The Change Process in Clients with High Needs

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ABSTRACT

This study examined the outcome of extended counselling sessions at a community counselling centre. Participants were 38 female and 7 male clients who were categorized as dealing with one of the following issues: trauma, multiple acute issues, complicated grief, or support while waiting for referral. Results showed a significant lessening of symptoms and increase in coping skills between sessions 12 and 24 for all clients. Having previous counselling was significantly related to magnitude of change on the Target Complaint change score. Through qualitative analyses, trauma and nontrauma clients described similar types of change from counselling: gaining insight, experiencing feelings, counselling relationship, self-growth, and new ways of being. However, some differences were apparent in the way that these categories were discussed by the trauma and nontrauma clients.

RÉSUMÉ

Cette étude a examiné les résultats des séances de counseling prolongées à un centre de conseil communautaire de counseling. Les participants consistaient de 38 clientes et 7 clients classés selon un des facteurs suivants : traumatisme, multiples problèmes aigus, deuil compliqué, ou soutien en attendant d'être référé. Les résultats ont démontré une diminuation significative de symptômes et une augmentation dans les habiletés d'adaptation entre séance 12 et 24 pour tous les clients. L'ampleur du changement dans le taux de changement *Target Complaint* était reliée de façon significative au fait d'avoir eu de l'expérience antérieure de counseling. Lors des analyses qualitatives, les clients ayant vécu ou non un traumatisme ont décrit des types similaires de changement avec le counseling : gain d'intéroception, expérience de sentiments, relation de counseling, développement de soi, et nouvelles manières d'être. Cependant, certaines différences ont été identifiées dans la façon de discuter ces catégories par les clients ayant vécu ou non un traumatisme.

Research in the area of time-limited counselling is extremely relevant to the current conditions in our society. With budget cuts and increased demand for therapy, time-limited therapy (also known as short-term or solution-focused therapy) is becoming commonplace in community agencies (Barkham, Shapiro, Hardy, & Rees, 1999). Many people who seek counselling cannot afford the costs associated with therapy, which limits treatment accessible to them. Although this shift toward brief therapy is necessary to allow for more accessibility to counselling, there are some clients (e.g., trauma, multiple acute issues, complicated grief) who would benefit from extended counselling sessions.

The goal of the current study was to investigate the change process from the perspective of clients who received an extended number of counselling sessions because of dealing with deep issues. Although many variables are involved in the

change process in counselling, we chose to focus on three aspects of change that are important for clients and counsellors who are engaged in brief counselling: symptom reduction, coping skills, and clients' perception of why change occurred for them. For counselling to be considered effective, clients usually experience a reduction in their symptoms. As well, a decrease in symptoms often occurs when clients acquire new coping skills during counselling sessions. Finally, examining the understandings of both trauma and nontrauma clients about what contributed to their change in counselling should provide helpful information for clinicians about the change process.

Trauma

A traumatic event (e.g., physical or sexual harm, verbal abuse, or witnessing a violent act) can have serious detrimental effects on people for the rest of their lives if it is not effectively treated (Bills, 2003; Ehlers & Clark, 2000). In many cases, survivors of trauma feel they have lost their sense of control and safety (Herman, 1992). Their relationships and connections with their family, friends, and community become strained as the survivors have problems trusting others. They experience their previous knowledge and beliefs as no longer holding truth because they have to reevaluate what it means to live in a world where terrible, hurtful things can happen (Ehlers & Clark, 2000).

Briere (2002) suggests that the goals of therapy with trauma survivors should be to desensitize and integrate traumatic memories, strengthen and restore coping resources within the client, and eliminate intrusive or avoidant symptoms. In order to complete successful treatment, Briere recommends that therapy consist of regular sessions for a lengthy period of time. The time period required will vary depending on clients' symptoms related to trauma. These symptoms include disturbed affect, use of avoidance, cognitive disturbance, and severe negative relational schema. Because of the complexity of the impact of trauma on clients, it is difficult to deal effectively with it in brief therapy.

Symptoms

It is well documented that after a traumatic event or complicated grief, many survivors of trauma experience problematic symptoms (Ehlers & Clark, 2003). These symptoms can be quite intrusive and interfere with survivors' lives. In fact, a desire to decrease symptoms associated with trauma may be one reason people seek counselling. Previous research has shown that after experiencing a traumatic event, it is common for many people to exhibit a constellation of posttraumatic stress symptoms (Cason, Resick, & Weaver, 2002; Ehlers & Clark, 2003). A review of literature by Foa and Meadows (1997) found symptoms of posttraumatic stress included reexperiencing (nightmares and flashbacks), avoidance/numbing (staying away from anything related to the trauma), and increased arousal (difficulty sleeping and irritability). Ehlers and Clark (2000) developed a cognitive model to explain symptoms of posttraumatic stress as occurring when survivors of trauma view a past event as a continuing and current threat. The perceived current threat

might be explained by negative appraisals of the trauma (e.g., world is no longer seen as a safe place) and disturbances in memory (e.g., poor intentional recall of the traumatic event and intrusive reliving of the event through flashbacks and nightmares).

Coping

Besides wanting to reduce symptoms, clients often seek counselling because they have been unable to resolve issues in their lives. These issues may continue to cause distress when clients lack coping skills or have developed ineffective coping styles. Thus, one goal of counselling is to help clients learn more effective coping styles. One of the most influential contributors to research on coping styles are Folkman and Lazarus (1988), who theorized that coping styles include strategies that are both problem- and emotion-focused, which vary depending on people's perceived control of situations.

Research on coping styles has focused on how they affect psychological and physical states. Effective coping styles such as problem solving aid in resolving client issues by helping clients learn to work through emotional pain. If clients are able to learn more effective coping styles during counselling sessions, the result is likely to be a change in their affect by the conclusion of therapy (Heppner & Lee, 2002). In other words, counselling allows clients to reflect and discover new ways to deal with stressful situations. The current study will investigate whether endorsement of effective coping styles increases at the conclusion of counselling.

Change Process in Counselling

In order for effective client coping styles to increase and client symptoms to decrease, clients need to be actively involved in a change process. Although there are many models of the change process in counselling, one model that is particularly applicable to a study investigating extended sessions for clients is the dosage and phase model of psychotherapeutic effectiveness (Howard, Moras, Brill, Martinovich, & Lutz, 1996). These authors propose a linear relationship between the log of the number of sessions and the normalized probability of client improvement. In other words, more efforts or sessions are needed to effect more change in a response or symptom. They conceptualize this change occurring over three phases: (a) remobilization when clients are helped to mobilize their coping resources, (b) remediation where clients' coping skills are refocused to effect symptomatic relief, and (c) rehabilitation that focuses on unlearning maladaptive behaviours and learning new ways of coping. In plotting improvement in mental health for a number of clients, Howard et al. most often found an increase over the first eight sessions. However, there were even more gains in mental health between sessions 8 and 20 or 8 and 40.

While the Howard et al. (1996) model describes general change in therapy, a theory of change specifically related to trauma survivors was developed by Herman (1992). She believes that recovery is only able to occur through relationships, including the therapeutic relationship. Similar to Howard et al., Herman suggests

a three-stage model of recovery, and thus change: (a) safety, where clients first need to feel safe before they can deal with their trauma; (b) remembrance and mourning, when survivors tell stories of their trauma and mourn the many losses resulting from it; and (c) reconnection with ordinary life, when clients view and interact with the world in less negative ways, build new relationships, and find new beliefs.

Both of these models delineate a change process in therapy that is complex and dynamic, making it difficult to find empirical validation for them. Several researchers have attempted to do so through two qualitative studies (Cummings & Hallberg, 1995; Cummings, Hallberg, & Slemon, 1994) of short-term counselling with female university clients. Their results indicated three patterns of change: consistent change, interrupted change, and minimal change. The difficulty with these studies is that the short number of sessions did not allow for deep level of processing of client issues, nor for the stages hypothesized by Herman (1992) and Howard et al. (1996) to appear. Additional research has focused on specific components of the change process. For example, in a study of longer-term individual counselling (Jinks, 1999), clients identified three areas of the counselling process as being fundamental to their change process: the therapeutic relationship, specific skills used by the counsellor, and key moments of the counselling sessions.

Although a few studies have investigated a general change process in therapy, very few studies have researched change in symptoms of trauma survivors in therapy. In a study of survivors of childhood sexual abuse who received group therapy, Morgan and Cummings (1999) found participants showed significant decreases after 20 sessions on measures of depression, self-blame, social maladjustment, and posttraumatic stress symptoms. However, more research is needed to understand how change for trauma survivors in individual therapy occurs.

RATIONALE AND RESEARCH QUESTIONS

Research on the change process to date has several weaknesses, including lack of investigation on the process of change for trauma survivors, assessing change through a single approach, and few clinical samples. The current research intends to address some of these weaknesses by comparing the process of change for trauma survivors versus nontrauma clients in a clinical setting and by assessing client change both qualitatively and quantitatively. The counselling agency that participated in the research was mandated to provide a maximum of 12 sessions to all clients. They had recently received funding to provide 12 additional sessions to a limited number of high-needs clients (e.g., trauma, multiple acute issues, complicated grief). Thus, the focus of the research was to determine how change occurred for these clients between sessions 12 and 24.

It was hypothesized that there would be a lessening of symptoms and an increase in coping skills from session 12 to session 24. The study also investigated whether there were differences between trauma and nontrauma clients in symptom reduction and ways of coping. In addition, the relationship of client demographic

variables (gender, age, previous counselling) with coping strategies and symptoms at the beginning of counselling and with magnitude of change in these variables at the completion of counselling was examined. The final research question assessed whether changes identified by clients at the end of counselling were similar or different for the two groups.

METHOD

Participants

Participants were 38 female and 7 male clients who received counselling from a community counselling centre in Southwestern Ontario. The sample was predominantly Caucasian with six clients born outside of Canada. Clients were invited by counsellors to participate based on their need for 12 additional sessions of counselling beyond the 12 sessions normally provided by the centre. Clients were categorized by the agency as one of the following issues: (a) trauma (28 clients dealing with abuse); (b) multiple acute issues (6 clients with multiple issues such as alcoholism, job loss, conflicts); (c) complicated grief (8 clients grieving loss of loved one or way of life); and (d) support while waiting for referral elsewhere (3 clients). For the purpose of analyses, clients were combined into two groups: trauma (28; 3 men, 25 women) and other client issues (17; 4 men, 13 women). Mean age of the clients was 39, with a range of 18–69 years. The majority of clients (36) had received previous counselling. Clients completed an average of 23.6 sessions with a range of 16–24 sessions. The attrition rate was 39%. Of 74 clients who completed measures at session 12, 19 clients dropped out of counselling and the study (some because of moving out of town) before session 24. Of the 55 who completed 24 sessions, research data was received from 45 clients (either because counsellors did not give the posttest instruments or clients dropped out of the research).

Counsellors

There were eight counsellors (seven women and one man). Six counsellors had Master's degrees in counselling, social work, or marital and family therapy, and one counsellor was a Master of Counselling intern. Years of experience as a counsellor ranged from 0 (intern) to 28, with a mean of 13 years. Counsellors self-identified as using an eclectic blend of person-centred, feminist, spiritual, psychodynamic, and cognitive therapies. When appropriate, they also used techniques such as eye movement desensitization and reprocessing (EMDR), relaxation, grounding, and cognitive reframing.

Instruments

Hopkins Symptom Checklist (HSCL). The HSCL (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) is a self-report measure containing 58 items measuring general symptoms of distress rated on a 4-point Likert scale. The HSCL consists of five dimensions: somatization, obsessive-compulsive, interpersonal sensitivity,

depression, and anxiety. Total possible score is 232 with a high score indicating greater distress. The HSCL has been used extensively in counselling research and was included in the study to determine whether there was change in the types of symptoms that clients typically present in counselling. Derogatis et al. reported internal consistencies ranging from .84 to .87 for the five dimensions. Cronbach's Alpha for the total score for the current study was .95.

The Modified Posttraumatic Stress Symptom Scale Self-Report (MPSS-SR). The MPSS-SR (Resick, Falsetti, Resnick, & Kilpatrick, 1991) is a self-report scale containing 17 items measuring symptoms specific to trauma survivors. For each item, the frequency of the symptom is rated using a 4-point Likert scale and the severity of the symptom is rated on a 5-point Likert scale. Total possible scores are 68 for frequency and 75 for severity with a high score indicating greater distress. This instrument was included because we expected a large percentage of participants would be trauma survivors and thought it was important to examine change in symptoms specific to trauma and not included in the HSCL (e.g., nightmares, intrusive thoughts). Coffey, Dansky, Falsetti, Saladin, and Brady (1998) found internal consistency values of .95 for Severity and .94 for Frequency. Internal consistency for the current sample was .90 for Severity and .92 for Frequency.

Target Complaint Technique (TCT). The TCT (Battle et al., 1966) is a self-report measure for clients to rate two issues they are processing in counselling sessions on a 13-point Likert scale. Counsellors were asked to determine with clients two major goals for them to address in their 12 extra sessions. Counsellors wrote these goals at the top of the rating scale and clients then rated each goal for how much it currently bothered them. A higher score indicated that the issue was more problematic for the client. This instrument was included to augment information about change in general symptoms from the HSCL and MPSS-SR by showing whether clients improved on their specific client issues. Battle et al. report adequate test-retest reliability and concurrent validity with four other client outcome measures.

Ways of Coping Questionnaire (WOC). The WOC (Folkman & Lazarus, 1988) is a self-report measure rated on a 4-point Likert scale assessing coping strategies. For the purposes of this study, four of the eight most relevant subscales to counselling were used (26 items): seeking social support, escape-avoidance, planful problem solving, and positive reappraisal. Total possible score was 104 with a high score indicating more effective coping skills. The WOC has been used extensively in research and was included in the study because its subscales capture some of the typical strategies used by clients in dealing with their issues. Internal consistency reported by Folkman and Lazarus for the four subscales range from .68 to .79. Cronbach's Alpha for the total score in the current sample was .78.

Client Feedback Questionnaire (CFQ). The CFQ (Cummings, Leschied, & Rodger, 2003) is a self-report questionnaire with three questions about what changes clients saw in themselves and in their lives, and what in their counselling contributed to those changes. These answers were analyzed qualitatively.

Procedure

The researchers were asked by the agency to investigate the effectiveness of 12 additional counselling sessions for a group of high-needs clients. At the end of the 12th session, counsellors explained the research study to clients who fit the project criteria and gave them three questionnaires to complete: HSCL, WOC, and the TCT. Trauma clients received an additional questionnaire: MPSS-SR. At the end of the last session, counsellors provided clients with packets of the same three or four questionnaires and the CFQ. On the TCT, clients rated the same two issues that they had rated at the end of their 12th session. Because the agency provides service to almost 1,000 clients per year for a wide variety of issues, it was not possible to give the instruments to all clients at session 1 and then only use the data for the clients who continued for 24 sessions.

Qualitative analyses. For the question on changes in self, a coding manual by Cummings, Slemon, and Hallberg (1993) was used to categorize responses. The categories included (a) attaining personal insight; (b) experiencing or exploring feelings; (c) experiencing a good therapeutic relationship, counselling interventions, or counselling process; (d) praising self or acknowledging self-growth; and (e) identifying or experimenting with new ways of being. For the question on changes in clients' lives, the first author developed additional categories of life transitions, improved relationships, and improved health to describe other commonly occurring types of change. The first and third authors coded 25% of the responses, achieving an interrater reliability of 82% agreement. Differences in coding were resolved by consensus discussion.

RESULTS

Change in Symptoms, Coping Skills, and Client Issues

The hypothesis that there would be an increase in coping skills on the WOC and a decrease on the HSCL, TCT, and MPSS-SR from session 12 to the final session for all categories of clients was investigated using a 2 x 2 repeated-measures MANOVA with two levels of time as the within-subjects factor and two levels of client (trauma and nontrauma) as the between-subjects factor. There was a significant multivariate effect for time, $F(3,37) = 19.72$, $p < .001$. A*s* predicted, there was a significant univariate effect for HSCL, $F(1,39) = 6.94$, $p < .05$, with general symptoms of distress decreasing from session 12 ($M = 110.6$) to session 24 ($M = 87.9$). There was also a significant univariate effect for WOC, $F(1,39) = 51.49$, $p < .001$, with coping skills increasing from session 12 ($M = 41.4$) to session 24 ($M = 46.8$) (see Table 1 for variable means).This effect was due to significant increases on the subscales of planful problem solving, $F(1,39) = 4.5$, $p < .05$, and positive reappraisal, $F(1,39) = 20.8$, $p < .001$, only.

The two issues specific to each client that were rated on the TCT were averaged for session 12 and for session 24 for the analysis. There was a significant univariate effect, $F(1,39) = 44.40$, $p < .001$, indicating that the degree to which issues were bothering clients decreased from session 12 ($M = 10.0$) to session 24 (M

= 6.1). Finally, for 21 clients who completed the MPSS-SR at both times, there were significant univariate effects on the MPSS-SR for both frequency, $F(1,20) = 20.58$, $p < .001$, and severity of posttraumatic stress disorder (PTSD) symptoms, $F(1,20) = 38.94$, $p < .001$. Frequency of symptoms specific to trauma survivors decreased significantly from session 12 ($M = 21.9$) to session 24 ($M = 14.9$), and severity of symptoms also decreased significantly from session 12 ($M = 45.4$) to session 24 ($M = 32.6$). Eta squared values were calculated to determine the clinical significance of the change in scores on all instruments and can be seen in Table 2. Changes on the MPSS-SR and WOC were clinically significant, while change on the HSCL did not reach clinical significance.

Table 1
Means and Standard Deviations for the Total Score of Major Variables at Session 12 and Session 24

	Trauma					Other Issues					Total				
	Session 12		Session 24			Session 12		Session 24			Session 12		Session 24		
Variable	*M*	*SD*	*M*	*SD*	*n*	*M*	*SD*	*M*	*SD*	*n*	*M*	*SD*	*M*	*SD*	*n*
WOC	41.2	12.1	47.7	8.5	28	41.7	8.9	45.4	8.9	17	41.4	10.9	46.8	8.6	45
MPSS-SR															
Frequency	21.9	11.6	14.9	11.5	21										
Severity	45.4	14.6	32.6	14.5	25										
HSCL	109.2	4.4	84.6	5.0	28	112.8	5.7	93.3	6.4	17	110.6	23.2	87.9	26.3	45
TCT	9.4	0.4	5.7	0.6	25	10.5	0.5	7.1	0.8	16	10.0	2.0	6.1	3.1	41

Note. WOC = Ways of Coping Questionnaire; MPSS-SR = The Modified Posttraumatic Stress Symptom Scale Self-Report; HSCL = Hopkins Symptom Checklist; TCT = Target Complaint Technique.

Table 2
Univariate Effects (Greenhouse-Geisser) and Eta Squared for All Outcome Measures

Measure	*N*	*F*	Eta Squared
Hopkins Symptom Checklist	40	6.9	.15
Ways of Coping Questionnaire	40	51.5	.56*
Target Complaint Technique	40	44.4	.53*
MPSS-SR			
Frequency	21	20.6	.51*
Severity	21	38.9	.66*

Note. MPSS-SR = Modified Posttraumatic Stress Symptom Scale Self-Report
* < .05

In contrast, the multivariate effect for group was not significant. There were no significant differences between trauma and nontrauma clients in the amount of change that occurred between sessions 12 and 24 on the HSCL, TCT, or WOC.

Interrelationship Among Variables

Pearson product-moment correlations were computed to investigate whether client demographic variables of age, gender, or previous counselling were related to WOC, HSCL, and TCT at session 12. No significant correlations resulted (see Table 3). Client demographic variables were also investigated in relation to magnitude of change at the completion of counselling. For magnitude of change, a change score was calculated by using the difference in scores on all measures between posttest and pretest. Only previous counselling was significantly related to magnitude of change on the TCT ($r = .30$, $p < .05$).

Table 3
Pearson Product-Moment Correlations Among Major Variables at Session 12

Measures		1	2	3	4
(1) Ways of Coping	($n = 45$)				
MPSS-SR					
(2) Frequency	($n = 21$)	-.51**			
(3) Severity	($n = 25$)	-.58**	.92**		
(4) Hopkins Symptom Checklist	($n = 45$)	-.48**	.79**	.76**	
(5) Average Target Complaint	($n = 41$)	-.44**	.70**	.74**	.60**

Note. MPSS-SR = The Modified Posttraumatic Stress Symptom Scale Self-Report.
**$p < .01$

Pearson product-moment correlations were also computed to investigate whether variables of coping, symptoms, and target complaints were related at Session 12, before the extended sessions began. There were significant negative correlations for WOC with HSCL ($r = -.48$, $p < .01$), MPSS-SR Frequency ($r = -.51$, $p < .01$), MPSS-SR Severity ($r = -.58$, $p < .01$), and TCT ($r = -.44$, $p < .01$). Clients with lower coping skills had higher general symptoms, higher symptoms of posttraumatic stress, and were bothered more by their specific client issues.

The three measures of symptoms were significantly correlated: the HSCL with the MPSS-SR Frequency ($r = .79$, $p < .01$) and Severity scales ($r = .76$, $p < .01$). As well, both of the symptom measures were found to have significant positive correlations with the TCT at session 12: MPSS-SR Frequency ($r = .70$, $p < .01$) and Severity ($r = .74$, $p < .01$) and HSCL ($r = .60$, $p < .01$). A higher rating on issues bothering clients was associated with higher levels of both general symptoms and symptoms of posttraumatic stress.

Client-Identified Components of Change in Counselling

Types of change in clients. In general, the two groups of clients were more similar than different in the types of change they experienced from their counselling. Both

trauma and nontrauma clients appeared to be fairly similar in two categories of changes in the self: insight and the counselling relationship (see Table 4). However, there were some differences in emphasis in the other categories. For example, self-growth was the category coded most often for trauma clients (27.5%) and the second highest for nontrauma clients (28%). Trauma survivors most frequently described increased confidence and self-esteem (e.g., "I learned that I could handle things as I am a strong person"), while nontrauma clients reported increased emotional strength and ability to take control to make changes in their lives (e.g., "I now have the courage and strength to make certain decisions that I feel have been long overdue"). Trauma clients also frequently reported new hope with an increased focus on the future and awareness about self.

Table 4
Frequencies and Percentages for Types of Change in Clients

	Trauma (n = 27)		Other Client Issues (n = 17)	
Categories	Frequency	Percentage	Frequency	Percentage
Insight	9	11.2	5	10.0
Experiencing Feelings	8	10.0	2	4.0
Counselling Relationship	5	6.2	3	6.0
Self-Growth	22	27.5	14	28.0
New Ways of Being	18	22.5	15	30.0
Life Transitions	5	6.2	5	5.0
Improved Relationships	8	10.0	1	2.0
Improved Health	5	6.2	5	10.0
Total Responses	80	50		

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

New ways of being was the most frequent response for nontrauma clients (30%) and the second most frequent response for trauma clients (22.5%). Nontrauma clients reported trying new behaviours such as learning parenting skills, dealing with stress, and improved communication (e.g., "I've learned strategies on how to better deal with people"). In contrast, trauma survivors often commented on learning how to say no to others and beginning to put themselves first ("I don't work to make my parents happy. I do it for me"). Trauma clients reported experiencing feelings (10%) more frequently than nontrauma clients (4%), with decreases in feelings of anxiety being most notable. Trauma clients also mentioned increased satisfaction with relationships (10%) slightly more often than did nontrauma clients (2%). Both groups included a few clients who indicated that life transitions of employment, changes in residence, and pursuing education were changes that had occurred as a result of counselling.

Components of counselling that contributed to client change. Participants were queried about what in their counselling helped them to change. Once again, the two groups had similar frequencies for all of the categories with some subtle differences in emphasis. The counselling relationship was the most frequently mentioned category for both trauma survivors (56.4%) and nontrauma clients (52.4%). In particular, being listened to and not being judged by their counsellor helped facilitate their change. However, trauma clients additionally reported being validated and receiving guidance from their counsellor as important (e.g., "Realization of the need to express my feelings more and have them validated"). The second highest category was insight, with equal frequency for the trauma (20.5%) and nontrauma groups (19.0%). The trauma group differed somewhat from the nontrauma group in that they described realizations about abuse or the past and how to integrate their trauma (e.g., "I needed someone to listen and help me see patterns of abuse I experienced. I needed to appreciate that I am a survivor"), while there was no discernable pattern in responses of the nontrauma group.

A few trauma clients (12.8%) indicated experiencing feelings as an important part of their change process (nontrauma clients 9.5%). Trauma clients reported that discussing feelings with their counsellor was important, including the counsellor's empathy and normalizing of their feelings. In contrast, nontrauma clients more often mentioned specific feelings that they processed during their sessions (e.g., "The counsellor's sensitivity to these . . . self-esteem and confidence issues"). Self-growth was indicated slightly more often for nontrauma clients (9.5%) than trauma survivors (2.6%). Nontrauma clients were more likely to praise their progress and growth while talking about what helped them in their counselling experience (e.g., "I was able to better contain my emotions and become more productive").

In summary, clients reported decreases in three types of symptoms and increases in coping skills after 12 additional counselling sessions. The most frequent types of change described by clients involved self-growth and new ways of being in themselves and their lives. Trauma and nontrauma clients differed slightly in what they emphasized in their change process, while the majority of clients attributed their change to the counselling relationship.

DISCUSSION

Change in Symptoms, Coping Skills, and Client Issues

The hypothesis of a lessening of symptoms and an increase in coping skills from session 12 to the final session of counselling was supported by scores on the WOC significantly increasing as scores on the HSCL, MPSS-SR, and TCT decreased. Besides being statistically significant, evidence for clinical significance was provided by significant eta squared values (variance accounted for) for the change in scores on all instruments except the HSCL. These findings are congruent with research conducted by Heppner and Lee (2002), who suggested that clients who learn ef-

fective coping styles should experience a positive change in affect. These results are also supported by research (Bryant, Sackville, Dang, Moulds, & Guthrie, 1999) conducted with trauma survivors that shows that cognitive techniques such as systematic desensitization, exposure therapies, EMDR, and anxiety management reduced symptoms of fear, depression, and anxiety in clients who had experienced trauma. In the current study, many of the counsellors used relaxation techniques and almost half of the counsellors used EMDR, which may have helped clients process their traumatic experiences and thus decreased symptoms. Interestingly, the coping skills that increased for clients in the current study were planful problem solving and cognitive reappraisal: two cognitive, internal skills that are particularly amenable to counsellor intervention.

However, there were no differences between trauma and nontrauma clients in symptom reduction and improvement in ways of coping. These results indicate that all clients, regardless of category, improved in their symptoms and coping skills during the counselling. Although the possibility existed that there might have been some differences between trauma and nontrauma clients on these measures, the MANOVA showed that both groups began the additional sessions being equally distressed and then benefited equally from the counselling. Likely both groups of clients had made gains in counselling during their first 12 sessions that may have levelled any initial differences between the groups.

Interrelationship Among Variables

The demographic variables of gender, age, and previous counselling were not found to be related to client symptoms, coping levels, or magnitude of change. The significant relationship between previous counselling and change on the TCT may have been due to previous clients knowing how to use the counselling process and thus being more likely to make more change on their two issues. It is also likely that clients with deep issues need a significant amount of counselling, often over a period of years, for gains to occur. However, the sample was unevenly divided between clients with previous counselling (36) and those without (9). Thus, it is possible that a larger, more balanced sample would have yielded different results.

Client-Identified Components of Change in Counselling

The quantitative analyses answered the question of *what* changed for these clients. The qualitative analyses attempted to answer *why* change occurred. Although trauma survivors and nontrauma clients reported a similar frequency of categories for internal and external change as a result of the extended counselling sessions, there were subtle differences in how the two groups of clients described their changes.

Most frequently, trauma survivors indicated change through self-growth by mentioning increased self-esteem, confidence, self-awareness, and hope. As well, trauma clients indicated a focus on the future rather than the past. To facilitate recovery from trauma, Herman (1992) believes clients benefit from learning to

interpret the world in a new way. Such new outlook is evident in the present study, with some clients describing finding hope as a result of their extended counselling. In contrast, clients with other issues indicated self-growth by highlighting increased emotional strength, ability to take control of their lives, and ability to make changes. It appears that trauma survivors experienced more changes involving understanding themselves and increasing their confidence and self-esteem. This finding is consistent with Herman's description of trauma survivors often believing they deserved their abuse, especially when the perpetrator was a loved one or caretaker, which contributes to low self-esteem.

The two groups also differed in new ways of being, with trauma survivors stating they learned to put themselves first and say "no" to others, while other clients reported trying new behaviours such as learning parenting and communication skills. It is not surprising that trauma clients indicated putting themselves first as a new behaviour because many of them would have learned to put their perpetrator's needs first in an attempt to avoid further abuse (Herman, 1992). Furthermore, many trauma clients experience a blurring of boundaries between themselves and others because they were unable to say "no" or have any control during the trauma.

In considering models of change, the results are consistent with Howard et al.'s (1996) dosage and phase model of psychotherapy that accounts for the incremental nature of the change process over many sessions of counselling. Clients clearly demonstrated the increased coping skills and symptom relief of their remediation phase, as well as showing new behaviours of their rehabilitation phase. In addition, many of the trauma clients provided evidence of Herman's (1992) three stages of recovery for trauma survivors. Several clients indicated they experienced the counselling relationship as safe and nonjudgemental, her first stage. As well, the remembrance and mourning stage was evident in a few clients' responses describing past events and associated feelings. The third stage, reconnection with ordinary life and a focus toward the future, also appeared to be present in several client responses.

Clients were also asked which aspects of their counselling helped them to change. For both groups the counselling relationship was most often identified as contributing to their change. This result is congruent with research by Jinks (1999), whose participants reported both the therapeutic relationship and counsellors' skills as being fundamental to their change. For trauma clients in particular, Herman (1992) believes they heal in counselling through a relationship where they feel safe, which involves being able to control what they discuss and being listened to by a nonjudgemental counsellor. Trauma survivors often have not experienced safe or healthy relationships in their lives, which often contributes to the severity and complexity of their client issues. Furthermore, some clients spoke about the need to hear another person's perspective on their issues, gaining insight, and having a safe place to talk about their feelings. In order to change and experiment with new ways of being, clients need a safe base, and the counsellors in this study seem to have provided clients with that base.

LIMITATIONS AND IMPLICATIONS OF THE STUDY

Before the implications of the study can be discussed, limitations to the study must be addressed. The first limitation is that the sample used was not randomly chosen. Clients were asked whether they were interested in participating and clients who agreed to participate may have been different from those who chose not to participate. Those clients who had greater expectations for the counselling process may have been more likely to participate. Furthermore, because clients were assigned to groups based on their self-disclosure, it is possible some clients may not have disclosed past abuse and thus, the nontrauma group could have contained some trauma clients. However, this limitation was minimized by clients having 12 sessions of counselling before they were categorized, which increased the likelihood of disclosure. Another limitation was not being able to assess all clients at session 1 and the absence of a control group. Attrition is also a possible limitation with several clients terminating before session 24, resulting in loss of posttest data. These clients may have differed from completers by not experiencing as much relief from their symptoms or gaining as many coping skills. In addition, with the small number of male participants, results may be more applicable to female clients. As well, the broad categorizations of components of change may not be as applicable to more unique client groups (e.g., ethnicities, disabilities). Finally, the small sample likely reduced the power of the analyses. A larger sample could have allowed for comparisons among all four groups of clients (trauma, complicated grief, multiple issues, interim support).

Even though the study had limitations, some important implications can still be drawn from the data for counsellors. With the move toward brief therapy in community counselling agencies, particular attention needs to be paid to outcome studies evaluating longer-term counselling for clients with more serious concerns. Counselling centres may be doing a disservice to clients with serious issues by not providing them with an adequate length of counselling and should consult research before deciding to limit counselling for these clients. Thus, our recommendation for agency policy and clinical practice is for counselling services and employee assistance programs to adjust their guidelines so that clients with deeper issues are given the choice of receiving 20–30 sessions rather than the prevalent standard of 8–12 sessions.

Extended sessions for high-needs clients is very important because of the time needed for them to build a trusting relationship with their counsellor, to reduce more severe symptoms, to acquire better coping strategies, and to engage in the change process. Several trauma clients in the current study indicated the first 12 sessions were just the beginning of their change process. For example, "I think it would have been a negative thing for me to end at the 12th session. More progress was made later on (after the 12th session) because I knew my counsellor better," and "The first 12 sessions were only about 1/3 of the growth and action I see in me now."

For researchers, the results provide a beginning point for future studies to examine further the needs of clients in community agencies who have more

complex issues. Because the majority of counselling research uses the university population who generally receive shorter-term counselling, much less is known about the change process for other client groups. In conclusion, the result of all clients benefiting from extended counselling suggests it is the common elements of counselling that are most helpful for client change. The one common element among many different approaches to counselling is the therapeutic relationship that these clients credited with facilitating changes in themselves and their lives.

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