Pilot randomised controlled trial of school-based humanistic counselling for psychological distress in young people: Outcomes and methodological reflections

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Abstract

Aim: The purpose of this study was to replicate and extend a pilot evaluation of the effectiveness of school-based humanistic counselling for psychological distress in young people. Method: Data were available on 32 young people who were randomised to either school-based humanistic counselling or waiting list conditions for one school term. The primary outcome measure was psychological distress using the Young Person’s CORE (YP-CORE), at six and 12 weeks post-assessment. Secondary measures at these time-points were psychological difficulties, self-esteem, levels of depression, and attainment of personal goals; with longitudinal evaluation of outcomes at six months post-assessment. Results: On the primary outcome measure, participants who received counselling were significantly less distressed at six weeks than those in the waiting list group but not at 12 weeks, with effect sizes (Cohen’s d) of 0.59 and 0.39 respectively. Reductions in psychological distress were maintained at follow-up. Discussion: Although the present findings, in isolation, are equivocal, they contribute to a body of evidence that supports the effectiveness of school-based humanistic counselling. However, the principal lesson learnt from this study was the need for rigorous training of researchers, counsellors and pastoral care teachers to ensure adherence to protocols.

Keywords: randomised controlled trial, counselling, children and young people, outcome measures

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Introduction

Mental health problems in children and young people are becoming increasingly prevalent (World Health Organization, 2006), and the risk of experiencing similar difficulties in adulthood is thought to be related to such problems (Geller, Zimmerman, Williams, Bolhofner, & Craney, 2001; Kessler et al., 2005; Weissman et al., 1999; Woodward & Ferguson, 2001). One response to this challenge has been the development of school-based counselling services.

A recent meta-analysis indicates that school-based counselling significantly reduces psychological distress in children and young people, with an effect size of 0.45 (Baskin et al., 2010). Most of the interventions included in this meta-analysis, however, were of a cognitive-behavioural or group nature, and hence less relevant to the form of counselling that is typically practised in UK secondary schools, which is predominantly of a humanistic or integrative nature (Cooper, 2009, 2013; Hill et al., 2011).

An initial pilot RCT of school-based humanistic counselling (SBHC) for psychological distress in young people, based on humanistic competences for psychological therapy interventions (Roth, Hill, & Pilling, 2009) and with 27 participants (Cooper et al., 2010), found no evidence that the intervention significantly reduced emotional symptoms. However, there
were significant limitations of this trial: the screening procedure used for recruitment was atypical of intake procedures for school-based counselling; the intervention was delivered for only six weeks; and the inclusion criteria allowed some young people into the trial whose initial levels of distress were relatively low (and hence were unlikely to change in either condition).

To address these limitations, McArthur, Cooper, and Berdonini (2013) developed a revised protocol for evaluating SBHC in which young people were recruited into the trial through the more commonplace procedure of pastoral care referral, and were offered up to 12 weeks of counselling rather than six. In addition, a higher cut-off for baseline levels of emotional symptoms was used as inclusion criteria to reduce potential ‘floor effects’ (the inability of a test to measure or discriminate below a certain point); and the primary outcome measure was revised from the Strengths and Difficulties Questionnaire’s (SDQ) Emotional Symptoms Scale to the Young Person’s CORE (YP-CORE), which has proved more sensitive to change in studies of school-based counselling (Cooper, 2009, 2013; Hill et al., 2011). McArthur et al. (2013) obtained data from 33 participants, and this time found that SBHC brought about significant reductions in psychological distress on the primary outcome measure at six weeks (ES (Cohen’s $d = 0.71$), as well as at 12 weeks post-assessment (ES = 1.14). Significant improvements for those in the counselling condition were also found on goal-attainment, self-esteem and psychological difficulties, with a mean effect size of 0.55 at six weeks and 0.73 at 12 weeks.

Despite the promising findings of the McArthur et al. (2013) study, the small number of participants in the trial means that the results must be treated with a high level of caution. Confidence intervals, for the effect sizes are very wide, and the small numbers limit confidence that the young people in the study are representative of all those who may attend school-based counselling. These confidence intervals indicate the range within which we can be 95% certain that the ‘true’ effect of the intervention could be found. Furthermore, the study did not look at longer-term effects of the counselling intervention.

The aim of the present study, therefore, was to replicate the method used by McArthur et al. (2013) to investigate the effectiveness of SBHC. This replication also afforded an opportunity to explore whether gains that were made during SBHC were sustained at a post-therapy follow-up period; and to consider the feasibility of the study design within a different service delivery context: where the counselling was provided by a third sector organisation rather than by counsellors directly employed through university research funding.

Method

Design

The study replicated McArthur et al.’s (2013) individual randomised controlled trial, comparing the outcomes of school-based counselling to a waiting list control at six and 12 weeks post-randomisation. Outcomes were also measured six months post-counselling, both for those in the experimental group and those in the control group who went on to receive counselling.

Ethics

Ethical approval for this study was granted by the University of Strathclyde research ethics committee.

Participants

Participants came from four schools in an urban area of England with a diverse population. The schools included both private and public sector, single and mixed sex, and were located in both affluent and more economically deprived areas. Eligibility criteria for young people’s participation in the study were: (1) aged at least 13 years at baseline assessment; (2) experiencing moderate or high levels of psychological distress, as assessed by a score of five or more on the Emotional Symptoms subscale of the self-reported Strengths and Difficulties Questionnaire (SDQ-ES; Goodman, Meltzer, & Bailey, 1998) at baseline assessment; (3) considered capable of giving informed consent for participation in the trial, as assessed by teachers and by the researcher at baseline assessment; (4) greater than 80% attendance at the school, as assessed by the teaching staff; (5) not at serious risk of harm to self or others, as assessed by teachers and by the researcher at baseline assessment; and (6) not planning to leave school within the current academic year, as assessed by the teaching staff.

A total of 83 young people were referred by pastoral care workers for assessment (Figure 1). Of these, 69 young people attended an assessment meeting; with 19 subsequently excluded (primarily due to insufficient levels of baseline distress), and 50 considered eligible and randomised into the trial. Immediately after randomisation, however, it became apparent
that eight participants had been wrongly accepted into the trial as their levels of baseline distress had been incorrectly calculated, and they were subsequently excluded from the study (although, due to ethical reasons, they were still offered counselling outside of the trial).

Of the 42 participants correctly recruited into the trial, 21 were randomised to the counselling condition and 21 to the waiting list condition. The demographic profile of all randomised participants is shown in Table 1. At six-week assessment, six participants had dropped out of the trial, and data were unavailable for a further two participants who remained within the trial. At 12-week assessment, a further three participants had dropped out of the trial, and data were unavailable for one participant who remained in the...
Table 1: Demographic information for all who were randomized.

<table>
<thead>
<tr>
<th></th>
<th>Waiting list (n = 21)</th>
<th>Counselling (n = 21)</th>
<th>Total (n = 42)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>14.14 (1.19)</td>
<td>14.5 (1.35)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male n (%)</td>
<td>7 (33.3%)</td>
<td>5 (23.8%)</td>
<td>12 (28.6%)</td>
</tr>
<tr>
<td>Female n (%)</td>
<td>14 (66.7%)</td>
<td>16 (76.2%)</td>
<td>30 (71.4%)</td>
</tr>
<tr>
<td>Ethnic origin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British n (%)</td>
<td>14 (66.7%)</td>
<td>15 (71.4%)</td>
<td>29 (70.7%)</td>
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<tr>
<td>Other n (%)</td>
<td>4 (19%)</td>
<td>5 (23.8%)</td>
<td>9 (21.4%)</td>
</tr>
<tr>
<td>Unknown n (%)</td>
<td>2 (9.5%)</td>
<td>1 (4.8%)</td>
<td>3 (7.1%)</td>
</tr>
</tbody>
</table>

trial. The primary reason for attrition was participants no longer attending school, and hence the inability of the researcher to follow up on these individuals. Therefore, at the six-week assessment, data were available for 34 participants, and at the 12-week assessment, for 32 participants. Of these, 21 completed assessments at the six-month follow-up (12 from the counselling group and nine from the waiting list group.

Data available across the various measures administered (detailed below) were as follows: for the primary outcome measure (YP-CORE), data were available for 34 participants at six-week assessments, and for 32 participants at 12-week assessments. Data were also available for the Strengths and Difficulties Questionnaire (SDQ) and the Rosenberg Self Esteem Questionnaire (SEQ). For the Moods and Feelings Questionnaire (MFQ), data were missing for three participants at baseline due to the reversed side of the form not being completed. For the Goal-Based Outcomes (GBO) tool, ratings were not captured at baseline for 20 participants due to administrative error. At six-month follow-up data were available for all measures for 21 participants.

Measures

The primary outcome measure was the Young Person’s CORE (YP-CORE), which is a validated self-report measure of psychological distress in young people aged 11–16 years (Twigg, Barkham, Bewick, Connell, & Cooper, 2009) and the most commonly used outcome measure in secondary school-based counselling in the UK (Cooper, 2013). Young people are asked to rate their psychological distress on ten items using a five point scale (0–4), giving a total score between 0 and 40, with higher scores indicating greater levels of distress. Examples of items on the measures are ‘I’ve felt edgy or nervous’ and ‘I’ve felt able to cope when things go wrong’ (reversed item).

The YP-CORE measure has been shown to be acceptable to young people, with a high level of inter-item reliability (a measure of reliability used to evaluate the degree to which different items on a measure that are intended to explore the same construct produce similar results) (Cronbach’s α = .85; Twigg et al., 2009).

The self-report Strengths and Difficulties Questionnaire (SDQ) is a widely used and well-validated brief behavioural screening instrument for children and young people aged 11 to 16 that can also be used to evaluate the efficacy of specific interventions (Goodman, 2001). Young people are asked to rate 25 items according to how they have been feeling over the past six months (at assessment) and over the past month (at follow-up).

The total difficulties score of the SDQ (SDQ-TD) is generated by summing all the scores on each of the four distress-related scales (emotional symptoms, conduct problems, hyperactivity and peer problems). Inter-item reliability on the SDQ-TD has previously been reported to be acceptable (Cronbach’s α = .82 and .78, Goodman et al., 1998 and McArthur et al., 2013, respectively).

The Rosenberg (1965) Self Esteem Questionnaire (SEQ) comprises ten items that are rated on a four-point scale from ‘Strongly disagree’ to ‘Strongly agree’. It was originally developed for use with young people and has since been evaluated as a reliable and valid measure of self-esteem (Blascovich & Tomaka, 1993). Inter-item reliability has previously been found to be acceptable for young people accessing school-based counselling (Cronbach’s α = .91, Cooper et al., 2010).

The Moods and Feelings Questionnaire (MFQ), is a measure of depression consisting of 33 descriptive phrases regarding how the young person has been feeling or acting over the previous two weeks. Participants respond to each phrase to reflect whether it is descriptive of how they have been feeling most of the time, sometimes, or not at all in the past two weeks. Inter-item reliability has previously been found to be acceptable with young people in school-based counselling (Cronbach’s α = .90, Cooper et al., 2010).

The Goal-Based Outcomes (GBO) tool is a personalised questionnaire developed by Law and the Child and Adolescent Mental Health Services (CAMHS) Outcome Research Consortium (CORC) for use with under-18s (Law, 2011). Young people are asked to identify up to three goals for therapy and, at each of the time points, rate how close they feel to achieving each goal. Inter-item reliability has previously been reported to be acceptable (Cronbach’s α = .77, McArthur et al., 2013).
Interventions

School-based humanistic counselling

Counsellors were asked to offer school-based humanistic counselling (SBHC), delivered in up to ten weekly sessions of approximately 45 minutes each. This therapy is based on competences for humanistic psychological therapy (Roth, Hill, & Pilling, 2009). The assumption underlying SBHC is that young people have the capacity to successfully address difficulties in their lives if they have an opportunity to talk through these problems with an empathic, supportive, and independent adult. School-based humanistic counsellors use a range of techniques to facilitate this process, including active listening, empathic reflections, inviting clients to access and express underlying emotions and needs, and helping clients to reflect on and make sense of their experiences and behaviours. Clients are also encouraged to consider the range of options that they are facing, and to make choices that are most likely to be helpful within their given circumstances.

Waiting list

Young people allocated to the waiting list condition were not offered any formal counselling intervention until the following school term, however they were informed that they could access any other psychological support available within their school whilst on the waiting list. At the endpoint assessment, those on the waiting list were offered the opportunity to receive a standard programme of weekly counselling for up to one school term.

Procedures

Contact was made with all secondary schools across an urban area of England, and 10 schools indicated an interest in participating in the trial. Following consultation with school management, pastoral care workers in six schools who did not have an existing counselling service agreed to be visited to discuss the project in further detail. Based on an assessment of the number of referrals needed and the schools' capacities to participate, four of the six schools were identified for participation in the trial and pastoral care teachers were approached and asked to identify young people within their school who they thought might benefit from counselling.

Parents or carers of pupils deemed to be potentially eligible – and who were interested in participating in the study and willing for their parents to be informed – were sent letters outlining the study with an opt-out consent form. If a parent/carer did not opt their young person out, the young person then met with the researcher in a confidential and secure environment in the school. Young people who were considered appropriate for inclusion in the study were randomised using an automated telephone system provided by an academic institution, and advised of their allocation (intervention group or waiting list) before the end of the assessment interview.

At six weeks (midpoint) and 12 weeks (endpoint) post-randomisation, the participants met with a researcher to complete the psychological measures. Endpoint researchers were blind to the young person's allocation.

Fourteen of the participants in the waiting list group went on to receive counselling. Six months after commencing counselling, participants (both those initially randomised to counselling, and those who took up counselling post-waiting list), met with a researcher to complete six-month follow-up measures.

Counsellors

Four counsellors were employed to work within the trial (three female and one male) with a mean age of 48 years. The counsellors all had experience of working with young people through a young people's service in the charity in which they work. All had a minimum of a diploma level qualification in counselling, had successfully completed additional training specific to working with young people, and were familiar with child protection and risk policies and procedures. All counsellors indicated that they had the ability to work using a humanistic/person-centred approach, although in some cases this may not have been the model in which they originally trained. Counsellors were asked to study a brief manual of humanistic competences prior to the commencement of the trial and then attended two days' training in how to deliver the intervention.

Researchers and pastoral care workers

Three qualified counsellors, with experience of working with young people, were employed to undertake the assessments within the trial. Researchers attended one full day's training in which they were familiarised with procedures for assessments, the use of and scoring of the outcome measures, and the eligibility criteria for randomisation. Pastoral care workers were provided with copies of the protocol and information sheets for the trial and met with members of the
research team to discuss the eligibility criteria for identifying participants and the processes involved in undertaking the trial.

Data analysis

Data were analysed using SPSS version 21. Due to the pilot nature of this trial, missing data was not imputed—only data from complete samples at each time point were analysed. Group means at six-week midpoint and 12-week endpoint for each outcome were analysed using analysis of covariance (ANCOVA), with baseline data as the covariate. Data at the six-month follow-up were examined descriptively. Effect sizes and 95% confidence intervals were calculated using the Effect Size Calculator from the Centre for Evaluation and Monitoring, Durham University (http://www.cemcentre.org/). Effect sizes are given as Hedges’ g (Hedges & Olkin, 1985), which multiplies Cohen’s d by a small correction factor to compensate for bias in small sample sizes. To describe the magnitude of effect sizes, we have used standardised criteria from Cohen (1988) whereby an effect size (Cohen’s d) of .2 can be considered small, .5 medium and .8 large. Hedges’ g can be converted to Cohen’s d for this purpose.

Adherence to humanistic competences

Ten-minute segments of sessions were randomly selected from audio recordings and audited by two raters (a member of the research team and an independent clinician) to assess adherence to the humanistic competences, using the Person-Centred & Experiential Psychotherapy Scale (PCEPS; Freire, Elliott, & Westwell, 2013). Two segments were taken for each counsellor: one from a session of counselling early on in the trial and one from a later session. The PCEPS scale is a validated measure of adherence to person-centred and experiential competences, and consisted, at the time of analysis, of two subscales: the Person-centred process subscale and the Experiential process subscale. The first of these subscales contained 10 items including ‘Client frame of reference/track’, ‘Core meaning’ and ‘Clarity of language’. The second subscale contained five items including ‘Collaboration’ and ‘Experiential specificity’. For each item, the rater is required to score the therapist on a scale of 1–6, with a higher score indicating greater adherence to that competency. This can be illustrated for the first item on the scale, ‘Client frame of reference/track’, where the raters are required to consider ‘How much do the therapist’s responses convey an understanding of the client’s experiences as the client themselves understands or perceives it? To what extent is the therapist following the client’s track?’ and then to rate the audio segment of counselling between 1 (‘No tracking: Therapist’s responses convey no understanding of the client’s frame of reference; or therapist adds meaning based completely on their own frame of reference’) to 6 (‘Excellent tracking: Therapist’s responses convey an accurate understanding of the client’s frame of reference and therapist adds no meaning from their own frame of reference.’)

Practice was deemed to be adherent if the average score on the PCEPS scale was over 45. Where practice did not meet the threshold for competence, this was recorded and discussed in detail with the counsellor to look at ways of facilitating increased adherence. There was a high inter-rater correlation between the two auditors (r = .93). Feedback on practice was provided to all of the counsellors.

Following auditing, one of the counsellors was rated as not being adherent to SBHC competences, scoring an average of 41.3 on the PCEPS. The other counsellors were rated as adherent, with average scores of 49.50, 51.63 and 57.25. Analyses were undertaken both with and without the four participants from the site of the non-adherent counsellor. However, as differences in the results were not substantial, data from all participants are reported.

Results

Controlled outcomes

At six-week midpoint, participants in the intervention condition improved significantly more than those in the waiting list condition on the primary outcome measure, the YP-CORE (F = 5.67, p = .02, g = .59, n = 34) (Table II). However, at 12-week endpoint this difference was no longer significant (F = 1.40, p = .25, g = .39, n = 32). The only significant difference in outcomes between the waiting list and the intervention group on the secondary outcome measures at 12 weeks was on the Goal-Based Outcomes tool (F = 6.91, p = .02, g = 1.32, n = 16). However, on all of the secondary measures changes for the intervention group were greater than for the waiting list condition (Tables II and III).

Follow-up data

Available data at six-month follow-up indicated that levels of psychological distress did not change markedly from endpoint to approximately three months
Table II: Baseline to midpoint (six weeks).

<table>
<thead>
<tr>
<th></th>
<th>Waiting list</th>
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<th></th>
<th></th>
<th></th>
<th>Counselling</th>
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<tbody>
<tr>
<td></td>
<td>n</td>
<td>Baseline</td>
<td>Midpoint</td>
<td>Change</td>
<td>ES (d)</td>
<td>n</td>
<td>Baseline</td>
<td>Midpoint</td>
<td>Change</td>
<td>ES (d)</td>
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<tr>
<td>YP-CORE</td>
<td>17</td>
<td>21.29 (19.13)</td>
<td>22.06 (8.31)</td>
<td>0.77</td>
<td>-0.08</td>
<td>17</td>
<td>21.94 (7.74)</td>
<td>17.00 (8.39)</td>
<td>-4.94</td>
<td>0.64</td>
</tr>
<tr>
<td>SDQ-TD</td>
<td>17</td>
<td>19.41 (6.54)</td>
<td>17.82 (6.13)</td>
<td>-1.59</td>
<td>0.24</td>
<td>17</td>
<td>19.76 (4.51)</td>
<td>17.65 (4.48)</td>
<td>-2.11</td>
<td>0.47</td>
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<tr>
<td>SEQ</td>
<td>17</td>
<td>13.35 (5.38)</td>
<td>14.41 (5.94)</td>
<td>1.06</td>
<td>0.20</td>
<td>17</td>
<td>12.06 (6.10)</td>
<td>13.12 (6.39)</td>
<td>1.06</td>
<td>0.17</td>
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<tr>
<td>MFQ</td>
<td>15</td>
<td>29.33 (13.35)</td>
<td>26.67 (15.36)</td>
<td>-2.66</td>
<td>0.20</td>
<td>16</td>
<td>35.06 (12.95)</td>
<td>28.69 (13.88)</td>
<td>-6.37</td>
<td>0.49</td>
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<tr>
<td>GBOM</td>
<td>9</td>
<td>2.26 (1.53)</td>
<td>3.87 (1.72)</td>
<td>1.61</td>
<td>1.05</td>
<td>7</td>
<td>3.00 (1.23)</td>
<td>4.33 (1.70)</td>
<td>1.33</td>
<td>1.08</td>
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</table>

Note: YP-CORE, Young Person’s CORE; SDQ-TD, self-report SDQ Total Difficulties; SEQ, Self-Esteem Questionnaire; MFQ, Mood and Feelings Questionnaire; GBOM, Goal-Based Outcome Measure. Higher scores on YP-CORE, SDQ and MFQ = greater distress; higher scores on SEQ and GBOM = less distress. Raw change = change from baseline to midpoint. ES (d) = Cohen’s d effect size for baseline to midpoint change for waiting list and counselling group, calculated by dividing raw change by baseline standard deviation, with positive ESs indicating positive change. F and p based on univariate analysis of variance using midpoint score as dependent variable, baseline scores as covariate, and allocation as independent variable. ES (g) = Hedge’s g bias corrected effect size at midpoint between waiting list and counselling group; positive values indicate better outcomes for counselling group.

*p < .05.

Table III: Baseline to (12 weeks) endpoint.

<table>
<thead>
<tr>
<th></th>
<th>Waiting list</th>
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<th>Counselling</th>
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<tbody>
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<td>n</td>
<td>Baseline</td>
<td>Endpoint</td>
<td>Change</td>
<td>ES (d)</td>
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<td>Baseline</td>
<td>Endpoint</td>
<td>Change</td>
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<td>YP-CORE</td>
<td>16</td>
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<td>18.13 (6.04)</td>
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<td>0.03</td>
<td>16</td>
<td>19.88 (4.46)</td>
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<td>0.77</td>
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<tr>
<td>SEQ</td>
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<td>1.75</td>
<td>0.36</td>
<td>16</td>
<td>12.56 (6.28)</td>
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<td>0.38</td>
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<td>25.88 (11.45)</td>
<td>24.07 (14.01)</td>
<td>-1.73</td>
<td>0.15</td>
<td>15</td>
<td>33.73 (13.43)</td>
<td>24.73 (15.29)</td>
<td>9.00</td>
<td>0.67</td>
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<tr>
<td>GBOM</td>
<td>9</td>
<td>2.21 (1.52)</td>
<td>3.83 (2.12)</td>
<td>1.62</td>
<td>1.07</td>
<td>7</td>
<td>3.00 (1.22)</td>
<td>6.59 (1.77)</td>
<td>3.59</td>
<td>2.94</td>
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</table>

Note: YP-CORE, Young Person’s CORE; SDQ-TD, self-report SDQ Total Difficulties; SEQ, Self-Esteem Questionnaire; MFQ, Mood and Feelings Questionnaire; GBOM, Goal-Based Outcome Measure. Higher scores on YP-CORE, SDQ and MFQ = greater distress; higher scores on SEQ and GBOM = less distress. F and p based on univariate analysis of variance using endpoint score as dependent variable, baseline scores as covariate, and allocation as independent variable. ES (g) = Hedge’s g bias corrected effect size at endpoint between waiting list and counselling group; positive values indicate better outcomes for counselling group.

*p < .05.

Table IV: Mean scores to follow-up.

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>Baseline</th>
<th>Midpoint</th>
<th>Endpoint</th>
<th>Six months post-baseline follow-up</th>
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<td>YP-CORE</td>
<td>17</td>
<td>20.5</td>
<td>15.89</td>
<td>12.79</td>
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<td>SDQ</td>
<td>17</td>
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<td>16.59</td>
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<td>MFQ</td>
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<tr>
<td>SEQ</td>
<td>15</td>
<td>13.87</td>
<td>14.57</td>
<td>16.35</td>
<td>17.44</td>
</tr>
<tr>
<td>GBOM</td>
<td>10</td>
<td>4.29</td>
<td>5.41</td>
<td>6.63</td>
<td>6.82</td>
</tr>
</tbody>
</table>

Note. Data are only presented for clients across both conditions who subsequently completed counselling to six-month follow-up. YP-CORE, Young Person’s CORE; SDQ-TD, self-report SDQ Total Difficulties; SEQ, Self-Esteem Questionnaire; MFQ, Mood and Feelings Questionnaire; GBOM, Goal-Based Outcome Measure. Higher scores on YP-CORE, SDQ and MFQ = greater distress; higher scores on SEQ and GBOM = less distress.

Discussion

Effectiveness of school-based humanistic counselling

Data from this study show that participation in school-based humanistic counselling was associated with significant reductions in psychological distress after the end of counselling (Table IV). YP-CORE scores showed a small increase in distress of 0.97 points; while SDQ-TD and MFQ scores showed small post-counselling decreases in distress of 1.18 and 1.10 points, respectively. Similarly, scores on the SEQ and the GBO showed small increases in wellbeing, with rises (indicating greater wellbeing) from endpoint to follow-up of 1.09 and 0.19 respectively.
on the YP-Core at six weeks, but not at 12 weeks, and there were no significant reductions on any of the other measures. The significant finding at six weeks may simply be due to chance, given that this was just one out of 10 outcomes (as the measure was completed at every session), and no Bonferroni correction (a statistical method used to counteract the problem of multiple comparisons) was used. Hence, in themselves, the present findings do not provide the level of support for school-based humanistic counselling that was indicated by McArthur et al. (2013).

However, given the small numbers of participants in this trial and consequent low power, non-significant findings were not an unexpected outcome. Indeed, when the results from this study are meta-analytically combined with findings from McArthur et al. (2013), as well as Cooper et al. (2010) (see Cooper, 2013), school-based humanistic counselling is found to bring about significant reductions in psychological distress at six and 12 weeks (Cohen’s $d = 0.59$ and 0.82 respectively); and significant improvements in goal attainment (Cohen’s $d = 0.67$ and 0.64 respectively).

Follow-up

While previous studies have not examined the longer-term outcomes of school-based counselling, this study found that approximately three months after the end of counselling, young people’s gains in psychological wellbeing were sustained and, in some instances, improved upon. However, further evidence is required with larger samples, and with longer follow-up periods, before the longer term benefits of school-based humanistic counselling can be established.

Limitations and lessons learnt

Several significant procedural difficulties emerged during this trial, providing some important lessons for other researchers attempting a similar study design. First, several participants were wrongly accepted into the study, and although this did not affect the integrity of the randomisation process, it was costly in terms of the resources required to address the problem. Second, one of the counsellors was found to be non-adherent to SBHC practice and, indeed, the overall levels of adherence to SBHC practice were relatively low. It is important to note that this lack of adherence is not a negative reflection on the practice of the counsellors, but rather means that they were delivering a form of intervention that was not within the remit of the trial. Third, there was a large (25%) rate of drop-out between endpoint assessment and six-month follow-up, primarily as a result of participants being away from school or undertaking exams. Recruitment of participants who are not in the final years of school or undertaking exams could help to avoid similar levels of drop-out in future studies. Fourth, some ratings were missed by the assessor, particularly on the Goal-Based Outcomes (GBO) tool. Finally, there was some confusion and misunderstanding among pastoral care teachers regarding the eligibility criteria for participation in the study (such as age range), with some young people inappropriately referred for assessment. There was also evidence that pastoral care teachers misunderstood criteria for withdrawing from the study, with some assuming that if a young person withdrew from the counselling, they were then withdrawing from the study as a whole. In addition, some pastoral care teachers were disappointed that young people referred to counselling were not accepted into the study, primarily due to insufficiently high levels of emotional symptoms (though this possibility was explained at the commencement of the study).

In terms of lessons learnt, many of these difficulties could have been alleviated through fuller and more extensive training for counsellors, researchers and pastoral care teachers; and by checking and rechecking that those delivering the study were fully aware of the protocol. For example, the researchers undertaking the baseline assessments indicated that they were fairly confident, as were the core research team, that after one day’s training they were aware of the assessment protocols. However, on commencement of the trial it became apparent that some key aspects of the protocol had not been sufficiently learnt, and further training and closer assessment of the researchers’ knowledge and understanding would have been beneficial. Similarly, in recruiting counsellors it was not a specific requirement that they had a background in person-centred/humanistic counselling – only that they indicated feeling capable of practising in this way. Although the core research team assumed their individual assessment of their abilities and proficiency in this modality was sufficient, it proved not to be in all cases.

Finally, with respect to drop-out, it is a concern that only 66.7% of participants completed to endpoint; with 50% of those randomised providing follow-up data. The main reasons for this were that the young people were no longer attending the school, despite this being one of the exclusion criteria. Future trials ought to take into consideration the
time of year when assessments are to take place to ensure as high a retention rate of participants as possible. For future trials in this context, more extended training of pastoral care teachers may also be important to ensure that they are aware of the inclusion criteria for participating in the study and of the difference between having school counselling provided as part of a trial and a standard school-based counselling service.

Conclusion

This pilot RCT of school-based counselling has provided preliminary indications of effectiveness and, when combined with previous data, contributes to the evidence-base for school-based humanistic counselling. This suggests that a series of pilot RCT studies can make a meaningful contribution to the literature in the absence of large-scale funding. However, there were lessons learnt from this study for future trials, primarily concerning the need for extended training, and not to make assumptions about researchers’ and counsellors’ levels of understanding and competence. Despite this, the authors encourage others to consider RCTs of this nature in other areas of counselling and psychotherapy as a feasible, valuable, and cost-effective approach to building the evidence base for counselling and psychotherapy in the absence of large funding grants.

References


Biographies

**Joanne Pybis** is Research Facilitator at BACP. She project managed the research aspect of this trial and also manages BACP’s counselling children and young people practice research network (CYP PRN).

**Mick Cooper** is a Professor of Counselling Psychology at the University of Roehampton, London; and a practising counselling psychologist and existential psychotherapist. Mick has also led a range of research studies exploring the process and outcomes of humanistic counselling with young people, and is author of *Essential Research Findings in Counselling and Psychotherapy* (Sage, 2008).

**Andy Hill** is an accredited counsellor, an experienced counsellor trainer and is Head of Research at BACP.

**Karen Cromarty** works for the British Association for Counselling and Psychotherapy and is their Senior Lead Advisor. In her role Karen works strategically with opinion formers, academics, governments, and service managers in all sectors, across the UK, to try to ensure that counselling services for children and young people are accessible, effective and based upon the most recent research.

**Ruth Levesley** is the Chief Executive of Relate Birmingham and set up their young people’s counselling service both in the centre and in schools.

**Jamie Murdoch** is the national lead for Children and Young People Services at Relate and has worked with Relate for the last seven years. Jamie has managed and developed services for young people for the last 12 years and is passionate about providing services that help young people to overcome the difficulties that they may face in order to achieve their potential.

**Nick Turner** is Interim Head of Clinical Services at Relate. Under his leadership the Relate Institute has developed a curriculum for relationship and family counsellors and sex therapists in partnership with Doncaster College and Hull University.