Therapy Outcome Evaluation of Symptoms and Wellbeing In a Large Psychology Practice

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Background

Is it true that psychological therapies have traditionally eased suffering without promoting positive wellbeing?

Martin Seligman and other proponents of positive psychology have long suggested that to be the case, as reflected in the quotes below.

> "For the last half century psychology has been consumed with a single topic only – mental illness… relieving the states that make life miserable it seems, has made building the states that make life worth living less of a priority." – Martin Seligman, *Authentic Happiness*, 2002, p. xi.
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> "Psychotherapy and drugs as they now are used are half baked. On the rare occasions when they are completely successful, they rid the patient of suffering, misery and negative symptoms. In short they remove the internal disabling conditions of life [rather than] building the enabling conditions of life. The skills and exercises that build these are entirely different from the skills that minimize our suffering". – Martin Seligman, *Flourish*, 2011, p. 53.

More recently, Tayyab Rashid and Martin Seligman in the 2018 Positive Psychotherapy Clinician Manual write that clinicians have "lost sight of the importance of positives" by focusing on the negatives such as "uncovering childhood trauma, untwisting faulty thinking, or restoring dysfunctional relationships" (p.3).
This conjecture is understandable, but there is minimal research evidence to support or refute the claim that traditional therapies do little to promote positive wellbeing.

This study aims to provide rare objective and empirical evidence for the extent to which commonly practiced psychological therapies go beyond merely reducing symptoms and alleviating suffering to also enhance wellbeing.

It explores treatment effectiveness of prevailing cognitive-behavioural therapy approaches in reducing distress and enhancing wellbeing with a large clinically representative sample in the everyday treatment setting of a group private practice in Geelong, Australia. It is based on the contribution of all 35 therapists at the practice over a ten-year period.

Consistent with usual clinical psychology training, all psychologists were encouraged to initially focus on the more problematic aspects of clients' functioning, such as identifying anxiety and depressive conditions and trauma reactions early in therapy. Indeed government funding support in Australia (Medicare rebates) requires this to be the focus for clients referred through the *Better Access scheme*.

Common interventions included cognitive-behavioural and related approaches including Acceptance and Commitment Therapy, Schema Therapy, Dialectical Behaviour Therapy and EMDR. All psychologists had postgraduate training in clinical, counseling or health psychology, generally with an emphasis on cognitive-behavioural therapy.

All therapists were familiar with basic principles of positive psychology, which were broadly endorsed by the principal psychologist in individual and group supervision. All psychologists were encouraged to complete the VIA Survey of Character Strengths, and all were given a personal copy of either *Authentic Happiness* or *Flourish* when joining the practice. Positive psychology strategies, including a focus on clients' character strengths, were typically used with a small proportion of clients at a later stage of therapy after applying more traditional psychological interventions for anxiety, depressive and trauma-related conditions. All psychologists were nonetheless encouraged to work collaboratively with clients, drawing on their strengths and adopting the explicit practice mission of helping clients transform psychological problems into personal growth.

By collecting objective data on symptomatic as well as subjective wellbeing measures at pre-treatment, at session 5, and at post-treatment, the results might then serve as useful benchmarking data for relative improvement that might be anticipated at intermediate and final stages of therapy. Given that positive psychology strategies were typically only introduced at later stages of therapy, the data might reflect the extent to which clients showed progressive improvement on subjective wellbeing measures despite the main focus being on alleviating symptoms, consistent with usual psychotherapy approaches.

Method

The attempt was made to evaluate therapy outcomes for each treatment episode of all adults attending the practice from January 2009 to April 2019 using measures of symptomatic distress and positive wellbeing.
Therapy was offered by each of the 35 psychologists in the practice throughout that period, all of whom had postgraduate training in clinical, counselling or health psychology.

Measures used
- Beck Anxiety Inventory (BAI; Beck, 1990)
- Beck Depression Inventory (BDI; Beck, 1978),
- Positive and Negative Affect Scale (PANAS; Watson et al., 1988),
- Positive Affect Subscale (PA),
- Negative Affect Subscale (NA)
- Satisfaction With Life Scale (SWLS; Diener et al., 1985)

All measures were administered at pre-treatment, session 5 or 6, and at post-treatment.

If scores were not obtained at session 5, the attempt was made to collect them at session 6, which applied to approximately 15% of treatment episodes.

If data was not obtained at a final treatment session, the most recent data collected was used, provided it was at least 70% of the way into therapy (e.g. Session 10 data could be used as final treatment outcome data if the client discontinued after 14 sessions, but not after 15 sessions).

Client Sample

Client treatment episodes were included from a base of 3805 episodes after applying successive inclusion criteria.

Inclusion criteria:
Treatment episodes were for private clients referred by themselves or through the Better Access scheme, seen from 2009 until the present, with the first session occurring between 1-1-2009 and 31-12-2017. Some clients (approx. 10%) were seen for more than one episode.

Clients were excluded from the evaluation if they were concurrently seen in couple or group therapy, primarily seen about another family member, had language or cognitive problems, refused to answer questionnaires, if they were unwilling attenders, presented in a medicolegal context, were mainly seen for assessment, or whose responses seemed invalid. These criteria excluded approximately 10% of treatment episodes.

1853 of the remaining 3805 adult treatment episodes (48.7%) met further inclusion criteria of the client having at least mild anxiety or depressive symptoms (score of at least 10 on the BAI or BDI) and being seen for at least five sessions.

A full set of data was obtained for 1208 treatment episodes, including 1092 Better Access (Medicare rebate) and 116 other private clients.

Results

1208 treatment episodes were evaluated using pre-treatment, intermediate (session 5 or 6), and post-treatment scores.
This represents 65.5% of all episodes meeting inclusion criteria, providing a representative sample for private clients with clinically significant distress seen for at least five sessions (mean = 11.4 sessions, s.d = 8.6)

These data may serve as benchmarks for anticipated improvement in both symptoms and subjective wellbeing for adult psychotherapy clients with at least mild symptomatic distress.

Table 1
Mean Pre-treatment, Session 5/6 and post-treatment questionnaire scores

Questionnaire	Pre-Tx Mean (s.d.)	Sess 5/6 Mean (s.d.)	Post-Tx Mean (s.d.)
BAI	18.6 (10.5)	12.3 (9.5) *	9.5 (8.6) *
BDI	21.0 (9.1)	12.9 (9.0) *	9.7 (8.6) *
PA	21.8 (7.4)	27.3 (8.6) *	30.0 (9.1) *
NA	27.6 (7.6)	20.8 (7.6) *	18.3 (7.3) *
SWLS	17.2 (6.7)	19.7 (7.2) *	21.8 (7.3) *

* $p < 0.0001$

Intermediate- and post-treatment scores were found to differ significantly from pre-treatment scores on all questionnaires based on paired t-tests.

These data show that clients reported relatively rapid changes on all five measures, indicating improvement in not just symptomatic distress, but also on measures of subjective wellbeing.

The mean reduction in anxiety and depressive symptoms for episodes of treatment were clinically significant, representing a reduction from a mild-moderate level to a slight to mild level, around the upper bounds of the normal range.

Changes on the Positive Affect subscale showed the average client improved from the 13th percentile to the 41st percentile in comparison to PANAS norms, ending their therapy within the normal range on this measure. Changes on the Negative Affect subscale showed the average client left therapy with their negative affect reduced from the 94th to the 75th percentile, at the higher edge of the normal range. It seems noteworthy that the average client at the end of therapy reported more normal positive affect than negative affect, which remained slightly elevated.

Changes on the Satisfaction With Life Scale indicated the average client reported their satisfaction with life improved into the normal range (SWLS normal range is 20 - 25).

The above data indicate the improvement attained by an intermediate stage of therapy relative to that by the end of treatment. The following table more meaningfully identifies the relative rate of improvement on each measure in terms of treatment effect size.

Table 2
Treatment Effect Size at Session 5/6 and Post-treatment (N=1208)

Questionnaire	Effect Size Session 5/6	Effect Size Post-Tx
BAI	0.67	0.90
BDI	1.08	1.29
PA	0.54	0.73
NA	0.80	0.99
SWLS	0.29	0.48

Note. Treatment effect sizes of 0.2 are considered small, 0.5 are moderate and 0.8 are large.

Large treatment effects were found at the end of therapy for anxiety, depression and negative affect. The treatment effect on the positive wellbeing measures was moderate for satisfaction with life and approached a large effect in improving positive affect.

Session 5 and 6 data showed that large treatment effects were already apparent for depression and negative affect by that stage. Treatment effects for anxiety were moderate to large by session 5 or 6. Changes on satisfaction with life and positive affect showed a small and moderate treatment effect respectively by session 5 or 6, seeming more gradual.

Conclusions

A key finding from this study is that common psychological therapies are likely effective in not only alleviating symptomatic distress, but also in enhancing positive wellbeing. This at least applied in the present study to cognitive-behavioural and related therapies for adults presenting for therapy with anxiety and depressive symptoms and seen in an Australian private practice setting. **This research found that a large and clinically representative group of clients showed moderate improvement in satisfaction with life and a relatively large improvement in positive affect by the end of treatment. However, even larger treatment effects were evident for anxiety, depression and negative affect.**

These data suggest that proponents of positive psychology might best refrain from suggesting that traditional psychotherapy, such as cognitive-behavioural therapy, fails to enhance positive wellbeing in addition to reducing symptoms until more objective data is available to support such conjecture.

However, the current research found some support for the more moderate claim that commonly used psychological interventions might have a somewhat greater or more rapid effect in alleviating symptoms and negative states than enhancing positive wellbeing. Whereas large treatment effects were evident for depression and negative affect within five or six sessions of therapy, treatment effects were only moderate by that stage for positive affect and relatively small for satisfaction with life. It remains possible that differences in size of treatment effects found here could be influenced by psychometric properties of the questionnaires. For example, the author has previously reported on a large treatment effect size of 1.09 using similar therapy as described here with over 2000 adult clients using the Outcome Rating Scale, a measure of wellbeing (see Better Access research reference in box below). Further investigation using a wider range of measures is warranted.

It could be argued that the psychological therapy evaluated in the current study was more effective in promoting positive wellbeing than usual owing to a greater interest of the practice principal and other psychologists in positive psychology than most clinicians. However, therapists in the practice are initially encouraged to use their usual therapy methods to "focus on the dark" aspects of a client's experience. The therapists typically began with a focus on assessing and treating the client's main psychological difficulties, such as using cognitive-behavioural and related interventions for anxiety, depression and trauma reactions. However, all therapists were urged to encourage an optimistic attitude in helping clients address their difficulties, which are typically described as being potentially temporary, able to be contained and amenable to the client's active influence.

Psychologists were occasionally encouraged in individual and group supervision to apply positive psychology interventions. However, anecdotal observations suggest that specific positive psychology interventions were explicitly used with a small proportion of clients, typically at later stages of therapy.

The author personally often finds positive psychology principles and strategies to be helpful with clients, including the three blessings exercise and having a focus on what went well in the client's recent experience. In particular, exploring the client's signature character strengths often seems particularly helpful at later stages of therapy whilst addressing relapse prevention. It often seems to encourage a sense of resilience and ongoing hope for the future. Positive psychology concepts such as "post-traumatic growth" also seem helpful in promoting hope. However, many therapists outside the positive psychology field would also likely construe their clients facing their problems as contributing to their psychological growth, consistent with the traditional theme of "the hero's journey".

The findings from this study are likely more generalizable as they are based on a large and clinically representative sample of clients seen by all psychologists in the everyday clinical setting of a private psychology practice. It is hoped that this research provides useful objective benchmarking data for therapy practitioners within and outside the positive psychology field.

The findings show that it reasonable and realistic to expect that those seeking psychological therapy might seek improvement in wellbeing along with significant easing of their symptomatic distress, as long advocated by Martin Seligman and others within the positive psychology field. However, it seems that a focus on successful alleviation of symptomatic distress is also likely to lead to improved positive wellbeing, perhaps at a slower rate.

It is also hoped that this research encourages other practitioners in everyday therapy settings to conduct effectiveness studies, to add to the very limited body of objective data currently available from more clinically representative and generalizable settings. This might include positive psychology therapists conducting research using positive psychology interventions with every client in their clinical sample, and reporting their improvement on positive wellbeing as well as symptom measures.

References

Seligman, M.E. Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Fulfilment. Random House, Sydney. 2002.
Seligman, M.E. Flourish: A Visionary New Understanding of Happiness and Well-being. Free Press, New York. 2011.
Rashid, T. & Seligman, M.E. Positive Psychotherapy: Clinician Manual. Oxford University Press, New York. 2011.

Also see Better Access Updated Research (WCBCT, 2016) at **www.chrismackey.com/resources/our-research** for additional detailed outcome data, including on the Outcome Rating Scale (ORS), on over 2000 clients seen through the Better Access (Medicare Rebate) Scheme

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