Humanistic and Integrative Therapies for Anxiety and Depression: Practice-Based Evaluation of Transactional Analysis, Gestalt, and Integrative Psychotherapies and Person-Centered Counseling

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Abstract

The research described in this article involved a naturalistic, nonrandomized evaluation of transactional analysis and gestalt psychotherapies, integrative counseling psychology, and person-centered counseling within a medium-term, community-based service. Routine outcome evaluation used standardized measures to assess treatment outcomes and the 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 counseling psychology, and person-centered counseling can 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 therapists. Both choices had clinical implications in terms of attrition and outcomes and require further research.

Keywords

transactional analysis psychotherapy, gestalt psychotherapy, person-centered counseling, routine outcome evaluation, integrative counseling psychology, research clinic

Depression and anxiety are some of the most common difficulties that bring people into therapy. Type, duration, and cost of therapy depend largely on the setting. In the United Kingdom (UK), therapy takes place in a variety of settings: statutory, including educational and National Health Services (NHS); private sector; and voluntary agencies. The NHS is by far the largest provider of psychological therapies. This service is funded by health departments and is highly impacted by government policies. Therapy is provided free of charge to patients.

Voluntary agencies are not-for-profit or charitable organizations. They are frequently grant funded by statutory agencies to provide a range of counseling and psychotherapy services. Therapists in these organizations operate from a variety of theoretical orientations. Many are students who work free of charge to gain experience required by their training. These organizations tend to respond to the needs of their local communities and fill the gaps statutory services are 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 from the statutory sector, they have also been affected by government health policies in the last 10 years.

The private sector is broadly regulated by professional umbrella bodies. Therapists practice independently and charge for the service. Even within this sector, a number of therapists are contracted by organizations such as employee assistance schemes and private health insurers, which are guided by national health policies. This structure of services means that government policies impact all sectors of counseling and psychotherapy, an influence that has grown substantially over the last decade.

Department of Health (2002) recognition of the prevalence of depression and anxiety in the population emphasized that treatments had to be based on research evidence. As a result, within the UK, treatment is primarily cognitive-behavioral therapy. Research evidence in this climate has become essential to the recognition of therapeutic approaches and treatments and more difficult to develop within the nonstatutory 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 that takes place within them (Moore, 2006).

Transactional analysis and other approaches that are practiced more frequently in private practice and outside of

the health system in the UK have been impacted by this reliance on research evidence. To address this, a research clinic, Metanoia Institute Counselling and Psychotherapy Service (MCPS), was developed at Metanoia Institute. It has many of the features of a voluntary agency. It is a low-cost counseling and psychotherapy service serving a multicultural, multiethnic, inner-city community. The service became a research clinic in 2010 following an evaluation project in primary care (van Rijn, Wild, & Moran, 2011). This article 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 Metanoia Institute leads to a master's degree-level of academic training and recognized qualification by the European Association for Transactional Analysis and the International Transactional Analysis Association. Therapists use the relational model within transactional analysis (Fowlie & Sills, 2011b; Hargaden & Sills, 2001).

The Integrative Psychotherapy and Counseling Psychology (DCP) Training Departments at Metanoia use the same (integrative) theoretical orientation in their training, which leads to a master's or a doctoral degree. The integrative theoretical framework is based on the work of Gilbert and Orlans (2010) and uses psychodynamic and humanistic theories as well as research to develop an individualized approach to integration. In this article, this approach is referred to as *integrative counseling psychology* and *integrative psychotherapy.*

Gestalt psychotherapy and person-centered counseling training courses also lead to academic and national qualifications. All the approaches used at Metanoia Institute are based on relational principles (Fowlie & Sills, 2011a) and share an emphasis on the centrality of the therapeutic relationship and cocreation in the therapeutic process (Summers & Tudor, 2000).

The aims of this article are to present the outcomes of transactional analysis, gestalt psychotherapies, integrative counseling psychology, and person-centered counseling in the treatment of anxiety and depression in routine practice along with differences in outcomes between clients who engaged in therapy and those who 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 randomized control trials (RCT), focuses on the effect of treatments on specific diagnostic categories. A research body of evidence for efficacy of cognitive behavioral therapies for depression and anxiety has led to it being recognized by the clinical guidelines in the United Kingdom National Institute for Clinical Excellent (NICE). The policy of Increasing Access to Psychological Therapies (IAPT) within the UK evaluated cognitive-behavioral therapy for depression and anxiety within the NHS (Clark et al., 2009) using large-scale, routine outcome evaluation, which showed positive outcomes for just over 50% of patients.

Generic counseling has also been evaluated in primary care in individual studies (Mellor-Clark, Connell, Barkham, & Cummins, 2001; Stiles, Barkham, Mellor-Clark, & Connell, 2008; 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 transactional analysis, gestalt, and integrative psychotherapies have had limited evaluation, even though they are practiced in a variety of settings and taught in higher education. In recent years, there has been more research into the general effectiveness of transactional analysis through quantitative evaluation (van Rijn et al., 2011) and case-study research into its 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 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, both of which use standardized questionnaires to evaluate outcomes: (1) efficacy research, which is based on experimental design and used in randomized control trials, and (2) effectiveness evaluation, which focuses on evaluation in naturalistic practice.

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

clients, usually based on single diagnostic categories; and there is a randomized 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 health authorities. Their critics suggest that they have a limited level of generalizability 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 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 is often limited because there is frequently a high percentage of missing questionnaires due to unplanned endings of therapy (Clark, Fairburn, & Wessely, 2008). These questions about the methodological or internal validity of naturalistic evaluation have to some extent been counterbalanced by the external validity of these studies (Stirman, DeRubeis, Crits-Christoph, & Brody, 2003), which gives a true picture of how therapies perform in real clinical practice. The findings of these types of research thus have the potential to develop clinical practice (Rao, Hendry, & Watson, 2010).

Because of its applicability to clinical practice, researchers decided to use naturalistic evaluation while taking measures to address the methodological limitations by using the design developed by Nathan, Stuart, and Dolan (2000) in integrating the features of effectiveness and efficacy designs. This approach was first used by the research team in the evaluation of brief transactional analysis and integrative counseling psychology in primary care (van Rijn et al., 2011).

The following summarizes the methodology: The project was a naturalistic, nonrandomized evaluation of routine outcomes of transactional analysis and gestalt psychotherapies, integrative counseling psychology, and person-centered counseling. Routine outcomes evaluation combined pre-, mid- and posttherapy questionnaires with sessional evaluation in order to increase validity. The research aimed to investigate the effectiveness of these different theoretical approaches and variables that accounted for change. The design involved monitoring and evaluating the approaches therapists practiced by developing and using questionnaires about adherence to the theoretical model.

The hypothesis of the research team, based on *common factors* research outcomes, was that transactional analysis and gestalt psychotherapies, integrative counseling psychology, and person-centered counseling would demonstrate effectiveness and lead to a statistically significant reduction in the symptoms of depression and anxiety.

The Research Setting. The counseling and psychotherapy service where the research clinic was established has been operating since 1995. Metanoia Institute Counselling and Psychotherapy Service provides low-cost counseling and psychotherapy to the general public. Therapy may be extended to up to a year, depending on the client's need and availability.

Therapists. The therapists in the study 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 1 hour of supervision for every 4 hours of clinical practice. There were 67 practitioners during the year. Table 1 shows the theoretical approaches within the group.

Table 1 about here
Therapists

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 age span within a community service. The ethnic mix reflected the local area. Seventy-two percent of the clients were female, 67% were white British, and 16.25% were Asian and black. The average age was 38. The majority of clients were between the ages of 20 and 49 (82.17%), with 15.29% over 50 and 1.27% under 20.

To assess levels of anxiety and depression, within the clinic clients were given two standardized questionnaires at the assessment session: the Patient Health Questionnaire 9 (PHQ-9) and the General Anxiety Measure 7 (GAD-7). The research clinic used a clinical cutoff point of 9 for the PHQ-9 and 7 for the GAD 7, just as 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 cutoff for depression (PHQ-9)
- 74.9% of clients were above the clinical cutoff for anxiety (GAD-7)

- 89.5% of clients were above the clinical cutoff for anxiety and depression

The clinic did not take clients who had psychotic disorders, fully developed personality disorders, or active addiction.

Treatment. After the initial contact, clients had an assessment session with a trained clinical assessor. The assessment format was previously 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 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 or her level of competency. For the client, it was an opportunity to have a trial period of therapy and decide whether the therapist and his or her way of working were suitable. When clients asked to change therapists, they sometimes expressed a preference 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; 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 Inventory (WAI).

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 they heard being used matched the theoretical approach. The role of the supervisor was both to assess and to support the students in developing their adherence to the model. This role was formalized by the use of adherence questionnaires. Adherence questionnaires have been designed by the tutor teams at Metanoia for each theoretical approach. 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, the sixth session, and the end of therapy, each client was given Beck’s Depression Inventory (BDI-II) (Beck, 1996), a 21-item questionnaire measuring depression.

After each session, clients were given a Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer, & Williams, 2001), a 9-item questionnaire that distinguished between clinical and nonclinical populations, and a General Anxiety Measure (GAD -7) (Spitzer, Kroenke, Williams, & Lowe, 2006), a 7-item questionnaire that was initially developed to evaluate generalized anxiety disorder and found to have sensitivity for other anxiety disorders (Kroenke, Spitzer, Williams, Monahan, & Lowe, 2007)

Therapeutic Alliance Questionnaire. After each session, clients were given the short form of the Working Alliance Inventory (WAI) (Horvath, 1986), a 12-item questionnaire developed to measure the working alliance as defined by 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 who withdrew from research during treatment, continued to receive the service. Outcomes of questionnaires were discussed transparently between therapists and clients and became a part of the therapeutic dialogue. All the data was confidential and anonymized before analysis. The Metanoia Institute Ethics Committee (an independent body approved by Middlesex University) gave 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 the 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 the 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 who did not engage in therapy past the assessment period.
- Group 3 was not analyzed because of the lack of the adherence questionnaires for the therapeutic approach used.

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

Table 2 about here
Research Sample

Number of Sessions. The 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 about here
Group 1 Number of Sessions

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 (PHQ-9, GAD-7, and WAI) than for questionnaires given at the beginning, middle, and end of therapy (BDI-II). In addition, data completeness for Group 2 was lower than for Group 1.

Table 4 about here
Data Completeness

Outcomes

Tables 5 and 6 show the descriptive statistics for Groups 1 and 2. The measures of central tendency were close in value, which suggests that few or no outliers affected the sample. However, the standard deviations for all the measures were large in comparison to the mean. This demonstrates a wide spread of scores from the mean in the sample on all of the measures and across all of the groups. It infers that clients entered therapy with a wide range of levels of distress, ended at different levels, and achieved change differently from each other. The wide spread of scores was examined statistically using a 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 in which clients usually had higher scores at the beginning than at the end.

These figures illustrate 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 shows that by the end of therapy the majority of clients reported less distress on the measures. This was different for the working alliance, which showed high scores at the end of therapy.

Table 5 about here
Descriptive Statistics for Group1

Table 6 about here
Descriptive Statistics for Group 2

Improvement Rates. Criteria for improvement were calculated by taking the difference between scores at the start of therapy and at the end using the percentage of improvement, no change, and deterioration. The descriptive statistics

show that posttherapy scores were mainly low, with the exception of the WAI, which was high. Tables 7and 8 show the percentage improvement scores for Groups 1 and 2.

Table 7 about here
Improvement Rates for Group 1

Table 8 about here
Improvement Rates for Group 2

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 a mixture of normal and non-normal distributions in the sample, a Wilcoxon Signed Ranks test was used to examine the difference between pre- and posttherapy 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, in which scores decreased from pre- to posttherapy. 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 about here
Z Scores for Group 1

Table 10 about here
Z Scores for Group 2

Which Variables Accounted for Change? A regression was carried out to investigate which of the variables accounted for the greatest change in clients' scores from pre- to posttherapy and which variable had the greatest impact on posttherapy scores. Total attendance, prescore (severity), adherence score, and WAI total score were entered stepwise into the regression. A regression could only be performed on Group 1 data because Group 2 had too many missing cases. The regression showed that severity (prescores) and WAI accounted for a significant proportion of the variation in the regression model for postscores and change scores on all measures as follows:

- BDI-II Post - $\beta = .47$, $t = (142) = 4.71$, severity and $\beta = -.29$, $t = (142) = -2.96$; WAI explained a significant proportion of the variance in scores, where adjusted R2 = .252, $F (2, 75) =13.96$, which is a large effect.
- BDI-II Change - $\beta = .42$, $t = (142) = 4.16$, severity and $\beta = .2.16$, $t = (142) = 2.16$; WAI explained a significant proportion of the variance in scores, adjusted R2 = .227, $F (4, 77) = 12.63$, which is a large effect.
- PHQ-9 Post - $\beta = .29$, $t = (142) = 3.4$, severity and $\beta = .29$, $t = (142) = -3.43$; WAI explained a significant proportion of the variance in scores, adjusted R2 = .149, $F (2, 115) = 11.24$, which is a large effect.
- PHQ-9 Change - $\beta = .682$, $t = (142) = 10.68$, severity and $\beta = .231$, $t = (142) = 3.62$; WAI explained a significant proportion of the variance in scores, adjusted R2 = .523, $F (2, 115) = 65.1$, which is a large effect.
- GAD Post - $\beta = .232$, $t = (142) = 2.69$, severity and $\beta = -.307$, $t = (142) = -3.56$; WAI explained a significant proportion of the variance in scores, adjusted R2 = .125, $F (2, 116) = 9.47$, which is a large effect.
- GAD Change - $\beta = .6$, $t = (142) = 8.5$, severity and $\beta = 0.25$, $t = (142) = 3.5$; WAI explained a significant proportion of the variance in scores, adjusted R2 = .423, $F (2, 116) = 44.18$, which is a large effect.

These results suggest that severity of depression and anxiety at the outset accounted for the greatest variation in scores. Those with the highest scores pretherapy showed the greatest difference on the outcome measures between pre- and posttherapy 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 checking the pretherapy scores to see if there were differences between the theoretical orientations that might have impacted the analysis. A Kruskal Wallis test was carried out. That is a nonparametric 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 X2 (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 models was high, which 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 41-81,and High 82-120; average score 92.1

Transactional analysis: Low 1-26, Medium 27-53, and High 54-80; average score 57.9

Person-Centered Counseling: Low 1-18, Medium, 19-37, and High 38-55; average score 54.9

Discussion

Limitations of the Study. The limitations of this research are contained within the naturalistic methodology. Therefore, the research suggests effectiveness in clinical practice but not causality. There was no follow up, and we have no indication whether changes were maintained over time. Clients presented with a range of issues and were not chosen especially 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 cannot claim that they were the single cause of change.

Effectiveness. The outcome measures showed that clients who engaged in therapy achieved a high rate of improvement (77.5%) on sessional measures for depression and anxiety. The outcomes were statistically significant, with a large effect size, which confirms 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 the GAD-7, PHQ-9, and WAI, completed 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 evaluations 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 because they could not capture change from clients with moderate or low pretherapy scores. The length of therapy varied following the assessment period but did not have a significant impact on the outcomes. This suggests that the optimal number of sessions for clients was individual and that therapists' responsiveness (Stiles, Barkham, Connell, & Mellor-Clark, 2008) and contracting about the length of therapy were more important than the actual number of sessions.

Outcomes showed no difference in effectiveness between theoretical approaches. These outcomes are supported by the evidence of common factors research and meta-analytic research (Lambert & Bergin, 1994; Lambert & Ogles, 2004; Wampold, 2001).

Overall, these outcomes strongly demonstrate that transactional analysis and gestalt psychotherapies, integrative counseling psychology, and person-centered counseling can 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 that 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 about which they then reported 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 on or inquire into what the client had said. Working Alliance Inventory questionnaires gave clients the overt message that the therapeutic relationship was a bona fide area for discussion and that their therapist was interested in knowing how they experienced the working relationship.

It is likely that this had an impact on outcomes and could be an area that has potential to enhance effective therapeutic practice when used respectfully and dialogically, even outside of the research inquiry. This suggestion is supported by research showing that client feedback increases engagement in therapy and improves outcomes (Lambert & Shimokawa, 2011; Lambert et al., 2002; Miller et al., 2006). Similarly, previous research has suggested that attention to the working alliance and ruptures to it has a 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 was evident in this research by those in 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, a particular feature of the Metanoia clinic is that it allowed clients to change therapists. Eighty-eight percent (12) of clients decided to change therapists within the assessment period; only 28% (7) of clients then had four sessions or less. The remaining 71.2% of clients engaged in therapy past the assessment period. They had indistinguishable outcomes to other clients in Group 1. This again highlighted the importance of therapist responsiveness (Stiles, Barkham, Connell 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 organizations in developing services.

Implications for Practice and Research

The research described in this article highlighted several implications for practice and further research:

- Transactional analysis and gestalt psychotherapies, integrative counseling psychology, and person-centered counseling can be used effectively in the treatment of anxiety and depression within a community setting. A randomized control trial would be required to establish the efficacy of these approaches.
- Features of overt collaboration and therapist responsiveness suggest the importance and centrality of the therapeutic relationship, which is one of the principles of relational transactional analysis (Fowlie & Sills, 2011a). This research illustrated that standardized quantitative questionnaires could be used in relational therapeutic practice and have good impact on outcomes. In-depth qualitative research could investigate this impact further.

References

Bager-Charleson, S., & van Rijn, B. (2011). *Understanding assessment in counselling and psychotherapy*. Exeter, England: Learning Matters.

Beck, A. (1996). *Beck depression inventory.* United States of America Patent No. 0154018392.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, Practice, 16*(3), 252-260.

Bower, P., Rowland, N., & Hardy, G. (2003). The clinical effectiveness of counselling in primary care: A systematic review and meta-analysis. *Psychological Medicine, 33*(2), 203-215.

Clark, D. M., Fairburn, C. G., & Wessely, S. (2008). Psychological treatment outcomes in routine NHS services: A commentary on Stiles et al. (2007). *Psychological Medicine, 38*(5), 629-634.

Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two demonstration sites. *Behaviour Research and Therapy, 47,* 910-920.

Department of Health. (2002). *A national service framework for mental health.* London, England: Author.

Fowlie, H., & Sills, C. (2011a). Introduction. In H. Fowlie & C. Sills (Eds.), *Relational transactional analysis: Principles in practice* (pp. xxv-xxxii). London, England: Karnac Books.

Fowlie, H., & Sills, C. (Eds.). (2011b). *Relational transactional analysis: Principles in practice.* London, England: Karnac Books.

Gilbert, M., & Orlans, V. (2010). *Integrative therapy: 100 key points and techniques.* London, England: Routledge.

Hargaden, H., & Sills, C. (2001). *Transactional analysis: A relational perspective.* Hove, England: Brunner-Routledge.

Hill, A., Brettle, A., Jenkins, P., & Hulme, C. (Eds.). (2008). *Counselling in primary care: A systematic review of the evidence.* Lutterwoth, England: British Association for Counselling and Psychotherapy.

Horvath, A. O. (1986, April). *Another approach to assess the counseling relationship: The working alliance.* Paper presented at the American Educational Research Association, San Francisco, CA, USA.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-69). New York, NY: Oxford University Press.

Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work. Evidence based responsiveness* (pp. 25-69). New York, NY: Oxford University Press.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General and Internal Medicine, 16,* 606-613.

Kroenke, K., Spitzer, R. L., Williams, J., Monahan, P. O., & Lowe, B. (2007). Anxiety disorders in primary care: Prevalence, impairment, comorbidity, and detection. *Annals of Internal Medicine, 146,* 317-325.

Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.) (pp. 143-189). New York, NY: Wiley.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.) (pp. 139-193). New York, NY: Wiley.

Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.) (pp. 203-223). New York, NY: Oxford University Press.

Lambert, M. J., Whipple, J. L., Vermeersch, D. A. D., Smart, W., Hawkins, E. J., Nielsen, S. L., & M. Goates. (2002). Enhancing psychotherapy outcomes via providing feedback on client progress: A replication. *Clinical Psychology & Psychotherapy, 9*(2), 91-103.

McLeod, J. (2012). Process and outcome in pluralistic transactional analysis counselling for long-term health conditions: A case series. *Counselling and Psychotherapy Research, 13*(4), 1-12.

Mellor-Clark, J., Connell, J., Barkham, M., & Cummins, P. (2001). Counselling outcomes in primary health care: A CORE system data profile. *European Journal of Psychotherapy & Counselling, 4*(1), 65-86.

Miller, S., Duncan, B. L., Brown, J., Sorrel, R., & Chalk, M. B. (2006). Using formal client feedback to improve retention and outcome: Making ongoing real-time assessment feasible. *Journal of Brief Therapy, 5*(1), 5-21.

Moore, S. (2006). Voluntary sector counselling: Has inadequate research resulted in a misunderstood and underutilised resource? *Counselling and Psychotherapy Research, 6*(4), 221-226.

Nathan, P. E., Stuart, S. P., & Dolan, S. L. (2000). Research on psychotherapy efficacy and effectiveness: Between Scylla and Charybdis? *Psychological Bulletin, 126*(6), 964-981.

Ogrodniczuc, J., Joyce, A., & Piper, W. (2005). Strategies for reducing patient-initiated premature termination of psychotherapy. *Harvard Review of Psychiatry, 13*(2), 57-70.

Rao, A. S., Hendry, G., & Watson, R. (2010). The implementation of routine outcome measures in a tier 3 psychological therapies service: The process of enhancing data quality and reflections of implementation challenges. *Counselling & Psychotherapy Research, 10*(1), 32-38.

Reis, B., & Brown, L. (1999). Reducing psychotherapy dropouts: Maximizing perspective convergence in the psychotherapy dyad. *Psychotherapy, 36*(2), 123-136.

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.) (pp. 224-238). New York, NY: Oxford University Press.

Spitzer, R. L., Kroenke, R., Williams, J. B., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166,* 1092-1097.

Stiles, W. B., Barkham, M., Connell, J., & Mellor-Clark, J. (2008). Responsive regulation of treatment duration in routine practice in United Kingdom primary care settings: Replication in a larger sample. *Journal of Consulting and Clinical Psychology, 76,* 298-305.

Stiles, W. B., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies in UK primary-care routine practice: Replication in a larger sample.

Psychological Medicine, 38(5), 677-688.
Stiles, W. B., Barkham, M., Twigg, E., Mellor-Clark , J., & Cooper, M. (2006). Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies as practised in the UK national health service settings. *Psychological Medicine, 36*(4)*,* 555-566.
Stirman, S. W., DeRubeis, R. J., Crits-Christoph, P., & Brody, P. E. (2003). Are samples in randomized controlled trials of psychotherapy representative of community outpatients?: A new methodology and initial findings. *Journal of Consulting and Clinical Psychology, 71*(6), 963-972.
Summers, G., & Tudor, K. (2000). Cocreative transactional analysis. *Transactional Analysis Journal, 30*, 24-40.
van Rijn, B., Wild, C., & Moran, P. (2011). Evaluating the outcomes of transactional analysis and integrative counselling psychology within UK primary care settings. *International Journal of Transactional Analysis Research, 2*(2), 34-43.
Wampold, B. (2001). *The great psychotherapy debate.* Mahway, NJ: Lawrence Erlbaum Associates.
Widdowson, M. (2012). TA treatment of depression: A hermeneutic single-case efficacy design study—'Denise.' *International Journal of Transactional Analysis Research, 3*(2), 3-14

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