The International Journal of Psychosocial Rehabilitation
Volume 18, Number 2
July 2013– June 2014

# The Effectiveness of Counseling at a Local Crisis Center

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**Citation:**
Folkesson PF & Lindgrin OK (2014) The Effectiveness of Counseling at a Local Crisis Center .
***International Journal of Psychosocial Rehabilitation. Vol 18(2)*** 121-140

## Abstract

Samtalsakuten (the Counseling Emergency) is an open crisis center operated in collaboration between the municipalities of Forshaga, Hammarö, Karlstad, and Kil; the Church of Sweden; and the County Council of Värmland. Its mandate is to offer crisis counseling to adults who contact the center when they are in an acute life crisis. Samtalsakuten uses a working model influenced by the various traditions and approaches of several talk therapies. The aim of the study was to examine counseling effectiveness at Samtalsakuten. The study was based on a replicated single-case design, and quantitative and qualitative data were collected prior to each counseling session as well as six months after the completion of the session series. Our main finding is that counseling made a significant difference and had a positive effect on anxiety, depression, insomnia, and sense of coherence for clients who completed their sessions in mutual agreement with their therapist.

**Keywords:** Mental health and public policy, crisis intervention, common factors in psychological treatment, eclectic psychosocial treatment.

# Introduction

Samtalsakuten (the Counseling Emergency) is an open crisis center available to adults over 18 years who live in one of the municipalities of Forshaga, Hammarö, Karlstad, or Kil, in the County of Värmland, Sweden. These persons are able to call the center directly for support and help in the event of an "acute life crisis". All clients are received within a few days and have the right to anonymity; no records will be kept.

In 2012, Samtalsakuten had 2000 visits, of which 359 were first visits by new clients. Women accounted for 80% of all visits and men for 20%. There is an upper limit of ten counseling sessions and the fee for each one-hour session is SEK 120, payable upon visit. The sessions may be distributed over a shorter or longer period of time.

Samtalsakuten is a collaborative effort between the municipalities Forshaga, Hammarö, Karlstad, and Kil; the Church of Sweden; and the County Council of Värmland. Each responsible authority or organization hires and finances one of the four therapists who thus become anchored in different contexts, organizations, and frames of reference. The crisis center was established 15 years ago and started out as a project in one of the social districts in Karlstad in the early 1990s. The objective of the project was to support clients with long-term dependence on sedatives, tranquilizers, or painkillers. Social workers in the district had discovered that many of the clients whom they had had contact with had been dependent on sedatives for a long time. At the time of the initiation of the project, statistics from the National Association for Aid to Drug Abusers (www.rfhl.se) showed that 85% of all persons with a long-term dependence on sedatives, tranquilizers, or painkillers had had their first drugs prescribed to them as they suffered a personal crisis. For many people, a personal crisis was thus pivotal to developing a long-term addiction to the aforementioned pharmaceuticals. The absence of a local and easily accessible resource that people could turn to for support and help in critical life situations hence became apparent. This realization was the starting point of a project that, in a few years, led to the establishment of Samtalsakuten.

## Mental Health and Public Policy

In Sweden, sick leave due to mental illness is increasing. Approximately 40% of those on sick leave have a psychiatric diagnosis, and no other illness category is growing as fast (Carlsson, 2013a; 2013b; AFA Insurance, 2013). This form of ill health accounts for closer to 40% of the total health insurance costs and costs society more than SEK 70 billion per year (National Board of Health and Welfare, 2013). Psychological distress is one of the most common reasons why people of working age are unemployed. Unemployed women between 16 and 19 years of age who experience an economic crisis are most affected by impaired psychological well-being, insomnia, uneasiness, worry, or anxiety (National Institute of Public Health, 2013).

Reavley and Jorm (2013) referred to research showing that only a minority of people affected by mood and anxiety disorders received help or treatment within a year of the onset of their symptoms. For those who did receive help or treatment, the median time delay between onset and treatment varied from 1–14 years for mood disorder, and from 3–30 years for anxiety disorder. The authors emphasized that this is problematic because early intervention is a key factor for improving the prognosis.

In its final report almost ten years ago, the Swedish national psychiatry coordination campaign pointed out that mental illness should be treated as early as possible by prevention, assessment, and easily accessible counseling (SOU, 2006). Samtalsakuten meets these recommendations in several respects and is an example of a local community support system (Reavley & Jorm, 2013) that offers patient-centered care (Hensley, 2012), and adults living in any of the four municipalities of Forshaga, Hammarö, Karlstad, and Kil can contact the center directly when needed.

# Crisis Reactions and Crisis Interventions

Crisis reactions are the focal problem for the target group of the crisis center and, consequently, crisis interventions are central to the therapists. The term crisis reaction has been defined in research literature by, among others, Roberts as ”an acute disruption of psychological homeostasis in which one’s usual coping mechanisms fail and there exists evidence of distress and functional impairment” (Lewis & Roberts, 2001, p. 19).

The main cause of a crisis reaction is an external event, but, for a crisis reaction to occur, the person affected also needs to experience the event as the cause of severe stress and be unable to cope with the situation by using his or her usual coping strategies.

In Sweden, Cullberg’s (2006) description of the various stages of a crisis reaction and how a crisis is manifested is often used. Cullberg talks about an acute shock phase, a subsequent reaction phase followed by a processing phase, and a concluding reorientation phase. Common symptoms of a crisis reaction are anxiety, moodiness, insomnia, and loss of trust and meaning. A divorce, a death, job loss, children growing up and leaving home are examples of external factors of change that, sometimes, can disrupt a person’s external social as well as internal personal context. Life is no longer the same. The belief that life is good and predictable is shattered and needs to be restored.

A typical and uncomplicated crisis process rarely needs treatment, even though it can be experienced as very distressing for both the person undergoing the crisis and others. Indeed, an attempt to treat uncomplicated grief reactions may even worsen the situation. If the therapist tries to expedite the process and the processing, there is a risk of both overwhelming the person affected and causing blockages and obstacles in a process that otherwise would have been resolved in its own due course (Everly Jr, 2000). Usually, also severe crisis reactions will pass because people can generally restore their temporary loss of inner balance with the help of their basically stable personality and their social network. However, if their protective social context is shattered or missing, or if their personal ability to deal with the reactions is reduced, professional support may be needed. Roberts’ seven-stage crisis intervention model (R-SSCIM) is a seven-step model used by crisis workers from various disciplines: social workers, psychologists, church employees, and so on (Roberts & Ottens, 2005). The first step is to identify risks and investigate what support can be found in the person’s social network or surroundings. Thereafter, a good working alliance is established through counseling sessions where: the triggering event as well as the acute problem is identified, thoughts and emotions are analyzed, some resistance is offered, and alternative coping strategies are explored. Eventually, the ability to function is restored by new strategies and, finally, a follow-up is planned. The follow-up session usually occurs at a time near the anniversary of the triggering event. Furthermore, Roberts’ model also stresses the ”fundamental character strengths of the crisis worker” (p. 334).

## The working model of Samtalsakuten

Samtalsakuten offers a form of psychological treatment that the therapists and others involved in the operations of the crisis center refer to as *crisis counseling.* In the annual report, as well as in everyday talk, the interventions are also called *counseling* or *brief therapy*. It is not entirely clear what specifically signifies this form of psychological conversational treatment, or where it stands in terms of theoretical basis, approach, or specific treatment interventions. In the absence of a clear “declaration of contents”, we have tried to account for the working model of Samtalsakuten through a brief overview of current research in this field, and a presentation of those traditional and established psychological treatment forms with *talking* as the common denominator that have made major contributions to the working model used at Samtalsakuten.

Within psychotherapy research there is an ongoing discussion of effective factors specific to certain therapeutic methods, and factors common to all methods (APA, 2006; Duncan, Miller, Wampold, & Hubble, 2010; Oscarsson, 2009). The way crisis counseling is described in everyday conversation among the therapists at

Samtalsakuten suggests that it is largely based on factors common to all psychotherapies.

According to Norcross (2010), some of the factors common to all evidence-based psychotherapies are

- the therapists' empathic ability, sensitivity, and willingness to understand their clients' situation;
- the quality and strength of the working alliance;
- the existence of common goals;
- the therapist's warm and accepting attitude;
- the congruence and genuineness of the therapist;
- the tactful and well-balanced feedback from the therapist regarding the client's behavior and how it affects others;
- the therapist's ability to mend any flaws or ruptures in the working alliance; and
- the therapist's ability to manage his or her own reactions and not act on them in relation to the client.

In addition to the factors common to the working model of Samtalsakuten, there are also method specific elements: the number of sessions are limited to ten, each session lasts 60 minutes, clients can remain anonymous, no records are kept, there is a target group of people older than 18 who are in an acute life crisis, etc. This crisis-intervening counseling model exists within a field that draws on elements of psychotherapy, brief therapy, counseling, and pastoral care. We have tried to define the working model by contextualizing it and describing various models of conversational treatment.

## Different forms of psychological conversational treatment

Psychotherapy can be viewed as a central reference for all forms of psychological treatment based on conversation. The range of psychotherapy that we see today primarily has its roots in the psychoanalytic practice developed around the turn of the 20th century (Etchegoyen, 1991; Freud, 1937/2002). Another strong influence in today's psychotherapies is derived from learning psychology and behaviorism (Skinner, 1953; Watson, 1924/1925). From research findings within the field of learning psychology, clinical methods were developed that, when completed with, among other things, cognitive therapy (Beck, Rush, Shaw, & Emery, 1979), evolved into cognitive behavioral therapy, CBT (Öst, 2006).

On the one hand, psychotherapy is a mutual collaboration undertaken by two parties on an equal basis and with certain guidelines regarding personal integrity, confidentiality, time, place, and financial remuneration. On the other hand, the relation is asymmetrical, i.e., the one who turns to a psychotherapist for help is to provide the therapist with an continuous narrative of his or her symptoms and life problems and it is then the therapist's task to—together with the person seeking help—try to understand and reflect on effective approaches to these issues. Together, the parties also set up a goal for their work and make agreements for follow-ups and evaluation.

The theories, methods, and practices of different psychotherapies differ, but there is no scientific evidence of any clear differences in effectiveness between the various schools (Wampold, 2010). Instead, there appear to be greater differences between psychotherapists in terms of treatment outcomes than between different methods of psychotherapy (Luborsky, McLellan, Diguer, Woody, & Seligman, 1997). Hence, the psychotherapist is central to how the method is used and adapted to each therapeutic process as well as to each patient's situation and context (Krause & Lutz, 2009; Stiles, 2009).

Various short-term psychotherapeutic techniques apply the knowledge of psychotherapy. The idea behind these techniques is that sometimes it is possible to work with a more limited objective and a narrower focus than in regular psychotherapy. In short, clients in short-term therapy should be able to easily bond with and separate from the psychotherapeutic relationship, have a sound and clearly stated motivation, and have the

ability to present a psychological problem to serve as the focal point of treatment. Short-term psychotherapy often has a pre-set number of sessions or an end date. Hence the selection of clients is extremely important: Short-term psychotherapy should not be regarded as a faster version of long-term psychotherapy (Bravesmith, 2010).

There is scientific evidence of the effects of both psychodynamic short-term therapy and various CBT therapies of shorter duration (Abbass, Hancock, Henderson, & Kisely, 2006; SBU, 2004). The requirement common to all short-term treatments is that the patient currently has problems that serve as a strong incentive to work for change.
The English term *counseling* is often used also in Swedish. Carlsson (2001) defined counseling—in a Swedish primary care context—as "a limited intervention aimed at helping the individual cope with a difficult situation" (p. 6). Counseling has preventative and supportive qualities and focuses on individuals' own recourses to enhance their ability to handle their problems.

In a British primary care context, counseling is a talking treatment with the same theoretical foundation as psychotherapy, psychoanalysis, client-centered therapy, cognitive psychotherapy, and behavior therapy (Perris, 2003). Counseling can either be based on one of the established schools or be the result of a single therapist's pluralistic and integrative personal mix (McLeod, 2012). Along with the psychodynamic approach and the broad base of cognitive-behavioral therapy, also the client-centered psychotherapy is central to the field of counseling (Perris, 2003). Client-centered work focuses on the human encounter between client and therapist and is a non-directive approach.

Privacy, confidentiality, and the processing of problems are three characteristics that the pastoral care conversation shares with other talking treatments. What primarily distinguishes pastoral caregivers is that they apply the Christian gospel to the difficulties experienced by the care-seeker. Pastoral caregivers offer the same helping and supporting relationship as secular therapists, but—in addition to their own and their clients' resources—also offer their clients the opportunity to find and form a relationship with God. A pastoral care conversation is usually one single session, but could be several ones (The Church of Sweden, 2013).

A starting point for deciding the process of the talking treatment could be the contextual factors and the context in which the sessions are conducted. When therapeutic sessions are conducted at a private practice or in a health care context, they are often referred to as psychotherapy. In a time-limited context the talking could be described as short-term therapy. When psychotherapeutic knowledge is applied in settings influenced by "other" contextual conditions—such as a primary care clinic, a school, or the social services—the activity is often referred to as counseling: Within the church it is called pastoral care.

On a general level, the working model of Samtalsakuten can be made comprehensible through its mandate and the multi-sectoral context in which it is firmly anchored. By having several different responsible authorities, its operations have been labeled in terms sometimes leaning to the context of one authority, sometimes to that of another: thereby giving rise to a multidimensional eclectic discourse.

## The aim of the study

The aim of this study was to investigate the effectiveness of the talking sessions taking place at Samtalsakuten, with as minimal impact as possible on its normal operations. The results of the study were expected to provide knowledge of the effect these counseling sessions had for the clients and thereby provide a basis for the development of therapeutic activities, work approaches, and counseling models. The following two questions were formulated for this study:

- Do counseling sessions at Samtalsakuten make a difference to the clients?

- Do the clients get help with the problems they seek help for?

# Materials and Methods

## Design

The study had a quasi-experimental design based on continuous assessment (Kazdin, 2011) at each counseling session and at a follow-up six months after completion of the session series. Before each session, data were collected regarding the participants' self-reported anxiety, depressiveness, and insomnia. Furthermore, data were also collected for sense of coherence before the first session, before the concluding session, and at the follow-up six months later. In addition, participants filled out a completion form during the concluding session and a follow-up questionnaire at the six-month follow-up.

## Sample

All 153 persons who contacted Samtalsakuten from September 1, 2011, to February 10, 2012, received information about the ongoing study and were invited to participate. Of these, 108 persons chose to participate in the study, which means that 45 persons, 29.4%, declined to participate. Eventually, two more persons decided to withdraw from the study. Hence, after the dropping out, the results of the study were based on 106 participants. The sample is regarded as an opportunity sample because data collection occurred during a short and limited time span.

Seventy-seven of the 106 participants were women (72.6%) and 29 were men (27.4%). The average age of women was 41.0 years ($SD$ = 14.88) and slightly higher for men with 42.4 years ($SD$ = 12.53). The youngest participant was 18 years old; the oldest was 82. The age quartiles for all participants were $P_{25} = 30$ years, $P_{50} = 40.5$ years, and $P_{75} = 52$ years.

For reasons unknown, 48 persons (45.3%) broke off contact and stopped coming to their sessions. Consequently, there were 58 persons (54.7%) who completed their treatment within the framework of the client–therapist agreement. These participants filled out a concluding SOC-13 questionnaire along with other self-assessment questionnaires and a completion form. Participants also wrote their address on an envelope so a follow-up questionnaire could be sent to them six months later. Thirty-five persons (60.3% of 58, and 33.0% of 106 persons) returned their completed follow-up questionnaires six months after their concluding session. This means that the empirical material includes both external and internal non-response, as shown in Table 1.

Table 1: Overview of the empirical material. N = 106. EN = External non-response. IN = Internal non-response. X = Number of participants with complete measured values.

| | First session | | | Last session | | | Concluding session | | | 6-month follow-up | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | EN | IN | X | EN | IN | X | EN | IN | X | EN | IN | X |
| Anxiety | 0 | 0 | 106 | 0 | 7 | 99 | 48 | 4 | 54 | 71 | 1 | 34 |
| Depression | 0 | 9 | 97 | 0 | 3 | 103 | 48 | 1 | 57 | 71 | 1 | 34 |
| Insomnia | 0 | 10 | 96 | 0 | 14 | 92 | 48 | 8 | 50 | 71 | 4 | 31 |
| SOC | 0 | 0 | 106 | | | | 48 | 1 | 57 | 71 | 0 | 35 |

Of the 48 persons who, for reasons unknown, broke off contact, 19 did so after their first session. For these 19 participants there was, hence, only one measurement for all variables. In processing the data, this single value was used as a measure of the first and last session in accordance with the *intention-to-treat* principle (Roth & Fonagy, 2005). This approach thus offered a conservative rating of differences and treatment outcomes.

## Measures and instruments

The study used both established self-assessment questionnaires and questionnaires developed specifically for this study.

A form for new clients is used in the regular activities at Samtalsakuten. From this form, background data were extracted regarding gender, age, waiting time, and reason for seeking help.

The Hospital Anxiety and Depression Scale (HAD) consists of fourteen items: seven that measure anxiety and seven that measures symptoms of depression. Each item has four possible answers on a scale from *strongly agree* to *not at all.* Zero to three points per item can be obtained; in all 21 points for each scale. Zigmond and Snaith (1983) specified the following clinically meaningful degrees for anxiety and depressiveness: probable absence (score 0-7), possible presence (score 8-10), and probable presence (score 11-21).

Insomnia was measured with an assessment instrument developed by Bäccman et al. (2012). The instrument was revised slightly to apply to the target group and activities of Samtalsakuten. It comprised a total of twelve items, of which nine items with the response alternatives *yes* or *no* were used as an index measure, 0–9, of the participants' insomnia status.

Sense of Coherence (SOC; Antonovsky, 1987; Lindström & Eriksson, 2006; Westlund & Sjöberg, 2010) was assessed using SOC-13. Each item is responded to on a 7-point scale and the total score varies from 13 to 91.

At Samtalsakuten, a completion form was developed in cooperation with staff and management. The form consisted of five VAS scales, 0–100, on which informants indicated the extent to which they had received help with what they sought help for as well as help with other problems, how satisfied they were with their therapist and the therapist's method of working, and how they were received at Samtalsakuten. In addition, there were five open-ended questions that were to be answered in free text—i.e., written qualitative data—concerning what had been of help, not of help, if there was anything they wished had been done differently regarding the sessions, their reception at the clinic, as well as other comments.

The follow-up questionnaire was also developed in cooperation with the staff and management at Samtalsakuten, and was sent out six months after the concluding session. This questionnaire resembled the completion form but concerned the situation after six months.

# Method for processing data

A within-subjects design served as the guiding principle during the data processing and analysis. In addition to exploratory data analyses and descriptive statistics, we also estimated the effect size for the difference in symptom prevalence before and after the series of sessions, as well as after six months (Cohen, 1988; Field, 2005), and—with respect to our first resarch question—conducted a repeated measures ANOVA (Field, 2005)

To process the qualitative data in the open-ended questions, an inductive, thematic analysis was used (Braun & Clarke, 2006; Hayes, 2000). Initially, the information from the open-ended questions was coded into so-called proto-themes (tentative themes) that reflect the meaning of this information. In a second processing procedure, particularly prominent themes were discerned and defined. These themes then constituted the basis for the presentation of our research findings in the form of a thematic structure that described, defined, and related to the phenomena that we found in the material.

## Procedure

As mentioned above, participants filled out questionnaires before each session. The therapists handed out questionnaires prior to each session; thereafter they were not responsible for what happened with the questionnaires. The participants themselves put the completed questionnaires into a locked mailbox intended for this purpose. The therapists copied the regular form used for new clients—decoded with regard to personal data—and placed it in the said mailbox. The mailbox was then emptied by one of the researchers and the data were entered into an SPSS matrix.

In addition to filling out questionnaires during their concluding session, each participant got to write today's date and their address on an envelope that was to be sent out six months later with all the self-assessment questionnaires, a follow-up questionnaire, and a reply envelope addressed to the principal researcher.

## Ethical vetting

The study was reviewed and approved both by the Research Ethics Committee at Karlstad University (Reg. No. C2011/266) and the Central Ethical Review Board in Uppsala (Reg. No. 2011/197).

# Results

This section presents the reasons why the 106 participants contacted Samtalsakuten; participants' self-rated levels of anxiety, depression, insomnia, and sense of coherence; duration of the session series; effectiveness of the sessions; participants' perception of what had an effect; and their evaluation of the help received.

### ”A situation has arisen”

Those who contacted Samtalsakuten were in “a situation that had arisen”, which was described as unbearable. In their situation, they experienced a substantial need for someone to whom they could turn for support and help in order to understand the situation and sort it out. They found themselves in an existential dilemma that had arisen either due to a single event that had occurred relatively recently or had developed over time so that they could no longer cope with their life situation on their own like they had before.

”Ended up with the Swedish Enforcement Authority. Is ashamed to have ended up there. Needs to talk about life situation.
Furthermore, experiences earlier in life could become reactivated by the current situation or interrelated situations.

”Dad drank while she was growing up. This comes up now that she herself has become a mother. “

A longer sick leave could have eroded a participant’s life and contributed to a critical life situation. To have received a diagnosis or a definite confirmation of illness—for oneself or a family member—could also culminate in an existential crisis. ”Husband is seriously ill; has had several strokes. Furthermore, there have been several deaths in the family in a short time. Now depressed herself. Often thinks about death and how life turned out. Feels lost. “

For some of the participants, working conditions or unemployment could have given rise to a very problematic life situation.
”Feelings of panic. Feels awful. Anxiety. A lot of it stemming from the job situation. Destructive. Feels trapped in the situation.”

Relationship problems with or without violent features may eventually culminate in an intolerable situation.
”Previous psychological and physical violence in the relationship (20 years.) Divorced after four and a half years. Made a police report in November. Assault, molestation. Case dismissed.”

Alcohol or drug abuse, or a gambling addiction, could also have caused critical life conditions.
”Sober alcoholic. Cannot get on with life. On the verge of giving up. A relapse lately but that is not the problem. Needs to talk about a previous separation and feelings of loneliness and abandonment. “

Further examples of situations that had arisen and made people turn to Samtalsakuten for support and help were the suicide or attempted suicide of a relative, to have moved house, discontinued their studies, or experienced infidelity.

The 106 study participants were struggling with their lives when they contacted the clinic. Separations, losses, adversities, loneliness, life, death, and anxiety had disrupted their lives to such an extent that they felt a strong need for support and aid. They contacted Samtalsakuten because they did not have access to such support in their ordinary network or life context.

## Common reactions and conditions

Participants’ new life situation gave rise to some common reactions and symptoms that indicate that the persons were not doing well; that their psychological well-being was significantly reduced. Anxiety and worry were the most prominent symptoms, but also depression, insomnia, and feeling somewhat disoriented in life were mentioned as reasons for contacting Samtalsakuten, as well as reported by participants in their self-assessments.
”Separation. Was walked out on about a month ago. Severe crisis reactions. Insomnia. Anxiety. Everyday life severely impaired. On sick leave now. Has difficulty concentrating. Cannot eat normally. “

At their first session, two thirds of all 106 participants rated their anxiety in the highest category *probable presence of anxiety* (Zigmond & Snaith, 1983). Less than one third did so for depression.

Table 2: Clinically meaningful degrees of anxiety and depression at the time of the first session according to the Hospital Anxiety and Depression Scale (HAD; Zigmond & Snaith, 1983).

| | Anxiety | | Depression | |
|---|---|---|---|---|
| Clinically meaningful degrees | **n** | **%** | **n** | **%** |
| Probable absence (score 0-7) | 17 | 16.0 | 43 | 40.6 |
| Possible presence (score 8-10) | 18 | 17.0 | 34 | 32.1 |
| Probable presence (score >11) | 71 | 67.0 | 29 | 27.4 |
| Sum | 106 | | 106 | |

A paired samples t-test showed a significant difference between anxiety, $M = 11.85$, $SD = 4.24$, and depression, $M = 8.38$, $SD = 3.84$, $t(105) = 9.36$ $p < 0.01$. Hence, anxiety was more prominent than depression during participants' first counseling session at Samtalsakuten. A one-way ANOVA showed no significant differences between the sexes for either anxiety, $F(1, 104) = 1.27$, $p > 0.05$, or depression, $F(1, 104) = 0.73$, $p > 0.05$.

At the first session, the self-rated level for insomnia was $M_1 = 5.32$ and $SD_1 = 2.43$. There were no norms for assessment of these scores, which means that they can only be compared with the scores of the last session in the session series, which were $M_2 = 3.63$ and $SD_2 = 2.73$. The corresponding scores for SOC-13 were $M_1 = 50.28$ and $SD_1 = 11.92$ for the first session and $M_2 = 56.18$ and $SD_2 = 12.11$ for the concluding session.

## The form and extent of the counseling session series

The session series varied concerning waiting time, number of sessions, time interval between sessions, time span between first and last session, and how the counseling series terminated.

Waiting time in number of days from first contact over the phone to first session was distributed as follows; $M = 11.2$ days, $SD = 8.9$, $MD = 11$, Mode = 14, Range 0-47. There were no significant correlations between waiting time and gender or age. An independent samples t-test showed the following for women, $M = 11.57$, $SD = 9.46$, and men, $M = 10.24$, $SD = 7.56$, $t(103) = 0.68$, $p > 0.05$, and a significance test of correlation between age and waiting time showed $r = 0.12$, $N = 106$, $p > 0.05$.

During 16½ months—between September 7, 2011, and January 21, 2013—the five therapists conducted 655 sessions with the 106 participants, $M = 6.18$ sessions $SD = 3.97$, $MD = 7$, Mode = 1, and Range 1–17. The session series exceeded the stipulated limit of 10 sessions for 11 of the participants (10.4%).

On average, the number of days between the sessions in a session series continuously increased until the 7th session, after which they leveled off for women but increased sharply for men. The time spans from first to last session varied from 0 to 454 days, $M = 127.1$, $SD = 106.8$, $MD = 133$. Quartiles for length of session series were $P_{25} = 17$ days, $P_{50} = 133$ days, and $P_{75} = 198$ days.

The mode for number of sessions is 1 because 48 persons (45.3 %) dropped out for reasons unknown: 19 of whom dropped out after the first session. More than one fourth of the participants (27.4 %) dropped out for reasons unknown after the first or second session. Hence, the dropping out was a significant phenomenon.

Table 3: One-way ANOVA with respect to anxiety, depression, insomnia, and SOC during first and last sessions for participants who completed their session series and participants who dropped out.

| | *First session* | *Last session* |
|---|---|---|

| | | |
|---|---|---|
| Anxiety | $F(1,104) = 1.27$, $p > 0.05$ | $F(1, 97) = 17.63$, $p < 0.01$ |
| Depression | $F(1,104) = 0.04$, $p > 0.05$ | $F(1,101) = 15.00$, $p < 0.01$ |
| Insomnia | $F(1, 94) = 2.77$, $p > 0.05$ | $F(1, 90) = 18.21$, $p < 0.01$ |
| SOC | $F(1,104) = 0.20$, $p > 0.05$ | $SOC_2$ is missing for participants who dropped out |

No significant differences were revealed during the first session regarding the main variables of the study between participants who followed through with the session series and those who, for reasons unknown, dropped out. However, at the time of the last session there were highly significant differences.

## The effectiveness of the counseling sessions

There were substantial differences in effect size from first to last session between participants who completed their session series and those who did not, as illustrated in Table 4.

Table 4: Effect sizes from first to last session in a session series for all participants: for those who completed and those who dropped out of their session series. Cohen's $d = (M_1-M_2)/(SD_1+SD_2)/2$. Effect size: Small = $0.2 < d < 0.5$, Medium = $0.5 < d < 0.8$, Large = $d > 0.8$ (Cohen, 1988; Andersson 2003). $N_{all} = 106$, $N_{completed} = 58$, $N_{dropped\ out} = 48$.

| | $M_1$ | $SD_1$ | $M_2$ | $SD_2$ | Cohen's $d$ | Size |
|---|---|---|---|---|---|---|
| *Anxiety* | | | | | | |
| All participants | 11.85 | 4.24 | 9.26 | 4.79 | 0.57 | Medium |
| Participants who completed | 11.43 | 3.77 | 7.56 | 3.72 | 1.03 | Large |
| Participants who dropped out | 12.47 | 4.83 | 11.31 | 5.16 | 0.23 | Small |
| *Depression* | | | | | | |
| All participants | 8.38 | 3.84 | 6.49 | 4.18 | 0.47 | Small |
| Participants who completed | 8.31 | 3.99 | 5.14 | 3.44 | 0.85 | Large |
| Participants who dropped out | 8.52 | 3.73 | 8.15 | 4.45 | 0.09 | — |
| *Insomnia* | | | | | | |
| All participants | 5.32 | 2.43 | 3.97 | 2.75 | 0.52 | Medium |
| Participants who completed | 4.96 | 2.32 | 2.94 | 2.54 | 0.83 | Large |
| Participants who dropped out | 5.76 | 2.53 | 5.24 | 2.51 | 0.21 | Small |

The counseling sessions hence had a positive effect for participants who followed through with their session series.

Differences between first and last sessions were also noted for those who terminated their therapy sessions beforehand. Paired samples t-tests showed for anxiety at first session, $M = 12.47$, $SD = 4.83$, and at last session, $M = 11.31$, $SD = 5.16$, $t(44) = 2.09$, $p < 0.05$; for depression at first session, $M = 8.52$, $SD = 3.73$, and last session, $M = 8.15$, $SD = 4.45$, $t(45) = 0.63$, $p > 0.05$; and for insomnia at first session, $M = 5.76$, $SD = 2.53$, and last session, $M = 5.24$, $SD = 2.51$, $t(40) = 2.44$, $p < 0.05$. Although the effect was small, there was a significant difference for anxiety and insomnia—even though the first and last value were the same, in accordance with the intention-to-treat model, for the 19 persons who dropped out after their first session.

One of the research questions of this study was whether the sessions conducted at Samtalsakuten made a difference to the clients. According to the results presented above, they did; especially for those who completed the session series. A repeated-measures ANOVA of the main variables of the study is shown in Table 5.

Table 5: Repeated measures ANOVA: First session; Concluding session; 6-month follow-up for anxiety, depression, insomnia, and SOC. *W* = Mauchly's *W*. *ε* = Greenhouse–Geisser correction. *r* = Effect size for contrasts according to Field (2005, p. 453). Effect size: Small, *r* = .1; Medium, *r* = .3; Large, *r* = .5 (Field, 2005, p. 32); $r_1$ = effect first–last session; $r_2$ = effect concluding session–six months after.

| | | | **Model effect** | **Contrasts (repeated)** | | | |
|---|---|---|---|---|---|---|---|
| | *W* | Sphericity | | First–Concluding | $r_1$ | Concluding–6 months | $r_2$ |
| Anxiety | .92 | Assumed | $F(2, 62) = 17.29$, $p < .01$ | $F(1, 31) = 16.89$, $p < .01$ | .59 | $F(1, 31) = 1.35$, $p > .05$ | .20 |
| Depression | .79 | $\varepsilon = .827$ | $F(1.65, 52.94) = 20.34$, $p < .01$ | $F(1, 32) = 22.52$, $p < .01$ | .64 | $F(1, 32) = 0.93$, $p > .05$ | .17 |
| Insomnia | .88 | Assumed | $F(2, 52) = 19.57$, $p < .01$ | $F(1, 26) = 22.22$, $p < .01$ | .68 | $F(1, 26) = 0.01$, $p > .05$ | .02 |
| SOC | .84 | Assumed | $F(2, 66) = 17.64$, p < .01 | $F(1, 33) = 14.60$, $p < .01$ | .55 | $F(1, 33) = 5.24$, $p < .05$ | .37 |

The analysis showed that the treatment model made a significant difference with a high effect size ($r_1$) for each variable. The contrasts indicated that these effects mainly took place during the time of the session series. The effects of the sessions were persistent but low after the session series had been completed ($r_2$). The sessions thus made a difference to, and had a positive effect on, the participants.

## Participants' own perceptions of what had been effective

Participants emphasized that what had helped the most was the opportunity to "speak openly" and talk "about everything" that they needed to verbalize.

"To be able to speak openly with another person and feel that there are no taboos."

The approach and attitude of the therapists were of fundamental importance in order to gain the trust of the participants and enable them to open up and speak freely.

"To 'get rid of all baggage' without being interrupted or questioned. To have someone who listens without be-

coming offended or upset."

Results showed that an unconditionally listening therapist with an outsider perspective helped increase participants' courage to open to "new perspectives", "other perspectives", and "gain insight": The words quoted occurred frequently in the answers to what had been of help. These quotes all focused on sight and the ability to see, and one aspect of the effectiveness of the counseling sessions was when they helped participants view situations differently: with insight. Participants stated that having been able to see themselves, their new situation, and the context in which they existed from a new perspective and in a new light, were central to what had been of help.

"The talk sessions have given me a new take on myself and my life. Many insights. My new as well as my old qualities and traits have in a way become illumined from behind."

Also found in the respondents' answers was a spatial theme that focused on unraveling, sorting out, and rearranging. It appeared that these two themes—visibility and spatiality—and the phenomena to which they referred interacted with one another. When someone listens the way a competent therapist does, visibility improves and that which can be seen can also be rummaged through and rearranged to accommodate a new comprehensibility and meaning.

Having been able to—at short notice—express themselves freely in their own words in a counseling conversation with an outside party who accepts, listens, and understands without interrupting or becoming upset, gave participants confidence and a safe platform: the prerequisites for the sessions to have an effect. Support, affirmation, balanced comments, and attentive questions gave participants the courage to open up and look at themselves, their situation, and their life context in new ways and reconstruct their inner world; which, in turn, led to a renewed ability to cope with their life situation in a more rational and functional way. This was a summary of what participants perceived as helpful and what contributed to the effectiveness of the counseling sessions.

Table 6: Participants' self-ratings on the five VAS scales (0–100) in the completion form.

| Item | *N* | *MD* | *M* | Mode | *SD* | Min | Max |
|---|---|---|---|---|---|---|---|
| I have received help with what I sought help for | 56 | 88.5 | 83.3 | 95 | 19.8 | 0 | 100 |
| I also received help with other problems | 56 | 79.0 | 71.9 | 78 | 26.6 | 7 | 100 |
| I am satisfied with my therapist | 56 | 97.0 | 93.1 | 100 | 12.2 | 29 | 100 |
| I am satisfied with my therapist's work methods | 56 | 97.0 | 92.1 | 100 | 14.0 | 30 | 100 |
| I was well received at Samtalsakuten | 56 | 97.5 | 94.8 | 100 | 8.6 | 46 | 100 |

Upon completion of the session series, participants felt that they had received good help with what they contacted the clinic for. In addition, they also got help with other problems than those they initially sought help for. Furthermore, they were very satisfied with the therapists and their practice, stated that they had been well received at Samtalsakuten, and were thus generally very satisfied.

# Discussion

Those who contacted Samtalsakuten did so when they found themselves in a situation that either arose as a consequence of a recent specific event or was developed over time and finally culminated in an unbearable

situation. It was this insufferable situation and the need for support and assistance from outside that we perceived as incentives for contacting the crisis center. It was primarily women who contacted the center, which is in line with both international research (Maxwell, 2013; Pirog & Good, 2013) and annual Swedish national public health statistics (www.fhi.se) on reduced psychological well-being.

Reduced psychological well-being and significantly elevated anxiety levels (Zigmond & Snaith, 1983) were salient for those who sought help. Participants' sleep and sense of coherence were probably also affected since the index measure we used for insomnia decreased significantly from first to last counseling session, whereas the mean score for sense of coherence increased.

Since *MD = 11* days and *Mode = 14* days concerning the time period from first contact via phone to first counseling session, the waiting time markedly exceeded the objective of the crisis center to offer counseling within two workdays. Nevertheless, we consider availability to be high since everyone was offered counseling, and both our professional experience and research findings (Reavley & Jorm, 2013) have shown that waiting times usually are considerably longer. However, we believe that the gap between objective and reality concerning waiting time needs to be monitored and, eventually, closed since early interventions are important for positive prognoses (Reavley & Jorm 2013; SOU 2006), as well as a hallmark for Samtalsakuten.

During a 16½ month period, the five therapists at Samtalsakuten conducted a series of counseling sessions with the 106 participants of the study. The number of sessions per participant varied between 1 and 17 ($M$ = 6.18, $SD$ = 3.97, $MD$ = 7, Mode = 1), over a time period of 0–454 days ($M$ = 127.1, $SD$ = 106.8, $MD$ = 133) from first to last session. Hence, variations were considerable in both form and extent. In the light of this we conclude that the therapeutic framework for everyday practice at Samtalsakuten is unclear or missing with regard to number of sessions, time interval between sessions, and the completion of a series of sessions. We wish to problematize these issues since we believe that some persons who contact Samtalsakuten when they are in an intolerable and critical life situation are in need of a more predictable framework to be able to gain the trust and confidence we regard as crucial to establish a strong bond and facilitate for the development process.

Our main result was that the eclectic treatment model *crisis counseling* used at Samtalsakuten worked well for clients and on symptoms usually associated with crisis reactions—such as anxiety, depression, insomnia, and sense of coherence (Cullberg, 2006). This was most evident for those who concluded their series of counseling sessions in mutual agreement with their therapist. We will return to this.

## Participants' own evaluations and comments

On the whole, the 58 participants who completed their counseling sessions and, hence, filled out the completion form were very satisfied with the help they had received, with their therapists, and with the reception at Samtalsakuten. They particularly mentioned the opportunity to speak freely about anything without being interrupted or questioned and without the listener getting upset. The response from the therapist was considered crucial. Words frequently used to describe what had been of help related to seeing and visibility as well as to spatiality. It appeared as if these two themes, visibility and spatiality, and the phenomena to which they referred interact with one another. When someone listens the way a competent therapist does, visibility will improve and that which can be seen can also be rummaged through and rearranged to accommodate a new comprehensibility and meaning.

The comments above support, and are supported by, recent research findings (Lindgren, Folkesson, & Almqvist, 2012) on what psychotherapists and clients view as effective in psychotherapy. Both categories stressed that therapeutic methods and the human encounter, combined with a responsive adaption of method and relationship to each therapist-client alliance, are contributory and cooperative factors for successful psychother-

apy. From the psychotherapists' perspective, treatment effectiveness was obtained when the client had had a *renewing experience*. A renewing experience is a cumulative process where the client's experiences change due to the continuous input of new impressions and material into the therapeutic relationship. In a patient study (Lindgren, Almqvist, & Folkesson, 2014), the term *responsive acceptance* summarized what patients perceived as effective. Responsive acceptance means that the therapist is sensitive to the patient's needs and emotional condition and provides feedback in an appropriate and constructive manner. The therapist's response and presence, physically and emotionally, were particularly emphasized. Acceptance means that the therapist's approach is supportive and non-judgmental, tolerant, sympathetic, and understanding.

## Two distinct analytical categories

The mode for number of counseling sessions in a session series turned out to be 1 session. This indicated a reappearing and significant phenomenon concerning the activities of the crisis center: Almost one in five clients (17.9 %) broke off contact after the first session. This phenomenon and fact formed two crucial analytical categories for interpreting the results of the effectiveness of crisis counseling: *completed* and *uncompleted* series of counseling sessions. We related our findings on the effectiveness of crisis counseling to these two categories since they differ significantly regarding crisis counseling outcome. International studies (Connell, Grant, & Mullin, 2006) showed similar results: hence, uncompleted counseling series were not unique to Samtalsakuten.

The effect size for improved mental health for the entire group from first to last session was moderate for anxiety ($d = 0.57$), small for depressive symptoms ($d = 0.47$) and moderate for insomnia ($d = 0.52$). However, the values are significantly higher for the subgroup that completed its counseling series. Here, improvement is considerable for anxiety ($d = 1.03$), depression symptoms ($d = 0.85$), as well as insomnia ($d = 0.83$). For the uncompleted counseling series category, the effect size was small for anxiety ($d = 0.23$), negligible for depression ($d = 0.09$), and small for insomnia ($d = 0.21$). The positive effect of the treatment model was thus clearly linked to the category of participants who completed their counseling series. The uncompleted counseling series phenomenon is, however, both interesting and important to investigate further from an operational as well as from a research perspective. Further knowledge of this phenomenon is needed.

Initially, there were no significant differences between the two categories. What made participants drop out of counseling? Were there different reasons and, consequently, several subcategories among the drop-outs?

According to our findings, the clients at Samtalsakuten were a heterogeneous group. Consequently, major differences may be found regarding their background and problems. Persons with more severe or complex problems might experience the relatively unclear framework of Samtalsakuten—i.e., the unspecified but limited number of sessions at intervals that are decided from session to session—as too vague and unsettling. Clear frameworks might be crucial for them to experience the needed predictability and trust in an acute crisis situation. Furthermore, an initial counseling session during a difficult life situation could increase the level of anxiety instead of reducing it, which could lead to an avoidance of further sessions. Another plausible explanation is that the client does not get the reception or the response that he or she had expected and therefore breaks off contact. Yet another reason could be that a client feels that he or she has received the help needed and thus breaks off contact.

There are more questions and hypotheses than answers, and the final plausible solution accounted for above—that clients may be content with just one session—raises the question whether the term uncompleted is applicable to this plausible category. There was without question a very noticeable difference in counseling effectiveness for these two categories. The question is what can explain this difference.

## Areas of development for clinical practice -

Currently, much research is conducted within the field of talk therapy to find models and means to improve treatment outcome through real-time progress feedback (Lambert, 2010, 2013; Miller, Hubble, Chow, & Seidel, 2013), which means that clients fill out brief rating scales before or during each session. The results are then immediately available for the therapists who, often via a computerized service, receive feedback on their work as well as on where on the symptom severity scale their clients are at the time of each session. Another scale is frequently used at the end of the session to see how the client rated today's therapist–client alliance. Results showed that such feedback facilitated for more treatments with a positive outcome since the therapist was alerted early on to factors that needed adjusting regarding setup or work approach (Lambert, 2010, 2013; Miller, et al., 2013). Furthermore, the questionnaires and feedback also provided a natural opportunity for therapist and client to have a dialogue about the sessions and "how things are proceeding". In addition, the therapist gets continuous feedback from all counseling series: an ongoing training leading to professional development. However, the greatest benefit is that counseling series about to fail can be saved and, hence, more clients receive help. Both early terminations and long session series without any noticeable improvement—or even leading to deterioration—could hereby be avoided to a greater extent. At a clinic such as Samtalsakuten, with limited resources and an administrative limit for number of sessions, a model with real-time feedback on the progress of the client and the alliance might help reduce the number of uncompleted counseling series.

A more elaborate and explicit therapeutic framework, especially regarding time intervals between sessions and how session series are completed in the best way, is another area of development. An initial evaluation to get an overview of the complexity of the client's problems might provide a basis for contacting, or referring, the client to a more appropriate support resource.

## Limitations of the study

Participants who did not complete their counseling series had an impact on the access of data for this study. The number of participants who provided complete before-and-after data were 58 out of 106 (54.7 %). Furthermore, only this category could be contacted for a follow-up six months after the concluding session since no personal information is stored at Samtalsakuten.

There is reason to reflect on the outcome measures chosen and the instruments developed for our study, and on their ability to capture and make visible the change processes and the personal benefits that they had for clients who received crisis counseling at Samtalsakuten (Hill, Chui, & Baumann, 2013). We chose the self-assessment scales we deemed appropriate for capturing changes in symptoms typical for persons in crisis. Information from the open-ended questions of the completion form, such as what participants considered helpful, was limited in comparison to interviews. Qualitative studies of psychotherapy outcome have shown that clients' perceptions and experiences of psychotherapy differ for different kinds of therapies and processes (Hill, et al., 2013). Hence, we cannot draw any in-depth and detailed conclusions concerning the personal benefits that our participants had of the counseling at Samtalsakuten.

Furthermore, our study lacked information about the therapists that might have contributed to the understanding of what was helpful and why. Data on the therapists' skills, theoretical orientation, and practice, would have been useful for increasing the understanding of the counseling treatment. We also tried to circumscribe the working model of Samtalsakuten by describing the context in which it operates, but it was not enough: We were not able to say anything about the specific factors of the working model (APA, 2006; Duncan, Miller, Wampold, & Hubble, 2010; Oscarsson, 2009). However, we define the working model of Samtalsakuten as eclectic and assume that the positive effect that we were able to demonstrate stem from the so-called common factors (ibid.), i.e., therapists' empathy, sensitivity, and willingness to understand their clients' situation; therapists' warm and accepting attitude; and therapists' ability to handle their own reactions and not act on them in relation to the patient (Norcross, 2010). These factors correspond well with what the study participants highlighted as helpful.

# Conclusions

We would like to state the obvious: Persons who are 18 and older, live in the municipalities of Forshaga, Hammarö, Karlstad, and Kil, and contact Samtalsakuten, do so because they can. Samtalsakuten exists. It is an available resource, at a structural level, which is there for people who need it. Existence, availability, and acquaintance are crucial for people in a crisis situation to get the support and help they need—when they need it.

Reavley and Jorm (2013) pointed out that people who suffer from depression and anxiety may have to wait for years to get the support and assistance they need. This is very problematic since it could delay or hinder recovery considerably. The Swedish national psychiatry coordination campaign (SOU, 2006:100) pointed out that mental illness should be treated as early as possible. In some aspects, Samtalsakuten makes this possible by being easily accessible and conducting important interventions for a limited time—with a good outcome at a relatively low cost. The results of our study illustrate that the local crisis center defends its position very well: It even fills a gap in the support and help supply of the welfare state since centers like Samtalsakuten still are very rare on a national level—despite the wording of the final report from the national psychiatry coordination campaign.

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