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Evaluation of long-term counselling at a community health service for women who are on a low-income

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Abstract

Aims. Given the lack of research evaluating long-term counselling, coupled with the lack of women-only counselling services, the present study evaluated the long-term counselling service offered by a women-only community health centre. Method. The research ascertained: 1) the characteristics of 155 service users pre-counselling, 2) the views and experiences of 75 service users post-counselling and 3) pre-post-counselling clinical change in 98 service users via the Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM). Results. Unemployment, low income and reports of abuse were related to poorer mental health as measured by the CORE-OM. Content analysis of open-ended questions revealed that women felt supported, comfortable and gained insight through the counselling relationship. They also reported positive changes in their lives, relationships, health behaviours, and psychological wellbeing. Post-counselling improvements were found in CORE-OM scores. Conclusions. Long-term counselling in a women-only environment for socially disempowered women may be beneficial. A research-informed approach to counselling and therapy evaluation, which acknowledges the social context of psychological distress, should be taken across institutions.

Keywords: abuse, CORE-OM, long-term counselling, low income, women

Introduction

According to the Department of Health (2002), certain groups of women, such as those who have experienced violence or abuse or those who lack paid employment, or are socially isolated/deprived are particularly at risk of experiencing mental health issues. However, most studies evaluating counselling neglect groups on a low-income (McLeod, Johnston & Griffin, 2000). An evaluation of brief counselling in a sample of individuals on a low-income (68% unemployed) found post-counselling improvements in mental health, although employed service users showed the greatest improvements (McLeod et al., 2000). Winter et al. (2003) found no differences in improvement in Clinical Outcomes in Routine Evaluation - Outcome Measure scores (CORE-OM) between disadvantaged groups and non-disadvantaged groups undergoing psychodynamic counselling. However, the disadvantaged group had poorer pre-counselling CORE-OM scores. McLeod et al. (2000) concluded that any under-use of counselling services among groups on a low-income is more likely to be due to issues of access (e.g. payment, location) and perceptions of counselling, than to difficulties in the counselling process or therapeutic relationship.

Of particular concern to women who are on a low-income are issues such as poor social support and emotional and sexual abuse (McCarthy, Reese, Schueneman & Reese, 1991). The psychological problems of women survivors of childhood sexual abuse include low self-esteem, depression, suicidal feelings and behaviours, and substance abuse (Molnar, Buka & Kessler, 2001). Counselling for women in such circumstances may be helpful (Peleikis & Dahl, 2005) but women with multiple abuse histories tend to make fewer gains (Bagley & Young, 1998).

Providers of mental health services to women in the UK describe 72% of the needs of women using these services as being linked to their gendered lives and experiences (Williams & Waterhouse, 2000). Thus women-only services may be important. A survey of 35 Rape

Crisis Centres found that after using the service, women reported improved mental well-being, reduced self-harm and increased employment (Women's Resource Centre, 2008). A survey of 101 women-only organisations showed they provided a sense of safety, support and understanding of women's needs, which increased self-esteem and empowered women (Women's Resource Centre, 2007). Many service users said they would not use mixed services and 97% felt that women who have been sexually assaulted should have access to a women-only service. This need for women-only mental health services has been acknowledged by the UK's Department of Health (2002), yet they remain relatively scarce. Evaluation studies may support the maintenance of existing services and the creation of new ones.

Services for women are often provided by voluntary and community organisations, which are vital to meet the demand for counselling (Tan, 1997). In voluntary organisations, practice-based evaluation studies are common. For practical and ethical reasons they are arguably more suitable than Randomised Controlled Trials (cf. Westen et al., 2004; Vanheule, 2009). Since benchmarking on standardised measures of outcome is now available (Mullin, Barkham, Mothersole, Bewick & Kinder, 2006), this may be used in such studies.

Armstrong's (2010) evaluation of outcomes from counselling offered by volunteer, paraprofessional counsellors, showed significant improvements in CORE-OM scores, with 48% of clients showing improvement or recovery. This is compared to a rate of 72-80% in three evaluations of counselling in UK NHS primary care services (Mullin et al., 2006; Stiles, Bower, Mellor-Clark, Heywood & Hardy, 2006, Stiles, Barkham, Mellor-Clark & Connell, 2008). Winter et al. (2003) evaluated brief psychodynamic counselling offered by a large voluntary organisation and also found significant improvements in clients' CORE-OM scores. However, studies should also examine service users' views and experiences (Edwards & Staniszewska, 2000; Vanheule, 2009).

McLeod et al. (2000) found that themes that emerged from clients' experiences of brief counselling included the importance of having someone to talk to, being able to express emotion, gaining a broader perspective on a problem, and developing self-confidence. Archer et al. (2000) found that aspects of psychodynamic counselling in a large voluntary organisation perceived to be most useful included unconditional positive regard, catharsis, re-interpretation of material, and finding time for oneself. Perceived changes following counselling included changes in emotional state, 'internal' life, relationships and life changes. Gallagher, Tracey and Millar (2005) found that perceptions of the outcomes of bereavement counselling were viewed positively by 60-80% of service users. They viewed the counselling relationship positively, in terms of trust, honesty, helpfulness, and experience.

The services in most of these studies offered relatively short-term counselling. Investment in the Improving Access to Psychological Therapies programme (IAPT) in the UK (Department of Health, 2008), with its emphasis on short-term Cognitive Behavioural Therapy (CBT), means that the NHS generally offers only short-term treatment. NHS counselling has been found to lead to modest short-term improvements (e.g. Bower, Rowland & Hardy, 2003). Westen et al. (2004) and Vanheule (2009) suggest that financial concerns and the attempt to compare psychotherapy to pharmaceutical treatments are what drive this emphasis on short-term therapy, rather than our knowledge about the inner dynamics of the psychotherapeutic process. Yet little research has evaluated longer-term treatment, although studies of psychoanalytic therapy over a number of years suggest that it can result in lasting changes in mental and social functioning (e.g. Blomberg, Lazar & Sandell, 2001). Thus, more evaluations of long-term counselling are valuable.

In view of the lack of research evaluating longer-term counselling, and the lack of women-only counselling services in the UK, the present study evaluated the long-term counselling offered by a community, voluntary, women-only, health centre. The study aimed

to: 1. determine the characteristics of service users pre-counselling, and test whether unemployment, lower income, and having experienced abuse are related to poorer mental health, 2. ascertain the views and experiences of service users post-counselling, and 3. test the effectiveness of the service through examining pre-post-counselling change in mental health.

Method

The service

This service is situated in an inner-London Borough. Service users tend to be women with psychiatric diagnoses, a history of abuse, and inadequate social support. The service provides psychological and physical treatments including homeopathy, acupuncture, massage and long-term low-cost counselling (up to 90 sessions over two years). The centre is staffed by 39 female counsellors, who are mostly volunteers and approximately one-third are trainees. Counsellors are trained in diverse theoretical orientations including psychoanalytic, attachment, Gestalt, person-centred, existential, and integrative approaches.

Samples

All 550 women having counselling at the service between December 2003 and May 2010 were posted a pre-counselling questionnaire and CORE-OM to complete and return. The questionnaires were anonymous but given a code to enable matching of pre- and post-counselling questionnaires. Approximately 300 service users who finished counselling between December 2004 and June 2010 were sent a post-counselling questionnaire and CORE-OM to complete and return. Written informed consent was obtained from all participants and ethical approval for the research was granted by the authors' University's ethics committee.

Three samples were formed to address the three aims of the research:

1. Sample 1 (the pre-counselling sample), to address research aim 1 consisted of 155 service users (28% response rate) who completed the pre-counselling questionnaire and CORE-OM.
2. Sample 2 (the post-counselling sample), to address research aim 2 consisted of 75 services users (25% response rate) who completed the post-counselling questionnaire and CORE-OM.
3. Sample 3 (the pre-post counselling sample), to address research aim 3 consisted of 98 service users who completed the CORE-OM both pre- and post-counselling. This included 38 service users from samples 1 and 2 who completed both pre- and post-counselling questionnaires and CORE-OMs (a response rate of 13%), and 60 service users who completed only the CORE-OM pre- and post-counselling (but did not complete the other measures).

The samples did not differ on any demographic variables. Additionally, pre-counselling CORE-OM scores did not differ across samples 1 and 3, nor did post-counselling scores differ across samples 2 and 3 (all p values > .05). Thus women who, for example, decided to participate in the study both pre- and post-counselling (i.e. sample 3) do not appear to be different in some way, such as psychologically more or less healthy, than women who decided to participate only once. Since these non-significant results do not show anything, for reasons of brevity, they are not reported.

Measures

Pre-counselling questionnaire. This assessed demographics, including ethnicity, living arrangements, number of children, household income, employment, and history of physical, sexual and mental abuse. Each type of abuse was defined and then for each type service users were asked whether they had experienced abuse, the age of first and most recent abuse, whether it occurred on more than one occasion and was by more than one person.

Post-counselling questionnaire. This assessed the same demographics as the pre-counselling questionnaire, and also satisfaction with the counselling and the relationship with the counsellor, both measured on a scale ranging from very good (1) to very bad (5); an open-ended question subsequently asked why they felt this way about the relationship with their counsellor. The questionnaire also asked three open-ended questions about whether there had been any major life changes and any important changes in physical health since starting counselling, and whether and why the individual would recommend the service.

CORE-OM. This 34-item self-report measure (Evans et al., 2000) was administered pre- and post-counselling to assess subjective wellbeing (4 items), psychological problems/symptoms (12 items), life functioning (12 items), and risk (6 items assessing risk to others, risk of self-harm and risk of suicide). Respondents were asked the extent to which they had experienced various feelings during the preceding week (e.g. 'I have felt optimistic about my future'), with responses on a scale from 'not at all' (0) to 'most or all the time' (4). A total mean score was calculated for the CORE-OM, as well as scores for individual subscales. Mean scores were multiplied by 10 to aid interpretation, thus scores ranged from 0 (no distress) to 40 (most distress). A total score of 10 is recommended as the cut-off between clinical (above 10) and non-clinical populations (Mullin et al, 2006). Subscale and total scale reliabilities ranged from .73 to .94.

Data analysis

Data were analysed using SPSS 19. The distributions of pre-counselling risk scores and post-counselling total and all subscales scores were negatively skewed (i.e. the majority of participants tended to have relatively low scores) and thus the data were not normally distributed. Therefore non-parametric tests were conducted. These are slightly less powerful than parametric tests, so for example, a larger change in CORE-OM scores may be necessary in order for it to be detected as a statistically significant change. Mann-Whitney U tests were

used to examine whether service users who are unemployed, or who report having experienced physical, sexual or mental abuse have higher pre-counselling CORE-OM scores. Kruskal-Wallis tests were used to examine whether service users who have a lower income or who report having experienced more than one type of abuse have higher pre-counselling CORE-OM scores. Wilcoxon tests were used to examine whether there were pre-post counselling improvements in CORE-OM scores. To be consistent with past research using the CORE-OM and for comparisons to be made with the findings from past research, means, standard deviations and effect sizes are reported.

To examine the views and experiences of service users post-counselling, inductive content analysis was conducted for each of the four open-ended questions (cf. Elo and Kyngas, 2008). For each question, participant responses were read by the first author and codes were generated to describe all aspects of the content (open coding). The first author then generated categories by grouping together codes that were similar (creating categories). The second author then read the participant responses to each question and where necessary added additional codes within the existing categories, suggested possible changes to the grouping of existing codes, and added new codes and categories. Finally, the two authors grouped categories with similar content under main categories and named these using phrases or words provided by participants in their responses (by using abstraction).

Results

Research aim 1: Characteristics of service users

The average age of participants in the pre-counselling sample was 40 (*SD* = 11.12). The majority (80%) were 'white', 30% of the sample lived alone, 34% had children at home, 24% were single parents, 56% were unemployed, and 29% had an annual household income of less than £5,000. The majority of participants (77%) reported having experienced abuse; 44% reported physical abuse, 40% reported sexual abuse, and 66% reported mental abuse. Fifty

percent reported having experienced more than one type of abuse and 50% reported abuse by more than one perpetrator.

In the pre-counselling sample, the average total CORE-OM score was in the clinical range (M = 17.02, SD = 6.70). Participants who were not employed had significantly higher pre-counselling CORE-OM total scores than those who were employed (Unemployed M = 18.88, SD = 7.05; employed M = 14.44, SD = 6.50; U = -3.24, p <.001.). Comparison of four annual household income groups (<£5,000, £5-15,000, £15-25,000, >£25,000) showed that participants with the lowest household income had significantly higher pre-counselling CORE-OM total scores than those with the highest income (<£5,000: M = 19.55, SD = 7.76; >£25,000: M = 13.77, SD = 6.37; H = 8.27, p < .05).

Women who reported having experienced mental, physical or sexual abuse had significantly higher pre-counselling CORE-OM total scores compared to those who had not experienced abuse (sexual abuse: M = 18.10, SD = 7.69; no sexual abuse M = 15.10, SD = 6.68; H = -2.56, p < .05; physical abuse: M = 18.66, SD = 6.92, no physical abuse M = 15.54, SD = 7.04; H = -2.24, p < .05; mental abuse: M = 18.22, SD = 6.84; no mental abuse M = 14.38, SD = 7.08; H = -2.92, p < .01). Women who reported experiencing no abuse (23%), one type of abuse (27%), two types (27%) or all three types (23%) were also compared. Participants who reported experiencing all three types of abuse had significantly higher pre-counselling CORE-OM total scores than those who had no history of abuse (all 3 types: M = 20.18, SD = 7.79; no abuse M = 14.47, SD = 7.28; H = 9.38, p < .001).

Research aim 2: Views and experiences of service users

In the post-counselling sample the average total CORE-OM score was not in the clinical range (M = 9.44, SD = 6.12). The average duration of counselling at the service was 16.58 months (SD = 11.78).

The counselling was rated as very good by 65% of women and 72% rated their relationship with their counsellor as very good. Further information about the client-counsellor relationship was provided by 48 service users (64%). Content analysis of these data is presented in Table 1. The most frequently reported positive aspects were feeling supported and comfortable and gaining insight. Relatively few negative aspects of the counselling relationship were reported.

Table 1 here

Positive post-counselling life changes were reported by 84% of women, and 60 women (80%) provided further information about these changes. Content analysis of these data is presented in Table 2. All changes reported were positive, including improved relationships with family, changes in the self such as feeling more hopeful and confident, improvements in health behaviours, and life changes such as finding a job.

Table 2 here

All participants reported that they would recommend the service and 56 (75%) provided further information about why. The content analysis of this is presented in Table 3. The quality and security of a women-only service, the positive outcomes experienced, and the accessibility of the service were all key issues.

Insert Table 3 about here

Research aim 3: Clinical outcomes

In the pre-post-counselling sample 91% scored in the clinical range on the total CORE-OM pre-counselling, and post-counselling, 42% of service users scored in the clinical range. The average total and all subscale scores were in the clinical range pre-counselling, with the exception of risk to others and risk of self-harm pre-counselling. Post-counselling, the average total and all subscale scores were outside the clinical range.

A significant reduction was found in CORE-OM total scores and on all subscale scores, with the exception of risk of harm to others but this was low before counselling (shown in Table 4). Additionally, reliable and clinically significant improvement (RCSI) was shown by 42% of women; i.e. these women showed a decrease in total CORE-OM scores of 5 points (reliable improvement) and a reduction from above to below the clinical cut-off score of 10 (clinical improvement) based on recommended benchmarks (Mullin et al., 2006). A further 14% showed reliable (although not clinically significant) improvement, while 40% showed no reliable change and 2% showed reliable deterioration. Thus in total, 56% (RCSI plus reliable improvement only) can be considered recovered or improved.

Insert Table 4 about here

Discussion

The majority of participants were unemployed, had low incomes, and had experienced some form of abuse. There were significant levels of mental ill health prior to counselling and those who had experienced abuse, were unemployed, or had the lowest income had the highest levels, supporting Winter et al. (2003). Black, Asian and minority ethnic communities were slightly under-represented in the samples compared to the population of the London borough in which the service operates. This may be because they did not want to participate in the research. However, there may also be a lack of awareness of the service or perceived

obstacles (e.g. language barriers) to accessing it among these communities. Further attention could be paid to the development of culturally relevant treatments.

Levels of satisfaction with the counselling and the counsellor were high. However, responses to satisfaction surveys tend to be positive (Edwards & Staniszewska, 2000), so, as suggested by Edwards and Staniszewska, and by Vanheule (2009), responses to open-ended questions were utilised to identify helpful and unhelpful aspects of the service and of the counselling relationship, although enquiries were not made about the counselling process in general. Gallagher et al. (2005) suggested that the quality of the relationship with a counsellor is an issue considered to be of primary concern to service users. Supporting McLeod et al. (2000) and Gallaher et al. (2000), women in the present study reported that of key importance to them was that the counsellor was caring, easy to talk to, understanding and trustworthy, and that they were able to gain personal insight. Only a very small number of negative experiences were reported and these related to lack of interaction, not being able to connect, and lack of counsellor experience. This suggests that a minority of women may not be satisfied with the trainee status of approximately one-third of the counsellors, perhaps due to their relative lack of experience, or the approach of the counselling (e.g. psychodynamic).

A second issue reported by Gallagher et al. (2005) to be of primary importance for service users is valued outcomes. In the present study 84% of service users felt that counselling had helped them to make positive changes in their lives. These included life changes such as finding or changing job; improved relationships; changes in the self, such as feeling more hopeful, and confident and gaining insight; and changes in physical health such as improvements in health behaviours. With the exception of changes in physical health, these perceived changes are similar to those found by Archer et al. (2000).

One of the primary reasons women would recommend the service is because it is run by, and for, women. The Women's Resource Centre (2007) reported that many users of

women's services said they would not use mixed services. A women-only environment may be particularly important for service users who have suffered abuse (Department of Health, 2002). Additionally, the service was perceived to be high quality, welcoming and secure, affordable and accessible in terms of location and opening hours.

The large effect size of the significant pre-post counselling improvement found in total CORE-OM scores and the 56% of service users considered recovered or improved were better than in other studies of voluntary organisations (e.g. Armstrong, 2010; Winter et al., 2003) but not quite as good as benchmark data from counselling in some NHS primary care services (e.g. Mullin et al., 2006; Stiles et al., 2006, 2008). Armstrong (2010) also obtained lower recovery and improvement rates. He suggested that unemployed service users, which made up 40% of his sample, may benefit less from counselling than those in employment, which is supported by McLeod et al. (2000). He also suggested that the paraprofessional counsellors in his study may not have been as effective as experienced counsellors, although Winter et al. (2003) found no differences in the outcome of clients seen by qualified and trainee counsellors. These issues may also apply here, as 75% of the counsellors were trainees and 56% of service users were unemployed. Furthermore, 50% of women had experienced more than one type of abuse and abuse by more than one perpetrator, and women with multiple abuse histories have been found to make fewer gains (Bagley & Young, 1998). However, it is not possible to draw any conclusions relating to these suppositions, as we did not directly examine these issues in the present study.

Limitations

There are a number of limitations to this research. First, the study did not include a no-treatment control group or a group receiving alternative treatment, so improvements were not necessarily a direct result of the counselling. Second, around three-quarters of service users invited to participate did not respond. When conducting longitudinal, practice-based research

with a population of socially disadvantaged participants, a relatively small response rate is not surprising. As participants were volunteers, the sample could be biased. For example, the sample could be biased in favour of the most satisfied service users. However, it was not possible to make a comparison with service users who did not participate. Third, again due to conducting longitudinal, practice-based research, only a small number of women (n=98) completed the CORE-OM both pre- and post-counselling and an even smaller number (n=38) also completed the pre- and post-counselling questionnaires. This led to a complicated structure of three partly overlapping samples. The lack of complete pre-post counselling data also meant it was not possible to examine service user characteristics that may be related to pre-post-counselling change in CORE-OM scores. Fourth, the study relied on self-report measures. In particular, self-reports of abuse cannot be validated by medical or police records, and there are difficulties with defining and measuring abuse (Wathen & MacMillan, 2003). Finally, post-counselling measures were completed shortly after counselling ended; for logistical reasons a longer-term follow-up was not possible.

Conclusion

Long-term counselling offered by this women-only community health centre is valued. Despite the limitations of the present study experienced in most practice-based research, the findings provide preliminary evidence for effectiveness. In light of the IAPT programme in the UK and the emphasis on short-term CBT, further evaluation studies should compare the treatment in such services with that provided by other local (or even national) services, and incorporate a longer-term follow-up, although this is likely to be a challenge in the voluntary sector due to funding issues.

The findings of this research also confirm links between poverty, abuse and psychological distress. Abuse should be viewed in its widest social context and is symptomatic of wider social and gender inequality. The World Health Organisation (2012,

p.4), in its analysis of risks to mental health, suggested that ‘social and gender inequality and conflict are examples of adverse structural determinants of mental wellbeing’. Thus a research-informed approach to counselling and therapy evaluation, which acknowledges the social context of psychological distress, should be taken to inform future community and voluntary counselling practice, and enhance service development.

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Table 1: Helpful and unhelpful aspects of the counselling relationship (n = 48)

	Number (%) of service users
Helpful aspects of the counselling relationship	
She helped me to see things clearly and gain insight	15 (31%)
There were professional boundaries but we built up rapport	5 (10%)
She challenged me in a positive way	4 (8%)
She taught me strategies to use in the future	3 (6%)
Qualities of the counsellor	
She was caring and supportive	25 (52%)
She was easy to talk to and relate to and I felt comfortable	17 (35%)
She understood me	12 (25%)
I trusted her and could be honest and open	11 (23%)
She was professional and experienced	8 (17%)
She listened to me	6 (13%)
Unhelpful aspects	
Counsellors who just listen with little interaction are not helpful	3 (6%)
I felt distant and could not connect with her	3 (6%)
I would prefer someone qualified/more experienced	2 (4%)

Table 2: Perceived changes since the start of counselling (n = 60)

	Number (%) of service users
Life changes	
Found a job/a better job/attending a course	17 (28%)
Got a home/moved house/moved in with partner	7 (12%)
Counselling helped me through a negative life event (e.g. death of a parent, having a termination, post-natal depression)	7 (12%)
Changes in relationships	
Improved relationship with family and/or friends	20 (33%)
Improved relationship with partner/able to start a new relationship	11 (18%)
Ended/avoided negative relationships	7 (12%)
Changes in the self	
Feel hope/more positive about self, life and future	19 (32%)
Understand myself better/have insight	18 (30%)
Feel more confident/assertive/stronger	17 (28%)
Able to think of myself more	14 (23%)
More in control of emotions (e.g. anger, guilt)	13 (22%)
Can manage stress/problems better/have coping strategies	9 (15%)
Decreased self-harm/suicidal feelings	3 (5%)
Changes in physical health	
Positive changes in health behaviours (e.g. eating, drinking)	15 (25%)
Sleep better/have more energy	7 (12%)
Fewer minor illnesses e.g. colds, headaches	6 (10%)

Table 3: Reasons for recommending the Service (n = 56)

	Number (%) of service users
Quality of the service and facilties	
Excellent/high quality service for local women	25 (45%)
Warm/welcoming/secure/trusted environment	21 (38%)
Affordable and accessible	16 (29%)
Cares for the mind and body/offers many treatments and a crèche	13 (23%)
Quality and impact of the counselling	
Helped me so much/was a very positive experience/led to major life changes	16 (29%)
Felt comfortable and supported/good about myself/could take time for myself	14 (25%)
High quality and kind female counsellors and staff	12 (21%)

Table 4: Change in CORE-OM scores (n = 98)

CORE-OM subscale	Cut off [a]	*M (SD)*	*M (SD)*	*Effect size*	*W*
		Pre-counselling	Post-counselling		
Total	10.0	16.27 (5.56)	9.22 (5.91)	1.11	-7.77***
Functioning	13.0	17.04 (6.50)	9.99 (6.67)	.93	-7.12***
Problems	16.2	20.25 (6.85)	11.43 (7.66)	1.16	-7.91***
Wellbeing	17.7	21.13 (7.23)	11.70 (7.93)	1.11	-7.62***
Risk	3.1	3.54 (4.83)	1.61 (3.95)	.36	-4.19***
Risk to others		2.47 (4.85)	1.86 (5.12)	.08	-1.08
Risk of self harm		2.94 (6.64)	1.44 (5.05)	.23	-2.70**
Risk of suicide		5.21 (8.41)	1.55 (4.35)	.47	-4.27***

Note: [a] This value is the recommended benchmark cut off between clinical and non-clinical populations (Mullin et al., 2006). ** $p < .01$, *** $p < .001$