in scores. The test indicated that there were significant differences at P<0.05 between orientations in Group1, only on the Core 34 X^2 (4, N = 107) = 11.98. A chi-squared through Crosstabs analysis was run to search for a difference between theoretical orientations and association with outcomes. There was no difference found between Orientation and Improvement in any of the groups.

Adherence to the therapeutic model

Each practitioner and supervisor completed an adherence form specific to their modality. On average, adherence to the model was high as this is demonstrated below along with a demonstration of how scores were grouped into low, medium and high adherence.

Gestalt – Low 1-24, Medium 48-85 and High 86-125, average score 86.5

Integrative/ DCP – Low 1-40, Medium 41-81and High 82 – 120, average score 92.1

TA – Low 1-26, Medium 27-53 and High 54-80, average score 57.9

PCC - Low 1-18, Medium, 19-37 and High 38-55, average score 54.9

Discussion

The Limitations

The limitations of this research are contained within the naturalistic methodology. Therefore, the research suggested effectiveness in clinical practice, but not causality. There was no follow up and we had not indication whether changes were maintained over the period of time.

Clients presented with a range of issues and were not chosen specially for the research, or randomly allocated to treatment. There was no control group. This was the same for the therapists and their supervisors.

Because of this, the outcomes showed how these therapies performed in practice, but could not claim that they were the single cause of change.

Effectiveness

The outcome measures showed that clients, who engaged in therapy, achieved a very high rate of improvement of 77.5% on sessional measures for depression and anxiety. The outcomes were statistically significant, with a large effect size, which confirmed the hypothesis of the research team.

Adherence to the model was high on average, as would be expected with trainee therapists who were being trained in their model and did their best to practice it. High completion rates for GAD -7, PHQ -9, and WAI, competed by over 90% of the clients, suggested that these outcomes were reliable. Completion rates for the BDI-II were lower, and reflected unplanned endings. However the sessional evaluation showed that the clients had improved by the time they ended therapy, if the ending was not planned.

Higher severity at the outset resulted in more change. However, some of this might have been due to the sensitivity of the measures as they could not capture change from clients with moderate or low pre therapy scores.

The length of therapy varied following the assessment period, but in it did not have a significant impact on the outcomes. This suggested that the optimal number of sessions for clients was individual and that therapist's responsiveness (W. B. Stiles, Barkham, Connell, & Mellor-Clark, 2008) and contracting about the length of therapy were more important that the actual number of sessions.

The outcomes showed no differences in effectiveness between theoretical approaches. These outcomes are supported by the evidence of 'common factors research' and meta –analytic research (M.J Lambert & Bergin, 1994; M. J. Lambert & Ogles, 2004; Wampold, 2001).

 Overall, these outcomes strongly demonstrated that Transactional Analysis and Gestalt psychotherapies, Integrative Counselling Psychology and Person Centred counselling could be used as effective treatments for anxiety and depression.

Use of Questionnaires

The design of this research created a particular therapeutic process. It involved therapists and clients in a structured dialogue about therapy, which included clinical questionnaires, as well as an overt discussion about the working alliance during therapy. Clients took away the questionnaires at the end of their sessions, and completed them during the week, engaging in a period of structured reflection, which they reported back to the therapists. Therapists and clients integrated questionnaires into therapy in different ways, usually contracted for at the beginning of each session. Sometimes clients wanted to spend time talking about the particular issues, brought up by the questionnaire, and sometimes they wanted to focus on other issues. In each case, therapists looked through the questionnaires briefly at the beginning of each session, which gave them an opportunity to comment or enquire into what the client had said. Working Alliance Inventory gave an overt message to the clients that

the therapeutic relationship was a bona fide area for discussion and that their therapists were interested in knowing how they experienced their working relationship.

It is likely that this had an impact on outcomes and could be an area that has a potential to enhance effective therapeutic practice, when used respectfully and dialogically, even outside of the research enquiry. This suggestion is supported by the body of research showing that client feedback increased engagement in therapy and improved outcomes (M.J. Lambert & Shimokawa, 2011; M.J. Lambert et al., 2002; Miller, et al., 2006) . Similarly, previous research suggested that attention to the working alliance and ruptures had positive impact on therapeutic outcomes (Horvath & Bedi, 2002; Horvath, et al., 2011; Safran, Muran, & Eubanks-Carter, 2011).

Transactional Analysis has always been based on the principles of client empowerment and transparency, and this approach could be particularly well suited to it.

Changing Therapists

A high level of attrition is one of the clinical realities of low cost clinics and health settings (Ogrodniczuc, Joyce, & Piper, 2005; Reis & Brown, 1999). This is evident in this research by the group 2, or clients who did not proceed after the assessment period. In the few sessions these clients had (an average of 2.5) they did not achieve much change. However, the particular feature of this clinic is that it allowed clients to change therapists. 88% (12) of clients decided to change therapists within the assessment period, only 28% (7) clients then had 4 sessions or less, the remaining 71.2% of clients engaged in therapy past the assessment period. They had indistinguishable outcomes to other clients in the group1. This again highlighted the importance of therapist responsiveness(W. B. Stiles, et al., 2008) and the early working alliance to successful outcomes.

Qualitative research could give further, more in depth, insight into this process and assist therapists and organisations in developing services.

Implications for Practice and Research

The research highlighted several implications for practice and further research:

- Transactional Analysis and Gestalt psychotherapies, Integrative Counselling psychology and Person Centred counselling could be used effectively in

treatment of anxiety and depression within a community setting. A
Randomised Control Trial would be required to establish efficacy of these
approaches.

- Features of overt collaboration and therapist responsiveness suggest the
importance and the centrality of the therapeutic relationship, which is one of
the principles of Relational Transactional Analysis (Fowlie & Sills, 2011a).
This research illustrated that standardised quantitative questionnaires could
be used in relational therapeutic practice and have good impact on outcomes.
In depth qualitative research could investigate this impact further.

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