

A naturalistic study of the effectiveness of time-limited counselling with low-income clients

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Abstract

The role of counselling and psychotherapy services in relation to the needs of economically disadvantaged individuals has been largely neglected in the recent research literature. Although a small number of theoretical papers and case analyses have been published, there is an absence of studies that examine the effectiveness of counselling with this client group. The present paper reports on a naturalistic outcome study of the effectiveness of time-limited counselling (seven sessions) with low-income clients. Analysis of pre-counselling, post-counselling and follow-up measures of mental health and problem ratings indicated levels of change equivalent to those achieved in controlled studies of counselling and psychotherapy with other client groups. Factors influencing the effectiveness of counselling included gender and employment status. Qualitative client reports suggested that the main benefits experienced by clients were in the areas of self-understanding and self-belief. For illustrative purposes, data from low-income clients are compared with results from employee counselling clients receiving a similar service. The implications of these findings for further research are discussed.

Keywords: counselling, gender, unemployment, brief therapy

Counselling and psychotherapy have evolved as forms of help that are specifically targeted at issues and problems in the sphere of emotion, behaviour, and relationships. The actual material circumstances of the lives of clients are seldom given much attention in therapy. For example, the challenge of economic disadvantage would not, in itself, be generally considered as a legitimate focus for therapy. Although it is clear that many

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low-income clients use psychotherapy and counselling services, their specific experiences and ways of engaging with therapy have been largely ignored in the recent literature. During the 1960s, by contrast, there were a number of studies of therapy with low-income clients. These studies have been reviewed by Bromley (1983) and Garfield (1986). Taken as a whole, this body of evidence suggests that the majority of clients are drawn from middle and upper-income groups, and that, when lower-income clients seek therapy, they are more likely to drop out of treatment prematurely. This pattern was also found in a more recent study of the demographic characteristics of users of a voluntary counselling agency in a UK city known to have substantial areas of social deprivation (Crouan 1994). The importance for counselling services of developing a fuller appreciation of the implications of economic disadvantage has been forcefully argued by Allen (1999).

The low up-take of counselling, and high dropout rates, in low-income groups can be explained in a number of ways. It may be that counselling is not perceived as relevant by those struggling to cope with poor housing, debt, and unemployment. Alternatively, it is possible that there are communication difficulties between a counselling profession that is mainly middle-class and university educated and a client group that is working class. A third possibility is that the physical location of counselling agencies and factors around access (e.g., perceived appropriateness, or 'do I belong here?', and the requirement of payment) may both prevent many low-income individuals from making use of counselling and result in low expectations, which lead to termination of treatment if and when the therapeutic process becomes frustrating or painful.

A belief in the validity of the third of these explanations (i.e., that the under-use of counselling in low-income clients is primarily a problem of access) was the motivation for a project carried out by the Dover Counselling Centre. This centre was formed in 1988, and is typical of many regional counselling agencies in that it offers a generic professional counselling service to members of the public, as well as holding contracts for employee counselling for a variety of local organizations. Routine monitoring of client statistics in the early years of the centre revealed low rates of service use among the most disadvantaged members of the community. Further informal inquiries showed that there was limited awareness of the existence of the centre among members of these groups, and that the requirement to make some payment (albeit on a sliding scale) was a deterrent. The centre was able in 1996 to obtain National Lottery Charity Board funding for a three-year project that combined outreach work in economically deprived neighbourhoods and an increase in the number of paid counsellors so that low-income clients could be offered a service that was substantially subsidized and prompt.

An evaluation of the project, carried out by an independent university-based counselling research centre, was made possible by the grant from the National Lotteries Charity Board. The aim of the study was to assess the effectiveness of the service, and to identify those factors associated with good and poor outcomes. For illustrative purposes, data on the Dover Counselling Centre low-income clients were also compared with similar data collected from an evaluation of the effectiveness of employee counselling for a client group comprising mainly health workers, firefighters, teachers, ferry workers, and other local authority staff who received a similar form of time-limited counselling. The employee counselling clients received a similar form of counselling intervention, were based in the same geographical area, and the outcomes of their counselling were evaluated using the same set of measures.

Method

Clients

Dover Counselling Centre Lottery project clients

Data were available from 265 clients at the start of their counselling (75 per cent of the Lottery Project clients seen by counsellors during the period of the study). Post-counselling questionnaires were completed by 110 clients, with forty-five responding at follow-up. The majority (69 per cent) of these clients were under 40 years of age, although their ages ranged from under 25 to over 60, with 4 per cent in the over-60 group. In terms of gender, 31 per cent of clients were male and 69 per cent female. The majority (95 per cent) were ethnic 'white'. Twelve per cent had previously used the Dover Counselling Centre (DCC). About one-third (32 per cent) of clients were in paid employment, 59 per cent were unemployed, 5 per cent carers, 3 per cent disabled, 1 per cent 'other' (students, retired). Clients had heard about the service from a variety of sources, with the sources mentioned most frequently being friends (24 per cent) or their GP (31 per cent). The majority (85 per cent) of clients confirmed that, on their first contact with DCC, the staff were very helpful. Clients were offered up to seven sessions of counselling, and received an average of 4.33 sessions. Problems identified by clients were (in order of frequency): relationship difficulties (54 per cent); stress/anxiety (32 per cent); depression (20 per cent); loss (20 per cent); sexual abuse (11 per cent); emotional complications from ill health; disaster; violence; work related (each less than 5 per cent) (clients were asked to identify their two main problem areas). They were, as a group, fairly frequent users of GP (average 2.5 GP visits in previous three months, with one in five using medication 'relevant to mental health') and other

services, with around half known to their counsellors to be clients of some form of psychiatric or social services.

Employee counselling clients

The employee counselling clients received counselling as part of a regionally based scheme in which a number of organizations contracted with an external provider to give up to seven sessions of counselling to their staff. An evaluation of this scheme was carried out by an external consultant (JMCL). Within this sample, there were 235 clients who completed pre-counselling questionnaires (62 per cent of those who received counselling), of whom 182 also supplied either post-counselling or six-month follow-up questionnaires (or both). The majority of these clients (76 per cent) were between 35 and 54 years of age (mean age: 43 years); 72 per cent were female and 28 per cent male; 98 per cent were ethnic 'white'; 56 per cent were married. The average number of sessions used by these clients was 5.03, with 17 per cent having used the employee counselling service at some time in the past. At the end of counselling, 19 per cent were referred on for further help, mainly to another counsellor (50 per cent of those referred) or their GP (29 per cent). These clients presented with a range of problems. The most salient personal problems were marital, lack of confidence, depression, and family problems. The most salient work problems were unrealistic job demands, stress and anxiety at work, feeling undervalued, and relationships with co-workers.

Counsellors

There were twenty-one Dover Counselling Centre Lottery project counsellors who saw low-income clients. All had completed professional training to postgraduate diploma level, and had at least two years' counselling experience. Most described themselves as person-centred or humanistic in orientation, with a minority reporting use of psychodynamic approaches, TA and the Egan model. All counsellors received regular supervision. Around half of the counsellors had received training in brief therapy approaches, although none claimed to be adopting an explicit brief therapy model. There were thirty-four employee support counsellors (fifteen of whom saw the majority of clients), with similar levels of qualifications, core orientation and supervision, but greater post-qualification experience than the Dover Counselling Centre Lottery project counsellors. The majority of counsellors in both groups were female.

Data collection procedures

Clients in both groups completed questionnaires at or before the first session, after their final session, and at follow-up three to six months later. The pre-counselling questionnaire included a covering letter, which explained the purpose of the research and informed consent procedures. All questionnaires were sent directly by clients to the independent researcher (JMCL), using an attached stamped addressed envelope. Confidential code numbers were written on questionnaires; the identity of clients was not known to the researcher.

Measures

For all clients, outcomes of counselling were assessed using a set of self-report scales.

Mental Health Scale (MHI-5)

The MHI-5 was originally developed as part of the SF36 Short Form Health Survey (Ware *et al.* 1993). It has also been used on its own as a measure of mental health (Berwick *et al.* 1991). The scale is brief, placing very little demand on the respondent, and it has also been found to give a good response and completion rate when administered as a postal survey. The MHI-5 consists of five items measuring mental health in terms of psychological distress and emotional well-being on a six-point scale (1-6, All of the Time - None of the Time) measuring the intensity/frequency of clients' emotional feelings over the previous month. It includes one or more items from each of the four major mental health dimensions (anxiety, depression, loss of behavioural or emotional control, and psychological well-being) confirmed in factor analytic studies of the full-length thirty-eight-item health survey questionnaire from which the MHI-5 was derived.

Problem Rating Scale

This scale was developed by Worrall (1999) as a more easily administered version of the Target Complaints Interview (Battle *et al.* 1966). Clients were given a list of ten problem areas and were asked to indicate the one or two problems with which they most wanted help. Following this, clients were asked to rate on a 14-point scale (1=Not at all, 4=A little, 7=Pretty much, 10=Very much, 14=Couldn't be worse) how much this problem bothered them now. At the end of counselling and at follow-up clients were asked "How much do you think the problems you felt you wanted help with at the start of counselling bother you now?" and again they were asked to rate their distress on the original 14-point scale.

Well-being

This was a one-item, five-point scale, designed for this study, which asked clients to rate their general well-being from Very poor=1 to Very good=5.

Client satisfaction scale

A series of eight items was included to assess different aspects of client satisfaction with their counsellor and the service they had received. Clients were asked to rate each item on the satisfaction scale on a five-point scale, scoring 1 for a response representing the lowest rating of satisfaction and 5 " for the highest satisfaction. Items were drawn from the satisfaction measure developed by Attkisson and Greenfield (1994) , with some questions re-phrased to reflect UK language usage and to focus on specific areas of satisfaction of interest to the agency.

Client change rating scale

This scale was derived by Worrall (1999) from the Counseling Update Model (Freiband *et al.* 1993). At the end of counselling and at follow-up, clients were invited to make ratings of how much their problem had changed, on a scale ranging from -5 (deterioration) to 0 (no change) to +5 (improvement).

In addition to these scales, a number of open-ended questions were included, to allow clients to describe in their own words their reasons for seeking counselling, what had been helpful or unhelpful, and what they had gained. Information was also gathered on demographic characteristics and health-care uptake indicators. Counsellors for the Lottery Project (but not the employee counselling service) completed a questionnaire at the end of each case, in which they recorded case details and gave a rating of improvement using a 5-point scale.

The questionnaires distributed to employee counselling service clients incorporated a number of scales (work functioning, work stress, coping, life events, interpersonal problems) that are not reported here.

Counselling procedures

All clients were voluntary self-referrals to the respective service. At Dover Counselling Centre, eligibility for entry to the Lottery Board scheme was restricted to clients in receipt of State benefits, or in employment but with income levels equivalent to those receiving benefits. It is widely recognized in the UK that basic State benefits for unemployed people are associated with a standard of living that is at or near the 'poverty line'. The majority

of these clients can therefore be regarded as experiencing significant financial hardship. The suitability for counselling of these clients was assessed in an initial interview. The employee counselling service clients made initial contact through a telephone helpline, where their request for counselling was assessed. Only data on those clients who formally entered counselling are reported in this paper.

Results

In this section, the results from the Dover Counselling Centre clients are reported in most detail, as the primary focus of the paper is on this sample. Selected results from the employee counselling sample are presented towards the end of the section.

Client satisfaction ratings in the low-income client group (Dover Counselling Centre) were high, with 90-100 per cent of clients indicating different aspects of the service they had received as either 'satisfactory' or 'highly satisfactory'. The effectiveness of the counselling delivered in this scheme can be estimated by comparing pre- and post-counselling and follow-up scores on mental health and problem rating for all the clients who completed questionnaires (Table 1).

Using data from clients who submitted complete sets of questionnaires, paired comparisons between pre-counselling scores, and both post-counselling and follow-up scores, were all statistically significant. (For mental health: pre/post $t = -8.10$, $df = 82$, $p < 0.01$; pre/follow-up $t = -5.15$, $df = 32$, $p < 0.01$. For problem severity: pre/post $t = 18.74$, $df = 82$, $p < 0.01$; pre/ follow-up $t = 11.82$, $df = 34$, $p < 0.01$.) Although there were improvements from post-counselling to follow-up, these were not statistically significant.

Table 1 Low-income clients: key outcome indicators (self-report mental health and problem severity ratings)

	Pre-counselling	Post-counselling	Follow-up
Mental health (MHI -5)	m = 36.18 (sd = 17.40) n=262	m = 52.96 (sd = 16.95) n=112	m = 61.12 (sd = 19.70) n=45
Problem severity (14-pointscale)	m = 11.39 (sd=2.19) n=265	m = 5.07 (sd=2.41) n=110	m = 4.75 (sd=2.77) n=48

Note

With the MHI-5 mental health scale, a higher score means *more* health, while the problem severity rating is constructed in such a way that a higher score means a *bigger* problem. These figures therefore indicate substantial improvements over the course of counselling, which continue through the follow-up period.

It is important to note that the population mean (average) score on the mental health scale (derived from a number of UK studies) is in the region 70-75. These DCC clients were therefore significantly more troubled than the average member of the population before counselling, and even after counselling the score is well below the population mean. Another way of looking at these figures is that before counselling 13 per cent were within the 'normal' range (i.e. within one standard deviation of the UK norm). Immediately after counselling 52 per cent of those who completed questionnaires were within the norm, and at follow-up 70 per cent.

The amount of change found in clients was not related to the age of the client. There was also no relationship between counselling outcome and initial problem severity (i.e. counselling was just as effective with highly troubled clients as with those nearer the norm). There was strong evidence that the more satisfied clients completed questionnaires. When those who returned either post-counselling or follow-up questionnaires were compared in terms of initial levels of problem severity, mental health, age, gender, and employment status with those who did not return post-counselling questionnaires, no difference was found. However, significant differences were found in counsellor ratings of change between those who did and did not return end-of-counselling questionnaires. Those who filled in end-of-counselling questionnaires were rated by their counsellors as having benefited significantly more than those who did not ($t = 4.86$, $df = 312$, $p < .001$). This result suggests that the estimates of benefit reported above are probably slightly exaggerated, since (as has been found in some other studies) less satisfied clients were less likely to complete follow-up questionnaires.

There were some trends relating to differences in effectiveness associated with client problem area. Counselling was *more* effective with clients with problems in the areas of violence and depression. Counselling was slightly *less* effective with clients reporting stress/anxiety problems. These findings appear to suggest that this kind of short-term counselling is more effective when the client's problem is specifically identified at the outset, and is less effective when generalized problems of 'anxiety' are presented. It is important to emphasize that there were successful (and unsuccessful) cases in *all* problem categories.

Content analysis of qualitative open-ended client accounts revealed that the main themes in clients' experiences of counselling were: having someone to talk to, expressing emotion, gaining a broader perspective on - a problem, and developing self-confidence. There was no mention at all in any of the client accounts of specific income-related issues. In the minority of clients who reported little or no change, or deterioration (on the quantitative measures), the failure to benefit from counselling was attributed either to a multiplicity of problems, or to counsellor errors. No clients wrote that counselling had been irrelevant to their needs.

On completion of counselling, 48 per cent of clients reported their sense of well-being as being 'good' or 'very good', with 9 per cent feeling that their well-being was 'poor' or 'very poor' at this stage. Well-being remained at this level in follow-up data.

Although both unemployed clients and those with jobs gained from counselling, unemployed clients were helped significantly less than those in employment (see Table 2). Employed and unemployed clients had similar mental health and problem rating scores at the start of counselling. Employment status was not linked to gender (i.e., equal numbers of men and women were employed/unemployed). Unemployed clients were relatively more likely than employed to present with problems which they identified as 'loss', while proportionally fewer reported relationship difficulties. Unemployed clients used significantly fewer sessions ($m=4.12$) than did those in employment ($m=4.80$) ($t=2.05$, $df=277$, $p<.05$).

Differences were found in therapeutic effectiveness in comparisons between clients seen in the first half of the project, and those seen in the second half. Those seen in the second half reported significantly greater change in mental health problems ($t = 2.39$, $df = 91$, $p<.05$). There was also a tendency for problem resolution to be more effective in the second half, but this finding did not quite reach statistical significance levels.

Although not achieving statistical significance, there were notable trends in relation to the effect of gender on outcome. Women gained more from counselling than men, in terms of the effect of counselling on mental health. However, men reported greater gains in problem resolution. Male and female pre-counselling mental health and problem rating scores were

Table 2 Effect of employment status on mental health and problem severity ratings at beginning and end of counselling

	<i>Employed clients</i>	<i>Unemployed clients</i>
<i>Mental Health</i>		
Pre-counselling	$m=39.40$ ($sd= 15.37$) $n=47$	$m=39.98$ ($sd= 17.31$) NS $n=106$
End of counselling	$m=59.12$ ($sd=20.33$) $n=32$	$m=49.97$ ($sd=15.03$) ($p<.05$) $n=67$
<i>Problem severity</i>		
Pre-counselling	$m=11.20$ ($sd=2.46$) $n=48$	$m=11.52$ ($sd=1.96$) NS $n=106$
End of counselling	$m=5.45$ ($sd=2.80$) $n=31$	$m=6.30$ ($sd=2.81$) ($p<.05$) $n=68$

similar. Male client/male counsellor dyads showed less gain in mental health but equal benefit in terms of problem resolution. Mixed male/female dyads were most successful, with women-only dyads being in-between. Female-only dyads used a somewhat higher number of sessions than other configurations.

Employee counselling client data

Illustrative results from the employee counselling clients are reported for purposes of general comparison rather than detailed analysis. The satisfaction levels of these clients were similar to the figures obtained for the low-income client group. Taking the mental health and problem rating scales as key measures of change, it can be seen that, again, very similar scores were reported (Table 3). However, the employee counselling clients used more sessions ($m=5.03$) than did the low-income group ($m=4.33$).

Discussion

It is important to acknowledge the limitations of this naturalistic study. This is not a randomized controlled trial supported by a major government grant. In consequence, only very limited resources were available to ensure compliance with data-collection procedures. The aim of this study has been to give as full an account as possible of the outcomes of counselling experienced by a group of low-income clients seen within a typical counselling agency, within the practical constraints represented by the primary requirement to provide a service for clients. On pragmatic and cost grounds a restricted set of outcome measures was used; it is possible that the inclusion of other measures may have produced a more differentiated picture of impact of counselling. Those clients rated by counsellors to have gained most from counselling were more likely to complete post-counselling questionnaires than were those perceived by counsellors to have gained less. This finding may suggest that the outcome effects reported in this study

Table 3 Employee counselling clients: key outcome indicators (self-report mental health and problem severity ratings)

	<i>Pre-counselling</i>	<i>Post-counselling</i>	<i>Follow-up</i>
Mental health (MHI-5)	$m = 36.58$ ($sd = 23.17$) $n = 235$	$m = 52.56$ ($sd = 20.89$) $n = 165$	$m = 60.3$ ($sd = 18.26$) $n = 81$
Problem severity (14-point rating scale)	$m = 9.81$ ($sd=2.12$) $n = 228$	$m = 5.50$ ($sd=2.55$) $n = 167$	$m = 3.45$ ($sd=.79$) $n = 82$

have been elevated by selective attrition from the study, with the least satisfied clients dropping out. On the other hand, there is some evidence that clients and counsellors may differ in their attribution of reasons for termination (Hunsley *et al.* 1999). It is possible that a proportion of clients who did not complete the planned number of sessions and failed to complete the questionnaires had simply found that their needs had been met by counselling, and did not return. Certainly, further research is needed into the characteristics and experiences of clients who drop out of naturalistic studies of this kind. Nevertheless, a high proportion of low-income clients did complete questionnaires, and the findings from quantitative and qualitative client reports, and between client and counsellor ratings, offer an encouraging degree of convergent validity. The findings of the study need to be regarded as tentative, offering suggestions for future directions in research and practice rather than making any claim to have arrived at any definitive conclusions. All approaches to evaluating the outcomes of counselling and psychotherapy have their own distinctive strengths and weaknesses (McLeod 1999, 2000). The weakness of a naturalistic study lies in the fact that attrition from the sample (incomplete data) and the brevity of scales that can be administered in everyday circumstances mean that it is always possible to construct plausible alternative interpretations for the data that are collected. The strengths of naturalistic studies are that they are closer to the reality of routine counselling practice, and that they are less demanding on resources than controlled studies, thus enabling more local-level research to be carried out.

The data presented in this study suggest that little difference can be detected between the usefulness of counselling for low-income clients and for clients drawn from professions such as health and local authority workers. Similar change scores and satisfaction ratings were found in the two groups. The low-income clients, particularly those who were unemployed, used fewer sessions, possibly because of the costs of travel to a counselling centre. However, the majority of low-income clients participated in enough sessions to be seen to have actively engaged in a therapeutic process. These findings suggest that it is possible to overcome the poor take-up rates and outcomes reported in previous studies (Bromley 1983; Garfield 1986) by designing a service that 'reaches out' to low-income users. It would appear from the present findings that there is nothing intrinsic in the socialization, language use, or values of low-income clients and professional counsellors that makes effective counselling impossible. The finding that the effectiveness of counselling provided to low-income clients improved over the three-year course of the project suggests that counsellors were able to adjust their approach to meet the needs of this client group. These results imply that the previously reported difficulties in the uptake of counselling in low-income clients can be attributed to issues around access and perception of services, rather than

being viewed as deriving from the perceived relevance of this form of help for people in this particular social group.

A second important finding in this study was that employment status was strongly associated with good outcome in counselling. In the low-income group, problem ratings and mental health scores for employed and unemployed clients were equivalent at intake. However, there was a difference between employed and unemployed clients at the end of counselling that was both statistically and clinically significant. Although unemployed clients reported themselves as satisfied with the counselling they had received, and showed some improvement in problem ratings and mental health scores, the gains recorded by employed clients in the ~ low-income group were significantly higher. There are several possible reasons for this finding. It could be that those in employment enjoyed a wider social network, and were better able to identify situations in which they could apply what they had learned in counselling (Fryer 1994). They may also have had access to greater social support (Brown and Harris 1978), thus enabling them to take more risks in counselling. Alternatively, it may be that the social stigma of unemployment is associated with a chronic sense of hopelessness and low self-esteem that cannot be addressed within six or seven sessions of counselling, even if considerable progress is made in respect of specific, concrete problems or presenting issues. This possibility is consistent with the results of a review of the effect of unemployment on mental health (Murphy and Athanasou 1999), which found that a high proportion of unemployed people experience psychiatric difficulties, particularly depression. There may be other factors, not measured in this study that, may account for this particular result. For example, in a study of low-income women in the USA, Ingram *et al.* (1996) found that lack of social support tended to be associated with experiences of victimization, particularly among homeless women. It may be that victimization and homelessness (or uncertainty over security of housing provision) may have been significant factors in the lives of the unemployed clients in the present study. The existence in this study of such a striking difference in outcome between employed and unemployed clients has implications for both research and practice. It would be useful in future research to look more, closely into this issue, for example, by carrying out detailed case analyses of good and poor outcome cases where clients were unemployed or by looking more closely at the role of social support.

At the beginning of counselling, the low-income clients were heavy users of other services, such as GPs, social work, and financial advice services. The data collected in this study did not make it possible to estimate with any reliability the extent to which counselling might have had the effect of lessening the need for other services. The data that are available suggest that counselling had a medium-term effect of promoting a greater sense of

well-being and personal empowerment. It is important to seek to establish the extent to which this effect was merely episodic or generalized into longer-term changes in life functioning and social activity.

From the point-of-view of counselling strategy, the results of the study reinforce the point that, for many people, a small number of sessions are sufficient to bring about worthwhile personal benefits. It is important to note here that clients in both the low-income and workplace counselling groups reported levels of mental health difficulties at the beginning of counselling that were much higher than the UK norms, and that counselling appeared to be effective regardless of level of initial severity. On the whole, counselling was most effective in cases where the client was able to identify a specific focus for the work, rather than presenting with a generalized long-term problem such as 'anxiety'. The counsellors in this study mainly used relationship and insight-oriented counselling approaches, suggesting that it is not only behavioural, cognitive, and solution-focused methods that can be effective in time-limited therapy.

To conclude, the findings of this study offer encouragement to those counsellors and counselling agencies striving to break out of what many people perceive as an allegedly narrow middle-class client base of counselling in Britain. Further research is certainly necessary, as is further innovation around patterns of service delivery (Holland 1990). But the message is that low-income clients can benefit from short-term counselling. The challenge for future research is two-fold. First, it is important to carry out more research into counselling with low-income clients, including not only more naturalistic studies but also well-funded controlled studies with lower attrition rates, a greater range of measures, longer-term follow-up, and closer definition of counselling interventions. A programme of research in this area is necessary in order to produce findings that are methodologically robust and generalizable. Second, it will be important to find ways to explore the ways in which counselling can be used constructively to engage with social problems around poverty and unemployment. As Allen (1999) has argued, it is necessary for a balance to be struck between conventional psychological interventions and 'an awareness of the broader social, cultural and economic correlates of mental distress and ill-health'. It is this 'balance' which the counsellors in the Dover Counselling Centre appear to have achieved over the period of time of the study. A more detailed specification and description of how this happened, and how it can be taught to other counsellors, would be a significant research priority.

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Note

This study was funded by a grant from the National Lottery Charities Board, whose support is gratefully acknowledged. Correspondence should be directed to the first author.

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