Paraprofessional counselling:
The effectiveness and development of a group of volunteer mental health counsellors

JOSEPH ARMSTRONG

Division of Nursing and Counselling
School of Social and Health Sciences
University of Abertay Dundee

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I certify that this thesis is a true and accurate version of the thesis approved by the examiners.

Signed: ........................................ Date: 5th May 2011

(Director of Studies)
Abstract

*Background:* Existing research findings provide evidence for the general effectiveness of paraprofessional counsellors. However, research into the effectiveness of paraprofessional counsellors with specific client populations is lacking, and we currently know little about the processes of development in this group of practitioners. To address these issues, two empirical studies were carried out.

*Aim of Study 1:* To evaluate the effectiveness of a group of 12 minimally trained/experienced volunteer mental health counsellors. *Method:* Data were collected over a one year period on 118 clients referred to a voluntary sector counselling agency. The CORE-OM was used to measure clients' levels of distress on a session-by-session basis. Clients and counsellors also completed a range of additional self-report measures before and after counselling. A benchmarking strategy was used to evaluate the outcomes achieved by participants in this study against three benchmark studies selected from published literature. *Results:* Paraprofessionals in this study achieved an effect size of .70 compared to effect sizes of 1.36, 1.39 and 1.42 in the selected benchmark studies. *Conclusions:* Minimally trained/experienced paraprofessional counsellors working in mental health settings may benefit from more targeted training before engaging in practice. Findings should be interpreted cautiously as the selected benchmarks may not reflect the organisational factors operating within all voluntary sector counselling agencies.

*Aims of Study 2:* To explore the meaning and experience of becoming a paraprofessional counsellor. *Participants:* The sample included two men and six
women. **Method:** Each participant was interviewed for approximately one hour at the end of their first year of practice. **Data analysis:** Data were analysed using a grounded theory approach. **Results:** Four main categories and a core category were identified. The core category of ‘finding a voice’ represented participant attempts to achieve and sustain an identity as a counsellor. This process involved four related experiences: 1) resonating with counselling and the role of counsellor, the agency ethos and values and the theoretical model employed within the agency; 2) learning the language of counselling; 3) putting the language of counselling into action; and 4) experiencing and resolving dissonant experiences. **Conclusions:** Findings contribute new understanding to existing models of counsellor development regarding the developmental processes that occur in counsellors prior to the period of professional training.

Data from Study 1 and Study 2 were also examined to determine if individual differences existed among participants in terms of their effectiveness, personal philosophies, and counselling practice. Findings showed that counsellors varied in their effectiveness with effect sizes ranging from .96 for the more effective counsellor to .21 for the least effective counsellor. Differences in levels of effectiveness were most apparent at the extremes of the three more effective and the three less effective counsellors. Preliminary findings suggested that the more effective counsellors could be distinguished from the less effective counsellors by the emphasis they placed on the relational aspects of counselling, flexibility, working collaboratively with clients, and by the degree of ‘fit’ that existed between their personal philosophy and the model of counselling preferred with the MHSS agency. Implications of these findings are discussed in section 7.4 of Chapter 7.
Acknowledgements

Completing this thesis has been a challenging and at times a daunting task, which would not have been possible without the generous assistance, support, advice and guidance of a number of people. I would like, therefore, to take this opportunity to extend my heartfelt thanks to the following people.

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Above all, I wish to record my deepest gratitude to my wife Suzanne, my daughters Rosanna and Rebecca, and to my son Joe for their patience and tolerance, and for making sure that life carried on as normal while I was preoccupied with this project.

\(^1\) In the interests of confidentiality, the pseudonym MHSS was invented for the actual agency where the research was carried out. This term is used throughout this thesis to refer to the setting for this research.
Dedication:

To Suzanne, Rosanna, Rebecca, and Joe,

and for my parents

Joseph Armstrong (1940-1998) and Rosemary Armstrong
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Chapter 1

Introduction

1.0 Preamble

This thesis reports on two studies of a group of volunteer mental health counsellors with minimal training and limited experience. It sets out to evaluate their effectiveness, and also to understand the processes involved in their development within the first two years of their engagement with the activity of counselling.

These are important areas for investigation because the activities of volunteer or paraprofessional counsellors represent a highly significant component of the delivery of psychological therapy not only in the United Kingdom (UK) but in other countries as well. Yet, despite their contribution there is a lack of research into issues associated with the provision of counselling by this group of practitioners. Consequently, little is known about paraprofessional counsellors in terms of: a) their distinct training and supervision needs; b) the processes involved in the development of competence and awareness; c) the factors that contribute to their general effectiveness; and d) their effectiveness with different client populations.

The absence of research into volunteer or paraprofessional counselling makes it difficult for government agencies committed to evidenced-based practice, such as the National Health Service in the UK, to channel financial resources into voluntary sector counselling. For counselling agencies, the absence of such research militates against the development of a research-informed understanding of the factors that contribute to achieving effective client outcomes within this area of practice.
This chapter outlines the aims and structure of the thesis. Initially, a brief account of the background to the research carried out and reported on in the thesis is provided in order to situate it within the context of my own professional practice and development as a counsellor and psychotherapist. Key terms are then defined before proceeding to discuss the emergence and professionalisation of counselling in the UK and the training of counsellors. These issues are discussed with reference to the voluntary sector and paraprofessional counselling. Significant public policy initiatives impacting on the voluntary sector are briefly discussed in relation to voluntary sector counselling. Subsequent sections orient the reader to the general themes evident in research into paraprofessional counselling and the overall aims of the research reported here. The concluding section provides an overview of the remaining chapters in the thesis.

1.1 Background to the research

The research reported in this thesis emerged from my experience of establishing, developing and managing a UK voluntary sector counselling service over a ten year period. My managerial role in relation to this service extended to include responsibility to co-ordinate routine audit and evaluation activities, and also to oversee the selection and training of volunteer counsellors to work within the service. These functions, in particular, played a significant part in developing my interest in the research questions pursued in this thesis. Also, my training and experience as a counsellor and psychotherapist were influential in relation to the design and delivery of the ‘in-house’ training that volunteer counsellors received within the agency.
Although I have received formal training in cognitive-behavioural psychotherapy and in solution-focused therapy and, at the time of writing, have been practicing as a mental health professional and therapist for more than 25 years, my experience of working with a diverse range of client populations during this time has persuaded me that no one model of therapy possesses 'therapeutic omnipotence': all approaches have their limitations. Consequently, I have gradually come to believe, based upon experience and my understanding of the counselling and psychotherapy outcome literature, that so-called ‘non-specific’ or ‘common factors’ (Hubble et al. 1999; Miller et al. 1997) are more important than the contribution of models and techniques in promoting good client outcomes.

These ideas have contributed greatly to my interest in integrative approaches to counselling practice and training, and led me to carry out a study which evaluated a brief training programme of volunteer counsellors working within a voluntary counselling agency setting (Armstrong 2003) that was sympathetic to the common factors perspective proposed by Miller et al. (1997). This study was carried out as part of a masters degree in counselling studies with the University of Abertay Dundee (Armstrong 2002; 2003) and was a precursor to the studies reported in this thesis. In fact, all of the participants in the two studies reported in this thesis participated in this training programme. Further information about the relationship between this study and the two studies carried out for this thesis is provided in Chapter 3. Copies of published work related to this thesis can be found in Appendix A.

1.2 Defining key terms

In this section, the terms ‘voluntary sector’, ‘counselling’, ‘paraprofessional’ and
'professional' counsellor are defined with reference to the research reported in this thesis.

1.2.1 Defining the voluntary sector

The Voluntary Sector, which is sometimes referred to as the Third Sector, comprises a diverse range of organisations and services. The Office of the Third Sector (OTS), which is part of the Cabinet Office of the UK Government, defines the Third Sector as follows:

Organisations in the sector share the common characteristics of being non-governmental organisations which are driven by their values and which principally reinvest any financial surpluses to further social, environmental or cultural objectives. It encompasses voluntary and community organisations, charities, social enterprises, cooperatives and mutuals both large and small (Cabinet Office 2008).

Tyndall (1993) has observed that this sector comprises welfare bodies and educational organisations, religious bodies of all faiths, art and drama associations, groups concerned with minority rights, women's issues and ethnic problems, as well as environmental and recreational bodies. Third Sector non-governmental organisations can be distinguished from statutory organisations insofar as the latter form part of a government-provided system of service provision that operates within a legal framework laid down by government, and are required to perform certain defined duties for the local population. For example, the National Health Service (NHS) is responsible for the provision of health care and community based social services come under the auspices of local authority provision (Robinson 2003).
In general terms, the voluntary sector comprises organisations that operate on a not-for-profit basis and are independent of the structure of local and central government. However, this rather simplistic definition belies the diversity and complexity of this sector. For instance:

*The voluntary sector includes some very large organisations that operate on a global scale, such as major charities like Oxfam, and numerous very small ones that operate on a local scale. Some are primarily campaigning organisations; others are primarily service providers. Some rely entirely on unpaid volunteers in all their activities; others rely mainly on paid staff. Some achieve a high level of participatory democracy; others are far more influenced by practices typical of private sector businesses* (Bondi 2003).

Furthermore, it is important to acknowledge that voluntary sector organisations are increasingly subject to commercial and market forces in relation to service provision. Although voluntary organisations are driven to a large extent by a charitable ethos, they also need to be responsive to the community or population they aim to provide services to and support. Consequently, voluntary organisations need to possess, at least to some extent, the qualities of a commercial venture by being responsive to 'gaps in the market' in relation to the provision of social and health care services (Robinson 2003).

It is also misleading to characterise the voluntary sector as being completely distinct from the statutory and private sectors because the vast majority of voluntary organisations rely, at least in part, on public funds and many service providing
voluntary organisations work in collaboration with private organisations and statutory services like the NHS. For example, voluntary sector counselling agencies often depend upon and actively cultivate close working relationships with GP practices and other healthcare professionals and in some instances may have contracts with private organisations to provide counselling to employees (Bondi 2003).

Voluntary sector organisations contribute to society in a variety of ways such as campaigning on issues of concern, experimenting with new ways of responding to existing problems, responding more quickly to newly emerging problems, and delivering services in ways that address the needs of groups within society that are not being catered for by public sector services (Bondi et al. 2003). In addition, voluntary organisations contribute significantly to efforts that seek to encourage, support and increase the contribution of volunteers in society. Volunteering can contribute to the wellbeing and quality of volunteers as much as to that of the individuals and communities which they seek to help and support:

*Almost every aspect of everyday life – the communities in which we live, the physical environment, our recreation and leisure activities, our places of work and worship, our schools and our hospitals – benefit from the input of volunteers. But volunteers themselves also benefit as a result of their actions. Volunteering can provide a real sense of personal fulfillment and achievement, the opportunity to make friends and to establish new contacts, and reward for developing new skills and mastering new challenges* (Curran 2004).

Staff and volunteers in voluntary organisations are generally passionate about and
committed to the underlying values of the organisations within which they work, which is often concerned with alleviating hardship and improving people’s quality of life (Bondi et al. 2003). The voluntary sector, through the provision of opportunities for volunteering, contributes to the creation of an inclusive society where people can participate actively as citizens. In other words, it is argued that it provides a means of connecting people to each other and with the communities within which they live, which in turn, serves to strengthen society in general (Curran 2004).

1.2.2 Defining counselling
At present, there is not in existence a universally accepted definition of the term counselling. It is a concept that holds different meanings for different people and as a result its meaning is widely contested (McLeod 2007). At least part of the reason for this confusion is that what we call counselling is not the sole province of a distinct profession of counselling but is rightfully owned by lots of different professions and disciplines, each of which can claim legitimate ownership of the term counselling (Mahler 1995). It can be argued that the majority of counselling that takes place is delivered by non-specialist practitioners such as doctors, nurses, teachers and social workers where counselling is ‘embedded’ in their roles as opposed to being the primary focus of their job (McLeod 2007). In addition, modern day counselling is closely related to a variety of helping activities such as advice-giving and befriending that may appear different but nonetheless share the same intentions and outcomes (Feltham 1995). Indeed, traditional uses of the term counselling reveal its associations with advice-giving in the domains of monarchy, law and everyday life (Feltham 1995).

In the UK, the emergence of professional organisations for counselling from the
middle of the twentieth century led to attempts to distinguish counselling from other similar activities and to define it as a distinct area of professional practice. For instance, Feltham and Dryden coined the following definition in the first specialised dictionary of counselling published in the UK:

[A] principled relationship characterised by the application of one or more psychological theories and a recognized set of communication skills, modified by experience, intuition and other interpersonal factors, to client's intimate concerns, problems or aspirations. Its predominant ethos in one of facilitation rather than advice-giving or coercion. It may be of very brief or long duration, take place in an organization or private practice setting and may or may not overlap with practical, medical and other matters of personal welfare. It is both a distinctive activity undertaken by people agreeing to occupy the roles of counsellor and client ...and it is an emergent profession...It is a service sought by people in distress or in some degree of confusion who wish to resolve these in a relationship which is more disciplined and confidential than friendship, and perhaps less stigmatizing than relationships offered in traditional medical or psychiatric settings (Feltham and Dryden 1993).

One of the authors of this definition later acknowledged that it was influenced by ongoing debates about the professionalisation of counselling and was an attempt to clearly differentiate counselling from other activities (Feltham 1995). Hence, the emphasis on the activity as being ethical and boundaried, drawing on a body of professional knowledge and that its practice is based on learning as opposed to being acquired through everyday experience or based on innate ability (notwithstanding that
personal qualities are recognised as important factors in shaping the application this expert knowledge). More recently, the British Association for Counselling and Psychotherapy stated that:

*Counselling occurs when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life or loss of a sense of direction and purpose. It is always at the request of the client and no one can properly be 'sent' for counselling. By listening attentively and patiently the counsellor can begin to perceive the difficulties from the client's point of view and can help them to see things more clearly, possibly from a slightly different angle. Counselling is a way of facilitating choice or change or reducing confusion (BACP 2008).*

This definition emphasises that the ultimate aim of counselling, whatever approach the counsellor uses, is for the client to make their own choices and decisions and to put them into action. A key principle emphasised in this definition is the autonomy of the client.

As McLeod (2003b) has pointed out, the one thing that current definitions of counselling have in common is that they are framed from the point of view of the counsellor and as such they can be regarded as reflecting the aims of professional bodies to establish counselling as a specialist professional activity within contemporary society. In contrast he has proposed a user-defined definition of counselling, which emphasizes elements that may not be available to the person
seeking help in their everyday life. These include; permission to speak, respect for
difference, trustworthiness and affirmation. Similar to the BACP definition, McLeod
(2007) emphasises the consensual nature of counselling but he also highlights the
collaborative and conversational aspects of counselling. In addition, he proposes three
broad categories of potential outcomes that might be achieved through counselling: 1)
resolution of the original problem in living for which the client sought help; 2)
learning in terms of acquiring new understandings, skills or strategies that facilitate
ability to handle future problems; and 3) social engagement and inclusion. McLeod
(2007) argues that adapting a user-perspective when defining counselling provides a
meaningful framework within which to make sense of the diversity of contemporary
counselling practice.

The way in which counselling is defined is also shaped and influenced by the context
within which it is delivered (McLeod 2007). The setting (e.g., private practice, NHS,
voluntary sector) has a bearing on factors such as accessibility, availability, type and
mode of service. For example, the meaning of counselling that is offered within an
NHS primary care setting is likely to be strongly influenced by a biomedical
perspective of emotional/psychological distress, whereas voluntary sector counselling
services may be better positioned to adapt a more flexible and perhaps user-definition
of counselling.

The definition of counselling adapted by the setting for the research carried out and
reported on in this thesis was certainly shaped by the context within which it was
delivered. In particular, the values and ethos of the agency (which offered a range of
community-based services to people experiencing mental health problems), the beliefs
and assumptions of the counsellors, the needs and expectations of funding bodies, clients and referring agents and the wider counselling community all contributed to the meaning of counselling within this agency:

*Counselling is a partnership between the person and the counsellor which takes place in a private and confidential setting. The counsellor listens to the person’s concerns without judging them and helps them to explore options they have for dealing with them. Counselling may be used to work out a direction, a way of moving forward or to set up and monitor goals in order to bring about change. Others use the sessions to become more self-aware about themselves and feelings and help them feel more in control. Ultimately, counselling can be used to help a person live in a more satisfying, resourceful, and meaningful way (Mental Health Support Services, 2008).*

More generally, attempts to define counselling have given rise to debates about the similarities and differences between counselling and other related activities. Debates in this area have tended to coalesce around distinctions between counselling and psychotherapy and the boundary between counselling and the use of counselling skills. McLeod (2007) has observed that despite the obvious similarities between counselling and psychotherapy the latter term is often associated with more in-depth psychological work, the qualifications and profession of the practitioner and the context of practice. Whereas counselling is often viewed as a more superficial activity aimed at resolving everyday problems and concerns. The more generic term ‘therapy’ is increasingly being used to refer to both activities (McLeod 2007) and to emphasise the similarities between them (Cooper 2008).
As noted above, counselling is often associated with activities carried out by other health and human service professionals such as nurses, social workers, and teachers for example. While practitioners in these fields may not have formal counselling qualifications it is clear that they often use ‘counselling skills’ in the course of their everyday working relationships with colleagues and people in their care. The concept of ‘counselling skills’ emerged as a way distinguishing professional counsellors who engage in formal, contracted and boundaried counselling with clients from practitioners who use counselling skills in an ad hoc way within the context of everyday interactions with the people in their care. Recently, McLeod (2007) has argued for the concept of ‘embedded counselling’ to avoid the reductionism inherent in the concept of counselling skills and also to acknowledge the counselling carried out by practitioners who are not specialist professional counsellors or psychotherapists.

In summary, it is extremely difficult to arrive at an undisputed definition of counselling. Counselling is simultaneously an ordinary everyday activity and a distinct specialist activity carried out professional trained counsellors, and its meaning is often shaped by the practitioner and the setting within which it is practiced. Attempts to define counselling by professional bodies can be viewed as an attempt of establish counselling as a professional activity within contemporary society.

Within this thesis, the term counselling is used to refer to a collaborative partnership between a person seeking help (the client) and another person offering help (the counsellor) which aims to assist the person seeking help to resolve, or manage more effectively, problems in living.
1.2.3 **Defining the terms professional and paraprofessional counsellor**

Brief definitions of the terms ‘paraprofessional’ and ‘professional’ counsellor are provided here to clarify their meaning in relation to this thesis. A more critical discussion of these terms is offered in Chapter 2, especially in relation to the term paraprofessional.

### 1.2.3.1 Professional counsellor

A professional counsellor is understood to refer to someone educated to at least diploma level in counselling, which the British Association for Counselling and Psychotherapy define as 450 hours of training. Diploma level training in counselling is regarded as the minimum qualification to practice as a professional counsellor in the UK.

### 1.2.3.2 Paraprofessional counsellor

The term paraprofessional is employed in this thesis to refer to counsellors who did not hold a professional qualification in counselling/psychotherapy (i.e., a diploma/masters degree), or in a mental health discipline (e.g., nursing or social work), and who had, on average, less than 150 hours experience of counselling practice. The term ‘volunteer counsellor’ is also used interchangeably to refer the participants who participated in the research reported in this thesis. Also, the generic terms therapist and practitioner are used at times to refer to both paraprofessional and professional counsellors and psychotherapists.

1.3 **The emergence of counselling in the UK**

Counselling as a distinct area of practice has relatively recent origins and owes its emergence to developments in the field of Vocational Guidance in the USA during the
early 1900s (Whiteley 1984), which were to influence the development of counselling in the UK (Feltham 1995). However, it was within voluntary organisations that offered help and support to people experiencing marital difficulties that counselling as a defined activity first emerged in Britain (Tyndall 1993). Inspired by the work of the American humanistic psychologist Carl Rogers, the term counselling was first adopted by the National Marriage Guidance Council (NMGC) to describe the services provided by trained volunteers to those in distress (Bondi et al. 2003).

It is important to situate the emergence of counselling in the UK within the historical and cultural context from which it evolved. For instance, Tyndall has noted that voluntary sector counselling services emerged alongside a multitude of other voluntary services following the Second World War stemming from the unprecedented amount of marital and family disharmony evident at the end of the war (Tyndall 1993). NMGC, for example, initially concerned itself with pre-marriage education, safeguarding the family unit and strengthening community life following the war and evolved to provide advice and guidance for marital problems (Lewis et al. 1992). Similarly, agencies such as The Samaritans, Victim Support, Cruse and Barnardos all emerged as responses by concerned individuals to perceived needs of particular groups of people: a tradition that has its roots in Victorian philanthropy and developed throughout the 20th century (Tyndall 2003). During the second half of the 20th century, counselling, as a response to a vast array of problems in living, has grown both within the voluntary sector and in the private and public sectors too. Yet, the voluntary sector remains a potent force in the provision of such services and it has been estimated that approximately fifty percent of all counselling that is delivered in
the UK is done so by voluntary organisations (Armstrong and McLeod 2003; Moffic et al. 1984).

There is now in existence a vast array of voluntary sector counselling services in Britain ranging from large organisations with a national network of branches such as Cruse, which provides counselling to bereaved people, and smaller locally based organisations (Tyndall 1993), such as the agency setting where the studies reported in this thesis were carried out (details of which are described in Chapter 3, section 3.3.7). Some counselling agencies rely extensively on volunteers and others on a combination of full-time paid staff working alongside volunteers who may be professional but unpaid or indeed lay helpers with minimal training and experience. Agencies also differ in the way in which they choose to deliver their counselling services, which may be from a designated office base, or satellite offices, via home visits, by telephone or correspondence (Tyndall 1993). It is interesting to note that counselling emerged as, and to a large extent remains, a highly gendered activity. With the exception of counselling for alcohol problems, which attracts significant numbers of men, the majority of counsellors are women (Bondi 2003).

Counselling emerged in the UK as an avowedly lay practice connected to traditions of mutual aid and rooted in a desire to foster egalitarian, non-hierarchical relationships between clients and practitioners (Bondi 2003). However, the landscape of counselling during the last quarter of the twentieth century changed significantly as a result of developments in relation to the selection, training and monitoring of counsellors and counselling practice, and the professionalisation of counselling.
1.4 The professionalisation of counselling

During the past two decades there has been a powerful drive toward the professionalisation of counselling. On one level, it can be argued that this is a result of a deliberate institutional strategy (House and Totton 1997) that involved the creation of professional bodies for counselling and psychotherapy, which sought to define and establish counselling as a professional activity within society (McLeod 1998). The designation professional in this sense refers to an occupational group that has achieved the status of a profession characterised by control over a domain of knowledge, a high degree of self-control of behaviour through codes of ethics, lengthy training, membership registration, a full-time paid workforce and a system of rewards (Giddens 1991; Macdonald 1995). It is a sociological concept and does not necessarily mean ethical or high quality although there is an association between these meanings and the preceding characteristics of a profession (Armstrong and McLeod 2003).

Institutions such as the British Association for Counselling and Psychotherapy (BACP), the UK Council for Psychotherapy (UKCP), the British Confederation of Psychotherapists (BCP) and in Scotland, the Confederation of Scottish Counselling Agencies (COSCA), have played a major role in the professionalisation agenda. Not everyone has welcomed this move and according to some commentators such institutions:

In their different ways, and with various degrees of cooperation and rivalry, these organisations all promulgate the idea that psychotherapy [counselling] is a profession; that this professions needs regulation; and that they are the
people to do it – preferably with the help of government (House and Totton 1997).

House and Totton (1997) also argue that on another level a cultural strategy has been operating with the aim of constructing a view of counselling and psychotherapy as a professional activity within society: a strategy which they regard as even more pernicious that the institutional strategy. In their view, this would ultimately mean that individuals seeking help would have less sources of counselling available to choose from because certain forms of helping (e.g., paraprofessional counselling) would no longer be available due to the requirements for practitioners to meet standardised levels of training and supervision for the purposes of professional accreditation required for statutory regulation.

Despite the disquiet among some practitioners and commentators, the professionalisation agenda continues unabated. At present, the Health Professions Council (HPC), (a regulator established by the government to protect the public, and ensure standards of training, skills and professional conduct for health professionals) is in consultation with practitioners and leading professional bodies for counselling to determine which titles (i.e., ‘counsellor’ and ‘psychotherapist’) should be protected under statutory regulation. In addition, it seems likely that theoretical orientations (e.g., Cognitive Behavioural Therapy) will also be regulated. At present, the precise scope of practice to come under statutory regulation has not been determined (BACP 2009b; COSCA 2009; Health Professions Council 2009).

Voluntary sector counselling agencies have experienced sustained pressure to become
more professionalised and in many instances had to change and adopt to survive in order to be responsive to wider changes in society. Accountability, responsibility and the protection of the public are key themes which underpin the ethical codes of the professional bodies for counselling. According to Hill (2003), changes in relation to consumerism, legislation and the governance of charitable voluntary agencies, competitive tendering for public funds and grants and the increased interdisciplinary and partnership working between statutory and non-statutory organisations have contributed significantly to the pursuit of the professionalisation agenda. He argues that the benefits of these changes are that voluntary agencies no longer suffer from highly idiosyncratic styles of management and that volunteers are restrained from pursuing individual agendas and meeting their own needs (Hill 2003).

Nonetheless, the potential for the professionalisation agenda to erode voluntarism and the work of volunteer counsellors should not be underestimated in terms of the negative consequences for both the public and for the future of counselling in Britain (McLeod 2000). McLeod (2000) has identified seven reasons why the voluntary sector is relevant to the balance of counselling provision in contemporary society. These are: demand; effectiveness, inclusiveness, preserving cultural resources, dissemination, generosity and citizenship.

At present, the full implications of professionalisation for this group of practitioners remains unclear but as Tyndall (1993) has noted that “for many in the voluntary sector the pressure remains the same, “to make a spontaneous human response to the person in distress who telephones or walks into the office” (p.4): an observation that still holds true today for many, if not all, voluntary sector service providers.
1.5 The training of counsellors

The movement toward the professionalisation of counselling has had a direct impact on the standards of training for counsellors to the extent that there is now broad agreement between educators that four core elements must be included in counselling programmes to prepare students for professional practice. The four elements are: 1) skills development; 2) theoretical knowledge; 3) personal development; and 4) supervised practice (Dryden and Thorne 1991; McLeod 2003b). Counselling training has come to be increasingly located in or affiliated with Higher Education institutions (HE) (Dryden and Thorne 1991). In fact, many private and voluntary sector counselling/training organisations have sought to have their courses validated by HE establishments in order to, among other things, demonstrate compliance with standards defined by professional bodies such as the British Association for Counselling and Psychotherapy.

The influence of professional bodies has meant that providers of counselling education (e.g., universities, colleges, private institutes, local/national voluntary sector counselling agencies) have had to formalise procedures around the selection, training and assessment of counsellors (Dryden and Thorne 1991; McLeod 2003b). The present situation is in stark contrast to early counselling training programmes that were to a large extent located in voluntary sector agencies such as NMGC (Tyndall 1993). The training courses offered by these agencies were run by professionals from disciplines such as clinical psychology, psychiatry and social work (Dryden and Thorne 1991). Consequently, there was great disparity between courses in terms of their duration, content, the supervision and mentoring of trainees. This was largely
because of the lack of regulation and the influence, interests and theoretical perspectives of trainers from the different disciplines (Dryden and Thorne 1991).

A general feature of these courses was that trainees were regarded as being prepared to carry out ancillary and less skilled work than the more professional work of their trainers. The general ethos of early voluntary sector training organisations in the UK was influenced to a large extent by the work of the American humanistic psychologist Carl Rogers who developed client-centred counselling (Rogers 1951). His egalitarian approach and emphasis on the personal qualities and relational skills of the counsellor resonated with the aims and aspirations of voluntarism and lay helping emerging in the UK in the post-war era of the 1950’s and was rapidly adopted as a robust rationale for non-academic counselling training.

Nonetheless, these courses were generally accessible to individuals with the requisite interpersonal qualities and provided free of charge in return for a minimum commitment to deliver a certain number of counselling hours and or to assist with organisational and administrative tasks associated with running the service (Tyndall, 1993).

The location of counselling education within Higher Education (HE) has implications for individuals wishing to access training programmes and for voluntary-sector training providers. For many people, costs can be prohibitive unless financial support is available from sympathetic employers, charitable trusts or other sources. The greater emphasis on academic ability as a requirement of entry to programmes poses a significant barrier to many people who wish to advance a career in counselling, which
may have begun as a volunteer counsellor. As Wheeler (1996) has pointed out, there is little evidence that academic ability is related to effectiveness as a counsellor. Indeed, a substantial body of evidence testifies to the effectiveness of paraprofessional/volunteer counsellors (at least with certain client groups) who typically receive minimal/non-academic training within voluntary sector organisations (Faust and Zlotnick 1995). These themes are explored further in Chapter 2.

This situation means that many potentially effective counsellors are being excluded from pursuing educational opportunities as counsellors in HE because they are deemed not to be sufficiently prepared to meet the academic demands of training. “But, in addition, as standards of training have increased, voluntary sector training providers have found it increasingly difficult to cover the costs of the courses they offer from their own funds, and therefore pass some of the costs on to the trainees themselves” (Bondi 2003, p. 321) This has fuelled a desire among counsellors to be properly remunerated for their work, but also creates a barrier to engaging in voluntary counselling activities and arguably, contributes to the further erosion of opportunities for voluntarism within society.

1.6 The public policy context: A Scottish perspective

1.6.1 Public protection

One of the most significant public policy concerns effecting counselling and the voluntary sector is that of public protection. The movement toward statutory regulation of counselling noted above is part of a wider public policy debate that reflects governmental concern with strengthening the protection available to members of the public in their dealings with health professionals (Bondi et al. 2003). Another
example of this policy is reflected in the requirement that all employees and volunteers working within the voluntary sector in Scotland must undergo criminal record checks designed to enhance public safety by providing potential employers and organisations within the voluntary sector with criminal history information on individuals applying for posts (Bondi et al. 2003).

1.6.2 Volunteering in Scotland
Another important policy issue is the Scottish Executive ‘Volunteering Strategy’, which was designed to embed a robust culture of volunteering in Scotland, particularly within younger members of the population (Curran 2004). This report notes that in comparison to the rest of the UK and other European countries, Scotland has higher rates of volunteering but that some groups of people continue to face formidable barriers to volunteering. In particular, people from lower socio-economic backgrounds, the unemployed, the long-term sick and disabled, the poor, and people lacking in formal qualifications, are consistently under-represented in volunteering activities.

The Scottish Executive strategy on volunteering aims to encourage more volunteering among young people, break down the barriers to volunteering, improve the volunteering experience and to monitor and evaluate the extent to which these aims are achieved. One of the ways in which this is being implemented is through a number of policies which seek to engage voluntary groups in achieving goals related to promoting community development and active citizenship (Fyfe et al. 2006).

1.6.3 The social significance of voluntary counselling
Scottish Executive commitment to support the growth and contribution of volunteering finds expression in the ideas of inclusiveness and citizenship in relation
to counselling (McLeod 2000). Voluntary agencies tend to be much more accessible to people seeking help and support and are much less likely to ‘pathologise’ clients’ distress by labelling them or turning them into a ‘case’. To this extent, voluntary agencies may be viewed as being more inclusive than statutory agencies, which are legitimated by society to label and diagnose clients.

Voluntary agencies also provide an arena where people can contribute, through volunteering, to the social economy by enhancing the wellbeing and resourcefulness of the population (Bondi et al. 2003). In many respects, counselling represents a meaningful way to participate actively as citizens by contributing to the common good and the improvement of social life (Armstrong and McLeod 2003). The interpersonal competence and self-awareness that accompany training and involvement in voluntary counselling benefits, not only individual volunteers, but is also likely to add to the resources available to their families, work environments and communities within which they live (Armstrong and McLeod 2003; Bondi et al. 2003).

1.7 Research into voluntary sector counselling: an overview

Despite the historical significance of the voluntary sector to the emergence of counselling and the extent of its contribution to the overall balance of counselling provision in Britain, it is surprising that so little research has been carried out in this area. The absence of published studies means that a substantial number of research questions pertaining to voluntary sector counselling, and volunteer counsellors in particular, have not been addressed in any systematic manner (Armstrong and McLeod 2003). A comprehensive review of existing literature is reported in chapter 2.
In this section the main themes emerging from research into the effectiveness of paraprofessional or voluntary counselling are briefly outlined.

The vast majority of this research has been carried out in the USA and has largely focused on comparing the effectiveness of professional versus paraprofessional counsellors and therapists (Armstrong 2003). Interest in the therapeutic effectiveness of paraprofessional counsellors peaked between the 1960s and early 1980s, with only sporadic interest in the last two decades. Studies in this area have concluded that paraprofessional counsellors can achieve results that are at least equal to, and at times better than, those obtained by professionally trained and experienced therapists (Atkins and Christensen 2001; Berman and Norton 1985; Durlak 1979) This finding runs contrary to received wisdom, which assumes that training and experience are important determining factors in the overall effectiveness of individual counsellors or therapists. It is important to note that while studies in this area have established the general effectiveness of paraprofessional counsellors, a number of questions remain unanswered concerning the effectiveness of this group of practitioners with the broad range of client populations that are typically encountered in routine counselling practice. The literature on paraprofessional counselling is reviewed in Chapter 2 of this thesis.

There is also an absence of research into the processes involved in the development of awareness and practitioner identity in paraprofessional counsellors. Existing developmental models are largely focused on the emergence of a professional identity in professional therapists (Skovholt and Rønnestad 1995). Study 2 in this thesis reports on the findings of a qualitative study which sought to explore the
developmental processes apparent in the initial stages of paraprofessionals engagement with counselling.

The general conclusion that can be drawn from existing research into voluntary sector counselling is that the general effectiveness of minimally trained therapists has been established. However, more research is required to determine the effectiveness of paraprofessional counsellors with specific client populations and also in relation to the processes of development particular to this group of practitioners.

1.8 Aims of the research

The overall aims of this thesis were to evaluate the effectiveness of a group of minimally trained/experienced paraprofessional counsellors and to explore the meaning and experience of becoming a paraprofessional counsellor. The research comprised two studies, which focused on a group of volunteer mental health counsellors who were minimally trained and had limited experience as counsellors. Study 1 was concerned with evaluating the effectiveness of the counselling provided by these paraprofessional therapists using a standardised outcome measure and a number of other self-report tools. Study 2 employed a qualitative methodology to explore research participants' experiences of becoming a volunteer mental health counsellor. The key results from Study 1 are reported in Chapter 4 and the findings from Study 2 are reported in Chapter 5. Chapter 6 brings the findings of Study 1 and Study 2 together in a preliminary attempt to examine individual differences among participants in terms of the effectiveness, personal philosophies and counselling practice.
1.9 Overview of thesis

This section provides an overview of the remaining chapters in the thesis.

Chapter 2 contains a critical review of relevant literature and concludes with a set of research questions distilled from analysis of the literature and which underpin the research presented in this thesis. Specifically, research on paraprofessional counsellors, the differential effectiveness of individual counsellors, counsellor development, and the meaning of volunteering are reviewed.

Chapter 3 presents the philosophical perspective that informed the empirical work reported in this thesis and describes the methods employed in Study 1 and Study 2. A case is made for methodological pluralism grounded in a pragmatic social constructionist perspective as an appropriate methodological and theoretical perspective to guide this research.

Chapter 4 reports the results of Study 1, which set out to evaluate the effectiveness of the sample of paraprofessional counsellors who participated in this study.

Chapter 5 reports the results of Study 2, which employed a grounded theory approach to explore participant views and experiences of becoming volunteer mental health counsellors.

Chapter 6 presents the results of an analysis of the findings from Study 1 and Study 2. A particular focus in this chapter was to examine the differential effectiveness of
participants and to undertake a preliminary investigation of the characteristics of more and less effective volunteer mental health counsellors.

Chapter 7 presents a summary of the findings of the research reported in Chapters 4, 5, and 6 and discusses them in relation to the literature that was reviewed in Chapter 2 of this thesis.
Chapter 2

Literature Review

2.0 Introduction

This chapter provides a context for the studies reported on in this thesis by reviewing research that is pertinent to the effectiveness and development of paraprofessional counsellors. The primary intention is to critically review relevant research in relation to the contemporary practice and development of minimally trained/experienced paraprofessional counsellors working in community-based mental health settings in the UK. This chapter is divided into four major sections which provide separate reviews of the following areas of the literature:

1. Review 1: Research into the effectiveness of paraprofessional counsellors - section 2.1 provides an in-depth critical review of research into the comparative effectiveness of paraprofessional counsellors, and also presents a systematic contemporary review of the effectiveness of paraprofessional counselling for common mental problems.

2. Review 2: The impact of individual counsellors on counselling outcomes - research into the effectiveness of counselling has tended to focus on the outcomes achieved by a group of counsellors, and has tended to neglect the role of therapist variables in the effectiveness of counselling. Section 2.2 reviews the essential features of the therapist effects literature, which highlights the contribution of the personal qualities and characteristics of individual counsellors and psychotherapists to client outcomes. The implication of this research is that it is important to consider individual counsellor effects to better understand the factors that contribute to positive and negative outcomes in counselling. To date, there
Chapter 2: Literature Review

does not appear to have been any research conducted into the differential effectiveness of paraprofessional counsellors.

3. Review 3: Research into counsellor development – section 2.3 reviews the main elements of research into counsellor development. This area of research is relevant to this thesis insofar as it relates to the aim of gaining a better understanding of the development of paraprofessional counsellors in the early stages of their work as counsellors.

4. Review 4: The meaning of volunteering – section 2.4 outlines the key issues associated with volunteering and being a volunteer. The rationale for referring to this area of the literature was that the research reported on in this thesis was carried out within the context of a voluntary organisation and the participants were all volunteer counsellors.

Methodological and theoretical issues associated with each of these areas of literature are also considered within the respective sections of this chapter. For the purposes of this review, the above areas of the literature were regarded as being interrelated and providing different theoretical and research perspectives on paraprofessional counselling. The chapter concludes with a summary and synthesis of the findings from these related areas of the counselling literature, and identifies a set of research questions which formed the basis for the studies that were carried out and reported on in this thesis.

2.1 Review 1: Paraprofessional counselling

2.1.1 Introduction

One of the most controversial findings to emerge from counselling research in the last
Chapter 2: Literature Review

thirty years has been that minimally trained/experienced paraprofessional counsellors can be as effective as fully qualified and experienced counsellors. The term paraprofessional has been used to distinguish between practitioners with limited training and practitioners who have received full professional training in counselling (Armstrong and McLeod 2003). However, it is important to note that this term has been interpreted in a variety of ways and is often used interchangeably with the terms, non-professional, lay or volunteer counsellors and helpers. The term lay of volunteer counsellor is more commonly used in Britain while the term paraprofessional is more often used in North America. Methodological issues pertaining to the definition of these terms will be addressed later in this chapter at section 2.1.4.1.

The use of paraprofessionals within counselling and a variety of other types of psychological services became popular in North America during the 1960s and the 1970s (Sawatzky and Paterson 1982). In 1974 the Personnel and Guidance Journal carried a special issue on the emerging paraprofessional movement in the United States of America (USA) in an attempt to present an up to date and accurate picture of the use of paraprofessionals across a range of human services. In her guest editorial for this special issue, Ursula Delworth was optimistic about the potential of paraprofessionals to improve and revitalise counselling programmes and indeed all human services (Delworth 1974). A range of perspectives on the paraprofessional movement in the USA were included in this special edition of the Personnel and Guidance Journal which considered general issues regarding the paraprofessional movement such as their effectiveness and capacity as agents of social change (Brown 1974; Gartner and Riessman 1974; Pearl 1974), provided examples of paraprofessional interventions with different client groups and across a range of
settings (Allen 1974; Nicoletti and Flater-Benz 1974; Rudow 1974; Thomas and Yates 1974; Varenhorst 1974), discussed the issue of paraprofessional training (Danish and Brock 1974; Moore 1974; True and Young 1974), and included a number of accounts by paraprofessionals of their experience of being a paraprofessional within different roles and contexts (e.g., DeMoss 1974; Donavan 1974; Favela and Fuzessery 1974; Jenks 1974; Millick 1974).

The emergence of paraprofessional services in North America during this time has been attributed to changes in philosophies and policies in mental health services that required the deinstitutionalisation of services and the development of community-based models of service provision (Kalafat and Boroto 1977). This shift provided the impetus to use paraprofessionals because there was an acute shortage of professional resources available to meet the demand for mental health services (Kalafat and Boroto 1977; Karlsruher 1974). The increased use of paraprofessionals during the 1960s and 1970s can also be viewed as a response to criticisms of traditional models of mental health service delivery by consumers of mental health, particularly the poor (Delworth 1974). As Walter and Petr (2006) have noted, “The shift toward community-based philosophies also led to the increased recruitment of paraprofessionals who were indigenous to the communities served, in hopes of gaining easier access to clients” (p.460). The use of paraprofessionals to provide mental health and psychological services has not been without controversy (Holland 1998). DiFillippo et al. (2003), for example, have commented that the increased use of minimally trained paraprofessionals to provide counselling and psychotherapy may give rise to inferior services because of their lack of ability to carry out accurate assessments and conceptualise cases, and manage crises.
In the UK, the use of paraprofessionals can be traced back to the emergence of the Voluntary Sector in the post World War II era (see section 1.4, Chapter 2 of this thesis). In Britain, the role of paraprofessionals or lay volunteers was also associated with a philanthropic spirit of a small group of influential individuals who were instrumental in developing services for people in need that were run largely by unpaid volunteers (e.g., Barnados, the Samaritans, the National Marriage Guidance Council).

Much of the research in the area of paraprofessional counselling or helping was carried out in the USA during the 1970s and 1980s. During this time, there was a move toward identifying the nature and scope of the functions paraprofessionals could fulfil in relation to a broad spectrum of human distress within different settings (Sawatzky and Paterson 1982). Little further research has been conducted into the effectiveness of paraprofessional counsellors in the past two decades. This is surprising, especially when one considers the significant contribution that paraprofessional counsellors make to counselling provision within the UK and other countries. Perhaps, as Lambert and Ogles (2004) have noted, the range of methodological problems (discussed in section 2.1.4) that have jeopardised the quality of previous research in this area have acted as a disincentive for new research into the effectiveness of paraprofessional counsellors.

In summary, the preceding brief discussion has highlighted the origins of paraprofessional services in North America and in Britain, particularly in relation to the provision of mental health care and psychological services such as counselling. Concerns that the increased use of paraprofessional therapists will impact negatively on the quality of services were also noted, as well as the lack of research in this area.
Chapter 2: Literature Review

of practice in recent decades.

The following sections of Review 1 critically appraise existing research on paraprofessional counsellors, with a view to identifying the effectiveness of minimally trained/experienced paraprofessionals delivering counselling and psychotherapy services in community-based mental health settings. Sections 2.1.2, 2.1.3, 2.1.4, 2.1.5 and 2.1.6 below address questions concerning the evidence base for paraprofessional counselling contained in the extant published literature. Section 2.1.7 presents a new review of effectiveness studies of minimally trained paraprofessional counselling for common mental health problems, which was carried out for this thesis.

More specifically, section 2.1.2 identifies early reviews of paraprofessionals. Section 2.1.3 describes and evaluates the findings from a core set of meta-analytic reviews of paraprofessionals that were carried out in the late 1970s and early 1980s, which examined the effectiveness of paraprofessionals delivering a range of interventions including, but not limited to, individual and group counselling and psychotherapy. Current understanding of the effectiveness of paraprofessional counselling rests, to a considerable extent, on the conclusions that were drawn from these early meta-analyses. Consequently, in addition to outlining each review in section 2.1.3, section 2.1.4 identifies the main methodological problems associated with these reviews, and section 2.1.5 revisits these early reviews and critically appraises only those studies that investigated the effectiveness of paraprofessionals delivering individual or group counselling or psychotherapy. Section 2.1.6 outlines the key findings of other more recent studies and reviews of paraprofessionals. Section 2.1.7 reports on a new review carried out for this thesis on the effectiveness of community-based
paraprofessional counselling for common mental health problems. Section 2.1.8 provides a summary of Review 1 of this chapter concerning research into the effectiveness of minimally trained paraprofessional counselling.

2.1.2 Early reviews of research into the effectiveness paraprofessional counsellors

Early reviews by Carkhuff (1968), Sobey (1970), Karlsruher (1974) and a well controlled study by Strupp and Hadley (1979), which compared paraprofessionals with professional treatments, found clients of non-professional helpers improved as much or more than clients of professional therapists.

2.1.3 Meta-analytic reviews of research into the effectiveness of paraprofessional counsellors

The main body of research in this area consists of a core set of studies that have been repeatedly meta-analysed. The first of these analyses was carried out by Durlak (1979). He identified forty-two studies that compared the effectiveness of professional and paraprofessional therapists and evaluated them in terms of outcome and quality of design. Paraprofessionals were defined as individuals who had not received formal clinical training in psychology, psychiatry, social work and psychiatric nursing. Professionally trained and experienced psychologists, psychiatrists and social workers constituted the professional therapists. The client populations in these studies were drawn from five categories of helping services, which included: 1) group psychotherapy or counselling for adults experiencing moderate to severe mental health problems; 2) academic counselling for college students; 3) crisis intervention for adults; 4) prescribed treatment programmes targeted at specific problems such as obesity and insomnia; 5) other interventions aimed handicapped children and college students (Durlak 1979).
Durlak (1979) concluded that paraprofessionals achieved clinical outcomes that were equal to and in some cases significantly better than professionally trained therapists and that professional mental health training and experience may not be required to be an effective helper. Durlak’s (1979) findings generated a significant degree of controversy and prompted further analyses of the same group of studies by Nietzel and Fisher (1981), Hattie and Sharpley (1984), and Berman and Norton (1985).

Nietzel and Fisher (1981) re-evaluated Durlak’s (1979) review arguing that results were constrained because he included studies that lacked sufficient internal validity, poorly defined professionals and paraprofessionals and that study designs lacked the power to detect differences in the two groups. Overall, Nietzel and Fisher believed only five of the forty-two studies in the Durlak (1979) review to be free of problems, of which three favoured paraprofessionals and two showed no difference. In addition, they cited four studies not included in Durlak's (1979) review (two of which demonstrated superior outcomes for professionals) and noted that the evidence supporting the superiority of professional therapists was accumulating following Durlak's (1979) review.

In an effort to resolve the contentious debate between Durlak (1979) and Nietzel and Fisher (1981), Hattie et al. (1984) re-examined the 42 studies originally reviewed by Durlak (1979) using meta-analysis procedures to clarify many of the issues raised by these authors. Except for three studies, which had to be excluded for various reasons, Hattie et al. (1984) analysed effect sizes based on 154 comparisons available across the remaining 39 studies and also included 4 later studies identified by Nietzel and Fisher (1981). Hattie et al. (1984) concluded: "...the average person who received
help from a paraprofessional was better off at the end of therapy than 63% of the persons who received help from professionals" (p.536).

A number of other interesting findings emerged from the Hattie et al. (1984) study, namely: 1) experience and length of training appeared to be related to the effectiveness of paraprofessionals; 2) when the helper rated the effectiveness of counselling, paraprofessionals were most effective; 3) when the client rated the effectiveness of counselling, differences in effectiveness of paraprofessionals versus professionals decreased; and 4) there was no difference in the effectiveness of paraprofessionals and professionals when a specific behaviour measure was used to assess client change. Although the results of this review appear to indicate that more experienced professionals had less effect than paraprofessionals, Hattie et al. (1984) suggested that, in contrast to paraprofessionals, more experienced professionals are likely to work with individuals with more severe problems or in environments where brief forms of intervention are unlikely to be that effective. Their general conclusions were supportive of, but not as strong as, those reported by Durlak (1979); however, they acknowledged that in many cases paraprofessionals were more effective than professional counsellors, and consequently, should be considered effective additions to the helping services.

Berman & Norton (1985) regarded the results reported by Hattie et al. (1984) to be problematic for a variety of reasons. Berman & Norton (1985) asserted that the Hattie et al. (1984) results were based on a number of inappropriate studies, that individuals were incorrectly labelled as professionals in some studies and in others the designation of paraprofessional and professional appeared arbitrary. Furthermore,
Berman and Norton (1985) noted that in some instances Hattie et al. (1984) included studies in which treatment did not involve psychological counselling or psychotherapy. Given these methodological problems, Berman and Norton (1985) excluded 11 studies and based their analysis on the remaining sample of 32 studies. Berman and Norton (1985) reported that their analyses did not reveal any significant differences between professional and paraprofessional effectiveness in relation to type of patient complaint, form of treatment or the type or source of outcome measure. Results of this study suggested that professionals achieved better outcomes with briefer interventions and paraprofessionals appeared to be more effective when treatment was of longer duration. Overall, however, professional training did not appear to contribute to clinical effectiveness.

In addition to these general conclusions, some important findings also emerged from this series of reviews (Berman and Norton 1985; Durlak 1979; Hattie et al. 1984; Nietzel and Fisher 1981). Hattie et al. (1984) noted that the longer paraprofessional training the greater their effectiveness compared with professional therapists. In other words, experience and length of training seemed to be significantly related to the effectiveness of paraprofessionals. The review by Berman & Norton (1985) indicated that professionals achieved better outcomes with briefer interventions and paraprofessionals appeared to be more effective when treatment was of longer duration.

Overall, the outcome of the intense scrutiny of the studies included in the reviews by Berman and Norton (1985), Durlak (1979), Hattie et al. (1984), and Nietzel and Fisher (1981) has contributed to a widely held view that minimally trained paraprofessionals
can be as effective as professional therapists under certain conditions. Nonetheless, methodological problems associated with these earlier studies and reviews means that, ultimately, their findings are inconclusive. Essentially, the main criticism of the original review by Durlak (1979) and the subsequent reviews described above was that the studies that were included were not adequately designed to evaluate the comparative effectiveness of paraprofessional versus professional therapists.

The following sections consider in more detail the methodological issues in studies of paraprofessional counselling and helping identified in the review by Durlak (1979). Section 2.1.4 below examines general methodological issues pertinent to all 42 studies that Durlak (1979) included in his original review, which were categorised into five groups of helping services (described earlier in this section). Section 2.1.5 focuses specifically on the 19 studies identified in the Durlak (1979) review that investigated individual or group psychotherapy or counselling because they are specifically relevant to this thesis. Before considering these studies, the next section identifies the methodological issues related to studies of paraprofessional counselling that have been included in reviews by Berman and Norton (1985), Durlak (1979), Hattie et al. (1984), and Nietzel and Fisher (1981), which were discussed in this section.

2.1.4 Methodological problems in research into paraprofessionals
A variety of methodological problems have been alluded to in the preceding section(s). In general, these problems coalesce around the fact that conclusions about the apparent effectiveness of paraprofessionals were drawn from studies that had serious internal validity problems, which meant that the findings were largely inconclusive and ambiguous (Stein and Lambert 1984). More specifically, critiques of this research have identified methodological problems in relation to: a) definitions of
professional status; b) sampling; c) confounding of treatment status and professional status; d) the use of outcome measure that were not validated; and e) the lack of adequate follow-up studies. These issues are considered below.

2.1.4.1 Definitions of professional status

In order to make valid comparisons between or across professional and paraprofessional therapists it is essential to establish and agree on “clear and consistent rules for assigning helpers to professional and paraprofessional categories” (Nietzel and Fisher 1981). Previous research has failed to do this effectively, and therefore, a major methodological problem in paraprofessional research concerns the definition of professional status. This section reviews the key methodological problems in relation to the issues that have arisen in previous studies.

Originally, Durlak (1979, p.80) offered the following distinction between professional and paraprofessional therapists: “Individuals who have received post-baccalaureate, formal clinical training in professional programs of psychology, psychiatry, social work, and psychiatric nursing are considered to be the professionals. Those individuals who have not received this training are paraprofessionals.” On the basis of this definition he argued that “experienced psychologists, psychiatrists and social workers typically constituted the professional therapist group” (Durlak 1979, p.81) in the studies he reviewed. Subsequent reviewers took issue with this definition and identified several instances in the 42 studies Durlak reviewed where the classification of professional and paraprofessional was questionable or problematic.

Nietzel and Fisher (1981), for instance, defined a professional as someone who has completed training in one of the core mental health fields and a paraprofessional as
someone who has not completed nor is currently enrolled in a recognised postgraduate training program in a health speciality. Consequently, they objected strongly to Durlak’s designation of postgraduate student trainees as professionals, which occurred in approximately 25% of the studies he reviewed. They noted that the original authors of these studies did not use the term professional for graduate students (See Getz et al. 1975).

Berman and Norton (1985), for example, excluded six studies in their review because of problems related to the classification of professionals or paraprofessionals. In one study social workers and nurses were designated as paraprofessionals (Jensen 1961) and in three studies (Brown and Myers 1975; Murry 1972; Zultowski and Catron 1976) college professors who did not have any training in mental health were classified as professionals. In another study (Moleski and Tosi 1976) a trained speech pathologist was labelled as the paraprofessional therapist in a study assessing the treatment of stutterers, while a psychiatric intern was categorised as the professional therapist. Finally, in a study investigating the behavioural treatment of obesity the paraprofessional was an experimental psychologist with a strong background in learning theory and the professional was a medical student (Penick et al. 1971).

The key issue here is that the systems used to categorise professionals and paraprofessionals did not differentiate sufficiently between professional training (e.g., nurse, social worker) and psychotherapeutic training, which appears to have led to a blurring of the distinction between professionals and paraprofessionals in these earlier studies and reviews (Roth and Fonagy 2006).
2.1.4.2 Problematic sampling
A significant criticism of the studies in Durlak’s (1979) review is that the patient populations or types of problems in the selected studies were unrepresentative of those found in everyday counselling and psychotherapy practice (Lambert et al. 1986). For instance, the most commonly occurring categories of patient complaints or problems were social adjustment, phobia, schizophrenia, and obesity (Faust and Zlotnick 1995). The relative effectiveness of paraprofessional versus professional therapists in relation to depression, one of the most common presenting problems in routine practice, was not represented in any of these original studies. The implication of the non-representative sampling of client groups is that it is unclear from these studies the extent to which paraprofessionals may be more or less effective than professionals with clients presenting with problems more typically found in routine practice in psychological services.

2.1.4.3 Sample size and outcome measurement
A related criticism is that the sample sizes of therapists and clients in most of the comparative studies were small, and therefore, lacked sufficient power to detect differences between professionals and paraprofessionals. In fact, there was significant variability in sample sizes in the studies in the Durlak (1979) review, ranging from one to 67 therapists in each group of helping services. Another issue concerns the diverse range outcome measures that were employed in studies and their sensitivity to accurately detect therapeutic change. On this matter, as Faust and Zlotnick (1995) have commented, it is difficult to attribute the lack of differences between professionals and paraprofessionals to poor outcome measurement given that no significant differences were found in effect size between type of outcome and source of outcome, and also because this argument is predicated on the assumption that the
outcome measures were not sensitive to the outcomes that professionals differentially produce. Nevertheless, it is preferable in outcome research to use a standardised measure that has been shown to be sensitive to change.

2.1.4.4 Confounding of treatment status with type of problem and other therapist characteristics, and lack of follow-up

A general criticism of these studies is that they lacked adequate control of potentially confounding variables. Specifically, that treatment status (i.e., professional versus paraprofessional) has been confounded with type of treatment or intervention and other therapist characteristics such as type of training and experience, demographic background, cognitive complexity, values and beliefs and so on. This is an important point because ‘unless therapist variables are isolated, differences between professionals and paraprofessionals become obscured (Faust and Zlotnick 1995). This is especially the case in relation to variables such as training and experience, which have not been clearly described or defined in many of these studies, and in other instances have been categorised using different systems (Roth and Fonagy 2006; Stein and Lambert 1984).

Another concern is that a lack of follow-up in relation to these studies may obscure the possibility that paraprofessionals may have merely been alleviating symptoms in the short term, whereas professionals may in fact have been achieving more in-depth and longer lasting change. This is an important theoretical point and raises the question of whether paraprofessionals merely achieve short-term ‘symptom’ relief through the healing effects of a benign human relationship or whether longer lasting change is a function of the methods of ‘treatment’ employed by professional counsellors and psychotherapists (Faust and Zlotnick 1995).
Section 2.1.4 above has identified the main methodological issues in research into the effectiveness of paraprofessional helping. The next section takes a closer look at the group of 19 studies that investigated paraprofessional helping in relation to individual or group psychotherapy or counselling that were originally identified by Durlak (1979) because they are of particular relevance to counselling provided by minimally trained volunteer mental health counsellors, which is the focus of this thesis.

2.1.5 Group 1 studies in the Durlak (1979) review

2.1.5.1 Introduction
The evidence base for the effectiveness of paraprofessional counselling is based, to a large extent, on the repeated meta-analysis of a set of core studies originally identified by Durlak (1979), and subsequently reviewed and commented on by other researchers (see section 2.1.3 of this chapter). The studies included in the review by Durlak (1979) encompassed five categories of helping services described earlier at section 2.1.3 of this chapter. Of the five categories of studies included in Durlak (1979), the most relevant to the research reported on in this thesis were the 19 studies in ‘Group 1’, which involved paraprofessional therapists delivering individual or group psychotherapy or counselling. More recent studies of paraprofessional counselling are discussed in the following sections of this chapter. However, before proceeding to a consideration of more recent research in this area, it is important to critically evaluate the evidence base for the effectiveness of paraprofessionals providing individual and group therapy in these original studies, primarily because these studies are particularly relevant to Study 1 of this thesis.

The methodological rigour of all 42 studies included in the original review by Durlak (1979) have been discussed extensively by other reviewers (Berman and Norton 1985;
Hattie et al. 1984; Nietzel and Fisher 1981), and were summarised in section 2.1.4 above. Therefore, the focus of this section has been restricted to issues that have received less critical evaluation in previous reviews. In particular, the 19 studies dealing with individual or group psychotherapy or counselling identified by Durlak (1979) are examined in terms of the extent to which the client populations, problem type, setting, type of intervention and characteristics of the paraprofessionals in these studies are representative of those in the contemporary practice of paraprofessional counsellors working in routine mental health practice settings, especially within a UK context.

2.1.5.2 Summary of Group 1 studies identified by Durlak (1979)
Table 2.1 summarises the studies of paraprofessional interventions involving individual or group psychotherapy or counselling identified by Durlak (1979). The presentation of studies in Table 2.1 has been adapted from Durlak (1979) insofar as studies are listed according to the experimental quality assigned by Durlak (1979), and the column headings are similar. However, additional information has been added to columns dealing with the characteristics of the client populations and paraprofessionals in each study, which was not originally provided by Durlak (1979). The 19 studies have been summarised in Table 2.1 to provide an outline of the main characteristics of these studies, and also as a point of reference for the discussion that follows in section 2.1.5.3 below.
### Table 2.1 Summary of Group 1 Studies adapted from Durlak (1979)

<table>
<thead>
<tr>
<th>Study</th>
<th>Experimental quality</th>
<th>Client populations and problem types</th>
<th>Paraprofessionals</th>
<th>Outcomes: Paraprofessionals vs professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Jensen 1961)</td>
<td>B</td>
<td>Psychiatric inpatients. (Neuropsychiatric patients - specific diagnosis not provided).</td>
<td>Nurses, nursing assistants, social workers. Details of levels of training/experience not fully described.</td>
<td>Neither group.</td>
</tr>
<tr>
<td>(Miles et al. 1976)</td>
<td>B</td>
<td>Psychiatric inpatients. (Range of diagnosis: schizophrenia (28%), neurosis (33%), depression (15%).</td>
<td>Third year medical students.</td>
<td>Neither group.</td>
</tr>
<tr>
<td>(O'Brien et al. 1972)</td>
<td>B</td>
<td>Psychiatric outpatients (Schizophrenia).</td>
<td>Medical students with average of 1.5 years experience.</td>
<td>Neither group.</td>
</tr>
<tr>
<td>(Truax 1967)</td>
<td>B</td>
<td>Vocational rehabilitation clients (range of issues).</td>
<td>Adult women. Details of levels of training/experience not fully described.</td>
<td>Paraprofessionals.</td>
</tr>
<tr>
<td>(Truax and Lister 1970)</td>
<td>B</td>
<td>Vocational rehabilitation clients. (Range of vocational issues: personality/behavioural problems; speech, hearing, mental retardation; orthopaedic, spinal cord injury and epilepsy).</td>
<td>Counsellor aides-recruited from secretarial staff. Did not have special training in counselling.</td>
<td>Paraprofessionals.</td>
</tr>
<tr>
<td>(Weinman et al. 1974)</td>
<td>B</td>
<td>Psychiatric out-patients ('functional psychotic patients suffering form apathy, isolation and dependency').</td>
<td>Community volunteers. Information about paraprofessionals' academic qualifications or related helping training or experience not provided.</td>
<td>Neither group.</td>
</tr>
<tr>
<td>----------------------</td>
<td>---</td>
<td>------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>(Anker and Walsh 1961)</td>
<td>C</td>
<td>In-patient psychiatric patients (Chronic schizophrenia).</td>
<td>Recreational therapist. Details of any training/experience in group therapy not provided.</td>
<td>Paraprofessionals.</td>
</tr>
<tr>
<td>(Cole et al. 1969)</td>
<td>C</td>
<td>Adolescent females (Exhibiting delinquent and behavioural problems such as stealing, sexual acting out behaviour).</td>
<td>Adult women volunteers in a community-based voluntary organisation for women. Details of volunteer training not provided.</td>
<td>Neither group.</td>
</tr>
<tr>
<td>(Mosher et al. 1975)</td>
<td>C</td>
<td>Psychiatric in-patients (Schizophrenia).</td>
<td>“Specially trained non-professional staff.” Details of this training was not provided.</td>
<td>Paraprofessionals.</td>
</tr>
<tr>
<td>(Poser 1966)</td>
<td>C</td>
<td>Psychiatric in-patients (Males with schizophrenia).</td>
<td>Female undergraduate students. No prior training/experience in mental health or counselling/psychotherapy.</td>
<td>Paraprofessionals.</td>
</tr>
<tr>
<td>(Sheldon 1964)</td>
<td>C</td>
<td>Psychiatric out-patients (Adult men and women with diagnosis of schizophrenia and depression).</td>
<td>GPs providing care as usual, but it is not clear from the report what this entailed. Details of GPs training/experience in counselling</td>
<td>Professionals (better than GPs but equal to nurses.</td>
</tr>
<tr>
<td>Reference</td>
<td>Group</td>
<td>Condition</td>
<td>Description</td>
<td>Outcome</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>(Mendel and Rapport 1963)</td>
<td>D</td>
<td>Psychiatric out-patients.</td>
<td>Psychiatric aides selected on basis of ability to deal with chronic, emotionally disturbed patients. Aides had no formal psychiatric training but received a brief training in an existentially-based approach specifically developed for this study.</td>
<td>Neither group.</td>
</tr>
<tr>
<td>(Covner 1969)</td>
<td>E</td>
<td>Alcoholics/Problem drinkers.</td>
<td>Community volunteers with varied backgrounds, including some with work or volunteer experience in guidance counselling and human service professions. More than 60% of volunteers had a history of alcoholism.</td>
<td>Neither group.</td>
</tr>
<tr>
<td>(Magoon and Golann 1966)</td>
<td>E</td>
<td>Psychiatric outpatients (Range of mental health problems).</td>
<td>Women community volunteers. Received training in psychotherapy over 2 year period which involved theory, skills and supervised practice.</td>
<td>Neither group.</td>
</tr>
</tbody>
</table>

Chapter 2: Literature Review
Table 2.1 above has provided a summary of the 19 Group 1 studies involving individual or group counselling and psychotherapy included in the original review by Durlak (1979) of the comparative effectiveness of professional versus paraprofessional therapists. The next section examines methodological issues in these studies with a view to determining their relevance of findings to the contemporary routine practice of paraprofessional counsellors in the UK.

2.1.5.3 Characteristics of paraprofessionals, client populations/problem types, setting and type of interventions employed in Group 1 studies identified by Durlak (1979)

This section considers the extent to which the client populations and paraprofessionals in the studies listed in Table 2.1 are, in fact, representative of routine counselling practice, and also evaluates the extent to which the conclusions drawn from the review by Durlak (1979) are applicable to routine counselling within a UK context.

Table 2.2 below illustrates that the client populations in the vast majority of Durlak’s (1979) Group 1 studies were psychiatric inpatients or outpatients (68%). The predominant diagnosis of patients in studies of psychiatric inpatients or outpatients was schizophrenia, which was often of a chronic nature. For example, the study by Appleby (1963) involved 30 adult women psychiatric inpatients of whom 12 had been lobotomised. The study by Weinman et al. (1974) involved psychiatric outpatients which the authors described as, “...functional psychotic patients with the characteristic symptoms of apathy, isolation and dependency” (p.358).

Durlak (1979) also included three investigations of vocational rehabilitation clients in the category of individual or group counselling or psychotherapy studies. Truax and
Table 2.2. Client populations and problem types in Durlak (1979) Group 1 Studies

<table>
<thead>
<tr>
<th>Client population</th>
<th>Type of problems</th>
<th>Number of studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric in-patients</td>
<td>Schizophrenia, neurosis, depression</td>
<td>7</td>
</tr>
<tr>
<td>Psychiatric out-patients</td>
<td>Schizophrenia</td>
<td>6</td>
</tr>
<tr>
<td>School children</td>
<td>Behavioural problems</td>
<td>1</td>
</tr>
<tr>
<td>Vocational rehabilitation</td>
<td>Range of problems – e.g., behavioural, speech, hearing, and orthopedic problems</td>
<td>3</td>
</tr>
<tr>
<td>Adolescent delinquents</td>
<td>Delinquent / behavioural problems</td>
<td>1</td>
</tr>
<tr>
<td>Alcoholics</td>
<td>Problem drinking</td>
<td>1</td>
</tr>
</tbody>
</table>

Lister (1970), for instance, examined the impact of paraprofessional counselling on clients experiencing a range of vocational issues, which included behavioural and personality problems, speech and hearing difficulties, mental retardation, orthopaedic and spinal cord injury, and epilepsy. Two of the studies allocated to Group 1 by Durlak (1979) involved young people and children. The study by Cole et al. (1969) was based on 14 adolescent females who were demonstrating behavioural problems such as stealing and sexual acting-out. The study by Karlsruher (1976) examined the impact of paraprofessional counselling on 60 “poorly adjusted” 6th grade (i.e., 10-12 year old) male school children. Finally, Durlak (1979) included one study in the Group 1 category that involved paraprofessionals delivering pre-treatment counselling to families of problem drinkers in a community based alcohol service (Covner 1969).

The client populations in the Durlak (1979) Group 1 studies are not representative of those encountered in routine community-based counselling practice in the UK where the most common presenting problems are depression, anxiety/stress, interpersonal
and relationship difficulties which are typically in the moderate range of severity (Mellor-Clark et al. 2001).

Similarly, in many instances, the type of interventions in the 19 Group 1 studies of individual or group counselling or psychotherapy described in Durlak (1979) represented unorthodox interventions, which are not representative of routine counselling practice. In the UK, for example, primary care counselling interventions are based on main stream counselling models such as person-centred and cognitive-behavioural therapies, or on some form of integrative model (Freeman and Power 2007). Bearing this in mind, it is interesting to note that in some instances the authors of a number of studies categorised as representing individual or group counselling or psychotherapy by Durlak (1979) indicated that the interventions were not therapy in a conventional sense or that the paraprofessionals did not regard themselves as therapists. By way of illustration, consider the following studies that were categorised by Durlak (1979) as individual or group psychotherapy or counselling interventions.

Anker and Walsh (1961), for example, described a special activity programme for psychiatric inpatients with a diagnosis of chronic schizophrenia delivered by a paraprofessional therapist that involved the production of plays for hospital patients and staff. Patients in the Anker and Walsh (1961) study were not given a choice about joining the group therapy programme. In fact, there were instructed to do so and informed that they were obliged to meet the aims of the group whether they objected or not. The authors of this study acknowledged in their paper that, “It would be insufficient to describe the type of group psychotherapy studies as ‘orthodox’ (Anker and Walsh 1961, p.477).
In another study, Cole et al. (1969) compared a professional and a paraprofessional group programme for adolescent females (13 to 17 years) with behavioural and delinquent problems. The aim of the group treatment was to produce changes in the adolescents' self-concept. Both the professional and paraprofessional groups were run by female group leaders who were intended to act as role models to the adolescent females in the groups. Group sessions focused on issues related to wearing make-up, hair styling, exercise and diet, clothes and accessories, posture and general demeanour, and dating etiquette. Again, the intervention described in the Cole et al. (1969) study does not fit easily into and orthodox definition of group psychotherapy where the focus is more typically on the exploration and understanding of problems in living, and on discovering and implementing ways of resolving such problems (Trotzer 2006). In fact, Cole et al. (1969) stated in their paper that the intervention could more readily be described as "attractiveness training" or as "training in socially relevant skills" (Cole et al. 1969, p.643).

Studies involving individual counselling or psychotherapy in Durlak’s (1979) Group 1 studies also highlighted issues around the designation of the interventions employed in these studies as therapy. For instance, the study by Mosher et al. (1975) described a home-based treatment programme for schizophrenia. This study involved a comparison of the outcome of a hospital-based treatment and a community-based residential facility for patients who had recently been diagnosed with schizophrenia. Patients in the professional hospital-based group received treatment as usual, which included drugs. Mosher et al. (1975) stated in their paper that the intervention in the non-professional community-based residential setting was organised around the idea of a "treatment milieu" (p.456), which did not usually involve drug treatment.
The non-professionals in the Mosher et al. (1975) study worked long shifts of 36-48 hours in the residential facility and shared responsibility with residents (i.e., patients) for the maintenance of the house and the preparation of meals. In addition to these household chores, the non-professionals in this study also provided one-to-one or two-to-one attention to residents. However, specific details of what this interpersonal activity actually involved was not provided in the report. Mosher et al. (1975) did not provide details of the training of the non-professionals in this study. Although Mosher et al. (1975) noted that the non-professionals had been specially trained for their role in the residential facility, it is interesting to note that the authors state in their report that the non-professionals in this study did not regard themselves as therapists.

The investigation by Sheldon (1964) was the only UK based study included by Durlak (1979) in the Group 1 category. This study was carried out in Warlingham Park Hospital, Croydon, South London and its locality, and involved a comparison of psychiatric after-care at outpatient mental health clinics versus care as usual from GPs for adult men and women following inpatient treatment for schizophrenia and depression. The paraprofessionals in this study were the GPs and the intervention was care as usual; however, it is unclear from the Sheldon (1964) report what care as usual involved or whether the paraprofessionals in this study had any training or experience in counselling or psychotherapy.

Magoon and Golann (1966) reported on a particularly interesting study that investigated the effectiveness of a group of paraprofessionals, which they described as, “Non-traditionally trained women as mental health counsellors/psychotherapists” (p.788). The paraprofessional counsellors in this study were eight women volunteers
selected for being mature, bright, and socially sensitive. They delivered both individual and group psychotherapy in a variety of mostly community-based mental health settings, but also in a college counselling service, a high school counselling service and within two in-patient settings. The effectiveness of the paraprofessionals in the Magoon and Golann (1966) study was evaluated solely on the basis of supervisor and co-worker evaluations, which were very positive and indicated that the paraprofessionals in this study provided “quite creditable professional counseling and psychotherapy” (Magoon and Golann 1966, p.788).

A remarkable feature of the Magoon and Golann (1966) study is the breath and depth of the training in psychotherapy the paraprofessionals received. It is remarkable because the content, duration and structure of the training described in the report is more closely aligned with contemporary training for professional counsellors (within a UK context at least) than that which minimally trained paraprofessional therapists might be expected to receive. For example, Magoon and Golann (1966) described the training as follows:

The content of the training program was narrow but intensive, focusing upon instruction and practice in and about psychotherapy. Over the course of the two years, the trainees participated in coursework seminars on personality development, problems of adolescents, family dynamics, psychopathology, contributions of modern psychiatry, and in casework presentations...The trainees carried on directly supervised casework...Individual and group supervision was a regular component of their training ...Over the course of
training, the trainees also had opportunity to directly observe the therapeutic work of at least 14 different therapists.

It is noteworthy that the paraprofessionals in the Magoon and Golann (1966) study underwent an intensive selection process before being selected for this specially designed training programme for mental health counsellors, which was previously reported on by Rioch et al. (1965). The goal of this training programme was to evaluate the extent to which carefully selected, mature, and bright people could be trained over a two year period to do psychotherapy under supervision. Magoon and Golann (1966) reported that during the course of the two year training, which spanned 38 weeks per year, the paraprofessional counsellors that participated in the study spent approximately 800 hours in clinical activities that included interviewing patients, conducting individual and group therapy with clients and participating in individual and group supervision sessions. In addition, 684 hours were devoted to lecture and seminar discussions, 532 hours were spent in work-placement experience in a community mental health agency, 532 hours were allocated to outside reading and report writing, and approximately 114 hours were set aside to observe experienced professional therapists conducting individual, group, and family interviews. Overall, this represents approximately 2,660 hours of training over two academic years, which works out at 35 hours per week devoted to training/practice.

This level of training far exceeds the requirements for professional counsellor training in the UK. For example, the requirements for diploma level training laid down by the British Association for Counselling and Psychotherapy (BACP), a leading professional body for counselling and psychotherapy, stipulate 450 hours of face-to-
face classroom-based teaching, a minimum of 150 hours of supervised client work experience plus 50 hours of work-based learning activities (BACP 2009a). Viewed in terms of contemporary training requirements for professional counsellors, it is difficult to see how the counsellors in the Magoon and Golann (1966) study could be regarded as minimally trained paraprofessional therapists.

Another significant methodological issue in the Magoon and Golann (1966) study is that evaluation of paraprofessional counsellors’ effectiveness did not include any independent client assessment or ratings of the helpfulness of counselling: as noted above, evaluations were based solely on supervisors and co-worker accounts. The absence of such data and information about client presenting problems or levels of distress means that it is impossible to know to what extent this group of paraprofessional counsellors were effective in alleviating client distress.

2.1.5.4 Conclusion
What is evident from this brief consideration of the 19 studies that Durlak (1979) categorised as paraprofessionals delivering individual or group psychotherapy or counselling is that the client populations and problem types represented in these studies are not typical of those encountered in contemporary routine counselling practice within mental health settings, especially within the UK. For example, the most common presenting problems in primary care or community-based counselling services in the UK are depression, anxiety/stress, interpersonal problems. Moreover, the paraprofessional interventions in many of these studies are not readily identifiable as reflecting common strategies or techniques associated with individual or group psychotherapy or counselling models (e.g., person-centred, psychodynamic or cognitive/behavioural approaches). Indeed, in a number of studies the interventions
were described as unorthodox by the study author(s), and in other instances the paraprofessionals involved did not regard their work as counselling or psychotherapy. Furthermore, in a number of studies the counselling intervention was not clearly contracted and boundaried and was therefore confounded by the fact that the paraprofessional therapists also engaged with their clients in other more practical helping activities such as providing assistance to clients in relation to daily living activities such as shopping and meal preparation.

In addition, the majority of studies did not provide sufficient information about the characteristics of the paraprofessionals involved. In particular, there was a lack of detail about their experience with the client group they were working with, levels of academic qualifications or the type, duration and content of any therapy oriented training they may have undertaken prior to or during the study period. Also, too little attention has been paid to the role and influence of supervision (which may be viewed as a form of training) of paraprofessionals by professionals on the outcomes achieved in individual studies.

An important implication of these methodological issues is that this body of literature does not really provide a sufficient evidence base for the effectiveness of paraprofessional counselling for common mental health problems such as depression, anxiety, and other problems in living such as interpersonal/relationship difficulties, eating disorder and trauma, which may be encountered in routine primary care and community-based counselling practice, particularly within a UK context. Section 2.1.7 of this chapter addresses this question by undertaking a new review of the effectiveness of paraprofessionals providing individual counselling for common
mental health problems.

2.1.6 Overview of other reviews and studies related to paraprofessional counselling

This section briefly describes other reviews of paraprofessional counselling. Some of these reviews encompass the broader question of the relevance of training to outcome in counselling, while others deal more specifically with methodological criticisms of the main body of literature on paraprofessional counsellors reviewed in the preceding sections of this chapter.

Reviews by Stein and Lambert (1984), Christensen and Jacobson (1994) Faust and Zlotnick (1995), Atkins and Christensen (2001), and a recent systematic review by den Boer et al. (2005) support the general conclusion that professional training and experience appear to contribute little to therapist effectiveness. In addition to the support for the findings of prior research, these reviews also highlighted a number of areas of practice where professionals may have advantages over paraprofessionals.

2.1.6.1 Other relevant reviews of paraprofessional counselling

The meta-analysis by Stein and Lambert (1984) set out to provide a broader examination of the relationship between therapist experience on psychotherapy outcome, than that provided in previous reviews by Berman and Norton (1985), Durlak (1979), Hattie et al. (1984), and Nietzel and Fisher (1981). In addition to studies comparing professional with paraprofessional therapists, they also included studies comparing novice and experienced therapists, and only selected studies where “real clinical problems using such treatment approaches as psychodynamic, client-centred therapy, and behavioural methods were employed” (Stein and Lambert 1984, p.130). They found no significant evidence that experienced therapists produced more
positive outcomes than inexperienced therapists. However, they noted that the level of therapist training may be related to client drop-out rates, and that a “relationship between experience and outcome is most likely to occur in studies where “techniques other than non-specific counseling or specific behaviour techniques for circumscribed problems are the focus of study” (Stein and Lambert 1984, p.139). In other words, favourable outcomes for therapists with less training relative to experienced ones tended to be found when less trained therapists employed circumscribed, behavioural interventions for specified problems as opposed to employing psychodynamic approaches.

Reviews by Christensen and Jacobson (1994), and Faust and Zlotnick (1995) examined methodological criticisms of the main meta-analytic reviews discussed in section 2.1.3 above (Berman and Norton 1985; Durlak 1979; Hattie et al. 1984; Nietzel and Fisher 1981). Both reviews concluded that the finding that formal training does not predict successful therapy was sound.

Christensen and Jacobson (1994), commenting on these successive reviews noted that, “whatever refinements are made, whatever studies are included or excluded, the results show either no differences between professionals and paraprofessionals or, surprisingly, differences that favour paraprofessionals” (p.9). Interestingly, they also pointed out that a number of methodological factors limit the conclusions that can be drawn from this research, which in turn, affect the relevance of this research for clinical practice. For instance, they noted that this research has not really investigated the comparative effectiveness question across the full spectrum of psychiatric disorders and professional treatments, that comparisons typically involved
mild/moderately trained professionals as opposed to very experienced therapists, and that in many instances the paraprofessionals were trained and supervised by professionals.

Faust and Zlotnick (1995) examined in detail some of the major methodological criticisms of this body of literature and concluded that it is difficult to defend the criticism that methodological weaknesses in these studies produced systematic biases against professional therapists. On the contrary, they argued that “unless one begins with the assumption of professional superiority and sets harsher, or much harsher, standards of evidence for studies suggesting otherwise, the conclusion that naturally follows is that formal training, in general, is not a predictor of successful psychotherapy” (p.164). Similar to Christensen and Jacobson (1994), Faust and Zlotnick (1995) also commented on the fact that research comparing the effectiveness of professionals and paraprofessionals had thus far not addressed more fine-grained questions related to the scope of paraprofessionals effectiveness with specific problem types or the impact of characteristics of individual therapists and their practice that may contribute to differences between these two groups of practitioners.

Atkins and Christensen (2001) reviewed the literature on the effectiveness of paraprofessionals and the impact of training on client outcomes. They also included in their review a number of well designed studies not included in previous reviews, but which contribute further to our understanding of the effectiveness of paraprofessionals, and the impact of training on both professional and paraprofessionals’ effectiveness. These authors concurred with the findings from previous reviews that the existing evidence supported the efficacy of paraprofessional
counsellors, but noted that a variety of methodological problems (identified earlier in this section) meant that it is not possible to draw any definitive conclusions from this body of literature. In particular, they reported that the general finding for the effectiveness of paraprofessionals is qualified by evidence that professional training may be instrumental in greater client retention, briefer therapy and in promoting better overall wellbeing for clients.

2.1.6.2 Systematic reviews of paraprofessionals delivering psychological interventions

Den Boer et al. (2005) carried out a systematic review to investigate the effectiveness of paraprofessionals delivering any kind of psychological treatment for anxiety and depression. An extensive search strategy aimed at identifying randomised controlled trials comparing the effects of professional and paraprofessional treatments, and with waiting list or placebo condition, yielded 5 studies (Barnett and Parker 1985; Bright et al. 1999; Dennis 2003; Harris et al. 1999; Russell and Wise 1976) that matched their inclusion criteria. These studies, which are summarised below, encompassed a range of paraprofessional interventions including telephone-based peer support, group treatment and befriending.

Barnett and Parker (1985) and Dennis (2003) compared standard professional treatments with paraprofessional interventions that involved experienced mothers providing telephone-based peer support to highly anxious first time mothers and mothers with postpartum depression, respectively.

The study by Barnett and Parker (1985) evaluated the effectiveness of professional and non-professional interventions in reducing levels of anxiety in highly anxious
first-time mothers. The professionals in this study were experienced social workers, and the non-professionals were experienced mothers who volunteered to participate in the study. The volunteer paraprofessionals in the Barnett and Parker (1985) study were selected on the basis of their ability to act as a support figure and provide common sense advice and practical assistance to clients: they did not receive special training but were given a set of guidelines on how to respond to clients. By contrast, the professionals in this study adopted a more active therapeutic stance which included strategies aimed at reducing anxiety levels, enhancing self-esteem and confidence, promoting mother-father and father-child interaction, and reducing the intensity of the mother-infant interaction. Results of the Barnett and Parker (1985) study indicated that the professional intervention was more effective than the paraprofessional intervention.

Dennis (2003) employed a waiting list control design to evaluate the effect of volunteer mothers providing telephone-based peer support to mothers identified as being at high-risk for postpartum depression using the Edinburgh Postnatal Depression Scale (EPDS). The paraprofessionals (i.e., volunteer mothers) in this study were selected on the basis that they were similar to the client group in terms of socio-demographic characteristics, and also because they had personal experience of postpartum depression in the past. Paraprofessionals in the Dennis (2003) study received a 4-hour training session which focused on developing telephone support skills, knowledge of, and ability to refer clients on to local professional services where appropriate. In addition, paraprofessionals in this study were given an extensive handbook, which included a range of practical advice and guidance on providing effective telephone support to clients with postpartum depression. Overall, Dennis
(2003) found that, compared to the control group, the paraprofessional intervention had a significant effect in reducing levels of anxiety in clients at the 4-week and 8-week assessment points as measured by the EPDS.

A controlled study by Bright et al. (1999) investigated the comparative effectiveness of professional and paraprofessional therapists in relation to the provision of group cognitive-behavioural therapy and mutual support group therapy. The general finding from this study was that paraprofessionals were equal in effectiveness to professional therapists in reducing depressive symptoms, and that clients in both group conditions appeared to improve equally as measured by a range of participant and therapist rated measures. In addition, they also found that professionals appeared to be more effective than paraprofessionals in leading cognitive-behaviour groups. The authors speculated that a possible explanation for this finding may be that enhanced relational and technical competence may be needed by paraprofessionals in order to obtain acceptable treatment outcomes in some treatments (e.g., cognitive-behaviour group).

An interesting issue regarding the professional and paraprofessional therapists in this study was that half of the paraprofessionals had experience of leading support groups and all of them had experience of being a group member, whereas only half of the professional therapists had led group therapy programmes prior to the study. The authors noted that it was unclear from this study the extent to which the finding of equivalence in relation to the group treatments is applicable to more seasoned therapists. This point echoes a significant criticism of the paraprofessional literature, referred to earlier, insofar as studies have generally failed to evaluate the comparative effectiveness of paraprofessionals with highly experienced therapists.
The randomised controlled trial by Harris et al. (1999) examined volunteer befriending for women with chronic depression in inner London. The design of this study incorporated a waiting list control group which aimed to compare at least 40 chronically depressed women with a similar untreated control group. The paraprofessional intervention was described as befriending which Harris et al. (1999) defined as, “meeting and talking with the depressed woman for a minimum of one hour each week, and acting as a ‘friend’ to her, listening and ‘being there’ for her” (p.220). In addition to this interpersonal activity, the paraprofessional volunteers also provided practical support to their clients and accompanied them on trips outside of their homes to help clients broaden their range of activities. Details of the nature of the practical support offered or the nature of the trips outside was not provided by Harris et al. (1999).

The paraprofessionals in this study received a three-day training which emphasised the development of a facilitative and confiding relationship; however specific details to the topics covered in this training was not reported by Harris et al. (1999). A range of measures were used to evaluate outcome in this study. The main finding from the Harris et al. (1999) study was that the paraprofessional befriending intervention had a statistically significant effect on rates of remission in depressed women, and that this type of intervention could prove to be a useful adjunct to treatment as usual for chronic depression.

Russell and Wise (1976) investigated the comparative effectiveness of a professionally led group-based cue-controlled relaxation intervention to group-based systematic desensitization delivered by paraprofessional counsellors for 50
undergraduates students with speech anxiety. The professionals in this study were three experienced counsellors and PhD psychology graduates, all of whom had prior experience of delivering relaxation training, cue-controlled relaxation, and systematic desensitization. The paraprofessional counsellors were advanced undergraduate students without prior experience or training in behavioural interventions, and were selected on the basis of an interview by the lead researcher in the Russell and Wise (1976) study: details of the selection criteria for paraprofessionals in this study was not provided. Paraprofessionals received five training sessions that included training in desensitization and cue-controlled techniques in advance of the study, as well as information on the rationale for the study. Both the professional and paraprofessional counsellors received weekly supervision which provided an opportunity to discuss the group sessions. Outcome was assessed using the ‘Personal Report and Confidence as a Speaker Scale’, which was administered pre- and post-treatment.

The main findings of the Russell and Wise (1976) study were that both treatment conditions were more effective than no treatment and that the undergraduate paraprofessionals were equally effective to the experienced professional counsellors.

On the basis of their systematic review of five studies of paraprofessional treatments for anxiety and depression, den Boer et al. (2005) concluded that, overall, it was not possible to draw robust conclusions about the effect of paraprofessionals compared to professionals in the treatment of anxiety and depressive disorders. According to den Boer et al. (2005) the evidence from studies involving women only (Barnett and Parker 1985; Dennis 2003; Harris et al. 1999) indicated a significant effect for paraprofessional interventions compared to no treatment (den Boer et al. 2005).
Furthermore, den Boer et al. (2005) recommended the continued investigation of paraprofessional interventions for anxiety and depression.

### 2.1.6.3 An example of a study evaluating group-based paraprofessional psychotherapy

Burlingame and Barlow (1996) examined client outcomes for professional and non-professional therapists providing group psychotherapy. The professional therapists were ‘expert’ group therapists with clinical experience of between thirty and forty years, and the non-professional therapists were college professors with a reputation for possessing ‘natural’ helping abilities. The main finding from this study was that there were no significant differences between the two groups.

However, the authors observed that client improvement in the non-professional group tended to occur while treatment was being offered, and that improvement rates for this group declined during the follow-up period after treatment was withdrawn. The suggestion here is that the effects of providing a caring, supportive relationship may not have been sufficient to produce longer lasting change in this sample of clients. Clients in the professional group, on the other hand, showed most improvement during the follow up period. One possible explanation for this effect may be that professionals may have been more able to create a therapeutic experience that facilitated the development of new adaptive skills in clients, which provided some form of inoculation for clients against relapse (Burlingame and Barlow 1996).

Another issue in this study is that due to ethical considerations only minimally distressed clients could be recruited to treatment conditions, which may have
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obscured any significant differences between these two groups of practitioners as, “the effects of greater expertise in group treatment may be most evident when groups are composed of moderately to severely disturbed members who require greater management skill” (Burlingame and Barlow 1996, p.474). These issues raise a general question about the extent of paraprofessional effectiveness beyond short-term symptom reduction, and also highlight a significant methodological/ethical challenge in studying minimally trained paraprofessional therapists.

2.1.7 Paraprofessional counselling for common mental health problems: A review of effectiveness studies

This section aims to review the evidence for the effectiveness of minimally trained paraprofessional counsellors. For the purposes of this review, the term ‘minimally trained paraprofessional counsellor’ relates to the definitions provided at section 1.2.3 in Chapter 1 of this thesis.

2.1.7.1 Objectives

The focus of this review was to assess studies that have evaluated the effectiveness of individual counselling provided by minimally trained paraprofessional counsellors on common mental health problems. This review encompassed all years to December 2009 and was restricted to studies published in the English language.

2.1.7.2 Criteria for assessing studies for this review

Inclusion criteria

Studies were selected for inclusion in this review where paraprofessional counsellors met the following criteria: 1) they were minimally trained (i.e., they did not have a professional qualification in a social/healthcare profession or a diploma level qualification in counselling); 2) the counselling consisted of individual face-to-face counselling; 3) the counselling approach was based on the principles and techniques
of an established or clearly articulated counselling approach (e.g., person-centred, psychodynamic, cognitive-behavioural, solution-focused counselling); 4) the client group were adults (including young adults) experiencing common mental health problems typically encountered in routine counselling practice.

Exclusion criteria

Studies that involved highly focused or specialised areas of practice were excluded because they require (arguably) a distinct body of knowledge and a different set of skills. Consequently, studies that investigated group therapy or the delivery of structured psycho-educational programmes directed at specific target problems such as insomnia and obesity were excluded.

Also excluded were studies that investigated paraprofessional counselling for children and adolescents (i.e., under 16 years), drug and alcohol problems, crisis intervention, rape crisis counselling, and academic counselling aimed at students experiencing problems such as exam stress and test anxiety. Studies that involved simulated paraprofessional counselling with pseudo-clients were also excluded because the focus of this review was on evaluation the effectiveness of minimally trained counsellors with ‘real’ clients.

Target problems

Studies were included if the client group comprised adults with common mental health problems. This criterion was interpreted to include specific problems such as depression or anxiety, as well as problems in living that may be encountered in routine counselling practice: for example, stress, interpersonal/relationship
difficulties, trauma, eating problems, bereavement, and work related difficulties.

Outcome measures

Only studies that included independent client ratings of the impact of counselling on client psychological and social functioning using standardised outcome measures were included in this review. Studies that examined paraprofessional effectiveness only on the basis of supervisor or other observer evaluations were not included in this review (e.g., Magoon et al. 2006). The rationale for this decision was that it was deemed essential to determine the extent to which paraprofessional counsellors have a direct impact on the client group they are endeavouring to help; and importantly, to ascertain whether or not an evidence base actually exists for paraprofessional counselling for common mental health problems.

Research design

A pluralistic approach to the inclusion/exclusion criteria in relation to research design has been adopted in this review. This methodological choice was made because of the applied nature of research into paraprofessional counselling, and also because the position adopted in this thesis is that multiple sources of evidence are deemed important and valuable in addressing the question of paraprofessional effectiveness (see section 3.1.5 of Chapter 3 of this thesis) Consequently, the review will include studies that have employed a range of methodological approaches.

2.1.7.3 The search strategy

Three strategies were used to identify relevant studies for this review. First, existing reviews of paraprofessional counselling literature were identified and potential papers were identified from their reference lists. Second, on-line searches of the electronic
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databases PsychINFO, PsychArticles, and PubMed were carried out using combinations of the following key words: para-/professional; non-/professional; lay; volunteer; minimally trained; counsellor; mental health; depression; anxiety. Terms were further delimited using the asterisk symbol to encompass variants of the key search terms. For example: paraprofessional* for paraprofessionals; vol* for voluntary, volunteers, volunteering; minimal* train* for minimally trained, minimal training; counsel* for counsellor(s), counselor(s), counselling, counseling. Third, key journals were hand searched where possible or an electronic search of the table of contents of these key journals was carried out using the above search terms.

2.1.7.4 Examples of studies excluded from this review
A number of studies were excluded from this review because they failed to meet one or more of the inclusion criteria described in section 2.1.7.2 of this chapter. Some studies did not fully meet the criteria regarding the type of intervention, in this case individual counselling, and or confounded individual counselling with other helping activities.

For instance, Lenihan and Kirk (1990) reported on the use of paraprofessionals in the treatment of university students with eating disorders. The paraprofessionals in this study were psychology trainees whose role involved acting as “companion therapists” to clients experiencing problems related to anorexia/bulimia. The Lenihan and Kirk (1990) study was excluded from this review because the paraprofessional intervention was not limited to individual counselling, but instead involved a range of therapeutic activities that included group therapy, daily personal or phone contact with clients. In addition, the paraprofessional therapists in the Lenihan and Kirk (1990) study also spent time with clients that involved a range of activities such as walking and joint
exercise, having lunch together, and study sessions. Although this study did involve one-to-one support it was not possible to separate this component of the intervention from other helping activities the paraprofessionals engaged in with clients.

In a systematic review of RCTs, den Boer et al. (2005) identified five studies of paraprofessionals delivering psychological interventions for anxiety and depressive disorders (see section 2.1.6.2 or this chapter). All five of these studies (Barnett and Parker 1985; Bright et al. 1999; Dennis 2003; Harris et al. 1999; Russell and Wise 1976) were excluded from this review because the paraprofessional intervention did not involve, or was not restricted to, individual face-to-face counselling.

One study examined mothers providing telephone-based peer support to highly anxious primiparous mothers (Barnett and Parker 1985), and another evaluated a specially designed telephone-based paraprofessional support intervention for mothers at high-risk for postpartum depression (Dennis 2003). The study by Bright et al. (1999) was excluded because it was concerned with group treatments for depression. The study by Harris (1999) described a befriending intervention for chronic depression. In many respects the paraprofessional befriending intervention in the Harris (1999) study resembled a supportive counselling intervention. However, it was decided to exclude it from this review because the paraprofessionals also included a range of other activities, which were not clearly delineated or specified by Harris (1999), such as offering practical support to clients, and accompanying them on outside trips.

The Magoon and Golann study (1966) discussed in section 2.1.5.3 of this chapter was
excluded primarily because it did not include any independent client ratings of the impact of counselling on levels of client distress or symptomatology.

Kieft et al. (2008) described a pilot project in which paraprofessional counsellors were trained to provide counselling to asylum seekers’ in the Netherlands. The paraprofessional counsellors in this study were also asylum seekers and refugees, and were selected from the same asylum seekers’ groups to which they provided individual counselling and a range of other psychosocial helping activities (e.g., psycho-education and general family support).

The paraprofessional counsellors in the Kieft et al. (2008) study received four to six months of counselling training based on the models described by Egan (1998) and Ivey (1999), and which also included supervised practical placements. The overall aim of the project that Kieft et al. (2008) study reported on was to evaluate the extent to which the provision of paraprofessional counselling (and other psychosocial helping activities) within asylum seekers groups would improve psychosocial health, and increase assess to basic psychosocial care among this population. Kieft et al. (2008) reported that over a six-month period the 14 paraprofessional counsellors provided approximately 240 counselling sessions in which the predominant presenting issues were feelings of depression, guilt and loneliness; sleeping problems; stress; somatic complaints; alcohol abuse; interpersonal and relationship problems; and problems related to asylum seekers’ status.

Overall, Kieft et al. (2008) reported that this pilot project demonstrated the viability of establishing a paraprofessional community-based psychosocial service for asylum
seekers and refugees who may not use or have access to mental health services despite a high prevalence of mental health problems within this group of people (Kieft et al. 2008). This is an interesting example of a paraprofessional counselling intervention, in which the characteristics of the paraprofessionals are reasonably well described, especially the type of training they received. However, although Kieft et al. (2008) noted in their paper that there were, “some indications that the project had a positive effect on the well-being of the asylum seekers that received the counselling services …we did not conduct effectiveness research on the intervention…” (p.115). In other words, the authors did not assess the outcome of counselling using standardised outcome measures. Consequently, it is not possible to determine objectively to what extent the paraprofessional counselling intervention was effective in alleviating client distress. For this reason, the Kieft et al. (2008) study was excluded from this review.

Two studies (Alder and Truman 2002; Moore 2006) of voluntary sector counselling in the UK were identified in a search of the literature but were also excluded from this review. A study by Moore (2006) used the CORE-OM (Evans et al. 2000) to evaluate the effectiveness of volunteer counsellors working in a UK based Voluntary Sector counselling agency. Findings indicated that volunteer counsellors appeared to achieve better outcomes than those reported in CORE-OM datasets of professional counsellors and psychotherapists working in NHS psychological services, which were used for comparison purposes. However, the majority of the volunteer counsellors in the Moore (2006) study were professional counsellors with extensive training and experience. For instance, two-thirds of counsellors had counselling diplomas in addition to holding other healthcare qualifications in disciplines such as nursing, social work and psychology. Furthermore, some seventy percent of the counsellors
had over two years experience and a significant number (thirty five percent) had in excess of eight years experience. The study by Moore (2006) can therefore be regarded as an investigation of the effectiveness of professionally trained counsellors working in a voluntary capacity, rather than comprising a study of minimally trained or paraprofessional counsellors.

The study by Alder and Truman (2002) investigated the effectiveness of counselling for postnatal depression in a voluntary sector agency in Scotland. Seven counsellors offered individual or group counselling based on person centred, gestalt, or psychodynamic principles. Outcome was evaluated using a range of standardised measures. Overall, findings from the Alder and Truman study (2002) indicated that voluntary sector counselling was effective in alleviating symptoms of postnatal depression. This study was excluded from this review because no data were provided on counsellors levels of training or experience, and consequently, it was not possible to determine if counsellors met the criteria regarding minimal training for this review.

From the information that was provided about the counselling intervention in the Alder and Truman (2002) study, it would appear that the counsellors were trained counsellors. For example, the authors noted that the interventions depended largely on the background and approach of individual counsellors, who provided counselling based on the principles of psychodynamic, person-centred, and gestalt therapies, or art therapy. This seems to imply that the counsellors in the Alder and Truman (2002) study had received training in gestalt, person-centred, and psychodynamic approaches.
2.1.7.5 Results

Four studies were identified that met the inclusion criteria for this review. The methodological characteristics of the studies are summarised in Table 2.3. Two studies used a randomized controlled design. In one study, a randomized controlled design was used to assess the effectiveness of eight counselling sessions delivered by women minimally trained as community counselors on levels of anxiety and/or depression in female clients (Sabir et al. 2003). In another study, a randomized controlled design was employed to examine whether trained lay counsellors could provide effective treatment of posttraumatic stress disorder (PTSD) in an African refugee settlement (Neuner et al. 2008). One study employed a controlled design to compare the effectiveness of counselling provided by college professors, without any counselling training, with counselling delivered by professional therapists on levels of depression/anxiety in male college students (Strupp and Hadley 1979). The final study reported on the effectiveness of a paraprofessional counselling intervention in a single case of posttraumatic stress disorder (Plouffe 2007).

All four studies used at least one standardised outcome measure which assessed psychological symptoms and or social functioning. Two studies were carried out in the USA (Plouffe 2007; Strupp and Hadley 1979), one study was conducted in Karachi, Pakistan (Sabir et al. 2003), and one study was based in Africa (Neuner et al. 2008). In one study, counselling was carried out in clients’ homes on a domiciliary basis (Sabir et al. 2003). One study was conducted within a refugee settlement (Neuner et al. 2008), another in a university counselling center (Strupp and Hadley 1979), and the fourth study took place in a mental health clinic (Plouffe 2007). Details of the individual studies are summarised in Table 2.3. The main findings for each study are reported below according to the type of target problem.
### Table 2.3. Methodological features of studies of paraprofessional counselling for common mental health problems

<table>
<thead>
<tr>
<th>Feature</th>
<th>Number of studies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Design</strong></td>
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<tr>
<td>Randomized controlled trial</td>
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<tr>
<td>Controlled study</td>
<td>1</td>
</tr>
<tr>
<td>Case study</td>
<td>1</td>
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<tr>
<td><strong>Client population</strong></td>
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<tr>
<td>Adult women</td>
<td>1</td>
</tr>
<tr>
<td>Male college students</td>
<td>1</td>
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<tr>
<td>Adult female</td>
<td>1</td>
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<tr>
<td>Refugees</td>
<td>1</td>
</tr>
<tr>
<td><strong>Counselling setting/location</strong></td>
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<tr>
<td>Domiciliary visits to client’s home.</td>
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</tr>
<tr>
<td>Semi-urban community/Karachi, Pakistan</td>
<td>1</td>
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<tr>
<td>University counselling center/USA</td>
<td>1</td>
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<tr>
<td>Air Force outpatient mental health clinic/USA</td>
<td>1</td>
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<tr>
<td>Refugee settlement in Africa</td>
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<tr>
<td><strong>Target problem</strong></td>
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<tr>
<td>Depression/anxiety</td>
<td>2</td>
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<tr>
<td>Posttraumatic stress disorder</td>
<td>2</td>
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<tr>
<td><strong>Type of outcome measure</strong></td>
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<td><strong>Assessment points</strong></td>
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### Paraprofessional counselling for anxiety and depression

Two studies investigated the effectiveness of paraprofessional counselling for anxiety and depression. Both studies reported some evidence for the effectiveness of paraprofessional counsellors with minimal or no training in counselling.

**Sabir et al. (2003)**

Sabir et al. (2003) used a randomized controlled design to determine if eight counseling sessions conducted by minimally trained female counselors could reduce levels of anxiety and or depression in women aged 18 to 50 years. This study was carried out in a semi-urban community in Karachi, Pakistan, which the authors
described as having a lower middle-class population. 21 women without any prior counselling training were recruited from the local community (through a leafleting campaign/word of mouth) and given 33 hours of training over a one month period. The selection criteria for counselors included culturally specific requirements such as an ability to read and write Urdu, freedom to move around in the local community as well as more generic criteria related to interpersonal skills, attitudinal and motivational characteristics appropriate to a disposition to help others. The training comprised 11 three hourly sessions on topics related anxiety, depression, stress and anger management; basic communication skills such as active listening, probing and giving feedback; and supportive counselling skills as well as sessions on problem-solving and cognitive-behavioural techniques. The training team included three clinical psychologists, a psychiatrist, a family practitioner and a sociologist. The authors reported that the training was conducted in a facilitating and participatory manner.

Sabir et al. (2003) identified 366 women with anxiety and or depression by systematically sampling a total of 1,226 women in Qayoomabad, a semi-urban community in Karachi. The researchers in this study used an indigenous self-report measure ‘The Aga Khan University Anxiety and Depression Scale’ (AKUADS) (Ali and Amanullah 1998) to screen all the women in the sample ($n = 1226$) for the presence of anxiety/depression, and excluded women who were assessed to be actively suicidal or who had been bereaved during the preceding six weeks. The AKUADS was re-administered at the end of counselling (i.e., after the eight session).

Of the 366 women who consented to participate in the study, 216 were randomly
assigned to a counselling intervention group and 150 to a control condition. Sabir et al. (2003) assigned 40% more cases to the counselling intervention group because they anticipated a high rate of refusal to provide consent to participate in the study. 124 women provide informed consent for counselling and were assigned to the counselors. Eight counselling sessions consisting of problem solving, supportive, and cognitive behavioural strategies were provided on a domiciliary basis in clients’ homes. All the counselors had access to supervision from members of the counselling training team during the intervention phase.

Overall, Sabir et al. (2003) found that counselling by minimally trained counsellors was effective in reducing client levels of anxiety/depression as measured by the AKUADS. Although not reported in their paper, an effect size of 1.6 was calculated from data published in Sabir et al. (2003) [i.e., effect size = the mean pre-counselling AKUADS score (28.35) minus the mean post-counselling AKUADS score (18.44) divided by the pre-counselling standard deviation (8.49)]. According to Cohen’s $d$ (Cohen 1988) this is a large effect and indicates that counselling had a significant impact on client levels of anxiety and depression.

**Methodological issues of Sabir et al. (2003)**

A weakness of the Sabir et al. study (2003) is that the design did not include any follow-up data once counselling had ended. For example, it would have been useful to re-administer the UKUADS at one or more predetermined periods following the counselling intervention (e.g., at 3, 6, and 12 months) to determine if the reduction in client levels of anxiety/depression were maintained over time. Another limitation of this study is that the outcome measure that was used, the AKUADS, was intentionally
developed to be a culturally specific instrument. Consequently, it is not clear how the AKUADS relates to more standardised change measures such as the Beck Depression Inventory (Beck et al. 1988), or to what extent the findings reported by Sabir et al. (2003) may be applicable in different cultural settings such as the UK. Furthermore, in the Sabir et al. study (2003) counselling was provided on a domiciliary basis, which is not typical of the pattern of the delivery of counselling services in primary care and the voluntary sector in the UK. One of the issues here is the lack of clarity about the potential impact of the environment in which the counselling took place on the process and outcome of counselling in this study compared to counselling that is delivered in more routine practice settings.

*Strupp and Hadley* (1979)

In a well controlled study carried out at Vanderbilt University, Strupp and Hadley (1979) evaluated the helping skills of college professors, without training in counselling but known for their ability to form caring and understanding relationships, with those of highly experienced professional therapists. Strupp and Hadley (1979) were interested in determining the relative contribution of non-specific relational factors characteristic of any benign human relationship compared with the therapist’s technical skills to client outcome in time-limited individual psychotherapy. Clients were male college students experiencing problems related to depression, isolation and social anxiety. Assessment of change was evaluated using a range of both quantitative and qualitative change indicators at intake, post counselling and at a one-year follow-up. These included a standardised personality questionnaire, the Minnesota Multiphasic Personality Inventory (MMPI) (Hathaway and McKinley 1940), a target complaints questionnaire, the Barrett-Lennard Relationship Inventory (Barrett-
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Lennard 1962), and a retrospective account of therapy experience which was completed at follow-up (Strupp and Hadley 1979). In addition to these measures counselling sessions were audio or video recorded.

Following in-take assessment clients were randomly assigned to either the paraprofessional counsellors (i.e., the college professors) or experienced therapists or to a monitoring group. Counselling consisted of twice weekly sessions of up to a maximum of 25 hours. During counselling sessions the paraprofessional and the experienced counsellors were encouraged to use whatever therapeutic strategies or techniques they deemed most helpful. The professional therapists were analytically oriented. Counselling sessions were closely monitored through the use of audio and video recordings, and both groups of therapists had the opportunity to discuss case material with the research project co-ordinator.

Strupp and Hadley (1979) concluded that under certain conditions non-trained paraprofessional counsellors, within the context of a caring a supportive relationship, could be as effective as professionals. More detailed analysis revealed that the college professors, compared to professional counsellors, tended to engage in more informal conversation and advice giving, ran out of relevant material to talk about and appeared less equipped to manage some of the challenges and dilemmas that occurred in particular cases, such as coping with client resistance and negative transference reactions (Gomes-Schwartz and Schwartz 1978; Strupp and Hadley 1979).

Methodological issues in the Strupp and Hadley (1979) study

The Strupp and Hadley (1979) study was well controlled and represents a good
example of a piece of research comparing the effectiveness of professional and paraprofessional counsellors. However, as Strupp and Hadley (1979) noted in their report there are a number of methodological issues in this study that warrant some caution in interpreting the results. For instance, the paraprofessional therapists in this study were carefully selected by the researchers and had access to levels of professional support and supervision that are not typical of routine practice. Another issue concerning the paraprofessional therapists is that they were already familiar with the kinds of issues and concerns that the client group presented with in counselling through their roles as educators within the university setting that this study took place. To some extent it could be argued that while they may have been untrained as counsellors they may well have had experience of providing informal support to students with similar concerns during the course of their normal duties as college professors. It is unclear from the Strupp and Hadley (1979) study to what extent any prior informal helping experience of the paraprofessional counsellors may have influenced the outcomes in this study.

An alternative explanation for the finding that the paraprofessional counsellors in the Strupp and Hadley study (1979) were as effective as the professional therapists is that the client group were more likely to benefit from the healing effects of a benign human relationship than more severely distressed clients by virtue of the fact that they were carefully selected for this particular study, and were experiencing relatively mild neurotic complaints. Yet another explanation for the equivalence finding in this study is that the client group were at a stage of transition in their development from adolescence to adulthood, which raises the possibility that maturational factors may have been responsible for client change rather than the counselling they received.
Paraprofessional counselling for posttraumatic stress disorder

*Neuner et al.* (2008)

Neuner et al. (2008) conducted a randomized controlled trial to determine whether trained lay counsellors could provide effective treatment of posttraumatic stress disorder (PTSD) in an African refugee settlement. This study was carried out in the Nakivale refugee settlement in Uganda with 277 Rwandan and Somalian refugees who fulfilled DSM-IV (American Psychiatric Association 1994) criteria for PTSD. Participants were randomly assigned to one of three groups in the study. Two groups received paraprofessional interventions to treat PTSD and the third group was established as a monitoring group. In one of the paraprofessional treatment groups clients received Narrative Exposure Therapy (NET), which Neuner et al. (2008) described as “a standardized short-term approach that is based on the principles of cognitive-behavioral exposure therapy by adapting the classical form of exposure therapy to meet the needs of traumatized survivors of war and torture” (p.687). In the second paraprofessional treatment group participants received a more flexible form of counselling referred to as trauma counselling (TC), which was less directive than NET and included supportive counselling, problem solving and grief interventions as well as an emphasis on assisting clients to identify coping skills (*Neuner et al.* 2008).

The lay counsellors in the Neuner et al. (2008) study were themselves refugees (five women, four men) with an mean age of 27 years. They were selected for participation in the study on the basis of their motivation and interest in helping other refugees, their interpersonal qualities, and their literacy in English and their respective mother
languages. The majority of the counsellors ($n = 7$) were educated to secondary school level, although one person had received university level education and one person had been educated to primary school level only. Interestingly, five of the lay counsellors in the Neuner et al. (2008) study had a diagnosis of PTSD and received treatment for this as part of their counselling training for this study. Neuner et al. (2008) reported that all of the lay counsellors in this study participated in a six-week training course that included instruction in general counselling skills and specific sessions on both the NET and TC approaches. The authors did not specify the number of hours devoted to specific topics or to the whole training over the six-week course. During the study period, counsellors received supervision on a weekly basis and were monitored closely to ensure adherence to the treatment protocols (Neuner et al. 2008).

In contrast to the NET group where paraprofessionals adhered to a strict treatment protocol, the lay counsellors in the TC group were encouraged to follow their own intuition in the application of the treatment for individual clients. Neuner et al. (2008) stated in their report that the rationale for including the TC group in the trial was that the authors wanted to simulate how NET might be delivered in routine practice outside the strict monitoring conditions of a randomized trial. By doing so these researchers hoped to determine the extent to which the treatment could be disseminated to more naturalistic settings where practitioners are likely to employ a variety of methods in a flexible way. Clients in both NET and TC treatments received a total of six counselling sessions (approximately two counselling sessions per week) that lasted for one to two hours in duration. The effectiveness of counselling was evaluated on the basis of changes in scores on the Posttraumatic Stress Diagnostic Scale pre- to post-counseling and at follow-up at six months, and also by expert
evaluation of the presence of PTSD in clients who had completed treatment.

Overall, Neuner et al. (2008) found that both the NET and the TC interventions had a statistically and clinically significant effect on PTSD symptoms compared to the monitoring group. Interestingly, there were no significant differences between NET and TC in reducing PTSD symptoms. The authors concluded that “it is possible to treat war-related PTSD in refugee populations and that effective psychotherapy can be carried out by trained lay counsellors after only six weeks of training” (Neuner et al. 2008, p. 692).

Methodological issues in the Neuner et al. (2008) study

One limitation of the Neuner et al. (2008) study was the significant numbers of participants who dropped out of treatment in both the NET and TC groups (25 and 26 respectively), and who could not be located for follow-up assessment (55 in the NET group and 58 in the TC group). Therefore, it is not known whether participants who dropped out of treatment improved more or less than those who completed treatment, or whether some unknown systematic effect was responsible for selective drop-out from the study (Neuner et al. 2008). Another methodological issue in this study concerns the context in which it was carried out. For instance, both forms of paraprofessional intervention (i.e., NET and TC) were carried out within the context of a highly controlled research study where the paraprofessionals were closely monitored and supervised by professionally trained and experienced therapists. Furthermore, both NET and TC were developed by the authors as approaches to treat war-related PTSD, and as such they are not typical of interventions found in routine counselling practice in mental health settings outside of a war-related context.
More generally, the fact that the Neuner et al. (2008) study was set within a refugee settlement in a Non-Western context where the social and political environment was unstable and subject to the occurrence of unpredictable political events raises questions about the extent to which the findings may be relevant to routine counselling practice settings such as those found in the UK where such factors are not pertinent.

*Plouffe (2007)*

Plouffe (2007) reported on the outcomes achieved by a paraprofessional therapist in a single case of posttraumatic stress disorder (PTSD) secondary of past physical, psychological, and sexual abuse.

Detailed information about the training and experience of the paraprofessional in this study was not provided. However, Plouffe (2007) did report that the paraprofessional therapist had training and experience in cognitive-behaviour therapy in general, and had also received training in the cognitive processing therapy protocol developed by Resick and Schnicke (1992; 1996), which was employed in this case. The paraprofessional’s role in this case was to deliver the 12 session treatment protocol of cognitive processing therapy. A clinical psychologist carried out a comprehensive intake assessment and provided ongoing supervision during treatment, and also conducted four ‘check-up’ appointments with the client during counselling. Specific details of these ‘check-up’ sessions was not documented in the paper by Plouffe (2007). Counselling sessions were conducted at a US Air Force outpatient mental health clinic.
The client in this case was a single 21 year-old female who had previously received counselling for depression, and had also been prescribed anti-depressants. At the age of 16 she had been subjected to an attempted sexual assault and throughout her teenage years she had experienced emotional and physical abuse from boyfriends, her parents and brothers. Plouffe (2007) reported that the client presented most recently for counselling with symptoms of depression. However, a comprehensive assessment was carried out by the supervising psychologist that included interviewing the client and administering a standardised outcome questionnaire, the Outcome Questionnaire-45 (Lambert et al. 1996), which indicated that the client was experiencing a range of problems which could be interpreted as reflecting aspects of PTSD resulting from the effects of past physical, emotional and sexual abuse.

In total, the client received thirteen counselling sessions over a five month period, a further two sessions six months later and a follow-up appointment thirteen months after counselling had ended. Outcome was assessed by calculating the difference between the client’s pre/post-counselling scores on the Outcome Questionnaire-45 (Lambert et al. 1996), which is a brief 45-item self-report measure that assesses overall levels of client distress and also includes subscales related to symptoms, interpersonal relationships and social role functioning. Scores can range from 0 to 180. A total score of 63 or more indicates levels of client distress characteristic of a clinical population. Reliable change is defined as a reduction in client scores by 14 points or more. At in-take, the client’s OQ-45 score in the Plouffe study (2007) was 71 and at follow-up it was 52, which indicated that the client had achieved clinical change (a non-clinical score of less than 63), and reliable change (a reduction of 14 points or more) in levels of global distress pre to post-counselling according to OQ-45.
scores. Plouffe (2007) reported that this change was evident in the client’s improvement in mood, ability to develop and sustain an intimate relationship, assertiveness and social skills, and also in her increased self-awareness and self-acceptance.

Methodological issues in the Plouffe (2007) study

There are a number of methodological issues with this study. A general criticism of case study research is that it is difficult to generalise the findings from a single case. For example, it is difficult to know to what extent the client in this case study is representative of a larger population of clients who may be described as suffering from PTSD. Similarly, there is a lack of information regarding the characteristics of the paraprofessional therapist in this study. In particular, sufficient details were not provided regarding any counselling qualifications, training and experience the paraprofessional therapist in this study may have had, which makes it difficult to evaluate the extent to which the variables of training and experience may have contributed to the positive outcomes reported in this case. It also makes it difficult to compare the performance of this therapist with other paraprofessional therapists working with clients with PTSD.

A strength of this case study is that it provided a rich and detailed account of the process and outcome of counselling of a paraprofessional intervention for PTSD. Also, the manual-based treatment protocol facilitated treatment and supervision, and facilitates further attempts to replicate this study. More generally, the in-depth study of one individual is useful in generating hypotheses and theory which could be tested in subsequent case studies.
2.1.7.6 Discussion

The aim of this review was to evaluate the effectiveness of paraprofessional counselling for common mental health problems typically encountered in routine counselling practice. Four studies were identified that were categorised into two groups: paraprofessional counselling for depression and anxiety, and paraprofessional counselling for posttraumatic stress disorder. Overall, the studies that were identified and reviewed provide limited evidence for the effectiveness of minimally trained paraprofessional counsellors delivering individual face-to-face counselling for common mental health problems. All four studies reported positive client outcomes following paraprofessional counselling interventions. The strongest evidence came from two randomised controlled trials of paraprofessional counselling interventions, which showed that minimally trained paraprofessional counsellors could provide effective therapy to women experiencing depression (Sabir et al. 2003) and to refugees experiencing war-related PTSD (Neuner et al. 2008).

It was surprising that so few studies could be identified that met the criteria for inclusion in this review, especially when one considers the significant contribution that minimally trained paraprofessional or volunteer counsellors make to the provision of counselling services in the UK and other countries as well. All of the studies that are frequently cited in the literature as providing evidence for the effectiveness of paraprofessional or non-professional counselling were excluded from this review because they did not meet the criteria regarding the requirements for the counselling intervention to be individual and face-to-face in mode of delivery, and clearly delineated form other forms of helping activity provided by the paraprofessionals being investigated in particular studies.
Other studies were excluded because the paraprofessionals did not meet the criterion regarding minimal training, or did not include independent client ratings or assessment of outcome using standardized outcome measures. The small number of studies that did meet the inclusion criteria are of limited value in terms of providing an evidence base for the effectiveness of minimally trained paraprofessional counselling for common mental health problems because the context in which counselling was offered and the client populations that were studied are not truly representative of those found in routine counselling practice in mental health settings, especially within a UK context.

Methodological issues

A flexible approach to the methodological strategies employed in studies was adapted when considering studies for inclusion in the review. The main focus was on treatment evaluation; therefore, only studies that evaluated psychosocial functioning in some way were included. The main methodological issues pertinent to each study were identified in the preceding section, and are summarised here in terms of their overall impact on the quality of the evidence base for the effectiveness of paraprofessional counselling for common mental health problems.

One of the methodological issues in the studies that were reviewed is that they all used a variety of different outcome measures to assess the outcomes of counselling, which makes it difficult to assess the extent to which findings are applicable across studies. Moreover, not all studies included a follow-up assessment which raises questions about the extent that change was maintained over time.
Another issue concerns the client populations that were studied and the context in which counselling was provided. Two of the studies (Neuner et al. 2008; Sabir et al. 2003) were set within non-Western contexts where different social, political and cultural factors are likely to impact on the process and outcome of counselling. This is especially true of the Neuner et al. (2008) study which was carried out in a refugee settlement in Africa where refugees were under the constant threat for forced repatriation to their home countries.

The presenting issue in two of the studies that was included in this review was PTSD, which, although encountered in routine counselling practice it is unlikely that this would be concerned with war-related trauma as in the Neuner et al. (2008) study. The most relevant studies to this review in terms the commonality of the types of problems clients presented with were those that reported on paraprofessional counselling for women experiencing depression/anxiety (Sabir et al. 2003) and young depressed and anxious men (Strupp and Hadley 1979). One of the methodological issues with the Sabir et al. (2003) study is that counselling was delivered on a domiciliary basis, which does not reflect the usual pattern of deliver of counselling within a UK context.

Recommendations for future research

Research into the effectiveness of paraprofessional counselling is characterised by a variety of methodological, ethical and practical problems, which may account for the difficulty in being able to identify studies for this review, and the general lack of research in this area, particularly in recent years. These issues have been discussed in section 2.1.7.6 above in relation to each of the studies identified in this review, and more generally in section 2.1.4 of this chapter.
A key finding from this review is that there is a distinct lack of research into the effectiveness of minimally trained paraprofessional counsellors delivering individual face-to-face counselling for common mental health problems. With the exception of the Plouffe (2007) study, all of the studies in this review were carried out under highly controlled conditions which do not reflect the everyday realities of routine counselling practice. Even the Plouffe (2007) study is not typical of routine practice because it was carried out in a US Military mental health clinic. Therefore, more naturalistic studies are required to determine the effectiveness of paraprofessional counselling under everyday practice conditions.

As noted in section 2.1.7.5 above, a number of studies were excluded from this review because the counselling intervention was confounded by the simultaneous provision of other forms of support and assistance, and because the nature of the counselling was not fully or clearly described. In this regard, it will be essential in future research to clearly delineate and evaluate the effectiveness of the paraprofessional counselling intervention within studies from any other form of paraprofessional helping activity being delivered simultaneously (e.g., befriending). Similarly, the characteristics of the paraprofessionals (i.e., levels of training, experience and educational level), and the counselling intervention should be clearly described in terms of the counselling approach, the frequency and duration of sessions and the setting within which counselling took place.

This review was restricted to studies evaluating the effectiveness of minimally trained paraprofessional counsellors delivering individual face-to-face counselling for mental health problems. In addition to determining the scope of minimally trained
paraprofessional counsellors’ effectiveness, more specific questions also need to be answered regarding the type and level of training required for paraprofessionals to practice effectively with specific client groups, the characteristics of more and less effective paraprofessional counsellors, as well as counselling process questions concerning paraprofessionals in-session behaviour and how this relates to client outcome.

2.1.8 Summary of research on the effectiveness of paraprofessional counselling

Overall, existing research findings appear to provide evidence for the general effectiveness of paraprofessional helpers. Nonetheless, it is important to interpret the results cautiously as findings are largely inconclusive due to the methodological limitations noted in the foregoing sections. The diversity of helpers, client populations, modes of intervention, lack of clarity regarding the type and level of paraprofessional training, methods of evaluating effectiveness and definitions of the terms volunteer, non-professional and paraprofessional represented in existing studies makes it difficult to evaluate the effectiveness of paraprofessional counsellors with specific client groups relative to their levels of training and experience.

Findings from the meta-analytic reviews examined in section 2.1.3 and other related studies considered at section 2.1.6 indicate that the longer paraprofessional training the greater their effectiveness compared with professional therapists (Hattie et al. 1984). In other words, experience and length of training seem to be significantly related to the effectiveness of paraprofessionals. The review by Berman and Norton (1985) indicated that professionals achieved better outcomes with briefer interventions and paraprofessionals appeared to be more effective when treatment was of longer duration.
There is modest evidence that more training is associated with greater client retention, fewer ‘drop-outs’, briefer therapy and better overall wellbeing for clients (Atkins and Christensen 2001; Stein and Lambert 1984). Favourable outcomes for therapists with less training relative to experienced ones tends to be found when less trained therapists employ circumscribed, behavioural interventions for specified problems. Interestingly, this finding echoes the conclusions drawn by Durlak (1979) in the first meta-analysis (discussed in section 2.1.3 above) in which he reported that paraprofessionals appeared to be most effective when delivering structured interventions directed at specific target problems such as insomnia, lack of assertiveness, obesity, stuttering and speech anxiety in college students.

Research into the effectiveness of paraprofessional counsellors has been hampered by a number of methodological limitations. The most notable of these are that studies have not been adequately designed to evaluate the comparative effectiveness of professional versus paraprofessionals, and have suffered from a range of internal validity problems such as questionable definitions of professional/paraprofessional status and a lack of information regarding levels of training and experience of the practitioners. Notwithstanding these methodological limitations, and more recent findings that suggest that professionals may achieve better outcomes in relation to some areas of practice (e.g., fewer drop-outs), the general conclusion from this body of literature supporting the effectiveness of paraprofessional helpers can not be negated. Given the significant contribution that paraprofessional counsellors make to the provision of counselling service provision in the UK and in other countries, and the fact that they may comprise up to fifty percent of the unofficial mental health care manpower (Armstrong and McLeod 2003; Moffic et al. 1984), future research into
their effectiveness and development is required in order to determine the conditions under which they can be most effective.

From a theoretical perspective, research into paraprofessional effectiveness can help to address fundamental questions about the necessary ingredients for therapeutic change (Christensen and Jacobson 1994). If, for example, paraprofessionals with little or no training can effect change through a warm, caring and empathic relationship that is equal to that of professionals, then it may be that core, non-specific factors may be responsible for therapeutic change. On the other hand, if particular therapeutic techniques and strategies are found to be associated with greater effectiveness, then it may be argued that professional training will enhance therapeutic effectiveness (Atkins and Christensen 2001). This area of research also has implications for the counselling and mental health professions in relation to service delivery. By clarifying the type and level of training required for the effective delivery of services it may be possible to make more use of paraprofessionals in front line positions and thus reduce the cost of service provision, and allow professionals to extend their clinical roles to include training, support and supervision activities for paraprofessionals (Atkins and Christensen 2001; Christensen and Jacobson 1994).

2.2 Review 2: The differential effectiveness of individual therapists: the therapist effects literature

2.2.1 Introduction
The preceding sections of Review 1 have examined the literature on the effectiveness of paraprofessional counsellors. Overall, it was identified that there appears to be evidence for the general effectiveness of paraprofessionals but that evidence was
lacking in relation to their effectiveness in routine practice settings. As with most outcome research in counselling and psychotherapy, research into paraprofessional effectiveness has generally examined the effectiveness of groups of practitioners rather than the outcomes achieved by individual therapists. As the research in the sections of Review 2 below will show, it is increasingly recognised that the personal qualities of the therapist can have a significant influence on client outcomes, and consequently, researchers have begun to pay more attention to such factors in outcome studies.

Therefore, the aim of Review 2 of this chapter is to provide an overview of research that has investigated the contribution of the individual therapist to client outcome. This area of research is generally referred to as the therapist effects literature and is part of the broader area of outcome research in counselling and psychotherapy. Investigating therapist effects is one of many strategies that researchers have adopted to identify causal factors in therapy (Lambert and Ogles 2004). Research on the comparative effectiveness of professional and paraprofessional therapists can be regarded as being a subset of the therapist effects literature (Lambert and Ogles 2004), which in turn, is a subset of the broad area of psychotherapy outcome research. More generally, these areas of the literature are also concerned with questions about the relationship of training to counsellor effectiveness (Atkins and Christensen 2001). Review 2 will focus on key studies in this relatively small body of literature, paying particular attention to methodological issues, and implications for further research. First, the historical and theoretical significance of this literature is briefly outlined.

2.2.2 Historical and theoretical significance of research into therapist effects
In his introductory commentary on a symposium in the journal of Clinical
Psychology: Science and Practice, which addressed the impact of the individual therapist on therapy outcome, Allen Bergin noted that there had been a steady and significant interest in studying the therapist since the early days of psychotherapy research (Bergin 1997). However, he also commented that this interest appeared to be declining steadily since the 1970s when researchers began a “trend of putting all of the eggs in the ‘technique’ basket” (Bergin 1997, p.83). Hence, a major focus of counselling research in recent decades has been on investigating the efficacy of particular interventions and theoretical models using research strategies that follow the assumptions of clinical drug trials in pharmacological studies (Beutler et al. 2004; Lambert and Okiishi 1997). This trend has been influenced by economic and political changes that have impacted the way in which psychological services are delivered and funded: particularly in North America where the advent of managed health care has brought with it an increasing requirement for providers of therapy to employ empirically validated interventions for specific psychological disorders (Bergin 1997; Lambert and Okiishi 1997).

As a result of these historical trends, contemporary counselling and psychotherapy research has been dominated by manual-driven treatments and randomised clinical trial methodologies, which have been accompanied by efforts to control, minimise or eliminate the influence of counsellor factors such as age, sex, and ethnicity, level of training, experience, skill and a host of other variables, on treatment outcome (Beutler et al. 2004). A fundamental theoretical assumption underlying this kind of research is that the role of therapist factors are to a large extent incidental to treatment models and procedures, which are believed to possess the active ingredients that produce change: “The epitome of this conception is the notion that people (personalities and
psychological problems) are objects (dependent variables) to be acted upon by therapeutic interventions (independent variables) designed by experts” (Bergin 1997, p.83). From this perspective, the client is regarded as no more than a passive recipient of treatment, and the therapist is viewed as little more than an inert vessel for transmitting treatment (Beutler 1997). A consequence of this approach to research has been that therapist (and client) characteristics have not been adequately addressed, with the result that relatively few studies have been carried out that have specifically investigated the contribution of the individual counsellor to outcome (Elkin et al. 2006b). Indeed, the lack of research into therapist effects has been referred to as a ‘neglected variable’ in psychotherapy research (Beutler 1997; Garfield 1997).

Interestingly, although researchers have gone to great lengths to reduce counsellor effects, research evidence appears to indicate that counsellor differences “may account for more variance in client outcomes than either the specific treatment approaches used or pre-treatment characteristics of clients” (Miller et al. 1998, p. 457). A challenging implication of this finding is that counsellor factors may play a more important role in determining client outcomes than the theoretical approach or specific techniques they employ. There are theoretical, practice, and training implications arising from these findings. For instance, as Hill (2006) has noted, if the therapist is more responsible for change then it will be essential to focus on selecting good therapists and fostering their growth and development. Conversely, if it is the treatment that works then carefully specified manual-based treatments will be of more importance. Another implication of this finding is that more research should be directed at studying the unique contribution of the counsellor to client outcomes.
The following section provides an overview of key studies on therapist effects, which is followed by a consideration of the most salient methodological problems associated with this literature. This section concludes with a summary of the therapist effects literature and implications for further research.

2.2.3 Overview of research on therapist effects

The empirical literature on therapist effects is relatively small. Although a few studies appeared before the early 1980s (e.g., Nash et al. 1965; Orlinsky and Howard 1980; Ricks 1974), it was not until 1984 onwards that research in this area began to receive more attention, particularly in the area of alcohol and substance abuse (Luborsky et al. 1997; Najavits and Weiss 1994; Project Match 1998). Other notable studies include those by Huppert et al. (2001), Luborsky et al. (1985), Pilkonis (1984), Piper et al. (1984) and Shapiro et al. (1989), and Wampold (2001) has argued convincingly, based on a review of empirical evidence, that the “essence of therapy is embodied in the therapist” (p.202). In other words, more competent therapists achieve better client outcomes than less competent therapists (Wampold 2001).

In 1997 the journal ‘Clinical Psychology: Science and Practice’ included a series of papers in a symposium that discussed the therapist’s contribution to outcomes in counselling, and related issues concerning variability in effectiveness of therapists with similar levels of training and experience (Bergin 1997; Beutler 1997; Garfield 1997; Lambert and Okiishi 1997; Luborsky et al. 1997; Strupp and Anderson 1997). A central concern running through the papers in this symposium was that psychotherapy researchers had devoted too much attention to investigating techniques, fostered by the influence of medicine, mechanistic and reductionist psychological philosophies, and the dictates of governmental agencies and insurance
companies: as a result, the role of the therapist as a change agent had been neglected. This symposium was an attempt to redress the balance in favour of more systematic research on the therapist as a ‘variable’ worthy of further study.

More recently, the journal ‘Psychotherapy Research’ included six papers in a special section, introduced by Clara Hill (2006), devoted to research on therapist effects (Crits-Christoph and Gallop 2006; Elkin et al. 2006a; 2006b; Kim et al. 2006; Soldz 2006; Wampold and Bolt 2006). The contributors focused on analyses and commentary on two studies (Elkin et al. 2006b; Kim et al. 2006), reported in this special section, which used the same data set from the National Institute of Mental Health’s Treatment of Depression Collaborative Research Program to investigate therapist effects. Elkin et al. (2006b) and Kim et al. (2006) separately analysed this data set using different but sophisticated statistical analyses and arrived at different conclusions. Elkin et al. (2006b) did not find any significant therapist effects and no interaction between therapists and levels of patient distress. Kim et al. (2006), on the other hand, concluded that there were significant therapist effects, and noted that “with regard to outcomes, therapists are more important than treatments” (p.167). The papers by Crits-Christoph and Gallop (2006), and Soldz (2006) provided a critical commentary on the Elkin et al. (2006b) and the Kim et al. (2006) studies, and highlighted a variety of methodological and statistical issues that need to be taken into account when evaluating their contradictory results.

Due to the controversial nature of this research the original authors (Elkin et al. 2006b; Kim et al. 2006) were invited to respond to the critiques by Crits-Christoph and Gallop (2006), and Soldz (2006) in order to explain further their choice of
methods and statistical analyses in their respective studies. A key recommendation emerging from the debate among this group of researchers was that further research on therapist effects using different statistical procedures with different client samples should be encouraged in order to sort out the methodological challenges inherent in this area of research (Hill 2006).

2.2.4 Examples of studies and reviews on therapist effects

This section includes a review of selected studies identified in section 2.2.3.

2.2.4.1 ‘Supershrink’: Ricks (1974)

One of the earliest and most dramatic examples of therapist effects was reported by Ricks (1974). In this study, a group of adolescent boys seen by either of two therapists in a child guidance clinic were followed up as adults. The boys in this study had experienced severe problems including anxiety, vulnerability, feelings of unreality and isolation. The criterion for positive outcome in adulthood was the extent to which the patients of each therapist were hospitalised or not during the intervening years. In addition, Ricks (1974) examined the case notes of each of these two therapists' caseloads to gain a better understanding of their respective approaches to therapy with the identified sample. The overall aim of the study was to attempt to identify psychotherapeutic strategies that may prevent hospitalisation.

The more effective therapist in this study was labelled ‘supershrink’ (or Therapist A) and the less effective was referred to as Therapist B - later labelled ‘pseudoshrink’ by Bergin and Suinn (1975). Evaluation of the outcomes achieved by these therapists indicated that ‘supershrink’ achieved remarkably good outcomes, whereas the adult adjustment and rates of hospitalisation for those treated by Therapist B were alarmingly poor. For instance, approximately 27% of the adolescents seen by
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'supershink' were diagnosed as schizophrenic as adults, compared to 84% of cases treated by Therapist B even though levels of disturbance and other demographic characteristics were equivalent at the start of therapy.

An examination of case notes of each therapist revealed differences in their interpersonal and therapeutic styles. Therapist A appeared to invest much more time in building a therapeutic relationship with his patients, facilitated problem-solving skills in their everyday lives, encouraged autonomy, was firm and direct with parents, and also made use of resources outside of the immediate therapy context. Therapist B on the other hand, invested far less time and effort with his patients, overloaded them with psychodynamic interpretation which intensified feelings of anxiety and depression, and tended to unwittingly reinforce negative feelings in his patients. More generally, 'supershink' appeared to take a more engaged, open and focused approach, whereas Therapist B seemed to adopt a more distant, cognitive stance that often lacked clear direction.

2.2.4.2 Alcohol and substance abuse

Najavits and Weiss (Najavits and Weiss 1994) carried out an empirical review of therapist effects in relation to the treatment of patients with substance use disorders. The authors reviewed studies that reported variability in therapist effectiveness in relation to patient outcome and dropout rates. The primary conclusion from this review was that therapists differ widely in their effectiveness, independent of patient factors or professional background, and that strong interpersonal skills were associated with greater effectiveness. A particularly interesting finding from this review was that variability in therapist effectiveness was evident across different treatment settings, theoretical orientation, and notably, in relation to the subject matter.
of this thesis, among paraprofessional and professional therapists (including novices
and more experienced practitioners). Below, two of the studies that were included in
the Najavits and Weiss (1994) review are briefly described. In addition, a large scale
RCT that was carried out some years after the Najavitis and Weiss (1994) review is
also included as a further example of research in this area.

Luborsky et al. (1985) evaluated the outcomes of nine therapists who offered either
drug counselling (DC) alone or in combination with cognitive behavioural
psychotherapy (CB) or supportive expressive psychotherapy (SE) to male clients with
opiate dependency. Clients were randomly assigned to one of three treatment
conditions (i.e., DC, SE plus DC, or CB plus DC). All therapists were carefully
selected, trained to offer the prescribed treatment using detailed treatment manuals,
regularly monitored, and received supervision from expert practitioners. Outcomes
were assessed using a series of standardised and psychometrically validated self-
report measures that were administered under supervised conditions. The authors
reported profound differences among this group of therapists with the clients on their
caseloads. The most notable differences were between Therapist A and Therapist C.
Therapist A saw 10 clients, all of whom showed substantial improvement across the
range of outcomes measures employed in the study. In contrast to Therapist A,
Therapist C saw 8 clients who showed minimal improvement, and in some instances
deteriorated as a result of treatment.

In addition to examining variability in therapists’ effectiveness, Luborsky et al. (1985)
also attempted to identify factors that may have accounted for the differences in
effectiveness they observed in this study. In their analyses of these factors, the authors
concluded that three factors were associated with the more helpful therapists: 1) the therapist’s ability to form a helping alliance; 2) the purity of the treatment they offered; and 3) the therapist’s level of adjustment, skill, and interest in helping clients. A striking feature of this study was that despite efforts to minimize the influence of therapist factors on treatment outcome, the findings revealed significant variability in effectiveness among the sample of therapists investigated.

One of the largest studies of therapist effects in the area of substance abuse was a RCT carried out by the Project Match Research Group (Project Match 1998). This study evaluated variability in therapist effectiveness across three treatment conditions (twelve-step facilitation, cognitive-behavioural skills training, and motivational enhancement therapy) for alcohol abuse carried out in two treatment settings (outpatient versus aftercare treatment following inpatient or intensive day treatment). A total sample of 54 therapists was studied, each of whom saw at least 10 patients. Findings indicated that therapist effects were significantly related to measures of client satisfaction and drinking outcomes, were consistent during follow-up, and only modestly affected by the specific treatment condition to which patients were assigned.

An important finding from this study was that in all but one instance, the differences among therapists were attributable to one outlier therapist, whose clients typically showed poorer outcomes. Interestingly, the particular outlier therapist was different in different analyses and at different points in time during treatment. For example, in the motivational enhancement treatment condition, one therapist performed poorly in relation to abstinence rates, whereas another therapist’s patients demonstrated unusually high rates on a measure of the number of drinks consumed in a day. Such
findings led the authors of this report to recommend strongly that future research on therapist effects should take into account the impact of outlier therapists on outcome.

This study was able to demonstrate variability in therapist effectiveness in relation to a number of outcome measures, but it was less able to account for these differences in relation to therapist characteristics, primarily because the study was designed as, “a treatment-matching, rather than a therapist matching study, and clients were not randomly assigned to therapists or particular therapist characteristics” (Project Match 1998, p.470). Moreover, the method of allocation of clients to therapists was done informally within each of the two treatment settings on the basis of therapist availability. This means that a variety of confounding factors may have been operating in relation to the assignment of clients to therapists, such as more clients being allocated to therapists perceived to be more skilful. Nonetheless, these researchers were confident in stating that therapist factors such as age, gender, education, and experience accounted for very little variance in client outcomes.

2.2.4.3 University counselling
Okiishi et al. (2003) examined therapist effects in a study involving 56 therapists and 1841 clients in a university counselling centre clinic over a two and a half year period. The authors wanted to know whether or not clients achieved similar outcomes across therapists. Client outcome was assessed using a single self-report measure, which was administered on a weekly basis, and each therapist saw 15 or more clients. Data were also gathered on therapists’ primary theoretical orientation, level and type of training, and sex. Therapists in this study were generally male counselling psychologists with a PhD whose primary theoretical orientation was cognitive-behavioural. Clients typically presented with mood and anxiety disorders and were assigned to a particular
therapist, following a brief intake interview, based on their needs and therapist availability.

The authors found that client rates of improvement varied considerably among therapists. Specifically, the most effective therapists tended to see their clients for a shorter period of time compared to the less effective therapists, who tended to see their clients for longer with no appreciable gains. In addition, therapist sex, level and type of training, and theoretical orientation did not contribute to the differences in client outcome between therapist caseloads. One of the strengths of this study was that it had a large therapist sample and included a reasonable number of clients in each therapist’s caseload. However, as Okiishi et al. (2003) acknowledged in their paper, clients were not randomly assigned to therapists, they were unable to identify more specific details about therapists’ characteristics or in-session behaviour, and outcome measurement was limited to only one self-report measure.

2.2.4.4 NIMH Treatment of Depression Collaborative Research Program

As noted earlier, Elkin et al. (2006b) and Kim et al. (2006) investigated therapist effects using data from the National Institute of Mental Health’s (NIMH) Treatment of Depression Collaborative Research Program (TDCRP). The TDCRP was a large scale collaborative project involving three research sites. Patients with major depressive disorder were randomly assigned to four treatment conditions: interpersonal psychotherapy, cognitive-behaviour therapy, anti-depressant treatment plus clinical management, and pill-placebo plus clinical management. All therapists were carefully selected, trained and monitored during the study.

Both Elkin et al. (2006b) and Kim et al. (2006) used statistical modelling procedures
to analyse this data set in order to determine the role of therapist effects, and also to ascertain if therapists were differentially effective with different types of patients. Elkin et al. (2006b) used a statistical approach known as hierarchical linear modelling (HLM) to analyse the longitudinal course of change for all clients in the study including clients who terminated counselling prematurely. Elkin et al. (2006b) chose this form of multilevel analysis because it allows variance in outcome variables to be analysed at multiple hierarchical levels, which facilitates the investigation of the therapist effect in counselling. In their analysis, Elkin et al. (2006b) used a three-level HLM where Level 1 denoted the number of weeks in therapy, Level 2 referred to clients, and Level 3 included therapists and treatments. This statistical model was used by Elkin et al. (2006b) to examine: a) overall therapist effects in mean rates of client change; b) therapist variation in effects of initial severity on rates of change; and c) therapist variation in effects of initial difficulty on rates of change.

Kim et al. (2006b) used a different form of multilevel analysis which modelled therapist variability in several different ways. Intriguingly, these papers arrived at different conclusions regarding the impact of the therapist on treatment outcome. Elkin et al. (2006b) reported no significant findings in relation to overall effects of therapists; although they noted that there was some evidence of therapists performing particularly well and others who performed badly in terms of rates of patient retention and recovery. Kim et al. (2006), on the other hand, found that approximately 8% of the variance in therapist outcomes could be attributed to therapist effects, and asserted that therapists were more important than treatments when it comes to patient outcomes.
The Elkin et al. (2006b) and Kim et al. papers (2006) represent an important addition to the therapist effects literature. Moreover, they contributed to a controversial methodological debate about the statistical procedures used in therapist effects studies, which in turn, raised questions about the extent to which findings of substantial therapist effects reported in this literature are, in fact, statistically significant (Crits-Christoph and Gallop 2006).

2.2.4.5 Meta-analyses
Crits-Christoph et al. (1991) summarised the therapist effects literature in a meta-analysis of 15 studies. They examined factors that could account for findings from psychotherapy outcome studies demonstrating variability in therapist effectiveness in relation to two broad treatment categories; namely, cognitive-behavioural therapy and psychodynamic psychotherapy. In particular, they investigated the influence of the use of a treatment manual, the average level of therapist experience, the length of treatment, and the type of treatment offered. An important finding was that variations in therapist effectiveness were at the level of a medium effect.

This review showed that in some studies the effect of individual therapists was insignificant, while in others it accounted for a substantial amount of the variance in treatment outcomes. For example, in one study the outcome variance attributable to the therapist was 49%. Crits-Christoph et al. (1991) concluded that, “the use of a treatment manual and more experienced therapists were associated with small differences between therapists, whereas more inexperienced therapists and no treatment manual were associated with larger therapist effects” (p.81).

A number of factors need to be considered when interpreting the results of this meta-
analysis. For instance, the authors noted that therapist experience may interact with the type of patient in ways that influence outcome (e.g., therapist experience may be less relevant in behavioural treatments of simple phobias, while being more crucial in treating more complex or difficult patients). The authors argued strongly for researchers to include analysis of therapist effects in outcome studies to ensure that treatment outcomes are not wrongly attributed to treatment types when they may be a function of therapist differences: a strategy that would help to redress the neglect of the therapist ‘variable’ in psychotherapy research in recent decades (Garfield 1997).

2.2.5 Methodological problems in research on therapist effects: a summary
The key methodological problems associated with this body of literature are identified below.

2.2.5.1 Sample sizes of therapists, and study design issues
The findings from many of the older studies of therapist effects were based on limited numbers of therapists. The Ricks’ (1974) study, for example, was based on only two therapists, and the studies by Nash et al. (1965), and McLellan et al. (1988) included only four therapists in each of their respective projects. Findings based on such small therapist samples warrant caution in making any generalisations about therapist effects. Some researchers have argued that to do so necessitates much larger numbers of therapists, and requires careful consideration of issues regarding study design and the selection of appropriate statistical procedures to investigate therapist effects (Crits-Christoph and Mintz 1991; Crits-Christoph et al. 2003; Martindale 1978; Wampold 2001; Wampold and Bolt 2006).

2.2.5.2 Non random assignment of clients to therapists
In some studies clients were assigned to therapists on the basis of clinical judgement by members of staff at research sites who had responsibility for performing intake
assessments (e.g., Okiishi et al. 2003; Project Match 1998). In studies where this method of allocation was used the validity of findings could be threatened. For instance, in the absence of random assignment it is possible that a particular therapist may be allocated a greater number of ‘easy’ or ‘difficult’ cases, which may enhance or diminish their effectiveness (Okiishi et al. 2003). Random assignment of clients to therapists excludes the possibility that client factors, such as levels of distress, and or type of problem at intake, could account for the differential effectiveness of therapists in any given study.

2.2.5.3 Outcome measures
Some studies of therapist effects can be criticised for their reliance on a single self-report measure to assess client outcomes (e.g., Okiishi et al. 2003) or the use of therapist-rated measures to test for therapist effects (Najavits and Weiss 1994). Regarding the use of therapist rated measures of outcome, Elkin et al. (2006b) have questioned whether the variability in therapist effectiveness reported in some studies are due to differences in their effectiveness or whether they are a function of the “therapists response tendencies in the evaluation of outcome for their patients” (p.152).

2.2.5.4 Lack of monitoring of adherence to a particular treatment model
Some commentators on the therapist effects literature have observed that the absence or lack of monitoring of adherence to a particular model by therapists confounds the therapist ‘variable’ with treatment. The basis for this criticism can be found in findings that suggest that use of treatment manuals to guide treatment (along with more experienced therapists) has been reported to reduce variability in therapist effectiveness within studies (Crits-Christoph and Mintz 1991).
In addition to the above methodological problems, critiques of this literature have noted that research on the differential effectiveness of therapists has been retrospective rather than prospective (Najavits and Weiss 1994). In other words, in many instances studies have not been designed to investigate therapist effects as a primary research question. Some of the methodological issues regarding study design pertain to the lack of random assignment of clients to therapists, the absence of control of therapist caseload or indeed the number of clients seen by individual therapists, or the control and monitoring of therapists actual in-session behaviours. Moreover, therapist characteristics such as levels of training and experience have not always been reported in previous studies, which may help to account for the fact that researchers have largely failed to identify therapist characteristics associated with therapist effects across a range of forms of psychotherapy and patient populations (Brown et al. 2005; Crits-Christoph and Mintz 1991).

2.2.6 Summary of research on therapist effects, and implications for future research
The personal qualities of the individual therapist, and their influence on the therapeutic encounter, have been of interest to psychotherapy researchers for some five decades. All manner of discrete therapist characteristics (such as age, sex, race, personality, levels of training and experience) have been studied in order to gain an understanding of their respective contribution to psychotherapy outcome. Reviews of studies correlating therapist qualities with psychotherapeutic change show a modest influence of only a small number of qualities on client outcome. One of the most consistent findings has been that the quality of the therapeutic alliance is an important predictor of outcome (Luborsky 1985).
The absence of strong correlations between qualities, assumed by experts to be associated with good or effective therapists, heralded a shift from a research strategy based on therapist characteristics to one that involved study designs that focused on evaluating therapist effectiveness based on the outcomes of their individual caseloads (Luborsky 1997). A classic example of this shift is evident in the Ricks (1974) study described at section 2.2.4.1 in this chapter.

Researchers have employed a variety of research strategies to investigate the impact of the individual therapist on treatment outcome in psychotherapy. In many instances, questions about therapist effects have been secondary to questions about the efficacy of particular treatments. As a consequence, many early studies that examined the influence of the therapist on outcome suffered from methodological problems, which means that caution is warranted in interpreting the findings of published studies in this area. Indeed, it is only in recent years that such methodological issues have received more thorough attention from researchers, particularly the importance of appropriate research design and statistical analysis of data.

Psychotherapy outcome researchers have devoted more attention to investigating techniques than therapists in recent decades, and as a result, great efforts have been invested in eliminating or controlling the therapist 'variable' in outcome studies. The careful selection, training and supervision of therapists along with the use of treatment manuals to standardise treatment and monitoring of therapist adherence to treatment protocols are some of the key features of well controlled outcome studies of therapist effects. Yet, even in such highly controlled designs, variability in therapist effectiveness is still evident (Wampold 2001).
There is some evidence that the use of treatment manuals and more experienced therapists reduces the influence of therapist effects (Crits-Christoph 1991). However, it is unclear to what extent patient factors interact with therapist factors to produce variability in outcome, or how the influence of therapist factors may manifest across a range of forms of psychotherapy. In fact, there is some evidence that attempts to standardise treatment using manuals can contribute to a forced and mechanical approach which can interfere with the therapeutic relationship (Strupp and Anderson 1997).

The most important conclusion from this review is that the unique qualities of the therapist can influence treatment outcome across a range of client populations. With the exception of some studies of therapist effects in the alcohol and substance abuse fields (Najavits and Weiss 1994), which included some paraprofessional therapists, the vast majority of studies in this area have involved experienced and licensed counsellors or psychotherapists in North America.

There have been a lack of studies of variability in outcomes of paraprofessional counsellors working with a range of client problems, particularly in the area of mental health. Studies of this nature have the potential to contribute to understanding about the characteristics of effective therapists and the relative importance of technical procedures and non-specific or common factors in therapeutic change (Garfield 1991; Karasu 1986; Omer 1989; Strupp and Hadley 1979). One potentially effective future research strategy that may prove fruitful in this respect would be to study ‘outliers’ or relatively effective and relatively ineffective therapists (Elkin et al. 2006b; Luborsky et al. 1985). It would be interesting to find out, for example, whether minimally
trained paraprofessional counsellors varied in their effectiveness, and if so, what characteristics are associated with more and less effective counsellors. The findings of such research would not only contribute to understanding of theoretical concerns in relation to the ingredients of therapeutic change, but would also have practical implications in relation to the selection, training, counselling practice and supervision of paraprofessional counsellors.

The realisation that the personal qualities of the counsellor have an impact on counselling outcomes has contributed to a renewed interest in studying development processes in counsellors in order to understand how best to facilitate positive development and thus enhance practitioner effectiveness. Consequently, the main elements of the literature on counsellor development are addressed in the next major section of this chapter.

2.3 Review 3: Counsellor development

2.3.1 Introduction
The process of counsellor development has attracted increasing attention from researchers in recent decades. This can be attributed, at least in part, to a growing awareness of the interrelationship between the personal and professional selves of the therapist (Guy 1987). Moreover, the recognition of the importance of therapist factors (discussed in the preceding sections), and the quality of the personal relatedness between client and therapist to client outcome, has also contributed to interest in studying counsellor development. More broadly, the study of counsellor development has been informed by diverse areas of inquiry such as sociological studies of professions, studies of expertise, wisdom, career development, supervision, and adult
developmental psychology (Orlinsky and Rønnestad 2005; Rønnestad and Skovholt 2003).

Gaining a deeper understanding of the developmental processes and changes that counsellors encounter during their professional lives can contribute to the enhancement of methods of counsellor training and supervision, and enhance knowledge about how best to facilitate positive development and prevent or lessen the consequences of negative development such as incompetence and burnout (Rønnestad and Skovholt 2003). Furthermore, to the extent that the successful outcome of counselling is a function of the quality of the therapeutic relationship and therapist qualities, it can be argued that research on professional development compliments outcome research in counselling and can serve to enhance positive client outcomes.

The aim of Review 3, therefore, is to provide a brief overview of research on counsellor development. The concept of development is briefly discussed before providing an overview of a number of influential developmental models. Following this, two influential developmental models are described in more detail to exemplify the developmental processes that theorists and researchers have endeavoured to capture in these models. This section ends with a consideration of methodological issues related to research in this area, and a summary of this literature.

2.3.2 The concept of development
Rønnestad and Skovholt (2003) have noted that the concept of development can be traced back to the Enlightenment era of the 18th century, and that the ideas of growth, advancement, the valuing of science and education associated with this period in time provide a helpful context for understanding the concept of development. In simple terms the concept of development implies an ongoing process of change over time.
However, it is a concept that embraces a diverse range of attributes, and according to Lerner (1986), it is more appropriately regarded as a theoretical rather than an empirical concept, and must contain certain minimal features regardless of the diversity of elements that have been postulated form different philosophical and theoretical perspectives. These are: a) development always implies some form of change; b) change is organised systematically; and c) the change occurs successively over time (Lerner 1986). Furthermore, the concept of development may also include additional features, for example: changes must serve an adaptive function and be organised so that systems change from a global to a more differentiated, integrated, and hierarchical form, and that change must be qualitative as well as quantitative in nature (Skovholt and Rønnestad 1995).

2.3.3 Overview and examples of models of counsellor development

According to Orlinsky and Rønnestad (2005), the majority of research on psychotherapists has addressed specific practical concerns rather than their essential characteristics and development. Examples of such practical concerns can be found in studies that have examined therapist burnout, therapists’ experience of personal therapy, the ethical conduct of therapists, and in studies that have investigated questions concerning the selection, training and supervision of student therapists (Orlinsky and Rønnestad 2005).

Nonetheless, there are in existence a number of influential models of counsellor development. Holloway (1987) has noted that in relation to the counselling literature, the focus of thinking and research has centred on five developmental models (Blocher 1983; Hogan 1964; Littrell et al. 1979; Loganbill et al. 1982; Stoltenberg 1981), three of which are specifically rooted in psychosocial developmental theory (Blocher 1983;
Loganbill et al. 1982; Stoltenberg 1981). The models proposed by Hogan (1964) and Littrel et al. (1979) are not based on any particular theory of development, but instead draw on the language of developmental theory to portray development in relation to the supervisory process.

In addition to these key models, a number of other models have been proposed. Hill et al. (1981), for example, described a four-phase model of counselor development based on an extensive study of counseling psychology doctoral students. Grater (1985) formulated a model comprising four stages grounded in his experience as a psychotherapy teacher and supervisor. The model proposed by Hess (1987) attempted to distil key elements of various supervisory models of development into an overarching conceptualisation comprising four stages through which practitioners can recycle through in a spiral fashion. Sawatzky et al. (1994) employed a qualitative methodology to investigate the process of development of counseling psychology students. These authors characterised development as an ongoing process of 'becoming empowered', which involves the negotiation of a set of recurring themes related to feelings of anxiety and dissonant experiences.

Skovholt and Rønnestad (2003; 1995) have provided a comprehensive career-span account of counselor development based on extensive analysis of qualitative data collected from therapists at different stages of their professional development. This model is described in more detail below. More recently, Orlinsky and Rønnestad (2005) reported the findings of a 15-year international study, which set out to examine the interrelatedness of psychotherapeutic work and professional development. Findings were based on data collected from some 5,000 therapists from 14 different countries, and provide an insight into the experiences and development of therapists at
varying stages of professional life.

Orlinsky and Rønnestad (2005) conceptualised therapists’ experience of therapeutic work in relation to three factors, which they referred to as Healing Involvement, Stressful Involvement, and Controlling Involvement. One or more of these factors are believed to contribute to a therapist’s overall functioning regardless of personal or professional development. Healing Involvement, for instance, characterises the therapist as personally invested, efficacious in relational agency, affirming in relational manner, as currently highly skilful, as using constructive coping strategies, and as experiencing flow states during therapy sessions. By contrast, Stressful Involvement portrays the therapist’s experience of therapeutic work as one that is dominated by feelings of anxiety, boredom, a sense of inadequacy in relation to their competence, and the experience of frequent difficulties in practice. Therapists who experience high levels of Stressful Involvement are at risk of burnout and damaging practice. Controlling Involvement is concerned with the therapist’s relation manner with clients, which is typically experienced by therapists who found they were directive, demanding, challenging, or in general, adapting a dominant stance in therapy sessions.

In terms of professional development, Orlinsky and Rønnestad (2005) identified two central processes which they defined as Currently Experienced Development and Cumulative Career Development. Currently Experienced Development ‘represents therapists ongoing experiences of growth and depletion as they engage in psychotherapeutic work’ (Orlinsky and Rønnestad 2005, p. 163), and Cumulative Career Development describes therapists’ overall experience of development (in terms of experiencing a sense of change, developing expertise and therapeutic skills), during
the time from their first contact with clients until the present (Orlinsky and Rønnestad 2005).

This study is unique insofar as it is one of only two studies that have investigated the development of therapists across their entire career – the other being Skovholt and Rønnestad’s career span model (Rønnestad and Skovholt 2003; Skovholt and Rønnestad 1995). In addition, it provides compelling evidence for the pervasive influence that therapists’ current and career development impacts on the quality of their experiences of therapeutic work. Hogan’s (1964) influential model, and Rønnestad and Skovholt’s (2003) life-span model are described below by way of exemplifying models of counsellor development.

2.3.3.1 Hogan (1964)
One of the most influential models of counsellor development is Hogan’s (1964) four level model. Hogan’s model is regarded by many to represent a comprehensive, yet succinct, theoretical model of the process of counsellor development and supervision (Reising and Daniels 1983). He characterised counsellors in training as progressing through four levels of development, each of which necessitated the negotiation of specific tasks or issues; and which also had implications for the supervision of therapists at different levels of development.

Counsellors at Level 1 are typically highly motivated to help though they often lack awareness of their motivations for being a therapist. The predominant affect is one of anxiety, which is associated with dependence on supervisors and a reliance on a limited repertoire of helping strategies. At this level, the supervisor’s role is one of teaching, support, awareness training and interpretation. Level 2 counsellors are striving to become more autonomous and establish a more personalised approach, and
may be prone to overconfidence. However, they are not quite equipped to handle the challenges of client work and may experience feelings of being overwhelmed. A key supervisory intervention during Level 2 is ambivalence clarification. Level 3 is characterised by increased professional self-confidence and a growing awareness of one's motivation for being a counsellor. Counsellors at this level are more independent and less reliant on supervisors. During this period, supervisors are more likely to use sharing, exemplification, and confrontation to facilitate development.

Finally, during Level 4, counsellors are portrayed as autonomous, secure, stable in terms of their motivation, as well as being aware of, and open to addressing, personal and professional problems. The supervisory relationship during Level 4 is based on mutual sharing and confrontation.

2.3.3.2 Skovholt and Ronnestad (1992)

Skovholt and Ronnestad (1992) put forward a career-span model of counsellor development, which they derived from in-depth interviews with counsellors at different stages in their careers. The original formulation (Skovholt and Ronnestad 1992) included 8 stages. The authors re-formulated their model and collapsed the eight stages into six, which they renamed phases in order to do justice to the interrelationship of content, and to denote the gradual and continuous changes that therapists’ experience (Ronnestad and Skovholt 2003). The six phases in this most recent conceptualisation of their model are outlined below.

The Lay Helper: Phase 1

The lay helper bases their helping strategies on a common sense approach informed by personal everyday experiences of helping family, friends and colleagues. The
passionate engagement of the lay helper and commitment to helping another person can contribute to an over-involved helping style, and give rise to numerous boundary issues in the helping relationship. In addition, a strong sense of identification with the person being helped can also lead to difficulties in the lay helper’s ability to regulate and control their emotional involvement in helping situations.

The Beginning Student: Phase 2
The beginning student phase is characterised by a sense of excitement, but it is also accompanied by feelings of self-doubt, uncertainty, and frequently, by a feeling of being overwhelmed by the multiple personal and professional challenges during the early period of professional training. These feelings are especially evident in relation to the early experiences of client work. A crucial task for beginning student counsellors is to develop an initial framework for counselling, and competence in a set of easily mastered, straightforward counselling methods. Developing an initial repertoire of methods and intervention strategies helps to reduce anxiety and provide reassurance to the beginning student. Furthermore, having positive support and feedback from supervisors and mentors are equally important in facilitating positive development and competence as a counsellor. Positive development is also fostered in beginning students by openness to new learning, a reflective attitude, and a willingness to experiment with and try out new learning in practice.

The Advanced Student Phase: Phase 3
Toward the end of professional training, the typical student is working as a counsellor under supervision in a counselling placement setting. During this phase many students are likely to aspire to professional standards beyond the expected
requirement to establish a basic professional level of competence. This can lead to a sense of over-responsibility for clients, and a proneness to want to practice perfectly, which can lead to an unwillingness to experiment with new ideas, or to be creative and spontaneous in practice. The advanced student may experience a tension between the pursuit of a more autonomous professional identity while still being very dependent on supervisors and professional mentors. Consequently, these sources of influence can have a powerful impact on development. In general, the advanced student demonstrates more willingness to reflect on complex issues related to their personal and professional development. Moreover, it appears that a lack of interest or identification with any theoretical orientation is associated with negative developmental pathways. Conversely, an attitude of openness and enthusiastic commitment to learn is associated with positive developmental pathways.

The Novice Professional: Phase 4

The description of the novice professional phase is based on the experience of professionals with an average of four years post-qualification experience. The transition to professional practice brings with it an opportunity to confirm or test-out the validity of graduate training. Generally, it is an intense and engaging period of development during which the novice professional is engaged in a process of refining the concepts that inform practice and at the same time pursuing a more personal approach to practice.

Specific challenges during this phase relate to the experience of isolation and a feeling of not being fully prepared for the challenges of professional practice. This can lead to disillusionment with professional training and indeed with self. For instance,
encountering clients who are non-responsive to one’s approach can contribute to feelings of inadequacy, but also lead to a renewed interest in learning new techniques and helping strategies. During this early professional phase, there is openness to internal processing of one’s development combined with a search for a working environment and roles that are compatible with one’s evolving personal/professional philosophy of life and counselling. An increasing awareness of the role of one’s personal qualities and the importance of the therapeutic relationship for client progress contribute to more intense personal exploration and a desire to master the relational aspects of counselling work. This awareness is a step toward integrating the personal and professional aspects of work.

The Experienced Professional Phase: Phase 5

The experienced professional has accumulated a great deal of experience with a wide range of clients and work settings. A central developmental task during this phase is to establish a working role that is consistent with one’s personal/professional philosophy, which allows the practitioner to practice in an authentic way. The typical practitioner at this phase has developed an extensive repertoire of methods which are applied in a flexible and personalised manner according to individual client need. Also, during this period of development counsellors are much more adept at regulating emotional and professional boundaries. However, for some experienced professionals, burnout and distressing practice experiences represent significant professional challenges at this stage of development. During this phase of development, it appears that clients are a major source of influence as is learning from personal life experience.
The Senior Professional Phase: Phase 6

The senior professional phase describes practitioners who have practised for up to 25 years. The experience of loss is a common theme during this period of development: loss of professional elders and a sense of anticipatory loss associated with growing old, for example. Although this phase can be accompanied by cynicism, boredom, and apathy, it is more usually characterised by an ongoing commitment to professional development, a sense of self-acceptance, and a more modest perspective on what can be achieved in therapy.

In conclusion, this section has outlined a number of influential models of counsellor development. Research examining the validity of the conceptualisation of counsellor development proposed in these models has yielded consistent, yet modest, support for the concept of development expressed within these models. “The predominant finding regarding trainee characteristics across various levels of trainee experience indicate that differences exist only between very beginning-level and intern-level trainees and that these differences centre on relationship characteristics” (Holloway 1987, p. 214). It appears that beginning counsellors require a supportive and encouraging environment in supervision, whereas more advanced students tend to be more independent and less reliant on the supervisor.

2.3.4 Methodological issues in the study of counsellor development

The central methodological issues in the study of counsellor development concern questions of how to study development, methods of measurement, sources of data collection, the importance of distinguishing models of development from models of training and supervision, and clarification of how the term development is understood and operationalised within studies.
The question of how best to study therapist development raises methodological issues related to optimal study design. In an ideal world studies would employ longitudinal designs, which would facilitate the exploration of the process and extent of change manifest in the same therapist, or group of therapists, over the full span of their careers. Although methodologically sound, longitudinal designs have the disadvantage that individual studies are likely to continue over many decades in order to capture the full range of developmental processes in the professional career of the therapist. Of the studies described earlier, the Hill et al. (1981) study was the only one that employed a longitudinal approach; however, this was limited to the period of training. As Holloway (1987) has noted, empirical investigations of counsellor development have been restricted to approximately four year time spans: typically during the time from the start to finish of the training programme.

To date, research on counsellor development has relied on cross-sectional designs, which allow for the comparison of different groups of therapists (referred to as cohorts) who are at different stages in their professional careers (Holloway 1987; Orlinsky and Rønnestad 2005). Cross-sectional designs overcome the practical limitations of longitudinal approaches, and need to take repeated measures over an extended period, but they are not sensitive to the historical and cultural contexts and changing professional circumstances of the different cohorts in any given study (Orlinsky and Rønnestad 2005).

Indeed, Orlinsky and Rønnestad (2005) have proposed supplementing data from traditional cross-sectional and longitudinal designs with phenomenological data, which draws on therapists own experiences of their development. In particular, they
make a case for collecting data on therapists’ subjective experiences on what they refer to as ‘currently experienced development’ and cumulative career development’. Such data would provide some insight into therapist’s own perspectives on development and help to counterbalance the predominately ‘outsider’ observational stance adopted in most of the studies on counsellor development to date (Orlinsky and Rønnestad 2005; Sawatzky et al. 1994).

An important theoretical issue, which has methodological implications, relates to the lack of agreement among developmental theorists and researchers on the underlying processes and essential features of development. This means that “there is no consistent guidance for researchers concerning what to measure” (Orlinsky and Rønnestad 2005, p. 105). Moreover, the lack of critical examination of models of counsellor development (developmental models of supervision especially) gives rise to the question of whether such models are actually describing developmental processes or whether, in fact, they are merely describing changes that reflect particular training and supervisory contexts (Holloway 1987).

Yet another question concerns the definition of professional status. The fact that counsellors and psychotherapists have diverse professional backgrounds, that there is not at present in existence a distinct profession of counselling, means that it is difficult to define precisely the nature and role of the counsellor or psychotherapist (Orlinsky and Rønnestad 2005). Overall, the study of counsellor development requires further research in order to address a number of broader questions, such as the extent to which counsellors develop over the course of their careers, which will facilitate the development of empirically-based theories.
2.3.5 Summary of research on counsellor development, and implications for future research

Section 2.3 has endeavoured to provide an overview of the literature on counsellor development, and the key methodological issues associated with this body of research. A number of models of counsellor development were identified, which tend to characterise development as a relatively linear progression through a series of discrete stages that move from a state of anxiety and dependence during the early stages, to feelings of self-efficacy and integration of personal and professional selves in the latter stages of professional development (Sawatzky et al. 1994). For the most part these models have been developed in relation to supervision and training, and generally focus on the early stages of a therapist’s career (Orlinsky and Rønneset 2005). Furthermore, findings from existing studies tends to rely on the perspective of supervisors and trainers, and there is an absence of data on the pre-training or lay helping stage within existing models of counsellor development. The most notable exception to this is the career span model described by Skovholt and Rønneset, which employed a qualitative methodology, and also outlined a pre-training stage or phase of development (Rønneset and Skovholt 2003; Skovholt and Rønneset 1995). Moreover, it is notable that models of counsellor development do not really address issues related to gender or social class and the impact that such factors might have on the development of counsellors and psychotherapists.

2.4 Review 4: The meaning of volunteering and becoming a counsellor

2.4.1 Introduction

The research reported on in this thesis was carried out within the context of a
voluntary organisation that depended, to a large extent, on volunteers to provide a
counselling service to people experiencing a range of problems in living. Indeed, as
noted in Chapter 1 of this thesis, counselling in Britain emerged from a small number
of voluntary organisations and it owes much to the volunteer (Walker and Jacobs
1993). It is important, therefore, to give some consideration to volunteering to provide
a meaningful context for the research reported on in this thesis.

In contemporary society, the voluntary sector and volunteering have become
increasingly important both politically and socially (Paolicchi 1995). In Scotland, for
instance, the country where the research reported on in this thesis was conducted, the
present Scottish government has initiated a number of policies focused on voluntary
organisations and volunteering, which seek to engage voluntary groups in achieving
goals related to promoting community development and active citizenship (Fyfe et al.
2006). More generally, voluntary activity within Britain was an important component
of the programme of welfare reforms of the New Labour government (Powell 1999),
and the newly elected coalition government is championing the role of voluntarism
under the banner of the concept of the ‘Big Society’ (Cameron 2010). In addition to
the policy context, it is also important to consider the meaning of volunteering, both
as an activity in itself, and for the individuals that engage in it. This is important
because without some shared understanding of the meaning of volunteering,
government efforts to promote it become redundant (Davis Smith 2000).

The purpose of this section – Review 4 of this chapter - is to provide an overview of
research that has examined the meaning of volunteering. This literature is relevant to
the aims of Study 2 of this thesis, which sought to gain an insight into the experience
Chapter 2: Literature Review

of becoming a paraprofessional or volunteer counsellor. The review of the literature in this section is organised around a set of recurring themes in this body of research, namely: definitional concerns; questions related to who volunteers and why, and the experience of volunteering. It should be noted that there is a distinct lack of research in this area that relates to paraprofessional or voluntary counselling, especially in relation to reasons why people choose to become volunteer counsellors. Consequently, this review also draws on a broader area of literature that examines the meaning of becoming a counsellor or psychotherapist, particularly in relation to the background variables and motivational patterns of professional counsellors and psychotherapists.

2.4.2 Defining the terms volunteer and volunteering

The Oxford English Dictionary defines the term volunteering as “freely offering to do something”, and the term volunteer as “a person who freely offers to do something” or “a person who works for an organisation without being paid” (Oxford English Dictionary 2005). The term volunteering has also been defined as, “any activity intended to help others that is provided without obligation for which the volunteer does not receive pay or other material compensation” (Harootyan 1996). Omoto and Snyder (1995) make the point that volunteering shares many elements that are characteristic of spontaneous helping and obligated care-giving, but can be distinguished from these forms of helping insofar as volunteers are proactive in searching out helping opportunities, and give considerable thought to the nature and extent of their involvement in volunteering activities.

In this thesis, the defining characteristic of the term volunteering is that the volunteer counsellors in this study were not undertaking their volunteering activities for
financial reward. The idea of the absence of financial reward is flexible to the extent that it allows for the reimbursement of minimal expenses, such as travel costs (Davis Smith 2000).

2.4.3 Who volunteers?
Each year, millions of people around the world devote large amounts of their time and energy to helping other people through voluntary activities (Clary et al. 1998). For instance, a recent Scottish Household Survey (2008) found that almost one third of the adult population in Scotland, which accounts for approximately 1.4 million people, were engaged in voluntary activity during 2007/2008. The estimated economic value of this voluntary service was £2.2 billion. Similar patterns of volunteerism can be found in other countries. A national survey on volunteering in America, for example, estimated that 94.2 million adults engaged in some form of volunteerism, a quarter of whom contributed more than 5 hours voluntary service on a weekly basis (Independent Sector 1992). In addition, some early North American studies identified that volunteering activity was provided primarily by more affluent communities and philanthropic donors.

The pattern of volunteerism identified in the North American national survey was, in general, supported by the findings from the 1992 General Household Survey on Volunteering in the UK (Goddard 1992). In some cases within the UK, however, there is evidence that unemployed people who are living in economically deprived areas are participating more in voluntary activities (Milligan and Conradson 2006). According to Milligan and Conradson (2006), these studies suggest that any attempt at understanding who volunteers (where and why) must consider the socio-cultural context and place within which volunteerism takes place.
Chapter 2: Literature Review

Research indicates that interest and participation in volunteering among specific populations is increasing (Nassar-McMillan and Lambert 2003). Older citizens (Chambre 1993) and younger people (Hettman and Jenkins 1990) have increased their voluntary activity. There is also evidence to suggest that volunteering is relatively evenly distributed across age ranges and also among men and women, but it appears that educational levels among volunteers varies widely (Lammers 1991). These findings reflect the broad tapestry of volunteering in Scotland; however, there is some evidence to indicate that in Scotland people from disadvantaged groups are under-represented in volunteering (Scottish Household Survey 2008).

Volunteering in Scotland takes place in a wide range of settings including: organisations connected to children and young people; religion-based organisations; health and welfare organisations; agencies involved in sport or exercise; within community and neighbourhood groups; and in organisations providing unpaid help in relation to the environment or animals (Scottish Household Survey 2008). Volunteers undertake activities ranging from generally helping out with practical or administrative tasks to providing direct services such as counselling to people in need of help. Interestingly, voluntary counselling services accounted for 7% of all volunteering activity in most deprived areas of Scotland, compared to only 4% of voluntary activity in the rest of Scotland (Scottish Household Survey 2008). Voluntary sector counselling services in Scotland appear to be concentrated in major cities and urban areas while many smaller towns and rural areas receive only very limited provision (Bondi et al. 2003).

2.4.4 Why do people volunteer?
Researchers have devoted considerable attention to identifying individuals’
motivations for volunteering. In a review of the American literature, for example, Smith (1994) reported that volunteering tended to be greater in smaller communities and that volunteers were more likely to be better educated and to have an internal locus of control or sense of self-efficacy. In addition, volunteering was more evident in situations where the voluntary role was perceived as attractive and satisfying and the voluntary group activities were regarded as interesting and worthwhile. Overall, however, the extant literature on motivations to volunteer has not led to a clear consensus of results (Nassar-McMillan and Lambert 2003). Nevertheless, there is evidence that people are motivated to volunteer because of a sense of altruism (Black and Jirovic 1999; Cnaan and Goldberg-Glen 1990), to promote self-growth (D'Braunstein and Ebersole 1992) and career prospects (Brown and Zahrly 1989; Clary et al. 1998; Ellis 1993), because it provides people with an opportunity to engage in meaningful activities (Chambre 1993), facilitates well-being, and provides opportunities to meet with and socialise with others, particularly in people over the age of 55 (Morrow-Howell et al. 1999).

In their attempts to understand why people volunteer, researchers have posited different theoretical perspectives to explain motivation to volunteer. The most common view is that people engaging in the same volunteering activity may have different motivations for doing so. This is known as the functional theory of motivation, which Clary et al. (1998, p. 1517) have described as follows:

_The core propositions of a functional analysis of volunteerism are that acts of volunteerism that appear to be quite similar on the surface may reflect markedly different underlying motivational processes and that the functions_
served by volunteerism manifest themselves in the unfolding dynamics of this form of helpfulness, influencing critical events associated with the initiation and maintenance of voluntary helping behaviour.

So, in addition to acknowledging the multidimensional nature of volunteering, the functional approach to volunteering also highlights the relationship between motivation to volunteer and the retention and maintenance of engagement in voluntary activity. According to this theory, sustained volunteering is likely to be a function of the extent to which an individual continues to satisfy their own particular interests and needs through volunteering. Clary et al. (Clary et al. 1998) applied a functional approach to the question of motivations to volunteer and identified six motivational functions served by volunteerism:

1. *Values* - opportunities to express altruistic and humanitarian concern for others.
2. *Understanding* - opportunities for new learning, to use existing knowledge, skills and abilities.
3. *Social* – opportunities to be with others, to make friends, to form relationships
4. *Career* – opportunities to enhance career prospects through developing skills, gaining experience.
5. *Protective* – volunteering may serve to assuage a sense of guilt associated with being more affluent/fortunate than others and to address one’s own personal problems.

The functional approach is useful because it fosters a multidimensional perspective, and recognises that a wide range of personal and social motivations may lie behind
volunteering behaviour. Moreover, by positing a reciprocal relationship between motivations to volunteer and satisfaction with, and duration of, volunteering service, "it argues that important consequences follow from matching the motivations characteristic of individuals to the opportunities afforded by their environments" (Clary et al. 1998, p.1518).

A criticism of the functional approach is that it locates motivation within the individual. Consequently, it does not address the potential for the social and cultural context within which volunteering takes place to influence motivation to volunteer (Paolicchi 1995). Rather than view motivation as an essential feature of the individual, or as a predetermined antecedent of behaviour, some researchers have argued that a more useful perspective is to view motivation as an interpersonal and socially constructed part of behaviour.

Paolicchi (1995), for instance, has advanced a narrative perspective on volunteering, which argues that volunteers cannot simply be understood in terms of a set of stable personality traits or intrinsic motivations, nor by a common set of values. Instead, Paolicchi (1995) believes that volunteering can best be understood as a search for meaning at the individual level, and a co-construction of meanings and goals at the collective level. Hence, volunteering is regarded as a goal-oriented behaviour in which motivation is communicated, supported and modified through social interaction and the act of volunteering (Paolicchi 1995). Within this perspective, individual motivational processes are reformulated as psycho-social processes, which are informed by constructs such as biography, narrative, co-construction, and communication of values and meanings.
2.4.4.1 Why choose to become a counsellor?

While there is a growing body of literature examining the reasons why people choose to volunteer in general, there is a distinct lack of research on the motivational and developmental processes of paraprofessional or voluntary counsellors (McLeod 2003b). Consequently, this section mainly examines the literature on why people choose to become counsellors or psychotherapists in order to provide a context within which to understand the possible reasons that people may have for choosing to become paraprofessional or voluntary counsellors.

In one study involving the work of voluntary sector counsellors in Scotland, Bondi et al. (2003) identified that people volunteer as counsellors for altruistic, social, and personal development reasons such as helping others, doing some good for their communities, and developing new skills. However, the decision to become a voluntary counsellor also appeared to be influenced by prior experience of having been helped by counselling, and because the individual had had experience of the problems for which counselling was being provided by the agency with which they choose to become a volunteer.

Findings from the Bondi et al. (2003) study are consistent to some extent with the literature on motivations to become a professional counsellor or psychotherapist, particularly in relation to the importance of the experience of personal distress in influencing the decision to become a counsellor. Farber et al. (2005), for instance, reviewed the empirical and clinical literature on therapists’ choice of career. These authors identified two approaches that have been used to identify career choice factors for therapists. The common-elements approach assumes that all therapists share common childhood experiences that triggered a particular interest in the psychological
processes of people. For example, the notion of the ‘wounded healer’ (Guggenbuhl-Craig 1971; Rippere and Williams 1985) draws attention to the importance of the experience of personal or familial distress in relation to choosing a career as a counsellor or psychotherapist: a metaphor that resonates with many therapists as a way of explaining their motivations to become a therapist.

The specific-factors approach, on the other hand, argues for a multiple pathways perspective to explain motivations to pursue a career as a therapist. This approach proposes that a multitude of sociocultural and historical factors interact to account for motivation to enter the counselling or psychotherapy profession. Factors such as gender, ethnic and family background, role models, personality disposition to helping, as well as the cultural zeitgeist of the day may all play a part in an individual’s motivations to become a therapist (Farber et al. 2005).

Farber et al. (Farber et al. 2005) concluded their review of the motivational patterns influencing the career choice of therapists by stating that:

*It is clear that no single gene nor individual experience, book, or person suffices as an explanation; not one event can be examined in isolation. Rather, multiple influences together motivate a particular individual – one perhaps already predisposed genetically to be highly attuned and sensitive to inner cues and the experiences of others – to become a therapist. Typical significant events are experiencing personal distress, witnessing the distress of others, observing the behaviours and emotions of others, reading, engaging in*
personal therapy, playing the role of confidant, modelling and behaviour of others, and learning from a mentor (Farber et al. 2005, p. 1029).

It is important to be aware that motives to become a therapist can be regarded as both functional and dysfunctional (Guy 1987). Functional motivators include having a natural interest in people, being emotionally insightful, psychological-mindedness, having a capacity to tolerate uncertainty, interpersonally and relationally competent, and being introspective. Conversely, dysfunctional motivators include an over-preoccupation with unresolved personal needs, voyeuristic tendencies, compensating for an inner sense of loneliness or isolation, fulfilling a need for power or a messianic need to help others, or unconscious narcissistic motives (Guy 1987; Maeder 1989; Sussman 1992).

The most essential characteristic influencing motivation to become a therapist appears to be the development of psychological-mindedness, which seems to be promoted by the experience of familial or personal distress and through the experience of personal therapy (Farber et al. 2005). Interestingly, findings from an in-depth international study of the careers of psychotherapists, comprising a diverse sample of therapists, indicated that approximately 48% or 3,577 respondents acknowledged that their decision to become a therapist was to some extent a function of having experienced personal distress (Orlinsky and Rønnestad 2005).

2.4.4.2 The experience of volunteering
Researchers have examined the experiences of volunteers to determine the factors that may promote or deter continuing involvement in volunteering activities. The main areas that have been investigated concern volunteers’ levels of satisfaction with their
work and the organisational integration or socialisation of volunteers into their roles (Haski-Leventhal and Bargal 2008; Omoto and Snyder 1995).

Omoto and Snyder (1995) proposed a conceptual framework that sought to identify the antecedents, experiences and consequences of AIDS volunteers. In relation to the experience of AIDS volunteers they noted that having a helping disposition did not correlate with greater satisfaction or longer duration as an AIDS volunteer. Intriguingly, findings from the Omoto and Snyder (1995) study indicate that satisfaction and continued active involvement as an AIDS volunteer was related to “the opportunity to have personal, self-oriented, and perhaps even selfish functions served by volunteering…” (p.683). It appears that both altruistic and egoistic or self-oriented motivations exist among this group of volunteers. However, somewhat ironically, it seems that greater benefits are afforded to others by volunteers who are primarily motivated by the pursuit of personal goals related to learning and understanding, personal development, the development of new social networks and the enhancement of self-esteem than by volunteers who are primarily motivated by purely altruistic reasons.

Haski-Leventhal and Bargal (2008) represented the experiences and process of volunteering in their Volunteering Stages and Transitions Model (VSTM), which sought to explain different aspects of volunteer work activity and training within a youth project in Israel. Findings from this study suggested that volunteers progress through different phases of socialization within an organization that involves learning the job, internalising the organisational values and goals, and ultimately becoming an effective and involved volunteer. Initially, volunteers typically experienced shock and
surprise, and contradictions in their roles because the reality of volunteering did not conform to their expectations. To overcome these challenges, volunteers tended to reframe these difficult experiences to make sense of what they were doing, and to give meaning to their relationships with the young people with whom they were working (Haski-Leventhal and Bargal 2008).

2.4.5 Summary of research on volunteering

Review 4 above has provided an overview of research on volunteering because the studies reported on in this thesis involved volunteer counsellors and was carried out within the context of a voluntary sector counselling service. The social and political meanings of volunteering were highlighted and it was noted that in Scotland almost one third of the population are involved in some form of voluntary activity. Volunteering appears to be increasing among the young and in older groups of people but overall, volunteerism is relatively evenly distributed in relation to age and gender. In Scotland, involvement in voluntary activity is more prevalent in urban areas and some studies have reported that people who are unemployed and living in economically deprived areas are getting more involved in voluntary activities.

People volunteer for a variety of reasons and research findings suggest that participating in the same voluntary activity may serve different functions for different individuals. A range of motivations have been proposed to account for volunteerism, which include; altruism, personal and skills development, enhancement of career prospects, engagement in meaningful activities, pursuing opportunities to meet and socialise with people. Beyond individual motivations to volunteer, which represent the pursuit of individual goals and needs, it is possible to argue that the meaning of volunteering is constructed and modified through the social processes (e.g.,
interaction with people, use of language) involved in the act of volunteering.

The way in which an individual constructs meaning in relation to the experience of volunteering is also important in determining their capacity to deal successfully with any dilemmas and challenges that may arise while working as a volunteer, which in turn, appears to be a good predictor of ongoing involvement and commitment to volunteer work. Being socialised into the agency values, working environment and the purpose of a particular volunteering role within the agency are important factors in engaging volunteers; however, it appears that the pursuit of self-oriented goals through volunteering is a more reliable predictor of continuing involvement in volunteering than the pursuit of purely altruistic motives. It would seem that individuals who are motivated to pursue personal goals through volunteering may be more invested in finding ways to overcome dilemmas and challenges associated with volunteering than individuals who are not so predisposed.

Finally, as noted in Chapter 1 of this thesis, counselling in Britain emerged from the voluntary sector and to a considerable extent it continues to rely on unpaid volunteers to deliver and extend the availability of counselling services to a wide range of client populations. Becoming a counsellor is often associated with prior experience of personal and family distress and characterised by a significant personal investment in promoting self-growth and development as well as providing an opportunity to learn new skills and perhaps to embark on a new career as a professional counsellor. As yet, however, there has not been much research into the motivational processes and development of volunteer or paraprofessional counsellors.
2.5 Chapter overview: Key themes and emerging research questions

The primary aim of this chapter has been to critically review research into the effectiveness of paraprofessional counsellors. In addition, the key features of research into the differential effectiveness of individual therapists, the process of development in counsellors and psychotherapists, and the meaning of volunteering have also been outlined. Each of these areas of the literature contributes different theoretical and research perspectives on paraprofessional and voluntary counselling that are relevant to the studies reported on in this thesis. The key themes together with the methodological and theoretical issues pertinent to each of these areas of the literature have been highlighted and summarised within the relevant sections of this chapter. In this concluding section, key themes and emerging research questions arising from this literature are identified.

There are at least four major themes that arise within the literature on paraprofessional counselling. First, there is a distinct lack of research into the effectiveness of paraprofessional counsellors working with specific client groups within routine practice settings. Studies that are frequently cited in the literature as providing evidence for the effectiveness of paraprofessional counselling are predominately North American studies that are more than 30 years old and do not reflect the realities of everyday counselling practice in contemporary mental health settings in Britain. Moreover, the counselling interventions in these studies were often unorthodox, delivered in psychiatric inpatient or outpatient settings, and are therefore not representative of mainstream counselling approaches commonly found in contemporary community-based counselling practice settings, especially with the UK. Indeed, the most common problem type in these older studies was schizophrenia, and
consequently, there is a virtual absence of research on the effectiveness of paraprofessional counselling for common mental health problems such as depression and anxiety.

A small number of more recent studies were identified that examined the effectiveness of minimally trained paraprofessional counsellors; however, they provided only minimal evidence for the effectiveness of paraprofessional counselling for common mental health problems typically found in routine practice settings. At present, it is possible state that paraprofessionals can be as effective as professional counsellors and psychotherapists, but, based on the findings from existing research, the extent of paraprofessionals’ effectiveness with a range of client groups is unknown and warrants further investigation.

Second, the question of the comparative effectiveness of minimally trained therapists versus fully trained professional counsellors and psychotherapists represents a major theme running through the paraprofessional literature. The general finding from the literature that paraprofessionals can produce client outcomes that are equal to those of professionals has given rise to questions about the type and level of training that is required for effective counselling practice. So far, this question has not been addressed sufficiently in relation to paraprofessional counsellors in terms of counselling interventions with specific client groups. In the vast majority of studies of paraprofessional counselling, details of the type, content, and duration of the training that paraprofessionals received was only minimally described or not reported at all. Similarly, many previous studies have not adequately addressed the role and function of supervision in relation to client outcome in paraprofessional studies.
A further issue that has commanded only limited consideration concerns the way in which experience has been operationalised and examined as a variable in outcome studies of paraprofessional counselling. The point here being that while paraprofessionals in any given study may have received only minimal training, they may in fact have many years of helping experience which is likely to have facilitated the development of a great deal of skill and practical competence in working with a particular client group. Once again, previous studies have largely failed to accurately describe paraprofessionals helping experience or take this into account when reporting findings. Overall, we have only a limited understanding of the features of paraprofessional counselling training required to facilitate effective practice with particular client groups, and we know little about how paraprofessional counsellors experience and utilise the training they have received.

A third theme in the paraprofessional literature concerns the question of the qualities and characteristics of paraprofessional counsellors that are associated with effective helping. The literature on therapist effects reviewed in section 2.2 of this chapter highlighted the importance of therapist factors such as interpersonal and relational competence to positive client outcome. Research in this area has the potential to address important theoretical and practical questions about the ingredients of effective helping as well as the training and supervision of counsellors and psychotherapists. Studying the effectiveness of minimally trained paraprofessional therapists has the potential to provide researchers with opportunities to address such questions. Yet to date, there does not appear to have been any attempt to study the differential effectiveness of minimally trained paraprofessional counsellors or to identify the qualities associated with more and less effective paraprofessionals.
Finally, a fourth important theme is that we currently know little of the processes involved in the development of awareness and skill in paraprofessional counsellors or what their experiences are of entering practice and client work during the early stages of their development. The models of counsellor development outlined in section 2.3 of this chapter do not really illuminate our understanding of the lay or pre-professional training stage of counsellor development to any great extent because they are mostly concerned with novice counsellors and psychotherapists during the professional training stage of their careers. Research into the developmental processes associated with becoming a paraprofessional counsellor could help to enhance the selection, training, and supervision of paraprofessionals, and in turn their effectiveness.

On the basis of these conclusions, the research that was carried out and reported on in this thesis was designed to address the following questions:

1. How effective are minimally trained paraprofessional counsellors with clients typically found in routine counselling practice? For example, with clients experiencing depression and anxiety.
2. Is there evidence of differential effectiveness among minimally trained paraprofessional counsellors working in routine counselling practice settings?
3. What are the processes involved in the development of skill and competence of minimally trained paraprofessional counsellors? How do paraprofessional counsellors experience training, entering practice, and client work?

The overall aims of this research were to:

1. Contribute to understanding about the scope of paraprofessional counsellors’
effectiveness with specific client populations, in this case common mental health problems, and explore factors associated with effective practice.

2. Examine the outcomes achieved by individual paraprofessional counsellors and explore the therapist qualities associated with effective practice.

3. Illuminate understanding of the developmental processes and pathways of paraprofessional counsellors.

Chapter 3 explains the philosophical and theoretical perspective that underpinned the methodological choices that were made in pursuit of these aims and research questions.
Chapter 3: Methodology and Method: Issues and choices

Chapter 3
Methodology and Method: Issues and Choices

3.0 Introduction
The purpose of this chapter is to outline the philosophical assumptions and theoretical framework underpinning the research reported in this thesis. In addition, the methodological issues that arose in planning and conducting this research are discussed with reference to the choice of methods of data collection and analysis for Study 1 and Study 2.

The chapter is divided into two parts. Part one outlines key philosophical issues about the nature of knowledge associated with research involving people and describes the methodological perspective and theoretical framework adapted to guide this thesis. Part two describes the methods and procedures employed in each study. Each study is presented in separate sections which set out to: a) present the key methodological issues and choices associated with the methods used in each of the two studies that were carried out; and b) describe the specific methods and procedures utilised in each study.

The literature review presented in Chapter 2 highlighted the need for research into paraprofessionals that sought to understand:

- the effectiveness of minimally trained/experienced paraprofessional therapists with specific client populations
• the processes of development and awareness of minimally trained/experienced paraprofessional therapists during the early stages of their engagement with the activity of counselling.

An underlying theme inherent in these statements is a desire to understand the conditions under which paraprofessional therapists can be most effective. More specifically, the aims of this research (described in Chapter 1, section 1.8, and at the end of Chapter 2) were to evaluate the effectiveness of a group of paraprofessional counsellors and to explore in a broad sense the meaning and experience of becoming a paraprofessional counsellor. The research comprised two studies, which focused on one group of minimally trained/experienced volunteer mental health counsellors. Study 1 set out to evaluate the effectiveness of this group using a standardised outcome measure and Study 2 employed a qualitative methodology to explore the meaning and experience of becoming a paraprofessional counsellor for this group of people.

In order to achieve these aims a number of issues had to be addressed and choices made about the methodology and methods to be utilised in this research. The remaining sections in this chapter set out the choices that were made in designing this research, and the rationale behind them, in pursuit of these aims.

3.1 Part I - Philosophical issues

3.1.1 Introduction
McLeod (2003a) has noted that counselling research is situated within the context of
an ongoing philosophical debate about the nature of knowledge and emphasised the need for counselling researchers to reflect deeply on the methodological and philosophical choices that guide their work. This is important because counselling research is informed by a diversity of disciplines and traditions, and consequently, it is grounded in different philosophical assumptions about what is real and what counts as valid knowledge. The purpose of this section, therefore, is to discuss the key philosophical positions that researchers may adopt in carrying out a research project and identify the implications of these positions in relation to knowledge claims and methodological choices, particularly in relation to the studies reported in his thesis. To conclude this section, a social constructionist theoretical framework which incorporates key elements of the philosophy of pragmatism is identified as providing an appropriate and coherent set of theoretical and philosophical assumptions to guide this research.

3.1.2 The nature of science

The nature of scientific inquiry or research, in a broad sense, is about asking and answering questions (Sanders and Liptrot 1993). It aims to get at 'truth' (Robson 2007). However, within the social sciences there is disagreement over how best to go about answering questions and considerable argument over the meaning of 'truth' (Chalmers 1982; Robson 2007). At the heart of these disagreements is an ongoing and lively debate about what science consists of, which in turn reflects some enduring controversies within counselling and social science research and related fields.

The central issues in this disagreement arise from conflicting underlying philosophical stances in relation to the nature of reality (ontology) and knowledge (epistemology). For centuries, much philosophical debate has been devoted to understanding the
nature of whatever it is that exists and secondly, to questions which seek to understand what, if anything, we can learn or know (Magee 1998). These are core issues in research generally and concern fundamental questions about the kind of knowledge that is considered scientific (Robson 2002) and therefore valid, useful or acceptable (McLeod 2003a). Debates around these issues have resulted in the emergence of different traditions within social science research, each of which favour the use of different research methodologies which are consistent with the way in which science is defined and operationalised in terms of the goals of research within these traditions.

3.1.3 **Positivism**

The traditional view of science is that knowledge is derived from the facts of experience. According to this view, science starts with disciplined observation from which theories are then derived (Barker et al. 1994). This approach is known as induction and characterises science as a value-free, objective endeavour which produces and accumulates reliable and proven knowledge of the world (Chalmers 1982). The ontological position within this perspective of science is that there is an objective reality that exists independently of, and untainted by, our observations; moreover, that this objective reality is characterised by the existence of cause and effect relationships and of universal laws or 'truths'. In terms of its epistemological stance, positivism asserts that objective knowledge in the form of facts can be discovered from direct experience or observation, and such knowledge is the only kind available to science (Robson 2002). This standard view of science suggests that we are able to have an objective knowledge of reality through the use of reason and it is associated with a philosophical approach known as *positivism* (Robson 2002).
Barker et al., (2002; 1994) suggest that positivist research is characterised by an exclusive focus on observable facts, a belief that the methods of the physical sciences (e.g., quantification, separation into independent and dependent variables, and formulation of general laws) should also be applied to the social sciences and finally that science is objective and value free. The goal of research within this tradition, therefore, is to seek objectivity and to explain events using general statements or laws, usually in terms of cause and effect relationships. In order to facilitate this process research that is informed by this perspective primarily makes use of quantitative methods (Goodley et al. 2003). This philosophical view is reflected in the traditional model of the scientific experiment as a controlled test of a hypothesis using established methods (Coolican 1996).

A positivist approach to research has been heavily criticised on the grounds that, in the extreme, it may lead to a sterile and trivial discipline alienated from human experience (Barker et al. 1994). It encourages a uniformity of scientific methods across all disciplines and privileges explanations only that are specified in terms of ‘cause-effect’ relationships. Furthermore, as McLeod (2003a, p.7) has noted, “The very aims of traditional science, centring on the prediction and control of events, are seen as philosophically and politically inappropriate when applied to the study of human action, which can be regarded as intentional and reflexive.”

In an attempt to reconcile the criticisms made of positivism some researchers have adopted the term ‘post-positivism’ to describe their approach. The term post-positivism has been used to refer to a philosophical stance that came after and as a reaction to a positivist view of science, and also to describe a reformulated version of
positivism which seeks to acknowledge that the pre-understandings and expectations of the researcher in terms of their theories, hypothesis, background knowledge and values can influence what is observed (Reichardt and Rallis 1994). Nonetheless, within a post-positivistic approach there is still a commitment to pursuing objectivity and a belief in the existence of an independent reality, which can only be known imperfectly and probabilistically because of the limitations of the researcher (Robson 2002). The philosophical tensions and dilemmas associated with attempts to apply these approaches to social research have contributed to the use of alternative philosophical perspectives and approaches to research involving people that are associated with relativist traditions.

3.1.4 Relativism

Relativism challenges the ontological and epistemological assumptions that underpin the positivist tradition. According to the Oxford English Dictionary, it reflects a philosophical stance that proposes that “knowledge, truth, and morality exist in relation to culture, society, or historical context, and are not always the same” (Oxford English Dictionary 2005). An extreme relativist philosophy argues that reality does not exist outside of human consciousness and that all that exists are different sets of meanings and observations which people attach to the world (Robson 2002). A relativist perspective does not necessarily entail the rejection of the idea of an independent reality but it does warrant a belief that even if an external reality exists, it is inaccessible to us (Burr 2003). Furthermore, a relativist position argues that “the only things we have access to are our various representations of the world, and these therefore cannot be judged against ‘reality’ for their truthfulness of accuracy. Relativists therefore cannot prefer one account to another on the basis of its veridicality” (Burr 2003, p. 23).
Although there are different ontological positions regarding the nature of reality within the relativist tradition, there is a general commitment to the epistemological view that knowledge is socially constructed. In terms of research, the idea that it is possible to establish ‘truths’ about the social world using natural science methods associated with the positivist tradition is therefore rejected (Robson 2002). The main reason for this is that the subject of social science research, people, are active and purposeful agents who make meaning in relation to their experience, which in turn, influences and guides their behaviour (Creswell 2003; Robson 2002).

Robson (2002) highlights that a relativist critique of positivistic approaches have undoubtedly contributed to the methodology of social science research. In particular, he notes relativist ideas which draw attention to the socially constructed nature of scientific knowledge, the recognition that science is not value free, and the view that the connection between data and theory confirmation (or disconfirmation) is not as closely connected as is assumed in positivist doctrine (Robson 2002). Barker et al. (Barker et al. 2002; Barker et al. 1994) also note the importance of recognising that the researcher is not a detached observer and that ‘facts’ are a joint construction of what is being observed and our knowing process.

Relativist approaches to research challenge the privileged position afforded to scientific knowledge and theories and instead propose that such accounts are but one of many different ways of looking at the world (Chalmers 1982). Qualitative methodologies are preferred to quantitative approaches because the former allows the researcher to inquire into the personal meaning of experiences and behaviour of research participants and to represent these in detailed accounts in an attempt to
illuminate meaning (McLeod 1999; Robson 2002). This research strategy represents a fundamental difference between quantitative and qualitative approaches to research (McLeod 1999).

Relativism is evident in a variety of forms in approaches which are sometimes referred to as constructivist, social constructionist, naturalistic or interpretive (Robson 2002). Each of these approaches can provide a theoretical framework to guide the research process. The most relevant to this thesis is social constructionism because this perspective was adapted as a broad theoretical framework for this research and more specifically in relation to study 2, which sought to illuminate the meaning and experience of becoming a volunteer mental health counsellor.

3.1.5 Methodological perspective underpinning this research

The primary methodological choice that was made in this thesis was that the aims of the research would be best accomplished by adopting a pluralist approach to the research methodology. Methodological pluralism proposes that different methods are appropriate to different kinds of research questions (Barker et al. 1994). This does not, however, mean that ‘anything goes’. As Barker et al. (Barker et al. 1994) have commented, a pluralist approach implies rigorous attention to the methodological rules and principles within the context of each method in order to guard against drawing conclusions that are not supported by the data. The advantage of a pluralist approach is that it is inclusive, and values and respects the diversity of research methods and method philosophies (Slife and Gantt 1999). “Methodological pluralism values the traditional scientific approach equally as much as its alternatives – regarding each as appropriate for different types of enquiry under different circumstances” (Barker and Pistrang 2005). As such, methodological pluralism
embraces the idea that knowledge accumulates from a variety of sources in a variety of ways and that no one method or approach to research is inherently superior or better than any other. Instead, what is more relevant is that the methods employed in any given study are appropriate for the questions under investigation. Ultimately, all approaches and methods have their advantages and disadvantages (Barker and Pistrang 2005).

In addition, a social constructionist perspective (Burr 2003; Gergen and Gergen 2003) that incorporated key elements of the philosophy of pragmatism (Cherryholmes 1992; Hastings 2002; Rorty 1983) were selected as an appropriate theoretical framework to guide this thesis, which includes a quantitative and a qualitative study. The primary justification for this theoretical/philosophical approach is that both social constructionism and pragmatism advocate a pluralist approach to research methodology and accept the existence of a variety of competing interests and forms of knowledge (Cornish and Gillespie 2009). Social constructionism and pragmatism embrace philosophical pluralism and reject the idea that there is one, true, overarching theory to explain everything (Hastings 2002). Furthermore, both perspectives advocate the acceptance of a pluralistic reality and argue for the acceptance of a multiplicity of explanations for human activity which calls for a range of methods in the pursuit of knowledge (Hastings 2002). Another similarity is that social constructionism and pragmatism agree that knowledge is always relative to the social, historical, cultural and political context within which it is produced (Creswell 2003). Indeed, some leading social constructionist theorists have identified the close association between this perspective and philosophical pragmatism and suggest that there is a notably concern in both perspectives for the practical consequences that
follow from honouring one account of truth or reality over another (Gergen and Gergen 2003).

Although these perspectives share a number of common features they are not equivalent. Social constructionism is more firmly located in a relativist tradition (than pragmatism) where no one account of reality can be privileged over another. As Marshall et al. (2005) have noted, a social constructionist perspective poses a dilemma for the researcher and asks, “Are all pictures of reality and all understandings of reality truly equal in terms of providing understanding about the target area of research? Are all research approaches and processes helpful in a given situation? Is all research evidence including all interviewees’ transcripts equally important of valid?” (p.3). These authors assert that some accounts of reality, research approaches and data may be more useful in different research situations than others and argue that a pragmatic approach provides a way of approaching the difficulties associated with a relativist stance.

So, for example, whereas social constructionism does not privilege any one picture of reality, pragmatism privileges the one that is most useful to one’s purposes. In other words, “Given a particular problem or research objective, that picture or reality, that framework or sense-making categorisation that is most useful or helpful is the ‘true’ one; or more simply, the one to apply in practice” (Marshall et al. 2005, p.5). Hence, pragmatism functions as a philosophical method to evaluate the multitude of ideas that emerge within a theoretical framework informed by social constructionism (Hastings 2002). Consequently, this affords the researcher much more flexibility in the choice of methods, techniques and procedures that best accommodates their needs.
Methodological pluralism underpinned by a pragmatic social constructionism provided a coherent theoretical and philosophical foundation for a programme of research that included both quantitative and qualitative studies. More specifically, Study 1 used a quantitative method to investigate the comparative effectiveness of a group of paraprofessional counsellors and Study 2 employed a qualitative approach to inquire into the meaning paraprofessionals ascribed to the experience of becoming a volunteer mental health counsellor.

The knowledge claims that are made in this thesis are founded, therefore, upon the following epistemological and ontological assumptions:

1. All forms of knowledge are historically and culturally specific and are derived from and sustained by social processes (Burr 2003). For example, the ways in which people use language in their everyday lives can be regarded as a social practice through which shared versions of knowledge are constructed (Burr 2003). A key implication of this view for research is that notions of truth and objectivity are rejected in favour of a belief that such concepts may be regarded as transient and reflect current accepted ways of understanding the world (Burr 2003).

2. The idea of an external reality independent of our observations is not completely rejected as in more thoroughgoing versions of social constructionism. Consequently, the assumptions about the nature of reality underpinning this research are sympathetic to a critical realist ontological perspective (Burr 2003;
Critical realism acknowledges the constructed nature of knowledge but argues that some constructions of events and experiences are more likely than others because the things we observe and experience are "generated by underlying, relatively enduring structures, such as biochemical, economic or social structures" (Willig 1999a). Therefore, the ontological perspective adopted in this thesis does not subscribe to an extreme relativist stance. This is consistent with philosophical pragmatism which, although it is less concerned with questions about metaphysical reality, does not require a commitment to any one ontological perspective (Creswell 2003). It is also consistent with some versions of social constructionism (Burr 2003).

In addition, a pragmatist approach to the knowledge claims that are made in this thesis has been influential to the extent that an emphasis has been placed on producing practical outcomes and knowledge that may be useful to a range of individuals and organisations, particularly those connected with paraprofessional and voluntary counselling. Ultimately, the criteria for judging knowledge claims are whether they work in practice or are useful for a given interest (Rorty 1983). The focus on the practical usefulness of knowledge advocated in this thesis is not intended to reflect a narrow utilitarian position, but rather, a critical perspective that invites questioning and reflection on the interests being served by particular knowledge claims (Cornish and Gillespie 2009).

3.1.6 Researcher reflexivity
The philosophical and theoretical perspective underpinning this thesis necessitates attention to the question of researcher reflexivity for at least two reasons. First, social constructionism emphasises the constructed nature of knowledge and consequently,
the researcher is positioned as being actively involved in the construction of the many stages of the research process, as opposed to being a detached observer in a value free, objective enterprise (Finlay and Gough 2003b; Steier 1991). Second, both social constructionism and pragmatism recognise the influence that power and the vested interests of various stakeholders may have on the research process and the findings from any given study. Gough (2003), for example, has commented that researchers often have a vested interest in studying specific topics. Hence, critical reflection and transparency is required in order to provide the reader with sufficient information about the personal history and experience of the researcher, the social location and context of the research, and the way in which the research was carried out so that the reader can evaluate the relevance of the findings (Burr 2003; McLeod 2001b), and determine whose interests may be being served by particular knowledge claims (Cornish and Gillespie 2009). In this section, a brief reflexive account in provided in the first person in relation to these issues. Before doing so, the concept of reflexivity is defined in relation to its use in this thesis.

3.1.6.1 The concept of reflexivity

The concept of reflexivity has come to occupy an increasingly central position in contemporary social science research (Etherington 2004). It is a contested term that is associated with a variety of activities and goals (Gough 2003), which has given rise to an ongoing debate about its meaning and value in social research (Etherington 2004). According to Gough (2003), “A broad distinction can be made between realist uses of reflexivity, wherein researcher confession is deployed to reinforce the ‘accuracy’ or ‘authenticity’ of analysis, and postmodern or relativist forms of reflexivity, which tends towards disrupting narrative coherence and advertise analysis as constructed” (p.32). Reflexivity within traditional positivist methodologies may be limited to using
it as a tool to identify the presence of subjective bias in a research experiment or survey, whereas for others, it may represent a bridge between research and practice or indeed, it may form the basis for their primary methodological approach (Etherington 2004).

The notion of reflexivity suggests an ability to ‘bend back’ or ‘turn back’ one’s awareness on oneself (McLeod 2001b). There is a danger here, though, that in looking back at him or herself the researcher may get sucked into a vortex of narcissism and pretentiousness (Finlay and Gough 2003a) or an infinite regress of cognitive dispositions from which there is no exit from personal subjectivity (Gergen and Gergen 1991, p.79). In this thesis the concept of reflexivity is valued insofar as it is acknowledged that the experience and identity of the researcher, and the cultural and historical context within which a research project takes place, will influence and shape the process and outcome of any research endeavour (Finlay and Gough 2003b; Woolgar and Ashmore 1988). Furthermore, reflexivity is not taken to mean that ‘anything personal goes’, but instead, it is regarded as an intentional activity in terms of the research outcome: a means to and end rather than an end in itself (Etherington 2004). Consequently, the following reflexive account is an attempt to be transparent about aspects of the research environment and my own personal experience of carrying out this research that may have influenced the findings reported in this thesis.

3.1.6.2 Personal ‘motivations’ and background to the research setting

In section 1.1 of Chapter 1 of this thesis I outlined some of the background to my personal investment in carrying out the studies presented in this thesis. In particular, I highlighted how my experience of client work as a counsellor had been instrumental in shaping my theoretical perspective and practice and taking me in the direction of a
more integrated counselling approach. I also referred to how my growing interest in an integrative approach to counselling training and practice had been influential in the way in which I developed, in my capacity as counselling service manager, the counselling service and volunteer training programme at the MHSS agency where this research was carried out. These interests, together with a desire to enhance my professional development and career prospects, constituted the background to my first research endeavour which involved carrying out an evaluation of the brief in-house volunteer counselling training programme, which I designed within the MHSS counselling service. This research project formed the basis for my Masters degree (Armstrong 2003), and was also a preliminary part of the research programme conducted for this thesis.

Information about the setting for the research carried out for this thesis is provided in section 3.3.7 in this chapter. Below, I have provided more information about my personal involvement with this voluntary sector agency and outlined a number of issues pertaining to the environment which seemed to me to be important to acknowledge in terms of this reflexive account.

My involvement with the MHSS agency began when I took up a position there as a counsellor in 1994, having spent the previous 10 years working in a variety of institutional and community-based mental health settings in the National Health Service (NHS) as a mental health nurse and later as a counsellor and cognitive-behavioural psychotherapist. The position of counsellor with MHSS was a new post and counselling was a new venture for the agency – although it had for many years prior to the introduction of its counselling service been providing a range of
community-based services to people with mental health problems. Consequently, my role also included responsibility for the development of a counselling service for people experiencing mental health problems. At the time there were no administrative procedures or operational policies in place to support a counselling service so I was literally starting from scratch. Over a ten year period I successfully developed a counselling service that had secured ongoing core funding from the Local Authority, and a number of contracts with GP practices to provide counselling to their clients, which together, covered the costs of 4 full-time and part-time members of staff that included myself as counselling service manager, a senior counsellor/volunteer co-ordinator, several part-time counsellors, and approximately 20 volunteer counsellors.

Looking back I am very much aware that the fact that I was the first, and for a time, the only counsellor within the MHSS agency, and was charged with establishing and running the counselling service, meant that I had a significant personal investment in doing a good job, of establishing an effective and respected service. In addition to my personal motivations and aspirations for the counselling service, there were also pressures from other stakeholders, funders in particular, to demonstrate the value and effectiveness of the counselling service. The survival of the counselling service rested to a considerable extent on our ability to secure ongoing funding to pay for staff costs, which meant that we were constantly in a position of having to 'defend' and 'prove' our worth and effectiveness to existing and potential funders.

One of the main ways in which I endeavoured to accomplish this was to introduce a culture of evaluation and reflection on the overall effectiveness of the counselling service as well as the effectiveness of individual counsellors. This strategy was, I
believed, a necessity if the counselling service was survive and flourish. However, it was also rooted in my growing awareness of the limitations of all counselling models and an increasing openness and willingness to respond flexibly to client feedback regarding our approach to counselling and the way in which the counselling service was operated and delivered. As a result, I initiated several external evaluations of the counselling service (Goss 1996; 1998), which were influential in shaping my thinking and eventual implementation of the studies carried out for this thesis.

3.1.6.3 Managing dual roles and responsibilities: issues and challenges

One of the key challenges that I encountered while carrying out this research was the challenge of managing the multiple roles I occupied within the MHSS agency. I had a unique ‘insider’ perspective of the MHSS agency as a whole and a comprehensive understanding of, and involvement with, all aspects to the counselling service within this agency. I had an identity as the counselling service manager, and as a consequence, I was also identified as a member of the senior management group for the MHSS agency – as were all other service managers within the organisation. In relation to the counselling service within the MHSS agency, I also acted as mentor and supervisor to junior counselling colleagues and volunteer counsellors, and I was course leader and primary tutor for the in-house volunteer counselling training programme (Armstrong 2003) (which I had developed) that all volunteer counsellors had to complete successfully prior to progressing onto client work within the MHSS counselling service for which I was responsible.

The implications of this ‘insider’ perspective were that I had to reflect on my pre-

2 Please note that as indicated in the acknowledgements to this thesis, and in section 3.3.7 of this chapter, the name of the agency in these references have been changed in the interests of confidentiality.
understandings, experience, and knowledge of the MHSS organisation and its counselling service and consider their potential impact on my research programme for this thesis (Coghlan 2001). I employed a variety of strategies to accomplish this which included writing a research journal, reflecting on and discussing these issues with my research supervisors, professional colleagues and fellow PhD students. Through these activities I was able to become aware of and manage my ‘taken for granted’ assumptions and manage the tensions and dilemmas I experienced as a practitioner-researcher with multiple roles with the MHSS agency.

For example, a significant challenge that emerged for me early on in the research process concerned managing my organisational roles with my role as a practitioner-researcher. Although the MHSS agency was generally supportive of my commitment to the ongoing audit and evaluation of the counselling service, there were concerns about the demands that this research would place on my time, and indeed, on the time and resources of members of the counselling team and the agency administrative staff. I had to build a case for the studies that were carried out for this thesis, and negotiate ways of working that allowed me to meet my organisational commitments and at the same time carry out the research reported on in this thesis.

Another issue arising from my insider practitioner-researcher perspective was my awareness of feelings of anxiety among the volunteer counsellors within the MHSS counselling service about the prospect of participating in research that intended to evaluate their effectiveness, as in Study 1 described in section 3.3 of this thesis, and which also invited them to talk about their experience of training and client work within this agency, as in Study 2 described in section 3.4 of this thesis. This was
understandably a threatening prospect, especially when this research was being carried out by the service manager. It is conceivable that volunteer counsellors may have been hesitant about consenting to participate in the research because of a fear of negative evaluation, which in turn may have contributed to concerns about the impact that such a judgement may have had on their continuing involvement as volunteer counsellors within the agency.

More specifically, for Study 2 of this thesis I carried out semi-structured interviews with participants drawn from the volunteer counselling group which required attention to a number of issues related to the duality of my roles within the MHSS agency. In this instance, I had to ensure that I did not assume too much because of my ‘insider knowledge’ (Coghlan 2007), which may have prevented me from gathering detailed and rich accounts of participant experiences. It was also necessary to ensure that participants were reassured that expressing negative comments about any aspect of their involvement with the MHSS agency and its counselling service would be listened to and would not adversely their roles within the agency.

In summary, by considering the above issues reflexively the intention was to demonstrate transparency and awareness of my experience of the research process. In addition, by adhering to the ethical principles of informed consent, confidentiality, and maintaining the wellbeing of research participants I was able to manage the tensions and challenges that arose for me during this research, and explore their potential impact on the findings reported in Chapters 4, 5, and 6 of this thesis.
3.2 Part II – Method

3.2.1 Introduction
The research reported in this thesis employed a pluralist research methodology informed by an epistemological framework derived from a pragmatic social constructionist perspective. This approach was considered to be appropriate for a programme of research that incorporated both quantitative and qualitative methodologies, which set out to evaluate the effectiveness of a group of minimally trained/experienced volunteer mental health counsellors (Study 1), and to inquiry into their experiences of, and the meaning they attributed to, becoming paraprofessional counsellors (Study 2).

Part I of this chapter introduced and discussed the philosophical issues underpinning research involving people and then clarified the methodological approach that informed the design of this programme of research. This part of the chapter provides an overview of the research design and subsequently describes, in separate sections, the aims, research questions, participants, ethical issues, procedures, and methods of data collection and analysis for the two studies within this research project. Within each section, methodological issues specific to each study are also considered. The rationale for this was that Study 1 employed a quantitative methodology and Study 2 used a qualitative approach and each type of study gave rise to a variety of different methodological considerations. Although these two studies were distinct, it is important to highlight that each study formed part of a larger programme of research (outlined in section 3.2.2) and thus contributed to a fuller understanding of paraprofessional counsellors with minimally training/experience during the early
stages of their helping endeavours. The findings from this research are discussed in Chapter 7 of this thesis in relation to the literature that was reviewed in Chapter 2.

3.2.2 Overview of the research design

This research project involved carrying out two separate but related studies, which are outlined in Table 3.1.

<table>
<thead>
<tr>
<th>Design</th>
<th>Study 1</th>
<th>Study 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodology</td>
<td>Quantitative - benchmarking strategy to evaluate the clinical effectiveness of a group of minimally trained/experienced paraprofessional counsellors.</td>
<td>Qualitative - grounded theory approach (Charmaz 2006) to inquire into the meaning and experience of becoming a paraprofessional counsellor.</td>
</tr>
<tr>
<td>Method of data collection</td>
<td>CORE Outcome Measure (Evans et al. 2000) used to measure changes in client levels of distress on a session by session basis. Clients and counsellors also completed a range of additional self-report measures before and after counselling.</td>
<td>In depth audio recorded semi-structured interviews.</td>
</tr>
<tr>
<td>Sample</td>
<td>118 clients and 12 counsellors</td>
<td>8 paraprofessional counsellors, 7 of whom also participated in Study 1.</td>
</tr>
<tr>
<td>Method of data analysis</td>
<td>Clinical and reliable change scores, and effect size were calculated and compared with benchmark studies.</td>
<td>Grounded theory approach utilising constant comparison to elicit emergent themes/categories.</td>
</tr>
<tr>
<td>Tools Used in Data Storage/Analysis</td>
<td>Data were entered into and analysed using SPSS (Field 2009).</td>
<td>Use of word processor/index card system, memos and journal to carry out and manage data analysis.</td>
</tr>
</tbody>
</table>

Studides 1 and 2 detailed in Table 3.1 are related to an earlier study that involved an evaluation of a brief training programme for paraprofessional counsellors, which was
Chapter 3: Methodology and Method: Issues and choices

carried out as part of a Masters degree in Counselling Studies (Armstrong 2003). A
copy of this paper can be found in Appendix A of this thesis. Eight participants from
the earlier training study \((n = 12)\) were recruited into Study 1 \((n = 12)\). Of the four
people from the training study that were not recruited into Study 1, two people were
unable to progress their interest in becoming volunteer counsellors at that time
because of changing personal circumstances. Another person decided, in collaboration
with the counselling training team, that they were not yet ready to progress to client
work within the MHSS agency and went on to become involved in more generic
voluntary work with another MHSS service. The fourth person progressed to client
work but declined to participate in Study 1.

Table 3.2 below shows the counsellors that participated in both Study 1 and Study 2.
The numbers used to designate counsellors in column 1 of Table 3.1 are also used
throughout the remainder of this thesis, especially in Chapters 4 and 6 where the
results of Study 1 are reported. The pseudonyms listed in column two of Table 3.2
correspond to the counsellor number designation and are provided only for those
counsellors who participated in Study 2. Participant pseudonyms are used exclusively
to refer to participants in Chapter 5 where the findings of Study 2 are reported.

At the start of Study 1, 13 participants had been recruited to participate. Eight
participants had just completed the MHSS in-house brief counselling training and had
also participated in the training study referred to above. In addition to the eight people
recruited to Study 1 from the earlier training study, five other minimally
trained/experienced paraprofessional counsellors working in the MHSS counselling
service were recruited into Study 1. These five counsellors had already completed a
previous version of same in-house brief counselling training within the MHSS agency.

Counsellor 13 (pseudonym Lily in Study 2) detailed in Table 3.2 withdrew almost immediately from Study 1 and before any data were collected, which left a total of 12 participants – the ✓ representing her participation in Study 1 in Table 3.2 below is enclosed in parenthesis to indicate her initial consent to participate in Study 1 and subsequent withdrawal. The experiences of Counsellor 13/Lily are documented in Chapter 5 in relation to the findings of Study 2, and provide an insight into the possible reasons for her withdrawal from Study 1.

The same group of 8 people who were originally recruited into Study 1 from the Training Study (which included Counsellor 13/Lily) were interviewed for Study 2 (n = 8) after approximately one year of counselling practice experience.

Table 3.2 Participants who participated in Study 1 and Study 2 and the earlier Training Study

<table>
<thead>
<tr>
<th>Counsellor Study 1</th>
<th>Counsellor pseudonym Study 2</th>
<th>Study 1</th>
<th>Study 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Stephen</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>n/a</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Agnes</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4</td>
<td>n/a</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Tom</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6</td>
<td>Frances</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7</td>
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</tr>
<tr>
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<td>Amy</td>
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<tr>
<td>9</td>
<td>n/a</td>
<td>✓</td>
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<tr>
<td>10</td>
<td>Sophie</td>
<td>✓</td>
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</tr>
<tr>
<td>11</td>
<td>Margaret</td>
<td>✓</td>
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<td>12</td>
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<tr>
<td>13</td>
<td>Lily</td>
<td>✓</td>
<td>(✓)</td>
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</tbody>
</table>

The studies reported on in this thesis and the earlier training study form part of a larger programme of research into the training, effectiveness and development of
paraprofessional counsellors. Although each of these studies was distinct they were connected insofar as they all involved essentially the same group of paraprofessional counsellors from the same agency. The relationship between these studies is outlined in Figure 3.1.

Figure 3.1. Relationship between Masters and PhD research

<table>
<thead>
<tr>
<th>Masters Research - Phase 1</th>
<th>PhD Research - Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training Study ((n = 12))</td>
<td>Study 1 – Quantitative study ((n = 12), including 7 from training study)</td>
</tr>
<tr>
<td>7 participants from this study recruited to Study 1</td>
<td></td>
</tr>
<tr>
<td>Study 2 - Qualitative study ((n = 8), all from the training study – 7 of whom were also recruited to Study 1)</td>
<td></td>
</tr>
</tbody>
</table>

### 3.3 Study 1

#### 3.3.1 Aim
The aim of Study 1 was to evaluate the clinical effectiveness of a group of minimally trained/experienced volunteer (paraprofessional) mental health counsellors.

#### 3.3.2 Research questions
The primary research questions for Study 1 were:

1. How effective are minimally trained/experienced volunteer mental health counsellors working in a routine mental health practice setting?
Chapter 3: Methodology and Method: Issues and choices

2. Is there evidence of differential effectiveness among minimally trained/experienced volunteer mental health counsellors working in a routine mental health practice setting?

3.3.3 Methodological considerations in outcome research of counselling

3.3.3.1 Introduction

Counselling, as part of a wide range of psychological services, is now firmly embedded in healthcare settings in both the statutory and non-statutory sectors in Britain and in other countries as well. The increasing availability of such services has been accompanied by a concern by policy makers and practitioners to ensure that clients receive the best possible service, and a growing demand for therapists to be able to justify their practice. One of the most important (and earliest) issues for counselling and psychotherapy researchers, therefore, has concerned the evaluation of therapy outcome. Lambert et al. (1991) have suggested that counselling-outcome research is a crucial aspect of counselling services and is necessary to ensure the highest levels of ethical practice. It is not surprising therefore, that therapy researchers have expended a significant amount of time and effort attempting to answer one fundamental question: does counselling work (McLeod 1994)? This is not an easy or straightforward question to answer because counselling is a highly complex activity that involves a multiplicity of interacting factors. Consequently, there are a variety of methodological issues that need to be addressed in making choices about how best to assess counselling outcomes.

This section outlines the main aims of counselling outcome research and the research strategies that have been used to evaluate outcome. Subsequently, a discussion of the key methodological issues in assessing counselling outcomes precedes an argument
for the decision to employ a benchmarking strategy in Study 1 to evaluate the outcomes achieved in routine practice by a group of minimally trained/experienced volunteer mental health counsellors.

3.3.3.2 Outcome research in counselling: Aims and research strategies

Outcome research in counselling has been defined as “the experimental investigation of the impact of counselling on the client” (Lambert et al. 1991, p.52). Research strategies in the evaluation of counselling outcomes have evolved from single-subject case histories to highly complex experimental investigations that involve careful specification of treatments applied to specific client populations (Kendall et al. 2004). Lambert et al. (1991) have proposed that the goals of counselling outcome research can be grouped together according to three major categories of questions, which reflect the interests and focus of inquiry for different researchers as the profession has evolved. For instance, category one questions reflect the early interest in answering the general question of whether or not therapy was effective. Category two questions emerged from this earlier stage and were concerned with delineating the relationship between specific therapeutic ingredients and outcomes. Category three questions reflect more contemporary ambitions to determine how to improve or enhance the effects of well-established treatments of interventions.

Early outcome studies employed simple research designs that involved assessing clients before and after treatment on a range of dimensions pertinent to their life functioning. Although these studies facilitated an evaluation of outcome by therapists and independent practitioners they lacked methodological rigor because a simple pre-post treatment design cannot exclude the possibility that client change may have occurred simply due to the passage of time (Lambert et al. 1991). To overcome these
design weakness researchers began to use control procedures derived from experimental science in order to separate the effects of therapy from other factors such as the passage of time or client expectancy of change (Kendall et al. 2004). Studies of this kind set out to establish the ‘efficacy’ of a particular therapeutic approach or intervention and are typically carried out in highly controlled situations such as those found in randomised controlled trials (RCTs). Efficacy studies can be contrasted with ‘effectiveness’ studies which aim to determine the extent to which an approach or intervention is effective under normal day to day practice conditions.

Another strategy has been to use research designs that are aimed at comparing the differential effectiveness of different models of therapy, specific components of treatment or differences among therapists within treatments (Kendall et al. 2004). The latter strategy is typical of studies comparing the relative effectiveness of professional versus paraprofessional therapists, which is of particular interest to the research reported on in this thesis.

Outcome research, therefore, is predominantly concerned with “comparing one group of participants that receives an experimental treatment with another group – the comparison group – that does not receive the treatment” (Heppner et al. 1999, p.386). Consequently, there is a predominance of experimental or quasi-experimental designs which give rise to a number of methodological issues when conducting outcome research. The following sections address key methodological issues in relation to: a) threats to validity; b) the use of control or comparison groups; c) treatment fidelity; and d) the measurement of change.
3.3.3.3 Threats to validity

The concepts of internal and external validity (Campbell and Stanley 1963) represent the broad range of methodological difficulties associated with carrying out outcome studies in counselling (McLeod 2003a). Internal validity within a study refers to the degree to which competing explanations that may account for client outcomes have been eliminated so that causal relationships between treatment and outcome can be inferred (Lambert et al. 1991; Roth and Fonagy 2004). A variety of factors can undermine the internal validity of a study and thus provide alternative or competing hypotheses to account for the outcomes of a study other than the treatment intervention. The most common threats to internal validity are statistical regression, selection biases, differential attrition rates between treatment and control groups, and external events (Lambert et al. 1991).

Kendall et al. (2004) have proposed that outcome researchers should strive to design studies that have high degrees of internal validity in order to enhance the methodological rigour of studies. However, these and other authors also recognise that ethical, financial and practical considerations mean that not all studies will achieve such methodologically rigorous standards (Lambert et al. 1991; McLeod 2003a; Roth and Fonagy 2004). According to McLeod (2003a), the reason that these problems arise in the first place is because outcome researchers have largely adapted a laboratory-based experimental design to what is essentially a real world applied problem. As a consequence, such highly controlled 'efficacy' studies may have little relevance to the real-world everyday practice of counsellors and psychotherapists. The key issue in striving for such methodological rigor is to be able to isolate the factor or factors responsible for therapeutic change so that the results of any given study can be
interpreted unambiguously.

External validity is concerned with the extent to which the findings from a study can be meaningfully generalised to other external settings, clients and counsellors (Lambert et al. 1991; McLeod 2003a). Studies that closely resemble the conditions of routine counselling practice have been characterised by designs that are weighted toward high generalisability and thus possess higher levels of external validity than ‘efficacy’ studies. The limitations of this kind of ‘effectiveness’ research is that there are greater threats to internal validity, which limits the inferences that can be made between treatment variables and counselling outcomes (Roth and Fonagy 2004).

In summary, outcome researchers have privileged experimental research designs that maximise internal validity within studies in order to adequately assess the causal relationships between therapeutic interventions and their impact on clients. This strategy has resulted in a preference in the use of control or comparison groups in outcome research, which in turn, has contributed to difficulties in managing attrition from studies and in assessing the fidelity of treatment delivered by different therapists. These issues are considered next and lead into a consideration of the critical issue of how client change is defined and measured in outcome research.

3.3.3.4 Control groups, attrition and treatment fidelity

The use of control groups in counselling outcome research evolved as a way of achieving high levels methodological rigor within studies. Typically, studies of this kind randomly assign participants to one of two conditions. To ensure comparability in each condition, participants are assessed to ensure compatibility on a range of psychosocial dimensions such as age, gender, ethnicity, presenting problems, levels
and duration of distress and so on. In studies that use control or comparison groups researchers need to decide which type of control group or condition to use. In general, the choice has been between no-treatment, waiting list, attention-placebo or standard/treatment as usual (Kendall et al. 2004). Each of these strategies raises a range of methodological problems in relation to ethical issues, credibility or adequacy of the control condition and the practicality of employing a particular type of control.

For example, the use of waiting list controls are limited by the fact that it is difficult to ensure clients will remain on the waiting list and not seek alternative treatment (Timulak 2008). In addition, withholding treatment from clients who are actively seeking help raises serious ethical concerns (Kendall et al. 2004). Nevertheless, the waiting list condition allows some more control of treatment variables than the no treatment condition (Kendall et al. 2004).

An alternative approach has been to use placebo controls, which have been inspired by the use of placebos in pharmacological research (Timulak 2008). The rationale behind this kind of control condition is to eliminate or control for client expectancy and hope as rival hypothesis to the active treatment condition in accounting for client outcomes. In doing so, researchers hope to be able to identify the specific therapeutic interventions that produce client change beyond those that could be attributed to the effects of non-specific factors (Kendall et al. 2004). However, as Wampold (2001) has commented, it is virtually impossible to construct placebos that reflect the same non-specific factors in terms of quality and quantity that exist in the psychotherapeutic encounter.
Yet another strategy involves the use of standard/treatment as usual controls in order to compare and evaluate new interventions. This method is limited by the fact that it is largely only appropriate in situations where the standard treatment has been shown to be superior to conditions that control for competing explanations of outcome (Kendall et al. 2004). The most frequent control used by contemporary researchers involves alternative therapy control groups (Timulak 2008). Despite their popularity there are also limitations inherent in this strategy, such as alternative treatments being implemented with less integrity than in the experimental condition (Heppner et al. 1999).

In addition to the methodological challenges associated with the use of control groups, outcome researchers must also find ways to address the loss of participants from control and experimental conditions and to ensure the fidelity of treatment across different therapists in any given study. With regard to the latter, researchers have relied on the use of manualised treatment to maximise consistency of approach in the way an intervention is delivered, and thus maximise the internal validity of a study (Timulak 2008). There is a great deal of controversy surrounding which type of control group is most appropriate. However, the key point to acknowledge is that each strategy has inherent strengths and limitations. Consequently, it is essential that researchers interpret and evaluate the results of their studies with due regard for the limitations of the approach they employed (Heppner et al. 1999).

3.3.3.5 Issues in the measurement of change: Statistical versus clinical significance of change, effect size

A fundamental methodological issue in counselling outcome research concerns the question of how best to assess client change (Heppner et al. 1999; Kendall et al. 2004;
McLeod 2003a). The diversity of counselling theories and approaches that currently exist has contributed to the development of a vast array of outcome measures and strategies to assess client change. This is partly a function of the fact that researchers influenced by different theoretical perspectives have developed measures that are aimed at assessing change in terms of the theoretical constructs hypothesised within their particular model. Thus, the outcomes from any given study are likely to be heavily dependent on the perspective that is being assessed (Heppner et al. 1999). It appears that outcome is very much dependent upon the source that provides the data (e.g., client, therapist, significant other), the method of data collection and on the dimensions of client functioning at which counselling was directed (Lambert et al. 1991). Current best practice suggests that outcome is best assessed by: 1) clearly defining what is being measured; 2) including multiple perspectives (e.g., client and therapist) and measurement scales; 3) using pan-theoretical measures; and 4) evaluating change over time (Kendall et al. 2004; Roth and Fonagy 2004). This strategy may well represent an ideal that is largely unobtainable for many researchers due to practical factors and resource limitations (McLeod 2003a).

In addition to the issue of measurement strategies, outcome researchers have also debated the most appropriate statistical techniques to use in assessing client scores on an outcome measure (McLeod 2003a). In general, the outcomes of counselling for clients have been expressed by using three groups of statistics: statistical significance of within-group and between group differences, effect size and clinical significance (Lambert et al. 2008). These are briefly discussed below.

A central debate in relation to how best to assess counselling outcomes involves
arguments about the relative merits of statistical versus clinical significance criteria for change. For the most part, results of studies have been reported in terms of statistical significance levels. This approach involves comparing the mean scores of a group of participants on measures taken before counselling with those taken after counselling and then applying statistical tests to determine if the difference is attributable to chance or whether it is possible to infer that the difference can reasonably be attributed to the effects of counselling (Heppner et al. 1999; McLeod 2003a). This strategy has been criticised on the grounds that it obscures the meaningfulness of change for individual clients. This is because statistical comparisons within and between groups are based on the average improvement score for all clients and consequently they do not provide any information on the impact of counselling for individual clients in any given study (Jacobson et al. 1984). For instance, it is possible for a study to achieve statistically significant differences between treatment groups but fail to produce any meaningful differences in client well-being and day to day functioning (Lambert et al. 2008; Lambert and Hill 1994).

An alternative strategy involves assessing counselling outcomes in relation to the meaningfulness and magnitude of change for individual clients following their participation in counselling. Jacobson and colleagues (Jacobson et al. 1984; Jacobson and Truax 1991), for example, have argued that outcomes should be reported on the basis of: a) whether clients’ post-counselling scores on an outcome measure have moved from the dysfunctional to the functional range; and b) should be assessed against a reliable change index. Assessment of change in relation to these criteria requires that norms are established for the functional population (Kendall et al. 2004). This may not always be possible and furthermore, the criterion of movement into the
functional or 'normal' range of functioning may be unobtainable for some clients and populations (McLeod 2003a).

3.3.3.6 **Summary of methodological issues in counselling outcome research**

This section has reviewed the key methodological issues associated with outcome research in counselling. The evaluation of the impact of counselling on client well-being and functioning is not only important in contributing to ethical practice, but also because it plays a crucial role in demonstrating to resource providers such as government bodies that counselling is effective. A lack of sophistication in the design of early outcome studies left many questions unanswered. Subsequently, researchers began to use highly controlled experimental designs to determine the efficacy of counselling approaches and interventions. Typically, this involves the random assignment of clients to either a treatment group or an appropriate control group that do not receive treatment. The use of control groups in outcome research is important because they help to eliminate confounding factors which may account for client change in relation to the treatment being evaluated. This strategy has been referred to as efficacy research and is characteristic of well-controlled outcome studies which possess high levels of internal validity. However, efficacy research may have little relevance to everyday counselling practice. Consequently, the use of effectiveness studies has become popular in assessing the outcome of counselling in routine practice settings.

Another significant methodological issue concerns the question of how to measure the impact of counselling for clients. A multitude of outcome measures have been used that are often derived from the theoretical constructs pertinent to particular models of counselling, which has made it difficult to interpret and evaluate findings across
studies. In addition, data has been collected from diverse sources: therapists, clients, and significant others, for example. The key methodological issue here is that findings can vary depending on the source of data collection. It was noted that it is important to include multiple data sources and to include standardised outcome measures where possible. Finally, the debate surrounding which statistical tests are most appropriate to use in evaluating outcomes was briefly discussed. The relative merits of statistical versus clinical significance testing were also highlighted.

The following section puts forward an argument for the use of a benchmarking strategy as a practical method of evaluating counselling outcomes which address many of the practical and resource implications of carrying out efficacy studies. It is argued that this is a valuable strategy in fulfilling the aims and research questions pursued in Study 1.

3.3.4 Benchmarking
Benchmarking provides a practical method for evaluating treatment outcomes in applied settings against findings from published research (Weersing, 2005). To date, this method has involved either selecting a best practice benchmark from published clinical trials or creating one from analysis of existing published literature (Weersing and Weisz, 2002; Weersing, 2005). Benchmarking strategies have largely been used to determine the extent to which empirically supported treatments (EST) generalise from highly controlled research environments to practice settings (Weersing and Weisz, 2002). Typically, this method involves comparing, on a point by point basis, the outcomes achieved following delivery of the EST in the practice setting to those obtained in one or more randomized controlled trials (RCTs) using the same outcome measures and definitions of improvement.
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An overarching concern pertaining to this traditional type of benchmarking strategy is that simplistic numeric comparisons between the outcomes achieved in clinical trials and those in naturalistic settings may obscure the numerous differences that exist in these conditions (Weersing, 2002). For example, clients typically have to meet stringent inclusion/exclusion criteria to be selected for participation in clinical trials whereas clients seen in routine practice present a more diffuse range of problems and concerns. Likewise, therapists in RCTs are generally selected for their levels of expertise and training and follow highly structured, manualised treatment protocols, whereas therapists in routine practice operate more flexibly. Minami et al. (2007) argue that despite these difficulties benchmarks from clinical trials should be regarded as the best practice standard to strive for precisely because of their observed efficacy under such rigorous conditions. It is important to note that RCTs of psychotherapy have important limitations, which may compromise their privileged position as a ‘gold standard’ benchmark of best practice. Luborsky et al. (1999), for instance, noted that researcher allegiance to a preferred model/treatment could account for more than two-thirds of the outcome variance in comparisons of treatment efficacy.

Notwithstanding these difficulties, a major advantage of a benchmarking strategy from a practice perspective is that it addresses many of the practical and resource implications associated with carrying out large scale RCTs as well as some of the attendant ethical concerns such as the use of control groups where treatment is delayed or withheld.

In the UK, benchmarking has become an established activity within NHS primary care psychological therapy and counselling services in particular. The development of
the CORE-OM (Evans et al. 2000), described below, and the subsequent creation of a series of CORE Research Databases (Mellor-Clark et al. 2006), into which services donate CORE-OM data, has made it possible to create outcome benchmarks at the level of individual therapists and also at a service level. While such benchmarks are not precise measurements (Barkham 2006), they provide useful reference points that can be used to interpret and evaluate the outcomes achieved by individual counsellors, psychotherapists and services.

3.3.5 Design
Study 1 employed a standardised outcome measure, the CORE-OM (Evans et al. 2000), to measure changes in client levels of distress on a session by session basis. Clients and counsellors also completed a range of additional self-report measures before and after counselling. A benchmarking strategy, described in the following sections, was used to interpret and evaluate the outcomes achieved by the paraprofessional counsellors in this study against to those achieved by professional therapists working with a client population that were similar to those in the present study in terms of types and levels of presenting distress.

3.3.6 Benchmarking strategy used in this study
A research standard of effectiveness of professional therapists within a UK context was sought. Three published studies were identified and used as benchmarks against which to interpret and evaluate the outcomes achieved by participants in the present study. These were: a) CORE-OM benchmarks for counselling and psychological therapies as delivered in routine NHS primary care settings (Mullin et al. 2006); and b) the findings from two large scale studies of professional therapists working mainly in primary care settings in the UK, which used the CORE-OM to measure rates of clients’ recovery and improvement (Stiles et al. 2008; 2006).
The reasons for selecting these outcome benchmarks were: a) all benchmark studies used the same outcome measure as the one used in the present study, which meant comparison of outcomes and exploration of reasons for any differences would be facilitated; b) they reflected routine care delivered within a UK context by professional therapists, which could be compared with routine counselling delivered by the sample of minimally trained/experienced volunteers in the present study; and c) the client population in the study reported here and in the benchmark studies were broadly similar in terms of the types and levels of distress at in-take. The benchmark studies are outlined below.

3.3.6.1 Summary of benchmark studies

The study by Mullin et al. (2006) aimed to establish outcome benchmarks for client recovery and improvement in routine primary care psychological services at the level of services and individual practitioners. Rates of no reliable change and deterioration were also recorded. The intention was to establish practice-based benchmarks against which services and practitioners could make comparisons. A data set drawn from the CORE National Research Database (Mellor-Clark et al. 2006) comprising approximately 11,000 clients who completed the CORE-OM pre- and post-therapy from thirty-two primary care NHS services was used. Outcomes were assessed in relation to four categories: recovery, improvement, no reliable change, and reliable deterioration. The mean CORE-OM clinical scores for men and women in relation to these categories were calculated.

Clients presented with problems related to depression, anxiety and interpersonal problems primarily. Approximately 28% of clients were male and 72% were female.
There were 513 therapists, each of whom saw an average of 23 clients. Therapist levels of training and experience were not recorded.

The Stiles et al. (2008; 2006) studies set out to evaluate the effectiveness of routine practice of cognitive-behavioural, person-centred and psychodynamic therapies in National Health Service (NHS) settings. In both studies, effectiveness was assessed by comparing pre-treatment and post-treatment scores on the CORE-OM. Therapists' characteristics such as level of training or experience were not recorded in either study. The Stiles et al. (2006) study comprised 1309 patients across 58 NHS primary and secondary care sites during a three-year period. Patients typically presented with problems related to anxiety, depression, interpersonal problems and self-esteem. Most patients were seen in primary care counselling services (64.5%) or psychology and counselling services (22.8%). Fewer clients were seen in secondary care psychology services (10.4%) or tertiary care/specialist services (3.3%). This study concluded that routine practice for these three approaches tended to produce equivalent outcomes.

Stiles and colleagues (2008) replicated their earlier study (Stiles et al. 2006) in a larger sample ($n = 5613$), and focused on thirty-two NHS primary care settings only during a three-year period. Treatment approaches and client presenting problems were similar. Findings replicated those of the earlier study. For comparison purposes in the present study, it was assumed, because details of therapist characteristics were not available, that the therapists in Mullen et al. (2006) and the Stiles et al. (2008; 2006) studies were fully trained, professional practitioners. The basis for this assumption was that: a) the Stiles et al. (2008; 2006) studies were comparing professional treatments which were presumably delivered by fully qualified and experienced
practitioners; and b) counsellors working in primary care, as in the Mullin et al. (2006) study, are generally required to meet minimum standards of professional training and experience to be eligible to practice as primary care counsellors, which exceed those of the participants in the present study. Bond (2002), for example, has indicated that a minimum of 450 hours training and 250 hours of supervised practice over two years are essential characteristics of counsellors working in primary care.

3.3.7 The setting
The setting for this study was a medium sized inner city voluntary organisation based in the west of Scotland. For the purposes of protecting confidentiality this organisation is referred to as Mental Health Support Services agency (MHSS) throughout this thesis. The organisation provided a range of community-based mental health services, including one-to-one counselling, to people experiencing mental health problems. Counselling was offered within a brief counselling framework of six to twelve sessions. Additional sessions were sometimes offered depending on a client’s needs. The service comprised both full-time and part-time paid counsellors and also recruited and trained volunteer counsellors to work within the service who did not receive any payment for their work other than minimal expenses such as travelling costs. The service received core funding from the local authority and had several contracts with local GP practices to provide counselling to their patients. The findings reported below relate to a group of volunteer counsellors operating within this agency at a specific point in time and are therefore not an evaluation of the effectiveness of the service as a whole.

3.3.8 Participants
Clients: Data were collected on 171 clients who attended the agency for routine counselling over a 1 year period. Of these, 53 clients were excluded because they did
not return pre- or post-counselling CORE-OM forms. 7 clients returned post-
counselling forms but not pre-counselling forms; 46 clients completed a pre-
counselling form but did not return any subsequent CORE forms following individual
sessions or post counselling. The latter category included clients who attended only
one counselling session and ended counselling; and clients who returned a pre-
counselling form and attended several sessions but who then dropped out of
counselling prematurely without returning a post-counselling form. The remaining
118 clients presented with a range of mental health problems, which are described
later. Clients ($n = 118$) accessed the service via their GPs (70%), other NHS
professionals (10%), local voluntary organisations (18%) and self-referrals (2%).
Counselling sessions took place in a variety of locations in the local area including the
main office base of the agency, satellite offices and also in rooms in local health
centres. Clients’ use of prescribed psychotropic medication was not recorded.

Counsellors: 13 volunteer counsellors working within the agency’s counselling
service were recruited to participate in this study. However, one participant
(Counsellor 13, see section 3.2.2 of this chapter) withdrew almost immediately
following consenting to participate and before any data were collected. Study 1,
therefore, was based on a total sample of 12 volunteers. This group of 12 participants
comprised 3 male and 9 female counsellors from a ‘White British/European’
background living in the local area. Counsellors’ ages ranged from 25 to 64 years with
a mean age of 44 years. All participants had completed 40 hours of counselling
training provided by the agency (Armstrong 2003), which introduced participants to
the general framework of the solution-focused approach (O’Connell 1998) and also
emphasised the importance of common factors (Miller et al. 1997) in effective helping.

In addition to this basic training, five participants had certificate level training in counselling skills equivalent to 120 hours: three of whom also had between 75 and 100 hours practice experience as a volunteer. At the start of this study, six counsellors did not have any prior counselling or helping experience at all (which included two counsellors who held certificate level training). Six people (including three with certificates) had completed up to 150 hours of client work. This experience was gained in the agency where this study was carried out (5 people) or through being a telephone helpline counsellor in another organisation (1 person). Counsellors contributed an average of 5 hours counselling per week, which included time for administrative tasks and supervision. Two counsellors contributed up to 10 hours per week and saw significantly more clients that the other counsellors (i.e., Counsellors 4 and 7 detailed in Table 3.1 in section 3.2.2 above).

3.3.9 Measures

3.3.9.1 CORE Outcome Measure

The CORE-OM (see Appendix B) is a 34 item self-report measure comprising domains of subjective well-being, commonly experienced problems or symptoms, functioning and risk (Barkham et al. 2006). Items are scored on a five-point (0-4) scale defined as Not at all, Only occasionally, Sometimes, Often, and All or most of the time. An overall score can range from 0 to 40 and is calculated as the mean of completed item responses, which is multiplied by 10 to represent scores as whole numbers. A score of 10 has been established as a cut-off between clinical and non-clinical populations. Reliable change is defined as a pre-post difference (i.e., decrease)
of five points. Clinical change is defined as movement from the clinical population (i.e., a score of 10 and above) to the non-clinical population (below 10) (Barkham et al. 2006). Internal consistency and test-retest reliability has been reported at 0.94 and 0.90 respectively (Evans et al. 2002).

3.3.9.2 Reason for Attending Counselling Questionnaire
This brief self-report questionnaire was designed for use in this study. It collected basic demographic information on clients, type and duration of their presenting problems and details of previous psychological help (Appendix C contains a copy of this questionnaire).

3.3.9.3 Client View of Outcome Questionnaire
This questionnaire, available in Appendix D, was constructed for use in this study and incorporated items related to clients’ perceptions of the overall helpfulness of counselling, their general satisfaction with their counsellor and the most and least helpful aspects of counselling.

3.3.9.4 End of Counselling Form
This form, designed for use in this study, was completed by counsellors at the end of counselling. It collected audit information such as the number of sessions attended and missed, reason for ending and source of referral. Free-response items were also included which invited counsellors to comment on how the counselling could have been improved and what they had learned form working with this client, for example. (Please refer to Appendix E to view a copy of this form).

3.3.10 Ethical approval
Ethical approval was obtained from the Research Ethics Committee within the School of Social and Health Sciences of the University of Abertay Dundee.
3.3.11 Procedure

Informed consent was obtained from all participants before any data were collected. Counsellors and clients were invited in writing to participate in this study – copies of client and counsellor information sheets and consent forms are provided in Appendices F and G. It was emphasised that they were not required to participate and that choosing not to be involved would not disadvantage them (as clients or volunteer counsellors) in any way. Counsellors completed an ‘In-take form’ (see Appendix H) on recruitment to the study, which recorded basic demographic details together with information about their levels of training and experience in counselling. Over a 12 month period, all clients allocated to participating counsellors were invited to participate in the research. An information sheet about the study and consent form was posted to each client in advance of their first session.

On arrival for their first appointment, the counsellor asked each client if they had received the information and briefly answered any questions about the study. Clients who consented to participate signed a consent form and then completed the ‘Reasons for attending counselling questionnaire’ and the CORE-OM. The CORE-OM was also completed by clients at each subsequent session, including the last counselling session. Immediately after the last counselling session, clients completed the ‘Client view of outcome questionnaire’ and counsellors completed the ‘End of counselling form’. A comprehensive network of informal support and supervision was established for counsellors to ensure both their own and their clients’ wellbeing and safety.

3.3.12 Data analysis

Data from all self-report questionnaires and the CORE-OM data were entered into SPSS and checked. Results are presented in Chapters 4 and 6 of this thesis.
3.4 Study 2

3.4.1 Aim
The aim of Study 2 was to explore the meaning and experience of becoming a paraprofessional counsellor for a group of minimally trained/experienced volunteer mental health counsellors. This study aimed to gain a deeper understanding of the reasons why people become paraprofessional counsellors, the impact of training, entering practice and client work on the development of competence and awareness in this group of practitioners. In essence, this study was interested in the story of each counsellor’s development as a paraprofessional counsellor.

3.4.2 Research questions
The research questions were:

1. How do paraprofessional counsellors account for their interest and engagement in the activity of counselling?
2. What is the meaning of counselling training for paraprofessional counsellors in relation to their development?
3. How does the experience of client work impact on paraprofessional counsellors?
4. What are the processes involved in the development of competence and awareness in paraprofessional counsellors?

3.4.3 Methodological considerations in qualitative research
The questions pursued in Study 2 are concerned with the subjective meanings that participants attributed to the experience of becoming paraprofessional counsellors. Consequently, it was decided that a qualitative methodology informed by social constructionism would be the most appropriate research strategy to adopt to address these questions. As noted in section 3.1.4 of this chapter, this perspective is grounded
in a relativist stance that attempts to honour a multiplicity of worldviews without privileging any one perspective. Section 3.1.5 highlighted the problems associated with a thoroughly relativist stance and proposed that the philosophy of pragmatism could be used in conjunction with a social constructionist perspective as a way of making practical decisions, and to evaluate the multitude of ideas that emerge within a theoretical framework informed by social constructionism.

3.4.3.1 What is qualitative research?

Qualitative research is a multifaceted field of inquiry, which traverses different disciplines, fields and subject matters (Denzin and Lincoln 2005). In contrast to quantitative methodologies, which seek objectivity, qualitative research is concerned with exploring subjectivity. “This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them” (Denzin and Lincoln 2005, p. 3).

Qualitative data generally consists of verbal or written representations of some aspect of human experience. However, the fundamental “aim of all qualitative data collection techniques is to generate a qualitative text which will form the basis for analysis and interpretation” (McLeod 1999, p.123). There exists a variety of methods for collecting qualitative data such as interviewing, the use of diaries, observational methods and the use of open-ended questionnaires. Within the field of counselling the most frequently used method is the semi-structured interview (Kvale 2007; McLeod 1999), where the researcher determines a set of topics around which questions are framed for the participant. This method is discussed in more detail below at section 3.4.3.6.
Although there are a diversity of traditions and data gathering techniques within the field of qualitative research, all qualitative approaches aim to develop an understanding of how the world is constructed (McLeod 2001b). This highlights an important distinction between quantitative and qualitative epistemologies in that the former sets out to observe, measure and quantify human action and draw conclusions from data in order to establish general trends or laws that are universally applicable, whereas the latter is concerned with constructing local knowledges that do not claim to be generalisable to people outside of the group that were studied. In effect, quantitative research aims to represent the world as it is assumed to exist in reality whereas qualitative epistemologies acknowledge the constructed nature of the world.

Implicit in qualitative research, therefore, is the idea that we “inhabit a social, personal and relational world that is complex, layered, and can be viewed from different perspectives” (McLeod 2001b, p.2); and furthermore, that the social world is multiply constructed in and through language and other social practices and activities. A consequence of taking this perspective is that the knowledge claims that emerge from qualitative research are necessarily tentative and temporary because it is accepted that it is not possible to arrive at a ‘true’ understanding of how the world is constructed. Instead, the findings from qualitative studies contribute to new ways of understanding aspects of human experience which may generate new possibilities for action (McLeod 2001b).

Within the academic community, the value of qualitative research has been challenged on the grounds that it is unscientific, merely exploratory and subjective, and that it resembles literary criticism rather than theory or science (Denzin and
Lincoln 2005). Consequently, a significant issue for qualitative research concerns the soundness or validity of the knowledge it produces. At the heart of such negative evaluation lies an enduring epistemological debate (that was referred to in earlier sections of this chapter) within the social sciences that centre on the issue of what counts as valid, scientific knowledge. This is also a political critique insofar as qualitative research is regarded as an assault on the positivist tradition and by implication, an attack on reason and truth (Denzin and Lincoln 2005). In contrast, qualitative researchers argue that “the positivist science attack on qualitative research is regarded as an attempt to legislate one version of truth over another” (Denzin and Lincoln 2005). The consequences of this may have far-reaching implications, especially when one considers how findings from research may be used to inform social policy.

These key criticisms form the backdrop to a range of methodological issues associated with qualitative research, which reflect questions about how best to assess the quality of a piece of qualitative research. The issues of reliability, validity and truth as they pertain to qualitative research are addressed in the following section.

3.4.3.2 Validity and reliability in qualitative research

Qualitative researchers must address a range of methodological issues that coalesce around the question of how best to assess or make judgements about the quality of a piece of research (McLeod 2001b). At the heart of this matter is the fact that qualitative research is underpinned by a relativist philosophical stance in relation to knowledge. As a consequence, the concepts of validity and reliability associated with positivist quantitative research are of limited value when applied to qualitative studies. This section discusses these concepts in relation to qualitative research.
Validity is another word for truth and originated in quantitative (positivist) research (Silverman 2001). Broadly speaking, validity is concerned with the extent to which findings from a study can be judged to be well-founded, valid or 'true'. Within the quantitative tradition validity encompasses four types of experimental validity: internal; external; construct and statistical conclusion validity (Kazdin 1994). Each of these types of validity combines to defend against a variety of threats that may compromise the robustness and validity of the interpretation of findings from a research study. For example, the concepts of internal and external validity were outlined in section 3.3.3 above.

The rationale and logic of justification for the construct of validity makes sense within a quantitative/positivistic approach that is underpinned by a belief in a unitary external reality that is accessible through a value-free objectivist science. However, because qualitative research is informed by a philosophical stance that does not assume the existence of a fixed knowable reality independent of observation, and is primarily concerned with the world of lived experience and in developing rich, detailed and holistic accounts of human experience, the reductionism associated with the concept of validity in quantitative research is of questionable value in qualitative research. Ultimately, for instance, quantitative researchers arrive at judgements of validity (and reliability) by applying standardised statistical tests and comparing sets of numbers whereas qualitative researchers can only compare sets of words (McLeod 2001b).

The ambiguous nature of meaning within language makes it difficult to arrive at absolute or universal representations of people's experiences. This is because words
hold different meanings for different people and in different contexts, and also because events may be constructed differently from different perspectives. This gives rise to a further methodological issue to do with determining the ‘reliability’ of the findings from a qualitative study. Reliability is another term that is rooted in experimental science that can be defined in terms of the possibility of different researchers obtaining the same results on two separate occasions (McLeod 2001b).

A key issue underpinning these issues concerns the question of how best to assess the quality of a piece of qualitative that provide some kind of basis upon which to defend against criticisms (Flick 2009; McLeod 1999). This concern has contributed to attempts by a number of qualitative researchers to develop quality control criteria to enhance the ‘truth-value’ of a qualitative study. These are discussed next.

3.4.3.3 Quality and credibility in qualitative research

Silverman (2001) argues that while the concepts of validity and reliability of positivistic science may not be appropriate when applied to qualitative research, it is essential that qualitative researchers strive for equally stringent criteria for assessing the ‘truth-value’ or validity of the knowledge produced by qualitative research. There appears to be some agreement among qualitative researchers over the value of establishing quality control criteria: but exactly what these criteria should comprise has been the subject of a long debate. A central tension in this debate concerns, on the one hand, an acknowledgement of the requirement for quality, but on the other, a concern not to compromise the underpinning philosophical stance that reflects a view of research participants as purposeful, reflexive agents, and an image of the researcher as involved (McLeod 2001b).
Chapter 3: Methodology and Method: Issues and choices

Flick (2009) has observed that in their pursuit of quality, qualitative researchers have adopted three approaches to assessing the procedure and results of qualitative research. One approach has been to import and transform the meaning of positivistic concepts such as validity and reliability and their associated procedures in an attempt to establish some scientific credibility for qualitative research. Another strategy has been to develop 'method-appropriate criteria' which honours the theoretical and philosophical background of qualitative research. And yet another approach has been to call into question the value and utility of searching for quality criteria given the nature of qualitative inquiry.

An inevitable outcome of efforts to define quality criteria in qualitative research has been the emergence of different terms to reflect the distinctive nature of qualitative research. Heron (1996), for instance, has noted that validity has became a matter of establishing the trustworthiness of the findings of a qualitative study and the term reliability has been translated as dependability. The concept of authenticity has also been proposed to be a significant feature of good qualitative research (Lincoln and Guba 1985).

Regardless of the particular terminology that is employed, the central issue is about demonstrating that the knowledge claims of qualitative research are well-founded, 'true' or valid. A number of prominent qualitative researchers have proposed criteria and guidelines for enhancing and ensuring quality in qualitative research. Morrow (2005) has argued that questions of quality or validity in qualitative research are in many ways bound to the particular paradigm or philosophical perspective underpinning the research, and consequently, particular standards of trustworthiness

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emerge from, and are most consistent with, particular paradigms. For example, the
criteria for assessing trustworthiness in a study underpinned by a postpositivist
perspective will be different to the standards in a study informed by social
collection (Morrow 2005). Even so, the qualitative research endeavour requires
the researcher to attend to a number of particular issues that transcend these
philosophical concerns, such as subjectivity and reflexivity, the social validity of the
research, and the adequacy of data and its interpretation (Morrow 2005).

In a similar vein, Williams and Morrow (2009) have articulated a pan-paradigmatic
perspective for achieving trustworthiness in qualitative research, and emphasise the
need for a shared language that all researchers can understand in order to reduce
confusion between qualitative researchers and those more firmly located in a
quantitative tradition. The Williams and Morrow (2009) paper is interesting insofar as
the authors represent different qualitative research traditions and have attempted to
distil the critical elements of trustworthiness in qualitative research from their
knowledge and experience of grounded theory methodology and consensual
qualitative research. According to Williams and Morrow (2009), the features that are
essential to ensure trustworthiness include: a) integrity of the data – e.g., clearly
articulating the methods and analytic strategies, providing evidence that sufficient
quantity and quality of data has been collected, demonstrating how researcher
interpretations fit the data; b) achieving a balance between participant meaning and
researcher interpretation – e.g., acknowledging subjectivity and addressing researcher
bias through reflexivity; and c) clear communication of the findings and their
application in relation to context, current theory, and existing literature.
Elliott et al. (1999) have presented a set of evolving guidelines for reviewing and publishing qualitative research in psychology and related fields in an attempt to legitimise qualitative research, enhance its quality, and foster more scientific reviews and the further development of qualitative research. They identified a set of criteria of what constitutes good practice in qualitative research from an extensive consultation process across a range of professional groups. The criteria comprised a list of seven criterion: 1) owning one’s perspective; 2) situating the sample; 3) grounding in examples; 4) providing credibility checks; 5) coherence; accomplishing general vs. specific research tasks; and 7) resonating with readers.

McLeod (2001b) has noted that the value of the evolving guidelines developed by Elliott et al. (1999) is that they provide qualitative researchers with a language and a set of parameters that facilitates evaluation of their work; however, he also questions the extent to which they advance the debate around quality in qualitative research. For McLeod (2001b), "There is no straightforward 'quality criteria' that can be applied in any kind of automatic fashion" (p. 189), instead, the issue of quality comes down to questions of what makes a research report interesting, evocative, and useful to the extent to which findings from qualitative studies will facilitate changes in practice among counsellors and psychotherapists and agency administrators. McLeod (2001b) cites the guidelines developed by Stiles (1993), which call for clarity of explication of methods, presenting sufficient evidence, and establishing credibility through 'member checking' and triangulation, as representing a definitive guide for good practice in this area.

In conclusion, the question of what sort of criteria are appropriate for guiding and
evaluating the quality and credibility of qualitative research has been the subject of an ongoing debate among qualitative researchers (Barker and Pistrang 2005). The issue of quality in qualitative research has emerged in part because the concepts of reliability and validity associated with traditional quantitative approaches do not easily translate to qualitative inquiry (Barker and Pistrang 2005). Hence, qualitative researchers have attempted to articulate criteria and guidelines deemed to be more appropriate to the distinctive features of qualitative approaches. The different sets of guidelines and quality criteria that are available represent attempts of enhance the methodological rigor of qualitative research. However, for some qualitative researchers the idea of specific quality criteria can lead to difficulties in assessing the extent to which specific criteria have been sufficiently addressed (Flick 2009; McLeod 2001b). Even general formulations of quality criteria such as those proposed by Elliott et al. (1999) have not been universally accepted (see Reicher 2000). The difficulties and dilemmas associated with framing the ‘real’ qualities of qualitative research in criteria has prompted the argument that a more fruitful direction may be in pursuing strategies of quality assessment rather than formulating criteria (Flick 2009).

3.4.3.4 Quality standards used in Study 2 of this thesis

A variety of procedures were used in this thesis in relation to Study 2 to demonstrate the truth-value of this study. Stiles’ (1993) good practice guidelines for qualitative research design were employed as an underpinning quality framework for Study 2 for this thesis. The key quality control strategies adopted included: a) providing a detailed description of the methods and procedures employed in this study within this chapter; b) locating the study within its social and institutional context; c) member checking; and d) keeping a reflexive journal.
3.4.3.5 A grounded theory approach

The aim of grounded theory methodology is to develop a theory or model of the phenomenon being investigated that is demonstrably faithful to the actual lived experience of the people being studied (Charmaz 2006). It seeks to generate theory from research data rather than impose preconceived ideas, and requires that emergent theory is grounded in the actions, interactions, and processes of the people involved (Robson 2002). It is important to be aware of the fact that grounded theory is not a unified methodology (Dey 2007). This approach was first introduced in the late 1960s by sociologists Barney Glaser and Anselm Strauss (1967), and it has continued to evolve to the point where there are now a variety of interpretations of Glaser and Strauss' original work (Dey 2007).

Within Study 2, data analysis was informed by Strauss and Corbin's (1998) interpretation of grounded theory. The approach was attractive because it provided a set of analytic guidelines and procedures for data analysis. However, it should be noted that this study is not claiming to be a 'genuine' grounded theory analysis. Rather, this method formed the basis for a flexible approach to data analysis. Furthermore, the grounded theory analysis used in Study 2 was informed by a social constructionist perspective which regarded "both data and analysis as created from the shared experiences of researcher and participants, and the researcher's relationships with participants" (Charmaz 2002). The features of grounded theory that are evident in Study 2 are that it set out to: a) find conceptual categories in the data; b) find relationships between these categories; and c) identify a core category as a way of accounting for relationships between conceptual categories (Robson 2002). Strauss
and Corbin (1998) advocated a highly prescriptive coding procedures to find categories, determine their interrelationships and to establish a core category.

However, a more flexible approach was taken in relation to the coding of data to generate categories in Study 2. The approach to grounded theory analysis advanced by Charmaz (2006) was influential in this respect because of the emphasis she places on the flexible application of grounded theory methods as opposed to viewing grounded theory methods as a set of methodological rules or prescriptions that must be adhered to. Furthermore, Charmaz (2006) takes a more constructionist approach to grounded theory research (Flick 2009), and argues that a pragmatist philosophy “can help to preserve an emphasis on language, meaning, and action in grounded theory” (Charmaz 2006, p.84).

The critical issue here is that Charmaz (2006) is acknowledging that grounded theories are constructed “through our past and present involvements and interactions with people, perspectives, and research practices” (Charmaz 2006, p.10). This is in contrast to the idea that theory is discovered in data separate from the researcher - a view which is evident in the classic grounded theory works of Glaser and Strauss (1967). The pragmatist philosophy and social constructionist perspective advocated by Charmaz (2006) is consistent with the philosophical and theoretical perspective underpinning the knowledge claims made in this thesis, and consequently, the work or Charmaz (2006) influenced the way in which grounded theory methods were viewed and used in Study 2. Further details of data analysis procedures are provided later in section 3.4.7 of this chapter.
3.4.3.6 Using interviews

Within counselling, and other social science disciplines, interviews are one of the major methods of data collection in qualitative research (Kvale 2007; 2008; McLeod 1999). The aims of a qualitative research interview are “to understand the world from the subject’s points of view, to unfold the meaning of peoples’ experiences, to uncover their lived world prior to scientific explanations” (Kvale 2007). Qualitative interviews can be regarded as a purposeful, professional conversation, which is particularly suited to in-depth exploration of the meanings people attach to their actions and experiences. Ultimately, the purpose of the interview is to generate rich, detailed accounts of peoples’ experiences in order to derive interpretations, as opposed to the generation of facts or general laws (Warren 2002).

There are a number of different approaches that can be adapted in collecting interview data. For example, interviews may be structured, semi-structured or conducted in focus groups (McLeod 1999). The approach used in Study 2 reported on in this thesis was the semi-structured interview. This approach was used because it provided interviewees with a structure for what to talk about that was organised around the research questions identified in section 3.4.2 of this chapter, and at the same time allowed interviewees as much scope as possible to express their views (Flick 2009).

According to Rapley (2007), interviews can be regarded as social encounters or as sites for the collaborative production of retrospective, and prospective accounts of past and future actions, experiences, feelings and thoughts. This perspective implies a postmodern, social constructionist epistemology, which in turn highlights the importance of paying attention to the personal, social, contextual, historical and
institutional factors that influence and shape the interview process and the knowledge that emerges from interviews (Fontana 2002). Furthermore, this view is in keeping with the epistemological stance adapted in this thesis insofar as the data generated from interviews in Study 2 were viewed as representing a co-constructed reality by the interviewee and the interviewer (Rapley 2007). In addition, this perspective complements a constructionist approach to the grounded theory analysis as constructions of reality (Charmaz 2006).

Interviews in Study 2 followed a semi-structured format. The interview began with a set of orienting tasks such as explaining the purpose and duration of the interview, and revisited issues of consent and confidentiality of the material generated form the interview. Following this, a set of broad open questions were used to engage participants in talking about their experience of becoming volunteer mental health counselling. This lead on to more focused questions as the interview progressed. It should be noted that as the interviewing process continued additional areas of interest emerged and were pursued in subsequent interviews with different participants.

3.4.4 Participants
Eight participants were recruited to participate in Study 2. The sample included two men and six women, seven of whom also participated in data collection for Study 1 detailed above. These eight people were invited to participate in Study 1 because: a) they had successfully completed a brief in-house counselling training within the agency setting where the research reported in this thesis was carried out; b) they were about to enter practice for the first time; and c) the majority had also consented to participate in Study 1 described above. In this respect these eight participants represented a total sample of paraprofessional counsellors available within the agency.
that met these criteria. All of the participants were White/British and lived in the locality within which they would be practicing as volunteer mental health counsellors. Characteristics of participants are summarised in Table 3.3.

Table 3.3. Characteristics of participants in Study 2

<table>
<thead>
<tr>
<th>Counsellor (Designation as per Study 1)</th>
<th>Pseudonym: (Used in Study 2)</th>
<th>Level of counselling training at point of entering practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Stephen</td>
<td>• 40 hrs: MHSS counselling training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 30 hrs: Introduction to counselling</td>
</tr>
<tr>
<td>3</td>
<td>Agnes</td>
<td>• 40 hrs: MHSS counselling training</td>
</tr>
<tr>
<td>5</td>
<td>Tom</td>
<td>• 40 hrs: MHSS counselling training</td>
</tr>
<tr>
<td>6</td>
<td>Frances</td>
<td>• 40 hrs: MHSS counselling training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 30 hrs: Introduction to counselling</td>
</tr>
<tr>
<td>8</td>
<td>Amy</td>
<td>• 40 hrs: MHSS counselling training</td>
</tr>
<tr>
<td>10</td>
<td>Sophie</td>
<td>• 40 hrs: MHSS counselling training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 120 hrs: Certificate in Counselling Skills</td>
</tr>
<tr>
<td>11</td>
<td>Margaret</td>
<td>• 40 hrs: MHSS counselling training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 120 hrs: Certificate in Counselling Skills</td>
</tr>
<tr>
<td>13</td>
<td>Lily</td>
<td>• 40 hrs: MHSS counselling training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 120 hrs: Certificate in Counselling Skills</td>
</tr>
</tbody>
</table>

Notes: Column 1 in Table 3.3 above denotes the number designation allocated to each counsellor at the time of their recruitment to Study 1 (see Table 3.2 of this chapter). Column 2 denotes the corresponding pseudonym given to participants who also participated in Study 2.

During recruitment it was emphasised in the information material sent to counsellors that non-participation would not in any way affect counsellors’ work as volunteers within the MHSS agency. The next section deals with ethical issues and how participants were recruited to Study 2.

3.4.5 Ethical issues and consent

Ethical approval for Study 2 was obtained from the Research Ethics Committee within the School of Social and Health Sciences of the University of Abertay Dundee.
3.4.6 Procedure

Each participant was interviewed for approximately one hour at the end of their first year of practice following successful completion of the MHSS agency volunteer counsellor training. Interviews were semi-structured and explored the following main themes: a) the general experience of becoming a volunteer counsellor; b) the experience of training and its relative utility in relation to preparation for practice; c) the experience of entering practice, client work and related issues (e.g., supervision); and d) future plans (e.g., personal and professional development). A list of potential broad questions was developed so that encouraged participant reflection on, and exploration of their experiences in relation to the above broad topic areas (see Appendix A). Initial questions in relation to the above topic areas were kept open-ended and sufficiently general to cover a variety of participant experiences.

For example, at the beginning of the research interview the researcher indicated that the purpose of the interview was to explore each participant’s story of becoming a volunteer counsellor, and then invited them to take a moment to think about this and then say something of their experience. Similarly, the researcher used open question to invite participants to talk about their experiences of training and entering practice. More focused questions were used to elicit participants’ implicit meanings and assumptions, and their definition of terms and events. Toward the end of the interview, questions were again more general and intended to facilitate a positive ending to the proceedings (Charmaz 2006). For instance, participants were asked question like: ‘Is there anything else you would like to add about your experience of becoming a volunteer counsellor that might be useful for me (i.e., the researcher) to know? or ‘What are the main things you have learned as a result of being a volunteer counsellor?’
In framing interview questions, an attempt was made to balance open-ended questions to accommodate the emergence of unanticipated material with more probing questions which focused on specific, detailed aspects of participant experiences. Overall, interview questions reflected a willingness to listen to and learn about participant perspectives and experiences.

It should be noted that, following initial interviews some adjustments were made in response to emerging themes and issues. The interviews were conducted in counselling rooms in the main office building of the MHSS agency, which was the setting for this study. All interviews were recorded using an audio-tape recorder. Interviews lasted approximately 60 minutes and were transcribed by an experienced transcriber, and then checked for accuracy by the researcher.

3.4.7 Data analysis
Data were analysed using a grounded theory approach (Charmaz 2006; Strauss and Corbin 1998). The analysis involved the flexible application of a series of analytical procedures and strategies, which included:

**Coding and categorising**: This involved systematically working through the interview data, assigning labels or codes to bits of text. A variety of coding strategies were employed including line-by-line coding to facilitate close inspection of the data and initial conceptualisation, and more focused coding to separate and synthesise initial codes into higher order categories. Theoretical coding was used to specify possible relationships between categories developed during focused coding.

**Memo writing**: writing notes or memos was employed as an analytic strategy throughout the analysis as a way of exploring ideas about codes and relationships among categories, as a means of keeping track of the analysis and providing direction.
for further data collection and analysis. Written memos and diagrams were recorded in a handwritten research journal.

*Constant comparison:* Constant comparative methods were used to make comparisons between data, codes and categories. The meaning of individual categories were compared and contrasted with each other both within and across participant interview transcript material. The intention was to enhance conceptual understanding of the data and to subject the emerging category system and theoretical framework to rigorous scrutiny.

*Auditing:* An auditing strategy was employed to check the procedural dependability and trustworthiness of the analysis. This involved the supervisory panel for this thesis having access to examples of the raw interview data, theoretical notes and memos, and how emerging categories were grounded in participant experiences. In addition, findings from Study 2 were made available to, and commented on by two people who participated in Study 2.

Chapter 4 presents the main findings of Study 1 in relation to the overall group effectiveness of participants, and the findings from Study 2 can be found in Chapter 5. Selected findings from both Study 1 and Study 2 are reported in Chapter 6 in relation to individual differences among the more and less effective counsellors in terms of their effectiveness, personal philosophies and counselling practice. Discussion and interpretation of these findings can be found in Chapter 7, the concluding chapter to this thesis.
Chapter 4

How effective are minimal trained/experienced volunteer mental health counsellors: Evaluation of CORE-OM data

4.0 Overall group effectiveness of volunteer counsellors

The results reported below are based, primarily, on analysis of the CORE-OM data. Pre- and post-counselling data were available for 118 of the 171 clients who were initially recruited into Study 1. The results reported below are based on $n = 118$. A limited amount of the data obtained from the self-report questionnaires, described in section 3.3.9 of Chapter 3 of this thesis, is reported to provide relevant contextual information.

4.0.1 Clients’ characteristics

Clients were predominantly ‘White British/European’ (97%). Approximately 71% of clients were female, 29% were male, and the mean age was 36 yrs (min. 20 yrs, max. 65). 48% of clients were either married or co-habitating, approximately 30% were single, 13% were either divorced or widowed and 9% described themselves as single parents. Almost 40% of clients were either unemployed or on sickness/disability benefit, 55% were employed or self-employed, and the remaining 5% were classified as ‘other’ (e.g. student, retired). The majority of clients had not received previous help (58%), while 42% had seen a counsellor, psychologist or psychiatrist in the past.

Presenting problems were identified from clients’ self-reports in the ‘Reason for Attending Counselling Questionnaire’. Clients’ primary presenting problems were categorised as depression (26%), anxiety/stress (18%), interpersonal/relationship issues (20%) and bereavement/loss (8%). A smaller percentage of clients presented
Chapter 4: Effectiveness of minimally trained paraprofessional counsellors

with problems associated self-esteem (8%), trauma/abuse (5%), eating disorders (3%) and addictions (3%). 9% of clients' presenting problems were categorised as 'other'. Clients reported experiencing their primary problem for a mean of 2.5 years (min. 3 months, max. 5 years), and attended between 1 (6 clients) and 25 (1 client) counselling sessions; the mean was 4.6.

Data on planned and unplanned endings were collected from the ‘End of Counselling Form’ completed by counsellors. Planned endings (i.e., agreed between client and counsellor) took place in 43% of cases. Unplanned endings (defined as clients not returning for scheduled sessions without notifying the counsellor) accounted for 44% of endings. In approximately 11% of cases clients indicated that they did not want to continue with counselling. The reasons for this were not recorded. 2% of endings were categorised as other.

Unplanned endings were unevenly distributed between counsellors. Two counsellors reported more unplanned endings. Each counsellor contributed between 2 and 32 clients to the data set. The modal number of clients seen by each counsellor was 6 and the mean was 9.9.

**4.0.2 CORE-OM data**

Clients who completed the CORE-OM pre and post-counselling showed moderate gains with a decrease in CORE scores from 18.19 (S.D. = 6.65) to 13.49 (S.D. = 7.90), a difference of 4.70 (S.D. = 6.57). The effect size was .70, calculated as the mean pre/post difference divided by the pre-counselling S.D., which can be interpreted as a moderate effect (Cohen 1988).
Table 4.1. CORE-OM scores and effect sizes for present and comparison studies

<table>
<thead>
<tr>
<th>Study</th>
<th>n</th>
<th>Pre-counselling</th>
<th>Post-counselling</th>
<th>Pre-post difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
</tr>
<tr>
<td>Present study</td>
<td>118</td>
<td>18.1</td>
<td>6.6</td>
<td>13.4</td>
</tr>
<tr>
<td>Stiles et al. 2006</td>
<td>1309</td>
<td>17.4</td>
<td>6.5</td>
<td>8.5</td>
</tr>
<tr>
<td>Stiles et al. 2006</td>
<td>5613</td>
<td>17.6</td>
<td>6.3</td>
<td>8.7</td>
</tr>
<tr>
<td>Mullin et al. 2006</td>
<td>11,953</td>
<td>17.5</td>
<td>6.3</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Notes: *Effect size calculated as pre-post mean difference divided by the pre-counselling standard deviation. **Pre-post difference and effect size calculated from service benchmark data published in the Mullin et al. (2006), pre-post difference SD not available.

Table 4.1 shows the pre-counselling and post-counselling CORE-OM scores and effect sizes for this study, and those from the studies selected as benchmarks (Mullin et al. 2006; Stiles et al. 2008; Stiles et al. 2006). Clients presented with levels of distress in the upper range of the moderate level of distress according to CORE-OM scores (Barkham et al. 2006), which were modestly higher than clients attending NHS psychological services (see pre-counselling means column in Table 4.1). In addition, the overall effect of counselling was roughly half of that achieved by professional therapists in the benchmark studies. For example, an effect of .70 reported in this study compared to 1.36 in Stiles et al. (2006) and 1.39 in Stiles et al. (2008). An effect size of 1.42 was calculated from the data published by Mullin et al. (2006) for CORE-OM benchmarks. The mean number of sessions attended by clients in the present study was 4.6, compared to 6.5 in the Stiles et al. (2008; 2006) studies.
Connell et al. (2007) estimated the average number of sessions attended in NHS counselling services to be 5.3.

4.0.3 Reliable and clinically significant improvement rates
Reliable and clinically significant improvement is reported in Table 4.2. Analysis was based on all clients for whom pre and post CORE-OM scores were available (n=118), including those with pre-counselling CORE-OM scores that were below the cut-off point of 10 (13.5% of clients). The rationale for doing so was to remain consistent with the way in which CORE-OM benchmarks have been calculated (Mullin et al., 2006). Change was evaluated by the extent to which clients’ pre to post-counselling scores reflected: a) reliable improvement (RI) - defined as decrease in CORE-OM scores of 5 or more points; b) reliable and clinically significant improvement (RCSI) – a decrease of 5 or more points in CORE-OM scores and movement from the clinical (above 10) to the non-clinical range (below 10); and c) reliable deterioration – defined as an increase of 5 or more points on the CORE-OM. Clients meeting criteria for reliable change are regarded as having improved and recovered if they meet the criterion for RCSI. Both categories are combined in column three in Table 4.2 to show the overall percentage of clients that showed improvement.

It should be noted that in the Stiles et al. (2008; 2006) studies, the figure of 4.8 was used as the criteria to measure reliable change in terms of CORE-OM scores. This is in keeping with previous practice (Barkham et al. 2006). Recently, the figure of 5 has been recommended because it is easier to calculate and more practitioner-friendly (Mullin et al. 2006). It is also the figure used to calculate CORE-OM benchmarks (Mullin et al. 2006). For these reasons, the figure of 5 has been adapted in this study.
Chapter 4: Effectiveness of minimally trained paraprofessional counsellors

Approximately 48% of clients recovered or improved, over 30% achieved RCSI and almost 18% achieved RI alone. 44% of clients did not achieve reliable change and more than 7% showed reliable deterioration. Compared to CORE-OM benchmarks (Mullin et al. 2006), data from the present study suggest that the present sample of paraprofessional counsellors were operating within the bottom quartile or 25% of services, where less than 49% of clients achieve the criterion for recovery. In addition, the percentages of clients in the present study that had unplanned or premature endings (57%) and whose CORE-OM scores showed reliable deterioration (7.62%) are significantly higher than existing benchmarks, which are 49% and 1.8% respectively (Connell et al. 2007; Mullin et al. 2006).

Table 4.2. Reliable and clinically significant improvement rates for present and comparison studies.

<table>
<thead>
<tr>
<th>Study</th>
<th>n</th>
<th>Recovered or improved</th>
<th>RCSI</th>
<th>Reliable improvement only</th>
<th>No reliable change</th>
<th>Reliable Deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
<td>Count</td>
<td>%</td>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td>Present Study</td>
<td>118</td>
<td>57 48.3</td>
<td>36</td>
<td>30.5</td>
<td>21</td>
<td>17.8</td>
</tr>
<tr>
<td>Stiles et al. 2006</td>
<td>1309</td>
<td>905 79.5</td>
<td>693  61</td>
<td>212   18.5</td>
<td>210   19.3</td>
<td>14</td>
</tr>
<tr>
<td>Stiles et al. 2008</td>
<td>5613</td>
<td>3,847 77.7</td>
<td>2,887 58.3</td>
<td>960   19.4</td>
<td>1,047 21.1</td>
<td>60</td>
</tr>
<tr>
<td>*Mullin et al. 2006</td>
<td>11,953</td>
<td>* 72.2</td>
<td>* 53.0</td>
<td>* 18.4</td>
<td>* 26.1</td>
<td>* 1.8</td>
</tr>
</tbody>
</table>

Notes: *n not provided by Mullin et al. (2006)

An independent samples t-test was conducted to assess the outcomes achieved for clients with planned versus unplanned endings. Results showed a statistically
significant result, in that clients who had planned endings achieved a mean decrease of 7.0 points on CORE-OM scores at the end of counselling, compared to a mean of 3.7 for those with unplanned endings ($t = -2.64$, $df = 101$, $p = .009$).

A summary and discussion of the findings presented in this chapter can be found in section 7.1 of Chapter 7 of this thesis.
Chapter 5

Finding a voice: the meaning and experience of becoming a volunteer mental health counsellor

5.0 Introduction

This chapter reports the findings of Study 2. For this study, eight volunteer mental health counsellors were interviewed at the end of their first year of practice. Participants had completed a brief counselling training programme (see Appendix A) within the counselling service of a community mental health organisation, referred to here as the Mental Health Support Services agency (MHSS), immediately prior to entering practice. Interviews were semi-structured and explored the following key themes: a) the general experience of becoming a volunteer counsellor; b) the experience of training and its relative utility in relation to preparation for practice; c) the experience of entering practice, client work and related issues (e.g., supervision); and d) future plans such as personal and professional development. The methods used in this study are outlined in Chapter 3, section 3.4.6.

A grounded theory approach (Charmaz 2006; Strauss and Corbin 1998) was used to analyse the data. Results represented the meaning and experience of becoming a volunteer counsellor within an overarching core category of ‘finding a voice’ and five main categories: 1) resonating; 2) learning the language of counselling; 4) putting the language of counselling into action; and 5) experiencing and resolving dissonance (see Table 5.1). In this chapter, the main categories and their subcategories are described and illustrated using verbatim quotes from participant interviews. Subsequently, the core category is introduced and described. Discussion and interpretation of the findings can be found at section 7.2.2 of Chapter 7.
Table 5.1. The category system

<table>
<thead>
<tr>
<th>Categories and subcategories</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>The core category: Finding a voice</td>
<td>8</td>
</tr>
<tr>
<td><strong>Main category 1. Resonating</strong></td>
<td></td>
</tr>
<tr>
<td>• Resonating with counselling and the role of counsellor</td>
<td>8</td>
</tr>
<tr>
<td>• Resonating with the agency environment: values, ethos and culture</td>
<td>8</td>
</tr>
<tr>
<td>• Resonating with the core counselling model used in the agency</td>
<td>6</td>
</tr>
<tr>
<td><strong>Main category 2. Learning the language of counselling</strong></td>
<td></td>
</tr>
<tr>
<td>• Building on an existing helping vocabulary</td>
<td>3</td>
</tr>
<tr>
<td>• Rehearsing and reflecting on the language</td>
<td>5</td>
</tr>
<tr>
<td>• Personalising the language of counselling</td>
<td>8</td>
</tr>
<tr>
<td>• Nurturing an inward curiosity: applying the language of counselling to ‘self’</td>
<td>4</td>
</tr>
<tr>
<td><strong>Main category 3. Putting the language of counselling into action</strong></td>
<td></td>
</tr>
<tr>
<td>• Overcoming challenges</td>
<td>8</td>
</tr>
<tr>
<td>• Improvising with the language of counselling</td>
<td>6</td>
</tr>
<tr>
<td>• Engaging in ongoing conversations about practice</td>
<td>6</td>
</tr>
<tr>
<td>• Reviewing personal ability to perform the language of counselling</td>
<td>5</td>
</tr>
<tr>
<td><strong>Main category 4. Experiencing and resolving dissonance</strong></td>
<td>6</td>
</tr>
<tr>
<td>• Experiencing / resolving dissonance in relation to the solution-focused approach</td>
<td>2</td>
</tr>
<tr>
<td>• Experiencing and resolving dissonance in relation to being in practice</td>
<td>5</td>
</tr>
<tr>
<td>• Experiencing and resolving dissonance in relation to establishing and maintaining an identity as a (volunteer) counsellor</td>
<td>2</td>
</tr>
</tbody>
</table>

5.1 **Main Category 1: Resonating**
The concept of resonating captures the sense of identification that participants experienced in relation to their discovery of and engagement with counselling. It encompasses many different types of experience, which ranged from participant’s early encounters with counselling and active pursuit of counselling work, to their experiences of being a volunteer counsellor within the MHSS agency. More specifically, it refers to counsellors’ experiences of resonating with counselling and the role of counsellor, the agency ethos and culture and the preferred counselling approach of the agency, each of which is described below.
5.1.1 Resonating with counselling and the role of counsellor

All eight participants reported a feeling of identification with counselling as an activity and the role of counsellor. They encountered counselling in different ways but in all cases this encounter was experienced as personally meaningful. These ‘meaningful encounters’ had the effect of prompting an interest in counselling, which led participants to seek training opportunities in order to explore and nurture an emerging sense of potential as a counsellor. Participants reported encountering counselling through personal distress and a positive experience of being helped through counselling (4 people) or through incidental introductions (e.g., through work in a human service profession), which prompted exploration of counselling by attending training workshops or courses (4 people).

These experiences called forth and amplified participants’ sense of their potential to help others through being a counsellor. Tom, for example, discovered counselling through his experience of personal distress. He found he enjoyed the experience and developed a belief in its usefulness, which prompted him to explore training opportunities. He remarked: “I quite enjoyed it [the counselling] actually…” (Line: 12). As Tom became more involved in counselling his prior sense of his potential as a helper contributed to him being able to construct an identity as a counsellor. At one point in the interview he stated:

“I’ve always been someone that was interested in folks and talked to a lot of people and people would often come and talk to me…” (Lines: 122-124).

Remembering past helping experiences appears to have affirmed and facilitated his emerging identity as a counsellor. Sophie also encountered counselling as a result of
personal distress:

“*I lost contact with my sense of who I was and where I was going... At that time I found it helpful to talk with someone who was totally objective, who was a skilled listener.*” (Lines: 481-483).

This existential crisis led Sophie to develop a high regard for counselling and the work of counsellors. Indeed, her decision to become involved in volunteer counselling was influenced by her own experience of receiving counselling during this time.

Another participant, Lily, highlighted the influence of role models in cultivating her interest in counselling. She traced her interest in counselling back to her grandmother who she remembered as someone who had time to listen to others in the course of her daily routine. However, it was through her work in a human service profession that she was introduced to counselling as an activity and found she was unwittingly engaging in counselling oriented work:

“*Through my work I realised I had done a lot of this without knowing it ... so I went to a series of workshops on counselling to find out what is was. Looking back I remember my grandmother listening to lots of peoples' problems while making pancakes or making a cup of tea. Nowadays people don’t have large families or grannies that do this so I see counselling as a way of reaching out to people in need of help.*” (Lines: 21-27).

This incidental introduction prompted this participant to explore counselling through
engagement in training and to understand the activity of counselling as a substitute for the informal help and assistance that may no longer be available from one's family due to social changes.

The experience of resonating with counselling and the role of counsellor prompted participants to explore their potential as helpers by attending workshops, short courses and, importantly in relation to this study, by pursuing an opportunity to become volunteer counsellors. All eight participants wanted to become volunteer counsellors because it provided them with an opportunity to help others. The degree to which they felt equipped to help others in a counselling capacity varied and their involvement in volunteer counselling provided a means to test-out their potential as a counsellor. In the following quote Stephen indicates his belief in his potential as a helper and his wish to use this to help others:

“I felt I had something to give or at least I had a skill I felt that could be developed and used for the benefit of other people...” (Lines: 24-27).

Another person, Tom, stated:

“I do genuinely feel I could be very good at this and want to find out if I can help others in this way...” (Lines: 657-658).

Frances appears to be expressing similar altruistic intentions but also recognised that her desire to help others could be better served by further developing her competence as a helper:
Chapter 5: Finding a voice

"I want to be able to assist those in need...and feel I could assist more if better trained." (Lines: 408-409).

And Sophie remarked:

"I’m committed to myself to pursuing this [but] won’t know how suited I am until I try." (Lines: 405-407).

Clearly, for these participants, helping others would appear to have been an important reason for engaging in voluntary counselling, which was related to an emerging sense of a personal potential to help others in this way. However, as can be seen in subsequent categories participants also offered other explanations for being involved in this activity.

5.1.2 Resonating with the agency

This concept pertains to participants’ engagement with the MHSS agency and how they identified with aspects of the agency’s ethos, culture, and general environment. A significant aspect of resonating with the agency was that it afforded all participants the opportunity to pursue personal goals, which were not exclusively related to becoming volunteer counsellors. In fact, participants appeared to be engaged in counselling within the agency for a variety of different reasons. For instance, participants referred to their involvement in volunteer counselling because it afforded them the possibility of meeting other people and developing relationships, or because it formed part of a personal strategy to overcome a period of personal distress. More generally, participants appeared to resonate with the agency because they experienced
it as friendly and inclusive, and professional. Margaret commented on the importance of feeling included and valued by the organisation:

"There's a different kind of atmosphere when you come in here. People are friendly and the volunteers are an integral part ... you're not treated as separate entities. Everybody was treated as an individual ... clients, staff, you know ... that enabled trust and also to feel that, not only myself, but others were valued for what they were saying and that was really worthwhile." (Lines: 29-37).

Agnes expressed similar sentiments and talked about the way in which the general ethos and culture ("the whole set-up") within the organisation contributed to helping everyone feel relaxed and also to her perception of the environment as person-friendly:

"The whole setup put everybody at ease. It was so person friendly... You felt integrated ... it's the way that everybody mixes in. That is really important for me." (Lines: 10-22).

Like many other participants in this study, Agnes encountered counselling through her own experience of personal distress. Being engaged as a volunteer with an agency that conveyed a warm and friendly atmosphere where volunteers were valued and included appeared to affirm volunteers' self-worth and boost their self-esteem. Clearly, feeling welcomed and included were important features of both Margaret's and Agnes' experiences.
For Tom, becoming a volunteer counsellor allowed him to follow-up on an interest in counselling that was ignited by the experience of counselling he had received during a period of personal distress. Interestingly, Tom appeared to use the opportunity to become a volunteer counsellor to find out more about counselling and to test his potential as a counsellor, but also as part of a strategy to re-introduce more structure into his life, and to facilitate his recovery from a period of mental distress. He remarked in his interview that:

“\textit{I was also just looking for something that would make me leave the house from a health point of view, and go somewhere and do something.}” (Lines: 15-17).

Another significant feature of some participants’ experience of resonance with the agency environment is that it was an arena within which participants could express a desire to be connected to other people. It allowed individuals to interact with others in both informal and more socially intimate ways, to feel accepted and respected and to be part of a community that shared common values. This was important for all participants but especially so for two individuals. Amy, for example, commented that the experience:

“\textit{... was a great opportunity to meet people who were quite similar...and to be part of something that I consider important with people who feel the same way.”} (Lines: 9-10).

Stephen, too, was inspired by the opportunity to meet and interact with people in ways that would not usually occur in other social settings in his life. At several points in the
interview he commented on the importance of the social side of his engagement with
counselling and the opportunity afforded by the environment to form relationships
with others. In the following extract he was commenting on the way in which role-
play activities within the training environment especially facilitated this:

“...you know, you formed relationships...the course content allowed you to interact in
sort of a different way and to understand what was going on with other people...the
social side was, I feel, a good form of support...” (Lines: 412-425).

Stephen is referring to the way in which the somewhat contrived nature of the role-
play sessions participants engaged in during the training experience within the MHSS
agency, which allowed trainees to talk more intimately about aspects of their personal
experience and lives that would not usually happen in ordinary social situations. This
appeared to facilitate the development of relationships and act as a form of social
support for some participants.

Margaret remarked on the positive training environment and how this impacted on
her:

“...the whole feeling of the training was extraordinarily positive and I felt very
positive, which is very unusual for me in training. Yeah, I felt tremendously positive
... it was a very positive attitude and the wonderful sort of working together. So you
know [the trainers] had really set the environment...there were no put downs, there
was not cattiness, which I’ve experienced on other training. That was really
worthwhile...” (Lines: 26-35).
Sophie, for example, talked about this experience of support, especially in relation to the training environment. She commented:

"...people were dealing with things in their lives that were very similar [to me] you know kind of big issues [and] looking back there’s a couple of people I’ve become close to from that group because of that..." (Lines: 127-149).

As a voluntary sector organisation, MHSS was (and remains) committed to promoting social inclusion through a variety of initiatives, including providing opportunities for local people to engage in a range of volunteering activities. Volunteers were encouraged to be active in shaping its policies and development and this kind of ethos appears to have contributed to the experience of resonating with the agency environment, which was experienced as affirming personal worth, providing an opportunity to form relationships and to be part of a supportive community that shared similar values. On one level it appeared that participants were engaged with the MHSS agency in order to pursue their interest and to explore their potential as volunteer counsellors; on another level, however, it appears that participants were actively pursuing more personal and individual goals and aspirations.

5.1.3 Resonating with the core counselling model used in the agency
This category describes the ‘goodness of fit’ between the person’s approach to problem-solving and their evolving ideas about helping and that of the solution-focused counselling model that was favoured within the agency and which informed its training programme. Two people expressed concerns about some solution-focused techniques because they conflicted with their own beliefs and values and their experiences are described within the category of ‘experiencing and resolving
dissonance’. The remaining six participants commented on their personal affinity with the solution-focused approach in terms of its underlying philosophy and its techniques.

Stephen was one of the individuals who had concerns about the potentially mechanistic nature of the solution-focused approach. However, he also appeared to identify with its general principles around focusing on peoples’ resourcefulness and the possibilities for change. He stated:

“I think solution-focused ideas were good because that was my own way of thinking.” (Lines: 47-48).

Lily expressed similar sentiments:

“I felt that the type of counselling that I was being asked to do fitted with me and the way I tackle things myself ... you know if I have a problem myself, I realise, looking back that that is the kind of thing I do anyway.” (Lines: 30-50).

Yet another participant, Agnes, said:

“I felt really comfortable with it [the solution-focused approach] ... it was almost like common sense.” (Lines: 120-121).

Tom also found agreement with the approach and commented:
A common element in these reports is that participants identified with the solution-focused approach because it fitted with their own common sense approach to dealing with problems in living. Another aspect to this sense of identification is that the approach provided a framework for practice that appealed to some participants. It was evident in participants' interviews that the solution-focused approach provided participants with a set of skills with which to interact purposively with clients and that this was a source of reassurance during training and the early stages of practice. These themes are explored further in the category 'learning the language of counselling'.

In summary, the concept of resonating highlights the paths that led participants into counselling, the importance they placed on being accepted and valued and having a voice within the MHSS agency. In addition, it describes the experience of identification with the core counselling model used within the agency. Some participants experienced conflicts in relation to the solution-focused model and this was evident also in relation to other aspects of the experience of becoming a volunteer counsellor. These experiences are described later in this chapter under the category 'experiencing and resolving dissonance'. Nevertheless, each participant felt sufficient resonance to be able to make a commitment to entering training to explore their potential as counsellors. The basis for the experience of resonance appeared to be located in the earlier life experience of the participants. The role of counsellor, the ethos of the agency, and the counselling model espoused by the agency was viewed as
Chapter 5: Finding a voice

giving tangible expression to personal values related to helping and being helped, respect for others, intimacy and the importance of relationships with other people.

5.2 Main Category 2: Learning the language of counselling
Learning the language of counselling refers to the process of developing a therapeutic vocabulary and repertoire of strategies for engaging in helping conversations. Counselling training, client work, individual and group supervision were the most important sites where this process took place. Participating in these activities enabled each participant to learn the language of counselling and expanded their supply of conversational resources, which in turn, enhanced their capacity to express their helping intentions. These linguistic resources were drawn largely from a general repertoire of ‘counselling-speak’ such as empathy, listening, reflecting feelings and a more specific vocabulary of solution-focused strategies. These themes are described below in relation to: a) building on an existing helping vocabulary; b) rehearsing and reflecting on the language of counselling; c) nurturing an inward curiosity: applying the language of counselling to self; and d) personalising the language of counselling.

5.2.1 Building on an existing helping vocabulary
For some participants, the purpose of entering counselling training was explicitly about learning how to use language to help others more effectively. For instance, Tom talked about his sense of frustration during times when he could not find the ‘right thing to say’ to people with whom he had informal helping experiences:

“People would come and talk to me but at times I felt very frustrated because I couldn’t say the right thing. I was always trying to search for the right thing to say
and I was often frustrated because I would say the wrong thing or say something I thought was good and it wouldn’t really help them.” (Lines: 122-128).

Stephen expressed similar sentiments related to his experience of trying to help family and friends prior to engaging in counselling training. Although he had a sense of his ability to be helpful he recognised that he could be more so if he could make more use of conversations with people.

“I just wanted to make more use of conversations ... to engage people ...empower them to do their own thing.” (Lines: 82-84).

Inherent in these extracts is the belief that helping involves doing something with words or language. In other words, being able to say the right thing or having the ability to make more use of conversations makes a difference in terms of your capacity to help another person.

Margaret, who had some experience of being a telephone counsellor, talked about her desire to expand her helping repertoire, which embraced the idea of having skills, experience, self-awareness and a specific type of knowledge:

“I had reached a stage in my counselling skills and experience and self-awareness that I felt the need ... to continue learning ... gaining a wider understanding of how to work with clients who have psychological problems ... ” (Lines: 7-8).

There is a strong sense in the above quotes that participants were seeking to build on
pre-existing helping vocabularies. Entering the MHSS counselling training programme was seen by participants as a way of expanding their repertoire of knowledge, skills and awareness, which appeared to have been regarded by participants as essential features of effective helping. It is interesting to note that participants represented their intentions in this way and that they appealed to notions that are common in counselling discourse, such as self-awareness, even where they had little of no prior experience of being a counsellor. Participating in training was a significant experience because it enabled participants to acquire the language of counselling and build on their informal helping language.

5.2.2 Rehearsing and reflecting on the language of counselling
The training environment provided different sites where participants were able to rehearse and reflect on the language of counselling. For example, this occurred within structured skills practice exercises, during feedback discussions and through participating in simulated counselling sessions that were video recorded. The most important of these appears to have been the skills practice sessions that comprised three people each taking turns in the role so counsellor, client and observer.

These activities facilitated discussion and encouraged the giving and receiving of feedback to each other in relation to the ability to ‘perform’ the language of counselling. Skills practice sessions were highly valued by participants because they acted as scaffolding for participants as they learned the language of counselling. This temporary structure allowed participants to build on and develop their helping vocabulary, and discover how to use it in conversation with others, which in turn, acted as a rehearsal for engaging with ‘real’ clients. Stephen discussed how participating in skills practice sessions in the roles of client, counsellor and observer
during the MHSS training helped him to understand and ‘see’ how particular interventions impacted on the person in the role of the client. He stated:

“I think it was sort of ah, the practice sessions you did when you were actually doing an active participation in it and you could see a result from someone you were talking to. Whether it be a phrase or opening line or whatever, then you actually saw a response to that and you felt that what you were actually learning in the training you were using and it was having a positive impact on someone ... being able to use that and seeing how other people were doing it and adapting it [Solution-focused therapy] to suit themselves was a good thing for me.” (Lines: 31-44).

Margaret also highlighted the importance of receiving feedback, which can be viewed as a type of conversation within which participants were able to practice the language of counselling.

“[T]he amount of time that was enabled to work in counselling sessions and the feedback received was very important.” (Lines: 182-184).

Agnes emphasised how some of the practice exercises challenged her view of herself as a good listener and provided opportunity to rehearse being a good listener in terms of the way this activity is understood within counselling discourse (e.g., “… when we sort of new good listening …”). She remarked:

“At first I thought, I’m a good listener, but I wasn’t! I thought I was and everyone around me thought I was but when we sort of ‘knew’ good listening, it was so much
better ... all the practical exercises around listening to somebody and not being able to respond really stick in my mind because I remember clamping both hands over my mouth ... it was so difficult not say something!” (Lines: 85-91).

Another person, Sophie, talked about the experience of participating in simulated counselling sessions that were video recorded:

"The video work was scary but I would probably encourage more of that because it really stands you in good stead ... feeling challenged in situations like that made the difference for me when I had to walk in here with a client.” (Lines: 188-193).

Like Sophie, most participants found this activity challenging; however, all participants agreed that is was a valuable and realistic rehearsal for counselling ‘real’ clients. Participants’ accounts also revealed that it is important to devote sufficient time to preparing people for this experience by providing opportunities to discuss any concerns especially where such sessions are used to determine readiness to practice.

More generally, it can be said that practice sessions appear to have been highly valued by participants as a means of expanding and developing their helping skills. These sessions afforded participants the opportunity to practice new skills, refine existing skills and in some cases contributed to enhancing self-awareness, which seems to have played a significant role in boosting a sense of counselling self-efficacy and readiness to engage in client work. Tom, for instance, highlighted the key role of practice sessions and feedback from peers in promoting his self-awareness. He remarked:
“I started to realise that I had an angle on everything and other people had a different perspective and as we went through the role plays I was becoming aware of my angles ... some of the exercises we did helped to highlight those things ... so I realised that’s a pitfall. If you are giving your opinion and colouring everything your way then that isn’t going to help the person at all.” (Lines: 338-343).

This kind of learning experience was more powerful when participants choose to talk about (non-threatening) personal material while in the role of client during practice sessions. In addition to the actual practice sessions, the accompanying feedback-conversations provided further opportunities for participants to reflect on and engage with the language of counselling. Within these conversations the meaning of personal experience and intentions were open to negotiation. In the preceding quote, Tom appears to be reflecting on the language in relation to his own experience and through this process has arrived at a new way of thinking about his helping behaviours and intentions: that being helpful to clients involves suspending one’s own opinions and perhaps having a degree of self-awareness. The idea of applying the language of counselling to self is taken up in the next section.

Individual supervision and client work were also important sites for learning the language of counselling. In relation to her experience of working with clients, Agnes made the following comments:

“...I think what certain clients do for you is they just give you extra ammunition ... whether it would be for dealing with something that could upset you or protecting yourself or just giving you some extra tools ...” (Lines: 384-389).
And Margaret stated:

"Clients offer you the experience and allow you to think, allow you to expand ... I'm much more careful now in what I say in some respects. Saying less. Short sentences. Shorter sentences and being willing to ask something which will clarify when I'm muddled. " (Lines: 482-486).

Individual and group supervision was another important site for learning the language of counselling. Tom talked about the value of individual and group supervision as a resource for learning new therapeutic strategies and for developing and refining his existing counselling skills. He remarked:

"One of the good things was I would go to my supervisor and say, 'Right, here's where I am at. What do I do now?' and we would just talk it through and she'd give me ideas and I could try them out." (Lines: 411-414).

And later in his interview he talked about the role of supervision in helping him to develop and refine his counselling skills, especially his ability to work in a relational way with clients:

"I've learned a lot through the group supervision and one-to-one. If feel as if I've developed those abilities and refined them. " (Lines: 704-706).

Engaging in training, client work and supervision provided participants with opportunities to rehearse and reflect on the language of counselling, which they
translated into actual client work. Throughout the process of learning the language of counselling, participants were endeavouring to build a personal account of the meaning of counselling and their role as counsellors. This was a significant theme in participant accounts and will be explored in the next section.

5.2.3 Personalising the language of counselling

On entering training, participants’ representations of counselling and the role of counsellor were based on pre-understandings that arose from past experiences of helping and being helped, role models and media and cultural images of counselling. The experience of training and client work were instrumental in assisting participants in transforming these images and refining the use of counselling language. An important theme within this category concerns the giving up of previous images of counselling, which is illustrated in the following quotes.

Tom, for example, described an image of counselling he held at the start of training with MHSS that was characterised by cultural representations and the notion of ‘the expert’, which was based on his personal experience of receiving counselling. At one point he stated:

“I mean my image of counselling was very much you know, Freud and lying on the couch or American things where it’s all analysis and you know, to me, spurious things like you have a shrink and it’s all very important ... do you know what I mean?” (Lines: 108).

At another point in the interview he talked about how his perspective of counselling influenced his expectations of counselling training within the MHSS agency:
When I came here what I imagined was going to happen was I was going to be trained in all these techniques, sort of techniques about how to tell what was wrong with people. I think that’s a fairly common conception and ... it was very different from that. It was very much you emphasised the relationship aspect of counselling ... and the other key factor was to give them [clients] a chance to realise their resources and use them better. And that made a big impact on me ... it’s away from being the expert and more about helping them [clients] realise what they’ve got and to see things differently but in their own way.” (Lines: 18-36).

Tom also acknowledged in his interview that his perception of counselling was influenced by his own experience of receiving counselling based on the medical model, which in his view set the counsellor in the role of expert: as someone who was skilled in diagnosis and use of techniques to ‘cure’ people of their psychological problems or disorders. Clearly, MHSS represented counselling in a different way and over the course of the training and his experience as a volunteer counsellor with MHSS he appears to have adopted this philosophical stance and rejected the notion of expert. Towards the end of his interview he remarked:

“The fundamental important things that I’ve learned seem to be whether you are actually helping someone rather that becoming this technician person. That’s a very valuable thing I feel I’ve gained from coming here ... is getting away from the idea of wanting to be an expert, like a surgeon for people, a doctor for people, with their minds.” (Lines: 723-729).
Stephen’s understanding of his role as counsellor was influenced by his experience of working with clients within the agency counselling service. He stated:

"I suppose in general, it’s a support structure [for clients] ... to figure out what they need and where they are and for them to understand that they’re not on their own ... that they are going through a process ... It’s having a bit of expertise that allows them to understand that ..." (Lines: 304-315).

The following extracts from Amy’s interview, illustrate her changing understanding of counselling and the role of counsellor. At the beginning of the interview she said:

"I was looking for ways, prior to the training, of sorting out people’s problems and after I realised that’s not what counselling is about." (Lines: 18-19).

After making these comments Amy described her realisation that she had been going through her life trying to save people from themselves and more or less telling people how they should live. She went on to talk about how this perception changed, which she attributes to the training experience with MHSS:

"I realised counselling was more than being nice to people and making people feel nice about themselves. Somewhere in the training I realised it was about them coming to some sort of realisation that they could cope. That’s what helped me to turn the table ... it took it away from me and I learned a certain degree of humility as well." (Lines: 110-112).
Leading up to these comments Amy had been talking about how feedback from other participants following a simulated counselling session during the MHSS training had made her realise that she had been going “through life trying to be some guardian angel to people” and that this “saving attitude” was being perceived by others as quite patronising. This appears to have been a critical moment in terms of her evolving understanding of her role as a counsellor and also in terms of developing her self-awareness. Amy’s experience suggests that learning the language of counselling involved an ability to make it your own: to personalise it in some way so that it becomes embedded in the way in which one might express oneself as a counsellor. Increased self-awareness would seem to have been an indirect consequence of this process for Amy. However, participants were also proactive in applying the language of counselling to themselves as a way of nurturing and promoting self-understanding. This theme is explored in the following section.

5.2.4 Nurturing an inward curiosity: applying the language of counselling to ‘self’

Developing self-awareness and promoting personal development was a key concern for all participants. Indeed, for some participants, becoming a volunteer counsellor was a way of continuing to nurture an inward curiosity that arose from the experience of personal distress or more generally from the experience of resonating with counselling and the role of counsellor. Each participant reported a tendency to be reflective and to being open to learning about themselves. Understanding one’s own processes was regarded as a matter of personal responsibility borne out of a belief that they should be prepared to engage in this kind of process because, as counsellors, they were encouraging their clients to engage in a process of self-discovery.
Within the MHSS agency counselling training, the most important site for personal development work was writing a personal journal. Participants were encouraged to write ongoing personal journals to record feelings, experiences and events related to their development as counsellors. The activity of journal writing gave participants permission to articulate aspects of their experience that were unheard or difficult to express in other areas of the training/agency environment or indeed in their lives in general. It can also be seen to have acted as a framework for participants to interpret and give meaning to their own experience by applying the language of counselling to ‘self’.

Agnes viewed her engagement in the MHSS training and client work as an opportunity for personal development and invested a great deal of time and effort to personal development activities. Journal writing was especially important because it was a way of working on personal issues and dilemmas. She believed that engaging in this activity impacted positively on her level of self-awareness and in turn contributed to her effectiveness as a counsellor. She stated:

“I was one of the people who kept journal-type reflection logs...I think it was good because a lot of things I wrote down I wouldn’t have said. I remember on one occasion writing, ‘I find this really hard to say so I won’t say it but you know what I mean.’ I was even speaking to my log as if it was going to blurt out what I was going to say ... and further down the line it was, ‘Okay, I’m going to say it.’ And I wrote it. And as soon as I wrote it and when I look at it now I actually laugh at it. But it is important because you can actually see the progress of where you start to understand yourself.” (Lines: 34-46).
Lily commented that:

“[T]he journal. I found that good. I’ve always said that when I have a problem I go for a walk up the braes ... but now I found another way. If I feel rotten, writing it down – not always, but a lot of the time writing it down and at the end of it thinking, ‘Ach right, there really isn’t anything’. You know, I’m being irritated over something or perhaps this is something I have to deal with or you know; I handled that wrongly today or whatever. So I found it good from that point of view. It was quite beneficial from a personal point of view just in how you deal with life in general ... just learning to look at things ... I’ve got a front of the journal which is just for writing but at the back I’ve got sort of significant things that I add to. You know, things that I’ve been trying to work out.” (Lines: 71-80).

Stephen talked about the value of keeping a journal as a way of reflecting on and clarifying his thinking. The activity of journaling helped him to weave parts of his past and present experience into a more coherent account of the reasons why he held a particular perspective.

“...being able to write it down makes you more aware of what your thinking because it’s slowed right down and if you put it away for a week and then you read over it again then it gives it a new sense of clarity ... [it] allows you to see where you are and possibly where you’ve come from as well and what’s influenced you as to why you think that way ... it’s important for me to understand what I was thinking.” (Lines: 363-375).
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The interesting thing about the above accounts is that it was as if participants were having a conversation with themselves through the process of journaling which gave voice to aspects of their experience that were previously unacknowledged, or out of their awareness, which in turn facilitated self-understanding. For some participants pursuing personal development appears to have been a major reason for their engagement in voluntary counselling. In the following extract Sophie acknowledges that her involvement in counselling training was not purely altruistic:

"...I did it because it was a way to keep learning about myself, you know, I wasn’t doing it purely for altruistic reasons. I found it exciting ...I read a wide range of things concerning counselling and a lot of that is about self exploration as well ... I still go therapy as well ‘cause I still find that dead exciting and I use that in a lot of ways for my personal development ... and I suppose if I use it [the training] for my own personal development it’s because I still see it as my responsibility [as a counsellor] ...” (Lines: 416-419).

Self exploration and personal development were important goals for Sophie. Based on her interview material, these goals seem to have emerged from her previous experience of being distressed and receiving counselling. Becoming a volunteer counsellor enabled her to pursue a pre-existing interest in self-exploration.

In summary, the concept of ‘learning a language’ suggests that participants’ used the experience of training, in particular, to build on existing and common sense notions of helping. It is noteworthy that participants did not have any prior knowledge of the particular model of counselling espoused within the MHSS agency and very little, if
any, understanding of counselling or the role of counsellor in terms of professional definitions or conceptualisations. Nonetheless, they all brought to bear a range of pre-understandings and perceptions of counselling to this experience, which were based on their informal helping experiences and their own experiences of coping with challenging or distressing personal life events. Even though these perspectives did not always map onto the MHSS perspective, it appears that participants were being socialised into the agency perspective and at the same time assimilating this perspective into their own evolving understanding of counselling and their role as counsellors. A key element in this was process was that participants seemed to be endeavouring to make sense of the language of counselling in a way that was more personally meaningful.

Participating in counselling training facilitated, to some extent, the refinement of existing relational skills and provided the opportunity to develop a vocabulary of counselling skills and solution-focused strategies. Engaging in client work and supervision provided participants with further opportunities to expand their therapeutic repertoires. Essentially, undertaking counselling training, having the experience of being a client, writing a personal journal, doing client work and receiving supervision enabled participants to become engaged in counselling discourse, which in turn, acted as a lens through which they viewed and made sense of their own and others experience.

5.3 Main Category 3: Putting the language of counselling into action
This category refers primarily to participants’ experiences of working with clients within the MHSS counselling service during their first year of practice. To a lesser
extent it embraces participants’ experience of being judged or assessed by others, in
the context of training, on their ability to perform the language of counselling: for
eexample, the requirement to participate in a simulated counselling session to assess
participants’ readiness to enter practice. Emerging themes are described in relation to
the following subcategories: a) overcoming challenges; b) improvising the language
of counselling; c) engaging in on-going conversations about practice; and d)
reviewing personal ability to perform the language of counselling.

5.3.1 Overcoming challenges
Overcoming challenges refers to the experience of being faced with situations that
tested participants’ ability to perform the language of counselling. It embraces
participants’ ability to navigate successfully the transition from counselling training to
practice and the challenges that arose for participants as they engaged in client work.
One such challenge related to the requirement to participate in a simulated counselling
session that was video recorded during the MHSS counselling training. This activity
formed part of the assessment strategy to determine their readiness to enter
counselling practice. It was noted earlier that this was a challenging experience for all
participants. Frances described it as follows:

“That was a culmination of bringing everything we’d been taught into practice ... you
walked in that door, you were going to be under the spotlight and you couldn’t tell if
you could remember ... it was like going into an exam room with only a pen in your
hand. You can only write what is there. [You’re being asked] ‘What did we teach
you? Tell me.’” (Lines: 358-369).

Frances’ account suggests that she felt like she was being tested, that the experience
was like taking an exam. Another way of looking at this is that this experience was akin to an ‘audition’ where participants were required to give a short ‘performance’ of their abilities to put the language of counselling into action and thereby demonstrate their readiness to engage with ‘real’ clients. This interpretation is echoed in Stephen’s comments:

“It was quite frightening at the start ‘cause you think, ‘Right, okay, we’re doing all these skills and then we’re going to be putting them into practice’. It wasn’t so much the videoing ... it was just the fact that you were going to be in this situation to see how you perform.” (Lines: 113-115).

Clearly, this was a challenging experience for Stephen, however, he went on to say that it was ultimately beneficial insofar as it helped to prepare him for actual client work. The image of taking an exam was also highlighted by some participants in relation to the challenge of entering practice and seeing the first ‘real’ client. Most participants reported concerns about ‘not getting it right’ and a preoccupation with doing things properly. Agnes, for instance, remarked:

“On the lead up to seeing the first client, I was studying like I was going to sit an exam ... I wanted to make sure that I did it properly and I was almost memorising in sequence what to do ... as it got really close though I was really ill with nerves. Terrified!” (Lines: 247-256).

An interesting issue that is hinted at in Agnes’ remarks relates to her comment about ‘memorising in sequence what to do.’ She appears to be uncertain about her ability to
put the language of counselling into action. There was a sense that, for Agnes, this language skill felt stilted and unnatural, perhaps because of her preoccupation with doing it 'properly'. Sophie was also concerned about this:

"I felt quite shaky initially and the initial sessions that I had I was very pedantic about holding onto the ways I thought things had to be done and trying to do it properly." (Lines: 10-13).

Once again, there seems to have been a preoccupation with the perceived rules of the language of counselling, which is likely to have been influenced by the structured nature of solution-focused counselling. A major concern for some participants, inherent in this preoccupation, was about the potential to do harm to a 'real' client. This was a daunting prospect for Tom. He was very aware of the difference between training and actually 'doing it for real':

"I was obviously nervous ... I had kind of doubts about what if this happens and you know it's always different going and actually doing the thing than training for it. I was very aware that I could go in and cock it up on someone real, you know." (Lines: 70-75).

Another challenge that participants experienced as they became more involved in client work was around the limitations of the language of counselling that had been learned. Tom described this very well:

"I felt as if I needed more ways of keeping things going ... just more ways of keeping
the communication, the conversations going. I think it was more skills than anything else to be honest with you. I just felt as if I was a bit, you know, clumsy, or wasn’t very good at keeping things going naturally” (Lines: 452-458).

Tom encountered feelings of being ‘lost’ and ‘clumsy’ with increasing frequency as he began to see clients who were more ambivalent about change. He recognised that his therapeutic repertoire was being exhausted with some clients, which led him to pursue further training in counselling skills. He said that this helped him to refine his relational skills and helped him to grow in confidence and be more relaxed with clients.

Agnes encountered similar challenges. She talked about the difficulties she experienced in relation to getting some clients to talk or reflect on things. This made her uncomfortable and she felt that some clients might, metaphorically speaking, be placing her on a pedestal and positioning her as the person responsible for solving their problems:

“There are clients I have seen before who it was just so hard to get them to say anything about themselves. To even get them to think about things or look at things and it almost seemed they came with the complete expectation that they would just come in and sit there and everything would get solved ... I didn’t quite like that because it made me feel uncomfortable. It is almost like they put you up on a pedestal ... I just didn’t like that. It makes you panic because you think I can’t help this person.” (Lines: 182 -198).
To some extent Agnes’ experience seems to be around the limitations of the vocabulary of helping skills and conversational strategies that she had learned or was able to articulate at that point in time. Another participant, Amy, reported her concerns related to trying to resist some clients’ expectations of her as a counsellor:

"It was quite difficult at first because it was something completely new and it was difficult to remain just a blank slate. They were looking for something from me and the expectation for me to solve their problems was there from some clients. So trying not to fall into that was very difficult. (Lines: 132-136).

Other participants talked about the challenge of learning to deal with clients not turning up for appointments and coping with administrative tasks (such as keeping notes) associated with client work. The transition from training to practice was characterised by feelings of anxiety for most participants and concerns about not ‘getting it right’. One of the main ways in which some participants managed these anxieties within counselling sessions was by applying solution-focused techniques and strategies in a highly structured manner in the belief that counselling would be effective by doing so. In fact, having a repertoire of skills and a clear conceptual framework for practice (in the form of the solution-focused approach) was highlighted by participants as being important in number of ways, not least because it provided a map with which to navigate counselling sessions and conversations with clients. As participants gained more experience and encountered a range of different clients and presenting issues they reported experiencing limitations in the language of counselling that they had learned. This was an important learning experience and one which fostered a more flexible use of solution-focused strategies and a pursuit of additional
conversational strategies through further training and reading, and within supervision.

5.3.2 *Improvising with the language of counselling*

This concept refers to a shift in participants’ use of solution-focused strategies from a rigid to a more flexible approach. Participants’ accounts suggest that over time they were increasingly able to draw on a range of solution-focused strategies and respond to clients ‘in the moment’ as opposed to being pedantic about following a highly structured approach within counselling sessions.

As noted earlier, participants reported that the general language and skills of the solution-focused approach that participants learned provided a satisfactory conceptual framework for guiding their therapeutic work. Having a framework for therapeutic work appears to have been important for participants because it promoted a sense of counselling self-efficacy, helped them to make sense of their role as counsellors, and equipped them with a range of specific skills with which to interact purposively with clients (for example, knowing what questions to ask clients, and how best to respond helpfully to clients to facilitate change or manage impasses). Solution-focused techniques were relatively easy to understand and master and this served to boost participants’ confidence in their ability to help.

This sense of confidence was described by participants as being particularly important during the initial weeks and months of their practice, which tended to be characterised by a rigid adherence to the solution-focused model. Toward the end of their first year of practice this approach was beginning to give way, for most participants, to a willingness to take risks and be more spontaneous, arising from a growing confidence in their helping abilities and more clarity about their role and boundary issues. In part,
this shift was a result of experiencing limitations associated with a rigid adherence to this approach and the repertoire of strategies available within this model. The following quotes illustrate a gradual transition from a highly structured to a more flexible use of techniques and working style. Sophie described this process and highlighted the value of techniques in dealing with situations in which she felt stuck. Although, it appears that as she gained experience she felt less dependent on techniques and more able to work at a relation level with clients:

“As the weeks progressed I found I wasn’t as rigid, you know, with the scaling questions and the miracle question but what I did start to do was find that I’d be a lot more selective about when I was using them and in any situations I felt stuck I found it a really good resource to come back to.” (Lines: 14-18).

When asked by the interviewer to reflect on what had changed Sophie said she had begun to trust the therapeutic relationship a bit more and felt more confident about using her experience and reactions to clients within counselling sessions. For example, she talked about having the confidence to check out her assumptions without worrying that the client would react negatively, or unnecessarily criticising herself if she was wrong about something. She stated that the solution-focused approach provided an important structure/framework that helped her to find her way and make sense of her work with clients and that solution-focused ‘tools’ were especially helpful in situations where she felt stuck or lost. For instance, at times when she didn’t know what to say in response to a client or felt the client was waiting for her to say something.
Stephen told a similar story about his experience of working with clients. Although, he acknowledged that from the beginning he attempted to privilege his relationship with clients over the impersonal use of techniques he nonetheless found himself initially adhering to the solution-focused approach in a strict manner. Over the course of his first year in practice his working style became less structured, more relaxed and flexible. The following extracts from his interview highlight this shift. In the first extract he is highlighting the way in which the solution-focused approach offered a valuable way of structuring a counselling session and helped to clarify both his and his client’s role within the counselling relationship:

“Being able to put that [structure] in place sorta gave you a good starting point and allowed them [the client] to tell their story. So it gave some structure as to what was expected both from the client and counsellor.” (Lines: 126-132).

Later, he said that while the structure continued to be a useful foundation for his practice he had become more selective about how he implemented it, which he attributed to gaining more clinical experience. Like Sophie, he too found its techniques useful when dealing with therapeutic impasses or times when he felt stuck:

“Certainly, the structure at the start proved a good basis and now it’s just using the different techniques that in the course of the interview you can actually pull on.” (Lines: 201 -203).

A little later he said of his approach “I would say it’s not as structured as it was initially. I think because you were new to it you tended to stick to that.” (Lines: 209-
Stephen attributed this change to experience and stated:

“I think it was a case of seeing different clients with different needs. Some needed the opportunity just to open up and have that time to talk. Others were looking for answers to questions. So it was a case of adapting to the individual client at the time...” (Lines: 220-223)

Even though he applied it more flexibly, Stephen described how the structure and techniques of the solution-focused approach acted as a safety net for him when he encountered difficulties in practice. He talked about the importance of having a structure to fall back on when things weren’t working. For example, when dealing with an unresponsive client or someone who had difficulty “opening up” and also about the need to be selective in when and how he introduced particular solution-focused techniques to ensure he was being sensitive to clients’ needs.

Amy also reported a significant shift in the way she applied solution-focused ideas in her practice. She said:

“The tools that I use now in counselling seem quite natural. They flow quite nicely because I don’t feel worried about using them. I don’t feel anxious. All those feelings have gone. There’s definitely been a development. I can make a judgement when it would be appropriate to use a particular tool and when it wouldn’t. I think it has to be tailored to the situation.” (Lines: 295-302).
This shift to being less structured and more flexible in applying solution-focused techniques and strategies was evident in the account of each participant. Experience of working with clients appears to have been the most significant factor in facilitating this shift. Through their engagement in client work most participants appear to have become more attuned to the relational aspects of their work and more confident in making judgments about the relevance and appropriateness of using particular solution-focused techniques (e.g., the miracle question). Indeed, all participants would appear to have realised the limits of a purely technique oriented approach and endeavoured to find ways of adapting their approach to meet their clients' needs. While it is clear that participants relied heavily on the solution-focused session structure and techniques in the early stages of their first year of practice there was evidence that experience prompted a gradual shift away from rigid adherence to it. And yet, participants' reports indicated that they often retreated to its methods when feeling lost or stuck during conversations with clients.

5.3.3 Engaging in on-going conversations about practice

This concept refers to the forms of dialogical interaction that participants engaged in about their counselling practice. Participants' accounts can be interpreted as indicating three sites of dialogical interaction that were significant sources of influence in shaping their learning and development in relation to the experience of working with clients. These relate to the discursive activity that took place with mentors (i.e., supervisors and senior colleagues), with fellow counsellors in the context of peer-supervision and in relation to the internal or silent dialogue that participants engaged in during periods of private reflection on their practice. In addition to providing opportunities to become more immersed in the language of counselling and to continue to build a therapeutic vocabulary, these activities were also experienced as a
form of ongoing support and as important stress relieving activities. Frances referred to individual supervision on several occasions in her interview. At one point she stated:

"Very early on I had a client who disclosed [sexual] abuse ... I felt so emotional. I couldn't wait to say to [supervisor name] and she took it very coolly but professionally. I thought to myself, 'you have heard that so often and this raw recruit is wanting to bubble or something.' It was just the calm professionalism; the way she talked to me that was helpful. It said to me there is someone there who knows, who can deal with this heavy emotion ... " (Lines: 322-328).

Here, Frances is sharing a conversation with her supervisor about applying the language of counselling to a specific, 'real' problem. There is a sense in which she has placed herself in a 'one-down' position in relation to her supervisor, which may indicate something about her tacit perception of the power dynamic within the supervisory relationship. Nonetheless, her comments suggest that the dialogue or 'talk' that took place between them was helpful insofar as it communicated calmness and professionalism, which reassured her that it was okay to talk about a 'heavy emotion' in supervision.

Another participant, Amy, commented:

"Supervision has definitely been helpful and sometimes not hearing what you wanted to hear. I think it is good that supervision is always very honest and very much about, "Well do you really think? ... it was difficult to hear, 'Well no, it's not the best thing.'"
Amy appears to have construed the experience of “not hearing what you wanted to hear” (which could be interpreted as a potentially negative and undermining encounter) as a positive event, which helped her to stay on track. The supervisory enterprise seems to have been regarded as a collaborative endeavour and concerned with making sense of her work with clients. It could also be seen to be an arena within which the agency values were communicated to counsellors. For instance, her comment, “…it was difficult to hear, ‘Well no, it’s not the best thing’ …” suggests that Amy’s ability to perform the language of counselling with clients was being judged in relation to, and shaped by, the agency’s perception of successful performance.

A number of participants highlighted the importance of ad hoc access to mentors to talk about practice issues. One participant recounted a situation in which she was disturbed by a client’s level of distress in a counselling session. Following the session in question she described experiencing an urgent need to “get rid of” or “pass on” her feelings of distress in order to protect her wellbeing. It appears she had had a similar experience where she did not talk to her supervisor about a distressing client issue and subsequently continued to ruminate about it and feel distressed. Agnes stated:

“Afterwards my sole mission was to source somebody out to talk to me. It didn’t have to be [supervisor name] ... I realised that as soon as I could find somebody to tell
them what had happened I would be absolutely fine. Once it is out I can go home and put it out of my mind. But if I go home and don’t speak about it I can’t stop thinking about it. So that is my way of protecting myself.” (Lines: 424-435).

Agnes went on to say that in the absence of being able to talk to someone that she had found it helpful to write about the experience in her journal. She described how this process of externalising the experience in writing rendered it less threatening and made it easier for her to deal with on an emotional level.

Peer support was another important site of dialogic interaction where participants could talk about on-going practice issues. Margaret highlighted the importance of having the opportunity to talk about challenging and rewarding experiences with other volunteer counsellors immediately after client sessions. She experienced this as cathartic and valued access to this kind of informal peer support between regular individual supervision sessions. Indeed, she remarked that access to brief but even more frequent supervision sessions in the early stages of entering practice would have been helpful.

“... you’ve got too many questions that you’re asking yourself and where do you go with that. Maybe it doesn’t need a full hour at supervision ... even just quarter of an hour or ten minutes would have been really helpful.” (Lines: 599-60).

Internal dialogue was also a significant form of engaging in on-going (private) conversations about practice. Frances explained that over time she began to enjoy the challenge of figuring things out for herself. She talked about an ongoing self-
questioning in relation to her practice and reported an increasing sense of self-reliance and satisfaction in being able to resolve challenges associated with client work without feeling an urgent need for frequent supervision sessions as she did on entering practice. She made the following comments:

“Although at the beginning it was wonderful to go in and say, ‘Well, this is happening’ or to be reassured or guided but I didn’t realise I had stopped doing that until someone asked me if I still do that ... It wasn’t a conscious decision. It just happened ... it’s like now, I like figuring it out, you know, enjoying it in your own mind and thinking, ‘Did you do that right, or that ..?’” (Lines: 345-353).

Sophie, talked about the importance for her in taking time out to reflect on her own process in relation to her client work. She commented:

“It’s an inherent part of the responsibility that we have in sitting down and talking to folk that you do have to keep looking at, ‘Why am I doing this?’ and I think what when things come up for you ... that you feel really sad or whatever as a response to your client, then I think you need to go away and think about that.” (Lines: 457-461).

She went on to say that she typically engaged in this type of reflection while writing up the clients case notes:

“When I start to write the notes from a session, that’s when I start to reflect on stuff. I probably spend more time reflecting than writing because it takes me sideways and I start to think about what that was about for me.” (Lines: 487-490)
Other participants talked about how doing things like going to the cinema, reading and viewing pieces of art facilitated unexpected insights which helped them to make sense of client experiences, their role as counsellors and manage stressful feelings associated with client work. In general, private reflection, individual supervision, regular contact with fellow volunteers together with ad hoc access to senior practitioners were important sources of support, especially in the early weeks and months of entering practice. These activities were valued because they provided opportunities to obtain practical suggestions, guidance and emotional support. Interestingly, participants’ accounts suggest that experience contributed to an increasing willingness to trust their own judgement, a growing confidence in their ability to manage the challenges associated with client work and a gradual decrease in the frequent and urgent use of the support and supervision structures that were available within the MHSS agency.

5.3.4 Reviewing personal ability to perform the language of counselling
This concept refers to the ways in which participants made judgments about their effectiveness as counsellors. It suggests that participants evaluated their effectiveness in accordance with their ability to use the language of counselling to bring about particular ends in relation to their conversations with clients. Participants appeared to evaluate their practice in relation to counselling concepts and values that were embedded in their own evolving philosophy of counselling.

When invited to comment on their estimation of their effectiveness as counsellors each individual represented themselves as an effective practitioner or to have the potential to be (even more) effective. Tom said that he felt that some people could have been helped more during the early stages of his practice. He referred to one
client who presented for counselling following bereavement and commented that because he had not encountered this in a helping capacity before he was “a wee bit scared” and tried to apply an overly rigid approach and as a consequence failed to establish a good working relationship with the person. Overall, he believed himself to be effective and said:

“I think I’m fairly effective ... some people I’ve been very effective with. I think that is mostly people who are pretty much close to knowing what they want to do and are able to do it. And it’s just giving them the opportunity to talk it through.” (Lines: 777-785).

In addition to attributing his effectiveness to clients’ readiness for change and giving them space to talk, Tom emphasised the importance of his capacity to be empathic and to develop and maintain a good relationship with clients:

“I think my ability to maintain a good relationship with the person: to offer empathy. Without doubt, that’s the main thing.” (Lines: 788-789).

Amy made the following comments in her interview about her effectiveness:

“Now, I think I am quite effective. I think in the beginning I was probably effective in a different way. But now I think the range [of issues] I can deal with has definitely increased ... with my new attitude that counselling is about the person who is in counselling and not the counsellor at all, I would say I was pretty effective.” (Lines: 365-371).
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An important dimension to Amy’s belief in her effectiveness was what she referred to as her new perspective on her role and the nature of counselling. In the early stages of practice she was immobilised by a fear of upsetting her clients by saying the wrong thing or by being too challenging. In her own words, she was a ‘yes counsellor’. The turning point came when she realised that this anxiety was rooted in a fear of being disliked and that it was in some cases undermining her effectiveness. It seems that once she acknowledged this and could separate out her fears from her clients’ needs she felt more confident and effective. For instance, she talked about feeling more able to be assertive or to challenge clients if necessary. For Amy, becoming an effective counsellor meant developing self-awareness and a new perspective about her role as counsellor.

Stephen evaluated his effectiveness on the basis on receiving positive feedback from clients and in relation to the extent to which his clients were able to generate their own solutions to their problems and concerns:

“I always felt at the end of a session there is a positive feedback from the client. So I’m doing something. If it wasn’t doing it right then I think I would have got a message from [the client] ...” (Lines: 511-513).

He went on to say:

“I feel it’s going quite well because the people I am seeing are coming up with results for themselves.” (Lines: 517-521).
Frances believed she was quite effective and judged her effectiveness by the extent to which her clients engaged in ‘change-talk’. She described a process of on-going reflection and self-questioning in relation to her sense of her competence and effectiveness. She commented:

"I think I’m quite effective. When I see clients kind of question themselves or thinking or making decisions to bring about change you can sit back and watch and remember their miserable face the first day they came in and see them smiling as they are talking about bringing about change." (Lines: 404-407).

Sophie expressed some uncertainty about her effectiveness but was confident that if she had the opportunity to devote more time to being a volunteer counsellor she could be very effective. When asked how effective she thought she was she said:

"My God’s honest truth is that sometimes I think I’m effective and sometimes I don’t. It’s dead funny because I don’t put any less effort or attention into somebody than anybody else but there’s been times when people have come in and I have thought ‘Your not coming back are you’ ...but I think I’ve got the potential to be very effective but I think I don’t spend enough of my life here." (Lines 521-525).

Sophie described her awareness that she had a tendency to be quite direct and found it difficult to go at other people’s pace, which might have had an adverse effect on some clients. Nonetheless, she believed that experience would allow her to develop her counselling skills and be more effective.
Overall, participants judged their effectiveness in relation to their capacity to form a relationship and be empathic, to respond to a wider range of clients concerns and to facilitate ‘change-talk’ in clients: concepts that are either associated with a generic counselling repertoire or a solution-focused approach to counselling. Entering practice and engaging in helping conversations for the first time was an anxious time for participants in this study. It presented them with many challenges that often invited feelings of self-doubt and a preoccupation with ‘doing things right’, which tended to be expressed in a rigid adherence to the solution-focused model. Over time there was a gradual shift away for this rigidity toward a more flexible, collaborative approach, which was accompanied by a growing sense of competence as a counsellor. Individual supervision, peer support and personal reflection were valued sources of inspiration, guidance and a key ‘defence’ against the stresses and challenges associated with client work, especially in the initial months of practice.

5.4 Main Category 4: Experiencing & Resolving Dissonance

Experiencing and resolving dissonance refers to the more enduring and deeply felt struggles and dilemmas experienced by participants, and the strategies they employed to resolve them, in relation to being a volunteer counsellor within the MHSS agency, and more generally to the process of developing an identity as a counsellor. Consequently, this kind of dissonance is not intended to refer to the cognitive dissonance theory proposed by Festinger (1957), which is concerned mainly with inconsistencies between people’s attitudes and their behaviour (Taylor et al. 2000).

The process of experiencing and resolving dissonant experiences emerged as an ongoing and central dynamic to participants’ development as counsellors. The tension
created by these disharmonious experiences pulled counsellors toward ways of thinking and behaving that facilitated their resolution. For two people (i.e., Lily and Sophie) this meant abandoning their involvement in volunteer counselling. Other individuals found ways of resolving dilemmas that facilitated their continued involvement as volunteer counsellors, which in turn, strengthened and provided further validation for a feeling of resonance with counselling and the role of counsellor. All of the participants reported experiencing and resolving dissonance in relation to: a) the solution-focused approach; b) being in practice; and c) establishing and maintaining an identity as a counsellor. These categories are described below.

5.4.1 Experiencing and resolving dissonance in relation to the solution-focused approach

As noted previously, the solution-focused approach was the core counselling model employed within the MHSS counselling service. Participants first encountered this model during the brief counselling training programme within this agency. This training experience was integral to their involvement with the agency and a prerequisite to their work as volunteer counsellors within its counselling service. Although the majority of participants reported positive reactions to this model two participants expressed criticisms of it.

Margaret expressed general doubts about her affinity with this approach and had strong negative emotional reactions to particular solution-focused techniques. At several points in the interview, while talking about her engagement with the solution-focused approach, she expressed doubts such as, “I felt very doubtful about the solution-focused approach” (Lines 215-216); “I don’t really think I fit totally into this” (Line 369). She talked about having felt antagonism toward the use of the
technique of the 'miracle question', which is intended to facilitate clients in envisioning a future free of their present concerns or where they are less problematic. This is intended to contribute to helping clients formulate and work toward goals for change. She stated:

"...I was a bit antagonistic but didn't show it towards, you know, magic wands! That really is a bit troubling...it was going against what I felt was right ..." (Lines: 386-387).

Margaret appears to have experienced a conflict between her values and those she believed to be embedded in the language of solution-focused model (i.e., “...it was going against what I felt was right...”). She also reported being sceptical about the validity of the idea that every problem had a solution and was unsettled by the overt emphasis on goals, being positive and finding solutions because it might appear false and uncaring to clients. She had struggled with this dilemma throughout the MHSS training and her account suggests that it was intensified as she began to see clients within the agency’s counselling service. Nonetheless, she continued to struggle with it because she wanted to take advantage of the opportunity to work with clients on a one-to-one basis within the MHSS agency and build on her prior experience of being a telephone counsellor. This personal goal seems to have provided Margaret with the impetus to find ways to resolve her struggles with this counselling model. She employed several strategies that helped her to achieve a satisfactory resolution to this ‘jarring’ with solution-focused techniques. One strategy involved construing her previous experience as a telephone helpline counsellor as a form of solution-focused practice. She commented:
“How was I going to manage that [doubts about the solution-focused approach] because that was [pause] and then I thought hey, but you’ve sort of done this thing anyway with the telephone work.” (Lines: 216-218).

Another important strategy revolved around reframing the meaning of the word ‘solution’. She said:

“Well you see, solution is an interesting word. I think I looked at it previously as a sort of final thing: a resolution. Whereas a solution (emphasising and pausing) ... can be a variety of things ... “ (Lines: 249-252).

Redefining the meaning of the word solution allowed Margaret to accommodate the idea of being solution-focused within her evolving philosophy of counselling. Indeed, she remarked that this reframing made it more palatable to her and was “Like adding sugar to what they used to do to medicines for children” (Line: 260). When asked by the interviewer about her reasons for continuing to struggle with this internal conflict she stated, “I think I wanted to because another aspect is wanting to develop and have the experience of working with people face to face. That was really important” (Lines: 397-399). Margaret’s investment in developing her competence and range of experience as a counsellor would appear to have played a significant part in determining her willingness to continue to struggle with these dissonant experiences and find ways of resolving them.

Stephen, too, objected to solution-focused techniques, which he regarded as impersonal. His interview is replete with references to the importance of personal
relationships to successful counselling and he seems to have struggled with a feeling that the application of these techniques in a mechanistic and formulaic way would have a detrimental effect on his relationships with clients. He remarked:

"You could talk techniques and you could know theories and everything else but is was actually about the person himself and how they took that on and what that meant to them ... I felt you could learn all the techniques that you wanted but unless it really meant something to you then there was no way you could relay that over to someone else that you were in a session with ... it's very much a personal thing." (Lines: 12-18).

Stephen’s account indicates that he valued a relational approach to counselling over a more technique oriented stance, which he associated with the solution-focused model. He believed that he needed to ‘own’ the techniques, to personalise them in some way before he could use them in the context of a counselling session. He went on to say that developing a personal approach which incorporated values and strategies that he believed in helped him to resolve this tension and find a way of working that suited him.

"I found the techniques impersonal ... okay there is a process to go through, but it's what you actually put into it, you know, form your own point of view whether it be trust or being genuine and that type of thing. It's mixing that all in, all together...it was actually having an eclectic look at it and not just purely focusing on the solution-focused approach." (Lines: 61-65).
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Stephen seems to have been exercised by a search for a way to express himself within counselling relationships which felt genuine and authentic as opposed to merely applying techniques to ‘fix’ people. Hence, he personalised the techniques in order to guard against coming across as distant or impersonal to his clients.

5.4.2 Experiencing and resolving dissonance in relation to being in practice

The themes involved in this area of dissonance were associated with conflicts that some participants experienced in relation to developing a framework for practice, coping with the complexities of client work and the experience of receiving supervision. One participant, Tom, appears to have been engaged in a struggle to release a part of himself that he intuitively recognised as having a role to play in relation to his client work. On the one hand he wanted to bring more of himself into his client work but on the other hand he was anxious about imposing on the client his own values and ideas about what they should or should not do to resolve their particular problems in living. Tom’s desire to be authentic with his clients contributed to what he described as a “mismatch” between what he felt he should be doing (i.e., following the rules) and an intuitive desire to be spontaneous and bring other parts of his ‘self’ to his work with clients.

“I wasn’t being fully myself ... I was still kind of ‘putting on the counsellor’. There was a part of me that was there, that I felt had some part to play, but I couldn’t bring it out...I still feel there’s a way to go in that [but] I feel I’ve managed to come a fair distance.” (Lines: 610-617).

It appears that this on-going struggle helped Tom to let go gradually of the façade of the counsellor role and to articulate a more authentic voice as a counsellor. Margaret
too, seems to have struggled to achieve a level of authenticity that accommodated her own values and beliefs with that of the agency. During her interview she drew attention to the factors that influenced the way she expressed her ‘counsellor-self’. Prior to making the following comments she had been talking about the ways in which some of the techniques associated with the preferred core counselling model within the MHSS agency had jarred with her own sensibilities about how to ‘do’ counselling (see previous section). In relation to her engagement with MHSS, she was concerned to integrate her own values and beliefs about counselling with that of the agency while being sensitive to her clients’ needs. This was clearly challenging, but she appeared to be saying that she eventually clarified this for herself through an ongoing process of reflection and self-questioning.

"Isn’t it tough! It’s a bit ambiguous in my own mind, but I think there is a certain questioning of what will be appropriate at the time working with that client. And actually, what will be appropriate for (emphasising) THIS AGENCY, OK. And I suppose I’ve also learned what is appropriate for me ..." (Lines: 300-304).

This cycle of experiencing and resolving dissonance in terms of the ‘goodness of fit’ between counsellors’ perceptions of agency expectations and personal values and beliefs was a common theme for participants. Margaret was beginning to discover her own voice within the ‘community of voices’ that surrounded her engagement with counselling within this agency. Ultimately, the resolution of this kind of dilemma contributed to her being able to establish a framework for practice that remained more or less faithful to her values and beliefs within the context of the agency’s
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expectations and culture. This latter point is important because it highlights the extent to which the environment shaped the expression each participant’s ‘counsellor-voice’.

Another individual, Amy, described herself as a “yes counsellor” and recounted instances where she felt overwhelmed and intimated by clients. Although she wanted to address such situations she worried about challenging clients because of a lack of assertiveness and a fear that if she did so the client would be upset and not return to counselling. Amy reported one experience which seemed to have been a turning point in her struggle with this ongoing dilemma:

“A particular client who comes to mind is a client who seemed quite aggressive and he came across as quite aggressive. He was constantly swearing, he moved a lot, his manner was aggressive. He would be quite frequently be invading your personal space. In the beginning I let it go ... but then I think I realised that if we were going to get anywhere I had to put aside my own fears of being disliked or upsetting a client and think, ‘we’re not going to get anywhere with you being aggressive and or being able to discuss this.’ I was prepared to take more of a risk.” (Lines: 206-213).

Amy attributed her ability to overcome this dilemma to experience, to growing self-awareness and the fact that her role had become more clearly defined and less fuzzy in her own mind.

Lily reported a difficult relationship with her supervisor, which compounded other difficulties she was experiencing related to her counselling role. She said that her supervisor reminded her of a former boss who was unsupportive and critical. This
resulted in her not talking to her supervisor about difficult issues that had arisen in her practice because she felt she would be labelled as the problem. She stated:

“I don’t think [supervisor name] was a good supporter ... I got to the point where I just didn’t tell her about things.” (Lines: 442-446).

Lily’s account indicates that this situation was a source of ongoing stress, which was intensified by a growing feeling of powerlessness because she did not believe she could do anything to resolve it. Regrettably, this situation was compounded by other concerns and contributed to her decision to leave the agency.

Overall, experiencing and resolving dissonance in relation to being in practice concerned a number of diverse themes, such as striving for a more authentic way of relating to clients that incorporated participant’s personal values. A central theme related to a struggle to establish a framework for practice that was faithful to the values of each participant, and which also accommodated agency expectations related to practice.

5.4.3 Experiencing & resolving dissonance in relation to establishing & maintaining an identity as a counsellor

This concept refers to the dilemmas that participants experienced in relation to establishing an identity as a counsellor or continuing their practice as volunteer counsellors within the MHSS agency. Two participants in particular reported difficulties in this area and eventually decided to stop being volunteer counsellors.

The following extract highlights the way in which an opportunity to pursue career
development opportunities with more financial reward within the context of an established career in another human service profession silenced Sophie’s emerging identity as a counsellor. This appears to have been a difficult experience. On the one hand, this participant expressed a strong desire to spend more time counselling to develop her competence and also harboured ambitions to become a professional counsellor. On the other hand, such a future seemed uncertain and lacked the possibility of financial reward which would be available to her if she continued to pursue opportunities within her current job – which in turn would mean she could maintain her current standard of living. In the end, this person resolved this dilemma by deciding to abandon her ambitions to become a counsellor in favour of furthering an existing career path. This is how she explained the dilemma:

“... I spent probably about four or five months last year... thinking, how do I make this happen for myself and it’s been really difficult ... I’m at a time in my life where I’ve got an awful lot of experience in what I do and in order to start to develop professionally I either stop doing what I’ve been doing or I continue with what I’m doing [i.e., counselling] ... so that’s kind of been a dilemma, it’s been difficult actually. I’ve felt quite split. Oh, I mean I would love to do it [counselling] full time but ... I don’t know whether I’m committed enough to give up a salary and go and do [it]...I would love to but it’s about making the right move cause it’s going to kind of formalise where I’m at in my life you know in terms of what I’m earning, what I’m doing." (Lines: 372-396).

Sophie seems to have reached a turning point in her life in terms of her professional development at least. One cannot say for certain what role being a volunteer
counsellor played in her life. However, it is evident from her interview that the timing of her involvement in counselling both as a client and her engagement in training and volunteering was related to a time of change and transition in her life, which has been reported elsewhere in this chapter. Perhaps her engagement in training and client work together with ongoing personal therapy were but some of a multitude of factors that played facilitative roles in assisting her to navigate this period of transition. Indeed, she described the benefits of being a volunteer counsellor in terms of increased self-awareness and enhanced interpersonal competence: essentially, it was about personal development.

Returning to Lily’s experience, it is apparent that a primary goal associated with her involvement in the activity of volunteer counselling concerned her desire for affiliation with others: to be in an arena where she had the opportunity to meet and socialise with other people. This is an example of resonating with the agency in terms of the opportunity it afforded Lily to pursue a personal goal to connect with other people. Indeed, she stated this clearly in her interview. In relation to establishing and maintaining an identity as a counsellor, many of the problems Lily encountered appear to have arisen because her goal of meeting other people was not sufficiently realised through being a volunteer with this agency.

In addition, Lily’s experiences of supervision and client work highlight the fact that at times she felt unsupported and was aware that she may not have been most suited to this kind of role. Ultimately, a combination of factors contributed to her decision to leave the agency and pursue other similar volunteering work, which she stated was more rewarding for her. The following series of extracts from her interview (which
took place after she had left the agency) illustrate some of key issues that she struggled with in relation to establishing an identity as a volunteer counsellor. In this first extract, Lily talks about how writing in her journal helped her to come to the realisation that she wanted to leave.

“I kept writing it and writing it and going back and reading it again, you know. When I had another occasion to write it down, I would say, 'I've written that before. I've written exactly the same as that before so what am I still doing here.' And it was while I was in that frame of mind with whatever it was, either no clients turning up or wanting support and not getting it, that one day I saw this advertisement in the paper for [another volunteer/support job]. And I answered it, got an interview and started their course.” (Lines: 477-486).

Lily explained that she continued with her counselling and this new role for a while but soon realised she was enjoying the latter and decided to leave the MHSS agency. She also described the how the loss of a significant person in her life impacted on her client work and ultimately her decision to leave.

“Added to this of course my [names person] died and that knocked me sideways as well. I think in a way I needed something cheerier than listening to a depressed person ...I think I lost patience a wee bit as well because of that, you know, because I thought, ‘Oh come on we could all lie down and behave like that and you know I’m not doing it’. That came through for me because of that [person dying].” (Lines: 495-503).
In the end, Lily resolved these issues by leaving the MHSS agency and taking up a volunteering/support role with another agency where there was a less formalised type contact with 'clients', and where there was more interaction with colleagues while carrying out her volunteering duties. She described the difference as follows:

"Well the difference is that people haven't made an appointment where I'm meant to sit with them for an hour and they don't turn up. We [i.e., new agency] don't make appointments. They just turn up and you see people ...you're just giving help at the point of where they need help. " (Lines: 541-558).

Lily made it clear in her interview that things did not work out for her at MHSS because she felt there was a lack of support and not because of the actual counselling or contact with clients. It is interesting to note, however, the extent to which contact with others was a critical factor in contributing to her decision to explore this activity and that her experience of a lack of contact with others was a significant factor in her decision to leave and find another volunteering activity, which appeared to match better what she was looking for at that particular time.

In summary, participants experienced a range of dilemmas and struggles related to pursuing, establishing and maintaining the role of volunteer counsellor. Participants used a variety of strategies and resources to resolve dilemmas such as seeking support and advice, adopting a different perspective, developing self-awareness, obtaining further training or abandoning their involvement in volunteering.

These struggles appear to have been a 'normal' and ongoing part of participants'
experience. Although each participant in this study expressed a desire to help others as a reason for becoming a volunteer counsellor not everyone was able to establish an identity as a counsellor and articulate this helping voice through this activity. Less than a year after joining the counselling service two people abandoned their involvement in this activity for different reasons: one because of negative experiences and the other because of an opportunity to develop her career. The other six people appear to have found ways to resolve their dilemmas which provide sufficient validation of an emerging voice as a counsellor to allow them to continue in the role.

The question of why some individuals stayed and others quit is important to understand because of its implications for selection and retention of volunteer counsellors within services. Based on the data in this study it is not possible to offer a definitive answer to this question. However, one could reasonably suggest that the extent to which individuals realise the goals they are pursuing in becoming a volunteer counsellor may provide good indications of who will stay and those that are likely to leave. This is strongly suggested in Lily’s account as reported above and expanded on in the next section.

5.5 The Core Category: Finding a voice

In the grounded theory approach a core category is meant to capture the meaning of the phenomena of investigation in a holistic way. It should embrace the meaning common to all other categories and the relationships between them. In essence, it should contain the core meaning of the phenomena being investigated (Charmaz 2006; Strauss and Corbin 1998). Analysis of the interview transcripts of this group of individuals’ experiences of becoming volunteer counsellors yielded a core category,
The metaphor of finding a voice denotes a process of development that embraces participants’ experiences of informal helping, their engagement with counselling and quest to achieve and sustain an identity as a counsellor. This process was shaped by the experience of resonating with counselling and the role of counselling, learning the language of helping, putting this language into action within helping conversations and experiencing and resolving dilemmas in relation to being a volunteer counsellor. Through these experiences participants engaged with, appropriated and positioned themselves within a discourse concerning the nature of counselling and the role of counsellor.

Within this discourse participants had at their disposal a range of conversational resources, linguistic concepts, images and metaphors that facilitated and shaped the way in which they expressed their own voice within the ‘community of voices’ (e.g., trainers, supervisors, peers, clients) that surrounded their engagement with counselling with the MHSS agency. A significant theme running through this analysis, therefore, is that the experience of becoming a volunteer counsellor was about acquiring a language, which gave expression to a desire to help others and enabled participants to talk about, enact and construct meaning out of their helping experiences and the process of developing an identity as a counsellor.

These themes are embedded in the main categories that emerged in this analysis and represent common experiences among this group of people, which highlighted that successful resolution of areas of dissonance contributed to a deepening of the
experience of resonance with counselling, the role of counsellor, the agency and its
counselling approach. It is important to note that the categories described in this
chapter are not being defined as discrete or hierarchical processes. Instead, it is
proposed that the process of finding a voice involved a plurality of processes
operating in a synergistic fashion.

To illustrate these processes Tom’s experience is described in more detail below
because it exemplifies quite well the successful establishment of an identity as a
volunteer counsellor. Following this, Lily’s experience is described because she tells a
different story: one characterised by overwhelming challenges and dissonant
experiences that silenced her emerging counsellor-voice and led to her abandoning her
engagement with the MHSS agency as a volunteer counsellor.

5.5.1 Tom’s story
For Tom, the experience of resonating emerged from his experience of receiving
counselling during a time of personal distress. He found the counselling helpful and
this experience sparked an interest in this form of helping and he began to explore
training opportunities to test out his potential as a counsellor. The experience of
resonating with counselling was reinforced for Tom by his informal helping
experiences. He described himself as someone who was predisposed to listening and
talking to people. However, he was often frustrated by his inability to ‘say the right
thing’ in helping situations. Therefore, Tom’s decision to enter training was also
shaped by a desire to build on his existing helping vocabulary to enable him to enact
his helping intentions.

The experience of learning the language of counselling through training appears to
have increased Tom’s sense of self-efficacy as a counsellor and, although he had some anxieties about seeing ‘real’ clients following the MHSS agency counselling training, he stated that he “felt he had learned enough to not make a big disaster” (Lines: 75-76).

During the training experience, he also reported resonating with the solution-focused approach and the agency environment. For example, he commented that this counselling model made a lot of sense to him and corresponded with his own way of thinking about things. He described a sense of ‘fit’ with the agency environment, which he felt “suited him” and allowed him to develop his interest in counselling.

Working with ‘real’ clients afforded Tom the opportunity to put the language of counselling into action. Initially, he applied this language in a rigid manner and with experience became more flexible. He described this process as “learning to do things mechanically and then eventually they became more like second nature.” (Lines: 214-215).

He expanded on these comments later in the interview and said:

“...the solution-focused thing, I guess at first I thought you do this and you do that [with clients] and it will work. Well, I do that a lot less now, you know, structured wise.” (Lines: 282-284).

The movement toward a more flexible way of engaging with clients is related to Tom’s experience of exhausting his vocabulary of helping skills. He described
“feeling stuck” (Line: 375) and “a bit lost” (Line: 378) by the end of the second or third session with clients because he had “used up all the techniques” (Line: 386).

Encountering limitations in the solution-focused language that he had learned was a significant challenge for Tom in the early months of practice. As a result of this experience he recognised a need to develop more skills to help him to keep the conversation going when working with clients. Tom overcame this challenge by pursuing further training in counselling skills outside the MHSS agency, which helped him to refine and develop his existing skills. He said that:

“Although I wouldn’t say I’ve picked up any new techniques from that at all, I think I’ve done some more practice and I think I’ve kind of refined my skill, in the relationship, though doing this course.” (Lines: 465-467).

Engaging in this additional training seems to have helped Tom to expand his stock of conversational resources and enabled him to engage in therapeutic conversations with clients more confidently and flexibly. During this time Tom was also struggling with a significant dilemma related to his way of being as a counsellor, which was described earlier in relation to experiencing and resolving dissonance. He used the metaphor of “putting on the counsellor” (Line: 610) to draw attention to the dissonance he experienced as he became more aware that he was not being fully himself in the role of counsellor. He was trying to figure out how to articulate more of ‘himself’ in his work with clients but was struggling to do so because he was concerned that by doing so he would be imposing his values on them. As he gained more experience he began to resolve this dilemma. He described it in this way:
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“It’s like sharing insights or impressions but in a way that isn’t you imposing that on the person. It’s putting it on the table and saying ‘How does that look to you? What is that saying to you?’ ... At first, I thought that had got no part in what we do, well not no part but I would go right away from that because I was so concerned that my agendas and my perceptions would be what’s coming out. I feel I’ve now got to the point where I am now able to say ‘Well, that’s not my agenda. That’s something I’m picking up from the client.’ And I can offer it in a way that gives them [clients] the chance to discuss it rather that me trying to make them see that this is what’s going on. I feel more able now to do that and in a helpful way.” (Lines: 681-690).

Resolving this dilemma reinforced Tom’s feeling of identification with counselling and the role of counsellor. Indeed, his willingness to find ways to overcome the challenges he faced during the experience of training and while in practice would appear to indicate a deepening of the experience of resonance. For instance, the experience of resonance was evident following completing of the MHSS counselling training programme. At that point he recalled thinking, “Yeah, I think I can do this.” (Line: 322). Tom believed he had developed sufficient self-awareness and had learned enough to start working with clients. At the end of his first year in practice he had a clearer sense of what he could offer in a counselling relationship.

“I think what I’ve learned is that I can offer things in the relationship. I can offer things that help clients see things more clearly, that can aid them in the process of becoming self-aware and see what’s going on. And also being able to sort out fears and things in the back of their mind.” (Lines: 648-652).
Tom’s story suggests that he was evolving a way of working that felt ‘right’ for him. The preceding quote suggests that he believed he had acquired sufficient mastery of the language of counselling to enable him to use it in specific ways. Fundamentally, for Tom, the process of finding a voice meant being able to use the language of counselling to articulate a more congruent and authentic counsellor-voice.

5.5.2 Lily’s story
Lily said that her interest in counselling was derived from her work in a human service profession that involved working closely with other people. She realised that she had actually been engaged in counselling oriented work without realising it and so she decided to attend some workshops on counselling to satisfy her curiosity. Lily was inspired by the opportunity to reach out to people in need through counselling, in much the same way that her grandmother did through her willingness to make time to listen to help others during the course of her daily routine.

Entering the MHSS counselling training programme was a positive experience overall. She reported a strong sense of identification with the solution-focused approach, which reflected her own way of tackling problems. Personal development was a significant area of interest for Lily during the training and she nurtured this interest through keeping a personal journal. Being with and interacting with other people was also an important element of her satisfaction with the training experience.

However, she reported that “problems” emerged when she entered practice following the MHSS agency counselling training programme. At one point in her interview she commented:
“That somebody that has depression and just wants to come back week after week and go over the same story ...I really get fed up with that. That’s just me. I really want them to pick up things and start moving. That to me was a success story, when somebody actually did something.” (Lines: 397-399).

Her relationship with her supervisor was particularly difficult. Lily felt criticised and undermined by her supervisor and stated that she had “got to the stage of thinking I’m not going to tell [supervisors name] about certain things”, (Lines: 457-458). The requirement to participate in an activity that she experienced as unhelpful and stressful was one of the factors that contributed to Lily’s decision to leave the MHSS agency. The most significant area of conflict emerged when she entered practice. She reported feeling increasingly isolated from her peers and members of the counselling team. This may, in part, have been related to the fact that the MHSS counselling service was operated out of different centres and volunteer counsellors did not always have immediate access to other members of the counselling team (although members of agency staff were available in each centre). She commented:

“I got the feeling there would be a team and back up. I was nae wantin’ back up once a month. Supervision once a month?! I wanted other people to be there. And that’s what I needed and I didn’t get. Now that’s why it didn’t work for me. It wasn’t the actual counselling that didn’t work.” (Lines: 199-204).

The desire to have contact with other people was a recurring theme in Lily’s story. Indeed, she stated that becoming a volunteer counsellor was about spending time with others because she lived on her own and had limited contact with people during the
course of her day. Toward the end of her interview she commented that she was disappointed that relationships formed during the MHSS counselling training did not extend beyond the training itself. Reflecting on the whole experience she said:

"The counselling skills were good to have but maybe sitting for an hour with a person in a one-to-one was not for me ...I wouldn't for one minute think that it had all been a waste of time. I don't think that at all. It was a valuable learning process but it was just that it didn't work out. I've moved on." (Lines: 598-606).

Lily left the MHSS agency to join another agency where she continued to volunteer in an advice-giving role, which she said suited her much more. Although she was stoical about her experience of being a volunteer counsellor, her experience was characterised by feelings of isolation, alienation from her supervisor, frustration and impatience related to her work with clients. Lily appears to have carried these feelings by herself and did not seem to have access to resources within the agency to help her to resolve these issues. Private reflection and writing in her journal were the means by which she ‘worked-through’ these dilemmas and eventually decided to move on to something else.

As previously noted, the concept of experiencing and resolving dissonance was a central dynamic in the process if finding a voice as a volunteer counsellor. Tom’s story illustrates a process of successful resolution of dilemmas, which made it possible for him to build a sense of competence and self-efficacy in the role of counsellor. So much so that he was making plans to pursue professional training in counselling. Lily’s experience, on the other hand, illustrates the outcome of ongoing,
pervasive challenges and dilemmas that were not satisfactorily resolved: the silencing of an aspiration to express oneself as a counsellor.

5.5.3 **Summary of concept of finding a voice**

In summary, the concept of finding a voice can be regarded as a dynamic process that began with participants’ experience of a feeling of resonance. Through the experience of personal distress or exposure to counselling in other arenas, participants ‘discovered’ a part of themselves that resonated with counselling and the role of counsellor, which prompted them to enter training and become volunteer counsellors. The training experience, and indeed supervision, was largely about acquiring a language of helping that enabled participants to build on and develop a repertoire of knowledge (including knowledge of ‘self’), skills and strategies with which to engage in and navigate helping conversations. Working with clients and engaging in supervision and private reflection provided further opportunities to extend this helping repertoire and to construct a personal understanding of the meaning of counselling and how this could be articulated in practice.

The process of finding a voice was shaped and strengthened by the resolution of dissonant experiences that arose during the course of learning the language of counselling, putting this language into action and, more generally, from the challenges that participants encountered in pursuing and sustaining their engagement in voluntary counselling. In most cases, overcoming challenges and successfully resolving dilemmas along the way served to enrich and deepen the experience of resonance with counselling as an activity, the role of counsellor, and contributed to participants being able to begin to evolve a personal approach and working style. For Lily and Sophie, however, the desire to express a counsellor-voice was silenced or perhaps it may be
more appropriate to say that it was transformed and found expression in different helping roles and contexts.
Chapter 6

Differences between more and less effective volunteer mental health counsellors

6.0 Aims of chapter
The aims of this chapter are twofold. First, pre-post CORE-OM data, effect sizes and rates of client recovery and improvement are reported for each of the 12 paraprofessional counsellors that participated in Study 1. Counsellor effectiveness was determined by the size of the effect they achieved in relation to client outcomes. Effect size calculations in this sample showed that counsellors varied significantly in their effectiveness. Second, a preliminary examination of individual differences among the three more effective and the three less effective counsellors was carried out in relation to their effectiveness, personal philosophies, and the theoretical perspectives that informed their counselling practice. For this analysis, qualitative data from client and counsellor self-report questionnaires (see Appendices C, D, and E) collected for Study 1 regarding client and counsellor experiences and perspectives on the process and outcomes of counselling were combined with qualitative data from participant interviews carried out for Study 2.

6.1 Effectiveness of individual counsellors

6.1.1 CORE-OM data
Table 6.1 presents the pre-post counselling CORE-OM scores and effect sizes for the 12 counsellors that participated in Study 1. Counsellors are rank ordered in Table 6.1 from most to least effective according to the effect size they achieved in relation to client outcomes. In this group of practitioners, Counsellor 1, row 1 in Table 6.1, was the most
effective counsellor with an effect size of .96, and a mean pre-post counselling reduction in CORE scores of 6.17. Counsellor 12, row 12 in Table 6.1, was the least effective with an effect size of .21, and a pre-post difference of 1.39 on the CORE-OM. Overall, the effect sizes indicated that individual counsellors varied in their effectiveness.

Levels of client distress at intake were broadly similar across the majority of counsellor caseloads with mean CORE-OM scores for clients falling within the moderate range of distress (i.e., CORE-OM scores within the range of 15 to 20). However, mean CORE-OM scores for client caseloads for Counsellors 9 and 10 shown in Table 6.1 fell within the mild range of distress (i.e., CORE-OM scores within the range of 10 to 15). Counsellor 3, one of the more effective counsellors, had a mean client CORE-OM score of 21 at intake, which was the highest in this sample and indicated levels of client distress that were within the moderate-to-severe range.

Table 6.1 also shows that there were differences in the number of clients seen by each counsellor. For example, Counsellor 9 contributed only two clients with pre-post CORE-OM data, while Counsellor 4 contributed 32 clients. In part, such differences may reflect variations in the number of hours per week individual counsellors devoted to counselling with the MHSS agency (see section 3.3.8 of the methodology chapter in this thesis).

Another interesting point to note from the data in Table 6.1 is the disparity in effect sizes between the more and less effective counsellors in this group of practitioners. For instance, Counsellors 1, 2, and 3 achieved what can be considered to be large effect sizes (Cohen 1988) that were significantly greater than the other counsellors. Similarly, Counsellors 10, 11, and 12 achieved relatively small effect sizes compared to other
counsellors in this sample. Further analysis of the outcomes for the three more effective and the three less effective counsellors in this sample is provided later in this chapter.

Table 6.1 CORE-OM scores and effect sizes for each counsellor

<table>
<thead>
<tr>
<th>C</th>
<th>n</th>
<th>Pre-counselling</th>
<th>Post-counselling</th>
<th>Pre-post difference</th>
<th>Effect size*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>1</td>
<td>4 (7)</td>
<td>17.13</td>
<td>3.24</td>
<td>10.96</td>
<td>8.48</td>
</tr>
<tr>
<td>2</td>
<td>7 (12)</td>
<td>19.36</td>
<td>3.52</td>
<td>13.10</td>
<td>8.72</td>
</tr>
<tr>
<td>3</td>
<td>6 (12)</td>
<td>21.00</td>
<td>7.06</td>
<td>13.53</td>
<td>9.40</td>
</tr>
<tr>
<td>4</td>
<td>32 (43)</td>
<td>18.72</td>
<td>5.66</td>
<td>13.54</td>
<td>7.25</td>
</tr>
<tr>
<td>5</td>
<td>8 (12)</td>
<td>17.85</td>
<td>5.61</td>
<td>12.92</td>
<td>8.31</td>
</tr>
<tr>
<td>6</td>
<td>9 (11)</td>
<td>19.27</td>
<td>5.94</td>
<td>14.37</td>
<td>10.35</td>
</tr>
<tr>
<td>7</td>
<td>23 (32)</td>
<td>18.82</td>
<td>7.09</td>
<td>14.40</td>
<td>8.10</td>
</tr>
<tr>
<td>8</td>
<td>6 (10)</td>
<td>16.37</td>
<td>6.98</td>
<td>12.27</td>
<td>6.29</td>
</tr>
<tr>
<td>9</td>
<td>2 (3)</td>
<td>13.53</td>
<td>3.74</td>
<td>9.56</td>
<td>10.39</td>
</tr>
<tr>
<td>10</td>
<td>6 (7)</td>
<td>13.60</td>
<td>9.44</td>
<td>10.19</td>
<td>8.50</td>
</tr>
<tr>
<td>11</td>
<td>9 (11)</td>
<td>16.69</td>
<td>8.14</td>
<td>13.40</td>
<td>9.94</td>
</tr>
<tr>
<td>12</td>
<td>6 (11)</td>
<td>18.69</td>
<td>6.82</td>
<td>17.30</td>
<td>6.06</td>
</tr>
</tbody>
</table>

Column one denoted ‘C’, represents each counsellor – rank ordered from most effective to least effective according to effect size. n represents the total number of clients seen by each counsellor: the top number = clients with pre and post CORE-OM scores. The number in brackets is the overall number of clients seen by each counsellor. *Effect sizes were calculated as difference of pre-post means divided by the pooled SD.
6.1.2 Reliable and clinically significant improvement rates

Table 6.2 presents reliable and clinically improvement rates for each counsellor’s caseload based on the total number of clients for whom pre and post CORE-OM data were available \((n = 118)\). In keeping with the way in which reliable and clinically significant improvement was evaluated for the complete sample of counsellors in this study (see section 4.0.1 of Chapter 4), rates of change for each counsellor was evaluated by examining the extent to which clients’ pre-post counselling scores reflected: a) reliable improvement (RI) - defined as a decrease in CORE-OM scores of 5 or more points; b) reliable and clinically significant improvement (RCSI) – a decrease of 5 or more points in CORE-OM scores and movement form the clinical (above 10) to the non-clinical range (below 10); and c) reliable deterioration – defined as an increase of 5 or more points on the CORE-OM. Clients meeting criteria for reliable change are regarded as having improved and recovered if they meet the criterion for RCSI. Both categories are combined in column three in Table 6.2 to show the overall percentage of clients that showed improvement.

Eight counsellors achieved outcomes where 50% or more of their clients met the criterion for recovery or improvement according to CORE-OM benchmarks (Mullin et al. 2006). The overall percentage of recovered of improved clients for four counsellors fell well below 49%, indicating that these counsellors were operating within the bottom quartile or 25% in terms of CORE-OM effectiveness benchmarks (Mullin et al. 2006).

Rates of recovery and improvement for clients seen by five of the counsellors in this sample showed reliable deterioration. Rates of reliable deterioration for clients seen by these five counsellors ranged from 11% of clients for one counsellor (i.e., Counsellor 6) to 22% of clients for another counsellor (Counsellor 12). The rates of reliable
deterioration evident in individual counsellors’ clients is significantly higher than existing CORE-OM benchmarks, which have been reported to range from 1.8% to 3% (Mullin et al. 2006). Counsellors 10, 11, and 12 had the highest rates of reliable deterioration, and they were also the three least effective counsellors in this sample.

Table 6.2 Reliable and clinically significant improvement rates for each counsellor

<table>
<thead>
<tr>
<th>Counsellor*</th>
<th>n</th>
<th>Recovered or improved</th>
<th>RCSI</th>
<th>Reliable improvement only</th>
<th>No reliable change</th>
<th>Reliable Deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Count</td>
<td>%</td>
<td>Count</td>
<td>%</td>
<td>Count</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>3</td>
<td>75</td>
<td>3</td>
<td>75</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>4</td>
<td>57.1</td>
<td>2</td>
<td>28.5</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>5</td>
<td>83.3</td>
<td>3</td>
<td>50</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>32</td>
<td>16</td>
<td>50</td>
<td>10</td>
<td>31.2</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>8</td>
<td>5</td>
<td>62.5</td>
<td>4</td>
<td>50</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>9</td>
<td>4</td>
<td>44.4</td>
<td>3</td>
<td>33.33</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>23</td>
<td>7</td>
<td>30.4</td>
<td>4</td>
<td>17.3</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>6</td>
<td>3</td>
<td>50</td>
<td>2</td>
<td>33.3</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>2</td>
<td>100</td>
<td>1</td>
<td>50</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>6</td>
<td>3</td>
<td>33.3</td>
<td>1</td>
<td>33.3</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>9</td>
<td>6</td>
<td>66.6</td>
<td>3</td>
<td>33.3</td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>6</td>
<td>2</td>
<td>33.3</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

*Counsellors rank ordered in terms of effectiveness in relation to effect size as per Table 6.1. n refers to number of clients with pre- and post CORE-OM data for each counsellor.
It is interesting to note that counsellors overall performance in terms of their effectiveness in relation to CORE-OM recovery and improvement rates reported in Table 6.2 does not accord with their overall effectiveness ranking in relation to effect sizes detailed in Table 6.1. For example, more than 66% of clients seen by Counsellor 11 with pre-post CORE-OM data \( (n = 9) \) were recovered or improved following counselling; however, this counsellor only achieved a relatively small effect size of .36 (please refer to row 11 in Table 6.1). Discussion of this methodological issue can be found in section 7.3.1.1 in Chapter 7 of this thesis.

6.2 Client characteristics and outcomes of the three more effective and the three less effective counsellors

Researchers exploring the differential effectiveness of individual counsellors and psychotherapists have recommended that one potentially effective research strategy would be to study relatively effective and relatively ineffective therapists (Elkin et al. 2006b; Luborsky et al. 1985) in order to learn more about the factors that contribute to effective practice. As noted in section 2.2.6 of Chapter 3 of this thesis, to date, little attention has been given to examining variability in the effectiveness of paraprofessional counsellors. Given that analysis of effect sizes for the present sample of paraprofessional counsellors showed variability in effectiveness, particularly in relation to the more and less effective counsellors, an analysis was carried out of the caseloads of the three more effective and the three less effective counsellors as detailed in Table 6.1 above.

The labels ‘more effective’ and ‘less effective’ are used here as descriptive terms to facilitate the presentation of data concerning the apparent differential effectiveness of counsellors in the present sample of paraprofessional counsellors. It is important to
emphasise that these labels are not being employed in any way pejoratively with regard to counsellors’ abilities. Their use in this chapter and in Chapter 7 seemed appropriate because they provided a convenient means of communicating clearly the variability in individual counsellors’ effectiveness according to effect size calculations, and also because they are consistent with the way in which the effectiveness of individual therapists has been characterised in previous literature concerning therapist effects.

Table 6.3 summarises the effect sizes and client completion rates for the three more and three less effective counsellors: counsellors 1, 2, 3, and 10, 11, 12 respectively. Column two shows the total number of clients each counsellor accepted for counselling, and column three shows the actual number of clients that completed counselling and returned a CORE-OM form before and after counselling. Based on these numbers, the last column in Table 6.3 details the percentage of clients on each counsellor’s caseload that completed the CORE-OM following counselling. Interestingly, it appears that the less effective counsellors had a higher completion rate than did the more effective counsellors.

Table 6.3 Effect sizes and completion rates for the three more and three less effective counsellors

<table>
<thead>
<tr>
<th>Counsellor</th>
<th>n clients on caseload</th>
<th>n clients with pre-post CORE-OM data</th>
<th>Effect size</th>
<th>% Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7</td>
<td>4</td>
<td>.96</td>
<td>57</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>6</td>
<td>.94</td>
<td>50</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>7</td>
<td>.89</td>
<td>58</td>
</tr>
<tr>
<td>10</td>
<td>7</td>
<td>5</td>
<td>.37</td>
<td>71</td>
</tr>
<tr>
<td>11</td>
<td>11</td>
<td>9</td>
<td>.36</td>
<td>81</td>
</tr>
<tr>
<td>12</td>
<td>11</td>
<td>6</td>
<td>.21</td>
<td>54</td>
</tr>
</tbody>
</table>

It was not possible to conduct chi-squared analyses on the dimensions of client attributes

304
such as gender, age, and problem type to determine the equivalence of client assignment across counsellor caseloads because of the small number of clients on some counsellor’s caseloads. However, Table 6.4 below summarises the distribution of such client characteristics for each counsellor as well as previous psychological help, problem type and the type of ending. All clients were classified as being ‘White/British’ in terms of ethnicity.

Visual inspection of Table 6.4 did not reveal any obvious systematic differences in the demographic characteristics of clients across counsellor caseloads. However, there are some issues that are worth highlighting. First, 75% or more of clients seen by counsellors were female except for Counsellor 10, the least effective counsellor, whose clients were predominately men (i.e., 66.6%).

Second, the majority of clients across counsellor caseloads were either married, single or living with a partner. It may be of interest to note that approximately 50% of clients seen by Counsellor 11 were divorced or separated. Third, in relation to employment status, most clients seemed to be employed. However, all but Counsellor 1, the most effective counsellor, had at least one client on their caseload that was on sickness/disability benefits of some kind. Also, all clients of Counsellor 1 were employed whereas the employment status of the other five counsellors was more diverse. Fourth, one or more of the clients seen by all counsellors, except Counsellor 1, reported having had previous help such as some form of therapy or input from psychiatric services. Fifth, the less effective counsellors appeared to see slightly more depressed and anxious clients than the more effective counsellors. Finally, all counsellors reported a mixture of planned and unplanned endings in relation to their client work.
Table 6.4 Client characteristics across counsellor caseloads

<table>
<thead>
<tr>
<th>Counsellor</th>
<th>The more effective counsellors</th>
<th>The less effective counsellors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>n clients</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>F</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Single</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Single parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Living with partner</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Not known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability benefits</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Student</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td></td>
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<tr>
<td>Not known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Problem type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Anxiety/stress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interper/relationship</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Bereavement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low self-esteem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work/academic</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Addictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other/not known</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Type of ending</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Unplanned</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Not known</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Case descriptions and client outcomes are reported in the following sections for the three more effective and the three less effective counsellors. Results for the three more effective counsellors are presented in section 6.3, and results of the less effective group of counsellors are reported in section 6.4 below.

The presentation of data within sections 6.3 and 6.4 is organised into separate subsections which provides the following information for each of these six counsellors: 1) a brief summary of the characteristics of the counsellor; 2) a summary table that provides an overview of client attributes and outcomes for each client with pre-post
CORE-OM data; 3) a descriptive account of each case that draws on data from client and counsellor self-report questionnaires completed before and after counselling, particularly qualitative data from free-response items in these questionnaires that provided an insight in client and counsellor perspectives on the process of counselling. For clients, these questionnaires were the ‘Reason for Attending Counselling’ questionnaire completed at the start of counselling, and the client ‘View of the Outcome of Counselling’ questionnaire completed at the end of counselling. For counsellors, the relevant questionnaire was the ‘End of Counselling Form’ which was completed by counsellors following counselling with each client. Please refer to section 3.9 of Chapter 3 for a description of these questionnaires or to the relevant appendices to view them; and 4) a summary of the personal philosophy and theoretical perspective of each counsellor is provided based on analysis of qualitative data extracted for the client and counsellor self-report questionnaires referred to above. In addition, counsellor interview transcripts for the more and less effective counsellors from Study (reported in Chapter 5 of this thesis) were reanalysed to explore each counsellor’s personal philosophy and approach to counselling. Unfortunately, interview data were not available for one of the more effective and one of the less effective counsellors as they did not participate in Study 2: counsellors 2 and 12 respectively.

The purpose of combining qualitative data from counsellor and client self-report questionnaires collected for Study 1 and counsellor interviews from Study 2 in this analysis was to examine, and attempt to identify, qualities that might have been associated with the more and less effective counsellors.
6.3 The more effective counsellors

6.3.1 Counsellor 1: the most effective counsellor

Counsellor 1 was the most effective of the 12 counsellors in the present sample in terms of effect size calculations shown in Table 6.1. He was a 41 year old man with approximately 70 hours of counselling training and he had no prior experience as a counsellor or of informal helping. His training included a short course in counselling skills which he attended at local community college, and he also completed 40 hours of in-house counselling training provided by the MHSS agency prior to engaging in counselling practice in its counselling service. Counsellor 1 had received some personal counselling prior to becoming a volunteer counsellor with the MHSS agency in relation to a period of crises in his life.

6.3.1.1 Overview of client characteristics and counselling outcomes

Counsellor 1 had six clients in all but only four completed pre- and post-counselling CORE-OM forms. Table 6.5 presents the general characteristics of clients and counselling outcomes for each of the four clients with completed pre- and post-counselling CORE-OM data seen by Counsellor 1. Table 6.5 shows that three of the four clients seen by Counsellor 1 presented with levels of distress at intake that were in the moderate to severe range (15.9 to 21.2), and one client presented with mild levels of distress (13.5) according to CORE-OM severity levels. Two clients achieved reliable and clinically significant improvement with significant reductions in levels of global distress in terms of the difference between pre- and post-counselling CORE-OM scores. One client showed moderate, but not reliable improvement following counselling with a reduction in CORE-OM scores from 13.5 at intake to 9.7 at termination of counselling: a reduction of 3.8 points. The fourth client seen by Counsellor 1 had deteriorated at the
end of counselling with their CORE-OM scores rising from 21.2 at intake to 23.2 at the final session.

The two most successful outcome cases had planned endings. In the other two cases, one was unplanned and the reason for the client that showed deterioration in CORE-OM scores was not reported. Apart from one female client in her late 30s, all of the clients seen by Counsellor 1 were mainly younger people in their twenties. Clients presented with a range of problems and reported experiencing difficulties in relation to these problems for several months; up to two years in one case. All of Counsellor 1’s clients were in employment, and had not had any form of psychological help or support prior to this episode of counselling. Clients attended for an average of 3.75 sessions (minimum of 3 and maximum of 5 sessions).
### Table 6.5 Client characteristics and outcomes for Counsellor 1: the most effective counsellor

<table>
<thead>
<tr>
<th>Client</th>
<th>Client characteristics</th>
<th>Primary problem</th>
<th>Duration of primary problem</th>
<th>No. of sessions</th>
<th>Type of ending</th>
<th>CORE-OM Scores</th>
<th>Overall outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male, 22yrs, living with partner, employed. No previous help.</td>
<td>Interpersonal/relationship</td>
<td>Not known</td>
<td>3</td>
<td>Planned</td>
<td>Pre-counselling: 19.9, Post-counselling: 9.1, Pre-post difference: 10.8</td>
<td>Reliable and clinically significant change</td>
</tr>
<tr>
<td>2</td>
<td>Female, 27yrs, single, employed. No previous help.</td>
<td>Work/Academic</td>
<td>3 months</td>
<td>3</td>
<td>Planned</td>
<td>Pre-counselling: 15.9, Post-counselling: 7.6, Pre-post difference: 8.3</td>
<td>Reliable and clinically significant change</td>
</tr>
<tr>
<td>3</td>
<td>Female, 25yrs, single, employed. No previous help.</td>
<td>Addictions / (Alcohol problem)</td>
<td>2yrs</td>
<td>5</td>
<td>Unplanned</td>
<td>Pre-counselling: 13.5, Post-counselling: 9.7, Pre-post difference: 3.8</td>
<td>No Reliable Change</td>
</tr>
<tr>
<td>4</td>
<td>Female, 39yrs, living with partner, employed. No previous help.</td>
<td>Depression</td>
<td>7 months</td>
<td>4</td>
<td>Not known</td>
<td>Pre-counselling: 21.2, Post-counselling: 23.2, Pre-post difference: -2.0</td>
<td>Deterioration (but not reliable deterioration)</td>
</tr>
</tbody>
</table>
6.3.1.2 Case descriptions

Analysis of the data in the client ‘View of the Outcome of Counselling’ questionnaires for the two clients that achieved reliable and clinically significant improvement revealed that both clients were very satisfied with the counsellor and the counselling they had received. For instance, client 2, a 27 year old female client who attended counselling because of problems adjusting to and managing an increased workload in her new job commented in the ‘View of the Outcome of Counselling’ questionnaire that the most helpful aspect of counselling was, “Talking through my problems and identifying solutions and new ways to approach similar situations.” In relation to this client, Counsellor 1 commented in the ‘End of Counselling Form’ that counselling focused on “…helping the client to identify what needed to change and making the first steps toward this.”

Similarly, client 1, a 22 year old man who was experiencing difficulties managing his emotional responses to his partners jealousy, remarked in the questionnaire that the most helpful aspect of counselling was, “Talking over issues on my mind”. In the ‘End of Counselling Form’ for this client Counsellor 1 noted that the success of counselling could be attributed, at least in part, to his ability to assist the client to “…focus on the main issue and eliminate irrelevant details”, and also to “helping the client to learn how to express his emotions more positively.”

Client 3, a 25 year old single woman was referred to counselling by her GP for help in relation to her use of alcohol. In the ‘Reasons for Attending Counselling’ questionnaire, which she completed at the start of counselling, this client reported that she, “Worried about situations after drinking and about issues which are insignificant.” This client also
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noted that she was hopeful that counselling could help but that she was, “Unclear of my expectations, or my reasons for being here.”

Counsellor 1 noted in his “End of Counselling Form” for this client that he was conscious of the fact that the client was concerned that she was “…wasting the counsellors time”, and that he had been unsure of his ability to work effectively with the client because of this and also because of the nature of the presenting problem. Counselling for this client ended prematurely as the client did not return for a planned session; however, she did return her ‘View of the Outcome of Counselling’ questionnaire in which she rated the counselling she had received as being moderately helpful and noted that, “It helped keep me focused and clearly helped me to see how to better help myself.” The client also returned a final CORE-OM form which indicated a reduction in her CORE-OM scores of 3.8 points from pre- to post-counselling. Although not reliable, the CORE-OM scores indicate a trend toward improvement and moderate positive gains following counselling. When considered alongside the client’s qualitative evaluation of counselling from her completed ‘View of the Outcome of Counselling’ questionnaire, it appears that overall, counselling was helpful for this client. The unplanned nature of the ending of counselling may well be related to the fact that she had already achieved sufficient change and did not believe further counselling was necessary.

Counsellor 1 also saw one client that deteriorated slightly on CORE-OM scores after four counselling sessions, and subsequently stopped attending counselling unexpectedly. The client was a 39 year old woman who described her problem in the ‘Reasons for Attending Counselling’ questionnaire as depression. At intake her CORE-OM score was
21.2 (indicating moderate-to-severe levels of distress) and at the fourth session it had increased to 23.2, which suggests that the client had become more distressed during counselling. Unfortunately, this client did not complete a ‘Client View of the Outcome of Counselling’ questionnaire so there were no qualitative data available on her experiences of the counselling she received.

In the ‘End of Counselling Form’ for this client, Counsellor 1 noted that his perception of the clients’ primary problem was “Lack of confidence” and that he had been hopeful of being able to work effectively with the client because she appeared to have had a “…positive outlook.” Due to the lack of post-counselling data from both the client and counsellor, it is not possible to state with certainty the reasons why this client appeared to become more distressed during counselling or why she stopped attending. However, in contrast to the other three clients seen by Counsellor 1 (described above), it is notably that there appeared to be differences of opinion between the client and counsellor on the client’s primary problem, which may have resulted in a lack of agreement on the goals and the focus of counselling for this client.

6.3.1.3 Personal philosophy and theoretical perspective

Based on the available data extracted from the self-report questionnaires completed by clients (1, 2, and 3 in particular) before and after counselling, and the ‘End of Counselling Forms’ completed by Counsellor 1 in relation to these clients, it is possible to suggest, tentatively, that this counsellor’s approach was characterised by a willingness to allow clients to ‘talk through’ their concerns, an orientation towards identifying goals for counselling, and a problem or task-focused approach.

Qualitative analysis of the interview transcript obtained during data collection for Study
2 of this thesis revealed that Counsellor 1 (referred to as Stephen in Study 2) held a philosophy of counselling that was interrelated with his personal values and a belief that he had the necessary qualities to be an effective counsellor: “I felt I had something that I could give to help other people.” (Lines: 24-25). More generally, his philosophy included:

- being sensitive to, and valuing, the interpersonal and relational aspects of counselling and privileging these over the use to techniques (i.e., solution-focused techniques)
- a belief in a positive, focused, and empowering approach to counselling
- a willingness to work flexibly in response to individual client needs
- a preference for working in a structured and focused way with clients (e.g., establishing boundaries, clarifying roles and expectations, and setting goals for counselling).

The following verbatim quotes, taken from the interview transcript with Counsellor 1 for Study 2 of this thesis, illustrates his commitment to this philosophy. For example, his privileging of the interpersonal and relational aspects of counselling is evident in the following remarks:

“You know, someone coming into a strange building to meet a strange person first time seems quite and anxious situation. So it’s just taking a couple of minutes initially to forget about their main issue and make it as comfortable as possible for them.” (Lines: 135-138).

During his interview, Counsellor 1 emphasised his belief that counselling was very much a “personal thing”, and at one point he stated explicitly his belief in the importance of
the relationship and trust to the counselling process, over the use of the solution-focused
techniques he had learned during the MHSS training:

“For me it’s developing a relationship with the person ... So I found that, initially, rather than bombarding the client with questions it’s allowing a bit of trust to develop between the people rather than using a technique in the relationship.” (Lines: 185-187).

There was evidence from the interview with Counsellor 1 that he believed in the solution-focused approach to counselling (which he had received training in at the MHSS agency) because it reflected his personal beliefs about being positive and focused when dealing with problems. For instance, he commented that he identified with the solution-focused approach because, “I feel that way myself, sort of being positive and having a more focused outlook. So it’s natural for me to use that with clients.” The solution-focused approach was also important to Counsellor 1 because it provided him with a language with which to enact a philosophy of counselling which was about “empowering people to do their own thing.” Counsellor 1 also appeared to value a structured approach, while at the same time being flexible in his response to individual clients. The following quote indicates his beliefs about the importance of structure, clarification of roles and boundaries and expectations to the counselling process:

“The initial meeting is just making them aware of what could happen, what the roles of everyone were and sort of boundaries that were set up. Being able to put that in place sorta gave a good starting point ... and some structure as to what was expected both from the client and counsellor.” (Lines: 127-130).
Another aspect of the way in which Counsellor 1 practiced was his concern about being flexible and being adaptive to individual client needs. For instance, during his interview he stated that toward the end of his first year of practice he became more flexible in his approach:

“*You know, seeing different clients with different needs. Some needed the opportunity just to open up and have that time to talk, others were looking for answers to questions. So it was a case of adapting to the individual client at the time.*” (Lines: 220-223).

Finally, Counsellor 1 appeared to be concerned with understanding his clients and their problems in relation to the wider context of their lives, and not just in a reductionist, problem-focused way. For example, during his interview for Study 2 he commented:

“*It was being able to listen to what the person was saying and trying to find the other story that was going on. You know, sorta, the bigger picture and what’s actually happening in their world and what other influences are going on in their life around the problem they come with.*” (Lines: 141-144).

In summary, Counsellor 1 appears to have had a personal and practice philosophy that could be broadly defined as being person-centred insofar as he valued the interpersonal and relational aspects of counselling, and pragmatic to the extent that he appeared to focus on working flexibly with different clients to meet their individual needs. Moreover, his philosophy appeared to endorse a personal belief in being positive, having a holistic view of clients and their problems, and a belief that he had the necessary attributes to be helpful to others as a counsellor.
6.3.2 Counsellor 2: the second most effective counsellor

Counsellor 2 was the second most effective counsellor in this group of practitioners. She was a 57 year old woman in part-time employment. At the start of Study 1 she had been working as a volunteer counsellor within the MHSS agency for one year and had accumulated approximately 125 hours of counselling practice. Also, at the time of recruitment to Study 1, Counsellor 2 had approximately six months experience of working part-time as a support worker with another local voluntary sector mental health agency where her duties involved befriending people with long-term mental health problems. It was not known whether or not Counsellor 2 had had any experience of personal therapy.

6.3.2.1 Overview of client characteristics and counselling outcomes

The general characteristics and counselling outcomes for each of the seven clients with completed pre- and post-counselling CORE-OM data seen by counsellor 2 are presented in Table 6.6. It can be seen from Table 6.6 that client CORE-OM scores at intake ranged from mild to severe levels of distress; except for one client whose intake score of 7.6 was within the non-clinical population.

Of these seven clients, two clients (clients 1 and 4) achieved CORE-OM change scores at the end of counselling that indicated reliable and clinically significant improvement. Both of these clients presented with interpersonal/relationship problems and their CORE-OM scores at intake were in the mild range of distress which returned to the non-clinical range (i.e., below the cut-off of 10) after counselling. The ending in both of these cases was planned between the counsellor and the client.

Another two clients presented with levels of distress that were approaching the mid-
point of the severe range of distress levels according to CORE-OM scores (i.e., Client 2 at 30.3 and Client 3 at 29.1). One of these clients was a young adult who had presented with problems related to an eating disorder, and the other had sought counselling because of a recent bereavement. Counselling ended in an unplanned way in both of these cases. However, CORE-OM change scores were calculated for these clients using the last counselling session as an end point, which showed that each of these two clients had made substantial gains during the very brief counselling intervention they had received (e.g., a reduction CORE-OM scores of more than 9 points in one case and over 11 in the other case following only two or three sessions).

A further two clients seen by Counsellor 2 showed modest but not reliable levels of change. One of these clients attended counselling for help following the break-up of her marriage and presented with a CORE-OM score in the severe range of distress. The other client was a young man who was having difficulties with anger management but his CORE-OM scores at the start of counselling indicated he was in the non-clinical population in terms of overall levels of distress. The former client stopped attending counselling unexpectedly after three counselling sessions, and the later had a planned ending after three sessions.

One client seen by Counsellor 2 presented with mild levels of distress according to the CORE-OM and showed slight deterioration after two counselling sessions. The client presented with a two year history of depression and secondary issues related to an ongoing eating disorder. The client dropped-out of counselling after two sessions.
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Table 6.6 Client characteristics and CORE-OM scores for Counsellor 2: the second most effective counsellor

<table>
<thead>
<tr>
<th>Client</th>
<th>Client characteristics</th>
<th>Primary problem</th>
<th>Duration of primary problem</th>
<th>No. of sessions</th>
<th>Type of ending</th>
<th>CORE-OM Scores</th>
<th>Overall outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pre-counselling</td>
<td>Post-counselling</td>
</tr>
<tr>
<td>1</td>
<td>Female, 29yrs, married, employed. No previous help.</td>
<td>Interpersonal /relationship</td>
<td>6 months</td>
<td>10</td>
<td>Planned</td>
<td>13.8</td>
<td>2.1</td>
</tr>
<tr>
<td>2</td>
<td>Female, 16yrs, single, student. No previous help.</td>
<td>Eating disorder</td>
<td>1 year</td>
<td>2</td>
<td>Unplanned</td>
<td>30.3</td>
<td>19.1</td>
</tr>
<tr>
<td>3</td>
<td>Female, 34yrs, divorced, disability benefits. Previous help.</td>
<td>Loss /bereavement</td>
<td>4 months</td>
<td>3</td>
<td>Unplanned</td>
<td>29.1</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>Female, 36yrs. Single, Employed. No previous help.</td>
<td>Other</td>
<td>2 months</td>
<td>4</td>
<td>Planned</td>
<td>12.6</td>
<td>6.2</td>
</tr>
<tr>
<td>5</td>
<td>Female, 42yrs, married, disability benefits. Previous help.</td>
<td>Interpersonal /relationship</td>
<td>n/k</td>
<td>3</td>
<td>Unplanned</td>
<td>27.6</td>
<td>24.4</td>
</tr>
</tbody>
</table>
## Table 6.6 continued

<table>
<thead>
<tr>
<th>Client</th>
<th>Client characteristics</th>
<th>Primary problem</th>
<th>Duration of primary problem</th>
<th>No. of sessions</th>
<th>Type of ending</th>
<th>CORE-OM Scores</th>
<th>Overall outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pre-counselling</td>
<td>Post-counselling</td>
</tr>
<tr>
<td>6</td>
<td>Male, age n/k, married, self-employed. No previous help.</td>
<td>Interpersonal/relationship</td>
<td>n/k</td>
<td>3</td>
<td>Planned</td>
<td>7.6</td>
<td>4.7</td>
</tr>
<tr>
<td>7</td>
<td>Female, 28ys, single, employed. No previous help.</td>
<td>Depression</td>
<td>2 years</td>
<td>2</td>
<td>Unplanned</td>
<td>14.4</td>
<td>15.3</td>
</tr>
</tbody>
</table>
In summary, the clients seen by Counsellor 2 were predominately female with an age range of 16 to 42 years, and she also saw a 19 year old man with anger management issues. The clients on her caseload were diverse in terms of demographic characteristics and only one had received counselling previously. More than half of her clients ($n = 4$) presented with interpersonal/relationship oriented problems; two of whom were her best outcome cases. Counsellor 2 also achieved good outcomes with a bereaved client and a client who presented with an apparent eating disorder. Clients attended for a mean of 3.8 sessions.

6.3.2.2 Case descriptions
Qualitative data from free-response items in both the 'Reasons for Attending Counselling' and the client 'View of the Outcome of Counselling' questionnaires which clients completed before and after counselling, were only available for the two clients seen by Counsellor 2 who showed reliable and clinically significant improvement (Clients 1 and 4 shown in Table 6.6) and for the client that showed slight deterioration (Client 7 in Table 6.6). In the remaining cases clients did not return the 'View of the Outcome of Counselling' questionnaire. Counsellor 2 completed an 'End of Counselling Form' for all seven clients on her caseload.

Analysis of the client 'View of the Outcome of Counselling' questionnaires for the two clients that achieved reliable and clinically significant improvement showed that both clients were very satisfied with the counsellor and the counselling they had received. Client 1, the best outcome case, was struggling to come to terms with the break up of her marriage and needed to make a decision about whether she should remain living in Scotland or return to her country of origin. She had ten counselling sessions and her CORE-OM score had reduced by 11.8 points from 13.8 to 2.1 at the end of counselling.
In her ‘View of the Outcome of Counselling’ questionnaire she commented that, “[counsellor name] is a very warm and caring person that helped me in many ways. She really helped me in helping myself. I’m thankful I had counselling and it will help me in dealing with future problems.” This client reported that the most helpful aspect of counselling was to have, “Someone to help sort out my thoughts.” In her ‘End of Counselling Form’ for this client, Counsellor 2 noted that the client had been, “Very motivated and committed throughout counselling and appeared confident that counselling would allow her to come to some decision for her future.”

Client 4 also achieved a reliable and clinically significant change score at the end of 4 counselling sessions, which had focused on difficulties she was experiencing in a relationship. Her CORE-OM score moved from 12.6 to 6.2 by the end of counselling. In her ‘View of the Outcome of Counselling’ questionnaire she noted that the most helpful aspects of counselling were, “Taking to someone impartial. Someone there to help me help myself. Positive reassurance. Someone professional/impartial.” Counsellor 2 noted in her ‘End of Counselling Form’ for this client that the client was, “Very motivated and confident counselling would help” and that the “Client worked well within counselling sessions and outwith, completing tasks allotted. Counselling helped her to explore certain areas of her life, allowing her to move forward with optimism for the future.”

In contrast to the above successful outcome cases, Client 7 showed slight deterioration after only two counselling sessions and stopped attending unexpectedly. This client did return a ‘Client View of the Outcome of Counselling’ questionnaire but did not complete any of the free-response items, and choose instead to rate the counselling she had received and the counsellor as ‘Not at all helpful’. Interestingly, the counsellor also
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noted that counselling had not been helpful for this client and stated that the outcome may have been improved had there been an opportunity to have “another session or two.” In her ‘End of Counselling Form’ for this client, Counsellor 2 made extensive notes regarding the fact that she had unintentionally kept the client waiting for more than twenty minutes for her first session because she had run over time with the preceding client who had been extremely distressed. From the notes Counsellor 2 made in this form, it appears that the client was very unhappy about this situation, and as a consequence, Counsellor 2 reported that she found it difficult to establish a working relationship with the client. Another issue of note is that the counsellor described the client’s primary problem as, “Stress, mood swings and anxieties” whereas the client defined her main problem as “Depression and a feeling of being unwanted.” Perhaps difficulties in establishing a relationship and lack of agreement on the client’s primary problem, and consequently, the goals for counselling contributed to the poor outcome in this case.

Counsellor 2 also saw two clients who achieved reliable change following counselling (clients 2 and 3 noted shown Table 6.6), and two clients that showed modest but not reliable change at the end of counselling (clients 5 and 6 in Table 6.6). Unfortunately none of these clients completed the client ‘View of the Outcome of Counselling’ questionnaire so there were no qualitative data available on their perceptions and experiences of the counselling they had received. However, Counsellor 2 did complete and ‘End of Counselling Form’ for each of these clients which provided some insight into her evaluation of counselling for these clients.

Client 2 was one of the clients whose outcome indicated reliable change. This was a 16
year old female referred to counselling by her social worker for help with an eating disorder with a pre-counselling CORE-OM score of 30.3 indicating severe levels of distress. After two counselling sessions her CORE score had reduced by 11.2 points to 19.1, which still indicated moderate levels of distress. In the ‘End of Counselling Form’ for this client, Counsellor 2 noted that the client’s eating disorder appeared to be linked to, “Relationship problems within the family, particularly with her father.” She also noted that counselling could have been improved had she been able to more fully engage the client which she believed would have allowed, “More time to set goals/tasks.” Counsellor 2 also noted in this form that the client was accompanied to the second session by her father’s new partner whom she described as, “Caring and supportive” of the client and, “Motivated to help her to overcome her difficulties.”

Client 3, a 34 year old divorced and single mum who presented to counselling following the death of her father also achieved an outcome of reliable change. This appears to have been a complex case as the client also reported in her ‘Reasons for Attending Counselling’ questionnaire that she was experiencing secondary problems of anxiety and panic attacks related to a previous experience of physical, mental and sexual abuse from her former husband (the marriage ended 10 years prior to this presentation for counselling). As the client noted in this form, “I have been shelving my other problems of abuse and feel with my dad’s illness and death everything as resurfaced and I’m finding it very hard to cope.” The client had received counselling previously for depression, anxiety and panic attacks related to the abuse she had suffered. In the ‘Reasons for Attending Counselling’ questionnaire this client recorded that the counselling she had received in relation to these problems had been helpful. In the ‘End of Counselling Form’ for this client, Counsellor 2 noted that at the start of counselling
the client had been motivated and optimistic that counselling would help, however she
did not comment further on the reasons why the client may have terminated counselling
prematurely or how counselling might have been improved.

The remaining two clients with pre- and post-counselling CORE data showed modest
but not reliable change at termination of counselling. Client 5, a 42 year old married
woman on sickness/disability benefits attended counselling because of difficulties
related to the break-up of her marriage and had a CORE score at intake of 27.6
indicating severe levels of distress. In the ‘Reasons for Attending Counselling’
questionnaire the client stated that she hoped counselling would help her to, “Settle my
conscience and give me peace of mind about things.” The client also indicated in this
form that she had had help in the past for psychological problems but she did not provide
any details about this. In the ‘End of Counselling Form’ for this client, Counsellor 2
noted that the marriage break-up had been very traumatic and that the client had been
hopeful that counselling would help her. However, Counsellor 2 also recorded that the
client was experiencing, “Overwhelming difficulties and anxieties over her marriage
break-up.” Counsellor 2 also noted in the ‘End of Counselling Form’ that the client used
the three sessions she attended to talk about the trauma of the past, and recorded that she
was aware that the client was, “Looking for some purpose to her life” and that they were
beginning to work on this when the client stopped attending counselling unexpectedly
after the third session.

Client 6 presented to counselling with problems related to managing his anger, which
was causing difficulties in his marriage in particular. His CORE score at the start of
counselling was 7.6 indicating that he was in the non-clinical population. After three
sessions of counselling his CORE score had reduced by 4.7 points to 2.9 at which point counselling ended by mutual agreement between the client and Counsellor 3. Unfortunately, the client did not return a ‘View of the Outcome’ questionnaire. However, Counsellor 2 recorded in the ‘End of Counselling Form’ for this client that the client was, “...very motivated to improving his coping strategies and worked very well within sessions and with completing tasks”, and that the client had been referred on, at the client’s request, to an anger management course with a local mental health support agency.

6.3.2.3 Personal philosophy and theoretical perspective
Counsellor 2 did not participate in Study 2 (the findings of which can be found in Chapter 5 of this thesis), and consequently, the only qualitative data available to analyse for the purposes of determining the values and beliefs that informed her personal philosophy an orientation to practice came from the free-response items in the self-report questionnaires completed by clients before and after counselling (i.e., the ‘Reasons for Attending Counselling’ questionnaire and the ‘View of the Outcome’ questionnaire), and from the ‘End of Counselling Form’ which Counsellor 2 completed at the end of counselling for each client. Unfortunately, data were somewhat limited and of variable quality. Nevertheless, there were indications that Counsellor 2 adopted a largely task or goal-focused approach to counselling. In both her successful and unsuccessful cases Counsellor 2 referred to goals and tasks. For instance, in one of the successful cases, Client 4 described above, Counsellor 2 noted that, “The client completed allotted tasks.”

Similarly, in relation to Client 2 the young adult with an apparent eating disorder, Counsellor 2 noted in the ‘End of Counselling Form’ for this case that counselling could
have been improved had there been, “More time with the client to set goals and tasks for counselling.”

Counsellor 2 was experienced by one client as “warm and caring”, which suggests a relational approach - at least in this one case, though it seems reasonable to assume that these personal qualities were evident in other cases as well even if not directly commented upon by clients. Another element of Counsellor 2’s approach related to encouraging clients to carry out in-between session tasks, which is consistent with the solution-focused model she had been introduced to during the MHSS brief counselling training programme. Finally, Counsellor 2 appeared to reflect, at least to some extent, on both good and poor outcome cases in terms of what had gone well and what could have been done differently to improve counselling.

6.3.3 Counsellor 3: the third most effective counsellor
Counsellor 3 was a 30 year old single woman who had completed only 40 hours of counselling training with the MHSS agency, and who did not have any formal experience as a counsellor prior to volunteering with the MHSS agency. She became involved in voluntary counselling as a result of having had a positive experience of receiving counselling herself during a period of distress in her life.

6.3.3.1 Overview of client characteristics and counselling outcomes
Table 6.7 shows the general characteristics of clients and counselling outcomes for the six clients with completed pre- and post-counselling CORE-OM data seen by counsellor 3, the third most effective counsellor. Inspection of the pre-counselling CORE-OM scores in Table 6.7 shows that clients presented with levels of global distress that were spread across the spectrum of CORE-OM severity levels. The lowest client CORE score
### Table 6.7 Client characteristics and CORE-OM scores for Counsellor 3: the third most effective counsellor

<table>
<thead>
<tr>
<th>Client</th>
<th>Client characteristics</th>
<th>Primary problem</th>
<th>Duration of primary problem</th>
<th>No. of sessions</th>
<th>Type of ending</th>
<th>CORE-OM Scores</th>
<th>Overall outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pre-counselling</td>
<td>Post-counselling</td>
</tr>
<tr>
<td>1</td>
<td>Female, 25yrs, living with partner, employed.</td>
<td>Depression</td>
<td>1 year</td>
<td>2</td>
<td>Unplanned</td>
<td>21.2</td>
<td>9.7</td>
</tr>
<tr>
<td>2</td>
<td>Female, 40yrs, single, unemployed.</td>
<td>Interpersonal / relationship</td>
<td>n/k</td>
<td>15</td>
<td>Unplanned</td>
<td>29.7</td>
<td>18.5</td>
</tr>
<tr>
<td>3</td>
<td>Female, 49yrs, divorced, disability benefits.</td>
<td>Interpersonal / relationship</td>
<td>n/k</td>
<td>10</td>
<td>Planned</td>
<td>23.2</td>
<td>12.6</td>
</tr>
<tr>
<td>4</td>
<td>Female, 40yrs, single parent, employed.</td>
<td>Interpersonal / relationship</td>
<td>n/k</td>
<td>4</td>
<td>Planned</td>
<td>15.0</td>
<td>6.8</td>
</tr>
<tr>
<td>5</td>
<td>Female, 54yrs, married, employed.</td>
<td>Anxiety / Stress</td>
<td>n/k</td>
<td>2</td>
<td>Planned</td>
<td>10.7</td>
<td>3.8</td>
</tr>
<tr>
<td>6</td>
<td>Male, 21yrs, living with partner, unemployed.</td>
<td>Depression</td>
<td>n/k</td>
<td>6</td>
<td>Unplanned</td>
<td>26.2</td>
<td>29.7</td>
</tr>
</tbody>
</table>
was 10.7 which is just above the cut-off for the non-clinical range, and the highest score was 29.7 which is well within the severe level in the clinical range of CORE scores.

Three clients achieved reductions in CORE scores pre- to post-counselling that were indicative of reliable and clinically significant change. Two clients achieved reliable change, and one client’s CORE score post-counselling had deteriorated by 3.5 points from 26.2 at intake to 29.7 at the end of counselling, which suggested that they were slightly more distressed than they were at the start of counselling. Two of the clients that showed reliable and clinically significant change had planned endings and the ending in the other case was unplanned. A similar pattern of endings was evident in the two cases that showed reliable change in that one was planned and the other unplanned. The ending in the case that showed deterioration was unplanned.

Clients’ presenting problems included interpersonal/relationship problems (n = 3), depression (n= 2) and anxiety/stress (n = 1). Clients were mostly women in their 40s and 50s (n = 4), although one woman was in her mid-twenties and one client was a 21 year old man. The six clients were diverse in terms of their marital and employment status. Three clients reported in their ‘Reasons for Attending Counselling’ questionnaires that they had received previous psychological or psychiatric help. Clients attended for a mean of 6.5 sessions.

6.3.3.2 Case descriptions
Only one of the six clients seen by Counsellor 3 completed the client ‘View of the Outcome of Counselling’ questionnaire. Counsellor 3 completed an ‘End of Counselling Form’ for each of the six clients with pre- and post CORE-OM data but only made brief notes in relation to free-response items for some clients.
The only client for whom qualitative data were available from the client ‘View of the Outcome of Counselling’ questionnaire and the counsellor ‘End of Counselling Form’ was a 40 year old female, single parent, who had received previous help from psychiatric services for mental health problems; manic-depressive illness in particular (Client 4 shown Table 6.7). The client was referred to counselling by a local voluntary sector organisation which she attended as part of her ongoing psychiatric care for help with difficulties associated with her estranged husband’s behaviour toward her and her young children.

At intake this client’s CORE-OM score was 15, which indicated moderate levels of distress, and at termination following four sessions of counselling it was 6.8. The pre-post-counselling difference in CORE scores was 8.2 which showed that the client had achieved reliable and clinically significant change. In the ‘View of the Outcome of Counselling’ questionnaire the client rated the counsellor and the counselling she had received as highly satisfactory. In relation to the question in this questionnaire about the helpful aspects of counselling the client stated, “[counsellor name] was a very understanding person with real empathy. She was very easy to talk to and helped me arrive at what changes would be necessary to improve how I felt about my estranged husband and gave me stress handling methods.”

In the ‘End of Counselling Form’ for this case Counsellor 3 noted only that counselling had ended because the client was “feeling better” and also because the client was finding it difficult to attend sessions because of work and childcare issues.

6.3.3.3 Personal philosophy and theoretical perspective
The lack of client and counsellor comments in their respective self-report questionnaires
means that it is not possible to draw any firm conclusions about Counsellor 3’s overall approach or philosophy of counselling from these sources. Fortunately, Counsellor 3 participated in Study 2 of this thesis (where she was referred to as Agnes) and analysis of her interview transcript from this study provides some insight into her views about the nature of counselling and her role as a counsellor, and indeed the personal qualities she believed were relevant to this work. The key aspects of Counsellor 3’s philosophy included:

- a belief in the importance of being ‘natural’ and letting one’s personality and character come through in the role of counsellor
- a client-focused, conversational approach rather than a purely technique-focused approach (which engendered a flexible way of working)
- a commitment to being non-judgemental in the counselling role and in life in general
- a privileging of the interpersonal and relational aspects of counselling
- a preference for being positive and change-focused
- an openness to, and thirst for learning, and a willingness to reflect on, and learn from experience.

During her interview, Counsellor 3 made repeated references to the importance in counselling of connecting with and building relationships with clients. For example, in relation to one experience of a difficult session with a client Counsellor 3 remarked:

“I thought I managed to connect with the client really easily and that to me is the most important thing. It’s building up a relationship with the client. I think this is my forte, being able to connect with people and build rapport.” (Lines: 278-280).
She also talked about being open-minded and non-judgemental, qualities which she seems to have developed further through her engagement in counselling training and client work within the MHSS agency:

"... not to be judgmental and learning to be that way. It is the right way to be. There is no reason to be judgmental about anybody. So, it is the way people should be anyway, not being judgmental and staying with the person." (Lines: 135-138).

Counsellor 3 returned to the importance of a non-judgemental attitude later in her interview and commented:

"I’ve always thought I was an open minded person and you shouldn’t judge someone on what you hear and you should reserve judgement." (Lines: 346-348).

Closely related to this non-judgemental stance, Counsellor 3 appeared to have a desire to let her personality come through in her work with clients. In the following extracts from her interview, Counsellor 3 emphasised her personal preference for integrating solution-focused techniques into her own personal approach:

"You let your character and personality come into it. It’s natural, I think, to develop your own style. I didn’t take it like this rigid wall of solution-focused stuff whereas some of the other counsellors did [i.e., within the MHSS agency]. But again I think that’s just a personal thing." (Lines: 227-231).

This preference for developing a personal style of counselling appeared to encourage
Counsellor 3 to adopt a flexible and creative approach in relation to the use of solution-focused techniques. Indeed, she disliked the word technique and appeared to prefer to think of her use of so-called techniques as a natural extension of her everyday approach to problem-solving. This may be because there seemed to be a high degree of ‘fit’ between her personal philosophy and the assumptions underpinning the solution-focused approach and its therapeutic methods. During her interview she described her approach as follows:

“It is much more natural than when I started. If someone says to me, ‘So what did you do in your session?’ I would say, I don’t know. That sounds ridiculous but it is completely natural. It is not as if I am following something or a routine. It is like a natural process – I am positive the client doesn’t think, ‘Oh, now she is using a technique,’ I feel it is really natural.” (Lines: 451-456).

And later in her interview, Counsellor 3 remarked:

“I don’t like the word technique. I think it sounds clinical. Obviously I use techniques but maybe because I focus so much on the client, and techniques mean nothing to the client, they are just integrated so well into the conversation.” (Lines: 522-525).

At one point in her interview, Counsellor 3 provided an example of how she tried to incorporate the solution-focused technique of encouraging clients to clarify their goals by using a future-oriented question in place of the solution-focused miracle question. In the following extract from her interview she appears to be trying to illustrate that although she has a repertoire of counselling techniques she does not apply them in a
mechanistic fashion, but instead, endeavoured to incorporate them into the natural flow of a conversation with a client:

“I suppose it is different with everybody, but I usually stay with the client. If the client is saying, ‘I wish it was different’ then I’ll go, well okay, imagine things are a year down the line, what do you want things to be like? What do you want to be different? And that way it’s just like a natural conversation. This is important because sometimes a miracle question doesn’t fit – it could maybe offend them or they [clients] might think you are being patronising. But if you are natural and relaxed it comes anyway what to say whether it be, ‘In two years what do you want things to be like?, or whatever.’” (Lines: 528-534).

Another aspect of the way in which Counsellor 3 approached counselling was her concern with being positive and change-focused. Again, these are elements which sit comfortably within a solution-focused perspective, but they also seemed to reflect the personal beliefs of this counsellor and her outlook on life more generally. In relation to the solution-focused approach, which she was introduced to during the MHSS counselling training, she said, “I felt really comfortable with it and it made perfect sense.” (Line: 121). “It was just the small things that felt right, like putting things in a positive sense instead of a negative sense.” (Lines: 142-143). This positive perspective seemed to resonate with Counsellor 1 on a personal level:

“I get annoyed with people round about me who are quite negative. I tend to say to them, ‘Do you have to be so negative?’ A recent example is my friend who wasn’t very well and she told me, ‘I am going to be in pain for weeks.’ To which I said, ‘You don’t know that. If you think that you are going to be in pain for weeks, then you will be!’ I
think the power of the mind is a very important thing.” (Lines: 146-147).

She went on to say that,

“The majority of my adult life I have been like that, so it makes sense to me to focus on the positive and what could be rather than the past. I think this is linked to my personal life as well ... Play the negative down... so there is something positive.” (Lines: 156-161).

In addition to having a positive outlook, Counsellor 3 appeared to be enthusiastic and optimistic, and interested in helping clients to experience immediate emotional change in counselling. For example, during her interview she commented,

“I enjoy seeing clients going out of sessions feeling chirpy ... I like the fact that a lot of clients go away from here feeling good and it makes them feel great that day. There has got to be something in that, and if we can just work together to find what gives them that feeling then they can have that all the time.” (Lines: 484-489).

Counsellor 3 also talked about establishing goals for counselling during her interview; however this seemed to be a subtle and perhaps less focused process in her approach:

“Obviously, I know it is important to establish goals. We always get there. I just don’t do it blatantly.” (Lines: 550-551).

Finally, Counsellor 3 appeared to be an avid reader of counselling books and articles, and reported in her interview that she devoted a lot of time to exploring solution-focused
websites on the internet in order to develop her understanding to this approach and
enhance her learning. For instance:

“I am constantly on the internet looking for solution-focused stuff. I found this one
website where there is a quote of the month which is interesting and I read all the time.
It’s not just about counselling but about psychology and other spiritual stuff as well. It’s
all about being positive and seeing the best in people and myself. All this reading helps
and it teaches you. I really believe in life-long learning.” (Lines 590-596).

Overall, Counsellor 3 appeared to ground her approach to counselling work in a personal
philosophy that valued genuineness, being non-judgemental, and connecting with
people. She believed in a positive, change-focused and flexible counselling approach
that prized the counselling relationship over a purely mechanistic or technical approach.

6.4 The less effective counsellors

6.4.1 Counsellor 12: the least effective counsellor
Counsellor 12 was a single man in his forties who was claiming sickness/disability
benefits for a physical condition which made it difficult for him to continue to work full-
time as a tradesman. Since becoming unemployed he had pursued a variety of short
skills-based college courses, although these had not lead to any form of employment. He
became involved with the MHSS agency as a voluntary counsellor because he wanted to
develop new skills and to help people. At the time of recruitment into Study 1 he had
been volunteering for approximately 12 months with the MHSS agency counselling
service, and his only counselling training had been the 40 hours in-house course at
MHSS. No data were available on whether or not he had had any experience of being a counselling client.

6.4.1.1 Overview of client characteristics and counselling outcomes

The general characteristics and counselling outcomes for each of the six clients with completed pre- and post-counselling CORE-OM data seen by counsellor 12 are presented in Table 6.8.

Table 6.8 shows that clients seen by Counsellor 12 presented to counselling with mild to severe levels of distress according their CORE-OM scores (i.e., CORE-OM scores that ranged from 11.5 to 29.2). Two clients achieved reliable change at the end of counselling, another two clients showed only minimally degrees of change which was not reliable, and a further two clients were deteriorated following counselling - one of whom had reliably deteriorated. In both cases that showed reliable change counselling ended in a planned manner; and interestingly, the endings for the two clients that had deteriorated were also planned. The endings in the two cases that did not achieve reliable change were unplanned.

It can also be seen from Table 6.8 that clients presented to counselling with depression ($n = 3$), interpersonal problems ($n = 2$), and for help with anxiety/stress ($n = 1$). The least successful outcomes for Counsellor 12 were with four male clients who were aged between 48 years and 58 years, two of whom had had help for psychological problems in the past. The most successful outcome cases for Counsellor 12 were two female clients who presented with moderate to severe levels of distress, neither of whom had received any previous help for psychological problems.
## Table 6.8 Client characteristics and CORE-OM scores for Counsellor 12: the least effective counsellor

<table>
<thead>
<tr>
<th>Client</th>
<th>Client characteristics</th>
<th>Primary problem</th>
<th>Duration of problem</th>
<th>No. of sessions</th>
<th>Type of ending</th>
<th>CORE-OM Scores</th>
<th>Overall outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pre-counselling</td>
<td>Post-counselling</td>
</tr>
<tr>
<td>1</td>
<td>Female, 36yrs, single parent, unemployed. No previous help.</td>
<td>Depression</td>
<td>10 months</td>
<td>n/k</td>
<td>Planned</td>
<td>18.8</td>
<td>11.5</td>
</tr>
<tr>
<td>2</td>
<td>Female, 41yrs, married, employed. No previous help.</td>
<td>Interpersonal / relationship</td>
<td>6 months</td>
<td>8</td>
<td>Planned</td>
<td>23.5</td>
<td>17.9</td>
</tr>
<tr>
<td>3</td>
<td>Male, 48yrs, separated, employed. No previous help.</td>
<td>Interpersonal / relationship</td>
<td>12 months</td>
<td>2</td>
<td>Unplanned</td>
<td>17.1</td>
<td>15.3</td>
</tr>
<tr>
<td>4</td>
<td>Male, 58yrs, single, disability benefits. Previous help.</td>
<td>Depression</td>
<td>5 years +</td>
<td>3</td>
<td>Unplanned</td>
<td>29.2</td>
<td>28.5</td>
</tr>
<tr>
<td>5</td>
<td>Male, 48yrs, co-habiting, employed. No previous help.</td>
<td>Anxiety/Stress</td>
<td>15 months</td>
<td>2</td>
<td>Planned</td>
<td>11.5</td>
<td>12.9</td>
</tr>
<tr>
<td>6</td>
<td>Male, 56yrs, married, retired. Previous help.</td>
<td>Depression</td>
<td>8 months</td>
<td>3</td>
<td>Planned</td>
<td>12.1</td>
<td>17.6</td>
</tr>
</tbody>
</table>
6.4.1.2 Case descriptions

Counsellor 12 completed an ‘End of Counselling Form’ for all six clients with completed pre- and post-counselling CORE-OM forms. All six clients completed the ‘Reasons for Attending Counselling’ questionnaire; however, only two of these clients also completed the client ‘View of the Outcome of Counselling’ questionnaire (i.e., Clients 2 and 3 detailed in Table 6.8). Unfortunately, the free-response data in the counsellor and client questionnaires was limited, and so, it is difficult to draw robust conclusions regarding counsellor and client perspectives on the counselling that took place. The data that were available is presented below in relation to each case as detailed in Table 6.8.

In relation to Counsellor 12’s most successful cases, the best outcome cases were clients 1 and 2 detailed in Table 6.8. The most successful outcome case was Client 1, a 36 year old woman who presented with depression related to marital problems, which had resulted in separation from her husband. This client had been experiencing problems associated with depression for some 10 months and had a CORE-OM score of 18.8 at intake, which was in the upper end of the moderate range of distress levels. She did not make any written comments in the free-response items in her ‘Reason for Attending Counselling’ questionnaire, and unfortunately she did not complete a ‘View of the Outcome of Counselling’ questionnaire either. In the ‘End of Counselling Form’ for this client, Counsellor 12 noted that, “The client was very keen on changing her circumstances. I felt confident we could make progress with the issues presented.” He also commented on the ending of counselling, “The client phoned to say she had made enough progress on issues first presented to the extent that we agreed to end counselling.”
The next best outcome case for Counsellor 12 was a 41 year old married woman who sought counselling for help in relation to the deterioration in her marriage, as a consequence of her husband’s severe mental health problems. The client reported in her ‘Reason for Attending Counselling’ questionnaire that she had been distressed for six months and had a pre-counselling CORE-OM score of 23.5, which indicated moderate to severe levels of distress. At the end of counselling this client reported in the ‘View of the Outcome of Counselling’ of counselling questionnaire that the most helpful aspect of counselling was having, “Someone to talk to in confidence”, and she rated both the counsellor and the counselling she had received highly in terms of overall levels of satisfaction. At the end of counselling, this client’s CORE-OM score had reduced by 5.6 points to 17.9, which had lowered her overall levels of distress to the moderate range in terms of severity. In the ‘End of Counselling Form’ for this client, Counsellor 12 noted only that, “My role consisted for supporting the client through the emotional upheaval and trauma connected to her marital break-up.”

Two of the six clients seen by Counsellor 12 showed only minimal change on CORE-OM scores pre- to post-counselling. Client 3 presented in Table 6.8 was a 48 year old man who presented to counselling with interpersonal/relationship problems related to the break-up of his marriage. At the beginning of counselling his CORE score was 17.1 suggestive of moderate severity levels, and at the end of counselling after two counselling sessions it had reduced by only 1.8 points to 15.3, which was still within the moderate range of distress levels. This client retuned a ‘View of the Outcome of Counselling’ questionnaire following counselling and rated the counselling he had received as not at all helpful, and commented that there was nothing helpful about counselling and that all aspects of the counselling he had received were unhelpful. Client
Chapter 6: Differences between more and less effective mental health counsellors

3 gave the lowest satisfaction rating possible of the counsellor on the 7-point likert scale in the client ‘View of the Outcome’ questionnaire (i.e., Not at all satisfied). In the ‘End of Counselling Form’ for this client, Counsellor 12 noted that, “Client thought that in time he would revert back to his old self and that in the meantime he had to get on with life. He had custody of his children and this was keeping him focused.”

The other client seen by Counsellor 12 that did not achieve reliable change was a 58 year old single man who had retired early due to ongoing mental health problems, and chronic health problems related to diabetes. He was on sickness/disability benefits as result of these problems. At intake this client’s CORE-OM score was 29.2 which indicated severe levels of distress, and at the end of counselling after three counselling sessions it had reduced by only 0.7 points to 28.5. This client had received previous, but unspecified, help from mental health/psychiatric services. This client presented with chronic depression of more than 5 years, which he linked to long-standing problems with, “Nerves and an inferiority complex” in his ‘Reasons for Attending Counselling Questionnaire’. In the same questionnaire he indicated that he had received help from psychiatric services in the past for mental health problems, and also indicated that he was not at all hopeful that counselling would be helpful. He added a free response comment to the questionnaire item on his hopefulness about counselling which read, “Often when talking I get emotionally choked and cannot speak.”

In the ‘End of Counselling Form’ for this client, Counsellor 12 noted, “The client had long term issues” and that counselling had, “Helped the client clarify his needs.” Counsellor 12 also noted in the additional comments section in the ‘End of Counselling Form’ that, “Client was on a waiting list to see a psychologist and saw counselling as not
what he needed.” It is perhaps interesting to note that this client was referred from a local voluntary agency which supported people with long-term mental health problems, and that the client did not actively seek out counselling, which may explain his lack of hopefulness that it would help. It appears that he was referred to counselling as an interim measure while waiting for an appointment with a clinical psychologist. Furthermore, it is noteworthy that the counsellor seemed to have a more sanguine view of the usefulness of counselling than the client in this case.

The remaining two clients seen by Counsellor 12 detailed in Table 6.8 showed deterioration at the end of counselling. Client 5 showed only slight deterioration, however, Client 6 showed reliable deterioration following counselling. Both cases are described below.

Client 5, a 48 year old man presented to counselling with stress related to problems at work of 15 months duration. His CORE-OM score at intake was 11.5, which is in the mild range of distress and just above the clinical cut-off score of 10. After two sessions the counsellor and client mutually agreed to end counselling. Counsellor 12 did not provide any details on how the ending of counselling was negotiated other than to note (in the ‘End of Counselling Form’ for this client) that the ending was planned and mutually agreed. Counsellor 12 also noted in this form that, “The client had frustrations over proper policy being enforced at work. This I had not control over.” He also noted that, “I could see no way counselling could have been improved.” The client did not return a ‘View of the Outcome of Counselling’ questionnaire, so there were no qualitative data on his perspective or experience of counselling.
Client 6 showed reliable deterioration pre-to post-counselling. This client was a 54 year old married, retired man who attended counselling for help with periodic bouts of depression. He had consulted his GP and a psychiatrist in the past for help in relation to this problem and was referred to counselling by a local voluntary sector mental health agency which he had been attending on a regular basis for generic support related to his mental health problems. In his ‘Reasons for Attending Counselling’ questionnaire, this client stated that a major part of his problem was concerned with, “Lack of confidence and an inability to do everyday chores, and an inability to work and earn money.” He also noted in this questionnaire that, “I am a bit sceptical that counselling might help.” At the start of counselling his CORE-OM score of 12.1 – which was indicative of mild levels of distress. At the end of counselling after three counselling sessions his score had increased by 5.5 points to 17.5, which placed him in the moderate range of distress in terms of levels of severity.

Unfortunately, this client did not return a ‘View of the Outcome of Counselling’ questionnaire, but Counsellor 12 noted in the ‘End of Counselling Form’ for this client that both he and the client mutually agreed to end counselling at their last session. He also commented that the “Client was lacking in motivation and complained of being stuck in a rut. He has now taken steps to address areas of his life previously neglected such as fitness level, vocational and interpersonal issues.” However, Counsellor 12 did not provide any further details about what steps exactly this client had taken and what role counselling, if any, played in this process.

6.4.1.3 Personal philosophy and theoretical perspective
Counsellor 12 did not participate in Study 2 reported in this thesis, and the lack of qualitative data from client and counsellor self-report questionnaires in relation to the six
clients with completed pre-post counselling CORE-OM forms makes it difficult to draw any conclusions about his personal philosophy or general approach to counselling. This counsellor was experienced as being helpful by some of his clients and appeared to provide these clients with an opportunity to talk through their concerns in a supportive environment. However, it is also clear that the counselling provided by Counsellor 12 was experienced as being ineffective and unhelpful by other clients.

One of the notable features of the limited comments that Counsellor 12 made in the ‘End of Counselling Form’ for the poorer outcome cases was his view that counselling could not have been improved (i.e., Client 5), and the suggestion that counselling was unsuccessful because the client lacked motivation (i.e., Client 6). Although speculative because of the lack of data, one interpretation of these comments is that Counsellor 12 appeared to attribute the failure of counselling to external factors or client attributes and did not seem to engage in much, if indeed any, personal reflection on his practice.

6.4.2 Counsellor 11: the second least effective counsellor
Counsellor 11 was a sixty-four year old woman who had approximately 100 hours of experience as a telephone counsellor at the start of Study 1 of this thesis. She had also completed a certificate in counselling skills of 120 hours duration and, in addition, had completed the MHSS in-house counselling course (which consisted of 40 hours of contact time and focused mainly on the solution-focused approach). Counsellor 11 began volunteering with the MHSS agency as a way of gaining more practical skills in face-to-face counselling. Counsellor 11 had received counselling in the past related to personal and familial crises.

6.4.2.1 Overview of client characteristics and counselling outcomes
Counsellor 11 had nine clients with completed pre- and post-counselling CORE-OM
data. The characteristics of these clients and the overall outcomes for each client are presented in Table 6.9. In terms of levels of distress at intake, seven clients presented with levels of distress that were within the clinical range and two clients had CORE scores that were well within the non-clinical range (i.e., Clients 6 and 7 shown in Table 6.9). Of the seven clients with CORE scores that were within the clinical range, four presented with levels of distress that were just inside the moderate category (i.e., Clients 2, 3, 5, and 8 shown in Table 6.9). One client had moderate-to-severe levels of distress (Client 9), and two clients presented with severe levels of distress at the start of counselling (Clients 1 and 4).

In terms of client outcomes for Counsellor 11, three clients achieved reliably and clinically significant change, three clients achieved reliable change only (one of whom was in the non-clinical range before counselling), one client (who was also in the non-clinical range of distress pre-counselling) did not achieve reliable change, and two clients had reliably deteriorated post-counselling. Four clients seen by Counsellor 11 had planned endings, which included two clients who had achieved reliable and clinically significant change, one who had achieved reliable change, and one client that did not obtain reliable change post-counselling. Three clients had unplanned endings, two of whom had achieved reliable change and one who had achieved reliable and clinically significant change at the last counselling session. The type of ending for the two clients who had reliably deteriorated was not recorded.

Except for one male client, all of the clients seen by Counsellor 11 were female and ranged in age from 19yrs to 49yrs. The presenting problems were depression ($n = 3$),
### Table 6.9 Client characteristics and CORE-OM scores for Counsellor 11: the second least effective counsellor

<table>
<thead>
<tr>
<th>Client</th>
<th>Client characteristics</th>
<th>Primary problem</th>
<th>Duration of problem</th>
<th>No. of sessions</th>
<th>Type of ending</th>
<th>CORE-OM Scores</th>
<th>Overall outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Female, 29yrs, divorced, disability benefits. No previous help.</td>
<td>Depression</td>
<td>12 months</td>
<td>2</td>
<td>Unplanned</td>
<td>28.5 18.2 10.3</td>
<td>Reliable change</td>
</tr>
<tr>
<td>2</td>
<td>Female, 35yrs, single, employed. Previous help.</td>
<td>Interpersonal / relationship</td>
<td>3 years +</td>
<td>2</td>
<td>Planned</td>
<td>15.0 .68 8.2</td>
<td>Reliable and clinically significant change</td>
</tr>
<tr>
<td>3</td>
<td>Male, age not recorded, married, employed. No previous help.</td>
<td>Anxiety</td>
<td>12 months</td>
<td>10</td>
<td>Planned</td>
<td>15.3 7.2 8.1</td>
<td>Reliable and clinically significant change</td>
</tr>
<tr>
<td>4</td>
<td>Female, 33 yrs, divorced, disability benefits. No previous help.</td>
<td>Low self-esteem</td>
<td>8 months</td>
<td>2</td>
<td>Unplanned</td>
<td>27.4 19.6 7.8</td>
<td>Reliable change</td>
</tr>
<tr>
<td>5</td>
<td>Female, 19yrs, single, employed. No previous help.</td>
<td>Interpersonal / relationship</td>
<td>18 months</td>
<td>2</td>
<td>Unplanned</td>
<td>15.6 9.7 5.9</td>
<td>Reliable and clinically significant change</td>
</tr>
</tbody>
</table>
### Table 6.9 continued

<table>
<thead>
<tr>
<th>Client</th>
<th>Client characteristics</th>
<th>Primary problem</th>
<th>Duration of problem</th>
<th>No. of sessions</th>
<th>Type of ending</th>
<th>CORE-OM Scores</th>
<th>Overall outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Female, 32yrs, living with partner, employed. No previous help.</td>
<td>Anxiety</td>
<td>6 months</td>
<td>3</td>
<td>Planned</td>
<td>Pre-counselling: 6.2</td>
<td>Post-counselling: 1.5</td>
</tr>
<tr>
<td>7</td>
<td>Female, 45yrs, married, employed. No previous help.</td>
<td>Bereavement</td>
<td>14 months</td>
<td>2</td>
<td>Planned</td>
<td>Pre-counselling: 5.0</td>
<td>Post-counselling: 3.5</td>
</tr>
<tr>
<td>8</td>
<td>Female, 49yrs, divorced, employed. Previous help.</td>
<td>Depression</td>
<td>k/n</td>
<td>k/n</td>
<td>n/k</td>
<td>Pre-counselling: 15.9</td>
<td>Post-counselling: 23.2</td>
</tr>
<tr>
<td>9</td>
<td>Female, 45yrs, divorced, employed. Previous help.</td>
<td>Depression</td>
<td>3 years +</td>
<td>k/n</td>
<td>n/k</td>
<td>Pre-counselling: 21.5</td>
<td>Post-counselling: 30.3</td>
</tr>
</tbody>
</table>
anxiety \((n=2)\), interpersonal/relationship issues \((n=2)\), bereavement \((n=1)\), and low self-esteem \((n=1)\). Clients reported experiencing these problems (in their respective ‘Reasons for Attending Counselling’ questionnaire) from between six months and more than three years in two cases. Most clients received 2 to 3 counselling sessions, although the only male client who presented with anxiety had 10 sessions. The number of sessions for two clients was not recorded.

6.4.2.2 Case descriptions

All nine clients seen by Counsellor 11 with pre- and post-counselling CORE-OM data completed the ‘Reasons for Attending Counselling’ questionnaire, but only six also completed the client ‘View of the Outcome of Counselling’ questionnaire at the end of counselling (i.e., Clients 2, 3, 5, 6, 7, and 8 shown in Table 6.9). Counsellor 11 completed an ‘End of Counselling Form’ for all clients except Client 9 who had deteriorated reliably post-counselling. However, she did not provide written comments in relation to the free-response items in all of the completed questionnaires (e.g., in relation to the item which asked if counselling could have been improved, or if there were any additional issues she wished to comment on regarding counselling). Qualitative data extracted from the client ‘Reason for attending Counselling’ and the ‘View of the Outcome of counselling’ questionnaires are presented below for the six clients who completed both of these questionnaires (as noted above). Where available, counsellor comments from the ‘End of Counselling Form’ are reported to supplement client comments in relation to their experience of counselling.

Clients 2, 3, and 5 shown in Table 6.9 achieved reliable and clinically significant change post-counselling and were among the best outcome cases for Counsellor 11. Client 2 was a 35 year-old single, employed woman who attended counselling for help with
interpersonal/relationship issues. She presented with a CORE score of 15 which had reduced to 6.8 after only 2 sessions - a pre-post difference of 8.2 points, which moved her levels of distress from the moderate range to within the non-clinical range. In her ‘Reasons for Attending Counselling’ questionnaire Client 2 noted that part of the reason she was seeking help because of difficulties she was experiencing in handling difficult interpersonal situations, and managing her relationships with other people when her self-esteem and confidence were at a low ebb. This client also reported in this questionnaire that she had received counselling 5 years previously for depression, which she found helpful, and also noted that she was very hopeful that counselling would help noting that, “The problem has gone on too long and needs to be resolved.”

Analysis of the client ‘View of the Outcome of Counselling’ questionnaire for Client 2 revealed that this client was moderately satisfied with her counsellor (i.e., a rating of 6 on the 7-point likert scale item which asked, ‘To what extent were you satisfied with your counsellor?, with 1 being ‘Not at all satisfied’ and 7 being ‘Very satisfied’), and noted in the free-response space for this item that the counsellor was a “Very good listener.” Similarly, Client 2 rated the overall helpfulness of counselling as being helpful (i.e., a rating of 5 on the 7-point likert scale item which asked, ‘How helpful has counselling been to you overall?’ with 1 being ‘Not at all helpful’ and 7 being ‘Very helpful’. In relation to the free-response item in the client ‘View of the Outcome’ questionnaire that asked, ‘What was there, if anything, about counselling that you found particularly useful’? Client 2 wrote, “Being able to express myself without being judged and without the listener being emotionally involved.”

In the ‘End of Counselling Form’ for Client 2, Counsellor 11 noted that, “The client had
an openness to looking at actions and reactions of others which I worked with.” Counsellor 11 also noted in this form that she, “Enjoyed working with this client who was welcoming the opportunity to look at issues in different ways and worked with new insights.” The ending in this case was negotiated and agreed between client and counsellor.

Client 3 shown in Table 6.9 also achieved clinical and reliable change post-counselling. This client was a married, employed man who presented to counselling with problems related to anxiety which he had been experiencing for 12 months prior to attending counselling. In addition to this primary problem, Client 3 reported in his ‘Reasons for Attending Counselling’ questionnaire that he also had difficulties related to, “Aggression and being argumentative because of excessive alcohol use.” At the start of counselling the client rated himself as being moderately hopeful that counselling would be helpful in relation to these issues. At intake Client 3 scored 15.3 on the CORE-OM, indicating moderate levels of distress, and after 10 counselling sessions it had reduced by 8.1 points to 7.2 reducing his levels of distress to the non-clinical range. Client and counsellor mutually agreed to end counselling.

In the ‘View of the Outcome of Counselling’ questionnaire, Client 3 gave a rating of ‘Very satisfied’ for his satisfaction with the counsellor noting that he felt, “Confident to express his problems.” Overall, this client rated counselling as being helpful and commented in the same questionnaire that the most helpful aspect of counselling was that the counsellor was, “Open, honest and trustworthy” and provided, “A confident listening ear.” In the ‘End of Counselling Form’ for this client, Counsellor 11 commented that, “My sense of competence relating to alcohol issues was seriously
challenged. I was comfortable with establishing rapport and reflecting back and empathy was developed and remained present throughout. This allowed issues to be explored and an understanding emerged together which led to progress.”

Client 5 also achieved reliable and clinically significant change following counselling with Counsellor 11. This client was a 19 year old single, employed woman with no prior history of psychological problems or help seeking. She presented to counselling for assistance with interpersonal/relationship problems related to her parents divorce. Her CORE score at intake was 15.6 indicating moderate levels of distress. At the end of counselling her CORE score was 9.7, a reduction of 5.9 points. In her ‘Reason for Attending Counselling’ questionnaire this client commented that, “I hope that by talking about this it will make things less stressful.” The client stopped attending unexpectedly after the second session but did return a ‘View of the Outcome of Counselling’ questionnaire in which she stated that the most helpful thing about the counselling she had received was “Being able to talk openly.” Client 5 also stated in this questionnaire that she found the counsellor “Very good”, and that, “The questions she asked helped me express myself.” Overall she rated the counsellor and the counselling she had received as helpful.

Qualitative data from the client self-report questionnaires was also available for Clients 6 and 7 shown in Table 6.9, both of whom presented to counselling with CORE scores that were in the non-clinical range. Client 6 was a 32 year old employed woman who was living with her partner and attended counselling for help with anxiety problems related to her mothers deteriorating health. Her CORE score at the start of counselling was 6.2, and at the end of counselling after 3 sessions it had reduced to 1.5, a pre-post
difference of 4.7 points. In her ‘Reasons for Attending Counselling’ questionnaire Client 3 rated herself as being moderately hopeful that counselling would help her to, “Put tasks in place to help her to cope for the future”, presumable related to coping with her mothers health problems. In the ‘View of the Outcome of Counselling’ questionnaire this client rated the counsellor and the counselling she had received as being helpful and commented that counselling was helpful to the extent that it assisted her to affirm her own conclusions about how to address her current anxieties and concerns. But, she also commented that the unhelpful aspects of counselling were that, “I felt more could have been said by the counsellor.” This client also noted that she was “Not sure if someone needed more help than me that it would be of any use to them.” In her ‘End of Counselling Form’ relating to this client, Counsellor 11 only commented that the client had been “Open-minded and had worked at helping herself.”

Client 7 was a 45 year old married and employed woman who attended counselling following a bereavement. At intake her CORE score of 5.0 was well within the non-clinical range. At the end of counselling it had reduced by 1.5 points to 3.5. In her ‘Reason for Attending Counselling’ questionnaire the client rated herself as being very hopeful that counselling would help, and after 2 sessions she indicated to the counsellor that she had made sufficient progress to stop attending counselling, and consequently, counselling ended in a planned manner (data extracted from the Counsellor 11’s ‘End of Counselling Form’). In her ‘View of the Outcome of Counselling’ questionnaire Client 7 rated the counsellor as being very helpful and commented that the most helpful aspect of counselling was, “To share problems/difficulties with someone who was non-judgemental – she removed my fears of someone viewing me as silly so that I did not feel embarrassed about revealing thoughts.” Similarly, this client rated the counsellor as
very helpful and noted that, “She was understanding, listened very carefully and gave positive responses and reassurance when appropriate.”

In the ‘End of Counselling Form’ for this client Counsellor 11 noted that she felt that she had worked well with the client insofar as she was able to, “Establish rapport, and felt more able to work with the issue of bereavement than previously when I needed to work through my own grieving.” Counsellor 11 also noted in this form that counselling was facilitated because the client was “open with feelings, thoughts and strengths.”

The final client for whom qualitative data were available from both the client and the counsellor in their respective self-report questionnaires was Client 8 shown in Table 6.9. This client was a 49 year old divorced woman who attended counselling for help with depression related to the death of her son some years previously, which contributed to the subsequent break-up of her marriage. The client reported in her ‘Reasons for Attending Counselling’ questionnaire that she had received counselling in the past related to these issues, which she stated had been “helpful to a degree.” Her CORE score at intake was within the moderate range of distress at 15.9; however, after the final session (the number of sessions was not recorded for this client) it had increased by 7.9 points to 23.2, which indicated significant deterioration and moved her levels of distress from the moderate to the moderate-to-severe range. Curiously, in her completed ‘View of the Outcome of Counselling’ questionnaire this client rated the counsellor and the counselling she had received as moderately helpful noting that the counsellor had been, “Helpful in guiding me in the right direction”, and that it was helpful that, “The counsellor was a similar age as myself. When a person is younger than yourself you feel as if you are talking to your children, which is not good.”
In the ‘End of Counselling Form’ for Client 8, Counsellor 11 noted only that she had, "Difficulty in keying into the client’s way of speaking and was concerned about her ‘mask-like’ expression. I did not feel confident in working with the issues she had.” Unfortunately, the counsellor did not record the way in which counselling ended or why it ended.

6.4.2.3 Personal philosophy and theoretical perspective
Information about the personal philosophy and practice of Counsellor 11 was gathered from the written comments that clients made in relation to the free-response items in the client ‘View of the Outcome of Counselling’ questionnaires, and the ‘End of Counselling Form’ completed by Counsellor 12 for each of her clients presented in Table 6.9. Counsellor 11 also participated in Study 2 of this thesis so additional details about her philosophy were gleaned from her interview transcript for this study. For Study 2, Counsellor 11 was referred to using the pseudonym Margaret – some of her experiences of becoming a volunteer mental health counsellor are presented in Chapter 5 of this thesis. Overall, data from these sources suggest that Counsellor 11 had a personal philosophy and theoretical perspective on counselling that included:

- a commitment to being genuine and non-judgemental in a counselling relationship
- a desire to integrate and express personal values within a flexible approach
- a belief in the importance of self-awareness and personal development to counselling work
- a belief that counselling can be used as a creative activity to promote personal growth, and not just as a means of resolving problems and difficulties.

In terms of the qualitative data from client self-report questionnaires it appeared that Counsellor 11 believed in providing an attentive and non-judgemental environment that
facilitated clients in expressing their thoughts and feelings and developing “new insights” in relation to the issues for which they had sought help. Evidence for this can be found in the case descriptions for Clients 2, 3, and 7, outlined in the preceding section. For example, these three clients made comments in their respective ‘View of the Outcome of Counselling’ questionnaires that highlighted the helpfulness of the counsellor’s listening skills, genuineness and non-judgemental attitude. In her interview for Study 2, Counsellor 11 also referred to the importance of these aspects of counselling when working with clients. For instance:

“You know, clients can sense falsity, and you can sense it yourself. So, I think it’s really important to be yourself as far as possible.” (Lines: 113-114).

Counsellor 11 appeared to be most comfortable with the interpersonal and relational aspects of counselling. However, she appeared to be less inclined to engage in a more directive, task-focused way of working. Client 6, for instance, presented with levels of distress that were within the non-clinical population and indicated in her ‘Reasons for Attending Counselling’ questionnaire that she hoped that counselling would have a more task oriented focus. At the end of counselling this client noted that while counselling had helped to affirm her own solutions, her written comments in the ‘View of the Outcome of Counselling’ questionnaire appeared to suggest that she felt the counsellor could have been more active, which led her to express doubts about the usefulness of counselling for other clients who may be more distressed than she had been. In fact, in relation to another client, who Counsellor 11 experienced as a challenging case, she commented in the ‘End of Counselling Form’ that she had felt most comfortable with the relational aspects of counselling such as building rapport and empathic responding.
Interestingly, Counsellor 11 was one of the counsellors in Study 2 who expressed strong negative and antagonist feelings toward solution-focused counselling and its methods (see section 5.4.1 of Chapter 5). It appears that she had to work hard to find ways to resolve sufficiently these dissonant experiences in order to pursue the personal goals of gaining experience of face-to-face client work, which she was hoping to achieve through voluntary counselling with the MHSS agency. There is a real sense in the interview account that Counsellor 11 provided for Study 2 that this conflict between her personal values and the solution-focused approach preferred with the MHSS agency demanded a great deal of personal reflection on her part to begin to establish a way of working that felt right for her. For instance, in relation to the solution-focused approach she remarked:

“Oh hey, come on! There isn’t a magic wand to wave to solve problems or miracles. And it’s so inappropriate to use with some clients when their story is what they bring. You know ... they just look at you and think, there’s another one whose not listening.”

(Lines: 92-95).

The above quote illustrates the struggle that Counsellor 11 had with the solution-focused technique of asking the miracle question or one of its derivates as a way of identifying client goals. Interestingly, Counsellor 11 did not make any reference to goals or tasks in relation to working with individual clients. Nevertheless, she did state that in relation to the solution-focused approach, her perception was that the overall goals of counselling could be interpreted as either, “Enabling clients to recognise the strengths they have and to learn to use them in difficult situations” or “If the client is not able to change the situation somehow to work with them to come to terms with that.”
The preceding quote could also be interpreted as providing an indication of the value Counsellor 11 appeared to place on ensuring that her clients felt heard. Judging by comments made by some of her clients in the client ‘View of the Outcome of Counselling’ questionnaire it seems clear that Counsellor 11 attempted to pay a lot of attention to listening to clients and allowing them to tell their story. Being listened to appeared to have been highly valued by Counsellor 11 as, for her, it demonstrated respect and a valuing of the other person. This was something that was important to her on a personal level and she talked about this in her interview in relation to her experience of the brief in-house counselling training she received with the MHSS agency:

“There was a feeling of being valued and respected, a real sense of genuineness. There wasn’t falsity there, which enabled me to speak out and feel valued for what I was saying.” (Lines: 65-68).

This personal experience of being on the receiving end of feeling valued and listened to during the MHSS training appears to reflect some of the qualities that Counsellor 11 appeared to value in her life in general and also in relation to her counselling practice.

Another assumption that underpinned the practice of Counsellor 11 concerned the importance she placed on self-awareness and personal development.

“I think in building up that relationship you’ve got to know yourself. It’s a really important part of it – paying attention to how you interact and the messages you’re giving the client. Yes, I see personal development as rather essential.” (Lines: 290-293).
And later in her interview she talked about the links between the role of counselling in promoting creativity and personal development:

“*I really want to look at creativity and personal development...why just come to counselling for the negative aspects? You know, let’s work on the positive aspects because that enables growth too.*” (Lines: 692-698).

As noted above, Counsellor 11 appeared to have struggled to resolve the tension and conflict she experienced between her personal values and the solution-focused approached preferred with the MHSS agency. Nevertheless, there was some evidence from her interview for Study 2 that over time she managed to find an accommodation on these issues which allayed her anxieties about having to practice in a rigid solution-focused manner. For instance, she remarked in her interview that,

“*The aims and objectives of the organisation and the way you see counselling ... provided a framework. I knew what I was required to work within. But at the same time there was also my own personal approach and my own personal values, which I sometimes felt, yeah they can be worked with too. Why not use that. It’s not as if it’s going against the framework but it is shall we say putting a more personalised approach on it.*” (Lines: 331-338).

Indeed, Counsellor 11 indicated that she eventually incorporated solution-focused methods into her approach in a flexible manner and in ways that were meaningful within the context of the client’s life:
“I don’t know that I’ve ever used the miracle question, okay. But I’ve used the scaling one several times and am getting more confident each time. What I try to do is not just says it’s a scale - you know, 0 – 10 – but to try and orientate it to the client’s perception of the world or the world they know from maybe work of family. So with one client who couldn’t read or write but has done building, I actually referred back to a piece of building he had done and could use that to get over the idea of progress or whatever instead of using a scale question.” (Lines: 97-105).

It is perhaps important to note that this process appeared to be prolonged, during which time Counsellor 11 experienced uncertainty and self-doubt about how she should practice within the MHSS agency. There was also some indication that Counsellor 11 found a number of her clients challenging, and at times felt overwhelmed by their presentation and uncertain about how to respond helpfully. For example, in relation to one particular client she talked about in her interview she remarked:

“The pace of the client has been so rapid I’ve hardly been able to open my mouth. It’s really something to have this torrent for 60 minutes. No space. No space. Quite overwhelming.” (Lines 509-512).

Overall, Counsellor 11’s personal philosophy and theoretical perspective appeared to focus, primarily, on providing a relationship characterised by attentive listening, genuineness and being non-judgemental, and helping clients to find their own solutions to their problems and concerns. There is a clear sense that she was conscientious and concerned for her clients, and attempted to work in a way that was consistent with her personal values and those of the MHSS agency. Indeed, her struggle to establish a
framework for her practice can be seen as a process of ‘finding a voice’ as a counsellor within the MHSS agency.

### 6.4.3 Counsellor 10: the third least effective counsellor

Counsellor 10 was a woman in her thirties who had approximately 11 years experience of working with people in a voluntary organisation. In addition to undertaking the brief in-house counselling course with MHSS, Counsellor 10 had also completed a COSCA (Confederation of Scottish Counselling Agencies) certificate in counselling skills.

Counsellor 10 participated in Study 2 of this thesis. The pseudonym Sophie was used in to refer to her in Chapter 5 where the findings of this Study were reported. In her interview for Study 2, Counsellor 10 acknowledged that she became interested in counselling following a personal experience of receiving counselling at a time of crisis in her life. Following this she undertook the COSCA course. She acknowledged in her interview for Study 2 of this thesis that one of her primary intentions in undertaking further counselling training with the MHSS agency and in becoming a volunteer counsellor was to use it to promote her own personal development and to test out her potential as a counsellor (see sections 5.1.1 and 5.2.4 for details).

#### 6.4.3.1 Overview of client characteristics and counselling outcomes

Counsellor 10 had five clients with completed pre-post counselling CORE-OM data. Table 6.10 shows the characteristics and outcomes for these clients. It can be seen from Table 6.10 that four clients were female, and one was male. Unfortunately, demographic characteristics such as marital and employment status, and history of previous psychological help for two clients seen by Counsellor 11 was incomplete.
### Table 6.10 Client characteristics and CORE-OM scores for Counsellor 10: the third least effective counsellor

<table>
<thead>
<tr>
<th>Client</th>
<th>Client characteristics</th>
<th>Primary problem</th>
<th>Duration of primary problem</th>
<th>No. of sessions</th>
<th>Type of ending</th>
<th>CORE-OM Scores</th>
<th>Overall outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male, 36yrs, single, disability benefits. No previous help.</td>
<td>Depression</td>
<td>17 months</td>
<td>10</td>
<td>Unplanned</td>
<td>16.8</td>
<td>5.0</td>
</tr>
<tr>
<td>2</td>
<td>Female - no other details recorded.</td>
<td>Interpersonal / relationship</td>
<td>n/k</td>
<td>11</td>
<td>Planned</td>
<td>25.9</td>
<td>16.2</td>
</tr>
<tr>
<td>3</td>
<td>Female - 49yrs, married, employed. Previous help.</td>
<td>Interpersonal / relationship</td>
<td>3 years</td>
<td>6</td>
<td>Planned</td>
<td>7.4</td>
<td>1.5</td>
</tr>
<tr>
<td>4</td>
<td>Female, 18yrs, single parent, employment status n/k</td>
<td>Depression</td>
<td>n/k</td>
<td>4</td>
<td>Unplanned</td>
<td>22.3</td>
<td>22.4</td>
</tr>
<tr>
<td>5</td>
<td>Female - no other details recorded.</td>
<td>n/k</td>
<td>n/k</td>
<td>n/k</td>
<td>n/k</td>
<td>7.0</td>
<td>13.8</td>
</tr>
</tbody>
</table>
Table 6.10 also shows that two of the five clients presented with levels of distress that were within the non-clinical range, and three clients had CORE-OM scores that fell within the clinical range. Client presenting problems included depression (n = 2) and interpersonal and relationship issues (n = 2). The presenting issue for the poorest outcome case was not recorded.

Data on the duration of time clients had been experiencing their primary presenting problem were only available for two of the five clients and indicated that the problems these clients had presented to counselling with were of a chronic nature: one client reported being distressed by their problem for approximately 17 months, and the other client had endured their difficulties for more than three years. The type of ending was recorded in four cases: two clients had planned endings and two had unplanned endings (including the best outcome case). The number of counselling sessions per client was only recorded for four of the five clients and the mean for these clients was five sessions.

6.4.3.2 Case descriptions

Only three of the five clients detailed in Table 6.10 completed a ‘View of the Outcome of Counselling’ questionnaire post-counselling (Clients 2, 3, and 4 shown in Table 6.10), two of whom also completed the ‘Reason for attending Counselling’ questionnaire at the start of counselling (i.e., Clients 3 and 4 shown in Table 6.10). Counsellor 10 only completed an ‘End of Counselling Form’ for her best outcome case, and for the client who did not make any appreciable change following counselling (Clients 1 and 4 respectively detailed in Table 6.10). A complete set of client and counsellor self-report questionnaires was only available for one of the clients seen by Counsellor 10 (i.e., Client 4 shown in Table 6.10). Case descriptions are provided below drawing on client and counsellor data, where available, from their respective self-report questionnaires for
clients 1, 2, 3, and 4. Client 5, the poorest outcome case is not included as the only data available for this client was their pre- and post-counselling CORE scores.

The best outcome case for Counsellor 10 was Client 1 shown in Table 6.10. This was a 36 year old single man who presented to counselling for help with depression, and secondary issues related to his sexuality, feeling isolated, and sustaining paid employment. At the start of counselling this client reported in the 'Reason for Attending Counselling' questionnaire that he had been experiencing problems with depression for approximately 17 months prior to seeking help, and rated himself as being, ‘Very hopeful’ that counselling would help. At intake his CORE score was within the moderate range at 16.8, and on completion of counselling it had reduced by 11.8 points to 5, which indicated that his levels of distress had not only reduced significantly but also returned to the non-clinical range. Counselling ended unexpectedly when this client did not return for a planned session, and unfortunately the client did not return a completed ‘View of the Outcome of Counselling’ questionnaire so there were no data on their experience of counselling. Counsellor 10, however, did complete an ‘End of Counselling Form’ for this client and commented that, “Counselling seemed to help the client, although I found myself getting confused about what the issue was for him. However, I feel that talking about his sexuality impacted profoundly on him as he hasn’t vocalised this at length previously.” Counsellor 10 also noted that the fact that the client was in a new relationship may have also been a factor in his apparent improvement and decision not to return to counselling.

The second best outcome case for Counsellor 10 was Client 2 (shown in Table 6.10). Unfortunately, the only data on the characteristics of this client were that she was female.
and presented to counselling for help with interpersonal/relationships issues. At intake her CORE score was 25.9, just within the severe range of distress levels, and at the end of counselling following 11 sessions, it had reduced by 9.7 points to 16.2 - moving her levels of distress to the moderate range. The ending in this case was planned and the client returned a ‘View of the Outcome of Counselling’ questionnaire in which she rated the counselling she received as being ‘Helpful’ and noted that a particularly useful aspect of counselling was, “Being able to talk to someone impartial.” Interestingly, this client gave a neutral evaluation of the counsellor’s performance overall, and commented that an unhelpful aspect of counselling was that although, “The counsellor seemed competent though I sometimes felt I was being pushed hard to act on things [by the counsellor] but I didn’t feel ready. Also, I felt my personality sometimes clashed with the counsellor’s personality.”

Client 3, a 49 year old female who presented to counselling for help with interpersonal and relationship problems was also a good outcome case for Counsellor 10. This client had a CORE score of 7.4 at the start of counselling, which was within the non-clinical range. At the end of counselling, following 6 sessions, her CORE score was 1.5 – a reduction of 5.9 points. Counselling ended in a planned manner with the mutual agreement of client and counsellor.

Client 3 did not complete a ‘Reason for Attending Counselling’ questionnaire, but she did return a ‘View of the Outcome of Counselling’ questionnaire in which she rated the counsellor and the counselling she had received as helpful overall, and commented that one of the most useful aspects of counselling was, “The fact that the counsellor joined in and discussed some issues with me, challenging me at times and made things clearer for
me.” In relation to her experience of Counsellor 10, the client wrote that, “[Counsellor name] managed to break through my veneer, I found her warm, and was reassured by the way she remembered details from one session to the next. In fact, she remembered more than I did at times!” This client also made notes in the margins of the ‘View of the Outcome of Counselling’ questionnaire which stated that she had, “Also been reading self-help books and have seen a kinesiologist. There is still work to be done!” Counsellor 10 did not return an ‘End of Counselling Form’ for this client.

Client 4 was an 18 year old woman and single parent who attended counselling for help with depression related to feelings of isolation and limited support in coping with the responsibility of looking after a baby. In addition, this client was experiencing on-going gynaecological bleeding which was causing her to feel fatigued and emotionally depleted. In her ‘Reason for Attending Counselling’ questionnaire she reported that she was taking anti-depressants prescribed by her GP, and rated herself as ‘Very Hopeful’ that counselling would help. Her CORE score at intake was within the moderate-to-severe range at 22.3. After four sessions the client dropped-out of counselling, at which point her CORE score had deteriorated very slightly to 22.4. This client returned a client ‘View of the Outcome of Counselling’ questionnaire in which she rated the counsellor highly in terms of helpfulness and commented, “The lady was nice and not judgemental.” This client also noted in this questionnaire that the most useful aspect of attending counselling for her was that it gave her, “The feeling of doing something to try and help myself.” Curiously the client also noted that she continued to be distressed by the issues she had originally presented to counselling with.

6.4.3.3 Personal philosophy and theoretical perspective
Based on the available qualitative data from client and counsellor self-report
questionnaires (in particular, the client ‘View of the Outcome of Counselling’ questionnaire and the counsellor ‘End of Counselling Form’) and from Counsellor 10’s interview transcript for Study 2, it appeared that this counsellor’s personal philosophy and theoretical perspective on counselling centred on the following key themes:

- Creating a therapeutic space for clients to feel safe and to discuss their concerns
- Being directive and action oriented
- Challenging clients
- Helping clients to develop new perspectives and to harness their resources to overcome their problems
- Valuing self-reflection and personal development.

Client feedback, described in the preceding section, on their perceptions of Counsellor 10 and the counselling they received suggested that this counsellor was experienced by different clients as being warm, non-judgemental, competent and also challenging. In one case (i.e., Client 2 shown in Table 6.10) Counsellor 10 was regarded as being helpful by the client to the extent that she found her to be competent, but less helpful because the client experienced her approach to be too directive and challenging insofar as the client felt pushed to act before being ready to do so.

Analysis of the interview transcript for Counsellor 10 in relation to Study 2 of this thesis indicated that an important belief underpinning her practice concerned the importance of creating a space for clients to talk:

“I think that when people come in there it’s there time so it’s crucial to create the most comfortable environment for somebody to talk in.” (Lines 350-352).
Chapter 6: Differences between more and less effective mental health counsellors

And,

“I have a real appreciation that when a client comes in here I have a responsibility to try and make sure the environment is as supportive as possible for them.” (Lines: 499-500).

In relation to this issue of creating a supportive therapeutic space, Counsellor 10 appeared to be influenced by a belief in the importance of reflection to facilitate her own self-awareness, which appeared to be informed, at least to some extent, by her understanding of the psychodynamic concept of projection. For example, in relation to the need for self-reflection she remarked:

“I think you need to keep looking at, ‘Why am I doing this?’ [i.e., counselling] And when things come up for you - when you genuinely feel that somebody is exploring their own experience - and you feel yourself feeling really sad or whatever as a response to that, I think you need to go away and think about that in order that you keep the environment as clean as possible.” (Lines: 457-462).

Regarding the relevance of projection she stated:

“I spoke about projection before in the training [i.e., the MHSS in-house counselling course] and keeping the therapeutic environment clean. I mean, I think you can’t cut yourself off from reacting ... if someone said something you connect with. How can you possibly? You would need to be in-human not to feel but I think what you need to do is do something with that instead of associating it with that person.” (Lines: 467-12).
Counsellor 10 also talked about what appeared to be a strong sense of identification with clients that further contributed to her interest in self-reflection:

“One of the things that really surprised me about doing counselling was there are some people who I’ve really strongly, strongly identified with what they were saying and sometimes that’s people talking about their relationships or about their childhood or about their mental health. And there would be times where I’d think, I know exactly what you mean and I did. So, what I found is that that sort of gets me thinking, ‘What’s that about?’, and I go and read up on stuff to figure it out.” (Lines: 439-445).

What Counsellor 10 appeared to be trying to achieve was to create a therapeutic space that would allow her clients to talk openly about their concerns and difficulties. To accomplish this she believed that reflection and self-awareness were essential in order to ensure her own personal issues did not get in the way of that.

Counsellor 10 was clearly very reflective and motivated to learn about herself and her reactions to clients, and she certainly felt she had a clear responsibility to understand herself as much as possible in order to be most helpful to her clients. Yet, there were indications that Counsellor 10 was very ‘self-focused’ even in relation to her client work. In fact, she identified this herself in her interview for Study 2 and talked about how she was learning to shift her focus away from herself. In the following quote from her interview she was talking about her increasing awareness of this self-focus in relation to her experience during the MHSS in-house counselling training prior to entering practice.
“When I was in the training group I started to become aware of myself as talking too much, and I started to annoy myself because it was always like, me, me me!! I’ve got an idea, I know what we can do with this. And then I started to think quite genuinely about what I would feel like in a group where somebody wouldn’t shut up, and so I tried to still contribute but in a way that wasn’t overbearing but was still enthusiastic.” (Lines: 319-322)

Counsellor 10 seemed to continue to struggle with this issue in relation to her client work following the MHSS counselling training course. In the next quote she explains how she became aware of how preoccupied she had become with her performance as a counsellor and needed to remind herself that she needed to shift her focus onto the client:

“I think that experience has highlighted that it’s not about me, it’s about them [i.e., clients]. You know, I need to keep coming back to that and allow people the opportunity to explore things in their own way and sometimes that takes time.” (Lines: 238-242)

The preceding quotes appear to be saying something about an increasing awareness in Counsellor 10 about her potential to be self-focused, even overbearing, and perhaps too preoccupied with her own performance as a counsellor. She also talked about how this awareness translated into her counselling practice.

“I think I’m more careful now with clients. I know people don’t go at my pace. They go at theirs and I have to go at their pace. I think I’m learning to take my time a bit more. It was a wee bit, I think, about me maturing into the role.” (Lines: 335-338).
Notwithstanding this increasing awareness, Counsellor 10 appeared to have a preference for being active, directive and at times challenging in her approach, particularly as she gained more experience:

“I probably push a little further sometimes now than I would have initially. I feed back to people, particular people who are working on things they have discovered about themselves like, for example, if a client gets into a victim role, if I see it coming up in a session then I'll say to them, 'Are you doing that now?’” (Lines: 251-255).

In part, Counsellor 10 attributed this stance to skills she had already developed prior to becoming a volunteer counsellor with the MHSS agency. Regarding this she commented:

“Before I came here some of the skills I had were about observing and being able to pick up on stuff like body language, they way people said things or did things or how they spoke with their body or what they were doing with their feet when they said certain things. And I suppose I’ve become more confident about introducing that into my counselling work.” (Lines: 270-75).

Another theme that emerged during the interview with Counsellor 10 for Study 2 was her concern for the professional aspects of her work. She referred to the importance of "boundaries” and the importance of having a “professional code that you really need to be aware of for your own sake and for your clients’ sake. It would be really irresponsible of the service [i.e., the MHSS counselling service] and a counsellor if they were not as professional as they could be.”
Counsellor 10 appeared to be comfortable using the solution-focused methods she was introduced to during the MHSS counselling training course, and stated that she found them helpful to, “Get clients to look at things from a different angle” and for, “Highlighting to clients how they are managing a situation so that they can start to find their own resources.” Although she adhered to a rigid application of the solution-focused approach in the earlier stages of her first year of counselling practice, she stated in her interview for Study 2 that she became more flexible in applying its methods and was beginning to trust in her capacity to work in a more relational way with clients. It was not clear exactly what Counsellor 10 meant by this; however, it would appear that to some extent this related to her learning to work at the client’s pace and to be more selective in her use of solution-focused methods.

Overall, Counsellor 10 appeared to base her counselling approach on a belief in the importance of counsellor self-awareness to effective practice; a concern to create an environment for clients to talk about their concerns that was not unduly influenced by her personal reactions; a preference for being an active participant and at times challenging of clients; and an appreciation of the importance of being professional.

6.4.4 Summary of findings

6.4.4.1 CORE-OM data
Evaluation of pre-post CORE-OM data in terms of effect size showed that the 12 paraprofessional counsellors in the present sample varied in their effectiveness. The three more effective counsellors achieved large effect sizes of .96, .94, and .89 respectively, and the three less effective counsellors achieved small effect sizes of .21, .36, and .37.
Improvement and recovery rates across this group of counsellors also showed variability. In particular, of the 12 counsellors in this sample, rates of reliable deterioration were recorded for five counsellors in all, which were significantly higher than current CORE-OM benchmark estimates of 1.8 to 3%. In fact, rates of reliable deterioration in this sample ranged from approximately 11% for Counsellor 6 to 22% for Counsellor 12 shown in Table 6.2. Three of the five counsellors whose clients showed reliable deterioration were the less effective counsellors described in section 6.3 above. The highest rates of reliable deterioration were evident among clients seen by Counsellor 12 (22%), the least effective counsellor according to effect size calculations. Clients that were seen by counsellors 10 and 11, also part of the less effective group of counsellors in this sample, showed rates of reliable deterioration that were close to 17%.

In is important to note that the more effective counsellors, described in section 6.3 above, also had cases that showed deterioration in terms of levels of distress as measured by the CORE-OM pre- to post-counselling but they did not meet the criteria for reliable deterioration (i.e., an increase of five or more point on the CORE-OM pre-counselling to post-counselling). Another point to note is that a higher percentage of clients seen by the three less effective counsellors compared to the three more effective counsellors completed post-counselling CORE-OM forms (please refer to Table 6.3 for details).

The mean number of clients seen by the less effective group was 7 compared to a mean of 5.6 clients seen by the more effective group, which reflects a response rate of 74% and 55% respectively in relation to completion of pre- and post-counselling CORE-OM data. There were no significant differences in the mean number of counselling sessions
between the more effective and the less effective counsellors (mean of 4.6 and 4.7 respectively).

6.4.4.2 Characteristics of more and less effective counsellors and their caseloads

Table 6.11 summarises the levels of training and experience of the three more effective and the three less effective counsellors at the start of Study 1, according to the overall effect sizes they achieved in relation to client outcomes.

Both groups of counsellors were broadly similar in terms of personal characteristics such as age and gender, and they were diverse in relation to employment status. There were some differences between the more effective group of counsellors and the less effective group of counsellors in relation to levels of counselling training and experience. Interestingly, the three less effective counsellors had twice as many hours of counselling training than the more effective counsellors: 120 hours and 60 hours respectively. Similarly, the three less effective counsellors had more counselling and general helping experience than the more effective counsellors. For example, within the group of three less effective counsellors, one had approximately 100 hours of prior experience as a volunteer telephone helpline counsellor, another had accumulated 100 hours as a volunteer mental health counsellor within the MHSS agency, and the other counsellor had approximately eleven years of general helping experience, but not as a counsellor, in a non-statutory human service agency.

From the somewhat limited data that was available, it appears that both the three more effective counsellors and the three less effective counsellors in this sample were experienced by their clients as being warm and caring individuals, who were in fact...
helpful in many instances even with clients who presented to counselling with high levels of distress in terms of CORE scores.

Table 6.11 Characteristics of the three more effective and the three less effective counsellors

<table>
<thead>
<tr>
<th>C</th>
<th>Sex</th>
<th>Level of counselling training</th>
<th>Level of helping experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Type</td>
<td>Duration</td>
</tr>
<tr>
<td>1</td>
<td>M</td>
<td>1. MHSS in-house training</td>
<td>1. 40hrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Introduction to counselling</td>
<td>2. 30hrs</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>1. MHSS in-house training</td>
<td>1. 40hrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>1. MHSS in-house training</td>
<td>1. 40hrs</td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>1. MHSS in-house training</td>
<td>1. 40hrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. COSCA Certificate in counselling skills</td>
<td>2. 120hrs</td>
</tr>
<tr>
<td>11</td>
<td>F</td>
<td>1. MHSS in-house training</td>
<td>1. 40hrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. COSCA Certificate in counselling skills</td>
<td>2. 120hrs</td>
</tr>
<tr>
<td>12</td>
<td>M</td>
<td>1. MHSS in-house training</td>
<td>1. 40hrs</td>
</tr>
</tbody>
</table>

Column C denotes counsellor, rank ordered in terms of effectiveness according to effect size - counsellors 1, 2, and 3 were the most effective, and counsellors 10, 11, and 12 were the least effective.

It is difficult to draw any firm conclusion about potential differences between the three more and the three less effective counsellors in terms of their philosophies and approach to counselling because of the limited amount of data that was available. Nevertheless, there was some evidence that compared to the three less effective counsellors, the counsellors in the more effective group tended to work in a structured and focused manner in relation to engaging clients in an active collaboration around the development of goals and tasks for counselling. Also, evidence from the interviews with Counsellors...
1 and 3 of the more effective counsellors indicated that there was a high degree of ‘fit’ between their personal philosophies and the solution-focused approach. However, they also emphasised the importance of implementing solution-focused methods in a flexible manner within the context of their own personal style.

In contrast to the more effective counsellors, within the less effective group of counsellors there was evidence from the interviews with Counsellors 10 and 11, conducted for Study 2 of this thesis, that these counsellors experienced some tensions in relation to the solution-focused approach. Counsellor 11 in particular appeared to experience a high degree of conflict with the solution-focused approach and its methods because it clashed with her values and personal philosophy. She reported in her interview that she struggled for some time to find ways of resolving these tensions – principally, it seems, so that she could achieve her personal goals of gaining more practical experience of face-to-face-counselling through volunteering with the MHSS agency. Although Counsellor 10 reported in her interview that she was comfortable with the solution-focused approach she also indicated that she implemented it in a rather rigid and perhaps technical manner.

There was also some indication that Counsellors 10 and 12 in the less effective group appeared to be more concerned with the technical aspects of counselling such as implementing techniques, and tended to impose goals on clients or prescribe what they should do, whereas Counsellors in the more effective group seemed to engage in more negotiation around the goals and tasks for counselling and there was a stronger sense that the interpersonal and relational aspects of counselling were more important than the use of techniques. This latter point seemed to be particularly relevant for Counsellors 1
and 3 within the more effective group of counsellors and was evident in the themes that emerged in relation to their personal philosophies and their approach to counselling.

A summary and discussion of the findings presented in this chapter can be found at sections 7.2.1 and 7.2.3 of Chapter 7 of this thesis.
Chapter 7

Discussion and Conclusions

7.0 Introduction

The overall aim of this thesis was to investigate the effectiveness and development of a group of paraprofessional counsellors. This aim comprised two major objectives, which necessitated conducting two separate but related studies involving a group of volunteer mental health counsellors working in a voluntary sector counselling agency in the UK.

The first objective was to evaluate the effectiveness of a group of minimally trained/experienced paraprofessional counsellors with clients presenting with a range of mental health problems. To accomplish this objective, a naturalistic benchmarking study was carried that evaluated the effectiveness of 12 paraprofessional counsellors over a 12 month period using the CORE Outcome Measure (Study 1). The CORE-OM data were supplemented by a range of client and counsellor self-report measures administered before and after counselling. The outcomes achieved by this group of paraprofessionals were evaluated in relation to the outcomes of professional counsellors reported in three published studies, which were selected as benchmarks for comparison purposes.

The second objective was to investigate paraprofessional counsellors’ experience of becoming a paraprofessional counsellor. To address this objective, a qualitative study was undertaken that involved conducting semi-structured interviews with participants at the end of their first year of practice (Study 2).

This chapter is organised into five main sections. First, section 7.1 returns to the primary
research questions pursued in this thesis and provides a summary of the findings for Study 1 and Study 2. Second, in section 7.2 these findings are interpreted and discussed in relation to relevant theory and previous research, which was identified and reviewed in Chapter 2 of this thesis. Third, section 7.3 provides a critical appraisal of the limitations of this research and the methodological issues that have emerged from it. Fourth, the implications of this research in relation to the selection, training, supervision and practice of paraprofessional counsellors are addressed in section 7.4. Fifth, section 7.5 provides a summary of the research reported in this thesis, the primary conclusions that can be drawn from it, and suggestions for future research.

7.1 Summary of findings
The primary goal of the research reported in this thesis was to examine the effectiveness of a group of paraprofessional counsellors working in a mental health setting, and to gain an understanding of the meaning and experience of becoming a volunteer mental health counsellor. Chapter 2 endeavoured to provide a critical review of theory and research that was considered relevant to the contemporary practice of paraprofessional counselling, which in turn, generated a set of research questions that formed the basis for two empirical studies.

This section summarises the main findings that emerged from the studies reported in this thesis, which set out to answer these research questions. First, the findings of Study 1, reported in Chapter 4 regarding the effectiveness of the present sample of paraprofessional counsellors are summarised. Second, the findings of Study 2, which sought to explore participants’ perspectives of the experience of client work and development, are précised in section 7.1.2. Third, links between the findings of Study 1
and Study 2 regarding individual differences between participants in terms of their effectiveness, personal philosophies and counselling practice are summarised in section 7.1.3.

7.1.1 Study 1
Study 1 sought to address two research questions. The primary research question pursued in relation to Study 1 was, 'How effective are minimally trained/experienced volunteer mental health counsellors?' The results pertaining to this question can be found in Chapter 4 of this thesis. A secondary question in Study 1 sought to examine, 'To what extent, if at all, are minimally trained/experienced volunteer mental health counsellors differentially effective?' Findings in relation to this secondary question were reported in Chapter 6. This section summarises the findings in relation to each of these research questions.

7.1.1.1 Question 1: How effective are minimally trained/experienced volunteer mental health counsellors?
The primary finding in relation to this question was that the group of paraprofessional counsellors who participated in Study 1 were less effective than professional counsellors working with a similar client population. Evidence for this conclusion can be found in Chapter 4 of this thesis. This conclusion is based on the comparison of outcomes achieved by the paraprofessional counsellors in the Study 1 with the outcomes of professional counsellors reported in three selected benchmark studies. It was found that professional counsellors achieved almost twice the effect of the paraprofessional counsellors (an effect size of .70 for the present sample of paraprofessionals compared to and effect size of 1.39 for professional counsellors).

Also, when rates for reliable and clinically significant improvement were examined for
both groups, it was found that less than 49% of clients seen by the paraprofessionals achieved the status of improved or recovered compared to between 72% and almost 80% of clients seen by professional counsellors in the benchmarking studies. This suggests that the paraprofessionals in Study 1 were operating within the bottom twenty-five percent of practitioners according to CORE-OM benchmarks. It was also noted that the rates of unplanned and premature endings for paraprofessional counsellors (57%) was significantly higher than those reported by professional counsellors in the benchmark studies, and that the rates of reliable deterioration were also much higher for paraprofessional counsellors compared to professionals.

Overall, the results of this study challenge the general findings from previous research that paraprofessional counsellors can achieve similar outcomes to their professional counterparts. As noted in section 2.1 of Chapter 2 in this thesis, there has been a distinct lack of research into the effectiveness of paraprofessional counselling for common mental health problems. Hence, the findings from Study 1 contribute new understanding to the scope of paraprofessional effectiveness in relation to a range of mental health problems commonly found in routine practice within the voluntary and statutory sector psychological services within the UK. Discussion of these findings can be found at section 7.2.1 of this chapter.

7.1.1.2 Question 2: To what extent, if at all, are minimally trained/experienced volunteer mental health counsellors differentially effective?

The main finding in relation to this question was that counsellors varied in their effectiveness. The overall effectiveness of individual counsellors was determined by the effect size they achieved in relation to client outcomes. Examination of effect sizes achieved by each counsellor showed differential effectiveness within the present group
of paraprofessional counsellors. Of the 12 counsellors that participated in Study 1, evidence of differential effectiveness among counsellors was most apparent at the extremes of the three more effective and the three less effective counsellors. For example, the more effective counsellor achieved an effect size of .96 while the less effective counsellor achieved an effect size of .21. (see Table 6.1, Chapter 6).

Analysis of rates of client recovery and improvement in terms of CORE-OM benchmarks (Mullin et al. 2006) revealed that 50% or more of clients seen by eight of the 12 counsellors in the present sample of counsellors had recovered or improved post-counselling. The other four counsellors were performing within the bottom quartile or 25% of counsellors according to CORE-OM benchmarks with recovery and improvements rates that were below 49%. Rates of reliable deterioration among clients seen by this group of 12 practitioners was significantly higher than those reported among professional counsellor caseloads (1.8% to 3% among professional counsellors according to CORE-OM benchmarks, compared to 7.6% in the present study). However, it is noteworthy that client deterioration was most evident in clients seen by the three less effective counsellors among this group of paraprofessional counsellors (see Table 6.2, Chapter 6 of this thesis).

Levels of client distress, as measured by CORE-OM scores, were broadly similar across counsellor caseloads. Mean CORE-OM intake scores for the majority of clients across counsellor caseloads were within the moderate range of distress; however, mean CORE scores at the start of counselling for clients seen by two counsellors fell with the mild range of distress according to CORE-OM severity levels.
Overall, the finding that counsellors vary in their effectiveness is consistent with the extant literature on therapist effects, which was reviewed at section 2.2 in Chapter 2. For the most part, studies in this area have focused on investigating variability in the effectiveness of experienced and licensed counsellors or psychotherapists in North America. To date, there appears to have been a lack of research into the impact of the qualities of individual paraprofessional counsellors on client outcomes in relation to a range of client problems, particularly in the area of mental health. Further discussion of individual differences in the effectiveness among the present sample of paraprofessional counsellors can be found in section 7.1.3 of this chapter.

7.1.2 Study 2

7.1.2.1 Finding a voice: The meaning and experience of becoming a volunteer mental health counsellor

Study 2 aimed, broadly, to gain an understanding of the meaning and experience of becoming a paraprofessional counsellor. It centred on a number of general questions:

1. How do paraprofessional counsellors account for their interest in, and engagement in the activity of counselling?

2. What is the meaning of counselling training for paraprofessional counsellors in relation to their development?

3. How does the experience of client work impact on paraprofessional counsellors?

4. What are the processes involved in the development of competence and awareness in paraprofessional counsellors?

A qualitative analysis, informed by a grounded theory approach, was carried out on interview transcripts obtained from eight paraprofessional counsellors at the end of their first year of practice. The analysis yielded four main categories and a core category that
encapsulated participant experiences of becoming volunteer mental health counsellors. The category system encompassed the experience of training, entering practice, client work, and the tensions and dilemmas that this group of counsellors experienced in relation to being a volunteer counsellor within the MHSS agency.

The metaphor of ‘finding a voice’ was used to characterise the core meaning that participants attributed to being and becoming paraprofessional counsellors. The concept of finding a voice was used to represent a process whereby participants were attempting to achieve and sustain an identity as a counsellor or, in more general terms, a process that embodied the pursuit of a possible-self-as-counsellor. It was suggested that this process entailed four related dimensions, which contributed in a synergistic manner to participant experiences of ‘finding a voice’. These dimensions were: 1) the experience of resonating with counselling and the role of counsellor, the agency ethos and values including the theoretical model employed within the agency; 2) the experience of learning the language of counselling; 3) the opportunity to, and experience of, putting the language of counselling into action with real clients; and 4) the process of experiencing and resolving dissonance or dilemmas and tensions in relation to being a volunteer counsellor. These categories are discussed in section 7.2.2 of this chapter in relation to the research questions pursued in Study 2. A detailed account of the findings from Study 2 was presented in Chapter 5 of this thesis.

7.1.3 Linking the findings from Study 1 and Study 2: Individual differences between counsellors in relation to their effectiveness, personal philosophies and counselling practice

Chapter 6 of this thesis reported findings from Study 1 and Study 2 concerning individual differences among the present sample of paraprofessional counsellors in relation to their effectiveness, personal philosophies and counselling practice.
Specifically, in relation to Study 1, effect sizes were calculated and reported for each of the 12 counsellors that participated in Study 1. Individual counsellor effectiveness was determined by the size of the effect they achieved in relation to client outcomes. Variability in counsellor effectiveness was most apparent at the extremes of the three more and three less effective counsellors in the present sample. The more effective counsellors achieved large effect sizes of .96, .94, and .89, compared to the three less effective counsellors who achieved relatively small effect sizes of .21, .36, and .37 (see Table 6.1, Chapter 6).

In an attempt to gain an understanding of the factors that may have contributed to the overall effectiveness of these two groups of counsellors findings from an analysis of qualitative data from client self-report questionnaires (i.e., only those with pre-post CORE-OM data) completed before and after counselling were reported for the three more effective and the three less effective counsellors. In addition to this data from Study 1, findings from an analysis of qualitative data form counsellor self-report questionnaires completed at the end of counselling for each client with pre-post CORE-OM seen by the three more effective and the three less effective counsellors were also reported, which provided some insight into individual counsellor perspectives on their practice and the outcomes for individual clients.

It is important to acknowledge, however, that data from both client and counsellor self-report questionnaires was somewhat limited and of variable quality. Nonetheless, it was possible to suggest, tentatively, that both the three more effective and the three less effective counsellors were experienced by many, if not most, of their clients as caring and understanding individuals who were able to offer a helpful counselling relationship
in many instances.

In general, it appeared that as well as conveying a caring and understanding attitude to clients, the three more effective counsellors within this group of practitioners appeared to work in a more structured and focused way with clients in relation to the negotiation of goals and tasks for counselling compared to the three less effective counsellors. Moreover, within the less effective group of counsellors (Counsellors 10 and 12 in particular – see section 6.4, Chapter 6) there seemed to be a tendency to adopt a more directive approach where counsellors imposed goals on clients or pushed them to act in particular ways which was not always in accordance with clients’ wishes or readiness to change. To this extent, it appeared that there were differences in the interpersonal and relational style between the more and less effective counsellors.

Another factor concerning the overall effectiveness of the more and less effective counsellors in the present study concerns the degree to which individual counsellors appeared to reflect on their practice, and in particular on the outcomes in individual cases in the ‘End of Counselling Form’, which counsellors were requested to complete following counselling with each client on their caseload. It is interesting to note that, compared to the three less effective counsellors, the three more effective counsellors seemed to make more use of the ‘End of Counselling Form’ to reflect on their practice. This was evidence by the fact that for the majority of their clients the more effective counsellors made at least some reflective comments about the process and outcome of counselling in each of their cases.

In contrast, the three less effective counsellors made far less use of this opportunity to
reflect on the outcomes of counselling in individual cases, particularly in relation to poor outcome cases. Interestingly, Counsellor 12 the least effective counselling in the group did complete an ‘End of Counselling Form’ for all of his clients; however, his comments in relation to the free-response item that invited reflection on how counselling might have been improved tended to attribute poor outcomes to negative client characteristics such as lack of motivation, or to factors which were outside of his or the clients control (e.g., workplace policies). It was notable that other than these kind of comments, there was an absence of reflective comments about how counselling might have been improved. In fact, in one case he commented that counselling could not have been improved.

Findings from counsellor self-report questionnaires from Study 1 summarised above were supplemented with findings from interviews with participants from Study 2, where available, regarding the personal philosophies and practice of the three more and the three less effective counsellors in the present sample of practitioners. The purpose of doing so was to make a preliminary attempt to explore the assumptions, beliefs, and values that underpinned counsellors’ practice and to illuminate potential factors that may have contributed to the variability in their effectiveness observed in relation to client outcomes (See Table 6.1, Chapter 6). As noted in Chapter 6 of this thesis, interview data were only available for two of the more effective group of counsellors (i.e., Counsellors 1 and 3), and for two of the less effective group of counsellors (i.e., Counsellors 10 and 11).

The main findings from the analysis of interview data were that, compared to the less effective counsellors, the more effective counsellors talked more about privileging the
relational aspects of counselling, establishing goals for counselling, having a flexible approach in terms of responding to client needs, especially in relation to the implementation of solution-focused counselling methods. Within the more effective group, Counsellors 1 and 3, in particular, placed a lot of emphasis on having a personal approach. There was also a high degree of ‘fit’ between these counsellors’ personal philosophies and the underlying assumptions of the solution-focused model of counselling preferred within the MHSS agency.

Interview data were only available for Counsellors 10 and 11 of the three less effective counsellors (interview data were not available for the least effective counsellor within this group). Overall, there seemed to be several characteristics of both of these counsellors’ philosophies and practice that were distinct from the more effective counsellors. Counsellor 10, for instance, had a preference for practicing in what appeared to be a highly directive way, which was experienced by at least one client as being ‘pushy’. This counsellor was also prone to implement solution-focused methods, at least initially, in a rigid manner, which may have undermined their ability to pay sufficient attention to the relational aspects of counselling. Overall, Counsellor 10 appeared to want to solve client problems by pushing them to act in ways that she believed would be helpful. Counsellor 11, on the other hand, appeared to be most comfortable working in a non-directive way with clients and was clearly experienced by her clients as a ‘good listener’. However, she seemed to struggle to move beyond this way of working to a more structured and goal or task-focused approach. In fact, Counsellor 11 encountered significant tensions between her personal values and the solution-focused model of counselling. Indeed, she struggled to resolve these tensions and establish a framework for practice within the MHSS agency that accommodated her
values. In this respect, there appeared to be a ‘poor fit’ between her personal philosophy and the theoretical orientation preferred with the MHSS agency.

7.2 Interpretation and integration of findings in relation to previous theory and research

The aim of this section is to discuss and integrate the findings from the studies reported in this thesis in relation to previous theory and research.

7.2.1 Study 1: The effectiveness of volunteer mental health counsellors

The findings from Study 1 are discussed below in relation the overall effectiveness of all participants, and also in relation to the effectiveness of individual counsellors within this sample of paraprofessional counsellors.

7.2.1.1 The overall group effectiveness of volunteer mental health counsellors

The focus of the debate within the literature on paraprofessional counsellors has been on the extent of their effectiveness compared to qualified and experienced professional counsellors. The literature on this topic was reviewed in Chapter 2, section 2.1, of this thesis where it was noted that the main findings from existing research in this area was that paraprofessionals can be as effective as professional counsellors. This finding gave rise to a controversial debate concerning the relevance of training to counsellor effectiveness and client outcomes. It was also noted that there is an absence of research examining the effectiveness of paraprofessional counsellors with specific client groups, especially within a UK context. The main conclusion drawn from this review was that existing research findings provide evidence for the general effectiveness of paraprofessionals, particularly when delivering structured interventions directed at specific target problems. The findings from Study 1, reported in Chapter 4 of this thesis, challenge the generally consistent finding from previous research that paraprofessional
counsellors can be as effective as professionals.

A number of findings from previous research may account for the apparent poor performance of this group of paraprofessional counsellors compared to outcomes achieved by their professional counterparts as reported in the selected benchmark studies. Specifically, research evidence suggests that paraprofessional therapists are more effective in longer term treatments (Berman and Norton, 1985), that length of training and experience are important factors in determining the effectiveness of paraprofessional therapists (Hattie et al., 1984) and that training may facilitate client retention and briefer therapy (Atkins and Christensen, 2001).

Given these findings, a number of factors may help to explain the lack of effectiveness of the paraprofessionals in Study 1 compared to professional therapists in the selected benchmarks; and the greater percentages of unplanned endings and levels of client deterioration. These include the fact that the paraprofessional counsellors who participated in Study 1 had limited training and experience, were working within a brief counselling framework in a routine practice setting where clients were mostly referred by GPs, and where clients presented with levels of distress approaching the moderate-severe range in terms of CORE-OM scores. Indeed, complementary evidence from Study 2, reported in Chapter 5 of this thesis, into the experiences of the counsellors in Study 1 of working with clients in their first year of practice, suggests that in many instances participants exhausted quickly their limited repertoire of counselling skills/strategies and felt unable to respond helpfully to clients who were experienced as difficult, ambivalent about change or who did not seem to be responding to counselling.
As noted in section 2.1 in Chapter 2, previous research findings also suggest that paraprofessional therapists may be most effective when delivering structured treatment programmes under supervision (Stein and Lambert 1984). In Study 1, paraprofessionals employed a solution-focused approach, which tends to be highly structured. However, it is possible that in relation to the levels of client distress they encountered, their effectiveness was compromised by a rigid adherence to the solution-focused approach. Also, as reported in Chapter 4, section 4.0.1, a significant number of clients in the present study were either unemployed or on sickness or disability benefits (40%). This may be an important factor to consider when interpreting the results of this study because there is some evidence to show that unemployed people benefit less from counselling than those in work (Saxon et al. 2008). More generally, it may be that, on the whole, this group of paraprofessionals were ill-equipped to respond effectively within a brief therapy framework to the broad range of clients and levels of distress they encountered in practice.

7.2.1.2 Variability in effectiveness of individual volunteer mental health counsellors
In Chapter 2, section 2.2 of this thesis, research on the differential effectiveness of individual therapists was evaluated. The primary conclusions drawn from this review were that counsellors vary in their effectiveness both within and across counselling modalities, and that the unique qualities of the counsellor can have a significant influence on counselling outcomes across a range of client populations and forms of therapy. Variability in counsellor effectiveness is particularly evident in some studies in relation to so-called ‘outliers’, or the most and least effective counsellors (Timulak 2008).

At present, not much is known about the characteristics of highly effective therapists
versus those therapists who achieve consistently poor client outcomes (Timulak 2008), and variability in the effectiveness of individual paraprofessional counsellors does not appear to have been examined. Consequently, an attempt was made within Study 1 to address this gap in knowledge. The strategy adopted for examining variability in the effectiveness of individual counsellors in Study 1 was based on calculating differences between pre-post scores on the CORE Outcome Measure (Evans et al. 2000). Ultimately, the effectiveness or competence of the counsellor was determined by client outcome. In this regard, more effective counsellors were expected to achieve better client outcomes than less effective counsellors (Wampold 2001) in terms of effect size calculations.

Examination of differential effectiveness of counsellors in Study 1 indicated that there was a wide range of variability among counsellors in terms of their individual effectiveness. This was most apparent in the extremes of the three more effective and the three less effective counsellor among this group of practitioners (see Table 6.1, Chapter 6). The more three more effective counsellors in this sample of paraprofessional counsellors achieved large effect sizes of .96, .94, and .89 compared to the less effective counsellors, who achieved relatively modest effect sizes of 0.21, .36, and .37. In relation to rates of recovery and improvement, the mean percentage of recovered or improved clients for the three more effective counsellors was 71.8%, whereas for the three less effective counsellors the percentage was 44.4%. Moreover, more than 54% of clients who showed reliable deterioration post-counselling across the caseloads of the whole sample of counsellors who participated in Study 1 ($n = 12$) were clients seen by the three less effective counsellors.
In contrast to the less effective group, the three more effective counsellors did not have any clients that showed reliable deterioration, although they all had clients who had deteriorated to some extent post-counselling in terms of CORE-OM scores, but the level of deterioration was less than the five points required to meet the criteria for reliable deterioration according to CORE-OM benchmarks (Mullin et al. 2006).

The finding of variability in the effectiveness of the paraprofessional counsellors in Study 1 is entirely consistent with the preponderance of evidence from previous research regarding the differential effectiveness of professional therapists (Kim et al. 2006; Luborsky et al. 1997; Luborsky et al. 1985; Okiishi et al. 2003; Project Match 1998; Ricks 1974), which was summarised in section 2.2.6 in Chapter 2 of this thesis. Moreover, this finding was particularly evident among counsellors at the extremes of the most and least effective counsellors within this sample of paraprofessionals, which is also consistent with previous research into the differential effectiveness of individual counsellors and psychotherapists (Luborsky et al. 1985).

The fact that differences were evident among this group of paraprofessionals is an interesting finding, especially so because of their generally similar profile in terms of their lack of training and experience compared to professional therapists. Further discussion of this finding in relation to the potential factors that may have contributed to the variability in the effectiveness of the three more effective and the three less effective counsellors in the present sample can be found in section 7.2.3 below.

7.2.2 Study 2: The meaning and experience of becoming a volunteer mental health counsellor
The question of how counsellors and psychotherapists develop has received more
attention in recent decades. One of the major reasons for this is a growing appreciation of the link between client outcome and the personal and professional qualities of the therapist (Lambert and Okiishi 1997; Luborsky et al. 1997; Okiishi et al. 2003). In addition, it is recognised increasingly that counsellor training and supervision can be enhanced by knowing more about the developmental processes and changes that counsellors encounter in their careers. Furthermore, it has been argued that such knowledge will be beneficial in terms of limiting negative developmental process such as burnout and incompetence (Orlinsky and Rønnestad 2005). To date, the literature on counsellor development has not addressed, in any detail, the developmental experiences of paraprofessional counsellors. Moreover, there is a lack of research into the motivational patterns of this group of practitioners, especially in relation to minimally trained voluntary counsellors within Britain (McLeod 2003b).

The focus of much previous research on counsellor development has been restricted to the period of professional training. Little attention has been devoted to the paraprofessional phase of development prior to professional training. The career-span model proposed by Skovholt and Rønnestad (1995; 2003), in which they describe a lay helping phase, is a notable exception. However, this lay helper phase seems to be more concerned with the everyday helping experiences of parents, children and work colleagues (Rønnestad and Skovholt 2003), which is perhaps less typical of paraprofessional counsellors who work within established counselling agencies where practice is more formal and organised (Tan 1992).

In the following sections, the findings from Study 2 are discussed in relation to the research questions that were identified at section 3.3.2 of Chapter 3 in this thesis.
7.2.2.1 *Question 1: How do paraprofessional counsellors account for their interest in, and engagement in the activity of counselling?*

Findings from Study 2 regarding participants’ interest in, and engagement in the activity of counselling are consistent with previous research on motivations to become a counsellor or psychotherapist (Bondi et al. 2003; Farber et al. 2005; Orlinsky and Rønnestad 2005), and also reflect more general motivational patterns in people who volunteer (Clary et al. 1998). These aspects of participant experiences were encompassed within the main category of ‘resonating’, and its subcategories described at section 5.1 in Chapter 5 of this thesis; in particular, within the subcategories of ‘resonating with counselling and the role of counsellor’, and ‘resonating with the agency’.

In relation to these concepts, participant accounts reflected a variety of reasons to explain their interest in counselling, and a diverse range of intentions in relation to the pursuit of this interest through becoming volunteer mental health counsellors with the MHSS agency. For instance, participants attributed their interest in counselling to significant life events such as experiencing personal distress, and having a positive experience of being helped by counselling. In fact, four of the eight participants in Study 2 stated that experiencing personal distress sparked their interest in counselling. This finding is consistent with previous research findings in this area, which show that the experience of personal or familial distress is a common motivating factor for choosing a career as a counsellor or psychotherapist (Bondi et al. 2003; Farber et al. 2005; Guggenbuhl-Craig 1971; Orlinsky and Rønnestad 2005; Rippere and Williams 1985). Other participants stated that their interest in counselling emerged from their engagement in related fields of human service work, but in all cases participant accounts suggested that there was a significant personal investment in becoming involved in
counselling training and client work, which seemed to relate to satisfying personal aspirations and desires. For example, within the concept of ‘resonating with counselling and the role of counsellor’, and ‘resonating with the agency’ it was apparent that participants were pursuing a variety of personal and social goals, and as such were seeking to give expression to different intentions through their engagement in voluntary counselling.

While on one level, it appeared that all participants were endeavouring to express altruistic intentions related to helping others through volunteering (Black and Jirovic 1999; Cnaan and Goldberg-Glen 1990), it was also apparent that on another level each participant was attempting to satisfy individual goals which were equally, if not more important in relation to their involvement in voluntary counselling. For example, participants appeared to be actively pursuing goals related to creating opportunities for new learning, to be with others and to form new relationships, and also to promote their personal growth and development. In this respect, the act of volunteering as a mental health counsellor can be regarded as fulfilling a wide range of personal and social goals for participants. This finding fits with a functional perspective on volunteering described by Clary et al. (1998), which argues that “acts of volunteerism that appear to be quite similar on the surface may reflect markedly different underlying motivational processes” (p.1517).

The vast majority of the literature on motivational patterns of volunteers and counsellors and psychotherapists appears to be grounded in traditional functional theories of motivation (Clary et al. 1998), which locate motivation within the individual. There are many advantages to this perspective, and the findings reported above suggest that a
functional perspective can help to explain the question of why participants in Study 2 choose to become volunteer counsellors. The functional approach also helps to explain the factors that sustain voluntary activity and the reasons why people may decide to stop volunteering. (These issues are discussed in section 7.2.2.4 below in relation to the overall processes of development of paraprofessional counsellors). However, functional theories do not consider how individual intentions or motivations may be modified by the act of volunteering and the social and cultural context within which volunteering takes place.

In contrast to functional theories of motivation, socially oriented models consider motivation as 'activity in progress' (Paolicchi 1995). In other words, the experience of volunteering may modify initial motivations to volunteer so that some people may stop volunteering because their initial goals for volunteering were not met, while other people may continue to volunteer for quite different reasons than those that attracted them to volunteering in the first place. At the heart of this kind of narrative perspective is the view that volunteering can be understood as a goal-oriented activity through which people co-construct and communicate their values and identities (Paolicchi 1995).

From a narrative standpoint on volunteering, findings regarding the reasons participants in Study 2 gave for choosing to become involved in voluntary counselling can be understood within a much wider context. More specifically, when considered alongside the core category of 'finding a voice', which relates to the process of establishing and sustaining an identity as a volunteer counsellor (see section 5.5, Chapter 5), it is possible to view participants' engagement in counselling as a meaning making activity in which participants were actively striving to construct and re-construct their identity within the
social and cultural resources available to them (Paolicchi 1995). In relation to Study 2, the MHSS agency and the opportunities it provided for counselling training and voluntary counselling work could be regarded as some of the social and cultural resources available to, and used by, the participants in Study 2 in order to test out their interest in and potential as counsellors. Furthermore, it is conceivable that participants were drawn to exploring their potential as counsellors with the MHSS agency because it afforded them an opportunity to make sense of, and respond to, challenging life events and transitions (e.g., personal distress, retirement, choosing a potential career in the helping professions). Hence, on one level this may be regarded as an attempt to develop an identity as a counsellor, on another level, however, it could be regarded as being related to the ongoing process of identity construction within the individual’s life in general (Gergen 1999).

7.2.2.2 Question 2: What is the meaning of counselling training for paraprofessional counsellors in relation to their development?

Findings from Study 2 suggest that the brief training that participants received within the MHSS agency prior to entering practice was valued for a number of reasons. In particular, participants reported in their interviews with the researcher that training facilitated the development of a range of helping skills, and also provided opportunities for participants to engage in personal development work through writing a personal journal. These findings are consistent with the findings from an earlier study (Armstrong 2003), carried out by the author of this thesis and which involved all of the participants in this study, which showed that both intrapersonal learning and the development of interpersonal skills were significant outcomes of the training experience for participants.

The meaning and experience of training for the paraprofessional counsellors in Study 2
was described as involving a process of learning a language of counselling, which allowed participants to build on and enhance a pre-existing, common-sense language of helping. At present, we know little about the meaning of training for paraprofessional counsellors, or indeed, how they utilise the experience of training in relation to their practice as counsellors. So, the findings from Study 2 provide the basis for at least further investigation in this area, which may illuminate how best to organise and deliver training for paraprofessional counsellors.

7.2.2.3 Question 3: How does the experience of client work impact on paraprofessional counsellors?

In chapter 2, section 2.3, of this thesis a number of models of counsellor development were identified (Blocher 1983; Hogan 1964; Littrell et al. 1979; Loganbill et al. 1982; Rønnestad and Skovholt 2003; Sawatzky et al. 1994; Skovholt and Rønnestad 1995; Stoltenberg 1981) together with more general research addressing the question of development in counsellors and psychotherapists (e.g., Orlinsky and Rønnestad 2005). A pervasive theme running through these models and research on counsellor development is that the experience of client work is tremendously important in shaping the philosophical and theoretical stance of therapists. In general, these models characterise development as a more or less linear movement from a state of anxiety and uncertainty in the early stages to a confident and self-assured stage in more advanced phases of professional development. So far, the question of how paraprofessional counsellors develop has not really been addressed in the literature. Consequently, the findings regarding the experience of entering practice for the group of paraprofessional counsellors in Study 2 are discussed below in relation to the literature that was available, which concerns the experiences of novice professional therapists, and also relates to the literature on volunteering more generally. Data concerning participant experiences of
client work were reported in Chapter 5 of this thesis within category 3, ‘putting the language of counselling into practice’, and within category 4, ‘experiencing and resolving dissonance in relation to being in practice’.

Participant accounts in Study 2 of this thesis showed that the theme of anxiety was prevalent among this group of practitioners during the early stages of their practice. This anxiety was expressed as doubts about being able to handle unexpected events in sessions, concerns about doing harm to clients, preoccupation with not being able to implement counselling techniques properly, as worries about being able to maintain a conversation for the duration of a counselling session, and as more general concerns about their abilities and qualities as counsellors. Many of these themes are evident in the literature on counsellor development and reflect common concerns among beginning counsellors and psychotherapists related to anticipatory anxiety (Friedman and Kaslow 1986; Yogev 1982) and performance anxiety and fear (Skovholt and Rønnestad 2003), which can often be overwhelming at the start of counselling practice (Rønnestad and Skovholt 2003).

Some participants also talked about concerns about clients not turning up for appointments following the initial session, which in some instances appeared to intensify feelings of doubt in relation to their competence as counsellors. Rønnestad an Skovholt (2003) have observed that beginning counselling students are vulnerable to criticism (actual or perceived) from senior colleagues and supervisors in particular, and that this can have a detrimental effects on morale and the fragile sense of competence that is evident in novice therapists as they begin to meet clients for the first time. In relation to the participants in Study 2 who expressed concerns about clients not returning to
scheduled appointments, it is possible that these participants may have experienced client non-attendance for scheduled appointments as a form of indirect criticism of their abilities as counsellors which, in turn, exacerbated the understandable sense of anxiety that seems to characterise counsellors and psychotherapists’ initial encounters with clients.

Another source of concern for participants as they began work with the MHSS agency related to adjusting to the administrative tasks associated with client work. Writing client case notes, for example, was experienced as challenging and time consuming by many participants. This issue has not featured as being important for novice counsellors and psychotherapists in existing models of therapist development; however, problems of adjusting to organisational procedures, expectations and culture are reflected in the literature on paraprofessionals (e.g., Feild and Gatewood 1976) and volunteering in general (e.g., Haski-Leventhal and Bargal 2008). At least one participant (Lily) in Study 2 expressed the view that not enough time was devoted to preparing and supporting volunteers in relation to administrative tasks related to client work (e.g., record keeping, understanding the appointment booking system).

In addition to the above concerns, participants in Study 2 also encountered a variety of challenges and dilemmas in relation to engaging in therapeutic conversations with clients. It would appear that the conceptual framework of the solution-focused approach that participants received training in within the MHSS agency prior to entering practice provided them with a sense of security within counselling sessions insofar as it acted as a guide to their role and the tasks of counselling. Initially, at least, some participants appeared to apply this framework in a somewhat rigid manner as a way of managing the
axieties noted above. As participants began to see more clients they encountered problems in being able to respond helpfully to clients that were experienced as challenging in some way; for example, clients that were deemed to lack motivation, or were uncommunicative or who appeared to be ambivalent about change. In these kinds of situations, participants often felt that they did not have the skills set to help clients, and began to experience limitations to the solution-focused approach they had learned, and indeed, in relation to their own common-sense problem solving strategies.

These experiences are consistent with the experience of novice professional therapists. For example, Hogan (1964) characterised beginning counsellors as being anxious and as relying on a limited repertoire of helping strategies. Supervision becomes an important source of reassurance and guidance for the beginning counsellor, and it was evident that participants in Study 2 generally found the support of senior colleagues, and peers to be extremely valuable in the early stages of their practice experiences.

A key dynamic underlying participant experiences in relation to practice was the challenge of developing a framework for their practice that honoured each participants’ personal values and which also accommodated the MHSS agency expectations regarding the preferred model of counselling that informed practice. In many respects, many of the challenges and dilemmas that participants experienced in relation to client work, especially regarding implementing a solution-focused approach, had arisen because aspects of this model appeared to conflict with their own values. Research indicates that where there is a ‘poor fit’ between therapist values and beliefs and the theory that informs their practice, then the therapist will experience varying degrees of internal conflict (Vasco and Dryden 1994). From this perspective, the experience of conflict
provides the impetus for therapists to find ways to resolve these dissonant practice-based experiences. Participants in Study 2 used a variety of strategies to cope with and resolve these dissonant experiences such as pursuing further training in counselling skills, applying solution-focused techniques in a more flexible manner, and seeking support and advice from supervisors.

Investment in resolving challenges and dilemmas appeared to be related to the investment participants had in pursuing personal and social goals through volunteering. The extent to which participants were able to satisfy the pursuit of personal and social goals (e.g., meeting people and making friends, developing skills) through volunteering as counsellor - as opposed to satisfying purely altruistic intentions – seemed to be related to the effort participants were willing to expend in relation to resolving the dilemmas and challenges they encountered in practice, and more generally, in relation to their engagement in voluntary counselling. As already noted, the opportunity to have personal and self-oriented goals fulfilled by volunteering appears to be what sustains the active involvement of volunteers (Omoto and Snyder 1995).

For instance, Lily was one participant who seemed to be volunteering as a counsellor as a way of pursuing social goals related to meeting and being with other people. Lily became frustrated by clients not turning up for appointments and by the fact that she would often have to spend time on her own waiting for clients, which she felt was unproductive and isolating. To a large extent Lily’s goals of meeting and socialising with other people were not realised through being a volunteer counsellor, and consequently, she decided to leave the MHSS agency and take up a new volunteering opportunity with an agency where there was much more interaction with fellow
Finally, another theme evident in relation to participant experiences of client work concerned the way in which they evaluated their practice. In some instances participants were unsure about their effectiveness. Sophie (i.e., Counsellor 10, one of the less effective group of counsellors) expressed uncertainty about her effectiveness and commented that she was aware of being effective with some clients but not so effective with other clients. More generally, participants appeared to evaluate their effectiveness against their ability to be empathic and to form a relationship with clients, or on the basis of client feedback, or in relation to their capacity to facilitate change in client awareness and behaviour. In many instances they were hesitant to make definitive statements about their effectiveness. Indeed, their reports in their interviews for Study 2 reflect an element of self-doubt about their effectiveness, and an awareness of their evolving potential to be effective especially with a wider range of clients and levels of distress. Becoming an effective counsellor seemed to be a work in progress for participants.

Overall, it appeared that participants used a narrow range of relational and client indicators to evaluate their practice, which contrasts with more experienced professional counsellors who have a more highly developed sensitivity to the complexity of outcome that is embedded in the moment-to-moment interaction within counselling sessions (McLeod and Daniel 2006).

7.2.2.4 Question 4: What are the processes involved in the development of competence and awareness in paraprofessional counsellors?

The literature on counsellor development reviewed in section 2.3 of Chapter 2 in this thesis noted that the majority of existing models portray counsellor development as a
linear progression from a state of anxiety and dependence to one of independence and self-confidence; and furthermore, that the developmental process have been described from the perspective of supervisors (Sawatzky et al. 1994). It was also noted that the question of development in paraprofessional counsellors has not been addressed by researchers. A major objective in Study 2, therefore, was to derive a description of paraprofessional counsellor development from the perspective of a group of minimally trained volunteer mental health counsellors that captured their experiences during the first two years of their involvement in voluntary counselling.

The overall finding from Study 2 was that the development of competence and awareness in this group of paraprofessional counsellors was characterised by four key processes, which contributed to the ability of each participant to establish and sustain an identity as a volunteer counsellor: The metaphor of ‘finding a voice’ was used to describe the process as a whole. These processes were described in detail in Chapter 5 of this thesis.

Findings reported in Chapter 5 of this thesis make a new contribution to the literature as the processes of development in this group of practitioners have largely been ignored in existing models of counsellor development. Furthermore, findings from Study 2 highlighted the experience of resonance and dissonance as central features in shaping a sense of identity as a counsellor. The successful resolution of dissonant experiences related to working with clients, and tensions between participant values and those of the agency expectations appeared to contribute to a stronger sense among participants of their potential and competence as counsellors. In situations where participants were unable to resolve dissonant experiences this lead to them ceasing to continue their
volunteering activity as counsellors. This happened for two participants in Study 2 (i.e., Lily and Sophie described in Chapter 5).

An important dimension in the process of resolving dissonant experiences related to the reasons each participant had for becoming involved as a volunteer counsellor with the MHSS agency. It appeared that participants who were able to satisfy personal and social goals through volunteering (e.g., the development of skills, or gaining experience of working with clients in face-to-face counselling work) were also more likely to be invested in finding ways of resolving dissonant experiences than participants who were not successful in achieving their own personal goals through volunteering as a counsellor.

For example, Margaret, one of the participants in Study 2 had joined the MHSS agency as a volunteer counsellor in order to develop her skills in face-to-face counselling. However, she experienced a great deal of tension between the solution-focused approach and her personal values. The word ‘solution’, in particular, was troubling to her because it implied, rather simplistically in her view, that there was a solution to every problem – a belief she found difficult to entertain given her understanding of the word solution. These difficulties did not deter Margaret from volunteering with the MHSS agency because she was invested in pursuing her personal goal of developing new skills. Eventually, Margaret resolved this dissonant experience by reframing the meaning of the word ‘solution’ so that it had a much broader meaning for her: a meaning that sat more comfortably with her personal values and her preferred way of practicing as a counsellor.
7.2.3 Individual differences between paraprofessional counsellors in terms of effectiveness, personal philosophies and counselling practice

This section discusses individual differences among the three more effective and the three less effective paraprofessional counsellors among the present sample of 12 counsellors that participated in Study 1 in relation to their effectiveness, personal philosophies and counselling practice. In order to do so it was necessary to attempt to link the findings from Study 1, concerning the differential effectiveness of individual counsellors, with the findings from an analysis of interview data from participants that also participated in Study 2 which sought to develop an understanding of the values, assumptions and beliefs that informed each counsellor’s practice. Interview data from Study 2 was only available for two of the more effective counsellors (Counsellors 1 and 3) and for two of the less effective counsellors (Counsellors 10 and 11). Qualitative data from free-response items in client and counsellor self-report questionnaires, which were collected before and after counselling in Study 1, were also analysed in an attempt to determine client and counsellor perspectives on the process and outcome of counselling in individual cases. The purpose of combining these data sources in this analysis was to attempt to examine the characteristics of the more and less effective counsellors, which may have been associated with their level of effectiveness.

Discussion of the characteristics of the three more effective and the three less effective counsellors is organised around a consideration of the following key themes: 1) training and experience levels; 2) caseload mix; and 3) personal philosophy and counselling practice. In attempting to discuss these findings in relation to previous research it is important to note that a number of methodological limitations of this study, discussed at section 7.3 of this chapter, mean that the interpretations that follow are offered tentatively, and in some instances somewhat speculative insofar as all that can be offered
are inferences from the limited data that was available.

7.2.3.1 Levels of training and experience

The finding of differential effectiveness among the three more effective and the three less effective counsellors in the present sample cannot easily be accounted for in terms of differences in their levels of counselling training and experience of helping. In fact, the relationship between training and effectiveness appeared to work in the opposite direction than might have been expected if the variables of training and experience alone were the sole contributors to counsellor effectiveness. For instance, the less effective group of counsellors had more counselling training than the three more effective counsellors. In particular, in addition to the 40 hours of in-house counselling training that all participants in Study 1 received within the MHSS agency, two of the three less effective counsellors had completed certificate level training in counselling skills of 120 hours duration prior to entering this study.

Similarly, in terms of counselling and general helping experience, the less effective group of counsellors had significantly more than the more effective group of counsellors in Study 1. Indeed, only one of the more effective counsellors (i.e., Counsellor 2) had any relevant counselling and helping experience, whereas two of the less effective counsellors had 100 hours of counselling experience, and the other counsellor within this group had 10 years experience of working with people in a helping capacity within a non-statutory human service agency. These findings were reported in section 6.4.4.2 of Chapter 6.

A central question that has arisen from research into the comparative effectiveness of paraprofessional counsellors concerns the relationship between training and experience
to effective practice. On the whole, the extant literature on paraprofessionals reviewed in section 2.1 of Chapter 2 of this thesis appears to call into question the common sense assumption that training and experience are positively correlated with effectiveness as a therapist. However, as noted in section 7.2.1.1 above, some studies of paraprofessional effectiveness have concluded that training does appear to enhance the effectiveness of paraprofessionals in terms of client outcomes (Hattie et al. 1984), client retention, and briefer therapy (Atkins and Christensen 2001), and that paraprofessionals appear to function more effectively in longer term, more structured treatments (Berman 1989; Stein and Lambert 1984).

These factors were considered in section 7.2.1.1 above in relation to the finding from Study 1 that the participants in Study 1 were less effective that their professional counterparts. More specifically, it was suggested that the lack of effectiveness observed in the present sample of paraprofessionals may have been related to their overall lack of training in relation to working within a brief counselling approach with clients experiencing a range of mental health problems in a community setting. While these conclusions may offer valid interpretations of the findings of Study 1 in relation to existing theory and research for the overall group effectiveness of the sample of counsellors in Study 1 ($n = 12$), it is important to acknowledge that the finding that the three more effective counsellors had less counselling training and general helping experience than the three less effective counsellors appears to run contrary to this view, and suggests that factors other than training and experience alone may also be operating which may have enhanced or detracted from counsellor effectiveness within this group of practitioners. Notwithstanding the possible contribution of other factors to the issue of the differential effectiveness of counsellors in Study 1, the question of the type and level
of training that paraprofessionals require to practice effectively with particular client
groups is an important topic that requires further research attention.

7.2.3.2 Caseload mix
Overall, both the three more effective and three less effective counsellors in Study 1 saw
approximately the same number of clients, and levels of client distress at in-take for both
groups of counsellors indicated that they were working with clients who were broadly
defined as being moderately distressed according to CORE-OM severity levels. The
mean level of client distress as measured by the CORE-OM for clients seen by the three
more effective counsellors was 19.1, which is in the upper end of the moderate range of
severity levels, while for the three less effective counsellors the mean level of distress at
intake fell within the lower end of the moderate range of severity at 16.32.
Consequently, the differences in their apparent effectiveness can not easily be accounted
for by significant differences in the severity of client problems they encountered in
practice: even in the absence of randomisation of clients to counsellors. In other words,
the broad similarity in degree of client distress across counsellors caseloads can help to
mitigate the lack of random assignment of clients to counsellors (Okiishi et al. 2003).

7.2.3.3 Personal philosophy and counselling practice
Within the therapist effects literature some researchers have attempted to identify factors
that might account for the differential effectiveness of counsellors and psychotherapists.
As yet, little is known about such factors (Lambert and Okiishi 1997; Timulak 2008);
however a number of characteristics have been proposed which suggest promising lines
of enquiry for further research. For instance, it has been found that factors associated
with more effective counsellors include: the purity of the treatment they offered; the
counsellor’s level of adjustment, skill and interest in helping (Luborsky et al. 1985);
strong interpersonal skills (Najavits and Weiss 1994); briefer therapy (Okiishi et al.

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2003); better retention and rates of recovery (Elkin et al. 2006b); openness to look critically at themselves (Lambert and Okiishi 1997); having a more relational and empathic interpersonal style (Lafferty et al. 1989); and being more psychologically minded (Blatt et al. 1996). Overall, the evidence from the therapist effects literature reviewed in Chapter 2 of this thesis (section 2.2) appears to suggest that the way in which therapists relate to their clients is an important factor in determining their effectiveness (Cooper 2008).

Exploration of the characteristics of the three more effective and the three less effective counsellors in Study 1 revealed that both groups of counsellors were experienced by many of their clients as being understanding and helpful. However, there was modest evidence from qualitative data in both client and counsellor self-report questionnaires completed before and after counselling in Study 1, and from analysis of counsellor interview transcripts from Study 2, that the more and less effective counsellors differed in several key respects in terms of their personal philosophies and counselling practice. For instance, compared to the less effective counsellors, the three more effective counsellors appeared to be somewhat more adept at forming and sustaining a collaborative counselling relationship with their clients, and more likely to reflect critically on the process and outcome of counselling in individual cases in terms of what went well and what might have been done differently. Having strong interpersonal skills (Najavits and Weiss 1994), being more relationally oriented (Lafferty et al. 1989) and open to critical reflection on practice (Lambert and Okiishi 1997) are characteristics that have been shown in previous research to be associated with more effective counsellors and psychotherapists. These qualities were evident in the three more effective counsellors in the present sample compared to the less effective counsellors, which may
account, to some degree, for their greater levels of effectiveness.

Another area of difference between the more and less effective counsellors concerned the degree of structure and focus that they incorporated into counselling sessions. There were indications that the more effective counsellors were able to introduce a helpful degree of structure and focus into counselling sessions which allowed them, on the whole, to assist clients to identify and work toward specific goals. This feature of the more effective counsellors’ practice was particularly evident for Counsellor 1, the most effective counsellor in this sample of practitioners. For instance, as noted in section 6.3.1.2 of Chapter 6 of this thesis, this counsellor was clear that the success of counselling in one of his cases (i.e., Client 1, shown in Table 6.5) was largely a function of his ability to assist the client to, “Focus on the main issue, and to eliminate irrelevant issues.”

The three less effective counsellors did refer to the relevance of goals in their practice but they appeared to have a less focused approach to this aspect of the counselling process than the three more effective counsellors. Also, in some instances, counsellors in the less effective group found it difficult to identify the client’s main issue, or were reluctant to introduce a high degree of focus into counselling sessions because of a concern that it would impact negatively on the therapeutic relationship. Counsellor 10 within the less effective group of counsellors, for instance, reported that in one of her cases she was confused about the client’s main issue and appeared to struggle to identify an appropriate focus for counselling. Counsellor 11, also one of the three less effective counsellors, seemed to have difficulty moving beyond the provision of an attentive and understanding presence in counselling sessions, which provoked one of her less
distressed clients to remark in the client 'View of the Outcome' questionnaire, which she completed after counselling, that although she found counselling with this counsellor helpful she was doubtful that it would be of benefit to someone more distressed than she had been at the start of counselling.

The literature on paraprofessional counsellors shows that they tend to be most effective when delivering structured treatment programmes (Stein and Lambert 1984). More generally, the research literature indicates that the effectiveness of counselling is associated with a structured and focused approach (Miller et al. 1997). Moreover, it appears that a lack of structure and focus is one of the key predictors of negative outcome in counselling and psychotherapy; the absence of which "can have a greater impact on treatment outcome than the personal qualities of either the therapist or client (Mohl 1995).

Given this evidence for the importance of a structured and focused approach to positive outcomes in counselling and psychotherapy, it is possible that, compared to the less effective counsellors, the effectiveness of the three more effective counsellors in this group of paraprofessional counsellors may have been associated with their ability to introduce and maintain a helpful degree of structure and focus in counselling sessions, especially in relation to the clarification of relevant goals and tasks to work on. In this respect it is important to note that research evidence indicates that client outcomes in counselling and psychotherapy are enhanced when there is agreement between client and therapist on therapeutic goals and when the client is involved in a collaborative way in this process (Tryon and Winograd 2001).
Yet another area where there appeared to be differences between the more and less effective counsellors related to their affinity with, and use of, solution-focused methods. All of the counsellors in both Study 1 and Study 2 received training in solution-focused counselling methods at the MHSS agency prior to entering practice in its counselling service. Among the three more effective counsellors, there was good evidence of a high degree of ‘fit’ between the personal values of these counsellors, and they also appeared to implement solution-focused methods in a flexible manner. In fact, both Counsellor 1 and Counsellor 3 of the more effective group of counsellors indicated that they believed in the underlying assumptions of solution-focused counselling and emphasised the importance of implementing solution-focused methods in a flexible and creative way within the context of a personal approach. For example, the most effective counsellor stated that the solution-focused approach reflected his own personal philosophy in relation to addressing problems in living, and he was clear that his approach should be flexible and responsive to client needs and goals (see section 6.3.1.3 of Chapter 6). Similarly, Counsellor 3 of the more effective group of counsellors reported a high degree of fit between her personal philosophy and the solution-focused assumptions and method, and also emphasised her preference for applying them creatively and flexibly (see section 6.3.3.3 of Chapter 6).

Compared to the more effective counsellors, there was some evidence that counsellors within the less effective group experienced more discordance with solution-focused methods, that they tended to apply them in a somewhat rigid manner and were not as flexible in adapting their approach to different client needs. This was especially true of Counsellors 10 and 11 within the less effective group of counsellors. Counsellor 10 reported in her interview for Study 2 that she applied solution-focused methods rigidly
and was preoccupied with ensuring she “got it right.” And Counsellor 11 appeared to experience significant conflict between her personal values and the solution-focused approach.

These issues have not been reported as being significant in the therapist effects literature reviewed in section 2.2 of Chapter 2 in this thesis. However, some research studies have shown that one of the factors that distinguish more and less effective counsellors and psychotherapists concerns their personal philosophy or belief system. Researchers examining this area of practice have found that there exists a positive relationship between counsellor effectiveness and person-centred philosophy and attitudes (Combs 1986; McLeod and McLeod 1993), and that effectiveness is also related to the degree of ‘fit’ or consonance between counsellor personal philosophy and the theoretical orientation that informs their practice (Fear and Woolfe 1996; Fear and Woolfe 1999; Vasco and Dryden 1994).

In relation to the research on person-centred philosophy and effectiveness, one possible explanation for the apparent superior effectiveness of the three more effective counsellors in Study 1 may concern their disposition toward privileging the interpersonal and relational aspects of counselling and their willingness to work collaboratively and flexibly with clients. Whereas, the lack of effectiveness of the three less effective counsellors (particularly Counsellors 10 and 12) may have been related to a more rigid application of solution-focused methods, and too little attention to the relational aspects of counselling. This is an interesting finding as existing theory and research evidence suggests that counsellor flexibility in relation to the interpersonal style or relationship stance of the therapist is important in establishing a sound therapeutic alliance and
maximising the effectiveness of counselling (Bachelor and Hovarth 1999; Beutler and Consoli 1993; Dolan et al. 1993; Lazarus 1993; Mahoney and Norcross 1993; Mahrer 1993; Norcross 1993). This does not mean, necessarily, that the use of techniques is unimportant, but it does highlight the possibility that the relational context within which they are used is an important factor in determining their overall usefulness in relation to promoting positive client outcomes (Strupp 1986; Wampold 2001). It may well be that in contrast to the three less effective counsellors, the more effective group of counsellors among this group of practitioners were able to form a helping alliance which facilitated their ability to implement counselling interventions more effectively (Luborsky et al. 1985).

One explanation of the preceding findings may be that clients seen by the less effective counsellors were less receptive to interventions because the therapeutic alliance was not well enough established, and because there was not a feeling of working together in terms of the goals for counselling or indeed how counselling might proceed. For example, Counsellor 11, one of the less effective group of counsellors, had a tendency to be directive and push clients to act outside of sessions, which one client found to be insensitive to her readiness to change and generally unhelpful. The literature on deleterious events in therapy indicate that one of the most unhelpful aspects of therapist behaviours include pressuring the client to take some action outside of counselling sessions (Elliott 1985). As Cooper has pointed out, counsellors should be cautious about introducing more challenging counselling interventions before establishing "a positive affective bond, a sense of working together towards the same goals, and some agreement about how therapy should proceed" (Cooper 2008, p.104).
In relation to research findings which indicate that counsellor effectiveness appears to be associated with a consonance between the personal philosophy of the counsellor and their theoretical orientation (Fear and Woolfe 1996; 1999; Vasco and Dryden 1994), it is interesting to note that, on the whole, there was a high degree of fit between the personal philosophies of the more effective counsellors and the assumptions and methods of the solution-focused model. This finding may well have been a significant factor in accounting for their effectiveness compared to the three less effective counsellors in the present sample of paraprofessional counsellors that participated in Study 1.

Overall, compared to the three less effective counsellors, the more effective counsellors in the present group of practitioners appeared to: a) have an ability to form and sustain a collaborative therapeutic alliance with clients, and a willingness to adjust their interpersonal style to match different client needs; b) emphasise the importance of accommodating solution-focused methods within the context of their own personal style, and use these methods flexibly in relation to the needs of different clients; c) have a preference for working in a more structured and focused way with clients in relation to the goals and tasks of counselling; and d) have a personal philosophy that was highly consonant with the values and assumptions embedded in the solution-focused model of counselling that was preferred with the MHSS agency.

7.3 Methodological issues raised by this research

7.3.1 Limitations of the research

7.3.1.1 Limitations of Study 1

Study 1 addressed the question of the effectiveness of a group of minimally trained paraprofessional counsellors. A limitation of this study was that it was based on a limited
number of counsellors and a relatively small sample of client data collected in one agency over a restricted period of time. In addition, no attempt was made to monitor or control for the in-session activities of counsellors, case mix or levels of clients’ distress across individual counsellors’ caseloads. Hence, some caution is warranted in interpreting the results in relation to the studies that were selected as benchmarks. In particular, the CORE-OM benchmarks (Mullin et al. 2006) have been defined in relation to brief counselling/therapy carried out in primary care settings and, therefore, may not be appropriate to all voluntary sector counselling agencies where different organisational and contextual factors may be operating (Mellor-Clark et al. 2006). Such factors might include differences in the type, mode and duration of counselling being offered, levels of client distress, client employment status, and differences in the levels of support, supervision, training and experience of counsellors.

Furthermore, as Barkham (2006) has noted, benchmarks are not precise measurements and should, therefore, be treated with caution. In relation to both the CORE-OM benchmarks (Mullin et al. 2006) and the Stiles et al. (2008; 2006) studies, it should be noted that details of therapist levels of training and experience were not reported. Furthermore, in relation to the Stiles et al. (2008; 2006) studies a significant number of clients did not return valid CORE-OM forms. For example, Stiles et al. (2008) based their findings on a return rate of only 38%. While it is common to have incomplete data in naturalistic studies, it is important to acknowledge that this is a significant methodological limitation in the Stiles et al. (2008; 2006) studies and raises the possibility of selective reporting of good outcome cases. By contrast, 69% of clients in Study 1 reported in Chapter 4 of this thesis returned valid pre- and post CORE-OM forms. This means that the large effect sizes reported in the Stiles et al. (2008; 2006)
studies may have been an over estimation of the pre-post treatment improvement (see Clark et al’s criticisms of the Stiles et al. (2008; 2006) studies, and Stiles et al’s (2007) rejoinder).

To make more valid comparisons between professional and paraprofessional therapists it will be necessary to have detailed data on therapist levels of experience and training as previous studies have suffered from methodological problems in relation to categorising these variables and their relationship to counselling outcomes (Roth and Fonagy 2006).

The CORE-OM that was used in Study 1 to evaluate client outcome has the benefit of being a reliable and valid instrument to assess client change. It is widely used in the evaluation of psychological therapies in the UK and there is now a tremendous amount of data available on the effectiveness of psychological therapy both at therapist and service levels, which makes it possible for therapists and services to evaluate their performance against established CORE-OM benchmarks. Notwithstanding these advantages, it is worth pointing out that self-report measures like the CORE-OM are subject to a number of disadvantages. For example, the standardised measurement of outcome that is obtained with the CORE-OM does not tell us much about the multifaceted nature of distress and how this impacts on the client’s life (Ashworth et al. 2007). Moreover, McLeod (2001a) has argued that the use of self-report questionnaires to evaluate therapeutic change suffer from three significant methodological problems: 1) the impact of the social setting on the way in which the client completes a self-report questionnaire; 2) the ‘response shift’ phenomena whereby client understanding of questionnaire items is changed by the experience of therapy; and 3) the disparity between the image of the person embedded in questionnaire design technology and the
way in which the person is conceptualised within most contemporary counselling and psychotherapy models.

Although there are limitations to the use of self-report questionnaires in counselling outcome research, they represent the dominant method of evaluating client outcome in psychological therapies. Therefore, the use of the CORE-OM in this thesis was employed because in the context of a pluralistic approach to research methodology it was recognised that this approach provided a credible and suitable means to evaluate client outcome in Study 1, the results of which were reported in Chapters 4 and 6.

Finally, it was noted in Chapter 6 that the effectiveness ranking of participants according to effect size differed somewhat from their ranking in terms of rates of client recovery and improvement on their caseloads. It is possible that differences in sample sizes, levels of client distress at in-take across counsellor caseloads, or variability in standard deviation scores on the pre- and post counselling CORE-OM questionnaire may have contributed to this observed difference in counsellor effectiveness ranking between effect size and rates of client recovery and improvement. According to Jacobson and Truax (1991), however, “The size of an effect is relatively independent of its clinical significance” (p. 12).

7.3.1.2 Limitations of Study 2
It is important to acknowledge that the findings from Study 2 are based on a small sample of paraprofessional counsellors drawn from one agency in the west of Scotland. Had this study included a larger sample of counsellors recruited from different voluntary agencies, it is possible that additional themes and categories may have emerged in
relation to the experience of the development of competence and awareness among paraprofessional counsellors.

Another issue that should be taken into account when evaluating the findings of Study 2 concerns the epistemological position adopted in this thesis, which was outlined in sections 3.1.5 and 3.1.6 of Chapter 3. It has to be acknowledged that the description and interpretation of participant experiences presented in this thesis have undoubtedly been shaped by my own pre-understandings, personal history, and connection with the MHSS agency. In particular, my interest in solution-focused therapy with its emphasis on the role of language in construction personal and social reality should be taken into account when evaluating the findings of Study 2 reported in Chapter 5. Consequently, it is possible that another researcher may have constructed an entirely different account of participant experiences.

7.3.1.3 Limitations of conclusions drawn from linking findings from Study 1 and Study 2

Section 7.2.3 above attempted to interpret the finding that the present sample of paraprofessionals varied in terms of their effectiveness, personal philosophies and counselling practice by drawing on data (especially qualitative data) from client and counsellor self-report questionnaire completed before and after counselling in Study 1, and from interview data from counsellors that participated in Study 2 (i.e., Counsellors 1 and 3 from the more effective group of counsellors, and Counsellors 10 and 11 from the less effective group of counsellors).

It should be acknowledged that neither of these studies were designed with the primary purpose of examining the differential effectiveness of paraprofessional counsellors, or
the characteristics of more and less effective counsellors among this group of practitioners. The intention was to carry out a preliminary investigation in relation to these questions based on the data that were available from Study 1 and Study 2. Consequently, it is difficult to draw robust conclusions from the data because of the small sample of clients seen by each counsellor, and because of the somewhat limited and variable quality of data that were available, particularly qualitative data gathered from free-response items in both client and counsellor self-report questionnaires at the end of counselling from Study 1.

Also, interview data from Study 2 were not available for one of the counsellors from the more effective group (i.e., Counsellor 2), and from one of the counsellors from the less effective group (i.e., Counsellor 12) which meant that understanding about their personal philosophy and counselling practice was based largely on the limited data that were available from client and counsellor self-report questionnaires. Given these limitations, it is imperative to regard the interpretation of the data that was offered in section 7.2 above as tentative and preliminary. Bearing this caveat in mind, the available evidence appears to point to the significance for counsellors of adapting a collaborative and flexible relational stance or interpersonal style, the value of a structured and focused approach, and the importance of having a ‘good fit’ between the counsellor’s personal philosophy and the model of counselling they are expected to use in practice.

Overall, these findings should be regarded as providing the basis for further research in relation to questions concerning the differential effectiveness of paraprofessional counsellors, and the factors that may be associated with more and less effective counsellors in this area of counselling practice.
7.3.2 **Strengths of the research**

To date, there does not appear to have been any studies that have investigated the effectiveness of minimally trained paraprofessional counsellors in routine mental health practice environments using standardised outcome measures, or any examination of the developmental processes in this group of practitioners when working in formalised counselling settings such as voluntary counselling agencies. Consequently, the main strength of the research carried out for this thesis was that it contributed new knowledge in relation to the effectiveness and development of minimally trained/experienced paraprofessional counsellors working with clients experiencing mental health problems in a routine practice setting during the early phase of their engagement with the activity of counselling.

More specifically, in relation to Study 1 the use of a benchmarking strategy - although not without methodological limitations - provided a valuable and practical means of evaluating the comparative effectiveness of paraprofessional versus professional therapists, particularly from a practitioner-researcher perspective. Furthermore, this methodology may facilitate further research in the area of paraprofessional counselling, particularly by practitioner-researchers, as a benchmarking strategy provides a means of overcoming many of the resource and ethical issues associated with larger scale research designs such as RCTs.

The in-depth qualitative inquiry carried out for Study 2 provided a rich and detailed account of the meaning and experience for participants of becoming volunteer mental health counsellors that has the potential to have practical utility for individual practitioners and voluntary counselling agencies in terms of the selection, training, support and supervision of voluntary counsellors.
Finally, the preliminary investigation of data from Study 1 and Study 2 in relation to individual differences among participants provided some interesting insights into their effectiveness, personal philosophies and counselling practice. Further research in this area may help to develop understanding of the counselling practice and the personal qualities and characteristics of more and less effective paraprofessional practitioners, and generate important implications for the training and practice of paraprofessional counsellors.

7.3.3 How the research might have been improved

On reflection, the research reported in this thesis may have been enhanced by making a number changes to its design. One such change would have been to incorporate audio recordings of counselling sessions, which would have provided access to the process of counselling, and in particular, the in-session behaviours of individual counsellors. Incorporating recordings of counselling sessions would have raised additional ethical and resource issues; however, having access to this kind of data would have been extremely valuable in understanding what actually happened in individual cases and the characteristics of the more and less effective counsellors. In addition, it would also have been useful to include an evaluation of client distress using the CORE-OM at a three or perhaps six-month follow-up after counselling had ended. Follow-up data would have made it possible to determine, for example, the extent to which the gains clients made during counselling had been maintained.

The self-report questionnaires that were designed for use in Study 1 were not entirely successful in gathering qualitative data from clients and counsellors regarding their perspectives and experiences of counselling. With hindsight, it would have been helpful to have monitored more closely the quality of data being returned in these self-report
questionnaires from clients and counsellors and to have had additional administrative procedures in place to follow-up clients and counsellors who did not complete these forms at all, or to gain additional information regarding their perspectives and experiences of counselling, especially where client and counsellors comments were limited.

More generally, it would have been advantageous to have attempted to ensure that some counsellors had slightly larger sample sizes of clients on their caseloads, and to have randomly allocated clients to individual counsellors in order to reduce potential bias in the allocation of clients to counsellors. Notwithstanding these suggested changes, it must be acknowledged that the limited resources that were available for this PhD research meant that compromises had to be made in relation to the overall design and research strategy.

7.4 Implications of this research for paraprofessional counselling
The findings from Study 1 and Study 2 suggest a range of implications that have practical relevance to voluntary agencies, practitioners and researchers involved in paraprofessional counselling. This section is organised into separate sections which discuss the implications of this research for paraprofessional counselling in relation to: a) selection and training; b) support and supervision; c) counselling practice; and d) future research directions.

7.4.1 Implications for the selection and training of paraprofessional counsellors
The selection and training of paraprofessional counsellors is an area that has not received a great deal of attention from counselling and psychotherapy researchers. The findings from Study 2, in particular, indicate that participants’ reasons for choosing to engage in counselling training and voluntary counselling were multifaceted and not purely related
to altruistic intentions to help other people. In fact, participants were pursuing a variety of personal and social goals through their participation in training and voluntary counselling with the MHSS agency. Moreover, there was some evidence to support prior research on volunteering insofar as it was found that the participants in the research reported in this thesis were more likely to sustain their voluntary activity if they were able to fulfil, at least in part, their own personal goals through being a volunteer counsellor within the MHSS agency. Conversely, in situations where this was not possible (for example, in the case of Lily described in section 5.5.2, in Chapter 5) participants withdrew from volunteering and sought other volunteering opportunities that allowed them to satisfy personal and social goals.

Given this finding, one of the implications in relation to the selection of voluntary counsellors is that beyond determining an individual’s aptitude and potential as a volunteer counsellor, voluntary counselling agencies may wish to consider exploring with individuals wishing to become volunteer counsellors the personal and social goals that they hope to fulfil through voluntary counselling. Moreover, in order to maximise an individual’s engagement with the agency, it will be necessary to strike an appropriate balance between ensuring their suitability to be a volunteer counsellor and accommodating, as far as possible, the diverse goals and intentions different individuals may have in relation to engaging in voluntary counselling.

Another implication that emerged from the findings of this thesis concerns the benefits that may be gained by ensuring that potential volunteers fully understand agency expectations, especially in relation to the model of counselling preferred within its service. There is a growing body of evidence, supported to some extent by the findings
from this thesis, which suggests that one of the factors that may contribute to counsellor effectiveness is the degree of ‘fit’ that exists between their personal philosophy and the theoretical orientation that informs their practice. In addition to enhancing counsellors potential to be effective, ensuring consonance between the personal philosophy of potential volunteer counsellors and the model of counselling used with the agency may also help to mitigate some of the stress and challenges that novice paraprofessional counsellors are likely to encounter during the early stages of practice. Furthermore, ensuring this kind of consonance may also contribute to the experience of more healing involvement (Orlinsky and Rønnestad 2005) for counsellors in their client work, and to more sustained voluntary activity.

In relation to training, the findings from this study suggest that, overall, minimally trained paraprofessional counsellors working in mental health settings may benefit from targeted training that pays particular attention to the following key elements: 1) the development of strong interpersonal skills and relational competence; 2) fostering an ability to introduce and maintain a sufficient degree of structure and focus into counselling sessions (e.g., regarding time and role boundaries, clarifying expectations and goals). This may be achieved by providing paraprofessionals with a framework for practice that is grounded in a model or models of counselling that are consistent with their own metatheoretical assumptions or personal philosophy; 3) the development of skills in relation to the collaborative negotiation of goals and tasks for counselling, while being sensitive to client readiness for change; and 4) sensitising paraprofessional counsellors to the importance of developing an ability to engage and monitor client involvement in counselling, and to the value of bringing counselling to an end in a planned manner where possible.
In addition to the above suggestions, it may be advantageous to assist paraprofessionals to develop therapeutic skills that facilitate their ability to work effectively with the type of problems clients typically present with within their particular agency. Furthermore, initial training could be supplemented by ongoing training to assist paraprofessionals to expand their repertoire of therapeutic skills.

### 7.4.2 Implications for the support and supervision of paraprofessional counsellors

Findings from both studies reported in this thesis suggest a number of potential implications for the support and supervision of minimally trained paraprofessional counsellors. In this section, the most salient practical implications that emerged from the results of Study 1 and Study 2 are presented.

Supervision has been shown to be the most positive influence on the development of beginning therapists (Orlinsky and Rønnestad 2005), and is of particular importance to minimally trained paraprofessional counsellors (Tan 1992) entering practice for the first time. The results of the research reported in this thesis suggest that the provision of support and supervision for novice paraprofessional counsellors is important insofar as it provides a means by which they can receive practical guidance on practice issues and concerns, obtain reassurance (where appropriate) regarding their performance and fragile identity as counsellors, learn about counselling theory and how it applies to practice, develop counselling skills, and learn how to manage the sometimes immobilising anxiety that is so pervasive in beginning counsellors and psychotherapists.

Overall, the provision of regular individual supervision and more informal staff and peer support is likely to provide the optimal balance of supervisory and work setting support for beginning paraprofessional counsellors. For example, ensuring counsellors have
access to a member of staff on an informal basis, especially in the period immediately following counselling sessions, may be a particularly valuable means by which to protect paraprofessionals from undue feelings of worry and anxiety related to client work, and also help to mitigate the experience of stressful involvement (Orlinsky and Ronnestad 2005) which can impact negatively on counsellor wellbeing and development. Similarly, creating opportunities within the agency for paraprofessionals to interact with their peers either in informal discussions or in peer group support sessions, case discussion seminars or in the context of on-going training workshops is likely to prove beneficial as these activities are all ways in which beginning paraprofessional counsellors can find support and opportunities for reflection and development.

In addition to the above general recommendations, staff providing support and supervision to paraprofessional counsellors should be alert to the potential difficulties that new paraprofessional counsellors may experience in relation to adjusting to the organisation and to any ancillary duties and tasks associated with the role of counsellor within the agency, and where necessary provide relevant guidance and support.

In relation to counselling practice, it is recommended that supervisors are aware of, and monitor, the extent to which early stage paraprofessional counsellors are experiencing and managing dissonant experiences concerning their role as counsellors, or in relation to tensions and dilemmas that may arise from a conflict between their personal philosophy and the preferred model of counselling employed within the agency.

Also, staff providing support and supervision to paraprofessional counsellors need to be aware of the importance of establishing a positive supervisory relationship (Orlinsky and
Rønnestad 2005) that facilitates the development of therapeutic skills, reduces anxiety, and promotes self-efficacy and a sense of competence in the role of counsellor. The experience of Lily, one of the participants in Study 2, reported in section 5.5.2 of Chapter 5, highlights the importance of this approach to supervising paraprofessionals. Lily reported feeling criticised by her supervisor and generally appeared to have had a negative experience of supervision, which did little to promote her development as a counsellor or engagement with the MHSS agency as a volunteer. Ideally, staff providing support and supervision to paraprofessional counsellors should have considerable relevant experience and be competent in this area of counselling practice.

Finally, it is axiomatic that voluntary counselling agencies should create and maintain a culture of inclusiveness that encourages volunteers to have a voice within the agency that is respected and valued for its contribution to the overall operation and development of the organisation.

7.4.3 Implications for the counselling practice of paraprofessional counsellors
Paraprofessional counsellors entering practice for the first time following only a minimal period of training and with little or no prior experience of individuals in psychological distress face a myriad of challenges that have the potential to nurture anxiety and self-doubt and overwhelm novice paraprofessional practitioners. The preceding section highlighted the role of support and supervision in mitigating the negative effects of such practice challenges. In addition to these recommendations, the results of the research reported in this thesis suggest a number of other implications for paraprofessionals entering practice for the first time.

First, it is recommended that clients are carefully selected and matched to
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paraprofessional’s levels of competence and experience as this may prove beneficial in ensuring inexperienced paraprofessional therapists are not overwhelmed by their clients’ problems. This strategy may help paraprofessionals to build a sense of self-efficacy and competence through experiencing successful outcomes with minimally distressed clients during the initial stages of their practice and development as therapists. Second, where paraprofessional counsellors are working within a brief therapy framework consideration might be given to the assessment of clients in terms of their readiness for change and appropriateness for brief therapy when allocating clients to paraprofessional therapists with minimal training and experience. Third, it is recommended that paraprofessional practitioners are encouraged to reflect carefully on their experience of client work and sense of development in their new role as counsellors and to take appropriate action, where necessary, to avoid potential harm to either themselves or to their clients. The role of supervisory support is likely to be of critical importance in this respect. Fourth, counselling agencies and paraprofessional counsellors may find it beneficial to monitor their effectiveness with individual clients using a standardised outcome measurement system such as the CORE-OM and to use this data to improve client care, and also to identify the on-going training needs of paraprofessional practitioners.

7.4.4 Implications for future research into paraprofessional counselling

Over the past thirty years there have been surprisingly few studies that have investigated the effectiveness of paraprofessional counsellors in routine practice settings relative to their levels of experience and training. It is possible that methodological issues associated with this area of research have discouraged researchers investigating this area of practice. However, the findings of this thesis indicate that the issues originally highlighted some three decades ago by Durlak (1979) in his controversial review of the effectiveness of paraprofessionals continue to be relevant to the contemporary practice
of this group of practitioners. Accordingly, the findings of the research presented in this thesis suggest a number of potentially fruitful directions for future research into paraprofessional counselling, which are outlined below.

Although the results of Study 1 of this thesis showed that the present sample of paraprofessional counsellors were less effective than professional counsellors, it is important to recognise that, overall, they were effective. For instance, the overall group effect size of .79 for the present sample can be considered to be a large effect according to Cohen's $d$ statistic (Cohen 1988), and is consistent with the average effect size achieved in psychotherapy outcome research in general (Cooper 2008). Admittedly, this effect size looks somewhat less impressive when compared to the effect sizes achieved by professional counsellors in the studies that were selected as benchmarks in Study 1 for comparison purposes, which were almost twice as large. Nonetheless, it demonstrates that participants had a positive impact on client outcomes.

Furthermore, in spite of the generally similar profile of participants in Study 1 in terms of their levels of training and experience, it was notable that there was a high degree of variability within participants in relation to their effectiveness in promoting positive client outcomes. The results of Study 1 regarding the overall effectiveness of participants, and the variability in their individual effectiveness provides evidence of the potential for paraprofessional counsellors to be effective and suggest that further naturalistic studies are required to determine the theoretical basis for their effectiveness and the scope of their therapeutic influence, not only in relation to clients experiencing mental health problems but with other client groups as well.
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The benchmarking approach employed in Study 1 is worthy of further examination as a methodological strategy in effectiveness research of paraprofessional counselling. It could, for example, be used to determine the extent to which the findings reported here in relation to the effectiveness of paraprofessional counsellors in mental health settings are applicable to other voluntary sector counselling agencies where paraprofessional counsellors possess a similar profile in terms of levels of training and experience. Over time such research may help to create benchmarks that reflect the diversity of practice and practitioners that exist within this sector and identify the type and level of training paraprofessionals require to practice effectively.

In addition to investigating the overall effectiveness of paraprofessional counsellors, future research attention could be directed toward identifying the factors associated with their effectiveness, and the characteristics of more and less effective practitioners. In this respect, it will be important to determine the extent to which individual differences among paraprofessional counsellors in terms of their personal qualities, values, beliefs and counselling methods are associated with positive and negative client outcomes.

As well as addressing questions concerning their effectiveness, future research efforts could be directed toward gaining a more comprehensive understanding of the developmental processes that occur in novice paraprofessional counsellors. Such research may help to bridge the gap in our current understanding of counsellor development between the lay or pre-professional training phase of counsellor development and the professional phase of development. As noted in section 2.3.5 in Chapter 2 of this thesis, the development of volunteer or paraprofessional counsellors has not been adequately described in most existing models of counsellor development.
7.5 Summary and conclusion

This thesis has sought to evaluate the effectiveness of a group of paraprofessional counsellors with minimal training and limited experience, and to gain a deeper understanding of the meaning and experience of becoming a volunteer mental health counsellor. This was achieved by adopting a pluralistic approach in relation to the research methodology that was employed in this thesis, which was grounded in a theoretical and philosophical perspective informed by pragmatism and social constructionism. This perspective provided the basis for designing and carrying out two studies that used different methodologies to address the specific questions that were pursued in this thesis.

Although the extant literature reviewed in Chapter 2 provided evidence that supported the general claim that paraprofessionals can be as effective as professionals, the findings from the naturalistic benchmarking study of the effectiveness of a group of paraprofessional counsellor presented in Chapter 4 of this thesis called into question the general finding from previous research that paraprofessionals can be as effective as professional counsellors, particularly when working in a routine mental health practice setting. In addition, the findings from the in-depth qualitative investigation carried out for Study 2 of this thesis provided an insight into paraprofessionals’ perspectives on such matters as their intentions in relation to becoming a volunteer counsellor, the experience of training, client work, supervision and overall development during the first two years of their engagement with the activity of counselling. Also, by attempting to combine the findings from the Study 1 and Study 2, it was possible to provide preliminary, but tentative, findings concerning individual differences among paraprofessional counsellors...
in relation to their personal philosophies, counselling practice, and counselling effectiveness.

From the findings of the two studies that were carried out for this thesis it has been possible to show that research into paraprofessional counselling represents a fruitful area for further investigation, and that the findings have the potential to have practical implications for the various stakeholders involved in this area of practice. Future research attention is required to extend existing knowledge of paraprofessional effectiveness in routine practice settings, the characteristics of more and less effective paraprofessional counsellors and the developmental processes associated with this group of practitioners. Addressing such research questions will help to elaborate understanding of this area of practice, which represents a significant part of contemporary counselling service provision in Britain and in other countries too.

The methodological limitations of the research reported in this thesis means that a degree of caution is warranted in generalising the findings to other groups of paraprofessional counsellors and practice settings. Overall, then, it is perhaps best to view the findings of this thesis as preliminary, and as providing the basis for further empirical investigation into the effectiveness and development of minimally trained/experienced paraprofessional counsellors.
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Appendices

Appendix A: Publications

Research into the organisation, training and effectiveness of counsellors who work for free

Author: J. Armstrong


Abstract

The activities of voluntary or ‘paraprofessional’ counsellors, who work for free, represent a highly significant component of the delivery of psychological therapy in Britain and other countries. However, in recent years there has been relatively little published research into issues associated with the provision of service by counsellors who work on a voluntary part-time basis, and who typically receive limited training and supervision. This paper introduces a special theme section on counselling in the voluntary sector, which highlights some recent examples of research into the context, organisation, training and effectiveness of such counsellors. Some suggestions are made concerning the research agenda for counselling in the voluntary sector.

Introduction

Counselling in Britain has developed and expanded significantly over the last 20 years. Year by year there are more counsellors, and more counselling organisations, working in an ever-increasing range of service settings and with a wider range of client groups. In Britain, counselling originated in the voluntary sector. Historically, it could be argued that the single most significant influence on the development of
counselling in Britain has been the marriage guidance movement (Lewis et al, 1992). Alongside RELATE, Couple Counselling Scotland and Marriage Care, the growth of counselling in Britain has been driven by other important national counselling agencies, such as the Westminster Pastoral Foundation (WPF) and CRUSE Bereavement Care, as well as a host of smaller local generic and specialist voluntary agencies operating in fields such as violence against women, bereavement, youth counselling, drug and alcohol work, and support for people with health problems. The voluntary sector has been the bedrock of counselling in Britain. If it were possible to calculate the total amount of counselling carried out in Britain every year, it would be likely that more than 50 per cent of counselling contacts would be made through voluntary sector agencies.

However, despite the importance of the voluntary sector, development of counselling in Britain has been accompanied by a steady movement in the direction of increasing professionalisation. The term ‘professional’ is used here in a sociological sense. ‘Professional’ is not taken to mean ‘ethical’ or ‘high quality’, although it can have these meanings too, but is understood to refer to an occupational group that has achieved the status of a profession. This status is characterised by control over a domain of knowledge and practice (backed up by research), lengthy training (usually in a university), controlled membership through accreditation by a professional association, a full-time, paid workforce, and legal recognition and regulation by the State. In our area of work, many colleagues are members of clear-cut professional organisations, such as clinical psychology, social work and psychiatric nursing. Many counsellors, and certainly the British Association for Counselling and Psychotherapy (BACP), would like to see counselling become a fully-fledged statutory profession.
with these features. The BACP Counselling and Psychotherapy Journal has, in the past few years, contained a steady debate over the issues concerned with achieving professional status.

Voluntary sector counselling agencies are caught in the middle of this debate. It is, of course, possible to be a fully professionalised voluntary agency, for example to have charitable status and yet employ only professional, qualified, paid workers. But most counselling voluntary agencies have a mixed economy, with some paid workers yet with the majority of service delivery provided by unpaid (or minimally paid) volunteer workers. There are many pressures on these agencies to seek to become more explicitly ‘professionalised’ by developing a fully salaried workforce. For example, voluntary sector agencies are increasingly winning NHS, social services and commercial contracts to provide counselling for specific groups of clients. Often, the conditions of these contracts demand ‘professional’ levels of training in counsellors, and levels of audit/evaluation associated with ‘professional’ organisations. Many voluntary sector counsellors, who feel strongly that their skills and experience are worthy of proper payment, support the movement towards salaried status and conditions.

The fact that so much counselling is being delivered by voluntary sector counsellors, and the existence of substantial tensions and change within voluntary sector counselling agencies, might be taken as suggesting that the topic of voluntary sector counselling would represent a major topic of interest for research. This is not the case. The majority of published studies into counselling are drawn from the professional, statutory sector. As a result, a substantial number of research questions about
‘counsellors who work for free’ have not been addressed in any systematic manner. The remainder of this paper seeks to provide an overview of this research agenda, by considering three main domains of inquiry: the effectiveness of voluntary sector counselling, the organisation of voluntary counselling services, and the social meaning and impact of voluntary counselling.

The effectiveness of voluntary sector counselling

Research into the effectiveness of voluntary sector counselling has concentrated largely on the outcomes produced by counsellors who work for free and have received limited training, rather than on the therapeutic results associated with voluntary sector or ‘not for-profit’ organisations. Much of this research has been carried out in the USA, and has used the term ‘paraprofessional’ to mark the distinction between volunteer counsellors and those who have received full professional training. Interest in the use of paraprofessionals as therapeutic agents peaked between the 1960s and the early 1980s. For example, in one well-known study, Strupp and Hadley (1979) investigated the comparative effectiveness of highly trained professional psychotherapists, and untrained college professors, when offering therapeutic counselling to students who were depressed and isolated. They found that the clients seen by untrained helpers improved just as much as the clients of professional therapists.

A number of reviews of research into the effectiveness of volunteer, paraprofessional or minimally trained counsellors have been carried out (Atkins and Christensen, 2001; Berman and Norton, 1985; Christensen and Jacobson, 1994; Durlak, 1979; Faust and Zlotnick, 1995; Hattie and Sharples, 1984; Karlsruher, 1974; Nietzel and Fisher,
1981; Stein and Lambert, 1984, 1995). Overall, these reviews have concluded that paraprofessionals can achieve clinical outcomes that are equal to or significantly better than those obtained by professionals. On the basis of this evidence, Durlak (1979) suggested that “professional mental health education, training and experience were not necessary prerequisites for an effective helping person” (p.89). Faust and Zlotnick (1995) commented that:

“...whatever refinements are made, whatever studies are included or excluded, the results show either no difference between professionals and paraprofessionals or, surprisingly, differences that favour paraprofessionals....the conclusion that naturally follows is that formal training, in general, is not a predictor of successful psychotherapy” (Faust and Zlotnick, 1995, p.164).

Since the 1980s, there has been relatively little further research into the effectiveness of paraprofessional counsellors. However, research into group psychotherapy has found that volunteer group leaders, and mutual support groups, can yield therapeutic results comparable to those found in groups facilitated by professional therapists (Baker and Neimeyer, 2003; Bright et al, 1999; Burlingame and Barlow, 1996).

How is it that people who have received limited training are able to achieve therapeutic results equivalent to those reported by highly trained professional specialists? One way of accounting for the equivalence outcome in the comparative effectiveness of professional and paraprofessional therapists is that in both cases the
effectiveness of the therapy derives from common or non-specific factors, rather than from the application of sophisticated techniques and theory (Frank, 1973). In an analysis of the role of non-specific factors in helping relationships, Wills (1982) identified certain helping processes that were more characteristic of professional therapists, whereas others were more evident in paraprofessional helping. For example, client self-attribution of change is possibly more likely to occur when the helper is a paraprofessional, because the client does not perceive the helper as possessing impressive credentials and expertise. On the other hand, a professional therapist may be more skilled in maintaining the client’s focus on a specific problem area, because he or she had a better understanding of how and why clients may avoid difficult issues. In addition, there are factors arising from the amount of therapy that the counsellor provides on a weekly basis. Paraprofessionals, who perhaps see two or three clients each week, may be less vulnerable to burnout, and better able to display authentic interest and presence in relation to each client, in contrast to professional therapists who may be seeing twenty or more clients in a typical working week.

In a world in which the principle of evidence-based practice and empirically validated treatment has become a cornerstone of government policy-making, the lack of recent research into the effectiveness of paraprofessional counsellors has served to undermine the credibility of the voluntary sector as a provider of services. For example, there is no research evidence available that compares the outcomes of volunteer/paraprofessional counsellors, and UK-trained counsellors, clinical psychologists, nurse therapists or psychotherapists working with major client groups such as those experiencing depression, bereavement or relationship difficulties. The absence of this research makes it difficult for government agencies committed to
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Evidence-based practice, such as the NHS, to channel financial resources into voluntary sector counselling. There is also a need for research that explores the conditions under which volunteer counselling is particularly effective. For example, does paraprofessional counselling work best where there is some kind of matching of client and counsellor, in age, gender or prior experience of the presenting problem?

The organisation of voluntary counselling services

A range of distinctive organisational factors can have an impact on the activities of voluntary sector counselling agencies. In virtually all voluntary sector counselling agencies in which counsellors ‘work for free’, the training, supervision and management of counsellors is carried out by people in salaried positions, who possess professional qualifications. However, little research attention has been given to the ways in which paid, professional counsellors and psychologists can work alongside volunteers. Few, if any, university counselling courses include inputs about the issues involved in working in the voluntary sector, such as supporting volunteers. The needs of volunteers have similarly received little attention. Although Hunot and Rosenbach (1998) reported that recognition, support, training and accreditation were important factors in retention — and in maintaining commitment and job satisfaction — in volunteer alcohol counsellors, subsequent research has not built on this important finding. Patterns of working life have shifted considerably in recent years, with those in employment working longer hours. The effect of this kind of shift has been to make ‘volunteering’ problematic for many people who, in principle, might wish to contribute to the voluntary sector counselling. Knowing more about the structures and incentives that could make it more possible for people to volunteer could have significant practical consequences.
Anyone who has managed a voluntary sector counselling agency will know that keeping the service functioning is a constant balancing act. Uncertainty over funding, the turnover of counsellors, and the ever-changing demands of regulatory bodies, mean that voluntary sector agencies have a tendency to undergo regular cycles of stability and crisis (Hasenfeld and Schmid, 1989; McLeod, 1994). The impact of these cycles on service quality, and the effectiveness of alternative management structures and strategies, represent important potential avenues for research. The budgetary realities of voluntary agencies mean that volunteer or paraprofessional counsellors are likely to receive relatively limited training and supervision. In such a situation, it is necessary to develop a research-informed understanding of the type and extent of training and supervision that is required to achieve good client outcomes.

The social significance of voluntary counselling

Voluntary sector counselling agencies are not merely service providers that happen to be financed differently from ‘professional’ therapy organisations. The existence of voluntary counselling has a broader social significance that reaches beyond issues of clinical effectiveness. This significance can be understood through consideration of two key themes: inclusiveness and citizenship.

Voluntary sector counselling agencies tend to describe themselves and their work in terms of assisting people to cope with life events, for example marital conflict, illness, bereavement and sexual violence. The psychotherapy, psychiatry and clinical psychology professions, on the other hand, tend to describe their work in terms of diagnostic categories or ‘deficits’ such as depression, borderline personality disorder, anxiety disorder, etc. These are labels that have personal and social consequences. On
the whole, people do not like to be labelled, and will avoid situations in which they anticipate being labelled. We would argue that there are few occasions when diagnosis or labelling makes a positive contribution to the therapeutic process. Voluntary agencies, and volunteer counsellors, are in a position where everyone knows that they do not label clients. Unlike statutory therapy providers, such as NHS clinical psychology and psychotherapy services, voluntary agencies are not legitimated by society to label clients. Voluntary agencies do not have this particular kind of social power. The result is that voluntary agencies are much more socially inclusive, and give a clear message to users that they offer a place where the person will be accepted for who they are, and not turned into a ‘case’. The majority of voluntary sector agencies are funded from local resources, and are well integrated into local care networks.

For many volunteers, counselling represents a meaningful way to participate actively as citizens, by contributing to the common good and the improvement of conditions of social life. In a world in which we are all becoming consumers of goods and services, and in which the institutions that bind us together (work, Church, political parties) are under threat, it is important to maintain forms of organisational life that permit active citizenship, through collaborative action in the service of a common good. The skills, awareness and values associated with counselling practice are useful in many areas of life beyond the counselling room. The well-being and psychological development of volunteer counsellors can be enhanced by involvement in this kind of work. It would also seem likely that volunteer counsellors benefit their families, work environments and communities by being able to use their counselling competencies in an appropriate fashion in a wide range of everyday situations.
Current research directions

The papers in this Theme Section reflect many of the research priorities that have been identified. The papers by Winter et al (2003) and Gardiner et al (2003) represent attempts to evaluate the effectiveness of volunteer counsellors. The Westminster Pastoral Foundation studies reported by Winter et al (2003) were large-scale, externally-funded projects that sought to collect data from a large number of service users. In contrast, the Gardiner et al (2003) study reports on the efforts of a small voluntary agency to evaluate its effectiveness, using its own local resources. The findings of both studies are strikingly similar. First, the counselling received by clients appears to be beneficial, when assessed using standard outcome measures — possibly as effective as psychotherapy delivered by professional psychologists. Second, the clients seen by these voluntary agencies report severity and length of problems that are comparable to that of NHS psychiatric patients. Third, it is very difficult to collect comprehensive data within the voluntary sector context.

The papers by Buckroyd (2003) and Armstrong (2003) explore different aspects of the organisation of voluntary sector counselling agencies: client assessment, management of waiting lists, and training. A common theme here is the capacity of voluntary agencies for flexibility and innovation, and the role of research in facilitating the development of new approaches.

The paper by Liz Bondi, Judith Fewell and Colin Kirkwood (2003) provides a summary of some of the key findings of a major recent research investigation in Scotland into the nature of voluntary sector counselling provision. This study brings a fresh perspective to our understanding of the work of the voluntary sector, and raises a
number of important questions for future research. For example, Bondi and her colleagues show that voluntary sector agencies have consistently been able to find ways to deliver services that adhere to the highest professional standards. Their work also raises the difficult and essential question of how best to describe counselling in the voluntary sector. Clearly, the voluntary sector encompasses both paid counsellors and those who work for free. Those who are unpaid, however, may (or may not) possess advanced qualifications and training. In this context, terms such as ‘paraprofessional’ or ‘volunteer’ are not sufficient to describe the role or activities of the people who are involved.

Conclusions

We have both spent much of our professional lives working in, or with, voluntary sector counselling agencies, in a variety of roles: counsellor, supervisor, manager, committee member, researcher. Our experience has shown us over and over again that counselling that is carried out by volunteers who “work for free” can be life-enhancing - for both clients and counsellors. There is something important for our society in retaining this kind of opportunity, for counselling to be local and everyday, rather than dominated by globalised theories and state-run services. We believe that research into voluntary sector counselling can provide a useful arena in which the complex issues that surround this area of practice can be documented and discussed. Our hope is that the papers in this Theme Section will stimulate others to conduct, and publish, further research in this domain.

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Training for paraprofessional Counsellors: Evaluating the meaning and impact of a common factors approach

Author: J. Armstrong.


Abstract

A group of 12 people participated in a short (40 hours) counselling training programme for paraprofessional counsellors, which emphasised the importance of common factors in accounting for therapeutic effectiveness. The general framework, language and skills of a brief, solution-focused approach was used as a means of translating the theoretical/conceptual ideas of the common factors model into specific counsellor behaviours and also to provide structure and focus for counselling sessions. A pluralist methodology was employed to assess the personal meaning of the training for participants and the impact of the training on the development of counselling skills and awareness. Results indicated the training impacted positively on the development of counselling skills and ability to handle difficult client behaviours but less so on personal values and ability to deal with process issues. The majority of participants believed the training contributed positively toward their personal development.

Key words: common factors, counselling, paraprofessionals, solution-focused therapy, training, voluntary sector

Introduction

Counselling in Britain has long been associated with voluntary organisations and the work of volunteer counsellors (Tyndall, 1993). However, there appears to be a lack of
research into aspects of volunteer counselling (Hunot and Rosenbach, 1997). As a consequence, little is known about the distinct training and supervision needs or the development of skills and awareness in volunteer or paraprofessional counsellors (McLeod, 2003). This is an important area for investigation because paraprofessional counselling already contributes significantly to service delivery across a wide range of settings. It is crucial therefore that we understand more about how best to educate paraprofessional counsellors and determine what factors contribute to their clinical effectiveness.

What we do know in this area comes, for the most part, from research comparing the effectiveness of professional versus paraprofessional helping. A number of reviews of this body of research have found that clients of non-professional helpers improved as much or more than clients of professional therapists (Berman and Norton, 1985; Carkhuff, 1968; Durlak, 1979; Faust and Zlotnick, 1995; Hattie and Sharpley, 1984; Karlsruher, 1974; Nietzel and Fisher, 1981; Sobey, 1970; Stein and Lambert, 1984). This conclusion is not only challenging but also surprising because it is generally assumed that training confers some benefit to the trainee in terms of increasing or maximising their effectiveness. If training is not a significant predictor of clinical effectiveness then what is? One interpretation of these findings is that counsellor effectiveness is not so much mediated by specific, theory or model-driven factors, which form the basis of most counsellor education, but by non-specific factors common to all counselling approaches even though such factors may not be emphasised by particular approaches. Evidence for this belief comes primarily from comparative studies of psychotherapy, which show that despite the multitude of different approaches there are no major differences between them in terms of their
effectiveness (Smith et al, 1980; Wampold et al, 1997).

The first advocate of this position was Saul Rosenzweig (1936). He suggested that the possibility for catharsis that existed in the therapeutic relationship, combined with the personal qualities of the therapist, and the provision of alternative and more functional ways of viewing the self and world, were all factors common to diverse therapies. It is Jerome Frank (1961;1991), however, who is most closely associated with this argument. He identified a number of common or non-specific factors that were essential to any kind of effective therapeutic intervention: the creation of a supportive relationship, the provision of a rationale by which the client can make sense of his or her problems, and the participation of both client and therapist in healing 'rituals'. During the 1980s what became known as the common factors hypothesis gathered momentum as one of three central strands of the psychotherapy integration movement (Garfield, 1982; Goldfried, 1982; Norcross and Greencavage, 1989; Weinberger, 1995). More recently, efforts have been made to identify implications for training and practice of a common factors approach (Hubble et al, 1999; Miller et al, 1997). These developments raise important questions concerning the relationship between research findings and training, particularly in view of the fact that counsellor education in Britain tends to be structured around single core theoretical models (Feltham, 1997). It can be argued that this kind of training culture runs contrary to research evidence. Rather than privileging models and techniques, it may be of value to give more emphasis to common factors in counsellor training.

The study reported in this paper forms part of a larger programme of research into the use of a common factors perspective in counsellor training. The present study focuses
on the experiences of a group of volunteer counsellors undertaking a short (40-hour) training course in preparation for working with clients in an inner-city voluntary sector counselling service in Scotland. The rationale for applying a common factors approach to volunteer training is that the effectiveness of volunteer or paraprofessional counsellors may be attributable to their ability to harness client resources, and the healing effects of the therapeutic relationship by virtue of their personal qualities and implicit everyday helping and relational skills — in other words, their ability to make use of common factors. It was hypothesised that focused training might capitalise on what may have been past incidental learning (Truax and Mitchell, 1971) that would be relevant to the tasks of counselling. Consequently, the general aim of the training was to ‘draw-out’ trainees’ everyday helping skills and provide the conditions within which they could be refined and developed.

Within the training course, participants were introduced to the general framework of a solution-focused approach (Miller et al, 1996; O'Connell, 1998). This theoretical approach was employed for a number of reasons. First, its general philosophy appeared to be consistent with a popular conceptualisation of common factors advanced by Lambert (1992) and subsequently developed by Miller et al (1997) and Hubble et al (1999). Second, it has been acknowledged that while common factors may contribute significantly to positive outcomes, it is not possible to work exclusively from a common factors perspective either in practice or in training (Norcross, 1999). Model and technique factors play an important role in terms of providing structure, novelty and a means of harnessing curative effects (Miller et al, 1997). Third, due to the brevity of the training (40 hours) and the fact that trainees were being prepared for practice it was assumed that providing trainees with a
vocabulary of skills that translated the conceptual ideas of the common factors into specific counsellor behaviours would facilitate their ability to interact purposively with clients and increase their confidence in their ability to counsel effectively.

The aim of this study was to evaluate the personal meaning and impact of a brief, solution-focused counselling training that emphasised and incorporated common factors on the development of skills and awareness in paraprofessional counsellors.

Method
To reflect the exploratory nature of the study, a pluralist approach to evaluation was adopted. Trainees were invited to complete open-ended questionnaires eliciting their expectations for training and personal accounts of the value and impact of the training programme. In addition, a widely used self-report scale, the COSE (Larson et al, 1992) was employed to collect data on trainees’ perceptions of the development of self-efficacy in relation to counselling skills and values.

Content of the training
The training comprised three core modules conducted over 11 training days (40 hours in total) within an eight-week period. Each training day consisted of an average of three and a half to four hours of actual training with additional time allocated for breaks. A series of follow-up training days took place once trainees began client work in order to consolidate the core training and identify areas for further development. A programme of ongoing peer support and ‘supervision’ groups (facilitated by a member of staff) was also established to facilitate learning and the development of competence. This study only investigated the impact of the three core modules
undertaken by trainees prior to engaging in client work. The key elements of the modules were as follows:

1. Module one aimed to cultivate a positive learning environment and orient trainees to the common factors philosophy of the course. In addition, it began the process of personal development and, importantly, sought to draw out and build on trainees’ existing helping and relational skills. It lasted four days and consisted of 14 hours of training time.

2. Module two provided trainees with an appreciation of the ways in which our attitudes and assumptions, and dominant theoretical perspectives and ways of understanding mental distress, may shape our response to clients’ problems. Approximately five hours were devoted to this module.

3. Module three introduced trainees to the principles and skills of the solution focused approach and the ways in which they could be used to tap into the common factors referred to earlier. This module consisted of six days and a total of 21 hours.

Teaching and assessment

Throughout the training the emphasis was on experiential learning, and opportunities were created to allow trainees to discover and experiment with existing human skills and abilities that, it was assumed, would enhance their ability to engage effectively with clients. Although I (JA) was the primary trainer, additional support was provided by two other members of the counselling team who facilitated discussion groups and role play exercises.

A variety of strategies were used to promote learning, including short lectures, guided
reading exercises, group discussion, role play exercises, together with video and live (role-play) demonstrations of counselling sessions (MHSS, 2000). Assessment of trainee competence to start seeing clients combined a variety of self-assessment and trainer assessment methods, for example, learning journals, reflective logs and videotapes of role-play sessions. Post-training interviews were also included to discuss with trainees their overall performance during the training and readiness to engage in client work.

The setting
The study was conducted within a medium sized voluntary counselling agency in the west of Scotland. This service has full-time administrative support and consists of up to 20 volunteer counsellors, two part-time paid counsellors, a volunteer co-ordinator and a service manager (the researcher and author of this paper), both of whom are involved in client work. The service has been in operation since 1994 and began recruiting and training volunteer counsellors following the award of a grant from the Unemployed Voluntary Action Fund in 1998. This study was carried out in autumn 2000, which was the second time the training had been offered.

Participants
Twelve out of the fourteen people who were accepted for the counselling service training were recruited to participate in this study. Of the two people who did not participate in the study one was a member of agency staff who was attending module one only to enhance interpersonal skills in relation to their role within the organisation — it did not seem appropriate to involve them in the study. The second person declined to participate and did not give any particular reason. However, later in the
course this individual expressed regret at not being involved. A total of 21 people had
applied for the training. Selection for the training involved an interview by two
members of staff, and selection criteria focused primarily on the personal qualities of
applicants and their ability to meet the practical (e.g. available time), emotional and
other requirements of the training (e.g. willingness to engage in role play/video work
and a degree of self-exploration). Ten of the participants were women and two were
men, all of whom were white and described themselves as British. Participants
ranged in age from 25 to 64 years (mean = 44.5). Seven were married, three were
single, one divorced and one widowed. Most were employed or self-employed (five),
two were retired, two were on sickness/disability benefits, one participant was
unemployed, another described herself as a housewife and there was one student.

Five people had no previous counselling training while seven had some form of
training experience. One participant had attended a one-day workshop on basic
counselling skills, and two had attended one or more short courses of up to six
months’ duration (part-time), which provided a general introduction to counselling
and basic counselling skills. Two participants had attended certificate courses in
counselling skills. Seven participants had some form of prior experience of working
with people in distress and five did not. Of the seven people who had previous
experience only two had experience in specific counselling roles. The remainder of
the participants’ experience was gained, for the most part, through a variety of roles in
human service professions.

Measures

Pre-training questionnaire. This self-report measure was completed by participants
before starting the training. It was designed for use in the present study in order to
capture something of the personal meanings that participants attached to the training
course. It consisted of 16 items and was divided into three sections. Section one
collected baseline information on participants’ personal characteristics (e.g., age,
gender, marital/employment status, ethnicity, together with details of previous
counselling training and experience). Participants were also asked to rate their
estimation of their suitability to the role of counsellor on a seven point Likert scale (1
- not at all suitable; 7 - very much suited). Section two attempted to clarify issues
related to the history of participants’ interest in counselling. For example, participants
were asked to complete the sentence: ‘Becoming a volunteer counsellor is important
to me because...’ Another question asked participants to comment on the key
moments or events in their lives that contributed to their interest in counselling.
Section three attempted to identify participants’ expectations and concerns about the
training. For example, participants were asked to comment on what they hoped to gain
or achieve by doing the training, to describe any concerns and or aspects of the
training they were most/least looking forward to. Additional space was also provided
for participants to make general comments about the training or about any aspect of
the research. Completed questionnaires were returned in a sealed envelope and not
opened until after the training.

*Counselling Self-Estimate Inventory (COSE)*

The COSE (Larson et al, 1992) is a 37-item instrument designed to measure
counsellors’ beliefs or judgements of their abilities to counsel effectively in real
counselling situations but does not assess actual counselling performance. It is
organised into five sections, which attempt to operationalise and measure counselling
self-efficacy in relation to confidence in using micro-skills, attending to process issues, dealing with difficult client behaviours, their cultural competence and awareness of values. Each item is scored on a six-point scale, ranging from disagree strongly (1) to agree strongly (6). Studies have shown the COSE to be internally consistent and stable over time. Although the COSE is intended to assess generic competencies that are assumed to be trans-theoretical, many of the items, particularly in the microskills and process sections, assume an existing knowledge of basic counselling concepts and skills. For example, items in the microskills section include statements that measure confidence in ability to use interpretation and confrontation responses and basic attending and listening skills. For this study, the COSE was modified to make it suitable for use with trainees without any prior counselling knowledge or skills. This involved removing all references to specific counselling skills from the items. For instance, the question: ‘I am worried that the wording of my responses like reflection of feeling, clarification, and probing may be confusing and hard to understand’, was changed to ‘I am worried that the wording of my responses may be confusing and hard to understand’. The version used in this study comprised 36 items. The COSE was completed by trainees before, during and after the core training modules in order to assess the impact of the training on the development of skills and awareness in trainees. On each occasion the completed form was placed in a sealed envelope and not opened until after the training.

Post-training questionnaire

This self-report measure was designed for use in the present study to evaluate the impact of the training on trainees. It consisted of 11 items that mirrored the pre-training questionnaire and was completed by participants after the training. For
example, trainees’ perception of their suitability to the role of counsellor was measured again using a 7-point scale. The impact of the training on them personally, their likes, dislikes and recommendations, was assessed with questions such as:

“Please comment on what the training has meant to you personally.”
“What were the key moments/events during the training that held special significance for you?”
“What, if anything, have you gained/achieved by doing this training?”
“In what ways, if at all, are you different as a result of doing this training?”
“What, if any, recommendations would you suggest to improve this training?”

Additional space was also provided to make general comments about the impact of the training or about the research study.

Results
Results from the pre-training questionnaire suggest that a variety of reasons accounted for participants’ interest in counselling. Of primary importance was a desire to help others and feel valued through doing something that they perceived to be worthwhile. Such motivations often stemmed from personal experience of distress and a positive experience of being helped through counselling or informal helping. Participants’ interest in counselling was generally sparked through a gradual realisation that they were ‘good listeners’, which in turn gave rise to a feeling that they had something to offer in a counselling role. In terms of expectations, the majority of participants hoped to gain new skills and knowledge in relation to counselling and also hoped the training would assist them in developing personal
qualities, to learn more about themselves and assist them to deal more effectively with personal issues or difficulties. In addition, people used the training as an opportunity to ‘test-out’ their interest and suitability in relation to counselling because there were no course fees and it was available in their area.

Participants’ views of the impact of training

Participants’ responses to the open-ended items in the post-training questionnaire were subjected to a content analysis by the researcher. This analysis yielded four dominant themes, detailed below in order of importance: intrapersonal meaning and impact of the training; importance of the learning environment; impact of the course philosophy and content of training; development of interpersonal skills/competence.

Intrapersonal impact of the training

All 12 participants reported that the training brought about positive change in self-confidence/self-esteem, feelings of well-being, and the development of new perspectives or ways of thinking. Such changes were reflected in participant statements like:

“[It] feels like I have opened a part of myself finally, having struggled to find a means to do it for some time.”

“...the training ...showed me the inner strength and strong survival instincts I must have to be here today.”

“I feel back to being me again.”

“The training has answered a need in me to try to help people going through problems and trauma because of my own experiences.”
"I am more self-confident in my ability, more self-aware and...more open to others views..."

"I have become even more tolerant of how others see and interpret life [and] more accepting of each person’s outlook."

Importance of the learning environment

When asked to comment on the most helpful aspects of the training and the personal meaning of the training, nine participants commented on aspects of the learning environment. Four people highlighted the value of working within a group and a stimulating learning environment, which allowed them to meet new people and share personal thoughts and feelings. Three trainees highlighted the importance of the supportive and encouraging environment, which was experienced as validating and appeared to facilitate participation and engagement in the training. Other responses emphasised the helpfulness of diverse learning strategies such as triad work, group discussion, handouts and video demonstrations of counselling sessions.

Impact of the philosophy and content of the training

Participants’ responses suggest that they valued a range of aspects of the training programme. For example, three participants commented that learning about and understanding the importance of common factors was helpful. For one of these participants, who had some counselling experience, the emphasis on common factors helped to move her practice forward from a feeling of being ‘stuck’. For another, with no helping experience, believing that common factors were more important than models or techniques seemed to increase her sense of self-efficacy and reassure her of her potential to become an effective counsellor without having to undergo extensive
Appendices

training. Three trainees found the solution-focused model helpful because it provided a way of structuring counselling sessions:

“Solution-focused therapy gave me a plan.”

“[It] has given me a framework ...”

Many people found this model helpful because it emphasised client resources and potential and focused on the client’s perspective and experience, which seemed to fit their existing values and belief systems. For instance, one trainee, who did not have any formal counselling training but who had worked in a human service profession, commented that, “When I saw how solution-focused therapy focuses on a person’s strengths and not their weaknesses... that is exactly the way I worked ... and it worked for me”. Other valued aspects of the philosophy/content of training concerned the extent to which ‘theoretical learning’ enhanced existing helping abilities. For example, one participant commented that the training was a good foundation for practice and that “personal experience and abilities were as relevant as the training”. Comments from three other participants make explicit reference to the training helping them to discover or enhance existing helping abilities.

The development of interpersonal skills/competence

Gains here were evidenced in terms of improved relational abilities and were reported by seven participants. One person who had completed a certificate course in counselling skills commented: ‘My gain is [that] I can begin to move towards open-ended questions and a more flexible approach in counselling’. Other comments highlighted gains in terms of enhanced listening skills and ability to empathise with
clients. For instance, “I have become aware about listening to people properly”; “I have gained insight and knowledge on how to approach people sensitively, allowing them time...remembering that it is their experience, making no assumptions...that your solution is necessarily theirs”. Along similar lines one trainee commented on learning “to assist the client by imposing very little into their line of thought”. Another participant reported that she had become less distant in relationships with family and friends and felt better equipped to deal with difficult situations. The development of interpersonal skills appears to have been helpful in relation to existing human service work, to their prospective role as counsellors and also in helping participants deal more effectively with interpersonal issues in their personal lives.

Unhelpful aspects of the training and recommendations for improvement

When asked to comment on the least helpful aspects of the training six people responded, although one respondent stated that ‘everything was helpful’ and another commented rather ambiguously that “[I]f we found anything unhelpful it made us aware of how we stood with our own ideas and were shown a new perspective”. Two trainees commented on the brevity of the training, suggesting that things were a little compressed, particularly toward the end of the core programme. However, both acknowledged that this was not detrimental to their learning. Indeed, one of these participants suggested elsewhere in the questionnaire that further training was not likely to be as beneficial as actual client work in advancing their learning. One person felt the training days were too long: “There was too much going on — I felt I wanted to go and sort it out before the next point”. Another trainee commented that too little time was devoted to understanding and dealing with various types of mental health difficulties.
Suitability to undertake to role of counsellor

Pre-training, two participants rated themselves very much suited to a counselling role, five estimated themselves as moderately suited, four as slightly suited and one person was unsure about their suitability. Post-training eight participants rated themselves as moderately suited, two as slightly suited and one person regarded themselves as very much suited to a counselling role. Information for one person was missing as they were unavailable to complete any post-training data. However, at the start of training they rated themselves as being unsure of their suitability for the role of counsellor.

Overall, only three trainees revised their pre-training ratings following the training. One of these trainees expressed certainty of their suitability to the role of counsellor pre-training but rated herself as only slightly suited, commenting that she would need to acquire training and skills to progress further. Post-training she revised her rating to moderately suited. Interestingly, her comments in the questionnaire did not include the development of skills but highlighted instead the extent to which she believed her personal qualities and experience of mental distress made her suitable for a counselling role. Another participant rated herself as moderately suited pre-training and as very much suited post-training. On both occasions she commented that her caring nature contributed to her suitability to being a counsellor. For another trainee, the training increased her confidence in her suitability to the extent that she changed her rating from slightly suited pre-training to very much suited post-training. In general, the training appears to have increased trainees’ belief in their suitability for the role of counsellor by affirming the existence of personal qualities assumed to be necessary for the role and through the development of interpersonal competence.
Table 1. Mean and standard deviation scores for COSE: before, during and after training.

<table>
<thead>
<tr>
<th>COSE dimension</th>
<th>Pre-training</th>
<th>Mid-training</th>
<th>Post-training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>N</td>
</tr>
<tr>
<td>Skills</td>
<td>48.91</td>
<td>7.07</td>
<td>12</td>
</tr>
<tr>
<td>Process</td>
<td>32.08</td>
<td>9.81</td>
<td>12</td>
</tr>
<tr>
<td>Difficult</td>
<td>23.41</td>
<td>8.2</td>
<td>12</td>
</tr>
<tr>
<td>Cultural</td>
<td>18.41</td>
<td>3.28</td>
<td>12</td>
</tr>
<tr>
<td>Awareness</td>
<td>19.83</td>
<td>2.55</td>
<td>12</td>
</tr>
</tbody>
</table>

Note:
* = statistically significant scores at p < .05, pre compared to post-training.
+ = statistically significant scores at p < .05, mid compared to post-training.
** = approaching significance at p < .05

Development of counselling skills and awareness

Table 1 presents mean COSE scores before, during and after the training. There was a general increase in mean scores over the course of the training. It should be noted, however, that one participant was not available to complete end-of-training questionnaires. To assess the significance of changes in COSE scores, t-tests were carried out on pre-training vs. mid-training, and pre-training vs. post-training scores. Statistically significant differences were found on skills competence, cultural competence, and ability to handle difficult client behaviours. A statistically significant difference was not found on the ability to handle process issues scale, although there was a trend in the direction of improvement on this domain. Two participants did not complete this part of the scale, leading to a small sample size at end of training (n=9).

No differences were found on values awareness.
Discussion

Results from this study suggest the training had a generally positive impact on trainees’ perception of their ability to counsel effectively in ‘real’ counselling situations, and had facilitated a process of self-reflection and personal development. It appears that participants used the training experience as an opportunity to facilitate their development as counsellors, to learn more about themselves, and to increase their personal effectiveness in their day-to-day lives. For example, newly acquired counselling skills could be used to resolve or better manage interpersonal dilemmas or relationships with family and friends.

The emphasis on common factors played an important role in increasing trainees’ sense of self-efficacy and confidence in their potential to become effective helpers. Participants experienced the common factors philosophy underpinning the training as communicating a belief in their potential value and ability as paraprofessional helpers. The language of the common factors helped trainees to connect to a familiar form of ‘common sense’ helping, which they identified with, based on their personal and everyday helping and relational experiences. In addition, the solution-focused model appears to have enhanced trainees’ vocabulary of relational skills, and provided a framework that increased their confidence in their ability to navigate a ‘therapeutic conversation’ with a client. However, it is important to bear in mind that the ‘degree-of-fit’ between this model and trainees’ existing values and beliefs was high and as such it may have allowed trainees to express their personal qualities and helping abilities more readily than if there was a conflict between the model and their values.

This study shows that a brief course like this still does produce appreciable gains in
skills and ability to handle difficult behaviours, and that the COSE (Larson et al, 1992) appears to be a suitable tool for measuring the effectiveness of training. However, it is essential to acknowledge the limitations of this exploratory study, which considered one group of trainees in one setting. It is important that we continue to build our knowledge of how paraprofessionals use the experience of training, find ways of translating research findings into counselling training for non-professionals, and establish training programmes based on the findings from research. Further research in this area could benefit from incorporating other perspectives and research strategies in the evaluation of counselling training. For example, it may prove valuable to include trainer perspectives and research methodologies, such as simulated client sessions to evaluate counselling competence. The inclusion of semi-structured interviews would help to gain a deeper appreciation of the personal meaning and impact of training on trainees.

This study was carried out as part of a larger project into the relationship between training and counsellor effectiveness. The next stage of the research will investigate the clinical effectiveness of the trainees who successfully completed this brief training.

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How effective are minimally trained/experienced volunteer mental health counsellors? Evaluation of CORE outcome data

Author: J Armstrong


Abstract

Background: Existing research findings indicate that minimally trained/experienced paraprofessional counsellors can be as effective as professionally trained and experienced counsellors. More research into the effectiveness of paraprofessionals with specific client populations is required to determine the conditions under which they can be most effective. Aims: To evaluate the effectiveness of a group of 12 minimally trained/experienced volunteer mental health counsellors. Method: Data were collected over a one year period on 118 clients referred to a voluntary sector counselling agency. The CORE-OM was used to measure clients' levels of distress on a session-by-session basis. Clients and counsellors also completed a range of additional self-report measures. A benchmarking strategy was used to evaluate the outcomes achieved by participants in this study against three benchmark studies selected from published literature. Results: Paraprofessionals in this study were less effective than their professional counterparts. Results showed that participants in this study achieved an effect size of .70 compared to effect sizes of 1.36, 1.39 and 1.42 in the selected benchmark studies. Implications: Findings suggest that minimally trained/experienced paraprofessional counsellors working in mental health settings may benefit from longer and more targeted training programmes before engaging in practice. Conclusions: The benchmarking strategy provided a valuable and practical means of evaluating the comparative effectiveness of paraprofessional and
professional counsellors. Findings should be interpreted cautiously as the selected benchmarks are not precise measurements and may not reflect the organisational factors operating within voluntary sector counselling agencies.

**Introduction**

One of the most controversial findings to emerge from counselling research in the last 30 years has been that minimally trained/experienced paraprofessional counsellors can be as effective as fully qualified and experienced counsellors. The term paraprofessional has been used to distinguish between practitioners with limited training and practitioners who have received full professional training in counselling (Armstrong & McLeod, 2003). Much of the research in this area was carried out in the USA during the 1970s and 1980s, and little further research has been conducted into the effectiveness of paraprofessional counsellors in the past two decades. This is surprising, especially when one considers the significant contribution that volunteer counsellors make to counselling provision within the UK and other countries.

Early reviews by Carkhuff (1968), Sobey (1970), Karlsruher (1974), and a well controlled study by Strupp and Hadley (1979), which compared para-professionals with professional treatments, found clients of non-professional helpers improved as much or more than clients of professional counsellors. The main body of research in this area consists of a core set of studies that have been repeatedly meta-analysed. Durlak (1979) carried out the first of these analyses. He identified 42 studies that compared the effectiveness of professional and paraprofessional therapists and evaluated them in terms of outcome and quality of design. Paraprofessionals were defined as individuals that had not received formal clinical training in psychology,
psychiatry, social work and psychiatric nursing. Professionally trained and experienced psychologists, psychiatrists and social workers constituted the professional group.

The client populations in these studies were drawn from five categories of helping services, which included group psychotherapy or counselling for adults experiencing moderate to severe mental health problems, academic counselling for college students, crisis intervention for adults, prescribed treatment programmes targeted at specific problems such as obesity and insomnia. Durlak (1979) concluded that paraprofessionals achieved clinical outcomes that were equal to, and in some cases significantly better than professionally trained therapists, and that professional mental health training and experience may not be required to be an effective helper. Durlak’s (1979) findings generated a significant degree of controversy and prompted further analyses of the same group of studies by Nietzel and Fisher (1981), Hattie, Sharpley, and Rogers (1984), and Berman and Norton (1985).

The main criticism of Durlak’s (1979) review was that the studies he included were not adequately designed to evaluate the comparative effectiveness of paraprofessional and professional therapists. More specifically, the studies included non-representative client samples, confounded treatment status with other therapist characteristics, had inadequate sample sizes of both therapists and patients to detect differences, lacked appropriate controls, and used poor outcome measures (Faust & Zlotnick, 1995). Yet, in spite of arguments over the methodological rigour of these studies, and successive refinements to each meta-analysis, results consistently showed either no difference between professionals and paraprofessionals or, surprisingly, differences that
favoured paraprofessionals (Christensen & Jacobson, 1994).


In addition to these general conclusions, some important findings also emerged from these reviews. Hattie, Sharpley, and Rogers (1984) noted that the longer the paraprofessional training, the greater their effectiveness compared with professional therapists. In other words, experience and length of training seem to be significantly related to the effectiveness of paraprofessionals. The review by Berman and Norton (1985) indicated that professionals achieved better outcomes with briefer interventions, and paraprofessionals appeared to be more effective when treatment was of longer duration. Atkins and Christensen (2001) noted that professional training may facilitate greater client retention, briefer therapy, and better overall wellbeing for clients.

Overall, current research findings appear to provide evidence for the general effectiveness of paraprofessional counsellors. Nonetheless, it is important to interpret the results cautiously. The diversity of helpers, client populations, modes of
intervention, lack of clarity regarding the type and level of paraprofessional training, methods of evaluating effectiveness and definitions of the terms volunteer, non-professional and paraprofessional represented in existing studies makes it difficult to evaluate the effectiveness of paraprofessional counsellors with specific client groups relative to their levels of training and experience. Such research is important in order to determine the conditions under which paraprofessional counsellors can be most effective.

Therefore, the aim of the present study was to evaluate the effectiveness of a group of minimally trained/experienced volunteer mental health counsellors using the CORE-OM (Evans et al., 2000). The primary research question addressed in this study was: how effective are minimally trained/ experienced volunteer mental health counsellors? For the purposes of this study, minimally trained/ experienced refers to individuals who did not hold a professional qualification in counselling/psychotherapy (i.e. a diploma/masters degree), or a mental health discipline and who had, on average, less than 160 hours of counselling practice experience. A benchmarking strategy, described below, was employed to assess the comparative effectiveness of the group of paraprofessionals included in this study.

Method

Design

This naturalistic study employed a standardised outcome measure, the CORE-OM (Evans et al., 2000), to measure changes in client levels of distress on a session-by-session basis. Clients and counsellors also completed a range of additional self-report measures before and after counselling.
Benchmarking

Benchmarking provides a practical method for evaluating treatment outcomes in applied settings against findings from published research (Minami, Wampold, Serlin, Kircher, & Brown, 2007; Weersing, 2005; Weersing & Weisz, 2002). A major advantage of a benchmarking strategy from a practice perspective is that it addresses many of the practical and resource implications associated with carrying out large scale randomised controlled trials as well as some of the attendant ethical concerns such as the use of control groups where treatment is delayed or withheld.

In the UK, benchmarking has become an established activity within NHS primary care psychological therapy and counselling services in particular. The development of the CORE-OM (Evans et al., 2000), described below, and the subsequent creation of a series of CORE Research Databases (Mellor-Clark, Jenkins, Evans, Mothersole, & McInnes, 2006), into which services donate CORE-OM data, has made it possible to create outcome benchmarks at the level of individual therapists and also at a service level. While such benchmarks are not precise measurements (Barkham, 2006), they provide useful reference points that can be used to interpret and evaluate the outcomes achieved by individual counsellors and services.

For the present study, a research standard of effectiveness of professional counsellors within a UK context was sought. Three published studies were identified and used as benchmarks against which to interpret and evaluate the outcomes achieved by participants in the present study. These were the CORE-OM benchmarks for counselling and psychological therapies as delivered in routine NHS primary care.
settings (Mullin, Barkham, Mothersole, Bewick, & Kinder, 2006), and the findings from two large scale studies of professional therapists working mainly in primary care settings in the UK, which used the CORE-OM to measure rates of clients’ recovery and improvement (Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006; Stiles, Barkham, Mellor-Clark, & Connell, 2008).

These benchmarks were selected for the following reasons. First, all benchmark studies used the same outcome measure as the one used in the present study, which meant comparison of outcomes and exploration of reasons for any differences would be facilitated. Second, they reflected routine care delivered within a UK context by professional therapists, which could be compared with routine counselling delivered by the sample of minimally trained/experienced volunteers in the present study. Third, the client population in the study reported here, and those in the benchmark studies, were broadly similar in terms of the types and levels of distress at in-take. Interested readers may wish to consult the original papers for further information on these studies.

For comparison purposes in the present study, it was assumed, because details of counsellors’ characteristics were not available, that the counsellors in Mullin et al. (2006) and Stiles et al. (2006, 2008) studies were fully trained, professional counsellors. The basis for this assumption was that the Stiles et al. studies (2006, 2008) were comparing professional treatments which were presumably delivered by fully qualified and experienced practitioners; and counsellors working in primary care, as in the Mullin et al. study (2006), are generally required to meet minimum standards of professional training and experience to be eligible to practice as primary
care counsellors, which exceed those of the participants in the present study. Bond (2002), for example, has indicated that a minimum of 450 hours training and 250 hours of supervised practice over two years are essential characteristics of counsellors working in primary care.

The Setting
The setting for this study was a medium sized inner city voluntary organisation based in the west of Scotland. The organisation provided a range of community-based mental health services, including one-to-one counselling, to people experiencing mental health problems. Counselling was offered within a brief counselling framework of six to twelve sessions. Additional sessions were sometimes offered depending on a client’s needs. The service comprised both full-time and part-time paid counsellors, and also recruited and trained volunteer counsellors to work within the service who did not receive any payment for their work other than minimal expenses, such as travelling costs. The service received core funding from the local authority, and had several contracts with local GP practices to provide counselling to their patients. The findings reported below relate to a group of volunteer counsellors operating within this agency at a specific point in time and are therefore not an evaluation of the effectiveness of the service as a whole.

Participants

Clients. Data were collected on 171 clients who attended the agency for routine counselling over a 1-year period. Of these, 53 were excluded because pre- and or post-counselling CORE-OM data were not available. The remaining 118 clients presented with a range of mental health problems, which are described later. Clients
Accessed the service via their GPs (70%), other NHS professionals (10%), local voluntary organisations (18%) and self-referrals (2%). Counselling sessions took place in a variety of locations in the local area, including the main office base of the agency, satellite offices and also in rooms in local health centres. Clients’ use of prescribed psychotropic medication was not recorded.

Counsellors. Twelve volunteer counsellors working within the agency’s counselling service were recruited to participate in this study. This group comprised 3 male and 9 female counsellors from a ‘White British/European’ background living in the local area. Counsellors’ ages ranged from 25 to 64 years, with an average age of 44 years. All participants had completed 40 hours of counselling training provided by the agency (Armstrong, 2003), which introduced participants to the general framework of the solution-focused approach (O’Connell, 1998), and also emphasised the importance of common factors (Miller, Duncan, & Hubble, 1997) in effective helping.

In addition to this basic training, five participants had certificate level training in counselling skills equivalent to 120 hours: three of whom had between 75 and 100 hours practice experience as a volunteer. At the start of this study, six counsellors did not have any prior counselling or helping experience at all (which included two counsellors who held certificate level training). Six people (including three with certificates) had completed up to 150 hours of client work. This experience was gained in the agency where this study was carried out (5 people) or through being a telephone helpline counsellor in another organisation (1 person). Counsellors contributed an average of 5 hours counselling per week, which included time for administrative tasks and supervision. Two counsellors contributed up to 10 hours per
week and saw significantly more clients than the other counsellors.

Measures

CORE Outcome Measure. The CORE-OM is a 34-item self-report measure comprising domains of subjective well-being, commonly experienced problems or symptoms, functioning and risk (Barkham et al., 2006). Items are scored on a five-point (0-4) scale defined as Not at all, Only occasionally, Sometimes, Often, and All or most of the time. An overall score can range from 0-40 and is calculated as the mean of completed item responses, which is multiplied by 10 to represent scores as whole numbers. A score of 10 has been established as a cut-off between clinical and non-clinical populations. Reliable change is defined as a pre-post difference (i.e. decrease) of five points. Clinical change is defined as movement from the clinical population (i.e. a score of 10 and above) to the non-clinical population (below 10) (Barkham et al., 2006). Internal consistency and test-retest reliability has been reported at 0.94 and 0.90 respectively (Evans et al., 2002).

Reasons for attending counselling questionnaire

This brief self-report questionnaire was designed for use in this study. It collected basic demographic information on clients, type and duration of their presenting problems and details of previous psychological help.

Client view of the outcome questionnaire

This questionnaire, constructed for use in this study, incorporated items related to the client’s perception of the overall helpfulness of counselling, their general satisfaction with their counsellor and the most and least helpful aspects of counselling.
Appendices

End of Counselling Form.

This form, designed for use in this study, was completed by counsellors at the end of counselling. It collected audit information such as the number of sessions attended and missed, reason for ending and source of referral. Free-response items were also included which invited counsellors to comment on how the counselling could have been improved and what they had learned form working with this client, for example.

Ethical considerations

Ethical approval was obtained from the Ethics Committee within the School of Social and Health Sciences of the University of Abertay Dundee. Informed consent was obtained from all participants before any data were collected. Counsellors and clients were invited in writing to participate in this study. It was emphasised that they were not required to participate, and that choosing not to be involved would not disadvantage them (as clients or volunteer counsellors) in any way. Counsellors completed an ‘In-take Form’ on recruitment to the study, which recorded basic demographic details together with information about their levels of training and experience in counselling. Over a 12-month period, all clients allocated to participating counsellors were invited to participate in the research. An information sheet about the study and consent form was posted to each client in advance of their first session. On arrival for their first appointment the counsellor asked each client if they had received the information and briefly answered any questions about the study.

Clients who consented to participate signed a consent form and then completed the ‘Reasons for Attending Counselling Questionnaire’ and the CORE-OM. Clients also
completed the CORE-OM at each subsequent session, including the last counselling session. Immediately after the last counselling session, clients completed the ‘Client View of Outcome Questionnaire’ and counsellors completed the ‘End of Counselling Form’. A comprehensive network of informal support and supervision was established for counsellors to ensure both their clients and their own wellbeing and safety.

Results
The results reported below are based, primarily, on analysis of the CORE-OM data. Pre- and post-counselling data were available for 118 of the 171 clients who were initially recruited into the study. The results reported below are based on \( n = 118 \). A limited amount of the data obtained from the self-report questionnaires described above is reported to provide relevant contextual information.

Clients’ characteristics
Clients were predominantly ‘White British/European’ (97%). Approximately 71% of clients were female, 29% were male, and the mean age was 36 years (min. 20 years, max. 65). A total of 48% of clients were either married or co-habitating, approximately 30% were single, 13% were either divorced or widowed and 9% described themselves as single parents. Almost 40% of clients were either unemployed or on sickness/ disability benefit, 55% were employed or self-employed, and the remaining 5% were classified as ‘other’ (e.g. student, retired). The majority of clients had not received previous help (58%), while 42% had seen a counsellor, psychologist or psychiatrist in the past.

Presenting problems were identified from clients’ self-reports in the ‘Reason for
Attending Counselling Questionnaire. Clients' primary presenting problems were categorised as depression (26%), anxiety/stress (18%), interpersonal/relationship issues (20%) and bereavement/loss (8%). A smaller percentage of clients presented with problems associated self-esteem (8%), trauma/abuse (5%), eating disorders (3%) and addictions (3%) and 9% of clients' presenting problems were categorised as 'other'. Clients reported experiencing their primary problem for a mean of 2.5 years (min. 3 months, max. 5 years), and attended between 1 (6 clients) and 25 (1 client) counselling sessions; the mean was 4.6.

Data on planned and unplanned endings was collected from the 'End of Counselling Form' completed by counsellors. Planned endings (i.e. agreed between client and counsellor) took place in 43% of cases. Unplanned endings (defined as clients not returning for scheduled sessions without notifying the counsellor) accounted for 44% of endings. In approximately 11% of cases clients indicated they did not want to continue with counselling. The reasons for this were not recorded. 2% of endings were categorised as other.

Unplanned endings were unevenly distributed between counsellors. Two counsellors reported more unplanned endings. Each counsellor contributed between 2 and 33 clients to the data set. The modal number of clients seen by each counsellor was 6 and the mean was 9.9.

CORE-OM data
Clients who completed the CORE-OM pre- and post-counselling showed moderate gains with a decrease in CORE scores from 18.19 (SD 06.65) to 13.49 (SD 07.90), a
difference of 4.70 (SD 0 6.57). The effect size was .70, calculated as the mean pre-post difference divided by the pre-counselling SD, which can be interpreted as a moderate effect (Cohen, 1988).

Table I shows the pre-counselling and post-counselling CORE-OM scores and effect sizes for this study, and those from the studies selected as benchmarks (Mullin et al., 2006; Stiles et al., 2006; Stiles et al., 2008). Clients presented with levels of distress in the upper range of the moderate level of distress according to CORE-OM scores (Barkham et al., 2006), which were modestly higher than clients attending NHS psychological services (see pre-counselling means column in Table I). In addition, the overall effect of counselling was roughly half of that achieved by professional therapists in the benchmark studies. For example, an effect of .70 reported in this study compared to 1.36 in Stiles et al. (2006) and 1.39 in Stiles et al. (2008). An effect size of 1.42 was calculated from the data published by Mullin et al. (2006) for CORE-OM benchmarks. The mean number of sessions attended by clients in the present study was 4.6, compared to 6.5 in the Stiles et al. studies (2006; 2008). Connell et al. (2006) estimated the average number of sessions attended in NHS counselling services to be 5.3.

Reliable and clinically significant improvement is reported in Table II. Analysis was based on all clients for whom pre- and post-CORE-OM scores were available (n 0118), including those with pre-counselling CORE-OM scores that were below the cut-off point of 10 (13.5% of clients). The rationale for doing so was to remain consistent with the way in which CORE-OM benchmarks have been calculated (Mullin et al., 2006).
Table I. CORE-OM scores and effect sizes for present and comparison studies.

<table>
<thead>
<tr>
<th>Study</th>
<th>n</th>
<th>Pre-counselling</th>
<th>Post-counselling</th>
<th>Pre-post difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
</tr>
<tr>
<td>Present study</td>
<td>118</td>
<td>18.1</td>
<td>6.6</td>
<td>13.4</td>
</tr>
<tr>
<td>Stiles et al.</td>
<td>1309</td>
<td>17.4</td>
<td>6.5</td>
<td>8.5</td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stiles et al.</td>
<td>5613</td>
<td>17.6</td>
<td>6.3</td>
<td>8.7</td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mullin et al.</td>
<td>11,953</td>
<td>17.5</td>
<td>6.3</td>
<td>8.5</td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Effect size calculated as the pre-post mean difference divided by the pre-counselling standard deviation. **Pre-post difference and effect size calculated from service benchmark data published in Mullin et al. (2006), pre-post difference SD not available

Change was evaluated by the extent to which clients' pre- to post-counselling scores reflected: (a) reliable improvement (RI) defined as decrease in CORE-OM scores of 5 or more points, (b) reliable and clinically significant improvement (RCSI) defined as a decrease of 5 or more points in CORE-OM scores and movement from the clinical (above 10) to the non-clinical range (below 10), (c) reliable deterioration defined as
an increase of 5 or more points on the CORE-OM. Clients meeting criteria for reliable change are regarded as having improved and recovered if they meet the criterion for RCSI. Both categories are combined in column three in Table II to show the overall percentage of clients that showed improvement.

It should be noted that in the Stiles et al. studies (2006, 2008), the figure of 4.8 was used as the criteria to measure reliable change in terms of CORE-OM scores. This is in keeping with previous practice (Barkham et al., 2006). Recently, the figure of 5 has been recommended because it is easier to calculate and more practitioner-friendly (Mullin et al., 2006). It is also the figure used to calculate CORE-OM benchmarks (Mullin et al., 2006). For these reasons, the figure of 5 has been adapted in this study.

Approximately 48% of clients recovered or improved, over 30% achieved RCSI and almost 18% achieved RI alone. A total of 44% of clients did not achieve reliable change and more than 7% showed reliable deterioration. Compared to CORE-OM benchmarks (Mullin et al., 2006), data from the present study suggest that the present sample of paraprofessional counsellors were operating within the bottom quartile or 25% of services, where less than 49% of clients achieve the criterion for recovery. In addition, the percentages of clients in the present study that had unplanned or premature endings (57%) and whose CORE-OM scores showed reliable deterioration (7.62%) are significantly higher than existing benchmarks, which are 49% and 1.8% respectively (Connell et al., 2006; Mullin et al., 2006).

An independent samples t-test was conducted to assess the outcomes achieved for clients with planned versus unplanned endings. Results showed a statistically
significant result, in that clients who had planned endings achieved a mean decrease of 7.0 points on CORE-OM scores at the end of counselling, compared to a mean of 3.7 for those with unplanned endings ($t_0(2.64, df 0101, p 0.009)$).

Table II. Reliable and clinically significant improvement for present and comparison studies.

<table>
<thead>
<tr>
<th>Study</th>
<th>n</th>
<th>Recovered or improved</th>
<th>RCSI</th>
<th>Reliable improvement only</th>
<th>No reliable change</th>
<th>Reliable Deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Count</td>
<td>%</td>
<td>Count</td>
<td>%</td>
<td>Count</td>
</tr>
<tr>
<td>Present Study</td>
<td>118</td>
<td>57</td>
<td>48.3</td>
<td>36</td>
<td>30.5</td>
<td>21</td>
</tr>
<tr>
<td>Stiles et al.</td>
<td>1309</td>
<td>905</td>
<td>79.5</td>
<td>693</td>
<td>61</td>
<td>212</td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stiles et al.</td>
<td>5613</td>
<td>3,847</td>
<td>77.7</td>
<td>2,887</td>
<td>58.3</td>
<td>960</td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Mullin et al.</td>
<td>11,953</td>
<td>*</td>
<td>72.2</td>
<td>*</td>
<td>53.0</td>
<td>*</td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* *n not provided in Mullin et al. (2006).*

Discussion
This study used a benchmarking strategy to evaluate the comparative effectiveness of paraprofessional and professional counsellors. Three published studies (Mullin et al., 2006; Stiles et al., 2006; Stiles et al., 2008) that used the CORE-OM to evaluate the outcomes achieved by professional counsellors were selected as benchmarks against which the findings of this study were interpreted and evaluated. Results indicated that professional counsellors produced approximately twice the effect of the volunteer counsellors in the present study. It is important to note that clients that had planned endings improved the most, and that client levels of distress at intake were comparable to clients attending statutory counselling/psychological services: a finding that has been reported in other studies of counselling in voluntary agencies (e.g. Gardiner et al., 2003; Moore, 2006).

Overall, the results of this study challenge the general finding from previous research that paraprofessional counsellors can achieve similar outcomes to their professional counterparts. Findings from previous research may help to account for the apparent poor performance of this group of paraprofessionals compared to the selected benchmarks. Specifically, research evidence suggests that paraprofessional counsellors are more effective in longer term treatments (Berman & Norton, 1985), that length of training and experience are important factors in determining their effectiveness (Hattie, Sharpley, & Rogers, 1984), and that training may facilitate client retention and briefer therapy (Atkins & Christensen, 2001).

The fact that this group of paraprofessional counsellors had limited training and experience, were working within a brief framework with clients who were approaching the moderate-severe range of distress in terms of CORE-OM scores, may
be significant factors in explaining their lack of effectiveness compared to the selected benchmarks for professional therapists, and the greater percentages of unplanned endings and levels of client deterioration. Indeed, complementary evidence from a qualitative study into the experiences of the counsellors in the present study of working with clients in their first year of practice suggests that they quickly exhausted their limited repertoire of counselling skills/strategies and felt unable to respond helpfully to clients that were experienced as difficult, ambivalent about change or who did not seem to be responding to counselling (Armstrong, 2006).

Previous research findings also suggest that paraprofessional counsellors may be most effective when delivering structured treatment programmes under supervision (Durlak, 1979; Lambert & Bergin, 1994). In the present study, paraprofessionals employed a solution-focused approach, which tends to be highly structured. However, it is possible that the levels of client distress at in-take combined with their limited training and experience and a rigid adherence to the solution-focused approach may have compromised their effectiveness. Also, a significant proportion of clients in the present study were either unemployed or on sickness or disability benefits (40%). This may be an important factor to consider when interpreting the results of this study because there is some evidence to suggest that unemployed people benefit less from counselling than those in work (McLeod, Johnston, & Griffin, 2000; Saxon, Ivey, & Young, 2008). More generally, it may be that this group of paraprofessionals were ill-equipped to respond effectively within a brief therapy framework to the broad range of clients and levels of distress they encountered in practice.
This study is based on a limited number of counsellors, and a relatively small sample of client data collected in one agency over a restricted period of time. In addition, no attempt was made to monitor or control for counsellors in-session activities, case mix or levels of clients’ distress across individual counsellors’ caseloads. Hence, some caution is warranted in interpreting the results in relation to these benchmarks. In particular, the CORE-OM benchmarks (Mullin et al., 2006) have been defined in relation to brief counselling carried out in primary care settings and, therefore, may not be appropriate to all voluntary sector counselling agencies where different organisational and contextual factors may be operating (Evans, 2006). Such factors might include differences in the type, mode and duration of counselling being offered, levels of clients’ distress, client employment status, and differences in the levels of support, supervision, training and experience of counsellors.

Furthermore, as Barkham (2006) has noted, benchmarks are not precise measurements and should therefore be treated with caution. In relation to both the CORE-OM benchmarks (Mullin et al., 2006), and the Stiles et al. studies (2006, 2008), it should be noted that details of therapists levels of training and experience were not reported. To make more valid comparisons between professional and paraprofessional counsellors, it will be necessary to have data on professional counsellors’ levels of experience and training in particular.

Implications for practice

Given the limitations of this study, the following implications for practice are offered tentatively. First, findings from this study suggest that paraprofessional counsellors working in mental health settings may benefit from longer training programmes than
the 40 hours offered to participants in this study prior to engaging in practice. Such training might, for example, pay particular attention to helping paraprofessionals develop their relational competence, ability to engage and monitor clients' involvement in therapy, and where possible to negotiate planned endings with clients. In addition, it may be advantageous to assist paraprofessionals to develop therapeutic skills that facilitate their ability to work effectively with the type of problems clients typically present with within their particular agency. Furthermore, initial training could be supplemented by ongoing training to assist paraprofessionals to expand their repertoire of therapeutic skills.

Second, more careful selection and matching of clients to paraprofessionals’ levels of competence and experience may prove beneficial in ensuring inexperienced paraprofessional counsellors are not overwhelmed by their clients’ problems. This may help paraprofessionals to build a sense of self-efficacy and competence through experiencing successful outcomes with minimally distressed clients in the initial stages of their practice and development. Third, where paraprofessional counsellors are working within a brief therapy framework, consideration might be given to the assessment of clients, in terms of their readiness for change and appropriateness for brief therapy. Finally, ongoing informal support and supervision are crucial to monitor and support paraprofessionals in practice.

Conclusion

The benchmarking strategy employed in this study provided a valuable and practical means of evaluating the comparative effectiveness of paraprofessional versus professional counsellors. Further benchmarking studies are required to determine the
extent to which the findings reported here are applicable to other voluntary sector counselling agencies, where paraprofessional or volunteer counsellors possess a similar profile in terms of levels of training and experience. More specific research is also required to determine the effectiveness of paraprofessional counsellors with specific client groups. Over time such research may help to create benchmarks that reflect the diversity of practice and practitioners that exist within this sector and identify the type and level of training paraprofessionals require to practice effectively.

References


Durlak, J.A. (1979). Comparative effectiveness of paraprofessional and professional
Appendices


Psychotherapy. Counselling and Health, 3, 263-278.


**Appendix B: CORE-OM**

**SAMPLE**

<table>
<thead>
<tr>
<th>CLINICAL</th>
<th>OUTCOMES in ROUTINE EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site ID</td>
<td>letters only numbers only</td>
</tr>
<tr>
<td>Client ID</td>
<td>numbers only 1</td>
</tr>
<tr>
<td>Therapist ID</td>
<td>numbers only 1</td>
</tr>
</tbody>
</table>

**| Stage Completed |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
</tr>
<tr>
<td>Referral</td>
</tr>
<tr>
<td>Assessment</td>
</tr>
<tr>
<td>First Therapy Session</td>
</tr>
<tr>
<td>Pre Therapy Overview</td>
</tr>
<tr>
<td>During Therapy</td>
</tr>
<tr>
<td>Last Therapy Session</td>
</tr>
<tr>
<td>Follow up 1</td>
</tr>
<tr>
<td>Follow up 2</td>
</tr>
</tbody>
</table>

**| Date form given |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage</td>
</tr>
<tr>
<td>Episode</td>
</tr>
</tbody>
</table>

**IMPORTANT - PLEASE READ THIS FIRST**

This form has 34 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this.

*Please use a dark pen (not pencil) and tick clearly within the boxes.*

**Over the last week**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>Yes Some</th>
<th>No</th>
<th>No</th>
<th>Not at all</th>
<th>Not True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 I have felt terribly alone and isolated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 I have felt tense, anxious or nervous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 I have felt I have someone to turn to for support when needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 I have felt O.K. about myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 I have felt totally lacking in energy and enthusiasm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 I have been physically violent to others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 I have felt able to cope when things go wrong</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 I have been troubled by aches, pains or other physical problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 I have thought of hurting myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Talking to people has felt too much for me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Tension and anxiety have prevented me doing important things</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 I have been happy with the things I have done.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 I have been disturbed by unwanted thoughts and feelings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 I have felt like crying</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please turn over**
SAMPLE

Over the last week

<table>
<thead>
<tr>
<th>Item</th>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have felt panic or terror</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Made plans to end my life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have felt overwhelmed by my problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have difficulty getting to sleep or staying asleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have felt warmth or affection for someone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems have been impossible to put to one side</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have been able to do most things I needed to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have threatened or intimidated another person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have felt despairing or hopeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thought it would be better if I were dead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have felt criticised by other people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have thought I have no friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have felt unhappy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unwanted images or memories have been distressing me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have been irritable when with other people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have thought I am to blame for my problems and difficulties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have felt optimistic about my future</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have achieved the things I wanted to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have felt humiliated or shamed by other people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have hurt myself physically or taken dangerous risks with my health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Total Scores
Mean Scores

(Scale scores for each dimension divided by 
number of items completed in that dimension)
Appendix C: Reasons for attending counselling questionnaire

Your Reasons for Attending Counselling Questionnaire

Please complete this form before your first session with your counsellor. These questions attempt to understand your primary reasons for attending counselling. It provides space for you to identify two reasons only in order to prevent the questionnaire being too long or complex. Whatever you write in this questionnaire is confidential and will be used only for research purposes. Individuals will not be identifiable in any research reports. Your counsellor will not know what you write about on this form unless you choose to tell them.

If, for any reason, you prefer not to complete this questionnaire please tick the box below and, if possible, tell us your reasons for deciding not to do so.


RAC 3. I decided not to complete this form [ ] Reason:

Please ensure you complete the following details:

RAC 4. Age: ______  RAC 5. Gender:  Male []  Female []

RAC 6. Marital Status: (please tick appropriate box)

Single []  Married []  Co-habiting []
Divorced []  Widowed []  Single Parent []

RAC 7. Employment Status: (please tick appropriate box)

Employed []  Self-employed []  Unemployed []  Student []
Retired []  Housewife or husband []  On Sickness/disability benefits []

RAC 8. Ethnicity (please tick appropriate box)

Asian (Bangladeshi) []  Asian (Indian) []  Asian (Pakistani) []
Asian (E. African) []  Asian (Chinese) []  Black (African) []
Black (Caribbean) []  White (British/European) []  Other []

RAC 9. Have you had help in the past for emotional, psychological or mental health problems?

Yes [ ]  No [ ]
If yes, please say what this was:

RAC 10. What is your major problem/issue or reason for attending counselling?

...continued
Appendices

RAC 11. How distressing is it?

1  2  3  4  5  6  7
Not at all distressing  Very distressing

RAC 12. How much difficulty does it cause in your life now?

1  2  3  4  5  6  7
Not at all difficult  Very difficult

RAC 13. How long, in approximate weeks or months, has it been an issue for you?

Number of Weeks: _______  Number of Months: _________

RAC 14. If there is a 2nd problem/issue or reason please say what it is?

RAC 15. How distressing is it?

1  2  3  4  5  6  7
Not at all distressing  Very distressing

RAC 16. How much difficulty does it cause in your life now?

1  2  3  4  5  6  7
Not at all difficult  Very difficult

RAC 17. How long, in approximate weeks or months, has it been an issue for you?

Number of Weeks: _______  Number of Months: _________

RAC 18. Overall, how hopeful are you that counselling will help?

1  2  3  4  5  6  7
Not at all hopeful  Very hopeful

Please comment briefly on your answer

RAC 19. Are there any comments you would like to record at this stage?
Appendix D: Client view of outcome of counselling questionnaire

Your View of the Outcome of Counselling

Please complete this form after your last session with your counsellor. These questions attempt to understand your view of the counselling you have received. Whatever you write in this questionnaire is confidential and will be used only for research purposes. Individuals will not be identifiable in any research reports. Please remember that your counsellor will not know what you write about on this form unless you choose to tell them. It is important that you are honest about your answers regardless of whether they seem positive, negative or just indifferent. This will help us to gain as true a picture as possible about the effectiveness of our service.

If you prefer not to complete this questionnaire please tick the box below and, if possible, tell us your reasons for deciding not to do so.

CVO 3. I decided not to complete this form [ ] Reason:

__________

CVO 4. How helpful has the counselling been to you overall?

1 2 3 4 5 6 7
Not at all helpful Very Helpful

CVO 5. What was there, if anything, about the counselling that you found particularly useful?

CVO 6. What aspects, if any, of counselling were particularly unhelpful?

CVO 7. To what extent were you satisfied with your counsellor?

1 2 3 4 5 6 7
Not at all satisfied Very satisfied

CVO 8. To what extent would you recommend your counsellor to a close friend who was having difficulties similar to you own?

1 2 3 4 5 6 7
Poor Recommendation High Recommendation

CVO 9. In general terms, what was your major problem/issue or reason for attending counselling?

CVO 10. How distressing is it now?

1 2 3 4 5 6 7
Not at all distressing Very distressing ...continued
Appendices

CVO 11. How much difficulty does it cause in your life now?

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<td>Not at all difficult</td>
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CVO 12. To what extent has it improved?

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CVO 13. To what extent do you think that this has been to do with the counselling you received?

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CVO 14. If there was a 2nd problem/issue or reason for attending counselling please say what it was?

CVO 15. How distressing is it now?

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<td>Not at all distressing</td>
<td>Very distressing</td>
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CVO 16. How much difficulty does it cause in your life now?

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<td>Not at all difficult</td>
<td>Very difficult</td>
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CVO 17. To what extent has it improved?

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CVO 18. To what extent do you think that this has been to do with the counselling you received?

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<td>Not at all</td>
<td>Completely</td>
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CVO 19. Would you like to make any further comments about counselling? (please use additional sheets if necessary)

Thank you for your co-operation.
Appendix E: End of counselling form

Counsellor End of Counselling Form

Please complete this questionnaire immediately after the client has stopped coming to see you. It will allow comparisons between this and similar information collected from the client. As with all parts of this study the client has been informed that they will not have to discuss their answers with their counsellor, unless they wish to do so. Whatever you write in this questionnaire is confidential and will be used only for research purposes. Individuals will not be identifiable in any research reports. When the research study is completed you will have an opportunity to learn about the results. If, for any reason, you do not feel it to be appropriate to complete this form please record the reason for this decision on the blue Admin Checklist form.


CPC 3. Date completed  CPC 4. Total number of Sessions Attended

CPC 5. Total number of Missed Sessions  CPC 6. Reason for ending:

Planned Ending [ ] E.g., from the outset, agreed during counselling, agreed at last session. Please outline reason in box

Unplanned Ending [ ] E.g., due to loss of contact, client did not wish to continue, crisis in client's life. Please outline reason in box.

CPC 7. How helpful has the counselling been to the person overall?


CPC 8. What was the person's primary problem or issue?

CPC 9. How distressing has it been for them?


CPC 10. How difficult does it make life for them now?


CPC 11. To what extent has it improved?


...continued over/
Appendices

CPC 12. To what extent do you think this has been to do with the counselling they received?

1  2  3  4  5  6  7
Not at all Completely

CPC 13. If there was a second problem or issue for which the person sought help, what was it?

CPC 14. How distressing has it been for them?

1  2  3  4  5  6  7
Not at all distressing Very distressing

CPC 15. How difficult does it make life for them now?

1  2  3  4  5  6  7
Not at all difficult Very difficult

CPC 16. To what extent has it improved?

1  2  3  4  5  6  7
Much Worse Much improved

CPC 17. To what extent do you think this has been to do with the counselling they received?

1  2  3  4  5  6  7
Not at all Completely

CPC 18. In what ways, if at all, could the counselling have been improved in order to have made it more helpful?

CPC 19. Did you take this case to supervision? Yes [ ] No [ ]

If yes, after which session? Session number __________

In what ways, if at all, was this helpful or unhelpful?

CPC 20. Are there any other issues of comments you would like to record at this stage? (e.g. about the client/their issues/your reaction to client/how you felt about working with this client/your approach/sense of competence etc. etc.) Please use additional sheets if required.

Thank you
Appendix F: Client information sheet and consent form

Client Information Sheet
&
Consent Form

MHSS Counselling Service regularly evaluates its effectiveness to ensure it continues to deliver and develop the best possible services to the people who seek help for their difficulties and concerns.

We hope you will agree to complete the necessary questionnaires, but would like to emphasise that participation is entirely voluntary and declining to complete them will not effect your counselling in any way. There is no penalty for refusal to participate and you are free to withdraw your consent and discontinue participation at any time.

However, the more people that complete questionnaires, the more comprehensive the information is for improving the service for future clients.

About our evaluation:

☐ We would like you to complete two brief questionnaires before and after your contact with our counselling service. These questionnaires will be repeated each time your visit you counsellor.

☐ Your responses to questionnaires help us to understand:
  • More about the problems that counselling is required to address
  • The problems that counselling is most effective in helping
  • The level of effectiveness of our service and the way in which it can be improved

☐ The processing of completed questionnaires is being undertaken by Joe Armstrong as part of his PhD Degree in Counselling Studies, under the supervision of Professor John Mcleod and the School of Social and health Sciences at the University of Abertay, Dundee, UK.

☐ The information from the questionnaires will be treated as strictly confidential. No names are used on the questionnaires and no one other than ourselves and people involved in the research will have access to your responses. The results of this research will be used in preparation of a MHSS Counselling Service Evaluation report and a PhD thesis and may be published or reported to scientific bodies, but you will not be identified in any such publications or reports.

☐ When the research study is completed you will have an opportunity to learn about the results.
If at any time you have questions about any procedure in this study you may contact the investigator, Joe Armstrong, at (MHSS telephone number) or write to him at (MHSS address). Alternatively, if you are concerned that any procedure in this study is violating your welfare then you may contact Professor John McLeod, Chairman of the School and Health Sciences Ethics Committee, at 01382 308000 (switchboard) or write to him at, University of Abertay, Marketgait House, 158 Marketgait, Dundee, DD1 1NJ.

Name: ________________________________

Signature: ____________________________

Date: ________________________________

Please sign both copies and retain one for yourself. Please return the other one to your counsellor at your first visit.
Appendix G: Counsellor information sheet and consent form

Counsellor Information Sheet

As part of a PhD Degree in Counselling Studies with the University of Abertay, Dundee, I am conducting research into the effectiveness and development of MHSS volunteer counsellors. This research aims to build on the previous MHSS counselling training study and to find out more about the relationship between training and the effectiveness of volunteer counsellors, and also to understand more about the overall experience of working as a volunteer mental health counsellor.

I hope you will agree to participate in this study, but would like to emphasise that participation is entirely voluntary and declining to participate will not affect your work as a volunteer counsellor with MHSS in any way.

About the research study

Please note that the time needed to fulfil the requirements of this research will be incorporated within your allocated working hours with the counselling service.

Should you agree to participate in this research, which will last for approximately one year, you will also be asked to complete the following:

Questionnaires

1. **Before you enter the study** you will be asked to complete a 'one-off' questionnaire called the "Counsellor In-take Questionnaire" (Form CIQ). This records basic information on volunteer characteristics, for example: age; gender; ethnicity, counselling experience and so on. (Many participants will have completed a similar questionnaire during the training study and some information is repeated here for accuracy and consistency for research purposes).

2. **After the first session for each client** you will be asked to complete a questionnaire entitled: the "Counsellor Assessment Questionnaire"(Form CAQ). This brief questionnaire will ask you to describe and rate (on a scale) clients presenting and secondary problems & concerns.

3. **After the last session for each client** you will be asked to complete a questionnaire called the "Counsellor Post-Counselling Questionnaire"( Form CPCQ). This short questionnaire follows up the assessment questionnaire and assesses counsellors' perceptions of client change in relation to the counselling offered.

Interviews

Toward the end of your first year in practice you will be invited to attend an interview with the researcher, Joe Armstrong, which will be audio recorded, to talk about your overall experience of becoming a volunteer counsellor, and to explore your experience of entering practice and client work.
Appendices

Your responses in the questionnaires together with what you discuss in any interviews with the researcher will be confidential and used only for research purposes. When the research study is completed you will have an opportunity to learn about the results.

If you would like to participate please sign below and return this form to Joe Armstrong at MHSS in the envelope provided.

Important
Please note that by signing this form you are indicating that you:

- Understand that your responses in any questionnaires, together with what you discuss in any interviews with the researcher, will be confidential and used only for research purposes. When the research study is completed you will have an opportunity to learn about the results.

- Are aware that although the results of this research will be used in preparation of a PhD thesis/MHSS Counselling Service Evaluation report and may be published or reported to scientific bodies, you will not be identified in any such publications or reports.

- Know that your participation is voluntary and that there is no penalty for refusal to participate and that you are free to withdraw your consent and discontinue participation at any time.

- May contact the investigator, Joe Armstrong, at (MHSS telephone number) or write to him at (MHSS address) if, at any time, you have questions about any procedure in this research. Alternatively, if you are concerned that any procedure in this study is violating your welfare then you may contact Professor John McLeod, Chairman of the School and Health Sciences Ethics Committee, and supervisor for this research at 01382 308000 (switchboard) or write to him at, University of Abertay, Marketgait House, 158 Marketgait, Dundee, DD1 1NJ.

Research participant

Name: .................................................. Date: ..................................................

Signature: ..................................................
Appendix H: Counsellor in-take form

Counsellor In-Take Questionnaire

This questionnaire should be completed before you enter the research study. It is intended to collect baseline information on all participants, which will be used to compare the characteristics of counsellors in this study with counsellors in other studies and contribute to our understanding of what contributes to counsellor effectiveness.

Whatever you write in this questionnaire is confidential and will be used only for research purposes. Individuals will not be identifiable in any research reports. When the research study is completed you will have an opportunity to learn about the results.

Once you have completed the questionnaire, make sure you sign it and return it to Joe Armstrong in the sealed envelope provided.

Your Details

Name: ___________________________ 1. Counsellor Code: __________

2. Age: _____

3. Gender: Male [ ] Female [ ]

4. Marital Status: (please tick appropriate box)
   - Single [ ] Married [ ] Co-habitating [ ]
   - Divorced [ ] Widowed [ ] Single Parent [ ]

5. Employment Status: (please tick appropriate box)
   - Employed [ ] Self-employed [ ] Unemployed [ ]
   - Student [ ] Retired [ ] Housewife or husband [ ]
   - On Sickness/disability benefits [ ]

6. Ethnicity (please tick appropriate box)
   - Asian (Bangladeshi) [ ] Asian (Indian) [ ] Asian (Pakistani) [ ]
   - Asian (E. African) [ ] Asian (Chinese) [ ] Black (African) [ ]
   - Black (Caribbean) [ ] White (British/European) [ ] Other [ ]
Education

7. Please give details below of any academic or professional qualifications (except counselling related courses, which is detailed in the next section) you have achieved, since leaving school. Please use additional sheets if necessary.

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<th>Post-School Education</th>
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Counselling Training

8. Previous Counselling Training

Have you had any prior training in counselling or counselling skills apart from MHSS Volunteer Counsellor training?

Yes [ ]    No [ ]

*If yes please list the details of each training event in the table below.*
### Appendices

<table>
<thead>
<tr>
<th>Name of Course</th>
<th>Institution</th>
<th>Dates From-To</th>
<th>Type of Training (please tick appropriate box)</th>
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<td>Workshop (E.g. One/two day events)</td>
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#### Counselling Experience

**9. Previous Experience**

Have you had any prior experience of working with people who are experiencing emotional or psychological problems (either paid or as a volunteer), including any work with MHSS?

Yes [ ] No [ ]

*If yes please state what this was:*

**10. Approximately, how many counselling hours have you completed to date?**

None [ ] Less than 25 [ ] 25 to 50 [ ] 50 to 75 [ ] 75 to 100 [ ]

100 to 125 [ ] 125 to 150 [ ] 150 to 175 [ ] 175 to 200 [ ] 200 to 250 [ ]

More than 250 [ ]

**11. On average, how many hours do you spend counselling on a weekly basis?**

None [ ] less than 5 [ ] 5 to 10 [ ] 10 to 15 [ ] 15 to 20 [ ]

More than 20 [ ]
12. Over what period of time have you accrued this counselling experience?

   *Number of years* _____   *Number of months* _____

13. Where have you gained this experience (*tick both boxes if necessary)*?

   [ ] MHSS Counselling Service  [ ] Other service  *Please specify:*

14. What percentage of your counselling experience has been gained at MHSS?

   _____%

15. What percentage of your counselling experience has been gained elsewhere?

   _____%

*SPACE FOR ANY ADDITIONAL COMMENTS ABOUT YOURSELF, YOUR COUNSELLING ROLE, OR ABOUT THIS STUDY IN PARTICULAR.*

Thank you for your co-operation.

Please return this questionnaire to Joe Armstrong in the envelope provided.
Appendix I: Interview schedule for Study 2

Introduction
I’m interested in your story about your experience of becoming a volunteer counsellor here at MHSS.

Initial open-ended questions
1. First of all, could you tell me about your interest in counselling and what lead you to decide to become a volunteer counsellor?
2. What, if anything, do you think were the key events or experiences in your life that influenced your decision to become a volunteer counsellor?
3. Who, if anybody, influenced your decision or stimulated your interest in counselling?
4. Could you say something about what, if anything, you were hoping to get from volunteering as a counsellor with MHSS?

Focused questions

Training
1. Take a moment to think back to the training you completed here at MHSS a year ago, and describe what comes to mind about the training and its impact on you.
2. What were your thoughts and feelings regarding the solution-focused approach that you were introduced to in the MHSS training? How did this approach ‘sit’ with you?
3. In terms of preparing you to see clients, what were:
   a. the most useful aspects of the training, as you see it now?
   b. the least helpful aspects of the training, as you see it now?
4. In what ways, if at all, has the MHSS training been important to your development as a counsellor during the last year?
5. Do you have any plans to pursue further counselling training?

Practice
1. Tell me about your experience entering practice and seeing clients?
2. What, if anything, has seeing clients taught you about counselling and the role of the counsellor?
3. Tell me about how you used solution-focused ideas in your client work? In what ways were these ideas useful? In what ways were these ideas unhelpful or challenging to use?
4. To what extent, if at all, is your counselling practice influenced now by solution-focused ideas?
5. Overall, how would you describe your approach to counselling?
6. What, if anything, were the positive things you experienced in relation to seeing clients/entering practice? What, if anything, were the difficult or challenging things you encountered in relation to seeing clients/entering practice? How did you handle these experiences?
7. Tell me about your estimation of your effectiveness as a counsellor? What has contributed most to your effectiveness, as you see it?
8. What kinds of activities, if any, do you engage in to promote your development as a counsellor? (e.g., keeping a journal, supervision, personal therapy, additional training, etc.).
MHSS Agency
1. Tell me about your impressions of the MHSS agency, and your experience of being a volunteer here?
2. What, if anything, has been positive about your experience of the MHSS agency?
3. What, if anything, has been negative about your experience of the MHSS agency?

Ending questions
1. Is there anything else you would like to add about your experience of becoming a volunteer counsellor here at MHSS that might be useful for me to know?
2. Overall, how would you describe your experience of being a volunteer counsellor here at MHSS?
3. What are the main things you have learned so far about being a volunteer counsellor?
4. Where do you see yourself going from here in relation to being a volunteer counsellor?

Thank you for your time.