

**Is Staff Counselling an Effective Intervention
into Employee Distress:**

**An Investigation of Two Employee Counselling
Services in the National Health Service**

VOL I

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**Thesis submitted to the University of Sheffield in part fulfilment of the
requirements of the degree of Doctor of Philosophy**

**MRC/ESRC Social and Applied Psychology Unit
University of Sheffield
September 1996**

Summary

Despite the abundance of studies of the efficacy of therapy in the literature and the growing investment into employee assistance and counselling, very few studies have investigated the effectiveness of work site counselling.

A number of broad questions were addressed (a) Is counselling effective?, (b) Are post-counselling gains maintained at follow-up? (c) Does the shape of change across counselling sessions adhere to the 'dose-effect' model?, (d) Do measures of distress and interpersonal problems differ in the extent of pre-post change? and (e) Are there any within-group differences in the extent of pre-post change on measures?, (f)

A further aim of the study was to collect qualitative accounts of the intervention from clients, to build up a 'picture' of clients experiences of service use: To obtain a consumers point of view.

The study took place at two sites, one in London, the second in the Midlands. A pre-post-follow-up design was adopted. In addition, measures were completed for each session of counselling. Finally, clients also completed an evaluation questionnaire.

Hypotheses were, generally, supported by analyses. There were substantial pre-post reductions on measures of distress and interpersonal problems, which were maintained at follow-up. Significant reductions on measures across sessions of counselling were observed, with change curves adhering to the 'dose-effect' model.

Qualitative analyses built-up a picture of the rationale for service use and the costs and benefits that clients perceived from counselling.

Discussion focused on a number of issues: The first, the difference between the reported study and the bulk of psychotherapeutic studies, secondly, the methodological and practical issues that arose during the study and, thirdly, the need to approach applied counselling research from a new perspective, that is less dependent on the techniques developed by efficacy studies.

Publications and reports arising

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Acknowledgements

When I started this Ph.D I can honestly say that I did not have any idea about what it would involve and the 'developmental' opportunity that it would provide. It has certainly been a very challenging few years.

I would like to thank a number of people who have supported me over the many 'ups and downs' of the last five years:

- There have been many people at SAPU. First of all my thanks to David Shapiro and Toby Wall for supervising me. I would also like to thank Paul Jackson for his statistical advice and support as Ph.D tutor, Jan Jackson for her support over the years for my many and varied computing needs and to Angie Carter, Rebecca Lawthom, Fiona Hill and Des Leach and for the other Ph.D students that have been in and around SAPU and the Psychology Department over the years, for their support at various times over the last few years.
- I would also like to thank the counsellors at both sites and, indeed, those clients at both services who completed measures.
- Outside of SAPU, I would like to thank Caroline Jackson, Racheal Proctor, Stella McHugh for their support. And last, but certainly not least, I would like to thank Caroline Robertson for her support over the last difficult phase of this Ph.D, the writing-up.

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Chapter One

An Overview of this Thesis

1.1 Introduction

The aim of this first chapter is to present an overview of the thesis and the 'story' of why this research happened and why it took the shape that it did.

This introductory chapter is structured around a number of questions: (a) Why the need for intervention?, (b) What is employee counselling?; (c) Why the need to research employee counselling?; (d) Why was the research undertaken in the National Health Service?; (e) What methodologies were employed and why and how does it differ from the studies in the literature? and (f) What are the questions that are going to be addressed in this thesis? A brief overview of the chapters, giving a broad description of the subject matter of each, is presented

1.2 Why the Need for Intervention?

In general, the requirement for some form of intervention into employee distress is based on a large, and ever-growing, body of literature that indicates that there exists, at any one time, a sizeable minority of general and occupational populations that are experiencing some level of distress (Depue and Monroe, 1986). Although this, in itself, is not conclusive for the provision of workplace intervention, the case for such resourcing becomes stronger once the evidence linking psychological distress with individual, and organisational performance, is added to the 'picture' (Brodsky, 1984; Henne and Locke, 1985; Sutherland and Cooper, 1990). In addition, with employees increasingly turning to litigation (Berridge and Cooper, 1993), there is an added stimulus for organisations to intervene to prevent the need to go to court. In its crudest form, the case for organisations resourcing any intervention is dependent, first of all, on the impact of employee distress on "the bottom line" (Cooper, 1991) and the extent to which intervention can minimise this impact. The argument for intervention does not, however, explain why so many organisations are selecting employee counselling as the core intervention.

Chapter Two details the various strands, of the case for intervention, in greater detail.

1.3. What is Employee Counselling?

Employee counselling is, effectively, the application of counselling technique and theory in the work-site. Counselling and therapy, generally, have attracted increasing levels of interest recently as society and, more specifically in this context, organisations have become increasingly aware of its potential. To some extent, this increased interest represents a cultural shift in attitudes, within organisations, to increasingly utilising counselling skills by, for example, managers when dealing with inter-personal situations, such as appraisal interviews (Wolfe, 1996). Orlans (1989) has noted the fact that management development programmes increasingly reflect the perceived importance of active listening and other basic counselling skills, by providing training in these skills within programmes. These changes, in addition to some (but far from complete) reductions in the stigma attached to psychological distress and help-seeking, means that the conditions may be considered ripe for the development of workplace counselling (Wolfe, 1996). Apart from this positive shift in attitudes, counselling and therapy, generally, has benefited from an increasing disillusionment with the medical model of responding to distress (Wolfe, 1996).

Historically, the origins of employee counselling have been diverse and have been affected by a number of influences. The current model of employee counselling can trace its roots back to the industrial social work movement (McLean, 1973; Smith, 1988; Swanson and Murphy, 1988) that can be dated back to the end of the 19th Century and the start of the 20th Century. Momentum for such a movement was curtailed for a while by the ascendancy of the scientific management movement which de-emphasised welfare concerns (Berridge and Cooper, 1993) before concerns about dealing with the emotional costs of World War Two and the impact of alcoholism on the US economy (McLean, 1973) triggered a re-evaluation of the need to address the issue of distressed employees. To some extent, much of the development of employee counselling, within a context of growing adoption of Employee Assistance Programmes (EAPs), has been located in the USA. It was in the USA, from the 1950s to the 1970s, that the nature of work-site interventions developed from single issue programmes, focusing on substance abuse, to 'broad-brush' 'interventions' (Berridge and Cooper, 1993; Murphy, 1988) that were given the remit to address a wide range of problems that clients were presenting with.

A more detailed history of the EAP movement and the various models that have been developed is presented in Chapter Three.

1.4. Why the need to research employee counselling?

In recent years there has been a dramatic increase in the number of EAPs and Employee Counselling Programmes, employed in a wide range of organisations to address a broad spectrum of the problems that distressed employees present with. Even though there is comparatively little evidence, in the literature, that these types of intervention are effective (Berridge and Cooper, 1993; Cooper, 1991; MacLeod, 1985; Murphy, 1988; Swanson and Murphy, 1991), considerable resources continue to be invested in these types of programme. The majority of the evaluations that have taken place have been economic in their focus: they have examined the impact of such programmes on levels of absenteeism, turnover and performance (Murphy, 1988). Although, these evaluations have generally been positive, there have been problems with their design and the methodologies that they have employed (Murphy, 1988). There have been very few studies that have examined the impacts of the specific interventions (for example counselling as opposed to the EAP, which is the overall vehicle) on individual clients: one exception this has been the Post Office study (Cooper and Sadri, 1991). There exists a considerable body that clearly illustrates that counselling is an effective intervention (Shapiro and Shapiro, 1982; Smith and Glass, 1977 and Smith, Glass and Miller, 1980). However, the vast majority of psychotherapy and counselling research has been undertaken in controlled, 'pure' settings, such as Universities, whilst comparatively little research has been completed that has examined such interventions in a more applied 'field' setting (for example in the workplace).

The lack of work-site counselling evaluations is surprising when one considers the amount of resource that is continuing to be invested into these programmes. At the moment, there exists the risk that, because of the lack of evidence that exists of the effectiveness of counselling at work, that those resourcing these interventions will decide that there is no evidence that they work and they will 'pull the plug' on the funding of these programmes.

In addition, there is a need to ensure that work-site counselling programmes are not harmful. This is salient in the context of the results of a survey by Highley and Cooper (1995) that suggested that a sizeable number of staff counselling providers are staffed by individuals who do not have any formal counselling qualifications.

The rationale of this research was to help to address this deficit, the lack of literature supporting the effectiveness of work-site counselling, to examine this type of intervention in greater detail.

The research, itself, was undertaken in the National Health Service and the next section explains why the study was based in the NHS.

1.5. Why was the research undertaken in the National Health Service?

At the start of the research process, in 1991, there was little information available about how one could identify which organisations had staff counselling services. There are accounts, in the literature (Murphy, 1988), of EAP researchers having to access a large number of organisations, that they already have a working relationship with, without gaining access. The problem of research into the effectiveness of employee counselling is that the researcher is faced with two sets of difficulties: both those associated with organisational research and those associated with counselling research. The current study serves as a concrete illustration of some of these difficulties.

The decision to base the reported study in a health care setting: the National Health Service stemmed not from any a priori objective but instead from the fact that the opportunity presented itself. The opportunity to access both sites for the study did not represent the first attempt, made by the author, to gain access into an organisation. The first attempt, triggered, literally, by a chance meeting at a railway station, was, for a variety of reasons (both practical and ethical) unsuccessful.

The current study took place in the National Health Service because of the need to acquire wherever the opportunity arose. The first attempt to gain access, which was not in the NHS, was triggered by a chance meeting with a member of an organisation that provided EAP programmes. This first attempt at access was not successful.

The successful attempt to gain access was based on the author following up a job advert in *The Guardian*, that was advertising a post as a work-site counsellor at the first of the two study sites. The personnel department, here, passed the letter onto the service director and the process that became this piece of research was triggered. Setting the second site, again located in the NHS, was less opportunistic and was largely the result of contacts between the second site and the Social and Applied Psychology Unit (SAPU) and there was an underlying aim of hoping that the second site would be in the NHS to help maintain some level of consistency.

Therefore, there was no rationale underpinning the fact of the NHS being the organisational setting for this research. The choice of location was purely opportunistic.

Indeed, considering the difficulties, noted by Murphy (1988), in attempting to gain access, success at the second attempt appears to be relatively lucky.

1.6. What methodologies were employed and why and how does it differ from the studies in the literature?

There were various options, in terms of the available methodologies to develop a protocol upon which to base data collection and analysis. The ideal in the psychotherapy/counselling literature, aimed at maximising internal validity (although at some cost to external validity), is the random assignment of participants to an experimental group (that receives the intervention) and to one or more control groups. In addition, other methodologies are also employed to maximise experimental control over extraneous variables.

This 'traditional' approach, that has attempted to establish efficacy, and which informed the methodology as reported here, was difficult to employ in the applied context that characterised the research process. There were a range of practical, organisational and ethical barriers that meant that many of the 'gold standards' of the efficacy approach could not be adopted, since the protocol that was employed could only exert a minimal degree of control. The implication that stems from these difficulties is that there exists a need to develop methodologies that can be successfully employed in an applied context.

In terms of the reported study, the methodologies and analyses employed here were also rooted in a pragmatism and opportunism. To be able to address the research questions listed below, the following design features were employed:

- The use of pre, post and follow-up measures
- The use of session measures completed before and after each session of counselling
- The collection of qualitative information through questionnaires and a number of interviews with ex-clients of the service

An attempt to access and analyse absenteeism records and to relate these to outcome, was attempted but for reasons discussed in Chapter Six, were discontinued.

A far more detailed account of the selection of the methodologies employed in this study can be found in Chapter Five. A detailed description of the design, the methodology and the measures employed in this study can be found in Chapter Six.

1.7. What are the questions that are going to be addressed in this thesis?

The research questions, addressed by this thesis, are presented under chapter headings:

Chapter Seven

- 1 Will there be significant pre-post reductions on measures of outcome?
- 2 Will pre-post effect sizes be comparable to those obtained from psychotherapy studies?
- 3 Will there be greater pre-post changes in distress than in interpersonal problems?
- 4 Will there be significant pre-post increases in the reported use of coping strategies?
- 5 Will clients rate counselling more positively at post-intervention, than at pre-counselling?
- 6 Will post-counselling gains will be maintained at follow-up?
- 8 Will there be a relationship between age and outcome?

Chapter Eight

- 9 Will there be differences in pre-post change, between men and women, on outcome measures?
- 10 Will there be differences in pre-post change, between shift and non-shift workers, on measures of outcome?
- 11 Will there be differences between sites in pre-post change?
- 12 Will there be a relationship between prior help-seeking and counselling outcome?

13 Will there be a relationship between occupation and pre-post change?

14 Will there be a relationship between relationship status and outcome?

Chapter Nine

15 Will there be relationships between outcome and session impact?

16 Will there be reductions in distress across sessions of counselling?

17 Will there be significant increases in global ratings of counselling?

18 Will there be a negative relationship between distress and session impact?

Chapter Ten

The evaluative chapter, Chapter Nine, was largely exploratory in nature and, as a result, there were no research questions as such.

Chapter Two:

The Case for Work Site Interventions

2.1. Introduction

The following headlines, taken from a range of lay and professional journals, illustrate concern about the impact of stress on individual and organisational well-being and performance, and the need for intervention are increasingly salient:

“Stress costs industry millions each year” (The Independent, 14/11/91);

“What’s new in stress” (Personnel Management, June 1994);

“Helping staff over their problems” (Personnel Management Plus, February 1993)

“A headache that just won’t go away” (The Guardian, 31/10/92)

This chapter presents the rationale for intervention, a discussion that draws on studies of community and occupational mental health, organisational impact (e.g. absenteeism, turnover, impaired performance) and the legal consequences. Chapter sections are organised around these presented arguments.

2.2. Studies of Community and Occupational Mental Health

A review of community and occupational mental health studies is presented. The final part of this section looks at the literature relating to specific health service occupations.

2.2.1. Community Studies

This section reviews studies that have examined the prevalence of psychological problems in community samples. Table 2.1. presents a summary of the prevalence of a range of disorders, as presented in the Diagnostic and Statistical Manual of Mental Disorders (4th Ed, 1994), published by the American Psychiatric Association. This list suggests that there exists a substantial minority, within the general population, who currently experience some form of psychological disorder. In the UK, figures of one or two percent translate into hundreds of thousands of individuals.

Table 2.1. Life-time and Twelve Month Prevalence of Disorders in the General Population. Taken from the Fourth Edition of the DSM		
Disorder	Prevalence	
	Life-time	1 year
Alcoholism	13-14%	¹ 6-7.5%
Amphetamines	2-7%	1.3%
Cannabis	>33%	10%
Cocaine	12%	3%
Hallucinogens	8% Users (0.3% Abusers)	
Smoking	20%	
Opiates	6% Users (0.7% Abusers)	2.5%
Benzodiazepines	15% a year. 4% Non-medical	1%
Major Depressive Disorder	Women (10-25%), Men (5-12%)	
Dysthonia	Point prevalence 6%	
Bipolar I	0.4-1.6%	
Bipolar II	0.5%	
Mood disorder & GMC ^a	25-40% Neuro 8-60% GMC ^a	
Panic Disorder	1.5-3.5%	1-2%
Phobia	10-11.3% Specific & 3-13% Social	
Obsessive-Compulsive	2.5%	1.5-2.1%
PTSD	1-14%	
General Affective Disorder	5%	3%
Pain disorder	10-15% Adults with back pain	
Anorexia Nervosa	(Women) 0.5-1%	
Bulimia	Women 1-3% Men 0.1-0.3%	
Paranoid	0.5-2.5%	
Schizotypal	3%	
Antisocial	Men 3%, Women 1%	

Wing, Bebbington, Hurry and Tennant's (1981) study of 800 adults, aged from 18 to 64, found that 10.9% of the general community sample were at, or above, threshold on the Present State Examination (PSE), which suggests that approximately ten percent of the general non-hospitalised, or out-patient population, experiences either a distinct or borderline disorder.

In a separate study, twenty-four percent of Zaleznik, Kets de Vries, and Howard's (1977) occupational sample, of 3131 middle and higher level employees, reported insomnia, twenty-one percent restlessness and agitation, 19 percent fatigue, sixteen percent that work was adversely affecting their health and eleven percent were worried about having a nervous breakdown. Finlay-Jones and Burvill (1977) took a one percent sample of the physically healthy general population, aged from 15 to 69, from a UK city, reported that 13.6 percent of men and 18.9 percent of women had General Health Questionnaire (GHQ) scores indicating a need for intervention.

Dohrenwend, Dohrenwend, Gould, Link, Neugebauer and Wunsch-Hitzig's (1980) review of North American and European epidemiological studies, reported since 1945, led to prevalence estimates ranging from sixteen to twenty-five percent for functional disorders with an additional thirteen percent experiencing severe psychological/somatic illnesses that were not accompanied by recognisable psychiatric disorders.

Kessler, McGonagle, Zhao, Nelson, Hughes, Eshelmen, Wittchen and Kedler (1994) study looked at the twelve month and lifetime prevalence of fourteen DSM-III-R disorders in a stratified sample (n = 8098) drawn from the general population of 48 US states. Fifty-two percent of the sample had not experienced any DSM-III-R disorder during their lifetime. However, the study established that disorder prevalence, in the community, was greater than previously thought. Lifetime prevalence (with twelve month figures in brackets) were 17% (10%) for major depressive episodes, 14% (7%) for alcohol abuse, 13% (8%) for social phobias and 11% (9%) for simple phobias. A 'hard-core' minority, who had experienced repeated episodes of psychological disorder over their lifetime was identified: 79% of disorders had been experienced by those experiencing at least two episodes. A 'hard core' of 14% had experienced 59% of the twelve month and 89% of the lifetime disorders.

A second US study, the NIMH Epidemiologic Catchment Area Program (Regier, Narrow, Rae, Manderscheid, Locke and Goodwin, 1993) interviewed 20,291 adults, aged over 18 years, with the aim of estimating the prospective one-year prevalence and service rates of mental and addictive disorders in the US population. An annual prevalence rate of 28.1% was identified for these disorders. Nearly seven percent (6.6) of the sample, with no previous history of disorder, developed one or more new disorders over the one year period. Just under six percent of the sample reported that they had used some part of the US mental health and addictive service system. Together, these figures mean that only 28.5% of those who reported a disorder went onto access any form of intervention.

The Kessler et al (1994) figure of fourteen percent corresponds with findings from other studies and reviews (Depue and Monroe, 1986; Hinkle, 1974; Najman, 1980; Thurlow, 1967) which suggests the existence of a group of vulnerable individuals who would appear to experience the majority of DSM-III-R disorders. Depue and Monroe (1986) suggested that twenty-five percent of the population experiences fifty percent of all mental illness events. These authors also suggest that there is evidence for an additional group of sub-clinical individuals who experience repeated bouts of mild, or moderate, levels of untreated episodes that are interspersed with periods of relative psychological

normality, a group of individuals who display chronically high levels of baseline symptoms.

An inverse relationship exists between disorder severity (reported symptoms) and the number of individuals at each increasing level of severity (Depue and Monroe, 1986; Goldberg and Huxley, 1980): A 'J-shaped' distribution of disorder severity, which is associated epidemiological studies of general and specific populations, and with studies of service users (Goldberg and Huxley, 1980). The mental health service pyramid, from the GP consultation at the bottom, to in-patient psychiatric care at the top (Goldberg and Huxley, 1980), finds greater numbers of symptoms and full cases at each, higher, level of the pyramid than the previous level.

A figure of 25% may well under-estimate the true extent of the problem. It has been argued (Shedler, Mayman and Manis, 1993) that the "objective" mental health scales are unable to identify those individuals whose defences lead to a denial of distress, who put up an illusion of positive mental health. They suggested that:

"...(a) many people who look healthy on standard mental health scales are not psychologically healthy and (b) [that] illusory mental health (based on defensive denial of distress) has physiological costs and may be a risk factor for medical illness."

Shedler et al concluded that reported studies may well be overly conservative in their estimates of the prevalence of disorder. Further research will be necessary to establish the extent to which illusory [good] mental health is a factor. The majority of the sub-clinical cases, experiencing fewer and less severe symptoms, will be participating economically in the workforce.

2.2.2. Occupational Studies

McIver (1969) noted that it was not difficult for industrial psychiatrists to accept that at any one time 25 percent of the working population has emotional problems of one type or another.

Work related problems represent a sizeable 'chunk' of the issues presented at intervention (Firth-Cozens and Hardy, 1992). There currently exists a an increasingly prolific, literature that has focused on employee well-being (Kahn and Byosiere, 1992) and the factors influencing well-being. This literature has concentrated on developing increasingly complex models, incorporating elements such as job factors, life-events,

primary, secondary appraisal social support, coping and personality (Dohrenwend, Pearlin, Clayton, Hanburg, Riley and Rose, 1982; Edwards, 1988; Elliot and Eisdorfer, 1982; Frankenhauser, 1989; French and Kahn, 1962; Ivancevich and Matteson, 1980; Kahn and Byosiere, 1992; Kasl, 1978; Lazarus, 1981; Lazarus, De Longis, Folkman and Gruen, 1985; Lazarus and Folkman, 1984; Levi, 1981; McGrath, 1976; Payne, 1988; Payne, Jick and Burke, 1982; Schuler, 1981). These models overlap greatly, differ only in terms of their differential emphasis on relationships and described components (Kahn and Byosiere, 1992).

Warr and Payne's (1982) study asked 3077 respondents (1964 men and 1113 women) about their experiences of strain and pleasure from the week day before the day of questionnaire completion. Fourteen percent of the men and nineteen percent of the women respondents reported experiencing unpleasant emotional strain for at least half of the previous day. Work related problems were identified by 44 percent of the men and 28 percent of the women as being the single most important factor underpinning their distress. Pleasurable feelings were rarely attributed to their jobs. Fifteen percent of the sample reported deriving pleasure from their jobs for at least half of the previous day (Warr and Payne, 1983).

2.3.1. Studies of Health Service Employees

As already stated this project is based in the National Health Service. The NHS workforce can be divided into three broad occupational groupings: (i) the health professionals (doctors, nurses, PAMs, ambulance staff), (ii) management, administrative and clerical employees and (iii) blue-collar, maintenance and ancillary workers. We shall now examine the relevant stress literature for each category of workers.

2.3.2. The National Health Service: A Context

The National Health Service (NHS), one of Europe's largest organisations, employs approximately four percent of the UK workforce, over one million employees (NAHAT, 1994) within a highly complex, multi-billion pound operation.

Community level studies suggest that, at any one time, 25 percent of the population is experiencing some level of disorder (Depue and Monroe, 1986; Dohrenwend, 1983). Most of this group will experience mild to moderate severity levels (Goldberg, 1980). It is unlikely that NHS employees will differ, in many respects, from the general population and therefore, it is likely that at any one time a quarter of the NHS workforce will be

experiencing psychological difficulties of one kind or another. The duties of many NHS employees, which often include highly interpersonal and potentially emotive components (Payne and Firth-Cozens, 1987), may actually mean that a higher percentage of NHS employees are distressed than in the general population.

2.3.3. Health Professionals

This group, that includes professions such as doctors, nurses, physiotherapists, occupational therapists, clinical psychologists, dentists, radiographers and so on may be considered to be the front-line' NHS professional grouping, individuals who deal directly with patient care. Studies suggest that a substantive minority of these employees experience emotional distress (Firth and Shapiro, 1986; Payne and Firth-Cozens, 1987; Sutherland and Cooper, 1990), with much of it attributable to their professional duties.

Studies have identified a range of specific contributory stressors that impact on reported levels of distress in studies of physicians (Firth-Cozens, 1994; Keinan and Melamed, 1987; Lemkau, Rafferty, Purdy and Rudisill, 1987; Scheiber, 1987; Spurgeon and Harrington, 1989), G.P.s (Porter, Howie and Levinson, 1987), consultants (Caplan, 1994), surgeons (Payne, 1987; Payne and Rick, 1986), junior doctors (Firth-Cozens, 1987; Firth-Cozens and Morrison, 1989), anaesthetists (Rick and Acton, 1988) and psychiatrists (Margison, 1987). Other studies report similar findings with intensive care nurses (Becker-Caus, Gunther and Hannich (1989), general nurses (Firth and Britton, 1989; (Glass, McKnight and Valdimarsdottir, 1993; Guppy and Gutteridge, 1991; Livingston and Livingston, 1984; McCarthy, 1985; McCranie, Lambert and Lambert, 1987; Wolfgang, 1991), psychiatric nurses (Jones, 1987; Jones, Janman, Payne and Rick, 1987), nursing assistants (Miles-Tapping, 1992) as well as dentists (DiMatteo, Shugars and Hays, 1993; Kent, 1987), medical social workers (Brookings, Bolton, Brown and McEvoy, 1985; Leiter and Meachem, 1986; Rushton, 1987), ambulance personnel (Sutherland and Cooper, 1990), clinical psychologists (Cushway, 1992) and pharmacists (Wolfgang, 1991). All of these studies have identified substantial minorities who report high levels of distress.

It is arguable that the job characteristics associated with these 'front-line' caring professions, mean that individual members

"...have special reasons for being more stressed than some other professional groups. The strain of dealing with clients face-to-face has been recognised in many groups of workers and is seen as one of the most important aspects of 'burnout' (Maslach 1982). However, within the health field the stress created by

such interactions may well be exaggerated by the involvement of deformity, physical suffering and sometimes death. The fact that many of these workers have not only to witness considerable suffering but also to inflict it through tests and medical procedures makes their interactions with clients very different from other professional groups. For health professional such as doctors, nurses and dentists, some of these procedures are invasive of the person, giving 'contact' an altogether more extreme definition."

Payne and Firth-Cozens (1987).

There is evidence for stronger relationships between levels of occupational stress and responsibility for people, rather than for objects (Caplan et al, 1975). Unlike most other professions, including others, such as teaching, that deal directly with people, wrong decisions in the caring professions may either exacerbate symptoms or result in the death of the individual patient (Cooper and Mitchell, 1990). Such responsibilities are rare in other professions. This strain has also been found in air traffic controllers (Cobb and Rose, 1973, cited in Martin and Wall, 1989) who similarly experience a combination of high attentional demands and the knowledge that mistakes are potentially fatal. Individuals in the Cobb and Rose sample suffered from unusually high levels of hypertension and peptic ulcers: Symptoms that suggest considerable stress. Similarly, many health professionals cite high levels of somatic, and other complaints, indicative of consistency in the accounts of individuals aware of the potential impact of their decisions.

In tandem with cited strains, there are additional aspects of the health-care culture that ensure that dealing with these pressures becomes more difficult, that

"...complaining about one's job is an activity enjoyed by all...regardless of nationality, race and sex, economic, cultural and educational status...except physicians....The 'conspiracy of silence' isolates physicians who are troubled by aspects of their work and makes it difficult for maladapted and impaired physicians to seek non-judgmental advice and counselling."

McCue (1986, cited in Payne and Firth-Cozens, 1987)

Finally, many health professionals have to work shifts. There exists a considerable body of evidence that suggests that such working patterns have potentially negative consequences for employees (Barton, 1994; Folkard, 1987; Folkard, 1989 Kasl, 1978).

The experience of distress and the frequent 'failure' of health professionals to recognise and to resolve personal issues leaves a troubled individual continuing to make decisions of the utmost importance. There are implications, with respect to patient care. Psychological distress may well lead to the individual impairment in cognitive

functioning, decision making, concentration and memory (Firth and Shapiro, 1986). Such impairment may well translate into a greater chance of mistakes being made. The failure to provide the opportunity for intervention, may well have long-term implications for the individual patient well-being and long term consequences for the host organisation through, claims for negligence arising from clinical error.

2.3.4. Management Professional and Administrative Employees

Evidence suggests that these employees, of whom there were 149,000 in the early 1990s (Ham, 1991), experience substantial levels of distress (Jamal, 1985).

Caplan (1994) sample of hospital general managers were experiencing higher levels of distress than those from other occupational groups. Forty-six percent of the sample reported levels of symptoms that classified them as cases. This compared with general population figures, for managers, of 27% for men and 28% for women (Caplan, 1994). In the NHS, management is responsible for making decisions at both the strategic and tactical levels that impact on patient care: Decisions about resource allocation, the scheduling of operations, bed allocation and staffing levels, decisions that impact on the quality of health care. The process of decision making is known to be impaired by stress (Firth and Shapiro, 1986) and, therefore, a distressed white-collar employee whether a manager, administrator or clerical officer has, through error, the potential to impact on patient and colleague well-being. Health organisations are dependent on many different individuals working inter-dependently, in a team, to provide health-care. There exists the possibility that the impairment of one team member could impact on team performance, with this, in turn, having an effect on the quality of health-care provision (Payne and Firth-Cozens, 1987).

Several frameworks have been developed with the aim of increasing our understanding of the stressors experienced by managerial and other white-collar employees (Burke, 1988; Kasl, 1978). Listed factors include: The *physical environment* (office noise, VDU's and open-plan offices), *role conflict*, *role ambiguity*, and *social relationships with others*, *career development*, *work-family conflicts*, '*organisational*' stressors, new technology, shift-working and *non-work issues*. These factors all have the potential to threaten individual well-being, according to the extent to which these are translated into psychological and emotional problems: Translation being dependent on a complex web of social supports, coping strategies, stressor severity, duration and personality. Experienced distress may then be translated into organisationally costly phenomena such

as absenteeism, turnover, impaired performance and impaired inter-personal relationships (Kahn and Bysosiere, 1992).

2.3.5. Blue Collar Employees

In 1993, the NHS employed 20,970 maintenance staff, 5,180 works professionals and 127,580 ancillary staff (NAHAT, 1994, p.58), all of whom can be included under the heading of blue-collar employees. The blue-collar worker can be defined as an employee who engages in manual work, whether skilled or unskilled, a definition encompassing a wide range of occupations. It should be noted that the boundaries between many skilled blue-collar and white-collar occupations is far from clear-cut.

Blue-collar employees have been identified, by a number of researchers (Cooper and Smith, 1985; Cox, 1985; Fisher, 1985; Fletcher and Payne, 1980; Jamal, 1985; Leven and Singer, 1988; MacIntyre, 1980; Monk and Tepas, 1985; Wallace, Levens and Singer, 1988), as being, relatively, more at risk from stress related illnesses, such as ischaemic heart disease, cancers and other illnesses suspected of having a substantial psycho-social component. Blue-collar employees are statistically at more risk from the major and minor causes of death, than those in the professions. They also, as a group, have a larger number of 'restricted activity days' than white-collar workers (General Household Surveys, 1974 and 1975, cited in Cooper and Smith, 1985).

Many of these differences are rooted in the characteristics of blue-collar employment: Less security; lower salaries and the greater likelihood of being exposed to potentially dangerous physical hazards. The majority, of blue-collar workers, are employed in the lower reaches of organisations and, as a result, they often have less control and autonomy than white-collar employees. The extent to which individuals are able to exercise control over their environments is increasingly being acknowledged as a key aetiological factor for impaired mental health (Kahn and Byosiere, 1992; Karasek, 1979). Some of these stressors, such as physical hazards, are almost unique to this broad occupational grouping and these are over and above the work and non-work stressors experienced by all employees.

However, the evidence linking job characteristics to differences in levels of mental and physical health between white and blue-collar employee levels is far from clear-cut (Wallace et al, 1988). Other factors associated with blue-collar status, such as lower income levels and so on, are, in part, responsible some of the discrepancy in health related variables. Lower salaries translate into purchasing lower quality, less healthy

food, restricted access to information that will inform lifestyle choices and living in poorer accommodation located in less well resources environments. Lower socio-economic status and poorer physical environments are known to be linked to higher levels of psychological and emotional disorder (Cochrane, 1982; Dohrenwend, 1983). Although rarely involved in direct patient care, blue-collar employees are an integral part of the health-care team, providing services in support of the direct care occupations. As such, there is a need to resource intervention for troubled individuals drawn from this occupational grouping.

2.3.6. Additional Stressors

A number of additional threats to well-being exist have been identified, which include the threat and reality of violence (Painter, 1991), part-time employment (Liff, 1991), membership of an ethnic minority (Iles and Auluck, 1991) being disabled (Knussen and Cunningham, 1988; McHugh, 1991) and serious illness (e.g. AIDS, Stallard, 1991).

There exists a substantial body of evidence, described in this section, that suggests that possibly twenty-five percent of individuals (Depue and Monroe, 1986), from all three groups of employees, experience at any one time a range of psychological and emotional disorders that require intervention. However, such a body of evidence will not be sufficient, for many organisations, to provide a case for resourcing intervention. Many organisations will demand more substantive, 'harder' evidence to support the case for funding interventions. This 'harder' evidence will be in terms of the costs, associated with impaired mental health, that will be carried by the employing organisation, in terms of absenteeism, turnover, errors and reduced quality and quantity of performance. There is also an argument that demands that the NHS should fund these interventions. In the US, because of the absence of a comparable resource, the case for organisational funding for in-house mental health interventions may be intrinsically stronger: Employers already resource much of the health-care in the US already. In the UK, however, the existence of the NHS acts, to an extent, as a cultural barrier to organisationally researched interventions. For organisations, there is a need for organisationally resourced interventions to add benefit, to provide an accountable return that is at least as great as the cost of implementing the intervention, it must appeal to the "bottom-line" (Cooper and Highley, 1995). The second section of this first chapter examines the business cost case for resourcing some form(s) of intervention.

2.4. The Economic and Legal Case for Intervention

This section presents the organisational level case for intervention. It is divided into two sections, the first addresses the direct business costs of not intervening, the second the indirect costs that relate to individual costs of work-related problems that become translated into litigation on behalf of individual employees against the employing organisation.

2.4.1. The Impact of Psychological Problems on Performance at Work

Several organisational costs have been identified as being linked to emotional and psychological well-being. These include poor industrial relations (Henne and Locke, 1985); absenteeism (Chadwick-Jones, Nicholson and Brown, 1982; Cole, 1995; Cooper, 1986; Dalton and Mesch, 1991; Dilts, Deitsch and Paul, 1985; Kearns, 1986; Miner and Brewer, 1976); employee turnover (Sutherland and Cooper, 1990); union activity (including strikes, Hene and Locke, 1985); reduced productivity (Brodsky, 1984; Henne and Locke, 1985) and errors, such as those resulting in medical malpractice (Jones, Barge, Steffy, Fay, Kunz and Wuebker, 1988). These have been translated into financial costs for the organisation. For example in 1992 absenteeism was said to have cost the UK economy £13 billion, with a specific cost to the NHS of an estimated £1 billion over the same period (HEA, 1994). Thirty percent of the NHS absence was, according to the HEA, related to stress, anxiety and depression, with certified mental illness accounting for the equivalent of 10,000 full-time staff posts, per year.

There is also an extensive body of evidence linking alcohol and drug misuse to work performance deterioration (Beaumont and Hyman, 1987; Lehman and Simpson, 1992; Quick and Quick, 1984; Sonnestuhl, 1988). Estimates of the cost of the impact of mental and emotional ill-health on organisations in the US, for example, range from 50 to 75 billion dollars per year (Brodsky, 1988; Dalton and Mesch, 1991). At any one time 8-10% of the US workforce may be experiencing disabling levels of emotional or somatic problems, whilst a further 30% experience a range of minor psychiatric disorders.

Jones, Barge, Steffy, Fay, Kunz and Wuebker (1988) found, in three studies, significant relationships between hospital stress levels and levels of medical malpractice claims. In the first study, using a sample of 12000 employees drawn from 67 hospitals, they found that hospitals with a current record of malpractice reported higher levels of on-the-job stress than levels reported in matched, low-risk departments. The second study, using 61 hospitals, found that workplace stress levels were significantly correlated with the frequency of malpractice claims. Since these studies could be criticised, because they

employed cross-sectional methodologies, the third study, a longitudinal assessment of the impact of an organisation-wide stress management program on claim levels, found a significant pre-post reduction in claim levels whilst the fourth study, a two-year longitudinal study looked at the impact of a stress management program on levels of malpractice claims. The 22 study 4 hospitals who implemented organisation-wide stress management programs had significantly fewer claims than a matched sample of 22 hospitals who did not implement the program. The methodological weaknesses of all four studies, meant that although the direction of causality was difficult to establish, they are suggestive of a relationship between stress and medical error.

Motowidlo, Packard and Manning (1986) reported two studies. The first identified, through the use of questionnaires and group discussion, a list of 45 stressful nursing events, whilst for the second study, 171 nurses completed a second questionnaire. The study two nurses were also rated, by their supervisors and/or co-workers, on their job performance. There were significant correlation's between interpersonal (e.g. sensitivity, warmth, consideration) and cognitive/motivational (concentration, composure, adaptability) aspects of job performance with self-reported perceptions of stressful events, subjective stress, depression and anxiety. Analyses suggested that perceptions of stressful event intensity and frequency led to depression, which then impacted on the interpersonal and cognitive/motivational aspects of job performance. The authors suggested that this stress-depression-performance model had several implications for interventions: Either (a) Selection could be used to match the most stressful jobs with the most stress-resistant individuals, (b) training programs should be developed which attempt to modify the employee dispositions or (c) depression could be dealt with more directly through generally encouraging more "personal warmth in supervision, administration and organisational climate" (p.647).

In a two year longitudinal study, Wright, Boney and Sweeney (1993) looked at the impact of mental health on subsequent work performance. A positive relationship between mental health and subsequent work performance was identified. Apart from major life events, daily hassles, their frequency and intensity, have also been implicated as impacting on job performance and absenteeism (Ivancevich, 1986). The addition of life-events to the analysis only added marginally to the amount of variance explained.

In a study investigating the impact of substance abuse on on-the-job behaviours, Lehman and Simpson (1992) found that employee substance use was predictive of psychological and physical withdrawal, but not of positive or antagonistic work behaviours. These

results that supported the existing empirical literature and casual observations of the substantial impact of substance use on work behaviours and performance.

Wesman and Eden (1996) examined the purported 'inverted-U' relationship between stress and performance with a group of 306 officer cadets in the Israel Defence Forces. They found that, although there wasn't an 'inverted-U' relationship between stress and performance, there was, instead, a linear relationship between stress and performance, with

"A high level of distress across different measures of performance [being] consistently associated with substantially lower performance."

These studies, therefore, suggest a relationship between the experience of 'stress', anxiety and depression and work performance.

2.4.2. The Legal Case for Intervention

Increasingly, employees are seeking compensation, through litigation, for the perceived and actual impact of stress (Appelson, 1983; Davis, 1985; Earnshaw and Cooper, 1991, 1994; Swanson and Murphy, 1991), in part a trend that reflects the literature indicative of a link between environmental factors, at work, and emotional and psychological outcomes (Kahn and Bysoiere, 1992). The impact of this evidence has also been shown in calls by the Health and Safety Executive (HSE) (Cox, 1993) stating that stress at work should be officially recognised as a health and safety issue.

The US and Canada, in terms of stress related litigation, would appear to be somewhat ahead of the UK (Earnshaw and Cooper, 1991), although there exists considerable variation between states and provinces in the strength of the response and the acceptability of cases by the courts. Several case types have been brought (Earnshaw and Cooper, 1991): 'Physical-mental', where psychological injury results from physical trauma; 'mental-physical', where physical symptoms result from mental stress at work and 'mental-mental', where the individual experiences psychiatric outcomes as a result to being exposed to psychological stress. The 'mental-mental' category has been further sub-divided into three sub-categories: An acute category, where a sudden traumatic incident triggers an emotional response or other psychological outcome and two 'chronic' categories, where the individual is subjected to stressful circumstances over a longer period of time. In the first of the two chronic sub-categories: 'unusual', the individuals resultant psychological state is indicative of a particular vulnerability to stressful

circumstances, whilst the second, the 'unusual', reflects the exposure of the individual to stresses that are 'greater than that of ordinary employment'.

The potential for litigation that has arisen from the increasing body of evidence for a link between work-site stress and employee well-being has been noted (McKenna, 1994; Wynn-Evans, 1995). In the UK, this interest has only been recent. The first, unsuccessful case was *Gillespie v Commonwealth of Australia* 1991 (McKenna, 1995). However, two recent, and successful, cases have been brought that have implications for employees: *Walker v Northumberland County* and *Johnstone v Bloomsbury Health Authority*.

In the *Walker v Northumberland County* case, the plaintiff, John Edward Walker, sued his ex-employer for failing to provide him with a less pressured workplace after his return to work, following a mental breakdown. The County was held to be "in breach of its duty to provide a safe workplace when the employer then suffered another nervous breakdown" (Wynn-Evans, 1995). Walker won and, as a result, he will recover damages for his lost career and psychological harm.

Johnstone, in the second case, *Johnstone v Bloomsbury Health Authority* (1991), was a junior doctor who was contractually obliged to work for 48 hours and to be 'on-call' for a further 48. He argued that the excessive hours had caused psychological harm. In this instance the court case was about whether he could bring a claim at all: His employers claimed not, because of his contractual obligations. The court decided in his favour, he was given leave to bring a claim (McKenna, 1995; Wynn-Evans, 1995). This was settled out of court in April 1995 (Hall, 1995; Mihill, 1995) with Johnstone accepting £5000 in settlement.

This case does not mean that if employees claim that they are 'cracking-up' because of work that they will be able claim damages (Wynn-Evans, 1995). The plaintiff will have to show that the illness was the result of work, that the employer was negligent in its actions towards the employee in exposing them to situations which the employer should have seen would lead to illness. In another case, *Petch v Customs and Excise Commissioners* (1993), the plaintiff failed to win the case (McKenna, 1995), because the employer had "successively sent him on sick leave, moved him to a less onerous post and granted him retirement on medical grounds" (Wynn-Evans, 1995), thus they had acted to improve Petch's working environment and thus "it is difficult to show that work stress caused a particular illness" (Wynn-Evans, 1995). The court needs to look at the individuals psychological state when making a decision about a specific case. McKenna (1995) also noted that if the plaintiff could show that his or her employers were aware,

or should have been aware, that they were likely to breakdown then he or she would have a case. Finally, McKenna (1995) states that an employer should ensure that if an individual returns to work after a breakdown that his or her working environment is modified to prevent further occurrence.

The implications of recent cases have come under some discussion: One major law firm, Dibb, Lupton and Broomhead, advised its corporate clients

"to dismiss employees suffering from work induced stress to save themselves from large personal injury claims" (People Management, Mid-December 1994).

They argued this solution, because, whilst the maximum cost of a lost dismissal case is £17500, it compares favourably to the £200,000 awarded in the Walker v Northumberland case. Others, however, have suggested that such statements are overly dramatic, since Walker won the case largely because promised improvements to his working environment weren't forthcoming on his return to work, which narrows the applicability of the ruling to other cases. Other commentators, such as Cooper (1995) suggest that the next few years will see a substantial increase in the case law as applied to employee distress and personal injury, with substantial implications for employers, in terms of litigation., if stress related factors such as over-work, long hours, bullying are not addressed.

A further case, with organisational implications, was brought by police officers against South Yorkshire Police, citing the trauma of the Hillsborough disaster as being responsible for subsequent mental and emotional health problems (Curry, 1995). Whilst, 23 officers failed in their compensation claims, largely because they had not been in the pens and, thus, were not strictly 'rescuers'. Liability was accepted, by South Yorkshire Police, in the case of fourteen officers carrying out rescue work within the pens where the deaths occurred (Curry, 1995). In addition, a fireman, in 1993, won £147,683 in damages as a result of trauma resulting from the Kings Cross Underground fire (Earnshaw and Cooper, 1994).

2.5. Conclusions: A Rationale for Intervention

Can an organisation afford to ignore the potential and actual costs of poor mental and emotional health on its employees? I would strongly suggest that the answer is no. The literature indicates a considerable problem that needs to be addressed, that there are psychological and emotional consequences of being exposed to a range of identified

work and non-work factors and that these translate into identified financial and legal consequences for the employing organisation.

In the US, much of the available health care provision is funded by employers and, in a sense, the cost of this provision provides an additional spur for the provision of workplace interventions to reduce costs. In the UK, this spur is largely missing, because the NHS provides much of the UK's health-care. It's arguable that the NHS should provide intervention. The NHS is a limited resource that is expected to meet almost unlimited demands. Given these limited resources, it cannot be relied upon, by organisations, to provide interventions that can be easily accessed by employees.

Although, counselling in the private sector does exist, for many staff its costs are prohibitively high. There is also a cultural expectation, and experience, of health-care that is free at the point of access and, thus, there remains a barrier to paying for counselling in the private sector. Employers who rely either on the NHS or private sector provision to resolve employee distress are probably expecting too much and are being unrealistic. They are leaving service use and access to interventions to chance and, as a result, organisations are at risk of incurring the costs of distressed employees identified in this chapter. If organisations are to minimise their exposure to the risk of incurring these costs then they need to resource interventions.

In addition, there are a number of practical reasons for workplace interventions, which include accessing a large and relatively stable population, the availability, in larger organisations, of suitable staff (e.g. occupational health) already committed to improving employee health and well-being, the existence of organisational supports for programs and worksite provided opportunities to utilise existing peer support systems to improve participation and compliance rates (Murphy, 1988).

In conclusion to this chapter, Cooper and Cartwright's (1994, p.455) statement seems apt:

"... financially healthy organisations are likely to be those which are successful in maintaining and retaining a workforce characterised by good physical, psychological and mental health."

Chapter Three:

Employee Counselling and Assistance Programs

3.1. Introduction

This chapter presents reviews the Employee Assistance and Counselling literature's. Various, successive, sections define the concepts of Employee Assistance and Counselling, before discussing, in detail, the historical development of these program, their structure and a review of their structure.

3.2. Interventions other than Counselling and Psychotherapy

Newman and Beehr's (1979) twelve cell categorisation of organisational interventions placed each approach along three dimensions: Its Primary Target (the organisation or the person); the Nature of the Response (curative or preventative) and the actor of the Adaptive Response (person, organisation or outsider). This framework was applied to the existing literature, at the time. Perhaps, the most important distinction made by this framework was the dichotomy between person and organisationally targeted interventions.

The individually targeted approaches, reviewed, included stress management training (e.g. Gavin, 1976), meditation (e.g. Kory, 1976), planning ahead (e.g. Hall, 1976), the adoption of a philosophy of life (e.g. Seyle, 1974), psychological strategy (e.g. McLean, 1974), physical fitness (e.g. Levi, 1967), social support (e.g. Mansfield, 1974), occupational withdrawal (e.g. Powell, 1973) and mental health 'first aid', for example talking to others (e.g. Levi, 1976). Historically, the individual has been the primary focus of intervention, rather than the organisation and the vast majority of studies have evaluated approaches such as relaxation and the various cognitive techniques.

Interventions typically include elements of the following: Meditation and relaxation (imagery and visualisation, muscle relaxation); an introduction to the whole topic of stress (causes, symptoms and effects); biofeedback (individuals are taught how to control particular physiological response such as hand temperature which requires monitoring equipment); cognitive techniques which attempt to restructure the individuals thinking about stress (based on the assumption that our responses to stress are mediated by cognitive processes) and finally social skills training (communication skills, assertiveness), which aim to enhance the individuals ability to handle demanding interpersonal situations. These approaches are also portable, once learnt they can easily be applied to environments other than work (Murphy, 1988). There is, arguably, an

implication, with individually focused interventions, of 'blaming the individual', an "inoculation" (Ganster et al, 1982) that enhances the individuals ability to cope with a damaging working environment, avoiding having to address the real environmental cause of difficulties.

An alternative is to target outside the individual, focusing either on the physical, interpersonal or organisational environments. Interventions, reviewed by Newman and Beehr (1979), included maximising the fit between the person and the environment (P-E) through changing organisational and role variables (e.g. French and Kaplan, 1973), participative decision making, changes to retirement policy (e.g. Jacobson, 1972), the development of company wide physical fitness programs and company sponsored, professionally staffed physical and mental health programs (e.g. Ferguson, 1973; Levi, 1967; Wright, 1975). Other interventions including approaches such as job redesign, changes to the organisational structure and changes to supervisory roles, attempt to change features of the workplace that are causing stress (Burke, 1993; Murphy, 1988), modifications to working methods, processes, work schedules, employee control, workplace relationships, communications as well as physical changes (Burke, 1993; Murphy, 1988; Newman and Beehr, 1979). Often such changes may involve significant shifts on the part of employees and the employing organisation in terms of values, attitudes and behaviours, changes that may often be similar to those brought about in the individually focused interventions discussed. Evaluations of organisational development (OD) interventions have looked at the impact of these approaches upon variables such as job satisfaction, job attitudes and measures of mental health and well-being, although, frequently, the outcome measures have not included specific indices of stress.

At present, there exist only a limited number of studies that have evaluated these interventions with any methodological rigour, a fact which questions the efficacy of these approaches (Burke, 1993; Ivancevich and Matteson, 1987; Murphy, 1988). Ivancevich and Matteson (1987) concluded that

"Perhaps the most glaring impression we received from the review was the lack of evaluative research in this domain [stress interventions in an organisational context]. Most of the strategies reviewed were based on professional opinions and 'related' research. Very few have been evaluated directly with any sort of scientific rigour."

This critique has since been reinforced and substantiated by other authors such as Ivancevich, Matteson, Freedman and Phillips (1990), Matteson and Ivancevich (1987) and Murphy (1984, 1988) and Reynolds and Briner (1994). Improvements, in terms of methodology, have been noted by these authors but the problems remain and there have

been calls for a complete reappraisal of both the conceptualisation of interventions and methodologies that are currently in use (Reynolds and Briner, 1994) in this field.

Organisational change does not necessarily come cheaply and such interventions can only impact on certain sources of distress. Certain job elements may not be modifiable. For example, health professionals will always have to deal with the consequences of working with people who are in considerable physical and mental distress. Finally, organisational interventions, however effective, are not able to impact on non-work sources of stress.

3.3. Counselling

Section 2.3 presents the concept of counselling, its definition, a review of the worksite counselling literature and studies examining the impact of counselling intervention on performance at work.

3.3.1. Definitions of Counselling

Counselling, a term often associated with humanistic school of interventions (Davidson and Neale, 1986) can be defined as;

- "1. a set of techniques, skills and attitudes ...
2. to help people manage their own problems ...
3. using their own resources".

Reddy (1987, p.7)

The term psychotherapy, often used interchangeably with counselling is defined as

"...a situation in which one human being (the therapist) tries to act in such a way as to enable another human being to act and feel differently than he has..."

Wachtel (1977, p.21)

The assumption is that particular kinds of verbal and non-verbal exchange, structured by some theoretical foundation, and set in a trusting relationship, can achieve various outcomes, such as reduced anxiety levels or modified behaviours or thoughts (Davidson and Neale, 1986). London (1964) classified the hundreds of existing therapies (Bloch, 1982; Davidson and Neale, 1986) into two broad categories: Insight and action (behavioural). Therapies from the first category attempt to promote control through greater understanding, whilst those from the second aim to provide an environment in which clients are helped to acquire skills to control overt and covert behaviours.

The term counselling has been broadly adopted across a range of helping relationships, lying along a continuum from professional/semi-professional, the trained counsellor and client, to the less formal 'helping contacts', for example between the employee and manager or the doctor/nurse and patient (Nelson-Jones, 1983).

Counselling, the subject of the research presented in this thesis, is an individually focused intervention. As such, it is subject to the same criticisms levelled at the other person-centred interventions that have already been noted. Swanson and Murphy (1991) define work-site counselling

"...encompass[ing] a range of counselling techniques. Those techniques include the interview approach of the Human Relations School, as well as more conventional psychotherapeutic approaches, offered both on-site and by external providers, such as community mental health centres. Counsellors (always non-managerial) have ranged from non-professionals, trained in non directive listening techniques, to professionals such as social workers, clinical psychologists and psychiatrists. The counselling programs have involved one or more therapeutic sessions with an employee who is seeking assistance for personal or job-related emotional distress. The primary objective of the majority of these programs has been the improvement of worker productivity; that is, to detect emotional problems impairing work performance and to restore troubled employees to full productivity." (p.265)

Counselling is an individually focused approach, which can arguably have a role as both a 'curative' and as a 'preventative' intervention. Counselling becomes preventative, if attending sessions allows clients to develop appropriate strategies aimed to reduce the likelihood of a reoccurrence of problems. It also becomes preventative, of more severe distress, if clients access counselling early on during the development of their problems. It has also been suggested (Firth and Shapiro, 1986), that intervening with clients with acknowledged distress levels might well be a more effective way of dealing with work-related problems than the preventative SMT approach which 'bluntly' deals both with those who are distressed and those who are not.

3.3.2. A Review of the Literature on Employee Counselling

There exists a considerable body of work on the subject of counselling and psychotherapy, with much of this work addressing questions of therapeutic outcome and process (Hill and Corbett, 1993; Lambert, Shapiro and Bergin, 1986; Shapiro and Shapiro, 1982; Smith et al, 1980). Almost all of this work has adopted designs aimed at maximising control over variables, to enhance internal validity (Howard, Orlinsky and Lueger, 1995; Lambert, Masters and Ogles, 1991; VandenBos and Pino, 1980). More applied research has, as a consequence, been largely overlooked. There is, indeed, an

absence of studies that have examined the psychological impact of employee counselling (Shapiro, Cheesman and Wall, 1994). One exception, to this rule, was the Post Office study (Cooper and Sadri, 1991; Cooper Sadri, Allison and Reynolds, 1990).

The Post Office counselling service, which was set-up in 1986 as a pilot study, can be accessed by all Post Office employees. It employed two counsellors at this point. Referrals, taken from a number of sources such as Occupational Health (40%), self-referral (31.5%); welfare (19%) and managers (9.5%, Cooper et al, 1990) brought problems to the service that included health/stress issues (46%) and relationship problems (24%), substance abuse, bereavement, assault, physical illness, disability and others (30%).

Measures of sickness absence (for the six months prior to the first session and for the six months post-counselling), anxiety, depression, somatic symptoms, self-esteem, overall job satisfaction, organisational commitment and health behaviours (drinking, smoking, caffeine intake, exercise and coping strategies) were employed in the study. The experimental group (n = 250) and the control group (n = 100) were matched in terms of age, sex, grade and years of experience (Cooper and Sadri, 1991). There were reduced levels of anxiety (for 62% of clients), somatic symptoms (61% of clients) and depression (60% of clients), higher levels of self-esteem (39%), job satisfaction (24%), job commitment (16%) for the client group at the end of counselling. There were also significant changes on behavioural measures (Cooper and Sadri, 1991); reduced caffeine intake, smoking and alcohol intake. There was little evidence of deterioration: Those who failed to improve generally remained stable. At post-counselling, clients reported an increased use of relaxation techniques, exercise, leaving the organisation for a break (e.g. for lunch) and humour to cope with work stress. Significant pre-post reductions in levels of absenteeism (events, days lost and warnings) for the experimental groups (service clients), but not for the control group (Cooper and Sadri, 1991) were reported. The authors noted two practical restrictions: First, the lack of a computerised absenteeism system, which prevented matching controls with the experimental group on pre-intervention levels of distress, secondly, the use of disciplinary procedures, which acted as an intervention in their own right (Cooper and Sadri, 1991).

Gray-Toft (1982) evaluated a group counselling intervention with seventeen female nurses (Gray-Toft, 1982), using a modified multiple group design with staggered and continuous single-treatment groups. Two groups, the night shift (n = 8) and the day-shift (n = 9) met one hour per week for a total of nine weeks. The groups were facilitated by

the study author and the hospital chaplain. Levels of stress were reduced and job satisfaction were increased by the intervention and there were reduced levels of turnover.

Other reports, of counselling service evaluations, such as Curry's (1995) are limited both in terms of scope and the presented evidence. Curry (1995) describes a system of 'debriefing', employed by a number of UK police forces, developed in response to events such as Lockerbie and Hillsborough. Police officers and other emergency service personnel are debriefed, using a mixture of counselling and team sessions, after traumatic events. Curry (1995) reported only anecdotal evidence for the efficacy of this approach, noting that the service requires formal evaluation.

3.3.3. The Impact of Intervention on Performance at Work

Minz, Minz, Arruda and Sook Hwang (1992), in reviewing ten studies, with a combined sample of 827 participants, evaluated the impacts of antidepressants and psychotherapy on work impairment in depressed patients. At baseline, respondents exhibited problems, such as unemployment, absenteeism and other on-job behaviours. Improvements in work behaviours were found to be associated with symptom improvement, although there was a delay. On-job behaviour improvements were delayed in comparison to symptom improvements. Thus psychological improvement is not matched by immediate improvements in absenteeism, productivity problems or work-related interpersonal problems. In the longer term, there were no differences between the effectiveness of antidepressants and psychotherapy with work outcomes, although there were differences initially. There was a longer delay for psychotherapy to impact on work outcomes. The authors concluded that there was evidence from these studies that psychotherapy had a positive impact on work functioning.

Firth-Cozens and Hardy (1992) reported from the Second Sheffield Psychotherapy Project (SPP2, Shapiro, Barkham, Hardy and Morrison, 1990) on a sample of 90 (49 men and 41 women) professional, managerial and white-collar clients (49 men and 41 women). Pre-post changes in job perceptions, measured through the use of the Aspects of Work Inventory (AWI, Barkham, Firth-Cozens, Reynolds, Shapiro and Warr, 1989), were associated with changes in affective state: As symptoms reduce job perceptions become more positive. However, Firth-Cozens and Hardy (1992) noted that the direction of causality was unclear and that affect and job perceptions changes could be underpinned by individual dispositional capacity to change, with therapy impacting on this disposition.

Firth and Shapiro (1986) reported an evaluation of exploratory (psychodynamic) and prescriptive (cognitive-behavioural) psychotherapies, with a sample of 40 managerial and professional employees who had reported work-related problems. Clients received two sets of eight sessions of prescriptive and exploratory therapies, with one set of 20 clients receiving first the exploratory and then the prescriptive therapy, with a second group receiving therapies in the reverse order. Personal Questionnaires responses indicated relationship problems (with colleagues), self-concept issues (e.g. self-confidence, inadequacy, setting too high standards), role problems (e.g. ambiguity, overload, responsibility) and distress (e.g. concentration / memory loss, disorganisation, difficulty making decisions). Both intervention types were reported to be equally effective (Shapiro and Firth-Cozens, 1986).

Firth-Cozens (1992) presented a case study which examined the personal meanings of job stress for one individual manager in psycho dynamic psychotherapy. She outlined the ways in which measured job perceptions and satisfactions became more positive as symptoms decreased. Firth-Cozens was able to illustrate the extent to which job perceptions and symptoms are enmeshed with one another and also the potential benefits of individual therapy for both the clients and for their employing organisation. This was a case study, and there are problems, as a result, in generalising the outcomes of this work to other settings. However, the outcome was highly suggestive of the potential of individual therapy to alleviate problems of distress and to improve the individuals performance at work.

3.4.1. Employee Assistance Programs (EAPs)

Two definitions are presented.

"An employee assistance program (EAP) is a work site based program designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal concerns including, but not limited to: health, marital, family, financial, alcohol, drug, legal, emotional, stress or other personal concerns which may adversely affect employee job performance."

The Employee Assistance Professionals Association (1988)

"...a programmatic intervention at the workplace, usually at the level of the individual employee, using behavioural science knowledge and methods for the control of certain work-related problems (notably alcoholism, drug abuse and mental health) that adversely affect job performance, with the objective of enabling the individual to return to making her or his full contribution and to attaining full functioning in personal life."

Berridge and Cooper (1988)

At their most literal, EAPs provide assistance to employees. Sonnestuhl (1988) differentiates EAPs from Employee Counselling Programs (ECPs) on the basis of referral., EAP clients are 'constructively confronted' into attending, ECP clients attend voluntarily. Arguably, this distinction is largely restricted to the narrowly focused substance abuse programs that characterised the early EAP movement and is less applicable to the wider 'broad-brush' programs now characterising the EAP movement. Constructive confrontation was developed to motivate substance abusers to access EAPs. There is little or no difference (Berridge and Cooper, 1991) between the two labels: Indeed many EAPs have been renamed as ECPs to avoid some of the negative connotations associated with the term 'assistance' (Masi, 1984). EAPs are now a vehicle for a range of interventions such as counselling, health promotion (hypertension screening, smoking cessation, weight loss), stress management, financial advice and exercise programs (Ivancevich and Matteson, 1988; Leakey, Littlewood, Reynolds, and Bunce, 1993; Murphy, 1988).

Organisations that have adopted EAP/ECPs include McDonnell Douglas (The Almacan, 1989), the US Department of Health and Human Services (Maiden, 1989), the State of Ohio, US (McClellan, 1982; McClellan, 1989), the Post Office (Allison, Cooper and Reynolds, 1989; Cooper and Sadri, 1991), the University of Maine (Ahn and Karris, 1989), North Derbyshire Health Authority (Leakey, Littlewood, Reynolds and Bunce, 1993) and the police force (Medd, 1991).

Employee Assistance Program (EAP) are not easily located, into a single cell, within Newman and Beehr's (1979) framework, since they are, first of all, vehicles for other interventions. secondly, an individually focused resource (counselling, stress management) and, finally, an intervention at the organisational and cultural level. Within a second typology, Cooper's (1987), which categorise interventions into three sub-groups (The individual; the individual/organisational interface and the organisation) differentiated on the basis of each techniques foci, EA/ECPs can be located, arguably, in all three categories, since they have impacts on the individual and on organisational culture.

3.4.2. The Origins of the Employee Assistance Movement

The roots of the EAP movement can be found in the industrial social work movement, the 'friendly visitors', welfare/social secretaries (Smith, 1988) and in concerns about the impact of alcoholism on productivity (Berridge and Cooper, 1993; Murphy, 1988; Swanson and Murphy, 1991). Employee counselling, specifically, can be traced back to

the early 20th century. These services concentrated on the impact of employee distress on organisationally relevant variables, such as absenteeism, health and safety and productivity (Noland, 1973; Swanson and Murphy, 1991). Programs either employed a psychiatrist, for example Metropolitan Life (1922) and R.H. Macey (1924, McLean, 1973; Swanson and Murphy, 1988), or used trained supervisors as 'non-directive' active listeners, for example Western Electric (Murphy, 1988). Program aims were often as much about categorisation, to distinguish between 'malingerers and hysterics', as much as treatment (Anderson, 1929, cited in McLean, 1973). The ascendancy of the scientific management revolution resulted in occupational health activities becoming restricted to physical health at the expense of psychological well-being (Berridge and Cooper, 1993). In Europe, there was the rise and development of the industrial social work movements (Googins, Reissner and Milton, 1986), with variations a reflection of cultural differences. Googins et al (1986) identified several elements, in the historical development of these programs, that cut across cultural and national boundaries, commonalities broadly conforming to Osawa's (1980) projected developmental stages of US social work.

A second wave of counselling programs, 'emotional first-aid stations' (McLean, 1973), reflected a need to support the war effort and a non-traditional work force (women, disabled employees) and then, at the end of WWII, to help integrate emotionally scarred veterans back into the US economy (McLean, 1973; VandenBos and Pino, 1980). The 1950s and 60s saw further counselling program set-ups at IBM, Metropolitan Life, America First Insurance Group (McLean, 1973), Caterpillar Tractor Company, Dupont and at the Tennessee Valley Authority (Swanson and Murphy, 1991).

3.4.3. Alcoholism and the US Economy: First Impetus for the EAP Movement

There has been a considerable amount of awareness in the US about the impact of alcoholism on productivity and on society as a whole, that was most explicit during prohibition. This concern became reflected in the development of the occupational alcoholism programs, offshoots of Alcoholics Anonymous which began to appear in the 1930s (Good, 1986) with the New England Telephone Company program which was set up in 1939 (MacLeod, 1985). Employee Assistance Programs were, in many instances, the professionally staffed successors to these volunteer run programs.

Concerns about alcoholism and its economic impacts fuelled the rapid expansion in the numbers of Employee Assistance Programs from 50, in 1959, to 300 in 1970 (Cohen, 1991), 5000 in 1979 (Stackel, 1987) and an estimated 8000 plus in 1984 (MacLeod,

1985). In 1981 between 60% and 80% of the Fortune 500 companies and from 8-12000 smaller companies were being covered by some type of EAP (Feldman, 1991; Luthans and Waldersee, 1989; Maiden and Hardcastle, 1988; Roman, 1981; Watts, 1988). Feldman (1991) estimated that the coverage of the US work force, by EAPs, increased from twelve percent, in 1980, to 36 percent by the early 1990s. General Motors EAP, one of the largest, treated half a million of its work force in 1986 (Appelbaum and Shapiro, 1986), a figure that included 100,000 treated for alcoholism. EAP coverage of the UK work force is considerably smaller, in comparison. Exact figures describing the extent of coverage in the UK work force is difficult to determine.

3.4.4. The Shift from Restricted to 'Broad-brush' Programs

The 1970s saw a shift towards increasingly 'broad-brush' EAPs, that targeted a wide range of psychological and emotional problems (Swanson and Murphy, 1991). This shift reflected increasing concern about the impact of mental health on productivity (McClellan, 1982; Roman and Blum, 1988), the costs of mental health care, which, in 1984, accounted for twelve percent of overall health costs (Berridge and Cooper, 1993; Swanson and Murphy, 1991), the recognition that substance abuse was often a symptom of other underlying problems and the perceived opportunity for improving economically important variables such as productivity and absenteeism. The 'broad-brush' EAP model has now been widely accepted by providers and is now the basis for the majority of programmes (Swanson and Murphy, 1991).

3.5.1. EAPs: Structure Functioning and Success

Structurally, EAPs reflect organisational variables such as size, the resources allocated (to the program), the makeup of the work force, organisational culture, staff expertise, flexibility, policies on confidentiality, the target population, the services to be offered and the administrative links with the host and other organisations (Flaherty, 1988; Fleischer and Kaplan, 1988; Murphy 1988). Core elements, of an EAP, include an explicit statement of EAP goals, the confidentiality of the program, its systems of identification, treatment and referral, managerial and union support and record maintenance for the purpose of evaluation (Balgopal and Patchner, 1988; MacLeod, 1985; Murphy, 1988; Roman and Homas, 1978; Walsh, 1982; Wrich, 1984).

Program success is influenced by employee education (about the service), its promotion to maximise uptake, the continuum of care from referral to community agencies (where necessary) and the collection and maintenance of records from the outset to allow

program evaluation (Balgopal and Patchner, 1988; MacLeod, 1985; Walsh, 1982; Wrich, 1984). These factors, amongst others, influence the level of program utilisation, which has been seen to vary from 1-10% (Berridge and Cooper, 1993; Shain and Groeneveld, 1980). Utilisation is also affected by how the 'troubled employee' is defined, which, in part, underpins program variation (Luthans and Waldersee, 1989). Wing and Hingson (1985) have noted that the shape and function of an EAP will represent a compromise between the conflicting agendas of interested parties.

The next section reviews a number of the EAP models that have been developed.

3.6. EAP Models

Models of EAPs have, separately, focused on development (Berridge and Cooper, 1993; Osawa's, 1980), function (Hellan, 1986; Masi and Friedland, 1988; Straussner, 1988) and system (Ford and Ford, 1986).

3.6.1. Developmental Models

Osawa's (1980) four stage 'developmental' typology charts EAP development from a unit of identification and referral to a final stage with the EAP adopting an internal consultancy role. Each successive stage represents a higher level of sophistication in terms of service provision. This model can be criticised on a number of grounds. First of all, many organisations start off with a professionally staffed EAP (Swanson, Sauter and Murphy, 1991). The second criticism is that it is unlikely that many organisations will allow its EAP/ECP to develop an internal consultancy role (Afield, 1989).

Seven successive stages, for setting up and developing, an EAP, are listed by Berridge and Cooper (1993): (1) the definition of the EAP organisational policy (its responsibilities, aims and goals), (2) needs assessment, (3) policy formulation, (4) procedure construction (for how troubled employees are to be identified, treated and followed-up), (5) resource assurance, (6) program induction (into the host organisation) and (7) the monitoring, control and evaluation of the program in operation.

3.6.2. Models of Employee Assistance Activity

Masi and Friedland (1988) categorised four types of EAPs: In-house, out-of-house, consortium (where smaller companies pool resources and affiliate) and the externally contracted consortium approach. Hellan's model (1986) included a therapeutic element

to the categorisation, with programs differentiated into four categories: Type 1 EAPs using volunteers to provide in-house assessment and referral services; Type 2, the 'classic' professionally staffed in-house referral and assessment service; Type 3, the community health model where clients are self-referred to community provided assessment and treatment resources and Type 4, the closed-ended externally contracted services that have been pre-paid by the employing organisation. A third three-way typology of 'employer-favouring', 'employee-favouring' and 'EAP staff-favouring' (Straussner's, 1988) was developed to compare the relative merits of in- and out-house provision. Straussner concluded that in-house provision was, due to its attractiveness to management and intrinsic coherency was, potentially, the best option.

3.6.3. The Systems Model

Ford and Ford (1986) applied systems theory concepts to EAPs, with programs being viewed as complex, dynamic systems that are connected to other systems, such as senior management, EAP funders, line-managers and referral organisations. Changes in any one of these systems has the potential to affect, in highly complex and non-linear ways, interconnecting systems (Bateson, 1980). There are implications for both EAP staff and for program evaluation. Staff, to deal effectively with presenting issues, must be aware of the complexities of the systems underpinning any one problem. System inter-relationships will affect the acute, follow-up and maintenance aspects of each case.

3.7. Employee Assistance: A Critique

Despite their evident success, employee assistance, as a movement, has been criticised on a number of grounds. The first is they are in apparent conflict between the values of capitalism and humanism (Hellan, 1986), a conflict which is resolved through mutual exploitation with managers gaining through increased productivity and health professionals being able to deliver services to a stable and easily identifiable population. EAPs have also been criticised for being a potentially coercive management tool (Luthans and Waldersee, 1989), for encouraging 'malingerers' and for supporting social deviants (Good, 1986). EAPs are also viewed as being potentially vulnerable to litigation for inappropriate assessment or for the failure to refer (Luthans and Waldersee, 1989).

3.8. Evaluations of Employee Assistance Programs

Sonnenstuhl (1988) reviewed the relative efficacy of EAPs, Health Promotion (HPs) and Quality of Work Life (QWL) programs in reducing levels of employee alcohol abuse.

HPPs attempt to modify employee behaviour, replacing 'unhealthy' behaviours with 'healthy' ones. Quality of Work Life programs, an off-shoot of the organisational development movement (Sonnestuhl, 1988), focus on increasing employee opportunities to participate in decision-making about the quality of work-life, which is viewed as a means to effect positive outcomes. These "competing social movements" have to some extent led to exaggerated claims for all of these approaches (Sonnestuhl, 1988). Program targets differ: EAPs are largely curative whilst HPP and QWL programs are preventative. Sonnestuhl (1988) concluded that the literature generally supported the use of EAPs as an intervention for alcohol related problems. The evidence did not allow him to state anything concrete about the respective efficacy of either the HPP or the QWL interventions and Sonnestuhl suggested that HPP and QWL advocates are overly enthusiastic in promoting these programs.

Several indicators have been used to assess EAP impact: (1) the percentage of employees entering treatment in comparison to the population of troubled employees, (2) the percentage of treated employees who return to work after treatment, (3) changes in the status of the presenting problem post treatment, (4) improved work performance and (5) cost-savings to the company (Murphy, 1988; Swanson and Murphy, 1991). Evaluations, generally, have concentrated on economic rather than psychological, impacts.

EAP evaluations, utilising a range of indicators, generally yield positive outcomes. Return to work figures range from 50 percent (Franco, 1960; Eggum, Keller and Burton, 1980) to around 70-80 percent (Asma, Hilker, Shevlin and Golden, 1980; Trice and Beyer, 1984). One UK evaluation, for ACCEPT, a London based alcoholism program (Vetter, 1981) found that 80% of its clients retained their jobs despite the fact that only 40-50 percent of the sample were completely abstinent (Asma et al, 1980). A sample of 480 private company EAPs found return to work rates of 60-80 percent (Blum and Roman, 1986). Similar success rates are quoted with respect to other indices such as absenteeism, turnover and health care costs (Wrich, 1984). Studies have reported reductions of 74.6% in worker compensation costs, a 55.4% reduction in health care costs and a 43% reduction in visits to company medical services (Swanson and Murphy, 1991)

Maiden (1989) evaluated the US. Department of Health and Human Services Employee Counselling Service (ECS). This sixteen program EAP covered 150,000 employees and saw over 2,500 clients during the 30 month evaluation. The evaluation collected data on measures of annual, sick and non-salaried leave. The ECS units, and thus service delivery

models and components, were compared with one another to address questions of relative effectiveness. A control group of non-ECS clients were compared with the ECS client group on the dependent variables in groups differentiated on the basis of demographic variable (Maiden, 1989). Various measures of cost-effectiveness (the cost per client for all clients served and the cost per unit change in counsellor ratings of client status) and cost-benefit (changes in sick leave and supervisory performance ratings of performance) were employed to compare the various EAP components. Maiden (1989) estimated that on average, over a six month period, there was a benefit of \$1.29 for every dollar invested in the program; a figure extrapolated by the author to \$7.01 over a five year post-intervention period. On average supervisory ratings of employee performance (recorded on a -3 to +3 scale) changed from an intake score of -2.3 to a post-intake score of +1.3.

Job rehabilitation rates of 77% were recorded in the ten year evaluation of the Illinois Bell Telephone Company EAP (Asma, Hilker, Shevlin and Golden, 1980; Wrich, 1984) which included 752 service clients in the study. Job efficiency ratings of 'good' rose from 10% to 60% whilst on and off-the-job accident rates decreased by 42 and 61% respectively. The authors translated these benefits into estimated savings, from reduced absenteeism alone, of over one and a quarter million dollars. Study clients had at least five years of pre and five years of post-referral employment.

A 16.35 to 1 return on investment in the EAP, in terms of absenteeism reduction, was estimated by Wrich's (1984) evaluation of the United Air Lines EAP. Absenteeism was measured for the twelve month periods before and after EAP attendance. The level of absenteeism at two of the United Air Line sites fell by as much as 74 and 80 percent after using the EAP.

The evaluation of the Kennecott Copper Companies EAP (Wrich, 1984) included 150 service clients. The study assessed change on measures comparing the six months, pre-referral period with both the twelve month treatment period and the six month post-intervention period. Although the program focused on alcoholism, eighty percent of the clients were experiencing other problems. A benefit: cost ratio of six to one was based on a 52 percent improvement in attendance by clients, a 75 percent decrease in weekly state disability costs and a 55 percent decrease in health and medical cost after participation in the program and in comparison to a group of 150 non-attendees.

Ahn and Karris (1989) note that most evaluators, when assessing EAP costs and benefits, have not accounted for problem severity and differential costs associated with

employees at different organisational levels (e.g. the loss of a manager, in economic terms, represents a greater loss than that of a shop floor employee), that the costs of absenteeism, turnover and so on are often averaged out over all employees. Their University of Maine's EAP (set-up in 1980) study, which served approximately thirteen percent of the university's 2231 employees, in its first three years of operation, attempted to redress this deficit. A six point grading of severity was employed as were the various costs of employment (salary, fringe benefits) that were associated with each type and level of job in the university. Annual, possibly conservatively estimated benefits of \$64000 were identified from an investment of \$28000 per annum (Ahn and Karris, 1989). Although the study was, in many respects, more sophisticated and comprehensive in terms of cost appraisal than other studies, it did not include other costs such as those of arbitration and grievance, lost supervisory time spent in dealing with a poorly functioning subordinate and so on.

McClellan (1989) evaluated the Ohio State EAP, set-up in 1984, which was designed to meet the needs of all State employees, with services provided by non-State contractors. There were a number of practical problems associated with the evaluation, which included not being able to access figures for employee salaries (because it was a State EAP), the contracting system's complexity (44 separate insurance plans, 86 separate vendors of fee-for-service interventions) and inconsistent accounting procedures. The range of potential dependent variables was restricted by the State's absenteeism policy which, effectively, treated absenteeism as if it was a right, non-systematic data collection, a decentralised, inconsistent personnel function and problems measuring output levels for some state functions, such as the fire service (McClellan, 1989). Often, it was impossible to measure, with any validity, dependent variables such as absenteeism and accidents.

Ohio's State program generally spent more on mental health than other states (McClellan, 1989), which could be attributed to a failure to intervene early in problems, thereby inevitably incurring the greater costs that are associated with more severe disorder such as longer stays in hospital, a higher percentage of hospitalisation, a large number of electroshock treatments (generally a treatment of last resort) and a greater number of therapy sessions (six, with 28% having 15 or more sessions) than the average (2.5, McClellan, 1989). The impact of the EAP was supported by other performance indicators such as employee utilisation and employee acceptance of the program, with the majority of users (86%) reporting at least a partial resolution of their problem. Of 146 clients, 57% stated complete or almost complete satisfaction with the service that they had received, although a return rate of only 31% suggests the possibility of a biased sample.

McClellan (1989) argued that whilst cost-effective, the Ohio State EAP was not cost-efficient, with the large numbers of vendors ensured high administrative costs. The impact on economic performance indicators such as absenteeism and turnover remains unanswered because of deficits in data collection and because of weak and inconsistently applied human resource policies. McClellan recommended that the complex system of insurance policies and vendors be replaced by an in-house program.

The McDonnell Douglas Corporation's EAP, a corporation wide program supporting over 125,000 employees, world-wide, was evaluated, longitudinally, over the 1985-88 operating period (The Almanac, 1989). The dependent variables were levels of medical claims and absenteeism. For each of several cohorts there was a focal year, the 'T-year', the year when individuals visited the EAP. Thus the 1986 'T-year' included all those individuals who visited the EAP during 1985. The medical claim records were examined for this first cohort in the 'T-year' and also in the follow-up years; T+1 (1987), T+2 (1988) and T+3 (1989). The pre-intervention years 1985 and 1984 were designated, respectively, T-1 and T-2. The case load for each year was: 1032 (1985), 2631 (1986), 4743 (1987) and 5492 (1988). Each respondent was then matched on the basis of six demographic variables of age, sex, marital status, geographic location, family size and job code to a cohort control group consisting of ten individuals. These allowed medical costs and absenteeism costs to be compared between EAP users and non-users. A number of "contaminated" cases (The Almanac, 1989), who included those who had obtained multiple treatments and catastrophic cases (e.g. transplants) were identified and removed from the sample, to avoid cost data becoming skewed. Evaluators accessed the medical files and selected those cases who had received some kind of psychiatric or psychological intervention. Costs were divided into *attributable costs* (payments for direct psychological intervention) and *residual costs* (payments for routine medical care). Study results indicated that EAP investment yielded a three to one return in terms of reduced medical costs and reduced absenteeism. A comparison of costs for alcoholism treatment indicated a cost of \$4000, for the EAP treated individual, and \$8000 for the non-EAP treated individual. Clients who sought help for family related problems or for mixed (substance abuse and psychiatric) problems were younger, hourly paid employees were more likely to seek help for substance abuse, psychiatric conditions and family stress, than salaried employees and single and divorced employees were far more likely than married employees to access the EAP.

Smewing and Cox (1995) compared levels of self-reported health and morale in two units (medical and surgical) from the same hospital. Medical unit staff could access an EAP, the surgery unit could not. Three hypotheses were tested: (1) That the presence of

an EAP will reduce the need for support through work, (2) that individual perceptions of organisational healthiness (Smewing, Cox and Kuk, 1994) would be more positive where an EAP is in operation and (3) EAPs will have a longer term influence on well-being. Those medical staff who accessed the EAP reported significantly less need for assistance, through work, than surgical staff and they reported a better development and problem solving environment. Whilst surgical, non-EAP employees reported a decrease in being uptight and tense from time one to time two, the medical, EAP staff, reported increases, on the same dimension, from time one to two. The authors concluded that an EAP's impact took time to work through. The EAP appeared to have an impact on unit culture, in particular on the quality of the problem solving and developmental aspects of this environment. The authors suggested that EAPs may have a wider impact than is usually acknowledged, that not only are they able to impact on the individual that they are also able to affect the host organisation at the level of personal perceptions of organisational healthiness and its culture.

EAP evaluations, apparently, strongly support the concept of employee assistance. Evaluations need to be treated with some caution due to a number of methodological weaknesses of employed evaluative designs (Berridge and Cooper, 1993; Kurtz, Googins and Howard, 1984; Murphy, 1988; Shapiro et al, 1994). Studies rarely include control groups or randomly assign participants to study groups. As a result, it is difficult to attribute change to an evaluated EAP since there is little to support the internal validity of the study (Cook and Campbell, 1979), although there are very real practical difficulties in applying certain methodologies, that maximise internal validity, in applied settings. These difficulties are illustrated in Walsh and Hingsons (1985) account which reported the problems in setting up a randomised and controlled evaluation of alternative interventions for problem drinkers. Only one of 68 companies contacted, whom the authors already had a research relationship with, agreed to participate.

The issue of selection bias, at the stages of program referral and intervention, also affects the reliability of findings (Trice and Beyer, 1984). Many troubled employees, potential service clients, may be terminated before accessing the EAP, during intervention or shortly afterwards. Terminated individuals may be the those who are most troubled and those who have the worst prognosis and/or the most impaired performance (Swanson and Murphy, 1991; Trice and Beyer, 1984). The impact of such biases is unclear. Trice and Beyer (1984) concluded that, on average, only a small proportion (8%) of success rates could be attributed to these biases.

Additional difficulties exist in accurately attributing change in terms of dependent variables such as absenteeism and turnover. For example, post-intervention absenteeism levels, may, in part, reflect other factors as much as the intervention itself. Changes in absenteeism may be due to changes in organisational policy (towards absenteeism), the economic environment or even abnormal weather patterns as well as the EAP. It is very difficult, in these circumstances, to be able to parcel changes on a dependent variable to the various factors that might have contributed to that change.

Thus in conclusion, despite the many claims for their efficacy, EAPs suffer in terms of credibility from a lack of evaluation (Murphy, 1988). Many of the claimed benefits are based on 'evaluations' that lack methodological rigour (Murphy, 1988; Shapiro et al, 1994; Swanson and Murphy, 1991). Many important questions, such as the comparative efficacy of interventions, the relative effectiveness of in-house versus external service provision, the impact of voluntary versus management referral and the utility of various approaches to the identification of troubled employees have yet to be systematically addressed (Murphy, 1988; Walsh and Hingson, 1985).

3.9. Conclusions

There have been few applied work-site studies, of counselling, that have addressed questions of psychological impact. The only exceptions are the Post Office study (Cooper and Sadri, 1991) and a number of investigations that have assessed the impact of EAPs on alcohol related behaviour. This question needs to be addressed. Studies that have addressed the extent of change, in employee distress, have rarely employed validated clinical measures. Change has often been assessed on a single measure of employee functioning, assessed either by service counsellors or by client supervisors.

The surprising extent of the failure to evaluate is illustrated by Highley and Cooper (1995). They reported from a survey of 145 company EAPs (23 internal and 122 external), that the majority of organisations did not evaluate the organisational impact of these interventions. They were happy to let them run so long as there were no overt problems. Fourteen percent of organisations thought that the presence of the EAP had affected levels of absenteeism, although few companies had actually measured it. The failure to evaluate is not merely a problem confined to US EAPs: It is a criticism that can be applied to EAPs everywhere (Albert, Smythe and Brook, 1985).

The majority of EAP/ECP evaluations have been economic, either investigating service cost-effectiveness (CEA) or program costs and benefits (CBA). Evaluations have, generally, been of whole programs, rather than of components. Examples of such

evaluations, which have been noted in the text here, include those reported by The Almacan (1989), Maiden (1988) and McClellan (1989). Employee Assistance Programs are usually the 'vehicle' for counselling services (Murphy, 1988; Shapiro et al, 1993); however, they often provide other resources under the rubric of assistance such as legal and financial advice. These services are rarely separated from one another in the context of EAP evaluations. There are, as the above review has illustrated, only a small number of work site counselling evaluations available in the literature. The one example of such an evaluation is the Post Office's employee counselling service study (Allison, Cooper and Reynolds, 1989; Cooper and Sadri, 1991) which included a relatively sophisticated assessment of psychological impact as well as economic impact.

Program components need to be evaluated. Questions about many of these elements, such as counselling, have been addressed in clinical and university settings (Kazdin, 1991; Lambert, Masters and Ogles, 1991; VandenBos and Pino, 1990), but still need to be addressed in applied settings. Can these findings be generalised to the applied setting of employee counselling? Studies which have addressed work performance, in psychotherapeutic research (Minz et al, 1992; Shapiro et al, 1994), have done so in very controlled conditions, with a focus on a single type of problem and with pre-specified client groups. It is difficult to generalise findings, from such specific settings, to real-world settings. Employee counselling services, who deal with very non-specific client groups, issues and settings are not able to exercise that level of control in service evaluation. There is a real need to address questions about the psychological impact of employee counselling. Other questions, relating to program operation, to client referral, identification (of troubled employees) and penetration (of the population of distressed employees) also need to be addressed (Berridge and Cooper, 1993; MacLeod, 1985; Murphy, 1988; Swanson and Murphy, 1981). Such research will not be easily undertaken because of the practical difficulties with applied research and with EAPs, in general (Albert et al, 1985; Bryman, 1988; Murphy, 1988; Robson, 1993; Shapiro et al, 1994).

Chapter Four: The Research Questions

4.1. Introduction

This chapter presents an explanation of how the research questions and methodologies, for this study, were selected. It begins at the level of a broad evaluative model that, through stages, becomes increasingly focused on the research questions, whilst providing a rationale of question selection that integrates the methodologies, the range of available questions, designs and the barriers to the research process.

4.2.1. Concepts and Definitions of Evaluation

Evaluation can be defined as:

“...the systematic application of social research procedures for assessing the conceptualisation, design, implementation and utility of social intervention programs.”

Rossi and Freeman (1989)

with the aims of programmes being to determine

“...to what extent the [program] objectives are actually being realised...the objectives aimed at are to produce certain desirable changes in the behaviour patterns of the [program clients], the evaluation is the process for determining the degree to which these changes in behaviour are actually taking place.”

Tyler (1929, cited in Guba and Lincoln, 1981)

An effective evaluation will, first of all, differentiate between successful and ineffectual programs, secondly, identify program strengths and weaknesses and, finally, identify the processes underpinning the achievement or otherwise of program objectives. There are a range of questions that an evaluation may address, the choice of which may be determined by the underpinning rationale for the evaluation. The questions that may be asked include (Rossi and Freeman, 1987) the following:

(i) "What is the nature and scope of the problem requiring new, expanded or modified social programs?"

(ii) Where is it [the program] located and whom does it affect?

- (iii) What feasible interventions are likely to ameliorate the problem significantly?
- (iv) What are the appropriate target populations for a particular intervention?
- (v) Is the intervention reaching its target population?
- (vi) Is the intervention being implemented in the ways envisioned?
- (vii) Is it effective?; How much does it cost? and what are its costs relative to its effectiveness and benefits?"

Rossi and Freeman (1989, p.18).

4.2.2. The Historical Roots of the Evaluation Movement

Several influences have underpinned the growth of the evaluation movement. The first, the growth of the critical consumer movement questioned the traditional assumptions that:

"...operating a service is equivalent to rendering a service, and that both are equivalent to rendering a quality service are no longer being honoured as inherently valid".

(Speer and Trapp, 1972, cited in Posovac and Carey, 1989, p.16)

Individuals and groups have become less willing to support services unless efficacy and claims of quality can be supported. An example of this increasingly critical stand point is the growth of medical litigation, a reflection of patients being increasingly willing to question medical outcomes. There is an increasing emphasis, on evaluation, for organisations in an increasingly competitive economic environment, to prevent costly errors. This applies as much to the EAP movement as to any other service.

The second influence, an increasing awareness of limited resource availability (Parry, 1992; Posovac and Carey, 1989; Rossi and Freeman, 1987) and a recognition that resources need to be used in the most effective manner possible to justify continued allocation. By implication, interventions are obliged to ensure that allocated resources are being used as effectively as possible and, therefore, they require evaluative frameworks and methodologies to ensure the maintenance of service quality.

The next section reviews a series of models of evaluation that have been developed. These are both general and specific to EAPs.

4.2.3. Models of Evaluation

A variety of evaluative models have been developed. The Evaluation Research Society (1980) bases its categorisation on each type's purpose, listing, in the process, the activities prescribed by each noted purpose. These are (a) *Front-end analysis* (pre-installation, context, feasibility analysis) which takes place before programme onset, to provide guidance for the planning of the program and its implementation, (b) *Evaluability assessment*, where the feasibility of evaluation approaches and methods are assessed, (c) *Formative evaluation*, which provides developmental and process data to aid program improvement, modification and management, (d) *Impact evaluation* (summative, outcome, effectiveness) which informs decisions about program continuation, expansion, reduction and funding, (e) *Programme monitoring*; (the assessment of program compliance with policy, service delivery and counting clients and (f) the *Evaluating the evaluation* (secondary evaluation, meta-evaluation, evaluation audit, critiques of evaluation reports, re-analysis of data, external reviews).

A second framework rationalise the evaluative process into a series of sequential stages (Posovac and Carey, 1989; Rossi and Freeman, 1987) of (i) Program Conceptualisation and Design, (ii) Program Monitoring, (iii) Implementation Accountability and the (iv) Assessment of Program Utility, its Impact and Efficiency.

During Stage One, a program must, if it is to achieve its aims and objectives be able

"...to define the problem precisely, assess its extent, describe the elements of the intervention, and accurately define the target population to be served." (Rossi and Freeman, 1987, p.67)

The initial step is to clearly define the problems to be tackled, to identify and define targeted problems which, in turn, sets program boundaries. Various questions are addressed at this stage: Will the EAP intervene at the level of the individual, the group, team or the whole organisation or a combination?; Will the EAP deal only with employees or will its remit also cover the families of employees? This process of program boundary definition has profound implications for the provision of services.

With program boundaries set, the level, type and extent of addressed problems in the target population need to be assessed. Information will be collected either through existing data sources (existing surveys, literature reviews, census data, existing personnel records) or through a comprehensive assessment of population needs. The quality of this information, through identifying problem patterns (severity, type and disorder type for an EAP), will affect decisions of overall resource allocation, the level of service provision

and resource distribution to each program element, which will allow resources to be accurately targeted to need. With targets specified, objectives and aims can be operationalised. Several factors need to be taken into account; the prevalence and incidence of cases, the population at risk (employees, employee families and the interaction of population sub-groups with the probability of disorder), the sensitivity of disorder measures, definition and measure specificity, population characteristics now, and in the future, program demand and the epidemiology of presenting issues (Posovac and Carey, 1989; Rossi and Freeman, 1987).

The second evaluative stage builds on the information collected during stage one. Program goals and objectives are developed on the basis of collected information during stage one. The impact of program content on goal achievement, the definition of the target population, resource allocation and outcome measurement needs to be assessed (Rossi and Freeman, 1987). The program is tailored to the needs of the host organisation, the target population and to available resources. Programs should not be standardised, they should reflect the local environment, which will maximise the chances of a successful program outcome (Rossi and Freeman, 1987).

Stage three, program monitoring, should address three questions (Rossi and Freeman, 1987): (i) Is the target population being reached?, (ii) Does service provision match program specifications? and (iii) What resources are being expended during program operation? If interventions are not reaching the appropriate target group(s), then there will be an impact on program outcomes, with gaps being identified, and rectified, at this point. Program monitoring needs to be continuous, to prevent programs 'veering' off course (Posovac and Carey, 1989; Rossi and Freeman, 1987). The final, fourth stage, assessing impact and efficiency (cost-effectiveness and cost-benefit analysis), again depends on initial planning and the needs analysis, since impact assessment is dependent on comparison with pre-set criteria.

4.2.4. Specific Employee Assistance/Counselling Evaluation Models

A number of evaluative models have been described that have been specifically applied to EAPs. These include the frameworks described by Cayer and Perry (1988), Kim (1988), Maiden (1989), Ford and Ford (1986) and Parry (1992).

Cayer and Perry's framework (1988) utilises five performance standards: *Effort* (resource quantity and quality); *program performance* (the programs impact on the individual and the organisation); the *adequacy of performance* (is program able to address the targeted

problems); *efficiency* (cost-benefits and effectiveness) and *process* (the operations and decisions associated with identifying, assessing, treating and re-integrating patients). Identifying a final performance standard is dependent on addressing four issues: EAP attributes (selection modes, the effect of being an EAP client on production and morale); differential treatment effects; operating conditions (the impact of resource allocation on program performance and individual outcomes) and the treatment effect specification (extent, immediacy and duration of impact).

Kim's (1988) model, based on those described by Freeman and Rossi (1987) and Posovac and Carey (1989) includes four stages: (i) Intervention planning, (ii) Program monitoring, (iii) Impact assessment and (iv) Economic efficiency. Seven evaluation models are generated from these four stages: (1) Needs evaluation, (2) Program development, (3) Utilisation analysis, (4) Outcome evaluation, (5) Net effect assessment, (6) Cost-benefit analysis and (7) Cost-effectiveness analysis.

A third model, a five element modification of the Stufflebeam CIPP Evaluation Model (employed by Maiden, 1989), allows management to be given continuous feedback whilst a data base is set-up for the end evaluation. The conceptual elements employed by this model include: context (geography and organisational and community characteristics); inputs (EAP structure and function, Staff and project characteristics, training, technical inputs and resource allocation); process (program operation, contract negotiations and day-to-day running which allows program outcomes to be interpreted); impact (changes to measured individual and organisational variables and predicted program deployment) and outcomes (economic impacts).

Models of functioning such as the systems approach, applied to EAPs by Ford and Ford (1986), also have implications for evaluation. The systems model, because of its emphasis on the interdependency of systems and non-linear causality has the potential to provide a range of additional performance criterion to the evaluative process.

Parry (1992) proposes a six category framework for evaluating existing psychotherapy services. Six different approaches are described, based on a model proposed by Donabedian (1980): Service evaluation; operational research (constructing and manipulating mathematical models, based on organisational prototypes, to provide a solution to problems); medical audit (professional self-monitoring, based on peer review of the care process); service audit (routine self-monitoring by practitioners as a core element of service delivery); quality assurance (set therapy performance standards are monitored) and total quality management (a management-led commitment to continually

improving service provision). Parry's argument, already stated elsewhere, is that service providers need to provide evidence to support continued resource allocation. Parry (1992) listed six assessment criteria: (1) Is the service relevant? (Is the intervention relevant to clients needs?), (2) Is it equitable? (Is the service reaching those who need it? Is anybody being excluded from service use?), (3) Is it accessible? (Are there blocks to access, such as geographic location?), (4) Is it acceptable? (Is it 'meeting customer requirements?'), (5) Is it effective? (Is counselling achieving intended outcomes, the reduction of psychological distress?) and (6) Is it efficient? (Cost-efficient use of available resources?), with criterion application generating benchmarks for service evaluation.

Evaluative frameworks provide researchers with a systematic and comprehensive approach to the generation of questions, strategies, methodologies and measures. There are, however, a range of 'filters' in applied research that act to restrict this choice. These 'filters' are described in the following section.

4.3. Research Questions, Design and Methodology

"Fieldwork is permeated with the conflict between what is theoretically desirable on the one hand and what is practically possible on the other. It is desirable to ensure that the sample was representative, uniformity of interview procedures, adequate data collection across the range of topics to be explored, and so on. But the members of organisations block access to information, constrain the time allowed for interviews, lose your questionnaires, go on holiday, and join other organisations in the middle of your unfinished study. In the conflict between the desirable and the possible, the possible always wins."

Buchanan, Boddy and McCalman (1988)

Thus, the applied researcher needs to be opportunistic in his, or her, approach to working in organisations. The process, the stages where decisions need to be made, within this organisational context, is described by Posovac and Carey (1989). The six steps, that an evaluator needs to take, in selecting appropriate questions and methodologies are to: (1) identify relevant personnel; (2) to negotiate resource allocation and the evaluative rationale, with program stockholders; (3) to assess program evaluability, (4) to review relevant literature; (5) to determine a range of appropriate methodologies and (6) to write the proposal. These all impact on question selection, with decisions made at each stage affecting those made later on. In addition, there is the need to identify appropriate, available data sources since this will impact on the scope and depth of evaluation.

Evaluative models, such as those described above, provide the researcher with a considerable selection of questions, designs and methodologies. Real-world constraints require the researcher to be realistic, to be opportunistic (Bryman, 1988; Robson, 1992). Barriers, such as resource allocation (finance, personnel and time), access negotiation, the potentially disruption from evaluation, compromise between organizational and research agenda, organizational changes and various practical constraints all had an impact on the process of question selection in the reported study. The next section of this chapter will describe the process of selecting the research questions, designs and methodologies for the studies presented in this thesis.

4.3.1. The Selection of Research Questions

The various evaluative frameworks, described above, provide a systematic basis for the generation of research questions. The selection of research questions is dependent on the types of methodology and designs that can be adopted in an applied context. The various obstacles, to research, that exist in organisations means that question selection is intimately dependent on the extent of access that can be negotiated with the host. This access, and its quality, defines the research designs and methodologies that can be adopted, which impacts on the selection of research questions. The final set of questions, therefore, is dependent on the available options, the access negotiated, and the available methodologies and designs. The next section describes the process of selecting questions for the reported study, starting with the range of questions that could be asked.

4.3.2. Selecting Research Questions in the Context of the Reported Study

The available evaluation frameworks generate a wide range of potential questions that could be addressed in a research program. These include addressing the efficacy of the intervention, questions of the economic and financial viability, needs analysis, the impact of the program, its accessibility (service users and non-users), resourcing, cost-benefit/effectiveness and whether it is addressing what it was designed to target. The process of negotiation, of determining the quality and extent of access meant that a range of these options could not be addressed in the reported study.

The study, reported here, was undertaken at two sites, One and Two. It was intended to undertake a detailed needs analysis of Site One. However, this option could not be proceeded with, because of the fact of several other surveys that were either in progress or scheduled to begin, at the time of the research. There was a fear of 'survey fatigue'.

The decision was taken to concentrate on a restricted range of questions, with a primary focus on the intervention, counselling, with a secondary focus on clients evaluations of the counselling service. In general terms, there were, at both research sites, restrictions on the amount of data that could be collected at any one time. These constraints, and how they had an impact on various decisions made during the research process, are described in subsequent sections of this chapter.

In examining counselling outcome, there are various considerations that need to be taken into account, influences that shape the final 'look' of the study. These include the theory underpinning the selection, from a range, of research questions that can be asked, the research designs that are applicable in a particular context, the measures that are available (and the implications of using each one) and the practical limitations that are apparent in the research context.

4.4. Counselling Outcome

Outcome, measured, usually, in terms of pre-post changes on standardised assessment measures (Lambert, Masters and Ogles, 1991), is defined, by Hill and Corbett (1993, p.3), as "...changes that happen as the result of the processes of psychotherapy."

Research, in this area, has attempted to address Paul's (1967) 'universal' question:

"What treatment, by whom, is most effective for this individual with a specific problem, under which set of circumstances?"

This question presents a considerable challenge, with over 400 described therapies (Lambert et al, 1991) and a large number of separate diagnoses listed by the American Psychiatric Association, in its DSM-III-R publication (Kazdin, 1991). When additional factors, such as client and therapist characteristics are added, the difficulties in addressing Paul's question, in full, is apparent, since it would demand a considerable resource investment. The research focus has, thus, been refocused on comparing broader therapy categories (e.g. insight and cognitive-behavioural).

Lambert et al (1991) developed a three category framework of outcome questions, presented in Table 4.1. Each successive category represents an increasing sophistication in terms of the questions posed, each demanding increasingly sophisticated methodologies and technologies (VandenBos and Pino, 1980). Historically, the Type I

questions were addressed first and the answers to these questions have allowed Type II and III questions to now be posed. The selection of questions, addressed in an applied context, is heavily influenced by the factors already discussed.

4.4.1. Research Designs: The Options and the Study

Once the research questions have been selected the next issue needs to be addressed is that of the design that will be adopted. Campbell and Stanley (1963) categorised a two element conceptual schema to categorise research designs. This conceptual framework, developed further by Cook and Campbell (1976; 1979; 1991) and Cook, Campbell and Peracchio (1990), evaluates designs according to their 'ability' to maximise internal (to eliminate competing, plausible explanation) and external (to extrapolate findings as widely as possible to as many alternative settings) validities.

To a great extent, maximising one validity compromises the other. The maximisation of internal validity demands a considerable level of control, that does not exist in the 'real world', and as a result findings are difficult to extrapolate to other, uncontrolled settings. In applied settings, the imposition of the control required to maximise internal validity may actually modify target programs to the extent that the program is no longer the target program. In field settings, where researchers have less control, the quasi-experimental designs described by Campbell et al attempt to maximise internal validity. These designs utilise, where possible, various control groups with the aim of negating as many threats to validity as possible. The application of such designs to program evaluation is dependent on the negotiation of suitable access.

Table 4.1. A Categorisation of Questions of Counselling Outcome

Type I. Questions of Effectiveness.

"Is Counselling / Psychotherapy Effective?"

"Do people who participate in therapy change more than people who do not?"

"Are the effects of therapy short-term or long-term?"

Type II. Questions of Therapeutic Ingredient.

"Are positive therapeutic outcomes due to patient expectancies or therapy?"

"Is client centred therapy more effective than rational-emotive therapy?"

"Are professionally trained therapists more helpful than paraprofessionals?"

Type III. Questions of Enhancement.

"Will matching therapy and patients increase efficacy?"

"Does adding a "gains maintenance" component reduce the likelihood of relapse?"

Historically, counselling and psychotherapy research has attempted to maximise internal validity, through adopting increasingly specific research designs (homogenous samples, multiple outcome assessments, exclusion and inclusion criteria, manualisation and comparison of the impacts of different treatments on target problems), by applying control to treatment, therapist, outcome and client variables (Edwards and Cronbach, 1952; Shapiro et al, 1994; VandenBos and Pino, 1980; Edwards and Cronbach, 1952).

In attempting to maximise internal validity, the research effort has focused on analogue studies, the assessment of interventions using non-clinical populations (Kazdin, 1991), a development reflecting practical barriers in using clinical populations, such as treatment and therapist preference, administrative restrictions, cost, ethical and legal issues and the difficulties ensuring a homogenous sample. Analogue settings allow control and internal validity to be maximised (Cook and Campbell, 1979), thus enabling many of the Lambert et al's (1991) level II and III questions to be addressed. But, the target problems addressed in analogue studies differ from clinical problems on a number of quantitative (e.g. severity) and qualitative dimensions. Analogue clients are often students chasing course credits and, as a result, there are difficulties extrapolating the findings from these studies to applied settings (Kazdin, 1991). Other studies, such as the Second Sheffield Psychotherapy Project (Shapiro, Barkham, Hardy and Morrison, 1990) and the National Institute of Mental Health Treatment of Depression Collaborative Research Program (Elkin, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Leber, Docherty, Fiester and Parloff, 1989) have used clinical samples, although clients were only included in the study if they met a series of pre-inclusion criteria. Therefore, one of the problems with the vast body of counselling and psychotherapy studies is that many research findings cannot easily be extrapolated to applied settings, because of the artificiality of many 'pure' contexts.

Traditional experimental designs randomly allocate participants to treatment group and non-intervention (control) group(s), a design employed to maximise control over study variables (Lambert, Shapiro and Bergin, 1986; VandenBos and Pino, 1980). There exist, considerable ethical problems when incorporating control groups into applied research settings. For example, there is the issue of denying an intervention to an individual in need, especially when one considers the considerable body of evidence that exists about the efficacy this type of intervention (Luborsky, Singer and Luborsky, 1975; Shapiro and Shapiro, 1982; Smith, Glass and Miller, 1980; VandenBos and Pino, 1980) and, thus, there is minimal benefit, in scientific terms, to be gained from investing resources that a control group requires. Adopting a design feature, such as a control group, may modify the existing program. Is one evaluating the original service, or a semi-artificial entity

which then makes it difficult to extrapolate findings to the original program? Finally, the investment may be wasted if distressed control group participants decide to access counselling from another source.

The study reported in this thesis included two research sites. These are described, in detail, in Chapter Four. Both research sites did not want either control groups or the random assignment of clients to groups. As a result, other design elements, such as placebo groups were also not an option. Other design elements, reported in the literature, that were developed to maximise internal validity, through focusing on a homogenous client group, focusing on specific, targeted problems of a pre-set severity level, therapy manualisation and other features designed were not applicable to an applied context, such as the one in which the reported study took place. Applied research settings rarely allow the investigator to exercise much control. In the case of the reported study there was little opportunity to maximise internal validity, through the inclusion of appropriate design elements. In effect, many of the research questions that selected illustrate the opportunism noted by Bryman (1988). This meant that only a selection of questions, that could have been addressed, were addressed.

4.4.2. Maximising Opportunity: Client Evaluation of the Counselling Service

In keeping with the opportunistic approach, characterising the reported study, it was decided to collect as much data as possible from clients about counselling received, the service and the context within which it operates. The number of questions that could be posed, the size of measures was affected by the 'trade-off' between questionnaire length and the likelihood of completion. Recruitment and retention issues also impact on the quantity and quality of collected data, in an applied setting, with a counselling environment exacerbating these problems. Counselling clients may be even less likely to want to complete a questionnaire, because of their experienced distress, with item completion being viewed as an additional burden.

4.5. Research Questions and Hypotheses

This chapter presents the specific research questions to be addressed by and reported in this thesis. The broad research questions are presented in this section with the supporting literature. Specific hypotheses, however, are presented at the start of individual chapters.

There are two approaches to establishing relationships between empirically collected facts and theory: The confirmatory/hypothetico-deductive and the exploratory/naturalistic method (Howard, Orlinsky and Lueger, 1994). These are differentiated by Howard et al (1994):

"The confirmatory approach emphasises internal validity at the expense of the generalizability of findings ... The exploratory approach, on the other hand, emphasises generalizability (external validity) often at the expense of failing to eliminate alternative explanations for the results. The exploratory approach seeks to establish how things do happen."

Howard et al (1994), p.4-5.

Due to circumstances, already noted, the study design reported in this thesis could not apply the control required for a purely confirmatory approach: Indeed, the context within which the research took place meant that an exploratory approach was appropriate. The following research questions are organised around the various empirical chapters.

4.6. The Research Questions for Chapter Six

4.6.1. Will there be Significant Pre-post Reductions on Outcome Measures

Chapter Seven addresses questions of counselling outcome and gain maintenance at post-counselling and follow-up. The overall question, addressed in this chapter, is whether the target services are effective interventions, in terms of reducing presenting problems, and whether pre-post reductions are maintained at follow-up. Specific hypotheses, with supporting reviews of the literature, are presented.

4.6.1.a. Why the Interest in Outcome

Eysenck's attack on psychotherapy in his 1952 paper "The Effects of Psychotherapy: An Evaluation" questioned the efficacy of therapy. These criticisms, since refuted on empirical and logical grounds (Bergin and Lambert, 1978; Hill and Corbett, 1993; McNeilly and Howard, 1991; VandenBos and Pino, 1980), identified a very real need for efficacy claims to be supported. At the time of Eysenck's paper, there was a lack of empirically rigorous studies in the literature (VandenBos and Pino, 1980) to support the claims made at the time of publication. The rapid expansion of mental health services, and the growing costs associated with this investment, led to increasing demands by

fundamental justification for resource allocation (VandenBos and Pino, 1980; Yates, 1994; Yates and Newman, 1980).

4.6.1.b. Reviews and Effect Sizes

The evidence for efficacy has been summarised in a number of traditional and meta-analytic quantitative reviews. The traditional approach involves an expert(s) reviewing the literature and drawing conclusions on the quality of findings. Quantitative reviews, on the other hand, attempt to systematically judge, through raters, the quality of the various study elements and to assess the extent to which an intervention is able to effect change in terms of effect size.

Effect sizes (ES) are usually calculated using Cohen's (1977) formula. This provides a ratio of change that divides the difference between pre and post mean scores, by the pre-intervention standard deviation. Reviews of therapeutic interventions have usually compared the treatment group pre-post change with pre-post change for various control groups. The approach, to effect sizes, takes the difference between post-test means and divide by a standard deviation . The standard deviation (SD) is either the control group SD or, alternatively, the pooled SD from across both groups. An ES of 1.0 means that there is a difference equivalent of one SD between the treatment and control groups. This formula differs from the pre-post effect sizes reported in this thesis, which are calculated by subtracting the post-counselling from the pre-counselling mean and then dividing the result by the pre-counselling standard deviation. This approach to effect sizes could not be employed in the study reported in this thesis because the design did not employ a control group.

A pre-post effect size, when compared to the review post-counselling treatment-control group ES, are generally the larger of the two, since control group participants, although not in receipt of intervention, often display pre-post changes (usually reductions, Lambert, Shapiro and Bergin, 1986) in scores. The treatment/control group ES ratio is a function of the relationship between treatment and control group means. Pre-post changes in control group scores, in the same direction as the treatment group, will reduce the size of this ratio. There is no such influence on the 'raw' pre-post ES, since it is a relationship between pre- and post-intervention scores for the same group. This presents problems for interpreting the outcome of the interventions being evaluated, since most of the literature utilises a different effect size formula.

4.6.1.c. Is Counselling an Effective Intervention

The qualitative reviews:

In their review, of 57 studies, Bergin and Strupp (1970) judged that 84% of 'methodologically adequate' and 75% of the 44 'questionable' studies reviewed had resulted in significant pre-post reductions in target variables. A second review by Bergin (1971) of 48 studies, ordered and assessed on the basis of sample type, therapy and other design features such as the use of a control group, supported this initial finding. Bergin concluded that, on average, psychotherapy worked. He also noted that the practice of averaging across studies obscured a number of helpful, as well as potentially harmful, therapeutic processes.

Whilst dynamic psychotherapy was effective for psychosomatic conditions, Malan (1973) stated that there was little, if any, evidence for its use as an intervention for neurotic and character disorders. Malan felt that, in part, this lack of support reflected the use of inappropriate outcome measures.

Luborsky, Singer and Luborsky (1975) used twelve criteria applied by several judges to evaluate the methodological adequacy or otherwise of 106 comparative outcome studies. Ratings, which were reliable between the judges; $r=.84$, were 'collapsed' into a single grade for each study. Positive or negative signs were assigned to each experimental and control group. A positive indicated greater change for the experimental group, a negative greater change for the control group and a zero indicated no difference between the groups. The authors found sufficient support to be able to conclude that "...a high percentage of the patients who go through any of these psychotherapies benefit from them."

Meta-Analytic Reviews of Comparative Studies:

Smith and Glass's (1977) review of 175 studies that produced 833 effect sizes (ES) and which included 25,000 controls and 25,000 treated participants. Effect sizes were used as dependent variables, with study elements such as client IQ, referral source, general diagnostic group and so on, being quantified as independent variables. Eighty-eight percent of reviewed studies reported positive therapeutic effects. Treated individuals could 'expect', on average, pre-post benefits that were .68 of a standard deviation greater than those in non-treatment control groups. They felt able to state that

"the average person who undergoes psychotherapy will be better off than 75% of those who do not.." p.754.

A second larger meta-analysis by Smith, Glass and Miller (1980) of 1,766 effect sizes, from 475 controlled studies identified an average effect size of .85. Thus, the average recipient, of psychotherapy, is better off than eighty percent of those who do not receive intervention. There was little evidence, from this review, of any negative effects from psychotherapy., with only nine percent of the effect sizes being negative. Removing placebo groups boosted the average ES to .89, whilst also removing the undifferentiated group boosted the mean ES to .93. These findings, and conclusions drawn, have since been supported, using the same data set, by Andrews and Harvey (1981) and by Landman and Dawes (1982).

The Shapiro and Shapiro (1982a) study reviewed 143 comparative outcome studies. Each study had to include at least two treatment groups in its design to be reviewed. The mean of 1,828 effect size, taken from 414 treated groups, was .93. The authors stated that although this result supported the previous review findings, that there were difficulties applying findings to applied settings because of the analogue nature of reviewed studies. Other studies, such as The Quality Assurance Project (1982; 1983) and those by Dush, Hirt and Schroeder (1983), Miller and Berman (1983) and Steinbrueck, Maxwell and Howard (1983) have, using other data sets, also substantiated findings.

Howard, Kopta, Krause and Orlinsky's (1986) meta-analysis, which included 2431 patients in the reviewed studies, found a stable relationship between therapy received and the degree of improvement. By the eighth session, 50% of clients had improved and by the 26th session, the figure had risen to 75%. A 'law of diminishing returns' was in evidence with the greatest, per session, improvement occurring during initial sessions.

A review of 58 comparative therapy studies, targeting depression, indicated that, on average, a treated group could 'expect' pre/post improvement, in terms of effect size, of .73 greater than a non-treatment control group (Robinson, Berman and Neimeyer, 1990). Improvement persisted to follow-up (.68).

Pre-Post Treatment Effect Sizes:

The Quality Assurance Project (1983) reported pre-post effect sizes for placebo (1.07) and treatment (1.72) groups, whilst the first Sheffield Psychotherapy Project (SPP1, Shapiro and Firth, 1987) reported effect sizes for exploratory (insight) and prescriptive (cognitive-behavioural) therapies of respectively 1.76 and 2.85 for insight and prescriptive therapies, for the Present State Examination (PSE), 1.84 (insight) and 1.77 (prescriptive) for the Beck Depression Inventory (BDI) and 2.09 (insight) and 1.50 (prescriptive) for the 90 item Symptom CheckList (SCL-90). The second Sheffield

Psychotherapy Project reported pre-post treatment effect sizes of 1.77 for the BDI, 1.64 for the depression sub-scale of the SCL-90R, 1.35 for the SCL-90R Global Severity Index, 1.00 for the Inventory of Interpersonal Problems (IIP) and 2.32 for the Present State Examination (Shapiro, Barkham, Rees, Hardy, Reynolds and Startup, 1994).

Uncontrolled pre-post effect sizes ranging from 1.59 to 5.48 were reported by Chambless and Gillis (1993) in their review of cognitive-behavioural therapy (CBT) interventions, for generalised anxiety disorder. The authors reported effect sizes for the CBT treatment, respectively, of .90 for panic disorders, 1.22 for anxiety, .20 to 1.31 for panic attacks and .62 to 1.79 for social phobias.

Cooper and Sadri's Post Office study (1991) evaluated the impact of work site counselling on employee well-being. Pre-post effect sizes ranging of .85 for anxiety and .90 for somatic anxiety were reported by this study.

An ES of one, as reported in the psychotherapy literature, is classified as being large in Cohen's (1977) effect size classification. Such an effect size compares favourably with ESs reported for other psychological interventions, such as .67 for a nine month long reading program in elementary schools in the US and .40 for a computer based intervention used in the teaching of mathematics (Smith et al, 1980). Therefore, there exists a considerable body of evidence that argues against Eysenck's 1952 critique of psychotherapy (Hill and Corbett, 1993; Lambert, Masters and Ogles, 1991; Lambert, Shapiro and Bergin, 1986; Orlinsky and Howard, 1986; Shapiro and Shapiro, 1982a; VandenBos and Pino, 1980), with improvement for treated groups exceeding that associated with no-treatment and placebo groups (Lambert, Shapiro and Bergin, 1986; Stiles, Shapiro and Elliott, 1986).

The literature, therefore, predicts that there will be significant pre-post reductions.

4.6.2. Differences between Measures in the Extent and Pattern of Change

Howard et al's (1986) dose-effect model "...demonstrated a linear relationship between the log of the number of sessions and the normalised provability of patient improvement" (Howard et al, 1995, p. 9). This model, when applied, has challenged the basis of Eysenck's (1952) damning critique of psycho-therapeutic outcomes. The impact of a few months of psychotherapy, in the studies reviewed by Eysenck, resulted in outcomes

equivalent to the impact of two years of all other forms of help available to an individual (McNeilly and Howard, 1991).

A number of authors have observed that symptoms and syndromes exhibit a differential responsiveness to therapy (Howard, Lueger, Maling and Martinovich, 1993; Horowitz et al, 1988). Howard et al (1993) have developed a three phase (demoralisation, remediation and rehabilitation) model of psychotherapeutic change to account for observations of differential responsiveness of psychological problems to intervention. The demoralisation phase implies a need to intervene where the individual client feels completely demoralised and unable to cope, with many clients being able to leave therapy after this stage, with their resources re-mobilised (Howard et al, 1994). Others will go onto the second therapeutic phase, remediation.

Remediation, is about reducing the symptoms of distress that led that the individual to seek help in the first place. It involves the refocusing the clients coping resources to alleviate symptoms. Once achieved, many clients will terminate counselling, whilst others having identified habitual difficulties, either in terms of recurring interpersonal problems or long-standing difficulties in dealing with various aspects of their lives, will move onto the third phase, rehabilitation.

The third intervention phase, rehabilitation, provides a context that allows deeper rooted problems to be addressed, with the focus being on unlearning inappropriate habits or destructive patterns and replacing them with new ways of dealing or relating to relationships, coping and so on.

The authors state that these sequentially dependent phases imply differences in therapeutic goals, at each stage, and that there is a need for different outcome measures (e.g. distress and interpersonal problems) to assess these different goals. This model suggests a differential responsiveness, both in terms of timing and the extent of change, of problem elements to intervention.

The reported study employs measures of distress and interpersonal problems. The Three Phase Model predicts that there will be differences, in the extent of pre-post change, between measures of distress and measures of interpersonal problems.

4.6.3. Will there be any Pre-Post Increases in Coping Strategy Use

"The coping process ... in its broadest sense refers to any attempts to deal with stressful situations which a person feels he must do something about, but which tax or exceed his existing adaptation response patterns ... all [methods] are undertaken with the same ultimate objectives-preventing, reducing or resolving the stress and its consequences."

Burke and Weir (1980) p.300.

On one level, an intervention's efficacy will be determined in terms of its ability to reduce reported levels of distress and to help the recipient of intervention to deal with the underlying causes of distress. However, as the quote from Burke and Weir (1980) suggests that post-intervention the recipient should, ideally, be able to deal with future problems with greater success. There should be improvements in the individuals ability to cope. Therefore, one would expect an intervention, in this instance counselling, to provide clients with enhanced coping strategies, to effectively 'inoculate' them against future problems (Ganster et al, 1982).

It is predicted that there will be increases in the reported use of coping strategies from pre-counselling to post-intervention.

4.6.4. Will there be Improvements in Client Evaluations of Counselling

The experience of counselling is likely to have an impact on positive and negative evaluations. If counselling is, for the client, a positive experience, with reductions in reported symptoms, then this is likely to be reflected in higher scores on measures of positive impact, with reduced scores on negative impact measures. If counselling has not been effective, then one would expect that clients will report more negative impacts.

Pre-post reductions in distress are likely to be translated into greater positive ratings of counselling impact at post-intervention.

4.6.5. Are Gains at the End of Counselling Maintained at Follow-up

The maintenance of therapeutic gain to follow-up is important in terms of therapy practice and funding. Therapy is an effective intervention that is associated with significant and clinically meaningful pre-post change (Lambert et al, 1986; Shapiro and Shapiro, 1982a; Smith et al, 1980). However, the case for resourcing psycho-therapeutic interventions is greatly weakened if post treatment gains are only short-lived. Whilst it is

unlikely that there will ever be an intervention that will inoculate the individual against all future disturbance and symptom development (Lambert et al, 1986), it is still necessary to ensure that gain maintenance into follow-up is maximised both in terms of duration and extent. The therapy, psychological or otherwise, that maximises benefit in terms of the extent of pre-post change and the maintenance of that improvement at follow-up is the therapy that will be selected from its 'rivals'. One problem, though is to clearly define what is meant by 'lasting improvement'.

Robinson et al (1990) found that the pre-post treatment effect size (ES) of .73 persisted into follow-up with little change (.68) from the post treatment ES. There was an average correlation of .92, between the post treatment and follow-up mean effect sizes, across the nine reviewed studies.

Nicholson and Berman's (1983) review, of 67 studies, included only those whose samples were self-referred neurotics and that utilised post-treatment and follow-up design elements. The average length of the follow-up period for the reviewed studies was 8.6 months, with the length of the follow-up period ranging from a few months to a couple of years. Three questions were addressed:

- "1. ... whether the status of a patient at post treatment accurately predicts that patients status at follow-up ...
2. ... whether differences between groups at the end of therapy accurately reflect differences between these groups at follow-up [and]
3. ... whether the status of a treatment group at the end of therapy is the same as its status at follow-up." (p.262-263).

Nicholson and Berman (1983) concluded, first, that gains at post-treatment were maintained at follow-up, secondly, that post-therapy status correlated with follow-up status, third, that differences at post treatment, between therapies, were maintained at follow-up and, fourth, that there was little change over the follow-up period. The length of the follow-up period did not affect correlation's between post-treatment and follow-up scores.

In contrast to Nicholson and Berman (1983), Smith et al (1980) and Shapiro and Shapiro (1982a) have reported treated and control group differences that were smaller at follow-up than at post treatment. However, Landman and Dawes (1982), using a subset of the Smith et al (1980) database that had both treatment and post-treatment assessments, and the Andrews and Harvey (1981) review support the Nicholson and Berman (1983)

conclusions, with little or no change in inter-group differences between comparison groups, over the course of follow-up. Differences in review findings may well reflect variations between sample characteristics (e.g. patients) and reviewed studies (Lambert et al, 1986).

Shea, Elkin, Imber, Sotsky, Watkins, Collins, Pilkonis, Becham, Glass, Dolan and Parloff (1992) traced the course of depressive symptoms over a year and a half, with assessments at six, twelve and eighteen months. Thirty-three percent of the therapy sample were classified as having met the recovery criteria, whilst twenty-four percent had recovered and remained well throughout the eighteen month follow-up period. This pattern of change was fairly consistent across the four conditions (cognitive-behavioural therapy, interpersonal therapy, imipramine and clinical management and placebo and clinical management).

Shapiro, Rees, Barkham, Hardy, Reynolds and Startup (in press) found that, whilst gains at post treatment were maintained at follow-up, that only 29 percent of the sample, who returned measures (n = 104), were free of symptoms on all three post-treatment and follow-up (three and twelve months) occasions. On the BDI, the respective figures for the number of asymptomatic, partially symptomatic and fully symptomatic clients were 54, 22 and 28, respectively, at the end of treatment, 54, 22 and 27 at three months and 69, 13 and 22 at twelve months, figures that suggest the maintenance of post-treatment gains at follow-up.

The benefits of therapy, and their maintenance, in the long term may be overstated, since many of those who fail to return follow-up measures were significantly more distressed at post-treatment than those who did return measures (Shapiro et al, in press). It would appear that some of the 'low responders', to treatment, effectively select themselves out of the follow-up element of the study design.

The results and conclusions, described by Shapiro et al (in press), contradict those of Nicholson and Berman (1983) and Robinson et al (1990) in that, although short term gains are maintained at follow-up, this relationship is far from uniform, since there was a sizeable minority who evidenced relapse and reoccurrence across the post-treatment and follow-up occasions.

Overall, the evidence suggests that the majority of clients, even those with a history of recurrent disturbance, remain healthily adjusted, maintaining post-treatment gains at follow-up (Lambert et al, 1986; Nicholson and Berman, 1983). There is evidence of

various sub-groups, 'hidden' within the overall mean, that display more varied behaviour. Some clients relapse, whilst others relapse and then recover (Shapiro et al, 1994). In all, half of the Shapiro et al (1994) sample were judged 'unstable' in their clinical status, by the authors, because of movement across the symptom threshold or because of their need to seek further treatment.

4.7. The Research Hypotheses for Chapter Eight

4.7.1. Within-group Differences in Pre-post Change across Measurement Occasions

Garfield (1986), in concluding his review of client variables as predictors of outcome, argued that judgement about the possible demographic predictors of outcome needed to be withheld because of the often ambiguous nature of the available evidence. Firm conclusions are not easily drawn as a result. Garfield noted, however, the need for further research and, more specifically, the need for more sophisticated, specific designs, samples and variables that would allow these questions to be addressed.

4.7.2. Age

Due to the continuous nature of the variable, any generalisations about age from research findings can only be made to samples with a similar age range (Garfield, 1986). Luborsky, Chandler, Auerbach, Cohen and Bachrach (1971) concluded, from their eleven study review, that 'Older patients tend to have a slightly poorer prognosis' (p.151). However, the data supporting this conclusion was weak (Garfield, 1986). At least one of the four supporting, 'positive' studies (Zigler and Phillips, 1961, cited in Luborsky et al, 1961) was a study of social competence and hospitalisation rather than psychotherapeutic outcome. The Smith et al (1980) meta-analysis provided no support whatsoever for a relationship between age and outcome.

No relationships between counselling outcome and age are expected.

4.7.3. Gender

According to Garfield (1986), the evidence supports the contention of Jones and Zoppels (1982) study, a retrospective evaluation of the impact of gender on therapeutic outcome, "that gender is not an over-riding influence in psychotherapy" (p.271).

No differences between men and women in terms of pre-post change are expected.

4.7.4. Career Status at Pre-counselling

There is a strong relationship between career and both education and socio-economic status (Vessey and Howard, 1993). Whilst, there would appear to be an absence of studies examining educational background, as a client variable, work exists that has addressed socio-economic status and outcome. There is, albeit limited, evidence of a positive association between socio-economic status and outcome (Garfield, 1986). Luborsky et al (1971) reviewed five studies that cited socio-economic class as a variable. Two studies found a positive relationship, two no relationship and one a negative relationship. One of the key difficulties was in defining this variable: should the classification be in terms of current economic status, parental status or environmental (and thus socialising) context? Lorion (1973) was more certain in his conclusions, having reviewed the link between socio-economic status and outcome

"while socio-economic status appears to be a significant correlate for [attending in the first place], and duration of, individual psychotherapy, it does not relate to treatment outcome' (p.263).

No differences, in pre-post change, between occupational groups are expected.

4.7.5. Relationship Status

The 'stress-buffering' hypothesis suggests that social support acts, help to reduce the impact of stressors on the individual (Burman and Margolin, 1992; Cohen and Willis, 1985). The more intimate the relationship, then the greater the social support resource. On this basis, those who are married or cohabiting should have greater access to quality social supports, than those who are single. There exists evidence that marital status can impact on the likelihood of the successful outcome of both medical (Neale, Tiley and Vernon, 1986) and psychological interventions (Moore and Chaney, 1985).

There is evidence that limited interpersonal relationships and social skills are associated with poor therapy outcomes (Auerbach, Luborsky and Johnson, 1972; Sotsky, Glass, Trace Shea, Pilkonis, Collins, Elkin, Watkins, Imber, Leber, Moyer and Oliveri, 1991), whilst perceived social support, social satisfaction and the ability to develop a good relationship have been associated with a positive therapy outcomes (Billings and Moos, 1985; Gonzales, Lewinsohn and Clarke, 1985; Sotsky et al, 1991). Those with stronger interpersonal relationships, possibly sign posted by the individual being married, or cohabiting, may well have a better chance of a positive outcome. One would expect that there will be a relationship between marital status, at pre-counselling, and therapy outcome. It may also be that it is the quality of the relationship(s), rather than the fact of

a relationship(s) per se, that may be of greater importance here. Even so given this possibility, the limited number of cases available for analyses will minimise the likelihood of such a relationship being identified. On this basis, the following hypothesis is formulated. There will be:

No differences, in pre-post change, is expected between relationship groups.

4.7.6. Prior Experience of Counselling and other Forms of Help-Seeking

There is little evidence, in the psychotherapy literature, for a relationship between prior help-seeking and outcome (Garfield, 1986). However, Depue and Monroe (1986) have identified a substantial minority of individuals who are chronically vulnerable to the experience of psychological distress. It is possible that many of these are repeat users of mental health services. It may be that this group of individuals are exposed, chronically, to stressors or that they have an innate vulnerability. Although, many of this group are repeat users, whilst they may benefit from intervention, they may also be more likely to experience relapse at follow-up. There is little evidence to support a hypothesis either for or against a difference. Given, the small number of cases available to analyses it is expected that there will be a reduced likelihood of a significant relationship being identified and the following hypothesis is, thus, formulated:

No differences between experienced and inexperienced help-seekers are expected.

4.8. The Research Questions for Chapter Nine

4.8.1. Change Across Sessions of Counselling

Authors such as Greenberg and Pinosof (1986) have argued for a 'finer-grained' analysis, examining the individual impact and outcomes of counselling sessions as opposed to 'cruder' pre-post outcome evaluations, representing the mainstay of research efforts. This is in contrast to the 'traditional' approach, to psychotherapeutic outcome, which assess pre-post treatment change. Proponents of a finer-grained analysis argue that counselling consists of a multiple series of events, occurring within each session of counselling, and that identified pre-post changes represent a series of intra-session changes and, thus, it is overly crude to use the whole counselling event, measured in sessions, as the unit of analysis.

A meta-analysis, employing sessions as the unit of analysis, was published by Howard, Kopta, Krause and Orlinsky in 1986. This study, which included 2431 patients from 30 years of published research, indicated that session-by-session improvement rates are in excess of rates associated with spontaneous remission. Analyses indicated a stable pattern of change across reviewed studies. The Howard et al (1986) analysis indicated that fifty percent of clients displayed measurable improvement by the eighth session of intervention and that by the end of six months of psychotherapy (twenty-six sessions), seventy-five percent of clients showed marked improvement. Results indicated that, even over a comparatively short period of time, a substantial therapeutic effect could occur. Howard et al (1986) estimated that fifteen percent of psychotherapy clients will show measurable improvement before attending their first session. It is likely that these individuals are the least distressed, receiving benefit from the expectation of help.

It is predicted that clients will exhibit a reduction in levels of distress across sessions of counselling and that the rate of improvement will decline across sessions.

4.8.2. Session Impacts

The interest in addressing questions of session impact, has largely been motivated by the 'equivalence paradox' (Stiles, Shapiro and Elliot, 1986), identified in both the psychotherapeutic (Lambert, Shapiro and Bergin, 1986; Shapiro and Shapiro, 1981) and SMT (Sallis, Trevorrow, Johnson, Hovell, and Kaplan, 1987; Reynolds and Shapiro, 1991; Reynolds, Taylor and Shapiro, 1993) literature's. This paradox refers to the 'problem' that theoretically differentiated interventions appear to result in equivalent outcomes. In response, there have been attempts to discriminate theoretically specific impacts from the general factors associated with positive outcome (Reynolds et al, 1993). Elliott and Shapiro (1988) and Stiles et al (1988) have demonstrated that clients are able to differentiate between therapy modes in terms of technical impacts and session evaluation: They can identify differences between therapy types. It has been suggested that studying the immediate impacts of treatment sessions can provide insight into the mechanisms underpinning change (Reynolds et al, 1993; Stiles, 1980; Stiles, Shapiro and Firth-Cozens, 1988; Stiles and Snow, 1984).

The Session Impact Scale assesses three impact types: (a) task impacts (e.g. problem definition or insight, that reflect session components, (b) non-specific interpersonal, relationship impacts (e.g. support, relief and involvement) and (c) unhelpful, negative impacts (e.g. confusion or feeling attacked). In Elliot and Shapiro's (1988) study, prescriptive (cognitive-behavioural) therapy sessions were associated with problem

definition and problem solution whilst exploratory sessions were associated with personal insight and awareness.

Reynolds et al (1993) employed a waiting-list control design with 92 participants assigned to ten treatment groups. The intervention, six two hour workshops included topics corresponding to 'typical' SMT programmes ('signs of stress', relaxation techniques, relationship difficulties and assertiveness, attributions, time management, goals setting, emotions and social support). These SMT session impacts were compared with a sample from the Second Sheffield Psychotherapy Project (SPP2, Shapiro, Barkham, Hardy and Morrison, 1990) who had either completed sessions of cognitive-behavioural or interpersonal therapy. Exploratory clients reported significantly higher levels of personal insight and awareness, the SMT clients reported more third party insight, than prescriptive therapy clients and both the prescriptive and SMT clients reported significantly higher levels of problem solution than exploratory clients. There were significant inter-session differences, on the SIS, for both positive and negative ratings. There were also significant linear and higher order polynomial trends for most of the items. There were no linear (or higher order) contrasts for personal insight, third party insight, awareness, involvement or any of the negative impacts. Participants from the SMT group reported session impacts that were similar to the prescriptive clients; impacts that differentiated these groups from the exploratory client group.

Clients will become more positive in their ratings of counselling impact across sessions of counselling.

4.8.3. Impact and Outcome

Reynolds, Taylor and Shapiro (1993a) reported correlation's between measures of psychological distress, job and non-job satisfaction (Warr, 1990) with session impacts. There were significant, negative correlation's between participant ratings of post-session mood and program involvement and psychological distress at one month. Clients reporting greater involvement and more positive post-session mood also reported fewer symptoms at follow-up. Whilst there were no relationships between job satisfaction and session impacts, there were positive correlation's between task and non-specific impacts and non-job satisfaction at one month follow-up. Positive ratings of the six sessions reported fewer symptoms at follow-up. These differences, between job and non-job satisfaction, were attributed to participants (92 women) having greater control over their home as opposed to their work environments, a control allowing them to exercise the various techniques learnt through attending SMT sessions. The authors concluded that

there was a role for the use of session-impact process methodology in evaluating the impact of SMT, since the SIS had allowed the identification of the apparent contributions of role task and relationship impacts in the reduction of psychological distress.

4.9. Summary of The Research Questions

Hypotheses are presented at the beginning of each separate results chapter.

Chapter Six

- 1 Will there be significant pre-post reductions on measures of outcome?
- 2 Will pre-post effect sizes be comparable to those obtained from psychotherapy studies?
- 3 Will there be greater pre-post changes in distress than in interpersonal problems?
- 4 Will there be significant pre-post increases in the reported use of coping strategies?
- 5 Will clients rate counselling more positively at post-intervention, than at pre-counselling?
- 6 Will post-counselling gains will be maintained at follow-up?
- 8 Will there be a relationship between age and outcome?

Chapter Seven

- 9 Will there be differences in pre-post change, between men and women, on outcome measures?
- 10 Will there be differences in pre-post change, between shift and non-shift workers, on measures of outcome?
- 11 Will there be differences between sites in pre-post change?

- 12 Will there be a relationship between prior help-seeking and counselling outcome?
- 13 Will there be a relationship between occupation and pre-post change?
- 14 Will there be a relationship between relationship status and outcome?

Chapter Eight

- 15 Will there be relationships between outcome and session impact?
- 16 Will there be reductions in distress across sessions of counselling?
- 17 Will there be significant increases in global ratings of counselling?
- 18 Will there be a negative relationship between distress and session impact?

Chapter Nine

The evaluative chapter, Chapter Nine, was largely exploratory in nature and, as a result, there are not any research questions as such.

Chapter Five: Methodology

5.1. Introduction

This chapter describes background information on the settings of the two sites included in the study presented in this thesis. In addition this chapter presents a description of the samples and measures included in the cross-sectional, retrospective pilot study that was conducted at Site One and the longitudinal pre, post and follow-up study that was undertaken at Sites One and Two.

5.2. The National Health Service: A Context

The current study is set in the National Health Service (NHS). The first two set the scene for the study by describing the NHS, recent changes to it and a breakdown of the organisation's workforce.

The NHS is a substantial organisation: the 1994 National Association of Health Authorities and Trusts (NAHAT) reported that, in 1990, the NHS employed over one million people and had a budget of over £16.6 billion in 1988/ 89. These figures mean that the NHS is, by far, the largest UK health care provider and, indeed, it is one of the largest organisations in Europe (NAHAT, 1994). Organisationally, at the start of the study, it consisted of the Department of Health and the NHS Management Executive which oversaw the operations of sixteen health service regions (fourteen Regional Health Authorities [RHAs] in England and health authorities for Wales, Scotland and Northern Ireland, NAHAT, 1994), the Special Health Authorities and the Trusts (Ham, 1991). The regions oversaw the functioning of the District Health Authorities (DHAs), the Family Health Services Authorities (FHSA) and the Community Health Councils (CHCs). This structure, which had only recently been put in place at the start of the research project, has been superseded by an evolved structure where the regions have become an 'outpost' of the NHS Executive and have, as a result, lost much of their power base. The recent reforms of the NHS stem from three White Papers; Promoting Better Health (1987), Working for Patients (1989) and Caring for People (1989). Many of the ideas that were introduced in the 1989 white paper, Working for Patients, originate from Alain Eindhoven's concept of the internal market (NAHAT, 1993-94) and its application to the health service. The aim of the internal market concept was to inject the spirit of competition into the state provision of health care, through (1) the separation of funding and provision, (2) the creation of NHS Trusts, (3) GP fund-holding practices and (4) Contracts for service agreements (Ham, 1991). The purchasers; the

District Health Authorities (DHAs) and the GP fund holders, buy health care for their patients from the autonomous acute and community Trusts.

The adoption of these new organisational structures and free market philosophies to the provision of health care by the NHS has demanded considerable change on the part of its employees at all levels of the organisation. This adoption has forced radical change in terms of culture, philosophy and ethos onto health care providers who, in the past, would not have necessarily viewed the provision of such services from a financial or economic perspective. Change is rarely made without some cost and resistance (Buchanan and Huczynski, 1985) which in part may stem from feelings of job insecurity that are associated with change (Kahn and Byosiere, 1992; Sutherland and Cooper, 1988) and a lack of satisfaction with a culture that may contrast with personal philosophies (Kahn and Byosiere, 1992; Sutherland and Cooper, 1988). There have been plenty of reports in the media, in recent years, about the resistance to and concerns about the changes in the NHS from professional groupings such as doctors and nurses.

5.2.1. The Health Service Occupations

Both study research sites in the study presented here in this thesis were located in the National health Service (NHS). The NHS is one of Europe's major service sector employers and, because of this, a huge slice of its budget (70%, Ham, 1991) is taken up by employee salaries. In 1990, the NHS employed, in the United Kingdom, a total of 1,001,340 employees (NAHAT, 1994). This figure could be broken down into 57,900 doctors and dentists, 505,250 nurses and midwives (excluding agency staff), 43,670 professional and technical staff (excluding works), 15,110 scientific and professional staff, 44,190 from the professions allied to medicine (PAMs), 20,970 maintenance staff, 22,290 ambulance staff (including officers), 148,790 administrative and clerical staff (which include Northern Ireland managers), 10,400 general managers (excluding Northern Ireland), 5,180 works professionals and 127,580 ancillary staff (NAHAT, 1994, p.58). Of the total, approximately 66.9% could be classified as being direct care staff (Ham, 1991). In addition to the directly described employees, described above, the NHS, in 1989, employed, as independent contractors, 25,300 GPs, 11,500 opticians and 10,100 retail pharmacists.

5.3. The Sites and their Counselling Services

5.3.1. Site One

The pilot study was undertaken at Site One, located in London. There are two organisationally separate, though interdependent components to Site One. The first was originally, at the start of the data collection period, a Special Health Authority (SHA) which later became a NHS Trust. This Trust located, principally, on one site, with several smaller sites: A maternity hospital and an elderly care unit. The time span of data collection, from 1992 to 94, has been characterised by upheaval at the SHA, general changes to the nature and structure of the NHS, nationally, as well as more localised changes: Two applications for Trust status. Its first 'solo' application, which was accepted, was superseded by the second, a joint application with another London hospital.

The SHA does not provide undergraduate medical teaching, although it is an internationally recognised provider of post-graduate medical, nursing and paramedic training. In addition, it has a world class reputation for its academic and research activities and has a considerable reputation for being a demanding, tough and competitive environment.

The second organisational component of Site One is a large and, again, highly prestigious academic research faculty. It is referred to, within the context of this thesis, as the 'ResFac'. This second, Site One component is also characterised by being highly competitive and demanding and, again, has also experienced considerable organisational change, due to the rationalisation of the funding research bodies and general changes to higher education.

5.3.2. The Site One Counselling Service

The origins of Site One's counselling service are to be found in growing concern about stress levels being experienced by Site One employees (Site One Annual Report, 1991). The following, specific stressors had been identified by Site One's management as being of particular concern:

- the high volume of research, an activity that inevitably generates uncertainty.

- the high level of technically complex medical treatment which places an added pressure on nursing staff already being asked to care for sicker patients occupying beds for shorter times.
- a competitive atmosphere engendered by highly motivated academic and medical staff producing an ethos in which any admission of stress or difficulty however temporary is an indication of failure.
- in common with other academic institutions and other areas of the NHS, the [host organisation] are seeing many organisational changes and having to operate within financial constraints. These affect managerial, administrative and support staff as well as clinical staff.

(Site One Annual Report 1991).

A decision was taken in 1989 to set up and develop a counselling and stress management service, with the head of the service being appointed in April 1990. The first month of operation was spent, by the service counsellors, making contacts with individuals and departments throughout Site one in an attempt to raise the profile of the service. Clients were first seen in May 1990.

The counselling service is organisationally separate from both Occupational Health and Human Resources, although it is managed by the latter function. This separateness allows the service to claim autonomy from Site One management, which helps to add credibility to claims of service confidentiality. The service only reports overall figures, for service use, to Human Resources, with nothing communicated that might identify individual clients.

The stated aims of the service, taken from the 1991 annual report of the service are:

"...[to] enable staff to function more effectively at work by reducing stress at individual and organisational levels. To achieve this the service offers an independent and confidential counselling service to individuals at all grades and promotes good practice in stress management in the SHA and the [ResFac]."

In addition to the counselling offered, the service also provides other resources to the host organisation: Consultation for managers and supervisors on organisational problems; workshops on work relationships, group support, team building and training; training seminars on stress management and coping with bereavement, as well as lunch time relaxation sessions. The counselling service works on a service provision model of a

maximum of eight sessions, although the model allows for extended availability in response to individual need. Long-term involvement, with clients is avoided where possible.

Initially, the service was promoted through the use of leaflets, posters, articles in hospital newspaper, departmental seminars, talks to various occupational groupings and an Open Day, in September 1990, to launch the service. Publicity, since 1990, has continued to employ similar approaches.

5.3.3. Service use: Breakdown by Occupation for 1990-91 and 1991-92

An occupational breakdown of service users, compared with a breakdown of the organisation, as a whole, are presented in Table 5.1. for the years 1990-91 and 1991-92 (both running from May to April). Several occupational groups, for example the medical profession, are under represented as service users, over both reported years when compared to their representation at Site One, as a whole. For doctors, this discrepancy widens over the two years. The scientific and technical and administrative and clerical groupings were under-represented at year one, although the year two figures indicate service use that increasingly matches their representation in the Site One work force as a whole. Indeed, the administrative and clerical group became slightly over-represented in the client sample. The proportion of nurses in the user sample remained relatively unchanged over the period, with only a marginal increase from 37 to 39 percent of the client group. Both ancillary workers and the professions allied to medicine (PAMs) were over-represented, in the client group, for both reporting periods.

Occupation	Site One Employees.	Clients 1990-91	Clients 1991-92
Medical	13	6	3
PAMs	3	6	5
Nursing	37	37	39
S & Tech	22	15	19
Admin & C	20	14	25
Ancillary	5	10	9
Other	0	2	0

PAMs: Professions Allied to Medicine. S & Tech: Scientific and Technical. Admin & C: Administrative and Clerical.

5.3.4. Service Clients Sessions Completed and an Organisational Breakdown of Clients

As Table 5.2. illustrates, the year 1991-92 saw increases in terms of the number of individual clients seen and in the number of completed sessions. Both increases are unsurprising: During year one, the service operated for only eleven months, whilst there were twelve months of operation during year two. In addition, it would be expected that by year two, both the formal, through posters, newsletters and articles in the Site One newspaper and the informal 'word of mouth', service profiles would be higher. The combination of increased service awareness and the longer period of operation was translated into observed increases in counselling activity.

Category	Years	
	1990-91	1991-92
Number of counselling sessions	525	648
Number of clients	85	106
Employed by the SHA	67	79
Employed by research faculty	15	25
Other	3	2

'Other users' were members of employee families and employees based in, but not employed, by the SHA/ResFac. An approximate 75:25 split, between SHA and research faculty employees, was maintained over both reporting periods, a split that mirrors the distribution of employees between the two site components.

The second annual report (1991-92) described the distribution of counselling sessions across the group of service users. Fifty-eight percent of clients attended between one and four sessions, 23 percent between five and ten sessions, fourteen percent between eleven and twenty sessions and five percent attended more than twenty sessions of counselling. There was no data that allows the underlying reasons for service use to be identified.

The service itself, uses a working maximum of eight sessions per client, although a review of the session data indicates a sizeable number of exceptions to this rule. This 'working ceiling' distorts the pattern of service use in terms of session completion. A number of clients will come to the end of their contracted number of appointments, although they might still wish to continue, although many of these clients would then be referred to external resources. The figures suggest that there is a distinction, in terms of presenting problem, between the less than ten session group (81 percent of the group) and the 'more than ten session' group of clients (nineteen percent). The distinction is not

clear cut, since, for example, the one to four session group will include individuals who have 'experimented' with counselling: They have tried it and have decided that counselling is not for them. Longer term clients may, generally, be presenting with 'deeper', more complex issues than those who have used the service for fewer sessions of counselling.

5.3.5. Negotiating and Developing Access to Site One

The author replied to an advert placed in the Guardian newspaper in May 1992 for a staff counsellor. A letter was sent to Site One's Human Resources department suggesting co-operation in evaluating the Site One staff counselling service. The aim was to provide data that would inform users and providers alike about service effectiveness and would also help to redress the lack of empirical evidence about counselling in the applied work-site context. Both aims would add to the knowledge base, that would help to inform future development, for the host organisation and for this type of service, in general. This letter was passed onto the head service counsellor, who then contacted the author.

A series of meetings were then arranged between the author, the authors supervisors, the counsellors and human resource management with a view to discussing the proposed evaluation, the project proposal and how the submission process would proceed. The proposal (see Appendix 5.1.) was submitted to the relevant Site One ethics and research committees, who agreed to the project before it was presented to the Site One managerial boards for final approval. Data collection, at Site One, began in December 1992 and continued accepting new participants until December 1993. Data collection, the receipt of session and post-counselling measures continued until December 1994.

5.3.6. Site Two

The Site Two service caters for the needs of employees of Trusts located within the administrative boundaries of a North Midland District Health Authority. It differs considerably from Site One in including both urban and rural areas within its boundaries and covers, geographically, a much larger area, characteristics that present communication problems for counsellors and clients alike. Site Two does not have an associated research faculty, as at Site One, although it does provide under- and post-graduate training for doctors, nurses and other health professionals.

5.3.7. The Site Two Counselling Service

Site Two has its roots in observations, dating from 1986/87, made about reported distress levels in district employees and the number of referrals of staff to psychologists, and other District mental health professionals from local GPs (Site One Counselling Service Report, 1991). The first step in response to the report was to set up a District Stress Working Group and one of its first decisions was to set up the Staff Counselling Service.

Counsellors were existing staff members who included psychologists (n=14), the hospital chaplain, two occupational health staff and a Relate trained former health visitor who had become a member of the health promotion unit. Since the service was not a dedicated one, counsellors having other duties other than staff counselling, the advantage of having a relatively large number of counsellors was that the workload could be spread thinly between those involved. It also allowed a wider geographical spread of counsellors over a geographically large area, ensuring in the process that staff at all sites could easily access members of the service.

Service contact, initially at least, was made through the Occupational Health Department. As the service developed, however, the names and addresses of counsellors were made available to staff as a whole, who could then directly contact counsellors without having to go through occupational health, which is, potentially, a barrier to service use, although this change risks overload for some members of the team.

The service aimed for a first contact to first appointment time lag of five days. Where this was not attainable, then clients would be informed of the situation and would then have the opportunity to be referred elsewhere if they so wished. The service was advertised through leaflets, posters, articles in the health authority paper, and also through word of mouth.

A code of conduct was developed for the service with its emphasis being on the maintenance of confidentiality. With this in mind, the code stipulates that client records be disposed of as soon as the 'period of help ends,' with the only exception being if the counsellor thought that a return to the service was likely in the future.

5.3.8. The Site One Service: Its First Two Years of Operation

The first two years of the service saw 48 clients, with a further 48 being seen during the first six months of 1990. A more detailed account of a single counsellors case load, from

April 1990 to March 1991 is provided in Site One's 1991 Counselling Service Report. Figures are reproduced here. Thirty-five clients were seen by the reports author over this period, for a total of 136 sessions, an average of just under four sessions per client. Of the 35, five dropped out during counselling. A breakdown of the issues taken to counselling include ten work-related problems and 25 with non-work issues. In terms of a finer grained analysis of presenting problems, these can then be broken down into the following sub-groups (with numbers in brackets): stress symptoms (10), depression (eight), complicated grief (five), phobia (one), habit problem, such as smoking (two), marital problems (one), Post Traumatic Stress Disorder (two), psychosomatic symptoms (one), childhood sexual abuse (two), panic attacks (three), drinking problems (one) and chronic pain (one). Occupationally, this sample could be sub-divided up into administrative and clerical staff (six), nursing (twenty-one), professions and technical (seven) and, finally, ancillary staff (one).

Twenty-six of these referrals came from the acute unit and nine from the community unit, a division ascribed to the fact that the author of the report (Leakey, 1991) has a higher profile in the former, than in the latter unit.

5.3.9. Negotiating Access to Site Two

Access to Site Two was negotiated in May 1993. This was undertaken in response to initial problems in client recruitment and retention at Site One. Historically, the authors academic base (SAPU) has close links with Site Two, having collaborated together in a number of research projects. These links acted as a vehicle to gain and develop access to Site Two. A number of meetings were held with members of the service team over several weeks, leading to a proposal submission both to management and ethics committees, with approval, to the project, being given at Board level by all of the Trusts covered by the staff counselling service.

Organisationally, Site Two's service is more informal than that provided at Site One. The resultant diversity of approaches, with respect to clients and service provision, and the geographical spread of the service throughout the Site Two location necessitated the author visiting each of the counsellors involved in the study. Meetings discussed the study protocol and how it could be adapted to 'local conditions.' It also enabled the author to be able to answer any questions about design, measures and general procedures.

5.3.10. How the Site One and Site Two Counselling Services differ

Organisational differences between the Site One and Two counselling services are a reflection of the differential application of resources to each services, as well as how they are run. The service at Site One is 'dedicated', run by two part-time salaried counsellors whose primary role is the provision of work-site counselling to the employees of Site One and associated organisations. Site Two, on the other hand, provides a service that is run comparatively informally, offered by individuals, such as clinical psychologists and nurse counsellors, on a voluntary basis, who have other roles within the organisation. Indeed, counselling provision is very much of secondary importance: Clients are seen when and if service counsellors have the time. Few of these counsellors are able to have more than one or two clients at any one time due to their workload from their contractual duties.

Site One collects and, more importantly, retains systematic client records, such as demographic data, outcome and the presenting problems of clients. Site Two, at the time of the study, lacked a detailed or systematic approach to collecting client records.

5.4. The Pilot Study

5.4.1. Rationale

The pilot study was undertaken at Site One. Its aims were to assess the questionnaire's content and length and also to collect qualitative data, from a series of open-ended questions and interviews, to help develop a service evaluation questionnaire for use in the main study and to help develop a more detailed 'picture' of the service and the counselling offered to clients.

5.4.2. Design

The pilot study involved former Site One counselling service clients completing a single cross-sectional questionnaire (Appendix 5.2), that contained measures to assess counselling impact, psychological well-being, coping strategy use by respondents and their attitudes to their jobs. Demographic items were also included. These measures are described, in detail, in the main study section of this chapter.

5.4.3. Client Recruitment

The first two years of Site One's service operation provided a pool of approximately 200 former service clients. The service collects and maintains client records for the purpose of evaluation, in keeping with the guidelines suggested by Murphy (1988). Service counsellors produced a list of approximately 100 contactable former clients. A letter (Appendix 5.3.) was then sent to each of this group asking them whether they would like to take part in the pilot study. The letter explained the project, its objectives, that participation was voluntary and, finally, that confidentiality would be maintained throughout the study. Included, with the letter, was a permission form (Appendix 5.4.) asking for the participants address and written permission to participate in the study and to allow collected data to be used for analysis. Thus selection depended on whether the service still had the addresses of former clients and whether the individual still worked at Site One. Certain occupational sub-groups, for example junior doctors, are largely excluded because of the rotational nature of their training which means that they regularly change posts and hospitals and, thus, are very difficult to track.

It is also possible that there was an element of selection on the part of counsellors, who may have excluded former clients, who might have been willing to participate, on the basis of subjective assessments of the likelihood of project participation, or reaction to the project. Signed permission forms, with respondents contact address, were then sent to the author at Sheffield, from Site One.

Fifty-three individuals returned slips stating an interest in participation. These were passed onto the author, at Sheffield, who then sent a questionnaire along with a reply-paid envelope. A second letter (Appendix 5.5.) emphasising the voluntary nature of the study, its confidentiality and the importance of service evaluation was sent along with this questionnaire. A second permission form (Appendix 5.6), asking whether clients would be interviewed, was sent. This letter emphasised the fact that confidentiality would be maintained throughout, with respect to whatever was said during the interview. In all, 30 of the 53 who were sent questionnaires returned them to Sheffield. No efforts were made to contact the 23 ex-service clients who did not return the retrospective questionnaire.

5.4.4. The Interview

Eighteen of the sample agreed to be interviewed and eleven were interviewed. A lack of resources prevented further interviews from being carried out. The aim of the interview schedule (Appendix 5.7.) was to obtain detailed information about the service, the

counselling, the reasons for using the service and the impact of counselling on various aspects of the service users life.

Former clients, who indicated their interest in being interviewed, were sent a letter listing possible times and dates for the interview, at Site One. Arrangements were confirmed, in writing, in a letter from Sheffield. The interview took place in a room adjacent to the main counselling room of the Site One service. Other arrangements were made on the occasions where participants did not work at the main Site One location. All correspondence was undertaken using reply-paid envelopes.

Interviews, which were all taped, lasted between 45 and 90 minutes. Before the start of each interview, participants were asked to sign a form (Appendix 5.8.) giving their permission to be interviewed. At the end of the counselling session they were asked to sign a release form, for the tape, so that it could be used for analysis by the author. Respondents had the option of asking the tape to be wiped, if they felt uncomfortable about the contents of the tape after the end of the interview. All participants were made aware of the fact, both verbally and in writing, that all tapes and materials would be wiped and shredded, respectively, once analyses had been completed. The data permission form is presented in Appendix 5. 9.

5.4.5. Interview Training

The author received training in interviewing skills through a series of role-plays undertaken both directly with the authors main supervisor and with friends of the author. The videos of each of these role-plays were then discussed with the authors main supervisor. The author had also completed an AEB CSCT Course in Counselling Skills in year one of his Ph.D. which was also of benefit in this context.

5.4.6. The Pilot Study Sample: A Description

The sample had all used the service between its opening, in May 1990, and just before the start of the project, in December 1992.

The respondents, twenty six women and four men, who completed the questionnaire were aged between 25 and 60 ($M=38.9$, $SD = 10.0$) years. Eleven were nurses, one a lecturer, two were managers, eight were administrative or clerical workers, four were in professions allied to medicine and four were scientific or technical staff. Sixteen clients were married or cohabiting, one was widowed, five were in a relationship, but were

living apart, and six were single. Eleven of the sample worked some type of shift system. The average length of career was 12.1 (SD = 9.3) years, they had worked, at Site One, for on average, seven (SD = 7.4) years and had been in their current posts for a mean of 4.9 (SD = 7.0) years.

5.4.7. The Outcome of the Site One Pilot Study

The main impact of the pilot study on the main study was to reduce the size of the questionnaire, through the removal of a number of measures. The original pilot study questionnaires contained two broad sub-categories of measures: (a) Clinical and (b) Attitudes to work. The feedback, from the pilot study, indicated that the questionnaire was too long. Since, there was only a small potential pool of counselling clients (approximately 100 were expected to use the service over the course of the study) available to the study, it was important to ensure that once recruited to the study, that their involvement continued. To reduce the questionnaire, to increase the likelihood of client retention, it was decided to narrow the studies focus to concentrate on the mental health measures and to drop the work attitude scales from the study.

The work attitude measures, included in the original questionnaire, were Rizzo, House and Lirtzman's (1970) eight item Role Conflict and six item Role Ambiguity measures, Cook and Wall's (1980) nine item Organisational Commitment scale, the intrinsic sub-scale of Warr, Cook and Wall's (1979) Job Satisfaction Scale and Jackson, Wall, Martin and David's (1993) Timing and Method Control scales, which were modified for a non-manufacturing context. From the health section the 22 item physical health scale (Barton, Costa, Smith, Spelten, Totterdell and Folkard, 1994) was also dropped from the questionnaire.

5.4.8. Site Two: Collecting Service Evaluation Data

An attempt to collect data from former Site Two clients was also made. Two approaches were taken to recruit former clients: Counsellors reviewed their files in an attempt to identify former clients and 300 leaflets were distributed, within the context of a related MSc project, undertaken at SAPU in the Summer of 1993. Unfortunately neither approach was successful. The failure of the first approach stemmed from the lack of any systematic attempt to collect and maintain client records, especially of data that would allow for the identification of ex-clients. For the second approach, 300 leaflets represented only a small number of Site Two employees and leaflet distribution only occurred at a small number of Site Two locations. This second approach involved more

'cold-calling' than the Site One pilot study recruitment process. Combined, both of these factors meant that there was little chance of reaching many ex-service clients. Only two former service clients took part in this part of the research process at Site Two.

5.5. The Main Longitudinal Study

This part of the Chapter describes Study Two. This is the main body of work presented in this thesis.

5.5.1. The Aims

The rationale for this study, along with the hypotheses, is described in Chapter Four. To reiterate, the aims of the study were

- (a) evaluate the staff counselling services at Sites One and Two
- (b) increase our understanding of what is happening in the applied context of counselling at work and
- (c) provide a sound empirical platform upon which to base recommendations for the future development of work-site counselling, both at the research sites and for staff counselling, generally.

Study aims are presented in Chapter Five (outcome), Chapter Six (change across sessions) and Chapter Seven (qualitative).

5.5.2. Definitions used in Analyses

Definitions and abbreviations that are used in this and subsequent chapters are presented in Box 5.1.

Box 5.1. Definitions	
EOC	End of Counselling
Pre-Only	Those who only completed only the pre-only questionnaire
Pre-Post	Those who Completed the Pre- and Post Measures
Outcome Indicators	The SCL-18, the GHQ-12 and the IIP-32
Session Impact	Session Impact Scale (SIS)
Expectations SIS	The pre-counselling Session Impact Scale

5.5.3. Design

A repeated measures design was adopted to assess change, across time, on a number of standardised measures of counselling outcome. This approach was employed to establish the degree of change, from pre- to post-intervention, and the extent to which changes, at post-counselling, are maintained to follow-up. This design allows for the 'added value' of the intervention to be assessed. Participants were asked to complete questionnaires at Pre-Counselling (PreC), End of Counselling (EOC) and follow-up, at one month, three months and six months. Each of the five questionnaires contained scales assessing the respondents psychological well-being, their utilisation of coping strategies, expectations of counselling (at PreC) and counselling impact (at EOC and follow-up).

In addition, participants completed pre and post-session measures. Counsellors completed a number of measures after the end of each session of counselling.

A separate service evaluation questionnaire was sent to participants along with the one month questionnaire. The same measure was sent at three or six months if the questionnaire was not returned along with the one month questionnaire.

5.5.4. Methodology

5.5.5. An Overview of the Questionnaire

The original questionnaire used in the pilot study contained 202 items. After the pilot study, the number of items was reduced to 123. In the pre-counselling questionnaire, items were sub-divided into the following sections (number of items per section in brackets) headed by: 'Some details about you' (fourteen), Service evaluation (five), 'About counselling' (fourteen), 'Your health in general' (twelve), 'Your feelings' (eighteen), 'Your relationships with others in and out of work' (32) and 'Dealing with pressure at work' (28). The last page of the questionnaire was blank and asked for 'Other comments' to allow respondents to provide additional comment on any aspect of the counselling service. The questionnaire is reproduced in Appendix 5.10. Post-counselling and follow-up questionnaires did not include any biographical or service evaluation items. Evaluation items sent to study participants during the follow-up phase of the study were contained in a separate document.

5.5.6. Biographical

Fourteen items covered the participants age, sex, marital status (married/living with partner, separated/divorced, widowed, not in a current relationship and finally in a relationship but living apart), present career, length of time in present career, the length of time spent working at site one, title of post, time in present post, team, department or ward membership, basic hours of work, whether the respondent worked shifts and finally if they do the type of shift pattern that they work (permanent early, afternoon or half-day shifts, night shifts, rotating shifts or other).

5.5.7. Measures of Psychological Distress

The General Health Questionnaire (GHQ-12)

This is a widely used short form version of the original scale designed by Goldberg (1972) to be an easily administered screening measure for detecting minor (non-psychotic) psychiatric disorders amongst community samples. There are several versions of the GHQ, all of which correlate highly with one another (Banks, Clegg, Jackson, Kemp, Stafford and Wall, 1980). This version was selected because of its brevity. Its use with occupational samples was validated by Banks et al (1980) using samples drawn from engineering workers, unemployed men and working and job-seeking school leavers. The GHQ-12 was selected for this study to allow comparison of study samples with other similar employee populations.

Participants select one of four responses to the stem "Have you recently" experienced 'x' 'within the past month', with response wording varying according to item content. Examples of the different item specific response categories include, for the item "Been able to concentrate on whatever you're doing?", the categories are 'Better than usual', 'Same as usual', 'Less than usual' and 'Much less than usual', and for the item, "Been able to face up to your problems?", the categories are 'More so than usual', 'Same as usual', 'Less able than usual' and 'Much less able'.

The GHQ-12 can be scored in two ways, with both methods employed in this study. The first, 'Likert' method scores the four response categories from zero to three, giving a maximum scale score of 36. The second approach, 'Case method' scores zero if either one of the first two categories (0, 1 in the 'Likert' method) are endorsed and one if the third and fourth (2, 3) are circled, for a maximum scale score of twelve. Those scoring more than, depending on the study, a threshold of two, three or four on this method are described as being 'cases', which allows a prevalence rate of emotional disturbance to be estimated. This method allows subjects to be placed into meaningful clinical categories,

enabling comparison between those who move or stay within each of the two categories (case and non-case) to be made. This approach has been validated by Banks (1983), when comparing three versions of the GHQ with the Present State Examination (PSE). All three versions of the GHQ, including the GHQ-12, correlated highly with the PSE Index of Definition and total scores. The Index of Definition, derived from the 140 item PSE, a research interview, is an attempt to specify psychiatric illness in operational terms (Goldberg and Huxley, 1980).

18 salient items from the SCL-90R

Eighteen salient items were used from Derogatis, Lipman and Covi's (1973) measure, the SCL-90R. Respondents are asked to indicate the extent to which a number of problems have troubled the individual using a five-point scale anchored "0. Not at all", "1 A little", "2. Moderately", 3. "Quite a lot" and "4. Extremely." There are two versions of the stem used in the study reported here. The following version of the SCL-18 stem was used in both study one and study two questionnaires. It states, "In the last two weeks how much were you bothered by". The second version of the stem was "Since the last session how much have the following bothered you." This second stem was used in pre-session measures in the second study, which will be described in Chapter Six. Scale items include; "Trouble remembering things?" and "Numbness or tingling in parts of your body?."

The original SCL-90 instrument has been found to be reliable (Derogatis and Cleary, 1977) and to be sensitive to symptom change following psychotherapy (Horowitz, Marmar, Weiss, Kalteider and Wilner, 1986) and relaxation training (Fielder, Vivona-Vaughan and Gochfeld, 1989). The original authors of the measure, Derogatis et al (1973) proposed a nine factor structure, however other authors have arrived at a six factor solution (Barkham, Hardy and Startup, 1994) and have, indeed, argued that the SCL-90R is better thought of as being a uni- rather than a multi-dimensional measure which then suggests that the identification of a core set of salient items would lead to a reduction in items from 90 to 15 to 20 items without much loss of fidelity (Barkham et al, 1994). The motivation to develop such a measure stems from the need to develop a core instrument battery for service evaluation and research that is both comprehensive, in its coverage, and manageable in its size (Barkham et al, 1994).

The sample for the study that identified salient items comprised of 327 consecutive therapy clients drawn from three psychotherapy projects; 166 clients from the Second Sheffield Psychotherapy Project (Shapiro et al, 1990), 42 from the MRC/NHS Collaborative Psychotherapy Projects (Halstead et al, 1990), 70 from the Sheffield Two-

plus-one Project (Barkham and Shapiro, 1990) and a further 42 clients who were referred to one of the above projects, but who were rejected, were also included in the sample. Eighteen items were selected through a principal components analysis. The three highest loading items from each of the six clearly interpretable factors that resulted from this analysis were then subjected to a principal components analysis. The same six factor structure was extracted, which accounted for 70.4 percent of the variance (Barkham et al, 1994). The 18 item mean total correlated highly ($r = .93$) with the SCL-90R. The SCL-18 matched the SCL-90R, in terms of sensitivity with pre therapy scores of 57.81 (SD = 6.10, SCL-18) and 57.88 (SD = 6.25, SCL-90R) and post-therapy scores of 47.49 (SD = 9.38, SCL-18) and 47.68 (SD = 9.91, SCL-90R) with effect sizes of 1.69 (SCL-18) and 1.63 (SCL-90R). The results of these analyses suggest that the SCL-18 is a reliable summary measure (Barkham et al, 1994).

5.5.8. Interpersonal Problems

The Inventory of Interpersonal Problems (32 item version)

The original 127 item scale (Horowitz, Rosenberg, Baer, Ureno and Villasenor, 1988) was designed as an easily administered self-report inventory with two purposes in mind: To identify sources of inter-personal distress that the counselling, or therapy, client is experiencing when he, or she first comes to use the service and to specify what has been achieved through intervention (Horowitz et al, 1988). The use of a standardised inventory allows for the systematic identification of the most frequent issues confronting the counsellor or therapist. Although its development stems from a background rooted in the psycho-dynamic and interpersonal therapies, it is also applicable to the cognitive-behavioural tradition, as well, since all orientations need to be concerned with the whole gamut of psychological problems (Barkham, Hardy and Startup, 1994a). There is, therefore, a need for an instrument that is able to tap into inter-personal domains, to supplement other outcome instruments, an instrument such as the SCL-90R.

The original instrument (Horowitz et al, 1988) contains 127 items, and was shown to be change sensitive with strong correlations with movements on other outcome measures completed by clients, therapist and independent evaluators. Increasingly it is an instrument which is being selected by psychotherapy researchers and practitioners as a measure of outcome (Barkham et al, 1994a).

The scale used here was a short form version of the original containing 32 items (Barkham et al, 1994a), with items divided into two sections. Part one contains nineteen items, prefaced by the wording: "The following are things that you find hard to do with

other people", with a stem for these items of: "It is hard for me to:" The second section, containing thirteen items uses the preface: "The following are things that some people feel they do too much, with the stem: "To what extent do they apply to you?". Scoring is based on a five point Likert type scale. The five response categories are: "Not at all", "A little", "Moderately", "Quite a lot" and "Extremely."

The short-form version of the original IIP was developed in response to the very real need to develop a core battery of outcome measures for service evaluation (Aveline, Shapiro, Parry and Freeman, 1995; Barkham, 1993; Barkham et al, 1994; Parry, 1992), a need first identified by Waskow in 1975. The need for such a battery demands the use of valid measures, which are as short as possible, with the aim of reducing the workload upon both the evaluator and the respondent. The length of the 127 item original is something of a barrier to its widespread use in general, day-to-day practice. The development of a core battery needs to balance the need for brevity and practicality with a demand for a valid, multi-dimensional instrument, the bandwidth-fidelity dilemma (Cronbach, 1970, cited in Barkham et al, 1994a).

The development of the IIP-32 was undertaken through three studies (Barkham et al, 1994a), using data collected from the second Sheffield Psychotherapy Project (SPP2) (N = 216) and the MRC/NHS Collaborative Psychotherapy Project (N = 34). Factor analysis led to the identification of clearly interpretable factors (sub-scale alpha coefficients are presented in brackets): Hard to be Assertive (.86), Hard to be Sociable (.89), Hard to be Supportive (.75), Too Dependent (.71), Too Caring (.72), Too Aggressive (.85), Hard to be Involved (.75) and Too Open (.80). The overall scale alpha was .86. Only item eight loaded greater than .30 onto more than one scale.

The items for each sub-scale (with the IIP-127 item number in brackets) are for T.Caring; 25 (101), 18 (73), 26 (104) and 32 (126), for H.Supportive; 16 (64), 14 (40), 15 (61) and 13 (38), for H.Involved; 5 (15), 19 (75), 12 (34) and 6 (26), for T.Dependent; 31 (117), 27 (106), 22 (84) and 23 (86), for H.Sociable; 7 (23), 3 (10), 1 (3) and 9 (27), for H.Assertive; 2 (9), 11 (33), 6 (20) and 4 (13), for T.Aggressive; 28 (112), 30 (116), 20 (79) and 21 (82) and T.Open; 10 (30), 24 (88), 29 (113) and 17 (71).

Scoring for the overall IIP-32 scale is the mean item score, calculated as the sum of the scores of the 32 items divided by 32. When sub-scales are calculated, items 10 and 17 are reverse scored (i.e., 0 = 4, 1 = 3, etc.). Both of these items are to be found in the Too Open sub-scale. Reverse scoring is not used for the overall IIP-32 score.

In terms of sensitivity, data from a sub-sample from the SPP2 study comprising 117 clients who had completed psychotherapy treatment, indicated a strong relationship between the IIP-127 and the IIP-32. Pre-therapy scores for the full and shorter instruments were 1.68 (SD = .45) and 1.62 (SD = .45) respectively, whilst at post-treatment, they were 1.23 (SD = .57) and 1.21 (SD = .56) respectively. Effect sizes for the instruments were 1.00 (IIP-127) and .91 (IIP-32). At the level of the sub-scales, there were significant improvements ($p = .001$ on all tests), with the exception, for both versions, of the Too Open sub-scale. At both the pre and post stages, correlation's between the two forms were .94 and .96 respectively.

5.5.9. Measures of Session and Counselling Impact

The Session Impact Scale (SIS)

This study employed a thirteen item version of the Session Impact Scale (SIS). The original version contained sixteen items. Wording for this scale varied according to whether the scale was used to measure counselling expectations, contained in the pre-counselling questionnaire), counselling impact, found in the EOC and follow-up questionnaires and to measure session impact.

Expectations and Impacts of Counselling

Expectations of counselling were tapped using a modified version of the Elliott and Wexler (1994) Session Impact Scale (SIS) Version 1. The original version of the SIS consists of sixteen items plus the opportunity for respondents to describe 'other' impacts that might have occurred, but which are not described by scale items. The scales employed here used thirteen items, including the 'Other' item, with modified wording being employed for the expectations and session impact measures. The use of similar items in pre- and post-counselling measures allows counselling expectations and impacts to be compared. Although, the original scale included a short explanatory paragraph after each item label, these were not included in any of the three modified versions.

The item labels, for the thirteen items, are (1) understand something new about myself, (2) understand something new about someone else, (3) more aware of, or clearer about my feelings, (4) a clearer definition of problem(s) to work on, (5) progress about knowing what to do about my problem, (6) more bothered by unpleasant thoughts or I will be more likely to push them away, (7) too much pressure or not enough direction from the counsellor, (8) felt impatient, doubted the use of therapy, (9) relieved, more comfortable as a result of counselling, (10) felt attacked, and I did not think that the counsellor cares, (11) confused and/or distracted and (12) I felt supported or

encouraged. The thirteenth, open-ended item asked respondents to describe additional impacts.

Three sub-scales as well as an overall scale total are calculated. The sub-scales (with items) are Hindering (items 6, 7, 8, 10, 11), for example "I think I will feel impatient, I will doubt the use of counselling", Task (1, 2, 3, 4, 5), for example "I think I will understand something new about myself" and Relationship impacts (9, 12), "I think I will feel supported and encouraged." In the original sixteen item scale, the task and relationship scales were combined into a ten item 'Helpful Impacts' scale (the original scale has five relationship items in it).

Participants were asked to rate the applicability of each item to their experience in terms of best fit on a five point adjective anchored scale (1 = not at all, 2 = slightly, 3 = somewhat, 4 = pretty much, 5 = very much). For the overall scale, the hindering sub-scale items were reversed scored. Higher overall scale scores are associated with more positive expectations of counselling. For the sub-scales, lower Hindering and higher Task and Relationship scores are associated with positive expectations.

Single Item Hindering Measure

Clients completed a single overall evaluative item that asked them to "Please rate how helpful or hindering do you feel counselling will be". Respondents answered on a single item nine-point adjective anchored scale that ranged from 'Extremely hindering' (1) through to 'Neither helpful nor hindering; neutral' (5) to 'Extremely helpful' (9).

5.5.10. Coping

This 28-item scale taken from the Occupational Stress Indicator (OSI) asks the respondent to assess the extent to which they use various listed strategies. The OSI is a self-completion questionnaire designed by Cooper, Sloan and Williams (1988). The introduction to the scale asks the individual "... to rate in terms of the extent to which you actually use them (*the strategies*) as ways of coping with stress." Participants were asked to rate the applicability of each item to their use of described strategies, in terms of best fit on a six point adjective anchored scale. Responses ranged from (1) "Never used by me", (2) "Seldom used by me", (3) "On balance not used by me", (4) "On balance used by me", (5) "Extensively used by me" and (6) "Very extensively used by me". There is no overall scale score. Item scoring is from one to six and scale scores are summative.

Factor analysis was employed for item selection (Cooper, Sloane and Williams, 1988). Thirty items were analysed, with the solution being dominated by a single factor. Because of this, multiple analyses were performed to identify the underlying reasons for such a factor. Despite these additional analyses, the single factor continued to dominate. Items were then content analysed and sub-scales extracted. All items, including those not located on the dominant factor were included, because those loading onto remaining factors were statistical constructions. Three factors, with eigen values and percentage of variance in parentheses, were identified: One (17.08 and 56.9%); two (2.57 and 8.6%) and three (0.81 and 2.7%). Good discriminant validity for the coping scale of the OSI was demonstrated by Kahn and Cooper (1991) with a sample of 220 financial dealers working in ten financial institutions in the City of London (a return rate of 36% with 627 distributed questionnaires). Sub-scale items, with exemplars are presented in Table 5.3.

5.5.11. Session Measures

Pre-session

The SCL-18 (see above for a description) was completed by participants before the start of each session of counselling. This measure is reproduced in Appendix 5.11.

Post-session

A thirteen item version (including 'Other Impacts') of the SIS was completed by clients after the end of each session of counselling. This measure is described in greater detail in Section 5.4.9. and is reproduced in Appendix 5.12. Clients also completed the single item Hindering measure. This is described, in detail, in Section 5.4.9.

OSI Sub-Scale	Items	Max Score	Example of item
Social Support	1, 6, 12, 28	24	Seek support and advice from my superiors
Task	5, 15, 20, 21,23,24,27	42	Reorganise my work
Logic	8, 10, 22	18	Try to deal with the situation objectively in an unemotional way
Home and Work Relationships	7, 11, 13, 17	24	Having a home that is a 'refuge'
Time	1, 3, 9, 25	24	Deal with the problems immediately as they occur
Involvement	2, 4, 14, 16, 19, 26	36	Try to recognise my own limitations.

5.5.12. Counsellor Measures

The following measures were completed by counsellor at the end of each session. The equivalent client measures were not included in the study because of restrictions on the amount of time that clients had to complete measures, for example, clients often had to return to work immediately after the end of a session of counselling. These measures are reproduced in Appendix 5.13.

Session Evaluation Questionnaire (SEQ)

Developed by Stiles (1980) the version of the SEQ used in the reported studies consists of 27 bipolar (seven point) adjective scales (the original scale used 22 items). Respondents are instructed to "Please circle the appropriate number to show you feel about this session." The first three items are preceded by the stem "Today I was" ask the counsellor to evaluate his or her own performance using items such as 'Skilful-Unskilful' and 'Cold-Warm' The next twelve items evaluate the session with the counsellor responding to the stem "This session was". The final set of twelve items tap into the counsellors post-session mood with items preceded by the stem "Right now I feel". Exemplars of the second two sets of items include 'Bad-Good', 'Shallow-Deep' and 'Rough-Smooth' for the first item set and 'Angry-Pleased', 'Confident-Afraid' and 'Quiet-Aroused' for the second set.

Agnew Relationship Measure

Developed by Agnew and Shapiro (1989) this 28 item, seven point scale is worded in the following way: Strongly Disagree (1), Moderately disagree (2), Slightly disagree (3), Neutral (4), Slightly agree (5), Moderately agree (6) and Strongly Agree (7) scale. This measure was used to assess the quality of the client-therapist relationship during the session of counselling that had just been completed. The respondent, the session counsellor, is asked to indicate his or her strength of agreement with each scale item. The first twelve items assess the counsellor's post-session mood, the next twelve tap into the counsellor's perception of the client during the completed session and the last four items assess the quality of the working relationship between the two parties. As a measure, it has been used in the context of a single case study (Agnew, Harper, Shapiro and Barkham, 1994) to examine the congruence between therapist and clients over eight sessions of psychodynamic/interpersonal therapy with respect to their evaluation of the relationship between them.

Session Intentions Questionnaire

Counsellors are asked, at the end of the session, to "Please rate the extent to which you were carrying out or working toward the following activities or goals generally in this

session....". There are nineteen items using a five point scale anchored from "1. Not at all" to "5. Very Much." Respondents are given a detailed descriptor for each item, for instance the "Set limits" item descriptor is:

"To structure, make arrangements, establish goals and objectives of treatment, outline methods to attain goals, correct expectations about treatment, or establish rules or parameters of relationships (e.g., time, fees, cancellation policies, homework).

A final additional 9-point item, a global "Overall Session Rating", was anchored from "1. Extremely hindering," through to "5. Neither helpful nor hindering" to "9. Extremely helpful." The respondent, the counsellor, is asked to "Please rate how helpful or hindering to your client you think this session was overall:"

5.6. Service Evaluation

There are two forms of this questionnaire. The first was developed for use with the pilot study questionnaire (Appendix 5.14), the second for the main longitudinal study (Appendix 5.15.). The second questionnaire was based on the pilot study questionnaire and on improvements that stemmed from looking at responses to the first questionnaire. The two questionnaires are described below.

5.6.1. The Pilot Study Questionnaire

The eighteen items contained in the pilot study questionnaire were split into two sections: (i) Closed and (ii) Open-ended. The response format of the closed questions was either a 'Yes' or a 'No'.

Closed Format Questions

Questions were selected, first of all on the basis of reading literature on service use, counselling expectations and barriers to service use and, secondly, through discussion with colleagues and individuals, known to the author, who had been to counselling. This section, in terms of its questions, was largely explorative in nature.

There were eleven closed format questions, which investigated the following areas of interest:

Prior experience of counselling. Four items asked whether the respondent had used a counselling service, or a help-line, before using the staff counselling service, whether they had any training in counselling skills and if they used counselling skills at work.

Future use of counselling. The four items, in the second group of fixed format questions, asked the respondent if they would use the staff counselling service again, whether they would use another service, whether they would suggest the Staff Counselling Service to a colleague and whether they had already suggested the service to a colleague.

The service itself. These three questions asked about the counselling service: Were there any barriers to service use, whether they felt supported in their service use and what they thought were the advantages and disadvantages in using a work-site counselling service.

Open-ended

Generally, the seven open-ended items followed on from the closed format questions, asking the respondent to explain why he or she had replied in the way that they had. Items asked about using counselling skills at work, about both the advantages and disadvantages of using a work-site service, barriers to service use, how the client would improve the service and if they would not use the staff service again, why not?

A final blank page was provided at the end of the questionnaire to allow further comment.

5.6.2. The Main Study Questionnaire

This questionnaire contains twenty-two questions: Fourteen closed and open-ended. The majority of open-ended questions followed-up responses to closed questions. The questionnaire was sub-divided into four sub-sections (with specific topics in brackets): Prior experience of counselling (prior help-seeking experience, training in counselling skills, use of counselling at work); Getting to counselling (whether the participant was sent, or referred to counselling, if yes, who sent, referred or suggested going, whether they felt under any pressure to go and their reasons for going to counselling); The service (publicity, advantages and disadvantages of attending a work-site service, problems in accessing the service) and In the future (use of the staff and other counselling services, any other comments about the service).

Examples of closed questions include, from Section A; "Have you ever undertaken any kind of training in counselling skills?" and from Section B; "How did you first find out about the staff counselling service?" and for open-ended questions, from Section B, "For what reasons did you decide to go to counselling?" and from Section C, "What are the advantages, or attractions, of using the counselling service at work?".

5.6.3. The Interview Schedule

The 42 questions in the interview schedule, which was used with ex-service clients, are sub-divided into the following sections: 'The problem'; 'Going to counselling'; 'The counselling itself'; 'Impact of counselling', 'Future use of counselling and feedback' and a final section that asked for other comments to be made, if they had not been covered by the rest of the schedule. The questions in the interview schedule were developed through reading the literature on service use and help-seeking. The questions are reproduced in full in Appendix 5.10.

The aim of the interviews was to collect detailed qualitative information that would add depth and 'richness' to the 'picture' being built up about employee counselling, the reasons for using employee counselling, the clients experience of the counselling, its impact on various aspects of the individual participant's life, their perceptions of the counselling service and of the host organisation's attitude towards the service and dealing with distress in general.

The Problem

This first section included eight questions about what problem(s) were brought to the counselling service: The impact of the presenting issue(s) on work, home-life, relationships and the individual (questions two to five). The fifth question asked the interviewee to judge whether the issue had been rooted mainly at home, or at work. Questions six to eight asked about how the individual tried to cope with and resolve the issue(s) and about the level of available support. A final question asked the interviewee to evaluate the extent to which their initial attempts at coping were successful or otherwise.

Going to Counselling

This section included eleven questions. Question 9 asked why the interviewee had decided to go to counselling and whether anybody had suggested service use, question ten asked about prior help-seeking and question eleven asked why the respondent had decided on counselling as opposed to any alternative. Questions 12 to 15 asked about

the individuals' reasons for using the Site One service, why they hadn't gone elsewhere, the disadvantages of using work-site counselling, service publicity, how the interviewee had found out about the service, whether any barriers to service use had been encountered and whether they could think of any ways of improving the service.

Question 16 asked about support for service use from colleagues, whilst question 17 asked about support from family and friends, question 18 asked about whether the interviewee felt that the host organisation was supportive of the counselling service and its users, whether the work culture was supportive of help-seeking and the attitudes of various Site One groups towards the service. The final item, question 19, asked for a judgement about the need for a counselling service at Site One.

The Counselling Itself

Question 20 asked about the interviewee's expectations of counselling, what the individual wanted from counselling and how they thought that they might benefit, whilst question 21, asked the respondent to describe a typical counselling session, about what they thought the counsellor 'did' in the sessions and how they felt during sessions. Questions twenty-three asked about whether any other issues, other than those presented to the service by the respondent, were discussed in the sessions. Questions 24 and 25 asked, respectively, about what the 'good' and 'bad' bits of counselling were.

Counselling Impact

This section of the interview schedule contained ten questions. Question 28 asked about how the counselling had affected the individual in terms of self-perception, self-evaluation, personal relationships, perceptions of work and how the individual now dealt with his or her own feelings and thoughts. Questions 29 and 30 examined the interviewee's assessments about how counselling had affected his or her perceptions of other people and whether he or she had learnt anything new about any other specific individual or about people in general and the ways in which these changes, if any, had affected their relationships with these individuals or, again, with people in general.

Questions 31 and 32 asked about whether counselling had affected the way(s) in which the respondent dealt with problems in and outside of work. Question 33 asked about the impact of counselling on the issue that was first presented to the counselling service by the individual and also about the impact of counselling on other issues that came up during counselling. Questions 34 to 36 asked, respectively, about what were the biggest impacts, from counselling, was on their life, the ways in which counselling had affected the way in which the individual looked at their job and whether counselling had affected

their commitment to their job. Question 37 asked the interviewee to judge where the greatest negative or positive impact was.

Future Use of Counselling and Feedback

This final section contained six items. Questions 38 and 39 asked whether the interviewee would use the staff counselling service again and what they would use it for. Questions 40 to 43 asked, respectively, for any suggested service changes, whether there was anything else that the interviewee would like to discuss, for feedback with respect to the interview schedule and whether the individual wanted a copy of the service evaluation report.

5.7. Client Recruitment and Completing the Pre-Counselling (PreC) Questionnaire

5.7.1. Site One

The first contact for most Site One clients, wanting to access the service, is via the phone, which, at times, necessitated leaving a message on the answer phone. The subject of study participation was broached in the first 'live' conversation with a potential client. Exceptions occurred in instances where the counsellor judged that the emotional state of the potential client was such that participation was not an option.

If verbal agreement to participate was given, then the counsellor sent a package containing an address and permission form (Appendix 5.16.), study information (Appendix 5.17.) and the pre-counselling questionnaire to an address of the clients own choice. The participant would be asked to bring the completed questionnaire and signed consent form along to the first session of counselling.

If the time-lag between the initial service contact, and the first session was too short or if the letter had not reached the client, then the participant would be asked to complete the questionnaire upon arrival at the service and before the start of the first counselling session. This second option was rarely required.

5.7.2. Site Two

In most respects, there were no procedural differences between Sites One and Two, with differences reflected variations in the working practices of Site Two counsellors. In most instances, recruitment was very similar to Site One: However, in a number of instances

there were modifications to the general procedure that reflected the individual approach, to counselling, of a number of Site Two counsellors. For example, one of the Site Two counsellors had a pre-counselling meeting with a potential client to discuss the suitability of the counsellors skill level, and experience, and whether these are sufficient to meet the needs of the potential client. If the outcome of this discussion was positive, the client would be taken on and the subject of study participation broached. If not, then the client would be referred to another Site Two counsellor. Client recruitment, at Site Two, started in May 1993 and continued through until the end of December 1993.

5.7.3. Session Measures

Procedures employed were the same for both Sites One and Two. At the end of session one, participants were asked to complete the SIS before they left the service. For reasons of maintaining confidentiality, participants were also given an envelope for them to put the completed measure into. The sealed envelope would then be handed back to the counsellor, who would then post it to Sheffield in a pre-paid envelope. Initially, the client took both the measure, and the envelope, away to complete and post. This approach was discontinued, due to delays in returning materials.

From session two, participants were asked to complete the outcome measure (the SCL-18) before the start of the session and the SIS after the end of the session. This separation of measures was to prevent an overload of work for the client and to ensure that scale completion did not interfere with counselling.

After the last counselling session was completed, the participant would be given the post-counselling questionnaire to complete as well as the session impact scale. On several occasions there was a delay between the end of counselling, in terms of the last session of counselling and giving out the End of Counselling (EOC) questionnaire. This was due to the often ambiguous nature of counselling termination: Clients frequently terminated counselling, before the contracted number of sessions were completed. It was often unclear, to the counsellor whether, when a client did not turn up to a pre-arranged session, this meant termination or that the client was ill and so on. This time-lag was aggravated where sessions had become fortnightly, or monthly or where the last session was going to be a follow-up meeting to be held sometime after the penultimate session.

5.7.4. Follow-up

Follow-up measures, along with an evaluation questionnaire, were sent directly to participants from Sheffield, by the author, along with a pre-paid envelope. Letters were included (Appendix 5.13.) to thank the participant for his or her co-operation during the first part of the study, and to encourage their continued involvement in the study. The six month questionnaire was accompanied with a letter thanking the individual for their involvement.

Mid-way through the project it became clear that problems were developing with respect to questionnaire return rates, a reflection of the voluntary nature of participation and the lack of contact between the author and study participants. To increase response rates and to ensure client retention, participants were offered expenses, of £10, for the completion and return of the three follow-up questionnaires. The offer of expenses, for completion and return, was sent in the letter accompanying the one month questionnaire. It was also mentioned, by service counsellors, at the end of counselling.

5.7.5. The Collection of Absenteeism Data

Data was collected from Site One in June 1994. Data was not collected from Site Two, because it lacked any kind of systematic data collection for this type of information. At the time, absenteeism data, at Site Two, is held locally if it is collected at all. The potential outcome, in terms of data quantity and quality, collected from Site Two would have necessitated an unwarranted application of resources. There would have been a need to negotiate, with each department, to access records, with no guarantee of successful access. The small size of some of these departments would have threatened client anonymity.

Both the Site One organisations had adopted different computerised personnel systems. Access had to be negotiated, separately, with Human Resources at both organisations. In the case of the SHA, the author was given an honorary researcher post for the purposes of collecting the absence data, since only authorised employees of the SHA were allowed to access this data. At both Site One parts, the author was shown how to use each system by the relevant departmental manager. Several types of data were collected. First of all, the absenteeism records of individual participants were accessed. These individuals had given their permission at the start of the study to allow the author access to their absenteeism records. At the SHA, the author was also able to produce lists for the personnel department of non-participants in comparable occupations. This allowed a comparison of absenteeism records comparing study participants with non-counselling

clients over the same time periods. The SHA was also able to provide quarterly absenteeism reports of all the SHA employees, with this data broken down into an occupational categorisation. Absenteeism was differentiated into either certified sickness or uncertified sickness.

At the Research Faculty at Site One, the author was unable to get a breakdown of the occupation-by-occupation absence. Although a department-by-department breakdown of the data was possible, an individual breakdown was not. The individual records were buried in the departmental records and could not be accessed by computer. Records at both sub-sites could not be compared to one another. It should be noted that data quality and quantity was such that it was felt that it was not worth analysing the data.

5.8. The Counselling Service During Data Collection

During the period of data collection, Site One counsellors saw 90 clients, 70 women and 20 men. Of this group, 54 began study participation, by completing the pre-counselling questionnaire. Of the thirty-six who did not take part, three were either returning to the service or had already received the retrospective questionnaire, thirteen refused to take part in the study and in twenty cases, a decision was made, by the counsellor, to not include the client in the study. This group of twenty breaks down into four clients with learning difficulties, eight who were seen at very short notice, one for whom participation was viewed as being 'counter-therapeutic', five were considered to be too distressed to be asked about participation, one never received a questionnaire and one client's written English (second language) was too limited to complete the questionnaires. There were no comparable figures available for Site Two.

5.9. A Description of the Sample

Figures are presented for the whole sample, for Sites One and Two, for the Pre-Only group, those who returned only the Pre-Counselling questionnaire and then for the Pre-Plus group, those who returned the Pre-Counselling questionnaire and at least one of the EOC and follow-up questionnaires.

5.9.1. The Whole Sample at Pre-Counselling (PreC) (n=74)

Sixty-one women and thirteen men took part in the study. The mean age of the sample was 33.6 years (SD = 9.1, n=71). Of the 70 clients who responded to the item, 33 were married or cohabiting, seven were separated or divorced, two were widowed, fifteen

were in a relationship, but living apart, and thirteen were single. There were 33 nurses, one doctor, seven from professions allied to medicine (PAMs), fifteen administrative and clerical staff, four managers, four scientists, one client working in catering, one porter, two cleaners, one maintenance operative and two technicians. Of the sixty-one who responded, 32 worked shifts and 29 did not. Of the 32 shift-workers, one worked on the permanent morning shift, one on the permanent afternoon shift, four were permanently on nights, 24 worked a rotating shift system, whilst two reported that they worked some 'other', unspecified type of system. The average length of time in career was 9.4 (SD = 7.6, n=71) years, for working at their current site, 3.9 (SD = 4.4, n=59) years and for working in their current post, 2.8 years (SD = 2.9, n=69) years.

At Site One, there were forty-one women and thirteen men, one doctor, twenty-five nurses, two PAMs, twelve administrative or clerical employees, four managers, four scientists, one porter, one cleaner, and one technician. Twenty-two worked shifts of whom one worked permanent mornings, one afternoons, one on nights, eighteen rotating shifts and one an unspecified 'other' shift system. Twenty-two of the Site One sample were married or cohabiting, four were separated or divorced, one was widowed, eleven were single and thirteen were in relationships, but living apart from their partners. Their average age was 32.1 (SD = 8.3) years and they had, on average, worked in their current careers for 8.8 (SD = 8.1) years, of which 3.7 (SD = 4.6) years had been at Site One, with 2.4 (SD = 2.8) years being spent in their current post. On average they worked 38.4 (SD = 5.7) hours a week.

The all female Site Two sample (n = 20) consisted of eight nurses, five PAMs, four administrative and clerical employees, one caterer, one cleaner and one maintenance operative. Ten worked shifts, with three on nights, six worked a rotating shift pattern and one worked an unspecified 'other' shift system. Eleven of the Site Two sample were married or cohabiting, three were separated or divorced, one was widowed, two were single and two were in relationships, but living apart. The average age of the group was 37.5 (SD = 10.4) years, and they had, on average, worked in their current careers for 11.1 (SD = 6.1) years, with 5.9 (SD = 2.7) years at Site Two and 4.1 (SD = 3.1) years in their current post. On average they worked 32.8 (SD = 16.1) hours a week.

5.9.2. The Pre-Only Group (n=16)

This included fifteen Site One and one Site Two client. Demographic data was returned by the fifteen Site One participants, whose average age was 29.1 (SD = 8.5) years. There were eleven women and five men of whom ten were married or cohabiting, two were

divorced or separated, three were in relationships, but living apart from their respective partners and four were single. Eight Site One clients worked a rotating shift system. The average age of this group was 28.8, (SD = 9.4) years, they'd been in their current careers for 6.5 (SD = 8.9) years, for 3.6 (SD = 6.3) years at Site One and in their current post for 2.5 (SD = 3.8) years. There were nine nurses, two administrative workers, one manager and one porter. The Site two individual was an administrator: She didn't work a shift system.

5.9.3. The Pre-Post Group (n=58)

There were 49 women and 9 men in the pre-post group and their average age was 35.0 (SD = 8.9) years. Twenty-two were married, or cohabiting, six were separated or divorced, two were widowed, thirteen were in a relationship, but living apart, and thirteen were single. There were 22 nurses, one doctor, seven from professions allied to medicine, twelve administrative and clerical workers, three managers, four scientists, one caterer, two cleaners, one in maintenance and one technician. The average length of time in occupation was 10.0 (SD = 7.2) years, they had spent 4.1 (SD = 3.9) years at the same site and 3.00 (SD = 2.7) years in their current post.

Site One had 31 women and eight men, one doctor, sixteen nurses, two PAMs, ten administrative and clerical employees, three managers, four scientists, one porter, one cleaner and one technician. Fourteen worked shifts: One apiece worked permanent am, pm and night shifts, ten worked rotating shifts and one worked an unspecified 'other' shift-system. Sixteen were married, or living together, three were separated or divorced, one was widowed, nine were single and ten were in a relationship, but were living apart. The average age of the Site One sub-group was 33.2 (SD = 7.7) years, they'd been in their current career for 9.6 (SD = 7.8) years, at Site One for 3.7 (SD = 3.9) years and had been in their current posts for 2.4 (SD = 2.4) years.

Site Two included twenty women. Of the 19 reporting biographical data, eight were nurses, five PAMs, two administrative and clerical employees, one caterer, one cleaner and one maintenance operative. Ten worked shifts, with one on nights, six rotating shifts and one an unspecified 'other' shift-system. Ten were married or living together, three were separated or divorced, one was widowed, two were single and two were in a relationship, but living apart. The average age of the Site Two sub-group was 37.5 (SD = 10.7) years, they had been in their current career for 10.4 (SD = 5.7) years, had worked at Site Two for 5.9 (SD = 2.7) years and had worked in their current posts for 4.3 (SD = 3.0) years.

5.10. The Results Chapter: An Overview

Chapter Five described the methodologies and data sets that were collected during the course of this study. However, despite initial fears that there would not be enough data, effectively the opposite has occurred and too much data has been collected for it all to go into the thesis. In the case of the absenteeism data, the quality and utility of the data was deemed to be too poor. Other data sets, such as the counsellor measures, the pilot study and the interviews are excluded for the sake of brevity.

Chapter Six:

Descriptive Data and Comparisons between Clients and Other Samples

6.1 Introduction

This chapter presents descriptive statistics for the sample at pre-counselling and then addresses the following seven questions: (a) Are service clients experiencing distress levels greater than those reported by occupational samples? (b) Are service clients reporting greater levels of interpersonal difficulty than the general population? (c) Are clients employing coping strategies, at pre-counselling, less frequently than other groups? (d) Are study participants different from those who did not participate? (e) Do those who completed post-counselling measures differ, at pre-counselling, from those who completed only the pre-counselling questionnaire (f) Does client status on measures at pre-counselling relate to the number of returned post-counselling measures and (g) Is pre-counselling status related to client characteristics.

The following hypotheses are generated from these questions:

- 1 Service clients will report greater levels of pre-counselling distress than occupational samples
- 2 Service clients will report greater levels of interpersonal difficulty, at pre-counselling, than levels reported in the general population
- 3 Clients will report the less frequent use of coping strategies than general occupational samples
- 4 There will be no difference between study participants and non-participants
- 5 There will be no differences, at pre-counselling, between those who completed post-counselling measures and those who completed only the pre-counselling questionnaire
- 6 There will be no differences, at pre-counselling, between clients who completed post-counselling measures sub-divided in terms of the number of returned measures
- 7 There will be no differences in client status at pre-counselling between participants divided into groups on the basis of the following client characteristics: Gender; Shift-working; Site location; Prior experience of help-seeking; Relationship status and Career

A full description of the methodologies and design employed by this study can be found in Chapter Four.

6.2. Descriptive Statistics Inter - Scale Correlations at Pre-counselling

Seventy-four clients completed the pre-counselling questionnaire. A full set of descriptive statistics, means, standard deviations, N's, internal consistencies (Cronbachs Alpha) and inter-scale correlation's for this group are presented in Table 6.1. Measures of outcome, the SIS and the OSI Coping Strategy sub-scales are presented in Table 6.2, whilst the IIP sub-scales, correlations between the IIP sub-scales and the outcome measures in Table 6.3. and Table 6.4. contains presents the SIS and the single item Hindering measure.

Internal Consistencies: Only two OSI Coping Strategy sub-scales are included in analyses. Four of the OSI Coping sub-scales, Time, Task, Home & Work and Involvement were excluded from analyses due to low internal reliability's, that ranged from .07 to .49. The two retained sub-scales, Social Support (.56) and Logic (.55) are included in further analyses, although reliability's were less than the ideal of .70. This problem of low reliability's, for the OSI Coping Strategy sub-scales, has also been reported by Davis (1996) from a re-analysis of the OSI. The reliability's for the SCL-18 (Barkham et al, 1994a) and the Likert and Case scored GHQ-12 (Banks et al, 1980) all had internal consistencies in excess of .84., reliability's that are comparable with those reported in the literature.

Inter-scale correlations: Pearson product moment correlations were computed. A full set of analyses are presented in Tables 6.1 and 6.2. As expected, since they are different facets of presenting issues, there were weak to moderately positive relationships between levels of client distress and interpersonal difficulty ($r = .38$ to $.55$). There were moderate relationships between the two distress measures ($r = .63$ and $.51$), the GHQ and the SCL and there was a very strong relationship between the two scored versions of the GHQ. This suggests redundancy: However both forms of the GHQ are presented for reasons of comparison with the existing literature.

Clients reporting higher levels of distress also reported greater problems with being too aggressive, difficulties with being assertive and with getting involved with other people and with being sociable. Clients reporting higher levels of distress, specifically on the SCL-18, also reported that they were too caring towards and too dependent on other people. As expected there were moderate to strong relationships between the IIP and its

sub-scales. There was one exception which was Too Open which was not related to the IIP or any of its sub-scales. All of the other IIP sub-scales were related to at least one other IIP sub-scale. Relationships between the IIP sub-scales which were all positive, though relatively weak, ranged from $r = .25$ to $r = .52$

Clients who reported being too aggressive, also had difficulties getting involved, being sociable and with being supportive of others. Those who reported difficulties with being assertive also had difficulties with being too caring and too dependent, with getting involved and with being sociable with other people. Those who reported being too caring also had difficulties in getting involved with and with being supportive of other people, whilst clients who were too dependent also had problems with getting involved, with being sociable and with being supportive of others. Those who found it difficult to get involved with others also reported problems with being sociable and with being supportive of other people. Finally, there was a weak relationship There was also a weak positive relationship between difficulties with being sociable and problems with being supportive.

As would be expected, the Logic and Social Support Coping Strategy sub-scales were related to each other. Scores on these two measures were not related to the scores on any of the other measures, at pre-counselling. There were no significant relationships between any of the measures of counselling expectation and any other measure. As would be expected, here were significant positive relationships between the SIS and its Relationship and Task sub-scales and a significant negative relationship with its Hindering sub-scale. Relationship and Task sub-scales were moderately related with one another and there was a weak, negative relationship between the Hindering and Task sub-scales. There were no significant correlations between age and any of the outcome indices.

6.3. A Comparison of Client Distress at Pre-Counselling with Other Samples

Comparisons with other studies indicated that service clients are, on average, more distressed than general population and occupational samples. These comparisons provide support for the hypothesis, that service clients will be more distressed than the samples included drawn from occupational and general populations which are presented in Tables 6.5 and 6.6. The mean score on the Likert GHQ-12, of 1.95 (SD = .64), is greater than those reported in the literature (.72 to 1.04, Banks et al, 1980; Firth-Cozens, 1987; Firth-Cozens, 1994, see Table 6.5.). On the Case scored GHQ-12, there were more

cases in the service sample than other occupational samples reported in the literature (Bank et al, 1980; Firth-Cozens, 1987; 1994, see Table 6.6.). The respective percentages of the service sample, who exceeded case thresholds of two, three and four, were 90%, 88% and 86%. Comparable figures for the comparison groups were 30-50%, for a threshold of two, 26-30% for a threshold of three, and 20-25% for a threshold of four.

There are no other published studies that have employed the SCL-18. This measure, however, is comparable to the SCL-90R, from which the SCL-18 is derived (Barkham et al, 1994). The SCL-18 pre-counselling mean of 1.43 (SD = .66) was at a level that is equivalent to that reported in SPP2 (Shapiro et al, 1994) for the SCL-90R at pre-intervention (1.41, SD = .52), although it was lower than the pre-screening mean (1.55, SD = .46).

6.4. A Comparison of Client Interpersonal Problems at Pre-Counselling with Other Samples

Service clients reported higher levels of interpersonal problems than a general population sample, with respective scores of 1.38 and .98. This supports the hypothesis that counselling service clients would be experiencing a greater level of difficulty, than individuals drawn from the general population. Scores, though, for the counselling service clients were lower than those reported for samples of outpatient (1.51) and psychotherapy clients (1.56), although the difference, in absolute terms, was not particularly great. Comparative studies, presented in Table 6.7 are cited from Barkham et al (1994a). The counselling service sample had more problems with being too open with others, than the other groups, whilst they reported similar levels of difficulty with being too caring and with getting involved with other people.

6.5. A Comparison of Client Coping Strategy Use at Pre-Counselling with Other Samples

These results present a mixed response to the question and only limited support for the hypothesis that service clients would, on average, use coping strategies less frequently than three general hospital general occupational samples (OSI Data Supplement, 1994), since, unexpectedly, there was no difference between service clients and other occupational samples in their use of coping strategies. As expected, there was a difference in the reported use of logic based coping strategies, with service clients reporting their less frequent use.

Table 6.1. Measure of Outcome Interpersonal Problems Counselling Expectations and Coping Strategy at Pre-Counselling

	1	2	3	4	5	6	7	8	9	10	11
Means	1.43	1.96	8.59	1.38	3.87	12.81	22.97	14.50	16.92	10.71	21.08
(SD)	0.66	0.63	3.73	0.69	0.51	2.86	4.73	3.72	4.07	2.86	4.37
α	0.84	0.92	0.91	0.90	0.65	0.07	0.13	0.49	0.56	0.55	0.42
N	74.	74.	74.	74.	73.	72.	72.	72.	72.	70.	72.
1. SCL-18	-										
2. GHQ-12L	0.63**	-									
3. GHQ-12C	0.51**	0.92**	-								
4. IIP-32	0.55**	0.38**	0.39**	-							
5. SIS Expectations	-0.03	-0.13	-0.14	-0.09	-						
6. OSI Time	-0.10	-0.10	-0.10	0.08	0.01	-					
7. OSI Task	-0.07	-0.03	-0.03	0.04	0.12	0.33**	-				
8. OSI Home & Work	-0.00	-0.04	-0.04	0.03	0.16	0.16	0.35**	-			
9. OSI Social Support	-0.07	-0.12	-0.12	-0.06	0.06	0.27*	0.28*	0.21	-		
10. OSI Logic	-0.10	0.06	0.06	0.08	0.10	0.36**	0.45***	0.48***	0.39***	-	
11. OSI Involvement	0.01	0.07	0.07	0.07	0.10	0.30*	0.66***	0.44***	0.45***	0.58***	-

Note: SCL = Symptom Checklist. GHQ = General Health Questionnaire. IIP = Inventory of Interpersonal Problems. SIS = Session Impact Scale. Higher means for the SCL-18 and the GHQ-12 are associated with higher levels of distress. Higher scores on the IIP-32 are associated with a greater reported levels of interpersonal problems. Higher means for the SIS are associated with more positive expectations of counselling. Higher means for the OSI sub-scales are associated with more frequent use of these coping strategies. *** p < .001, ** p < .01, * p < .05

Table 6.2. The IIP-32 Sub-Scales: Means, Standard Deviations, N's, Reliability's and Inter-Scale Correlations								
	1	2	3	4	5	6	7	8
Means	1.27	1.76	1.79	1.42	1.42	1.82	1.30	0.78
(SD)	1.23	1.20	1.03	0.96	1.21	0.87	1.20	1.04
α	0.90	0.80	0.64	0.64	0.86	0.70	0.85	0.86
N	74.00	74.00	74.00	74.00	74.00	74.00	74.00	74.00
1 Too Aggressive	-							
2 Hard to be Assertive	0.04	-						
3 Too Caring	0.06	0.31**	-					
4. Too Dependent	0.15	0.30**	0.22	-				
5 Hard to get Involved	0.38**	0.31**	0.25*	0.32**	-			
6 Too Open	0.00	-0.12	0.03	0.15	-0.12	-		
7. Hard to be Sociable	0.32**	0.52***	0.28*	0.50***	0.52***	-0.21	-	
8. Hard to be Supportive	0.34**	0.19	0.02	0.32**	0.48***	-0.07	0.39***	-

Note: IIP = Inventory of Interpersonal Problems. Higher scores on the IIP-32 sub-scales are associated with a greater reported levels of specific interpersonal problem. *** p < .001, ** p < .01, * p < .05.

Table 6.3. A Series of Inter-Scale Correlations between Measures of Outcome and Interpersonal Problems				
	SCL-18	GHQ-12 Likert	GHQ-12 Case	IIP-32
Too Aggressive	0.38***	0.29*	0.30**	0.55***
Hard to be Assertive	0.40***	0.35**	0.29*	0.59***
Too Caring	0.33**	0.13	0.08	0.49***
Too Dependent	0.24*	0.17	0.21	0.63***
Hard to get Involved	0.37***	0.25*	0.25*	0.77***
Too Open	0.07	-0.20	-0.22	-0.08
Hard to be Sociable	0.48***	0.35**	0.37***	0.79***
Hard to be Supportive	0.15	0.11	0.18	0.57***

Note: SCL = Symptom Checklist. GHQ = General Health Questionnaire. IIP = Inventory of Interpersonal Problems.
 *** p < .001, ** p < .01, * p < .05.

Table 6.4. The Measures of Session Impact: Means, Standard Deviations, Internal Consistencies and Inter-Scale Correlations

	1. Hindering Expectations	2. Relationship Expectations	3. Task Expectations	4. Hindering
Means	1.69	1.69	3.77	3.48
SD	0.58	0.58	0.85	0.78
α	0.55	0.74	0.82	NA
N	72	74	74	74
1. Hindering Expectations	-			
2. Relationship Expectations	-0.28*	-		
3. Tasks Expectations	-0.02	0.60***	-	
4. Hindering Measure	-0.19	0.71***	0.64***	-
5. Counselling Expectations	-0.57***	0.79***	0.81***	0.69***
6. SCL-18	0.23*	0.01	0.22	0.12
7. GHQ-12 Likert	0.35**	-0.07	0.08	0.08
8. GHQ-12 Case	0.30*	-0.05	0.02	0.10
9. IIP-32	0.23*	-0.06	0.06	0.08

Note: SIS - Session Impact Scale. SCL = Symptom Checklist. GHQ = General Health Questionnaire. IIP = Inventory of Interpersonal Problems. Higher means for the SIS and the Relationship and Task sub-scales are associated with more positive expectations of counselling. A higher means of the Hindering sub-scale is associated with more negative evaluations of counselling.
 *** p < .001, ** p < .01, * p < .05.

Sample	Mean	SD
Clients	1.95	0.64
1 Manufacturing One	0.75	0.34
1 Manufacturing Two	0.72	0.42
2 Medical Students	0.97	0.43
4 Nurses	1.04	NA

1. Banks et al (1980), 2. Firth (1986), 3. Firth-Cozens (1987), 4. Barton (1994).
NA = The standard deviation was not reported for this sample.

Samples	Percentage of Samples above Caseness Thresholds		
	Above 2	Above 3	Above 4
Counselling service sample	90	88	86
¹ Medical Students	30	29	23
² Junior House Officers	50	30	24
³ Mental Health Workers	39	30	25
³ Anaesthetists	33	26	20
³ Junior Doctors and GPs	36	30	24

Note: ¹. Firth (1986), ². Firth-Cozens (1987), ³. Firth-Cozens (1994).

Table 6.7. Measures of Inter-personal Problems at Pre-Counselling: A Comparison with Psychotherapy (Pre-Therapy) Out-Patient and General Populations Samples

	IIP-32	Hard to be Assertive	Hard to be Supportive	Hard to be Supportive	Too Caring	Too Dependent	Too Aggressive	Hard to be Involved	Too Open
Samples	M SD	M SD	M SD	M SD	M SD	M SD	M SD	M SD	M SD
Service Clients	1.38 0.69	1.76 1.20	1.30 1.20	0.78 1.04	1.79 1.03	1.42 0.96	1.27 1.23	1.42 1.21	1.82 0.87
SPP2 / CPP	1.56 0.50	1.99 1.02	1.77 1.07	0.97 0.83	1.63 0.91	1.71 0.90	1.30 0.95	1.36 0.98	1.48 1.00
Out-Patient	1.51 0.68	1.87 1.18	1.65 1.29	0.96 0.95	1.72 1.05	1.60 0.98	1.49 1.08	1.37 1.13	1.45 1.06
General Population	0.98 0.52	1.12 0.89	1.02 0.83	0.65 0.60	1.25 0.90	0.90 0.80	0.84 0.75	0.91 0.89	1.74 0.84

Note: Counselling sample, n = 74, SPP2/ CPP, n = 250, general population sample, n = 143 and outpatients, n = 120. 1. Barkham et al (1994a). Higher scores are associated with a greater reported level of inter-personal problem. SPP2/ CPP = The Second Sheffield Psychotherapy Project / Collaborative Psychotherapy Project.

		Hospital samples.		
	Clients	North	Midlands	South
Sub-scale	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
S.Support	16.92 (4.07)	16.58 (3.08)	16.25 (3.05)	16.74 (3.24)
Logic	10.71 (2.86)	12.29 (2.06)	12.51 (2.12)	12.47 (2.00)

Note: Client sample, n = 74, North, n = 1200, Midlands, n = 326, South, n = 530. S.Support = Social Support. Higher scores are associated with the more frequent reported use of strategies. Figures are taken from the 1994 OSI Data Supplement.

6.6. Do Study Participants Differ From Those Who Did Not Participate

Only the Site One counsellors collected demographic information about service clients. Site Two counsellors did not. Information was collected on client gender (men and women), occupation (nursing, administrative and clerical, scientific and technical, ancillary, auxiliary [nurses], medical, student and other), ethnic background (Caucasian-UK, Irish, Asian, Afro-Caribbean, Caucasian-Other and Arab), presenting problem (personal-relationship, personal/job stress, bereavement, work, personal-trauma, health, work-relationship, work-organisational, work exam/research, personal-eating, stress, and personal-other), seniority (junior or middle level), the reason for terminating counselling (client termination or the completion of the pre-agreed number of sessions), the source of information about the service (leaflet, management, returning to service, recommended, staff newspaper, other, relative and occupational health) and the number of years of service at Site One.

This information provides an opportunity to compare Site One clients who participated in the study and those who did not. A series of chi-squares and an independent t-test, between years of service and group, were run to assess differences between these participating and non-participating clients. Categories for three variables, ethnic background, occupation and presenting problem had to be collapsed to allow analyses to be run. Analyses are presented in Appendices 6a to 6h.

There was little evidence of any difference between the participating and non-participating client groups, with the exception of seniority. Junior staff were more likely to not participate in the study than middle-ranking staff ($\chi^2_{(1)} = 3.66, p = .056$). There were 41 junior and 13 middle level staff in the participating group and 33 junior and 3 middle staff in the non-participating group. Thus, the hypothesis that there would be no differences between participants and non-participants was largely supported.

6.7. Were There Any Differences Between Those Completing Pre and Post Measures and Those Who Only Completed the Pre-Counselling Measures

Fifty-eight participants returned at least one of the four post-counselling questionnaires. Thirty-nine were Site One clients and 19 were from Site Two. Sixteen clients only completed one questionnaire. A series of independent t-tests and chi-squares were run to test for any differences between the pre-only and pre-plus client groups. Analyses are presented, in full, in Appendices 6i and 6j to 6n. There was some evidence of differences between the two groups. Ninety-five percent of Site Two clients returned at least one of the post-counselling measures. Seventy-four percent of Site One clients returned at least one post-counselling questionnaire. This difference in return rates was significant ($\chi^2 = 4.86$, $df = 1$, $p = .028$).

Pre-only participants reported a greater level of interpersonal difficulty on a number of measures, than pre-post clients at pre-counselling. They felt overall difficulties with interpersonal difficulties on the IIP-32 and they had specific difficulties with being too caring and with getting involved with other people. The pre-post clients also tended to be older, with men being less likely to return post-intervention measures than women. Difference between the pre-only and the pre-post groups were significant for the IIP-32 ($t = 2.24$, $df = 20.1$, $p = .036$), “Too Caring” ($t = 2.96$, $df = 20.2$, $p = .008$) and with “Hard to get Involved with People” ($t = 2.51$, $df = 21.3$, $p = .020$). Near significant statistics were computed for age ($t = 1.93$, $df = 69$, $p = .058$) and for gender ($\chi^2 = 2.64$, $df = 1$, $p = .104$). Therefore, analyses indicate something of a mixed response to the question, since, unexpectedly, the results did not support the hypothesis that there would be no differences between the two groups.

6.8. Does Pre-Counselling Status Predict the Number of Returned Post Intervention Measures

There were four post-counselling measures to return: The EOC and three follow-up (one, three and six months) questionnaires. Analyses were performed to assess whether pre-counselling scores could predict differences in the number of returned measures. Clients were sub-divided into four sub-groups: Those who returned one ($n = 18$); two ($n = 14$), three ($n = 11$) and all four ($n = 15$) questionnaires. A series of one way ANOVAs were run to test for differences between the four groups. There were no significant differences between the four sub-groups on any of the outcome measures. This result supported the hypothesis

6.9. Is Pre-Counselling Status Related to Client Characteristics

To address this question, analyses were performed to identify relationships between client characteristics and pre-counselling scores. A series of independent t-tests were run for variables of gender, site location, prior experience of counselling and shift working. A series of one way ANOVAs were run for occupation and relationship status. Tukey HSD tests was run to identify which of the differences were significant. A full set of analyses are presented in Appendices 6p to 6u. No differences at pre-counselling were expected. However, there were some differences on all of the demographic variables in terms of measure scores at pre-counselling.

6.9.1. Gender

Although no differences were expected, female clients were older and reported the more frequent use of logic based coping strategies than men. Men reported a greater level of interpersonal difficulty with a specific problem with being supportive of others.

Differences were significant for age ($t = 2.70$, $df = 23.20$, $p = .012$), logic based strategies ($t = 3.70$, $df = 7.95$, $p = .038$), overall interpersonal difficulty, on the IIP-32 ($t = 2.24$, $df = 20.07$, $p = .036$) and with being supportive of others ($t = 2.61$, $df = 7.86$, $p = .032$).

6.9.2. Shift-Working

Shift-workers reported greater distress, longer working hours and that they were more positive in their expectations of the Task impacts of counselling, than non-shift workers. As Table 6.9 illustrates, differences between shift and non-shift workers were significant for the SCL and they approached significance for hours and task expectations.

Measures	Shifts	No Shifts	Matched t-tests		
	Means	Means	t	df	p
SCL-18	1.67	1.25	2.14	36.9	.012
Hours	39.50	34.50	1.76	55.0	.085
Task Expectations	3.76	3.38	1.92	54.1	.060

SCL = Symptom Checklist

6.9.3. Site Location

Site Two clients were more distressed at pre-counselling than their Site One counterparts, differences which were apparent for both the GHQ and for the SCL. Site Two clients had also spent longer in their current careers and had worked for a longer period for their current employer than those at Site One. Site Two clients used logic based coping strategies more frequently than Site One clients at pre-counselling. As Table 6.10 illustrates, differences were significant for the GHQ and time in current post, and differences approached significance for the SCL-18, for the length of time working in one's current organisation and for participant use of logic based strategies.

Measures	Site One	Site Two	Matched t-tests		
	Means	Means	t	df	p
Case GHQ-12	7.59	10.00	2.65	48.8	0.011
Likert GHQ-12	1.78	2.21	2.63	45.6	0.012
SCL-18	1.32	1.66	1.80	56.0	0.077
Time in post	2.40	4.3	2.20	22.8	0.039
Working at Site	3.7	5.9	1.81	11.1	0.098
OSI Logic	3.48	3.88	1.86	46.7	0.069

GHQ = General Health Questionnaire. SCL = Symptom Checklist. OSI = Occupational Stress Indicator.

6.9.4. Prior Help-Seeking

Clients, with prior experience of help-seeking, reported higher levels of distress, greater difficulties with being assertive with and supportive of other people and they also had more positive expectations of the task impacts of counselling. Differences between those who had prior experience of help-seeking, and those new to seeking help from formal organisations, were all significant with the exception of Task Impacts. These results are presented in Table 6.11.

6.9.5. Relationship Status

With an average of 24.5 years of service, widows had been in their present careers for significantly longer than the other relationship groups (6.6 to 11 years). They also tended to be older than the other relationship groups. The difference for service length was significant ($F = 3.60$, $df = 4,52$, $p = .012$), whilst the difference in age approached significance ($F = 2.22$, $df = 4,52$, $p = .080$).

6.9.6. Career

Scientists and Technicians reported lower levels of distress than the other occupational groups and more interpersonal difficulties than Management, Administrative and Clerical (MAC) employees. Differences approached significance on the Case GHQ ($F = 2.74$, $df = 3,53$, $p = .053$) and the IIP ($F = 2.24$, $df = 3,53$, $p = .094$). Ancillary employees reported being too caring more frequently than other groups, although this difference was not significant ($F = 2.51$, $df = 3,53$, $p = .069$).

	Experience	No experience			
Measures	Means	Means	t	df	p
SCL-18	1.63	1.16	2.05	36.6	0.048
GHQ-12 Likert	2.13	1.61	2.51	38.3	0.017
Hard to be Assertive	2.23	1.22	2.84	40.	0.007
Hard to be Supportive	0.91	0.36	2.35	38.4	0.024
SIS Task Expectations	3.71	3.20	1.81	26.1	0.081

SCL = Symptom Checklist. GHQ = General Health Questionnaire. SIS = Session Impact Scale.

Overall, the hypothesis, that there would be no relationship at pre-counselling, between client characteristics and scores on measures, at pre-counselling, is clearly not fully supported, with several significant and near significant differences between levels of demographic variable on measures of outcome.

6.10. Chapter Summary

6.10.1. Comparisons with Other Samples

A comparison of scores, on measures of outcome, at pre-counselling indicated that clients were as distressed as psychotherapy clients, at pre-therapy, and had a greater level of problems than occupational samples. They reported greater levels of interpersonal problems than the general population, a level of difficulty that was comparable to that reported by therapy clients at pre-therapy. Whilst clients reported comparable usage of Social Support strategies to occupational samples, they reported the less frequent use of logic strategy at pre-counselling.

6.10.2. Participants and Non-Participants

Against expectations, there were few differences between participants and non-participants at pre-counselling. The only difference was in terms of the organisational status of clients at pre-counselling, with junior staff being less likely to participate in staff than middle ranking employees.

6.10.3. Status on Measures of Outcome at Pre-Counselling and Client Characteristics

There were a series of differences between the participant group, differentiated on the basis of client characteristics at pre-counselling, in outcome status. Women were older and employed, with greater frequency, logic strategies whilst men had a greater level of interpersonal problems, with specific difficulties with being supportive of other people.

Shift working was a factor, with shift-workers reporting greater distress, that they worked longer hours and that they were more positive in their expectations of task impacts. Those who had sought help on a previous occasions reported greater levels of distress, difficulties with being assertive and with being supportive.

Site location was also a factor, with clients at Site Two reporting greater levels of distress, the more frequent use of logic strategies and that they had been in their current post and with their current employer for a longer period than clients at Site One.

There were differences between the occupational groups at pre-counselling, with Administrative and Managerial employees reporting greater distress and interpersonal difficulty than the other groups and with Ancillary staff feeling that they had greater difficulty with being too caring than the other groups.

Finally, widows were older and had spent a longer time in their current occupations than the other relationship groups.

Thus, against expectations there were systematic and statistically significant differences within the participant group at pre-counselling in terms of the status on outcome measures.

Chapter Seven:

Questions of Outcome: Pre-Post Change and Maintenance of Gain

7.1. Introduction: Questions and Hypotheses

The following questions are addressed by this chapter:

- (i) Is counselling associated with pre-post reductions in distress?
- (ii) Is counselling associated with pre-post reductions in interpersonal problems?
- (iii) Is counselling associated with pre-post increases in the use of coping strategies?
- (iv) Is counselling associated with pre-post increases in their ratings of counselling impact?
- (v) Is counselling associated with reductions in negative evaluations of counselling?
- (vi) Are changes from pre- to post-counselling maintained at follow-up?

Analyses are run to test the following hypotheses:

- 1 Clients will be less distressed at post-intervention than at pre-counselling.
- 2 There will be pre-post reductions in interpersonal problems.
- 3 There will be pre-post increases in the use of coping strategies?
- 4 Clients will be more positive in their ratings of counselling impact at post-intervention.
- 5 Gains established at the end of counselling will be maintained at follow-up.

7.2. Methodology

Fifty-eight clients completed both pre-counselling and at least one of the End of Counselling (EOC) and follow-up (at One, Three and Six Months) questionnaires. Participants received 305 sessions of counselling, with 203 at Site One and 102 at Site Two. The mean number of sessions for the whole group was 5.19 (SD = 4.53). Site One clients completed, on average, 5.23 (SD = 4.36) sessions and Site Two clients completed an average of 5.37 (SD = 4.89) sessions.

Statistics with probabilities of $p < .20$ are noted as well as those that significant at the $P < .05$ level. This threshold of $p < .20$ reflects the fact that the number of cases included in analyses was small. It is possible that the small sample sizes increases the likelihood of Type II errors occurring if the $p < .05$ level is employed as the sole criterion for noting statistics.

7.2.1 Five Occasions

Of the 58 clients who completed the pre-counselling questionnaire and at least one of the four end of counselling, one, three and six month questionnaires, only fifteen clients completed all five questionnaires.

The response to the problem of only fifteen participants completing all five questionnaires, a strategy of averaging across post-intervention (e.g. post-counselling, one, three and six months) occasions was adopted. The general aim of this approach was to increase the number of cases that could be included in analyses. Two strategies were employed: A pre-post analysis and a pre-EOC-follow-up analysis.

7.2.2. Pre-Post

For this analysis the average of the returned EOC, one, three and six month measures was computed and the resulting post-counselling mean compared with scores at pre-counselling. As long as a client had completed and returned at least one of the EOC, one, three and six month measures, then he or she would be included. The post-counselling mean was computed as the sum of the returned scores divided by the number of returned measures. Therefore, if a client had returned three questionnaires, then scores from these three would be added together and would then be divided by three.

The aim of this approach was to maximise the number of cases that could be included in analyses. Up to 58 clients could be included through aggregating scores in this manner. Analyses included all those who had completed all five questionnaires.

7.2.3. Pre-EOC-Follow-Up

Clients were included as cases for the pre-EOC-follow-up analyses, if they had completed the separate pre-counselling and end of counselling questionnaires and at least one of the one, three and six month questionnaires. Clients who had completed the pre-counselling questionnaire and one of the one, three and six month questionnaires, but who had not completed the specific end of counselling questionnaire were not included in this set of analyses.

The follow-up mean was the average of scores taken at one, three and six months. It was computed by summing each clients scores from returned questionnaires and dividing the product by the number of returned questionnaires. For example, if a client had returned

two of the one, three and six month questionnaires, then these scores would be added together and then divided by two.

This analysis was performed to 'trade-off' two competing demands: The first to maximise the number of cases included in analyses, the second to maximise the number of measurement points, to be included in analyses. The five occasion analysis maximised the number of occasions (five) but could only include fifteen participants in analyses. The pre-post analyses maximised the number of participants in analyses (fifty-eight) but analyses were across only two measurement occasions. The pre-EOC-follow-up analysis which included three measurement occasions and up to thirty-three clients maximised the 'trade-off' between these two competing demands.

7.3. Analyses

All of the analyses were performed through employing the mainframe version of SPSS, SPSSx.

Effect sizes (ES) were calculated, using Cohen's effect size formula, by subtracting the second mean (m_2) from the first (m_1) and then dividing the difference by the standard deviation of the first mean. The formula: $ES = m_1 \text{ pre minus } m_2 \text{ post} / \sigma_1 \text{ pre}$.

For all analyses, the first mean in the calculation of effect sizes were scores at pre-counselling.

7.3.1. Pre-Post Analyses

Scores at Pre-Counselling and Post-Counselling were compared by employing a series of matched t-tests. The means, standard deviations, effect sizes and the number of cases (N's) included in analyses are presented in text.

7.3.2. Pre-EOC-Follow-Up Analyses

A series of repeated measure MANOVA's were computed to compare scores at pre-counselling and EOC with the follow-up mean. A series of matched t-tests were also run, through employing a special matrix within the SPSSx MANOVA analysis, to compare scores across adjacent occasions. The adjacent occasions were pre-counselling and EOC and EOC and follow-up.

Two effect sizes were calculated between scores at pre-counselling and EOC and between scores at pre-counselling and the follow-up mean.

7.3.3. Five Occasion Analyses

A series of repeated measure MANOVA's were run for each measure to compare scores at pre-counselling, EOC, one, three and six months. A series of matched t-tests were run within the MANOVA's, through employing a special matrix (within SPSSx), to examine change in scores across adjacent occasions. The specific analyses were between pre-counselling and EOC, EOC and one months, one and three months and from three and six months.

Effect sizes were calculated between pre-counselling and EOC, pre-counselling and one month, pre-counselling and three months and pre-counselling and six months.

7.4. Is Counselling an Effective Intervention in Reducing Levels of Reported Distress

Three separate analyses are presented: (i) Pre-Post (see Fig 7.1) compares scores at pre-counselling with a post-counselling mean: The average of scores taken from EOC, one, three and six month, (ii) Pre-End-Follow (see Table 7.5 for effect sizes and MANOVA's and Table 7.6 for analyses across adjacent occasions): compares scores across pre-counselling and EOC and a follow-up mean: The average of scores taken at one, three and six months and (iii): Five-Occasions (see Table 7.7 effect sizes and MANOVA's and Table 7.8 for analyses across adjacent occasions): compares scores taken from the five separate occasions: Pre-counselling; EOC; one month; three months and six months.

Tables 7.1, 7.2 and 7.3 present, respectively, means, N's and standard deviations for the SCL-18, the Likert scored GHQ-12 and the Case scored GHQ-12. Table 7.1 compares scores for the SCL-18, from the reported study, with scores from the Second Sheffield Psychotherapy study for the SCL-90R (Shapiro et al, 1994).

Table 7.2 compares scores for the Likert GHQ for the reported study with scores reported for various occupational samples (Banks et al, 1980; Firth-Cozens, 1987; Firth-Cozens, 1994 and Barton, 1994), whilst Table 7.3 presents only descriptive statistics for the Case scored GHQ.

7.4.1. Were Clients Less Distressed on the SCL-18 at Post-intervention than at Pre-Counselling

There was a consistent pattern, across all three analyses, of clients being less distressed at post-intervention than at pre-counselling on the SCL-18. Pre-counselling scores, on the SCL-18, were comparable, across all three sets of analyses, to those reported at pre-therapy, on the SCL-90R, for clients from the Second Sheffield Psychotherapy Project (SPP2, Shapiro et al, 1994). Scores at post-intervention, for the reported study, were comparable to EOC and three month levels of distress reported for SPP2.

Pre-counselling scores were 1.45 for pre-post, 1.36 for pre-EOC-follow-up and 1.50 for the five occasion analysis. The SCL-90R mean, from SPP2, was 1.41. Clients were less distressed at post-intervention than at pre-counselling. The post-intervention scores and means for all three analyses were comparable to the EOC (0.71) and three month follow-up (0.72) SCL-90R means from SPP2. Post-intervention means were 0.66 at post-counselling for pre-post, 0.63, at EOC, and 0.49, at follow-up for pre-EOC-follow-up and, for the five occasion analysis, 0.63 at EOC, 0.47 at one month, 0.54 at three months and 0.44 at six months.

Reductions were significant for the pre-post ($t = 10.22$, $df = 56$, $p = .000$), pre-EOC-follow-up ($F = 39.22$, $df = 2,56$, $p = .001$) and five occasion ($F = 7.66$, $df = 4,52$, $p = .001$) analyses. Additional analyses, comparing scores across adjacent occasions, were run. There were significant pre-EOC reductions for the pre-EOC-follow-up ($t = 7.75$, $p = .001$) and for the five occasion ($t = 4.95$, $p = .000$) analyses. The EOC-follow-up reduction (pre-EOC-follow-up analysis) approached significance ($t = 1.62$, $p = .118$).

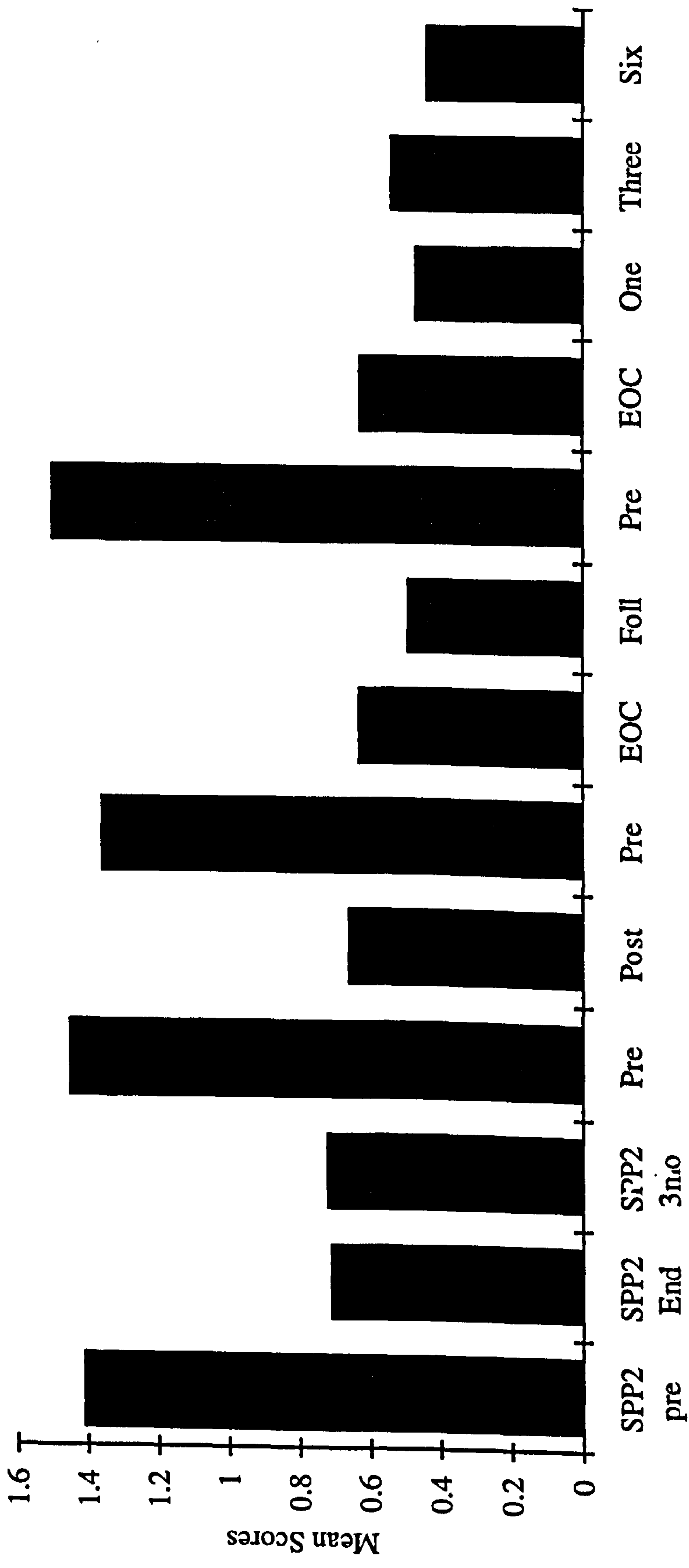
Effect sizes, across the three sets of analyses, were comparable, though smaller, Pre-End of therapy effect size of 1.35 reported from SPP2 (Shapiro et al, 1994). The pre-post effect size was 1.14. Effect sizes for the pre-EOC-follow-up analysis were 1.06 (pre-EOC) and 1.26 (pre-follow-up). For the five occasion analysis, effect sizes were 0.77 (pre-EOC), 1.15 (pre-one), 1.08 (pre-three) and 1.19 (pre-six). Standard deviations, ranging from 0.45 to 0.69, from the three analyses (see Table 7.1) were comparable to the SPP2 standard deviations (0.53 to 0.58).

Table 7.1. The SCL-18: Means, Standard Deviations and Ns for the Counselling Service Sample for the Pre-post, Pre-EOC-follow-up and Five Occasion Analyses with Statistics for the SCL-90R from Second Sheffield Psychotherapy Project.

Measurement Points for Analyses	N	Mean	SD
Comparison Groups			
Pre-Therapy (from SPP2)	117	1.41	0.52
End of Therapy (from SPP2)	117	0.71	0.55
Three Months (from SPP2)	117	0.72	0.58
Pre-Post			
Pre-Counselling	57	1.45	0.69
Post-Counselling	57	0.66	0.56
Pre-EOC-Follow-up			
Pre-Counselling	29	1.36	0.69
End of Counselling	29	0.63	0.60
Follow-up	29	0.49	0.45
Five Occasions			
Pre-Counselling	15	1.50	0.89
End of Counselling	15	0.63	0.50
One Month	15	0.47	0.51
Three Months	15	0.54	0.80
Six Months	15	0.44	0.54

SPP2 = Second Sheffield Psychotherapy Project. Means, N's and standard deviations are taken from Shapiro et al (1994). SCL = Symptom Checklist. The SCL-18 is a short-form version of the SCL-90R, which correlates highly with the SCL-90R (Barkham et al, 1994). EOC = End of Counselling. Post-Counselling = The average of scores taken from EOC, One, Three and Six Months. Follow-up = The average of scores taken at One, Three and Six Months.

Fig 7.1. Changes in client distress, on the SCL-18, across pre-post, pre-EOC-follow-up and five occasion analyses. Comparisons are made with pre-therapy, end of therapy and three month follow-up SCL-90R means from SPP2.



Pre-post, Pre-EOC-follow-up and Five Occasion analyses

7.4.2. Were there Pre-Post Reductions on Likert Scored GHQ-12

There was a consistent pattern, across all three sets of analyses, of clients being less distressed at post-intervention than at pre-counselling on the Likert GHQ. Whilst clients were greater distressed than occupational samples at pre-counselling, post-counselling levels of distress were comparable.

Pre-counselling scores on the Likert GHQ (see Table 7.2) of 1.92 for the pre-post, 1.81 for the pre-EOC-follow-up and 1.76 for the five occasions analyses were greater than the level of distress reported for two manufacturing samples (0.75 and 0.72, Banks et al, 1980), for medical students (0.97, Firth, 1986; Firth-Cozens, 1987) and for a sample of nurses (1.04, Barton, 1994). Scores at post-intervention indicated reductions, for counselling clients, that brought down their distress to a level comparable with the occupational samples. Post-intervention scores, on the Likert GHQ, were 0.90 for the pre-post analysis, 1.11 (EOC) and 0.49 (follow-up) for the pre-EOC-follow-up analysis and 1.14 (EOC), 0.83 (One month), 0.82 (three) and 0.94 (six) months for the five occasions analysis.

Reductions across analyses were significant for the pre-post ($t = 10.87$, $df = 57$, $p = .000$), pre-EOC-follow-up ($F = 15.14$, $df = 2,60$, $p = .001$) and five occasion ($F = 8.87$, $df = 4,56$, $p = .001$) analyses. Further analyses were run for the pre-EOC-follow-up and five occasion analyses to compare scores across adjacent occasions. There were significant pre-EOC reductions for the pre-EOC-follow-up ($t = 4.68$, $p = .001$) and five occasion ($t = 4.10$, $p = .001$) analyses. The EOC-follow-up reduction was significant for the pre-EOC-follow-up analysis ($t = 2.95$, $p = .001$). The EOC-one reduction for the five occasion analysis approached significance ($t = 1.70$, $p = .110$).

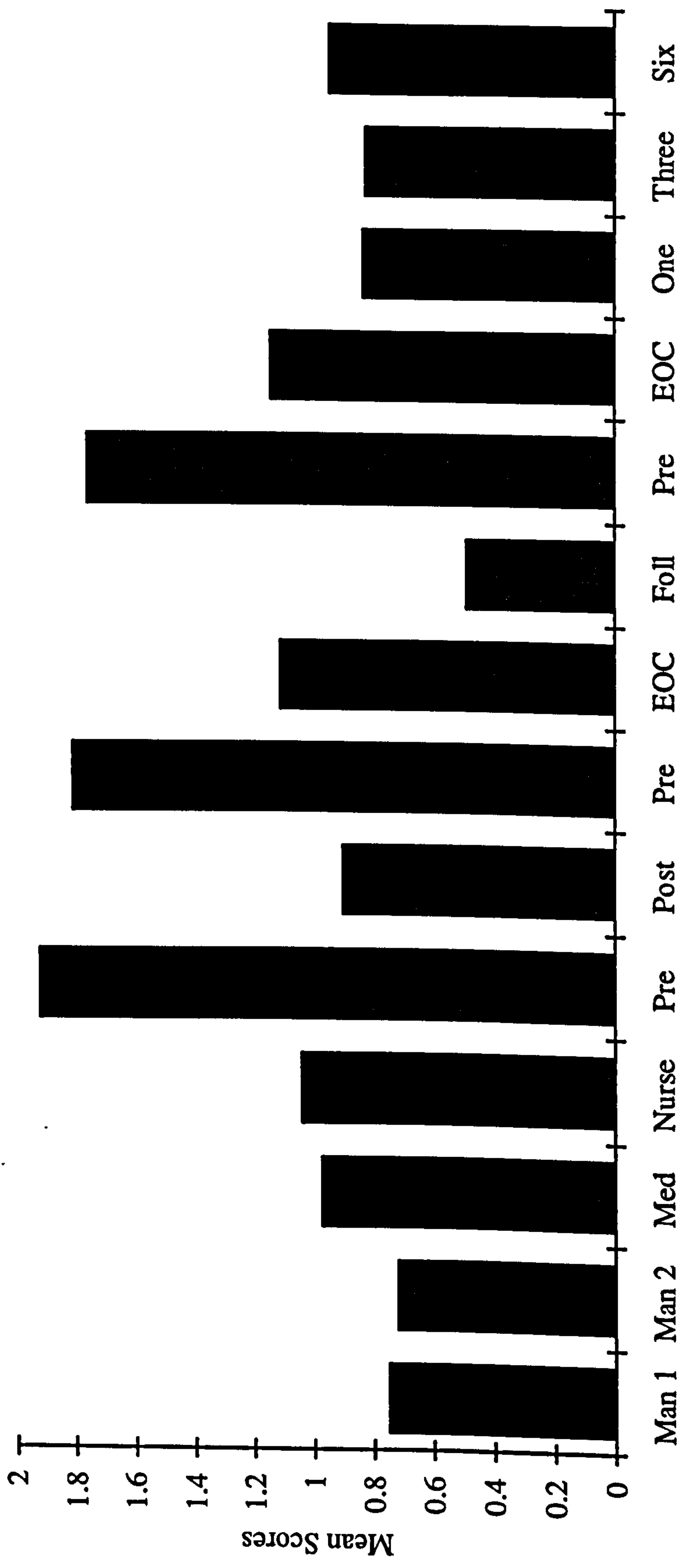
Effect sizes were 1.55 for the pre-post analysis, for the pre-EOC-follow-up analysis, 1.11 (pre-EOC) and 2.10 (pre-follow-up) and for the five occasion analysis, the effect sizes were 0.83 (pre-EOC), 1.56 (pre-one), 1.23 (pre-three) and 1.07 (pre-six). The standard deviations across the three analyses (0.75 to 0.43) were generally greater than those reported for the occupational samples (0.34 to 0.43).

Table 7.2. The Likert Scored GHQ-12: Means, Standard Deviations and Ns for Occupational Samples and the Counselling Service Sample for the Pre-post, Pre-EOC-follow-up and Five Occasion Analyses.

Reported Scores and Means	N	Mean	SD
Comparison Groups			
1. Manufacturing One		0.75	0.34
2. Manufacturing Two		0.72	0.42
3. Medical students		0.97	0.43
4. Nurses		1.04	NA
Pre-Post			
Pre-Counselling	58	1.92	0.66
Post-Counselling	58	0.90	0.56
Pre-EOC-Follow-up			
Pre-Counselling	31	1.81	0.63
End of Counselling	31	1.11	0.72
Follow-up	31	0.49	0.43
Five Occasions			
Pre-Counselling	15	1.76	0.75
End of Counselling	15	1.14	0.59
One Month	15	0.83	0.58
Three Months	15	0.82	0.68
Six Months	15	0.94	0.73

GHQ = General Health Questionnaire. EOC = End of Counselling. 1. Banks et al (1980), 2. Firth (1986), 3. Firth-Cozens (1987), 4. Barton (1994). NA = The standard deviation was not reported for this sample. Higher means are associated with a greater number of symptoms. Post-Counselling = The average of scores taken from EOC, One, Three and Six Months.

Fig 7.2. Change in client distress on the Likert GHQ-12, for the pre-post, pre-EOC-follow-up and five occasion analyses. Scores are compared with means for manufacturing (man 1 and 2), medical students (Med) and nurses (Nurse).



Pre-post, Pre-EOC-follow-up and Five Occasion analyses

7.4.3. Were There Pre-post Reductions on the Case Scored GHQ-12

Clients were less distressed on the Case GHQ, at post-intervention, than at pre-counselling (see Table 7.3). When the percentages of clients who exceeded three caseness thresholds of two, three and four (see Table 7.4) are examined, it is clear that there were substantial reductions, from pre-counselling to post-intervention in the percentage of clients who exceeded all three thresholds. This pattern holds true across all three sets of analyses. The percentages of service clients exceeding respective thresholds, at pre-counselling, had been in excess of those reported for comparison groups of medical students (Firth, 1986), Junior House Officers (Firth-Cozens, 1987), mental health workers, anaesthetists, junior doctors and GPs (Firth-Cozens, 1994). At post-intervention the percentages of service clients who were in excess of thresholds were comparable to or less than those reported by the health employee samples described above.

There were reductions from pre-counselling levels of distress, for the pre-post (8.38), pre-EOC-follow-up (7.97) and five occasion (7.53) analyses, to post-intervention. Post-intervention scores and means were 2.58 (post-counselling) for the pre-post analysis, 3.74 (EOC) and 1.69 (follow-up) for the pre-EOC-follow-up analysis and 4.20 (EOC), 4.80 (one month), three months (1.40) and six months (2.87).

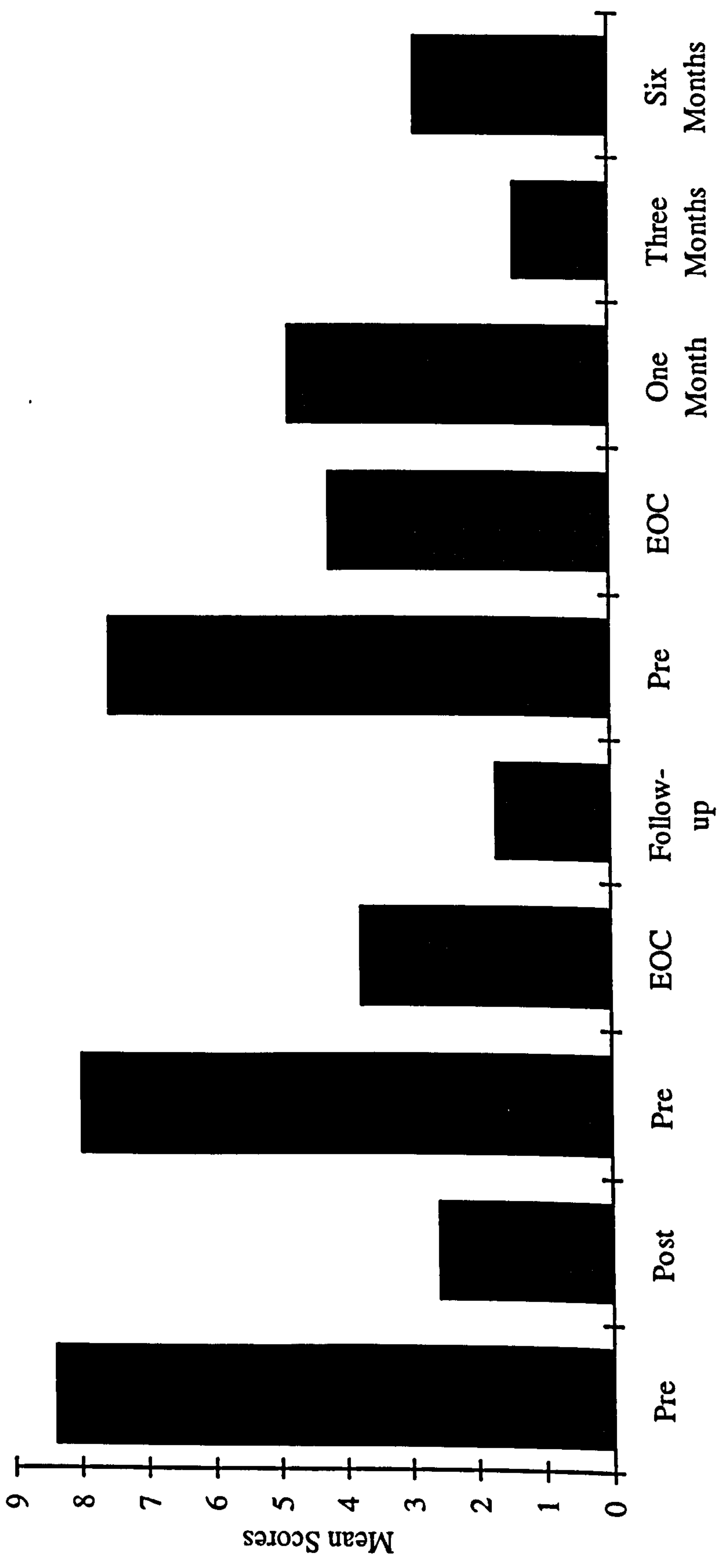
Reductions were significant for the pre-post ($F = 10.63$, $df = 57$, $p = .000$), pre-EOC-follow-up ($F = 33.93$, $df = 2,60$, $p = .001$) and five occasion ($F = 16.22$, $df = 4,56$, $p = .001$) analyses. Additional analyses (see Table 7.5) were run to compare scores across adjacent scores and means. There were significant reductions in distress, from pre-counselling to EOC, on the Case GHQ for the pre-EOC-follow-up ($t = 7.83$, $p = .001$) and five occasion ($t = 4.44$, $p = .001$) analyses. There was a significant reduction from EOC to follow-up for the pre-EOC-follow-up analysis ($t = 2.63$, $p = .013$) and a near significant reduction from EOC to one month on the five occasion analysis ($t = 1.93$, $p = .07$).

Table 7.3. The Case Scored GHQ-12: Means, N's and Standard Deviations for the Pre-Post, Pre-EOC-Follow-up and Five Occasion Analyses

Reported Scores and Means			
Pre-Post	N	Mean	SD
Pre-Counselling	58	8.38	3.81
Post-Counselling	58	2.58	3.26
Pre-EOC-Follow-up			
Pre-Counselling	31	7.97	3.89
End of Counselling	31	3.74	4.40
Follow-up	31	1.69	2.58
Five Occasions			
Pre-Counselling	15	7.53	4.34
End of Counselling	15	4.20	4.16
One Month	15	4.80	3.12
Three Months	15	1.40	3.58
Six Months	15	2.87	4.34

GHQ = General Health Questionnaire. EOC = End of Counselling. Higher means are associated with a greater number of symptoms. Post-Counselling = The average of scores taken from EOC, One, Three and Six Months. Follow-up = The average of scores taken from One, Three and Six Months.

Fig 7.3. Change in client distress on the Case GHQ-12 for the pre-post, pre-EOC-follow-up and five occasion analyses.



Pre-post, Pre-EOC-follow-up and Five Occasion analyses

Effect sizes were 1.52 for the pre-post analysis, 1.09 (pre-EOC) and 1.61 (pre-follow-up) for the pre-EOC-follow-up analysis and 0.77 (pre-EOC), 1.31 (pre-one), 1.41 (pre-three) and 1.07 (pre-six) for the five occasion analysis. There were reductions in the standard deviation from pre-counselling (4.40) and EOC (3.89) to follow-up (2.58) on the pre-EOC-follow-up analysis and a reduction from pre-counselling (4.34) to six months (2.87) on the five occasion analysis.

Comparison group thresholds, for the cut-offs of two, three and four were, respectively, 30%, 29% and 23% for medical students (Firth, 1986), 50%, 30% and 24% for Junior House Officers (Firth-Cozens, 1987), 39%, 30% and 25% for mental health workers, 33%, 26% and 20% for anaesthetists and 36%, 30% and 24% for junior doctors and GPs (Firth-Cozens, 1994).

Sample	Caseness Threshold		
	Two and above	Three and above	Four and above
Pre-Post			
Pre-Counselling	90	88	84
Post-Counselling	41	36	29
Pre-EOC-Follow-up			
Pre-Counselling	87	84	84
End of Counselling	48	45	35
Follow-up	32	23	13
Five Occasions			
Pre-Counselling	80	80	73
End of Counselling	79	67	58
One Month	13	33	17
Three Months	17	17	17
Six Months	50	33	33
Comparison Groups			
Medical Students*	30	29	23
Junior House Officers**	50	30	24
Mental Health Workers***	39	30	25
Anaesthetists***	33	26	20
Junior Doctors & GPs***	36	30	24

*Firth (1986), **Firth-Cozens (1987). ***Firth-Cozens (1994).

For the counselling service clients, there were pre-post reductions from 90% to 41% for the two threshold, 88% to 36% for the three threshold and 84% to 29% for the four threshold. For the pre-EOC-follow-up analysis, there were pre-EOC reductions from 87% to 48% (two), 84% to 45% (three) and 73% to 58% (four) and from EOC to follow-up, further reductions to 32% (two), 23% (three) and 13% (four). For the five occasion analysis, there were reductions, for the two threshold from pre-counselling (80%), to EOC (79%) to one month (17%) and three months (13%) and then an increase to six months (50%). For the caseness threshold of three, the percentages were 80% (pre-counselling), 67% (EOC), 33% (one month), 17% (three months) and 33% (six months). The respective figures for the four threshold were 73% (pre-counselling), 58% (EOC), 17% (one month), 17% (three months) and 33% (six months).

Across measures of outcome, there was a consistent pattern of reductions in distress from pre- to post-intervention. When scores were compared to those reported for other samples, both therapeutic and occupational, the level of client distress at pre-counselling, which was comparable to pre-therapy levels of distress and which was greater than the level reported by occupational samples was, at post-intervention, comparable to the therapy clients at the end of therapy (and follow-up) and to the level of distress reported by non-distressed occupational samples.

Scale	Comparison across measurement occasions							
	Pre-EOC		EOC/One		One/Three		Three/Six	
	t	p	t	p	t	p	t	p
SCL-18	4.95	.000	2.05	.66	0.190	.85	0.81	.43
GHQ-Likert	4.10	.001	1.70	.11	-0.36	.73	-0.73	.48
GHQ-Case	4.44	.001	1.93	.07	-0.61	.55	-1.31	.21

EOC = End of Counselling
SCL = Symptom Checklist
GHQ = General Health Questionnaire

7.5. Is Counselling Effective in Reducing Levels of Interpersonal Problems from Pre-Counselling to Post-Intervention

Three separate analyses are presented: (i) Pre-Post: comparing the pre-counselling score with the post-counselling mean. The post-counselling mean is the average of scores taken from the EOC, one, three and six month; (ii) Pre-End-Follow: comparing the separate pre-counselling and End of Counselling (EOC) scores with a follow-up mean, the average of scores taken across the one, three and six months; (iii): Five-Occasions: comparing scores from the five separate measures taken at pre-counselling, EOC, one month, three months and six months.

Clients were included in pre-post analyses if they completed pre-counselling measures and at least one of the four EOC, one, three and six month measures. Inclusion in the pre-EOC-follow-up analyses was dependent on clients completing the separate pre-counselling and EOC scales and at least one of the one, three and six month scales. Inclusion into the five occasion analysis was dependent on clients completing all five separate pre-counselling, EOC, one, three and six month scales.

Table 6. presents the means and standard deviations for the full scale and its eight sub-scales: Too Aggressive, Hard to be Assertive, Too Caring and Too Dependent, Hard to be Involved, Too Open, Hard to be Sociable and Hard to be Supportive for the pre-post (pre-counselling and post-counselling), pre-EOC-follow-up (pre-counselling, EOC and follow-up) and five occasion (pre-counselling, EOC, one, three and six months) analyses. The means and standard deviations for three comparison groups are also presented: (i) Pre-therapy scores reported for a combined Second Sheffield Psychotherapy Project (SPP2) and Comparative Psychotherapy Project (CPP) sample; (ii) a sample of Out-patients and (iii) a General Population group. The three samples are all reported in Barkham et al (1994a).

Pre-post, pre-EOC-follow-up and five occasion scores and means are presented in Figures 7.6 and 7.7 Means and standard deviations for the full-scale and for the Too Aggressive, Hard to be Assertive, Too Caring and Too Dependent sub-scales can be found in Figure 7.4 Four sub-scales: Hard to be Involved; Too Open; Hard to be Sociable and Hard to be Supportive are presented in Figure 7.5.

7.5.1. Were There Pre-Post Reductions in Interpersonal Problems

Clients had fewer interpersonal problems at post-intervention than at pre-counselling. This finding was consistent across all three analyses. Whilst clients had not reported a level of difficulty that was comparable with the level of difficulty reported by psychotherapy clients at pre-therapy (SPP2/ CPP, Barkham et al, 1994a) and Outpatient clients (Barkham et al, 1994a), they had more problems, than a General Population sample (Barkham et al, 1994a). There was a reduction from pre-counselling to post-intervention and the level or reported difficulty, at post-intervention, was comparable to the level of difficulty reported by the General Population sample.

Pre-counselling scores for the pre-post (1.28), pre-EOC-follow-up (1.24) and five occasion (1.37) analyses were less than the SPP2/ CPP pre-therapy (1.56) and Out-patient (1.51) means but greater than the General Population mean (0.98). The post-intervention scores and means were 1.03 (post-counselling) for the pre-post analysis, 1.05 (EOC) and 0.78 (follow-up) for the pre-EOC-follow-up analysis and 1.27 (EOC), 0.90 (one month), 0.81 (three months) and 0.89 (six months) for the five occasion analysis.

Reductions were significant for the pre-post ($t = 5.63$, $df = 57$, $p = .000$), pre-EOC-follow-up ($F = 16.88$, $df = 2, 60$, $p = .000$) and five occasion ($F = 9.13$, $df = 4, 56$, $p = .000$) analyses. Additional analyses were run to compare scores across adjacent scores and means. There were significant pre-post reductions for the pre-EOC-follow-up ($t = 4.38$, $p = .001$) and five occasion ($t = 3.70$, $p = .002$) analyses. There was a significant EOC-follow-up reduction for the pre-EOC-follow-up analysis ($t = 3.72$, $p = .001$) and a significant reduction from EOC to one month ($t = 4.15$, $p = .001$) for the five occasion analysis. The pre-post effect size was 0.40. Effect sizes for the pre-EOC-follow-up analysis were 0.32 (pre-EOC) and 0.78 (pre-follow-up), whilst five occasion effect sizes were 0.19 (pre-EOC), 0.89 (pre-one), 1.06 (pre-three) and 0.91 (pre-six).

7.5.2. Were There Pre-Post Reductions in Problems with Being Aggressive

Clients had fewer difficulties with being aggressive at post-intervention, than at pre-counselling. Clients, for the pre-post analysis, were experiencing a level of difficulty that was comparable to the level reported for the SPP2/ CPP and Outpatient (Barkham et al, 1994a) samples. Pre-counselling levels of difficulty, for the pre-EOC-follow-up and five occasion analyses, were comparable to the level reported by the General Population sample.

The level of problems with being aggressive were comparable, at post-intervention, with the level reported by the General Population sample.

The pre-counselling level of difficulty with being too aggressive, for the pre-post analysis (1.25), was comparable to the level reported by the SPP2/ CPP (1.30) and Outpatient samples (1.49) and greater than the General Population sample's level of difficulty (0.84). The pre-counselling levels of distress for the pre-EOC-follow-up (0.97) and five occasion (0.95) analyses were comparable to the level of difficulties reported by the General Population sample.

Post-intervention levels of difficulty, in being too aggressive, of 0.62 (post-counselling) for the pre-post analysis, 0.72 (EOC) and 0.52 (follow-up) for the pre-EOC-follow-up analysis and 0.66 (EOC), 0.50 (one month), 0.48 (three months) and 0.52 (six months) for the five occasions analysis were less than the General Population mean.

Reductions were significant for the pre-post ($t = 4.99$, $df = 57$, $p = .000$), pre-EOC-follow-up ($F = 6.65$, $df = 2, 60$, $p = .002$) and five occasion ($F = 2.55$, $df = 4, 56$, $p = .050$) analyses. Further analyses were run to compare across adjacent scores and means. The pre-EOC reduction for the five occasion analysis was significant ($t = 2.39$, $p = .032$). The reduction from EOC to follow-up was significant ($t = 2.11$, $p = .044$) for the pre-EOC-follow-up analysis.

Table 7.6. The IIP-32 and its Sub-scales. Means, Standard Deviations and Ns for Three Comparison Groups and the Counselling Service Sample for the Pre-post, Pre-EOC-follow-up and Five Occasion Analyses.

	IIP-32	Too Aggressive	Hard to be Assertive	Too Caring	Too Dependent	Hard to get Involved	Hard to be Sociable	Hard to be Supportive	Too Open
N	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)
SPP2/ CPP	250	1.56 (.50)	1.99 (1.02)	1.63 (.91)	1.71 (.90)	1.36 (.98)	1.77(1.07)	0.97 (.83)	1.48(1.00)
Out-patient	120	1.51 (.52)	1.87 (1.18)	1.72(1.05)	1.60 (.98)	1.37 (1.13)	1.65(1.29)	0.96 (.95)	1.45(1.06)
Gen-Pop	143	0.98 (.62)	1.12 (.89)	1.25 (.89)	0.90 (.80)	0.91 (.89)	1.02 (.83)	0.65 (.60)	1.74(.84)
Pre-C	58	1.28 (.62)	1.72 (1.18)	1.61 (.89)	1.43 (.97)	1.24 (1.12)	1.22(1.09)	0.67 (.80)	1.92(.90)
Post-C	58	1.03 (.54)	1.19 (.77)	1.32 (.97)	1.18 (.88)	0.97 (.90)	0.87 (.93)	0.48 (.64)	2.12(.77)
Pre-C	31	1.24 (.59)	1.72 (1.30)	1.58 (.89)	1.46 (1.05)	0.97 (1.02)	1.29(1.24)	0.63 (.71)	2.13(1.02)
EOC	31	1.05 (.54)	1.61 (1.09)	1.43(1.12)	1.36 (.89)	1.17 (1.08)	0.86 (.99)	0.45 (.59)	2.27(.96)
Follow-up	31	0.78 (.78)	0.99 (.72)	0.98 (.72)	1.02 (.77)	0.71 (.69)	0.89(1.04)	0.42 (.56)	2.18(.73)
Pre-C	15	1.37 (.53)	1.85 (1.34)	1.77(1.04)	1.85 (1.15)	1.08 (.87)	1.42(1.45)	0.77 (.87)	2.45(1.08)
EOC	15	1.27 (.44)	1.95 (1.01)	1.76(1.35)	1.68 (1.68)	1.47 (1.00)	0.92(1.04)	0.70 (.76)	2.75(.93)
One M	15	0.90 (.43)	1.21 (.95)	1.47(1.03)	1.19 (1.19)	0.83 (.62)	0.70 (.82)	0.37 (.49)	2.69(.76)
Three M	15	0.81 (.68)	1.10 (1.01)	1.03 (.67)	1.07 (1.07)	0.60 (.71)	0.88(1.22)	0.65(1.12)	2.25(.72)
Six M	15	0.89 (.51)	1.13 (.70)	1.25 (.94)	1.13 (1.13)	0.82 (.55)	0.80 (.88)	0.68 (.84)	2.23(.87)

EOC = End of Counselling. IIP = Inventory of Interpersonal problems. The IIP-32 is a short form version of the original IIP-127 (Derogatis et al, 1988). Higher mean scores are associated with greater levels of interpersonal difficulty. SPP2 = Second Sheffield Psychotherapy Project. CPP = Collaborative Psychotherapy Project. The SPP2/ CPP means are at pre-therapy. Gen-Pop = General Population. C = Counselling. M = Month. The SPP2/ CPP, Out-patient and General Population means are reported from Barkham et al (1994a). The Post-counselling mean is the average of scores taken from EOC, one, three and six months. The Follow-up mean is the average of scores taken from one, three and six months. The N for "Too Dependent", "Hard to get Involved", "Hard to be Sociable" and "Hard to be Supportive" was 57 and the N for "Too Open" was 53.

Fig 7.4. Change, across pre-post, pre-EOC-follow-up and five occasion analyses, on the IIP-32 and its Too Aggressive and Hard to be Assertive sub-scales. With SPP2/CPP (pre-therapy), Out-patient and General Population comparison groups.

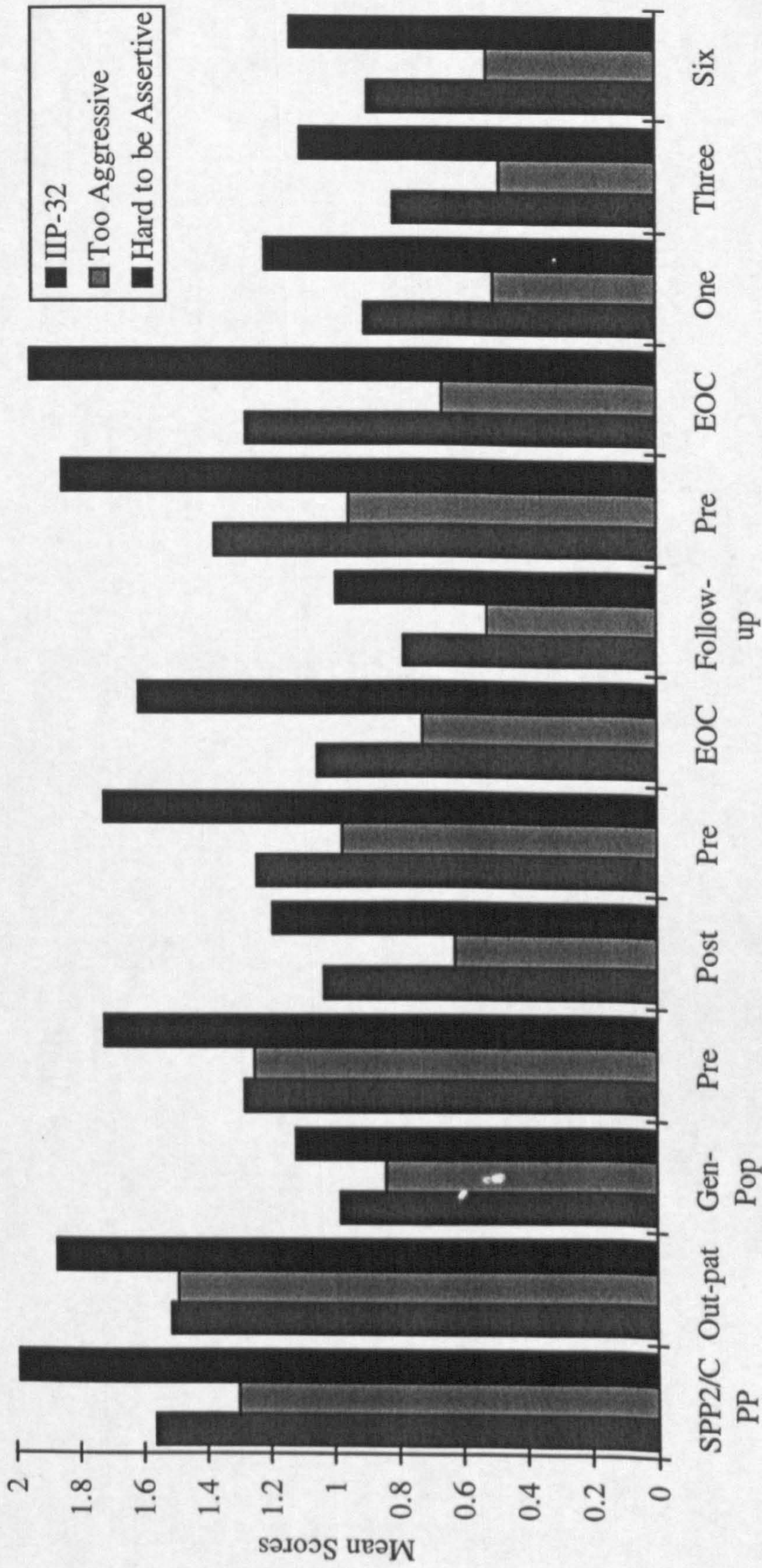


Fig 7.5. Change, across pre-post, pre-EOC-follow-up and five occasion analyses on the IIP-32 sub-scales of Too Caring, Too Dependent and Hard to get Involved. With SPP2/CPP (pre-therapy), Out-patient and General Population comparison groups.

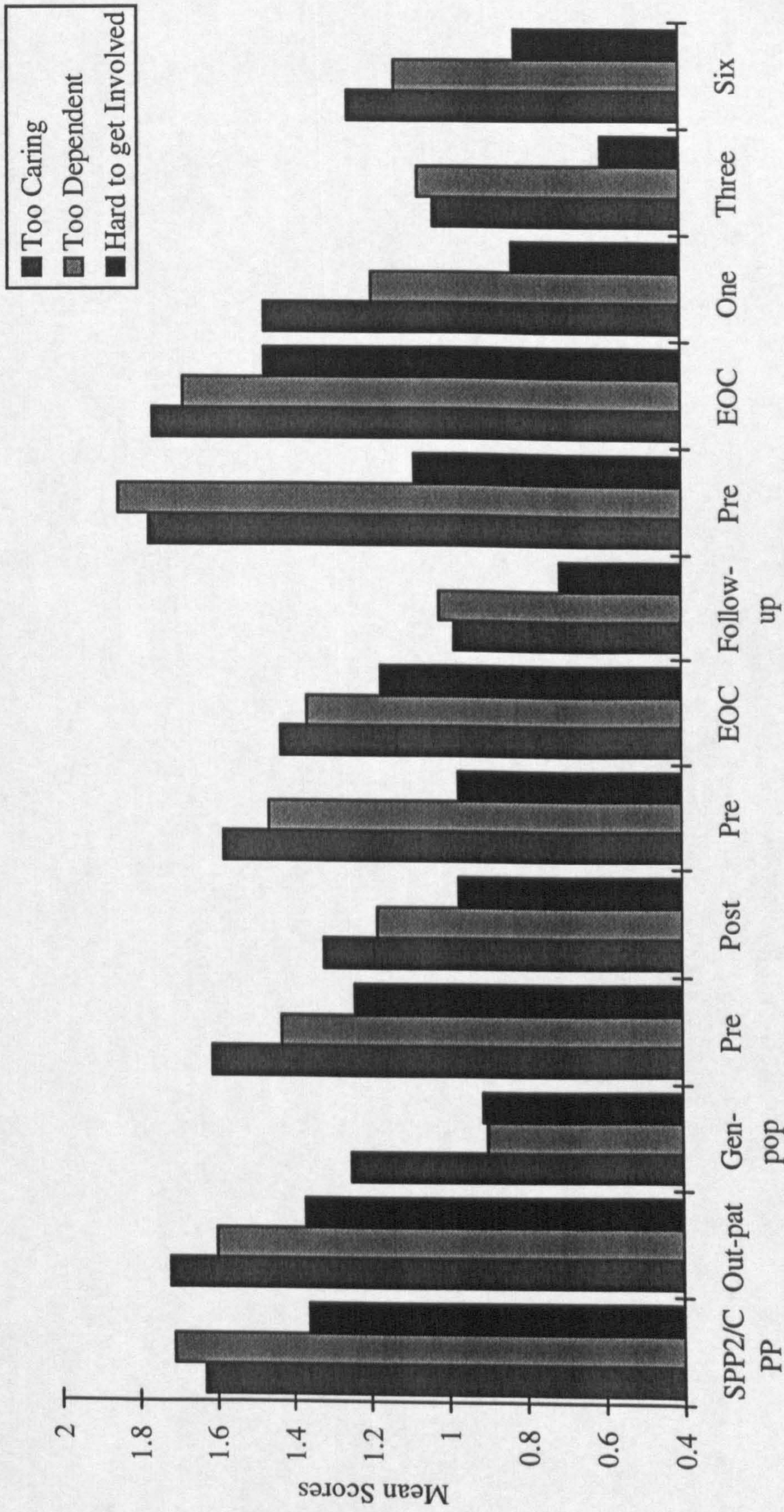
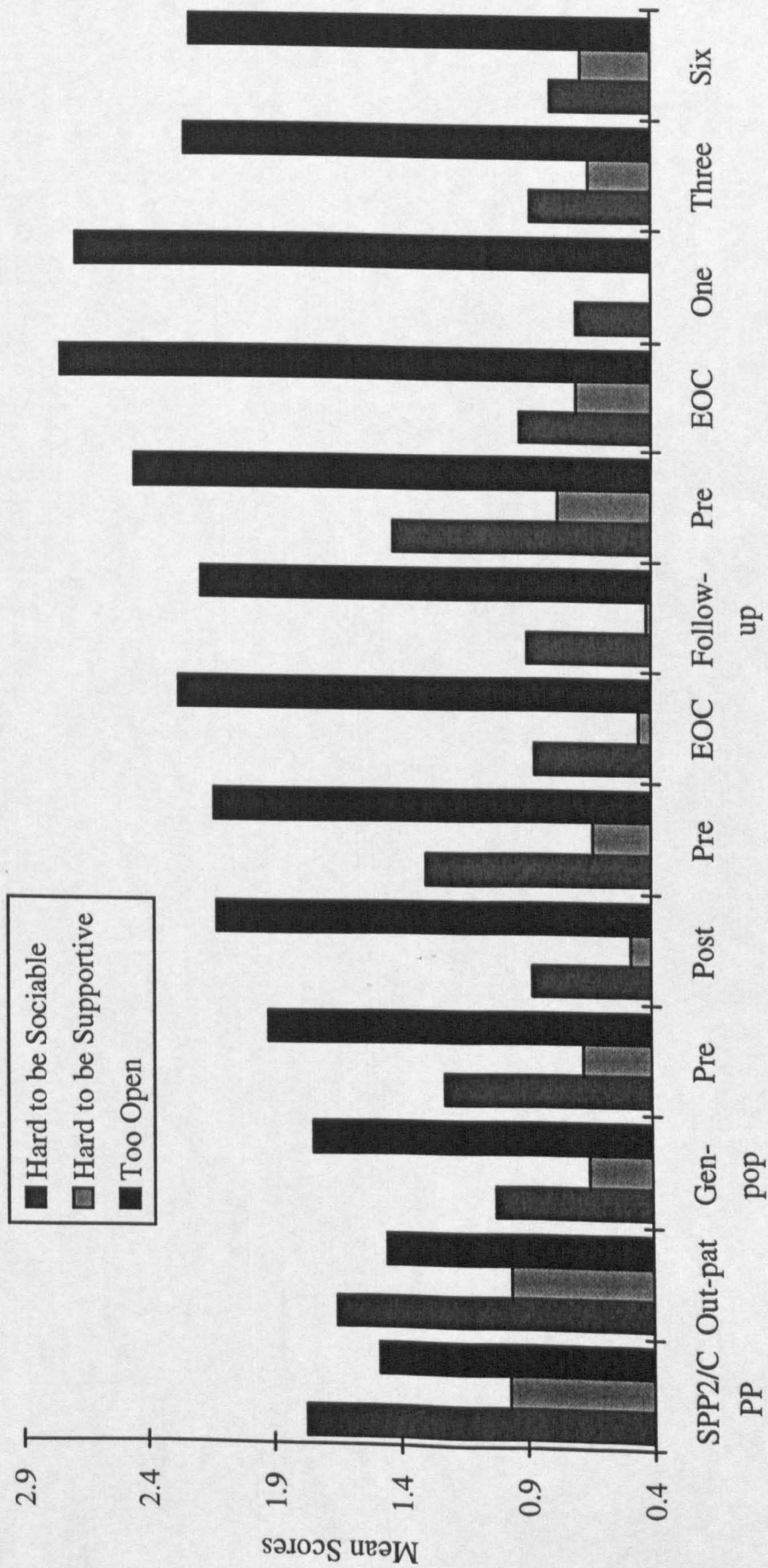


Fig 7.6. Change, across pre-post, pre-EOC-follow-up and five occasion analyses on the IIP-32 Hard to be Sociable, Hard to be Supportive and Too Open Sub-Scales. With SPP2/CPP (pre-therapy), Out-patient and General Population comparison groups.



The pre-post effect size was 0.50. Effect sizes for the pre-EOC-follow-up analysis were 0.26 (pre-EOC) and 0.44 (pre-follow-up) for the pre-EOC-follow-up analysis and 0.31 (pre-EOC), 0.48 (pre-one), 0.50 (pre-three) and 0.46 (pre-six) for the five occasion analysis.

7.5.3. Were There Pre-Post Reductions in Problems with being Assertive

Clients, consistently across all three analyses, reported fewer problems with being assertive at post-intervention than at pre-counselling. Pre-counselling levels of difficulty were comparable to the levels reported for the SPP2/ CPP and Outpatient samples and were greater than the General Population sample. However, scores at post-intervention, clearly indicated that the level of difficulty, with being assertive, reported by service clients was comparable to the problems reported by the General Population sample.

Pre-counselling levels of difficulty, on the Hard to be Assertive sub-scale, for the pre-post (1.72), pre-EOC-follow-up (1.72) and five occasion (1.85) analyses were comparable with scores reported for SPP2/ CPP (1.99) and Out-patient (1.87) samples. Post-intervention scores and means of 1.19 (post-counselling) for the pre-post analysis, 1.61 (EOC) and 0.99 (follow-up) for the pre-EOC-follow-up analysis and 1.91 (EOC), 1.21 (one month), 1.10 (three months) and 1.13 (six months) for the five occasion analysis, were comparable to the level reported for the General Population sample.

Reductions were significant for the pre-post ($t = 4.41$, $df = 57$, $p = .01$), pre-EOC-follow-up ($F = 10.69$, $p = .01$) and five occasion ($F = 6.24$, $df = 4, 56$, $p = .01$) analyses. Additional analyses were run to compare scores across adjacent scores and means. The pre-EOC increase for the five occasion analysis was significant ($t = 2.20$, $p = .05$). The EOC-follow-up reduction for the pre-EOC-follow-up analysis was significant ($t = 3.88$, $p = .01$), as was the EOC-one month reduction for the five occasion analysis ($t = 3.55$, $p = .01$). The pre-post effect size was 0.45, whilst pre-EOC-follow-up effect sizes were 0.08 and 0.56, whilst for the five occasion analysis, the effect sizes were 0.07 (pre-EOC), 0.48 (pre-one month), 0.56 (pre-three months) and 0.54 (pre-six months).

Measures	Effect Sizes		Repeated Measure MANOVA's		
	Pre/EOC	Pre-Follow-up	F	p	df
IIP-32	0.32	0.78	16.88	.01	2,60
Too Aggressive	0.26	0.44	6.65	.01	2,60
Hard to be Assertive	0.08	0.48	10.69	.01	2,60
Too Caring	0.17	0.67	13.43	.01	2,60
Too Dependent	0.10	0.42	6.47	.01	2,60
Hard to be Involved	-0.19	0.25	6.93	.01	2,60
Hard to be Sociable	0.36	0.32	4.30	.02	2,60
Hard to be Supportive	0.25	0.30	2.15	.10	2,60
Too Open	-0.14	-0.05	0.73	.48	2,60

EOC = End of Counselling. IIP = Inventory of Interpersonal problems. The IIP-32 is a short form version of the original IIP-127 (Derogatis et al, 1988). Higher mean scores are associated with greater levels of interpersonal difficulty. The Post-counselling mean is the average of scores taken from EOC, one, three and six months. The Follow-up mean is the average of scores taken from one, three and six months.

7.5.4. Were there Pre-post Reductions in Problems with being Too Caring

Clients had fewer difficulties at post-intervention, than at pre-counselling, with being too caring. This pattern was consistent across all three sets of analyses. Clients at pre-counselling and at the end of counselling, for the pre-EOC-follow-up and five occasion analysis, reported having as many difficulties with being too caring as psychotherapy, at pre-therapy (SPP2/ CPP) and Outpatient clients. At post-intervention, client levels of difficulty with being too caring were less than the level reported at pre-counselling and EOC and were comparable to the difficulties reported by the General Population sample.

Client levels of difficulty, at pre-counselling and EOC were 1.61 for the pre-post (pre-counselling) analysis, 1.58 (pre-counselling) and 1.43 (EOC) for the pre-EOC-follow-up analysis and 1.75 (pre-counselling) and 1.76 (EOC) for the five occasion analysis were comparable to the level of difficulty reported by SPP2/ CPP (1.63 at pre-therapy) and Out-patient (1.72) samples and greater than the level reported by the General Population sample (1.25). Post-intervention scores and means (follow-up for pre-EOC-follow-up and one, three and six months for the five occasion analysis) for the pre-post (1.32 at post-counselling), pre-EOC-follow-up (0.98 at follow-up) and five occasion, 1.47 (one month), 1.03 (three months) and 1.25 (six months) were comparable to the General Population sample's reported level of distress.

Reductions were significant for the pre-post ($t = 2.30$, $df = 57$, $p = .03$), pre-EOC-follow-up ($F = 13.42$, $df = 2, 60$, $p = .01$) and five occasion ($F = 4.61$, $df = 4, 56$, $p = .01$) analyses. Additional analyses were run to compare adjacent scores and means. Reductions from pre-counselling to EOC ($t = 2.71$, $p = .020$) and from EOC to follow-up ($t = 3.75$, $p = .01$), for the pre-EOC-follow-up analysis, were significant. Reductions from pre-counselling to EOC ($t = 2.20$, $p = .04$) and from EOC to one month ($t = 2.61$, $p = .02$) were significant. Effect sizes were 0.33 for the pre-post analysis, for the pre-EOC-follow-up analysis, 0.16 (pre-EOC) and 0.67 (pre-follow-up) and for the five occasion analysis, 0.00 (pre-EOC), 0.29 (pre-one month), 0.72 (pre-three months) and 0.50 (pre-six months).

7.5.5. Were there Pre-post Reductions in Problems with being Too Dependent

Clients had fewer problems with being too dependent on others at post-intervention, than at pre-counselling. Pre-counselling and EOC (for the pre-EOC-follow-up and five occasion analyses) levels of difficulty with being too dependent on other people were less, with the exception of the five occasion analysis, than the level of difficulty reported by SPP2/ CPP (at pre-therapy) and Out-patient clients but greater than the level of problem reported by a General Population sample. Difficulties at pre-counselling and EOC, for the five occasion analysis, were comparable to the SPP2/ CPP and Outpatient levels of problem. There were reductions to post-counselling (pre-post), to follow-up (pre-EOC-follow-up) and to one, three and six months (five occasions) in problems with being too dependent.

Pre-counselling scores for the Pre-post (1.43) and pre-EOC-follow-up (1.46) analyses were less than those reported for the SPP2/ CPP (1.71) and Out-patient (1.60) scores. The pre-counselling (1.85) and EOC (1.68) scores for the five occasion analysis were comparable to the SPP2/ CPP and Out-patient scores. Post-intervention scores were 1.18 at post-counselling (pre-post), 1.02 at follow-up (pre-EOC-follow-up) and 1.19 (one month), 1.07 (three months) and 1.13 (six months) for the five occasion analysis.

Reductions, from pre- to post-intervention, were significant for the pre-post ($t = 2.21$, $df = 56$, $p = .03$), pre-EOC-follow-up ($F = 6.47$, $df = 2, 60$, $p = .01$) and five occasion ($F = 5.70$, $df = 4, 56$, $p = .01$) analyses.

Table 7.8. Change on the IIP-32 and its Sub-Scales Across Adjacent Occasions: A Series of Matched T-Tests to Compare Scores at Pre-Counselling and EOC Scores and to Compare EOC and Follow-up Scores.

Scales	Adjacent Occasions			
	Pre-Counselling/EOC		EOC/Follow-up	
	t	p	t	p
IIP-32	4.38	.01	3.72	.01
Too Aggressive	2.71	.02	2.11	.04
Hard to be Assertive	2.74	.01	3.88	.01
Too Caring	3.60	.01	3.75	.01
Too Dependent	2.29	.03	2.74	.01
Hard to get Involved	0.28	.78	3.48	.01
Hard to be Sociable	2.60	.01	-0.25	.80
Hard to be Supportive	1.91	.07	0.49	.63
Too Open	-1.49	.15	0.87	.39

EOC = End of Counselling. Follow-up = The average of scores taken from one, three and six months. IIP = Inventory of Interpersonal Problems. This is a short-form version of the original IIP-127 (Derogatis et al, 1988).

Additional analyses were run, for the pre-EOC-follow-up and five occasion analyses, to compare adjacent scores and means. There were pre-EOC reductions for the pre-EOC-follow-up ($t = 2.29, p = .030$) and five occasion ($t = 3.01, p = .009$) analyses. There was a significant reduction, for the pre-EOC-follow-up analysis, from EOC to follow-up ($t = 2.74, p = .010$) and there was a significant reduction from EOC to one month ($t = 3.51, p = .004$) for the five occasion analysis. Effect sizes were 0.26 for the pre-post analysis, 0.09 (pre-EOC) and 0.41 (pre-follow-up) for the pre-EOC-follow-up analysis and 0.15 (Pre-EOC), 0.57 (pre-one month), 0.68 (pre-three months) and 0.63 (pre-six months).

7.5.6. Were there Pre-Post Reductions in Problems with Getting Involved

Clients had fewer problems at post-intervention, than at pre-counselling, with getting involved with other people. On the pre-post analysis, clients reported greater problems, than the General Population sample, with getting involved with other people. Pre-counselling difficulties for the pre-EOC-follow-up and five occasion analyses were comparable. The level of difficulty reported, cross all three analyses, was less than that reported from the SPP2/ CPP (at pre-therapy) and Outpatient samples. On two of the analyses, pre-EOC-follow-up and five occasions, clients reported an increase in problems from pre-counselling to EOC, before reductions from EOC to follow-up for the pre-EOC-follow-up analysis and from EOC to one month, for the five occasion analysis. Scores at post-counselling, for the pre-post analysis, follow-up, for the pre-EOC-follow-up analysis and at one, three and six months, for the five occasion analysis, were comparable to difficulties reported by the General Population sample.

Table 7.9. The IIP-32 its Eight Sub-Scales a Series of Repeated Measure MANOVA's and Effect Sizes

Measures	Effect Sizes				Repeated Measure MANOVA's		
	Pre-EOC	Pre-One	Pre-Three	Pre-Six	F	p	df
IIP-32	0.19	0.89	1.06	0.91	9.13	.01	4,56
Too Aggressive	0.31	0.48	0.50	0.46	2.55	.05	4,56
Hard to be Assertive	-0.07	0.48	0.56	0.54	6.24	.01	4,56
Too Caring	0.00	0.29	0.72	0.50	4.61	.01	4,56
Too Dependent	0.15	0.57	0.68	0.63	5.70	.01	4,56
Hard to be Involved	-0.45	0.29	0.80	0.30	6.55	.01	4,56
Hard to be Sociable	0.34	0.50	0.37	0.43	2.56	.080	4,56
Hard to be Supportive	0.08	0.46	0.14	0.10	0.93	.45	4,56
Too Open	0.28	0.22	0.19	0.20	3.26	.02	4,56

EOC = End of Counselling. IIP = Inventory of Interpersonal problems. The IIP-32 is a short form version of the original IIP-127 (Derogatis et al, 1988). Higher mean scores are associated with greater levels of interpersonal difficulty. The Post-counselling mean is the average of scores taken from EOC, one, three and six months. The Follow-up mean is the average of scores taken from one, three and six months.

Pre-counselling scores of 1.24 (pre-post), 0.97 (pre-EOC-follow-up) and 1.08 (five occasion) analyses were less than SPP2/ CPP (1.36) and Outpatient (1.37) client scores but greater than the General Population score (0.91). There were increases from pre-counselling to EOC in reported difficulties with getting involved for the pre-EOC-follow-up (1.17) and five occasion (1.47) analyses. There were reductions to post-

counselling (0.97 at post-counselling), follow-up (0.71, pre-EOC-follow-up) and at one (0.83), three (0.60) and six months (0.82, five occasions).

Scale	Comparison across measurement occasions							
	Pre-EOC		EOC/One		One/Three		Three/Six	
	t	p	t	p	t	p	t	p
IIP-32	3.70	.01	4.15	.01	0.63	.54	-0.68	.51
T.Aggressive	2.39	.03	1.02	.33	0.00	1.00	-0.52	.61
H.Assertive	2.20	.05	3.55	.01	0.83	.42	-0.17	.87
T.Caring	2.30	.04	2.61	.02	2.22	.04	-0.97	.35
T.Dependent	3.01	.01	3.51	.01	0.59	.57	-0.16	.87
H.Involved	1.12	.28	3.87	.01	1.19	.25	-1.23	.24
H.Sociable	1.93	.07	0.61	.55	-1.69	.11	0.33	.75
H.Supportive	.84	.42	0.93	.37	-1.71	.11	-0.38	.71
T.Open	-.74	.47	2.35	.03	2.91	.012	0.45	.66

EOC = End of Counselling. L = Likert; C = Case; H = Hard to; T = Too.

Reductions were significant for the pre-post ($t = 2.89$, $df = 56$, $p = .005$), pre-EOC-follow-up ($F = 6.93$, $df = 2, 60$, $p = .002$) and five occasion ($F = 6.55$, $df = 4, 56$, $p = .001$) analyses. Additional analyses were run to compare adjacent scores and means. There was a significant reduction from EOC to follow-up ($t = 3.48$, $p = .002$) for the pre-EOC-follow-up analysis and from EOC to one month ($t = 3.87$, $p = .002$) for the five occasion analysis. Effect sizes were 0.24 for the pre-post analysis, -0.19 (pre-EOC) and 0.17 (pre-follow-up) for the pre-EOC-follow-up analysis and -0.45 (pre-EOC), 0.29 (pre-one), 0.80 (pre-three) and 0.30 (pre-six).

7.5.7. Were there Pre-Post Reductions in Problems with being Sociable

Clients had fewer problems with being sociable with other people at post-intervention, than at pre-counselling. Clients at pre-counselling had fewer problems with being sociable with other people than pre-therapy (SPP2/ CPP) and Outpatient clients, although they had greater difficulties than the General Population sample. Service clients reported a consistent pattern of reductions to EOC across all three analyses, with stability to follow-up, on the pre-EOC-follow-up and five occasion analyses. The level of difficulty reported by service clients at post-intervention was comparable to the level of problem reported by the General Population sample.

Comparison scores were 1.77 for the SPP2/ CPP (at pre-therapy) sample, 1.65 for the Out-patient sample and 1.02 for the General Population sample. Scores at pre-counselling were 1.24 (pre-post), 0.97 (pre-EOC-follow-up) and 1.42 (five occasions). Scores at post-counselling, EOC and follow-up, which were all less than those at pre-counselling, were 0.87 for the pre-post analysis, 0.86 (EOC) and 0.89 (follow-up) for the pre-EOC-follow-up analysis and 0.92 (EOC), 0.70 (one month), 0.88 (three months) and 0.80 (six months) for the five occasion analysis.

Reductions were significant for the pre-post ($t = 3.25$, $df = 56$, $p = .002$) and pre-EOC-follow-up ($F = 4.30$, $df = 2, 60$, $p = .018$) analyses and approached significance for the five occasion ($F = 2.56$, $df = 4, 56$, $p = .079$) analysis. Additional analyses were run to compare adjacent scores and means. The pre-EOC reduction for the pre-EOC-follow-up analysis was significant ($t = 2.60$, $p = .014$), whilst the reduction from pre-counselling to EOC ($t = 1.93$, $p = 0.074$) approached significance. The increase from one to three months ($t = -1.69$, $p = .114$) also approached significance. Effect sizes were 0.32 for the pre-post analysis, 0.34 (pre-EOC) and 0.32 (pre-follow-up) for the pre-EOC-follow-up analysis and 0.34 (pre-post), 0.50 (pre-one month), 0.37 (pre-three months) and 0.43 (pre-six months).

7.5.8. Were there Pre-Post Reductions in Problems with being too Supportive

Clients had fewer difficulties with being supportive at post-intervention, than at pre-counselling on the pre-post and pre-EOC-follow-up analysis. On the five occasion analysis, although there was a reduction, from EOC to follow-up, there was evidence of deterioration from one to six months. At pre-counselling, service clients reported fewer problems with being supportive of other people than pre-therapy (SPP2/ CPP) and Outpatient clients and comparable to the level of difficulty reported by a General Population sample. There was a consistent pattern of reductions, across analyses, from pre-counselling to post-counselling and EOC.

Scores at pre-counselling were 0.67 (pre-post), 0.63 (pre-EOC-follow-up) and 0.77 (five occasions). These were less than the SPP2/ CPP (0.97) and Outpatient (0.96) levels of difficulty and were comparable to the level of problem reported by the General Population sample (0.65). Scores at post-counselling and EOC, which were lower than at pre-counselling, with the exception of the five occasion analysis, were 0.48 (at post-counselling) for the pre-post analysis, 0.45 (EOC) for the pre-EOC-follow-up analysis and 0.70 (EOC) for the five occasion analysis. Scores at follow-up were 0.42 for the pre-

EOC-follow-up analysis, and 0.37 (one month), 0.65 (three months) and 0.68 (six months) for the five occasion analysis.

The pre-post reduction was significant ($t = 2.18$, $df = 56$, $p = .034$), whilst the pre-EOC-follow-up reduction approached significance ($F = 2.15$, $df = 2, 60$, $p = .102$). Additional analyses were run to examine adjacent scores and means. The pre-EOC reduction for the pre-EOC-follow-up analysis approached significance ($t = 1.91$, $p = .066$), as did the increase from one to three months for the five occasion analysis ($t = -1.71$, $p = .110$). The pre-post effect size was 0.34, whilst effect sizes for the pre-EOC-follow-up analysis were 0.25 (pre-EOC) and 0.29 (pre-follow-up). Effect sizes for the five occasion analysis were 0.08 (pre-EOC), 0.46 (pre-one), 0.14 (pre-three) and 0.10 (pre-six).

7.5.9. Were there Pre-Post Reductions in Problems with being Too Open

Clients did not report reductions. Instead, they actually reported increases in difficulties with being too open at post-intervention, than at pre-counselling on the pre-post analysis. On the pre-EOC-follow-up and five occasion analyses, clients reported comparable levels of difficulty at pre and post-intervention. In all cases, levels of reported difficulty with being too open were in excess of levels of problems reported for the SPP2/ CPP, Outpatient and General Population samples (Barkham et al, 1994a) samples.

Pre-counselling scores 1.92 for the pre-post analysis, 2.13 for the pre-EOC-follow-up analysis and 2.45 for the five occasion analysis were all greater than the SPP2/ CPP (1.48), Outpatient (1.45) and General Population (1.74) sample scores. Post-counselling, EOC and follow-up means were for the 2.12 for the pre-post analysis (at post counselling), 2.27 (EOC) and 2.18 (follow-up) for the pre-EOC-follow-up analysis and 2.75 (EOC), 2.69 (one month), 2.25 (three months) and 2.23 (six months) for the five occasion analysis.

Increases in difficulties, from pre-counselling to post-intervention, were significant for the pre-post ($t = -2.36$, $df = 52$, $p = .002$) and five occasion ($F = 3.26$, $df = 5, 56$, $p = .017$) analyses. A series of additional analyses were run to compare adjacent scores and means. Both the reductions from EOC to one month ($t = 2.35$, $p = .034$) and from one to three months ($t = 2.91$, $p = .012$), for the five occasion analysis, were significant. The increase from pre-EOC increase for the pre-EOC-follow-up analysis approached significance ($t = -1.49$, $p = .147$). The pre-post effect size was -0.22. The effect sizes for

pre-EOC-follow-up analysis were 0.13 (pre-EOC) and 0.04 (pre-follow-up) and for the five occasion analysis, 0.28 (pre-EOC), 0.22 (pre-one), 0.19 (pre-three) and 0.20 (pre-six).

6.6. Were there Pre-Post Increases in Client Use of Coping Strategies

Three sets of analyses are presented: (i) Pre-Post: a comparison of scores at pre-counselling with a post-counselling mean. The post-counselling mean is the average of scores taken from EOC, one, three and six months, (ii) Pre-EOC-Follow-up: a comparison of scores taken from pre-counselling and EOC with a follow-up mean. The follow-up mean is the average of scores taken from one, three and six months and (iii) Five Occasions: scores taken from pre-counselling, EOC, one, three and six months.

7.6.1. Was there a Pre-post Increase in the Use of Social Support Strategies

Clients reported, consistently across the three analyses, that they used Social Support strategies more frequently at post-intervention than at pre-counselling. Pre-counselling levels of Social Support use were comparable to the levels reported by three hospital samples (OSI Data Supplement, 1994) for the pre-EOC-follow-up analysis and greater for the pre-post and five occasion analyses. At post-intervention, service clients reported a consistently greater use of strategies, than the three hospital samples.

The level of strategy use reported for the three Hospital samples were 16.58 (n = 1200), 16.25 (n = 326) and 16.74 (n = 530). Reported levels of use of Social Support strategies at pre-counselling were 18.00 (pre-post), 16.65 (pre-EOC-follow-up) and 17.40 (five occasions). Scores and means at post-intervention were 19.35 (post-counselling) for the pre-post analysis, 19.40 (EOC) and 20.23 (follow-up) for the pre-EOC-follow-up analysis and 19.65 (EOC), 20.65 (one month), 20.35 (three months) and 20.55 (six months) for the five occasion analysis.

Reductions were significant for the pre-post ($t = 5.52$, $df = 55$, $ES = -.32$, $p = .001$), pre-EOC-follow-up ($F = 10.80$, $df = 2,58$, $p = .000$) and five occasion ($F = 2.71$, $df = 4, 52$, $p = .039$) analyses. Additional analyses were run to compare adjacent scores and means. Increases from pre-counselling to EOC were significant for the pre-EOC-follow-up ($t = -3.73$, $p = .001$) and five occasion ($t = -2.19$, $p = .046$) analyses, whilst the increase from EOC to follow-up, for the pre-EOC-follow-up analysis, approached significance ($t = -1.36$, $p = .184$). Effect sizes were -0.31 for the pre-post analysis, -0.68 (pre-EOC) and $-$

0.89 (pre-follow-up) for the pre-EOC-follow-up analysis and -0.51 (pre-EOC), -0.75 (pre-one months), -0.68 (pre-three months) and -0.72 (pre-six months) for the five occasion analysis.

In terms of standard deviations, there was a pre-post decrease from 4.25 to 2.37, a decrease from 4.05, at pre-counselling, to 2.65, at follow-up for the pre-EOC-follow-up analysis and a reduction from 4.35, at pre-counselling, to 3.00 at six months for the five occasion analysis. These compare with the hospital sample standard deviations of 3.05, 3.08 and 3.24.

7.6.2. Was there a Pre-Post Increase in the Use of Logic Strategies

There was a consistent pattern of increases in the use of Logic strategies from pre-counselling to post-counselling. However, the reported use of Logic based strategies, by service clients, was consistently less than the level of use reported by three hospital samples (OSI Data Supplement, 1994).

Client scores at pre-counselling were 11.67 for the pre-post analysis, 10.80 for the pre-EOC-follow-up analysis and 11.01 for the five occasion analysis. These compare with scores for the three comparison hospital samples of 12.29, 12.51 and 12.47. The reported use of Logic strategies at post-intervention were 12.02 (post-counselling) for the pre-post analysis, 10.77 (EOC) and 11.60 (follow-up) for the pre-EOC-follow-up analysis and 10.23 (EOC), 10.86 (one month), 10.83 (three months) and 11.22 (six months) for the five occasions analysis.

The pre-post increase was significant ($t = 2.12$, $df = 56$, $ES = -.32$, $p = .038$), whilst the increased use of Logic strategies approached significance for the pre-EOC-follow-up analysis ($F = 2.08$, $df = 2,56$, $p = .134$).

Table 7.11. The Reported Frequency of Use of Coping Strategies: Comparisons Between the Three Hospital Samples and the Counselling Service Sample

Sample Scores	Social Support Strategies			Logic Strategies	
	N	Mean	SD	Mean	SD
OSI North Hospital	1200	16.58	3.08	12.29	2.06
OSI Midlands Hospital	326	16.25	3.05	12.51	2.12
OSI South Hospital	530	16.74	3.24	12.47	2.00
Pre-Counselling	58	18.00	4.25	11.67	2.37
Post-Counselling	58	19.35	3.20	12.02	1.56
Pre-Counselling	31	16.65	4.05	10.80	2.19
End of Counselling	31	19.40	3.40	10.77	2.46
Follow-up	31	20.23	2.65	11.60	1.38
Pre-Counselling	15	17.40	4.35	11.01	2.31
End of Counselling	15	19.65	4.30	10.23	2.64
One Month	15	20.65	2.65	10.86	2.49
Three Months	15	20.35	3.20	10.83	1.80
Six Months	15	20.55	3.00	11.22	1.32

OSI = Occupational Stress Indicator. EOC = End of Counselling. Post = The average of scores taken from EOC, one, three and six months. Follow-up = The average of scores taken from one, three and six months. Higher scores are associated with the more frequent use of strategies.

Fig 7.7. The OSI Social Support Sub-Scale and Pre-post, Pre-Follow-up and from Pre-Six Month Change, with Hospital based Comparison Groups.

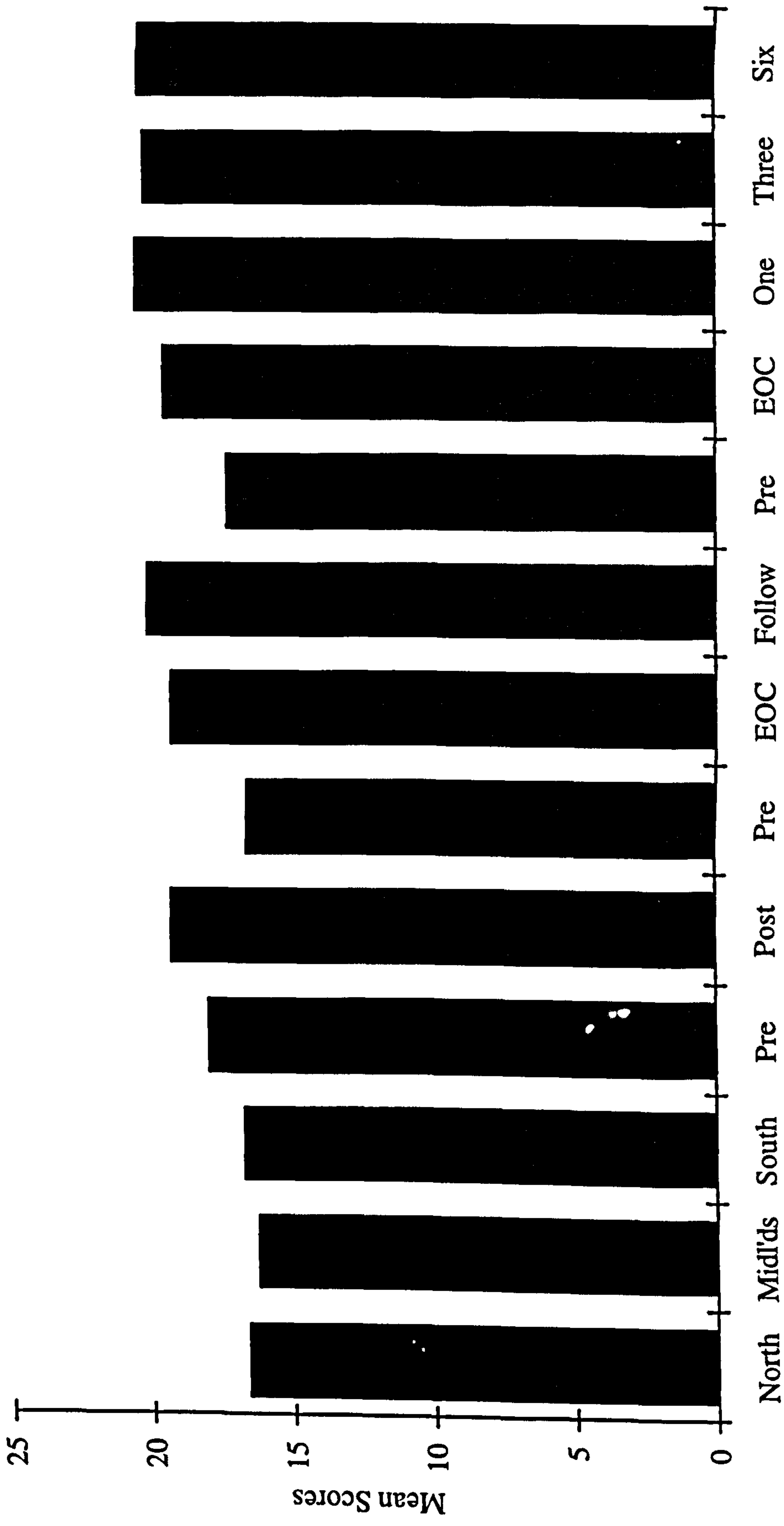
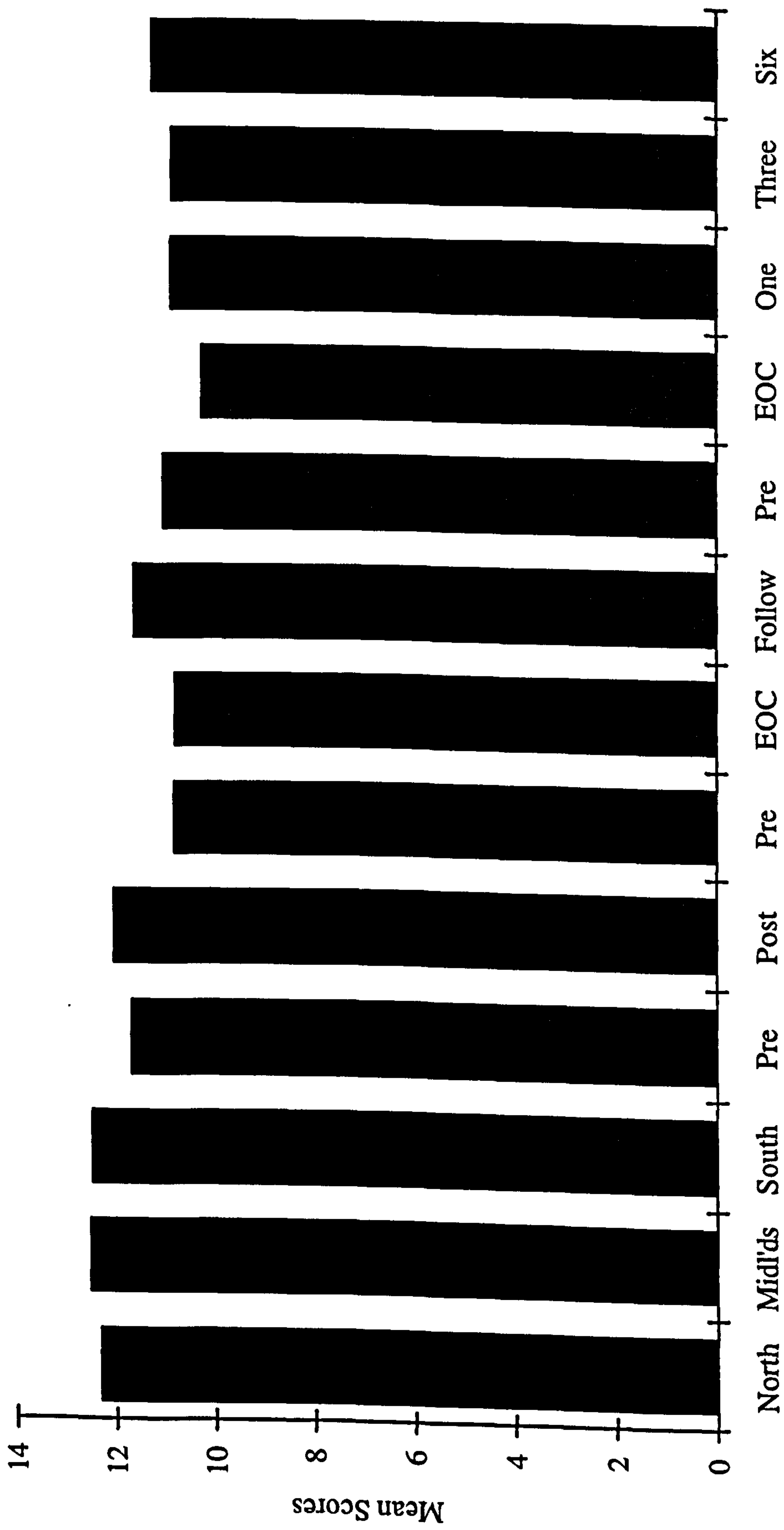


Fig 7.8. The OSI Logic Sub-scale and Pre-Post, Pre-Follow-up and Pre-Six Month Change. With Three Hospital Comparison Groups.



**Table 7.12. Coping Strategies and Change Across Adjacent Occasions.
A Series of Matched t-tests.**

	Comparison across measurement occasions							
	Pre-EOC		EOC/One		One/Three		Three/Six	
Scale	t	p	t	p	t	p	t	p
Social Support	-2.18	.06	-0.83	.42	0.50	.62	-0.26	.81
Logic	0.11	.91	-1.38	.19	-0.87	.40	0.43	.68

EOC = End of Counselling, Pre = Pre-Counselling, OSI = Occupational Stress Indicator.

Additional analyses were run to compare scores and means across adjacent occasions. The EOC-follow-up increase for the pre-EOC-follow-up analysis ($t = -1.86$, $p = .073$) and the EOC-One month for the five occasion analysis both approached significance ($t = -1.38$, $p = .192$). Effects sizes were -0.14 for the pre-post analysis, 0.01 (pre-EOC) and -0.34 (pre-follow-up) for the pre-EOC-follow-up analysis and 0.34 (pre-EOC), 0.06 (pre-one), 0.18 (pre-three months) and -0.09 (pre-six months).

7.7. Were there Pre-Post Changes in Client Ratings of Counselling Impact

Three separate analyses are presented: (i) Pre-Post (see Table 7.13. and Figure 7.9.): comparing the pre-counselling score with a post-counselling mean. The post-counselling mean is the average of scores taken from EOC, one, three and six months; (ii) Pre-End-Follow (see Table 7.13.. and Figure 7.9. and Table 7.9. for analyses across adjacent occasions); comparing scores at pre-counselling and EOC with a follow-up mean. The follow-up mean was the average of scores taken at one, three and six months and (iii): Five-Occasions (see Table 7.13. and Figure 7.9. and Table 7.17. for analyses across adjacent occasions). A comparison of scores across pre-counselling, EOC, one, three and six months.

7.7.1. Are there Pre-Post Increases in Client Ratings of Global Impacts

The picture in response to this question was mixed. There were increases in ratings of session impact from pre-counselling to post-intervention for the pre-post and pre-EOC-follow-up analyses, whilst for the five occasion analyses, an initial increase in more positive ratings gave way to successively less positive ratings from EOC to six months.

Pre-counselling levels on the SIS, the expectations that clients had about the impact of counselling were, respectively, for the pre-post, pre-EOC-follow-up and five occasion analyses, 3.92, 4.03 and 4.13. There were increases in ratings at post-counselling and EOC of 4.16 at post-counselling (pre-post), 4.37 at EOC (pre-EOC-follow-up) and 4.30 (five occasions). Follow-up scores were 4.28 for the pre-EOC-follow-up analysis and 4.21 (one month), 4.14 (three months) and 4.17 (six months) for the five occasion analysis. Increases in ratings were significant for the pre-post ($t = -2.82$, $df = 56$, $p = .007$) and pre-EOC-follow-up ($F = 6.68$, $df = 2, 60$, $p = .002$) and five occasion. Additional analyses were run to compare adjacent scores and means. There was a significant increase from pre-counselling to EOC ($T = 2.93$, $p = .006$) for the pre-EOC-follow-up analysis and a near significant reduction in ratings from EOC to one month ($t = 1.71$, $p = .110$) on the five occasion analysis. Effect sizes were 0.46 for the pre-post analysis, -0.61 (pre-EOC) and -0.45 (pre-follow-up) for the pre-EOC-follow-up analysis.

Table 7.13. Measures of Expectation and Counselling Impact: Means and Standard Deviations

	Single Item Hindering		Session Impact Scale		Hindering Impacts		Relationship Impacts		Task Impacts	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Pre-Counselling	6.64	1.21	3.92	0.52	1.64	0.55	3.87	0.85	3.51	0.81
Post-Counselling	6.70	1.52	4.16	0.59	1.36	0.48	4.04	0.92	3.73	0.85
Pre-Counselling	6.63	1.19	4.03	0.56	1.50	0.56	4.20	0.79	3.56	0.90
EOC	6.91	1.40	4.37	0.46	1.19	0.39	4.31	0.76	3.95	0.70
Follow-up	6.77	1.13	4.28	0.52	1.20	0.28	4.18	0.91	3.81	0.88
Pre-Counselling	6.93	0.88	4.13	0.46	1.43	0.51	4.07	0.73	3.72	0.79
EOC	7.07	1.16	4.30	0.43	1.16	0.25	4.27	0.88	3.77	0.68
One Month	6.93	1.03	4.21	0.52	1.17	0.29	4.17	0.84	3.60	0.94
Three Months	6.93	1.10	4.14	0.65	1.3	0.40	4.03	0.88	3.53	1.07
Six Months	6.87	1.19	4.17	0.56	1.13	0.29	3.93	1.05	3.57	0.95

Higher scores on the Single Item Hindering measure, the Session Impact Scale and the Relationship and Task Impact sub-scales are associated with greater positive ratings of the impact of counselling sessions. Higher scores on the Hindering Impacts sub-scale are associated with greater negative evaluations of the impact of counselling sessions.

Fig 7.9. Session Impact Scale and Hindering Impacts Sub-scale: Change, from pre-to post-counselling, from pre-counselling to follow-up and from pre-counselling to six months.

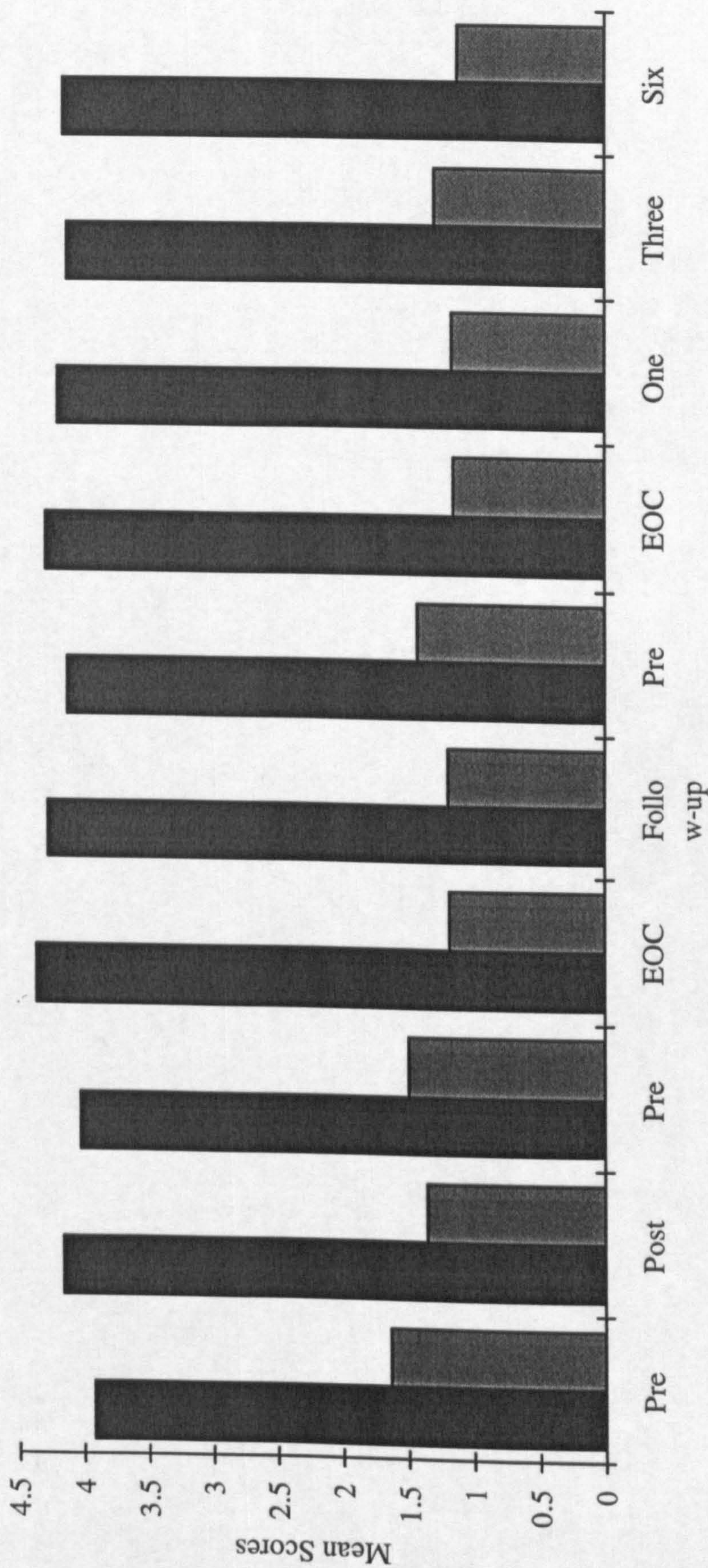
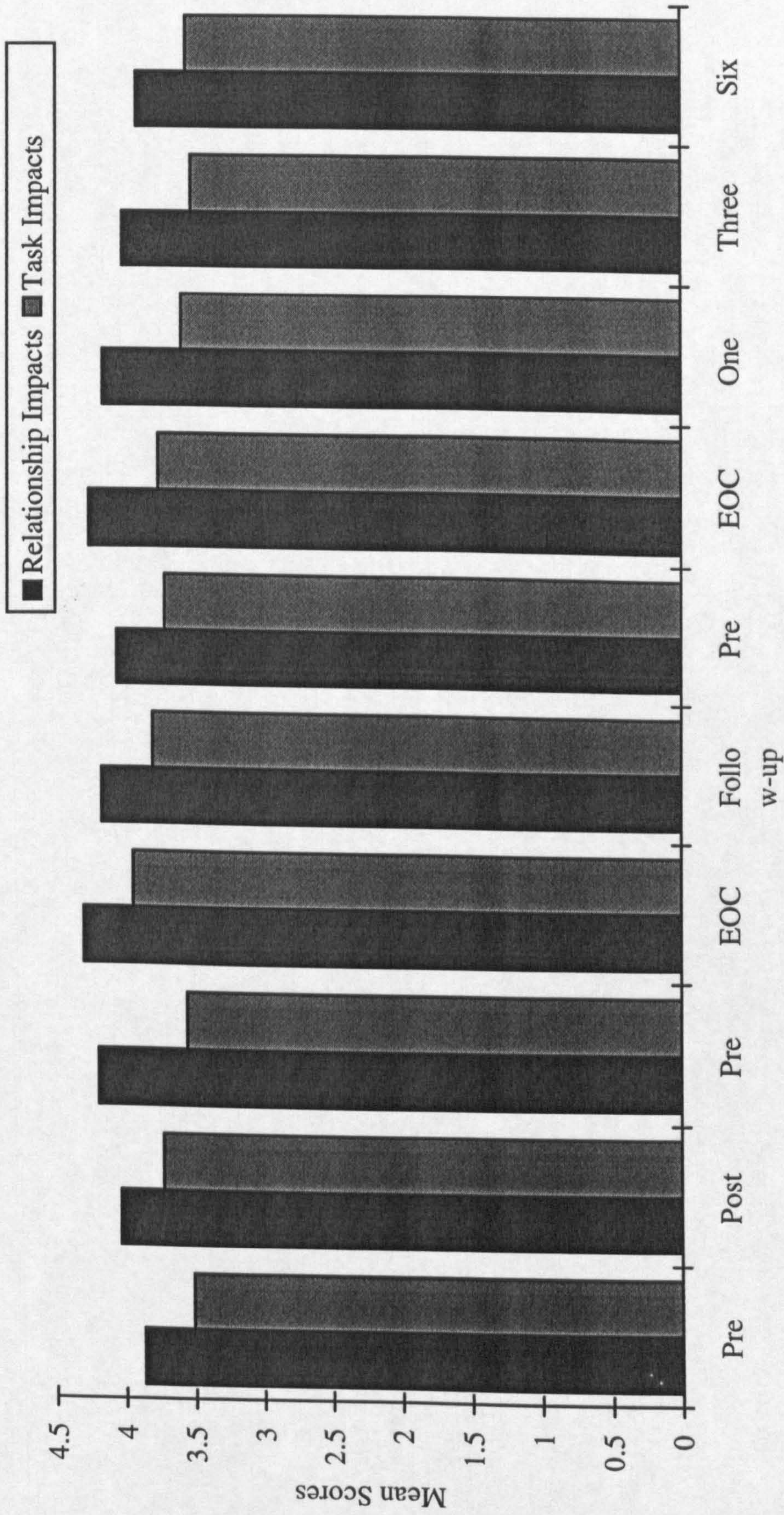


Fig 7.10. Relationship and Task Impact Scales: Change, from pre-to post-counselling, from pre-counselling to follow-up and from pre-counselling to six months.



7.7.2. Were there Pre-Post Reductions in Clients Ratings of Hindering Impacts

There was a consistent pattern, across all three analyses, of clients reporting fewer Hindering Impacts at post-intervention, than at pre-counselling. Client scores at pre-counselling for the pre-post (1.64), pre-EOC-follow-up (1.50) and five occasion (1.43) compare to post-intervention scores and means of 1.36 (post-counselling) for the pre-EOC-follow-up analysis, 1.19 (EOC) and 1.20 (follow-up) for the pre-EOC-follow-up analysis and 1.16 (EOC), 1.17 (one month), 1.30 (three months) and 1.13 (six months) for the five occasion analysis.

Reductions in Hindering Impacts from pre-counselling to post-intervention were significant for the pre-post ($t = 3.25$, $df = 56$, $p = .002$), pre-EOC-follow-up ($F = 10.54$, $df = 2, 60$, $p = .000$) and five occasion ($F = 2.89$, $df = 4, 56$, $p = .030$) analyses. Additional analyses were run across adjacent scores and means. Reductions from pre-counselling to EOC were significant for the pre-EOC-follow-up ($t = 3.73$, $p = .001$) analysis and approached significance for the five occasion ($t = 1.88$, $p = .087$). The reduction from three to six months five occasion analysis approached significance ($t = 1.71$, $p = .087$). Effect sizes were 0.51 for the pre-post analysis, 0.55 (pre-EOC) and 0.54 (pre-follow-up) for the pre-EOC-follow-up analysis and 0.53 (pre-EOC), 0.51 (pre-one), 0.39 (pre-three) and 0.59 (pre-six). For the pre-EOC-follow-up analysis, there was a decrease in the size of the standard deviation from pre-counselling (0.56) to follow-up (0.28).

7.7.3. Were there Pre-Post Increases in Client Ratings of Relationship Impacts

There were increases in client ratings of the Relationship Impacts of counselling for the pre-post analysis. On the pre-EOC-follow-up and five occasion analyses, initial pre-EOC increases in ratings were reversed across follow-up occasions.

The pre-EOC-follow-up analysis approached significance ($F = 1.77$, $df = 2, 60$, $p = .178$). Additional analyses were run to compare scores and means across adjacent occasions. The pre-EOC increase in ratings for the pre-EOC-follow-up analysis approached significance ($t = -1.46$, $p = .155$), as did the EOC-one ($t = 1.81$, $p = .091$) and one-three ($t = 1.59$, $p = .135$) reductions for the five occasions analysis.

7.7.4. Were there Pre-Post Increases in Client Ratings of Task Impacts

Clients at post-intervention were greater positive in their ratings of the Task Impacts of counselling, than at pre-counselling, for the pre-post and pre-EOC-follow-up analyses.

Client scores at pre-counselling, for the pre-post and pre-EOC-follow-up analyses, were, respectively, 3.51 and 3.56. Scores at post-intervention were 3.73 at post-counselling for the pre-post analysis and 3.95 at EOC and 3.81 at follow-up for the pre-EOC-follow-up analysis. Increases in ratings were significant for the pre-EOC-follow-up analysis ($F = 3.35$, $df = 2, 60$, $p = .042$) and approached significance for the pre-post analysis ($t = -1.85$, $df = 57$, $p = .069$). Additional analyses were run to compare adjacent scores and means. The pre-EOC increase in ratings for the pre-EOC-follow-up analysis approached significance ($t = -1.93$, $p = .063$), as did the reduction from EOC to follow-up ($t = 1.40$, $p = .171$) for the pre-EOC-follow-up analysis. Effect sizes were 0.27, for the pre-post analysis and -0.43 (pre-EOC) and -0.28 (pre-follow-up) for the pre-EOC-follow-up analysis.

Scale	Matched sample t-test				
	N	t	Effect Sizes	p	df
Single Item Hindering Scale	58	0.25	-0.05	.805	57
Session Impact Scale	57	-2.81	-0.46	.007	56
Hindering Impacts	57	3.25	0.51	.002	56
Relate Impacts	56	-1.26	-0.20	.212	55
Task Impacts	58	-1.85	-0.27	.069	57

Higher scores on the SIS Hindering sub-scale are associated with negative evaluations. Higher scores on the Single Item Hindering Scale, the SIS and its Relationship and Task sub-scales are associated with positive evaluations.

Table 7.15. The Session Impact Scale and its Hindering, Relationship and Task Impact sub-scales: Change on Measures from Pre-Counselling to Post-Intervention.

Measures	Matched t-tests				Effect Sizes			MANOVA		
	Pre-EOC		EOC-Follow-up		Pre-EOC	EOC-Foll	F	p	df	
	t	p	t	p						
<u>Single item Hindering scale</u>	NA	NA	NA	NA	-0.24	-0.12	0.75	.475	2,60	
<u>Session Impact Scale</u>	-2.93	.006	1.21	.237	-0.61	-0.45	6.68	.002	2,60	
<u>Hindering Impacts</u>	3.73	.001	-0.28	.778	0.55	0.54	10.54	.000	2,60	
<u>Relationship Impacts</u>	-1.46	.155	1.01	.322	-0.14	0.03	1.77	.178	2,60	
<u>Task Impacts</u>	-1.93	.063	1.40	.171	-0.43	-0.28	3.35	.042	2,60	

Pre = Pre-Counselling. EOC = End of Counselling. Foll = follow-up, the average of scores taken from one, three and six months. Effects sizes are comparisons with the pre-counselling score.

Table 7.16. Session Impact Scale and the Hindering, Relationship and Task Impact Sub-scales and Pre-Six Month Change: A Series of Repeated Measure MANOVA's with Effect Sizes.

Measures	Effect Sizes				MANOVA		
	Pre-EOC	Pre-One	Pre-Three	Pre-Six	F	p	df
Single Item Hindering	0.16	0.00	0.00	0.07	0.20	0.94	4,56
Session Impact Scale	-0.37	-0.17	-0.02	-0.09	0.65	0.63	4,56
Hindering Impacts	0.53	0.51	0.39	0.59	2.89	0.03	4,56
Relationship Impacts	-0.27	-0.14	0.05	0.19	0.82	0.52	4,56
Task Impacts	-0.06	0.15	0.24	0.19	0.46	0.77	4.56

EOC = End of Counselling. Pre = Pre-Counselling. All of the effect sizes are based on comparisons with the pre-counselling mean.

Table 7.17. Counselling Expectation and Impact: Matched t-tests to Compare Scores Across Adjacent Occasions.

Scale	Comparison across measurement occasions							
	Pre-EOC		EOC/One		One/Three		Three/Six	
	t	p	t	p	t	p	t	p
SIS	-0.47	.64	1.71	.11	0.76	.46	-0.39	.70
Hindering I	1.88	.09	-0.54	.60	-0.11	.92	1.71	.11
Relationship I	-0.15	.89	1.81	.09	1.59	.14	0.54	.60
Task I	0.44	.67	1.43	.18	0.29	.77	-0.14	.89

EOC = End of Counselling. SIS = Session Impact Scale. I = Impacts.

7.8. Were Gains at Post-Counselling Maintained at Follow-up

Gains were maintained at follow-up and, indeed, there was evidence of continued improvement on measures of distress and interpersonal problems. Evidence for such maintenance and the additional gains, comes from the t-tests that were run to compare adjacent scores and means within the MANOVA analyses. Changes on measures, that were either significant or near significant, are summarised in Table 7.18.

For the measures of distress, there was statistical support for additional gains from EOC to follow-up, from the pre-EOC-follow-up analysis for both the Likert ($t = 2.95, p = .01$) and Case ($t = 2.63, p = .01$) GHQs and near significant support for a further reduction for the SCL-18 ($t = 1.62, p = .12$). There was near significant support for further reductions, from

the five occasion analysis, for the Likert ($t = 1.70, p = .11$) and Case ($t = 1.93, p = .07$) GHQs.

For the measures of interpersonal problems, there were for the pre-EOC-follow-up analysis, significant EOC-follow-up reductions for the IIP-32 ($t = 3.72, p = .01$) and the Too Aggressive ($t = 2.11, p = .04$), Hard to be Assertive ($t = 3.88, p = .01$) Too Caring ($t = 3.75, p = .01$), Too Dependent ($t = 2.74, p = .010$) and Hard to get Involved ($t = 3.48, p = .01$) sub-scales.

Table 7.18. The Maintenance of Gain from EOC to Follow-up. A Series of Matched t-tests.						
	EOC		Follow-up			
Scale	Mean	SD	Mean	SD	t	p
SCL-18	0.63	0.60	0.49	0.45	1.62	.12
Likert GHQ-12	1.11	0.72	0.49	0.43	2.95	.01
Case GHQ-12	7.97	3.89	3.74	4.40	2.63	.01
IIP-32	1.05	0.54	0.78	0.78	3.72	.01
Too Aggressive	0.72	0.72	0.52	0.57	2.11	.04
Hard to be Assertive	1.61	1.09	0.99	0.72	3.88	.01
Too Caring	1.43	1.12	0.98	0.72	3.75	.01
Too Dependent	1.36	0.89	1.02	0.77	2.74	.01
Hard to get Involved	1.17	1.08	0.71	0.69	3.48	.01

EOC = End of Counselling. Follow-up = The average of scores taken at one, three and six months. SCL = Symptom Checklist. GHQ = General Health Questionnaire. IIP = Inventory of Interpersonal Problems. Higher scores on measures are associated with greater levels of distress and interpersonal problem.

Across five occasions (see Table 7.19.), there were additional reductions in interpersonal problems from EOC to one month for the IIP-32 ($t = 4.15, p = .001$) and for the Hard to be Assertive ($t = 3.55, p = .003$), Too Caring ($t = 2.61, p = .021$), Too Dependent ($t = 3.51, p = .004$), Hard to be Involved ($t = 3.87, p = .002$) and Too Open ($t = 2.35, p = .034$) subscales. There was a significant additional reduction, from one to three months, for Too Open ($t = 2.91, p = .012$) and near significant increases in reported difficulties on the Hard to be Supportive ($t = -1.71, p = .110$) and Hard to be Sociable ($-1.69, p = .114$).

Scales	EOC to One Month				One to Three Months			
	EOC	One	t	p	One	3 mo	t	p
Likert GHQ-12	1.14 0.59	0.83 0.58	1.70	0.11				
Case GHQ-12	4.20 4.16	4.80 4.12	1.93	0.07				
IIP-32	1.37 0.53	1.27 0.44	4.15	.001				
Hard to be Assertive	1.95 1.01	1.21 0.95	3.55	.003				
Too Caring	1.76 1.35	1.47 1.03	2.61	.021	1.47 1.03	1.03 0.67	2.22	.043
Too Dependent	1.68 1.68	1.19 1.19	3.51	.004				
Hard to be Involved	1.47 1.00	0.83 0.62	3.87	.002				
Hard to be Sociable	N/A	N/A	N/A	N/A	0.70 0.82	0.88 1.22	-1.69	.114
Hard to be Supportive	N/A	N/A	N/A	N/A	0.70 0.76	0.37 0.49	-1.71	.110
Too Open	2.75 0.93	2.69 0.76	2.35	.034	2.69 0.76	2.25 0.72	2.91	.012

EOC = End of Counselling. 3 mo = Three months. GHQ = General Health Questionnaire. SCL = Symptom Checklist. IIP = Inventory of Interpersonal Problems. N/A = Not Applicable. Higher scores on measures are associated with greater levels of distress and interpersonal problem.

7.9. Chapter Summary

Overall Chapter Seven presents a fairly consistent picture of supported hypotheses: As expected there were significant reductions in distress and interpersonal problems, with clients reporting that they used coping strategies more frequently, at the end of counselling, and they rated the impact of counselling more positively.

In terms of the extent of change (e.g. effect sizes), the degree of reduction in distress and interpersonal problems was not as great as those reported in the psychotherapy literature. As expected, the degree of change reported for distress, from pre-counselling to post-intervention, was greater than the level reported for interpersonal problems.

Levels of distress and interpersonal problem, at pre-counselling, were comparable to those reported at pre-therapy, and for an out-patient sample, and greater than the level reported for general population and occupational groups. At post-intervention clients levels of distress and interpersonal problems were comparable to the levels reported by the general population and occupational groups.

There were some unexpected patterns in the data, particularly with respect to the measures of interpersonal problems. Unexpectedly, there was a consistent pattern of pre-EOC reductions (on the pre-EOC-follow-up and five occasion analyses) was not evident. A number of measures exhibited successive reductions to follow-up (pre-EOC-follow-up) and to one and even three months (five occasions). Other measures exhibited no change from pre-counselling to EOC, but change from EOC to follow-up and one month.

There were differences in the extent of change on the measures of coping. There were greater increases in the use of social supports, than for logic strategies. The level of use of social supports, at pre-counselling, was comparable to the level of use reported by hospital samples. However, clients reported, at pre-counselling that they did not use logic based strategies as frequently as the comparison group participants.

Therefore, to conclude, counselling would appear to be associated with substantial reductions in clients distress and interpersonal problems, an increase in their use of coping strategies and with greater positive ratings of counselling itself. These results are discussed in Chapter Ten.

Chapter Eight:

Within-Group Differences and Pre-Post Change

8.1. Introduction

Analyses presented examine relationships between client characteristics, assessed at pre-counselling, and the extent of change on the measures of outcome, the SCL-18, the Likert and Case scored GHQ and the IIP-32, from pre-counselling to post-intervention. Post-intervention is defined as EOC, one, three and six months (five occasion analysis), follow-up and EOC (pre-EOC-follow-up) and post-counselling (pre-post).

Analyses examine whether there are any differences between levels (e.g. men and women) of biographical variables (e.g. gender) in the extent of change, from pre-counselling to post-intervention, on measures of outcome. The specific variables addressed in this chapter and the question posed for each are presented below.

- 1 Gender and pre-post change on measures of outcome: Were there any differences between men and women?
- 2 Shift working and pre-post change on measures of outcome: Were there any differences between shift and non-shift workers?
- 3 Experience of help-seeking and pre-post change on measures of outcome: Were there any differences between experienced and inexperienced help-seekers?
- 4 Site location and pre-post change on measures of outcome: Were there any differences between site location?
- 5 Occupational groups and pre-post change on measures of outcome: Were there any differences between occupational groups?
- 6 Relationship status at pre-counselling and pre-post change on measures of outcome: Were there any differences between relationship groups?

8.2. Method

The design of this study called for participants to complete a total of five questionnaires. These five questionnaires were timed to be completed before the start of counselling, at pre-counselling, at the end of counselling (EOC) and at follow-up at one, three and six months after the end of counselling.

Fifty-eight clients completed the pre-counselling questionnaire and at least one of the post-intervention (EOC, one, three, six months and follow-up). Only fifteen participants completed all four post-intervention measures. In response to this problem, a strategy of averaging across post-intervention (e.g. post-counselling, one, three and six months) occasions was adopted. The aim of this strategy was to increase the number of cases that could be included in analyses. Two strategies were employed, a pre-post analysis and a pre-EOC-follow-up analysis.

8.2.1. Pre-Post

Scores at pre-counselling were compared with a post-counselling mean. The post-counselling mean was the average of EOC, one, three and six month measures. Therefore, as long as a client had completed at least one of the EOC, one, three and six month measures, then he or she would be included. The post-counselling mean was computed as the sum of the returned scores divided by the number of returned measures. Therefore, if a client had returned three questionnaires, then scores from these three would be added together and would then be divided by three.

The comparison of the pre-counselling score with the post-counselling mean maximised the number of cases that could be included in analyses. As a result, 58 clients could be included in analyses. Analyses included all those who had completed at least one post-intervention questionnaires.

8.2.2. Pre-EOC-Follow-up

Scores at pre-counselling and EOC were compared with a follow-up mean, the average of scores taken at one, three and six months. Clients were included as cases for the pre-EOC-follow-up analyses, if they had completed the separate pre-counselling and end of counselling questionnaires and at least one of the one, three and six month questionnaires.

The follow-up mean was computed by summing each clients scores from their returned questionnaires and dividing the product by the number of returned questionnaires. For example, if a client had returned two of the one, three and six month questionnaires, then these scores would be added together and then divided by two.

This analysis was undertaken to meet two competing demands: The first to maximise the number of cases included in analyses, with the second to maximise the number of occasions that could be included in analyses. The five occasion analyses included fifteen cases but maximised the number of occasions across which analyses could be run. The pre-post analysis maximised the number of cases in analyses, although it minimised the number of measurement occasions. The pre-EOC-follow-up analysis 'traded-off' these two demands, maximising both the number of cases and the number of occasions that could both be included in analyses.

Information was collected, in the pre-counselling questionnaire for the biographical variables (with levels in parentheses) of Gender (Male, Female); Career (Medical, Nursing, Professions Allied to Medicine, Scientific and Technical, Administration, Clerical and Management, Ancillary); Shift-working (Shift workers and Non-shift workers); Relationship Status at Pre-counselling (Single, Married/Cohabiting, Widowed, In a Relationship but Living Apart); Prior Help-seeking (Prior Users of Intervention, Those new to Intervention); Site Location (Site One, Site Two) and Age. Analyses examined the extent to which change from pre counselling to post-intervention was associated with each of these biographical variables.

With a number of the biographical variables, the number of categories had to be collapsed to allow pre-EOC-follow-up and five occasion analyses to be run. This had to be done because for certain categories no clients had completed more than two or three measures. For example, there were three instead of four categories for the pre-six month occupations analysis because none of the ancillary employees returned all five measures and for relationship status, the original five categories had to be collapsed into two, for the five occasions analysis: Married/cohabiting and Single/Living apart.

8.3. Analyses

Reported analyses were undertaken on the mainframe version of SPPS, SPSSx.

Effect sizes (ES) were calculated, using Cohen's effect size formula, by subtracting the second mean (m_2) from the first (m_1) and then dividing the difference by the standard deviation of the first mean. The formula: $ES = (m_1 \text{ pre} - m_2 \text{ post}) / \sigma_1 \text{ pre}$.

For all analyses, the first mean for the calculation of effect sizes were the scores at pre-counselling.

Because of the small number of clients included in each analysis, near significant statistics within a criterion of $p < .20$ are reported along with those statistics that are significant at the $p < .05$ level. Analyses were run using the SCL-18, the Likert and Case scored GHQ-12 and the IIP-32 as dependent variables.

8.3.1. Pre-Post

A series of within factor repeated measure MANOVAs were run to compare the extent of pre-post change on measures of outcome, reported by each level of each biographical variable. Means, standard deviations, Ns and analyses (F-ratios, probabilities, and degrees of freedom) for significant and near-significant statistics are presented in text, with a full set of analyses presented in appendices.

8.3.2. Pre-EOC-Follow-up

A series of within factor repeated measure MANOVAs were run to compare reductions on measures of outcome from pre-counselling to follow-up, reported by each level of biographical variable. For example, pre-follow-up change for women on measures of outcome was compared pre-follow-up change for men. Means, standard deviations, Ns and analyses (F-ratios, probabilities and degrees of freedom) for significant and near-significant statistics are presented in text, with a full set of analyses presented in appendices.

8.3.3. Five Occasion Analyses

A series of within factor repeated measure MANOVAs were run to compare the extent of change on measures of outcome from pre-counselling to six months, reported by each level of biographical variable. For example, pre-six month change for men, on measures of outcome, was compared with pre-six month change for women. Means, standard deviations,

Ns and analyses (F ratios, p and degrees of freedom) for significant and near-significant statistics are presented in text, with a full set of analyses presented in appendices.

8.4. Gender and Change from Pre-Counselling to Post-Intervention: Were there any Differences between Men and Women

Women reported a greater reduction from pre- to post-counselling on the pre-post analysis. This difference was statistically significant. However, support for such a difference was only forthcoming for the pre-post analysis. Women reported a greater degree of distress at pre-counselling on the GHQ, though less, than men, on the SCL-18. At post-counselling, men consistently reported across measures that they were greater distressed than women. Analyses are presented in Table 8. 1 and Fig 8.1.

For the pre-post analysis, women reported greater distress on the Likert (1.95) and Case (8.53) GHQ than men (1.76 and 7.13 respectively). However, men (1.65) reported a greater level of distress on the SCL-18 than women (1.41). Both groups reported less distress at post-counselling. Women reported consistently greater pre-post reductions, with decreases from 1.41 to 0.58 on the SCL-18, from 1.95 to 0.83 on the Likert GHQ and from 8.53 to 2.26 on the Case GHQ.

Men reported reductions from 1.65 to 1.12 on the SCL-18, from 1.76 to 1.33 on the Likert GHQ and from 7.13 to 4.81 on the Case GHQ. Differences, between men and women, in pre-post reductions were significant for the Likert ($F = 6.98$, $df = 1, 1, 55$, $p = .010$) and for the Case ($F = 6.94$, $df = 1, 1, 55$, $p = .009$) GHQs. The difference approached significance for the SCL-18 ($F = 1.90$, $df = 1, 1, 54$, $p = .173$). Pre-post effect sizes for men were 0.57 (SCL-18), 0.48 (Likert GHQ) and 0.44 (Case GHQ), and for women 1.25 (SCL-18), 1.77 (Likert GHQ) and 1.87 (Case GHQ).

Scale	Pre-Counselling		Post-Counselling		MANOVA		
	Women	Men	Women	Men	F	p	df
	Mean SD	Mean SD	Mean SD	Mean SD			
SCL-18	1.14 0.66	1.65 0.93	0.58 0.49	1.12 0.57	1.90	0.17	1,1,55
GHQ-12 Likert	1.95 0.63	1.76 0.88	0.83 0.52	1.33 0.64	6.98	0.01	1,1,55
GHQ-12 Case	8.53 3.58	7.13 5.25	2.26 2.91	4.81 4.64	6.94	0.01	1,1,55
IIP-32	1.22 0.60	1.76 0.43	0.87 0.52	1.32 0.74	0.25	0.51	1,1,55

Ns: Women, n = 49. Men, n = 8. Post = The average of scores taken at the end of counselling and at follow-up at one, three and six months. SCL = Symptom Checklist. GHQ = General Health Questionnaire, IIP = Inventory of Interpersonal Problems. Higher scores on the SCL-18 and on the GHQ-12 are associated with greater levels of distress. Higher scores on the IIP-32 are associated with greater levels of interpersonal problems.

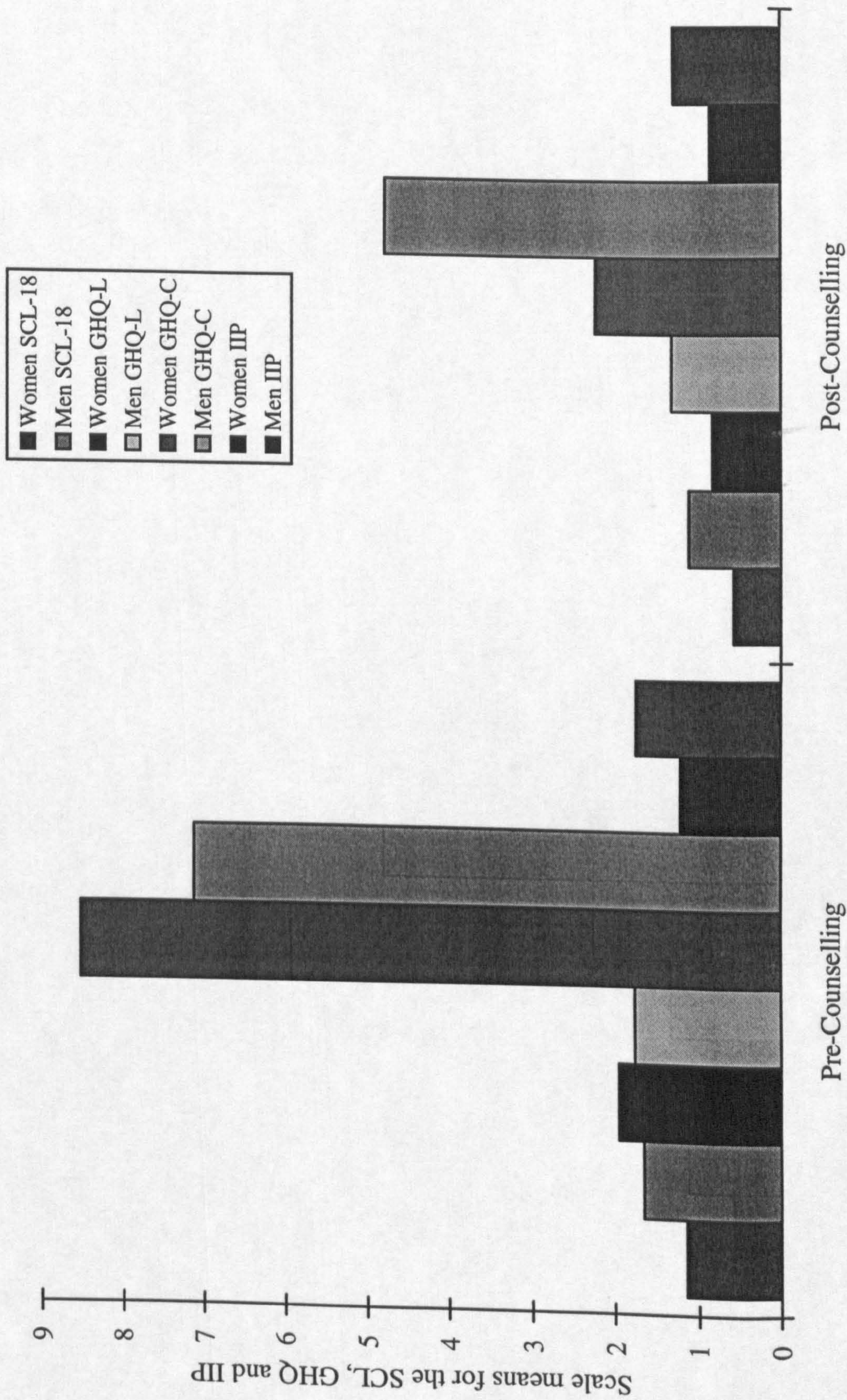
8.5. Shift working and Change from Pre-Counselling to Post-Intervention:

Were there any Differences between Shift and Non-shift Workers

Shift-workers reported a greater pre-follow-up reduction in interpersonal problems. The difference in the extent of pre-follow-up change was significant. There was a tendency for shift workers to report greater reductions in distress on the SCL-18, for the pre-post analysis, and on the Case GHQ, for the pre-EOC-follow-up analysis. Differences between shift and non-shift workers approached significance on a number of analyses.

There was a difference in the extent of pre-follow-up change between shift and non-shift workers. At pre-counselling, both shift and non-shift workers reported a comparable level of interpersonal problems (1.31 versus 1.15). Shift-workers reported no change at EOC (1.27), with a reduction to follow-up (0.77). The non-shift workers reported a pre-EOC reduction (to 0.86) with a further reduction to 0.76 at follow-up. This difference between shift and non-shift workers in pre-follow-up reductions (0.54 versus 0.39) was significant ($F = 3.31$, $df = 2, 2, 56$, $p = .044$). For shift-workers, the pre-post and pre-follow-up effect sizes were, respectively, 0.07 and 1.00, and for non-shift worker 0.46 and 0.62.

Fig 8.1.1. Gender and Pre-post Change on the Measures of Outcome, the SCL-18, the Likert (L) and Case (C) scored GHQ-12s and the IIP-32.



On the SCL-18, shift-workers reported greater pre-counselling distress than non-shift workers (1.59 versus 1.21). Shift workers reported successive reductions to EOC (0.86) and follow-up (0.45). Those not working shifts reported a reduction to EOC (0.47). The difference between shift and non-shift worker pre-follow-up reductions (1.14 versus 0.72) approached significance ($F = 2.39, df = 2, 2, 52, p = .101$).

On the Case GHQ, shift and non-shift workers reported a comparable level of distress at pre-counselling (7.92 versus 7.83). There were reductions to EOC for both the shift (4.67) and non-shift workers (3.28). Shift-workers reported a further reduction to follow-up (0.78). The difference in pre-follow-up reductions between shift and non-shift workers (7.14 versus 5.44) approached significance ($F = 1.79, df = 2, 2, 56, p = .177$).

Scale	Pre-Counselling		EOC		Follow-up		MANOVAs		
	Shifts	None	Shifts	None	Shifts	None	F	p	df
	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)			
SCL-18	1.59 0.92	1.21 0.53	0.86 0.73	0.47 0.47	0.45 0.26	0.49 0.53	2.39	0.10	2,2,52
GHQ-12 Likert	1.82 0.77	1.79 0.57	1.28 0.84	1.01 0.65	1.46 0.24	1.49 0.53	0.70	0.50	2,2,56
GHQ-12 Case	7.92 4.01	7.83 3.97	4.67 5.21	3.28 3.91	0.78 1.28	2.39 3.07	1.79	0.18	2,2,56
IIP-32	1.31 0.54	1.15 0.63	1.27 0.50	0.86 0.50	0.77 0.41	0.76 0.57	3.31	0.04	2,2,56

Ns: Shift-worker, n = 10. Non-shift workers, n = 18. Follow-up = The average of scores taken at one, three and six months. SCL = Symptom Checklist. GHQ = General Health Questionnaire. IIP = Inventory of Interpersonal Problems. Higher scores on the SCL-18 and on the GHQ-12 are associated with greater levels of distress. Higher scores on the IIP-32 are associated with greater levels of interpersonal problems.

8.6. Experience of Help-seeking and Change from Pre-Counselling to Post-Intervention: Were there any Differences between Experienced and Inexperienced Help-seekers

There was a tendency, though only reported for the pre-post analysis, for experienced help-seekers to report a greater reduction in distress than inexperienced help-seekers. Whilst experienced help-seekers reported a greater degree of distress at pre-counselling, than inexperienced help-seekers, both groups reported a comparable level of distress at post-counselling. Means, standard deviations and analyses are presented in Table 8.3 and Fig 8.3.

Experienced help-seekers reported greater pre-counselling distress, than inexperienced help-seekers and experienced help-seekers tended to exhibit greater pre-post reductions in distress. On the Likert GHQ, both experienced (2.12 to 0.98) and inexperienced (1.61 to 0.80) help-seekers were less distressed at post-counselling than at pre-counselling. The pre-post difference in reductions, between experienced and inexperienced (respectively 1.14 and 0.81) help-seekers, approached significance ($F = 2.08$, $df = 1, 1, 40$, $p = .157$).

Although, pre-six month reductions in interpersonal problems were comparable for both experienced and inexperienced help-seekers, there were differences in the extent of change from EOC to three months, with inexperienced help-seekers reported a greater reductions across these occasions. Means, standard deviations and analyses are presented in Table 8.3, whilst scores are also presented in Fig 8.3.

At pre-counselling, experienced help-seekers had fewer interpersonal problems (1.00) than inexperienced help-seekers (1.55). Experienced help-seekers reported an increase in problems to EOC (1.20) and then successive reductions to one (0.73) and three months (0.37). Inexperienced help-seekers reported successive reductions to EOC (1.30) and one month (0.98). Pre-six month differences approached significance ($F = 1.85$, $df = 4, 4, 52$, $p = .121$). Pre-EOC, pre-one, pre-three and pre-six month effect sizes for experienced help-seekers were, respectively, -0.57, 0.77, 1.80 and 1.31 and for inexperienced help-seekers, 0.48, 1.10, 0.98 and 0.94.

Table 8.3. Experienced and Inexperienced Help-Seekers and Pre-Post Change: A Series of Repeated Measure MANOVAs

	Pre-Counselling		Post-Counselling				
	Prior	None	Prior	None	MANOVA		
Scale	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	F	p	df
SCL-18	1.64 0.81	1.22 0.65	0.72 0.63	0.52 0.49	1.32	0.26	1,1,32
GHQ-12 Likert	2.12 0.74	1.61 0.56	0.98 0.58	0.80 0.45	2.08	0.16	1,1,40
GHQ-12 Case	9.00 4.03	7.25 4.03	3.16 3.53	1.54 2.26	0.01	0.92	1,1,40
IIP-32	1.18 0.66	1.39 0.65	0.85 0.59	1.01 0.55	0.08	0.83	1,1,39

Ns: GHQ: Experienced, n = 26, Inexperienced, n = 16. SCL-18/IIP-32: Experienced, n = 26, Inexperienced, n = 15. Post-Counselling = The average of scores taken at the end of counselling and follow-up at one, three and six months. Prior = Prior Experience of Counselling. None = No Prior Experience of Counselling. SCL = Symptom Checklist. GHQ = General Health Questionnaire. IIP = Inventory of Interpersonal Problems. Higher scores on the SCL-18 and on the GHQ-12 are associated with greater levels of distress. Higher scores on the IIP-32 are associated with greater levels of interpersonal problems.

Fig 8.2. Shift-Working and Change from Pre-Counselling to Follow-up: Differences between Shift and Non-Shift Workers.

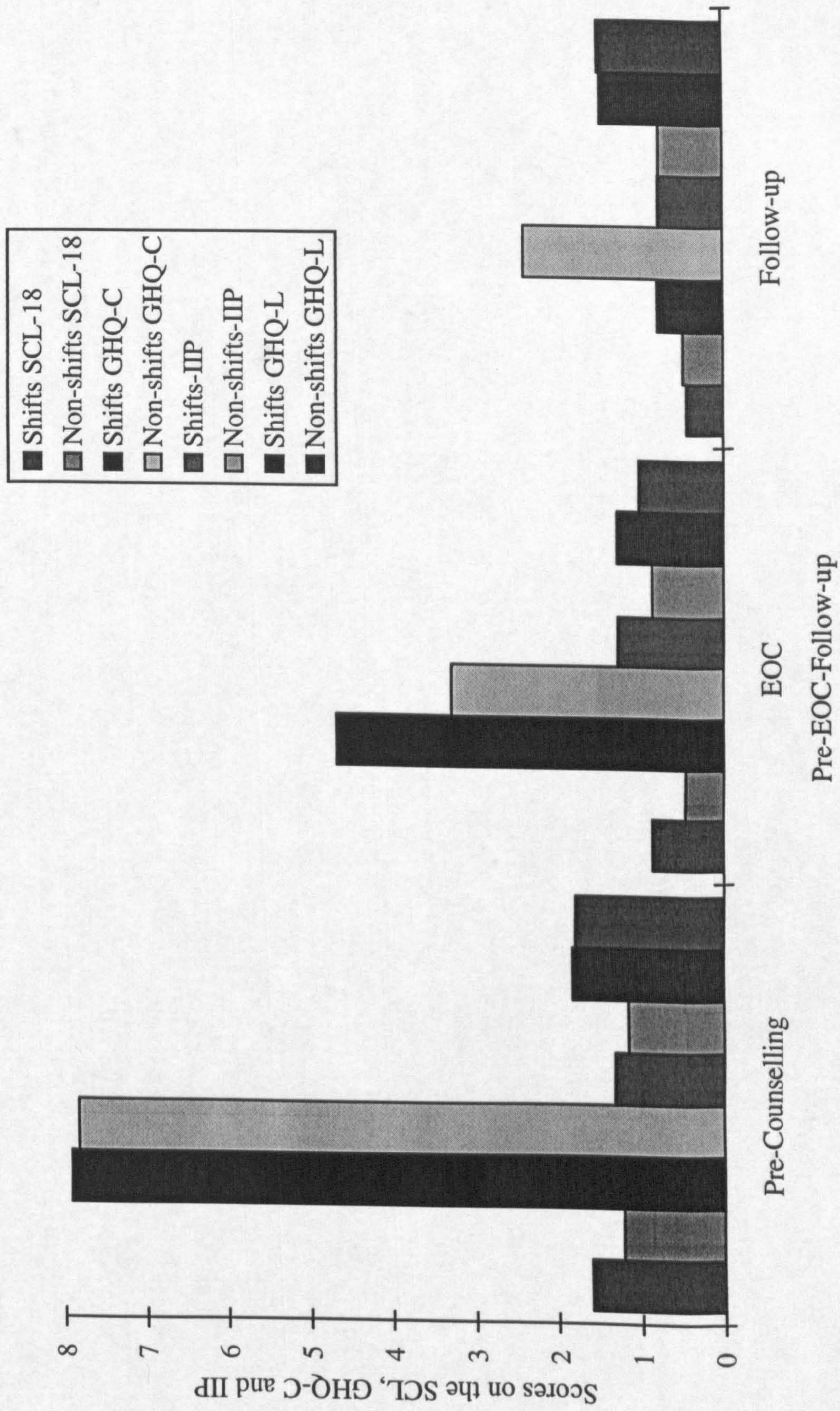


Table 8.4. Experienced and Inexperienced Help-Seekers and Change from Pre-Counselling to Six Months. A Series of Repeated Measure MANOVAs

Scale	Pre-Counselling		End of Counselling		One Month		Three Months		Six Months		MANOVA	F	p	df
	Prior	None	M (SD)	M (SD)	Prior	None	M (SD)	M (SD)	Prior	None				
Symptom Checklist	0.97	1.79	0.46	0.72	0.29	0.57	0.20	0.72	0.22	0.56	1.03	0.40	4,4,48	
	0.61	0.92	0.09	0.61	0.08	0.62	0.09	0.97	0.13	0.65				
Likert Scored GHQ-12	1.52	1.88	1.00	1.22	0.52	0.99	0.57	0.94	0.50	1.17	0.30	0.88	4,4,52	
	0.48	0.86	0.80	0.49	0.33	0.63	0.26	0.80	0.18	0.81				
Case Scored GHQ-12	7.00	7.80	3.80	4.40	0.20	2.60	0.00	2.10	0.00	4.30	0.69	0.60	4,4,52	
	3.54	4.85	5.31	3.78	0.45	3.60	0.00	4.28	0.00	4.74				
IIP-32	1.00	1.55	1.20	1.30	0.73	0.98	0.37	1.04	0.54	1.06	1.85	0.12	4,4,52	
	0.35	0.52	0.40	0.48	0.18	0.50	0.11	0.74	0.17	0.53				

Ns: Experienced, n = 5. Inexperienced, n = 9. Prior = Participants with prior experience of help-seeking. None = Participants with no experience of counselling. GHQ = General Health Questionnaire. IIP = Inventory of Interpersonal Problems. Higher scores on the SCL-18 and on the GHQ-12 are associated with greater levels of distress. Higher scores on the IIP-32 are associated with greater levels of interpersonal problems.

8.7. Prior Experience of Help-Seeking and Change on Measures of Outcome: Were there any Differences between Experienced and Inexperienced Help-seekers

Although, pre-six month reductions in interpersonal problems were comparable for both experienced and inexperienced help-seekers, there were differences in the extent of change from EOC to three months, with inexperienced help-seekers reported a greater reductions across these occasions. Means, standard deviations and analyses are presented in Table 8.3, whilst scores are also presented in Fig 8.3.

At pre-counselling, experienced help-seekers had fewer interpersonal problems (1.00) than inexperienced help-seekers (1.55). Those who had sought help on a prior occasion reported an increase in problems at EOC (1.20), with successive reductions to one (0.73) and three months (0.37). Inexperienced help-seekers reported successive reductions to EOC (1.30) and one month (0.98). The difference between the two groups in pre-six month change approached significance ($F = 1.85, df = 4, 4, 52, p = .121$). Pre-EOC, pre-one, pre-three and pre-six month effect sizes for prior help-seekers were, respectively, -0.57, 0.77, 1.80 and 1.31 and for non-prior users 0.48, 1.10, 0.98 and 0.94.

8.8. Were there any Differences between Sites One and Two in the Extent of Change in Levels of Distress from Pre- to Post-intervention

At pre-counselling, Site Two clients were greater distressed than Site One clients. Site Two clients exhibited greater reductions in distress from pre-counselling to post-intervention. Differences, between Sites, in the extent of pre-post change were significant for the SCL and the GHQ. Differences approached significance for the five occasion analysis on the SCL and the Case GHQ.

For the pre-post analyses (see Table 8.5.), Site Two clients were more distressed than those at Site One. Site One clients on the SCL-18 (1.67 versus 1.34), the Likert (2.21 versus 1.78) GHQ and the Case (10.00 versus 7.59) GHQ. There were pre-post reductions for both Site One and Two clients. Post-counselling levels of distress were comparable, for Site One and Two clients, on the SCL-18 (0.68 versus 0.64) and the Likert (0.90 and 0.90) and Case (2.62 and 2.50) GHQs. Site One pre-post effect sizes were 1.02 (SCL-18), 1.29 (Likert GHQ) and 1.49 (Case GHQ). Site Two effect sizes were 1.37 (SCL-18), 2.52 (Likert GHQ) and 2.67 (Case GHQ). Differences in pre-post reductions were significant for the SCL-18 (F

= 5.08, df = 1, 1, 55, p = .028) and for the Likert (F = 4.71, df = 1, 1,56, p = .034) and Case scored (F = 5.10, df = 1, 1, 56, p = .028) GHQs.

For the Five Occasion analyses (see Table 8.6), Site Two clients were more distressed than Site One clients on the SCL-18 (1.80 versus 1.27) and the Likert (1.93 versus 1.64) and Case (8.50 versus 6.89) GHQs. Site One clients reported further reductions to EOC on the SCL-18 (0.54), Likert GHQ(0.99) and Case GHQ (3.44). Site Two clients reported reductions to EOC on the SCL-18 (0.74) and on the Likert (1.38) and Case scored (5.33) GHQs. Further reductions in distress to one month were reported by Site Two clients on the SCL-18 (0.35) and on the Likert (0.64) and Case (0.67) GHQs. Difference in the extent of pre-six month change approached significance on the SCL-18 (F = 1.85, df = 4, 4, 48, p = .134) and on the Likert GHQ (F = 1.68, df = 4, 4, 52, p = .169).

Table 8.5. Site Location and Change on Measures of Outcome from Pre-Counselling to Post-Counselling. A series of Repeated Measure MANOVAs.							
	Pre-Counselling		Post-Counselling				
	Site One	Site Two	Site One	Site Two	MANOVA		
Scale	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	F	p	df
SCL-18	1.34 0.65	1.67 0.75	0.68 0.62	0.64 0.45	5.08	0.03	1,1,55
GHQ-12 Likert	1.78 0.68	2.21 0.52	0.90 0.58	0.90 0.53	4.71	0.03	1,1,56
GHQ-12 Case	7.59 3.34	10.00 2.81	2.62 3.34	2.50 3.19	5.10	0.03	1,1,56
IIP-32	1.31 0.64	1.26 0.54	0.94 0.58	0.93 0.55	0.10	0.75	1,1,55

Ns: GHQ: Site One, n = 39, Site Two = 19. SCL/IIP: Site One, n = 38, Site Two, n = 15. Post-Counselling = The average of scores taken from the end of counselling, one, three and six months. SCL = Symptom Checklist. GHQ = General Health Questionnaire. IIP = Inventory of Interpersonal Problems. Higher scores on the SCL-18 and on the GHQ-12 are associated with greater levels of distress. Higher scores on the IIP-32 are associated with greater levels of interpersonal problems.

Fig 8.3. Site Location and Change from Pre- to Post Counselling on Measures of Outcome.

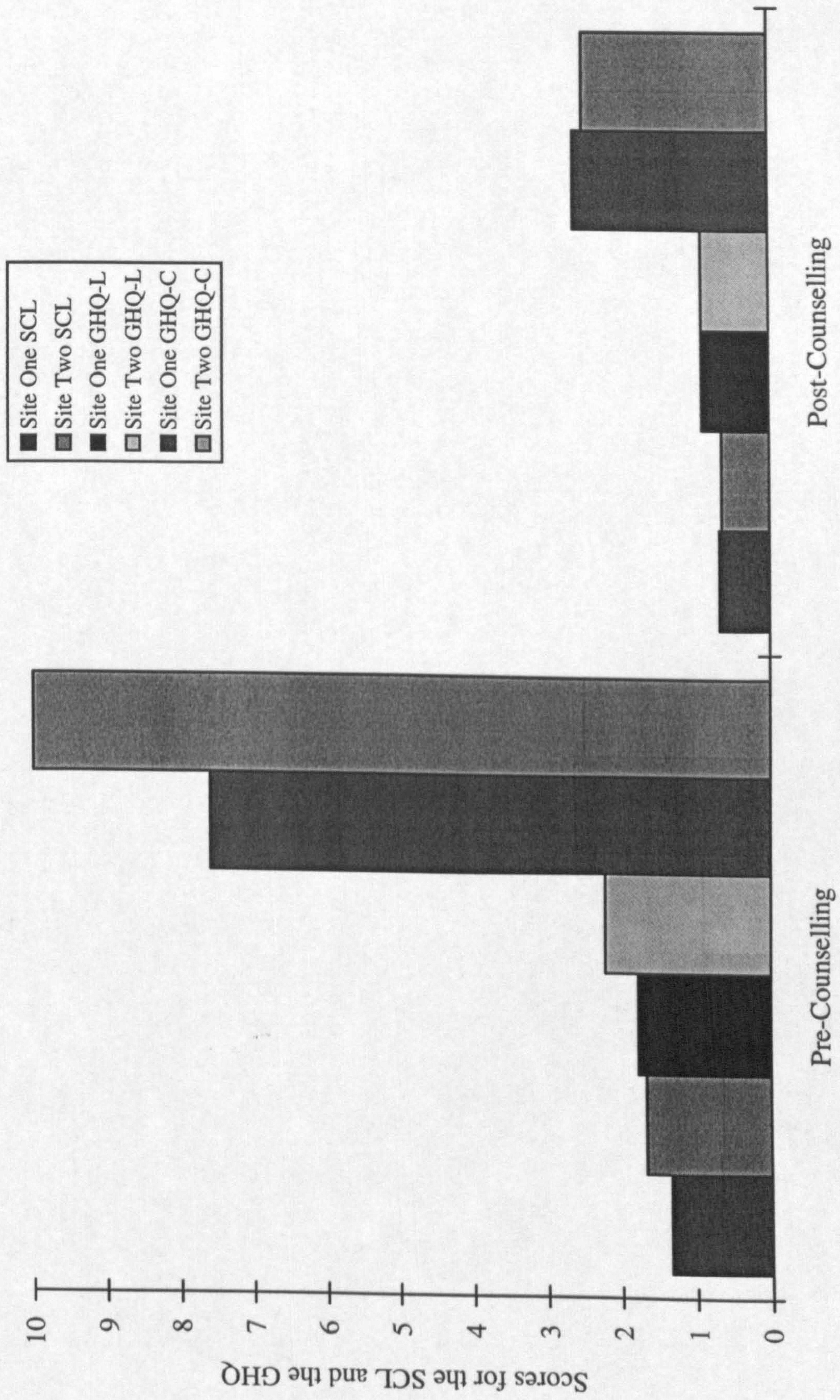


Table 8.6. Site Location and Pre-Six Month Change on Measures of Outcome. A Series of Repeated Measure MANOVAs.

Scale	Pre-Counselling		End of Counselling		One Month		Three Months		Six Months		MANOVA	df
	Site One	Site Two	Site One	Site Two	Site One	Site Two	Site One	Site Two	Site One	Site Two		
	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)		
SCL-18t	1.27	1.80	0.54	0.74	0.56	0.35	0.60	0.45	0.41	0.47	1.85	0.13
	0.71	1.08	0.62	0.29	0.66	0.15	1.07	0.28	0.59	0.52		
Likert GHQ-12	1.64	1.93	0.99	1.38	0.96	0.64	0.99	0.56	0.93	0.97	1.68	0.17
	0.85	0.60	0.57	0.59	0.65	0.44	0.85	0.07	0.74	0.79		
Case GHQ-12	6.89	8.50	3.44	5.33	2.56	0.67	2.33	0.00	2.89	2.83	1.33	0.27
	4.46	4.37	3.61	5.01	3.81	1.21	4.47	0.00	4.40	4.67		
IIP-32	1.43	1.27	1.24	1.31	0.97	0.78	0.93	0.64	0.98	0.75	0.66	0.63
	0.46	0.66	0.39	0.55	0.44	0.43	0.75	0.57	0.68	0.68		

Ns: SCL: Site One, n = 8, Site Two, n = 6. GHQ/IIP: Site One, n = 9, Site Two, n = 6. SCL = Symptom Checklist. GHQ = General Health Questionnaire. IIP = Inventory of Interpersonal Problems. Higher scores on the SCL-18 and on the GHQ-12 are associated with greater levels of distress. Higher scores on the IIP-32 are associated with greater levels of interpersonal problems.

8.9. Occupational Status and Change from Pre-Counselling to Post-Intervention: Were there any Differences between Occupational Groups

On a number of the analyses, there were a number of near significant changes, from pre-counselling to post-intervention, that suggest a tendency for some occupational groups to exhibit greater change than other groups.

Although not statistically significant, there were a number of differences in the extent of reductions in client reports of distress, for the pre-post and pre-EOC-follow-up analyses. For the pre-post analysis (see Table 8.7), Scientific and Technical staff reported a smaller pre-post reduction than the other occupational groups on the Likert GHQ. Ancillary employees reported a greater pre-post reduction on the Case GHQ. For the pre-EOC-follow-up analysis (see Table 8.8), Scientific and Technical staff exhibited a greater reduction than the other occupational groups.

For both the pre-EOC-follow-up and Five Occasion analyses, none of the Ancillary employees completed the EOC questionnaire and, therefore, the number of occupational groups was reduced to three (Health Professionals, Administrative and Managerial and Scientific and Technical).

There were pre-post reductions on the Likert GHQ for Health Professionals (from 2.04 to 1.00), Administrative and Managerial (from 1.78 to 0.70), Scientific and Technical (from 1.56 to 1.01) and Ancillary (from 2.06 to 0.65). Differences in pre-post reductions approached significance ($F = 1.31$, $df = 3, 1, 53$, $p = .120$). Pre-post effect sizes were 0.60 (Scientific and Technical), 1.55 (Health Professional), 2.00 (Administrative and Managerial) and 2.07 (Ancillary).

On the Case GHQ, there were pre-post reductions for the Health Professional (9.22 to 3.15), Administrative and Clerical (7.60 to 1.78), Scientific and Technical (4.83 to 3.42) and Ancillary (9.25 to 0.25) groups. Differences in pre-post reductions approached significance ($F = 1.48$, $df = 3, 1, 53$, $p = .139$). Effect sizes were 2.51 (Ancillary), 1.91 (Health Professionals), 1.48 (Administrative and Clerical) and 1.41 (Scientific and Technical).

Table 8.7. Occupational Status and Change on Measures of Outcome from Pre- to Post-Counselling. A Series of Repeated Measure MANOVAs.

Scale	Pre-Counselling				Post-Counselling				MANOVA		
	HP M (SD)	A/M M (SD)	S/T M (SD)	Anc M (SD)	HP M (SD)	A/M M (SD)	S/T M (SD)	Anc M (SD)	F	p	df
SCL-18	1.51 0.70	1.23 0.52	1.52 1.03	1.65 0.78	0.76 0.58	0.46 0.53	0.58 0.69	0.71 0.34	0.28	0.303	3,1,52
GHQ-12L	2.04 0.67	1.78 0.54	1.56 0.91	2.06 0.68	1.00 0.57	0.70 0.59	1.01 0.53	0.65 0.36	1.31	0.120	3,1,53
GHQ-12C	9.22 3.18	7.60 3.92	4.83 5.35	9.25 3.59	3.15 3.56	1.78 2.92	3.42 2.92	0.25 0.50	1.48	0.139	3,1,53
IIP-32	1.36 0.60	0.96 0.58	1.64 0.60	1.38 0.31	1.00 0.56	0.69 0.52	1.15 0.74	0.88 0.32	0.47	0.807	3,1,52

Ns: SCL/IIP: HP, n = 31, A & M, n = 15, S & T, n = 6, Anc, n = 4. GHQ: HP, n = 32, A & M, n = 15, S & T, n = 6, Anc, n = 4. Post-Counselling = The average of scores taken from the end of counselling, one, three and six months. SCL = Symptom Checklist. GHQ = General Health Questionnaire. IIP = Inventory of Interpersonal Problems. HP = Health Professionals. A & M = Administrative and Managerial. S & T = Scientific and Technical. Anc = Ancillary. Higher scores on the SCL-18 and on the GHQ-12 are associated with greater distress. Higher scores on the IIP-32 are associated with greater interpersonal problems.

For the pre-EOC-follow-up analysis (see Table 8.8), Scientific and Technical staff reported greater pre-counselling distress on the SCL-18 (1.70), than Health Professional (1.34) and Administrative and Managerial staff (1.26). Pre-EOC reductions for Scientific and Technical (from 1.70 to 0.32) staff were greater than those for Health Professional (from 1.34 to 0.80) and Administrative and Managerial (from 1.26 to 0.46) employees. Health professionals reported further reductions to follow-up (0.45). Scientific and Technical staff reported a greater pre-follow-up reduction (1.32) than the Health Professional (0.91) and Administrative and Managerial (0.73) groups. This difference approached significance ($F = 2.09, df = 4, 2, 50, p = .095$).

Table 8.8. Occupational Status at Pre-Counselling and Change, on Measures of Outcome, from Pre-Counselling to Follow-up. A Series of Repeated Measure MANOVAs.

Scale	Pre-Counselling				End of Counselling				Follow-up				MANOVA			
	HP	A & M		S & T		HP	A & M		S & T		HP	A & M		S & T		
		Mean	SD	Mean	SD		Mean	SD	Mean	SD		Mean		SD	Mean	SD
SCL-18	1.34 0.67	1.26 0.60	1.70 1.28	0.80 0.63	0.46 0.58	0.32 0.23	0.45 0.28	0.53 0.66	0.38 0.02	2.09	0.095	4,2,50				
GHQ-12L	1.81 0.66	1.70 0.56	2.11 0.99	1.31 0.81	0.86 0.62	1.00 0.52	1.46 0.26	1.53 0.66	1.38 0.02	1.31	0.279	4,2,54				
GHQ-12C	8.31 3.63	7.00 4.31	8.67 4.93	4.63 5.08	2.64 3.64	4.00 3.61	0.92 1.62	2.21 3.44	4.44 1.35	1.39	0.248	4,2,54				
IIP-32	1.26 0.51	0.98 0.62	1.85 0.49	1.23 0.47	0.70 0.55	1.12 0.21	0.82 0.48	0.65 0.59	0.90 0.26	1.20	0.534	4,2,54				

Follow-up = The average of scores taken at one, three and six months. SCL = Symptom Checklist. GHQ = General Health Questionnaire. IIP = Inventory of Interpersonal Problems. HP = Health Professionals. A & M = Administrative and Managerial. S & T = Scientific and Technical. Higher scores on the SCL-18 and on the GHQ-12 are associated with greater levels of distress. Higher scores on the IIP-32 are associated with greater levels of interpersonal problems.

There were no significant differences, between occupational groups, in the extent reductions across pre-post, pre-EOC-follow-up and five occasion analyses. Differences did approach significance. Means, standard deviations and analyses are presented in Table 7.9.

At pre-counselling, Scientific and Technical (1.85) staff reported a greater interpersonal problems than the other occupational groups (1.17 for Health Professionals and 1.39 for Administrative and Managerial staff). Scientific and Technical staff reported successive reductions to EOC (1.12) and One Month (0.90). In contrast, Health Professionals reported an increase to EOC (1.32) and then reductions to One (0.78) and Three (0.61) months. Administrative and Managerial employees reported reductions to EOC (1.27) and One month (1.13). The differences in these reductions in interpersonal problems approached significance ($F = 1.85, df = 8, 4, 48, p = .095$).

8.10. Chapter Summary

With the exception of the gender and site location analyses and one shift-worker analysis, there few significant analyses. There were several other near significant analyses for most of the variables, although there were none for the Relationship Status variable. Analyses, therefore, support the majority of hypotheses, of no differences in the extent of pre-post within biographical variables.

The significant differences, between men and women, in the extent of pre-post change in distress. Women reported a greater level of distress, on the GHQ, at pre-counselling and a greater pre-post reduction (in absolute terms) than for men.

For shift-working, there was a significant difference in the extent of change between shift and non-shift workers for the pre-EOC-follow-up analysis, with shift-workers reporting greater difficulties at pre-counselling but comparable levels of difficulty at follow-up.

For site location, Site Two exhibited a greater reduction in distress, on the SCL and on the GHQ, than Site One. Site Two clients were greater distressed at pre-counselling, than Site One clients and they reported a greater reduction (in absolute terms) from pre- to post-counselling. Levels of distress, at post-counselling, at both sites were comparable.

Table 8.9. Occupational Status at Pre-Counselling and Change on Measures of Outcome from Pre-Counselling to Six Months. A Series of Repeated Measure MANOVAs.

Scale	Pre-Counselling									EOC			One Month			Three Months			Six Months			MANOVA		
	HP	AM	ST	HP	AM	ST	HP	AM	ST	HP	AM	ST	HP	AM	ST	HP	AM	ST	HP	AM	ST	F	p	df
	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M			
SCL-18	1.26	1.76	1.70	0.61	0.89	0.32	0.33	0.75	0.41	0.37	0.97	0.35	0.39	0.56	0.39	0.61	0.53	0.39	0.50	0.83	0.28	0.61	0.53	8,4,48
	0.92	0.64	1.28	0.30	0.82	0.23	0.14	0.92	0.34	0.31	1.50	0.03	0.50	0.83	0.28									
GHQ-12L	1.56	1.88	2.11	1.20	1.15	1.00	0.65	1.13	0.94	0.65	1.08	0.92	0.66	0.96	1.69	0.91	0.28	0.66	0.42	0.95	0.77	0.91	0.28	8,4,48
	0.75	0.65	0.99	0.71	0.49	0.52	0.35	0.71	0.92	0.27	1.29	0.52	0.42	0.95	0.77									
GHQ-12C	7.13	7.50	8.67	4.63	3.50	4.00	0.63	3.25	3.00	0.13	3.00	2.67	1.00	3.00	7.67	0.99	0.25	1.00	2.14	5.35	4.93	0.99	0.25	8,4,48
	4.36	5.07	4.93	5.13	3.11	3.61	1.06	4.72	4.36	0.35	6.00	4.62	2.14	5.35	4.93									
IIP-32	1.17	1.39	1.85	1.32	1.27	1.12	0.78	1.13	0.90	0.61	1.15	0.90	0.83	0.97	0.91	1.85	0.10	0.83	0.61	0.44	0.38	1.85	0.10	8,4,48
	0.51	0.48	0.49	0.53	0.45	0.21	0.38	0.60	0.30	0.52	1.09	0.32	0.61	0.44	0.38									

M = Mean. EOC = End of Counselling. SCL = Symptom Checklist. GHQ = General Health Questionnaire. IIP = Inventory of Interpersonal Problems . HP = Health Professionals. AM = Administrative and Managerial. ST = Scientific and Technical. Higher scores on the SCL-18 and on the GHQ-12 are associated with greater levels of distress. Higher scores on the IIP-32 are associated with greater levels of interpersonal problems.

Chapter Nine:

Change across Sessions of Counselling

9.1. Introduction

Chapter nine presents analyses examining change on measures of outcome, across sessions of counselling. Analyses were performed to examine the extent and significance of session-by-session change and to identify the components (linear, cubic and quadratic) underpinning the shape of change curves.

9.1.1. Research Questions

- 1 Were there any significant relationships between measures of outcome and session impact?
- 2 Were there reductions in client distress across sessions of counselling?
If yes, were any of these reductions significant?
- 3 Were there increases in client's global ratings of session impact, across sessions?
If yes, were any of these increases significant?
- 4 Were there reductions in client ratings of hindering impacts, across sessions?
If yes, were any of these reductions significant?
- 5 Were there increases in client ratings of relationship impact, across sessions?
If yes, were any of these increases significant?
- 6 Were there increases in client ratings of task impacts, across sessions?
If yes, were any of these increases significant?
- 7 What were the change curve components?

9.1.2. Hypotheses

- 1 There will be significant reductions in distress across sessions.
- 2 There will be significant increases in client ratings of global impacts across sessions

- 3 There will be significant reductions in client ratings of hindering impacts across sessions
- 4 There will be significant increases in client ratings of relationship impacts across sessions
- 5 There will be significant increases in client ratings of task impacts across sessions
- 6 Change curves will exhibit negatively accelerating change curves. Curve components will, therefore, include significant linear and quadratic components.

9.2. Method

Clients completed a measure of session outcome and a measure of session impact. The outcome measure was the SCL-18 and it was completed by clients before the start of each session of counselling. The session one SCL-18 was the pre-counselling measure. The measure of session impact was the Session Impact Scale (SIS). This was completed at the end of each session of counselling. The SIS consists of three separate Hindering (e.g. confusion and impatience), Relationship (e.g. support and relief) and Task (technical content) sub-scales which each evaluate specific counselling impacts. A more detailed description of this measure is provided in Chapter Four.

Clients completed session measures separately because of practical constraints that impacted on the counselling service and its clients. Many clients attended sessions either during their lunch breaks or before the start of their shifts. This meant that many clients had very little time available to complete measures. In addition, counsellors only had a limited amount of time available between clients. A further important issue was that of client anonymity. Clients who 'hung around' too long, completing measures at the end of a session, risked being seen by the next client who might well have been a colleague. Clients were very sensitive about this issue (see Chapter 10). Despite instituting measures to minimise the workload on study participants, there remained a problem with clients not completing session measures.

9.3. Analyses

9.3.1. Change Across Sessions of Counselling

Repeated measure MANOVAs, run on the mainframe version of SPSS, were employed to compare session-by-session scores on the measures of outcome and session impact.

Each MANOVA included additional analyses to examine the components of each change curve. These additional analyses allowed linear, quadratic and cubic components to be identified. Two sets of statistics were performed: (a) Analyses across single sessions and (b) Analyses across averaged sessions.

Clients were included in analyses if they had completed the pre-counselling questionnaire and at least one of the session measures. The size of this group (n = 74) exceeds that of the group who completed the pre-counselling and at least one of the EOC and follow-up questionnaires (n = 58).

9.3.2. Analyses Across Single Sessions:

Clients were included in analyses if they completed the pre-counselling questionnaire and at least one session measure. In analyses, the Session One outcome measure, the SCL-18, was also the pre-counselling measure. This is because the pre-counselling questionnaire was completed immediately before the start of the first session of counselling. Clients did not have to have complete any of the EOC or follow-up measures to be included in analyses. For inclusion in any one analysis, clients had to complete a full set of session measures for each specific analysis. For example, for the Session One to Session Six (S1/S6) analysis, clients had to complete the Pre-counselling (Session One) questionnaire and measures for Sessions Two, Three, Four, Five and Six.

Three analyses were run across single counselling sessions. These separate analyses were from Session One to Sessions Four, Six and Eight. Analyses over a greater number of sessions, for example to Session Ten, were not possible because of the small number of cases that could be included in analyses. There was a distinct problem with missing data. Many clients not complete all of the sessions for a particular analysis. For example, although sixteen clients completed Session Eight counselling measures, only twelve clients had completed all met measures and only these twelve could be included in analyses.

9.3.3. Analyses across Averaged Measures

As noted, many clients did not complete a full set of session measures and, as a result, there were relatively few cases that could be included in the single session analyses described above. In response to this problem, a strategy of averaging across pairs of sessions was adopted.

Scores from every two sessions (e.g. Sessions One and Two and Sessions Three and Four) were added together, with the product being divided by the number of sessions completed. For example, if a client had only completed Session Five of the Sessions Five/Six pair, then this score would be taken as the Session Five/Six mean. If a second client had completed both the Session Five and Six questionnaires, then these scores would be summed and the product divided by the number of completed measures, case two. Individual means were then summed with all the other client means, with the product divided by the number of clients to produce an overall mean for the pair e.g. Session Five/Six.

To have a score for a specific paired occasion (e.g. Session Five/Six or Session Nine/Ten), clients had to have completed at least one of each adjacent pair. For example to have an Session Five/Six score, clients had to complete either the Session Five or Session Six or both measures. Analyses were then run across these paired measures. To be included in each analysis, clients had to have completed a full set of measures. For example, for clients to be included in the analysis comparing scores from Session One/Two to Session Seven/Eight, they would have had to have completed at least one qualifying session measure for all of the Session One/Two, Session Three/Four, Session Five/Six and Session Seven/Session Eight pairs.

The adoption of this strategy had two important outcomes. The first was that, because it compensated for missing session data, it increased the number of cases available for each analysis. The second outcome was that it increased the number of sessions across which analyses could be performed. The single session analyses were restricted to Session Eight, whilst the paired session allowed the analyses to be extended to the Session Fifteen/Sixteen.

For the repeated measure MANOVAs, both significant analyses and those approaching significance at the $p < .20$ level are discussed in the literature. Near significant analyses are noted because of the small number of cases that were available for analyses.

9.3.4. An Analysis of the Components of Change Curves

Concurrently with MANOVAs, a series of polynomial contrasts to test for linear, quadratic and cubic trends in the session data. Single and averaged session analyses for outcome and session impact measures are presented below. A *linear* trend indicates a uni-directional reduction or increase in scores across across measurement points. A *quadratic* component can either represent an acceleration or deceleration of the rate of change, with the direction of the trend remaining constant or a change in direction (e.g. an increase after a series of reductions in scores). A cubic trend indicates that there have been two changes in the direction of changes across measurement points.

For the analysis of trends, both significant analyses and analyses approaching significance at the $p < .10$ level are discussed in the literature. Near significant analyses are noted because of the small number of cases that were available for analyses.

Table 9.1. The SCL-18, the SIS and its Sub-scales. Means, Standard Deviations, the Number of Cases and Inter-scale Correlation's.																					
Means and standard deviations for the session measures.																					
Sess	SCL-18			SIS			SISH			SISR			SIST			Correlation's between the SCL-18 and the SIS and its three sub-scales					
	N	M	SD	N	M	SD	N	M	SD	N	M	SD	N	M	SD	N	SIS	SISH	SISR	SIST	
1	74	1.44	0.66	2.29	0.51	0.37	1.29	1.29	0.37	3.60	0.99	2.77	0.91	0.91	73	-0.12	0.31	-0.11	-0.08		
2	61	1.18	0.77	2.53	0.65	0.27	1.27	1.27	0.27	3.79	1.07	3.05	0.91	0.91	61	-0.16	0.43	-0.16	0.16		
3	50	1.02	0.69	2.60	0.57	0.32	1.24	1.24	0.32	3.92	0.89	3.19	0.77	0.77	50	-0.17	0.32	-0.12	-0.11		
4	39	0.99	0.85	2.73	0.50	0.25	1.19	1.19	0.25	4.14	0.97	3.49	0.87	0.87	39	-0.07	0.33	0.12	-0.06		
5	32	0.90	0.69	2.60	0.53	0.32	1.20	1.20	0.32	3.95	0.86	3.38	0.94	0.94	32	-0.40	0.65	-0.09	-0.32		
6	28	0.87	0.64	2.55	0.56	0.25	1.19	1.19	0.25	3.73	0.90	3.32	0.87	0.87	28	0.03	0.27	0.01	0.12		
7	23	0.92	0.50	2.61	0.57	0.22	1.12	1.12	0.22	4.07	1.05	3.53	1.11	1.11	23	0.08	0.25	0.00	0.10		
8	16	0.96	0.44	2.55	0.52	0.40	1.23	1.23	0.40	3.66	1.18	3.44	0.95	0.95	16	-0.26	0.49	-0.41	-0.04		
9	16	1.02	0.61	2.61	0.48	0.37	1.31	1.31	0.37	4.04	0.90	3.39	0.97	0.97	14	-0.32	0.33	-0.22	-0.28		
10	11	1.12	0.66	2.51	0.37	0.30	1.25	1.25	0.30	4.09	0.70	3.14	0.68	0.68	11	-0.40	0.62	0.20	-0.36		
11	10	1.35	0.63	2.55	0.40	0.25	1.25	1.25	0.25	4.05	0.76	3.23	0.75	0.75	10	-0.07	0.65	-0.19	0.15		
12	10	1.31	0.36	2.47	0.47	0.21	1.16	1.16	0.21	4.05	0.69	3.14	0.94	0.94	10	-0.25	0.75	0.03	-0.13		
13	8	1.05	0.49	2.45	0.47	0.36	1.23	1.23	0.36	3.44	1.32	3.28	1.10	1.10	8	-0.37	0.75	-0.49	0.00		
14	8	1.38	0.66	2.64	0.39	0.30	1.30	1.30	0.30	3.69	0.92	3.55	0.66	0.66	8	-0.64	0.74	-0.27	-0.55		
15	8	1.75	0.73	2.46	0.57	0.50	1.53	1.53	0.50	3.44	1.47	3.00	1.11	1.11	8	-0.26	0.59	-0.28	-0.05		
16	9	1.33	0.61	2.31	0.48	0.37	1.47	1.47	0.37	3.28	1.09	2.76	1.01	1.01	9	-0.72	0.63	-0.30	-0.65		
17	8	1.15	0.43	2.64	0.49	0.20	1.18	1.18	0.20	4.00	0.93	3.55	0.83	0.83	8	-0.83	0.48	-0.72	-0.70		
18	8	1.16	0.37	2.52	0.44	0.48	1.37	1.37	0.48	3.69	1.31	3.20	0.93	0.93	8	-0.19	0.38	-0.16	-0.06		
19	8	1.30	0.48	2.49	0.49	0.40	1.48	1.48	0.40	3.50	1.31	3.10	1.07	1.07	8	-0.45	-0.45	-0.33	-0.43		

Table 9.1 continued. The SCL-18, the SIS and its Sub-scales. Means, Standard Deviations, the Number of Cases and Inter-scale Correlation's.
Means and standard deviations for the session measures.

Sess	Means and standard deviations for the session measures.												Correlation's between the SCL-18 and the SIS and its sub-scales.							
	SCL-18			SIS			SISH			SISR			SIST			N	SIS	SISH	SISR	SIST
	M	SD	N	M	SD	N	M	SD	N	M	SD	N	M	SD	N					
20	1.06	0.65	6	2.55	0.68	6	1.29	0.38	6	3.93	1.40	6	3.26	1.04	6	-0.87	0.73	-0.36	-0.70	
21	1.09	0.26	3	2.08	0.36	3	1.27	0.31	3	3.00	2.00	3	2.53	0.76	3	0.30	-0.19	0.87	-0.38	
22	1.08	0.12	2	2.42	0.00	2	1.10	0.14	2	4.25	1.06	2	3.00	0.57	2	na	na	na	na	
23	1.17	0.31	2	2.73	0.13	2	1.30	0.42	2	4.50	0.00	2	3.63	0.18	2	na	na	na	na	
24	1.33	na	1	2.42	na	1	1.20	na	1	4.50	na	1	2.80	na	1	na	na	na	na	
25	1.17	na	1	2.50	na	1	1.40	na	1	5.00	na	1	2.60	na	1	na	na	na	na	
26	1.22	na	1	3.25	na	1	1.40	na	1	4.50	na	1	4.60	na	1	na	na	na	na	
27	1.11	na	1	2.58	na	1	1.20	na	1	5.00	na	1	3.00	na	1	na	na	na	na	
28	1.11	na	1	2.75	na	1	1.20	na	1	5.00	na	1	3.40	na	1	na	na	na	na	
29	1.39	na	1	2.67	na	1	1.20	na	1	2.67	na	1	2.67	na	1	na	na	na	na	
30	1.39	na	1	2.50	na	1	1.30	na	1	5.00	na	1	2.80	na	1	na	na	na	na	
31	1.22	na	1	2.50	na	1	1.40	na	1	5.00	na	1	2.60	na	1	na	na	na	na	
32	1.28	na	1	3.42	na	1	1.75	na	1	5.00	na	1	4.50	na	1	na	na	na	na	
33	1.33	na	1	2.92	na	1	1.40	na	1	5.00	na	1	3.60	na	1	na	na	na	na	

SIS = Session Impact Scale. H = Hindering, R = Relationship, T = Task. Higher scores on the SCL-18 are associated with greater distress. Higher scores on the SIS are associated with greater positive evaluations of counselling session impact. Higher scores on the Hindering Impacts sub-scale are associated with greater negative specific evaluations. Higher scores on the Relationship and Task Impact sub-scales are associated with greater positive evaluations of specific session impact. The SIS was the post-session measure and was thus completed by all clients at the end of the session. $1 = p > .05$, $2 = p < .01$, $3 = p < .001$.

9.4. Results

Seventy-four clients completed the pre-counselling questionnaire. The means, standard deviations and N's for the SCL-18, the Session Impact Scale (SIS) and its three Hindering, Relationship and Task sub-scales are presented in Table 9.1. This table also includes a series of inter-scale correlations performed to assess the degree of relationship between the outcome measures, the SCL-18 and measures of session impact.

9.4.1. Descriptive Statistics

Table 9.1 illustrates presents the means, standard deviations, Ns for the session measures. Inter-scale correlations at each session are also presented.

There was a session-on-session reduction in the number of cases as the session number increased. Seventy-four clients completed the pre-counselling (Session One) measures. By Session Two, only 61 clients had completed measures. There were then successive reductions in the number of cases across Sessions Three (n = 50), Four (n = 39), Five (n = 32), Six (n = 28), Seven (n = 23), Eight (n = 16), Nine (n = 16), Ten (n = 11), Eleven and Twelve (n = 10) and Thirteen to Fifteen (n = 8). There was an increase in the number of cases to Session Sixteen (n = 9), with a reduction to Sessions Seventeen to Nineteen (n = 8) and then successive reductions to Twenty (n = 6), Twenty-one (n = three) and sessions Twenty-two and Twenty-three (n = 2). From Session Twenty-four onwards, only one client completed session measures.

Session-to-session reductions in the number of clients completing measures at each successive session were calculated. There was a consistent pattern of session-on-session reductions of approximately twenty percent, for example from Session One (n = 74) to Session Two (n = 61) the reduction was eighteen percent and from Session Two (n = 61) to Session Three (n = 50), the reduction was also eighteen percent and the reduction from Session Five (n = 32) to Session Six (n = 28), the reduction was twelve percent. Therefore, the rate of reduction in clients from session-to-session was fairly constant.

9.4.2 The SCL-18

The pre-counselling (Session One) mean was 1.44. There were successive reductions from Session One to Sessions Two (1.18), Three (1.02), Four (0.99), Five (0.90) and Six (0.87). There were then successive increases to Sessions Seven (0.92), Eight (0.96), Nine (1.02), Ten (1.12) and Eleven (1.35). From Session Twelve onwards, as the number of clients at each successive session reduced, there were increasingly large

session-to-session changes, with session scores ranging from 1.06 to 1.75. There were increasingly large fluctuations in the size of the standard deviation across sessions of counselling. These ranged from 0.12 to 0.73, with the majority (sixteen out of twenty-three) being greater than 0.40.

9.4.3. Session Impact Scale (SIS)

Clients became increasingly positive, across initial sessions, in their overall ratings of session impact. There were successive increases in ratings across Sessions One (2.29), Two (2.53), Three (2.60) and Four (2.73). From Session Five (2.60) onwards, there was little change from session-to-session in ratings of impact, although there was a trend towards less positive ratings of session impact.

9.4.4. Hindering Impacts

From Session One (1.29) to Session Seven (1.12), there was a general trend of a reductions in client ratings of negative impacts. Session Eight onwards was characterised by a fairly stable level of ratings. As the number of cases decreased, there was a trend for clients to rate sessions more negatively, with scores of 1.53 (Session Fifteen, n = 8), 1.47 (Session Sixteen, n = 9) and 1.46 (Session Nineteen, n = 8).

9.4.5. Relationship Impacts

Clients became more positive in their ratings of relationship impacts, with successive increases from Session One (3.60) to Four (4.14). Greater session-to-session fluctuations from Session Five onwards were reported with client ratings ranging from 3.00 to 5.00.

9.4.6. Task Impacts:

There were successive increases in client ratings of Task Impacts across Sessions One (2.77), Two (3.05), Three (3.19) and Four (3.49). There were then successive reductions from Session Four to Sessions Five (3.38) and Six (3.32), an increase to 3.53 (Session Seven), before a successive reductions across Sessions Eight (3.44), Nine (3.39) and Ten (3.14). Sessions from Eleven onwards are associated with increasingly large session-to-session fluctuations.

9.5. Correlation's between the SCL-18 and the Session Impact Measures

Scores on the Session Impact Scale and its three Hindering, Relationship and Task Impact sub-scales were correlated with scores on the outcome measure, the SCL-18. Until Session Thirteen, there was a consistent pattern, at each separate session, of greater correlation's between the outcome measure and the Hindering Impacts sub-scale, than between the SCL-18 and the other impact scales. Correlation's across the first thirteen sessions, between the SCL-18 and the Hindering Impacts sub-scale, ranged from $r = .31$ to $r = .75$.

The correlation's for the SIS ranged from $r = .08$ to $r = -.40$, for Relationship Impacts from $r = .00$ to $r = -.49$ and for Task Impacts from $r = -.06$ to $r = -.36$. There were significant correlation's between the SCL-18 and the Hindering Impacts sub-scale for Sessions One ($r = .31$); Two ($r = .43$); Three ($r = .32$); Four ($r = .33$); Five ($r = .65$), Eight ($r = .49$); Ten ($r = .62$); Eleven ($r = .65$); Twelve ($r = .75$) and Thirteen ($r = .75$).

There was a significant correlation between the SCL-18 and the SIS at Session Five ($r = -.40$). From Session Thirteen onwards, as the number of cases decreased, there were increasingly large fluctuations in the correlation's between impact measures and the SCL-18. There were only two significant correlation's, between the SCL-18 and the SIS at Sessions Nine ($r = -0.72$) and Ten ($r = -0.83$).

Changes across sessions followed expected patterns of increases (SIS and Relationship and Task Impacts) and reductions (SCL-18 and Hindering Impacts) across early sessions. Subsequent sessions were characterised by increasingly large session-to-session fluctuations, that tended to suggest a reversal of initial gains. The strongest and most consistent relationship between the measures of impact and the measure of outcome was between the Hindering Impacts sub-scale and the SCL-18.

9.6. Were there Reductions in Distress Across Sessions of Counselling

There were reductions in distress levels across sessions of counselling. Clients reported greater distress at Session One, on all of the single session analyses and at Sessions One/Two, on the averaged session analyses, than at any of the succeeding sessions. Reductions across all of the analyses, with one exception, Sessions Thirteen/Fourteen, were significant, with the Sessions Thirteen/Fourteen analysis approached significance. There was statistical support for linear, quadratic and cubic trends in the change curves.

The single session analyses are presented in Table 9.2 and Fig 9.1, whilst the average session analyses are presented in Table 9.3 and Fig 9.2.

9.6.1. Single Sessions of Counselling

There were successive reductions across sessions in levels of distress on the SCL-18, across the three single session analyses. These analyses ran from Session One to Sessions Four (the Sessions One/Four analysis, $n = 31$), Six (the Session One/Six analysis, $n = 20$) and Eight (the Session One/Eight analysis, $n = 12$).

There were successive reductions for the SessionOne/Four analysis, from Session One (1.50) to Sessions Two (1.16), Three (0.93) and Four (0.87). This reduction was significant ($F = 16.93$, $df = 3, 90$, $p = .000$).

There were successive reductions, from Session One (1.57) to Sessions Two (1.28) and Three (0.98), for the Session One/Six analysis. This reduction was significant ($F = 11.25$, $df = 5, 95$, $p = .000$).

For the Session One/Eight analysis, there were successive reductions in distress from Session One (1.48) to Sessions Two (1.29) and Three (1.02), then stability to Session Four (1.04) with further reductions to Five (0.93) and Six (0.75). There was then an increase to Seven (1.03), with a reduction at Session Eight (0.88). This reduction, with scores from Session Two to Eight all being less than at Session One, was significant ($F = 6.45$, $df = 7, 77$, $p = .01$).

9.6.2. Averaged Sessions of Counselling

Five separate analyses were run, comparing levels of distress from Session One/Two to Sessions Five/Six ($n = 31$), Seven/Eight ($n = 21$), Nine/Ten ($n = 13$), Eleven/Twelve ($n = 8$) and Thirteen/Fourteen ($n = 7$). Sessions are abbreviated in the text: For example, the average of Session One and Session Two becomes S1/S2 and the average of Session Three and Session Four becomes S3/S4.

For the Session Five/Six analysis, there were successive reductions in distress from S1/S2 (1.30) to S3/S4 (0.92) and S5/S6 (0.80). This reduction, with scores from S3/S4 to S5/S6 all being less than at S1/S2 was significant ($F = 27.2$, $df = 2, 60$, $p = .01$).

There were successive reductions in distress from S1/S2 (1.28) to S3/S4 (0.88) and S5/S6 (0.80) on the Session Seven/Eight analysis. Scores from S3/S4 to S7/S8 were all less than at S1/S2. The reduction was significant ($F = 13.17$, $df = 3, 60$, $p = .01$).

For the Sessions Nine/Ten analysis, there were successive reductions from S1/S2 (1.41) to S3/S4 (1.06) and S5/S6 (0.96). Scores from S3/S4 to S9/S10 were all less than the S1/S2 mean. This reduction was significant ($F = 4.96$, $df = 4, 48$, $p = .02$).

There were successive reductions in client distress on the Sessions Eleven/Twelve analysis. These were from S1/S2 (1.63) to S3/S4 (1.22) and S5/S6 (1.15). Scores from S3/S4 to S11/S12 were all less than the S1/S2 mean. This reduction approached significant ($F = 2.47$, $df = 5, 35$, $p = .05$).

For the Sessions Thirteen/Fourteen analysis, there were successive reductions in client distress from Session S1/S2 (1.65) to Sessions S3/S4 (1.25) and S5/S6 (1.15). Client ratings of distress, from Session Three/Four to Session Thirteen/Fourteen, were less than at Session One/Two levels. This reduction approached significance ($F = 1.67$, $df = 6, 36$, $p = .156$).

9.6.3. What are the Components of the Outcome Measure Change Curves

There was a consistent pattern, across both single and averaged session analyses, of linear and quadratic trends in the change curves.

a. Single sessions of counselling

For the three single session change curves (see Fig 9.1), polynomial analyses provided statistical support for linear and quadratic trends. These translate, when one examines Fig 8.1, into a series of reductions across sessions that exhibits a negatively accelerating curve with an effective plateau being reached at Session Three. The Session One/Eight analysis exhibited this pattern, along with an increase from Session Six to Seven and then a reduction from Seven to Eight.

Table 9.2. The SCL-18: A Series of Repeated Measure MANOVAs, with Polynomial Analyses, for Analyses from Session One to Session Four, Six and Eight.

	Session One/Four		Session One/Six		Session One/Eight	
Sessions	Mean	sd	Mean	sd	Mean	sd
1	1.50	0.63	1.57	0.55	1.48	0.50
2	1.16	0.60	1.28	0.63	1.29	0.63
3	0.93	0.47	0.98	0.46	1.02	0.48
4	0.87	0.75	1.03	0.84	1.04	0.55
5			0.88	0.70	0.93	0.60
6			0.79	0.53	0.75	0.42
7					1.03	0.57
8					0.88	0.47
Repeated measure MANOVAs						
F	16.93		11.25		6.45	
df	3,90		5, 95		7, 77	
P	0.01		0.01		0.01	
Linear, cubic and quadratic curve analyses						
Linear						
t	-5.26		-5.04		-3.69	
p	0.01		0.01		0.02	
Quadratic						
t	2.52		1.97		2.76	
p	0.02		0.06		0.02	
Cubic						
t	0.31		-0.33		-0.48	
p	0.76		0.17		0.64	

Note: Ns: S1 to S4 = 31, S1 to S6, n =20, S1 to S8, n = 12. Higher scores on the SCL-18 are associated with greater levels of distress.

Fig 9.1. The SCL-18: Session Means for Analyses from from Session One to Sessions Four, Six and Eight.

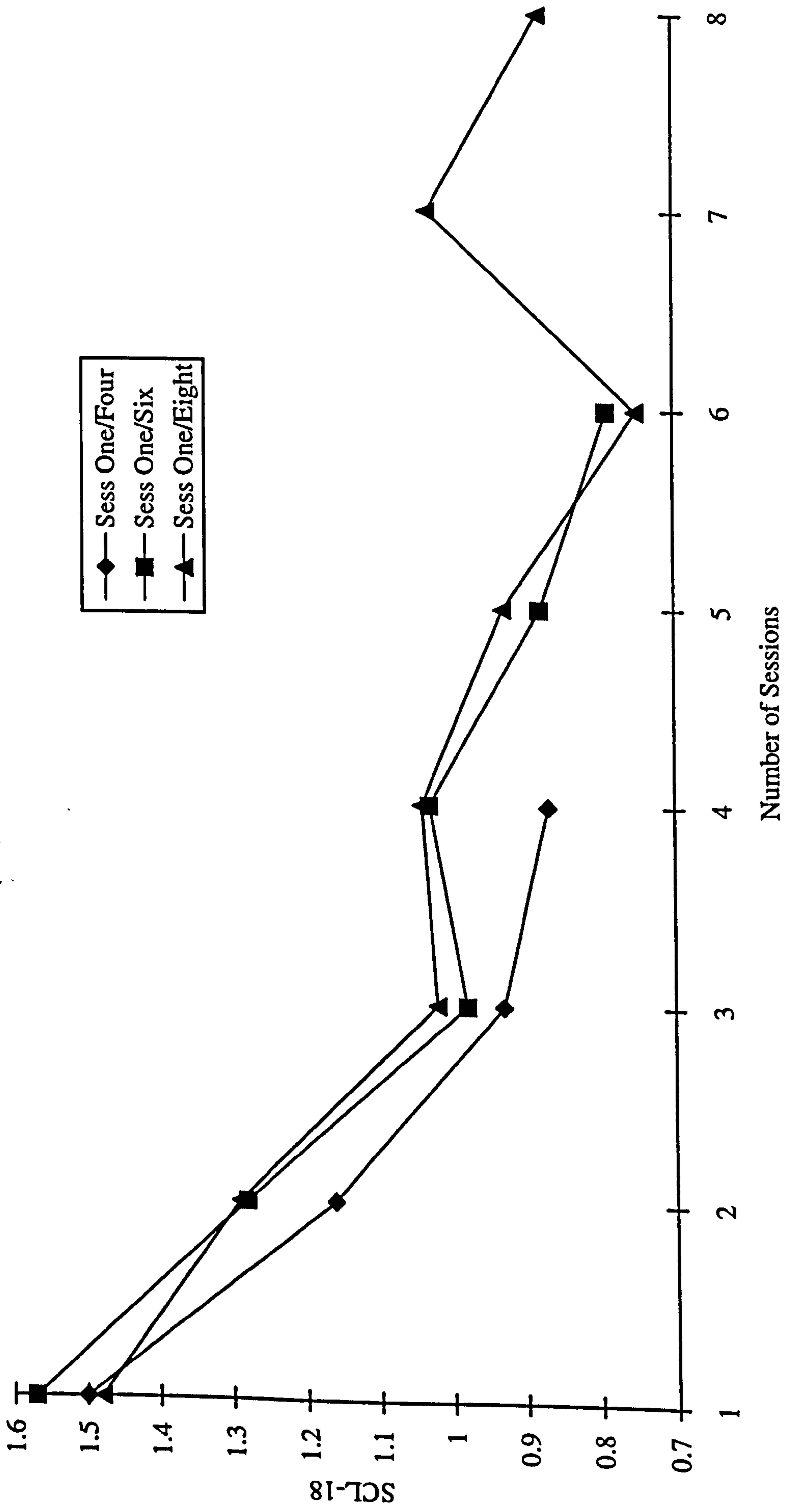


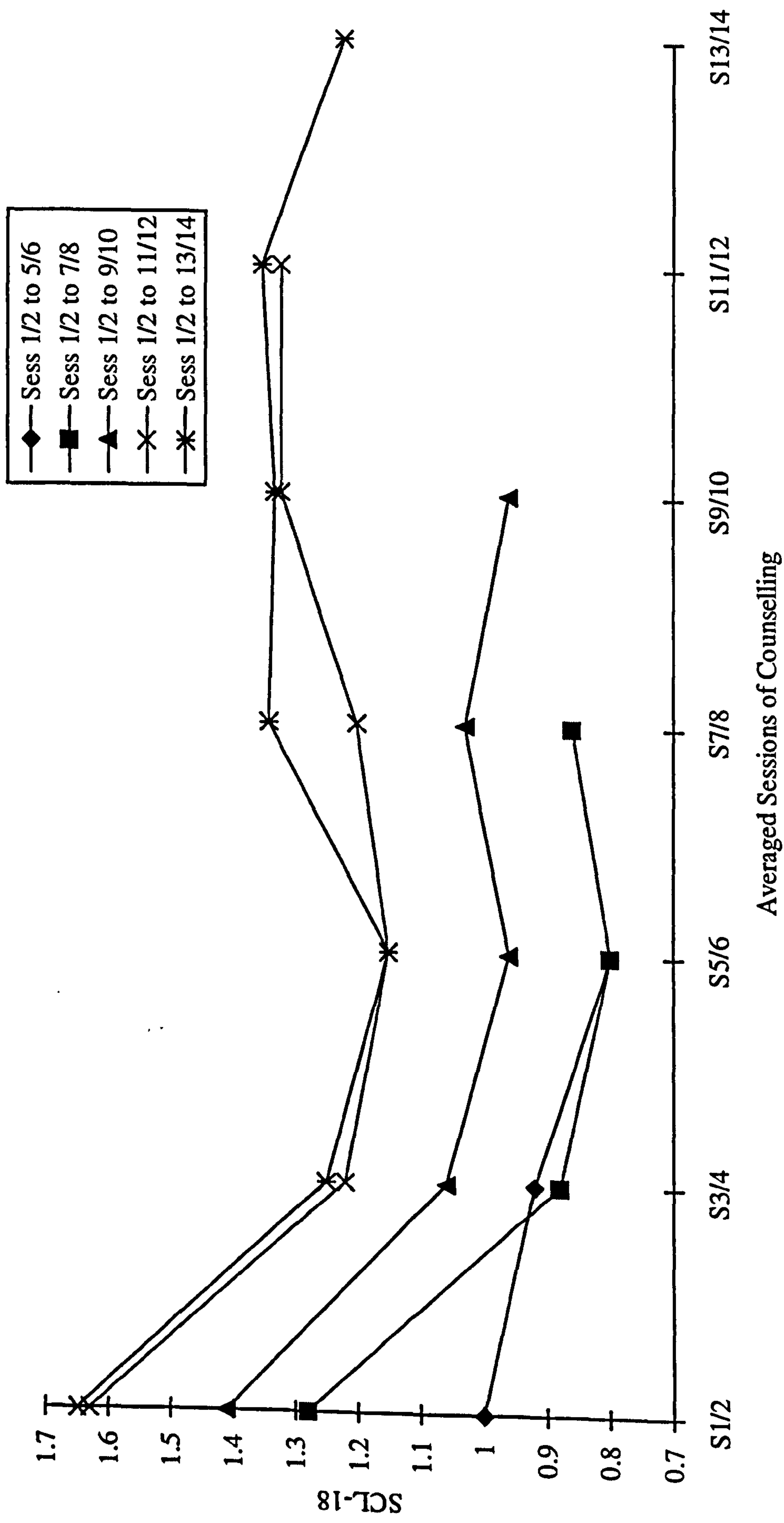
Table 9.3. The SCL-18: Session Means for Analyses from Sessions One/Two to Five/Six, Seven Eight, Nine/Ten, Eleven/Twelve and Thirteen/Fourteen. A Series of Repeated measure MANOVAs, with Polynomial (Linear, Quadratic and Cubic) Analyses.

Sessions	S1/2 to S5/6		S1/2 to S7/8		S1/2 to S9/10		S1/2 to S11/12		S1/2 to S13/14	
	Mean	sd	Mean	sd	Mean	sd	Mean	sd	Mean	sd
S1/S2	1.30	0.55	1.28	0.51	1.41	0.49	1.63	0.47	1.65	0.50
S3/S4	0.92	0.55	0.88	0.44	1.06	0.44	1.22	0.46	1.25	0.48
S5/S6	0.80	0.57	0.80	0.47	0.96	0.49	1.15	0.46	1.15	0.50
S7/S8			0.86	0.46	1.03	0.41	1.20	0.29	1.34	0.29
S9/S10					0.96	0.63	1.32	0.49	1.33	0.52
S11/S12							1.32	0.51	1.35	0.53
S13/S14									1.22	0.61

Repeated measure MANOVAs and linear, quadratic and cubic curve analyses										
F		27.220		13.17		4.96		2.47		1.67
df		2.,60		3.,60		4.,48		5,35		6,36
P		0.01		0.01		0.01		0.05		0.16
Linear										
t		-5.773		-5.17		-2.51		-1.26		-1.20
p		0.01		0.01		0.03		0.25		0.28
Quadratic										
t		2.98		3.02		2.12		2.71		1.30
p		0.01		0.01		0.06		0.03		0.24
Cubic										
t		n/a		-0.92		-2.42		-1.28		-2.51
p		n/a		0.37		0.03		0.24		0.05

SCL = Symptom Checklist. S = Session. Note: N's. S1/S2 to S5/S6, n = 31, S1/S2 to S7/S8, n = 21, S1/S2 to S9/S10, n = 13, S1/S2 to S11/S12, n = 8, S1/S2 to S13/S14, n = 7. Higher scores on the SCL-18 are associated with greater levels of distress.

Fig 9.2. The SCL-18: Session Means for Analyses from Sessions One/Two to Sessions Five/Six, Seven/Eight, Nine/Ten, Eleven/Twelve and Thirteen/Fourteen.



Polynomial contrasts indicated significant support for a linear trend for the Session One/Four ($t = -5.26, p = .000$), One/Six ($t = -5.04, p = .000$) and One/Eight ($t = -3.69, p = .019$) analyses. There was also significant support for a quadratic trend for the One/Four ($t = 2.52, p = .018$), One/Six ($t = -5.04, p = .000$) and One/Eight ($t = -3.69, p = .019$) change curves.

b. Averaged Sessions of Counselling:

As Fig 9.2 illustrates, the change curves for the averaged session analyses were characterised by linear and quadratic trends. The linear curves reflect the initial reductions, that are consistent across analyses, from S1/S2 to S3/S4, whilst the quadratic trends are a reflection of the fact that these curves are exhibiting negative acceleration, as the rate of change is reduced across sessions and as increases in distress from S5/S6. There was also evidence for a cubic trend for a number of analyses, which corresponds to further reductions in distress from S7/S8 to S9/S10, for the Sessions Nine/Ten analysis, and from S11/S12 to S13/S14 for the Sessions Thirteen/Fourteen analysis.

Support for a linear trend was significant for the Sessions Five/Six ($t = -5.77, p = .000$), Seven/Eight ($t = -5.17, p = .000$) and Nine/Ten ($t = -2.51, p = .028$) analyses. There was significant support for a quadratic component for the Sessions Five/Six ($t = 2.98, p = .006$), Seven/Eight ($t = 3.02, p = .007$), Nine/Ten ($t = 2.12, p = .055$) and Eleven/Twelve ($t = 2.71, p = .030$) analyses and there was statistical support for a cubic trend for the Sessions Nine/Ten ($t = -2.42, p = .032$) and Thirteen/Fourteen ($t = -2.51, p = .045$) analyses, corresponds to the further reductions

9.7. Were there Increases Across Sessions in Client Global Ratings of Session Impacts

Clients were more positive about counselling, in their global ratings of session impact, at Sessions Three and Four (single session analysis) and at Sessions Three/Four and Five/Six (averaged session analysis), than, respectively, at Session One and Sessions One/Two.

The single session analyses are presented in Table 9.4 and Fig 9.3, whilst averaged session analyses are presented in Table 9.5 and Fig 9.4.

9.7.1. Analyses Across Single Sessions

Three analyses could be run, from Session One to Session Four (Sessions One/Four, $n = 31$), from Session One to Session Six (Sessions One/Six, $n = 20$) and from Session One to Session Eight (Sessions One/Eight, $n = 12$).

Session One/Four participants were increasingly positive, in their global ratings of session impact, from Session One (3.71) to Sessions Two (3.88), Three (4.04) and Four (4.20). This increase, from ratings from Two to Four all being greater than at Session One was significant ($F = 9.25$, $df = 3, 87$, $p = .01$).

Session One/Six participants reported successive increases in global ratings of session impact from Session One (3.68) to Sessions Two (3.70), Three (3.95) and Four (4.16), with a reduction in client ratings to Sessions Five (3.95) and Six (4.02). This increase, with global ratings being greater from Sessions Two to Six, than at Session One was significant ($F = 4.47$, $df = 5, 85$, $p = .01$).

On the Session One/Eight analysis, clients reported an initial reduction, from Session One (3.81) to Session Two (3.64), in global ratings of session impact. Clients, became increasingly positive in their overall ratings from Session Two to Sessions Three (3.98), Four (4.09) and Five (4.11). There was than a reduction to Session Six (3.89) before an increase to Session Seven (4.11). With the exceptions of Sessions Two and Six, ratings were greater than at Session One. The increase in global session impact ratings was significant ($F = 2.60$, $df = 7, 70$, $p = .02$).

9.7.2. Analyses Across Averaged Sessions

Six separate analysis were run from Sessions One/Two to Sessions Five/Six ($n = 32$), Seven/Eight ($n = 22$), Nine/Ten ($n = 14$), Eleven/Twelve ($n = 9$), Thirteen/Fourteen ($n = 8$) and Fifteen/Sixteen ($n = 8$). Individual sessions are abbreviated in the text. For example, the Session One and Two average becomes S1/S2 and the Session Three and Four average becomes S3/S4.

There were increases from Session One/Two to Sessions Three/Four for the Sessions Five/Six (3.68 to 4.07), Seven/Eight (3.60 to 4.05), Nine/Ten (3.65 to 4.02), Eleven/Twelve (3.12 to 3.69), Thirteen/Fourteen (3.44 to 3.96) and Fifteen/Sixteen (3.44 to 3.96) analyses. Subsequent sessions were characterised by stability. There was a consistent pattern of global

impact ratings, from S3/S4 to S15/S16 (for the Sessions Fifteen/Sixteen analysis), all being greater than ratings at S1/S2.

Increases across sessions were statistically significant for the Sessions Five/Six ($F = 17.77$, $df = 2, 62$, $p = .000$), Seven/Eight ($F = 13.40$, $df = 3, 63$, $p = .000$), Nine/Ten ($F = 4.65$, $df = 4, 52$, $p = .003$), Eleven/Twelve ($F = 2.95$, $df = 5, 40$, $p = .023$), Thirteen/Fourteen ($F = 2.86$, $df = 6, 42$, $p = .020$) and Fifteen/Sixteen ($F = 2.22$, $df = 7, 49$, $p = .049$).

9.7.3. What were the Components of the SIS Change Curves

There was statistical evidence, across single and averaged session analyses, of linear and quadratic trends in the change curves for the Session Impact Scale. There was also some support for a cubic component for a number of the averaged session analyses that included a greater number of sessions.

a. Across Single Sessions:

The Session One/Four SIS curve is characterised only by a significant linear trend, that reflects the series of successive, unbroken increases from Session One to Four ($t = 4.89$, $p = .01$).

The Session One/Six curve was characterised by linear ($t = 3.93$, $p = .01$) and quadratic ($t = -2.25$, $p = .04$) trends, with the linear being a reflection of the increase in ratings from Session One to Three and the quadratic element being attributable to a reduction in ratings from Three to Four.

Table 9.4. The Sessions Impact Scale (SIS): Sessions Means for Analyses from Session One to Sessions Four, Six and Eight. A Series of Repeated Measure MANOVAs, with Polynomial Analyses (Linear, Quadratic and Cubic).

	Session One/Four		Session One/Six		Session One/Eight	
Session	Mean	sd	Mean	sd	Mean	sd
1	3.71	0.54	3.68	0.60	3.81	0.63
2	3.88	0.56	3.70	0.55	3.64	0.63
3	4.04	0.41	3.95	0.41	3.98	0.37
4	4.20	0.49	4.16	0.53	4.09	0.42
5			3.95	0.58	4.11	0.42
6			4.02	0.54	3.89	0.56
7					4.11	0.62
8					4.05	0.59
Repeated measure MANOVAs						
F		9.24		4.47		2.60
df		3,87		5, 85		7, 70
P		0.00		0.01		0.02
Linear, cubic and quadratic curve analyses						
Linear						
t		4.89		3.93		2.16
p		0.00		0.01		0.06
Quadratic						
t		-0.11		-2.25		-1.97
p		0.91		0.04		0.08
Cubic						
t		0.06		-0.65		-0.09
p		0.95		0.523		0.93

Note: N's. S1 to S4 = 31, S1 to S6, n =20, S1 to S8, n = 12 Higher scores on the SIS are associated with greater positive ratings of overall session impact.

Fig 9.3 The Session Impact Scale: Session Means for Analyses from Session One to Sessions Four, Six and Eight.

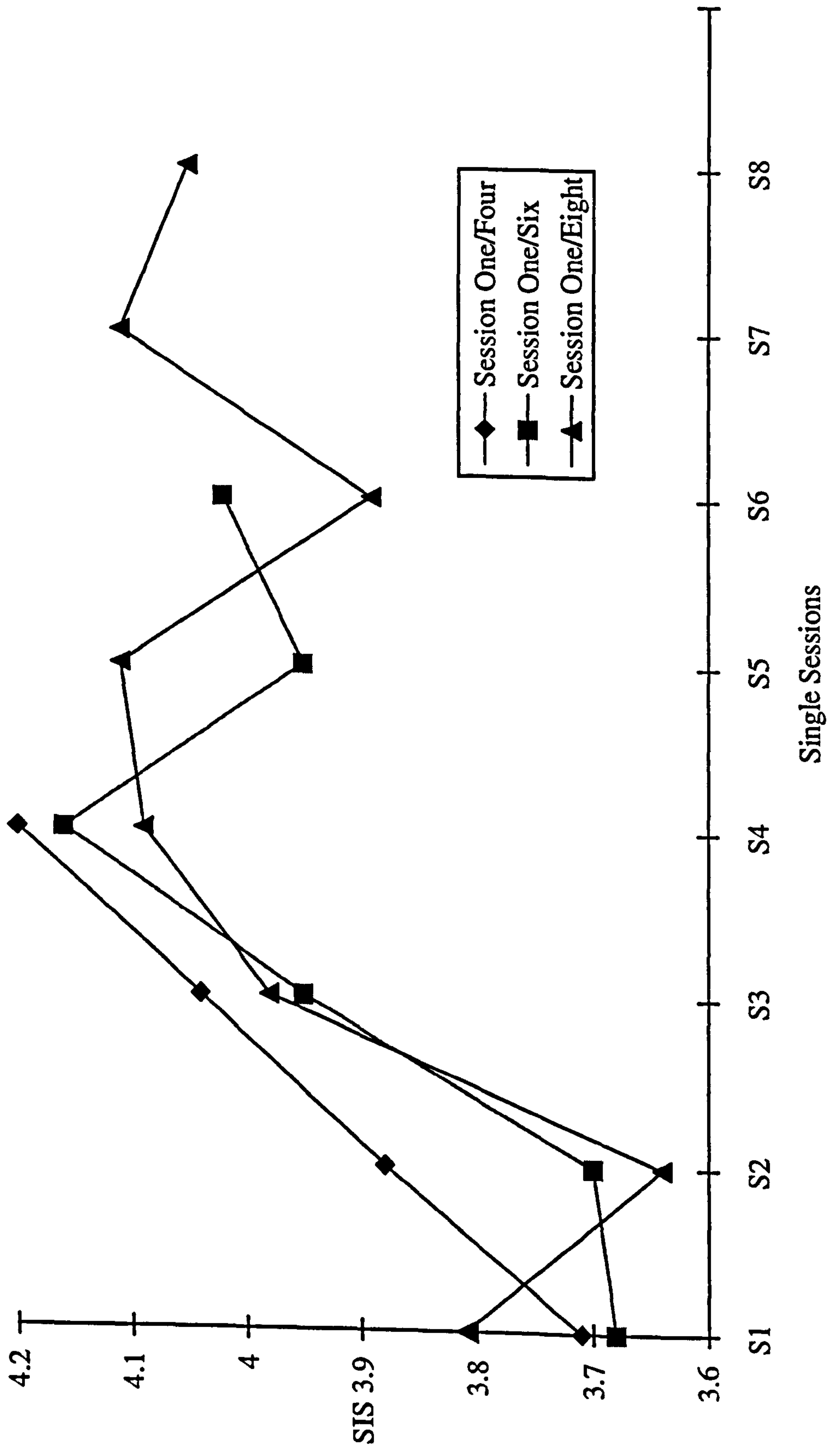


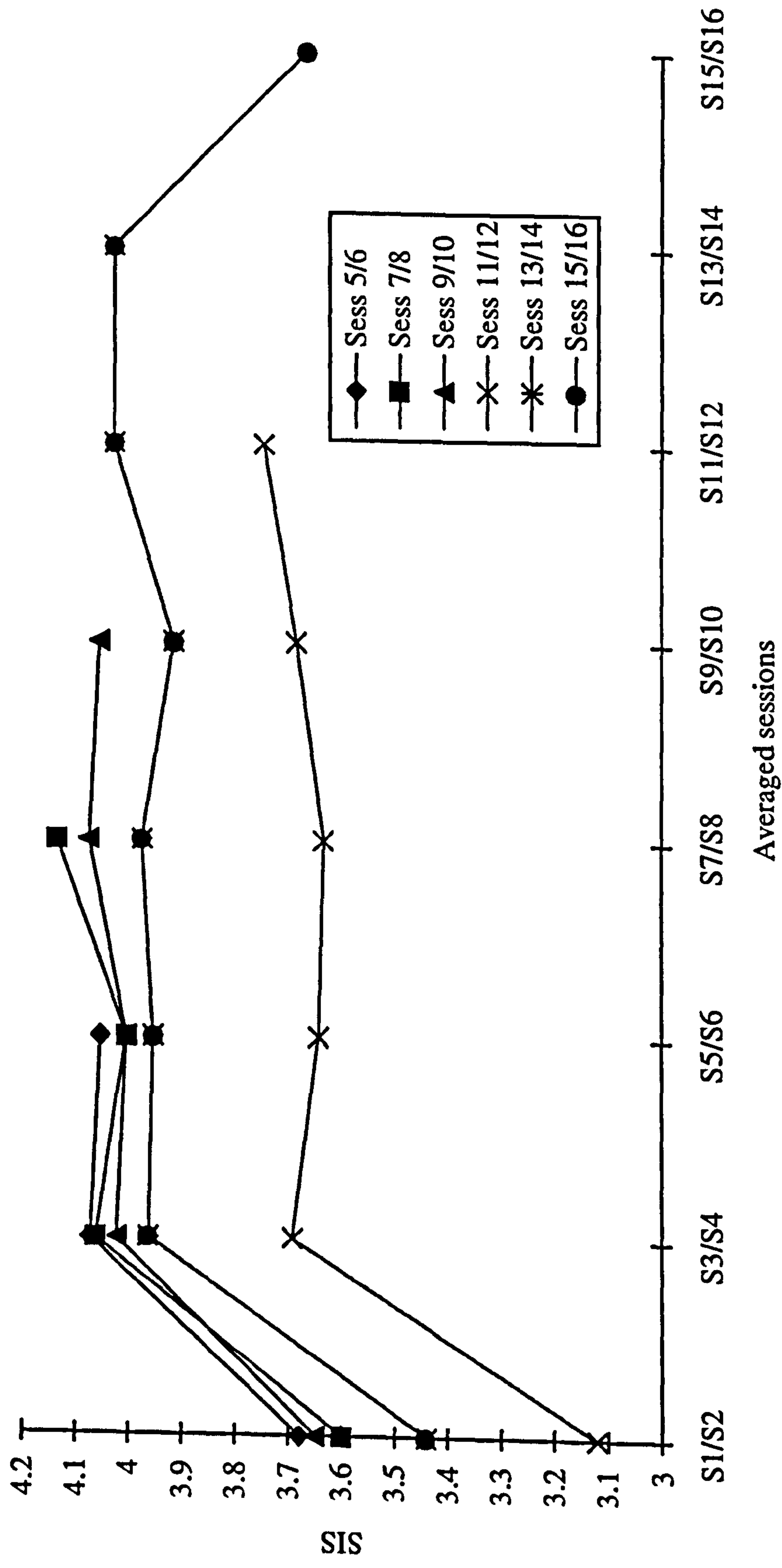
Table 9.5 The Session Impact Scale (SIS): Sessions Means for Analyses from Sessions One/Two to Sessions Five/Six, Seven/Eight, Nine/Ten, Eleven/Twelve, Thirteen/Fourteen and Fifteen/Sixteen. A Series of Repeated Measure MANOVAs, with Polynomial Analyses (Linear, Quadratic and Cubic).

S1/2 to S5/S6		S1/2 to S7/S8		S1/2 to S9/S10		S1/S2 to S11/S12		S1/S2 to S13/S14		S1/S2 to S15/S16		
Sessions	Mean	sd	Mean	sd	Mean	sd	Mean	sd	Mean	sd	Mean	sd
S1/S2	3.68	0.53	3.60	0.48	3.65	0.54	3.12	3.90	3.44	0.51	3.44	0.51
S3/S4	4.07	0.38	4.06	0.39	4.02	0.38	3.69	4.27	3.96	0.40	3.96	0.40
S5/S6	4.05	0.46	4.00	0.46	4.00	0.48	3.64	4.31	3.95	0.46	3.95	0.46
S7/S8			4.13	0.60	4.07	0.54	3.63	4.42	3.97	0.52	3.97	0.52
S9/S10					4.05	0.45	3.68	4.28	3.91	0.34	3.91	0.34
S11/S12							3.74	4.25	4.02	0.35	4.02	0.35
S13/S14									4.02	0.38	4.02	0.38
S15/S16											3.66	0.68

Repeated measure MANOVAs and linear, quadratic and cubic curve analyses												
F		17.77		13.40		4.65		2.95		2.86		2.22
df		2,62		3,63		4,52		5,40		6,42		7,49
P		0.01		0.01		0.01		0.02		0.02		0.05
Linear												
t		4.61		4.45		2.77		2.47		2.53		0.92
p		0.01		0.00		0.02		0.04		0.04		0.39
Quad												
t		-3.55		-2.75		-2.16		-2.13		-1.509		-1.81
p		0.01		0.12		0.05		0.07		0.18		0.11
Cubic												
t		n/a		2.83		1.71		1.60		2.96		0.67
p		n/a		0.01		0.11		0.15		0.02		0.52

Higher scores on the Session Impact Scale are associated with greater positive evaluations of counselling impact. Note: N's. S1 to S5/6, n = 32, S1 to S7/8, n = 22, S1 to S9/10, n = 14, S1 to S11/12, n = 9, S1 to S13/14, n = 8, S1 to S15/16, n = 8. Quad = Quadratic. Higher scores on the SIS are associated with greater positive ratings of overall session impact.

Fig 9.4 The Session Impact Scale: Session Means for Analyses from Session One/Two to Sessions Five/Six, Seven/Eight, Nine/Ten, Eleven/Twelve, Thirteen/Fourteen and Fifteen/Sixteen.



For the Session One/Eight analysis, there was near significant support for both linear ($t = 2.16$, $p = .06$) and quadratic ($t = -1.97$, $p = .08$) trends, with the linear curve representing the successive increases from Session Two to Five. The quadratic component relates, either to the bend at Session Two, where there is a complete change in direction of the curve, after an initial reduction (from Session One to Two), to an increase from Two to Three or, alternatively, it may relate to the inflection (bend) at Session Five where a negatively accelerating curve (increasing scores) becomes a reduction..

b. Across Averaged Sessions:

The Session Five/Six analysis was characterised by significant linear ($t = 4.61$, $p = .01$) and quadratic ($t = -3.55$, $p = .01$) trends. The linear trend reflects the increase in ratings, from S1/S2 to S3/S4, whilst the quadratic trend relates to the bend at S3/S4 and a plateau from S3/S4 to S5/S6.

The Session Seven/Eight Session Impact change curve was characterised by significant linear ($t = 4.45$, $p = .01$) and cubic ($t = 2.83$, $p = .01$) trends. These trends are a reflection of a curve that exhibits an increase from S1/S2 to S3/S4 (linear) and then a second bend at S5/S6 (cubic), with an increase to S7/S8.

The Sessions Nine/Ten change curve was characterised by significant linear ($t = 2.77$, $p = .02$) and quadratic ($t = -2.75$, $p = 0.05$) trends. For this analysis, the initial increase (linear component) to S3/S4 was followed by a plateau from S3/S4 to S9/S10, although there was a small increase from S5/S6 to S7/S8 which underpins the near significant cubic element.

The Sessions Eleven/Twelve change curve was characterised by a significant linear ($t = 2.47$, $p = .04$) trend and a near significant quadratic ($t = -2.13$, $p = .07$) trend. With the increase from S1/S2 to S3/S4 representing the linear trend, the bend at S3/S4 represents the quadratic trend, whilst the bend at S7/S8 represents the cubic element.

The Sessions Thirteen/Fourteen change curve was characterised by significant linear ($t = 2.53$, $p = .04$) and cubic ($t = 2.96$, $p = .02$) trends. The linear component reflects the increase in ratings from S1/S2 to S3/S4, whilst the cubic trend is attributable to the second bend, in the curve, at S9/S10 which is followed by an increase in ratings to S11/S12.

9.8. Were there Reductions in Client Ratings of the Hindering Impact

There were reductions in client ratings of hindering impacts, although these were restricted to the average session analyses. There was a consistent pattern, here, of clients reporting a greater level of hindering impact at Session One/Two than at subsequent sessions.

Single session analyses are presented in Table 9.6 and Fig 9.5. Averaged session analyses are presented in Table 9.7 and Fig 9.6.

9.8.1. Analyses Across Single Sessions

Three sets of analyses were run for the single session analyses, from Sessions One to Sessions Four ($n = 28$), Six ($n = 18$) and Eight ($n = 11$). None of the analyses were significant.

9.8.2. Analyses Across Averaged Sessions

Five sets of analyses were run to compare client evaluations of the Hindering Impacts of counselling across sessions. These were from Sessions One/Two to Five/Six ($n = 31$), Seven/Eight ($n = 20$), Nine/Ten ($n = 14$), Eleven/Twelve ($n = 8$) and Thirteen/Fourteen ($n = 7$). Averaged sessions are abbreviated. The average of Session One and Session Two becomes S1/S2 and the average of Sessions Three and Four becomes S3/S4.

Clients reported, on the Sessions Five/Six analysis, a reduction in Hindering Impacts from S1/S2 (1.29) to S3/S4 (1.20), with means at S3/S4 and S5/S6 both being greater than at S1/S2. This reduction was significant ($F = 4.31$, $df = 2, 60$, $p = .02$).

Sessions Seven/Eight participants reported a reduction in negative evaluations of session impact from S1/S2 (1.28) to S3/S4 (1.16). Scores from S3/S4 to S7/S8 were all greater than at S1/S2. The reduction in scores was significant ($F = 3.67$, $df = 5, 57$, $p = .02$).

9.8.3. What were the Components of the Hindering Impact Change Curves

There was evidence from analyses for linear, quadratic and cubic components, although the evidence was stronger for the averaged sessions, than for the single session analyses.

a Across Averaged Sessions:

For the Sessions Five Six analysis, there was significant support for a linear ($t = -2.86$, $p = 0.01$) trend. This is a reflection of the successive reductions in means from S1/S2 to S5/S6.

For the Sessions Seven/Eight change curve, there was significant support for a linear ($t = -2.47$, $p = 0.02$) trend and near significant support for a cubic ($t = -2.01$, $p = 0.06$) trend. The linear curve is a reflection of the reduction from S1/S2 to S3/S4, whilst the cubic component is a reflection of a second bend in the curve at S5/S6.

There was near significant support for the Sessions Nine/Ten ($t = -1.379$, $p = .193$) analysis for a quadratic trend ($t = 1.89$, $p = 0.08$), that corresponds to the bend in the curve at S3/S4 and the subsequent increase to S5/S6.

There was near significant support for the Sessions Eleven/Twelve analysis for both linear ($t = -1.96$, $p = .09$) and cubic ($t = -2.06$, $p = 0.08$) trends. The linear trend relates to the reduction in ratings from S1/S2 to S3/S4, whilst the cubic trend can be associated with the slight bend at S7/S8.

A further reduction, a second change of direction on the change curve, from S3/S4 to S5/S6, on the Sessions Seven/Eight ($t = -2.01$, $p = 0.06$) analysis and from S7/S8 to S9/S10 for the Sessions Eleven/Twelve ($t = -2.06$, $p = 0.08$) was reflected in near significant support for cubic change curve components.

Table 9.6 Hindering Impacts: Session Means for Analyses from Session One Session Four, Six and Eight. A Series of Repeated Measure MANOVAs with Polynomial Analyses (Linear, Quadratic and Cubic).

	Session One/Four		Session One/Six		Session One/Eight	
Session	Mean	sd	Mean	sd	Mean	sd
1	1.25	0.31	1.23	0.32	1.20	0.28
2	1.28	0.31	1.33	0.34	1.36	0.40
3	1.22	0.29	1.28	0.28	1.24	0.28
4	1.19	0.25	1.20	0.27	1.22	0.24
5			1.27	0.39	1.20	0.20
6			1.22	0.27	1.26	0.30
7					1.18	0.29
8					1.16	0.18
Repeated measure MANOVAs						
F		0.82		0.81		1.09
df		3,81		5,85		7,70
P		0.49		0.55		0.38
Linear, cubic and quadratic curve analyses						
Linear						
t		-1.40		-0.94		-1.72
p		0.17		0.36		0.12
Quadratic						
t		-0.66		-0.50		-1.47
p		0.17		0.62		0.17
Cubic						
t		0.57		0.80		0.51
p		0.52		0.62		0.62

Note: N's. S1 to S4, n = 28, S1 to S 6, n = 18, S1 to S8, n = 11. Higher scores on the Hindering Impacts sub-scale are associated with greater levels of negative evaluations of session impact.

Fig 9.5 Hindering Impacts: Session Means for Analyses from Session One to Sessions Four, Six and Eight.

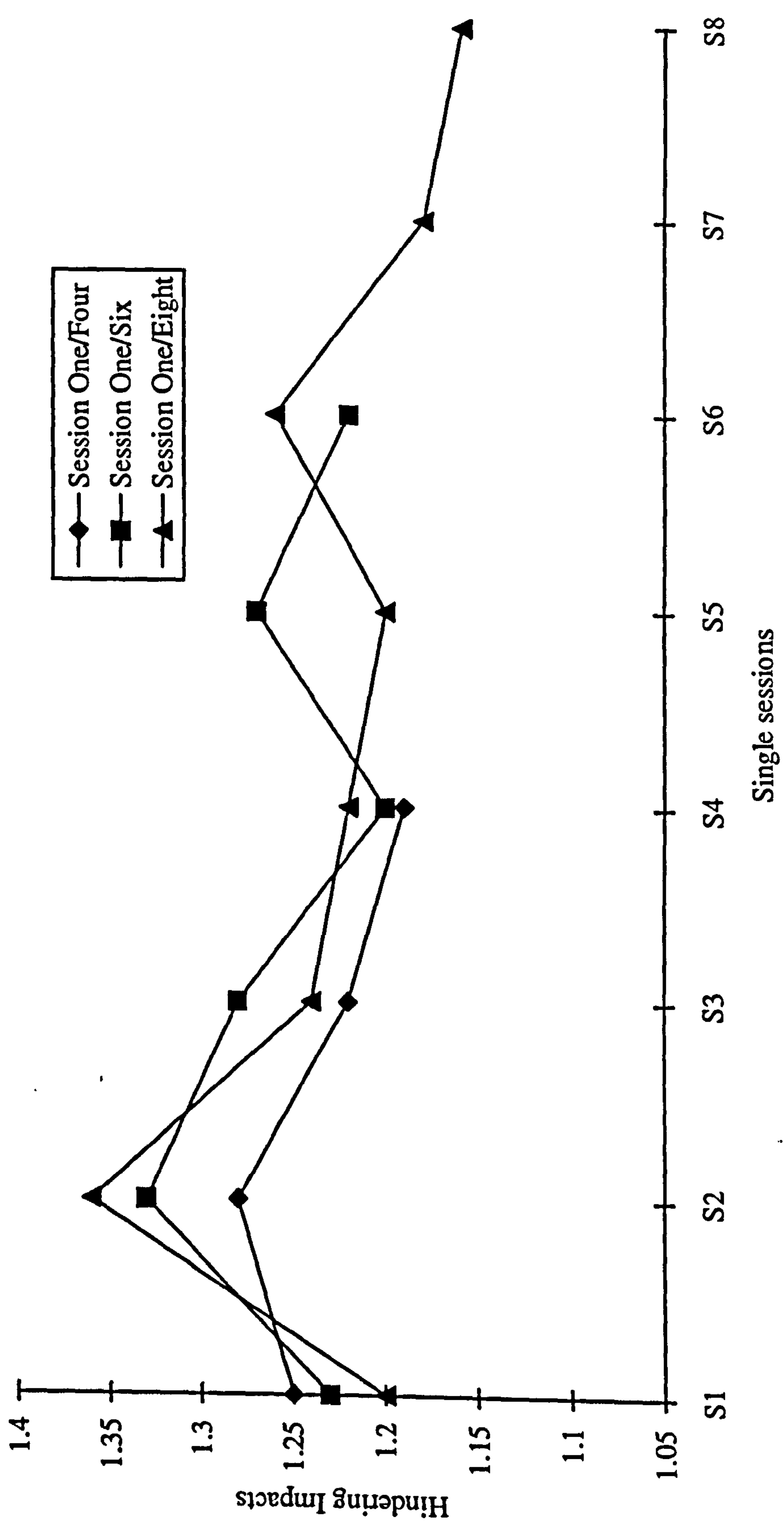
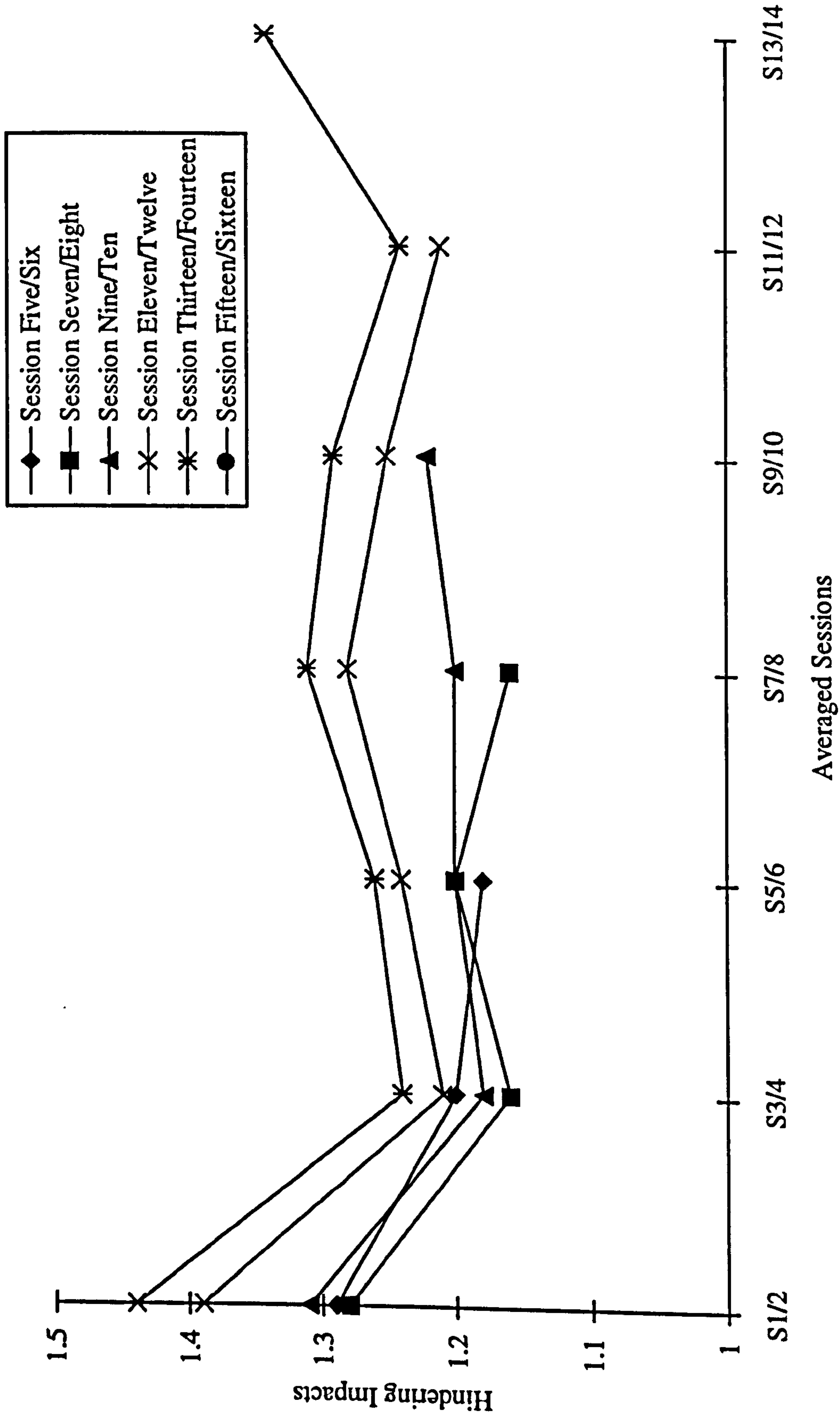


Table 9.7. Hindering Impacts: Session Means for Analyses from Sessions One/Two to Sessions Five/Six, Seven/Eight, Nine/Ten, Eleven/Twelve and Thirteen/Fourteen. A series of repeated measure MANOVAs, with polynomial analyses (Linear, Quadratic and Cubic).

Sessions	S1/2 to S5/6			S1/2 to S7/8			S1/2 to S9/10			S1/2 to S11/12			S1/2 to S13/14		
	Mean	sd		Mean	sd		Mean	sd		Mean	sd		Mean	sd	
S1/S2	1.29	0.24		1.28	0.24		1.31	0.27		1.39	0.28		1.44	0.25	
S3/S4	1.20	0.21		1.16	0.19		1.18	0.21		1.21	0.21		1.24	0.21	
S5/S6	1.18	0.25		1.20	0.20		1.20	0.18		1.24	0.19		1.26	0.20	
S7/S8				1.16	0.23		1.20	0.27		1.28	0.32		1.31	0.32	
S9/S10							1.22	0.28		1.25	0.28		1.29	0.29	
S11/S12										1.21	0.24		1.24	0.24	
S13/S14													1.34	0.31	
S15/S16															
Repeated measure MANOVAs and linear, quadratic and cubic curve analyses.															
F		4.31			3.67			1.46			1.36			1.32	
df		2,60			5,57			4,48			5,35			6,36	
P		0.02			0.02			0.23			0.26			0.27	
Linear															
t		-2.86			-2.47			-1.38			-1.96			-0.93	
p		0.01			0.02			0.19			0.09			0.39	
Quad															
t		0.94			1.23			1.89			1.26			1.78	
p		0.36			0.23			0.08			0.25			0.13	
Cubic															
t		n/a			-2.01			-0.73			-2.06			-1.44	
p		n/a			0.06			0.48			0.08			0.20	

Note: N's. S1 to S5/6, n = 31, S1 to S7/8, n = 20, S1 to S9/10, n = 14, S1 to S11/12, n = 8, S1 to S13/14, n = 7. Higher scores on the Hindering Impacts sub-scale are associated with greater levels of negative evaluations of session impact.

Fig 9.6 Hindering Impacts: Session Means for Analyses from Sessions One/Two to Sessions Five/Six, Seven/Eight, Nine/Ten, Eleven/Twelve and Thirteen/Fourteen.



9.9. Were There Increases Across Sessions in Client Ratings of Relationship Impacts

There were increases across sessions in client ratings of Relationship Impacts. With one or two exceptions, clients were more positive in their ratings of the relationship impacts at Sessions Two to Eight, than at Session One. They were generally more positive in their impact ratings from Session Three/Four to Fifteen/Sixteen, across all of the analyses, than at Session One/Two.

Single session analyses are presented in Table 9.8 and Fig 9.7. Averaged session analyses are presented in Table 9.9 and Fig 9.8.

9.9.1. Analyses Across Single Sessions:

Three sets of analyses were run. These were from Session One to Sessions Four ($n = 28$), Six ($n = 18$) and Eight ($n = 11$).

For the Session One/Four analysis, clients were more positive in rating Relationship Impacts at Session Four, than at Session One. There were successive increases, across sessions, from Session One (3.54) to Sessions Two (3.89), Three (3.89) and Four (4.13). This increase was significant ($F = 3.80$, $df = 3, 78$, $p = .013$).

9.9.2. Analyses Across Averaged Occasions:

Six separate analyses were run. These were from Sessions One/Two to Sessions Five/Six ($n = 32$), Seven/Eight ($n = 21$), Nine/Ten ($n = 14$), Eleven/Twelve ($n = 9$), Thirteen/Fourteen ($n = 8$) and Fifteen/Sixteen ($n = 8$). Averaged sessions are abbreviated. The average of Sessions One and Two becomes S1/S2 and the average of Sessions Three and Four becomes S3/S4.

There was a consistent pattern of increases from S1/S2 to S3/S4 for the Sessions Five/Six (from 3.63 to 3.97), Seven/Eight (from 3.62 to 3.98), Nine/Ten (from 3.79 to 4.05), Eleven/Twelve (from 3.64 to 3.89), Thirteen/Fourteen and Fifteen/Sixteen (both from 3.53 to 3.84) analyses.

Increases in client ratings of relationship impact were significant for the Sessions Five/Six analysis ($F = 4.09$, $df = 2, 62$, $p = .021$). Increases approached significance for the Sessions

Seven/Eight ($t = 1.73$, $df = 3$, 60 , $p = .171$), Nine/Ten ($t = 1.98$, $df = 4$, 52 , $p = .111$), Eleven/Twelve ($t = 2.08$, $df = 5$, 40 , $p = .088$), Thirteen/Fourteen ($t = 1.91$, $df = 6$, 42 , $p = .101$) and Fifteen/Sixteen ($t = 1.97$, $df = 7$, 49 , $p = .079$) analyses.

9.9.3. What were the Components of the Relationship Impact Change Curves

There was evidence for linear and quadratic components for single session analyses and for linear, quadratic and cubic components for the averaged session analyses.

a. Single Sessions:

The Session One/Four analysis exhibited a continuous, though decelerating change curve with increases, in absolute terms, becoming smaller across successive sessions. This pattern of change is mirrored, in analyses, by significant statistical support for linear ($t = 3.13$, $p = .01$) and quadratic ($t = -2.96$, $p = .01$) trends.

There was near significant support for a quadratic component for a quadratic component to the One/Eight ($t = -1.87$, $p = .094$) change curve. This can be attributed to the the first bend in the curve at Session Two where the reduction from Session one to Two becomes an increase from Two to Four.

b. Averaged Sessions:

There was near-significant statistical support for a linear ($t = 1.86$, $p = 0.07$) trend and significant support for a quadratic trend ($t = -2.20$, $p = 0.04$) for the Session Five/Six analysis. The linear trend is a reflection of the increase from Session One to Session Two in scores on the Relationship Impacts sub-scale, whilst the quadratic component is related to the bend at S3/S4.

There was significant support, however, for a cubic trend for the Sessions Nine/Ten ($t = 2.47$, $p = 0.03$) analysis and near significant support for the Sessions Eleven/Twelve ($t = 1.84$, $p = 0.10$) and Fifteen/Sixteen ($t = -2.12$, $p = 0.07$) analyses. The cubic trends are associated with bends in the change curves at Sessions Seven/Eight, with reductions in ratings of relationship impacts becoming increases in ratings.

Table 9.8. Relationship Impacts: Session Means for Analyses from Session One to Sessions Four, Six and Eight. A series of repeated measure MANOVAs, with polynomial (linear, quadratic and cubic) analyses.

	Session One/Four		Session One/Six		Session One/Eight	
Session	Mean	sd	Mean	sd	Mean	sd
1	3.54	0.90	3.68	0.97	4.00	1.00
2	3.89	0.96	3.68	0.98	3.85	1.00
3	4.06	0.71	3.91	0.82	4.15	0.41
4	4.13	0.87	4.15	0.88	4.20	0.68
5			3.71	0.94	4.05	0.83
6			3.82	0.88	3.80	1.03
7					4.05	1.17
8					3.70	1.06
Repeated measure MANOVAs						
F		3.80		1.36		0.65
df		3,78		5,80		7,63
P		0.01		0.25		0.65
Linear, cubic and quadratic curves analyses						
Linear						
t		3.13		0.79		-0.91
p		0.01		0.18		0.39
Quadratic						
t		-2.96		-1.39		-1.87
p		0.01		0.18		0.09
Cubic						
t		0.17		-0.21		-0.05
p		0.87		0.84		0.96

Note: N's. S1 to S4 = 27, S1 to S6, n = 17, S1 to S8, n = 10. Higher scores are associated with greater positive ratings of the Relationship Impacts of Counselling Sessions.

Fig 9.7 Relationship Impacts: Session Means for Analyses from Session One to Sessions Four, Six and Eight.

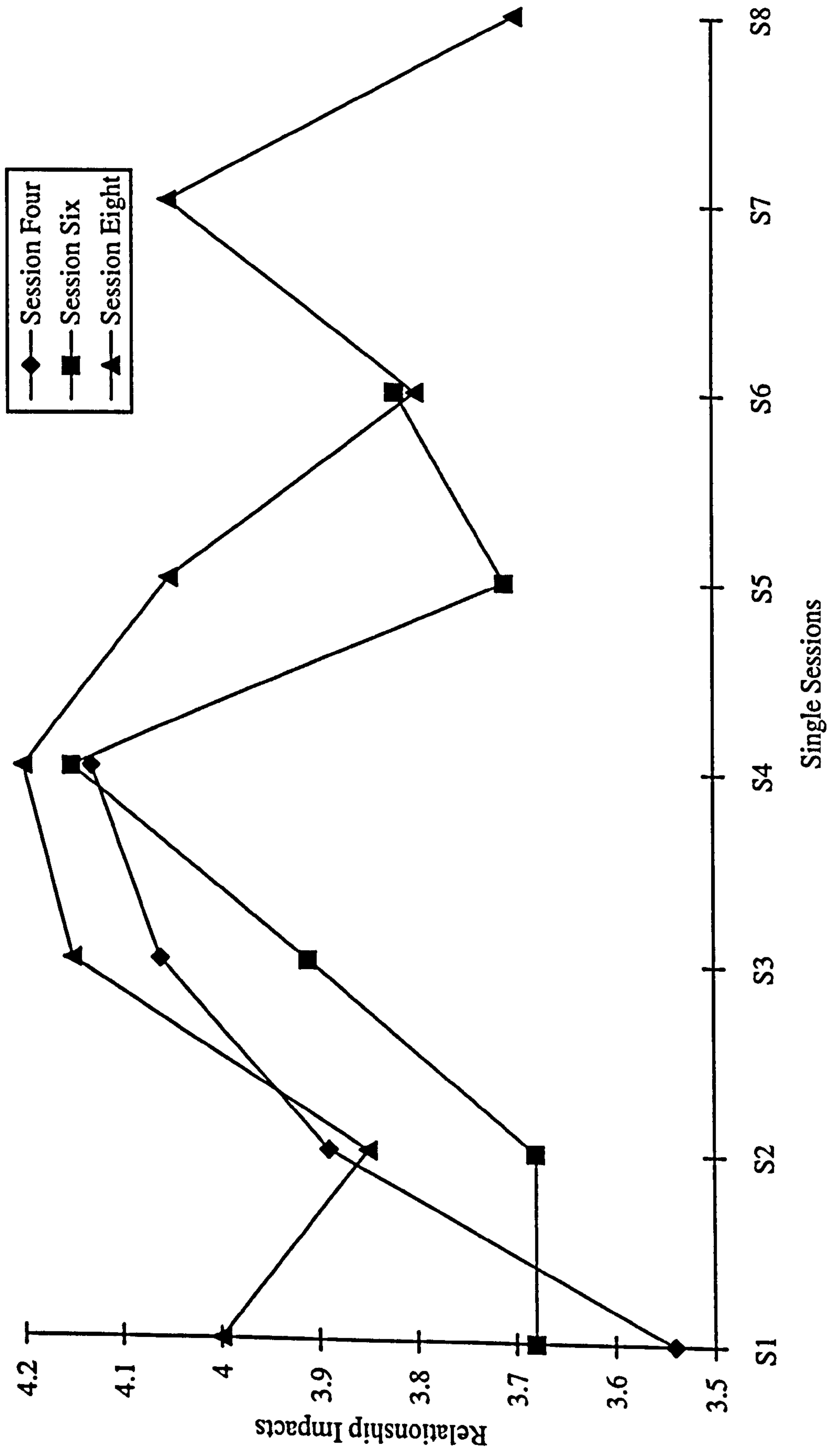


Table 9.9. Relationship Impacts: Session Means for Analyses from Sessions One/Two to Session Five/Six, Seven/Eight, Nine/Ten, Eleven/Twelve, Thirteen/Fourteen and Fifteen/Sixteen. A Series of Repeated Measure MANOVAs, with Polynomial Analyses (Linear, Quadratic and Cubic).

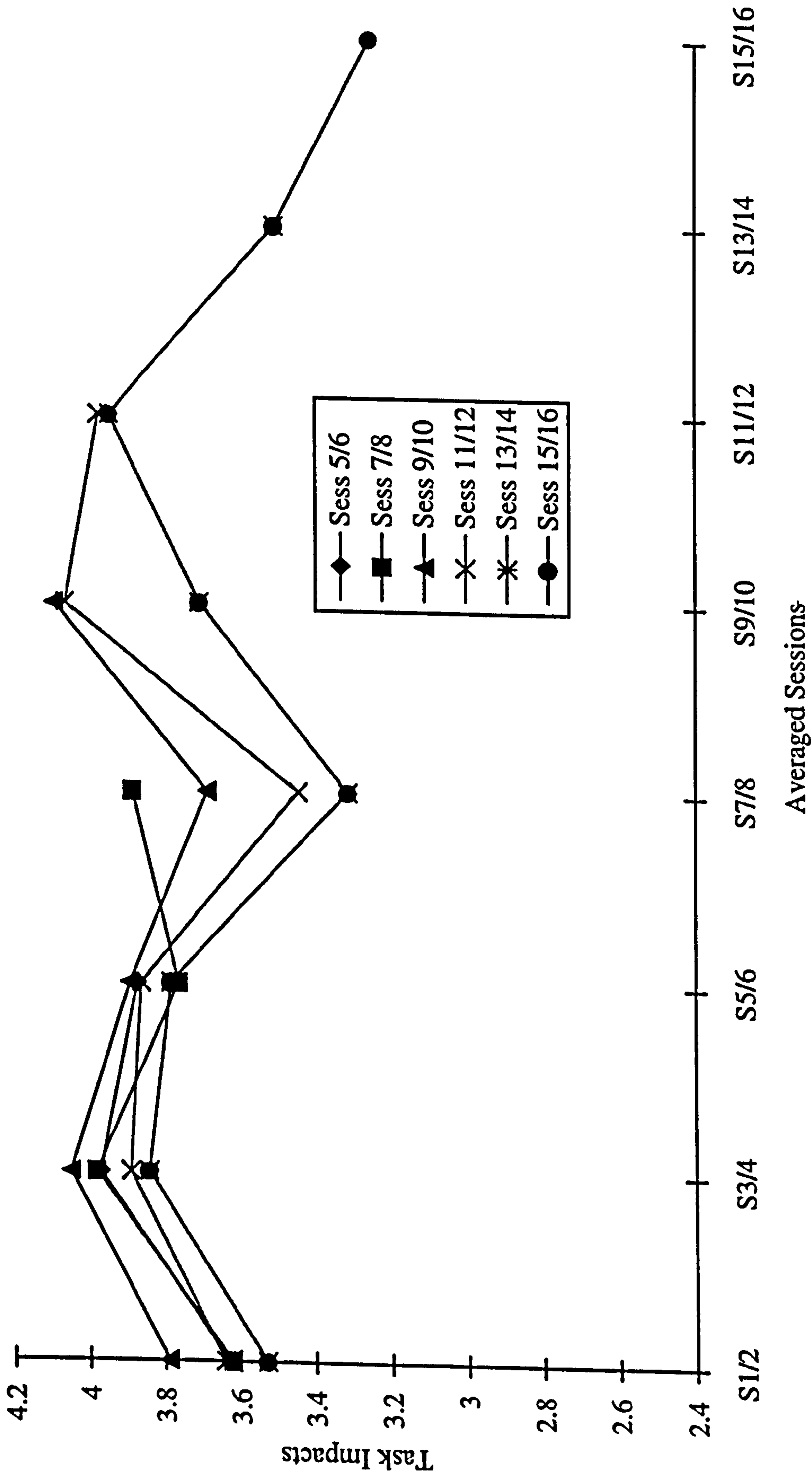
	S1/2 to S5/6		S1/2 to S7/8		S1/2 to S9/10		S1/2 to S11/12		S1/2 to S13/14		S1/2 to S15/16	
Sessions	Mean	sd	Mean	sd	Mean	sd	Mean	sd	Mean	sd	Mean	sd
S1/2	3.63	0.84	3.62	0.86	3.79	0.87	3.64	0.87	3.53	0.86	3.53	0.86
S3/4	3.97	0.66	3.98	0.72	4.05	0.56	3.89	0.57	3.84	0.60	3.84	0.60
S5/6	3.87	0.71	3.76	0.78	3.89	0.79	3.86	0.73	3.78	0.74	3.78	0.74
S7/8			3.88	1.00	3.68	0.97	3.44	0.95	3.31	0.92	3.31	0.92
S9/10					4.09	0.62	4.06	0.50	3.70	0.45	3.70	0.45
S11/12							3.97	0.51	3.94	0.53	3.94	0.53
S13/14									3.50	0.95	3.50	0.95
S15/16											3.25	1.13

Repeated measure MANOVAs and linear, quadratic and cubic curve analyses.

F	4.09	1.73	1.98	2.08	1.91	1.97
df	2,62	3,60	4,52	5,40	6,42	7,49
P	0.02	0.17	0.11	0.09	0.10	0.08
Linear						
t	1.86	1.08	0.70	1.38	0.37	-0.80
P	0.07	0.29	0.86	0.20	0.72	0.45
Quad						
t	-2.20	-1.06	0.86	1.05	-0.79	-1.42
P	0.04	0.30	0.40	0.33	0.46	0.20
Cubic						
t	n/a	-1.06	2.47	1.84	-0.88	-2.12
P		0.11	0.03	0.10	0.41	0.07

Note: N's. S1 to S5/6, n = 32, S1 to S7/8, n = 21, S1 to S9/10, n = 14, S1 to S11/12, n = 9, S1 to S13/14, n = 8, S1 to S15/16, n = 8. Higher scores are associated with greater positive ratings of the Relationship Impacts of Counselling Sessions.

Fig 9.8. Relationship Impacts: Session Means for Analyses from Sessions One/Two to Sessions Five/Six, Seven/Eight, Nine/Ten, Eleven/Twelve, Thirteen/Fourteen and Fifteen/Sixteen.



9.10. Were there Increases in Client Ratings of the Task Impacts of Counselling

Clients were more positive about Task Impacts of counselling at later sessions (e.g. Session One and Sessions Three/Four), than at Session One and Sessions One/Two. Increases were consistent across all the single and averaged session analyses. Increases were significant for all of the single session analyses and for five of the six averaged session analyses, with the sixth approaching significance.

Analyses are presented in Table 9.10 and Fig 9.7 for the single session analyses, with averaged session analyses in Table 9.11 and Fig 9.8.

9.10.1. Analyses Across Single Sessions

Three sets of analyses were run. These were from Session One to Sessions Four ($n = 27$), Six ($n = 17$) and Eight ($n = 10$).

Clients became more positive in rating Task Impacts on the Session One/Four analysis. There were successive increases from Session One (2.64) to Sessions Two (3.01), Three (3.26) and Four (3.57). With all of the ratings for Session Two to Four being greater than at Session One, the increase was significant ($F = 13.37$, $df = 3, 84$, $p = .000$).

For the Session One/Six analysis, there were successive increases from Session One (2.49) to Sessions Two (2.69), Three (3.17) and Four (3.48). There was then a reduction to Session Five (3.18) before an increase to Session Six (3.28). All of the scores from Sessions Two to Six were greater than at Session One. This increase was significant ($F = 6.75$, $df = 5, 80$, $p = .000$).

For the Sessions One/Eight analysis, clients were, with the exception of Session Two (2.46), greater positive in their Task Impact ratings across sessions, than at Session One (2.60). There were then successive increases from Session Two to Sessions Three (3.06), Four (3.26) and Five (3.30), then a decrease to Six (2.96) before increases to Seven (3.32) and Eight (3.28). This increase was significant ($F = 3.45$, $df = 7, 63$, $p = .003$).

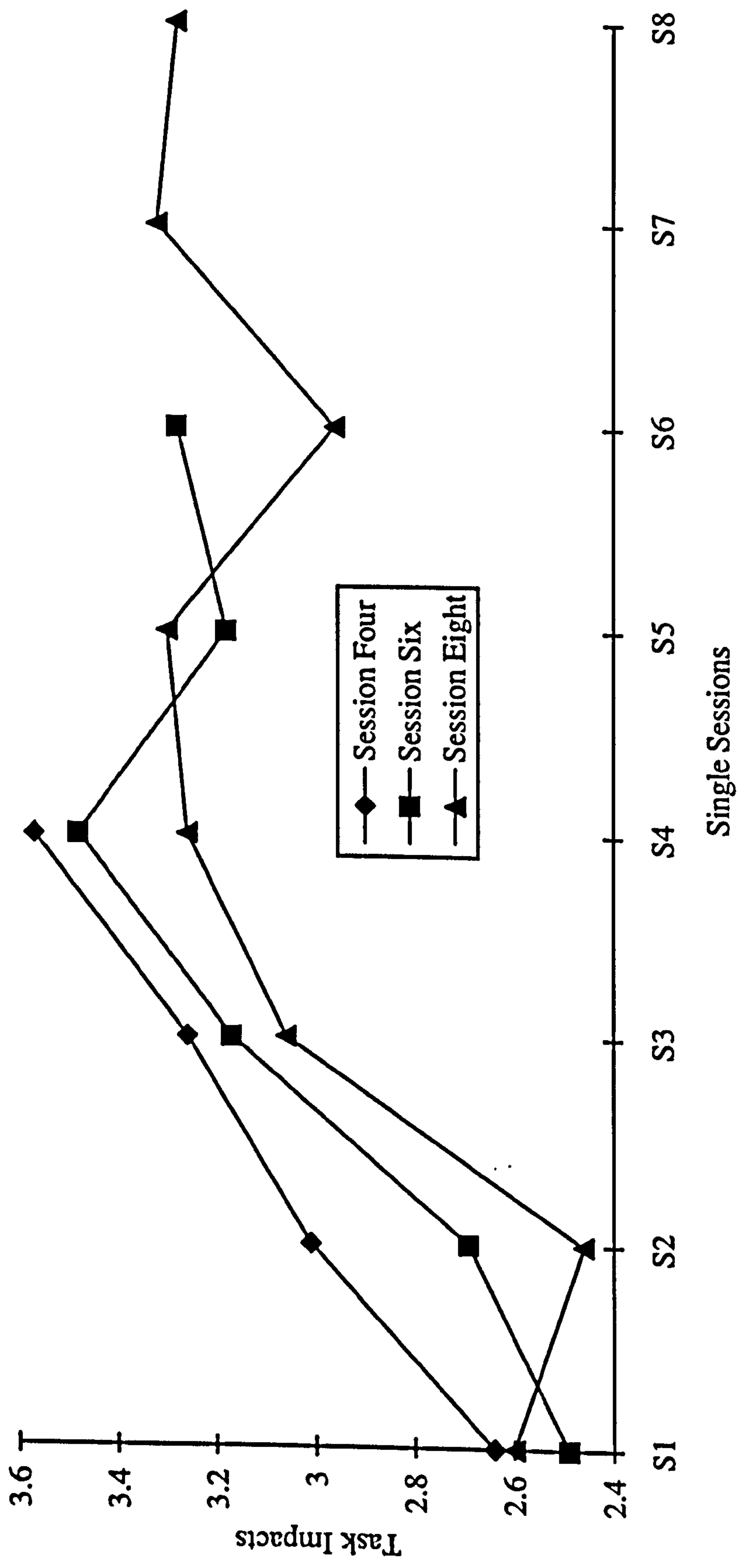
Table 9.10. Task Impacts: Session Means for Analyses from Session to Session Four, Six and Eight. A Series of Repeated Measure MANOVAs, with Polynomial Analyses (Linear, Quadratic and Cubic).

	Session One/Four		Session One/Six		Session One/Eight	
Session	Mean	sd	Mean	sd	Mean	sd
1	2.64	0.86	2.49	0.91	2.60	0.99
2	3.01	0.88	2.69	0.78	2.46	0.82
3	3.26	0.67	3.17	0.70	3.06	0.73
4	3.57	0.79	3.48	0.86	3.26	0.71
5			3.18	0.89	3.30	0.73
6			3.28	0.95	2.96	0.80
7					3.32	0.98
8					3.28	1.01
Repeated measure MANOVAs						
F		13.37		6.75		3.45
df		3,84		5,80		7,63
P		0.000		0.00		0.01
Linear, cubic and quadratic curve analyses						
Linear						
t		5.53		4.68		2.46
p		0.00		0.00		0.04
Quadratic						
t		0.24		-3.37		-2.23
p		0.82		0.04		0.05
Cubic						
t		0.48		-0.29		0.40
p		0.633		0.77		0.70
Note: N's. S1 to S4 = 27, S1 to S6, n = 17, S1 to S8, n = 10. Higher scores are associated with greater positive ratings of the Task Impacts of counselling sessions.						

9.10.2. Analyses Across Averaged Sessions

Five separate analyses were run. These were from Sessions One/Two to Sessions Five/Six (n = 32), Seven/Eight (n = 22), Nine/Ten (n = 14), Eleven/Twelve (n = 9), Thirteen/Fourteen (n = 8) and Fifteen/Sixteen (n = 8). Individual averaged sessions are abbreviated in the text. For example the Session One/Session two pairing becomes S1/S2 and the Session Three/Session Four pair becomes S3/S4.

Fig 9.9 Task Impacts: Session Means for Analyses from Session One to Sessions Four, Six and Eight.



For the Sessions Five/Six analysis, there was an increase in client ratings of Task Impacts from S1/S2 (2.71) to S3/S4 (3.40). This increase in was significant ($F = 20.36$, $df = 2, 62$, $p = .000$).

There was an increase in ratings of Task Impacts, on the Sessions Seven/Eight analysis from S1/S2 (2.53) to S3/S4 (3.33). There was then a further increase from S5/S6 (3.26) to S7/S8 (3.55). The increase, with S3/S4 to S7/S8 ratings being greater than S1/S2 ratings, was significant ($F = 16.89$, $df = 3, 63$, $p = .000$).

For the Sessions Nine/Ten analysis, there was an increase from S1/S2 (2.61) to S3/S4 (3.23). All of the ratings of Task Impact from S3/S4 to S7/S8 were greater than at S1/S2. The increase was significant ($F = 4.96$, $df = 4, 52$, $p = .002$).

There was an increase in ratings of Task Impacts on the Sessions Eleven/Twelve analysis from S1/S2 (2.47) to S3/S4 (3.22). Impact ratings from S3/S4 to S11/S12 were greater than the S1/S2 rating. This increase was significant ($F = 2, 62$, $df = 5, 40$, $p = .038$).

For the Sessions Thirteen/Fourteen analysis, there was an increase from S1/S2 (2.41) to S3/S4 (3.24). Scores from S3/S4 to S13/S14 were all greater than the S1/S2 score. This increase in ratings was significant ($F = 2.85$, $df = 6, 42$, $p = .020$).

Clients were more positive, on the Sessions Fifteen/Sixteen analysis, in their ratings of Task Impacts from S3/S4 to S15/S16 (3.24 to 3.99) than at S1/S2 (2.41). This increase in Task Impact ratings approached significance ($F = 1.99$, $df = 7, 49$, $p = .076$).

9.10.3. What were the Components of the Change Curves

There was support for linear, quadratic and cubic trends as components of the single and averaged session analyses.

Table 9.11. Task Impacts: Session Means for Analyses from Session One/Two to Sessions Five/Six, Seven/Eight Seven/Eight, Nine/Ten, Eleven/Twelve, Thirteen/Fourteen and Fifteen/Sixteen. A Series of Repeated Measure MANOVAs, with Polynomial Analyses (Linear, Quadratic and Cubic).

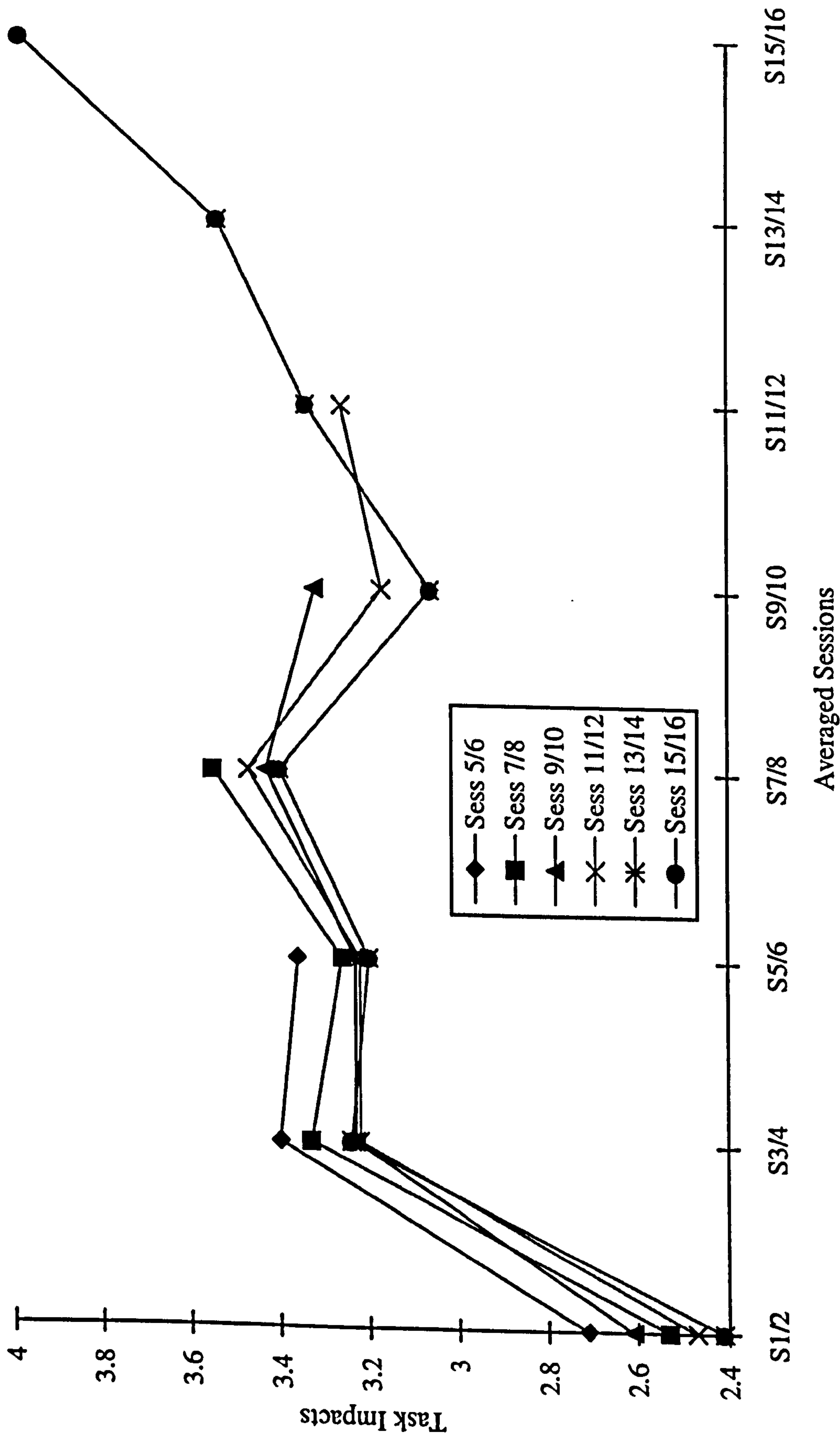
Sessions	S1/2 to S5/6		S1/2 to S7/8		S1/2 to S9/10		S1/2 to S11/12		S1/2 to S13/14		S1/2 to S15/16	
	Mean	sd	Mean	sd	Mean	sd	Mean	sd	Mean	sd	Mean	sd
S1/2	2.71	0.90	2.53	0.81	2.61	0.91	2.47	0.96	2.41	1.01	2.41	1.01
S3/4	3.40	0.68	3.33	0.74	3.23	0.76	3.22	0.80	3.24	0.86	3.24	0.86
S5/6	3.36	0.79	3.26	0.84	3.23	0.84	3.22	0.83	3.20	0.88	3.20	0.88
S7/8			3.55	1.03	3.43	0.98	3.47	0.98	3.40	1.02	3.40	1.02
S9/10					3.32	0.81	3.17	0.73	3.06	0.70	3.06	0.70
S11/12							3.26	0.69	3.34	0.69	3.34	0.69
S13/14									3.54	0.48	3.54	0.48
S15/16											3.99	1.01

Repeated measure MANOVAs and linear, quadratic and cubic curve analyses.

F		20.36		16.80		4.96		2.62		2.85		1.99
df		2,62		3,63		4,52		5,40		6,42		7,49
P		0.00		0.01		0.01		0.04		0.02		0.08
Linear												
t		4.70		4.85		2.72		1.94		2.37		1.46
p		0.01		0.01		0.02		0.09		0.05		0.19
Quad												
t		-4.14		-2.79		-2.17		-1.94		-1.01		-1.31
p		0.00		0.01		0.05		0.09		0.34		0.23
Cubic												
t		n/a		3.16		1.09		1.22		3.45		1.04
p		n/a		0.01		0.30		0.26		0.01		0.33

Note: N's. S1 to S5/6, n = 32, S1 to S7/8, n = 22, S1 to S9/10, n = 14, S1 to S11/12, n = 9, S1 to S13/14, n = 8, S1 to S15/16, n = 8. Higher scores on the Task Impacts sub-scale are associated with more positive ratings of the Task Impacts of counselling sessions.

Fig 9.10 Task Impacts: Session Means for Analyses from Sessions One/Two to Sessions Five/Six, Seven/Eight, Nine/Ten, Eleven/Twelve, Thirteen/Fourteen and Fifteen/Sixteen.



a. Single Sessions

For the Session One/Four analysis, there was significant support for a linear trend ($t = 5.53$, $p = .000$), a reflection of successive increases across sessions of counselling.

For the Sessions One/Six analysis, there was statistical support for both linear ($t = 4.68$, $p = .000$) and quadratic trends ($t = -3.66$, $p = .004$). The linear trend was a reflection of the increases in task ratings from Session One to Session Four, the quadratic trend a reflection of the bend at Session Four, with a reduction to Session Five.

For the Session One/Eight change curve, there was support for linear ($t = 2.46$, $p = .036$), a reflection of the increase in ratings from Sessions Two to Five and near significant support for a quadratic component ($t = -2.34$, $p = .053$). The quadratic component can be attributed to the bend at Session Two.

b. Average Sessions

There was a consistent pattern of increases from Session One/Two to Three/Four across all of the analyses. This is reflected, in statistical terms, in significant support for linear components to the Sessions Five/Six ($t = 4.70$, $p = .000$), Seven/Eight ($t = 4.85$, $p = .000$), Nine/Ten ($t = 2.72$, $p = .017$) and Thirteen/Fourteen ($t = 2.37$, $p = .049$) analyses, with near significant support for a linear trend for the Sessions Eleven/Twelve ($t = 1.94$, $p = .088$) change curve.

There was also a consistent pattern of significant and near significant statistical support for a quadratic trend. In terms of the change curve (see Fig 9.10) this can be translated into a bend at Sessions Three/Four, with the increase from S1/S2 to S3/S4 becoming a plateau until S5/S6. There was significant statistical support for a quadratic trend for the Sessions Five/Six ($t = -4.14$, $p = .000$), Seven/Eight ($t = -2.79$, $p = .011$) and Nine/Ten ($t = -2.17$, $p = .050$) analyses, with near significant support for the Eleven/Twelve ($t = -1.96$, $p = .086$) analysis.

There was also statistical support for a cubic trend, which can be linked to a second bend at S5/S6, with a plateau in the scores being replaced by an increase. Support was significant for a cubic component for the Sessions Seven/Eight ($t = 3.16$, $p = .01$) and Thirteen/Fourteen ($t = 3.45$, $p = .01$) analyses.

9.11. Chapter Summary

Analyses indicate support for hypotheses. As expected, there were increases in client ratings of the positive impacts of counselling, reductions in negative ratings (e.g. Hindering Impacts) and a reduction in client distress. Many of these reductions and increases were statistically significant.

Changes, from pre-counselling to post-intervention, were the strongest, and at their most consistent, for client distress and for ratings of task impacts. They were at their weakest for ratings of the hindering, relationship and global ratings of session impacts.

Substantive changes occurred early sessions of counselling, with some evidence of deterioration and session-to-session fluctuations for later sessions of counselling. This pattern of change was supported by statistical evidence for linear, quadratic and cubic components to change curves.

Chapter Ten: Service Evaluation

10.1. Introduction

In contrast to the previous chapters, Chapter Ten focuses on service evaluation, rather than counselling outcome. An analysis of feedback provided by clients through answering a series of service evaluation questions is presented.

10.1.1. The Rationale for Including a Qualitative Component in the Study

The quantitative methodologies have traditionally dominated psychological research. This domination has been underpinned by criticism that has centred on the supposed flaws of qualitative approaches. Two of the more commonly cited criticisms have been that qualitative methodologies, in comparison to quantitative approaches, lack rigour and replicability (Denzin and Lincoln, 1994, Robson, 1993). This in part reflects the weaknesses of the human analyst. A list of these weaknesses is presented in Table 10.1.

Recently, the limitations of a purely quantitative approaches has become increasingly evident, which in part results from growing disillusionment with the extent to which questionnaires and laboratory based methodologies have supported attempts to understand the processes that underpin social phenomena (Denzin and Lincoln, 1994). Whilst quantitative approaches are seen to

"...emphasise the measurement and analysis of causal relationships between variables, [and] not process"

Qualitative methodologies

"stress[es] the socially constructed nature of reality, the intimate relationships between the researcher and what is studied, and the situation constraints that shape inquiry"

Denzin and Lincoln (1994, p.4.)

Table 10.1. Deficiencies of the Human Analyst.	
1	<i>Data Overload:</i> A limit on the amount that can be processed at any one time.
2	<i>First Impressions:</i> Initial analyses lead to first impressions that are difficult to revise.
3	<i>Information Availability:</i> Information that is difficult to obtain becomes less salient.
4	<i>Positive Instances:</i> Tendency to ignore information that contradicts hypotheses and greater acceptance of confirmatory data.
5	<i>Internal Consistency:</i> Tendency to discount the novel and the unusual.
6	<i>Uneven Reliability:</i> Some sources are less reliable than others. This fact is often ignored.
7	<i>Missing Information:</i> Incomplete data sets are devalued.
8	<i>Revision of Hypotheses:</i> Tendency to over or under-react to new information. confidence in one's judgement.
9	<i>Fictional Base:</i> Tendency to compare with a base or average when no base data is available.
10	<i>Confidence in Judgement:</i> Over-confidence in one's judgement.
11	<i>Co-occurrence:</i> Tends to be interpreted as strong evidence.
12	<i>Inconsistency:</i> Repeated evaluations of the same data set tend to differ.

At the same time, there have been improvements in qualitative methodologies, with considerable effort being invested into developing more systematic and rigorous techniques. These improvements have helped to make these approaches more attractive and have aided their adoption by psychologists.

In response to the criticisms that have been levelled at qualitative approaches, there have moves towards developing more systematic approaches to the analysis of qualitative data.

Without such an approach, the fallibilities of the human analyst, that have been listed in Table 10.1, are such that there would be distinct difficulties with the reliability and validity of any conclusions that could be drawn from the data and its analysis. Quantitative methodologies are also vulnerable to the same human analytical deficiencies: However, quantitative methods have developed something of a lead in terms of the sophistication of the methods employed to minimise the threats to the validity and to the reliability of findings.

There have been attempts to develop methodologies that are comparable, in rigour, to methodologies such as the quasi-experimental approaches (Campbell, 1989). One of these has been the development of quasi-judicial approach to qualitative data collection and analysis. This approach has been developed by Bromley (1986, see Robson, 1993).

10.1.2 The 'Quasi-Judicial Approach

This is an attempt to minimise the impact of the various validity threats and to maximise methodological rigour. This framework, during any qualitative analysis, attempts to answer four questions:

- (1) What is at issue?
- (2) What other relevant evidence might there be?
- (3) How else might one make sense of the data?
- (4) How were the data obtained?

The 'quasi-judicial' approach provides a number of 'tools', in the form of sets of procedural steps and rules, that should be followed during the analytic process.

The 'quasi-judicial' approach attempts to maximise the chances of the development of a logically coherent, evidence based explanation that is derived from the analysis of any set of collected data. Validity is constantly checked through a process of continuously checking and rechecking the data against various criteria, throughout the analytic process. What hopefully emerges, is the most coherent and valid of the available alternative explanations of the patterns that exist within the data.

The first procedural steps are that the researcher should, first of all, clearly state the initial problems and issues, secondly, collect appropriate background information to develop an analytic context within which the meaning can be given to the data, thirdly, suggest prima facie explanations and solutions to the problems and issues (effectively a first 'model'. The development of this will be dependent on the amount of information) and, fourth, to use this first model to guide the search for additional credible (admissible) information.

Step five is about seeking evidence to eliminate alternative explanations, which parallels a process of 'cross-examining' the evidence to investigate its consistency and accuracy. This phase is then followed by critically evaluating the logic and external validity of arguments, which results in selecting the interpretation that is most compatible with the evidence. The implications of a final explanatory model are then examined before a final report is made on the research.

10.1.3. Analytic Strategies

At the start of the research process, there is a need to select an appropriate analytic strategy. The selection will be dependent on the body of knowledge that exists, theory, existing models and research questions, the available methodologies, the control that the researcher has over the environment and whatever practical limitations exist, that are specific to the context under consideration. Robson list three possible

The initial orientation towards the research process can adopt one of three analytic approaches (Robson, 1993): Theoretical propositions; Explanation building and Data exploration. The first strategy, Theoretical Propositions, is employed if the researcher has a theory that he, or she, wishes to employ to generate hypotheses, which will then be tested. The second strategy, Explanation Building, begins with a series of hypotheses which are revised on the basis of continued data collection and analysis, whilst the third approach, Data Exploration, identifies various themes from the data and then attempts to build these themes up into a descriptive framework. The final strategy is most appropriate when there is little theory or literature upon which to generate hypotheses. It does not mean that there won't be any research questions, but it does mean that there are unlikely to be any hypotheses to test.

10.2. Methodology

The selection of research questions was based loosely around discussion with colleagues and prior service users. These service users had used the Site One service (and were accessed through the interviews that have been described in Chapter Four) and the users of services other than Site One.

10.2.1. Procedure

Participants were sent an evaluation questionnaire, which is fully described in Chapter Five. This questionnaire was sent to participants at the end of counselling and, where appropriate because of the issue of missing data, at follow-up. Additional information was collected through the 'Other Comment' page that was included in all five study questionnaires.

The evaluation questionnaire included twenty-two items: Fourteen closed and eight open. Many of the open-ended questions followed-up client responses to the closed items. Questions addressed topics such as: Prior experience of counselling; service accessibility; the advantages and disadvantages of a work-site based counselling service, the reasons for going to counselling, their expectations, perceived benefits, whether they would use the service again and whether they would suggest its use to distressed colleagues.

10.2.2. Analyses

Responses to the closed questions are presented in Section Two. Section Three presents an analysis of the responses to the open ended questions and the information provided in the 'Other Comment' pages. Section Four addresses a single question as to whether there were any differences or similarities between Sites One and Two. Section Five examines the quantitative and qualitative 'accounts' of clients with a view to establishing whether these accounts coincided.

10.3. Section Two: Closed Questions

The majority of closed questions demanded either a 'Yes' or 'No' answer. Responses are presented in Table 10.2. The number of clients who responded to each question varied from item-to-item.

10.3.1. Prior Experience of Counselling, Service Access and Future Service Use

Five questions are addressed by this first sub-section: (1) If clients had prior experience of help-seeking, were had they accessed this help from? (2) Have participants had any training in counselling skills?; (3) Do participants use counselling skills at work?; (4) Have clients had any problems accessing the service? and (5) Will clients use the counselling service again?

The majority of participants (see Table 10.2) had previously sought help. Four clients had previously attended a work-site based service, two had used another 'face-to-face' service, five had used a telephone based service, six had sought help from their GPs, one from a psychiatrist and eleven had accessed help from more than one source.

Thirty clients reported that they used counselling skills at work. Fourteen clients reported having received any kind of formal training in these skills.

Five (out of 35) clients reported difficulties in accessing counselling. The majority of clients (32 out of 35) stated they would access counselling again. Twenty-three clients reported a preference for the in-house service. All 35 respondents would suggest service use to a colleague and twenty-three had already done so.

Question	Yes	No
Prior Experience of Help-Seeking?	29	21
Training in counselling skills?	14	36
Do you use Counselling Skills at Work?	30	20
Did you have problems accessing counselling?	5	30
Would you use the service again?	32	3
Would you use an alternative service?	12	23
Suggest Service Use to a Colleague	35	0
Have you already done so?	23	11

The majority of service clients have had prior experience of accessing some form of help, before the current episode of help-seeking. The majority of clients use counselling skills at work, although the majority also indicated that they have not received any formal training in

counselling. This means that the majority of clients, who use skills at work, have had no training in these skills. A minority of clients reported some difficulty in accessing the service. It is possible to imply, from the figures, that clients were reasonably satisfied with the counselling service, since the majority stated that they would use the service again, all of them would suggest its use to a colleague and, in fact, most of them had already done so.

10.3.2. How did Clients find out about Counselling?

Clients accessed information about the counselling service through several sources of publicity. These sources were (with the number of clients in brackets): posters (n = 4); 'word of mouth' (n = 2); staff newspapers (n = 3); personnel (n = 1); leaflets (n = 2); line-managers (n = 5); 'other sources' (n = 4) and more than one source of publicity (n = 14). Twenty-one clients wrote that they thought that the extent of publicity was inadequate.

10.3.3. Client Referral and Suggested Service Use:

Two questions are addressed: (1) Did anybody refer clients to the counselling service and (2) Did anybody suggests to clients that they should use the counselling service.

Most clients discussed service with at least one other person. Six clients reported having been referred by line managers, five by occupational health, two by 'other' managers and fifteen by more than one person.

There were a number of sources of suggested service use. These sources were: Line-managers (n = 9); Occupational health (n = 2); Other managers (n = 1); Family (n = 5); Friends (n = 2) and more than one influence (n = 10). Two clients reported experienced some pressure, from others, to access the counselling service. However, 32 clients reported being fully supported in their decision to attend.

There was a difference between the number of clients who answered 'Yes' to global (e.g. 'Yes' or 'No') questions about referral and suggestion and questions which were more specific (e.g. that asked about the specific source of referral or suggestion). There was a consistent pattern of more clients answering in the positive to the specific, than to the global questions. This suggests confusion on the part of clients when answering these items. For the global referral question, thirteen reported having been referred. However, 28 clients reported referral in response to the specific item. There was a similar gap between general

and specific questions about suggested service use, with 19 clients, on the global question, indicating suggested use and 31 clients identified suggested use on the specific question.

Figures suggest that the majority of clients had discussed the option of accessing the counselling service with at least one person.

10.4 Open-ended Questions and Other Comments

As already noted, qualitative data was collected through client responses to questionnaire items and the 'Other Comment' sections of each of the study questionnaires. Questions are presented as headings, with client responses to each question categorised under a series of sub-headings. Clients are identified in brackets with 'P' signifying Site One clients and 'N', the Site Two clients.

10.4.1 Counselling Skills at Work. For What?

Clients reported using counselling skills for a variety of reasons and in a variety of contexts. Responses to questions are categorised under four themes: Patients; Relatives; Staff and General.

With patients, clients used counselling skills to communicate with patients, to help them to accept their illness (P1), to maximise treatment compliance (P26), to explain medical procedures (N7; N9), to allow patients to express their fears (N7), for patient assessment (N9), to ensure a professional interaction (N12) and good patient communication (P38; N14; N18).

Skills were used with relatives to deal with bereavement issues (P15; N7) and to communicate with them in general terms (N9; N16), whilst they were employed skills with staff to deal with issues of absenteeism and lateness (P21, P23, P12, N3) and to support distressed colleagues (N9). Finally, participants (P40, N9, N14) described their use of counselling skills in more general terms. P40, for example, wrote that she used counselling skills for

"All communication. Listening, reflecting back, being non-judgmental. Concentrating on the problem, not the person etc, etc." (P40)

10.4.2. What kind of Training did Clients have in Counselling Skills?

A number of clients reported that they had some degree of formal training in counselling skills. The extent and depth of this training varied enormously.

P12 and P40 attended courses run by the Central School of Counselling and Therapy. Other clients (N7, N9, N12) had attended short, 'in-house' courses that dealt with single issues (e.g. on bereavement) courses and three Site Two (N12, N16, N18) clients had attended courses run, respectively, by the Workers Educational Association, the local Technical College and the local Polytechnic. Four others (P14, P30, P58, N12) had received training as part of courses in, respectively, Complimentary Therapies, Youth work, Social Work and Management, two clients (P33, P38) had skills tuition during their nurse training, whilst P14 had "[Read] around" the subject.

10.4.3. Were there any Problems for Clients when Accessing Services?

The process of accessing both counselling services wasn't without its difficulties. At Site Two these generally related to communication difficulties.

P1 had difficulties accessing the Site One service, because at the time of service use, clients had to go through a key-coded door. This is no longer an issue due to service relocation. At Site Two, personnel had misinformed P14 about having to seek her manager's permission to use the service and N9 had several difficulties, in accessing the phone number, getting an appointment and receiving a return call to messages left at the service.

10.4.4. Were there any Comments about Publicity.

Comments about publicity centred, in the first instance, on the quantity and prominence of materials and, secondly, on the need to focus more on raising awareness and overcoming some of the barriers (e.g. the fear of stigmatisation) to help-seeking.

Five clients (P14, P29, N4, N7, N9), reported a need for more posters to be located in more prominent locations. This need for an increased profile was seen as being particularly evident for more isolated departments such as intensive care. Additional methods of publicity were suggested. These included the use of payslips (P31, N9, N13, N14, N17), direct staff mailings (P58), circulars (P51), improved sign posting (P33), increased use of the staff newspaper (P31), annual service seminars, similar to the fire lecture (P21, N13), and

'outreach' activities such as informal departmental visits (N10) and a 'drop-in' day or session (N10).

Two clients (P51, N4) identified a need to raise general awareness about the service amongst hospital staff. Clients P9, P40 and P46 noted a key role for management in service publicity and the need for managerial awareness to underpin managerial support for service use. P49 felt that publicity needed to address the psychological barriers to service use so that

"...if those who need counselling talk about the stress, they would be easily directed."

Two clients provided personal anecdotes about accessing counselling. N10 accessed the service through her manager (N10), whilst N16 found out about the service through knowing the counsellor.

10.4.5. What Changes did Clients Propose to Counselling Services?

Changes, proposed, were both structural (e.g. opening hours) and in terms of the role that the service could play within the organisation as a whole.

A number of changes to the organisation of the service were suggested by clients. P7 suggested two extending 'out of work' hours to increase service availability and the provision of 'off-site' sessions'. P14 proposed that the service should adopt a role as an industrial conciliator because

"A neutral mediator [that] could be helpful in some conflicts...that might also be useful for departments experiencing widespread changes in working practices or equipment...counsellors would, hopefully, be regarded as neutral."

10.4.6. Were there any Problems with Using the Counselling Service?

Stated problems related to service funding and eligibility, which has impact on the extent of penetration of the service, and difficulties in effectively communicating with the Site Two service.

There were a number of problems with using services at Site One and Two. P31, who was being funded by a research council at Site One, was not eligible to use the service because his research council was not providing any funding for the Site One service and, as a result, he was eligible to use the service. He felt that this exclusion was "unfair", since he was being barred from accessing a service that was being widely publicised, at Site One, as being easily accessible.

At Site Two, N9 had difficulties accessing the phone number. She also had problems in getting her calls returned, which left her with the impression that the service counsellors were not interested and, as a result, she almost decided to not access the service.

10.4.7. Why did Clients use the Service?

The reasons for accessing the counselling service were varied and complex. Clients often had more than one reason why they were accessing service: There were issues to address and a need for support. Symptoms noted were varied and included some of the practical impacts of psychological problems on the workplace (e.g. impaired performance) and on relationships both in and out of work.

Clients reported a variety of reasons for accessing worksite counselling. These rationales are categorised under a number of themes: Presenting Issues; Inability to Cope; Learning to Cope; Psychological State and Impact on performance.

a. Presenting Issues:

Clients accessed counselling with a wide range of issues. These issues were from both the work and non-work spheres and related to change, relationships and bereavement amongst others. The issues were: Housing and occupational relocation (P12); changing hospital departments (P23); racial and religious discrimination (P49); the psychological well-being of the respondents team leader and its impact on others (P58); difficulties with bereavement (P23, P33); bullying at work (P14); problems with colleagues (P33, P49, P55) that evoked memories of being bullied at school (P33); family feuds (P33); exploring the potential use of grievance procedures (P14); management/staff relations (P14, P49); personal problems (N4); marital/relationship breakdown (P26, N8, N13, N14); a fathers heart attack (N8); suspected coronary problems (of the client, N8); abandonment by the clients partner during pregnancy (N8); a child's ill-health (N8); a traumatic birth (N13) and the murder of a close

family relative (N17). Client P33 reported that an error, that she had made whilst at work, had affected her self-confidence:

"I made a mistake at work which could have been detrimental to my patients health (drug error)...felt I could no longer work as a nurse.." (P33)

b. Inability to Cope:

Several clients (P1, P26, P29, P46, N4 and N10) had difficulties coping with events, change and loss. P26 wrote that

"Life seemed to have got out of hand and I really didn't seem to be coping with it very well.",

For N10, felt that her difficulties with coping meant that counselling was the only option left open to her. Four clients (P29, P38, P42, N12) reported needing the support of another person. P41 wanted "professional help" because, despite the support of her husband, she felt that she couldn't cope without additional support. P23 wrote that her coping difficulties were impacting on her work and family relationships.

c. Learning to Cope:

P49 and N16 had accessed counselling to learn new coping strategies and to develop existing ones. P49, specifically, wanted strategies to deal with work colleagues, who were described as being "intimidating", "discriminating" and "victimising". N16 wanted general "...guidance to learn how to cope."

d. Psychological State:

As scores on the outcome measures, reported earlier, indicate, the majority of clients at pre-intervention were experiencing some form of adverse psychological state. A number of clients were explicit in their descriptions of their pre-counselling state. P15 felt

"very bottled up, pressured and totally fed up with life on the whole".

For others distress was implied. P23 reported difficulties recovering from her mother's death.

Clients reported feeling lonely and isolated (P42), of being under pressure or strain (P55, P15, N4, N12, N17), of experiencing confusion (N4), anxiety (N7), depression (N12, N18), panic (N8) and feeling low (N17). Difficulties were reported in going to work (N8), in "function[ing] out of work" (N8), with negative thoughts (N9) and with loss of self-esteem (N14).

P38 wrote that she had attempted suicide and other self-harm behaviours and that after experiencing feelings of significant disturbance and

"after throwing myself out of a window and burning my arm became very scared.." and she decided to access the service.

e. Impact on performance:

A number of clients, wrote their difficulties were having an impact on their performance at work and that these impacts, in part, underpinned their decision to access counselling. P38 wrote that she was

"incapable of going to work" when external, non-work pressures got to the "level [where] I can no longer ignore or cope"

whilst P33 stated that her difficulties were causing her to

"[make] mistakes at work which increased the pressure I was feeling."

P40 presented an evaluation of how much counselling had reduced the amount of time that she had spent on sick leave, through comparing this episode with a prior one.

10.4.8. What did clients want from Counselling.

Clients brought a range of expectations to counselling. Some of these related to the qualities of the client-counsellor relationship, whilst other expectations were effectively the 'flip-side' to the problems that were being presented: Clients wanted issues to be resolved, distress levels to be reduced, an increased understanding of their difficulties and improvements in their ability to cope with people, situations and change.

When clients accessed counselling, they brought to it a series of expectations about what it would entail. These expectations can be organised around two themes: (1) Counselling and Counsellor Characteristics and (2) Understanding, Resolution and Acquisition.

a. Counselling and Counsellor Characteristics:

Clients had a range of expectations about what they thought the counsellors would be like and what the counselling, itself, would entail. Counsellors expected to be good listeners (P15), to be caring (P15) and interested in their problems (P15), to be neutral (P1, P14, P27, P29, N9, N16), that client confidentiality would be respected (P38, N9) and that counsellors would know nothing about the client (N10, N17).

Counselling was expected to provide an opportunity for skills acquisition and development (P49, N16). There was an expectation, due to the association with the host organisation (and its reputation), that counselling would be professional (P42, N10, N16). P13's expectations were based on a previous successful help-seeking experience, with a psychiatrist.

b. Understanding, Resolution and Acquisition:

A number of clients (P21, P30, P31 and N14) reported seeking a greater understanding of their difficulties and what underpinned them. P21 wrote that she wanted

"To try and understand more about myself and why I was feeling low and neglected"

P14 and P27 wanted reassurance and confirmation, whilst others wanted, respectively, clarification of their presenting issues (P27, P30, P48), problem resolution (P12, P27), an opportunity to acquire and develop methods of problem resolution (P27) and the chance to check out various behavioural options (P27). P49 wanted to identify ways of coping with colleagues (P49) and P29 wanted to "...think[] rationally again". Other objectives, in using the counselling service, included wanting to re-build self-esteem, to improve their situation (P51), for help (P32, P38, P46), to become redirected (P48, N9) and to avoid using drugs. Client P30 wrote that she was curious about counselling and what it involved.

c. What influences were there on the decision to access counselling?

Only two clients wrote about the decision to use the service. Client N9 discussed service use, first of all with her GP and then, secondly, with her line-manager, a friend who had previously used the service. N10 had spoken to her ward sister, already a user, who recommended the Site Two service to her.

10.4.9. What were the Advantages of Accessing Work-Site Counselling

There were a range of perceived advantages of having a service on-site. Some of these were practical: It was free and it was easily accessible, others related to the perceived benefits of having the type of support, that counselling represents, located within the host organisation. A work-site based service, unlike other general counselling services, was associated with a greater insight into the organisation and its workings and problems. The funding of such a service was also viewed as an endorsement of the impact of mental health on employee well-being and performance.

A wide range of advantages of a work-site service were listed by clients. These can be organised around a number of themes which are presented under a number of headings: Structural; Counsellor/Counselling Attributes and Attractions; Counsellor Knowledge of the Host Organisation; Self-referral; Acknowledgement of the Importance of Mental Health and Other issues.

a. Structural:

Two key themes emerged under this heading. The first, reported by ten clients (P1, P14, P15, P31, P40, P46, P48, N8, N10, N14), was that the service was free at the point of access, there was no cost to employees when they used the service. The second theme, reported by Eighteen clients (P1, P12, P14, P15, P21, P27, P29, P31, P32, P33, P42, P49, P51, P58, N4, N8, N14, N17) was that, because both services were on-site, they were both accessible and convenient to use.

Client's perceived that on-site services had shorter waiting times than other services. The fact that the service was on-site greatly reduced the need to travel. In addition, being on-site was associated with greater flexibility by employees in an environment where many work shifts and unsociable hours. Service users could go to session either before or after shifts with relative inconvenience. An off-site service, with noted time constraints, may not have been very practical from the standpoint of these considerations..

b. Counsellor and Counselling Attributes and Attractions:

Various characteristics of counselling and of the counsellors were associated with both services. These perceived characteristics, which are linked closely with the expectations that have been noted above, were definite attractions. However, it is arguable that client comments are non-specific, that they are an endorsement of counselling per se, rather than a specific affirmation of work-site counselling. Counsellors were perceived as being friendly, intelligent and warm and good listeners by clients, such as P1 and P58:

"Someone to listen to my worries. Someone to give a new perspective on my problems." (P1)

"...I felt the therapist was able to convey feelings of warmth, intelligence and was able to respond appropriately and spontaneously and accurately to me, my situation and my feelings." (P58)

Other attractions included professionalism (N16), that counsellors would provide an opportunity "To understand and collect my thoughts." (P7) and it would provide an environment that

"...allows parties time to discuss and also helps individuals to pinpoint and clarify problems." (P55).

c. Counsellor Knowledge of the Host Organisation:

Clients also wrote about a range of service characteristics, as a advantages, that were more specific to the context of work-site counselling. There were specific advantages of having a counsellor working within the host organisation. Six clients (P12, P14, P30, P33, N7, N8) felt that 'in-house' counsellors would have a greater "...presumed insight" (P14) into the host organisation and its issues. This insight had promoted an "...understanding of [the] workings within it [the hospital]" (P12) which translated into a series of tangible benefits for the client:

"It is understood from the start how stressful my particular job can be. This saves time by not having to explain my work situation and to concentrate on my problems." N7

d. Self-Referral:

For several clients (P27, P38, N4), the fact of having control over the referral process was an important attraction, that they did not have to go through their GP (P38) or "...other channels" (N4).

e. Acknowledgement of the Importance of Mental Health:

A number of clients (P27, P40, N8) wrote that, for them, an important advantage of having an on-site counselling service was that it represented an implicit acceptance of the importance of mental health issues by the host organisation. P40 wrote that it was an "...acknowledgement that mental and emotional health is important to performance." (P40) and that its on-site presence helped to reduce the stigma surrounding help-seeking "...because it [counselling] is so openly available, you do not feel you are a weirdo for going!" (N8). There is also an implication that clients (e.g. P40) were aware, implicitly, that service provision wasn't a completely altruistic act.

f. Other Issues:

Client P58 that "Since I got no support or supervision at work I felt my time with XXX was very justified during work hours". This suggests that, for this client, the existence of the service per se was advantageous, since it provided support that was not forthcoming from other parts of the host organisation.

There were indirect endorsements of the Site One service from P42 and P58, who wrote that counselling provision, within organisations, should be underpinned by legislation.

10.4.10. Were there any Disadvantages to having a Work-Site based Counselling Service?

There was a 'flip-side' to the service, a series of costs that went with the benefits that have already been noted, by clients, about having counselling on-site. One of the key issues here was the fact that having the service located physically on-site increased the perceived threat to anonymity and confidentiality. These were important issues because of the perceived individual and organisational consequences of others knowing that you were accessing counselling. There were also some doubts expressed about the relationship between the counselling services and the funding organisations. There were also some issues, at Site Two, that related to the dual role of the service counsellors there and the fact that there were opportunities, as a result, for a clash of interests.

These disadvantages can be grouped around a series of themes: Structural; Counselling outcome; Anonymity and Confidentiality; The Counsellor as a Colleague; Methodological Issues and Dependency on being Employed:

a. Structural:

P3 and P26 wrote that there was often a conflict between the hours that the client worked and the hours that the service was open for and that there were often clashes of commitment, on both sides, as a result. P26 wrote that "It wasn't always possible to organise a convenient appointment within a reasonable time because of clashes of commitments on my part and my counsellors."

P27 and N7 felt that both the Site One and Two services were located "too close" to the hospitals that they supported. This close proximity translated into the threat to anonymity that an increased risk of meeting colleagues represents. This fear wasn't without foundation as P14's experience illustrates. As she was leaving counselling, she bumped into a colleague who was entering the service.

Clients wrote that the emotional consequences of sessions, for example leaving counselling with "...red eyes from crying..." (P58), a general concern about "Becoming emotional in an inappropriate place" (P40) and whether such signs would threaten one's anonymity. P58 suggested that this fear of avoiding returning to work upset would be translated into a greater demand for sessions at certain peak times, for example at the end of shifts or at 5pm.

Counselling sessions were limited in number and P59 wrote that she would have liked more sessions, since it was an opportunity to alleviate "tension and the deep loneliness of being different [transsexual]." Therefore, there was an element of requiring continued social support.

P38 had difficulties the counsellor being male and, as a result of this problem, she was referred to a female counsellor by her GP. She also had difficulties with the act counsellor taking notes during sessions.

b. Counselling Outcome:

One client, P1, was critical of the outcome of counselling, since he did not feel that it had left him with any "...positive ideas [or] suggestions to work on." He had difficulties with the secular nature of counselling and felt that it failed to deal with his feelings of guilt, which stemmed from his religious beliefs.

P56 wrote that the outcome of "counselling very much depends on the counsellor and the client being able to communicate on level ground."

c. Anonymity:

Many of the study participants expressed their worries about anonymity. They did not want other people to know that they were going to counselling. Seventeen clients (P7, P14, P21, P23, P27, P29, P30, P32, P33, P38, P40, P46, N7, N8, N9, N14, N17) wrote about these fears. They did not want "...certain colleagues to know where I was going when I went to "meetings"(P7). As already noted, Site One's location was an issue with P40 perceiving a "Lack of privacy". These fears were not without foundation. P14 had bumped into a colleague as she was leaving counselling.

It was the perceived consequences that underpinned this apprehension. Consequences, which included being in receipt of "Sarcastic remarks about personal stability" (P31), left at least one client feeling "paranoid of gossip purely because the service was on-site." (P38). P38's fears were eventually translated into a referral to an outside counsellor.

P56 wrote about the fear of stigmatisation

"I did not want anyone to know I was visiting a counsellor, especially as they are psychologists and their involvement with mental illness is too close and I felt that others would think me unfit to work..." (P56) with these anxieties being translated into a number of consequences for P56

"If I had felt a little less ashamed or embarrassed of using the service, [I might have] better able to return to work more quickly." (P56)

with the process of stigmatisation being viewed as reflecting people's ignorance about mental health and about help-seeking since

"Lots of people still [do not] understand[ing] what a psychotherapist does and [they] seem to think you must be "unstable"." (N8)

d. Confidentiality:

This issue, related to anonymity, was commented on by P14, P23 and P30. Anxiety arose from the perceived relationship between counsellors and the host organisation. Counsellors were perceived as being "...being connected with colleagues" (P14), which meant that

"...information may be passed on without permission." (P14).

There were understandable concerns in the context of considerable change within the HS as a whole, and at each of the two sites, specifically, about the impact of a breach of confidentiality on career prospects, with P30 writing that accessing counselling "[implies] to some people that one cannot tolerate pressure". P14 also expressed this fear that

"...a request for counselling may adversely affect future job prospects, as it would probably be regarded as a sign of being "unable to cope" rather than as a sensible way to deal with work or outside stress." (P14)

As a separate issue, to that of perceived organisational relationships, the practical issue of security was noted, by P23, as a specific threat to confidentiality, since "Places do get broken into."

e. The Counsellor as a Colleague:

At Site Two, counsellors had dual roles because the service personnel were not 'dedicated', as they were at Site One. N5's counsellor also had a formal managerial role, which led to some conflict because

"[He] was defending some of my criticisms of work/structure of organisation as I described them as sources of stress" and she did not, as a result, "...feel a comfortable rapport had been built".

The outcome of this clash of conflicts was that, after the first session, N5 did not return for a second, although needed, session and in the end, she went off sick.

Further evidence of the difficulties of having dual-role counsellors was produced by N16 and N18, who reported difficulties because their counsellor was also a work colleague. N15 felt embarrassed whenever she met her counsellor at work, in a capacity other than for counselling, whilst N18 expressed concern about

"Being involved on a professional basis. Wondering if what they know about you colours their judgement when working together with a client on a project." (N18).

f. Dependency on being employed:

Counselling could only be accessed by employees of the organisation who were funding the service. During the course of her counselling, P56 left her job with her resignation being related to the reasons for accessing counselling. As a result, she was no longer eligible to

use the service. This additional loss added to the difficulties that were associated with leaving Site One and she stated that she would now have been feeling a lot better if she had been able to continue with her sessions. There is also, linked to this, issues surrounding redundancy and whether clients would be able to continue with sessions of counselling.

g. Methodological Issues:

Clients commented on the impact on their psychological well-being of the questionnaires. These evaluations were somewhat varied. P3 reported that the act of completing the pre-counselling questionnaire

"...added to my stressed state when I needed to talk as had a dreadful headache, felt sick & tired & poor concentration-it was a bit too much beforehand to be honest."

whilst P53, N9 and N10 all reported benefits from the act of completing the questionnaires. N10 reported that "the survey helped me to see what the underlying causes were also of my anxiety attacks" and P53 wrote that

"Even completing these questionnaires has helped me to concentrate my mind back to my initial counselling and has helped me enormously"

10.4.11. What were the Impacts and Benefits of Counselling?

Clients reported a range of impacts and benefits from counselling. These included, the clarification of presenting issues, an increased level of insight into their problems, the decision, after the end of counselling, to access additional intervention, fewer difficulties, the resolution of many of the problems that they had brought to counselling and support, gained from the service, for the process of decision making. Clients reported that they had benefit from the decision to access counselling and greatly from the first session of counselling.

A wide range of impacts and benefits, of counselling, were reported by clients. These fall under eight separate themes of Perception, Insight and clarification, Further therapy, Improved well-being, Acquired insight, The impact of service access and the first session, The impact of access and the first session, Support for decision-making and Making decisions.

a. Perception, Insight and Clarification:

Clients reported an improvement in the clarification of issues, with improved insights and the acquisition of an additional perspective. Clients (P13, P46, N7, N11) reported acquiring a

"...different perspective" that enabled them to see "the wood for the tress" (P23) and that they were now able to "stop and think about "my" problems and how I perceive them" (P8).

P39 reported an enhancement of self-awareness about how she was feeling, whilst other clients wrote that counselling had "help[ed] prioritise [the] areas to concentrate on" (P3) and had led to a "refocusing" (N6) and a rationalisation of feelings (N13).

b. Further Therapy:

One outcome was that a number of clients had decided to (P46), or were thinking about (P62) continuing with counselling, with an external agency, after their sessions had been completed. In part, this was because services were limited, by resources, in the number of sessions that they could provide for each client.

Another indirect endorsement of the Site One service came from P58. After her sessions had come to their conclusion, she was referred to another counsellor to continue with intervention. She was not as satisfied with the external counsellor and, as a result, did not continue with her sessions. Although, she continued to have difficulties, she hadn't returned to counselling and had, instead,

"taken up aerobics instead as a way to clear my head and reduce stress and depression and it works very well."

c. The Impact of Service Access and the First Session:

Several clients reported immediate benefits both from the act of accessing counselling and from the first session of counselling. P14 wrote about how "..relieved [she] felt even after taking the initial step of making an appointment", with the implication that such the decision of seeking help represent a step towards gaining control since she "felt that at least I had done something to move on from a difficult situation."

P14 and N2 reported immediate benefits from the first session of counselling. P14 had been more effective in a scheduled meeting, as a result of the issues discussed during counselling,

after the first session, whilst N2 generally "[felt] more positive than negative" after completing her first session of counselling.

d. Support for Decision-Making:

Clients made a number of decisions during counselling and counselling provided a means of support for the decision-making process. P14 had discussed the possibility of pursuing a grievance procedure, P55 decided to give up her job (to seek a less demanding and pressured role). Client P56 wrote that she had been supported by counselling during the decision-making process that ended with her deciding to leave her husband.

e. New Skills and Strategies:

Counselling provided a learning environment for several clients. Clients associated counselling with an opportunity to acquire new skills and coping strategies. P14 had learnt to adopt a strategy of keeping "a very low profile, instead of reacting and fighting for other staff" and N6 wrote that counselling had helped her to learn how to manage her life.

f. Departmental and Organisational Impacts:

There were impacts on the organisation as well as on the individual. P14 had come to counselling with the difficulties that she was having with her line-manager. During counselling she, eventually, told her manager that she was going to counselling and the reason(s) for seeking help. Whilst, initially, departmental relationships continued to deteriorate, she wrote that recently "...we have now begun to have much more regular staff meetings and better communications etc." She felt that at least part of this change was attributable to counselling

"In an indirect way I believe the counselling service did contribute to this improvement."

P56 reported improved relations with a colleague, as a result of strategies acquired during counselling and she wrote that they now "interact and work very well on day to day matters which surprised her, since "the relationship...seemed so "far gone.""

g. Improvements in Coping:

A number of clients reported improvements in their ability to cope with the challenges facing them.

P26 wrote that before accessing counselling that she "...felt...unhappy and unable to cope." but that by the end of counselling she was "...able to deal with the situation...a lot better than in the past."

There were attributed to counselling, increases in the ability of clients to cope with change. P7, as a result of counselling, had "...adjusted to my new situation much faster than if I had to deal with things on my own." She now felt "...able to give and receive advice from new friends in similar circumstances." N7 had acquired "ways of coping with things by myself" and had learnt to use her social supports, whilst N11 had developed ways of coping with "these times".

There were implicit reports of improved coping. N19 wrote that she was now living with her problems, whilst N7 and N11 both reported improved coping after the end of counselling.

h. Improvements to Self-image, Confidence and Esteem:

For a number of clients, counselling was associated with improvements in how they viewed themselves. When P33 had accessed counselling, she had "felt a worthless piece of dirt" and she wrote that without help, that she might have progressed onto a suicide attempt without help. She was now able to say "no" to demands, to prioritise jobs and problems and that she felt confident enough to seek help again if needed. P54 wrote that at post-counselling that she

"felt worthwhile as a human being...it has given me the strength to live my life as I wanted and not as how other people wanted."

P56, N1 and N10 also wrote that their self-confidence had improved as a result of counselling.

e. Improved Well-Being:

Eight clients (P42, P53, N4, N6, N8, N10, N11, N17) wrote about an improved sense of well-being. They reported fewer symptoms of distress at post-counselling, than at pre-counselling. N8 wrote:

"After so many things happening to me in such a short space of time, I could see no way of getting back to normal...I have found counselling very beneficial, I feel more able to talk to friends at work, generally feel more relaxed...In facing this situation I feel I am more able to deal with it."(N8).

N10 reported fewer anxiety attacks, N11 a general sense of improved well-being and N17 felt less pressured, that she was on an "upward turn instead of spiralling downwards".

P63 reported "Strong changes" and that counselling was of "long-term benefit", whilst N6, although not fully recovered, now felt that she was experiencing

"a normal depression rather than living in a 'black hole'".

f. Relationship Impacts:

A number of impacts on relationships, associated with counselling, were reported by clients. Counselling was a support whilst clients made important decisions about relationships. P56, over successive EOC and follow-up questionnaires, wrote about first separating and then divorcing from her husband. Counselling had "helped me to see my situation was not one I should have to endure".

g. Behavioural Changes:

A number of behavioural changes were reported by clients. N10 wrote that she had "stop[ped] smoking since August and [that she had] cut down on caffeine which has helped me tremendously". It is difficult, however, to determine whether these changes were as the direct result of counselling or whether they were 'spin-offs', a reflection of other changes that had occurred as the result of counselling.

h. Social Supports:

Clients wrote about the importance of the social support that counselling provided. N7's counsellor, for example, gave her support that was not forthcoming from her department. Having "Someone to talk to" was "greatly helpful".

P56 wrote about the support the service had provided during her separation from her husband and her decision to divorce. N12 also noted the extent of support that she had from the service, support that, again, was not forth-coming from her department:

"The counsellor has visited me at home, on an approximately monthly basis. This has been immensely valuable and helpful, in the following ways:- after the first few weeks of my illness (it has now lasted 10 months) there has been no support at all from my own department-my manager has had no appreciation of the seriousness of my illness and on her two visits with personnel to explain changes in pay and the need for a medical has caused severe stress and distress...The counsellor...has provided support, helped me through the stress caused by my

manager...maintaining a contact with someone from work -in some small way...I still feel 'in touch' despite the lack of support from my own department. I also feel that when I am able to return to work the continued contact with someone who has "seen me through the illness" will be very valuable."

10.4.12. Did Counselling Impact on Client Expectations Held at Pre-Counselling?

A number of clients wrote about the impact of counselling on their initial expectations of counselling. Clients who had reservations about what counselling would entail, and whether it would be useful or not, were positive at the end of counselling, in their evaluation of counselling.

Six clients (P25, P26 P54, N7, N10, N11) stated that the counselling experience had challenged their initial apprehension and scepticism.

P26 reported her initial "[scepticism] about the likelihood of any benefit to myself" and was surprised that "there was actually a situation where I could be quite so open about how I felt". P54 had been "pleasantly impressed and surprised", despite a previous negative experience with Marriage Guidance, whilst N5 "...was very nervous about attending the first session". She would have preferred to have seen her counsellor at home, in a safe environment, with her husband in attendance.

Though she initially "chickened out" of her first session, because of her apprehension, N10 eventually made a second appointment which she attended. Although not critical of counselling itself, she reported anger that "I had to seek professional help."

P23 and N13 wrote that counselling was exactly as they had expected.

10.4.13. The Impact of Not Going to Counselling

A number of clients wrote about what they thought might have happened to them if they had not attended counselling. There were a number of possible impacts from not being able to access counselling. These projections were largely a function of clients extrapolating their feelings at the time of accessing counselling. There is, of course, little opportunity to be able to judge the validity of these statements.

Without intervention, resignation or sick leave would have been the option for P14, whilst P33 felt that she would "have progressed to a suicide attempt because I could not cope". P40 and P53 wrote that they weren't sure that they would have been able to cope without counselling. One client, P40, wrote that she felt that her "abilities and judgement would have been more seriously impaired." without counselling and another client, P58, wrote about what had happened when her access to counselling had been removed from her, because of her resignation, that it had acted as a barrier to her further recovery. N5, although attending the first session, had not attended any more sessions, despite the need to, because of a clash with the counsellor. She reported that the outcome of not attending further sessions, because of this barrier, had led to her going sick instead.

10.4.14. Other Comments

There is an indication of departmental or organisational wide difficulties in P14's comments that her colleagues had thought that it would be 'amusing' to seek help "enmasse" to highlight the situation in their department. This suggests a potential organisational role for the counselling service in, at the very least, being able to feedback information about more global difficulties to the host organisation.

There is an indication of overt, or covert, pressures from colleagues or management in P56's account that she had accessed counselling to show that she was doing something after being sent home because of illness.

Finally, in a statement that suggests a failure to do so by the host organisation, the need for a caring organisation, to support its own staff, was discussed by N12

"A service that is about caring for the public should recognise that its own staff need support/help to carry out this role."

10.5. Differences and Similarities between Sites One and Two?

A detailed description of both study sites can be found in Chapter Five. There exist a number of distinct structural differences between both sites: Site One was urban (London) and was concentrated in a relatively small geographic area. It is a service that caters for two separate, although related, organisations. The Site One service was dedicated and employed

trained counsellors, with little or no research training, who had a single role to provide employee counselling within a formal and resourced framework.

Site Two covered a mixed urban and rural topography, spread across a large geographic area, with the demand being for the provision of a service for one organisation. Study counsellors were clinical psychologists, with substantial research training. However, the Site Two counsellors were not dedicated to the counselling service. Their primary role was to provide services to the public, through the employing trust. There were other, non-clinical, counsellors working for the Site Two service.

10.5.1. Differences Between Sites

As noted, there were structural differences between Sites One and Two. Client statements, from both sites, provide an opportunity to provide some explanation for why differences between sites may have impacted on client experiences.

There were a number of apparent impacts from the fact that Site Two was not a 'dedicated' service unlike Site One. N5, for example, reported that her counsellor still had his "managerial hat" on during counselling, which caused problems as he went onto the defensive when she criticised the organisation. Therefore, his counsellor role was being 'contaminated' by his managerial role, with this conflict being largely a reflection of the dual roles of Site One counsellors who were providing staff counselling on a largely voluntary basis. Because, there was a dedicated service at Site One, which employed counsellors whose primary role was to provide staff counselling, there should have been, in theory at least, little opportunity for this type of conflict to have arisen. However, there were still some difficulties, even at Site One, because of a perception that there were links, however unfounded, between Site One counsellors and the host organisation.

A second difference that again relates to the fact that Site Two was not 'dedicated' and had fewer resources than at Site One, is that clients apparently had greater difficulties in contacting the service (e.g. accessing the phone number, getting calls to be returned) than at Site One. These relative difficulties are likely to be, at least in part, a reflection of the part-time, dual-role status of Site Two counsellors.

10.5.2. Similarities Between Sites

However, despite the noted differences there were more similarities, between the two services, than there were differences. For example, clients from both sites, for example, cited a comparable list of advantages (e.g. accessibility) and disadvantages (e.g. threats to anonymity and confidentiality). Clients, from both sites, had doubts about the links that counsellors have with the host organisation. Clients consistently, across both sites, would be prepared to access the service again in the future and they would also suggest service use to a colleague.

Therefore, comparison between the two sites indicates some differences. However, there are a greater number of similarities, which suggests that the clients of work-site services, across organisations as a whole, might be expected to have similar fears (e.g. about client confidentiality) and may find comparable attractions to underpin their use of work-site services (e.g. accessibility and no cost).

10.6. Counselling Impact, Quantitative and Qualitative Accounts

Participants completed quantitative (pre, post and follow-up questionnaires) and qualitative measures. This provides an opportunity to compare the quantitative and qualitative accounts of impact, thereby allowing the following general question to be addressed:

Do the qualitative and quantitative account tell the same story?

Clients were included in analyses if they had met the following criteria:

- (a) They had completed the pre-counselling questionnaire and at least one of the EOC and follow-up measures
- (b) Clients had provided written accounts of counselling impact.

Those clients that had met both of these criteria ($n = 37$) were then sub-divided into four groups on the basis of scores on the Case GHQ-12 at pre-counselling and at post-counselling. The post-counselling mean was the average of measures taken at EOC, one, three and six months. The cut-off point was a caseness threshold of four. Those scoring four and above are deemed to be cases and those scoring less than four are deemed to not be cases. Several caseness thresholds (of two, three and four) have been cited in the literature

(Firth, 1986; Firth-Cozens, 1987; Firth-Cozens, 1994). A caseness threshold of four has been employed as a cut-off here. The groups, into which clients were categorised, were defined on the basis of whether scores were less than or greater than (and equal) to the threshold for caseness at pre- and post-counselling.

- 1 Clients who were cases at pre-counselling but were not cases at post-counselling (Table 10.4).
- 2 Clients who were cases at both pre and post-counselling (Table 10.5).
- 3 Clients who were not cases at pre-counselling but were at post-counselling (Table 10.6).
- 4 Clients who were not cases at both pre- and post-counselling (Table 10.7).

Table 10.3. Clients who were At or Above the Caseness Threshold (Four) at Pre-Counselling but below it at Post-Counselling.: A Comparison of Quantitative and Qualitative Accounts.

Clients	Pre	Post	Qualitative Comments
P12	6.00	0.67	"...felt very supported by my counsellor..." and had been "...able to deal with [moving from London into a new job] in a constructive way and pace myself."
P13	12.00	3.50	"Different perspective". "...easier for me to analyse them [problems] and solve them."
P14	8.00	0.00	Relief from contacting service. Immediate benefit in being able to deal, more effectively, with a scheduled meeting. Without counselling, would have either resigned or taken stress related sick leave. Discussed service access and the presenting issue (her manager) with her manager. This led to improved departmental relationships.
P23	12.00	1.00	"Enabled me to focus on life in general once more" - "very helpful and supportive"
P33	12.00	0.00	Regained coping mechanisms. No longer felt "...a worthless piece of dirt". Given opportunity to express suppressed feelings. Felt able to prioritise jobs & problems.
P42	9.0	0.50	General satisfaction with counselling
P45	10.00	0.00	General satisfaction with counselling
P46	10.00	0.00	Helped her to deal with personal problems, that were impacting on her work. Placed them into context and allowed her to deal with her problems "...in an objective and systematic way". It had "helped her through a crisis." Had moved onto therapy.
P53	8.00	3.00	Counselling "...helped me to see what my aims in life are..." Reported, over successive follow-up questionnaires, her separation and pending divorce. "Counselling [gave] me the confidence that what I was doing was the right thing."
Post = The average of scores taken at the end of counselling and at follow-up at one, three and six months.			

Table 10.3 continued. Clients who were At or Above the Caseness Threshold (Four) at Pre-Counselling but below it at Post-Counselling.: A Comparison of Quantitative and Qualitative Accounts.

P54	7.00	1.50	Expectations, based on experience with Marriage Guidance, were negative. Positive impact here. Counselling allowed her to talk through all of her home and work issues, allowed her to "feel worthwhile as a human being" and "it [had] given me the strength to live my life as I wanted and not as how other people wanted."
P55	5.00	0.00	Counselling outcomes, included increased confidence, the resolution of problems with her manager and, on the second occasion, she decided to find a less stressful job.
P58	7.00	1.33	A very safe, warm and responsive environment described as being "excellent".
P63	7.00	0.00	Counselling was "productive", with "strong changes" and had produced "long-term benefit".
N1	8.00	0.00	Increased confidence.
N4	10.00	3.00	"I found that the counselling I was given, although brief, was a great help to me personally." Off loaded personal feelings and thoughts. Very good. Helped tremendously
N5	12.00	3.00	Generally supportive, but no rapport-counsellor was manager and had 'managerial hat' on - no problem resolution - Took two weeks off work 'on-sick'.
N6	12.00	0.00	"Put things into perspective" - "Helped me to manage the way in which I approached life" - "[Counselling] helped me tremendously."
N9	11.00	3.00	"Helped a great deal" - "Very beneficial" - Identified a history of depression and, as a result, felt more able to deal with it.
N10	8.00	0.00	Relief. Identified problems. Increased coping. Excellent service. Reduced anxiety.
Post = The average of scores taken at the end of counselling and at follow-up at one, three and six months.			

Table 10.3 continued. Clients who were At or Above the Caseness Threshold (Four) at Pre-Counseling but below it at Post-Counseling.: A
Comparison of Quantitative and Qualitative Accounts.

N11	8.00	0.00	"Helpful". "[Felt] supported and encouraged". Less anxiety (attacks) More positive.
N14	12.00	0.00	Excellent service. Feelings rationalised. "...expectations have all been met"
N17	10.00	1.75	Relief to be able to talk to somebody - very helpful and relaxing - on "upward turn instead of spiralling downwards"
N19	11.00	0.00	"...very useful to get me through my bad feelings" -
Post = The average of scores taken at the end of counselling and at follow-up at one, three and six months.			

Table 10.4. Clients who were At or Above the Caseness Threshold (Four) on the Case GHQ-12 at Pre- and Post-Counselling. A Comparison of Quantitative and Qualitative Accounts.

Clients	Pre	Post	Qualitative Comments
P3	10.00	5.00	Problems with secular counselling, dealing with guilt. A great relief. "...bouncing board to help prioritise areas to concentrate on..."
P15	12.00	8.00	Thanks. "Hope to use the service again in ;the future". "as you can read in the questionnaire, I am not too happy with life at the present..."
P25	11.00	6.67	Initial doubts. "It did help me to stand back and take a new perspective on the problem and look at the situation from the inside." "...see things in future with 'new' eyes". "I would advise anyone else to seek help"
P62	9.00	11.00	Counselling defused problems. But not fully resolved. Decided to continue, privately.
N2	9.00	5.00	N2 After first session more positive than negative - "I realise now why I think and do the things I do and its has made me much more refocused knowing these things. I feel much happier these past three weeks..."
N7	12.00	5.00	Helpful to have non-family person to speak to. Felt relaxed. Opened-up feelings. Causes of anxiety/depression not fully resolved. Taught ways of coping with things and sharing them with family/close friends
N12	11.00	7.67	ME sufferer - Gained a lot of support from the counselling service. This support was not forth-coming from colleagues/management. Good understanding. Continued contact very valuable.
N18	12.00	12.00	"...much praise for the initiative of the counselling service"
Post = The average of scores taken at the end of counselling and at follow-up at one, three and six months.			

Table 10.5. Clients who were Below the Caseness Threshold (Four) at Pre-Counselling but were above it at Post-Counselling: A Comparison of Quantitative and Qualitative Accounts.

Clients	Pre	Post	Qualitative Comments
P8	3.00	7.00	Now "Stop[s] and think about problems and how I perceive them"
Post = The average of scores taken at the end of counselling and at follow-up at one, three and six months.			

Table 10.6. Clients who were Below the Caseness Threshold (Four) at Pre-Counselling and Post-Counselling; A Comparison of Quantitative and Qualitative Accounts

Clients	Pre	Post	Qualitative Comments
P1	0.00	1.00	Completed counselling with "No positive ideas, suggestions to work on."
P30	2.00	0.00	Female client. Had problems relating to the sex of the counsellor (male), the fact that he took notes during sessions, as well as difficulties with the threat to anonymity that was associated with being on-site. She was referred, by her GP, to a female counsellor.
P31	0.00	0.50	Not Impressed - was not eligible - Research Council employee
P37	0.00	0.00	Felt a lot better. Had been feeling (pre) under immense pressure, was making mistakes at work. Dealt with suppressed feelings. Improved coping. Better able to prioritise jobs and problems. Will seek help if I need it again.
P60	0.00	0.00	Found "...counselling extremely helpful" and that "Once I realised that there were other options, my problems didn't seem half as bad".
Post = The average of scores taken at the end of counselling and at follow-up at one, three and six months.			

10.6.1. Clients who were Cases at Pre-Counselling but not at Post-Counselling (Table 10.5)

Twenty-three clients in his group also provided qualitative data. All 23 clients were positive in their evaluations of counselling. They reported improved coping, general satisfaction with the service, that they felt more positive and that their confidence had improved. One client was more focused, three felt more supported and two reported that their anxiety was reduced. Three clients made decisions as a result of attending counselling: P53, to separate from and then divorce her husband; P46 began a programme of further therapy and P14 confronted her line-manager about departmental problems.

Comments from clients from this group reported feeling “worthwhile”, that they had more strength, that issues had been worked through, that changes, of lasting benefit, had been made, that a history of depression had been identified, whilst others noted gaining an improved perspective, a rationalisation of feelings and that the service had been helpful. Several clients noted that post-counselling state was an improvement on pre-counselling state.

However, one client reported that her counsellor had his “managerial hat” on during counselling and had been defensive about the organisation. She had only attended one session of counselling as a result, although she wanted further help. She had then gone off-sick. It is difficult in the case of this client, given her 'story', to attribute the reduction in distress on the case GHQ to counselling.

10.6.2. Greater than Twelve at Both Pre and Post-Counselling (see Table 10.7):

There were seven clients included in this group. Five of this group reported pre-post reductions on the case GHQ. One of this group, P3, reported criticism of the service, the result of an inappropriate fit between the 'secular' nature of the counselling on offer and the spiritual element of his counselling need. The other four clients were consistent in their positive appraisal of the counselling service.

One client reported a pre-post increase. She wrote that whilst counselling had 'defused problems', that it had not fully resolved them and she was going on to access further counselling. The seventh client, N18, reported no change from pre- to post-counselling: However, she offered “..much praise for the initiative of the counselling service.”

10.6.3. Less than Twelve at Pre-counselling and Greater than Twelve at Post-counselling (Table 10.7):

Only one client, P8, reported a greater degree of distress at post-counselling, than at pre-counselling. However, this client also reported benefit from counselling, that following intervention, that she now thinks about problems and how she perceives them,

10.6.4. Less than Twelve at Pre and Post-Counselling (Table 10.8):

There were five clients in this category. P1 criticised the service, stating that he had gained any "...positive ideas [or] suggestions to work on." A second client, P30, had some difficulties with having a male counsellor. She had discontinued with counselling and had gone onto arrange counselling, through a GP, with a female counsellor.

P31 was not impressed. He found that he was not eligible, because his employer, located at Site one, was not funding the service. Both P37 and P60 found "counselling to be extremely helpful" (P60) and P37 reported "Improved coping" and that she was "Better able to prioritise jobs and problems."

10.7. Chapter Summary

Not surprisingly, given the eclectic (in terms of problems, symptoms, experience and agendas) group of clients who presented to the service over the period of data collection, participants were able to provide a varied 'picture' of their service stories: The reasons that they had attended, what they thought of it and how they perceived the service and its 'fit' with the host organisation. On a general level, clients were generally favourably disposed towards the service, with the majority indicating that they would use it again in the future. There were no study hypotheses because of the exploratory nature of this chapter and the data set is discussed in more detail in the discussion.

Chapter Eleven: Discussion

This chapter is sub-divided into two substantial sections. Section One discusses the study findings in terms of the research questions and hypotheses listed in Chapter Four. Section Two discusses these findings in terms of their implications and further suggestions for future research.

Section One

11.1. Comparisons with Other Groups at Pre-Counselling

As expected, clients reported, at pre-counselling, levels of distress and interpersonal difficulty that were greater than those reported both for general population and occupational samples (Banks et al, 1980; Barkham et al, 1994; 1994a; Barton, 1994; Firth, 1986; Firth-Cozens, 1987; Firth-Cozens, 1994).

Pre-counselling levels on measures of outcome were comparable to levels reported for psychotherapy clients, at pre-therapy, from the Second Sheffield Psychotherapy Project (SPP2) and for a sample of outpatients (Barkham et al, 1994a; Shapiro et al, 1994). This level of distress provides clear support for the need for intervention at both sites. It is unclear, however, as to the extent to which this group of participants is representative of service clients, as a whole, and of the population of employees, at both sites, since no wider survey of employee mental health was undertaken (due to organisational barriers at both sites).

Clients reported using social support strategies at a level comparable to that reported at three hospital sites (OSI Data Supplement, 1994). However, participants at pre-counselling did not use logic based strategies as frequently as members of the hospital samples. Since accessing counselling is, conceptually, an act of seeking social support, then it is not surprising that clients, having accessed counselling, will report a greater level of using social supports, than logic based strategies since the act of accessing counselling is not, inherently, a logical strategy as defined by items on the OSI.

11.2. Comparison of Participants with Non-participants

Site One participants were compared with non-participants on the basis of biographical information, that was collected as part of Site One's own service evaluation.

There was only one significant difference between junior and middle ranked staff: Junior staff were less likely to participate than middle ranked staff. At Site One, clients were excluded from the study if they were deemed to be too distressed to be able to handle the burden of completing measure, if they had learning difficulties, if English was their second language and if they had literacy problems for any reasons other than those described above. Deficits in literacy skills will represent a barrier to junior staff to progress to more senior positions, in an organisation where organisational status will be closely related to professional qualifications and where good verbal and written communication skills are at a premium. Therefore junior staff are far more likely to be excluded from participating on the grounds of problems with skills of literacy.

This difference between 'junior' and 'middle' staff raises the question of why no senior staff? Both this study, and the Site One Annual Report, have identified the complete absence, in the case of study participants, and the under-representation of senior staff and members of certain professions, such as medicine as service clients.

It cannot be concluded that senior employees and medical staff are not experiencing distress, since various reviews of managerial distress (Burke, 1988; Caplan, 1994) and the problems experienced by medical staff (Payne and Firth-Cozens, 1987) clearly that this is not the case. Therefore, there must be some barrier to their accessing the service. One explanation is that these individuals feel particularly vulnerable to being labelled, or stigmatised, if knowledge of their service use 'leaked out': that because their roles are associated with leadership, that they cannot countenance, at least while they are at work, any perception of weakness. This anxiety about being stigmatised is not without foundation, since the highly pressurised NHS environment is associated with a culture that has little sympathy for help-seeking (Payne and Firth-Cozens, 1987) with senior personnel being expected to be stoical. A second explanation is that, given that these staff members are on higher salaries, than most of the rest of the staff at each of the two sites, that they can afford to seek help in the private sector and that, given the fears that are elicited about the threat to anonymity, that an on-site service can represent, that these individuals have the resources to ensure that they can maximise the likelihood of maintaining anonymity by going off-site. It is impossible to

provide support for these explanations without surveying staff to identify their help-seeking behaviours.

11.3. Differences between Pre-only and Pre-post Clients

Site One participants were less likely to be retained, in the post-counselling phase, than Site Two clients. This may be a reflection of the relative levels of research experience that counsellors at each site had, with the Site Two counsellors, who were all clinical psychologists, having greater experience and skill levels, than the Site Two counsellors.

It is possible, then, that the apparent problems that the Site One counsellors had in recruiting and retaining participants was a reflection of these differences, in experience and training. Levels of recruitment and retention, at Site One, increased over the course of the study, which suggests that counsellors were becoming more experienced.

Pre-only clients, those who did not complete post-counselling measures, reported a greater degree of inter-personal difficulty at pre-counselling than the pre-post clients who went onto complete the post-counselling measures. There were specific difficulties with being too caring and with becoming involved with other people.

One explanation for this difference is that those who have greater difficulties in these areas may find that "An intense, emotionally charged confiding..." (Frank, 1971) nature of the counselling relationship which inherently requires the help-seeker to be open and involved with another person is too threatening and, ultimately, something to be avoided. Assuming that this impacts on the likelihood of retention, to the study, then it is not surprising that those who have 'dropped out' of this study, after they have completed counselling, tend to have greater difficulties with being open and with being involved with others than those who decided to continue their participation. This also suggests that a potential service user needs to be equipped with certain interpersonal 'skills' before he or she is capable of accessing relationship based interventions, such as counselling.

The finding of 'client suitability' does tend to suggest support for Orlinsky, Grawe and Park's (1994) conclusion that 'patient suitability' were factors underpinning successful psychotherapeutic outcomes. Further research is required to examine whether this finding, and the proposed explanation, is generalisable and valid.

Contrary to expectations, there was a relationship between age and retention to the post-counselling phase of the research: older clients were more likely to complete post-counselling measures. Younger staff, who will tend to be in junior positions, are more likely to be on short-term contracts and/ or on rotation: characteristics which are common to a number of NHS professions and, as a result, they are likely to be changing departments, Trust and location. This relative instability translates into the practical difficulty in 'tracking' participants in order to distribute measures, an effect exaggerated by the distance between Site One, in London, and SAPU, in Sheffield.

11.4. Status at Pre-counselling & Client Characteristics

In contrast to expectations, there were differences on the outcome measures, between clients at pre-counselling.

1 Gender Differences

Female participants were older and used logic based strategies more frequently than men. Men reported greater levels of global interpersonal difficulty and had specific difficulties with being supportive of others.

Men, because of the cultural barriers that they reportedly face when accessing intervention (Good, Dell and Mintz, 1989; Vessey and Howard, 1993; Wills, 1987), may well have a higher threshold, that needs to be crossed, before they seek help. Men will need to experience, in this case, greater levels of interpersonal difficulty before they decide to access counselling. This difference provides indirect support for Barker, Pistrang, Shapiro and Shaw (1990) who found that, whilst women are more likely to seek support from a friend or relative (e.g. employ social support strategies to cope), men tend to cope by drinking or through exercise. There is also indirect support for Wills (1987) whose review, of community based studies, indicated that women sought help more frequently than men which, again, might reflect a greater help-seeking threshold. It would seem, therefore, that men may view help-seeking or seeking social supports, generally, as much more of a 'last resort' than women.

Male participants reported the less frequent use of logic-based strategies, than women. It is possible that another trigger for help-seeking, may be a reduction in coping, specifically, in this instance, with using logic based strategies. Given that there were few males included in the analyses, it is possible that this difference is spurious, that it only applies to this study. In

addition, there is also the problems of the poor reliability of the OSI and the very real possibility of self- and counsellor-selection to the study.

2 Site Location

Site Two clients, who were all female, also reported a greater use of logic based strategies. It is likely that differences between sites, in the use of logic based strategies, are attributable to the gender differences discussed earlier, rather than to site location. Alternatively, the difference may be due to the impact of counsellor selection of clients. Again, further research would be required to establish how generalisable this finding is, if it isn't a statistical artefact.

Site Two participants had tenure of their posts for longer than their Site One counterparts. Since Site One is associated with a substantive research and post-graduate function, it is not, perhaps, surprising that there is a difference, since many research posts are short-term and this type of organisation will be associated with high levels of turnover. In addition, differences between London based Site One and the relatively rural Site Two may also impact on the stability of staffing, with less competition for staff, between Hospital Trusts at Site Two, than at Site One.

Site Two clients reported greater levels of pre-counselling distress, than those at Site One. This is not surprising since Site One counsellors had 'filtered out' many of the most distressed clients, who were excluded if counsellors felt that clients would have difficulties coping with the additional burden of completing study measures. This selection process, which did not occur at Site Two, is likely to have suppressed the mean level of pre-counselling distress and interpersonal difficulty at Site One.

3 Shift-working

Shift-workers reported a greater level of pre-counselling distress, greater interpersonal difficulties and longer hours than non-shift workers. These differences may be related to the fact that shift workers frequently work unsociable hours which is known to have a disruptive impact on their lives outside of work and on levels of psychological well-being (Barton, 1994; Folkard, 1987; 1989).

Shift-workers were more positive in their expectations of task impacts, than non-shift workers. It is, however, unclear why those working shifts should be more optimistic about the impact of counselling on problem definition and insight than non-shift workers, unless it

relates to the experience of greater levels of distress and interpersonal difficulty, with higher expectations being demand driven.

Shift workers may be less aware of the reasons why they are having greater difficulties and that, as a result, they have greater optimism, that by seeking help, that they will be able to develop greater insight into their difficulties. With the small number of cases available to analyses, there are considerable difficulties in extrapolating these findings beyond the current study. Further research should be undertaken to examine client expectations as they access counselling.

4 Help-seeking

Those who had prior experience of help-seeking reported greater levels of pre-counselling distress than 'first time' help-seekers. It is possible that many of the experienced help-seekers are representative of chronically distressed individuals, identified by Depue and Monroe (1986) and Kessler et al (1994): individuals characterised by experiencing repeat episodes of psychological difficulty. Many of these episodes will be translated into episodes of help-seeking and the possibility arises of there being sub-groups of clients who are either chronically vulnerable (Depue and Monroe, 1986) or who have become 'therapy junkies' (Seligman, 1995), individuals who are dependent on counselling.

The implication for counselling service, from such groups is that there is threat of a minority of service users 'soaking up' a disproportionate amount of available resources. The majority of Employee Counselling Services stipulate limits on the number of sessions per client, over a given period. Site One, for example, worked towards an eight session maximum, although it wasn't always adhered to. There may be difficulties if a client, returning to use the service, is no longer eligible to use it even if he, or she, has a very real need for further help. This raises a number of questions about the ethical and legal implications of turning down, for intervention, someone who is clearly in need of help, especially if there are consequences, such as self-harm, that can be attributed to the denial of intervention.

Widows were older, than other relationship groups, and they had worked for a longer period of time with their current organisation. These difference are not surprising, since the likelihood of bereavement and the length of time spent working at any organisation will be associated with age.

11.5. Measures of Counselling Outcome

The hypothesis that there would be significant pre-post reductions, on measures of outcome, was supported by analyses. Clients, at post-intervention, had levels of distress and interpersonal difficulty comparable to those reported by general population and occupational samples (Banks et al, 1980; Barkham et al, 1994; 1994a; Barton, 1994; Firth, 1986; Firth-Cozens, 1987; Firth-Cozens, 1994). These post-counselling levels were somewhat lower than the levels of distress and interpersonal difficulty that were reported for psychotherapy (at pre-therapy) and out-patient clients (Barkham et al, 1994; 1994a; Shapiro et al, 1994). Pre-post effect sizes were, in terms of Cohen's (1977) effect size categorisation, substantial. With some qualification, the reported findings support those published in both the general (Hill and Corbett, 1993; Lambert, Masters and Ogles, 1991; Lambert, Shapiro and Bergin, 1986; Orlinsky and Howard, 1986; Shapiro and Shapiro, 1982a; Shapiro et al, 1994; VandenBos and Pino, 1980) and work site counselling literature (Cooper and Sadri, 1991). It is possible to include, then, that the counselling services, at both sites, are an effective intervention.

There are, however, a number of difficulties when comparing the results of this study with published studies. The vast majority of psychotherapy studies, and all of those reviewed in the major published meta-analyses (Shapiro and Shapiro, 1982; Smith and Glass, 1977; Smith, Glass and Miller, 1980), have employed one or more control groups, as well as a variety of other sophisticated technologies aimed at maximising control (Lambert, Shapiro and Bergin, 1986; VandenBos and Pino, 1980). The emphasis for these published efficacy studies has been to address a range of basic control questions and to do this they have had to employ as much control over extraneous variables as possible, in largely artificial environments.

In almost direct contrast to the above, the reported study attempted to apply a rigorous methodology, in a highly 'real-life' setting where there was little opportunity to employ any of the technologies, such as control groups, that have been employed in the major psychotherapy projects such as the Second Sheffield Psychotherapy Project (Shapiro et al, 1990; 1994). The emphasis was on maximising external validity as opposed to internal validity.

The pre-post effect sizes, for the reported study, were comparable, though smaller in size, than those reported for clinical studies, such as SPP1 (Shapiro and Firth, 1987), the Quality Assurance Project (1983) and SPP2 (Shapiro et al, 1994). It would appear that work-site

counselling, though associated with substantive reductions, may be less effective than comparable interventions in other contexts. Differences in the size of pre-post effect sizes are likely to, again, be attributable to methodological differences between this study and published efficacy studies. However, since post-counselling scores were comparable, it is likely that differences, on measures, at pre-counselling account for much of the difference in effect size.

The absence of a control group, in the reported study, means that there are problems in accurately attributing the extent to which pre-post change is a function of the intervention and not the result of other factors, although one cannot entirely rule out other explanations or influences even in the most controlled of the reported psychotherapy studies.

An appropriate control group would have provided greater support for the efficacy of intervention and would have allowed one to identify the extent to which improvement could be attributed to the intervention and not to extraneous factors, such as spontaneous remission. It is, therefore, difficult to identify the 'added value' that the intervention brought. The argument for such groups is to control for spontaneous remission, with individuals recovering over time without having accessed formal intervention. However, 'Spontaneous remission' may be the result of informal intervention from friends or family. Even if spontaneous remission is a valid phenomenon, it may not matter if counselling is shown to be capable of reducing the length of time that it takes to recover (Lambert and Bergin, 1978).

There are a number of additional ethical and practical concerns that make the adoption, as a design feature, of random assignment to experimental and control groups difficult to justify. The first concern is one of ethics, that the act of assigning an individual to a non-treatment control group, denies that person access to intervention on non-clinical grounds. This is of particular importance in applied settings where the primary purpose of the service is not research.

A second issue is that by adopting a design element, such as a control group, when evaluating a counselling service, that this act modifies the original service and you are no longer evaluating the original counselling service. This impacts on external validity and the degree to which findings can be generalised. Thus, the adoption of a design element, such as a control group, could be counter-productive.

In practical terms, in the context of this study, there were only limited resources that were available and that, on these grounds alone, a control group was not a feasible option. Despite the expense, a control group would only provided a limited amount of additional information. Since there already exists a substantive body of literature that supports the efficacy of counselling (Shapiro et al, 1990; 1994; Shapiro and Shapiro, 1982; Smith and Glass, 1977; Smith, Glass and Miller, 1980), there would appear to be little point in using such a feature. There is little to stop clients who are in a control group in an applied study and, indeed in any kind of study, from accessing counselling from another source. The other issue will be client refusal to take part in the study and differential rates of clients dropping out of the study. These feature, alone, would largely make random assignment in an applied setting, a futile gesture.

11.6. Differences between Measures in Patterns of Pre-post Change

Analyses supported the hypothesis that there would be differences, between measures of distress and interpersonal problems, in the extent of pre-post change. There were unexpected differences, in the pattern of pre-post change, between the IIP sub-scales.

There was a greater level of pre-post change on measures of distress, than for the measures of interpersonal problems. This difference provides support for Horowitz et al's (1988) and Howard et al's (1993; 94) three phase model of change, with intervention dealing sequentially with different 'layers' of any psychological problem. The measures of distress assess symptoms associated with the first phase, remoralisation, whilst measures of assess elements of a problem associated with the second, remediation, and third, rehabilitation, phases.

Differences between the IIP sub-scales suggest variance between interpersonal problems in terms of their relative depth and their responsiveness to intervention. This is not surprising given that individuals, presenting with problems, will not be experiencing equal levels of interpersonal difficulty across measures of interpersonal difficulty.

Analyses, for the reported study, actually indicated a pre-post increase for being Too Open with other people, as well as several different patterns of reductions from pre-counselling to follow-up. The increase in apprehension about being Too Open with others may well be a reaction to the fact of attending counselling: a mark of the unease that individuals may experience when help-seeking. This apprehension is likely to reflect anxiety about the response of the organisation to help-seeking: the fear of being stigmatised.

These differential patterns have not been reported elsewhere, although this may, again, be due to methodological differences. In the first instance, further research, both in applied and controlled contexts, is required to replicate these findings.

11.7. Coping Strategies

There were differences, between measures of coping strategy, in the extent of pre-post change in client use. Clients reported a greater increase in their use of social supports, than for logic based strategies.

At pre-counselling, clients employed social supports at a level comparable to three hospital samples (OSI Data Supplement, 1994), whilst at post-intervention, they reported a noticeably greater use of these strategies. This increase was consistent across analyses.

For the logic based strategies, clients reported their less frequent use, than the hospital sample, at both pre- and post-intervention. There was only support for significant increases for the pre-post analyses.

Discussion, earlier on in this chapter, suggested that the relatively greater use of social support strategies at pre-counselling was a 'marker' for accessing counselling, with counselling being conceptualised as a social support. It is likely that pre-post increases in the reported use of social supports is the result of the benefits of counselling, reductions in distress and interpersonal problems, acting as a reinforce for the choice of social supports as a coping strategy. The benefits, that are associated with pre-post reductions in distress, are not 'marked' by increases in the use of logic based strategies because counselling is not, at least in terms of the OSI items, an act of logic based coping. The reinforcement of social support as coping strategy, by pre-post reductions in distress, increases the likelihood that these coping strategies will be employed in the future, possibly at the expense of other strategies.

It is likely that in this context, that there will only be increases in the frequency of reported use logic based strategies if sessions content was focusing on these strategies. This suggests, indirectly, that there is a link between session content and impact, a link which has been established with stress management programmes (Reynolds et al, 1993; 1993a).

However, it should be noted that there are difficulties interpreting any change on measures of coping strategy, employed in this study, because of the poor reliability of the OSI Coping sub-scales. These problems have also been identified Davis (1996) in her re-analysis of the OSI, where she argued that the reliability's of the coping strategy sub-scales were so poor, that, if they were not revised, that they should be dispensed with.

11.8. Client Ratings of Counselling Impact

Clients reported improvements in global and specific ratings of counselling impact. Improvements in pre-post ratings of global impacts can be attributed to clients reporting fewer hindering impacts at post-counselling. On the whole, clients had largely positive expectations, with a few reservations, when they accessed counselling. These expectations may not be surprising given the number of participants who had sought help on previous occasions. It is possible that these positive expectations are a 'marker' or predictor of accessing counselling, that individuals will not access counselling unless they have fairly high expectations of a positive outcome.

This may not be surprising given the number of experienced help-seekers who participated in the study. This pre-post reduction in hindering impacts may well be 'flip-side' of the benefits associated with counselling, reductions in distress and interpersonal problems.

11.9. The Maintenance and Stability of Gain to Follow-up?

As expected, post-counselling gains were maintained at follow-up, a result which supports the conclusions of Nicholson and Berman (1983), Robinson et al (1990) and Shapiro et al (in press) that follow-up is characterised by stability. However, unexpectedly, in this study, there were further significant reductions from EOC to follow-up.

Differences between the reported study and the literature: the continued significant reductions in distress reported here, are likely to reflect methodological differences between this study and the published literature. On average, the participants in the reported study received only five sessions of counselling (although there was considerable variance around this figure), whilst in much of the published literature, participants are in receipt of considerably more sessions. It may be that, with a smaller number of session, the process of change, triggered by counselling, has not had sufficient time to 'work its way through' on a particular issue' and, as a result, continued change which, in the published studies would

occur during sessions and, thus, would not register during follow-up, can only occur, in a context of fewer sessions, after these sessions have come to an end. In addition, the follow-up changes on measures may be reflect change that relates to the deeper elements of an issue, the 'layer' of a problem addressed in the second and third phases of Howard et al's (1993) three phase model.

11.10. Within-Group Differences and Pre-Post Change

There were two significant analyses. The first of these was a difference between men and women in the extent of pre-post reductions in distress, with women reporting greater pre-EOC reductions on measures. Women also reported a greater degree of distress, than men, at pre-counselling and less distress at EOC.

The second significant difference was between sites: Site Two clients reported greater pre-counselling distress and significantly greater pre-post reductions, than clients at Site One. Reported levels of distress were comparable at both sites at both EOC and follow-up.

1 Gender

One of the difficulties with explaining the differences between men and women is the fact of the relatively small number of male clients who could be included in analyses. This makes generalisation to other settings difficult. In addition, it is possible that those men who, in the first instance, accessed counselling and, in the second, chose to and continued to participate in the study may be unrepresentative of their male colleagues, in general, because of their very act of seeking help and counselling. The fact that they have overcome some of the cultural barriers to help-seeking (Vessey and Howard, 1993; Wills, 1987) may make them, effectively, 'stand out' amongst their peers.

2 Sites

To some degree, differences between Site One and Two reflect Site One's policy of excluding, at pre-counselling, clients deemed to be too distressed to complete measures. Thus, it is likely that many of the most distressed Site One clients, who would probably have scored higher on measures, were excluded from the study which would have suppressed pre-counselling means at Site One.

Post-counselling means, at both sites, were comparable, which suggests a 'basement' effect for the measurement of client. Therefore, the significant difference between sites, in terms of

pre-post change, is a function of the higher pre-counselling scores at Site Two which, in turn, is a function of the exclusion policy at Site One. This illustrates the potential impact, on evaluations, of service policy and such differences will often make cross-service comparisons (e.g. between Sites One and Two) difficult.

It is likely that the size of the sample that was available for analysis prevented other relationship from being identified, if they exist at all. Further research is required to identify any predictors for pre-post outcome, since such differences, if they exist, would help to target resources.

11.11. Change across Sessions of Counselling

As expected, there was a consistent pattern, across sessions, of statistically significant reductions in client ratings of distress and hindering impacts, and significant increases in client ratings of relationship and task impacts across sessions of counselling.

The substantive element of these changes occurred across initial sessions of counselling, with the rate of change slowing across later sessions. This pattern of reductions conforms to the 'negatively accelerating' change curve described by Howard et al's (1986). In their 'dose-effect' model, the change curve 'flattens out' across successive sessions of counselling as the rate of reduction declines: effectively corresponding to the economic law of diminishing returns. There was further statistical support for this observation of the change curve shape, with a consistent pattern of linear and quadratic curve components across both analyses and measures. The evidence for these components was particularly strong for the SCL-18 and for the task impact sub-scale.

The high degree of variance across adjacent sessions, displayed by client ratings of relationship impacts, may be relate to session content. This sub-scale measures client ratings as to whether they felt supported, relieved or comfortable during each session. The noted adjacent-session variance, in ratings, may be a function of the difficulties inherent in maintaining, over time, the intense and involved one-to-one relationship, that counselling represents. Like any relationship, the client counsellor relationship is likely to have its 'ups' and 'downs' and the extent of support, for example, that the client perceives is likely to fluctuate, with the rating after any one session relating to the content of the just completed session.

For example, if the session was 'challenging' and 'difficult' for the client: if the counsellor identified something painful for the client, then the client may well have perceived that session, especially immediately after its conclusion, as being unsupportive. If on the other hand the content of the session was positive, then this might well translate into a more positive rating of relationship impact. Further research is suggested, in an applied context, to address this relationship and to examine the relationship between the measurement of impacts and session content. This would supplement the existing research (e.g. SPP2, Shapiro et al, 1994), though in an applied context, that is currently examining the relationship between session content and impacts. However, given the applied context and the noted difficulties with gaining any level of control, it is likely that alternative, possibly qualitative approaches would be more applicable to this context.

The only consistently significant relationship, between outcome and impact measures, was between the SCL-18 and hindering impacts. Greater levels of distress were associated with greater ratings of hindering impact. The hindering sub-scale includes items asking the respondent to evaluate whether the session has left them feeling angry, confused or attacked. It is not surprising that ratings of such feelings will be associated with greater distress, since such negative evaluations are unlikely to be associated with a successful session outcome, or positive session content. The fact that this is a correlation means that it is impossible to identify the direction of causation, to establish whether greater distress translates into negative ratings of impact or whether negative impacts (that relate to session content) are translated into ratings of emotional distress.

Given recent calls for the increased use of process-outcome methodologies (Reynolds et al, 1993) to address issues, such as the 'equivalence paradox' (Stiles et al, 1986), there is a need for further research in both 'pure' and applied contexts. It is likely that comparable research, in applied environments, will require modifications to the employed methodologies to compensate for the lack of control of variables.

11.12. Change from Pre- to Post-Counselling: Comparisons Between Quantitative and Qualitative Findings

Generally, client comments about the impact of counselling reinforced the pre-post data analyses. Those clients who had experienced significant pre-post reductions consistently positive in their evaluations of counselling at both sites.

Clients who remained cases at post-counselling were also complimentary when evaluating their experiences of work-site counselling. It should be noted that many of this group, although cases at post-counselling, had shown substantial pre-post reductions, on the GHQ-12. For example, client N7's pre-counselling score, on the GHQ, of 12 had become 5 at post-counselling. Therefore, although this group of clients continued to experience some difficulties, they had still experienced substantial improvement.

A number of clients, who were not cases either at pre- or at post-counselling, were also complimentary about the service: it is possible that they accessed counselling for non-health reasons, for example for careers counselling. However, a review of the qualitative accounts of these clients suggests that they had been experiencing some distress:

Felt a lot better. Had been feeling (pre) under immense pressure, was making mistakes at work. Dealt with suppressed feelings. Improved coping. Better able to prioritise jobs and problems. Will seek help if I need it again. (P37)

Found "...counselling extremely helpful" and that "Once I realised that there were other options, my problems didn't seem half as bad". (P60)

This suggests that the mesa employed, for this comparison, was not sensitive to the issues and feelings that these clients had. This indicates the need to not rely on a single measure of distress (especially when they are of limited length) when evaluating the impact of an intervention, since it is unlikely that any one measure is capable of reflecting the range of symptoms that distressed individuals may express. There is then the problem, however, that you can include too many items, in a questionnaire, which poses some risk to levels of recruitment and retention. Finally, on a broader level it also indicates the potential utility of qualitative methods, when evaluating service impact and of the importance of using as large a variety of methodologies when evaluating. Where possible, employed methodologies should try and ensure as far as possible that a comprehensive 'portrait' of the service and its impacts is 'painted'..

Section Two

11.13. Implications and Suggestions for Future Research

Study findings are discussed with reference to the evaluative frameworks and the future development of the concept of employee counselling. The need for further research is discussed and suggestions are made.

11.14. The Study and Models of Service Evaluation

Chapter Four reviewed both general and EAP specific evaluative models. Broadly speaking, the models reviewed and those described, such as Cayer and Perry (1988), Kim (1988), Posovac and Carey (1989). Rossi and Freeman (1987), share common stages that correspond to addressing four developmental phases of an intervention: (i) the planning of the intervention, (ii) the monitoring of its operation, (iii) the assessment of programme impact(s) on the target group(s) and (iv) the efficiency of the programme in economic terms.

A number of specific evaluation models have been developed to address questions at all four stages. These models are: (1) needs evaluation, (2) program development, (3) utilisation analysis, (4) outcome evaluation, (5) net effect assessment and (6) cost-benefit and (7) cost-benefit analyses.

So what has the study, reported in this thesis, achieved in terms of these larger evaluative frameworks? In terms of stages, this study has very much addressed questions that come under the broad head of Phase III, the "outcome impacts": In terms of evaluative models, the study is located under "outcome evaluation", although it does also address, in its qualitative element, questions relevant to "programme development".

Thus, this study has only considered a relatively small number of the questions that any evaluative framework can potentially address. This narrow focus is largely a function of limited resources and the quality of access that was available. These are factors that will be barriers to any evaluation. There will always have to be a compromise between resources and the number and type of questions that can be addressed. The selection of questions, in a context of pragmatism, from the many available, was driven by a specific interest in addressing the absence of research on work-site counselling. There remain a range of areas, such as needs evaluation, service use, cost-benefit and cost-effectiveness analyses which

need to be addressed by future research. Ideally, these questions should be addressed in parallel with those relating to about outcome impact..

In terms of evaluative models, such as Parry's (1992), that have focused specifically on counselling and psychotherapy services, the current study was unable to address the six evaluative criteria listed by Parry because of the trade-off between available resources and the questions that could be addressed given these resources. Parry's evaluative criteria were: (1) Is the service relevant to client needs?, (2) Is the service reaching those who need it and is anybody being excluded from using the service?, (3) Is it accessible to service users?, (4) Is it meeting customer requirements?, (5) Is it effective? and (6) Is it efficient? in this study.

The reported study was able to address questions surrounding service effectiveness (e.g. Criteria 5) and some of the questions centring on service accessibility and relevance (e.g. Criteria 1 and 4). There remains a requirement for further research to address these evaluative criteria and, also, the criteria that could not be addressed by this study. In field settings, Parry's framework provides, for those managing counselling and psychotherapy services, a tool that will aid service providers in generating questions, to be addressed, that are relevant to service objectives.

11.15. Study Findings, Implications for Service Development and Future Research

1. Why aren't Troubled Employees Using Work-site Counselling? Implications for the Service and for Research

In keeping with the findings of this study, there is likely to be significant discrepancies in terms of the relative penetration of the service into the various employee sub-groups, defined in terms of biographical variable, problem type and severity, as well as a gap between number so service users and distressed employees.

By surveying the population of employees as a whole, a needs analysis, it is possible to be able identify problem type and severity and how issues are 'spread' throughout the host organisation. This type of survey information, used in conjunction with evaluative data collected by the counselling service, will allow discrepancies between potential demand and service use, in terms of absolute penetration, and the extent to which the characteristics of the whole employee group are reflected by the group of service users.

These discrepancies have implications for the individual and organisation wide impacts of the counselling service. Ideally, organisations should resource employee counselling, so that it is accessible by all employees. The reality for probably all employee counselling services, is that the likelihood of accessing counselling, in response to distress is not consistent across employees. This has resource implications and there is a significant need to address this problem.

Client responses to the service evaluation questionnaire indicated that there were a number of barriers to help-seeking. There was apprehension about the response to help-seeking from colleagues, managers and the organisation as a whole, a fear of being stigmatised and the impact that this would have on one's career. For example:

"I did not want anyone to know I was visiting a counsellor, especially as they are psychologists and their involvement with mental illness is too close and I felt that others would think me unfit to work..."

This fears act as powerful disincentive to help-seeking. In the NHS, and the health sector in general, these disincentives may be even more pronounced, with fears being reinforced by the 'macho' culture of the NHS (Payne and Firth-Cozens, 1987). A number of professions (doctors and other senior personnel and men) were noticeable by their absence from the counselling service and the study: this suggests that the perception of these barriers is more pronounced in certain groups of employees, than in others.

There is a need, then, for further research to examine the attitudes, perceptions, the costs and benefit analyses that are employed by potential help-seekers that impact on the likelihood of accessing counselling and other interventions. Many of the advantages and disadvantages, the reasons for accessing counselling and the costs that are perceived to be associated with accessing counselling have been described in the qualitative chapter, Ten.

The implications for the current and other services is that, if the services are to improve their penetration into the population of troubled employees, then there is a need to examine the reasons for not accessing services and once these are identified, to modify the service design and service publicity to address these barriers. In the case of the services involved in this study, and, indeed, other counselling services, suggestions for service design include providing the opportunity for off-site sessions, developing managerial awareness and

acceptability of the service and the design of marketing materials that directly deal with the fear of stigmatisation, of labelling that are held by employees.

2. The Repeat Use: Implications for the Resourcing of Counselling and the Need for Further Research

In addition to the organisational and cultural factors that have been discussed above, there are additional factors that influence service use and which have distinct implications for the development and running of services. An exploration, in this study, of prior help-seeking experience indicated that the majority of study participants had been to counselling, or some other form of intervention, before the current episode of help-seeking. As has already been stated, in the absence of survey data, it was not possible to establish how representative this group is in comparison to service users, as a whole, or to employees at both sites. However, this phenomenon of repeat users has important implications for service resourcing, even if this group is in the minority, because this group is likely to be 'soaking-up' a disproportionate amount of resource.

What can a service do to address this issue? If it limits clients, for example, to five sessions and then clients return to access the service in the near future, say after three months, how should the service address this second episode? It may be necessary to establish the reason for returning to the service. Is the return a function of (i) a dependency on therapy (which suggests a deeper issue), (ii) repeated exposure to a chronic stressor, either at home or at work or (iii) is the client a representative of the chronically vulnerable group identified by Depue and Monroe (1986).

Apart from the issue of resource allocation, there are issues of potential litigation, if re-entry to the service is declined, if the return to service use is a function of chronic exposure to a stressor associated with the host organisation and what are the legal, and ethical, implications of refusing intervention, if the client, for example, commits suicide. In addition, what are the implications for the host organisation and, indeed, its relationship with the service, if denial of access leads to a distressed, performance impaired individual returning to the workplace. Therefore, service policies, for example about access, need to be well thought out and flexible enough to meet varied demands. It is possible, that an in-house counselling service will be able to provide a greater degree of flexibility, than an external, contracted provider. There is also a need to examine help-seeking behaviour and the factors that predict such behaviour.

3. The Pattern of Service Use and Relationships Between the Service Provider and the Host Organisation

If service use is monitored, it is likely that certain patterns of use will become apparent: a particular department, team of profession may become over-represented as service users, or information conveyed in the course of counselling may indicate difficulties. There are implications for the relationship between provider and host and between provider and clients, if patterns of service use were fed back to the organisation. This might be a role for the counselling service/ EAP if it develops towards Osawa's (1980) fourth, internal consultancy of development. There will be impacts on confidentiality (Murphy, 1988) and employee perceptions and these will need to be addressed if this step is to be taken.

4. Culture and Employee Counselling: Impacts in Both Directions

Both of the sites included in this study are in the NHS. This poses the question as to the extent to which the organisational setting of this study, its culture, values, and the occupational, age, educational and gender breakdown of staff has impacted on findings and, thus, the extent to which they can be generalised to other settings. This is may be particularly salient with respect to the qualitative information that has been collected and analysed. Further research is required. This issue will only be addressed through research that will evaluate work-site counselling in a wide range of organisations, using similar methodologies that will allow comparisons to be made.

In parallel to impacts on individual clients, the introduction of EAP/ ECPs will have considerable impact on organisational culture (Smewing and Cox, 1995). Further research is required to examine the interaction between an EAP/ ECPs and their host organisations (Shapiro et al, 1995; Sonnestuhl and Trice, 1986).

5. Client Pre-disposition Towards Counselling

Retention, in this study, was affected by issues such as short-term contract and training rotations, as well as other factors such as participant disinterest, communication breakdown, workload and changes in circumstance and so on. Many of these factors will affect, to some extent, all applied pieces of research, whilst others may be more specific to certain organisations: for example, training rotations (moving from job to job as part of your training) are characteristic of the NHS and major retailers but will not affect, to the same extent, other organisations.

There were differences, in pre-counselling levels of interpersonal difficulty, between pre-only and pre-post participants. This was explained as possibly being a function of the skills that clients had in being able to effectively use the opportunity of counselling: effectively a 'pre-disposition' towards counselling. Those clients who do not feel comfortable with the option are unlikely to access counselling. These findings need to be replicated and further research, generally, is required to examine clients suitability for counselling.

The implication of this, for service provision, is that reliance by a counselling service on a limited range of interventions (e.g. only counselling or only stress management) will impair the ability of the service to meet its aim of providing interventions that all employees can access. There is a need for services to employ a 'menu' or provision, a wide range of interventions that can be matched to client needs. This goes beyond the technical eclecticism, that is of increasing importance in counselling, to services being equipped to provide interventions, other than counselling. This global eclecticism will help the service to improve its penetration.

This study has focused on counselling and not on other approaches to dealing with employee distress, such as Stress Management Training and organisational change, which might suggest that counselling is the intervention of choice. However, the key objective of a counselling service or an Employee Assistance Programme is to provide interventions that will reduce employee distress, and the potential costs to the host organisation. Its aim, therefore, is not to provide counselling per se but, instead, to reduce distress and have some positive impact on the "bottom-line" (Cooper, 1991). Therefore, a provider should not allow itself to become 'hung-up' on one type of intervention at the expense of others.

6. The Impact of Counselling: Recommendations for Future Research

The reported study did not employ a control group, for reasons that have been discussed. There remains a need for work-site counselling to be evaluated employing some form of control group as a core design feature, to finally 'nail the coffin' of any doubts about the effectiveness of work-site counselling. This would address, in an applied setting, the Level One questions described in Lambert et al's (1991) framework, which address the basic question of efficacy of employee counselling. The Post Office (Cooper and Sadri, 1990; Cooper et al, 1991) study did employ a control group but this group was not comprised of distressed employees, with controls, instead, being matched on a number of variables with service clients.

It is likely that because of ethical constraints, the need for external validity, and industrial relations, that the option of employing a 'waiting-list' control group, or a variant, might be the most applicable, since it would avoid the issue of denial of treatment. Ideally, such a design would be employed in an organisation where there already exists a waiting list, since this would minimise the disruption to a counselling service, that employing a control group represents. An alternative option might be to employ a placebo control group, which would receive at least some form of 'attention'. Finally, a hybrid between the two, where those on the waiting list would receive some form of placebo intervention. There are problems, however, in counselling research with placebos because such controls cannot be considered to be inactive: the very receipt of some form of attention will be associated with some degree of change.

In general, there is a requirement that all work-site based counselling services should, from the outset, be continuously evaluating their impacts (Berridge and Cooper, 1993; Murphy, 1988) and that a pre-post design, comparable to the one employed in this study, though on a smaller scale in terms of employed measures, would be one approach to such evaluations.

Differences in the extent and rate of change, between measures of distress and interpersonal difficulties, reported in this study, which support Howard et al's (1993) and Orlinsky and Howard's (1987) phase model of therapeutic change need to be replicated in an applied setting. A greater level of control is required to take into account some of the methodological difficulties that were encountered in this study.

7. Coping Strategies Use as an Outcome Measure for Counselling

The fact that pre-post reductions in distress were not apparently associated with increases in the use of logic based coping strategies has a number of implications: The first is that reliance only on counselling as the intervention on offer will not necessarily help clients to become 'inoculated' (Ganster et al , 1982) against existing and future stressors. The second implication is the impact of this on the focus of a counselling service and its need to be flexible in the interventions that it offers to clients. It may be that there will be a need to have a menu of interventions available and that items, such as counselling, stress management and other interventions, such as acupuncture, exercise prescriptions, should be selected to address the individual needs of clients. Therefore, the therapeutic eclecticism that is currently on the ascendant in counselling (Hooper, 1996) is extended beyond the boundaries of counselling to encompass other forms of intervention. Therefore, if a client

needs counselling, stress management and maybe a life style check then these should be available at the counselling service, which should become a 'one-stop shop' that can either directly, or indirectly, provide the range of services that are required.

There is a need for further research to examine the impact of counselling on coping strategies, ideally using an instrument that is more reliable than the one employed by this study, the OSI and there is also a need to examine how a 'menu' type approach, and the EAP/ ECP as a diverse service provider, will work.

8. Counselling Expectations: Implications for Service Development

The expectations that potential clients have of counselling, and the specific services that they are able to access, will impact on the counselling service. It is likely that clients will only access counselling if, on balance, they have positive expectations of what counselling can and will do for them. These expectations has implications for the 'penetration' into the population of distressed employees.

Understanding the expectations that potential clients have, how these have developed and how they continue to be influenced will greatly aid the ability of the service to 'attract' potential clients. This information will help to inform publicity materials, to shape them to address these expectations and, if necessary, to modify them. It is possible that distressed non-users may differ considerably from the distressed user in terms of the expectations that they have. An examination of expectations will need to be extended further and there is a distinct need to undertake research to identify the expectations, beliefs and attitudes that underpin the act of help-seeking. Theoretical models, such as Ajzen's (1991) theory of planned behaviour, may be applicable in this instance to aid understanding.

9. The 'Dose-effect' Curve and its Implications for Service Provision

The 'dose-effect' curve (Howard et al, 1986), supported here, has implications for service provision. This model of change across time suggests that substantive change occurs during the first few sessions of counselling, with diminishing returns across subsequent sessions. This provides support, especially in a context of limited resources, for a 'triage' approach to counselling, where all clients receive a pre-set number of sessions, possibly as few as three (Barkham, 1989). For the majority of clients this will be sufficient. If clients are assessed before and after this triage, it will be possible to identify those who have successfully

responded, and, therefore, do not require any further sessions, and those who have not, or at least to the same extent, and these can be referred, internally or externally, to additional intervention.

An example of this triage type concept is the 'Two plus One' model developed by Barkham (1989) and Barkham and Shapiro (1989) with the rationale for the triage concept stemming from the gap between available resources demand (Barkham, 1989a; Barkham and Shapiro, 1989)

10. Skill Use and Training

Counselling skills were used, at work, by the majority of participants: However, less than half of this group reported having received any form of training and fewer still had received any substantial amount of training.

There appears, to be a gap between the use of skills and training in these skills. It is difficult to generalise this finding beyond this study, since it is unclear as to whether this skill deficit is representative of NHS staff as a whole. Further research is required to examine the question of whether there exists a wholesale deficit in counselling skills in the NHS.

If this skills gap is characteristic of the NHS, then it needs to be addressed. The majority of front-line staff have to deal with a range of difficult interpersonal situations (Payne and Firth-Cozens, 1987), training in counselling skills would be an invaluable addition to the repertoire of skills that staff have. There are likely to be a number of benefits: First of all to the quality of patient care and to the quality of the relationships between staff and patients, relatives and colleagues. It is possible that any comprehensive, organisation wide, training in counselling skills might have considerable impact on the culture of the host organisation.

There is an opportunity, here for work site counselling services to take a proactive approach and to become directly involved in the needs analysis, in the identification of the appropriate minimum level of skills that staff should have and in developing the training programmes and how they are delivered that would help to address these deficits.

Extending on from this, there is also the opportunity to extrapolate the idea further by developing a number of staff, along the lines of the 'active listeners' that were trained by General Electric after the Hawthorne studies (Murphy, 1988), into emotional First-Aiders. These would act, as part of a triage model, as a filter between distressed employees and the

counselling service. It is likely that the needs of many distressed employees would be met by these 'First-Aiders' with the more complex cases being referred onto service counsellors. This would help to manage any conflict between the demand for, and supply of, counselling services. There might also be a role if the service has to operate any kind of waiting-list. There would have to be a mechanism to allow clients to avoid this triage and access the service directly.

11. Publicity

There is a need to evaluate the relative effectiveness of different forms of publicity. This would help to provide a basis on which to maximise the effectiveness of materials in attracting client usage, of the service, throughout the host organisation. There is a need for research to establish the images, the concepts that are most useful in attracting clients to the service. Study participants suggested that there exists a need, through targeting publicity materials, to address the need to raise managerial awareness of service provision, to change attitudes and to respond to the anxiety that clients had about the possibility of stigmatisation. There is a need to balance publicity with available resources: one would not want to be too successful, with marketing, if its success led to the service becoming 'swamped'.

12. Service Accessibility

That there is a need to ensure that the lines of communication between potential users, and the service, are as clear and as simple as possible. Problems with communication can be counter-productive since they impact on perceptions of professionalism, confidentiality and credibility, which are particularly salient with respect to counselling. Indeed, if resources prevent an appropriate level of communication, then it would be advisable to delay the start of a new service until it was resourced sufficiently, since problems will have an impact on its 'attractiveness' to potential users.

13. Client Suggestions: A Role for Clients in Service Development

Study participants were provided with the opportunity of suggesting changes to the counselling service. Suggestions included extended hours, off-site sessions and the development of an internal consultancy role, as a mediator between management and employees.

It is suggested that ex- and potential service users should have an influence over service development and not just through user surveys: instead they should, ideally, have a more pro-active role. There would be a number of benefits from this involvement: An enhanced feeling of ownership, the development of a service that meets their needs and possible improvements in the confidence that employees will have about the relationship between the service and management.

14. What do Clients want from Counselling?

As stated, counselling services need to regularly survey employees to identify the issues that troubled employees may present with. In addition, the other reasons, that underpin the decision to access counselling, also need to be identified. For example, in the reported study, clients, who presented with a particular issue, also wanted particular benefits, such as improved assertiveness, self-confidence and inter-personal skills. In terms of service development, this information will aid counselling services to develop interventions and to help them to target them more accurately. A further source of information would be provided by systematic assessment, at pre-counselling, which again would help counsellors to target their resources.

The fact that clients were searching for certain relationship qualities, such as the opportunity to be listened to and to be supported suggests that these qualities are lacking in the workplace and, perhaps, One client justified using the service, during work hours, because of a lack of departmental support, whilst a second wrote that the counselling service was the only support that she had received whilst she was off-sick. This implies a deficit of inter-personal support, within the NHS, for its own staff. This may be related to the machismo culture that 'saturates' health-care organisations (Payne and Firth-Cozens, 1987). There may be a role for counselling services, in this instance, to help the organisation to develop its internal relationships, with its potential impact on organisational culture and 'interpersonal tone'.

There ties up with the concept of emotional First-Aider's and training, on an organisation wide basis, the workforce in basic counselling skills. It is arguable that this training should be extended further into society as whole, with training in preventative mental health skills being placed on the curriculum. This would represent a radical shift from the onus on the curative to the preventative.

15. Advantages and Disadvantages: Clients Ratings of the Costs and Benefits and the Implications of these for Service Development

There were several advantages and disadvantages cited by service clients in using a work-site based service.

The advantages were: (a) cost, with services being free at the point of access, (b) service accessibility: the fact that services were on-site and could be easily used after, or before, work, (c) counsellor awareness/ understanding of organisational issues, (d) Self-referral and (e) the service being perceived as managerial acknowledgement of the impact of employee mental health on work performance

The disadvantages were: (a) the potential threat to anonymity and confidentiality from the service being on-site, (b) apprehension about the relationship between counsellors and management, (c) issues surrounding service eligibility and (d) the impact of changes in employment status on completing a programme of sessions.

Of core importance, was the fact that work-site counselling was free at the point of access. A second key feature was that the service could be easily accessed, with employees being able to use the service before and after work and at lunch times. Therefore, the most salient predictors of service use may not be psychological at all but, instead, pragmatic. The implications are, that if a service is to avoid creating barriers, other than those which are psychological (e.g. the fear of stigmatisation), that it should both be free at the point of use and it should also be easily accessed by employees.

The counsellors, at both services, were 'in-house' and they were perceived as having an insight into and understanding of issues specific to the host organisation. This suggests that external, contracted counsellors will lack this insight and understanding.

Clients felt that such insight and understanding was important, in a context of a limited number of sessions being available to each client, because it meant that clients did not then have to spend part of their available session time having to explain these contextual elements to their counsellor. This has obvious implications for the competing model (in-house and out-house) of service provision that exist. It is unlikely, unless the external EAP/ ECP provider is able to offer a network of counsellors dedicated to a single organisation, that out-house counsellors will be able to develop an understanding of the employers

organisational issues. However, an external provider will be able to bring wider organisational experience to bear which might be useful in some situations.

Clients felt that the provision of work-site counselling represented an acknowledgement, by management, of the impact of mental health issues on work performance. This implicit acknowledgement was perceived as a positive step forward. Its development, however, would depend on the level of explicit, and implicit, support from management (at all levels) and unions, as well as perceptions of confidentiality and the relationship between the service and management (Murphy, 1988). The introduction of a counselling intervention will have a number of impacts (Maiden, 1989; Smewing and Cox, 1995), on staff attitudes, morale and staff-management relationships, as well as organisational culture. However, the act of introducing an EAP/ ECP into an organisation is not without risk and the process will have to be well thought out and handled effectively. A failure to handle such a process successfully could be disastrous for the host organisation, in terms of employee relations, staff morale and culture.

There were a number of disadvantages to having an in-house, on-site service. There was a risk of anonymity being compromised: indeed a number of clients reported 'bumping into' colleagues on the way to and from the service.

There was genuine anxiety about the potential consequences of anonymity and of confidentiality being compromised. Clients reported a fear of being stigmatised, of being labelled as having difficulties coping and there was anxiety about the impact of this on one's career. This anxiety was not without some foundation, since in the NHS, help-seeking may be regarded as being a sign of weakness (Payne and Firth-Cozens, 1987). There is a need to physically locate services in a way to minimise threats to anonymity and confidentiality. Services need to be flexible and, ideally, a variety of venues should be available to allay the fears that clients have about service use.

There was apprehension about the relationship between counselling services and management. Given the fears about stigmatisation, this anxiety needs to be addressed in publicity materials, although it is unlikely that such fears will ever dissipate completely.

At Site Two, there was added complexity because of the dual roles that counsellors had. One client experienced the inability of her counsellor, who was also a manager, to be able to completely remove his "managerial hat". A second client, found that the fact that she had

professional links to her counsellor, at work, difficult to deal with. The implication is that counselling services should not be staffed by those with dual roles. If the level of resourcing means that this duality of roles is inevitable, then systems should exist that should prevent counsellors seeing clients where such a role clash may exist.

Eligibility was dependent on the individual's employer part-funding the service and that clients should be employed by the host organisation. There was a problem with a Site One client whose employer, a research council, was not funding the service and, as a result, this individual could not use the service, which caused considerable bitterness. Other clients who were either made redundant, or who resigned found themselves to be ineligible. Services should ideally be available to everybody who works at a specific site. This should also include employees whose departments, such as catering, have been contracted off to another organisation. If services offer a pre-agreed number of sessions, then, even if the clients employment status changes before the end of the sessions, he, or she, should still be able to complete the series of 'contracted' sessions. Apart from the ethical issues involved in these cases, these solutions would also help to prevent the 'bad press' that might result from barriers to service use. Given the noted difficulties around anonymity, the fact that ex-employees would need to return, physically, to the service provides a further rationale for services to be able to provide alternative venues.

16. A Comparison Between Sites One and Two: Differences and their Implications

There were distinct structural differences between sites. These related to service structure, resourcing and geography. These features are likely to have impacted on service provision. For example, the duality of roles at Site Two, when Site One clients had a single role, increased the likelihood of role clashes. It would seem sensible, with fears about anonymity surrounding the issue, that counsellors with managerial responsibility should not be involved in counselling because of their association with the host organisation.

Site One's resourcing allowed for full-time employed counsellors: Counsellors at Site Two volunteers. A full-time level of resourcing will be reflected in better communication, administration and planning than a service attempting to run a comparatively 'ad hoc' service. There was certainly some evidence of difficulties at Site Two, with clients reporting difficulties accessing the service and there were the noted problems that related to the blurring of counsellor and organisational roles, which was translated into some anxiety, on the part of clients, about links between the service and the host organisation.

Within Osawa's (1980) typology, Site One could be categorised as a 'third stage' service: A researched, professionally staffed service, whilst Site Two can be categorised under 'Stage Two': A service run by volunteers. Whilst, Site Two service is an improvement on no resource, it's limited resourcing is associated with a number of difficulties: role clashes: increased anxiety, on the part of clients, about access and issues surrounding communication.

11.15. Future Research and Methodology

1. Survey Methodology

The exclusion, from Site One, of potential study participants because they were unable to use research materials employed by this study has some implications for the design of such materials. This is particularly important in the light of the 1995 Disability Discrimination Act, since, excluding an individual's participation in a study because the study has not 'translated' those materials into a form that meets that individual's needs is, arguably, an act of discrimination. This may be even of greater importance in the context of an evaluation, since if the evaluation will impact on programme development, you will not be giving a service user, excluded because of their disability, the opportunity to provide feedback on that programme's operation. Therefore, there may be a need to ensure that materials are translated into a form (for example Braille or larger writing for individuals with a visual impairment) that will prevent such exclusion from taking place.

2. The Need to Identify the Population of Troubled Employees

An assessment of the extent, range and severity of problems being experienced by employees: the identification of the population of troubled employees at both Sites One and Two was notable, in this study, by its absence. This meant that the following key evaluative questions could not be addressed by this study.

“What are the appropriate target populations for a particular intervention?”

“What is the nature and scope of the problem that requires a new, expanded or modified social programs?” and

"Is the programme reaching its intended target(s)?

(Rossi and Freeman, 1987)

This made comparison between service clients, who participated in the study, and Site One and Two employees, as a whole, impossible. It is not possible to state the extent to which both services were, at the time of data collection, addressing the needs of employees.

A needs analysis provides information that can be used as a benchmark to assess the success, or otherwise, of the intervention. This information establishes the programme's 'penetration' (Sonnestuhl and Trice, 1986), the proportion of distressed employees 'reached' by the service. In terms of service development, this information is essential when evaluating the service, since without it there is no guidance about how it should target its resources. The Site One service did collect some information, through its own evaluation, that allowed it to make comparisons between the breakdown of the service clients, in terms of variables such as gender and occupation, with a breakdown of employees, as a whole.

It is difficult to compare the reported study with those in the literature, because of the methodological differences in the extent to which control could and was employed. The focus of the reported study was on external validity, with an evaluation of two real-life counselling services: the majority of the studies in the literature are largely experimental in nature and they are able to exert a considerable amount of control over variables, a maximisation of internal validity at the expense of external validity.

3. The Problems Encountered by the Study

This study encountered a range of problems during the project.

1. There were difficulties with recruiting clients to the study: a process that was affected by factors such as the use of inclusion/ exclusion criteria by counsellors
2. Difficulties retaining clients: Clients dropped out of the study at a number of points, for example at the end of counselling. There was a problem with turnover and short-term contracts
3. Problems with the rate of return of measures, initially dealt with by reducing the number of questionnaire items, but which remained an issue throughout the study
4. The distance from researcher to the Site One counselling service, which made communication difficult

5. Missing data. Some of these will be salient whatever, because of the dynamic and complex nature of applied research means that little is likely to go to plan (Buchanan et al, 1988).
6. No warnings from clients about when clients terminated counselling which meant that the timing of end of counselling and follow-up measures was very difficult and often down to guesswork

These difficulties illustrate Buchanan, Boddy and MaCalman's (1988) view that the output of organisational research is

"... a conflict between what is theoretically desirable on the one hand and what is practically possible on the other... In the conflict between the desirable and the possible, the possible always wins."

4. Control Groups, Links Between Counselling and Economic Outcomes and Qualitative Methods

i Pre-post Designs and Control Groups

Pre-post designs remain relevant, in an applied context, but only as one of several tools to be employed where necessary. Since there exists almost a direct 'trade-off' between internal and external validities, with efficacy studies, such as SPP2 (Shapiro et al, 1994), attempting to maximise internal validity whilst studies such as Seligman's (1995) and the reported study attempt to maximise the extent to which findings can be generalised.

ii Links Between Counselling and Economic Outcomes

Given the claims that have been made in the literature about the economic impacts of EAPs (The Almacan, 1989; Maiden, 1989; McClellan, 1989), there is a very real need to establish the validity of such claims. The economic impacts, that have been cited in the literature, include indicators such as absenteeism, turnover and job performance (Berridge and Cooper, 1993; Murphy, 1988). The reported study attempted to address this, through examining the impact of intervention on absenteeism but was thwarted by organisational barriers: a lack of appropriate systems for data collection. Practical barriers to the collection of appropriate reliable, valid data that have been reported in the EAP/ ECP literature (Murphy, 1988;

Swanson and Murphy, 1991; Maiden, 1989) and characteristic of applied research in general (Buchanan et al, 1988).

One of the problems with attempting to link changes on individual measures of distress and counselling and economic and financial measures is the current difficulties that the stress literature has with being able to accurately attribute out the impact of stress on the economy and, more specifically to individual organisations (Briner and Reynolds, 1993; Reynolds and Briner, 1994). This process, by the very nature of applied research, is difficult because of the limited amount of control that can be exerted in applied settings. However, until there is evidence that reliably identifies a relationship between psychological problems and economic variables, it is going to be difficult to identify the extent to which pre-post changes in measures, such as absenteeism, relate to pre-post changes on measures of distress.

In terms of work-site counselling, there is a need to refocus and look at other elements of the system surrounding service utilisation, other than pre-post change. There is a need, for example, to look at the reasons for service use, under and over-representation of groups in the population of service users, the processes of referral, decision making and help-seeking in general, as well as the role of the organisation, and the organisational culture, on work-site counselling.

iii Qualitative Methodologies

The emergence, in recent years, of improved qualitative methodologies (Denizen and Lincoln, 1994; Robson, 1993) provides an opportunity, that needs to be grasped, to gain a whole new perspective on employee counselling and its impacts. The reported study employed some qualitative methodology that was 'bolted-on' to what was, largely, a quantitative study. Quantitative methodology is, as Seligman (1995) has pointed out, limited in an applied context. There is a need, therefore, for the development of qualitative methods that can apply comparable levels of rigour as those found in quasi-experimental designs (Campbell, 1989; Robson, 1993). Such a methodology would be able to build up a much more detailed 'picture' of work-site counselling, providing insight not just into the impacts of the service, and the experience of counselling, but also into the processes that are at play.

Overall, however, there is just a general need to expand the evaluative literature on employee counselling and, indeed, EAPs. A considerable amount of literature has been written on employee counselling but comparatively little of this output has focused on the evaluation of counselling.

The reported study has added to the body of work that exists, through employing a mixture of methods borrowed from efficacy research placed within a quasi-experimental framework, but this study has also clearly demonstrated the pitfalls of adopting such an approach and the organisational factors that can undermine the attempt. There exist other approaches, such as that described by Seligman (1995) that promise more through using different methodologies and by addressing a different set of questions. Reliance on modifications of efficacy methodology is likely to result in diminishing returns. It is, perhaps, time for psychotherapy research, generally, to examine interventions in applied settings and to transfer its gaze away from the experimental context to the real-world.

5. The Weakness of the Efficacy Approach in Applied Settings

Seligman (1995) states that the methodologies associated with the traditional psychotherapeutic studies, such as random assignment to experimental and control groups and manualisation are neither relevant, or, indeed, of much practical use, when evaluating real-life counselling services.

Seligman (1995) draws a range of distinct differences between psychotherapy, as it is researched in the field, and the efficacy research that is cited in the literature (Howard et al, 1986; Shapiro and Shapiro, 1982; Smith, Glass and Miller, 1980). He argues that the characteristics that are inherent to applied contexts makes it impossible to adhere to the protocols employed by efficacy studies. The characteristics:

"Psychotherapy ... is not of fixed duration. It usually keeps going until the patient is markedly improved or until he or she quits. In contrast, the intervention in efficacy studies stops after a limited number of sessions ...

Psychotherapy is self-correcting. If one technique is not working, another technique - or even another modality - is usually tried. In contrast, the intervention in efficacy studies is confined to a small number of techniques, all within one modality and manualised to be delivered in a fixed order.

Patients ... often get [to counselling] by active shopping, entering a kind of treatment they actively sought by a therapist they screened and chose. .. patients [in efficacy studies] enter by the passive process of random assignment to treatment and acquiescence with who and what may be offered in the study. ...

Patients ... [in applied settings] usually have multiple problems and psychotherapy is geared to relieving parallel and interacting difficulties ...

Patients in efficacy studies ... have but one diagnosis [selected] by a long set of exclusion and inclusion criteria [and] psychotherapy in the field is almost always concerned with improvement in the general functioning of patients, as well as ... relief of specific, presenting symptoms [whilst] efficacy studies usually focus on specific symptom reduction ." p. 966-67.

Seligman, who openly states his previous adherence to the efficacy approach, doubts that because of the huge difficulties in being able to control for a vast number of variables, in an applied setting, it will ever be possible to run a "scientifically compelling efficacy study" in an applied context. Indeed, it is arguable that even if such control were gained, that it would just mean that the setting was no longer applied.

6. Future Research: The Consumer Approach

Seligman (1995) provides an alternative approach to undertaking applied counselling research. He reported findings, from the Consumer Reports Survey in the USA, on the use of therapy. A questionnaire was sent to 180,000 readers of 'Consumer Reports', a consumer rights magazine, comparable to 'Which' in the UK. There were 7000 replies to the 26 item mental health section of a larger measure, which included questions on modality, therapist competence and qualifications, the number of sessions, the presenting problem(s), 'How much the therapy helped' and reasons for termination.

Analyses of the responses provided support for (i) the 'dose-effect' curve (Howard et al, 19986), (ii) that "...long-term therapy produced greater improvement than short-term therapy", (iii) that mental health practitioners were the most effective group, especially in the long-term and that (iv) "Most respondents got a lot better" and these results provide support for the various meta-analytic reviews, such as Howard et al (1986) and Shapiro and Shapiro (1982).

Seligman (1995) noted a range of "methodological virtues" in this approach, that ensured that the naturalistic context remained intact. These "methodological virtues" included: *Treatment duration* (with the study including all duration's of treatment. Clients only remained in therapy for as long as they needed to), *Multiple problems* (Most clients presented with more than one problems), *General functioning* (Self-reported impacts [of

counselling] on work and non-work functioning) and *Clinical significance* (Findings were expressed explicitly by respondents rather being dependent on arbitrary statistical and effect size thresholds).

Seligman argued that, although the use of measures like the Consumer Surveys measure, and related methodologies, could not hope to reproduce the scientific validity associated with efficacy studies, they still represent an important research tool to be employed in applied contexts: Indeed, the fact that tightly controlled efficacy studies are inherently inappropriate in an applied setting, means that consumer surveys represent an important means of addressing questions, in applied settings, that would otherwise remain unanswered. Seligman criticises the 'gold standard' of efficacy research, the random assignment of clients to treatment and non-treatment groups, as being irrelevant, since clients in the real-world adopt a much more active role for themselves: They know what they want and if elements of an intervention aren't working, then they will abandon it for an alternative.

Seligman also concluded that there is a need in applied settings to (a) frame a new set of questions, that are relevant to real counselling services and, from these, (b) to develop a range of appropriate methodologies to deal with the complexities of applied counselling/psychotherapy research.

As stated above, there is a need to develop more appropriate methodologies for the applied context in general and for work-site counselling, in particular. In parallel to this process, a further process is required to examine questions that are more pertinent to this applied context than those that are 'traditionally' addressed by efficacy research (Lambert et al's, 1991). Indeed, there seems little point in the 'pure' efficacy type studies unless the focus of the research effort is eventually going to land on real world settings. If this doesn't happen, then a likely outcome is that practitioners are going to view counselling and psychotherapy research as less and less relevant.

11.16. The future of work-site counselling

1. The Relationship of Work-site Counselling to Counselling Theory

Work-site counselling is not in itself a theoretical approach, in the sense of it being inherently cognitive-behavioural or psycho dynamic: instead it can be considered to be a context in which the whole range of therapy models can be employed. The only proviso is

that because of the limited range of resources that are available to any one counselling service, that if these resources are going to be used to penetrate as much of the population of distressed employees as possible, that whatever interventions are used will need to be time limited.

It is likely that the majority of services will only be able to provide a pre-set number of sessions to any one client and that the number of sessions available, per client, will be restricted to probably no more than ten and, in many instances, to considerably fewer. For example, the Site One counselling offered a maximum of 8 sessions of counselling, whilst the EAP that the Employment Service is contracted to (in 1997), is limited to five sessions per client: therapeutic models that presume a greater number of sessions will not be employed in such a context. It is this conflict between resources and demand that has led to the development of models such as the '2 + 1' model (Barkham 1989; 1989a; Barkham and Shapiro, 1989). Therefore, to be employed, therapies, in the context of work-site counselling, will need to be 'packaged' into a small number of sessions whose session effectiveness is maximised.

2 Flexibility and Pragmatism

Historically, the EAP movement, generally the vehicle for work-site counselling, has had to re-invent itself on a number of occasions to meet new changes and to address a changing world. Thus, the EAP movement has had to change from an intervention developed to address the single issue of substance abuse, to the 'broad-brush' programmes that are characteristic of the majority of EAPs in 1990s. There is no doubt that in the future that this movement, and indeed work-site counselling, will have to re-invent itself again (Hooper, 1996).

Although, there exists a considerable overlap between EAPs and ECPs, with the former usually providing the interventions that the latter represents, there has been the development of counselling only programmes. It is likely that these programmes will need to develop further, to widen their scope, if they are to meet the demands that are associated with responding to employee distress. Thus, these counselling only programmes may need to take on board some of the other services that will be associated with social work, with the welfare function that has historically been administered by personnel. Thus there be a movement, for many counselling services, in a manner comparable to the substance abuse-'broad-brush' shift, from single to multi-intervention providers.

3. A Role as a Preventative Agent

A further shift that counselling services may have to undertake is from a 'curative' perspective, with counselling as a means to resolve problems, to the adoption of a much enhanced role as a preventative instrument.

With limited resources, this transfer of focus may well be the way in which limited resources can be used to maximum effect. This would not mean the abandonment of counselling but instead use of a proportion of resources to ensure that employees are better equipped to cope. This might be through the providing stress management training (Palmer, 1996) or through training the majority of, if not all, employees in basic counselling skills (Burnard, 1996), which would mirror the system, implemented in the wake of the Hawthorne studies at General Electric, of a system of employees trained in basic counselling skills, such as active listening (Murphy, 1988). Indeed, this would be an adoption of the triage principle, the use of a 'filter' employees trained in emotional/ psychological first aid. There may also be some benefit in terms of team and organisational building, with employees trained to become better listeners, there may well be a 'pay-off' in improvements in communication between people. The training of employees as emotional First Aiders would be a proactive response to stratifying limited resources, on the basis of a triage model, to address the issue of employee mental health.

4. A Role as an Internal Consultant

A further potential development, described by Osawa (1980), in his developmental model, and suggested as a future development by a number of service clients, would be the development of employee counselling to Osawa's fourth stage where the counselling service takes on a role of internal consultant. The adoption of such a role has also been discussed by Wolfe (1996). Such a role would be a radical departure from the largely reactive role that counselling services currently have and the change of role would have to be very carefully thought out, and planned, to prevent confidentiality from being compromised. Effectively, the role of the service would be a consultant to both the individual employee, teams and departments within the organisation and to the organisation as a whole. The employee counselling service would have to become, by definition, a very 'hands-off' unit which would have particular implications for in-house programmes. In this context, the service would have a role in helping to communicate between the organisation and its employees: for example, it would be able to the organisation if there seemed to be problems with a particular team, or department, and it might well be required to intervene in these areas. In

its most from, it would have a consultancy role in helping the host organisation to shape its human resource policies at a strategic level, in implementing these and through helping individuals, teams and departments to change as the organisation, as a whole, changes.

5. Expanding the Remit of Employee Counselling beyond Psychological Health

The term employee counselling is invariably associated with a resource that focuses on the emotional and psychological health of the employee. This is not surprising given the historical background to employee counselling and the development of the EAP movement. However, there is an opportunity for employee counselling to 'grow out' of this role and to take on additional responsibilities for counselling for non-health related issues, such as career counselling (Kidd, 1996) and in enhancing learning skills (Ross, 1996) which is of particular salience, given the recent movement towards the development of the learning organisation.

6. Staffing the Employee Counselling Service: Skills and Knowledge

There are a number of implications about which profession, of the many that are involved in employee counselling, and the skills and training that will be required if employee is to be able to meet the demands that it may have to address in the future.

To be able to adopt the multi-faceted role envisaged here, there will be a need for those staffing the counselling service/ EAP to have skills in individual and group interventions, health education, social work, organisational/ occupational development and to have some business awareness and skills. This might be a role that could be taken on by an applied psychologist, trained as both an occupational and counselling psychologist. It is unlikely that either of these backgrounds alone would provide sufficient expertise and knowledge to meet the full role, although counselling psychology would be the core area of expertise. At the moment, there is no work-site counselling/ EAP profession in the UK, although there are post-graduate courses in the USA and, currently, UK EAPs and ECPs are staffed by a range of representatives from various professions.

Cooper (1986) has addressed this issue of work-site counsellors having to have skills from several different domains, the areas, at the time, of clinical and occupational psychology to create a "a cross-bred between a clinical and an occupational psychologist ... a clinical-occupational psychologist".

7. Benefits to the Organisation

Sub-sections 1 to 6 have described a number of possible developments to EAP/ ECPs. There are a number of organisational benefits that may flow from these proposed developments. In broad terms, the suggested developments are about two shifts: the first from a largely reactive individually focused provider of interventions to a more pro-active organisation that adopts a sizeable consultancy role, that deals with issues at the level of the team, department, site and organisation as well as at the level of the organisation. The second shift is from a largely curative focus to one of prevention.

The first shift might well benefit the host organisation by helping it to develop human resource policies that more accurately match the people resource that the organisation has available to it. Policies may well become more developmental in being able to use counselling type interventions, on a larger scale, to help effect attitudinal, cultural and organisational change. It would also provide a more open and direct level of communication, through its consultative role with both employees and management, that would allow difficulties to be more easily identified and dealt with: that would help with the development of relationships within the host organisation. The benefits here will be improved intra-organisational communication and a more positive and supportive culture.

In terms of the second shift, a movement towards prevention as opposed to cure will not negate the need for interventions to deal with distressed employees but instead, through concepts, such as emotional First-Aid and triage, the likelihood of distressed employees may be reduced through prevention and through dealing with issues earlier on in their developmental cycle. This shift towards the preventative may well be a much more effective way of using limited resources to deal with the demand for services.

11.17. Contributions that this study has made to the literature

This study has made a number of contributions to the literature on work-site counselling, specifically, and to counselling, in general. These contributions are:

- Study findings of pre-post reductions in reported levels of distress and interpersonal problems, provide support for work-site counselling as an effective intervention. There are a number of qualifications: the fact that there were no control groups means that it is difficult to accurately parcel out the change that can be specifically attributed to counselling from other factors that might have contributed to change. These findings

add considerably to the limited body of research, that currently exists, into the effectiveness of work-site counselling.

- A second contribution is the finding that gains at the end of counselling are maintained at follow-up which supports existing findings (Nicholson and Berman, 1983; Robinson et al, 1990).
- The third contribution, to the literature, is the finding that there are differences in the rate of change between measures of distress and measures of interpersonal difficulty. These differences in the rate of change provide support, from a study conducted in an applied setting, for Howard et al's (1995) and Orlinsky and Howard's (1987) three phase model of psycho-therapeutic change which suggests that the separate components of any one psychological problem will respond at a differential rate to intervention.
- The fourth contribution is the finding that the shape of change, across sessions of counselling, supports the 'dose-effect' model of change proposed by Howard et al (1986). The shape of the change curve, identified in the reported study, closely matches the negatively accelerating change curve described by Howard et al with the substantive component of change being associated with the first few sessions of counselling and with later sessions of counselling being associated with smaller change increments: effectively modelling the law of diminishing returns.
- A further finding of the study is that there appears to be a relationship between the number of sessions completed by clients and the shape of the change curve. Since, the number may well be associated with the severity of the presenting psychological problem, these differences in the curve shapes provides support for recent thinking (Howard et al, 1995) that the Howard et al change curve is an aggregate of different curves, with the differences in the shapes of the curves being associated with problem type and severity.
- The study has provided qualitative data that has helped to generate a more detailed 'picture' of two counselling services, than a quantitative account alone can provide alone. This has provided a user perspective on the service, to counterbalance the therapist/ researcher perspective that the majority of counselling studies employ. One of the specific outputs from employing this data has been the opportunity, in

conjunction with the pre-post data, to build up a dual perspective on the individual impacts of counselling on specific individuals.

- A final contribution, provided by this study, has been methodological. This study attempted to apply a rigorous methodology, largely borrowed in modified form, from the counselling and psychotherapy literature, and has attempted to apply it in a highly applied context. This largely opportunistic study has had to employ, because of the difficulties associated with applied research, a range of pragmatic solutions to the issues that have resulted from the problems of data collection and analyses.

This study has provided some answers to a range of questions, through using methodologies that have largely been drawn from efficacy research. The difficulties in attempting to address some of these questions and in using some of these methodologies has been discussed. There is an overwhelming need for further research that examines counselling, and the services that provide such interventions, in an applied context. It is likely that, in the future, such research will need to develop methodologies and address questions that are relevant to 'real world' settings rather than to adopt both from efficacy research.

Work-site counselling, a relatively recent development, is still in its early stages and the possible future(s) of work-site counselling have been discussed at length. It is arguable, however, that there are many opportunities for organisational counselling that need to be grasped and, in many ways, the future for work-site counselling appears to be very positive.