

**EVALUATION OF EXTENDED COUNSELLING SESSIONS**

**At**

**London Interfaith Counselling Centre**

**London, Ontario**

**Funded by a**

**TRILLIUM FOUNDATION GRANT**

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August 2005

Special thanks is extended to the counsellors and clients of London Interfaith Counselling Centre and Kristen Dowling in the data collection phase of this project.

## **Evaluation of Extended Counselling Sessions At London Interfaith Counselling Centre**

### ***Rationale and Background***

Research in the area of time-limited counselling is extremely relevant to the current conditions in our society. With budget cuts and increased demand for therapy, time-limited therapy is becoming commonplace in community agencies (Barkham, Shapiro, Hardy, & Rees, 1999). Many people who seek counselling cannot afford the costs associated with therapy, which limits the treatment that is accessible to them. The community centres that offer a sliding scale for the cost of therapy become backlogged with requests and often produce long waiting times between the initial request for therapy and the first appointment. Although this shift towards brief therapy is necessary to allow for more accessible counselling, there may be certain clients who would greatly benefit from extended counselling sessions.

Schaefer, Koeter, Wouters, Emmelkamp, and Schene (2003) investigated how clinicians decide which patients would benefit from brief therapy. They acknowledged that patients who require long-term treatment consisting of 10 to 20 sessions often are identified as dealing with specific issues such as major depression, anxiety disorders, or trauma. For the purposes of this evaluation, clients dealing with trauma, complicated grief, and multiple acute issues were identified for long-term counselling at London Interfaith Counselling Centre (LICC). Multiple acute issues consist of more than one pressing issue, such as depression and an anxiety disorder. These clients were identified as needing extra counselling sessions because trauma, complicated grief, and multiple acute issues impact clients at such a deep level that it often takes even more than 24 sessions to help clients work through their effects. Deep level change takes time, therefore, these clients would benefit from extended sessions.

Evaluation in counselling is imperative to assess whether the therapy was helpful. Some previous research has evaluated counselling by investigating whether there was a decrease of symptoms in clients (Baker et al., 2002; Busseri & Tyler, 2004), whether clients have improved or gained coping skills (Litt, Kadden, & Cooney, 2003), and the process of change (Gazzola, Iwakabe, & Stalikas, 2003) that clients experienced. It is important to assess symptom reduction, coping skills and the change process for trauma survivors and clients with other issues because all three variables are an integral part of the progress that occurs during counselling. For counselling to be considered effective, clients should experience reduced symptoms. As well, a decrease in symptoms often occurs when clients acquire new coping skills, which help them deal more effectively with their everyday lives. Both symptom reduction and skill acquisition are part of the change process that often occurs for clients over the duration of counselling. Understanding the change process can provide insight into which aspects of counselling facilitate change. The current research will provide valuable information to counsellors that may help them provide more effective counselling for their clients.

With this as a brief introduction, previous research on grief, trauma, symptoms, coping skills, and the change process in counselling will be reviewed next.

### *Grief*

One issue that requires longer-term therapy is complicated grief. Grief is a natural and normal phenomenon, which will touch every person at some point during his or her life. Freeman and Ward (1998) describe the grief process as requiring re-evaluation and reorganization of the grieving person's current attachments with others. A loss of a significant person may result in loss on many levels. For example, the grieving person may have lost a spouse and also his or her main source of income.

Complicated grief is described by Muller and Thompson (2003) as an extension of grief that is prolonged, postponed, displaced, or suppressed. Grief also can be complicated by trauma, e.g., death of an abuser. They describe the goal of therapy with clients who are dealing with complicated grief as reaching reconciliation, which involves adaptive behaviours such as surviving, remembering, changing perspective, accepting reality, honouring the past, and making choices about the future. Through the use of these adaptive behaviours, the traumatic events can become a part of the person's past instead of continuing to affect them in the present.

Freeman and Ward (1998) revealed that the resolution of the grieving process takes time and may take longer for some clients depending on influencing factors. These factors influence the client's life tremendously and their nature will influence the length of the grieving period. Clients dealing with issues surrounding complicated grief will certainly need longer-term counselling.

### *Trauma*

A traumatic event can have serious detrimental effects on people for the rest of their lives if it is never effectively treated (Bills, 2003; Ehlers & Clark, 2000). In many cases, survivors of trauma feel that they have lost their sense of control and safety (Herman, 1992). Their relationships and connections with their family, friends, and community become strained as the survivors have problems trusting others. They experience their previous knowledge and beliefs as no longer holding truth because they have to re-evaluate what it means to live in a world where terrible, hurtful things happen (Ehlers & Clark, 2000).

Herman (1992) described trauma as happening in one of two ways: a single traumatic event or prolonged, repeated trauma. A single traumatic event could occur anywhere, while the prolonged, repeated trauma occurs when the victim cannot get away from the perpetrator. These captive situations are likely when the victim is physically not able to leave the situation, or stays with the perpetrator because of economic, social or psychological dependency. A traumatic event could consist of physical or sexual harm, verbal abuse, or even witnessing a violent act.

A person who has experienced trauma has a long journey ahead of them in terms of recovery. They have to unlearn many of the defenses they have built over the years in order to function well in society. Repeated trauma that occurs during childhood has a maladaptive impact on the development of the survivor's personality, which affects every part of his or her being, including lack of trust in others and low self-esteem (Herman, 1992).

Briere (2002) suggests that the goals of therapy with trauma survivors should be to desensitize and integrate traumatic memories, strengthen and restore coping resources within the client, and to eliminate intrusive or avoidant symptoms. In order to complete successful treatment, Briere (2002) recommends that therapy consist of regular sessions for a lengthy period of time. The time period required will vary depending on clients' symptoms related to trauma. These include affect, use of avoidance, cognitive disturbance, and the severity of negative relational schema. Brief therapy does not seem extensive enough to deal effectively with all of the issues surrounding trauma.

### *Symptoms*

It has been well documented that after a traumatic event or complicated grief has been experienced, it is likely for survivors of trauma to experience problematic symptoms (Ehlers & Clark, 2003). These symptoms can be quite intrusive and interfere with survivors' lives. In fact, an interest in decreasing symptoms associated with trauma may be one reason people seek counselling.

Previous research has shown that after experiencing a traumatic event, it is common for people to exhibit a constellation of symptoms that have been labelled posttraumatic stress disorder (PTSD) (Ehlers & Clark, 2003; Cason, Resick, & Weaver, 2002). A review of the PTSD literature was conducted by Foa and Meadows (1997) in which they reported symptoms of PTSD as including reexperiencing, avoidance/numbing, and increased arousal. Reexperiencing consisted of nightmares and flashbacks, avoidance included staying away from anything related to the trauma, and increased arousal was composed of difficulty sleeping and irritability. Herman (1992) described similar symptoms for trauma survivors including hyperarousal and insomnia. Once trauma has been experienced, survivors seem to expect reoccurrence of danger at any moment. They often are in constant anxiety and can experience worry that the trauma will continue (Ehlers & Clark, 2000).

Herman (1992) reported that trauma survivors often find traumatic events impacting them in two conflicting ways: intrusion and constriction. They continually shift between intrusion and constriction until their trauma is processed. Intrusion occurs when trauma survivors relive the traumatic event in the present through flashbacks and nightmares, resulting in them no longer feeling safe in any environment as these intrusions cause them to relive aspects of the traumatic event anywhere. Constriction occurs when survivors feel that they have no power to stop the traumatic event and feel the need to protect themselves through escaping consciously (dissociation) because they are unable to physically escape the threat. Although dissociation may be helpful for

survivors during the traumatic event, afterwards it becomes maladaptive, because the survivor does not consciously deal with the trauma. Instead, the trauma can have an unconscious impact on the survivor by manifesting itself in behavioural and physical symptoms such as pain, headaches, and gastrointestinal problems.

Ehlers and Clark (2000) suggest that PTSD occurs when survivors of trauma view the past event as a continuing and current threat. In addition, research (Gilboa-Schechtman & Foa, 2001) with 209 hospital clients who had experienced assault found that the more time elapsed from the trauma to peak reaction from the trauma, the more severe were the symptoms related to the trauma.

### *Coping*

Besides wanting to reduce symptoms, clients often seek counselling because they have been unable to resolve issues in their lives. These issues may continue to cause distress when clients lack coping skills or have developed ineffective coping styles. Thus, one goal of counselling is to help clients to learn more effective coping styles.

The most influential contributors to research focussing on coping styles over the past twenty years are Folkman and Lazarus. The styles of coping they identified and their Ways of Coping Questionnaire (Folkman & Lazarus, 1988) have been widely used and accepted in coping research. Folkman and Lazarus (1988) theorized that coping styles involve strategies that are both problem and emotion focused; coping also involves a process. They concluded that coping style varied depending on the perceived control of the situation (i.e., what was at stake at different points during and following the stressful situation). Four of their coping styles that are particularly appropriate for clients were used in this research: seeking social support, escape-avoidance, planful problem solving, and positive reappraisal.

For people who have experienced childhood abuse, coping can be a way to survive the trauma (Bass & Davis, 1988). Although Bass and Davis (1988) view all ways of coping as being necessary to get through painful experiences, they differentiate between coping styles that subsequently develop into strengths and coping styles that develop into self-defeating behaviours. They suggested that through self-reflection, ineffective coping styles could be gradually replaced by more effective coping styles. An example of an ineffective coping style is avoidance of an issue in order to avoid emotional pain (Wei, Heppner, & Mallinckrodt, 2003). Although avoidance may seem to be an effective coping strategy for the short-term, in the long run the issue does not become resolved and can continue to cause emotional pain.

Much research has been conducted examining the relationship of these coping styles to various intrapersonal variables. For example, Heppner and Lee (2002) found that a higher perception of problem solving was related to a decrease in depression, anxiety, hopelessness, anger, and interpersonal distress. Similarly, Park and Adler (2003) found that the coping style of escape-avoidance was connected with a decrease of psychological well being and physical health in medical students, while increased

psychological well being was related to the coping styles of positive reappraisal and planful problem solving.

The research on coping styles has focused on how styles affect psychological and physical states. Researchers seem to be in agreement that certain coping styles are beneficial while others can be destructive. Effective coping styles such as problem solving help to resolve client issues by helping clients deal with and work through emotional pain. If clients are able to learn more effective coping styles during counselling sessions, the result is likely to be a change in their affect by the conclusion of the therapy (Heppner & Lee, 2002). Counselling allows clients to reflect and discover new ways to deal with stressful situations. However, there seems to be a gap in the research literature concerning the effect of counselling on coping styles. The current study will investigate whether endorsement of effective coping styles increases at the conclusion of counselling.

### *Change Process in Counselling*

In order for effective client coping styles to increase and client symptoms to decrease, clients need to be actively involved in a change process. There are many models of change in counselling. However, a theory of change or healing that is specifically related to trauma survivors was developed by Herman (1992). She believes that recovery from trauma is only able to occur through relationships. These relationships need to be empowering in nature by allowing survivors to take charge of their own recovery. The therapeutic relationship is one of these safe relationships where clients can take some control and eventually experience change.

Herman (1992) suggests that recovery, and thus change, occurs in three stages: safety, remembrance and mourning, and reconnection with ordinary life. Only when clients are in a safe situation, will they be able to focus on remembering and dealing with their trauma. Safety in counselling includes allowing clients to tell their stories in their own time and to be listened to with a nonjudgemental manner. As clients begin to trust their counsellors, they will be more able to dig deeper and begin to deal with the trauma that was experienced. During the remembrance and mourning stage, survivors tell their stories of their trauma in detail. Mourning may take place for a number of losses ranging from the loss of relationships to the loss of physical mobility. In Herman's (1992) final stage of reconnection with ordinary life, the client looks toward the future by giving up a view of life as generally negative and the world as a hurtful place, by building new relationships, finding new beliefs and generally learning to interact with the world more positively. It should be evident that this type of deep level change process requires months of counselling and cannot be achieved in a few weeks.

In research on the change process, Jinks (1999) found that clients' perceptions of improved problem solving were linked to a positive emotional state. Clients identified the therapeutic relationship, specific skills used by the counsellor, and key moments of the counselling sessions as being fundamental to their change. Clients perceived the therapeutic relationship as beneficial when it was built on trust, caring, nonjudgement, and interest. When change in trauma survivors is considered, one study (Morgan &

Cummings, 1999) of a 20-session group therapy found significant decreases in depression, social maladjustment, self-blame, and PTSD symptoms. However, more research is needed to understand how change for trauma survivors in individual therapy occurs.

### ***Research Questions***

On the basis of the preceding research, the following research questions guided the evaluation of 12 extended sessions for four types of clients at London Interfaith Counselling Centre.

- Will there be a lessening of symptoms from session 12 (the point at which a standard course of therapy is currently terminated) to the final session (24)?
- Will there be an increase in coping skills from session 12 to 24?
- Will there be differences in symptoms and coping skills among the four types of clients?
- Will client demographic variables (such as age, gender, previous counselling, place of birth) be related to the amount of change in symptoms and coping skills?
- What changes will clients identify in themselves at the end of their counselling and to what will they attribute this change?
- Will there be a significant difference in symptoms and coping skills between a comparison group of clients at session 1 and the clients receiving extended sessions at session 12? This last question was needed to determine how much change typically occurs for clients between sessions 1-12 compared to sessions 12-24. Ideally, it would have been helpful to have all clients who received extended sessions complete the questionnaires after session 1 to see the amount of change that occurred for them in the first half compared to the second half of counselling. However, it was impossible to identify which clients would need the extended sessions that early in the counselling process. Thus, counselors were asked to give the Hopkins Symptom Checklist and the Ways of Coping Questionnaire to some individual clients at the end of session 1 who had characteristics of one of the four target groups. These 20 clients served as a comparison group for the treatment group.
- Were clients satisfied with their counselling experience at LICC?

## **Research Method**

### *Participants*

London Interfaith Counselling Centre received funding to extend counselling sessions from 12 to 24 for 150 clients with more severe issues: Trauma, Complicated Grief, Multiple Acute Issues, and Interim Support. From this group receiving the extended counselling, 88 clients agreed to participate in the evaluation of their counselling experience. These clients were classified as trauma (44 clients) when their main issue in counselling focused on dealing with abuse (e.g., childhood molestation, current abusive relationship). The category of multiple acute issues was used for clients (12) who presented with several issues that caused them stress (e.g., interpersonal conflicts, alcoholism, chronic unemployment). Clients categorized as complicated grief (13) were grieving the loss of a loved one or loss of a way of life (e.g., suicide of a boyfriend, diagnosis of a terminal illness). Clients waiting for referral (14) were generally supported until other agencies were able to help them. We do not have classification for 3 of the clients. For the purpose of analyses, clients were also combined into two groups: trauma clients (44) and other client issues (42). Of these 86 clients, we have posttest data on 58 clients. Some clients moved from London before final testing could be done and some clients did not return the final questionnaires to the agency. See Table 1 for demographic information about these clients.

The mean age of the clients was 39, with ages ranging from 18 to 69 years. There were 81 women and 18 men. The majority of the clients were either single (35) or divorced or separated (26). For employment, the majority were either unemployed (29) or worked part-time (27). Twenty percent of clients had completed university (18), 40% (35) had completed college, and a third of the clients had completed high school (28). The majority of clients had low yearly incomes: \$0-9,999 (36) and \$10,000-\$19,999 (15). The majority of the clients were born in Canada (77) and 8 clients were born elsewhere. Interestingly, the majority of clients (68) had received counselling in the past, while 15 clients had never before been to counselling.

### *Counsellors*

The counsellors participating in the evaluation ranged in age from 32-51 years and were 7 women and 1 man. Six counsellors had completed Masters degrees in Counselling, Social Work, or Marital and Family Therapy and one counsellor was a graduate student counselling intern. Years of experience as a counsellor ranged from 0 (intern) to 28, with a mean of 13 years. Training and orientation of the counsellors was longer-term/process-oriented (5), shorter-term/solution-focused (2), and both (1 counsellor). All of the counsellors counselled from more than one theoretical approach: person-centred (8), feminist (6), cognitive behavioural theory (6), psychodynamic (5), spiritual approaches (5), solution-focused (4), family systems (4), gestalt (3), existential theories (3), multicultural (2), developmental problem solving (1), and Jungian (1). Counsellors used the following counselling interventions with their clients: relaxation (7), imagery (6), journaling (6), eye movement desensitization and reprocessing (3), dream analysis (3), two-chair (1), narrative (1), metaphor (1), emotionally-focused technique (1), and art imagery (1).

**Table 1****Demographic Information for Clients Receiving Extended Counselling**

Variable	Level	Freq	%
Group (N = 83)	Trauma	44	51.2
	Complicated Grief	13	15.1
	Multiple Acute Issues	12	14.0
	Support	14	16.3
Gender (N = 85)	Male	13	15.1
	Female	72	83.7
Marital Status (N = 84)	Single	35	41.7
	Married	12	14.3
	Divorced/Separated	26	31.0
	Living Together	11	13.1
Work Status (N = 83)	Unemployed	29	34.9
	Part time job	27	32.5
	Full time job	16	19.3
	Social Assistance	11	13.3
Education Level (N = 85)	Elementary School	4	4.7
	Secondary School	28	32.9
	College	35	41.2
	University	18	21.2
Income Level (N = 84)	0-\$10,000	36	42.4
	\$10,001-\$19,999	15	17.6
	\$20,000-\$29,999	10	11.8
	\$30,000-\$39,999	7	8.2
	\$40,000-\$49,999	3	3.5
	\$50,000-\$59,999	4	4.7
	Not reported	10	11.8
Country of Origin (N = 85)	Canada	77	90.6
	Outside Canada	8	9.4
Previous Counselling (n = 83)	No	15	17.9
	Yes	68	79.1

## Procedure

From April 2003-April 2005, counsellors at London Interfaith Counselling Centre identified which clients in the four target groups could benefit from extending counselling from the regular 12 sessions to an additional 12 sessions, for a total of 24 sessions. At the end of the 12<sup>th</sup> session, counsellors explained the research study to clients who fit the project criteria, provided them with a packet of three questionnaires (described below). Clients who were identified as dealing with trauma received the same packet with a fourth questionnaire. At the end of the last session (24<sup>th</sup> session), counsellors provided clients with packets of the same three or four questionnaires, as well as an additional feedback questionnaire that evaluated the effectiveness of their counselling. Clients either completed the questionnaires before they left the agency or arrived early and completed them before their next session.

## *Questionnaires*

1. For the **Target Complaint Questionnaire (TCQ; Battle et al., 1966)** clients and their counsellors first agreed on two goals that the client would work on in their 12 extra sessions. Clients then rated these two issues (client goals) that were specific to them for how much the issue was currently bothering them in their lives. These two ratings were averaged to provide one total score for each client on a scale of 0-13. A lower score indicates that the issue is bothering the client less. Some typical client issues were childhood trauma/flashbacks, loss of a child, making life more stable, dealing with a family member.
2. **Hopkins Symptom Checklist (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974)** assessed general symptoms of distress that clients were experiencing. A lower score indicates that the client has fewer symptoms. The HSCL consists of five dimensions: somatization (e.g., headaches), obsessive-compulsive (e.g., having to check and double check what you do), interpersonal sensitivity (e.g., easily annoyed, temper outbursts), depression (e.g., loss of sexual interest or pleasure), and anxiety (e.g., nervousness or shakiness inside). A higher score indicates greater distress.
3. **Ways of Coping Questionnaire (Folkman & Lazarus, 1988)** measured coping strategies of clients. A higher score indicates that the client has more positive coping strategies. This questionnaire contains four scales: seeking social support (e.g., “talked to someone to find out more about the situation”), escape-avoidance (e.g., “wished that the situation would go away or somehow be over with”), planful problem solving (e.g., “I knew what had to be done, so I doubled my efforts to make things work”), and positive reappraisal (e.g., “changed or grew as a person in a good way”). A higher score indicates better coping skills.
4. **The Modified Posttraumatic Stress Symptom Scale Self-Report (PTSS; Resick, Falsetti, Resnick, & Kilpatrick, 1991)** is a scale measuring the frequency and severity of symptoms specific to trauma survivors (e.g., recurrent or intrusive distressing thoughts or nightmares about the event). Only trauma clients received

this scale. A lower score indicates that the symptoms are less frequent and less severe.

5. **Client Feedback Questionnaire** (Cummings, Leschied, & Rodger, 2003). This questionnaire measured satisfaction with the counselling and agency, qualitative questions about the change process from counselling, and suggestions for the agency. This instrument was only given after the final counselling session.

## **Results**

### *Changes in Client Symptoms and Client Issues*

The first research question examined whether clients had a significant decrease in their symptoms between sessions 12 and 24. Using the statistical procedure, MANOVA, results showed that clients reported a significant decrease in their symptoms on the three questionnaires that assessed client symptoms (Hopkins, PTSS, Target Complaint).

On the Hopkins measure of general symptoms, [ $F(6,52) = 15.73, p < .001$ ], clients had a significant decrease in their symptoms of anxiety, depression, somatization (physical symptoms such as headaches, numbness), interpersonal sensitivity (e.g., annoyance, temper), and obsessive-compulsion (e.g., double checking things). On the measure of Posttraumatic Stress Symptoms that only trauma survivors completed, [ $F(2,28) = 34.16, p < .001$ ], clients had a significant decrease in the frequency and severity of symptoms such as intrusive thoughts, intense emotions, feeling detached from others, and difficulty in concentrating. The decreases in means on each of these subscales can be seen in Table 2.

Although it is helpful to know that clients experienced a decrease in their general symptoms after 12 additional sessions of counselling, it is also important to know whether clients experienced being helped with their own specific problems. On the measure of specific client issues (Target Complaint), there was also a significant decrease in how much two specific problems were currently bothering clients, [ $F(1,47) = 52.63, p < .001$ ].

### *Increase in Coping Skills*

The second research question asked whether there would be an increase in coping skills reported by the clients after receiving 24 sessions. Once again, the MANOVA was statistically significant, [ $F(1,52) = 9.25, p < .001$ ], with clients reporting increased use of planful problem solving, positive reappraisal of themselves and their lives, and seeking social support from other people. At the same time, there was a significant decrease in their use of escape-avoidance type coping strategies such as escaping through sleep, drugs, food, or avoiding people.

**Table 2****Means and Standard Deviations for Total Score Subscale Scores on Outcome Measures**

Measure	Scale	Time					
		Session 1		Session 12		Session 24	
		N	Mean (sd)	N	Mean (sd)	N	Mean (sd)
Ways of Coping Questionnaire	Total Score	20	38.4 (9.7)	86	39.5 (9.3)	58	41.0 (8.9)
	Social Support	21	11.4 (3.9)	86	11.2 (4.1)	58	12.4 (3.4)
	Escape Avoidance	20	12.8 (5.1)	86	11.4 (4.7)	58	8.7 (5.0)
	Planful Problem Solving	21	7.8 (3.4)	86	9.0 (3.9)	58	10.2 (3.1)
	Positive Reappraisal	21	6.4 (3.9)	86	7.8 (4.0)	58	9.6 (3.2)
Hopkins Symptom Checklist	Total Score	21	145.4 (28)	86	139.4 (28.3)	58	114.0 (34.6)
	Anxiety	21	16.2 (4.3)	86	16.1 (4.5)	58	13.1 (5.1)
	Somatization	21	33.9 (7.8)	86	32.4 (8.3)	58	27.4 (9.0)
	Depression	21	34.6 (7.6)	86	33.1 (7.7)	58	26.3 (8.7)
	Interpersonal Sensitivity	21	24.9 (5.9)	86	24.9 (5.5)	58	20.2 (6.3)
	Obsessive-Compulsive	21	21.4 (4.7)	86	18.0 (4.8)	58	14.7 (4.9)
Post Traumatic Stress Scale	Frequency			44	24.1 (9.9)	35	15.2 (9.3)
	Severity			44	46.6 (13.2)	35	29.5 (12.8)
Target Complaint Questionnaire				81	9.7 (2.0)	51	7.1 (8.2)

### ***Differences in Outcome Among the Four Types of Clients***

When MANOVAs were examined for the effect of whether a client was categorized as trauma, complicated grief, multiple acute issues, or support waiting for referral, no differences were found among the four types of clients in terms of how much they improved on the outcome measures. All clients improved equally in decreasing their symptoms and increasing their positive coping skills.

Because half of the clients were categorized as trauma survivors, it was important to check whether there were any differences between clients who had experienced trauma compared to clients in the other three groups. For this purpose, we grouped together the other three types of clients into one group so that we had a trauma group (44) and a nontrauma group (42). Once again, the MANOVA indicated that there were no significant differences between the two groups on how much their scores improved for symptoms, ways of coping, and on their specific counselling issues. Both groups of clients improved an equal amount on these measures.

### ***Relationship of Client Demographic Variables and Amount of Change in Outcome***

It was also important to check whether other client variables might be related to the type of change that occurred from the counselling at LICC. Client demographic variables of age, gender, previous counselling, and place of birth (Canada vs. elsewhere) were related to the amount of change that occurred on the outcome measures between sessions 12 and 24. Using MANOVAs with these variables coded as moderator variables, there was no significant relationship for age, gender, place of birth, and previous counselling, with how much clients improved from their counselling. Clients of all ages, both genders, as well as Canadian and immigrants improved equally from the counselling.

### ***Comparison Between Session 1 Clients and Clients Receiving Extended Counselling***

The comparison group of 20 clients completed the Hopkins Symptom Checklist and the Ways of Coping Questionnaire at session 1. They were matched by client issue, age, and gender to 20 clients in the group that continued to 24 sessions. The total scores on these two measures for the group at session 1 were then compared to the matched group at session 12 using MANOVA. There were no significant differences between the two groups on these measures,  $F(1,19) = .01, p > .05$ . This finding indicates that clients at session 12 who were dealing with trauma, multiple acute issues, complicated grief, and waiting for referral had symptoms and coping strategies that were similar to clients at session 1. In other words on average, one could conclude that there was likely a larger change in scores on these instruments between sessions 12 and 24 for clients than there was between sessions 1 and 12. The implications of this result will be discussed below.

### ***Client Satisfaction with Counselling Experience***

Besides determining that clients significantly improved in their symptoms and ways of coping with life, clients also completed an evaluation form about their counsellor, the agency, and the effectiveness of their 12 additional sessions. Client responses to these questions are presented in Appendix A. In summary, clients were very satisfied with the service they received from their counsellors, felt much more able to deal with their concerns, felt healthier/better about their issues, and were very willing to refer someone to LICC. Finally, they felt that the 12 additional sessions were very helpful. The qualitative data presented next describes the *how* and *why* of what was helpful about the extended counselling for these clients.

### ***Internal and External Changes Identified by Clients***

The preceding results were all based on quantitative measures that indicate some of *what* changed for the clients who received extended sessions. However, to know more specifically what changed in clients lives and *why* it changed, it was necessary to ask clients to write about their perceptions of the changes that they experienced as a result of their counselling sessions. To assess internal changes, clients answered the following question, “What changes have occurred in *you* as a result of your additional 12 sessions of counselling?” To assess external changes, clients then answered the following question, “What changes have occurred in your *life* as a result of your additional 12 sessions of counselling?”

Because qualitative analyses of written comments are very time consuming, responses to these questions were coded for a representative sample of 44 of the 88 clients into as many of the following eight categories as were relevant for each client: (a) Insight, (b) Experiencing Feelings, (c) Counselling Relationship, (d) Self-Growth, (e) New Ways of Being, (f) Life Transitions, (g) Improved Relationships, and (h) Improved Health. Table 3 contains the frequencies for each of these types of change.

Examples of ***Self-Growth*** were the most frequent type of internal change (27%) described by these clients. Their answers described such things as (a) increased confidence and self-esteem (e.g., “I learned that I could handle things as I am a strong person”); (b) increased emotional strength and increased ability to take control and make changes in their lives (e.g., “I now have the courage and strength to make certain decisions that I feel have been long overdue”); (c) newfound hope with an increased focus on the future (e.g., “I am stronger and was able to focus on the future, rather than the past and present”); and (d) increased awareness regarding the self (e.g., “I came to see, feel and know how I internalized things almost as an instinct”). Samples of complete answers to these questions are contained in Appendix A at the end of this report.

The next most frequent type of change (25%) for these clients was ***New Ways of Being***, a more external type of change. Clients reported trying new behaviours such as learning parenting skills, dealing with stress, and communicating in better ways (e.g., “I’ve learned strategies on how to better deal with people”). They also often commented

on learning how to say no to others and beginning to put themselves first (e.g., “I don’t work to make my parents happy. I do it for me”).

Less frequent types of internal changes in these clients included gaining *Insight* about themselves (e.g., “I got to know myself better and really saw what I was about”) and coming to realizations about their lives (e.g., “I realize my marriage was a possible mistake”). *Experiencing Feelings* was another type of change (10%) which included decreases in feelings of anxiety (e.g., “Increased ability to make decisions without anxiety”) and experiencing increased hope (e.g., “I feel quite different about myself- less shame, less guilt”).

Other, more external changes, included increased *Satisfaction with Relationships* (e.g., “I’ve had better relationships with boyfriend, friends, and family”); *Life Transitions* of employment (e.g., “I’ve given my notice at work”), changes in residence (e.g., “Moved in with daughter’s family”), and pursuing education (e.g., “I am going back to school”); and *Improved Health* such as better sleep and health being improved through physical activity (e.g., “I am physically healthier... exercising/doing yoga”).

**Table 3*****Frequencies and Percentages of Types of Changes Identified by Clients (N = 44)***


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Categories	Frequency	Percentage
Insight	14	10.8
Experiencing Feelings	10	7.7
Counselling Relationship	8	6.2
Self-Growth	36	27.7
New Ways of Being	33	25.4
Life Transitions	10	7.7
Improved Relationships	9	6.9
Improved Health	10	7.7
Total Responses	130	

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*Note.* Participant responses of several sentences were often coded into more than one category. Percentage was calculated by dividing the number of response units for each category by the total number of responses for 44 clients.

***Components of Counselling that Contributed to Client Change***

Clients were also queried about what in their counselling helped their changes to occur. Table 4 portrays the frequencies and percentages of responses for this question. The ***Counselling Relationship*** was the most frequently mentioned reason for change in clients (55%). Many clients indicated that being listened to and not being judged by their counsellor was what was most important in helping them to change (e.g., “Someone who listened and who cared about my thoughts and feelings,” and “She never judged me”). Other clients mentioned receiving advice and guidance from their counsellor as being important, as well as being validated (e.g., “Realization of the need to express my feelings more and have them validated,” and “She listened, commented, guided and offered concrete opinions...”).

The second highest contribution to change described by these clients was gaining *Insight* (20%). For trauma clients, realizations about abuse or the past and how to integrate their trauma were listed as contributing to their change (e.g., “I needed someone to listen and help me see patterns of abuse I experienced. I needed to appreciate that I am a survivor”). Other examples of how insight contributed to client change included: “Realizing how I used to deal with stress and other people,” and “Coming to realize that I judged myself for my brother’s death because my parents withdrew after he was killed.” A less frequently mentioned contributing factor to client change was *Experiencing Feelings*, including normalizing feelings and the counsellor’s empathic ability (e.g., “The time to discuss and open up about my feelings”), and specific feelings that they worked on during their sessions (e.g., “The counsellor’s sensitivity to these... self-esteem and confidence issues”).

**Table 4**

*Frequencies of Components of Counselling that Contributed to Client Change*

Categories	Frequency	Percentage
Insight	12	20.0
Experiencing Feelings	7	11.7
Counselling Relationship	33	55.0
Self-Growth	3	5.0
New Ways of Being	5	8.3
Total Responses	60	

*Note.* Participant responses of more than one sentence were often coded into more than one category. Percentage was calculated by dividing the number of responses for each category by the total number of response units for that client group.

## **Conclusions and Implications of the Evaluation**

The clients at London Interfaith Counselling Centre who received extended counselling of 12 additional sessions to deal with trauma, complicated grief, multiple acute issues, and support while waiting for referral improved significantly on their symptoms of distress, on their specific goals in counselling, and in their coping skills between sessions 12 and 24. These results, combined with the high ratings of satisfaction with the counselling experience that clients provided, indicate that the counselling provided by the counsellors at LICC was very effective in helping clients to become less anxious, less depressed, have fewer physical problems, less flashbacks and intrusive thoughts about their trauma, less use of avoidance coping and more use of positive reappraisal of themselves and their lives.

These findings are congruent with research conducted by Heppner and Lee (2002). They suggested that if clients learn effective coping styles, such as problem-solving, they should also experience a positive change in affect. Learning new coping skills and/or strengthening coping skills may help clients to deal with their target issues more effectively, which likely helps in decreasing their symptoms.

In addition, all clients, on average, showed equal improvement on all measures regardless of their type of client issue, age, gender, birth place, and previous counselling experience. This result indicates that these clients were more alike than they were different. In other words, clients were similar in that the client issues of trauma, complicated grief, and multiple acute issues are all complex problems that require more time in counselling sessions.

### ***The Impact of Counsellors on Change in Clients***

The improvement by all clients also indicates that the counsellors were equally effective in the work they did with many different types of clients, likely because they were highly trained, skilled counsellors who could work at a deeper level with clients. The central importance of the counsellors to the change process of these clients was further highlighted in the qualitative, written response from clients. The majority of clients wrote about the counselling relationship as the important part of the counselling process that facilitated the changes that occurred in themselves and in their lives.

Herman (1992) believes that trauma survivors only heal through a relationship where they feel safe during the counselling process, which involves being in control of what they discuss and being listened to by a nonjudgemental counsellor. Herman further states that clients need to tell their story and deal with their repressed feelings in association with the trauma that they experienced. It appears that the counsellors at LICC were successful at achieving these goals with these clients. Change for clients in this study appeared to be a direct result of their relationship with their counsellor, specifically experiencing a kind, competent person who listened nonjudgementally and genuinely cared about them. Furthermore, some clients spoke about the need to hear another person's perspective on their issues, gaining insight, and having a safe place to talk about

their feelings. For some clients, their relationship with their counsellor may have been the safest and healthiest relationship they had experienced until this point. In order to begin to change and experiment with new ways of being, clients need a safe base for when they have difficulties or setbacks and the counsellor relationship in this study seems to have provided them with that base, as described in their written responses.

### ***The Impact of Extended Sessions***

Although 12 sessions of counselling can be sufficient for some client issues such as dealing with an immediate crisis, getting job ready, learning parenting skills, there are other client issues that require more sessions. The central goal of this evaluation was to determine whether clients who were dealing with trauma, complicated grief, multiple acute issues, and support while waiting for referral benefit from receiving 12 additional sessions. Did they need 24 sessions to begin the healing process from these deeper, more complex client issues?

To answer this question, several approaches were taken. First, we compared the scores of these clients on symptoms and coping skills at session 12 (when they normally would have had to stop their counselling) with similar clients who were just beginning counselling at session 1. Finding no difference in scores between the two groups, is one indication that the treatment group had not yet been able to make changes in themselves by session 12. This finding is *not* due to any lack of skill on the part of counsellors in the first 12 sessions, but is directly due to the time required to heal from deep level trauma.

When Herman's (1992) three stages of recovery for trauma survivors and Freeman and Ward's stages of grieving are considered, it is clear that clients need months rather than weeks to begin the healing process from childhood trauma and complicated grief. In particular, for clients who have had their basic trust in caregivers shattered at an early age through abuse, it takes much time for them to learn to trust a new counsellor to feel safe enough to even tell their abuse story. Once clients begin the remembrance and mourning stage, much time is needed because their story does not usually come in a linear whole, but comes in fragments and flashbacks that are triggered as more work is done. Then much time is needed to integrate this new information into who they are as a person (e.g., "I needed someone to listen and help me see patterns of abuse I experienced. I needed to appreciate that I am a survivor"). Some clients would be in the middle of this process at session 12 and it would be a traumatic loss for them to have to lose the one person that they feel safe with (their counsellor) at that point.

The third stage, reconnection with ordinary life, also takes time to help clients develop more helpful coping skills, better interpersonal relating, and more positive views of themselves. For recovery from trauma, Herman (1992) believes that clients need to replace negative views on the world as a hurtful place with more positive views of the world. Trauma survivors also often believe that they somehow deserved it, especially when the perpetrator is a loved one or caretaker which can lead to decreased confidence and self-esteem. This is the stage that clients most often wrote about in answer to what changed in them. They described their self-growth and their new ways of being in the

world by writing about having found hope, increased emotional strength, ability to take control of their lives, ability to make changes, and letting go of the past. Not all clients will have completed their healing process in 24 sessions, but they all reported making significant progress in their healing.

The necessity of 24 sessions for this healing process to begin is best exemplified by the words of LICC clients:

- “The first 12 sessions helped identify my issues involving native identity, abuse by others, self abuse. My issues were complex including the illness of my daughter with a major mental illness. The additional 12 sessions helped me find ways to cope and overcome issues and problems.”
- I was given additional sessions and with that I found how I could put what I had learned about myself to practical use. I found how I suppressed things I didn't need to in my 1<sup>st</sup> 12 sessions (only one of the things I found about myself). In my next 12 sessions I came to see, feel and know how I internalized things almost as an instinct. I came to sense this was happening and discovered healthy and safe ways to start a new pattern in this way. This was just one of the new beginnings I could see happening. The first 12 sessions were only about 1/3 of the growth and action I see in me now. I had to be guided into actions that were safe for me or it might have taken another 20 years- if I lived that long.

### ***Recommendations***

- Provide a minimum of 24 sessions of counselling to clients who are dealing with deeper, more complex issues of trauma, multiple acute issues, complicated grief, and support while waiting for referral to another health care provider.
- Continue to evaluate the changes that clients make in their counselling at LICC.
- Support counsellors in continuing education through workshops and conferences on client issues of trauma and grief.

## Appendix A

### Client Feedback

3= Very                      2= Moderately                      1= Somewhat                      0= Not at all

\*The following information is based on 48 Questionnaires

1. **How satisfied were you with the service you received from your counsellor?**  
Average score = 2.91
  2. **How well do you feel that your counsellor addressed your concerns?**  
Average score = 2.91
  3. **After talking with your counsellor, how much more capable of dealing with your concerns did you feel?**  
Average score = 2.66
  4. **How willing would you be to refer someone else to this service?**  
Average score = 2.89
  5. **How satisfied are you with the amount of time it took for you to be seen by a counsellor?**  
Average score = 2.57
  6. **How affordable was the fee for you?**  
Average score = 2.74
  7. **Did your counselling deal with spiritual issues?**  
Yes = 28                      No = 20
- How satisfied are you that your spirituality was respected by your counsellor?**  
Average score = 2.86
8. **Looking back on where you were at the 12<sup>th</sup> session and where you are now, how helpful were your additional 12 sessions of counselling?**  
Average score = 2.95
  9. **How much better/healthier do you feel about the issues that you worked on in your counselling?**  
Average score = 2.67

**10. What changes have occurred in you and your life as a result of your 12 additional sessions of counselling?** (Sample of answers)

- The first 12 sessions helped identify my issues involving native identity, abuse by others, self abuse. My issues were complex including the illness of my daughter with a major mental illness. The additional 12 sessions helped me find ways to cope and overcome issues and problems.
- I can't believe the difference. I wish it was longer. I was happier and more productive with the second set of sessions. I got to know myself better and really saw what I was about. I learned that it was okay to say no to others. To take some time for me. I learned that I could handle things, as I am a strong person. Sometimes it takes bouncing thoughts to someone else for me to see what I need to do or change. I also learned that I am not the only person who can have these issues. I am not alone.
- I was given additional sessions and with that I found how I could put what I had learned about myself to practical use. I found how I suppressed things I didn't need to in my 1<sup>st</sup> 12 sessions (only one of the things I found about myself). In my next 12 sessions I came to see, feel & know how I internalized things almost as an instinct. I came to sense this was happening and discovered healthy and safe ways to start a new pattern in this way. This was just one of the new beginnings I could see happening. The first 12 sessions were only about 1/3 of the growth and action I see in me now. I had to be guided into actions that were safe for me or it might have taken another 20 years- if I lived that long.
- I felt like I was better able to deal with my issues because there was just that much more time to have someone help me work my issues out. I think it would have been a negative thing for me to end at the 12<sup>th</sup> session. More progress was made later on (after the 12<sup>th</sup>) because I knew my counsellor better.
- At the very end of my first 12, I just started to break through on what had happened to me. If I was not able to continue I would never have been able to deal with it and set it free.

**11. What was it in your counselling that helped these changes to occur?** (Sample of answers)

- Someone to encourage me, to make me do the homework, to make time for myself. To be honest with myself. To really soul search for my own answers.
- Lots of talking. The opportunity to vent. Through discussion I am able to sort out feelings and thoughts better. It helps to feel understood.
- She didn't solve or try to label my issues/problems. She allowed me to share openly and honestly and was able to feel my pain and my joy.
- Talking and being listened to. Being encouraged.

**12. What was most helpful about our counselling service? (Sample of answers)**

- The service was quickly arranged. The service was geared to income. The service provided an excellent counsellor.
- Someone telling you you're not crazy and lots of hope for the future. A safe place to go every week.
- Reassurance, support, easy access, availability of appointments- (not having to wait long). Referral to other services.
- Understanding, safe place to be. EMDR. Sliding scale. Flexibility. Caring counsellors.

**13. Did this counselling assist you with your return to work Action Plan?**

Yes = 13      No = 35

**If so, how? (Sample of answers)**

- I was quite immobilized when a present crisis of my daughter's illness and job loss set off past trauma of my own abuse experiences.
- Allowed me to work on personal issues, which were acting as a barrier to return to work action.
- I know I can't work full-time and it's not all mental. I have physical problems as well and finding a doctor has been a problem. I have one now, thanks to my counselling the support and encouragement she gave me.
- My counsellor has helped me enormously on writing my resume. Helping me to feel confident in putting my skills in perspective and on education.

**14. Do you have any suggestions for improving this counselling service? (All answers included)**

- For me it would be appreciated to have your counsellors set up to deal with funding for natives. I qualify for funding and need more counselling to resolve some more issues but I need to go elsewhere for this. Keep up the good work. Thank you.
- Yes, it is nice for the students to participate. But I feel that I lost time having to switch counsellors, getting them up to speed, and continuing to talk (trusting yet another person with my troubles). I found that hard, but worthwhile as the 2<sup>nd</sup> counsellor was more help.
- Not limit the number of sessions a client can attend. It has taken me years to get messed up, how can I possible change my life in 12-24 sessions?
- The only thing that bothered me is the wait to see a counsellor outside of interfaith is 3 months. I appreciate the extended 12 sessions, but I am at a place were I need it most, no one could see this coming, I just got used to a counsellor and although I know this is supposed to be brief counselling, I want to talk to Terri-Lynn and I can't. At the time in my life I need it most, I can't have it and it's frustrating, but I guess I knew this at the beginning and will just have to accept it. I am sorry if I am bitter, I really did appreciate your services.

- At times I wanted her to talk more, to tell me/help me decide what to do. I realize now that I had to do it on my own. At times it was frustrating to think I just talked for one hour and didn't get much feedback. Other times I got lots.
- For myself I would have appreciated more info on step-by-step "how to" overcome shame, guilt, lack of self-worth. Just love yourself means not too much when love is something which has been distorted and or absent from your life. Something to NOT view the world as such a terrifying place. I did not know how to trust the process.
- More counselling would mean healthier people in the community. There is a great deal of work needed there. I feel I need more and hope to return in six months as a new person.
- Allow clients to undergo therapy as long as necessary to address their problems.
- Creating a once a month or every two month feedback/continuing service at a low price.
- Yes, more funding so more people can become healthier
- Please make it long term, I still need to talk but now I'll just have to start over with someone new.
- Lobbying the government to include services like this one under OHIP.
- Perhaps a tapering off after 12 sessions, even though it's been a year, I still feel a little dependent on this counselling and I wonder how I'll be on my own, even though I have 6 months to go and I could come back or see counselling at my place of work. Perhaps a journal keeping thing- and seeing my counsellor in 2 month intervals for the next 6 months. Some accountability on my part, or a checking in system. Thanks.
- I had a wonderful counsellor, she did a great job I just needed more time. I am afraid I won't survive it a second time not as bad as I was, but the fear is there and the denial but sometimes reality rears its ugly head.
- Having more sessions and perhaps giving the counsellor more discretion in who requires more counselling and allowing some people who need it to do so. I feel sad that I will have to look elsewhere to continue my counselling and that I can only return after 6 months.

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