School of Psychological Sciences and Health

Counselling Unit

Effectiveness, Process and Outcomes in School-Based Humanistic Counselling

Katherine McArthur

PhD Counselling

2013

Declaration of Authenticity and Author's Rights

This thesis is the result of the author's original research. It has been composed by the author and has not been previously submitted for examination which has led to the award of a degree.

Signed: Date:

Statement on Previously Published Work

Chapter 2 is based on a co-authored chapter by Katherine McArthur and Professor Mick Cooper, which was commissioned for the SAGE Handbook of Counselling Children and Young People. Katherine McArthur drafted the manuscript, and Mick Cooper gave critical feedback and contributed to redrafting. The final draft was written, and subsequently adapted for this thesis, by Katherine McArthur.

Chapter 4 has been published in *Psychotherapy Research* as a co-authored article by Katherine McArthur, Mick Cooper and Dr Lucia Berdondini, and was adapted for this thesis by Katherine McArthur. The study was designed and implemented by Katherine McArthur, who recruited schools, counsellors and participants, managed the day-to-day running of the trial, collected data and conducted all analyses. Katherine McArthur wrote drafts of the manuscript and Mick Cooper wrote redrafts. Lucia Berdondini gave critical feedback and contributed to redrafting, and Katherine McArthur wrote the final draft. For this work, Katherine McArthur was given the Outstanding Research Award by the British Association for Counselling and Psychotherapy in February, 2013.

Chapter 5 is being prepared for publication as a co-authored chapter by Katherine McArthur, Adam Morrison, Mick Cooper, Lucia Berdondini and Professor John McLeod. Katherine McArthur designed and implemented the study, collecting all data. Adam Morrison participated in interviews, completed measures and wrote a short section in response to the analysis. Mick Cooper, Lucia Berdondini and John McLeod contributed to analysis led by Katherine McArthur, as detailed in

the text. Katherine McArthur wrote drafts of the manuscript; Mick Cooper, Lucia Berdondini and John McLeod gave critical feedback and contributed to redrafting.

Chapter 8 is an extension of a single authored article by Katherine McArthur published in *Therapy Today*, 2011, adapted for this thesis by Katherine McArthur.

All remaining chapters were solely authored by Katherine McArthur and have not previously been published.

Signed: Date:

Acknowledgements

I would like to thank all the clients, counsellors and school staff involved in this study for their hard work and commitment, the Economic and Social Research Council and the British Association for Counselling & Psychotherapy for funding this work, and Susan McGinnis for her help in establishing the project in its early stages.

I am deeply grateful to my supervisor Professor Mick Cooper who has inspired me to do the best work that I can, and offered genuine support throughout. I am equally grateful to my second supervisor Dr. Lucia Berdondini for her warmth and perceptiveness. I consider myself exceptionally fortunate to have worked with two such inspirational people: as a team their integrity, empathy, and intelligence has allowed me to complete this work with minimal stress and maximal enjoyment, and to move forward in my academic career with confidence.

I would like to extend special thanks to three colleagues: Professor John McLeod, for his influential work on research methodology, and for his invaluable advice; Karen Cromarty for her compassion and support, and Nancy Rowland for her encouragement and kind words.

For personal support I am indebted to Campbell Miller (who also proof read the thesis), my wonderful family and extended family, the former regulars of the Wednesday night Halt Bar open mic, the attendees of girls' night, all those involved in the Barrowlands Project, the previous inhabitants of the Crawfurd building's 3rd floor, Marley Wilson, my office mate Deborah Heard, and Steven Patrick Morrissey.

Part I

Part II

Part III

Part IV

List of Tables

List of Figures

Abstract

School-Based Humanistic Counselling (SBHC) is prevalent in the UK and directed towards the broad construct of psychological distress. Evidence of its effectiveness is limited, and little is known about the processes of change involved. This study aims to test the effectiveness of SBHC and develop understanding of change processes which may lead to enhanced outcomes. Young people aged 13-16 were recruited to a pilot randomised controlled trial comparing SBHC to a waiting list control for one school term (approximately 12 weeks). Psychometric measures were taken at baseline, midpoint and endpoint; adapted Client Change Interviews were conducted at midpoint and endpoint. The primary outcome was psychological distress as measured by YP-CORE. Case material from one male 14 year old participant was systematically analysed by an inquiry group and independent adjudicator. Transcripts from Client Change Interviews with 14 participants allocated to SBHC were analysed using a grounded theory approach. Young people allocated to SBHC showed significantly greater reduction in psychological distress, the primary outcome, with an effect size (*g*) of 1.14 at 12-week endpoint assessment. A range of positive outcomes were reported, including benefits to education. Five potential change processes for young people in SBHC were identified: relief, increasing self worth, developing insight, enhancing coping strategies and improving relational skills. Two processes potentially impeding change were identified: difficulty talking, and time limit. Case material suggested that SBHC made a major contribution to positive change, in addition to changes in parents' behaviour. SBHC reduces psychological distress in young people. Positive change may occur through a complex social process involving the young person's significant relationships. A range of processes are helpful to clients, and not mutually exclusive. Recommendations for further research include further RCTs including economic analysis, a wider range of systematic case studies and more in-depth qualitative analysis of change processes.

Part I

Chapter 1. Introduction

The purpose of this study is two-fold: to test the effectiveness of school-based counselling for young people, and to understand the processes of change that young people go through when they engage in it. By testing effectiveness, I hope to enhance the evidence base for this intervention, an alternative to Cognitive-Behavioural Therapy (CBT) geared specifically towards psychological distress. A more robust evidence base for school-based counselling has the potential to impact on policy and increase access to counselling in UK secondary schools. By understanding the processes of change, I hope to contribute to improvements in practice which will ultimately enhance the outcomes of school-based counselling for young people.

1.1 Personal motivation

My personal motivation to undertake this work comes from professional and personal interest in both empirical research and humanistic therapy. As a professional, my roles as researcher and counsellor have been intertwined to a large extent, and have led me to undertake this work. As a researcher, I worked on various psychology-related projects before training as a counsellor. After training, I had the opportunity to work as a researcher on two projects in parallel: one was a scoping study of the needs and rights of disabled children within the UK child protection system, and the other was the first pilot randomised controlled trial (RCT) of school-

based counselling. These projects cemented my interest in working with children and young people particularly, and allowed me to conduct research within a more humanistic approach. The steep learning curve involved in conducting a pilot RCT prepared me to develop and test an alternative set of procedures, as well as providing me with professional links to the British Association for Counselling and Psychotherapy (BACP). In making me more aware of the political imperative for rigorous research to secure the future of humanistic therapy, this experience made me both more motivated and more equipped to address it through this study.

A key aspect of my interest in school-based counselling is political. Private counselling sessions are only available to a minority of potential clients. State funded and voluntary sector services, where they exist, tend to offer counselling for specific populations, e.g. drug and alcohol counselling, or depend on psychiatric diagnosis. However, schools are environments with the potential to host universally accessible counselling services for pupils. This is not an ultimate solution to problems of access, since a proportion of young people in need of professional support do not attend school, and adults in psychological distress also have limited options for obtaining professional support. However, given the current provision of counselling services in Welsh and Northern Irish schools, applying this model to the rest of the UK seems like an achievable and important step towards a fairer system.

1.2 Prevalence of psychological distress in young people.

Ridner (2004) conducted a concept analysis of the term ‘psychological distress’ and proposed five defining attributes: ‘1) perceived inability to cope effectively, 2)

change in emotional status, 3) discomfort, 4) communication of discomfort, 5) harm' (p.539). The inversely related concept of 'mental health' is described by the World Health Organization (2010) as 'a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'. In health and psychological literature which discusses specific diagnosable psychiatric disorders (e.g. Aneshensel & Sucoff, 1996; Belfer, 2008), the phrases 'mental health problems' or 'mental health disorders' are used interchangeably to refer to the presence of a psychiatric diagnosis.

The key difference between 'psychological distress' and 'mental health problems' is that the former is conceptualised as an experience arising as a natural human response to life events or circumstances. While this model of distress does not necessarily imply deficiency in the person, focusing on distress reduction as a desirable outcome of counselling aligns this study to some extent with the medical model. It is worth noting that a growth-oriented approach would be more consistent with the humanistic tradition. However, stakeholders, commissioners, policy-makers and researchers more commonly subscribe to the conventional distress-oriented approach, reporting on diagnosable mental illnesses. Therefore, a pragmatic decision was taken to focus on psychological distress, which is a broader construct than mental illness, such that diagnosis of a mental disorder indicates the experience of psychological distress, but psychological distress may also be experienced in the absence of a diagnosable disorder. This means that the prevalence of psychological distress is to some extent indicated by the available information on mental health problems, but may be a more widespread problem.

The World Health Organization (2006) reports widespread and growing incidence of mental health problems in young people, and latest UK figures indicate that 10% of 5-16 year olds have a diagnosable mental health disorder (Green, McGinnity, Meltzer, Ford & Goodman, 2004). Additionally, it is estimated that half of all mental health problems begin in childhood and adolescence (Belfer, 2008; Kessler et al, 2005). Specifically, major depressive disorder tends to begin in adolescence (Weissman et al., 1999), and has been identified as a risk factor for suicide (Brent et al, 1993; Gould et al, 1998; Shaffer et al, 1996). Suicide is reported to be the fourth leading cause of death for young males, and the third for young females, though suicide rates are higher among males than females (Wasserman, Cheng & Jiang, 2005). Research shows that mental health problems often persist into adulthood (Geller, Zimmerman, Williams, Bolhofner & Craney, 2001; Weissman et al, 1999; Woodward & Fergusson, 2001) and have been linked to physical health problems in later life, such as cardiovascular disease (Goodwin, Davidson & Keyes, 2009).

1.3 Rationale for developing an alternative intervention

A widely available type of therapy, particularly in health settings, is CBT - a directive approach developed by Aaron Beck and colleagues (1976; Beck et al., 1979), which contrasts to relatively non-directive humanistic approaches. The central aim of CBT is to identify and change unhelpful processes of thought, feeling and behaviour which are associated to mental health problems such as depression and anxiety. Within the CBT model, different experiences of distress

are systematically labelled (using psychiatric diagnosis) and understood to be part of a vicious cycle determined by the individual's life experience. CB therapists often allocate a specific number of sessions according to the diagnosis, and work with the client to understand and overcome the vicious cycle underlying their problem. While humanistic approaches tend to characterise the relationship between client and counsellor as therapeutic in itself, CBT conceptualises this relationship as a vehicle through which to undertake the work of highlighting and modifying problematic thoughts, feelings and behaviours.

CBT is well represented in effectiveness research for psychological therapies, since 12 out of 15 'empirically supported treatments' take a cognitive-behavioural approach (Roth & Fonagy, 2004). However, studies have shown that for adults who are more reactive (Beutler, Harwood, Michelson, Song & Holman, 2011), have internalised coping styles (Beutler, Harwood, Kimpara, Verdirame & Blau, 2011) or *prefer* non-directive approaches (Swift, Callahan & Vollmer, 2011), non-directive therapies may be more effective. Similar studies have not yet been conducted with young people, but evidence shows that a proportion of depressed young people do not respond to CBT (e.g. Brent et al, 1997; Birmaher et al, 2000). Brent et al (1997) report that 64.7% of adolescents allocated to CBT in their trial experienced remission, i.e. an absence of major depressive disorder. While this is encouraging evidence for CBT, 35.3% of adolescents allocated to CBT did not recover, which is one reason for developing and testing alternatives.

Another key difference between CBT and humanistic therapies relates to the formulation of distress. CBT, which emerged from the tradition of behaviourism in psychology (Skinner, 1974) is targeted at specific symptoms which relate to diagnosable mental health disorders such as depression and general anxiety. Conversely, humanistic approaches conceptualise distress as an individual's unique response to their lived experience. Speaking in 1981, Carl Rogers described this approach, saying: 'it definitely rejects the medical model which involves looking for pathology and developing a specific diagnosis, or thinking of treatment in terms of cure. That model seems to me quite inappropriate for dealing with most psychological problems' (2007; p.1). As an alternative to concepts of mental illness, psychological distress is the experience of unpleasant emotional states which arise as a human reaction to stressful and/or harmful life circumstances including, but not limited to, sadness and anxiety (Ridner, 2004). Since CBT is not geared towards this formulation, there is no evidence of its effectiveness in reducing psychological distress, which is another reason to test alternative approaches.

A further argument for developing and testing humanistic approaches for young people relates to the potential impact of diagnosis itself. One study showed that among young people diagnosed with a mental health disorder, the majority chose to frame their problems in non-pathological terms, and those who described their problems in terms of mental illness had higher levels of self-stigma and depression and a lower sense of mastery (Moses, 2009). Other research has indicated that mental health diagnosis is actively avoided by young people (Biddle, Donovan, Sharp & Gunnell, 2007) and can be harmful to a young person's developing identity (Wisdom & Green, 2004). The potential negative impacts of diagnosis are also noted by the

Society for Humanistic Psychology in response to the newly published 5th edition of the Diagnostic and Statistical Manual (DSM-5), stating specific concern for children and young people whose normal development may be pathologised (Statement of Concern, available at: http://dsm5response.com/statement-of-concern/). It may be that some young people prefer a less stigmatising approach, in which initial diagnosis is not necessary, and therefore CBT may not be an appropriate treatment.

Alternatives to CBT are required as a response to mental health problems in young people on the grounds that it is not effective for a proportion of young people with depression; it is untested as an intervention for the broader construct of psychological distress; and it is dependent on psychiatric diagnosis, which for some young people is unhelpful, or undesirable.

1.4 Historical background

1.4.1 The development of school-based counselling

Counselling services in UK secondary schools first emerged in the 1960s, and became more prevalent during the 1970s, but this early growth was followed by a period of steep decline (Baginsky, 2004). Jenkins and Polat (2005) reported a resurgence in the 1990s, and recent research on the subject indicates that the majority of secondary schools across the UK now have a dedicated counselling service for pupils (Cooper, 2013).

More specifically, all Welsh secondary schools have a counselling service for pupils and in Northern Ireland, provision of school-based counselling includes all post-primary and all secondary schools (Cooper, 2013). In both Scotland and

England, a proportion of secondary schools remain without a counselling service, and provision varies widely between regions: estimates indicate 64-80% of Scottish and 61-85% of English secondary schools have a counselling service for pupils (Hanley, Barlow, Humphrey, Jenkins & Wigelsworth, 2012). From the approximate data available, Cooper (2013) has calculated that for young people in England of secondary school age, rates of attendance at NHS Child and Adolescent Mental Health Services (CAMHS) appear to be roughly equivalent to rates of attendance at school-based counselling, suggesting that the latter is a key source of therapeutic support for young people in the UK today.

Internationally, school-based counselling is prevalent: well-established in 23 countries and compulsory in 37 countries, 32 American states, one Australian state and two Canadian provinces (Harris, 2013). The practice of school-based counselling varies in nature from country to country, and in US schools includes career guidance as well as predominantly group-based therapy informed by CBT (Baskin et al, 2010; Dimmitt, Carey & Hatch, 2007; Cooper, 2013). In approximately one third of countries, school-based counselling services tend to employ a predominantly humanistic, person-centred model, though individual therapy is common in only 17 countries (Harris, 2013). In the UK, one-to-one therapy sessions are typical, focusing on emotional support as opposed to career guidance, and the humanistic model is the most prevalent (Cooper, 2009; Hill et al, 2011; Cooper, 2013).

1.4.2 The humanistic tradition

Humanistic psychology has represented an alternative to medicalised views of distress since its emergence in the 1950s, and stands in contrast to the more

established approaches of psychoanalysis and behaviourism (associated to Sigmund Freud and B.F. Skinner, respectively). Humanistic thought is rooted in existential philosophy and has been applied to psychology by Abraham Maslow in his 'hierarchy of needs' (1943) and by Carl Rogers in his development of client-centred therapy (1951; 1957; 1959).

Humanistic psychology focuses on the meta-consciousness of human beings, their social nature, their inherent tendency towards creativity and empathy, and their capacity for growth and self-actualisation (e.g. Rogers, 1951; 1957; 1959; Finke, 2002). Rogers' development of client-centred counselling (a type of individual personal therapy) is one articulation of the person-centred approach (a way of relating which is not specific to individual therapy). Humanistic psychology is broader still, incorporating the person-centred approach and including related approaches like positive psychology and transpersonal psychology.

Research in humanistic psychology suggests that psychological distress occurs when an individual's behaviour is motivated not by intrinsic needs and desires, but by the expectations of others (Patterson & Joseph, 2007; Ryan & Deci, 2000; Sheldon & Elliot, 1999; Sheldon & Kasser, 1998). The goal of humanistic therapy is to facilitate accurate symbolisation of emotions and empower the person to work towards a way of being which reflects their full potential (see Cooper, O'Hara, Schmid & Wyatt, 2007; Mearns & Thorne, 2007; Presbury, McKee, & Echterling, 2007; Rogers, 1959). Humanistic therapy allows clients to understand and accept their authentic lived experiences, with the aim of moving towards greater self-congruence (Rogers, 1959; Sheldon & Elliot, 1999; Sheldon & Kasser, 2001) and attunement to their own valuing processes (Patterson & Joseph, 2007).

Humanistic theory holds that a relationship with a genuine other characterised by empathy and unconditional positive regard can relieve distress by reducing incongruence between self-concept and experience (Rogers, 1959). The therapy emanates from a genuine egalitarian relationship formed between client and therapist, based on deep valuing of the client's expressions of their experience. Unlike forms of therapy based on deficiency, humanistic therapy does not aim to remove a problem and return the client to a previous, problem-free state. Rather, the individual is seen as constantly evolving, and therapy is conceptualised as a healing experience which can be interpreted and used by the client in a unique and unpredictable way.

In the person-centred approach specifically, developments since Rogers' original formulation have led to what Sanders (2007) dubbed a 'family' of person-centred therapies, varying in the degree to which they respond to the theory and incorporate new ideas. One point of differentiation within the person-centred approach is the degree of therapist intervention, ranging from 'principled non-directivity' (associated with the most classical incarnations of person-centred counselling) to 'process directivity' (a central aspect of experiential therapies, such as focusing). Principled non-directivity is an expression of respect for the client's pace and individual process, coupled with faith in the client's right to self-determine and ability to self-actualise. Classical person-centred therapists reject the expert role by following the client's self-directed process, with the aim of empowerment. However, many researchers and therapists (e.g. Stinckens, Lietaer & Leijssen, 2013; Elliott, Watson, Goldman & Greenberg, 2004) interpret the principles of the person-centred approach in a way that allows for *process* directivity, where the counsellor

may make suggestions and offer input to facilitate the process of therapy (perhaps by helping the client to access and express emotions) without directing its content. In contrast, psychoanalytic therapists assume expertise and make interpretations about the client's unconscious motivations. Behavioural approaches also assume the therapist's expertise and focus on manipulating the client's thoughts and behaviours towards a pre-conceived notion of positive functioning. These approaches are not only process directive, but also *content* directive, since the therapist acts as an authority on the client's inner world, and defines the goals of therapy. Warner (2000; p.31) outlines five different levels of 'therapist interventiveness', of which the first three represent the range of directivity within person-centred approaches to therapy. These are as follows:

> Level 1: the therapist brings nothing from outside the client's frame of reference.
>
> Level 2: the therapist uses personal experiences and theories in order better to understand (but not influence) the client's experience.
>
> Level 3: the therapist brings material into the relationship in ways that foster the client's choice as to whether and how to use such material.

In contrast, levels 4 and 5 illustrate the type of directivity which is characteristic of therapeutic approaches outside the person-centred model:

> Level 4: the therapist brings material into the relationship from his or her own frame of reference from a position of authority or expertise.

> Level 5: the therapist brings material from outside the client's frame of reference so that the client is unaware of the intervention, its nature or the therapist's purpose in making the intervention.

As it is practiced today, humanistic therapy as a whole continues to focus on the therapeutic relationship as the key to corrective interpersonal and emotional experience (e.g. Timulak, Belicova & Miller, 2010). Therefore, a humanistic approach to therapy is radically different to deficiency models of mental health which involve the person being acted on either by medication or by psychological treatment employed by an authoritative therapist.

1.5 Definition of school-based humanistic counselling

The term 'School-Based Humanistic Counselling' (SBHC) was coined by Cooper et al. (2010) to describe a manualised intervention for distressed young people in UK secondary schools. Manualising everyday school counselling practice in this way allows for it to be empirically tested through RCTs, and prior to Cooper et al. (2010), the type of therapy practiced in existing school counselling services had not been formally defined or tested. The nature of existing services in school settings is that the majority of counsellors describe their orientation as *integrative*, with a person-centred core (Cooper, 2009). This can be taken to mean that counsellors may incorporate aspects of other therapeutic approaches while maintaining a central attitude consistent with the person-centred approach, as illustrated in Warner's (2000) levels 2-3 of therapist interventiveness.

This tendency towards process directivity among school counsellors may be a response to preference from young clients. A number of studies have shown that young people appreciate advice and guidance from school counsellors, and that some young people would prefer more of this kind of directive input from the counsellor (Cooper, 2004; Bondi, Forbat, Gallagher, Plows & Prior, 2006; Lynass, Pyhktina & Cooper, 2012).

Therefore a manualised version of school-based counselling which accurately reflects everyday practice in UK schools would most appropriately be based on humanistic theory, particularly emphasise the person-centred approach, and also be flexible enough to include the potential for process-directive interventions from counsellors. The formal framework for SBHC is a set of competences for the delivery of humanistic therapy developed by Roth, Hill & Pilling (2009) at University College London as part of the Skills for Health programme. These competences are clearly based on the person-centred approach and include reference to both the actualising tendency and the necessary and sufficient conditions for therapeutic change set out by Rogers (1959). The framework also includes competences which represent experiential strands of person-centred therapy (e.g. Elliott et al., 2004), such as 'ability to help clients access and express emotions', and 'ability to make use of methods that encourage active expression', suggesting openness to process-directivity.

1.6 Epistemological framework

As noted, the manualisation of everyday school counselling practice was necessary for it to be rigorously tested using an RCT, a research method typically associated

with the positivist paradigm (e.g. Durkheim, 1895). Positivism has its roots in Enlightenment philosophy (e.g. Hume, 1739-1740; Kant, 1781), and a positivist philosophy of science was first detailed by Comte (1865). This paradigm is associated with a realist ontology (a theory of the nature of being whereby an objective reality exists) and a representational epistemology (a theory of the nature of knowledge whereby objective reality can be accurately observed and described). Thus, it entails a separation between subject (i.e. researcher) and object (i.e. reality). The goal of science within this paradigm is to ascertain the underlying laws of cause and effect which govern this objective reality. The assumption of empirical verification is that perceptual data is accurate and reliable for this purpose, and therefore methodological rigour allows objective, value-free investigation.

The epistemological standpoint taken in this study is best described as post-positivist critical realism, closely associated to Bhaskar (1975). The author of this thesis accepts two of the most basic principles of positivism: that defined concepts should be clearly articulated, and that assertions should be supported by a combination of empirical evidence and logical inference. However, many related assumptions underlying a positivist epistemology are rejected in this study. First, the assumption of naturalism: that social phenomena (such as counselling) can be meaningfully understood via the same methods as physical phenomena. Second, the related assumption of unity of science: that all scientific theories are reducible to lower-level laws, e.g. processes of change in counselling are reducible to the neurophysiological level. Third, the assumption that quantitative statements are preferable to qualitative description, therefore the outcomes and processes of counselling must first be quantified to be adequately understood. Fourth, that

explanation of a given phenomenon requires discovery of generalisable laws, and that these laws represent 'invariable relations' between cause and effect (Comte, 1865).

Instead, this study employs triangulation of results from both qualitative and quantitative research methods to seek objective truths (thereby adopting a realist ontology) about school-based counselling while accepting the fallibility of perception (a subjectivist, as opposed to representational, epistemology). In doing so, this study rejects the notion of incommensurability (Feyerabend, 1993) and adopts a pluralistic approach to research methods, assuming that different forms of data can be meaningfully combined and compared. Perceptual data from young people attending school-based counselling is collected and analysed, and the inherent bias in the researcher's theory-laden approach is noted. The study uses mixed methods to answer two related research questions. First, is SBHC effective at reducing psychological distress for young people? Second, what are the processes through which change can occur for young people in SBHC?

The first question is appropriately answered using the RCT method. Pre-post studies have demonstrated an association between school-based counselling and reduced psychological distress (Cooper, 2009), but some studies have shown similar improvement in young people not attending school-based counselling (Daniunaite, Ali & Cooper, 2012; Hanley, Sefi & Lennie, 2011). To inform policy and funding decisions, a well-designed RCT could demonstrate effectiveness by clarifying whether previously demonstrated improvements in young people are caused by school-based counselling or not.

However, RCTs of psychotherapy (as noted by Elliott, 2002) are unable to investigate the meaning behind a causal link, since this method assesses only whether an intervention is effective, without addressing how or why it may be effective. Systematic qualitative inquiry has the benefit of allowing engagement with causal processes which do not follow simple linear pathways (Stiles, 1993) as is the case for change processes in psychotherapy, relevant to the second research question in this study. It also gives a closer view of therapy from the point of view of those who access SBHC, facilitating understanding of the meaning that the experience has for clients. The realist perspective is again taken here in that participants' phenomenological data are treated as revelatory of underlying processes which may occur in SBHC.

1.7. Aims

1.7.1 General aims

First, this study aims to test the effectiveness of School-Based Humanistic Counselling in reducing psychological distress in young people: to contribute to the strengthening of the evidence base, to address the relative lack of empirical evidence for humanistic approaches to therapy, and to pave the way for further controlled studies. Second, this study aims to increase understanding of change processes that may occur in counselling in order to improve current practice: to explore in depth the perceptions of individual young people, to identify helpful and hindering aspects, and to reveal insights about the wider processes young people may participate in when they attend School-Based Humanistic Counselling.

1.7.2 Specific aims

Chapters 2 – 8 of this thesis have these specific aims:

- Provide a rationale for evaluating school-based counselling services, and outline options for outcome and process research with young people (Chapter 2).

- Review current evidence of the effectiveness of school-based counselling services, and of change processes for young people in school-based counselling. (Chapter 3).

- Report the results of a pilot randomised controlled trial (RCT) testing the effectiveness of SBHC compared with waiting list conditions (Chapter 4).

- Develop a grounded theory of change processes for young people in SBHC using interview data from 14 participants (Chapter 5).

- Describe a single case study conducted systematically with a team-based approach, analysing both process and outcome for one client (Chapter 6).

- Consider the implications of findings on effectiveness and change processes in the context of previous research, policy and practice (Chapter 7).

- Reflect on the personal process involved in conducting this research (Chapter 8).

Chapter 2. Evaluating Counselling Practice with Children and Young People

Evaluation of therapeutic outcomes is necessary for counselling services to secure and retain funding, and is seen by stakeholders as essential. The demand for evidence-based practice is directly impacting on counselling and psychotherapy provision in health and social care. Still, in both child and adult services, there are many counsellors – especially those of a humanistic orientation -- who are disinclined to participate in formal outcome evaluation (Daniel & McLeod, 2006); and this reluctance has been noted by the Department of Health's Improving Access to Psychological Therapies (IAPT) programme (Wheeler & Elliott, 2008; Department of Health, 2008). In fact, the divide between researchers and practitioners in psychotherapy has been widely noted (Datillio, 2002; Dattilio, Edwards & Fishman, 2010; Safran, Greenberg & Rice, 1988; Silverman, 2001; Begley, 2009). However, indications are that the current hierarchy of evidence which favours large-scale quantitative measurement is unlikely to change in the foreseeable future (Cooper, 2011; Wheeler & Elliott, 2008). Evaluation of practice, therefore, is now a fundamental issue for counsellors and psychotherapists.

This chapter aims to review a range of evaluation methods and outcome measures used in counselling with children and young people, in order to contextualise the methodological and procedural choices made in this study, and its relevance in the professional and scientific community. The issues surrounding evaluation, including its potential impact, are also discussed to emphasise its importance within an inter-relationship of research and practice.

2.1 Evidence-based practice

Evidence-based practice, a philosophical approach used in medicine, is becoming increasingly relevant in counselling and psychotherapy. In this approach, empirical research is systematically reviewed to develop practice guidelines, on which clinical decisions are based. Research studies are selected and interpreted according to specific methodological criteria governing what constitutes 'evidence', dominated by a positivist framework which seeks to discover generalised laws by studying large groups. All evidence is considered on a spectrum of rigorousness, typically leading to qualitative data being disregarded in favour of experimental investigations using quantitative methods in between-group comparisons. Context-independent knowledge (which arises from the latter) is not necessarily appropriate to inform the treatment of an individual case, as argued by Flyvbjerg (2006), and is thus incomplete. Failure to recognise context-*dependent* knowledge is considered to be at the core of the divide between researchers and practitioners (Dattilio et al, 2010; Upshur, 2005).

2.2 Practice-based evidence

Though often assumed to be an opposing concept, practice-based evidence is one way of informing evidence-based practice. It is the exercise of drawing evidence from practice settings in order to take this into account along with data from controlled experimental studies to form the basis for clinical decision making. In other words, rigorous research is conducted in routine clinical practice, and this evidence feeds back into decisions about clinical practice. Appreciating the

complementary contributions of different research methods, a broader concept of evidence-based practice has emerged (Sackett, Straus, Richardson, Rosenberg & Hayes, 2000; Wachtel, 2010) notably from the American Psychological Association's Task Force on Evidence-Based Practice in Psychology (APA, 2005). Therefore, practitioners can play a central role in strengthening the evidence base through formal research and evaluation.

2.3 Effect sizes

When different outcome measures are used in quantitative evaluation studies, direct comparisons can be made between them by calculating standardised 'effect sizes', which is a way of reporting the amount of change observed. The most common effect size in the counselling and psychotherapy literature is Cohen's *d*, which is the amount of difference between two groups on some variable (for instance, pre- and post-counselling scores on the CORE-OM), divided by their 'standard deviation' (a measure of the amount of variability across scores). Cohen (1988) proposed that in the social sciences, standardised effect sizes can be understood in the following way: small effect ≥ .2; medium effect ≥ .5; large effect ≥ .8. In this thesis, Cohen's rule of thumb is used to interpret effect sizes.

2.4. The impact of evaluation on counselling practice

Despite fears that some evaluation methods could impinge on humanistic or relationally-oriented counselling approaches, research suggests that there are two key benefits to practice.

2.4.1 The experience of evaluation

First, evaluation seems to be a positive experience for both clients and therapists. Recent studies in the context of school-based counselling have shown that young people report positive responses to completing psychometric measures at regular intervals before, during, and after counselling (Hanley et al., 2011; Cooper et al, 2010). Indeed, a recent interview study of young people allocated to the waiting list condition of a randomised controlled trial of school-based counselling (Daniunaite et al., 2012) found that these participants were able to make substantial progress from participation in the research project alone – without an active counselling intervention. From the practitioners' perspective too, a Northern Irish study showed that the process of participating in a large scale school counselling evaluation garnered considerable benefits for practice and professional development, although the experience was challenging (Tracey, McElearney, Adamson & Shevlin, 2009).

2.4.2. Impact on outcomes

Second, there is a growing body of evidence suggesting that evaluation improves therapeutic outcomes. In the field of adult psychotherapy, Lambert and Shimokawa (2011) recently published a meta-analysis of studies investigating the effects of

providing systematic feedback to clients. Their results showed that clients who are given systematic feedback on progress were 3.5 times more likely to experience reliable positive change, and had less than half the chance of deteriorating, when compared with clients who received no formal feedback. The potentially therapeutic effects of research also appear to extend to young people in counselling. For example, Saunders and Rey (2011) found that screening and assessment procedures contributed to improvement for 12-25 year olds with alcohol problems. A recent evaluation study (Cooper, Freire, McGinnis & Carrick, submitted) on school-based counselling for young people obtained a substantially larger effect size for counselling (1.26) than the mean weighted effect size (0.81) calculated in a comprehensive meta-analysis of UK audit and evaluation studies (Cooper, 2009). The key difference between this and previous evaluation studies was that counsellors administered weekly session by session outcome measures. This suggests that completing measures at every session, as opposed to only at the beginning and end of the entire counselling period, may improve outcomes for young people in school-based counselling. In fact, the results of a recent study of primary school-based counselling using systematic feedback with children as young as seven suggest that feedback may as much as double the impact on psychological distress (Cooper, Stewart, Sparks & Bunting, 2012).

2.4.3 Impact of therapist feedback

Providing feedback to therapists may also improve outcomes for clients: Michael Lambert has led a programme of research investigating the impact of systematic feedback for therapists on client progress using an algorithm to calculate predicted

outcomes with normative data (e.g. Lambert et al, 2001, Simon, Lambert, Harris, Busath & Vazquez, 2012; Shimokawa, Lambert & Smart, 2010; Simon et al, 2013). Clients complete psychometric measures at each session, and an automatic progress report is generated and provided to therapists with a traffic light alarm system to indicate when negative outcome is predicted. This alone has been shown to increase outcomes and reduce the percentage of clients who deteriorate in therapy, and even greater effects have been found when this feedback is accompanied by clinical decision-making tools to support therapists in addressing poor progress. Lambert (2013) also reported that without this feedback, therapists generally fail to intuit potential failure in cases where clients are deteriorating, over-estimating the positive impact therapy has and overlooking potential negative impacts. Furthermore, he noted that after using the signal alarm feedback system, therapists do not learn to intuit these cases of deterioration, suggesting that therapists' perceptions of client progress may be unreliable. Therefore, feedback from psychometric data provided to therapists has the potential to improve client wellbeing and compensate for inevitable blind spots.

2.4.4. Consistency with humanistic approaches

The appropriateness of using quantitative evaluation in humanistic counselling depends on the way this is viewed. To return to Warner's (2000) levels of interventiveness, it is conceivable that measures introduced by a practitioner could represent material brought in 'from a position of authority or expertise' (Level 4), which may compromise the client's autonomy. On the other hand, it could be argued that if measures are introduced in 'ways that foster the client's choice as to whether

and how to use the material' (Level 3), the client's autonomy can remain central. The BACP Ethical Framework for Good Practice in Counselling and Psychotherapy (2013) advises that practitioners who respect their client's autonomy 'seek freely given and adequately informed consent [and] emphasise the value of voluntary participation in the services being offered' (BACP, 2013, p.2). Therefore, ethical use of evaluation tools involves explaining to the client the reasons behind completing measures and emphasising the non-compulsory nature of this (as any) aspect of counselling. Another ethical principle to be considered in this decision is that of beneficence: in relation to this, BACP note that 'ensuring the client's best interests are achieved requires systematic monitoring of practice and outcomes by the best available means' (2013, p.2), which reflects the evidence that outcome evaluation is both positively experienced by clients and beneficial to their therapeutic outcomes.

2.5 The researcher-practitioner model

Research activity among counselling practitioners is now widely encouraged, and counsellors in training are expected to develop interest in research evidence and understanding of methods with a view to actively participating and securing the future of counselling as a profession (Dunnett, Cooper & Wheeler, 2007; Wheeler & Elliott, 2008). School-based counselling, in particular, has seen a flourish of research interest, and the BACP (British Association for Counselling and Psychotherapy) have recently launched a practice-research network dedicated to counselling with children and young people: CYP PRN (Children and Young People Practice Research Network). Its aims and objectives include promoting the inter-relationship of research and practice and creating a sustainable network of practitioner-

researchers to engage in ethical practice-based research. Practice Research Networks (PRNs) first emerged in the 1950s in healthcare fields, and are designed to close the gap between researchers and practitioners leading to a collaborative output of rigorous practice-based studies, and empowering practitioners through involvement in the scientific agenda (Castonguay, Barkham, Lutz & McAleavey, 2013).

Wheeler & Elliott (2008) outline three key questions for the evaluation of practice: 1) Do clients change substantially over the course of counselling? 2) Is counselling substantially responsible for these changes? 3) What specific aspects of counselling contribute to client change? Focusing more on the processes of therapy, McLeod (2001) claims that 'the contribution of research and inquiry lies in finding the most suitable ways to assemble and deliver a set of largely known therapeutic activities' (p.17). Adequately answering these questions, and reaching these goals, requires that they are addressed from a range of different perspectives, using a range of different tools and balancing scientific rigour with clinical relevance.

In established counselling services for children and young people, such as those based in schools, outcome measures can easily be incorporated to everyday practice, resulting in the potential to generate a large body of evaluation data which can be a powerful aid to the interpretation and application of evidence.

2.6 Outcome research

Outcome measurement is the exercise of monitoring change in individuals, with the aim of using this information systematically to improve practice. In counselling, it is complicated by the fact that practitioner-researchers from different theoretical

approaches may have different aims and different concepts of improvement for clients. For instance, CBT aims to address specific problems, such as obsessive-compulsive behaviour, and measures its outcomes accordingly. Conversely, person-centred counselling focuses on the client's intrinsic needs and wants and may be more appropriately tested by measuring overall wellbeing. Typically, outcome measures used to evaluate counselling interventions focus on constructs such as psychological distress, or difficulties (e.g. YP-CORE; Appendix 10.1). Some have a more 'positive' focus, attempting to measure wellbeing or achievement of personal goals (e.g. the Goal-Based Outcome Record; Appendix 10.2).

2.6.1 Frequency of measurement

In addition to the specific outcome measure used, decisions regarding when and how to administer these measures influence the results of outcome studies and must be carefully considered. Traditionally, measures are taken before counselling begins, and immediately after it ends, as in the 30 studies of school-based counselling meta-analysed by Cooper (2009). This approach allows practitioner-researchers to assess the amount of change that has occurred in a given domain (according to the specific outcome measure used) during the counselling period. However, a key recommendation for practice research networks like CYP PRN is for members to routinely collect data from all clients on a session-by-session basis (Parry, Castonguay, Borkovec & Wolf, 2010; Clark, Fairburn & Wessely, 2008) rather than only at the beginning and end of counselling. One reason for this recommendation is that weekly monitoring allows practitioner-researchers to collect more robust evaluation data than pre-post measurements alone. The majority of practice-based

evidence is limited by the problem of missing data (Stiles, Barkham, Mellor-Clark & Connell, 2008) and this is true of school-based counselling studies too (Cooper, 2009). Crucially, when measurements are taken at the beginning and end of counselling only, the endpoint data collected comes exclusively from clients who participated in a planned ending with the counsellor. Cooper (2009) found that in school-based counselling studies, the mean response rate was less than 65%, suggesting that a large proportion of young clients are not represented by these studies due to dropping out of counselling before completing endpoint questionnaires. This means that the calculated effect sizes cannot accurately reflect the whole population of young people in school-based counselling. This is a particularly pressing problem given that those who complete counselling tend to have better outcomes (e.g., Wierzbicki & Pekarik, 1993). Using weekly outcome monitoring ensures that data is available for all clients, producing more reliable evidence. Therefore, studies which use weekly session by session monitoring overcome one of the major limitations of practice-based research and have a greater chance of influencing clinical guidelines.

2.6.2 Outcome measures

Some of the most frequently used tools for evaluating counselling with children and young people are detailed in Table 1. As noted, clients in general tend to respond positively to outcome measures, and some may have additional benefits. For instance, the opportunity to collaborate on goals with a counsellor, which is part of completing the Goal-Based Outcome Record, has been shown to improve outcomes for clients (Tryon & Winograd, 2002).

Table 1. Outcome measures for evaluating counselling with children and young people

Name	Acronym	Key Publication	Age range	Prevalence	Strengths	Limitations
Young Person's CORE (Clinical Outcomes in Routine Evaluation) Outcome Measure	YP-CORE	Twigg, E., Barkham, M., Bewick, B.M., Mulhern, B., Connell, J. & Cooper, M. (2009) The Young Person's CORE: Development of a brief outcome measure for young people, Counselling and Psychotherapy Research 9(3):160-168.	11-16 years	Most widely used in UK school-based counselling	Sensitive to change Appropriate for brief interventions Concise User-friendly; simple, easy scoring system Suitable for weekly use	Not suitable for use with children <11 years Clinical norm data not currently available
Strengths and Difficulties Questionnaire	SDQ	Goodman, R. (2001). Psychometric properties of the strengths and difficulties questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry*, *40*(11), 1337-1345.	Self report version: 11-16 years Parent- and teacher-rated versions: 3-4 years and 4-16 years	Most widely used in specialist CAMHS (Child and Adolescent Mental Health Services)	Four distress-related subscales allow comprehensive view of difficulties; one subscale dedicated to pro-social behaviour Excellent evidence of reliability and validity Translated into a range of languages	Not suitable for brief interventions Not suitable for weekly use Relies on adult caregivers' perceptions for children <11 years
(Young) Child Outcome Rating Scale; from Partners for Change Outcome Management System (PCOMS)	CORS / YCORS	Duncan, B. L., Sparks, J. A., Miller, S. D., Bohanske, R., & Claud, D. A. (2006). Giving youth a voice: A preliminary study of the reliability and validity of a brief outcome measure for children, adolescents, and caretakers. *Journal of Brief Therapy, 5*(2), 66-82.	CORS: 6-11 years YCORS: children <6 years	Used internationally with growing popularity in UK	Focuses on child's own perception of wellbeing Concise User-friendly Appropriate for brief interventions Designed for session-by-session use	Psychometric validity yet to be well-established

Name	Acronym	Key publication	Age range	Prevalence	Strengths	Limitations
Goal-Based Outcome Record	G-BOR	Law, D. (2011) Goals and Goal-Based Outcomes (GBOs): *Some Useful Information*. Internal CORC publication. Available at: www.corc.co.uk.net	11-16 years Can be completed by parent/caregiver for children < 11 years	Growing use in specialist CAMHS in UK	Measures what child or young person wants to achieve Incorporates collaboration with counsellor on therapeutic goals Concise Appropriate for brief interventions Suitable for weekly use	Relies on adult caregivers' perceptions for children <11 years
Revised Children's Anxiety and Depression Scale	RCADS	Ebesutani, C., Bernstein, A., Nakamura, B.J., Chorpita,B.F., Weisz, J.R. (2010) A Psychometric Analysis of the Revised Child Anxiety and Depression Scale, The Research Network on Youth Mental Health, Journal of Abnormal Child Psychology, 38(2): 249–260.	6-18 years, (both self-report and parent/caregiver report versions)	Increasingly widespread use in specialist CAMHS	Evaluates changes in anxiety symptoms across range of subscales Includes assessment of depression symptoms Can be completed by both child/young person and adult caregiver	Limited to specific disorders (based on DSM-IV Diagnostic Criteria for range of anxiety disorders)
Health of the Nation Outcome Scales for Children and Adolescents	HoNOSCA	Gowers, S.G., Harrington, R.C., Whitton, A., Beevor, A., Lelliott, P., Jezzard, R., & Wing, J. (1999). Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Glossary for HoNOSCA score sheet. British Journal of Psychiatry, 174, 428-431.	3-18 years	Estimated use in <10% cases in specialist CAMHS in UK	Sensitive to change Good validity, reliability and feasibility 15 scales allow comprehensive view of difficulties	Primarily relies solely on clinician's report, though self-rated and parent-rated versions are available Designed to be used only by clinicians who know the child or young person well

2.7 Process research

As well as outcome measures, questionnaires are available to investigate clients' process in counselling. One of the most commonly used tools here is the Child Session Rating Scale (CSRS), which invites children and young people to rate the extent to which they felt listened to in the therapeutic work, and the degree to which the work met their personal needs and preferences (Duncan, Miller & Sparks, 2006). In addition, satisfaction questionnaires such as the Experience of Service Questionnaire (developed for children and young people by Bury NHS Trust) can give valuable insight into clients' views of counselling (available to download from CORC (CAMHS Outcome Research Consortium) at www.corc.uk.net/resources/downloads/). This measure asks young people to rate their experience of a service on 12 items related to satisfaction, such as 'I feel that the people who saw me listened to me'.

2.8 Qualitative research

While outcome studies focus on quantitative data taken from psychometric measures, qualitative data can also have a role in evaluation. Conducting semi-structured interviews is a potential way of collecting clients' views about the outcomes of therapy, and can provide a more in-depth perspective than psychometric measures. While outcome measures give valuable information about effectiveness and appear to have benefits for young people in their own right, combining this kind of data with qualitative records from children and young people can enrich and support findings, providing

crucial depth and context to our understanding of the counselling process. This form of interviewing generally involves using a pre-set series of open-ended questions and prompts, allowing the respondent to take the conversation in new directions as they come up. Elliott (1999) designed an interview schedule entitled the Client Change Interview, which asks clients whether and how they feel they have changed since beginning counselling, to what they attribute the change and how much it has impacted on their lives, as well as covering the client's overall experience of counselling. This has recently been adapted for use with young people in school-based counselling (Lynass et al., 2012; Appendix 10.3).

2.8.1 Qualitative analysis

Once semi-structured interviews have been conducted and transcribed, they can be analysed in various ways. Thematic analysis is a commonly employed method, and involves searching text for emerging themes and categories of responses (Guest, MacQueen & Namey, 2012). Using this approach, Lynass et al. (2012) found that young people in school-based counselling tended to experience positive changes in emotional, interpersonal and behavioural domains. When asked about the helpful aspects of counselling, young people mentioned talking and 'getting things out', as well as specific counsellor qualities.

A different approach to qualitative data is discourse analysis, which investigates a text on the level of underlying meanings as opposed to face value. A recent example of

this method is Prior's (2012) investigation of how young people manage stigma in relation to accessing a school counselling service. He described how young clients demonstrated critical views of help-seeking, which they had internalised, before going through a process of reformulating those critical views, so that they came to see their own behaviour (seeking counselling) as a sign of strength and self empowerment.

The most commonly employed method of qualitative inquiry is grounded theory, which has the benefit of clear guidelines for systematically conducting analysis (e.g. Glaser & Strauss, 1967; Glaser, 1978). Developing a grounded theory, a researcher must become immersed in the material, approaching it with an open mind (for instance, without having conducted a literature review) and synchronising data collection and analysis as far as is possible. Rennie (e.g. 1990; 1992) adopted this approach to explore the client's experience of psychotherapy using interpersonal process recall (IPR) post-counselling interviews, producing a series of papers on specific aspects of client experience (e.g. deference, Rennie, 1994).

Research on humanistic psychotherapy has largely consisted of quantitative studies, but their suitability to investigating the phenomenon of therapy has been challenged (e.g. McLeod, 2013; Elliott, Fischer & Rennie, 1999). McLeod (2001) provides a thorough discussion of qualitative inquiry, as applied to counselling and psychotherapy.

2.9 Case studies

Wheeler & Elliott (2008) argue that since the practice of therapy operates on a single case level, conducting systematic single case studies (those which analyse qualitative and quantitative data using systematic reasoning strategies) is a fundamental part of evaluation. This highlights the potential of case study research to contribute to developing a practice-research culture. Though few single case studies of psychotherapy are conducted or published today, the method was pivotal in the history of psychotherapy and its potential role in evaluation has been noted (McLeod, 2010; Wheeler & Elliott, 2008). There are a number of different methods for conducting systematic case studies, including narrative inquiry (where therapist and client keep detailed notes, which are compiled, as in Yalom and Elkin, 1974) and the hermeneutic single case efficacy design (HSCED) developed by Robert Elliott (2001, 2002). Single case studies allow researchers to make clear links between the practice of therapy and change in the client, on an individual level.

2.10 Randomised controlled trials

Randomised controlled trials (RCTs) are the most politically powerful method of evaluation in health research, since clinical guidelines groups (such as NICE, the National Institute for Health and Clinical Excellence, and SIGN, the Scottish Intercollegiate Guidelines Network) primarily draw on RCTs to develop guidelines for evidence-based practice. Torgerson and Torgerson (2008) argue that the RCT is 'the

best method for evaluating any proposed changes in health care, education, crime and justice, and other areas of public policy…because it is able to deal adequately with the level of complexity inherent in these fields' (p.4). The basic principle is that quantitative measures are taken from a sample of participants (the larger the sample, the more powerful the trial), who are then randomly allocated to two or more conditions: the treatment under investigation, and a control (or multiple control conditions), which essentially involves *not* receiving the treatment, or could also be a comparative treatment. Then measures taken from both groups at the end of the trial period are compared to assess differences, which are assumed to be solely caused by the treatment(s) under investigation, since random allocation is assumed to control for individual differences.

The method is criticised as having 'serious limitations' in assessing psychotherapy outcomes (see Dattilio et al, 2010, p. 428), and many consider it inappropriate for this use (e.g. Rogers, Maidman & House, 2011) due to the paradigm clash between the individually determined relational processes involved in psychotherapy and the high level of experimental manipulation involved in conducting an RCT. Other criticisms include the charge that randomisation is unethical, or that participants may perceive it to be, and that the results of such a highly controlled experiment are not generalisable to everyday practice (Hutchinson & Styles, 2010). One criticism of RCTs of counselling is the notion that there are 'no immediate benefits to clients seeking access to free therapy' (Rogers et al, 2011). However, this does not match the reported experiences of clients in the current study.

2.10.1 Sarah

The following vignette illustrates the possibility of positive impact on participants from both qualitative and quantitative research methods. As was often the case for young people in this study, outcome measurement was highlighted as a particularly helpful aspect, and taking part in semi-structured research interviews was perceived as similar to attending counselling itself. 'Sarah' was typical of the participants as a whole in her attitudes to completing measures and attending research interviews:

> Sarah was 15 when she took part in a randomised controlled trial in her school, comparing weekly sessions of SBHC against waiting list conditions. After being referred by her pastoral care teacher, Sarah had a one-to-one assessment with the author, who explained in detail what was involved. As a participant, Sarah would have a 50:50 chance of being allocated to the counselling intervention, which would start immediately, or to the waiting list condition for the rest of the school term (approximately 12 weeks), before having the opportunity to start counselling in the following term.
>
> In the middle of the waiting period, about six weeks later, Sarah attended a research interview. She reported feeling better, and when asked what might have made the difference, indicated that she thought it was her participation in the research study.

Sarah: I don't know, I think it just helped me. Like, some of the questions on the sheets kind of…brought me out a bit, I don't know. Questions about myself and stuff…just reading them back, I thought why? It's like it's been helpful like that, you notice a lot more about yourself, if you get me.

Author: So is it like some of the questions made you stop and think about things? Or made you sort of look at yourself in a different way?

Sarah: All of that. Like I used to always worry about what people think of me, since I came back, and I know I've lost weight after being ill, so I was always thinking people were talking about me or laughing at me. Then when I saw it on paper like that, I just thought 'why do I care?'

When asked about what had changed for her since the research project began, Sarah reported feeling more confident:

I don't know how to explain it, it's like I don't get nervous when they do the register in class any more. I used to hate that, because someone could say something or people might all look at me. I was kind of like the quiet one in class. And now I'm…well not loud or anything! But I don't worry so much.

At the end of the intervention period, approximately 12 weeks after the research project had begun, Sarah continued to report improvement in her mood:

Sarah: I think when I was coming here I was able to talk a bit about it. Just like talking to someone about how you feel about yourself, that's been helpful. And answering questions on the sheets.

Author: What is it about it that helps, do you think?

Sarah: Doing the questionnaires is like another way of not keeping me bottled up about how I'm feeling. Just recognising your feelings even when you're doing it. And then I was getting to talk to someone about it.

Author: So even though you didn't have counselling yet, it's like doing the research part of it made you kind of more aware, maybe, of things?

Sarah: Definitely.

2.11 Conclusions

While measuring the outcomes of counselling with children and young people raises many questions, it is increasingly necessary to secure funding, and generally helpful in terms of professional development. In addition, outcome research appears to have considerable benefits for the experience and effectiveness of counselling for children and young people, as is the case for adult clients. When psychometric data is used to provide feedback to therapists and/or clients, outcomes improve and deterioration is reduced. Engagement with research is now a requirement for every counselling

professional, and awareness of the issues surrounding evaluation is important. In any evaluation study, careful choices must be made about what exactly to measure, and when. A wide range of measures are available for children and young people relating to constructs such as psychological distress or wellbeing, to specific problems such as anxiety or depression, and more subjective concerns such as personal goal attainment. In addition, tools have been developed to measure counselling processes and experiences, and satisfaction with services.

Research shows that using outcome and process measures on a regular basis (i.e. at every session, as opposed to only before and after an episode of counselling) may improve outcomes for children and young people. Weekly monitoring also has benefits for creating a robust evidence base for counselling children and young people, since it produces more representative and reliable data on therapeutic outcomes. Evaluation methods available to counselling practitioner-researchers are both qualitative and quantitative, ranging from in-depth analysis of children and young people's experiences to large-scale evaluation studies and RCTs. This thesis describes a randomised controlled trial which incorporates qualitative data collection and analysis, including the development of a grounded theory and a systematic case study. Only by embracing a multitude of studies with diverse approaches, and balancing clinical relevance with scientific rigour, can the central questions related to psychotherapy practice be answered.

Chapter 3. The Effectiveness of School-Based Counselling: A Review

In 2006, Pattison and Harris published a review of the evidence for counselling children and young people (not specific to school-based counselling services). Their systematic review (Pattison & Harris, 2006) focused on effectiveness and encompassed evidence on cognitive-behavioural, psychoanalytic, humanistic and creative therapies. The studies included in this review related to group or individual counselling for a range of presenting issues: behavioural and conduct problems, emotional problems, medical illness, self-harming and sexual abuse. Pattison and Harris (2006) reported that there was a larger evidence base for cognitive-behavioural approaches, especially in relation to older children and adolescents. However, the authors of the review note that this finding reflects a lack of published research investigating the effect of other approaches. This chapter provides a narrative review of the current evidence base for secondary school-based counselling, including qualitative and quantitative data and with a particular focus on the UK, where school-based counselling tends to take a humanistic approach.

3.1 Method

The PsycINFO database was searched in November 2012 using the search terms ‘school counselling’, ‘children’ and ‘young people’, limited to peer-reviewed journal articles published in English from 2002 onwards. This search was replicated in June 2013 to include the most up to date evidence available. In addition, the author was aware of

several unpublished reports containing data on UK school-based counselling, which were included.

In relation to effectiveness, international controlled studies of secondary school-based counselling interventions (of which there are relatively few) were reviewed, including those investigating non-humanistic approaches. A recent meta-analysis of outcome studies of person-centred and experiential therapy for children and young people (not limited to school-based counselling interventions) was included for comparison. Pre-post evaluation studies were also included, but since a large number of these are available internationally, this section of the review was limited to UK studies reporting on school-based counselling using a humanistic approach. Similarly, in relation to helpful and hindering aspects, processes and outcomes, the review was limited to UK studies reporting on humanistic approaches to school-based counselling.

3.2 Effectiveness of school-based counselling

3.2.1 Controlled studies

Table 2 shows the characteristics of controlled studies of humanistic counselling for children and young people. In a meta-analysis of outcome studies of person-centred and experiential therapy for children and young people (aged 3-18), Hölldampf, Behr and Crawford (2010) found that across studies and across diagnoses, person-centred and experiential therapy was more effective than no treatment. Effect sizes for person-centred and experiential therapies ranged from 0.15 (Weisz, Weiss, Han, Granger &

Morton, 1995; n=2 studies) to 0.93 (Ray, Bratton, Rhine & Jones, 2001; n=55 studies), compared with those reported from studies of child and adolescent psychotherapy generally, which range from 0.45-0.7 (Kazdin, 2004; Weisz et al., 1995). One study compared treatments for 107 young people diagnosed with major depressive disorder (aged 13-18), and found that CBT was superior to 'nondirective supportive therapy' at the 12-16 week endpoint (Brent et al., 1997), though a further study showed no significant differences between treatments at 2 year follow-up (Birmaher et al., 2000).

School-based counselling

A meta-analysis of 107 studies evaluating US school-based counselling interventions showed significant improvements in mental health, with a mean ES (Cohen's *d*) of 0.45 (95% CI: 0.37 - 0.53) (Baskin et al., 2010). However, the nature of the studies included in Baskin et al.'s (2010) meta-analysis reflect the nature of school-based counselling in the US, which usually involves group-based therapy informed by CBT and specifically targeted towards mental illnesses or educational problems (Dimmitt, Carey, & Hatch, 2007). The majority (88.6%) of the 132 therapeutic interventions reported on by Baskin et al. were group or class-based, as opposed to individual. Interventions were most commonly behavioural, cognitive-behavioural or psychoeducational (65.9%), with the remaining interventions labelled interpersonal (15.2%), play therapy (3%) or 'Other' (15.9%). None of the studies tested a humanistic approach to school-based counselling, and controlled evidence for SBHC is currently very limited.

School-based humanistic counselling

The first pilot RCT published by Cooper et al. (2010) of SBHC for psychological distress showed mixed results. This study found no significant differences in distress reduction between young people allocated to six weeks of SBHC (n=13) and those allocated to an equivalent waiting period (n=14). Participants were aged 13-15 and scored 4 or above at assessment on the emotional symptoms scale of the Strengths and Difficulties Questionnaire (SDQ; Goodman, Meltzer, & Bailey, 1998), which was also the primary outcome measure. The recruitment procedure in this trial included a classroom screening process where young people were asked to complete the SDQ and a custom made short form indicating whether they would like to consider taking part in the trial and having school-based counselling. Those who volunteered by providing their name on this form were contacted individually and offered a one-to-one assessment meeting with a researcher to determine their eligibility. Participants completed outcome measures during this assessment meeting, and after six school weeks during which those allocated to counselling attended a mean number of 4.54 sessions.

The mean ES across nine outcome measures was 0.25 in favour of SBHC, smaller than the ES (*d*) of 0.45 found by Baskin et al. (2010) for group-based cognitive-behavioural counselling in US schools, and considerably smaller than the ES calculated from uncontrolled cohort studies of UK school-based counselling (0.81-1.36; Cooper, 2009; Hill et al., 2011; Cooper et al., submitted).

However, Cooper et al. (2010) also analysed results for a subgroup of participants (n=10) who met the cut-off point for major depressive episode on the

Moods and Feelings Questionnaire (MFQ-C; Costello & Angold, 1988). For these participants, SBHC did bring about significant reductions in emotional symptoms compared with waiting list conditions. The ES for this subgroup analysis was 1.13 (Hedges's *g*) in favour of SBHC. The large ES calculated for young people meeting the cut-off point for major depressive episode suggests that the efficacy of SBHC may be greater for more severe distress levels, but the subgroup sample is too small for these results to be conclusive.

Table 2. Characteristics of controlled studies of counselling for children and young people

Article	Study design	Interventions	Participants	Outcomes
Hölldampf, Behr & Crawford (2010)	Meta-analysis reviewing outcome studies	Person-centred and experiential therapies	n = 94 studies Age range = 3-18 Mean age not reported Range of difficulties including mood disorders and post-traumatic stress disorder	Person-centred and experiential therapies more effective than no treatment across studies and diagnoses Effect sizes ranged from 0.15 – 0.93
Brent et al. (1997)	Randomised controlled trial	CBT Systemic behavioural family therapy Non-directive supportive therapy	n = 107 Age range = 13-18 Mean age not reported Adolescents with major depressive disorder as measured by Beck Depression Inventory≥13	Higher rate of remission for CBT (60%) than systemic behavioural family therapy (29%) or non-directive supportive therapy (36%)
Birmaher et al. (2000)	2-year follow-up study to Brent et al. (1997)	CBT Systemic behavioural family therapy Non-directive supportive therapy	n = 107 Age range = 13-18 Adolescents with major depressive disorder as measured by Beck Depression Inventory≥13	No long-term differences in effect between interventions 80% of participants recovered

Article	Study design	Interventions	Participants	Outcomes
Baskin et al. (2010)	Meta-analysis reviewing outcome studies	School-based counselling, mostly cognitive, cognitive-behavioural and psychoeducational	n = 107 studies Mean age not reported Age range = 5-18 Range of difficulties including depression, anxiety and anger	Interventions more efficacious for adolescents than for children Effect size (*d*) = 0.45
Cooper et al. (2010)	Pilot randomised controlled trial	School-based humanistic counselling compared with waiting list control	n = 27 Age range = 13-15 Mean age = 14.2 Emotionally distressed as measured by SDQ-ES ≥4	No significant differences found between intervention and control group in emotional distress Effect size (*g*) = 0.03

3.2.2 Cohort studies

Table 3 shows the characteristics of cohort studies on school-based humanistic counselling in UK schools. A total of 30 uncontrolled cohort studies of school-based counselling in the UK, typically person-centred and humanistic, were meta-analysed by Cooper (2009). As recommended by Lipsey and Wilson (2001), it was possible to calculate a weighted mean effect size (which takes sample size into account in order to produce a more accurate population mean) for 15 of the studies, which was 0.81 (Cohen's *d*; 95% CI: 0.76-0.86) (Cooper, 2009). This is a comprehensive review of cohort studies of UK school-based counselling published between 1998 and 2008; the author is aware of four such studies conducted since then.

An evaluation study of one school-based counselling service in a Scottish secondary school collected data from 40 young people aged between 11 and 18; 55% (n=22) completed the YP-CORE pre- and post-counselling (McKenzie, Murray, Prior & Stark, 2011). The authors analysed four domains of the YP-CORE separately: functioning ES (r) = 0.78, problems ES (r) = 0.71, wellbeing ES (r) = 0.65 and risk ES (r) = 0.31. According to Cohen's (1988) conventions, the effect size statistic *r* relates to a small effect when ≥0.1, medium when ≥0.3 and large when ≥0.5 (unlike Cohen's *d*, for which conventions are given in Chapter 2, and also apply to Hedges' *g*). The participants showed significant improvement in YP-CORE scores related to functioning, problems and wellbeing, with large ESs for each. A medium effect size was calculated for risk, though there was no significant change in scores in this domain.

The largest scale cohort study of school-based counselling known to the author is an evaluation of the Welsh Government's School-based Counselling Strategy, commissioned by the Welsh Assembly Government (Hill et al., 2011) which includes data from counselling services in all secondary schools across Wales, as well as some primary schools. Significant reductions in psychological distress were found, and the ES for mean reduction in distress was large: 0.93. However, there were also significant variations in ES across the datasets studied, and larger ESs were associated with high rates of attrition (Hill et al., 2011), i.e. fewer participants completing post-counselling measures.

Loss of data due to attrition is a key problem with many practice-based cohort studies: if measures are taken only at pre- and post-counselling, clients who drop out are not included in analysis (Stiles et al, 2008; Cooper, 2009), which positively skews results (Wierzbicki & Pekarik, 1993). Approximately 60% of the clients included in Cooper's (2009) meta-analysis completed measures at the end of counselling, and in McKenzie et al.'s (2011) study 55%: this means the calculated ESs do not reflect outcomes from the whole sample. As noted in Chapter 2, attrition rates can be minimised by collecting outcome data at every session, a method employed in a recent cohort study by Cooper et al. (submitted).

Using the YP-CORE this study collected session-by-session outcome data for n=256 young people aged between 11 and 17 in Scottish secondary schools, and found a large ES of 1.36 (Cohen's *d*; 95% CI: 1.17-1.55) for SBHC (Cooper et al., submitted).

This suggests that the large ESs observed for SBHC in pre-post studies are not explicable by positive skew from attrition rates, and SBHC is indeed associated with large reductions in psychological distress. However, this association does not indicate a causal link between the two, and results from a small-scale study (n=8) conducted in English secondary schools found that improvement during the counselling period was roughly equivalent to improvement during a pre-counselling waiting period (Hanley et al., 2011).

Table 3. Characteristics of cohort studies on school-based humanistic counselling in UK schools

Article	Study design	Interventions	Participants	Outcomes
Cooper (2009)	Meta-analysis reviewing n = 30 audit and evaluation studies	School-based humanistic counselling services in UK secondary schools	n = approx. 10,830 participants Mean age = 13.86 Age range = 10-18	Counselling was associated with significant improvements in psychological distress Mean weighted effect size = 0.81
McKenzie, Murray, Prior & Stark (2011)	Pre-post evaluation study of one service	School-based humanistic counselling in a Scottish secondary school	n=40 Mean age not reported Age range = 11-18	Counselling was associated with significant improvements in functioning, problems and wellbeing
Hill et al. (2011)	Large scale pre-post evaluation study	School-based humanistic counselling in Welsh secondary schools	n = approx. 11,043 Mean age not reported Age range = 10- 18	Counselling was associated with significant reductions in psychological distress Effect size = 0.93
Cooper et al. (submitted)	Pre-post evaluation study	School-based humanistic counselling in Scottish secondary schools	n=256 Mean age = 13.62 Age range = 11-17	Counselling was associated with significant reductions in psychological distress Effect size (*d*) = 1.36
Hanley, Sefi & Lennie (2011)	Small scale evaluation study measuring distress during a pre-counselling waiting period and during counselling	School-based humanistic counselling in English secondary schools	n=8 Mean age not reported Age range = 13-15	Increases in wellbeing were shown during counselling as well as during a pre-counselling waiting period

3.2.3 Summary

Person-centred and experiential therapies (which fall under the umbrella of the humanistic approach) appear to be effective for children and young people (Hölldampf et al., 2010), with effect sizes comparable to those of child and adolescent psychotherapy as a whole (Kazdin, 2004; Weisz et al., 1995), though one study found that CBT was superior to 'non-directive supportive therapy' for depressed adolescents at 12-16 week assessment (Brent et al., 1997). School-based counselling as practiced in the US (with a predominantly cognitive-behavioural approach) appears to be effective but there is limited evidence for the humanistic approach to school-based counselling taken in the UK. Although uncontrolled UK outcome studies have demonstrated that school-based counselling is associated with reductions in psychological distress with large effect sizes (Cooper, 2009; Hill et al., 2011; Cooper et al., submitted), a pilot randomised controlled trial produced mixed results.

3.3 Change processes in school-based counselling

3.3.1 Helpful and hindering factors

Cooper (2013) reports that 'the opportunity to talk to someone who is listening' is the most commonly reported helpful factor in school-based counselling (Hill et al., 2011; Lynass et al., 2012; McKenzie et al., 2011; Cooper, 2009); approximately half of clients report directive activities as helpful factors (Cooper, 2009; Lynass et al., 2012) and though most clients do not report hindering factors (e.g. McKenzie et al., 2011), the

most common of these is wanting more counsellors or greater availability (Cooper, 2009; Lynass et al., 2012).

Of the 30 studies meta-analysed by Cooper (2009), seven (23.33%) collected sufficient qualitative data in response to the question 'Why do you think counselling was helpful?' and four (13.33%) collected helpfulness ratings for seven potentially helpful factors. Nine of the 30 studies (30%) collected qualitative data in response to the question 'What was unhelpful about your counselling?' and none collected ratings of unhelpful factors (Cooper, 2009). Ratings showed that the most commonly endorsed helpful factor was 'talking to someone who would listen', then 'getting things off your chest' and 'being able to talk in a confidential environment'. In addition, 'receiving suggestions/advice from the counsellor' was rated as quite helpful overall. Lower mean ratings were given for 'being asked questions', 'finding out why you think, feel and behave in the way you do' and 'working out new, and better, ways to behave'.

Similarly, qualitative data reviewed in this meta-analysis (Cooper, 2009) showed that the most commonly reported helpful factor for young people at the end of counselling was 'talking to someone and being listened to', which was more frequent than any other response by a factor of three (18.99% of respondents; Cooper, 2009). Other helpful factors reported in order of frequency were categorised as getting things off one's chest (5.71%), problem solving (4.40%), guidance (4.22%), insight (4.20%), confidentiality (3.13%), independence of the counsellor from the client's life (3.08%), being understood (2.56%), and being accepted (1.73%). Some respondents also

mentioned the personal qualities of the counsellor and the positive impact of talking in counselling on their ability to talk to others in their lives (Cooper, 2009).

Where young people were asked to report unhelpful factors, few responses were given (approximately 2-3% of respondents; Cooper, 2009). The five unhelpful factors which emerged from at least two studies were that counselling should be more available (seven studies), the counsellor should be more active (three studies), the service should be better promoted in the school (two studies), confidentiality should be upheld (two studies) and the process of counselling was difficult or painful (two studies).

Since Cooper (2009), four published studies have reported on helpful and hindering factors in school-based counselling, and one recent unpublished report meta-analysed helpful and hindering factors in school-based counselling from nine studies predominantly conducted in Scottish secondary schools (n=7 Scottish studies; n=1 Irish; n=1 English) (Griffiths, 2013). Six of the studies included in Griffiths' meta-analysis (66.67%) were also included in the earlier review by Cooper (2009); of the remaining three studies reviewed by Griffiths, two were conducted after the publication of Cooper's (2009) review, and one was not eligible for inclusion since no quantitative data was collected.

Griffiths (2013) developed meta-categories by combining categories that had emerged from each of the studies. Of the meta-categories for helpful factors, the most commonly endorsed was 'having an opportunity to talk/express self openly/ be listened

to', which incorporated categories emerging from all studies. Other meta-categories of helpful factors were 'client-led process/other client related factors', 'counsellor's strategies/suggestions/guidance/advice', 'release of tension/getting things off one's chest/positive experience', 'feeling understood/accepted/not judged', 'someone being there for them who is independent/new perspective', 'counsellor's personal qualities', 'confidentiality/privacy', and additional helpful factors such as practical issues and general comments. Of the seven meta-categories of unhelpful factors which were developed 'counsellor's strategies/advice/questions' covered categories from seven studies mostly related to clients wanting more input. Other meta-categories of unhelpful factors were 'practical issues', 'number or length of sessions', 'clients' difficulties', 'counsellor's personal factors', 'confidentiality/privacy' and 'no change/not helpful'.

3.3.2 Outcomes

Data on a wide range of positive outcomes for school-based counselling (as reported by clients) is available from a number of studies. A small number also report on teacher-rated outcomes, but little is known about parents or carers' perspectives. Cooper (2009) reports on types and domains of change using data from the five subscales of the SDQ (n=6 studies) and data from the impact supplement of the SDQ (n=5 studies). These suggested that the largest improvement was on the Emotional Symptoms subscale (mean ES =0.59; Cooper, 2009). Smaller positive changes were shown on the subscales relating to Conduct Problems (mean ES=0.34), Hyperactivity (mean ES=0.36) and Peer

Problems (mean ES=0.34). There was also an average small improvement on the Prosocial Behaviour subscale (mean ES=0.16). Data from the SDQ impact supplement showed that the largest improvements were in the domain of friendships (mean ES=0.47) as well as home life (mean ES=0.41). Smaller overall improvements were shown in classroom learning (mean ES=0.26) and leisure activities (mean ES=0.19).

Lynass et al. (2012) thematically analysed 11 semi-structured interviews with young people at the end of a period of SBHC which contained data on helpful and hindering factors (included in the meta-analysis by Griffiths) and specific changes reported by participants. Emerging themes revealed that the most commonly reported change was being seen differently by others (n=9 clients; 81.8%), followed by talking about feelings more easily, improvements in school, more confident/increased self-esteem and changed thinking/different perspective (n=7 clients each; 63.6%). Other commonly reported positive changes were feeling happier, improved relationships with friends and standing up for self more (n=6 clients each; 54.5%); more positive attitude, improved family relationships and socialising more (n= 5 clients each; 45.5%); and improved behaviour (n=4 clients; 36.4%). The authors divide these outcomes into three domains: interpersonal, emotional and behavioural changes (Lynass et al., 2012). No negative outcomes were reported in this study, but a minority of clients reported a lack of positive change (n=2 clients; 18.2%), and some reported things that they had wanted to change which had stayed the same (n=4 clients; 36.4%).

Two UK studies have looked specifically at the impact of school-based counselling on young people's academic achievement, with positive results (Ogden,

2006; Rupani, Haughey & Cooper, 2012). In addition, Cooper's (2009) meta-analysis showed that approximately two thirds of clients reported improvement in this area, and in Lynass et al.'s (2012) thematic analysis of post counselling interviews 'improvements in school' also emerged as a positive outcome.

As part of an evaluation study of a large multi-site school-based counselling service in Scotland, Ogden (2006) found that psychological distress impacted negatively on concentration for 76% of young people (n=17). In addition, other areas where young people's psychological distress negatively impacted on their performance at school included motivation to attend, attendance itself, motivation to study and learn, amount of school work done and relationships with teachers (Ogden, 2006). To investigate this phenomenon further, Rupani et al. (2012) conducted a mixed methods study with n=21 young people (aged between 12 and 17) who had attended school-based counselling in Scottish and English secondary schools. Semi-structured interviews revealed that the greatest impact of psychological distress on capacity to study and learn was difficulty concentrating (n=17; 81%). Furthermore, the greatest impact of school-based counselling on capacity to study and learn was increased concentration (n=20; 95%). Quantitative data from a brief rating scale confirmed that positive changes in concentration were the most commonly reported benefit of school-based counselling. As in Ogden's (2006) study, psychological distress negatively impacted on other aspects of school life (such as motivation, behaviour, and relationships with teachers) and counselling positively impacted on these aspects (Rupani et al., 2012). Additionally, school-based counselling was reported to impact positively on participation in class and

on confidence in relation to school work (Rupani et al., 2012). Clients' reports of improved capacity to study and learn are matched by teachers' perspectives: Cooper (2013) reported that 60-80% of teachers identified this as a positive outcome across three studies (Hill et al., 2011; Cooper, 2009; Pybis et al., submitted). Teachers perceive this improvement in relation to improved concentration, attendance and behaviour (Cooper, 2013).

Finally, a Northern Irish evaluation study collecting longitudinal data (n=202) showed that the proportion of young people presenting with problems related to being bullied (n=55; 27.2%) had a more rapid rate of decrease on the Peer Problems subscale of the SDQ compared with pupils referred for other reasons (McElearney, Adamson, Shevlin & Bunting, 2013). This suggests that, particularly for young people who are being bullied, school-based counselling impacts positively on relationships with peers.

3.3.3. Change processes

So far no research has been conducted which develops links between helpful and hindering factors and the outcomes of school-based counselling. A small number of case studies have been published which detail psychotherapy with young people, but these few tend to report on cognitive behavioural interventions (e.g. Christon et al, 2012; Schapman-Williams & Lock, 2007) or family-based therapy (e.g. Donohue & Azrin, 2002; Krautter & Lock, 2004). Flitton and Buckroyd (2005) conducted a study of one 11-year old female with complex needs who attended school-based counselling with a

person-centred approach as part of a wider evaluation project. The client reported that counselling had helped her with friends and with school work, and the counsellor (who is the first author of the study) observed positive change in the areas of communication, self awareness, and self confidence, though teaching staff did not report change in the client since beginning counselling. The authors of this case study identified a process whereby the young person became better able to describe her emotions through developing a secure attachment to the counsellor, although the time limited nature of the counselling meant that she was unable to 'consolidate the changes' (p.136; Flitton & Buckroyd, 2005). Although the authors of the study reviewed data from a number of sources, the method of analysis is not reported, and to date no systematic case studies of SBHC have been published. As a result little is known about the pathways to change for young people in psychological distress and the specific processes they may go through in school-based counselling.

3.4 Summary

Cohort studies of SBHC indicate a large effect and show significant reductions in psychological distress (Cooper, 2009; Hill et al., 2011; McKenzie et al., 2011; Cooper et al., submitted). However, a pilot randomised controlled trial found no significant differences between SBHC and waiting list conditions (Cooper et al, 2010). Although little is known about the processes of change in SBHC, young people have reported helpful factors such as the opportunity to talk, hindering factors such as lack of input

from the counsellor, and positive outcomes including improved relationships, increased self esteem and better academic performance.

Part II

Chapter 4. Pilot Randomised Controlled Trial of School-Based Humanistic Counselling

4.1 Aims

This study aims to pilot an improved set of procedures for evaluating SBHC, and to establish further indications of effect, following the first pilot RCT of SBHC by Cooper et al, (2010). Four main changes were made from Cooper et al.'s protocol. First, the intervention period was extended to 12 weeks. Some of the participants who received SBHC in Cooper et al.'s trial considered six school weeks to be insufficient, and none of those in the control condition reported that the waiting period was unacceptable. A period of 12 weeks was therefore considered an appropriate extension, while short enough to remain acceptable to those in the control condition, and with the added benefit of corresponding approximately to one UK school term. Second, a more externally valid method of recruitment into the trial was adopted, whereby young people were referred for assessment through members of the teaching staff (as would typically be the case for referral to school counselling; Cooper, 2009), rather than through self-selection. Third, to counteract possible floor effects in the previous design, a higher cut-off point for psychological distress was used as an eligibility criterion. Finally, a different primary outcome measure was used, the YP-CORE (Appendix 10.1), which has proved a more sensitive indicator of change for young people participating in school-based counselling (Cooper, 2009; Hill et al., 2011), and may be more appropriate

as a measure of psychological distress as a broad-range construct, compared with the SDQ-ES, which focuses specifically on emotional symptoms.

The null hypothesis of this study is that no significant differences in changes in psychological distress (as measured by YP-CORE) will be found between those allocated to SBHC and those allocated to the waiting list control condition. The alternative hypothesis is that significant differences in psychological distress reduction between groups will be found in favour of SBHC. In relation to the secondary outcomes, the null hypothesis is that no significant differences will be found between the groups and the alternative hypotheses are that significant differences will be found in favour of those allocated to SBHC showing more reduction in total difficulties (as measured by the Strengths and Difficulties Questionnaire), greater progress towards personal goals (as measured by the Goal-Based Outcome Record) and more improvement in self esteem (as measured by the Rosenberg Self Esteem Scale).

4.2 Method

All procedures in this study received ethical approval from the University Ethics Committee. Informed consent was obtained from young people at first assessment, and parents/carers gave assent before any assessment and/or intervention procedures were carried out. Participants were fully informed of the purpose of the trial.

4.2.1 Design

This pilot study adopted an individually randomised controlled trial design, comparing the outcomes of SBHC against a waiting list control using a 1:1 allocation ratio. Waiting-list or delayed treatment control groups are used widely in psychotherapy research (e.g., Posternak & Miller, 2001) and, although they do not control for the impact of non-specific therapy effects such as expectations, are an appropriate means of establishing preliminary evidence for the effectiveness of an intervention package, maximizing acceptability to participants while retaining some external validity advantages (Bower & King, 2000). Moreover, an active intervention control was not used because, at present, there are no other interventions, either in the CBT field or more widely, that are specifically designed to address psychological distress, as an affective response to a broad range of life stressors such as family discord and school bullying. A waiting-list (rather than pastoral care as usual) control was used to avoid evoking resentful demoralisation in control participants, because young people tend to exhibit positive attitudes towards school-based counselling (e.g., Hill et al., 2011). However, for ethical reasons, young people in the control condition continued to have full access to their school's pastoral care provisions.

4.2.2 Participants

Participants for the study were recruited from three secondary schools (typical age range 11-17 years) in the Glasgow region of Scotland, UK. The schools did not have a currently existing counselling service. All were non-fee-paying, state-run schools, in

socially deprived areas, with pupils from predominantly white backgrounds. Table 4 provides demographic information on the three schools.

Table 4. Demographic information on schools

School	1	2	3	Glasgow average
*Pupils eligible for Free School Meals	33.9%	39.4%	35.1%	29.3%
*Leavers entering Higher Education	17%	21%	21%	28%
*School roll	846	1,625	470	877.27
**Deprivation quintile of school postcode	2	1	2	3

*Data from September 2011, accessed from Scottish Schools Online (www.educationscotland.gov.uk) on 10/12/13.

**Quintile 1 = most deprived 20% of Scottish postal areas, Quintile = least deprived 20% of Scottish postal areas. Calculated from www.scotland.gov.uk/Topics/Statistics/SIMDPostcodeLookup on 10/12/13.

Eligibility criteria for young people for inclusion in the study were as follows: (1) aged at least 13 at baseline assessment; (2) experiencing moderate or high levels of psychological distress, as assessed by a score of 5 or more on the Emotional Symptoms subscale of the self-reported Strengths and Difficulties Questionnaire (SDQ-ES; Goodman et al., 1998; Appendix 10.4) at baseline assessment; (3) considered capable of giving informed consent for participation in the trial, as assessed by teachers and by the author at baseline assessment; (4) greater than 80% attendance at the school, as assessed by the teaching staff; (5) not at serious risk of harm to self or other, as assessed by teachers and by the author at baseline assessment; (6) not planning to leave school within the current academic year, as assessed by the teaching staff; (7) not currently involved with mental health services, as assessed by teaching staff and by the author at baseline assessment.

The study aimed to recruit 32 participants across the two arms, as recommended for a pilot trial (Torgerson & Torgerson, 2008). Table 5 shows participant demographics and Figure 1 shows the flow of participants through the study, using the CONSORT template by Moher, Schulz and Altman (2001). In total, 68 young people were referred to the researcher (the author) by a member of the school staff for assessment. Of these, three declined to participate, and 65 consented and were assessed for eligibility. Of those assessed, 31 were ineligible for participation due to scoring below five on the SDQ-ES. The remaining 34 young people were deemed eligible to participate in the trial, gave consent and were randomised: 16 to the counselling condition and 18 to the

waiting-list control condition. Following randomisation, one young person who had been allocated to the control condition moved schools and did not participate in any further aspects of the trial. Midpoint and endpoint assessments were completed with all of the 33 remaining participants, giving a completion rate of 97.1% at six-week midpoint and 12-week endpoint.

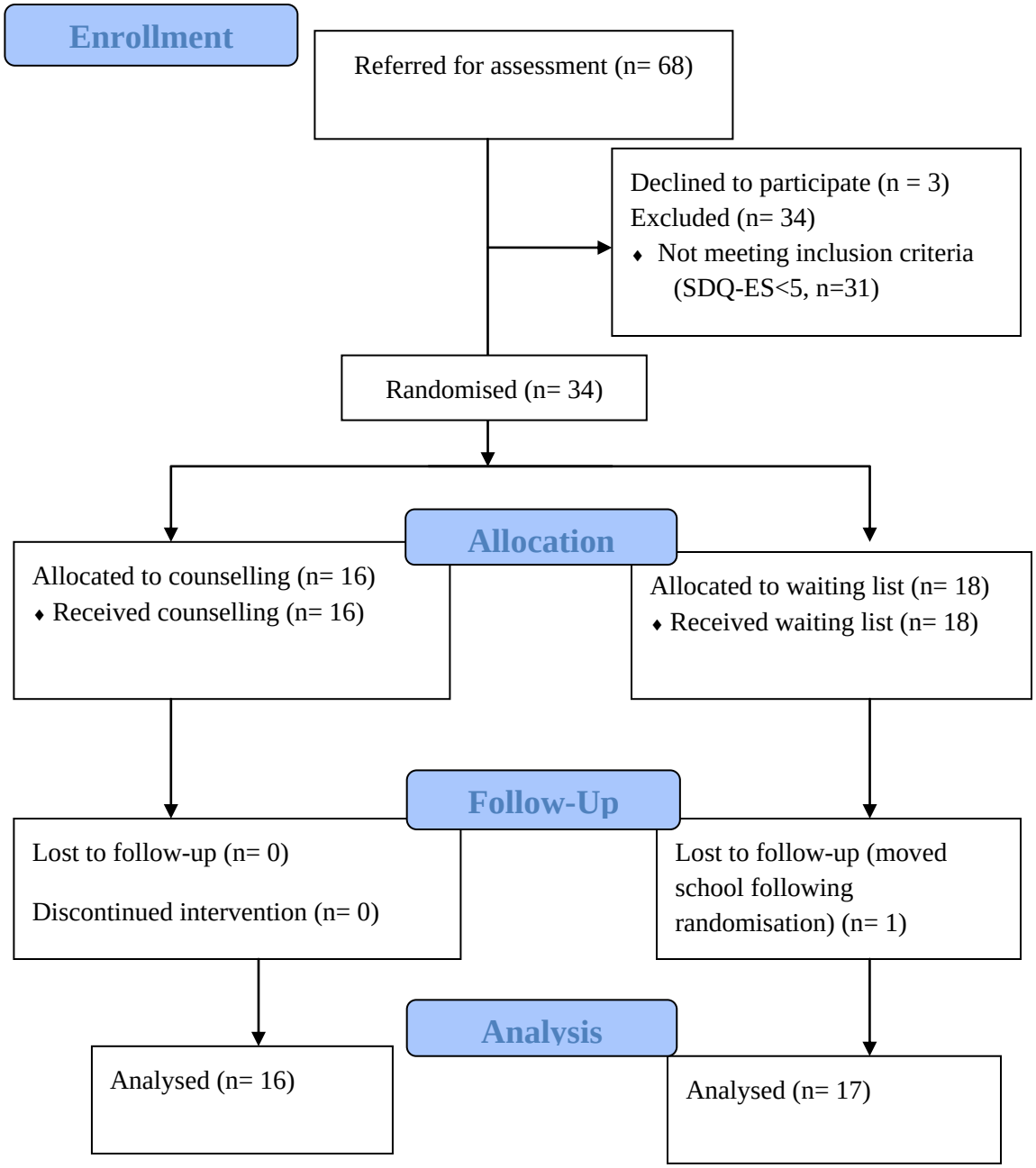

Figure 1. Participant flow chart

Table 5. Participant demographics

	Counselling (n = 16)	Waiting List (n = 17)	Total (n = 33)
Mean age in years (SD)	14.13 (1.2)	14.12 (0.6)	14.12 (0.93)
Gender			
Male (n, %)	10 (62.5%)	6 (35.3%)	16 (48.5%)
Female (n, %)	6 (37.5%)	11 (64.7%)	17 (51.5%)
Ethnic origin			
Scottish (n, %)	14 (87.5%)	13 (76.5%)	27 (81.8%)
Irish (n, %)	1 (6.3%)	1 (5.9%)	2 (6.1%)
British other (n, %)	1 (6.3%)	2 (11.8%)	3 (9.1%)
Mixed background (n, %)	0 (0)	1 (5.9%)	1 (3%)
Disabled (n, %)	2 (12.5%)	1 (5.9%)	3 (9.1%)
Duration of problems (n, %)			
Less than a month	1 (6.3%)	1 (5.9%)	2 (6.1%)
1 – 5 months	4 (25%)	4 (23.5%)	8 (24.2%)
6 – 12 months	1 (6.3%)	4 (23.5%)	5 (15.2%)
Over a year	10 (62.5%)	8 (47.1%)	18 (54.5%)

Note. Duration of problems from SDQ

The average age of the 33 young people who participated in the study to endpoint was 14.12 (Table 5); n=16 were male and n=17 were female. A higher proportion of males were allocated to the counselling condition as compared to the waiting-list condition (and vice versa for females), but the difference was not significant (χ^2 [1] =2.44, p=.12). Over half of the sample (54.5%) reported problems that had lasted for over a year. SDQ Total Difficulties (SDQ-TD) scores indicated that 36.4% of participants were in the abnormal range of psychological difficulties at baseline assessment (SDQ-TD >20). This compares with the 10% of a normal population who would be expected to score within this range (SDQ, 2009).

At baseline assessment, 91% of participants identified three distinct goals for therapy (using the Goal-Based Outcome Record; Appendix 10.2), and the remaining three participants (9%) identified two goals each. Participants' goals for counselling were coded according to the five broad categories outlined in the Bern Inventory of Treatment Goals (Holtforth & Grawe, 2002). Coping with Specific Problems or Symptoms was the most common type of goal, identified by 73% of participants, and included overcoming distress, anxiety, anger, and specific school-related problems (for instance, 'I want to concentrate more in class'). Personal Growth goals were identified by 61% of participants and related to themes such as developing confidence and emotional resilience. Interpersonal goals were identified by 39% of participants and generally related to improving family relationships, or developing an ability to communicate with others on an emotional level. Goals relating to Wellbeing and Functioning were identified by 27% of participants, and related to a desire for general contentment, such as 'I want to feel better'. Goals relating to Existential Issues were not identified by any of the participants.

4.2.3 Measures

The measures used in this study (described below) were chosen for theoretical and practical reasons, taking into account the author's experience of measures used in the Cooper et al (2010) trial. Self-report measures suitable for 13-16 year olds, which did not involve psychiatric diagnosis, were considered.

The author's first choice of primary outcome measure was the Goal-Based Outcome Record, since its personalised nature is more appropriate to the humanistic orientation of the counselling intervention. However, as a relatively new measure, the Goal-Based Outcome Record has not been validated and the author had no previous experience of its feasibility. The decision was made to use the Goal-Based Outcome Record as a secondary outcome measure and thus pilot its use for this purpose.

Instead, the YP-CORE was adopted as primary outcome measure. The benefits of this measure which were pertinent to the decision included its focus on the phenomenological experience of psychological distress as opposed to observable symptoms, the author's experience of the measure as both user-friendly and sensitive to change, its suitability for use in weekly counselling sessions, and its relevance to previous research as the most widely used tool in school counselling services.

In comparison, the Strengths and Difficulties Questionnaire (SDQ) was deemed to have a number of limitations, being less user-friendly and somewhat inappropriate for brief interventions or weekly use, since the follow-up version asks respondents to rate how they have felt 'over the last six months'. However, it was included based on the benefits of being one of the most widely used measures for counselling with children and young people and the wide variety of data provided by

its five subscales. Particularly, Cooper et al. (2010) found that SBHC had a significant effect on pro-social behaviour as measured by the SDQ-PS subscale, therefore it was desirable to collect this data in the current study.

The author was personally interested in the impact counselling may have on young people's self-esteem, which had not previously been quantitatively measured, therefore the Rosenberg Self-Esteem Scale (Appendix 10.5) was included as a secondary outcome measure.

YP-CORE

This is a well-validated pan-theoretical, self-report measure of psychological distress in young people aged 11-16, which has shown sensitivity to change and good construct validity (Twigg et al., 2009). The YP-CORE is the most widely used evaluation tool in UK school counselling services (Cooper, 2009) and, as it measures psychological distress 'over the last week', is sensitive to change. Young people are asked to rate 10 psychological distress items on a five point scale (0-4), giving a total score between 0 and 40, with higher scores indicating a greater level of distress. Examples of items on the measures are 'I've felt edgy or nervous' and 'I've felt able to cope when things go wrong' (reversed item). The YP-CORE measure has been shown to be acceptable to young people, with a good level of inter-item reliability (Cronbach's α=.85; Connell et al., 2007). Data from this study indicated similar levels of inter-item reliability (Cronbach's α=.86), and the measure showed acceptable levels of concurrent validity with other indicators of psychological distress and wellbeing (Pearson's correlations at endpoint: SDQ Total Difficulties=.73, Self-esteem Scale =-.64, Goal-based Outcome Measure =-.67).

Strengths and Difficulties Questionnaire

The self-report Strengths and Difficulties Questionnaire (SDQ) is a widely used and well-validated brief behavioural screening instrument for children and young people (aged 11 to 16) that can also be used to evaluate the efficacy of specific interventions (Goodman, 2001). Young people are asked to rate 25 items according to how they had been feeling over the past six months (at assessment) and past month (at endpoint or follow-up). The SDQ has five subscales: emotional symptoms (SDQ-ES), conduct problems (SDQ-CP), hyperactivity (SDQHA), peer problems (SDQ-PP), and pro-social behaviour (SDQ-PS) and these were used as secondary outcome measures for the present study, as well as the Total Difficulties score (SDQ-TD), which combines scores from each of the four distress-related subscales. The SDQ-TD score has been found to have adequate levels of inter-item reliability (Cronbach's α=0.82; Goodman et al., 1998), with a reliability in the present sample of α=.78. Inter-item reliabilities for the current sample were acceptable on the SDQ-ES (Cronbach's α=.70), the SDQ-PS (Cronbach's α=.67), the SDQ-HA (Cronbach's α=.78) and the SDQ-PP (Cronbach's α=.75). Inter-item reliability was low for the current sample on the SDQ-CP (Cronbach's α=.45). In this trial, the SDQ emotional symptoms subscale (SDQ-ES) was also used as a screening instrument to identify participants who, at baseline, had been experiencing heightened levels of psychological distress. Although emotional symptoms are not wholly synonymous with psychological distress, the SDQ-ES was used as a screening tool because it provides an indication of levels of distress over an extended period of time (six

months) and thereby identifies individuals who are experiencing long-standing, and not only intermittent, emotional distress.

Goal-Based Outcome Record

The Goal-Based Outcome Record is a personalized measure developed by the Child and Adolescent Mental Health Services (CAMHS) Outcome Research Consortium (CORC) for use with under 18s (www.corc.uk.net). Young people are asked to identify up to three goals for therapy and, at each of the time points, rate how close they feel to achieving each goal. Inter-item reliability for the current sample was acceptable (Cronbach's α=.77).

Self-Esteem Scale

The Rosenberg (1965) Self Esteem Scale comprises 10 items to be rated on a four point scale from 'Strongly disagree' to 'Strongly agree'. It was originally developed for use with young people and has since been evaluated as a reliable and valid measure of self-esteem (Blascovich & Tomaka, 1993). Inter-item reliability for the current sample was acceptable (Cronbach's α=.91).

Client Change Interview

Semi-structured interviews were carried out with all participants immediately after the measures were completed. At the six-week midpoint these interviews were conducted by the author and at the 12-week endpoint by an independent researcher who was blind to the allocation of participants. These interviews were based on Elliott's (1999) Client Change Interview, a qualitative research schedule which

examines clients' subjective experiences of a therapeutic intervention and perceived changes since its commencement. As the original schedule was developed for use with adults, the language and questions were simplified for the present study to make it appropriate for young people (Lynass et al., 2012; Appendix 10.3). A revised version was also developed for young people who had participated in the waiting list, and not intervention, condition (Appendix 10.6).

4.2.4 Interventions

School-based humanistic counselling

Participants allocated to the SBHC condition were offered a first appointment with a counsellor no more than one week after baseline assessment. Participants were then offered meetings with their counsellor for one school period (approximately 40 minutes) per week for that school term, which allowed for up to nine sessions. Counselling sessions were audio-recorded to encrypted data files using password-protected digital voice recorders, except when the participant explicitly stated that they preferred not to be recorded. Participants were asked to complete the YP-CORE outcome measure at the beginning of each counselling session.

The counsellors were three female practitioners, qualified in humanistic therapy to at least postgraduate Diploma level, which requires a minimum of 100 hours supervised practice. They were asked to deliver therapy in accordance with the Skills for Health funded competences for humanistic psychological therapies (Roth et al., 2009) which includes basic humanistic competences such as 'ability to experience and communicate empathy' and 'ability to experience and communicate a fundamentally accepting attitude to clients'; as well as more specific humanistic

competences such as ‘ability to help clients to articulate emotions’. Ten-minute segments of sessions were randomly selected from audio recordings and independently audited by the first two authors to assess adherence to these competences using the Person-Centred & Experiential Psychotherapy Scale (PCEPS; Freire, Elliott, & Westwell, 2010; Appendix 10.7). This measure asks raters to score segments from therapy sessions on dimensions of person-centred and experiential theory consistent with the Roth et al. humanistic competences. Items include ‘how much do the therapist’s responses convey an understanding of the client’s experiences as the client themselves understands or perceives it?’ and ‘how much does the therapist actively work to help the client focus on and actively articulate their emotional experiences and meanings, both explicit and implicit?’ All segments were deemed to adhere to humanistic competences, as defined by a mean rating of over four out of a maximum possible mean rating of six, with a high correlation (r =.98) between the auditors’ ratings across segments.

Waiting list

Young people allocated to the control condition were not offered any formal counselling. However, they were informed that they had access to the full psychological support provisions within their school, and could access these at any point during the trial. Only one participant in the waiting-list condition accessed additional support from a member of school staff during the trial; this participant remained in the trial and was included in the analyses presented. At endpoint assessment, participants in the waiting list condition were offered the option of direct entry to counselling.

4.2.5 Randomisation

A randomisation sequence was generated by an online computer program (http://www.randomisation.com) in blocks of four. Details of the allocation (counselling or waiting list) were then transferred to a series of sequentially numbered sealed envelopes by an independent researcher. Once young people were accepted into the study, the first author (who conducted baseline assessments and was blind to the allocation order) opened the envelopes sequentially and informed the young people of their allocation: immediate counselling or counselling in one term's time.

4.2.6 Procedures

Professional contacts of the author and first supervisor were consulted to identify Glasgow secondary schools without any provision of individual counselling for pupils, and the three schools were highlighted because headteachers and/or members of senior management in the school had expressed an interest in adopting a school counselling service. The author met in the first instance with the headteacher to explain and introduce the study on the basis of reciprocity, whereby schools were offered a limited provision of free counselling for a small number of pupils in return for facilitating the research project; at this stage headteachers were provided with a written summary of the proposed study (Appendix 10.8).

Following this, the author met with the schools' pupil support teams (groups of teachers with responsibility for emotional support and guidance) who were asked to identify young people who they considered potentially appropriate for

participation. The author briefed pupil support teachers on the study protocol and provided them with an information sheet (Appendix 10.9) which includes particular emphasis on the eligibility criteria. For instance, the five items of the SDQ-ES were given as an example of the type of problems which would make a young person eligible to participate. Pupil support teachers were then asked to approach young people they considered potentially eligible for the study based on this information, and discuss the possibility of the young person taking part. For those young people who expressed an interest in taking part, a parental assent letter was posted from the school to their guardian(s) (Appendix 10. 10). If participation was not refused at this stage, the young person was invited to attend a one-to-one assessment interview with the author.

At assessment the procedures were explained in full, and young people were provided with a copy of the Information Sheet for Young People (Appendix 10.11) and encouraged to ask questions and discuss their potential involvement in the study with the author. Informed consent was described at length to ensure that young people understood their lack of obligation to take part, and their option to withdraw at any point, before signing the Consent Form for Young People (Appendix 10.12). Following this, eligibility was checked according to the inclusion criteria, before the young person was invited to complete each of the measures. Following completion of the Strengths and Difficulties Questionnaire (Appendix 10.4), eligibility was rechecked and young people were informed of whether they were eligible or not, and given the opportunity to discuss this outcome. Those who were eligible were then randomised to immediate counselling or waiting-list control. The first assessment point (baseline) occurred in the first two weeks of a given school term, pre-

randomisation (in the UK, the school year is divided into three terms, each of which is approximately 13-14 weeks). The second was at the midpoint of the same term, approximately six weeks post-randomisation. The final assessment (endpoint) took place in the last two weeks of term, approximately 12 weeks post-randomisation. Baseline and midpoint assessments were conducted by the author and endpoint assessments were conducted by researchers who were blind to the allocation of participants.

4.2.7 Data analysis

All analyses were conducted using SPSS version 19. Given the pilot nature of the trial, missing outcome data for the one participant who dropped out were not imputed, and only data from the 33 participants who completed to endpoint were included in the analysis. Group means were compared at midpoint and endpoint using analysis of covariance (ANCOVA) with baseline data as the covariate. Using the covariate to adjust for baseline differences is not necessary, since randomisation ensures that differences in the baseline data are (by definition) due to chance and therefore not significant. However, using baseline data as a covariate reduces unexplained outcome variance in the test, and thus increases its power. In addition, it has been noted that statistically significant differences in baseline data can occur even when randomisation is successful (Fives et al., 2013). Therefore, independent samples t-tests were conducted on the baseline data for all measures.

The cut-off for statistical significance was set at $\alpha<.05$ (two-tailed) and, because of the small-scale nature of the trial and to avoid Type II errors, Bonferroni corrections were not applied to the ANCOVAs. Effect sizes and 95% confidence

intervals were calculated using the Effect Size Calculator from the Centre for Evaluation and Monitoring, Durham University (http://www.cemcentre.org/). Effect sizes are given as Hedges' *g* (Hedges & Olkin, 1985), which multiplies Cohen's *d* by a small correction factor to compensate for bias in small sample sizes. To describe the magnitude of effect sizes, standardized criteria from Cohen (1988) have been used whereby an effect size (Cohen's *d*) of .2 can be considered small, .5 medium and .8 large. Hedges' *g* can be converted to Cohen's *d* for this purpose.

Given the small numbers of participants involved in this pilot trial, all analyses are indicative only and not appropriate as a basis for clinical decision-making.

4.2.8 Ethical concerns

In designing this trial, a number of ethical issues were taken into account. First, the wellbeing of young people who were assessed and not eligible to take part in the study was considered (see eligibility criteria in section 4.2.2). The ethical concern here is that young people identified by their pupil support teachers and assessed by the author may have anticipated being able to take part and have counselling, and may have experienced feelings of rejection or disappointment on finding that they were ineligible. The author attempted to minimise the number of ineligible pupils referred for assessment by emphasising this concern in discuss with pupil support teams, and by providing details of the eligibility criteria to these teachers (Appendix 10.9). This proved adequate to ensure that none of the young people who attended an assessment interview were ineligible on the basis of age, attendance rate, capability

to give informed consent, intention to move school or current involvement with mental health services. The remaining criteria for eligibility were a score of at least five on the SDQ-ES at assessment, and no risk of significant harm to self or other. Both of these were considered by pupil support staff before making referrals, and it was hoped that this would reduce the number of young people assessed as ineligible.

The author initially planned to have no distress-related inclusion criterion in order to protect against this possibility, and focus the study on personal goal attainment. However, when the decision was taken to adopt psychological distress as the primary outcome measure (see section 4.2.3), this impacted on the decision to include a distress-related inclusion criterion. A cut-off point was deemed necessary to measure reduction in distress, making the study viable. In balancing this requirement against the ethical implications, one factor was the finding from Cooper et al (2010), that among participants meeting a cut-off point of SDQ-ES ≥4, those with lower levels of distress at the outset of the trial showed more improvement in the control condition than in SBHC, while the reverse was true for those with higher distress levels at the outset. This led the authors to recommend a higher cut-off point for distress in future studies. Despite being higher than the SDQ-ES ≥4 used in Cooper et al (2010), the decision to adopt SDQ-ES ≥ 5 as the cut-off point in this study was still conservative according to the SDQ scoring guide (available at www.sdqinfo.com/ScoreSheets/e2.pdf): scores above seven on the SDQ-ES are interpreted as indicating 'abnormal' levels of emotional symptoms; a score of six indicates 'borderline' levels and scores of five and less are interpreted as 'normal' levels, i.e. non-symptomatic. This reduces the likelihood of harm to young people assessed as ineligible to take part. Some precautions were taken to further reduce this

likelihood: the eligibility criteria and the possibility of scoring below the cut-off point was thoroughly explained to young people at assessment, and at all stages young people were encouraged to discuss with the author any negative feelings they had about this process. Following assessment, young people who were not eligible to take part were referred to their pupil support teacher to discuss their experience.

The ethical concerns relating to risk of harm to self or other were considered fully, and discussed with professional contacts as well as teaching staff. The exclusion criteria relating to risk of harm was employed to ensure that young people at risk would be able to access more immediate support through an urgent CAMHS referral, instead of being accepted into the trial which carried a 50% chance of being allocated to the waiting list control condition. For young people who disclosed any risk of harm to self or other, the researcher worked in partnership with the school's child protection officer and the young person's pupil support teacher to decide on the most supportive course of action for the young person, with participation in the trial representing one option. Therefore, young people were excluded from the trial on this basis only when a more immediate form of support was available.

Since the study was designed to operate in schools without an existing counselling service, it was viewed as providing additional support to a limited number of pupils who would otherwise have had no access to school-based counselling. The potential benefit of this for school pupils was considered to outweigh the potential for harm resulting from the study being introduced.

4.3 Results

Half (50%) of young people assessed by the author were randomised, 4.4% declined to participate and 45.6% were ineligible due to SDQ-ES scores below 5. Only one participant (allocated to the waiting list) did not complete outcome measures at midpoint and endpoint, resulting in a low attrition rate in this study of 2.94%.

Independent samples t-tests of baseline data revealed no significant differences between those allocated to counselling and those allocated to waiting list control on the primary outcome measure, YP-CORE: $t(31)=0.162$, $p=0.873$. In addition, no significant differences were found between groups at baseline on SDQ-TD: $t(31)=0.177$, $p=0.860$; G-BOR: $t(28)=0.598$, $p=0.555$; or SEQ: $t(31)=0.376$, $p=0.709$.

Table 6 shows means, standard deviations, effect sizes and ANCOVA results for both groups at baseline, midpoint and endpoint. Figures 2-5 illustrate each of the outcome measures against treatment allocation over time. Consistent with the alternative hypothesis, at 12-week endpoint, participants in the counselling condition improved significantly more than those in the control condition on the primary outcome measure, the YP-CORE ($F=11.69$, $p=.002$) (Table 6, Figure 2). This difference was also significant at the six-week midpoint assessment ($F=5.01$, $p=.003$). The ES (g) for counselling on this primary outcome measure was 1.14 at 12 weeks (95% confidence interval: 0.40-1.87), and 0.71 (95% CI: 0.00-1.41) at six weeks.

The secondary outcome measures also showed significant differences in favour of SBHC (Table 6). As hypothesised, at 12-week endpoint assessment, those

allocated to counselling, as compared with those allocated to the waiting list control condition, showed significantly higher levels of self-esteem (F=11.3, p=.002, g=.89, 95% CI: 0.18-1.61; Figure 5), were significantly closer to achieving their goals (F=5.45, p=.03, g=.79, 95% CI: .12-1.55; Figure 4), and had significantly fewer total difficulties (F=6.7, p=.015, g=.77, 95% CI: .06-1.48; Figure 3). In addition to those anticipated in the alternative hypotheses, a further significant difference in favour of SBHC was found: those allocated to counselling had significantly lower levels of hyperactivity than those allocated to the waiting list control (F=6.05, p=.02, g=.99, 95% CI: .27-1.71).

This effect was also evident at the six-week midpoint assessment, when significant differences in favour of counselling were also found on hyperactivity (F =7.31, p=.01, g =1.04, 95% CI: .31-1.77). Differences in goal attainment at the six week midpoint were significant in favour of the counselling condition (F =5.45, p=.03, g =.79, 95% CI: .08-1.50). Though the differences between groups at six week midpoint was in favour of SBHC, they did not reach significance on self-esteem (F =3.13, p =.09, g =.56, 95% CI:-.13-1.26) or total difficulties (F =2.45, p =.13, g =.61, 95% CI: -1.31-.09).

No significant differences were found at either time point on emotional symptoms (6 weeks: F=2.05, p =.16, g =.66, 95% CI: -1.36-.04; 12 weeks: F =3.97, p =.055, g =.86, 95% CI: .15-1.58), conduct problems (six weeks: F =.26, p =.61, g =.11, 95% CI: -.79-.58; 12 weeks: F =2.74, p =.11, g =.37, 95% CI: -1.06-.32), peer problems (six weeks: F =.66, p =.44, g =.1, 95% CI: -.59-.78; 12 weeks: F =.29, p =.60, g =.2, 95% CI: -.49-.88) and pro-social behaviour (six weeks: F =.1, p =.75, g =.25, 95% CI: -.94-.43; 12 weeks: F =.20, p =.66, g =.01, 95% CI: -.69-.68). Of the

18 F-tests conducted, therefore, eight emerged as statistically significant in favour of SBHC, with a mean effect size across all four outcome measures (with the SDQ distress subscales included within the SDQ-TD) of .73 at 12-week endpoint and .55 at six-week midpoint.

Table 6. Primary and secondary outcome measures by allocation

	Mean (SD)						Effect Sizes and ANCOVA					
	SBHC			Waiting List			Midpoint			Endpoint		
	Base	Mid	End	Base	Mid	End	*F*	*p*	*g*	*F*	*p*	*g*
YP-CORE	19.44 (6.24)	10.97 (7.08)	9.25 (7.26)	19.76 (5.38)	15.93 (6.59)	17.47 (6.83)	5.01	.003**	0.71	11.69	.002**	1.14
SDQ-TD	17.99 (5.15)	12.06 (4.93)	11.44 (4.98)	18.31 (4.95)	15.71 (6.54)	15.47 (5.23)	2.45	.13	0.61	6.70	.015*	0.77
SDQ-ES	6.13 (1.09)	3.56 (2.16)	3.5 (1.93)	7.00 (1.70)	5.12 (2.45)	5.35 (2.23)	2.05	.16	0.66	3.97	.055	0.86
SDQ-HA	4.68 (2.22)	3.37 (1.89)	3.38 (2.06)	5.65 (1.50)	5.53 (2.15)	5.41 (1.94)	7.31	.011*	1.04	6.05	.02*	0.99
SDQ-CP	3.25 (1.88)	2.25 (1.34)	1.88 (1.50)	2.84 (1.49)	2.41 (1.54)	2.47 (1.63)	0.26	.61	0.11	2.74	.11	0.37
SDQ-PP	3.94 (2.11)	2.88 (2.19)	2.69 (2.15)	2.82 (2.70)	2.65 (2.45)	2.24 (2.25)	0.66	.44	0.10	0.29	.60	0.20
SDQ-PS	7.25 (1.81)	7.56 (1.71)	7.81 (1.83)	7.78 (1.65)	7.94 (1.20)	7.82 (1.74)	0.10	.75	0.25	0.20	.66	0.01
SEQ	14.56 (5.30)	17.44 (4.69)	20.31 (6.27)	13.92 (4.47)	14.71 (4.75)	15.29 (4.62)	3.13	.09	0.56	11.33	.002**	0.89
G-BOR	3.18 (1.83)	6.32 (1.89)	7.29 (2.09)	3.28 (1.18)	4.86 (1.73)	5.65 (1.74)	5.45	.03*	0.79	6.16	.02*	0.83

Note. Base = baseline assessment; *Mid*= midpoint assessment; *End* = endpoint assessment; YP-CORE = young person's CORE; SDQ-TD = SDQ Total Difficulties; SDQ-ES = SDQ Emotional Symptoms; SDQ-HA = SDQ Hyperactivity; SDQ-CP = SDQ Conduct Problems; SDQ-PP = SDQ Peer Problems; SDQ-PS = SDQ Pro-social; SEQ = Self-esteem Questionnaire; G-BOR = Goal-Based Outcome Record. Lower scores indicate better outcomes on the YP-CORE, SDQ-TD, SDQ-ES, SDQ-HA, SDQ, CP, SDQ-PP; and poorer outcomes on the SDQ-PS, SEQ and G-BOR. Positive sign for *g* = favours SBHC. *p < 0.05; **p < 0.01

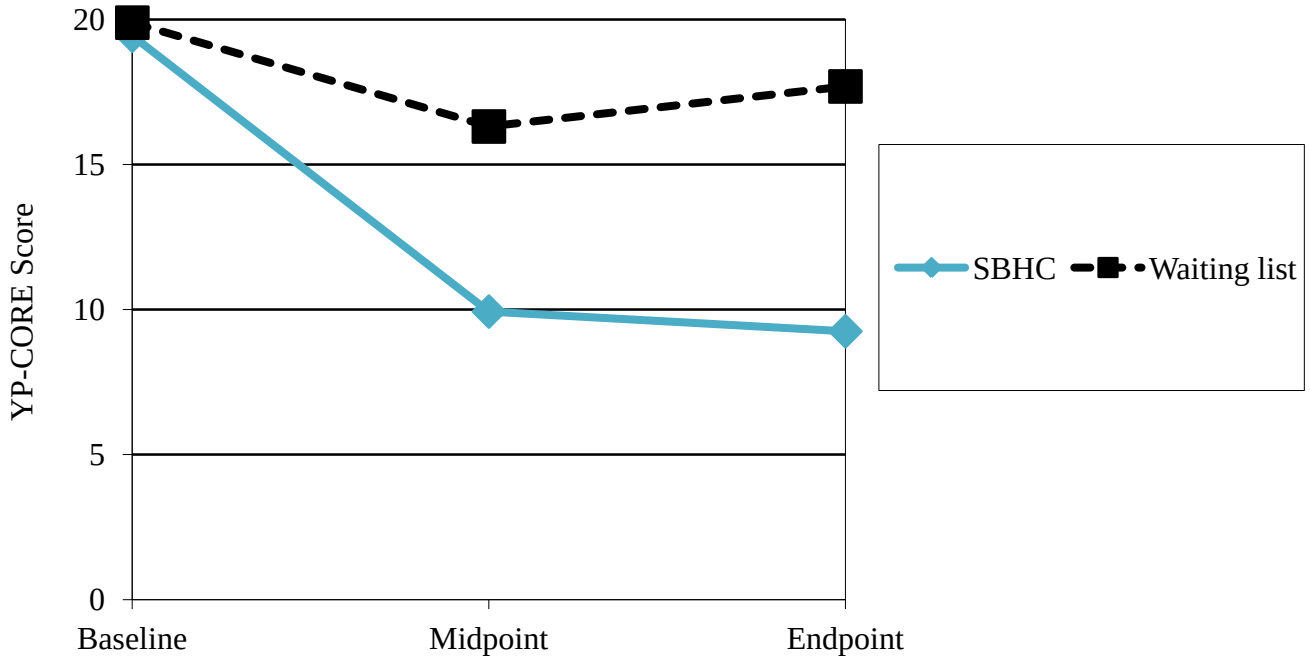

Figure 2. Psychological distress against treatment condition

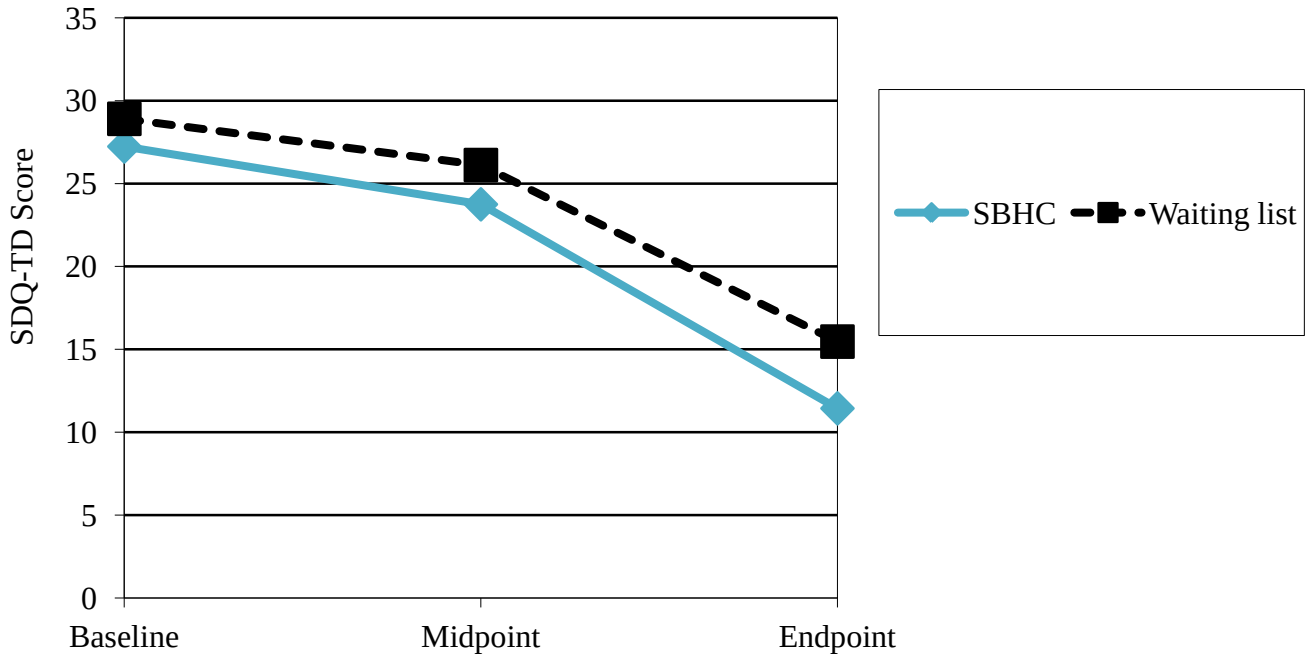

Figure 3. Total difficulties against treatment condition

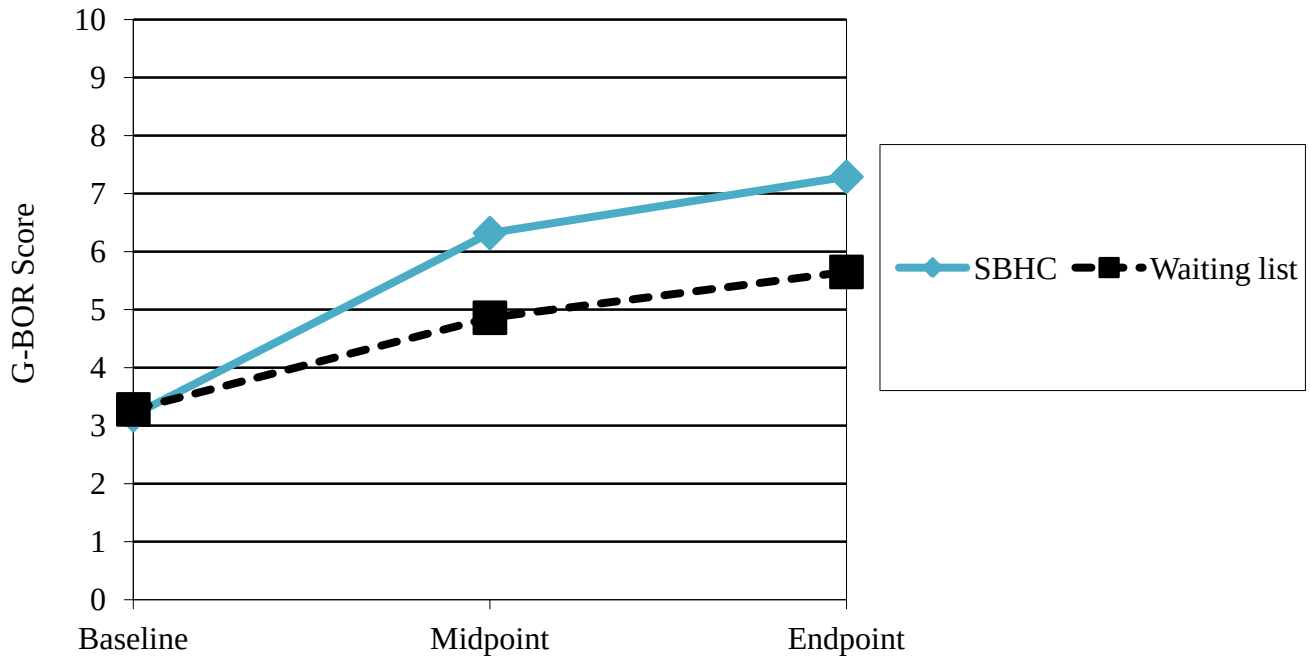

Figure 4. Personalised goals against treatment condition

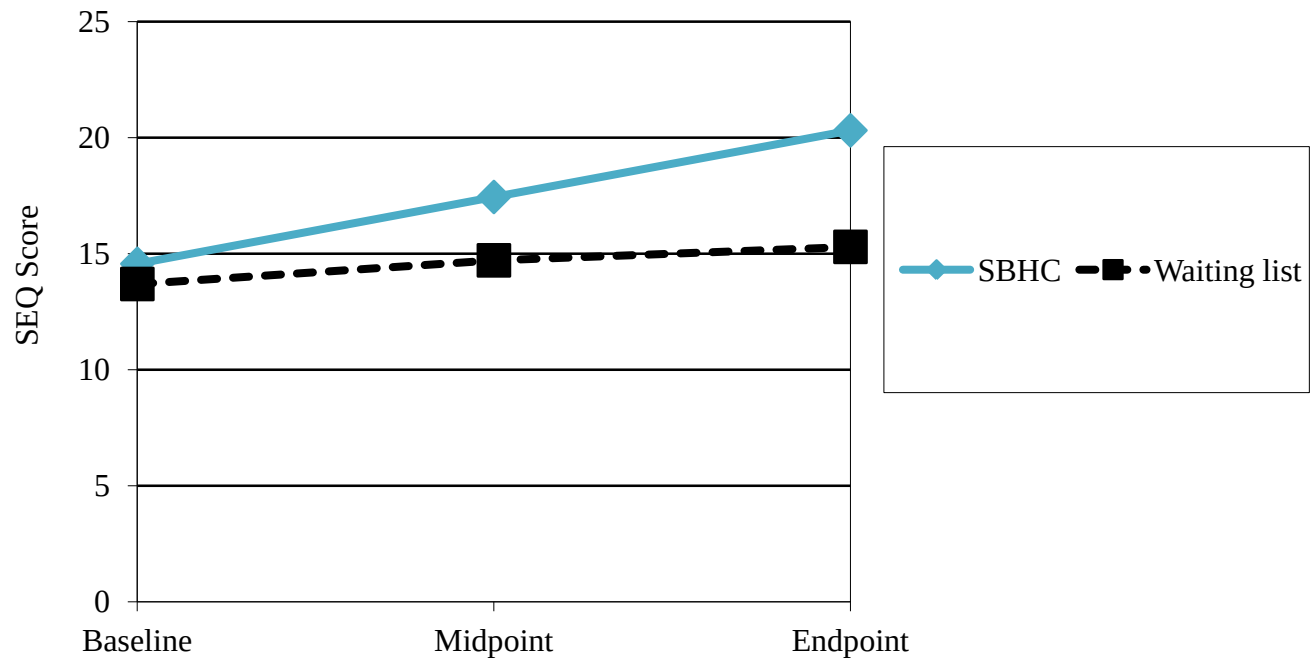

Figure 5. Self esteem against treatment condition

4.4 Discussion

The aim of this study was to pilot an improved set of procedures for evaluating SBHC, and to establish further indications of effect by comparing SBHC to a waiting list control condition. The null hypothesis that no significant differences would be found between those allocated to SBHC and those allocated to the waiting list control condition can be rejected for all four measures at the 12 week endpoint, and the alternative hypotheses that significant differences between groups would be found in favour of SBHC have been upheld.

Therefore, the present study suggests that SBHC may be effective in reducing psychological distress in young people. Indeed, despite the small sample size, improvement on the principal outcome was significant, with an ES that can be defined as large (Cohen, 1988), and comparable with those of most adult and child psychotherapy interventions (Kazdin, 2004; Lambert & Ogles, 2004; Weisz et al., 1995). The large effect size found in this study was outside the range reported by Hölldampf et al (2010) for person-centred and experiential therapies with children and young people (0.15 - 0.93). It was also greater than those found previously for school-based therapeutic treatments, both cognitive-behavioural (Baskin et al., 2010) and humanistic (Cooper et al., 2010).

With respect to secondary outcomes, all significant differences were in favour of SBHC, though the large number of tests being conducted and the absence of Bonferroni corrections means that caution is warranted in the interpretation of the six significant findings. However, these tentatively suggest that SBHC may be effective in ways other than reducing psychological distress, which are in keeping with the

aims of a humanistic therapeutic approach. Significant and large increases in self-esteem and personal goal attainment suggest that SBHC may serve the phenomenological needs of young people, and point to the potential benefits of humanistic counselling outside the realm of specific mental health diagnoses and problems. A further benefit of SBHC is suggested by a significant reduction in hyperactivity and inattention, with a large ES at both time points. Though this effect was not hypothesised at the outset of the trial, it is consistent with findings from previous research that school-based counselling may have educational benefits through improving concentration for distressed young people (Ogden, 2006; Rupani et al., 2012). The differences between groups on total difficulties, as measured by the SDQ, were significant at 12 weeks with moderate to large ESs at both time points. Since the total difficulties score is calculated by summing scores on all distress-related subscales, this result seems to be mainly caused by the impact of SBHC on hyperactivity (significant differences between groups were not found on the three remaining subscales), suggesting that this outcome may be more central to SBHC than previously anticipated.

Improvements in emotional symptoms, as measured by the SDQ-ES, did not reach the .05 significance level at 12 weeks, but the effect size was moderate to large at six and 12 weeks respectively. This suggests that changes experienced in SBHC by young people which can be detected by other tools such as the YP-CORE may not be measured by this subscale, which focuses on symptoms. Differences between groups in relation to pro-social behaviour were not significant at either timepoint, though the same measure showed significant differences in favour of SBHC in Cooper et al.'s (2010) study. In light of this, there is little evidence that SBHC

impacts on pro-social behaviour, since it was the only significant difference to be found between groups in Cooper et al.'s (2010) study, and may have been the result of a Type I error.

Although the results are encouraging, there are a number of important limitations to this study. First, SBHC was compared against an inert, rather than active, control condition: hence, non-specific effects cannot be ruled out as a possible cause of psychological changes. Second, the small sample size means that there were considerable variations across the two conditions at baseline and ES estimates are less precise. Third, the humanistic affiliation of the research team means that allegiance effects (Luborsky et al., 1999) must be taken into account. Although all outcome data at endpoint were collected by researchers who were blind to the allocation of participants, the author is a humanistic counsellor and had the most central role in conducting this research. This may have created a preferential bias among participants whereby their expectations and perceptions were influenced by the author's assumption that counselling would be more beneficial than waiting list conditions. The author took care not to communicate this explicitly to young people, but the possibility of implicitly influencing participants in this way cannot be ruled out. Fourth, generalisability is limited by the lack of diversity in the sample, which was primarily composed of young people from a white background. Fifth, randomisation was at an individual rather than a cluster level, such that contamination effects may have taken place: for instance, young people in the waiting-list condition may have learnt psychological coping skills from those attending counselling. Sixth, participants were recruited in the first instance by pastoral care teachers, and the author did not have control over the wording of this

initial conversation. Therefore, the selection of young people for assessment may have been influenced by such factors as the quality of relationship with the pastoral care teacher, and again young people's perceptions of their involvement in the study may have been influenced by positive assumptions about counselling on the part of the pastoral care teachers. Finally, there was no follow-up of effects beyond the 12-week endpoint and no economic evaluation. In addition, evaluating SBHC through randomised controlled trials is problematic since quantitative measures may fail to capture the nuances of participants' experiences, which are perceived as being central to the humanistic counselling process (Mearns & Thorne, 2007). However, the implications of randomised controlled data in support of this intervention are far-reaching, and the potential for wider dissemination of SBHC, should further studies continue to point to its efficacy, must be considered.

To conclude, preliminary evidence suggests that SBHC may be able to bring about large reductions in psychological distress over a 12-week period, with outcomes that are consistent with other psychological interventions for children and adults. In addition, the present procedure proved feasible and can be scaled up to a fully powered trial, although researchers may also wish to consider the use of a longer follow-up, cluster randomisation, an active control condition, and the incorporation of an economic analysis.

Chapter 5. Change Processes in School-Based Humanistic Counselling

As noted, little is known about the pathways to change for young people in school-based counselling and the specific processes involved. Therefore, generation of theory is required to clarify what happens in school-based counselling and how it brings about change in young people. Grounded theory is an appropriate method for theory generation, since it employs the phenomenological attitude of allowing meaning to emerge from data, rather than using a pre-formed conceptual scheme. At the same time, the goal is interpretation, which is achieved through an iterative process (Glaser & Strauss, 1967; Glaser, 1978). In this sense, grounded theory is a systematised form of qualitative inquiry influenced by both the hermeneutic tradition and by phenomenology. This chapter describes the formulation of a grounded theory of young people's experiences of school-based counselling. Through close engagement with interview transcripts and a repetitive cycle of checking between data and emerging theory, this study aims to develop trustworthy hypotheses regarding the potential pathways to change for young people in SBHC.

5.1 Method

5.1.1 Design

This was a post-hoc, qualitative interview study using an inductive approach (i.e. data-driven, not theory-driven). The design is informed by grounded theory (e.g. Glaser & Strauss, 1967; Glaser, 1978), combining elements of a phenomenological approach with those of a hermeneutic approach, in an iterative cycle. Since interview data was collected as part of the RCT element of this study, analysis did not occur in

parallel with data collection, as is traditionally the case in a grounded theory approach (McLeod, 2001; Glaser & Strauss, 1967).

5.1.2 Participants

Table 7 gives information on all participants allocated to SBHC, identified by pseudonym. Interviews were analysed from 14 participants allocated to the counselling intervention in the previously reported RCT; participants are identified in this text using pseudonyms. They were six females and eight males who were aged between 13 and 16 at the time of the interviews (mean age = 14.1). Seven were aged 13 (Abby, Beth, Fin, Hannah, Josh, Kimberley and Michael), two were aged 14 (Neil and Rachel), two were aged 15 (Ian and Paul) and three were aged 16 (Chloe, Dylan and Stuart). Two participants allocated to SBHC declined to have their interviews recorded (Thomas and James) and have not been included in this grounded theory analysis. All were Caucasian, and two considered themselves to be disabled. Since the subject of this chapter is young people's experiences of counselling and its effects, participants will hereafter be referred to as 'clients'.

Table 7. Information on SBHC participants

SBHC Participants (n=16)					
Pseudonym	M/F	Age	Sessions	School	Goals
Abby	F	13	6	2	I want to feel content in myself I want to stop being afraid I would like to stop worrying 24/7
Kimberley	F	13	5	2	I'd like to talk to my dad and mum more I'd like to feel more confident about myself I'd like to stop bottling things up
Chloe	F	16	7	2	Not feel as negative about my disability Feel more confident about joining clubs, etc. Not think as much about going to a different secondary school from my friends from primary
Ian	M	15	7	2	I'd like to stop shouting when I get angry I'd like to be able to help more in the house I want to do better in school, revise more
Dylan	M	16	4	2	I wish I didn't get so upset I want to control my behaviour I'd like to not worry so much
Beth	F	13	7	1	I want to stop being cheeky to my mum I want to get my confidence up a bit
Stuart	M	16	2	1	Keep calm in situations and not let things get to me Handle stress if the situation ever arises that I need help

Pseudonym	M/F	Age	Sessions	School	Goals
Rachel	F	14	6	2	I want to get more friends I want to feel better I want to get more confidence
Paul	M	15	6	3	I want to get on better with my mum and dad, stop being cheeky to them I want to change my behaviour towards other people and in school I want to talk to people about personal stuff, feel confident
Josh	M	13	7	2	I want to stop feeling angry Stop fighting with others and getting suspended I want to feel more confident
Michael	M	13	9	1	I wish I didn't get angry for no reason Be able to cope with the way I'm feeling I wish I could handle things at home
Hannah	F	13	8	1	I'd like to be able to commit to things Being able to handle things that worry me
Neil	M	14	9	3	I'd like other people in school to get on with me I want to feel better in myself, feel happy I want to feel better physically
Fin	M	13	9	3	I want to not get upset so easily I want to feel more confident I want to worry less
Thomas	M	14	9	2	I want to not get so annoyed with my sisters Try not to get angry in class Get in a mood less
James	M	15	9	2	Become less of a scatter cash Feel more confident and open to talk to people

5.1.3 Data collection

The Client Change Interview (Elliott, 1999) was developed for use with therapy clients to determine their experiences of changes since beginning therapy, what these changes may be attributed to, and any helpful and hindering aspects of the therapy process. Elliott (1999) suggests using the tool to aid in empathic exploration during a semi-structured interview shortly after the last counselling session, and ideally at regular intervals throughout (e.g. every 10 sessions). This tool was adapted for use with young people by Lynass et al. (2012) as part of a qualitative interview study of school counselling; the adapted version was used in this study (see Appendix 10.3). Of the 14 interviews analysed, eight were conducted by an independent researcher, and six by the author. All interviewers were trained in counselling and/or qualitative interviewing skills.

Each of the questions was used as a starting point, and interviewers had flexibility to explore related areas of experience raised by the client. Follow-up questions included those designed to explore clients' change attributions, in other words, any theories regarding the reasons for changes they had reported. However, in line with guidelines for good practice in qualitative inquiry (e.g. Stiles, 1993; Elliott et al., 1999), the focus of each interview was on clients' descriptions of their experience as opposed to explanations.

5.1.4 Procedure

Each client had been referred to the author by their pastoral care teacher, opted to take part in the RCT and been assigned to the counselling intervention as described in Chapter 4. Clients attended between two and nine counselling sessions each (mean

6.6) with one of three female counsellors trained to Masters level. As previously stated, the SBHC intervention was designed to adhere to specific competences for humanistic therapy developed by Roth et al. (2009); however, counsellors were encouraged to work according to their own personal style, preference and expertise within the confines of these competences. In other words, the intervention was manualised according to humanistic principles and person-centred attitudes, as opposed to providing a concrete directive for the counselling. Therefore, the moment to moment practice of therapy was determined to a large extent by the individual counsellor. An example of this is that one of the counsellors provided materials such as word cards and differently shaped stones in order to introduce activities to facilitate the client's process. Since these materials were the counsellor's own, they were not available to the other two counsellors, who worked in a more traditionally non-directive way. Semi-structured interviews were conducted approximately 12 weeks after clients began counselling.

5.1.5 Ethical considerations

Audio recordings of interviews were made using password protected recording devices with encrypted data files. Clients gave informed consent before being randomised to the counselling condition, and agreed to their anonymised data being stored and analysed in future studies. Prior to young people giving their consent, their parents/guardians were made aware of the study and had the opportunity to opt out should they object to the young person taking part. Ethical approval was obtained from the University Ethics Committee.

5.1.6 Analysis

The analysis was specifically informed by the illustration of grounded theory given by Rennie, Philips & Quartaro (1988), and its application in Rennie's (1990) study of clients' experiences of therapy. Verification steps (Elliott et al., 1999) were taken at every stage of the analysis, reviewing the data and subsequent interpretations for errors. This analysis was undertaken by the author alone, and 10% of the resulting categories were cross-checked by the first supervisor before process models were developed by the author.

Transcription

The author listened to the audio file from each interview three times. First, each file was played to form an overall impression of the interview. Second, the audio file was played at reduced speed and transcribed in its entirety. Third, the transcript was reviewed while playing the audio file at normal speed, allowing corrections to be made where necessary.

Meaning unit extraction

By close-reading each transcript in turn and selecting every client utterance potentially relevant to counselling, 'meaning units' were extracted. Rennie et al. (1988), describe meaning units as 'individual concepts conveyed by the interviewees', and note that the choice of analytic unit is 'somewhat arbitrary' (p.142). Similarly, McLeod (2001) notes that using a grounded theory approach allows flexibility regarding how the material is segmented for analysis. In this case, meaning units comprised the client's actual words, with none added by the first

author, such as ‘I prefer [counselling] to be inside the school’ (Dylan), and were extracted at the simplest level, such that a ‘turn’ of client speech was often separated into several meaning units, with linked content. The length of meaning units in this study is similar to those defined by Glaser (1978), who suggests analysing transcripts line by line. In interviews where the same comment was repeated by the client, each repetition was treated as a separate meaning unit. However, not every line was extracted as a meaning unit. Instances where clients simply confirmed or disconfirmed a statement made by the interviewer were *not* extracted as meaning units, nor were statements which were clearly irrelevant to counselling, such as ‘I’m hoping the snow doesn’t come back on’ (Chloe). While the context of each utterance was taken into account at every stage, extraction of meaning units was not limited to clients’ responses to specific questions, i.e. analysis began with clients’ words as opposed to segmenting the transcript according to the interview schedule.

Using this process, 550 meaning units were initially extracted from the 14 interviews. Each was hand-written on a separate index card labelled with the client code, transcript line number, and any necessary contextual information. For example, where a time scale was implied in the dialogue between client and interviewer, but not explicitly stated in the meaning unit, this was added in parenthesis: ‘I would get angry (before counselling)’ (Hannah). As a rule, clients were not asked leading questions, and in rare instances where leading questions were asked, client responses were not extracted as meaning units. Therefore, all categories describe comments made directly by clients in response to open questions.

Interpretation

Following the extraction of meaning units, each transcript was reviewed again and a short descriptive summary was written for each, conveying the author's overall impression of the interview at this stage (as recommended by McLeod, 2001). Then each transcript was re-read to extract 'interpretive statements', which are single concepts taken from the author's interpretation of the participants' words in context. Interpretive statements often employed terms not used by the client, for instance 'more present in conversation with Mum' or 'growth in sense of agency'. The two types of analytic unit extracted reflect an attempt to combine elements of a phenomenological approach (meaning units entirely in the words of the client) with those of a hermeneutic approach (interpretive statements emerging from the researcher's understanding), consistent with grounded theory which aims to integrate both. In this manner, 56 interpretive statements were extracted and hand-written on index cards with the client code.

Categorisation

The process of developing categories involved grouping and re-grouping meaning units several times while re-reading transcripts, descriptive summaries and interpretive statements. During this process, meaning units were added and removed in a move towards a more accurate representation of the interviews, finally resulting in 547 meaning units. Interpretive statements were used to develop categories where the clients' actual words did not provide an obvious label. For instance, the word 'confidence' was commonly used by clients and became the label for one category. By contrast, the word 'agency' became the label for one category despite *not* being

used by clients, since interpretive meaning units pointed to a collection of client utterances based on the concept, e.g. 'I can sort of make decisions for myself more' (Chloe). Table 8 shows 60 categories, 16 sub-domains, five domains and two over-arching themes, representing the entirety of the data. For each category, the number of respondents who made utterances related to this concept is listed with the total number of meaning units making up the category. Of the 547 meaning units represented, 175 (32%) were coded into more than one category. When this taxonomy was finalised by the author, a selection of six categories and the meaning units contained in them were presented with Table 8 to the first supervisor for auditing. The first supervisor approved the links made between meaning units and categories, and suggested focusing analysis on the categories which related to change processes in counselling. Following this, two domains were selected to form the body of the change process analysis: helpful factors and positive changes. A further two domains, hindering factors and negative changes were reviewed separately to develop an opposing process describing potential unhelpful processes. Therefore, the domains of general satisfaction with counselling and perception of outcome were omitted at this stage.

Developing process models

Change process models were developed where there was evidence of links between helpful factors in counselling and positive changes; models of processes impeding counselling were developed from links between hindering factors and negative outcomes. Trends emerging from this set of categories were considered in parallel to transcripts and descriptive summaries, and potential process models were developed

by making connections between categories across clients. Each client's process was reviewed thoroughly with reference to the interview as a whole and the categorisation of meaning units extracted from it. Particularly in cases where clients had expressed conflicting opinions, each extracted as meaning units and categorised, the interview was carefully reviewed to explore underlying processes. These process models were then tested against each interview and revised accordingly, as part of the ongoing iterative process comparing data with emerging theory.

5.2 Reflexive statement

The author trained as a person-centred counsellor and has conducted research interviews with young people in secondary schools as part of two RCTs of SBHC. This has involved in-depth, empathic engagement with young people and inevitably leads to personal theories which influence this study. Some key assumptions based on this experience were firstly that the respectful one-to-one attention of an adult is a powerful experience for young people, as it is quite different from the usual way of relating with significant adults, such as parents and teachers. Secondly, the development of autonomy is central to change processes of young clients, and the experience of a relationship which explicitly values the young person's autonomy can provide an important boost to confidence, which is often used by the young person to grow towards more self-acceptance and self-determination. In addition, the author holds an attitude of egalitarianism and a phenomenological standpoint, in line with the humanistic approach. These attitudes are arguably more pertinent in relation to young people, who tend to have little control over their own lives, and may be more likely to feel disempowered in their significant relationships. The analysis was

fuelled by curiosity and desire to understand clients' experiences as accurately as possible. With this goal in mind, preconceptions were bracketed and a systematic data-driven approach was taken in the hope of representing clients' words with minimal bias.

5.3 Results

Table 8 summarises the data in terms of number of meaning units and number of clients for each category. For the four domains relevant to process analysis (highlighted in blue on Table 8): helpful factors, hindering factors, positive outcomes and negative outcomes, description of the data is provided below.

Five change processes emerged from this data, which are outlined in turn. No unhelpful processes were demonstrated in the data since none of the hindering factors reported were evidently linked to negative outcomes. However, some connections were made between hindering factors and ongoing problems, resulting in the development of two models of processes which may have *impeded* change.

Table 8. Taxonomy of categorised meaning units

I. YOUNG PERSON'S EXPERIENCE OF COUNSELLING		
1. Satisfaction with Counselling	**Clients**	**Meaning Units**
a) Process		
Enjoyment	13	34
Neutral	2	3
Difficult	1	3
b) Outcome		
Helped	10	37
Met expectations	5	9
Exceeded expectations	3	6
Disappointed	1	2
2. Helpful factors		
a) Counsellor-related		
Personal qualities	8	9
Independence (from client's life)	6	16
Listening	6	11
Activities	5	20
Advice	5	10
Talking	4	6
Understanding	3	7
Asking questions	2	5
b) Client-related		
Talking about emotions (general)	13	41
Talking about specific emotions or subjects	5	12
Thinking	1	1
c) Relational		
Comfort/ease in relating	8	13
Dialogue	6	9
Liking/closeness	5	6
Trust	4	8
d) Practical		
Confidentiality	4	6
Timing of sessions	4	6
School context	3	4
Number of sessions	1	1
3. Hindering factors		
a) Counsellor-related		
Wanted counsellor to talk more	2	3
Wanted counsellor to ask more questions	2	4
Wanted more advice	2	3

Wanted more activities	1	2
b) Client-related		
Difficulty talking	4	15
c) Relational		
Awkwardness	3	9
d) Practical		
Miscellaneous practical issues	3	3
Wanted more counselling	2	9
Wanted less frequent sessions	1	4
II. OUTCOMES OF COUNSELLING		
1. Positive changes	**Clients**	**Meaning Units**
a) Relationships		
Better relationships with friends and peers	10	35
Better relationships with family	8	58
Better communication	7	36
More understanding of others/empathy	6	23
More positive perception of others	4	13
b) Emotions		
Happier	11	40
Less anxious	7	19
Less angry	6	19
More able to cope with emotions	6	21
c) Self		
Self-awareness	9	17
Agency	6	12
Self-esteem	6	9
Confidence	5	19
Hopefulness	4	20
Self-efficacy	4	8
d) Functioning		
School work	6	17
Focus and concentration	6	15
Behaviour	5	16
Sleep	4	9
2. Negative changes/ongoing problems		
a) Negative changes		
More angry	1	2
More difficulty focusing	1	1
b) Ongoing problems		
Family problems	4	5
Problems at school	3	7
Ongoing distress	3	4
Self	2	3

5.3.1 Helpful factors

Of the 191 occurrences of meaning units in the helpful factors domain, 84 (44%) were counsellor-related, 54 (28%) were client-related, 36 (19%) were relational and 17 (9%) were practical.

While there is some overlapping (since a proportion of meaning units were coded into more than one category), comments were deemed to be relational when the clients' language included both themselves and the counsellor. For example, 'we talk' as opposed to 'I talk' (client-related) or 'she listens' (counsellor-related). Confidentiality was considered to be a practical issue, but several meaning units overlapped with the relational category 'trust'. Distinctions were made between meaning units where the client described confidentiality with reference to their trust in the counsellor, e.g. 'I wasn't scared to talk to [counsellor], because she won't go talking to my Mum or anything' (Rachel), categorised under both confidentiality and trust, and those which were stated in more practical terms and categorised only under confidentiality, e.g. 'I know that it's confidential' (Paul).

Counsellor-related helpful factors

Descriptions of counsellor-related helpful factors were grouped into the following eight categories: personal qualities, independence, listening, activities, advice, talking, understanding and questions. Personal qualities included terms such as 'friendly' and 'nice', and were referenced by eight of the 14 clients (57%), e.g. 'she was good company' (Ian). The counsellor's independence from the client's life included references to the counsellor as a 'new face' and were mentioned by six clients (43%), e.g. 'having someone outwith the situation to talk to helped' (Hannah).

The counsellor listening was also described as helpful by six clients (43%), e.g. ‘she listened to what I had to say’ (Stuart). Activities were mentioned by five clients (36%), and described in both general terms, e.g. ‘we played games’ (Abby) and in reference to specific activities that the client found helpful, e.g. ‘there was a Pictionary game thing with cards, you had to draw the emotion on a face’ (Fin). Advice from the counsellor was also described in both general and specific terms, often related to techniques for controlling anger, and was reported as helpful by five clients (36%), e.g. ‘[counsellor] told me something to do if something went wrong’ (Josh). The counsellor talking, with no elaboration on what was said, was described as helpful by four clients (29%), e.g. ‘it felt good to have someone to talk to you’ (Hannah). The counsellor’s understanding was reported as helpful by three clients (21%) and included references to seeing things ‘from my perspective’ (Hannah) and ‘taking it seriously’ (Stuart). Finally, two clients (14%) reported that the counsellor asking questions was helpful, both generally and specifically about emotions, e.g. ‘I like the way the counsellor asks how I feel’ (Paul).

Client-related helpful factors

Meaning units about client-related helpful factors were categorised as talking about emotions generally, talking about specific emotions or subjects, and thinking. Though there are three categories in this sub-domain, all but one of the meaning units relate to the client talking about emotions. Most clients (13 out of 14, or 93%) mentioned talking about emotions generally as being helpful, and five clients (38%) reported talking about a specific subject which was emotionally salient, or a specific emotion, as helpful. For instance, Dylan said ‘it was actually really good just to sit

and talk about how you're feeling', Josh said 'I got to talk about my anger', and Paul said 'I lost a lot of family...and I've just been able to talk about that, and it's been better for me to talk about it'. Across these two categories, all clients described talking about their emotions as a helpful factor in counselling, and only one client (7%) mentioned anything other than talking about emotions as a client-related helpful factor. The third category, thinking, contained this one meaning unit: 'looking for something to say, you're sort of thinking more, and it's good in a way' (Chloe).

Relational helpful factors

Clients described relational helpful factors in four categories: comfort or ease in relating, dialogue, liking or closeness, and trust in the counsellor. The experience of comfort or ease between counsellor and client was reported by eight clients (57%), and described a lack of awkwardness, often specifically in relation to talking about emotions, e.g. 'I feel dead relaxed here...I feel at ease with [counsellor]' (Abby). Dialogue between counsellor and client was referenced by six clients (43%) and often related specifically to emotions, e.g. 'we talk about feelings' (Neil). Liking and closeness in the relationship was referenced by five clients (38%): 'me and the counsellor got to know each other better' (Chloe), 'I liked her' (Neil). Trust in the counsellor was mentioned by four clients (29%), and related either to confidentiality, e.g. 'you know your information is going to be safe with her' (Hannah) or the sense that the counsellor was 'there for me' (Abby).

Practical helpful factors

Confidentiality was described as a helpful factor by four clients (29%), the convenient timing of sessions by four clients (29%), the school context by three clients (21%) and the number of sessions by one client (7%) who stated that 'it stopped at the right time' (Paul). Interestingly, two of the four clients who referred to confidentiality as a helpful factor seemed ambivalent (in the interview as a whole) about its importance. Paul said 'I don't really care as long as I'm able to talk to somebody, I wouldn't really care if it wasn't confidential'. Rachel was asked what made it ok for her to talk to the counsellor, and she replied 'I'm not too sure, I don't know. I think it's because it's private, but I don't think it's just that'. For both of these clients it seemed that the counsellor's independence from their lives was more important than specifically the confidentiality agreement.

5.3.2 Hindering factors

Of the 52 occurrences of meaning units in the domain of hindering factors, 12 (23%) were counsellor-related, 15 (29%) were client-related, 9 (17%) relational and 16 (31%) were practical.

Counsellor-related hindering factors

Four categories of counsellor-related hindering factors were developed from the data: wanted counsellor to talk more, wanted more questions, wanted more advice and wanted more activities. Counsellor-related hindering factors were reported by four clients (29%) and all described variations of wanting more input from the counsellor. These meaning units related to the client's feeling that increased counsellor activity

would make them feel less awkward, would make it easier for them to talk about their emotions, or would be of practical help. Dylan said: ‘some weeks I came and it was just five minutes of me talking’.

Client-related hindering factors

The only category in the client-related sub-domain, difficulty talking, was the most commonly reported hindering factor overall, reported by four clients (29%). This overlapped with counsellor-related hindering factors for three of the four clients; in other words one client (7%), Rachel, reported difficulty talking, one (7%), Chloe, reported wanting more input from the counsellor, and three (21%) reported both: Hannah, Dylan and Paul. For two clients (14%), Chloe and Paul, difficulty talking was described as a problem only at the beginning of counselling, e.g. ‘it was easier to just talk towards the end, at first questions and prompts might have helped’ (Chloe).

Relational hindering factors

Awkwardness was the only category in the sub-domain of relational hindering factors, and was reported by three clients (21%): Hannah, Beth and Paul. For Beth and Paul, awkwardness was described as a problem only at the beginning of counselling, e.g. ‘when I first had counselling, I was slightly nervous’ (Beth). For Hannah and Paul, this category overlapped with difficulty talking and with wanting more input from the counsellor.

Practical hindering factors

Miscellaneous practical issues were reported by three clients (21%): these were wanting water to drink during sessions (Ian); wanting counselling to take place in a bigger room (Kimberley) and wanting to go on trips with the counsellor, researcher and other pupils involved in the study (Abby). Two clients (21%) reported wanting more counselling sessions: Abby described it as 'too short', saying 'I want to go back', and Rachel reported having missed some sessions for health reasons. Conversely, Hannah wanted less frequent sessions, saying 'maybe once every two weeks would be better'.

5.3.3 Positive changes

There were 406 occurrences of meaning units in the positive changes domain, divided into sub-domains as follows: relationships, 165 (41%), emotions, 99 (24%), self, 85 (21%) and functioning, 57 (14%). Hopefulness or positive outlook was considered to be self-related, as opposed to predominantly emotional, since this category represents a shift in attitude towards greater optimism rather than necessarily a change in specific emotions.

Relationships

Positive changes to relationships were reported by 13 clients (93%), and the categories represented were better relationships with friends and peers, better relationships with family, better communication in general, more understanding of others, and more positive perception of others. Ten clients (71%) reported positive changes in their relationships with friends and peers, which included making new

friends and feeling closer to existing friends, e.g. ‘I feel I’ve got more friends’ (Neil) and ‘I’m getting on better with pals’ (Josh). Eight clients (57%) reported better relationships with their families, which most often related to parents, but also included siblings, other family members and general references to family, e.g. ‘now I’ve started talking to [Mum] and we’ve got a holiday booked’ (Michael) and ‘I’ve started getting on with my wee brother’ (Ian). Better communication was reported by seven clients (50%), referencing general improvement in this area, or specifically improved ability to communicate with family, peers, teachers, and/or the counsellor, e.g. ‘I couldn’t talk to anyone [before counselling]’ (Neil) and ‘I’m talking to people a lot more than I used to’ (Dylan). Six clients (43%) had meaning units coded as more understanding of others. This was often related to developing empathy for significant others, or beginning to understand others’ viewpoints, e.g. ‘I realised everyone was quite close’ (Kimberley) and ‘I’m getting to really understand [teacher]’ (Beth). For Chloe, this included a broader awareness of and concern for society as a whole. More positive perception of others was reported by four clients (29%), and was voiced in both general terms and in relation to specific significant others, e.g. ‘I’m seeing my friends actually supporting me’ (Stuart) and ‘people are friendlier’ (Neil).

Emotions

Emotional changes spanned four different categories, which were: happier, less anxious, less angry, and more able to cope with emotions. An increase in happiness was reported by 11 clients (79%), and was expressed in both positive (e.g. happier, feeling better, enjoying life) and negative terms, e.g. ‘I’m not feeling so down’

(Dylan). Reductions in anxiety were referenced by seven clients (50%), were usually related to general worries and were also expressed in both positive and negative terms, e.g. 'I've been more laid back' (Hannah) and 'worries are not on my mind so much' (Chloe). Reduction in anger was reported by six clients (43%), and expressed in positive and negative terms, e.g. 'I've calmed down a wee bit', (Michael) and 'I've not been angry with anybody' (Josh). Greater ability to cope with emotions was reported by six clients (43%) and though this was expressed in general terms, e.g. 'I know how to deal with things at school now' (Neil), it also overlapped with anger for Josh, Michael, Paul and Stuart, and with anxiety for Hannah.

Self

Positive changes in relation to self were divided into six categories: self-awareness, agency, self-esteem, confidence, hopefulness and self-efficacy. Increased self-awareness was reported by nine clients (64%), and was usually related to developing insights about self in relationship to others, e.g. 'negative attitude was something that kept me back making good friends' (Stuart). Sense of agency was deemed to increase for six clients (43%), which included being more willing and/or able to make decisions, perceiving self as having choice, and making specific decisions about their lives, e.g. 'I'm a wee bit more decisive' (Chloe). Self-esteem was referenced by six clients (43%) and expressed in positive terms, e.g. 'I feel better about myself' (Beth), negative terms, e.g. 'I realised I'm not as bad as I think I am' (Stuart), and also in relation to feeling 'normal' (Dylan and Ian). Increased confidence was reported by five clients (36%), all of whom expressed this in general terms, e.g. 'I'm more confident in myself' (Kimberley). Rachel, Beth and Paul also related this specifically

to communicating with others, e.g. ‘counselling gave me confidence to phone my Dad’ (Rachel). Increased hopefulness was reported by four clients (29%) in both positive and negative terms, e.g. ‘I’ve got a more positive attitude to life’ (Stuart) and ‘I used to be dead worried and negative all the time’ (Kimberley). The category of self-efficacy included meaning units from four clients (29%): for Stuart and Paul, this related to school work, and for Beth it related to talking about emotions. For Chloe, meaning units categorised as an increase in self-efficacy were in two areas: trying out to sing in a choir, and using exercises to improve her ability to walk unaided.

Functioning

Positive changes in functioning were divided into four categories: school work, focus, behaviour and sleep. Improvements in school work were noted by six clients (43%), e.g. ‘I’ve started working better at school’ (Ian). This overlapped with self-efficacy for Paul and Stuart, and with improved focus for Beth, Ian and Josh. Improved ability to focus and concentrate was referenced by six clients (43%) and was linked not only to school work (as above), but to relationships for Kimberley, and for Michael to both relationships and agency, e.g. ‘with [friends] talking about stuff, I used to be in a wee daydream, but I’m not any more, I’m more, like active’. Behavioural improvements were noted by five clients (36%), including behaviour at home and at school, and relating to reduced aggression for Josh, Michael and Paul, and to making more effort to relate to peers for Beth, Dylan and Stuart. Improved ability to sleep was mentioned by four clients (29%), expressed in both positive and negative terms, e.g. ‘I can get to sleep at nights’ (Josh) and ‘I wasn’t able to get to

sleep before' (Ian). For Chloe and Dylan, this was expressed as a consequence of being less anxious.

5.3.4 Negative changes

Two clients (14%) reported a negative change and seven clients (50%) reported ongoing problems, or potential areas where there was no positive change. Of the 22 occurrences of meaning units in this domain, 3 (13.5%) were categorised as negative changes, 5 (23%) as ongoing family problems, 7 (32%) as problems at school, 4 (18%) as ongoing distress, and 3 (13.5%) as self-related problems.

Negative changes

Of the two clients (14%) reporting negative change, Abby described worsening of her temper since beginning counselling, repeating this statement twice and phrasing it as 'my temper's come back'. However, Abby also reported improvement in her temper since beginning counselling, and it was difficult to determine from the transcript which of these was meant. Though she seemed to state very clearly that her temper had 'come back' since beginning counselling, when the interviewer reflected this, Abby corrected her, saying 'no, it's better' and went on to describe feeling calmer. Unfortunately, Abby was not directly asked 'has anything changed for the worse since you started counselling?' which would usually be included as a follow-up question.

The second client reporting negative change was Hannah, who described more difficulty focusing, in the context of ongoing problems at home, saying: 'there's a lot going on at the house just now, and it's probably been harder to focus'.

This comment was made during a section of the interview which explores the young person's change attributions; as well as asking 'what do you think caused these changes?' the schedule includes suggested follow-up questions about whether external life factors may have helped or hindered positive change. Hannah mentioned ongoing problems at home, leading to difficulty focusing, as a potentially hindering factor in this context. In addition, she was asked earlier in the interview 'has anything changed for the worse since you've been in counselling?' and replied 'not at all, no'.

Family problems

Ongoing family problems were reported by four clients (29%) including Hannah (as noted above), in relation to difficulty focusing. The remaining three made specific comments comparing family members unfavourably to the counsellor. Abby perceived the counsellor as attentive, and described a family member as not listening, and Rachel described the counsellor as calm, saying that her family are always angry. Hannah, Abby and Rachel did not make positive comments about family members at other points in their interviews, or report any positive change in family relationships. Michael also reported an ongoing family problem, noting the counsellor's commitment to confidentiality and complaining about a family member breaking his trust. However, at other points in the interview, Michael made positive comments about this specific relationship, and reported improvement in his family relationships more generally.

Problems at school

Ongoing problems at school were reported by three clients (21%). Dylan had a general complaint, 'school's not the best place to be', and Abby had a specific complaint about a teacher, who she said 'won't do a thing [to help]'. Paul described ongoing concentration and behaviour issues, 'I'm easily distracted'.

Self-related problems

Ongoing self-related problems were reported by two clients (14%). Rachel felt that she was still not able to talk freely to other people, or assert herself, both things that she would have liked to change through counselling. These comments were made in response to the question 'is there anything you wanted to change that hasn't?'. Hannah also reported ongoing self-related problems in response to the interviewer's question on this subject, saying 'probably the commitment one, I thought [counselling] would have had more of an impact, but it hasn't really'. This is a reference to a goal she had set for herself at the beginning of counselling using the Goal-Based Outcome Measure (Law, 2011), which was 'I want to be able to commit more'.

Distress

Ongoing distress was reported by three clients (21%). Abby noted that she was still afraid of the dark, something she had hoped to change through counselling. Hannah described being down or anxious 'sometimes', but went on to note 'that's just normal for a teenager'. Kimberley mentioned being worried about her Mum's health, which was also categorised under ongoing distress, but the transcript suggested that she had

reframed this worry as appropriate, and no longer considered it problematic, saying 'I still worry a wee bit, but it's not really negative worrying...it'd worry anyone, really'.

5.3.5 Change processes

The following five processes of change were developed from the data: relief, increasing self worth, enhancing coping strategies, insight and improving relational skills. Three clients (21%) reported experiences compatible with just one of these processes (Abby, Dylan and Fin), five clients (36%) with two overlapping processes (Hannah, Ian, Josh, Neil and Rachel), four clients (29%) with three processes (Beth, Chloe, Michael and Stuart), one (7%) with four processes (Kimberley) and one (7%) with all five change processes (Paul). Specific outcomes were not confined to one pathway of change; rather, the same outcomes were achieved in different ways by different clients.

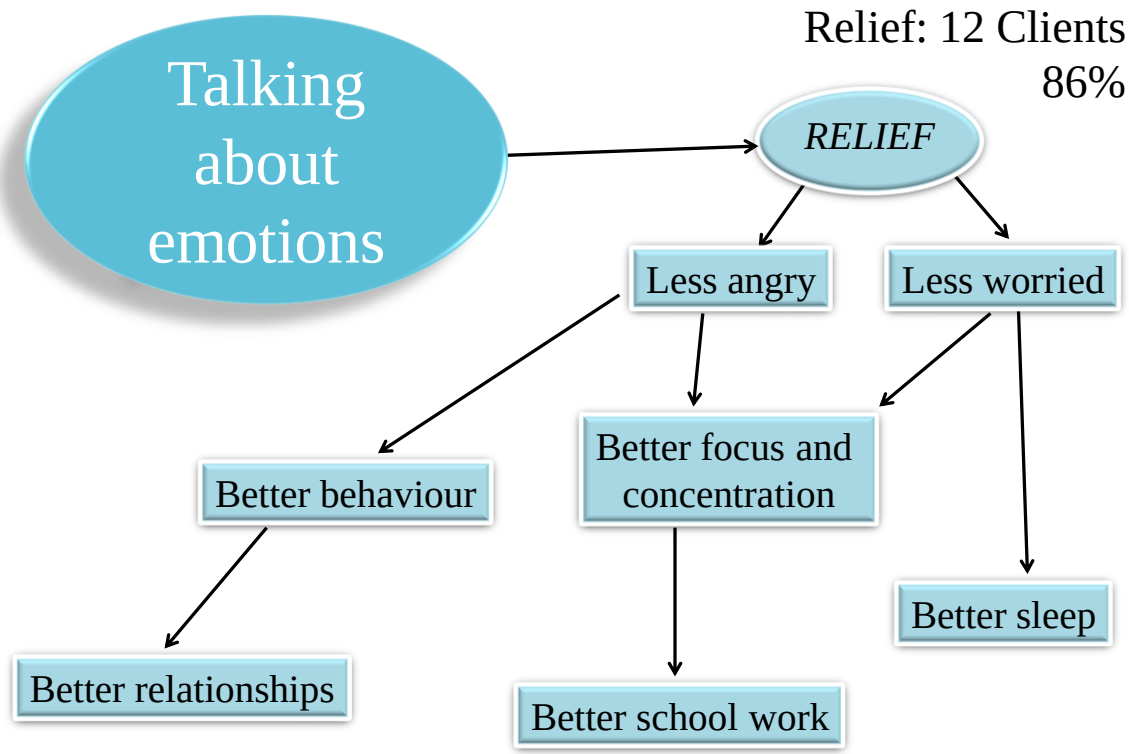

Figure 6. Relief change process

Relief

The process of relief applied to 12 clients (86%), seven males and five females, and is shown in Figure 6. In this process, talking about emotions leads directly to relief for the client, most often from anxiety or anger. Clients described a build-up of emotion which wasn't expressed, being dissipated by talking openly to the counsellor: 'when you've spoke about it you feel better because you've finally got it out and told someone how you feel' (Hannah), 'I just kind of build up and I just want to get it out, and [talking] does get it out, it's good' (Dylan). This was linked to the suggestion that talking openly about emotions was something that clients wouldn't be able or willing to do otherwise: 'just being able to tell somebody about stuff, instead of keeping it, that helps as well' (Kimberley), 'you talk in a way that, you know, you don't normally talk to people' (Chloe), 'you couldn't do that with a teacher, you couldn't sit with a teacher and talk about things like that…I think it's good like that, you can come in and be able to talk to somebody' (Paul).

It seems that this kind of catharsis was enough for some clients to meaningfully reduce problematic emotions: 'I got to talk about my anger…now I've not been angry with anybody' (Josh), 'feeling down and stuff, it wasn't as intense as it was…it was actually really good just to sit and talk about how you're feeling' (Dylan). There were several positive outcomes associated with this process of relief. For some clients, relieving worries by talking about emotions in counselling led to better sleep: 'I'm happier to go to bed…it's easier to relax, and I don't know, it feels like I'm not as worried' (Chloe). Relieving distress associated with negative emotions also tended to lead to better focus and concentration, which some clients reported being linked to an improvement in their school work: 'I wasn't really

concentrating, but now I am' (Beth); 'I think it helped me concentrate more, and I was able to communicate better with the teachers in school' (Ian). Relief from anger was also associated with improvements in behaviour: 'I'm not getting suspended and all that any more…because I'm not fighting' (Josh). These changes also led to improvements in relationships, both with friends and peers: 'I would get angry and start arguing and cause fall outs and it would make me upset…but now I'm sort of taking a back seat, and being able to control that' (Hannah) and with family members: 'at home my behaviour's changed, and I'm getting closer to [Mum and Dad]' (Paul).

Though not all clients showed evidence of this process, it was the most commonly demonstrated pathway to change, and the only one which, for some clients (three – 21%), did not overlap with any other. Of the three clients who showed evidence of this process only, Fin said relatively little in his interview, so that it was difficult to determine his change process. Abby was talkative, but did not make many comments which revealed her change process clearly. While it is possible that other processes occurred for these two clients, only relief was evident from their comments in interviews. Dylan, the other client for whom relief was the only evidenced change process, appeared to benefit a great deal from it: 'it's been a big difference, a big difference from the way I was, and it's like a lot better from how I would normally feel'. This process most commonly overlapped with increasing self worth (six clients – 43%). Relief also overlapped with developing insight for five clients (36%), with enhancing coping strategies for three clients (21%) and with improving relational skills for three clients (21%).

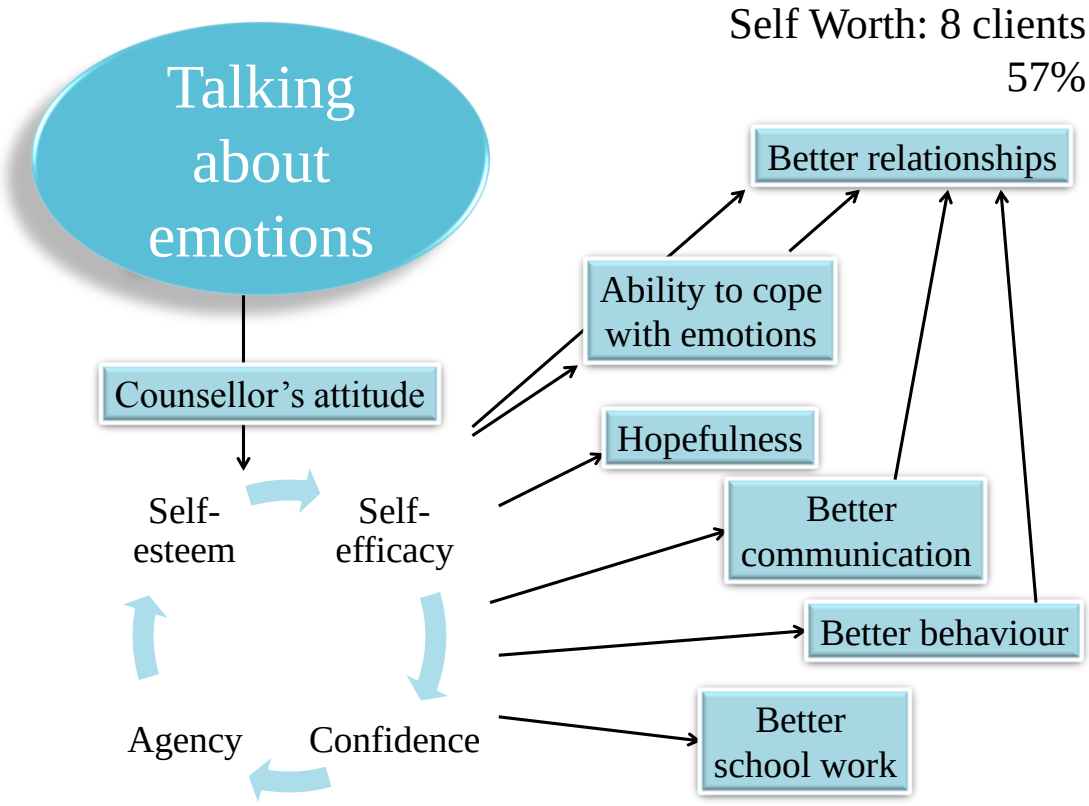

Figure 7. Self worth change process

Increasing Self Worth

The process of increasing self worth was evident for eight clients (57%), four males and four females, and is shown in Figure 7. Talking about emotions was central, as in each of the other processes, but also crucial to this process was the counsellor's response, mainly in terms of attitude. This included listening, understanding, accepting and valuing the client and their point of view: 'she didn't judge me, and listened to what I had to say' (Stuart); 'I got positive feedback, that helped' (Ian); 'someone that listens to me and doesn't…like understands, and doesn't have angry about them' (Rachel).

In response to this, the client entered a virtuous cycle of self-esteem, self-efficacy, confidence and agency: 'I like the way the counsellor asks how I feel, all the attention is on me…it's boosted my confidence a lot' (Paul). This had several different impacts for clients, and for Chloe, who had suffered a stroke two years earlier, was linked to improving her mobility: 'I feel kind of just better about myself'; 'I can walk a couple of wee steps on my own'; 'I've got my exercises, I'm meant to do that'; 'I think now I'll probably make more of an effort'. Chloe seemed to become more motivated to work towards the things that she wanted in life after counselling. At the beginning she had set herself a goal of 'taking part in things', and later described how she had changed her attitude to joining a choir, something she had expressed an interest in before: 'I think I've got a more positive outlook since the counselling'; 'I could never sing…I love it, but I just can't sing'; 'but I don't know, now I've kind of opened up a wee bit to myself and I'm sort of thinking…maybe'. For some clients, this impacted on their openness with other people: 'my confidence…like I feel much better and not as nervous as I was before…I'm starting

to sit with my pals at lunchtime' (Beth, who had told the author at the outset that she often ate her lunch alone through shyness), 'people I didn't really talk to, I've started talking to more' (Ian).

For some clients, the process of increasing self worth impacted on their school work. Often this related to increased self-efficacy and agency 'I can work better in school when I try' (Paul), and self-esteem 'I used to have thoughts like 'I'm just going to end up failing this'…[counselling] made me work harder and try and achieve more, and try and not be, you know, a failure that I thought I was at the start' (Stuart).

For some clients the process of increasing self worth was pivotal in terms of changing their way of relating to others. Stuart described how this process had impacted on his friendships: '[counselling] kind of increased my self-esteem really, and I realised I'm not as bad as I think I am', 'before this thing I had friends, but they did stuff like talk behind my back', 'now I've got proper friends', 'because negative attitude was something that kept me back from making good friends'. Rachel defined confidence specifically in terms of making contact with her Dad: 'I did enjoy [counselling], because she kind of gave me confidence, like I even got my Dad's phone number and called him', 'I'm glad [I decided to have counselling] because I would never have had the confidence to call my Dad'.

Kimberley, who started counselling feeling unhappy with how things were at home, described a powerful impact on her family relationships as part of this process: 'I feel way different, I feel noticed now', 'it's because I've been able to talk to my Mum and Dad', 'I think I have more fun with [Mum], I've got the courage to

ask if we're allowed to play this game or that game'. Kimberley specifically noted the counsellor's respect for her autonomy, 'she gave me a choice whether to talk or do some activities', and particular activities which made her feel more confident, '[the counsellor] came in with cards once, to describe myself…and it actually made me feel better because there were quite a lot of positives even though I was looking for negatives'. Kimberley described a change in her parents' attitude to her: 'I used to have to do a lot of things, my Mum and Dad didn't ask me if I wanted to do them, they'd just tell me', 'I still have responsibility, but it's just they ask me, and don't force me', 'instead of "[Kimberley], get that!", [Dad] wouldn't shout it at me, he'd turn round and ask me'. Elaborating on this change, Kimberley concluded that her improved ability to express herself resulted in her parents understanding her needs to a greater extent: 'I think being noticed more is generally because I've been able to talk more, so [Mum and Dad] have probably took my point of view and like…made me feel how they might want to feel'.

The process of increasing self worth overlapped with other change processes for all eight clients who experienced it, most commonly with relief and developing insight (six clients – 43%). For three clients (21%), increasing self worth overlapped with enhancing coping strategies, and for another three (21%) with improving relational skills.

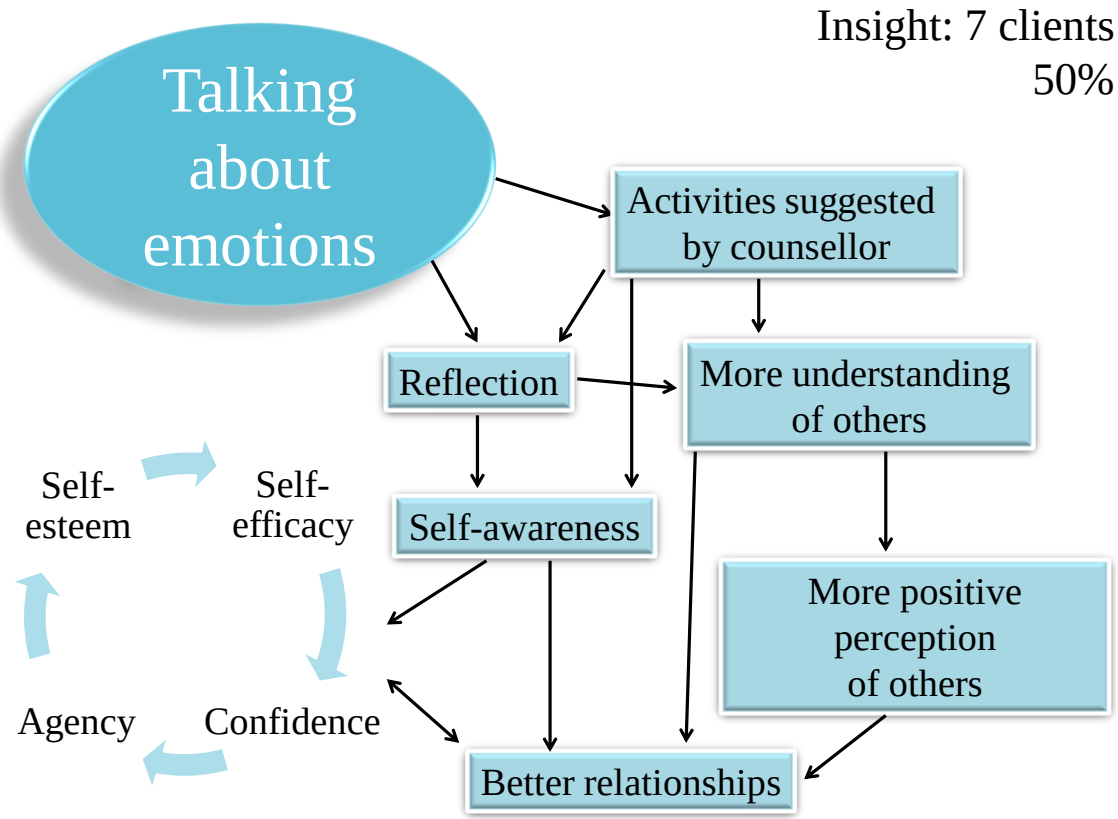

Figure 8. Insight change process

Insight

A process involving the development of insight was demonstrated for seven clients (50%), four female and three male, and is shown in Figure 8. For these clients, talking about their emotions led to reflection, which was often, but not always, linked to specific activities suggested by the counsellor. Insights led to self-awareness and more understanding of others, and often to the previously identified virtuous cycle of self-esteem, self-efficacy, confidence and agency. For some clients, activities helped them to understand their family relationships, such as Rachel and her relationship with her Dad: 'I never even thought of my Dad until I started talking to [counsellor]', 'we use little pebbles and we make a family, and make up a story about them', 'I made one for my Dad, and we went from there'. Describing a similar activity using stones to represent family members, Kimberley said 'when I'd finished I realised everyone was quite close…eventually it just all came to one corner because I was there, and it was like they were all dead special to me. I didn't actually realise that until I done it, so that helped me'.

Other clients used insights to understand their relationships with friends and peers, like Hannah: 'having someone outwith the situation to talk to, they don't have to take sides, so it's just good', 'now I'm seeing there's no point in arguing', 'I think my friends are even noticing that'. For Chloe, developing self-awareness and understanding of others impacted on her relationships: '[counselling] made me think more about things, and sort of realise more things about myself', 'it's like I can understand people more, it's better'. She also spoke about a specific friendship that had been bothering her, and how her attitude to it had changed 'I've just sort of

realised what [friend] is, it's like I can see now', 'I think that friendship's kind of grown apart, and I don't mind'.

For some clients, insights and understanding included developing a more positive perception of other people, either generally, or in relation to significant others. Stuart reported a more positive view of his family '[counselling] kind of got me trusting my parents more and being able to talk to them more about stuff like problems that are going on'; his friends 'it's like seeing my friends actually supporting me if I ever need anything'; the teachers at school 'the teachers are starting to believe in me properly', and people in general 'people are different, they're more kind hearted'.

Michael described a change in his attitude to his Mum: 'I didn't used to talk to her, I didn't used to like her that much', 'I was going to move in with my cousins, but that would have just passed the problem on', 'you need to get on with your Mum'. When asked if anything had changed for him, he said, 'just being able to go home and actually have a conversation with [Mum]', 'I would have just went up to my room, got ready, and said I was going out, but now I can go in, sit down, take my jacket off'. Often the changes described in clients' relationships involved more mutual caring, as with Michael and his Mum: 'because I told my Mum about [counselling], she's been trying to help me as well', 'when I go out, I pop back in to see if she's alright'.

As well as increasing self-awareness and understanding of relationships, Chloe described a more general process of developing insight and empathy. She said 'I think on the whole, [counselling] was a really good experience to have, because it

broadened my horizons', 'you think more about, like, who you are', 'it's good to think about what goes through other people's minds', 'since I started…I'm starting to properly understand, and not think about just me as much, think about like, other people, and…I don't know, it's quite a big thing'.

Developing insight overlapped most frequently with increasing self worth (six clients – 43%), with relief for five clients (36%), with enhancing coping strategies for two clients (14%) and with improving relational skills for two clients (14%).

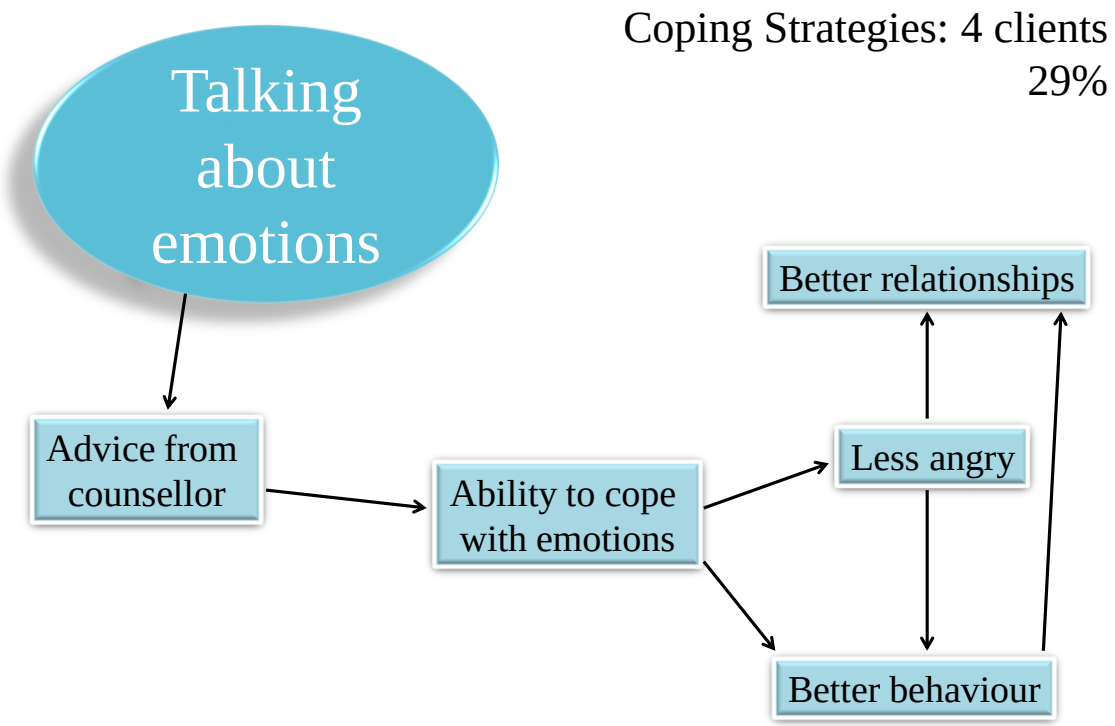

Figure 9. Coping strategies change process

Enhanced Coping Strategies

The enhancement of coping strategies was evident for four clients (29%), who were all male, and is shown in Figure 9. In this example, clients' talking about their emotions led to specific advice from the counsellor, often in the form of relaxation techniques or coping mechanisms. This led directly to an improved ability to cope with emotions, often anger specifically. Josh spoke about being able to cope with angry outbursts, by taking the counsellor's advice: 'I got somebody to talk to, and I don't know, she told me what to do if something went wrong', 'if I was to be in a fight, I was just to like go away somewhere else'. Similarly, Paul described a new approach to his anger which makes use of the counsellor's advice: 'I've been able to cope with my anger a bit better', '[counsellor] says if I feel it go from green, amber to red, then amber is when you know you're about to…', 'it's helped because I know when to calm down in a situation'. He went on to say 'I can feel it when I'm about to…if it's in school, I'll go out of class, say "miss, can I go outside and take a breather?" or something'.

Stuart reported being able to handle emotions more generally, linking this outcome to the counsellor's advice: 'she gave me the best advice', 'I've been able to handle more stuff and react in a better way than I used to react', 'just learned how to really handle emotions well, so [counselling] helped'. Neil also described coping with emotions by making use of advice from the counsellor: 'I've been taught how to deal with it', 'now I know how to deal with it and it's easier for me'.

The process of developing coping strategies overlapped with relief for three clients (21%), increasing self worth for three clients (21%), insight for two clients (14%) and relational skills for one client (7%).

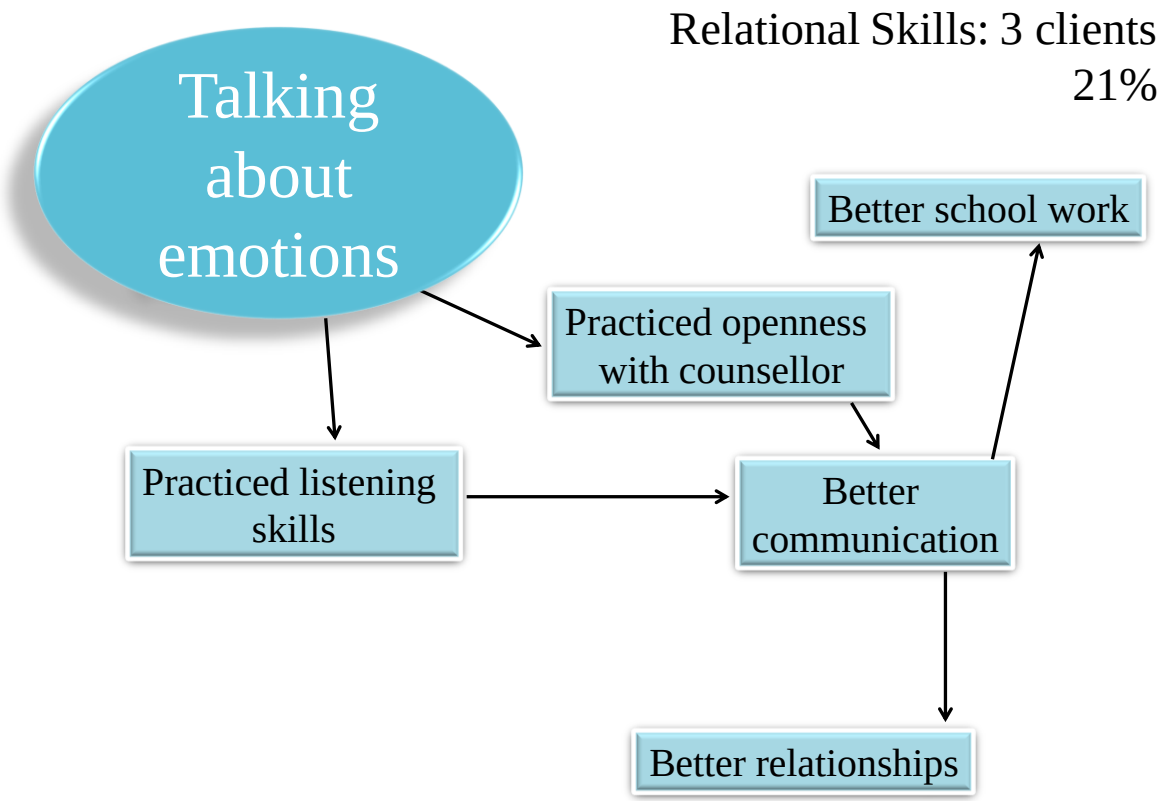

Figure 10. Relational skills change process

Improved Relational Skills

The process of practicing relational skills was evident for three clients (21%), two female and one male, and is shown in Figure 10. In this example, the experience of talking openly about emotions with the counsellor led to more open relating with others, both in terms of talking and listening. Clients had the opportunity to practice these communication skills with the counsellor, which led to better communication with others. Beth reported that after counselling, she found it easier both to open up to people and to take in what they were saying to her: 'when I first had [counselling], I was slightly nervous, but I've got a bit better at it', 'I feel much better and not as nervous as I was before', 'I'm sort of getting to really understand my teachers, I know what the teacher's talking about'.

For Paul this led to improvement in his school work, and overlapped with his growing confidence: 'I'm a bit scared about talks in English, last year I got a note for my talk because it was hard to do in front of the class because of my confidence and stuff', 'being in talking to [counsellor], my confidence, it's helped me as well', 'I was scared to talk to anyone, so it's boosted my confidence a lot'.

Kimberley noticed a marked change in her listening skills: 'my Mum actually noticed that I listen more...I didn't actually realise it at first, but I was getting every word she was saying...I used to blank out in a little dream or something'. She attributed this new skill to the counselling, saying 'it's made me listen more, because what [counsellor] was saying, obviously I was listening to that, so it's like helped me learn to listen more'. In response to a question from the interviewer about the impact of talking in counselling, Kimberley also mentioned an instance where she was able to comfort her aunt: 'she looked quite sad, so I was cheering her up. That was what

[talking in counselling] done, because we were talking about me cheering up and cheering other people up'.

All three clients (21%) who showed a process of improving relational skills also evidenced relief and increasing self worth. For two (14%) of them the process also overlapped with developing insight, and for one (7%) it also overlapped with enhancing coping strategies.

Stuart

The following vignette describes Stuart's experience, as an illustration of a case where a small number of sessions was therapeutic.

> Stuart was 16 when he met the author for an assessment interview. After listening to what was involved in the study, he spoke about why he wanted to take part. He talked about struggling to control his emotions sometimes, and how in previous years this had led to him having outbursts in school that really embarrassed him. The author was struck by the fact that Stuart seemed to be assuming that she had heard 'stories' about him from the teachers before meeting him. The author explained to Stuart that she didn't know about anything that might have happened to him before, and had only spoken to the teachers about whether he would be eligible to take part in the research project. At this point, Stuart was visibly relieved to be free of what for him seemed to be a burden of shame that had followed him through his school career.

They talked a bit more about counselling, and the author emphasised that the counsellor would not hear stories about Stuart before meeting him, and that it was up to him what he wanted to tell her, and what he did not. Stuart seemed very happy to go ahead and to have the chance to talk to someone impartial about how he was feeling. He was allocated to the counselling condition, and went on to have two sessions with the counsellor, before indicating to her that he didn't need to come back. At the midpoint assessment interview, the author was pleased to hear that Stuart felt the counselling had helped him.

Author: What was the counselling like?

Stuart: Mm, it's been- it's taught me a lot of things, especially with my two goals about keeping calm and knowing how to deal with stress. I feel like I do know more about handling stress and keeping myself calm, and I think this has actually helped a lot. So it's been getting better since I took it. It's just- it's easy to open up because they're no like a teacher and they just hear a story, hear another story and then they know all about you and reputations and all that

Author: Mmhmm, I remember you were really worried about that

Stuart: This person is like a clean slate and you can actually get some truth without them automatically judging you

Author: Yeah, yeah, like a clean slate and you don't feel judged

Stuart: So it's talking to a complete stranger. I've never really minded talking to people about, like, opening my feelings, but then it is that person that I'm worried about, I can't really talk to them, so counselling has been really useful

Stuart went on to describe improvements in his life in relation to his family, friends and school work, as well as feeling more positive generally: 'before this I was just completely pessimistic, I just feel more happy about the world now'. He also attributed these changes to the counselling.

Stuart: I think the counselling is the most part of it because like if I didn't have the counselling I still would have ended up bottling it up, lashing out and then getting into trouble. So the counselling has let me express my feelings really, so it's much easier for me to not get overwhelmed and angry, not let my temper get the best of me

Author: Right, so you think counselling has played quite a big part in making those changes?

Stuart: Yeah

Author: So, can you kind of sum up what it is about the counselling that you like, or that you find helpful?

Stuart: You can explain your whole life story to somebody who won't automatically judge you for something you've done that was stupid years ago and so…it's a clean slate basically, so it's much easier to open up with somebody who's trying to help you rather than like say the school, who just want you to get better, that's it, just get better

Author: So it's like- it sounds like actually wanting to help you rather than trying to fix you or something?

Stuart: Yeah, letting me fix myself, instead of trying to make me what they want me to be

Author: Right, right, so it sounds like just giving you that freedom to just kind of change yourself and not judging you and not putting anything on you and…

Stuart: It feels free to be myself because like I said to…your colleague…I usually have a reputation for being the silly one, so...and with the school teachers, I don't know, but I haven't got a good reputation really

Author: Right, right

Stuart: So, with this it's alright, I can change who I want to be

Author: Right, so you feel as if you're kind of escaping that reputation because you're talking to someone who's outside of it?

Stuart: Aye

By the time of the endpoint interview, Stuart seemed to have maintained the positive changes he'd made and reported feeling really good. Another interesting aspect was that in both interviews, Stuart made no distinction between the counsellor and the author, whom he referred to as 'the first counsellor', saying 'it was pretty easy to talk to them, I told them all the stuff that was bothering me'. This emphasises that the helpful aspects of counselling are not always particular to counselling.

5.3.6 Processes impeding change

There were two issues which impeded clients' engagement with counselling: difficulty talking, and the time-limited nature of the counselling. Rachel was the only client to show evidence of both of these, and she also showed evidence of two change processes: increasing self worth and developing insight. Three other clients (21%) showed some evidence of one impeding process. For the four clients (29%) whose experiences were consistent to some extent with processes impeding change, two (14%) showed evidence of only one change process and two (21%) showed evidence of two change processes.

Difficulty talking

In relation to this issue, client-related, counsellor-related and relational hindering factors were considered to be describing the same phenomenon framed differently. Therefore the category of 'difficulty talking' reflects clients responsibility for the counselling process, the four categories relating to desire for more activity on the part of the counsellor implies the counsellor's responsibility for the process, and the category of 'awkwardness' describes a non-differentiated relational problem. Difficulty talking was the most commonly reported hindering factor, and for three clients (21%) was part of a process which seemed to impede change. Clients who reported wanting more input from the counsellor (talking, questions, advice and activities) often described this in a context of nervousness about opening up emotionally, and the sense that more input from the counsellor, especially in the early stages of counselling, would alleviate the awkwardness categorised as a relational hindering factor. Though there was no evidence of negative impact, for Hannah and to a lesser extent Dylan and Rachel, this problem was linked to a relative lack of positive change compared with other clients.

Though Hannah reported positive changes in her emotions and relationships, and helpful factors in all four sub-domains, she also reported a negative change and ongoing problems in three categories: family problems, self-related problems and ongoing distress. Hannah experienced more hindering factors than any other client, linking her difficulty talking, and awkwardness, with her desire for more input from the counsellor: 'instead of just sitting talking, maybe more activities, or you know, it's hard to describe, but just a distraction to maybe…help you think of words, or…you know, just rather than sitting talking and not doing anything, sometimes it's just hard'. Her discomfort in the process was expressed to different degrees

throughout the interview, and lead to her concluding that once a week was too often for counselling sessions: ‘maybe once every two weeks…it was just sometimes you didn’t have anything to talk about’. For Hannah, it seems that the difficulty led to disengagement from counselling despite having some ongoing problems.

For the other clients mentioning difficulty talking as a hindering factor, its potential relation to ongoing problems was less clear. For instance, Paul experienced difficulty talking, awkwardness and a desire for more advice in counselling, but was also the only client to evidence all five change processes. Though Paul had ongoing problems at school, he also reported positive change in school work and behaviour in school, as part of a process of developing agency and self-efficacy around this issue. He made comments such as ‘I can work better in school, when I try’, ‘I’ve not helped myself change, even though I can’, and with reference to shouting at teachers, ‘I don’t want to do it any more’.

The role of the counsellor’s activity in easing the discomfort of talking about emotions was apparent also when the client’s experience was generally positive. Chloe, when asked what might have made it better for her, replied: ‘it might have been a touch easier at times, if you’d been asked a question, prompted to talk about something rather than just having to talk’. Often this was reported to be an issue only in the early stages of counselling, which resolved as the client became more comfortable in the relationship, e.g. ‘when I first came it was quite awkward’ (Paul). The idea that more input from the counsellor served the function of facilitating clients’ talking was also present in comments about helpful factors, e.g. ‘the activities help me explain it more’ (Kimberley).

In general, clients' talking about their emotions was of central importance in all cases. All clients reported this as a helpful factor of counselling, either generally, or with reference to discussing a specific emotion, or emotionally salient subject. Clients often reported not having anyone other than the counsellor to talk to, or not having been willing or able to talk about emotions before counselling. The factors which led to clients' perceiving the counsellor as an exception to this (someone they were willing and able to talk to) included personal qualities and independence from the client's life. Helpful factors involving the counsellor's behaviour (listening, activities, advice, talking, understanding and questioning) were often described in terms of facilitating the client's talking, or alleviating their difficulty. Conversely, hindering factors often related to times when the counsellor was perceived as too inactive, which may include *not* recognising or addressing the client's difficulty with opening up.

Time limit of counselling

Two clients (14%) reported wanting more counselling sessions, and the data suggest that the time-limit on the intervention period was problematic for them. Again, there was little evidence of negative impact, but for Abby and Rachel, there were ongoing problems, suggesting that the time limit may have impeded potential change processes.

For Rachel, difficulty talking played a role in the impeding process, as did missing sessions for health reasons. She said: 'when I first started [counselling], I didn't talk...after the first two [sessions] or something, I started talking' and 'I missed three sessions...it felt like, harder, because I've got no one to talk to that week'.

Though Rachel reported positive change, and evidenced change processes of increasing self worth and developing insight, she also mentioned ongoing family problems ‘my brother’s always angry, everyone around me is angry’, and self-related problems ‘I wanted to stop being so quiet around other people’. Abby reported no hindering factors other than wanting more counselling, but did report ongoing problems at home ‘my Mum doesn’t listen properly’, at school ‘[teacher] won’t do a thing [to help]’, and ongoing distress ‘I’m still afraid of the dark’. Abby showed evidence of only one change process, which was relief. For these clients, a longer period of counselling may have allowed time for them to engage in and work through further change processes, leading to more positive change.

Abby

The following vignette describes Abby’s experience, as an illustration of a case where counselling had relatively less apparent impact.

> Abby was 13 when she was referred to the author by her pupil support teacher for an initial assessment interview. In the first meeting with the author, Abby was more talkative than any other participant, engaging with the descriptions of the processes involved, asking relevant questions and sharing information about herself. She described her problems firstly in relation to her fear of the dark, saying that this had been a long standing issue, and setting a goal to overcome it through counselling, in addition to feeling more content in herself and worrying less. Although she didn’t describe her anger as a problem, she told several anecdotes about her experiences at school over the

last two years, including descriptions of her violent feelings towards other pupils and dissatisfaction with school: ‘I want to punch her’; ‘I attacked a lassie in 2nd year’; ‘the worst thing is the teachers don’t do anything at all’.

Abby was pleased to be allocated to the counselling condition of the trial, and went on to attend six sessions in total. She and the counsellor quickly developed a warm rapport, but the counsellor also described Abby as a ‘handful’, reporting that she often struggled to focus their sessions. This coincided with the author’s experience of Abby in research interviews. She seemed to regard both the author and the counsellor as friends, and described her counselling sessions as ‘fun’. The author also noted her tendency to push boundaries in various ways: for instance, making personal comments ‘you’re very pretty’, and attempting to initiate discussions about other participants.

Abby: Do you know Rachel that goes to this school? She’s got the other counsellor.

Author: I don’t talk about other pupils, Abby.

Abby: I know, but just say yes or no.

Author: No, I don’t talk about other pupils at all. It’s really important that I keep things confidential because…[Abby covers recorder]…no, it’s not just about the recorder.

The boundaries in relation to the time limit of the counselling offered in this study were particularly problematic for Abby. Due to severe weather during the intervention period, Abby was unable to travel to school on two of the

occasions when she would have had counselling sessions, which was a loss she felt keenly: ‘it’s not fair’. She mentioned wanting to spend the whole school day in counselling, and suggested going on a trip with the author and both counsellors working in the school.

Although Abby’s psychometric measures showed some improvement in each area, the evidence from her research interviews suggests that she did not experience substantial positive change compared to other participants, despite enjoying being involved in the study and having counselling.

One interpretation is that Abby would have needed a longer period of time to build a stable and trusting relationship with a counsellor, during which she could test and develop a secure sense of the boundaries, before engaging in the process of unpacking her emotions. She may even have recognised at the outset that time-limited counselling was not sufficient for her to fully explore her experience, and avoided engaging deeply for that reason. During the endpoint interview, she seemed to imply that she had deliberately avoided the counselling process:

Author: Did you get a chance to talk to [counsellor] about the way things have been at school?

Abby: Well, I kinda preoccupy her [laughs]

Another interpretation is that the form of counselling that was offered to Abby was not appropriate for her age, or personality, or both. It may be that she would have benefited more from play therapy, for example, where she may have been able to direct her energy and imagination into the therapy

itself. Finally, it may be that Abby's experience of counselling was right for her, and that working toward her therapeutic goals and/or reducing her distress was not as important to her as having the opportunity to spend time with an attentive adult.

5.4 Discussion

The helpful and hindering factors which emerged in this study support previous findings from school-based counselling research. Talking about emotions has frequently been highlighted as a helpful factor in previous research, as has counsellor listening and understanding (Lynass et al., 2012; Cooper, 2004). This suggests the possibility that helpful aspects which may prove therapeutic for young people are not necessarily specific to formal counselling. Indeed, the UK is unusual in its

Advice and specific techniques have also been reported as helpful factors by young people in some studies (Bondi et al., 2006; Cooper, 2004), despite the humanistic or psychodynamic orientation of counsellors. In addition, though young people generally report positive views of school-based counselling, criticisms tend to focus on desire for a more active, content-directive approach (Lynass et al., 2012; Cooper, 2004; Cooper, 2009). The results of this study concur with previous findings in these key ways, and the data presented here shed light on the potential role of more directive activities from counsellors in facilitating positive change for young people.

Pathways to change shown in this study were varied and overlapping. Relief resulting from talking about emotions, especially anger and anxiety, was the most

commonly experienced process, and the only one evident for three of the clients in this study. One of the outcomes linked to this process was improvement in school work, which is in line with the link between stress and impaired ability to learn (Schwabe & Wolf, 2010; Kovacs, 1997), and has previously been demonstrated as a benefit of school-based counselling (e.g. Rupani et al., 2012; Ogden, 2006). The process of increasing self worth, which in this study is conceptualised as a combination of self-esteem, self-efficacy, confidence and agency, is theoretically similar to empowerment, which has been shown to be significant in humanistic therapy with adults (e.g. Timulak, 2007), and is arguably an even more salient issue for young people (Christens & Peterson, 2012). In this study, increasing self worth was hypothesised to result primarily from the counsellor's valuing attitude towards the client, and was linked to multiple positive outcomes. The process of developing insight also linked to aspects of increasing self worth, since this led to increased self-awareness, understanding of others and ultimately more mutually supportive relationships. Relief, increasing self worth and insight are all categories which have also emerged from qualitative research into clients' views of significant events in therapy (see Timulak, 2003). Enhancing coping strategies, to regulate emotions such as anger, proved useful for some clients. Finally, some clients used the counselling relationship as an opportunity to practice and improve on the skills involved in open relating, both expressing and receiving. These clients were then able to exercise these skills with greater confidence in their significant relationships.

All of these clients went through helpful change processes in SBHC, despite 29% of them also experiencing processes which impeded positive change. For three clients (21%), difficulty talking in counselling was an impediment to change. For all

of the clients in this study, talking about their emotions was pivotal to achieving positive change in the domains of self, relationships, emotions and functioning. This was partly facilitated by counsellor behaviours which emerged as helpful factors including advice, activities, questions and general talking, while the lack of them emerged as hindering factors. In this study, counsellors offered activities such as relaxation techniques in response to a client's needs, representing the more experiential end of the humanistic counselling spectrum. These behaviours appear to serve a dual function for clients: they are helpful in their own right (for example, in learning to cope with emotions or developing insight), and they can facilitate the development of the counselling relationship by putting the client at ease. This encourages open discussion of emotions, a practice which for young people in their everyday lives appears to be both therapeutic and unusual. Difficulty talking about emotions was more obstructive for some young people than others, and it often became less problematic over time. In cases where the counsellor addressed the difficulty by becoming more active in the relationship, its negative impact was minimised early on. For two clients (14%) in this study, the counselling period was too short to achieve what they wanted to, and for one of them this linked to her initial difficulty opening up to the counsellor. Given that many young people are unused to talking openly about their emotions, it may take some time for this initial barrier to be overcome.

The processes emerging from the analysis of this data indicate that multiple concomitant pathways of change are possible, which is a core tenet of the pluralistic approach to counselling articulated by Cooper and McLeod (2007; 2010; 2012). The same positive changes were achieved by different clients in different ways, and a

range of processes were experienced as helpful. It seems likely that individual differences play a large role in determining how change is achieved in counselling, such as personality factors, age and gender. For instance, the process of enhancing coping strategies was only evident for young males in this study, and the time limit was problematic only for two of the youngest clients. It may also be that in this study, differences between schools could have played a role in how young people perceived and engaged with counselling. Furthermore, change processes associated with different theories of personality change were not mutually exclusive. For instance, clients who appreciate counsellor directivity in the form of advice or activities may also experience a process of increasing self worth brought about by the counsellor's attitude to them in the relationship. Similar processes may have different outcomes depending on the individual client and the same outcome can be achieved through different processes: some clients improve their relationships through developing their insight while others achieve the same goal by enhancing their coping strategies. Different processes of change overlap, demonstrating that progression in school-based humanistic counselling does not follow a single, predictable route.

5.4.1 Limitations

There are a number of important limitations with this study. First, since there was no opportunity to check participants' reactions to the analysis, the study has low testimonial validity (Stiles, 1993). Second, the sample size was determined by the available data and therefore has not necessarily reached saturation point. Third, the sample does not include a wide range of different young people, partly because data

was taken from a randomised controlled trial which employed distress-related inclusion and exclusion criteria for participation, and was set in a single geographical area with little ethnic diversity. Fourth, the theoretical orientation of the authors, as well as the nature of the counselling intervention, potentially biases the results towards humanistic change processes. Using a data-driven approach goes some way towards addressing this bias: meaning units were extracted on the basis of what clients said, without reference to specific research questions, which may have supported a particular theory of change. However, the first author's interpretation of the data is key, and potentially subject to humanistic bias. In addition, young people may have been primed to report experiences in line with this model, since they had experienced humanistic therapy. Having said this, the presence of disconfirming evidence supports the credibility of the analysis, since the results do not support a purely humanistic approach. Findings which do not correspond to the first author's preconceptions include the importance of behavioural techniques and the centrality of relief. The finding that young people appreciate directivity on the part of the counsellor is inconsistent with a purely person-centred approach which includes principled non-directivity, but is in keeping with the first author's experience.

5.4.2 Implications for practice

A key implication of these findings for the practice of SBHC is the need for counsellors to be aware that non-directivity may increase a young client's difficulty with talking about their emotions in counselling. Connected to this is the implication that incorporating more counsellor-led activities, including advice, can serve a relational purpose, making young people feel more at ease in the counselling

relationship. These activities, as well as being beneficial for some clients in themselves, may reduce anxiety for clients who are unprepared for the responsibility of directing their own process in therapy, thus more effectively balancing the power dynamic between adult counsellor and young client. School-based counsellors should be particularly attentive to this possibility in the early stages of counselling, when discomfort in the relationship is most likely. The study also highlights the positive impact of a valuing and understanding attitude towards young clients, and suggests that such an attitude can be communicated in different ways, which may include counsellor-led activities. A further implication for school-based counsellors is that though one school term of counselling may be sufficient for the majority of young people, some clients may need a longer period of counselling.

5.4.3 Conclusions

Pathways to change for young people in SBHC include relief, increasing self worth, developing insight, enhancing coping strategies and improving relational skills. Positive changes are experienced by young people in the domains of relationships, self, emotions and functioning. Positive change may be impeded by the client's difficulty talking, and/or by the time limited nature of counselling. Talking openly about emotions is a central benefit of school-based counselling for young people, and this can be facilitated through the counsellor's personal qualities and independence from the client's life, directive activities, and a therapeutic relationship characterised by liking, comfort and trust. The counsellor's attitude of respectful attention and valuing was shown to be healing, supportive of the client's self worth and linked to helpful insights. Learning skills and applying behavioural techniques was also

helpful, especially in relation to coping with emotions.

Chapter 6. A Team-Based Systematic Case Study of Process and Outcome

As noted in Chapter 2, the role of systematic case studies in outcome research has recently been highlighted (McLeod, 2010; Wheeler & Elliott, 2008), since they can add complexity and depth to group-based research, and have the further benefit of allowing the processes of therapy to be examined in parallel with its outcomes. Systematic case studies examine both qualitative and quantitative data using clear research questions and reasoning strategies; in this study analysis was undertaken collaboratively to determine whether change occurred in this case, the extent to which change could be attributed to SBHC and the nature of the specific change process.

6.1 Method

Informed consent was obtained from all participants at first assessment, and though this included permission for data to be stored and analysed in future research projects, specific consent was sought from the young person for this case study. The procedure received ethical approval from the University Ethics Committee.

6.1.1 Aim

The principal aim of this study was to examine the process of change in SBHC, and interpret it in the context of the mechanism suggested by humanistic theory. In addition, it was an opportunity to examine in more detail whether SBHC was associated with change and if so, to what extent that change was the result of counselling.

6.1.2 Design

This is a systematic case study of SBHC, analysed according to the team-based approach described by McLeod (2010), in which a small number of researchers/practitioners work together to analyse a rich case record as an 'inquiry group' before submitting to an external 'adjudicator' to validate their final analysis. In this case, a large amount of data had been collected for young people who participated in the RCT aspect of this study. The decision to conduct a case study was taken after data collection, therefore the team-based case study approach was applied post hoc. The inquiry group for this study comprised of the author, first supervisor and second supervisor; an independent colleague acted as adjudicator. The young person whose experience is the subject of this chapter approved the final analysis and wrote a response (included below).

6.1.3 Case selection

The case selection process began by excluding RCT participants who had been allocated immediately to counselling, as pre-counselling waitlist data (which could be used as natural case control data) was not available for these clients. From the waiting list participants (who had all gone on to have counselling), two were considered on the basis that they had attended the largest number of sessions and had most of their sessions recorded. Session and research interview transcripts were reviewed for these two cases by the author, and the current case was selected on the basis that the client demonstrated high levels of psychological mindedness, which would provide rich case materials. 'Adam' gave full informed consent to participate in the initial study, and to be the focus of the current case study. Some demographic

details including his name have been changed to protect his identity, and he has reviewed and approved the content.

While the case was not randomly selected, it is considered typical in terms of psychological distress, since the majority of Adam's scores are within one standard deviation of the waitlist participant mean (see Figure 11).

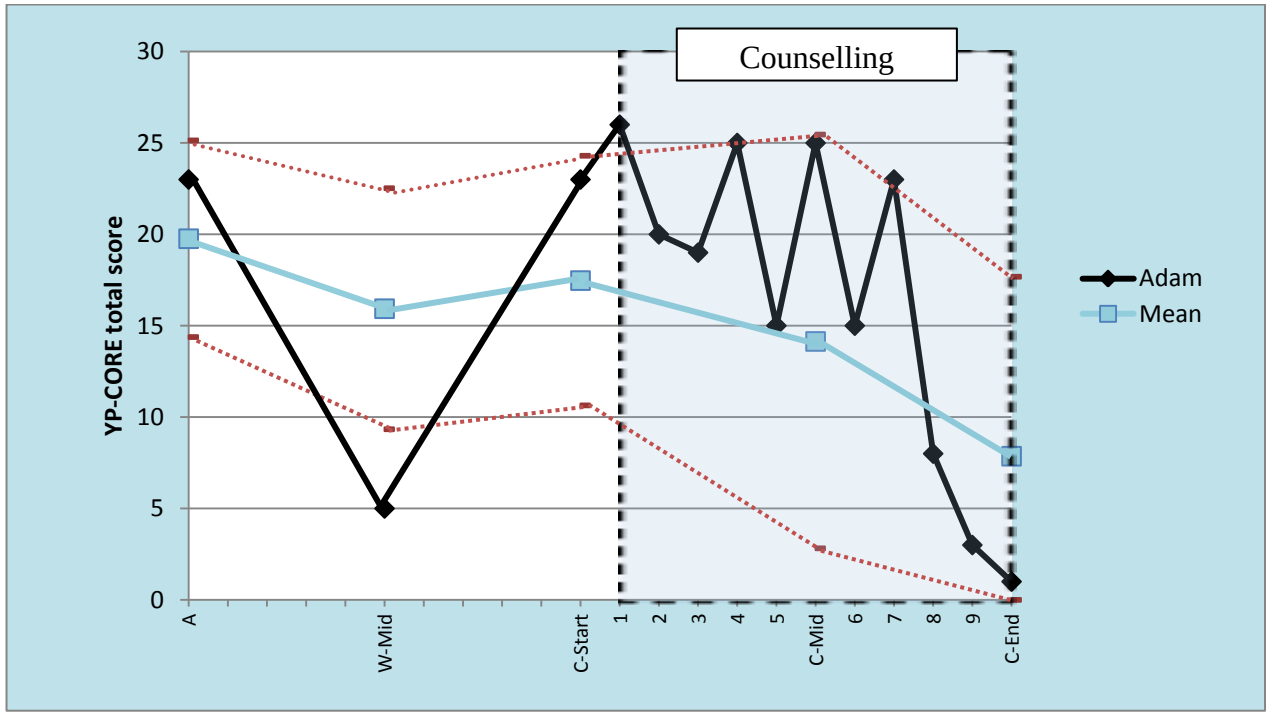

Figure 11. Adam's psychological distress scores compared with waitlist participant mean ± 1 Standard Deviation.

6.1.4 Measures

Adam completed psychometric measures at each time point, as detailed in Chapter 4: YP-CORE (Appendix 10.1), Strengths and Difficulties Questionnaire (SDQ; Appendix 10.4), Goal-Based Outcome Record (G-BOR; Appendix 10.2) and the Self Esteem Questionnaire (Appendix 10.5). During the pre-counselling waiting period he took part in research interviews using a Client Change Interview adapted for waiting list participants (Appendix 10.6), and during the counselling period, the adapted version of the Client Change Interview (Appendix 10.3). Used as the basis for a semi-structured interview, these interview schedules explore subjective experiences of a therapeutic intervention, and personal changes perceived since beginning.

6.1.5 Procedure

The author conducted an initial assessment interview (A) with Adam during which he completed each of the psychometric measures and was allocated to the waiting list control condition of the pilot RCT. The measures were completed at two further points during the waiting period (W-Mid and C-Start) each time followed by a semi-structured Change Interview. Adam then began weekly SBHC, attending nine sessions in total, of approximately 40 minutes each (S1 – S9), and completing the YP-CORE at the beginning of each session. Research interviews were conducted after the fifth counselling session (C-Mid) and immediately after counselling ended (C-End), with measures completed at each. Finally, Adam took part in a follow-up interview approximately a year after his counselling had ended (12m) and another (18m) approximately six months later, though psychometric measures were only taken at the second follow-up interview (18m). The majority of data was collected by

the author, with the exception of in-session YP-CORE data, which was collected by the counsellor, and psychometric measures taken at the end of the waiting period, immediately before counselling began (C-Start), which were administered by an independent researcher who was blind to the allocation of participants. Research interviews from W-Mid onwards were audio recorded using a password protected and digitally encrypted device, as were six of the nine counselling sessions.

6.1.6 Counsellor

The counsellor held a master's level qualification in person-centred counselling, and had three years' experience working as a school-based counsellor. She was employed to deliver SBHC as part of this study, and practiced in a way that adhered to the basic and specific competences for Humanistic Psychological Therapies developed by Roth et al. (2009).

6.1.7 Adherence

Three ten-minute segments of audio recorded sessions between Adam and the counsellor were selected by the author at random. These segments were then independently audited by the author and first supervisor using the Person-Centred and Experiential Psychotherapy Scale (PCEPS; Freire et al., 2010; Appendix 10.7), on which a mean rating of 4 or above indicates adherence. There was a high correlation (r =.96) between auditors across segments, all of which were rated adherent to humanistic competences.

6.1.8 Analysis

The author compiled a 'rich case record' containing all of the available case material: transcripts of research interviews, transcripts from those sessions which were audio recorded (S2-S4 and S6-S8), quantitative data from psychometric measures, and a brief summary of background information on the case, and provided electronic copies to the other two members of the inquiry group (first supervisor and second supervisor). Each member of the inquiry group then read and reviewed the rich case record independently, considering all of the available data in answering the following three questions.

Was school-based counselling associated with change?

This question was addressed on the basis of psychometric measures taken immediately before the outset of counselling (C-Start), at the midpoint of the counselling period (C-Mid) and at the end of counselling (C-End), as well as self-reported changes from the same time points. Data from follow-up interviews (12m and 18m) were used as a basis for analysing the stability of changes over time.

To what extent can change be attributed to counselling?

This question was addressed in two ways. First, by comparing changes during the counselling period against those in the waiting list period prior to counselling (which served as a natural 'case control') and second, through Adam's self-reported change attributions from research interviews and/or sessions.

What was the process of change?

This was the main research question and was addressed on the basis of Adam's verbalisations in the available session transcripts and research interviews.

Each member of the inquiry group produced a written analysis of the data in response to each of the three research questions. The inquiry group met and discussed their respective independent analyses of the case material, paying particular attention to any areas of differentiation, until a consensus was reached on each of the three questions. The author represented this consensus in a written account of the tentative conclusions reached at this stage, including that follow-up data from Adam was necessary to validate the analysis.

The author then conducted a further research interview (12m) with Adam, which was transcribed and circulated to the other members of the inquiry group, along with the author's redraft of the consensus analysis with modifications based on the new data. The inquiry group met once more to discuss the new data and debate the validity of the modified analysis. Again, a consensus was reached in relation to the three research questions, and the analysis was redrafted by the author, describing the consensus agreement and selecting quotes from the rich case record to illustrate and justify the decisions made by the group. This draft was then sent electronically, with the rich case record, to the independent adjudicator. The author met with the independent adjudicator to discuss the rich case record and the inquiry group analysis. Feedback from the adjudicator was noted by the author and relayed to the other members of the inquiry group for further discussion. A further redraft of the analysis was then produced by the author, incorporating the views of each member of the inquiry group as well as the independent adjudicator. The author met

with Adam again (18m), and presented him with this analysis for his review. Adam approved the analysis as accurate without suggesting modifications. The author offered him the chance to provide a written response to the analysis, emphasising the centrality of his perspective. Following this meeting, Adam emailed a written response to the author.

A Client Change Interview was also conducted during this meeting (18m) and each of the psychometric measures were taken. Therefore, a transcript of the interview as well as the quantitative data collected were sent electronically by the author to the other members of the inquiry group and to the independent adjudicator, with a redrafted analysis written by the author incorporating the new data. Feedback was provided electronically, until a final consensus was reached on each of the three research questions. The results presented below represent the final consensus analysis, using quotes from Adam to illustrate and justify the conclusions reached.

6.1.9 Ethical considerations

In beginning work on this strand of the project, the first ethical concern was the potential impact on Adam of being selected as the focus of a single case study. The risk that he may have felt he was being singled out as 'abnormal' was considered, alongside the possibility that he may respond positively. Second, Adam's anonymity and that of his parents was a central concern, and influenced the case study design. Finally, Adam's autonomy was considered in relation to his control over the material being presented. It was considered ethically important that Adam choose whether and how to disguise demographic information about himself, and have the

opportunity to not only approve the inquiry group's analysis, but also to contribute his own comment on the process.

6.2 Reflexive statements

All contributors are professionally allied to person-centred counselling. The author is a person-centred counsellor who promotes SBHC through her involvement with the British Association for Counselling and Psychotherapy's Children and Young People Practice Research Network CYP PRN (http://www.bacp.co.uk/schools/) and has published research supporting its effectiveness (McArthur, Cooper & Berdondini, 2013). She is skeptical regarding diagnostic and pharmaceutical approaches to psychological distress, and holds a questioning attitude to therapy.

The first supervisor has been closely involved in evaluating and developing SBHC over the past decade, and is closely allied with person-centred and humanistic approaches to therapy (e.g. Mearns & Cooper, 2005). However, he has a particular interest in researching the specific processes of change in counselling and psychotherapy, with a view to critiquing, revising and developing humanistic understandings and practices.

The second supervisor is a gestalt and person-centred psychotherapist and over the past 15 years has developed an extensive part of her professional experience working with children and young people, privately and in schools. She is interested in exploring and reflecting on various aspects of the counselling process and maintains an open curiosity about it.

The independent adjudicator is an experienced counsellor, with training in person-centred and integrative approaches, who has expertise in therapy case study methodology.

6.3 Results

6.3.1 Was school-based counselling associated with change?

The inquiry group concluded with a high degree of confidence that SBHC was associated with change, based on the results of psychometric measures taken at the beginning and end of the counselling period, and on Adam's self-reported distress levels during research interviews from the same period. Data from the follow-up interview (12m) strengthened the conclusion that reliable change had occurred, since Adam reported continued improvements in his wellbeing, although no psychometric data was collected at that point. Adam's reports at the second follow-up interview (18m) and the psychometric data collected at that point also confirmed this.

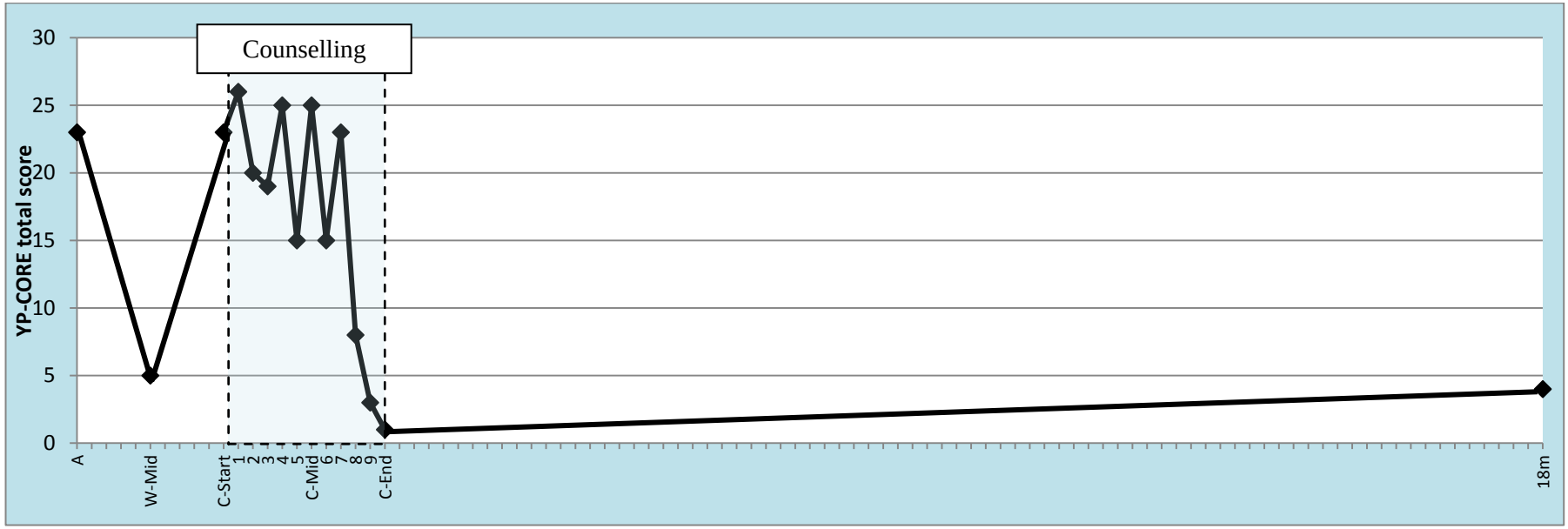

Figure 12. Change in Adam's psychological distress: waiting period, counselling and 18m follow-up

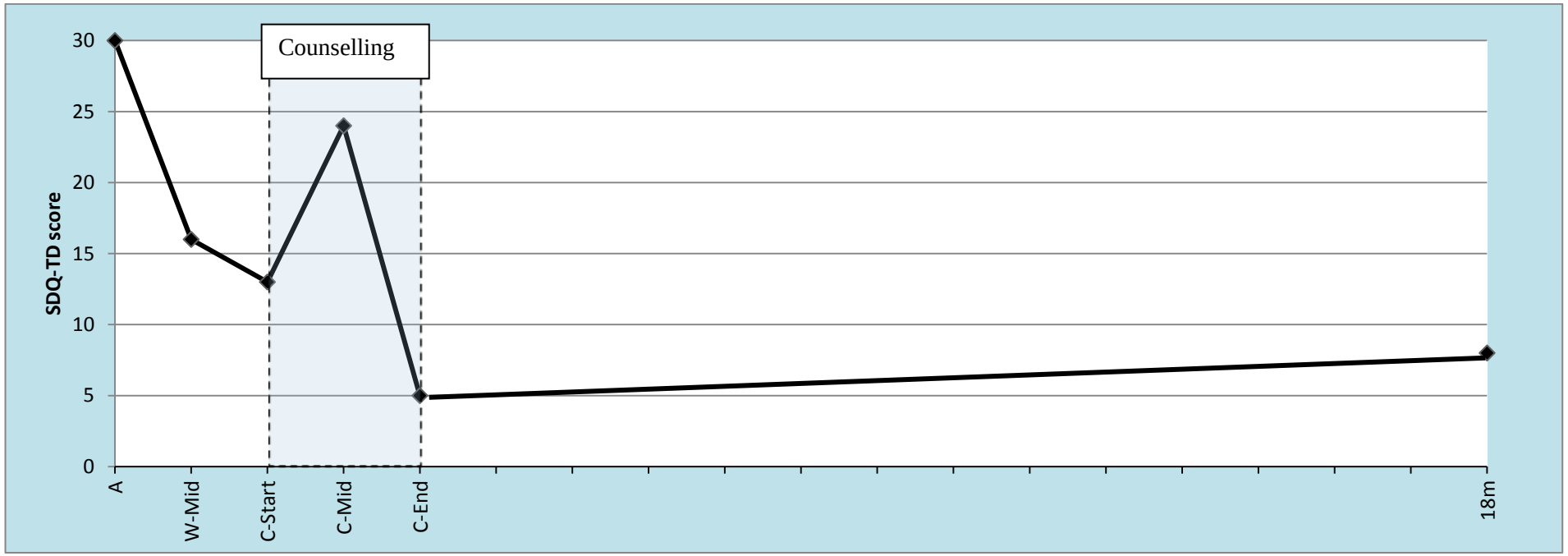

Figure 13. Change in Adam's total difficulties: waiting period, counselling and 18m follow-up

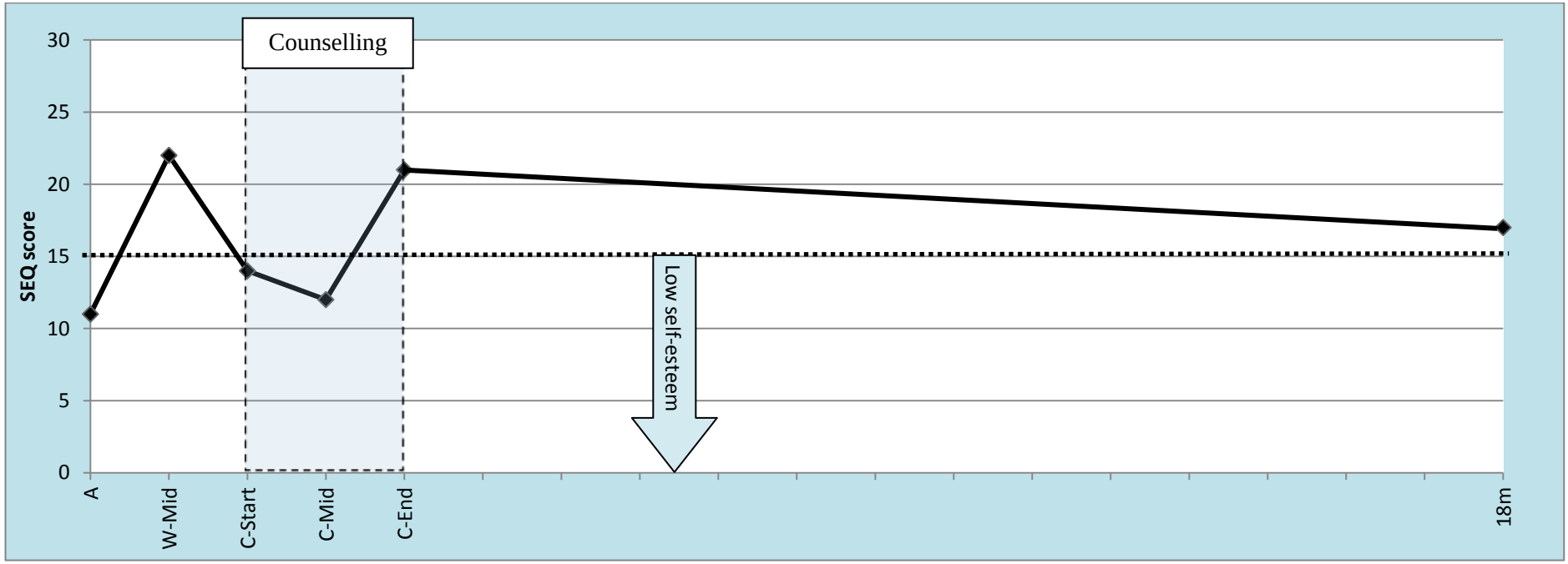

Figure 14. Change in Adam's self-esteem: waiting period, counselling and 18m follow-up

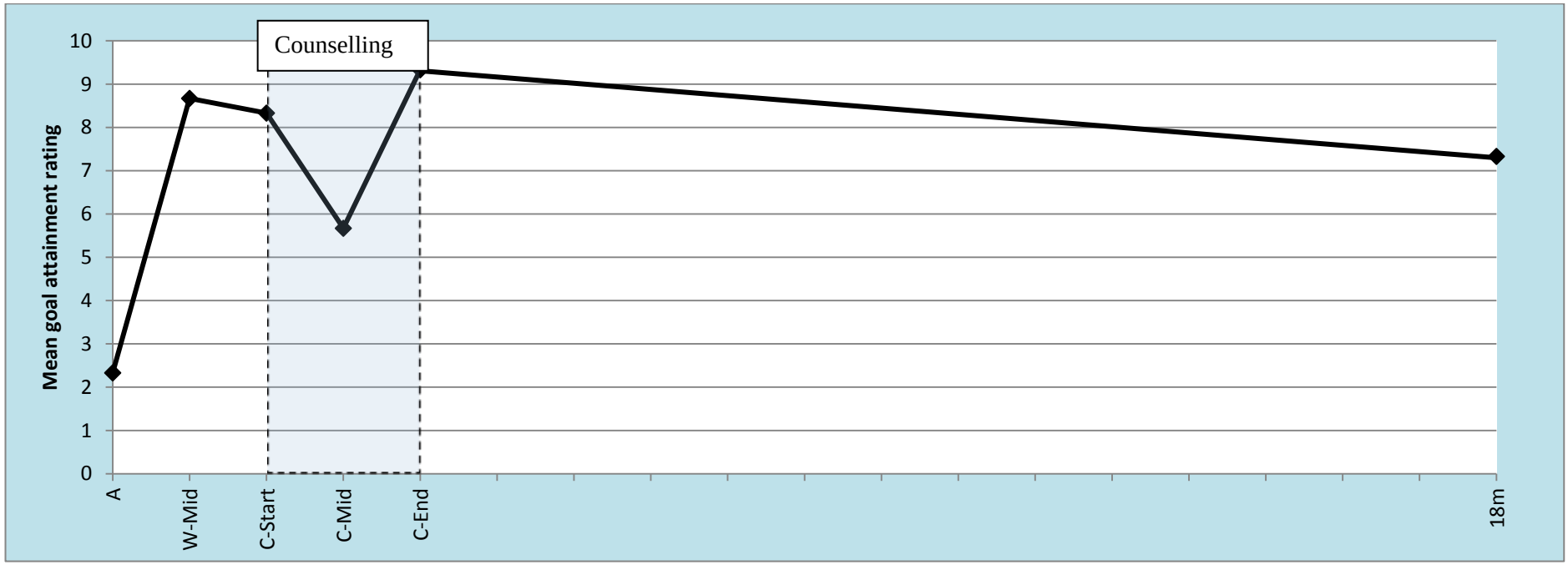

Figure 15. Change in Adam's goal attainment: waiting period vs. counselling

Psychometric measures

Figures 9-12 show results from the psychometric measures from the first assessment (A) to the final research interview (18m), with spacing proportional to time between assessments. Figure 9 shows change in total YP-CORE score during counselling, using scores taken from each of the nine sessions and the two research interviews which occurred during the counselling period (C-mid and C-End). Adam began counselling with a score of 26 out of a possible 40. His distress level reduced over the counselling period, dropping suddenly in the final few sessions and ending on a score of 1. Figure 10 shows change on the Total Difficulties score from the Strengths and Difficulties Questionnaire during the counselling period. Scores of 15 and below are categorized as 'normal'; Adam's score at the outset of counselling was 13, and decreased to a score of 5 at the end of counselling. Figure 11 shows change on the Self-Esteem Scale during the counselling period. Adam's score at the outset of counselling was 14, indicating low self-esteem, and by the end of counselling had risen to 21, which is considered within the healthy range. Figure 12 shows change in personalised goal attainment during the counselling period, based on goals which Adam set at the beginning of the waiting period (A). By the time counselling began, he had made more than 80% progress towards achieving the goals. At the end of counselling, his score indicated more than 90% progress towards the same goals.

Self-reported changes

Immediately before beginning counselling, Adam described high levels of distress during the research interview, saying 'I've been feeling really moody all the time now' and 'depressed all the time'. He mentioned feeling anxious and worried, 'I'm

dead panicky all the time', and explained that this sometimes made him withdrawn 'I don't want to go home, and when I go home I just go in my room and just lie down'.

At the end of the counselling period, Adam reported considerable improvement: 'everything's been a lot better'. He described positive changes in himself: 'I can open up to people', 'just a lot happier than I used to be', and 'I feel like a healthier person, not just outside, but inside'.

Self-reported stability of changes

During a research interview (12m), more than a year after Adam ended counselling, he reiterated this: 'I'm a lot happier'. He reported changing his attitude to school: 'I chose to stay on in school', and suggested that this decision was a very significant one, saying 'I'm a lot prouder of myself because I've stayed on'. At the final research interview (18m), Adam reported similar feelings: 'I'm much more confident, I notice it in my work and in the way I talk to people'.

The reports Adam gives of his experience throughout the counselling period validate the improvements shown on the quantitative measures, demonstrating his phenomenological view that large positive changes in his distress, anxiety, self-esteem, and relationships occurred during the time he attended school-based counselling. In addition, the responses he gives in the follow-up interviews (12m and 18m) demonstrate that the improvement he described during the counselling period persisted for more than eighteen months after counselling ended.

6.3.2 To what extent can change be attributed to counselling?

The consensus agreement was that Adam's improved wellbeing was attributable to several factors, of which counselling was one. The quantitative data alone was deemed insufficient to demonstrate a causal link, but triangulating it with qualitative data from the waiting period, the counselling period and the follow-up interviews, the inquiry group concluded with a moderate degree of confidence that counselling made a large contribution to positive change. Another contributing factor, behavioural changes made by Adam's parents, was judged with a high degree of confidence to have made a large contribution to his improvement. Two further contributing factors were identified with a moderate degree of confidence as having made small contributions to improvement: participation in the research project; and a meeting that took place between Adam, his Mum and a psychiatrist.

Psychometric measures

Figure 9 shows change in psychological distress for both the waiting period before counselling and the counselling period itself. In the waiting period, Adam's distress levels decreased, then returned to the same level of distress observed at the first point of contact. In contrast, the plot for the counselling period shows an overall reduction in distress level, with a particularly sudden drop after the 7th counselling session. Figure 10 shows change in total difficulties, as measured by the Strengths and Difficulties Questionnaire, compared between the waiting period and the counselling period. There was a reduction in total difficulties during both periods. Improvement observed during the waiting period was slightly greater than in the counselling period on this measure. Figure 11 shows change on the Self-Esteem Scale for both periods.

Adam's self-esteem increased in the waiting period and the counselling period, and the improvement observed during counselling was slightly greater. Figure 12 shows change on the Goal-Based Outcome Record, on which Adam rated three goals he had set at the beginning of the waiting period (A). On this measure, improvement during the waiting period outweighs that observed during the counselling period.

Comparing the quantitative measures between the waiting period and the counselling period gives inconclusive results. Reduction in psychological distress and total difficulties was evident during counselling, but these measures gave contrasting results in the waiting period. In addition, Adam's YP-CORE score reduced suddenly at a point towards the end of counselling, suggesting that some other factor could have impacted on his psychological distress at this point. Improvement in self-esteem was slightly greater during the counselling period than during the waiting period. In relation to goal attainment, more progress was shown during the waiting period, but this may be due to the rated goals being largely achieved by the beginning of counselling. In light of these mixed results, the quantitative data is not sufficient to establish a direct link between counselling and change.

Self-reported change attributions

Adam attributed his improved wellbeing to counselling at various points. During the research interview at the midpoint of the counselling period (C-Mid), he said 'I think it has been better since I'm able to talk to somebody now'. When asked what specifically had made the difference, he replied 'I think it's the talking to people,

because when I started coming here I was dead shy and I couldn't talk to people and I kept my feelings inside'.

In a follow-up interview (12m), he reiterated this, saying 'it made me a lot happier, speaking to somebody'. He talked about how the benefits he experienced through counselling outweighed his expectations: 'I never used to feel that speaking to somebody would do anything for me, but it did'. This view persisted at the second follow-up interview (18m), 'just talking to someone, that's all people really need. For someone like me, that was the most important thing'.

Other contributing factors

The inquiry group concluded that changes in Adam's parents' behaviour made a large contribution to his improved wellbeing by creating a more positive environment at home: 'my Dad's stopped drinking' and 'my Mum's a lot healthier, she goes out for jogs and all that now', '[Dad] took me out on the Saturday. He's never really took me out anywhere'. These behavioural changes had a positive impact on Adam's relationships with his parents and his home environment, which made a major contribution to his improved wellbeing: the session transcripts reveal that Adam's Dad came back to live with him, having stopped drinking, between the seventh and eighth counselling sessions, coinciding with the sudden improvement shown in Adam's psychological distress scores. However, there are some indications, discussed below, that changes in his parents' behaviour may have been influenced to some extent by Adam's involvement with the counselling.

Participation in the RCT (over and above the counselling intervention) was identified as making a small contribution to positive change in this case. This was

based on self-reported and psychometrically measured improvement during the waiting period, which Adam attributed to his taking part in the research. At the midpoint of the waiting period (W-Mid), he said 'I think [the research project] really helped me to express my feelings and my confidence and just stuff like that', 'it changed me really, I don't know how it did'.

In his fourth counselling session, Adam reported helpful contact with another mental health professional: 'my Mum took me to the doctors and it was a psychiatric unit thing', 'we had a talk […] and that was good because I like getting my feelings out', 'my Mum's never heard me talk this way and I told my Mum everything'. His comments suggest that seeing the psychiatrist with his Mum facilitated his communication with her to some extent, and the inquiry group also considered that this meeting may have played a role in supporting Adam's Mum in her capacity to support him. Since Adam did not attribute his improvement to this meeting, or mention it when asked if there was anything outside of school counselling that had helped him, there is limited evidence of its impact on his wellbeing. Therefore, the inquiry group concluded that this meeting made a small contribution to the positive changes Adam reported.

Figure 16. Adam’s change process

6.3.3 What was the process of change?

The process of change as perceived by the inquiry group is detailed in Figure 13. In counselling Adam talked about his feelings with the counsellor and felt listened to and understood. In the same way, Adam's contact with the researcher and with a psychiatrist offered further opportunities to talk about his feelings openly. These experiences caused Adam to feel 'brave', which he defined as having the confidence to speak openly and be himself with other people, combined with a sense of self-acceptance. Adam then felt more able to open up in relationships, especially with his parents. The author hypothesises that the change in Adam's way of relating 1) allowed his parents to understand his needs, 2) encouraged his parents to be more open with him and 3) caused his parents to make positive changes to their behaviour. This resulted in more open, understanding, caring, supportive, and satisfying relationships in Adam's family, and a major positive change in his home environment which decreased his distress. Counselling triggered a process in Adam's life, which improved his general wellbeing, self-esteem, and ability to cope with stress in a constructive way.

Talking, listening and understanding

Adam consistently reported that the most helpful aspects of counselling were being able to talk openly about his emotions, and being listened to and understood. This is evident in the interview at the end of the counselling period (C-End), when he said 'I like people listening, and [counsellor] could listen and understand where I'm coming from'. During the follow-up interview (12m), he reiterated this, saying 'she would

listen a lot, and it was like she could understand basically, and it was just like talking to somebody that could, like, know where I'm coming from'. Before beginning counselling, he reported the same helpful aspects in relation to his participation in the research project: 'talking to somebody and having somebody listen to me- it feels like…obviously you understand, and that's good because other people don't understand' (C-Start). When asked what he particularly liked about the research, or why he had found it helpful, Adam responded in a similar way to his later comments on the experience of counselling: 'saying my feelings out loud because usually I don't really do that, I don't say that to anybody, but now that I can- I like that about the research'.

Feeling 'brave' and self-accepting

Adam mentioned at several points how the experience of talking to the counselor made him feel brave, defining it as confidence in himself, self-acceptance and the courage to talk openly to people without feeling embarrassed. He suggested that this bravery made him more able to open up at home particularly:

> 'Even my ma's noticed it. She said "every time he comes back from his counselling, he always talks about it and he's always a lot happier, and doesn't just sit in his room, he comes in and speaks to me" ' (12m).

There are indications that by the end of counselling Adam felt more accepting of his own emotions, especially anger. In early counselling sessions, he discussed feelings of guilt about his anger towards his Mum, 'I had a dream that I punched [Mum] and I

was turning into pure evil, and I woke up sweating. I don't want that to be me' (s2). In the follow-up interview (12m), he displayed a more accepting attitude: 'I still do get a bit angry, but as I said I just…I let it go in there and out there and forget about it'. The inquiry group hypothesised that feeling understood and accepted by the counsellor helped to normalise Adam's problems and led to him feeling more comfortable with himself and his feelings.

Adam also made references to feeling like a 'freak' at several points before counselling, and in early sessions, saying 'I want to feel like I'm just like everybody else, I'm not an outsider, not a misfit'. When describing how counselling had helped, he referred to this again: 'I just thought I was different from everybody else, I couldn't fit in with anybody else'. By the end of counselling, he reported improvement in this, saying 'I don't feel like I'm a freaky person any more, like someone that's dead weird. I don't feel like that any more, I just feel normal…and better' (C-End). He repeated this at the follow-up interview, saying 'I'm a freak and I'm not normal and they are, that's what I used to always feel, but like…I can open up to people now and just like tell them about my life' (12m). In the second follow-up interview (18m), he mentioned this change again, referring to himself as 'a normal teenager'. Adam's belief that no one could understand him tied in with his view of himself as abnormal. Then, he experienced both the counsellor and the researcher as understanding, which increased his acceptance of himself and his feelings, and his bravery in expressing them.

Better relationships

Adam's new tendency to express his feelings was particularly crucial in terms of his relationship with his parents. At the outset of counselling he reported being closed off to his parents, saying 'I don't talk to my Mum and Dad'. After having counselling, his description of their relationships changed: 'I speak to [Mum] all the time, about anything that's upsetting me'. Towards the end of the counselling period, he also reported instances of being more emotionally expressive with others, for example a teacher: 'I had a meeting with [teacher] and like, I never open up in front of him, and then I opened up and I said all the stuff that's been going on with my Dad'. Adam's experience of counselling provided a positive experience of talking about his feelings, since the counsellor responded by listening and understanding. This encouraged him to open up to others, who then responded positively, which improved the quality of Adam's relationships. So a change in Adam's way of relating (facilitated by counselling) triggered an equal change in the way people related to him, and this process led to a greater sense of wellbeing.

Changes in home environment

There are some indications of how Adam's changed way of relating impacted positively on his family, and this lead to a more positive environment at home, which improved his wellbeing. During the seventh session, Adam described challenging his parents' assumptions about his feelings towards them:

> I said to my Mum and said to my Dad, "just calm down a bit and just sit down and relax a wee [little] bit, just calm down, that's all I want you to

> do", and they don't, like, believe that…they don't believe that I worry about them, and my Mum thinks that I hate her […] and my Dad thinks I hate him because he's an alcoholic, and that's just…I just want to get into their heads that I don't, and obviously they're my Mum and Dad and I love them.

Adam's openness with his parents improved their understanding of his needs, as suggested by his statements in the eighth session '[Mum] never really thought I was stressed because of her, and I told her "I really care about you, and I've been worrying about you" ', 'I had a talk with [Dad] about the alcohol and all that'. There is evidence from the session transcripts that Adam's parents responded positively to this and became more open with him in turn '[Mum] wanted me to do that, she said "if you open up and tell me, I can understand where you're coming from" ', '[Dad] was talking to me about alcohol […] he was telling me, like why he does it and stuff like that'. The inquiry group hypothesised that changes in Adam's way of relating to his parents may have triggered a substantial change in their relationships which ultimately led to positive changes in his parents' behaviour. This is also suggested by Adam's responses in research interviews: 'I can actually talk to [Mum] and communicate with her, and I used to never know how she felt and what she was thinking, and I can now'.

Impact on coping strategies

There are also indications that being able to talk about his feelings reduced Adam's tendency to turn to destructive coping strategies. During counselling sessions, he describes smoking and drinking to cope with negative emotions: 'usually if I'm

[stressed and angry]…I smoke one after the other after the other', 'that's what I crave, when I drink, a way to get away from it all'. In the follow-up interview, he says 'the counselling and all that […] it's changed me, because if I didn't have this, I would still be drinking and smoking and just being in that bad position'. The inquiry group hypothesised that talking about his worries with the counsellor and others in his life provided relief from stress, anxiety and negative emotions, which he had previously relieved by drinking and smoking. In other words, by sharing negative feelings, Adam was able to avoid a build-up of tension from unexpressed emotions. In addition, improvements in his confidence and self-esteem led to a greater sense of self-efficacy in terms of coping with stress. He suggests in the follow-up interview that he feels more able to cope with problems on his own in the absence of counselling:

> Sometimes I would say 'I wish I had my counselling back, to speak to somebody' and then I just said 'I'll maybe just do the stuff for myself, and tell myself 'you can do it' and I started to, like, do that. (12m).

Further reflections

The inquiry group concluded that talking to a helpful adult (primarily the counsellor, but also the author and a psychiatrist) was crucial for Adam to build better relationships with his parents, which in turn improved his wellbeing. Adam's reflections also suggest that formulating his problems as a mental illness was not helpful. Throughout both the waiting period and counselling period, Adam referred to himself as 'suffering from depression' and simultaneously rejected the possibility

of taking anti-depressants. Adam began by describing his problems in terms of mental illness: ‘it feels like a disease’, ‘I’m going to have [depression] my whole life’. As the research project progressed, he moved towards a more socially mediated explanation: ‘I don’t think I’m the one that needs help, I think that it’s my Dad and my Mum’. Throughout the research process, he is consistent in his rejection of anti-depressants: ‘I don’t want to take medication to change who I am’, ‘I don’t want to go on medication because then I’ll know there’s something really wrong with me’. Some of his comments suggest that the diagnosis of depression, and the idea of taking anti-depressants, add to his sense of being a ‘freak’: ‘I don’t want to go on medication, I just want to be normal’. During the follow-up interview, Adam reflects on his changed view of the problem: ‘I thought back then I’d have this all my life, and it’s just went away like that’.

6.4 Adam’s response

The counselling helped me in so many ways, not only was I becoming a more stronger person, I was regaining confidence within myself not to mention feeling a lot happier. I went home that first day after the meeting and thought about the meeting. I smiled in happiness. The meetings every Thursday just made me more excited for the week to come. The questionnaires definitely had a big impact too, they would ask me how I felt as a person, and looking at it as a whole I would see how really I did feel that day. Was I down that day? Or did something happen? It all just rolled into one another. It’s weird to think that just talking to someone about the problem you may be having (whether its family problems, death, bullying, etc.) really does help! And it does matter! All you really need is someone who's great at

listening and that's what I thought the counsellor was great at doing. Listening. Just speaking to someone really mends your well being and creates a more subtle happier you. I felt it in the first few meetings and now I look at myself and I'm proud of who I am. I'm proud of not only myself, but my Mum and my Dad as it did help them too.

6.5 Discussion

Consistent with previous research highlighting an association between school-based counselling and reductions in psychological distress (Cooper, 2009; McKenzie et al., 2011), positive change in distress, self-esteem and personal goal attainment occurred during counselling and persisted to 18 month follow-up. SBHC was hypothesised to be a major contributing factor in bringing about these improvements, consistent with the results of both the RCT from which this case was taken (McArthur et al., 2013) and a meta-analysis of that and two other trials (Cooper, 2013). The one other major contributing factor to positive change appeared to be parents' behavioural changes, which supports previous findings that the quality of relationship between adolescents and their parents contributes to affective wellbeing (McCauley, Pavlidis & Kendall, 2001), and that improvements in family relationships are considered 'extremely important' by the majority of young people (Lynass et al., 2012).

A factor which was deemed to make a small contribution to improved wellbeing was participation in the research project, consistent with the finding by Daniunaite et al. (2012) that young people who had not attended counselling attributed positive change to participation in a similar research project. One helpful aspect of research participation is indicated by Adam's response to the analysis: he experienced the psychometric questionnaires as helpful in contributing to

improvement in self-awareness. Other helpful aspects of research participation were described in terms of the opportunity to talk about problems to the researcher, feel listened to and understood.

The same phenomenon may explain the conclusion that meeting with a psychiatrist was helpful, in spite of the contrasting evidence that psychiatric diagnosis appeared to be hindering and psychopharmaceutical treatment was actively avoided. This finding is consistent with previous research showing that adolescents resist medicalised explanations of their experiences of distress (Biddle et al., 2007; Draucker, 2005), preferring to view problems as external or impermanent (Moses, 2009). One study showed that mental health diagnosis can damage adolescents' sense of normalcy, identity and independence, contributing to 'an illness identity that impedes recovery' (p. 1236, Wisdom & Green, 2004). Although this article did not investigate the impact of self-labelling on recovery, self-stigma and hopelessness linked to the diagnosis of depression are evident in this case.

In relation to therapeutic processes, aspects of the proposed model of change in this case coincide with previous research. For example, talking, listening and feeling understood have emerged as helpful aspects in SBHC (Cooper, 2004; Cooper, 2006; Cooper, 2009; Lynass et al., 2012) and for adolescents in general (Freake, Barley & Kent, 2007). This case could be seen as supportive of the humanistic assumption that people are best helped in relationship, since the factors identified as contributing to change for Adam were almost exclusively relational. However, this finding may be influenced by the relational orientation of the authors as well as the potential that having received humanistic counselling, Adam was primed to report

relational changes as opposed to, for instance, cognitive changes that a client in cognitive therapy may be expected to report.

The Rogerian (1959) person-centred model of change would anticipate that counselling would lead to greater congruence between Adam's experience and his self-concept making him more self-aware and self-accepting. Although there is evidence of improved self-acceptance through feeling understood and accepted by the counsellor, this model does not fully explain the process observed. In addition, the proposed model differs from the person-centred model of change in the sense that it places more emphasis on relational resources outside of counselling, and the crucial input of significant others. While it is hypothesised that Adam's changed way of relating (brought about by counselling) triggered improvements in his relationships with his parents, it is essential to note that changes in him were met with a positive response, and it follows that the process was dependent on the quality of his social support network. It may be that the role of significant others in facilitating therapeutic change is emphasized for young people. Draucker (2005) reports on interaction patterns between depressed adolescents and significant adults in their lives, recommending therapeutic interventions that focus on interpersonal relationships.

6.5.1 Limitations

As a single case study, generalisability is limited; the conclusions presented here cannot demonstrate that all young people will change in this way. However, this study shows that the process of change identified is possible for young people in psychotherapy. A further limitation is the potential for bias: while the analysis was

conducted in a systematic fashion, with several independent viewpoints involved, each member of the inquiry group (who conducted the core analysis) is allied to person-centred counselling, and potentially primed and motivated to view the process as consistent with humanistic theory. The selectiveness of the case could also have contributed to bias: although the case was deemed typical of the sample from which it was taken, it was selected partly for the client's high level of psychological mindedness, an aspect that is likely to positively influence the outcomes of psychotherapy.

The scope of this chapter was not sufficient to fully explore the rich material available on this case. More in depth analysis of the session transcripts and research interviews could have provided a wealth of alternative perspectives. For instance, attention has not been given to natural growing up processes and the growth of Adam's sense of agency over time, and how counselling may have contributed to that. Although efforts were made to analyse the data rigorously and thoroughly, the conclusions reached can only offer partial insight to the complex processes that occurred.

6.5.2 Conclusions

This case illustrates how SBHC can reduce psychological distress for young people through the opportunity to talk openly to a listening and understanding adult. In this case, counselling led to a feeling of 'bravery', which gave Adam the confidence to encourage more openness in his relationships with his parents. The behavioural changes made by his parents as a result of this openness helped to improve his

wellbeing. The benefits of talking, being listened to and feeling understood were not restricted to formal counselling, and it appears that the opportunity to talk to any supportive adult may have similar effects, lending support to a similar argument by Draucker (2005, p958): ‘only when the teens revealed the depth of their emotions and expressed who they were to an adult, and an adult responded by being wholly receptive and persistent in their support, did healing occur’.

Part III

Chapter 7. Discussion

7.1 Effectiveness of SBHC

7.1.1 Controlled data

The pilot RCT described in this thesis - the first to find significant differences in favour of SBHC over waiting list conditions - suggests a causal link between counselling and reduction in psychological distress. In other words, while improvement occurs during a waiting period, it is outweighed by the improvement which occurs in SBHC. Furthermore, the RCT results point to additional benefits of SBHC, particularly in facilitating personal goals, increasing self-esteem and reducing hyperactivity and inattention. The effect size found in this study suggests that SBHC has a similar impact on distress compared with US school-based counselling interventions (Baskin et al., 2010) and counselling for children and young people generally (Kazdin, 2004; Weisz et al., 1995). Despite the small sample size, these results give the most positive evidence so far for the effectiveness of SBHC. However, given the pilot nature of the trial, further evidence is required to replicate these findings.

Indeed, since its publication (McArthur et al., 2013), the procedures used in the RCT strand of this study have been replicated in a trial which also found significant differences in distress reduction in favour of SBHC at six week assessment, with an effect size of 0.59 (Pybis et al., submitted). However, at 12 week endpoint assessment, no significant differences were found between groups on the

primary outcome measure, and the effect size for SBHC (0.39) was small, in contrast to the large effect size found in this study (1.14). The disparity in findings may be a result of adherence problems in the Pybis et al. trial; one of the four counsellors was deemed not adherent to humanistic competences, and adherence levels generally were low, suggesting that the therapy examined in this study may not represent SBHC. A further replication study is now underway, and though data collection is not yet complete, indications of effect are so far promising (Pearce, Sewell & Osman, 2013), suggesting that adherence to humanistic competences impacts on outcomes.

Cooper (2013) has meta-analysed the current study, the replication study by Pybis et al. and the first pilot RCT of SBHC which used slightly different procedures (Cooper et al., 2010). This meta-analysis revealed that compared to waiting list conditions, SBHC led to significant improvements in psychological distress and personal goal attainment at both 6 weeks and 12 weeks (Cooper, 2013). Across the three studies (total n = 90), differences on other outcomes were not significant, though they were in favour of SBHC. The results of the meta-analysis strengthen the findings of the current study in relation to the effectiveness of SBHC for psychological distress and for personal goal attainment, but the findings relating to self-esteem and hyperactivity have not yet been replicated.

The mean effect size calculated in Cooper's (2013) meta-analysis across all outcomes after 12 weeks is 0.58, comparable to that found in this study alone (0.73), indicating a medium to large effect for SBHC (Cohen, 1988). The trial procedures piloted in this study have proved feasible and been successfully replicated once (Pybis et al., submitted). The replication study currently being conducted by Pearce

et al. (2013) has also incorporated economic analysis. A larger body of controlled studies, particularly a range of fully powered RCTs including economic analysis and comparisons with alternative treatments, will provide a clearer indication of effectiveness.

7.1.2 Pre- to post-counselling data

Psychometric measures presented in the systematic case study aspect of this thesis show that for one 14-year-old male client, reduction in psychological distress occurred during SBHC. However, this data also indicated that comparable reduction in psychological distress occurred during the pre-counselling waiting period. Similarly, secondary outcome measures from the case study indicated that improvement in goal attainment, self-esteem and total difficulties was equivalent between the counselling period and pre-counselling waiting period. This contrasts with the RCT results for the sample of participants as a whole and echoes previous research in which young people in waiting list conditions have shown similar improvements to those in counselling (Hanley et al., 2011; Cooper et al., 2010). It may be, as hypothesised in Adam's case, that participation in the research project was a contributor to reduced psychological distress, in line with a study by Daniunaite et al. (2012) which showed that research participation contributed to improvements for young people on a waiting list, as well as self-help and support from friends and family. This phenomenon only partly explains equivalence of improvement, but suggests that young people on a waiting list for counselling may benefit from completing outcome measures and attending an assessment interview.

7.2 Change processes in SBHC

7.2.1 Helpful and hindering factors

The finding that talking about emotions is the most commonly reported helpful factor in SBHC is consistent with Griffiths (2013) meta-analysis of previous studies, in which 'having an opportunity to talk/express self openly/be listened to' was identified as the most frequent helpful factor emerging from nine UK studies. Similarly, Cooper's (2009) meta-analysis showed that this factor was more commonly reported than any other by a factor of three. This points to the central importance of talking and being listened to for psychologically distressed young people in SBHC, a need which school-based counselling services are well placed to address given their greater accessibility (Hill et al., 2011; Catron, Harris & Weiss, 1998; Kaplan, Calonge, Guernsey & Hanrahan, 1998) compared with specialist CAMHS.

Other helpful factors which emerged from the current analysis are also represented in previous research on school-based counselling: the counsellor's personal qualities, independence from the client's life, confidentiality, and guidance or advice (Griffiths, 2013; Cooper, 2009). In relation to guidance and advice, Cooper (2013) reports that approximately half of young people in school-based counselling describe this sort of directive activity as helpful (despite the generally non-directive approach underlying most UK services, Cooper, 2009; Cooper, 2004), and this finding has been replicated in the current study.

The most commonly reported *hindering* factor in this study, difficulty talking, reinforces the centrality of talking as a helpful factor, and this too replicates previous findings on unhelpful factors (Griffiths, 2013; Cooper, 2009). Other hindering factors

were mainly related to wanting more input from the counsellor, a phenomenon which has been well represented in previous research (Griffiths, 2013; Lynass et al., 2012; Cooper, 2009), reinforcing its importance for young people. In this study, links were made between difficulty talking and counsellor-led directive activities (including questions and advice), such that non-directivity appears to worsen a young client's difficulty talking in counselling, while directive interventions may facilitate talking.

7.2.2 Outcomes

Positive changes reported by young people in this study were in the domains of relationships, emotions, self, and functioning and were broadly consistent with previous studies (Lynass et al., 2012; Cooper, 2009). The most commonly reported positive change was feeling happier, which may be the most obvious goal of any psychotherapeutic intervention, and supports the quantitative data demonstrating reduction in psychological distress. In addition, improved relationships with peers was commonly reported as a positive change (slightly more often than improved relationships with family members); this finding did not coincide with significant changes on the subscale of the SDQ related to peer problems (SDQ-PP). McElearney et al. (2013) found that for young people referred to school-based counselling for problems related to being bullied, SDQ-PP scores reduced significantly more than for young people referred for other reasons. Since the young people participating in the current study were not specifically referred for problems related to being bullied, the improvement in their peer relationships may indicate a positive move towards more satisfying peer relationships, as opposed to a reduction in specific problems with peers.

For example, other positive outcomes in the domain of relationships included better communication and more positive perception of others, consistent with the previous finding that counselling may lead to young people feeling more able to talk to others in their lives (Cooper, 2009; Lynass et al., 2012). Analysis of the case study showed that feeling more able to talk to others can have a considerable impact on family relationships, as was true for Adam. Improvement in family relationships were also commonly reported by young people.

Previous studies have established an association between school-based counselling and improved concentration on school work (Ogden, 2006; Rupani et al., 2012), which was supported in this study since both improved school work and improved concentration were reported as positive outcomes. In addition, RCT data showed that scores on the SDQ subscale for hyperactivity and inattention reduced significantly more for those in SBHC, which is likely to be linked to better concentration at school. Qualitative data from this study suggest that improved school work may also be connected to better relationships with teachers, confidence and/or self-efficacy, and that better concentration may also be associated with improved sleep. Together, the quantitative and qualitative results in this area, consistent with previous research, suggest that positive impact on concentration and school work is emerging as a key benefit of SBHC.

Generally, the diversity of positive outcomes for young people in this study suggests a benefit of SBHC compared to more directive approaches which are targeted to specific problems. SBHC is an intervention for the broad construct of psychological distress, and the humanistic approach assumes a wide range of individual responses to distress, and consequently a wide range of individual

outcomes for therapy. In tandem with significant improvements in personal goal attainment, this demonstrates that what young people want to gain from counselling may not always be represented by standardised outcome measures.

As in previous research, few negative outcomes were reported (Cooper, 2009; Lynass et al., 2012), and those that were did not seem to relate directly to SBHC. Although satisfaction with counselling was not investigated as part of this study, the qualitative data showed a positive response, consistent with previous reports from young people attending school-based counselling (Cooper, 2009; Lynass et al., 2012). For some clients, low levels of ongoing distress were reported, indicating a lack of hoped-for change during SBHC; this echoes Lynass et al.'s (2012) study, in which a minority of young people reported problems that had not been resolved through counselling.

7.2.3 Change processes

The qualitative data presented in this thesis provides potential models of change for young people in SBHC. The grounded theory which was developed from the data will be enriched by analysis of further interviews with a larger number of young people who have attended SBHC. In general, a great deal of further research is required to clarify the processes involved in counselling for children and young people, and this may also be achieved through a collection of systematic case studies investigating individual processes.

The change processes hypothesised in this study demonstrate that progress through SBHC follows distinctive pathways for individual young people, consistent with a humanistic understanding of distress and personal growth (e.g. Rogers, 1959;

Patterson & Joseph, 2007; Cooper et al., 2007). However, not all of the identified pathways to change are anticipated by humanistic theory: for instance, using the counsellor's advice to cope with emotions by changing behaviour (as shown by the change process related to enhancing coping strategies) is less consistent with moving towards autonomy and more self-concordant ways of being (Ryan & Deci, 2000; Sheldon & Elliot, 1999; Sheldon & Kasser, 2001) and more in line with cognitive-behavioural aims of resolving specific problems by addressing unhelpful thoughts and behaviours (Roth & Pilling, 2007).

Process data also suggest that a young person's difficulty talking can have a considerable inhibiting impact on the impact of SBHC, if it is not addressed. Young people in this study experienced change processes with positive outcomes despite their difficulty talking, but the results suggest that the experience could be more satisfactory for clients, and perhaps lead to more positive change if this difficulty could be alleviated. Young people seem to find directive interventions helpful to ease discomfort in a counselling relationship, which could explain consistent findings from this and previous research (Cooper, 2009; Griffiths, 2013) that clients tend to value guidance, advice and activities and want more input from the counsellor.

The time limit of counselling was also problematic for a minority of clients (in keeping with previous research, Cooper, 2009; Hill et al., 2011) but this too did not entirely prevent positive change. Rather, the results indicate that for some clients, greater benefit will be incurred from a longer period of counselling, and imposing time limits may result in some dissatisfaction for these clients.

Although difficulty talking and time limits have been highlighted in this study as part of processes which hinder change, it is also possible that SBHC is not an

appropriate and/or effective intervention for all young people in psychological distress. Therefore, the relative lack of positive change reported by a minority of participants could reflect their suitability for an alternative type of support.

7.3 Implications for policy and practice

7.3.1 Widening access to SBHC in UK schools

The now developing body of evidence for SBHC as an effective response to psychological distress in young people, implies that widening access in UK secondary schools would be appropriate and desirable if research findings continue to suggest effectiveness. An example of how a roll-out of services to all schools would work in practice is provided by the Welsh Assembly Government, having implemented a strategy for school-based counselling; the subsequent evaluation indicated high levels of satisfaction with school-based counselling services and significant reductions in psychological distress (Hill et al., 2011). Though a majority of secondary schools in England and Scotland have existing counselling services, a proportion do not, and provision between regions is currently imbalanced (Hanley et al., 2012). The findings of this study support a change in English and Scottish policy to provide counselling services for pupils in all secondary schools. However, it is also worth noting that school-based counselling in the UK is unusual in that it is delivered by dedicated professionals who do not have a dual role in the school (Harris, 2013).

Although 12 weeks of SBHC appears to be sufficient for a majority of clients, it should be noted that some clients may need longer periods of time to engage with

and progress through SBHC. This is reflected in current studies describing young clients' use of school-based counselling services: most attend between three and six sessions, a considerable proportion even less, and a small minority ten or more sessions (Hill et al., 2011; Cooper, 2009; McKenzie et al., 2011). Therefore, provision of SBHC should be flexible enough to allow for longer periods of counselling in some cases.

As in previous studies of UK school-based counselling services, young people from Black and Minority Ethnic (BME) backgrounds are under-represented in this study. The reasons for this inequity of access are unknown, though evaluation of school-counseling services in Wales suggested that access to online counselling may support more participation from BME young people (Hill et al., 2011). As a starting point, providing choice between online and face to face counselling for young people accessing SBHC could address this issue to some extent.

7.3.2 Increasing use of outcome measurement

As noted in Chapter 2, previous research has shown that regular use of outcome measures is associated with better outcomes for therapy generally (Lambert & Shimokawa, 2011; Saunders & Rey, 2011; Cooper et al., submitted); this study has supported the notion that participating in research can contribute to reducing psychological distress (Daniunaite et al., 2012). Current indications are that use of standardized outcome measures in UK school-based counselling is low (Cooper, 2013), therefore current services could substantially improve client outcomes by adopting routine outcome measurement, which has the added benefit of providing opportunities to demonstrate effectiveness.

In addition, outcome measures could be used to benefit young people waiting for counselling. Average waiting times for SBHC are low, but a proportion of young people may wait for a month or longer before beginning counselling (Hanley et al., 2012). In the event of long waiting lists, brief assessment meetings and use of outcome measurement could provide benefits to young people in the absence of counselling.

However, it is important to note that standardised outcome measures may not capture the changes that are valued by young people themselves, and further work is required to understand the experience of attending school-based counselling. Personalised measures (such as the Goal-Based Outcome Record) provide an opportunity to explore the changes that young people want to make through counselling, and measure the extent to which this occurs.

7.3.3 Improving practice in SBHC

As well as improving outcomes through routine use of outcome measures, this study suggests potential improvements to the practice of SBHC which may be incorporated into training courses for counsellors, especially those working with young people. First, counsellors should be attentive to the possibility of young people having difficulty 'opening up', and the potential for alleviating this with more directive interventions. In other words, counsellors working within a non-directive framework may consider incorporating some more directive activities, with the aim of reducing clients' difficulty in talking, since non-directivity can be experienced by young people as unhelpful.

The systematic case study described in this thesis demonstrates positive change occurring through a process involving the young person's social environment and life circumstances outside of counselling. Despite the individual focus of SBHC, the young people in this study demonstrated improvements in their relationships with others, and for Adam, his experience of counselling acted as a trigger for working towards more mutually satisfying relationships within his family. It may be that school counsellors already work with clients in such a way that their social environment is positively impacted. However, practice may be further improved by increased focus on a young person's social circumstances as a key area of change. One possibility would be to explore the use of group counselling in schools, another would be to include parents in the counselling process, with the aim of directly facilitating better communication within a young person's family.

7.4 Limitations

As noted in Chapters 4-6, there are limitations to each aspect of this study. Primarily, the RCT results are limited by the small sample size, which means that caution must be exercised in interpreting the results and replications are necessary to establish effectiveness. Overall, the study is subject to humanistic bias due to the professional background of the author, and supervisors. In addition, a lack of ethnic diversity limits the generalisability of the study as a whole. Standardised measures, such as the primary outcome measure in this study, may not address aspects that are important for young people themselves. However, this study demonstrates the feasibility of using the Goal-Based Outcome Record (G-BOR), a personalised tool which allows

counsellors to measure change according to the young person's frame of reference, making it an appropriate option as primary outcome measure in future research.

Chapter 8. Personal Reflections on Research Process

8.1 Reflections on effectiveness

There are a relatively small number of researchers studying humanistic and person-centred counselling in the UK generally, and even fewer are involved in RCTs. I became one of them when I worked as a researcher on the first pilot RCT of SBHC (Cooper et al., 2010). With that experience, I felt informed and confident enough to conduct my own pilot RCT (described in this thesis), the results of which were favourable to counselling and have been published in an international journal, leading to an Outstanding Research Award from BACP. I described my personal experience of conducting RCTs in *Therapy Today* (McArthur, 2011) in an article which contributes to a long-standing and ongoing debate around methodology in psychotherapy research.

8.1.1 Methodological controversy

Cooper (2011) defined a fundamental problem within the counselling world, which is the apparent need for evidence from RCTs to secure the future of the profession, coupled with a widespread reluctance among counsellors to engage in this type of research. He suggested seven possible responses to the problem, including arguably the most obvious but perhaps the least popular – developing skills in conducting RCTs within the counselling community. Under the heading ‘compromise’, an example of how this might work in practice was given, namely the pilot RCT described in this thesis.

Cooper's article (2011) advocating the use of RCTs in testing relational forms of counselling was followed by a critique from Rogers et al. (2011). The authors state that Cooper was in danger of advocating 'bad faith' research commitments. My understanding of the concept of bad faith is that it describes a process of denying to oneself the unavoidable freedom of choice, and therefore responsibility, that all human beings are in Sartre's words 'condemned to' (1945). A person is in bad faith when they (paradoxically) choose to believe that any of the possibilities available to them are precluded, for instance by a social role or value system that they have adopted. Rogers et al. (2011) repeatedly and firmly challenge the appropriateness of counsellors and researchers who adopt a relational approach acting outside of this value system by engaging in large scale quantitative research, particularly RCTs. To express my view on this, I first want to describe in more detail my personal experience of conducting RCTs in the context of my ambivalence about the methodology.

8.1.2 My experience of conducting an RCT

Researching school counselling through RCTs was a largely positive experience for me, primarily because of the interactions I had and the relationships I formed with the young people who participated, or considered participating. Both as a contract researcher and later as a PhD student, part of my role has been to meet young people who expressed an interest in taking part in this research and guide them through an assessment process to explain what the project can offer and decide whether they might want – and be eligible – to take part. Those who did take part, I also had the

opportunity to meet again, conducting semi-structured interviews on their experiences of having counselling, or of waiting for counselling.

Initial assessments and follow-up interviews were very emotionally involving, and my focus was on forming and building an empathic connection with each young person. Time and time again, I have been delighted and saddened in equal measure by young people's accounts of their experiences as participants. Delighted to witness first hand the extraordinary resilience of a human being; delighted to be part of something that seems to help distressed, disenchanted young people feel happier and more hopeful; delighted to have the privilege of those uniquely intimate connections with people I otherwise would not have the opportunity to hear from. But sad to know how rare this kind of support is, to realise how surprised most young people are simply to be treated as an equal, to appreciate the gulf between what is needed and what is currently available.

My interest in this group is fuelled by all too vivid memories of troubled adolescence and it seems as clear to me now as it was then that a simple conversation with a respectful, understanding adult can be as powerful as it is unusual. My sense is that people in this age group are chronically underestimated and undermined by well-intentioned adults who do not yet fully recognise their personhood. Some of the young people I spoke to started having counselling immediately after meeting me for the first time, and on subsequent meetings answered my questions about how that was going. Others (who were randomly assigned to the waiting list control condition) met me intermittently before even starting counselling. One of the most interesting findings from these trials was that both groups showed and expressed improvements. Participants tended not to distinguish between their counselling sessions and the

research interviews, and reported their experiences of these two aspects of the study in very similar ways: feeling listened to, cared about, taken seriously and having the chance to talk things out. To my relief, and to some extent surprise, participants did not seem to feel in any way disadvantaged by being assigned to the control group. Furthermore, research tasks such as completing questionnaires did not prevent meaningful connections. These tasks gave a different structure to the meetings than a traditional counselling session, but often facilitated dialogue and were experienced as therapeutic by young people. In the words of Andrew, a waiting list participant: 'If having these wee meetings has helped me as much as it has, I feel like the counselling will help me even more, so I want to do that as well.' Reassuringly, the benefits expressed (and quantitatively demonstrated) by the control group were outweighed by those in the counselling condition. Although one of the criticisms levelled by Rogers et al. (2011) was the unlikelihood of obtaining favourable findings using such inappropriate methods, the results of my RCT (McArthur et al., 2013) show clear support for school-based counselling, as does the first replication study (Pybis et al., submitted).

8.1.3 Challenges

Of course, there was a negative side to my experience too, and real frustrations with the limitations of this kind of research. There were times when it was clear to me that a young person would have preferred and benefited from a permanently available counselling service as opposed to a time-limited intervention. Since the trial was designed to compare counselling against a waiting list control group, a consistent limit on the number of counselling sessions was necessary in order to limit the

waiting period. In each school there were young people who may have benefited but could not be seen due to the small scale of the project and the need to restrict intake. However, similar limitations are experienced by anyone running a counselling service, either in schools or in the wider community. Funding for therapeutic work in the public and voluntary sectors is under constant threat, and ignoring the demand for evidence-based practice can only result in further marginalisation (or more likely privatisation) of relational therapies.

8.1.4 Response to criticism

My personal experience gives a context to methodological criticisms, in that the picture of an RCT emerging from Rogers et al.'s objections to the method bears virtually no relation to my understanding of this kind of research. Firstly, why shouldn't an RCT benefit participants directly, independently of research aims and potential consequences of disseminating positive results? Far from being only a means to an end, the trials I've been involved in have proved intrinsically valuable to participants, which at the very least justifies their funding and throws into question the assertion by Rogers et al. (2011) that money would be better spent raising public awareness of different kinds of therapeutic support. While the majority of counsellors and psychotherapists work in private practice, and distress correlates highly with financial disadvantage, how empowering would such information really be and to whom? The current reality is that a distressed person without considerable financial resources has few options for therapeutic support, and increasing understanding of different approaches to therapy would have little impact on this problem.

Secondly, why should researching subjective individual experiences and comparing group outcomes be mutually exclusive? Attempting to measure distress numerically at a population level may be flawed and limited, but it does not automatically prevent researchers from also exploring the lived experiences of the individuals involved. One-to-one interviews are fairly easily incorporated into an RCT framework and the extent to which qualitative data is collected is largely a matter of researcher choice. As noted, I conducted an RCT which included semi-structured interviews with participants at several points, and allowed me to gather data on the individual experiences of young people in counselling.

Finally, why should qualitative inquiry be considered any more capable than quantitative measurement of determining truth in any context? Personally I find as many reasons to question qualitative data as quantitative, and cannot accept that any methodology can determine what is fundamentally true. To my mind, combining methods as far as possible (rather than outlawing those that don't appeal) gives the best chance of addressing the limitations of research knowledge. The article by Rogers et al. (2011) critiques a blinkered and rigid approach to researching human experience, while demonstrating exactly that.

The notion that counsellors and psychotherapists should automatically and completely avoid RCTs on the basis of incompatibility with their assumed values is a near perfect example of bad faith, comparable to the opposite notion that qualitative research reveals nothing of practical value. My initial interest in RCTs was rooted in my ambivalence: where one group held the method as a 'gold standard' and another as a thoroughly unacceptable aberration, I felt inspired to develop my own relationship to it, based on the likelihood that its nature is more complex than either

of those views suggest. I hope that my choice to employ an RCT method will not be taken as a commitment to large-scale quantitative research above all else, but rather attributed to my view that this, along with the full range of potential methodologies, is a valid and worthwhile way to research something as complex as psychotherapy. Accepting RCTs as one possible option for counselling researchers, and working with the ambivalence that creates, is the opposite of bad faith.

8.1.5 Response to results

As a natural pre-requisite to becoming a counsellor, I believe that counselling benefits people on the whole. I also believe that assumptions like this should be questioned, and if possible, tested. Both of these beliefs are based on intuition, empathy and experience. During the first pilot RCT of SBHC (Cooper et al., 2010), I neglected to consider how the results would reflect on the counselling field: I was too focused on the demanding and rewarding job of running the trial. I was aware of the anxieties of the rest of the team, who were far more experienced and more invested in the result than I was at that stage. But I personally felt quite relaxed about the possibility that the specific procedures being piloted would not 'work'. Dr. Pascal Mamassian, who supervised the first research project I worked on as an undergraduate, told me that there are two ways to conduct a piece of research: do it first, or do it right. This seems to me to fit quite well with the task of conducting an RCT of school-based counselling. The first pilot was ground-breaking, showed that applying RCT procedures to counselling was feasible, and allowed a team of researchers to understand how to improve on those procedures to better test SBHC as

an intervention. The RCT presented in this thesis depends entirely on the lessons learned from the previous trial.

From the vantage point of someone involved in the day-to-day running of the Cooper et al. (2010) trial, it was easy to see methodological reasons for an end result which suggested that young people in counselling were no better off than those on the waiting list. For that reason, my reaction to the finding was that it seemed unlikely to reflect a failure of school-based counselling. This enhanced my motivation to conduct another trial, and by this stage my interest in effectiveness had also increased. I began this study from a stance of equipoise, genuinely curious to find out whether SBHC would help young people more than the waiting list condition. With the knowledge that the waiting list condition involved several therapeutic elements for young people (concern and care from a teacher, anticipation of support from a counsellor, one to one attention from a researcher, the opportunity to reflect on wellbeing through questionnaires, and the hope of feeling better soon), I was very prepared for an outcome which did not support SBHC as a superior intervention.

Therefore, the finding that young people allocated to SBHC improved significantly more than those on the waiting list was very welcome. It gave me a renewed sense of confidence in counselling and in the humanistic approach to think that even though young people were helped by the waiting list condition and all that it entailed, ultimately it could not compare to a therapeutic relationship with a counsellor. In hindsight, I realise that the results were consistent with the accounts young people had given in endpoint interviews: those on the waiting list usually described improvement, but those in counselling usually did so more

enthusiastically, with more in depth descriptions of how their lives had changed. The work has made me more passionate about widening access to counselling generally, and more hopeful about the future of SBHC in the UK.

8.2 Reflections on processes

Since the publication of the RCT aspect of this thesis, I have had the opportunity to deepen my relationship to qualitative inquiry and engage in process research through the case study and grounded theory aspects of the study. Engaging with the qualitative data from this study was fascinating, due to the emotional connection involved in dealing with people's life stories.

8.2.1 Experience of process research

I believe that I built good relationships with the majority of young people who took part in this study, and given unlimited time and resources, I would have liked to conduct case studies with all participants, exploring with them in more depth their experiences in the trial and in counselling. Instead, I had the opportunity to work with one client in depth, and to analyse a single post-counselling interview from 14 more. Studying interview transcripts was fascinating, and the different processes emerging for each of the young people made me see counselling in a new light, while at the same time often resembling processes that I have seen before in others (clients, friends, family) and experienced myself. It was an incredible privilege to work with Adam, to see him move gradually from the despair he felt when I first met him to the

positivity he exuded at the end of the counselling period, and to hear him describe how much better things were for him and his family.

I tend to be conscious of the social aspects of psychological distress, and have wondered about the limitations of counselling which focuses on the individual. The case study provided an encouraging example of how powerful a change in one person can be to trigger changes in an entire family, and this was reinforced by accounts from clients' interview transcripts. I developed five different processes of change, which between them represented the stories emerging from the transcripts. Some of the processes were more engaging to me than others (with my humanistic bias, the growth of self-worth and development of insight were particularly resonant), but most satisfying was to appreciate the diversity between clients. In keeping with my view of the world and with my sense of these young people before I began the analysis, their experiences of counselling were very different. For me, this was a further indicator of the value of qualitative research into counselling: young people defined and described counselling, and its outcomes, according to what was important to them personally and it was clear that this varied considerably between clients with nuance which cannot be conveyed using only quantitative data. Each client had a slightly different approach to making use of the help that was offered to them, and noticed different changes as a result. In instances where the same positive change was reported by several clients, it was in each case part of a different story, and had a unique significance.

At the same time, the similarities in processes for different clients were equally fascinating. The most striking commonality was that clients appreciated the chance to talk. This chimed with my sense of young people having less experience

than adults of being listened to in everyday life, and therefore the chance to talk being a more powerful experience. It could be considered obvious that people who opt to have counselling want to talk, but it seems to me that different approaches put more focus on the counsellor's interventions instead. Indeed, previous research on school-based counselling showed that young clients tended to want more advice and guidance (e.g. Cooper, 2004). But the transcripts I analysed suggested that often directivity on the part of the counsellor is useful mainly because it serves to alleviate the awkwardness of talking openly to a stranger. McLeod (2001) notes a paradox in qualitative analysis, since to be of value it must contain new and original insights, but to be valid, it must also be recognisable to those involved. For me, this finding met those standards: previous research has not linked young people's difficulty opening up in counselling to the counsellor's activity as a way to help with this, but the phenomenon fits with my experience as a researcher and a counsellor. Having started my counselling career eager to empower clients by taking a non-directive approach, I soon realised how disempowering non-directivity can sometimes be to a person who is already in a vulnerable state.

In a one-to-one meeting between a teenager in distress and an adult professional, the power dynamic is even more highly skewed than with an adult client and counsellor. Person-centred counsellors might aim to address this power imbalance by allowing the client to set their own agenda, and direct their own therapeutic process. I think that for many young people, as for some adults, this is a step too far; the barrier between client and counsellor is not so easily overcome. What was interesting for me in this data was to see how activities and more directive counsellor behaviours could help clients to ease into the new relationship, and begin

to open up at their own pace, without the paralysing focus of undivided attention. I think this is also a reason why the research interviews were experienced as helpful by so many of the young people. It seemed that the structure imposed by the goal of data collection helped young people to feel at ease, and the relatively small amount of space provided to talk about their emotions was deemed to be enough for many of them.

8.2.2 Challenges

One of the main challenges in the process-oriented elements of this study was balancing ethical principles. Analysing group data taken from psychometric measures is in some ways simpler ethically than exploring the real life stories of a group of young people, and particularly conducting an in-depth case study. I worried about Adam's wellbeing, about how he would interpret my offer to participate in a case study, how the study would impact on him generally, whether he would feel truly involved. My sense from communicating with Adam about all of this is that he was genuinely happy to take part. He was proud of what he'd come through, enjoyed taking part in the research, and saw the case study as an opportunity to contribute to helping other young people in distress by telling his own story, which had become an important part of his identity. He chose his pseudonym, and we talked about how we could disguise his identity without changing things that felt important to him. We discussed what he would like the article to look like, before agreeing that I would write it, he would approve it and then write a section himself, to be included. In an email to me later, he wrote: 'Thanks for making this article…I would love to be in every way part of this, and write something of my own. I feel really great about this,

once again thanks'. Adam's response is encouraging, but not grounds for complacency. My grappling with ethical considerations will continue as this aspect of the study is prepared and submitted for publication, and beyond. In relation to developing a grounded theory, I felt a great responsibility towards the young people whose words were being analysed. Not having the opportunity to check my analysis with them and hear their feedback on its accuracy and relevance, I was anxious to represent them honestly and to honour their experiences by thoroughly examining their words with open curiosity. I hope that my analysis truly reflects their accounts, and that this work will eventually benefit others accessing school-based counselling.

8.3 The impact of this study

The findings of the work that I have undertaken in this study are relevant to me as a counsellor, and as a person, as I hope they will be to others. The RCT aspect of the study has made a contribution to a developing evidence base which may lead to increased access to SBHC in the UK, and provided a template for similar studies. The process elements of the study can be built on and have the potential to inform and improve practice in SBHC. The study as a whole appears to have been intrinsically beneficial to the young people who took part, and at least one of the three participating schools has since employed a full counselling service as a result of this positive experience.

Both quantitative and qualitative data are limited, and cannot be considered revelatory of 'the truth'. I know that the qualitative work I have conducted may have somewhat different results if undertaken by a different researcher. Allegiance effects (Berman & Reich, 2010; Luborsky et al., 1999) show that quantitative research is

also subject to bias from the researchers' theoretical orientation, despite attempts to eliminate it by using experimental manipulation. To my mind, the best chance of addressing the limitations of research knowledge lies in triangulating data from a range of methods, both quantitative and qualitative. I analysed differences between randomly allocated groups, using quantitative data from psychometric measures. I examined both quantitative and qualitative data for one client, conducting further interviews with him to check the validity of the analysis. I explored the processes and outcomes of counselling for one group of 14 clients, in their own words. I feel that I have looked at the phenomenon from different angles, and that the ability to see those different views of it has enhanced my understanding of each. Taken as one mixed-methods study with three strands of inquiry, this study has generated new knowledge about the effectiveness, processes and outcomes of SBHC, potentially contributed to widening access to this important service in UK schools and directly benefited the young people who took part.

Part IV

9. References

Adamson, P. (2007). *Child poverty in perspective: An overview of child well-being in rich countries* (UNICEF Innocenti Report Card 7). Florence: The UN Children's Fund.

American Psychological Association (2005). *Report of the 2005 presidential task force on evidence-based practice*. Washington, DC: Author. Available at http://www.apa.org/practice/ebpreport.pdf

Aneshensel, C. S. & Sucoff, C.A. (1996). The neighbourhood concept of adolescent mental health. *Journal of Health and Social Behavior, 37*, 293-310.

Baginsky, W. (2004). *School counselling in England, Wales and Northern Ireland: A review*. London: NSPCC.

Baskin, T.W., Slaten, C.D., Crosby, N.R., Pufahl, T., Schneller, C.L. & Ladell, M. (2010). Efficacy of counseling and psychotherapy in schools: A meta-analytic review of treatment outcome studies. *The Counseling Psychologist, 38,* 878-903. doi:10.1177/0011000010369497.

Beck, A.T. (1976). *Cognitive Therapy and the Emotional Disorders*. New York: Penguin.

Beck, A. T., Rush, A.J., Shaw, B.F. & Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guildford Press.

Begley, S. (2009). Ignoring the evidence: Why do psychologists reject science? *Newsweek*. Available at http://www.newsweek.com/id/216506.

Belfer, M.L. (2008). Child and adolescent mental health disorders: The magnitude of the problem across the globe. *Journal of Child Psychology and Psychiatry, 49,* 226-236.

Berman, J.S. & Reich, C.M. (2010). Investigator allegiance and the evaluation of psychotherapy outcome research. *European Journal of Psychotherapy & Counselling, 12*, 11-21.

Beutler, L.E., Harwood, T.M., Kimpara, S., Verdirame, D., & Blau, K. (2011). Coping style. *Journal of Clinical Psychology*, *67*, 176-183.

Beutler, L.E., Harwood, T.M., Michelson, A., Song, X., & Holman, J. (2011). Resistance/reactance level. *Journal of Clinical Psychology*, *67,* 133-142.

Bhaskar, R.A. (1975). *A realist theory of science*. London: Verso.

Biddle, L., Donovan, J., Sharp, D. & Gunnell, D. (2007). Explaining non-help-seeking amongst young adults with mental distress: A dynamic interpretive model of illness behavior. *Sociology of Health & Illness, 29*(7), 983-1002.

Birmaher, B., Brent, D.A., Kolko, D., Baugher, M., Bridge, J., Holder, D., … Ulloa, R.E. (2000). Clinical outcome after short-term psychotherapy for adolescents with major depressive disorder. *Archives of General Psychiatry*, *57,* 29-36.

Blascovich, J., & Tomaka, J. (1993). Measures of self-esteem. In J.P. Robinson, P.R. Shavre, & L.S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes* (3rd ed., pp. 115-160). Ann Arbor: Institute for Social Research.

Bondi, L., Forbat, L., Gallagher, M., Plows, V., & Prior, S. (2006). *Evaluation of the youth counselling service*. University of Edinburgh.

Bower, P., & King, M. (2000). Randomised controlled trials and the evaluation of psychological therapy. In N Rowland & S Goss (Eds.), *Evidence-based counselling and psychological therapies* (pp. 79-110). London: Routledge.

Bradshaw, J., & Richardson, D. (2009). An index of child wellbeing in Europe. *Child Indicators Research, 2*, 319-351.

Brent, D.A., Perper, J.A., Moritz, G., Allman, C., Friend, A., Roth, C., … Baugher, M. (1993). Psychiatric risk factors for adolescent suicide: a case-control study. *Journal of the American Academy of Child & Adolescent Psychiatry, 32* (3), 521-529.

Brent, D.A., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., … Johnson, B.A. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Archives of General Psychiatry, 54*, 877-885.

Castonguay, L., Barkham, M., Lutz, W. & McAleavey, A. (2013). Practice-oriented research: Approaches and applications. In M.J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (6th ed., pp. 85-133). New Jersey: John Wiley and Sons.

Catron, T., Harris, V.S. & Weiss, B. (1998). Post-treatment results after 2 years of services in the Vanderbilt school-based counseling project. In M.H. Epstein, K. Kutash, and A. Duchnowski, (Eds.), *Outcomes for Children and Youths*

with Emotional and Behavioral Disorders and their Families: Programs for Evaluating Best Practice (pp. 633-656). Austin, TX: Pro-ED.

Christens, B.D. & Peterson, N.A. (2012). The role of empowerment in youth development: A study of sociopolitical control as mediator of ecological systems' influence on developmental outcomes. *Journal of Youth and Adolescence, 41*(5): 623-635.

Christon, L.M., Robinson, E.M., Arnold, C.C., Lund, H.G., Vrana, S.R. & Southam-Gerow, M.A. (2012). Modular cognitive-behavioral treatment of an adolescent female with selective mutism and social phobia: A case study. *Clinical Case Studies, 11*, 474.

Clark, D. M., Fairburn, C. G., & Wessely, S. (2008). Psychological treatment outcomes in routine NHS services: a commentary on Stiles et al. (2007). *Psychological Medicine*, *38*(5), 629-634.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

Comte, A. [1865] (2009). *A general view of positivism*. Cambridge University Press.

Connell, J., Barkham, M., Stiles, W. B., Twigg, E., Singleton, N., Evans, O. & Miles, J.N.V. (2007). Distribution of CORE-OM scores in a general population, clinical cut-off points and comparison with the CIS-R. *British Journal of Psychiatry, 190*, 69-74.

Cooper, M. (2004). *Counselling in schools project: Evaluation report*. Glasgow: Counselling Unit, University of Strathclyde.

Cooper, M. (2006). *Counselling in schools project phase II: Evaluation report*. Glasgow: Counselling Unit, University of Strathclyde.

Cooper, M., & McLeod, J. (2007). A pluralistic framework for counselling and psychotherapy: Implications for research. *Counselling and Psychotherapy Research, 7*, 135–143.

Cooper, M., O'Hara, M., Schmid, P.F. & Wyatt, G. (Eds.). (2007). *The handbook of person-centred psychotherapy and counselling*. Basingstoke: Palgrave.

Cooper, M. (2009). Counselling in UK secondary schools: A comprehensive review of audit and evaluation data. *Counselling and Psychotherapy Research, 9*(3), 137-150.

Cooper, M., & McLeod, J. (2010). Pluralism: Towards a new paradigm for therapy. *Therapy Today*, *21*, 10–14.

Cooper, M., Rowland, N., McArthur, K., Pattison, S., Cromarty, K. & Richards, K. (2010). Randomised controlled trial of school-based humanistic counselling for emotional distress in young people: Feasibility study and preliminary indications of efficacy. *Child and Adolescent Psychiatry and Mental Health*, *4*, 1-12. doi: 10/1186/1753-2000-4-12.

Cooper, M. (2011, May). Meeting the demand for evidence-based practice. *Therapy Today, 22*(4), 10-16.

Cooper, M. & McLeod, J. (2012). From either/or to both/and: Developing a pluralistic approach to counselling and psychotherapy. *European Journal of Psychotherapy & Counselling, 14*(1), 5-17.

Cooper, M., Stewart, D., Sparks, J. A., & Bunting, L. (2012). School-based counseling using systematic feedback : a cohort study evaluating outcomes and predictors of change. *Psychotherapy Research*. doi: 10.1080/10503307.2012.735777.

Cooper, M. (2013). *School-based counselling in UK secondary schools: A review and critical evaluation*. Lutterworth:BACP/Counselling MindEd. Download from www.counsellingminded.com .

Cooper, M., Freire, E., McGinnis, S., & Carrick, L. (submitted). School-based humanistic counselling for psychological distress in young people: A cohort study using a low attrition sample. *Counselling and Psychotherapy Research*.

Costello, E.J., & Angold, A. (1988). Scales to assess child and adolescent depression: Checklists, screens, and nets. *Journal of the American Academy of Child and Adolescent Psychiatry*, *27*, 726-737.

Daniel, T. & McLeod, J. (2006). Weighing up the evidence: A qualitative analysis of how person-centred counsellors evaluate the effectiveness of their practice, *Counselling and Psychotherapy Research, 6*(4), 244-249.

Daniunaite, A., Ali, Z.A. & Cooper, M. (2012). Psychological change in distressed young people who do not receive counselling: does improvement happen anyway? *British Journal of Guidance and Counselling, 40*(5), 515-525.

Datillio, F.M. (2002). A bridge and a couple of fences? A response to Silverman. *Psychotherapy: Theory, Research, Practice, Training, 39*, 261-263.

Datillio, F.M., Edwards, D.J.A. & Fishman, D.B. (2010). Case studies within a mixed methods paradigm: Toward a resolution of the alienation between

researcher and practitioner in psychotherapy research. *Psychotherapy Theory, Research, Practice, Training, 47*(4), 427-441.

Department of Health (2008). *Improving access to psychological therapies implementation plan: National guidelines for regional delivery*. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083150.

Dimmitt, C., Carey, J., & Hatch, T. (2007). *Evidence-based school counselling*. Thousand Oaks, CA: Corwin.

Donohue, B. & Azrin, N.H. (2002). Family behavior therapy in a conduct-disordered and substance-abusing adolescent. *Clinical Case Studies, 1*, 299.

Draucker, C.B. (2005). Interaction patterns of adolescents with depression and the important adults in their lives. *Qualitative Health Research, 15*(7), 942-963.

Duncan, B. L., Miller, S. D., & Sparks, J. A. (2006). *Child session rating scale*. Jensen Beach, FL: Author.

Duncan, B. L., Sparks, J. A., Miller, S. D., Bohanske, R., & Claud, D. A. (2006). Giving youth a voice: A preliminary study of the reliability and validity of a brief outcome measure for children, adolescents, and caretakers. *Journal of Brief Therapy, 5*(2), 66-82.

Dunnett, A., Cooper, M. & Wheeler, S. (2007). *A core curriculum for counselling and psychotherapy*. Lutterworth, UK: BACP.

Durkheim, E. [1895] (1982). *The rules of sociological method*. New York: The Free Press.

Ebesutani, C., Bernstein, A., Nakamura, B.J., Chorpita, B.F., Weisz, J.R. (2010). A psychometric analysis of the revised child anxiety and depression scale, the research network on youth mental health. *Journal of Abnormal Child Psychology*, *38*(2), 249–260.

Elliott, R. (1999). *Client change interview protocol*. Network for Research on Experiential Psychotherapies; available from http://experiential-researchers.org/instruments/elliott/changei.html.

Elliott, R., Fischer, C. & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215-229.

Elliott, R. (2001). Hermeneutic single case efficacy design: an overview. In K.J. Schneider, J. Bugental and J.F. Pierson (Eds), *The Handbook of Humanistic Psychology: Leading Edges in Theory, Research and Practice*. Thousand Oaks, CA: Sage.

Elliott, R. (2002). Hermeneutic single case efficacy design. *Psychotherapy Research, 12,* 1-20.

Elliott, R.E., Watson, J.C., Goldman, R.N. & Greenberg, L.S. (2004). *Learning emotion-focused therapy*. Washington: APA Books.

Feyerabend, P. (1993). *Against method.* London: Verso.

Finke, J. (2002). Aspects of the acutalizing tendency from a humanistic psychology perspective. *Person-Centred and Experiential Psychotherapies, 1*(1-2), 28-40.

Fives, A., Russell, D.W., Kearns, N., Lyons, R., Eaton, P. Canavan, J….O'Brien, A. (2013). The role of random allocation in randomised controlled trials:

distinguishing selection bias from baseline imbalance. *Journal of Multidisciplinary Evaluation, 9*(20), 33-42.

Flitton, B. & Buckroyd, J. (2005). Counselling children and young people who attend a school for children with complex needs: a case study. *Counselling and Psychotherapy Research, 5*(2), 131-137.

Flyvbjerg, B. (2006). Five misunderstandings about case study research. *Qualitative Inquiry, 12,* 219-245.

Freake, H., Barley, V. & Kent, G. (2007). Adolescents' views of helping professionals: A review of the literature. *Journal of Adolescence, 30*, 639-653.

Freire, E., Elliott, R., & Westwell, G. (2010). *Development and validation of an adherence/competence measure for person-centred and experiential psychotherapies*. Paper presented at the 8th World Conference for Person-Centred and Experiential Psychotherapy and Counselling.

Geller, B., Zimerman, B., Williams, M., Bolhofner, K., & Craney, J. L. (2001). Adult psychosocial outcome of prepubertal major depressive disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 673–677.

Glaser, B.G. & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Glaser, B.G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: The Sociology Press.

Goodman, R., Meltzer, H., & Bailey, V. (1998). The strengths and difficulties questionnaire: A pilot study on the validity of the self-report version. *European Child and Adolescent Psychiatry, 7*, 125-130.

Goodman, R. (2001). Psychometric properties of the strengths and difficulties questionnaire (SDQ). *Journal of the American Academy of Child and Adolescent Psychiatry*, *40*, 1337-1345.

Goodwin, R.D., Davidson, K.W., Keyes, K. (2009). Mental disorders and cardiovascular disease among adults in the United States. *Journal of Psychiatric Research*, *43*(3), 239–46.

Gould, M.S., King, R. Greenwald, S., Fisher, P., Schwab-Stone, M., Kramer, R., …Shaffer, D. (1998). Psychopatholgy associated with suicidal ideation and attempts among children and adolescents. *Journal of American Academy of Child & Adolescent Psychiatry*, *37*(9), 915-923.

Gowers, S.G., Harrington, R.C., Whitton, A., Beevor, A., Lelliott, P., Jezzard, R., & Wing, J. (1999). Health of the nation outcome scales for children and adolescents (HoNOSCA). Glossary for HoNOSCA score sheet. *British Journal of Psychiatry*, *174*, 428-431.

Green, H., McGinnity, A., Meltzer, H., Ford, T. & Goodman, R. (2004). *Mental health of children and young people in Great Britain*. London: Office of National Statistics.

Griffiths, G. (2013). *A systematic review of young people's experiences of helpful and unhelpful factors in school-based counselling*. (Unpublished thesis). University of Strathclyde and Glasgow Caledonian University, UK.

Guest, G., MacQueen, K.M. & Namey, E.E. (2012) *Applied thematic analysis*. London: Sage.

Hanley, T., Sefi, A., & Lennie, C. (2011). Practice-based evidence in school-based counselling. *Counselling and Psychotherapy Research, 11*, 300-309.

Hanley, T., Barlow, A., Humphrey, N., Jenkins, P. & Wigelsworth, M. (2012). *A scoping review of the access to secondary school counselling*, Lutterworth: BACP internal document.

Harris, B. (2013). *Counselling MindEd scoping review of school counselling internationally* (unpublished report). Counselling MindEd.

Hedges, L.V., & Olkin, I. (1985). *Statistical methods for meta-analysis*. Boston: Academic Press.

Hill, A., Cooper, M., Pybis, J., Cromarty, K., Pattison, S., Spong, S., … Maybanks, N. (2011). *Evaluation of the Welsh school-based counselling strategy*. Cardiff: Welsh Government Social Research.

Hölldampf, D., Behr, M., & Crawford, I. (2010). Effectiveness of person-centred and experiential psychotherapies with children and young people: A review of outcome studies. In M. Cooper, J.C. Watson, & D. Hölldampf (Eds.), *Person-centred and experiential therapy works: A review of the research on counselling, psychotherapy and related practices* (pp. 16-44). Ross-on-Wye: PCCS.

Holtforth, M.G., & Grawe, K. (2002). Bern inventory of treatment goals: Part 1. Development and first application of a taxonomy of treatment goal themes. *Psychotherapy Research, 12*, 79-99.

Hume, D. [1739-1740] (1969). *A treatise of human nature*. London: Penguin.

Hutchinson, D. & Styles, B. (2010). *A guide to running randomised controlled trials for educational researchers*. Slough: NFER.

Jenkins, P., & Polat, F. (2005). *The current provision of counselling services in secondary schools in England and Wales*. University of Manchester.

Kant, I. (1781). *Critique of pure reason*. USA: Hackett.

Kaplan, D.W., Calonge, B.N., Guernsey, B.P. & Hanrahan, M.B. (1998). Managed care and school-based health centers: Use of health services. *Archives of Pediatrics and Adolescent Medicine, 152*(1), 25-33.

Kazdin, A.E. (2004). Psychotherapy for children and adolescents. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behaviour change* (5th ed., pp. 543-589). Chicago: John Wiley and Sons.

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*, 593-602.

Kovacs, M. (1997). Depressive disorders in childhood: An impressionistic landscape. *Journal of Child Psychology and Psychiatry, 38*, 287-298.

Krautter, T.H. & Lock, J. (2004). Treatment of adolescent anorexia nervosa using manualized family-based treatment. *Clinical Case Studies, 3*, 107.

Lambert, M.J., Whipple, J.L., Smart, D.W., Vermeersch, D.A., Nielsen, S.L. & Hawkins, E,J. (2001). The effects of providing therapists with feedback on

patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research, 11*, 49-68.

Lambert, M.J., & Ogles, B.M. (2004). The efficacy and effectiveness of psychotherapy. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behaviour change* (5th ed., pp. 139-193). Chicago: John Wiley and Sons.

Lambert, M.J., Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy, 48*(1), 72-79.

Lambert, M.J. (2013). *How to double client outcomes in 18 seconds: Using mental health vital signs feedback and problem-solving tools*. Keynote presentation at the 19th BACP Research Conference.

Law, D. (2011). *Goals and goal-based outcomes (GBOs): Some useful information*. Internal CORC publication. Available at: www.corc.co.uk.net .

Lipsey, M. W., & Wilson, D. B. (2001). *Practical meta-analysis*. Thousand Oaks, CA: Sage Publications.

Luborsky, L., Diguer, L., Seligman, D.A., Rosenthal, R., Krause, E.D., Johnson, S.,...Schweizer, E. (1999). The researcher's own therapy allegiances: A ''wild card'' in comparisons of treatment efficacy. *Clinical Psychology: Science and Practice*, *6*(1), 95-106.

Lynass, R., Pykhtina, O., & Cooper, M. (2012). A thematic analysis of young people's experience of counselling in five secondary schools in the UK. *Counselling and Psychotherapy Research*, *12*(1), 53-62.

Maslow, A. (1943). A theory of human motivation. *Psychology Review, 50*, 370-396.

McArthur, K. (2011, September). RCTs: A personal experience. *Therapy Today*, *22*(7), 24-25.

McArthur, K., Cooper, M. & Berdondini, L. (2013). School-based humanistic counseling for psychological distress in young people: Pilot randomized controlled trial. *Psychotherapy Research, 23*(3), 355-365. doi:10.1080/10503307.2012.726750.

McCauley, E., Pavlidis, K. & Kendall, K. (2001). Developmental precursors of depression: The child and the social environment. In I.M. Goodyear (Ed.), *The depressed child and adolescent* (pp.46-78). Cambridge University Press.

McElearney, A., Adamson, G., Shevlin, M. & Bunting, B. (2013). Impact evaluation of a school-based counselling intervention in Northern Ireland: Is it effective for pupils who have been bullied? *Child Care in Practice, 19*(1), 4-22.

McKenzie, K., Murray, G.C., Prior, S. & Stark, L. (2011). An evaluation of a school counselling service with direct links to child and adolescent mental health (CAMH) services. *British Journal of Guidance and Counselling, 39*(1), 67-82.

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy.* London: Sage.

McLeod, J. (2010). *Case study research in counselling and psychotherapy*. London: Sage.

McLeod, J. (2013). Qualitative research: Methods and contributions. In M. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (6th ed., pp. 49-84). New Jersey: John Wiley and Sons.

Mearns, D. & Cooper, M. (2005). *Working at relational depth in counselling and psychotherapy*. London: Sage.

Mearns, D., & Thorne, B. (2007). *Person-centred counselling in action* (3rd ed.). London: Sage.

Moher, D., Schulz, K.F., & Altman, D.G. (2001). The CONSORT statement: Revised recommendations for improving the quality of reports of parallel-group randomised trials. *Lancet, 357*, 1191-1194.

Moses, T. (2009). Self-labeling and its effects among adolescents diagnosed with mental disorders. *Social Science & Medicine, 68*, 570-578.

Ogden, N. (2006). Interviews with clients regarding the impact of counselling on their studying and learning. In M. Cooper, *Counselling in Schools Project Phase II: Evaluation report*. Glasgow: Counselling Unit, University of Strathclyde. Available at http://strathprints.strath.ac.uk/26793/ .

Parry, G., Castonguay, L. G., Borkovec, T. D., & Wolf, A. (2010). Practice research networks and psychological services research in the UK and USA. In M. Barkham, G. Hardy & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence: A guide for the psychological therapies* (pp. 311-325). Chichester: John Wiley.

Patterson, T.G., & Joseph, S. (2007). Person-centred personality theory: Support from self-determination theory and positive psychology. *Journal of Humanistic Psychology*, *47*, 117-139. doi:10.1177/0022167806293008.

Pattison, S. & Harris, B. (2006). Counselling children and young people: A review of the evidence for its effectiveness. *Counselling and Psychotherapy Research, 6*(4), 233-237.

Pearce, P., Sewell, R. & Osman, S. (2013). *The ALIGN project: a randomised controlled trial of school-based person-centred counselling*. Paper presented at the 19th BACP Research Conference.

Posternak, M.A., & Miller, I. (2001). Untreated short-term course of major depression: a meta-analysis of outcomes from studies using wait-list control groups. *Journal of Affective Disorders*, *66*, 139-146. doi:10.1016/s01650327(00)003049.

Presbury, J.H., McKee, J.E., & Echterling, L.G. (2007). Person-centred approaches. In H.T. Prout & D.T. Brown (Eds.), *Counselling and psychotherapy with children and adolescents* (4th ed., pp. 180-240). Hoboken, NJ: John Wiley.

Prior, S. (2012). Overcoming stigma: how young people position themselves as counselling service users. *Sociology of Health & Illness*, *34*(5), 697-713.

Pybis, J., Cooper, M., Cromarty, K., Hill, A., Levesley, R., Murdoch, J. & Turner, N. (submitted). Small scale randomised controlled trial of school-based counselling for psychological distress in young people: Outcomes and methodological reflections. *Counselling and Psychotherapy Research*.

Ray, D.C., Bratton, S.C., Rhine, T. & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy, 10*(1), 85-08.

Rennie, D.L., Phillips, J.R. & Quartaro, G.K. (1988). Grounded theory: A promising approach to conceptualization in psychology? *Canadian Psychology*, *29*, 139-150.

Rennie, D.L. (1990). Towards a representation of the client's experience of the psychotherapy hour. In G. Lietaer, J. Rombauts & R. Van Balen (Eds.), *Client-centered and experiential therapy in the nineties* (pp. 155-172). Leuven, Belgium: Leuven University Press.

Rennie, D.L. (1992). Qualitative analysis of the client's experience of psychotherapy: The unfolding of reflexivity. In S.G. Toukmanian & D.L. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 211-233). London: Sage.

Rennie, D.L. (1994). Clients' deference in psychotherapy. *Journal of Counseling Psychology*, *41*, 427-37.

Ridner, S.H. (2004). Psychological distress: concept analysis. *Journal of Advanced Nursing*, *45*, 536-545.

Rogers, C.R. (1951). *Client-centered therapy: Its current practice, implications and theory*. London: Constable.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*, 95-103.

Rogers, C.R. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of science* (Vol. 3, pp. 184-256). New York: McGraw-Hill.

Rogers, C.R. (2007). The basic conditions of the facilitative therapeutic relationship. In M. Cooper, M. O'Hara, P.F. Scmid & G. Wyatt (Eds), *The Handbook of Person-Centred Psychotherapy and Counselling* (pp. 1-6). Hampshire: Palgrave Macmillan.

Rogers, A., Maidman, J., House, R. (2011, July). The bad faith of 'evidence-based practice': Beyond counsels of despair. *Therapy Today, 22*(6), 26-29.

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.

Roth, A. & Fonagy, P. (2004). *What works for whom? A critical review of psychotherapy research* (2nd ed.). New York: Guilford Press.

Roth, A., & Pilling, S. (2007). *The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders*. University College London.

Roth, A., Hill, A., & Pilling, S. (2009). *The competences required to deliver effective humanistic psychological therapies*. University College London.

Rupani, P., Haughey, N. & Cooper, M. (2012). The impact of school-based counselling on young people's capacity to study and learn. *British Journal of Guidance and Counselling, 40*(5), 499-514.

Ryan, R.M., & Deci, E.L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55, 68-78.

Sackett, D.L., Straus, S.E., Richardson, W.S., Rosenberg, W. & Hayes, R.B. (2000). *Evidenced-based medicine: How to practice and teach EBM* (2nd ed.) London: Churchill Livingstone.

Safran, J., Greenberg, L.S. & Rice, L. (1988). Integrative psychotherapy research and practice: Modeling the change process. *Psychotherapy, 25*, 1-17.

Sanders, P. (2007). The 'family' of person-centred and experiential therapies. In M. Cooper, M. O'Hara, P.F. Scmid & G. Wyatt (Eds), *The Handbook of Person-Centred Psychotherapy and Counselling* (pp. 9-18). Hampshire: Palgrave Macmillan.

Sartre, J.P. (1945). *Existentialism and humanism*. London: Methuen.

Saunders, J.B. & Rey, J.M. (2011). *Young people and alcohol: Impact, policy, prevention, treatment*. Oxford: Blackwell.

Schapman-Williams, A.M. & Lock, J. (2007). Using cognitive-behavioral therapy to treat adolescent-onset bulimia nervosa: A case study. *Clinical Case Studies, 6*, 508.

Schwabe, L. & Wolf, O.T. (2010). Learning under stress impairs memory formation. *Neurobiology of Learning and Memory*, *93*(2), 183-188.

SDQ. (2009). *Scoring the self-report strengths and difficulties questionnaire*. Retrieved 13 May 2009, from http://www.sdqinfo.com/py/doc/c0.py.

Shaffer, D., Gould, M.S., Fisher, P., Trautman, P., Moreau, D., Kleinman, M. & Flory, M. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry, 53*(4), 339-348.

Sheldon, K.M., & Kasser, T. (1998). Pursuing personal goals: Skills enable progress, but not all progress is beneficial. *Personality and Social Psychology Bulletin, 24*, 1319-1331.

Sheldon, K.M., & Elliot, A.J. (1999). Goal striving, need satisfaction, and longitudinal well-being: The self-concordance model. *Journal of Personality and Social Psychology*, *76*, 482-497. doi:10.1037/00223514.76.3.482.

Sheldon, K.M., & Kasser, T. (2001). Goals, congruence, and positive well-being: New empirical support for humanistic theories. *Journal of Humanistic Psychology*, *41*, 30-50. doi:10.1177/0022167801411004.

Shimokawa, K., Lambert, M.J. & Smart, D.W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-analytic review of psychotherapy quality assurance system. *Journal of Consulting and Clinical Psychology, 78*, 298-311.

Silverman, W. (2001). Editorial: Clinicians and researchers: A bridge to nowhere? *Psychotherapy: Theory, Research, Practice, Training, 38*, 249-251.

Simon, W., Lambert, M.J., Harris, M.W., Busath, G. & Vazquez, A. (2012). Providing patient progress information and clinical support tools to therapists: Effects on patients at risk for treatment failure. *Psychotherapy Research, 22*, 638-647.

Simon, W., Lambert, M.J., Busath, G., Vazquez, A., Berkeljon, A., Hyer, K., … Berrett, M. (2013). Effects of providing patient progress feedback and clinical support tools to psychotherapists in an inpatient eating disorders treatment program: A randomized controlled study. *Psychotherapy Research*, doi: 10.1080/10503307.2013.787497.

Skinner, B.F. (1974). *About behaviourism*. London: Jonathan Cape.

Stiles, W.B. (1993). Quality control in qualitative research. *Clinical Psychology Review, 13,* 593-618.

Stiles, W. B., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies in UK primary-care routine practice: replication in a larger sample. *Psychological Medicine, 38*(5), 677-688.

Stinckens, N. Lietaer, G. & Leijssen, M. (2013). Working with the inner critic: Therapeutic approach. *Person-Centered & Experiential Psychotherapies, 12*(2), 141-156.

Swift, J.K., Callahan, J.L., & Vollmer, B.M. (2011). Preferences. *Journal of Clinical Psychology*, *67*, 155-165.

Timulak, L. (2003). Empowerment events in process-experiential psychotherapy of depression: An exploratory qualitative analysis. *Psychotherapy Research, 13*(4), 443-460.

Timulak, L. (2007). Identifying core categories of client identified impact of helpful events in psychotherapy. A qualitative meta-analysis. *Psychotherapy Research, 17,* 305-314.

Timulak, L., Belicova, A & Miller, M. (2010). Client identified significant events in a successful therapy case: The link between the significant events and outcome. *Counselling Psychology Quarterly, 23*(4), 371-386.

Torgerson, D.J., & Torgerson, C.J. (2008). *Designing randomised controlled trials in health, education and the social sciences: An introduction*. Basingstoke: Palgrave.

Tracey, A., McElearney, A., Adamson, G. & Shevlin, M. (2009). Practitioners' views and experiences of participating in a school counselling evaluation study. *Counselling and Psychotherapy Research, 9*(3), 193-203.

Tryon, G.S., & Winograd, G. (2002). Goal consensus and collaboration. In J.C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 109-125). New York: Oxford University Press.

Twigg, E., Barkham, M., Bewick, B.M., Mulhern, B., Connell, J. & Cooper, M. (2009). The young person's CORE: Development of a brief outcome measure for young people. *Counselling and Psychotherapy Research, 9*(3), 160-168.

Upshur, R.E.G. (2005). Looking for rules in a world of exceptions: Reflections on evidence-based practice. *Perspectives in Biology and Medicine, 48*, 477-489.

Wachtel, P.L. (2010). Beyond "ESTs" problematic assumptions in the pursuit of evidence-based practice. *Psychoanalytic Psychology, 27*, 251-272.

Warner, M. S. (2000). Person-centered psychotherapy: one nation many tribes. *Person-Centered Journal, 7*(1), 28-39.

Wasserman, D., Cheng, Q. & Jiang, G. (2005). Global suicide rates among young people aged 15-19. *World Psychiatry, 4* (2), 114-120.

Weissman, M. M., Wolk, S., Goldstein, R. B., Moreau, D., Adams, P., Greenwald, S. … Wickramaratne, P. (1999). Depressed adolescents grown up. *Journal of the American Medical Association, 281,* 1707–1713.

Weisz, J.R., Weiss, B., Han, S.S., Granger, D.A., & Morton, T. (1995). Effects of psychotherapy with children and adolescents revisited -a meta-analysis of treatment outcome studies. *Psychological Bulletin, 117*, 450-468.

Wheeler, S. & Elliott, R. (2008). What do counsellors and psychotherapists need to know about research? *Counselling and Psychotherapy Research 8*(2), 133-135.

World Health Organization. (2006). *The world health report*. Geneva: WHO.

World Health Organization (2010). *Mental health: strengthening our response*. Geneva: WHO.

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24*(2), 190-195.

Wisdom, J. & Green, C. (2004). 'Being in a funk': teens' efforts to understand their depressive experiences. *Qualitative Health Research, 14*(9), 1227-1238.

Woodward, L.J., & Fergusson, D.M. (2001). Life course outcomes of young people with anxiety disorders in adolescence. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*, 1086-1093.

Yalom, I.D. and Elkin, G. (1974). *Every day gets a little closer: A twice-told therapy*. New York: Basic Books.

10. Appendices

10.3 Adapted Client Change Interview – Counselling

1. GENERAL QUESTIONS: [ABOUT 5 MIN]

1a. How are you doing now in general?

1b. What has counselling been like for you so far? How has it felt to be in counselling?

2. CHANGES: [ABOUT 10 MIN]

2a. What changes, if any, have you noticed in yourself since your counselling started? *(Interviewer: Reflect back change to client and write down brief versions of the changes for later. If it is helpful, you can use some of these follow-up questions: For example, are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from therapy so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)*

2b. Has anything changed for the worse for you since your counselling started?

2c. Is there anything that you wanted to change that hasn't since your counselling started?

3. CHANGE RATINGS: [ABOUT 5-10 MIN] *(RATE SIGNIFICANCE OF EACH CHANGE ON THE FOLLOWING SCALE:)*

3a. How important or significant to you personally do you think that these changes have been? (Use this rating scale:)

(1) Slightly important

(2) Pretty important

(3) Very important

(4) Extremely important

(5) Maximum possible importance

3b. Can you tell me something about how these changes have been significant in your life?

4. ATTRIBUTIONS: [ABOUT 5-10 MIN]

In general, what do you think has caused the various changes you described? In other words, what do you think might have brought them about? (Including things both outside of therapy and in therapy). Are there things about yourself that you think have helped or have been unhelpful? Are there things in your life (family, job, relationships, living arrangements) that have helped or have been unhelpful?

5. HELPFUL ASPECTS: [ABOUT 10 MIN]

Can you sum up what has been helpful about your counselling so far? Please give examples. (For example, general aspects, specific events)

6. PROBLEMATIC ASPECTS: [ABOUT 5 MIN]

6a. What kinds of things about the counselling have been unhelpful, negative or disappointing for you? (For example, general aspects. specific events)

6b. Were there things in the counselling which were difficult but still OK or perhaps helpful? What were they?

6c. Has anything been missing from your treatment? (What would make/have made your counselling more effective or helpful?)

7. THE RESEARCH:. [ABOUT 5 MIN]

What has it been like to be involved in this research? (Initial screening, research interview, completing questionnaires etc)

8. SUGGESTIONS: [ABOUT 5 MIN]

Do you have any suggestions for us, regarding the research or the counselling? Do you have anything else that you want to tell me? Is there anything that I should have asked in this interview that I have left out?

10.5 Adapted Client Change Interview – Waiting List

1. GENERAL QUESTIONS: [ABOUT 5 MIN]

1a. How are you doing now in general?

1b. What has it been like for you so far waiting for counselling?

2. CHANGES: [ABOUT 10 MIN]

2a. What changes, if any, have you noticed in yourself since your first assessment? *(Interviewer: Reflect back change to client and write down brief versions of the changes for later. If it is helpful, you can use some of these follow-up questions: For example, are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from therapy so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)*

2b. Has anything changed for the worse for you since your assessment?

3. CHANGE RATINGS: [ABOUT 5-10 MIN] *(RATE SIGNIFICANCE OF EACH CHANGE ON THE FOLLOWING SCALE:)*

3a. How important or significant to you personally do you think that these changes have been? (Use this rating scale:)

(1) Slightly important

(2) Pretty important

(3) Very important

(4) Extremely important

(5) Maximum possible important

3b. Can you tell me something about how these changes have been significant in your life?

4. ATTRIBUTIONS: [ABOUT 5-10 MIN]

In general, what do you think has caused the various changes you described? In other words, what do you think might have brought them about? Are there things about yourself that you think have helped or have been

unhelpful? Are there things in your life (family, job, relationships, living arrangements) that have helped or have been unhelpful?

5. SUPPORT

What support for your emotional problems have you accessed since participating in the assessment? (e.g. pastoral care support, seeing the GP). How helpful or unhelpful has this been?

6. <u>THE RESEARCH:</u>. [ABOUT 5 MIN]

What has it been like to be involved in this research so far? (Initial screening, assessment interview etc)

7. <u>SUGGESTIONS:</u> <u>[ABOUT 5 MIN]</u>

Do you have any <u>suggestions</u> for us, regarding the research on the counselling? Do you have <u>anything else</u> that you want to tell me? Is there anything that I should have asked in this interview that I have left out?

10.8 Trial summary for schools

Pilot Randomised Controlled Trial - School Counselling vs. Waiting List

Background

To date, there has been no fully powered randomised controlled trial (RCT) of school counselling for emotional distress. However, a team of researchers from the University of Strathclyde, Newcastle University and the British Association for Counselling and Psychotherapy have recently completed a pilot randomised controlled trial to test the feasibility of a procedure for carrying out such a study. Incorporating a screening process to recruit participants, this pilot demonstrated feasibility and potential for extending to a fully powered RCT. The currently proposed pilot will build on these findings, aiming to test the feasibility of an alternative recruitment procedure and extended intervention period. It is anticipated that this will lead to a main RCT using the same procedures. The current study is part of a 3-year PhD by Katherine McArthur, supervised by Professor Mick Cooper.

Setting

- Glasgow secondary schools with no existing counselling service

Process

- Pastoral care team briefed on study and encouraged to refer appropriate pupils, with reference to the inclusion criteria
- Opt-out parental assent letters posted at least 1-2 weeks in advance of assessment period
- Referred pupils meet researcher for one-to-one assessment
- Eligible pupils randomised to either counselling or waiting list

Inclusion criteria

- Motivated to have counselling
- In emotional distress (measured by researcher during assessment)
- Able to attend sessions for one school term (e.g. not moving school, attendance ≥80%)
- Not at risk of significant harm to self or other
- Not having counselling elsewhere

Counselling

- One-to-one sessions with a counsellor in school time for duration of term
- Sessions audio recorded

Waiting list

- No counselling during intervention period
- Support from pastoral care as usual
- Offered counselling beginning in the following school term

Initial assessment

- Study explained and eligibility checked (including risk assessment)
- Questionnaires completed: YP-CORE
  Strengths & Difficulties Questionnaire
  Goal-based Outcome Measure
  Self-Esteem Questionnaire
- If not eligible, referred back to pastoral care team.

Mid point interview (approximately middle of school term)

- One-to-one meeting with researcher
- Questionnaires completed
- Risk assessment
- Qualitative interview on experience of counselling/waiting list

End point interview (ideally last week of school term)

- One-to-one meeting with researcher
- Questionnaires completed
- Risk assessment
- Qualitative interview on experience of counselling/waiting list
- Waiting list pupils offered appointment with counsellor at beginning of following school term

10.9 Information for School Staff

Efficacy of counselling in schools: Pilot randomised controlled trial

For further information, please contact:

Katie McArthur (researcher), 0141 950 3143, katherine.mcarthur@strath.ac.uk
Mick Cooper (chief investigator), 0141 950 3361, mick.cooper@strath.ac.uk

REFERRING PUPILS TO THE STUDY
(Pastoral care team)

We are looking for pupils who are:

- Aged 13 – 18
- Interested in having counselling
- Capable of informed consent
- Able to attend sessions (i.e. not moving school and at least 80% attendance)
- Not having counselling elsewhere
- Not at risk of harming themselves or others
- Emotionally distressed.

We will be measuring emotional distress using the following 5 items which are taken from a well-validated questionnaire for young people, the Strengths and Difficulties Questionnaire (SDQ).

Pupils who agree with the following statements will score highly on the emotional distress subscale of the questionnaire and will be eligible to take part in the study.

- I get a lot of headaches, stomach-aches or sickness
- I worry a lot
- I am often unhappy, down-hearted or tearful
- I am nervous in new situations. I easily lose confidence
- I have many fears, I am easily scared

FACILITATING ASSESSMENT & COUNSELLING

1. Speak with any pupils who seem appropriate for the study to establish whether they might want to have counselling.
2. Explain the study briefly and offer the pupil the opportunity to meet the researcher during one school period for an assessment.
3. In liaison with the researcher, set up appointments for assessments.
4. If pupils are eligible for the study, liaise with researcher and counsellor to set up appointments for counselling sessions as appropriate.
5. If necessary, discuss alternative options with any pupil who is not eligible to take part in the study.

10.10 Parental Assent Letter

Date

Counselling in schools: A pilot randomised controlled trial

Request for Parental Assent

Dear Parent/Guardian

We are writing to you to inform you of a small pilot research study that will be conducted in the school over the next year. This work will be a further contribution to everything we already do to support the emotional well being of our pupils. We are working with an experienced group of academics and professionals at the University of Strathclyde to conduct a study of school counselling. The study intends to examine whether counselling is helpful for school pupils experiencing emotional difficulties.

Pupils will be referred to the study by the pastoral care team if they express an interest in talking to a counsellor. A researcher will explain the study to them and check that they are eligible to take part. Pupils who explicitly agree to participate in the study will then be randomly allocated to receive counselling either this term or next term. Neither the school nor the researchers will have any influence over which students will have counselling offered immediately and which will not.

The counselling for this study will be to a high professional standard, and the rules of confidentiality will operate within child protection guidelines.

At each stage of this study, pupils will be given full information about what they are being asked to do, and will only be invited to take part if they have given their signed consent to do so. However, if you do not want your child to take part in any aspect of this study, please let us know as soon as possible.

If you have any queries about this study, please do not hesitate to contact us.

Yours faithfully

[Name of Head Teacher] [Name of Pastoral Care Teacher]

10.12Consent Form for Young People

Consent form for pupils

I have read the 'Information Sheet for Pupils' for the School Counselling Study and any questions I have were answered to my satisfaction. I am aware of what taking part in this study involves, and that there is a small risk that I may feel more anxious or upset as a consequence of being asked questions, completing questionnaires and participating in counselling.

I understand that:

- I don't have to take part in this study.
- If I do agree to take part, I can stop taking part at any time without having to say why.
- If I decide not to take part in some or all of this study this will not affect me in any way.
- After taking part in this study, I can ask for the answers that I have given to be withdrawn.
- All the information I give will be treated with the utmost confidentiality and my anonymity will be respected at all times.
- Anonymised data may be kept for an unlimited period and used for future research projects, unless I ask for it to be withdrawn.

I Consent to be a participant in the project:

Name:…… Date: ……