Single Session Therapy in a Walk-in Counselling Clinic: A Pilot Study

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Acknowledgements
The authors would like to thank Melissa Cernigoy, Catherine Bailey and Marina Grosu for excellent research assistance. We would also like to thank the staff of the Kitchener Waterloo Counselling Services for making this study possible, in particular the Executive-Director, Leslie Josling, who initiated the study, the Director of the Walk-In Clinic, Cindy Jacobsen, and Jennifer Cardwell in reception. However, any errors are the responsibility solely of the authors.
Abstract

Single session therapy (SST) delivered in walk-in counselling clinics is dramatically increasing in Ontario; however, studies of the clinical effectiveness SST are few, and those that exist are limited by weak research designs. The pilot study reported here had two objectives: 1) to learn more about the clinical effectiveness of SST as delivered in a walk-in counselling clinic and 2) to better understand how the quality of research on this model of service delivery can be improved. We measured psychological distress, stage of change as posited by the Transtheoretical Model of Change (TTM), recent use of health and social services, and recent ability to work and undertake normal activities in a sample of clients attending the KW Counselling Services walk-in counselling clinic in Kitchener-Waterloo, Ontario. Follow-up data, although limited by a low response rate, suggests that clients show improvement in distress and general functioning, and decreased use of health services one month and four months after the walk-in visit. However, clients’ use of other social service organizations tended to increase following the walk-in visit. On the stages of change measure, the majority of clients were in the Contemplation stage; having a high score on either the Contemplation or Maintenance stages was significantly related to improvement at one month follow-up. However, contrary to what the TTM would predict, scoring highest on the Action stage was not significantly related to improvement. Ideas about how to strengthen studies of the effectiveness of single session therapy provided in walk-in counselling clinics are discussed.
This paper reports the findings from a pilot study that aimed to measure the clinical effectiveness of single session therapy (SST) delivered in a walk-in counselling clinic, and also to increase knowledge about how to improve the quality of research assessing outcomes for this approach to service delivery. The need for the study was evoked by the dramatic increase in the number of such clinics launched by family counselling and children’s mental health agencies in Ontario during the last decade (Bhanot-Mulhotra, Livingstone & Stalker, 2010). Lengthy wait lists and agencies’ commitments to making services more accessible to their communities have been the catalysts for the development of walk-in counselling services (Slive, 2008; Young, Dick, Herring & Lee, 2008). These clinics usually employ single-session therapy (SST), an iconoclastic approach positing that most clients can benefit from a single session with a professional counsellor, and that for many, the single session is sufficient to reduce client distress to manageable levels (Slive, McElheran & Lawson, 2008).

Walk-in counselling clinics are clearly attractive to administrators who continually struggle with insufficient resources; however rigorous research on their clinical effectiveness is lacking. Existing studies of SST, scheduled or offered in walk-in clinics, are limited in number, and most have methodological deficits including lack of a control group, small samples and failure to use standardized measures (Bloom 2001; Cameron, 2007, Perkins, 2006).

That some clients may benefit from a single session of psychotherapy has been recognized for some time (Bloom, 2001; Campbell, 1999). A few mental health clinics in the US have offered SST in walk-in counselling clinics for many years. By SST, we refer to a meeting where both therapist and client know that only one session is planned. Most agencies provide for additional sessions if the therapist and/or client see it as necessary. SST received renewed attention when, in the early 1990’s, Talmon reported that 78% of 200 clients whom he had seen
for a single session (often unplanned) in an outpatient psychiatric setting said they “felt better or much better about the problem that had led them to seek therapy” (p. 9). Talmon and his colleagues later conducted a study where they intentionally offered one session only, and discovered that 58% did not require additional sessions and 88% of these reported improvement when contacted 3 to 12 months later (Hoyt, Rosenbaum & Talmon, 1992; Talmon, 1990). The first walk-in clinic in Canada was introduced in Calgary in 1994 (Slive, McElheran & Lawson, 2001). To our knowledge, the first one in Ontario was instituted by Yorktown Child and Family Centre (Toronto) in 2000, and modeled on the experience in Calgary.

While there is no one theoretical approach that anchors SST, a number of guiding assumptions have been identified. First, it is assumed to be ethical to work with people promptly when they ask for help. Second, the counsellor must believe that change is possible and the client must be ready to change. Third, counsellors should take an active role in encouraging the client’s development of new perspectives and learning, and this active role can facilitate useful shifts in behaviour and feelings (Hoyt, Rosenbaum & Talmon, 1992).

The assumption that the client must be ready for change is compatible with the Transtheoretical Model of Change (TTM) developed by Prochaska and DiClemente (1982, 1983). The fundamental postulate of the TTM is that intentional behaviour change occurs as a result of a temporal or developmental process whereby people move from entrenched patterns of problematic behaviour to achieving sustained change, through a series of stages. Originally, four stages were identified. In the Precontemplation stage, individuals have little or no interest in making changes. In the Contemplation stage, they begin to think that the problem might be resolvable. When people begin to commit and make plans for change, they have reached the third stage, Action, which involves further problem-solving and beginning to take steps to
implement change. *Maintenance*, the final stage in the process, is illustrated when new behaviour becomes customary. TM posits that people oscillate, redoing particular stages, until they are at the place of sustained change (Lewis et al., 2009)\(^1\).

Although some have debated the strength of the empirical support for claims that stage of change can accurately predict treatment retention (Callaghan, 2005; Prochaska, 2005), a recent paper reporting the statistical analysis of 39 combined prior studies of the ability of a Stages of Change scale to predict psychotherapy outcomes found a clinically significant effect. The authors argued the findings “support the usefulness of stages of change in predicting important treatment outcome measures such as symptom relief, premature dropout, and the working alliance” (Norcross Krebs, & Prochaska, 2011, p.151). They acknowledged the limitation that almost all of the samples in these studies were people with issues of alcohol or substance abuse, domestic abuse, or eating disorders and only a few were persons presenting with anxiety, depression, relational problems, PTSD or clients receiving “general therapy”.

One of the early psychotherapy studies (Smith, Subich & Kalodner, 1995) focusing on students attending a college counselling centre found that all the clients who scored highest on Precontemplation did not return for a second session, whereas those who scored highest in the Preparation and Action stages did. Returning for a second session was not associated with the students’ scores on Contemplation. A study of psychotherapy clients in a UK mental health clinic found that high Contemplation was associated with positive therapeutic alliance at session one and three, and low Contemplation was associated with premature termination (Derisley & Reynolds, 2000). A study involving adolescents with major depressive disorder (a subsample of

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\(^1\) More recent descriptions of the theory have included a fifth stage called Preparation “in which individuals are intending to take action in the next month and are reporting some small behavioral changes (baby steps). . . patients in the preparation stage have not yet reached a criterion for effective action (Norcross, Krebs & Prochaska, 2011, p. 143).
a large multi-site randomized control study) found that, as expected, higher Action scores at baseline were associated with better outcomes regardless of the type of treatment received (Lewis et al., 2009).

Norcross et al. (2011) maintain that the Transtheoretical Model can provide guidance as to therapeutic stance that best fits the client’s Stage of Change. The appropriate roles suggested are: a nurturing parent i.e. “roll with resistance” (Precontemplation stage); a Socratic teacher role (Contemplation); an experienced coach (Action); and a consultant (Maintenance).

Kitchener-Waterloo Counselling Services (KWCS) launched a walk-in counselling clinic in 2007. At the time, the agency had more than 900 names on a waiting list. When clients were given an appointment after a long wait, many were “no-shows”. Since 2007, the one day per week walk-in clinic has served an average of 30 clients per week. The waiting list has declined to the point that clients who request ongoing counselling can usually be seen within a one or two weeks.

Clients pay on a sliding scale related to income, ranging from $3.00 to $187.50 for a one and one half hour session. Therapists have Masters-level training with a minimum of five years experience. Theoretical approaches employed include Solution-Focused Brief Therapy, Brief Narrative Therapy and Cognitive-Behavioral Therapy. MSW students trained in SST and supervised by staff also conduct sessions. Prior to the single session, clients are screened for suicidality, homicidality, addictions and intimate partner violence. About 25% of walk-in clients are referred for additional sessions within the agency. For the large majority, the therapist collaborates in the SST with the client(s) to develop a written plan. Clients are invited to “work the plan” and to come back to walk-in (or request ongoing counselling) if needed. Clients who are deemed high risk clients are assigned immediately for ongoing therapy.
Method

Recruitment

Clients were recruited at the KW Counselling Services walk-in counselling clinic over a period of 13 weeks between May and August 2010. The agency’s receptionists informed all walk-in clients aged 16 years and older that the agency had partnered with the researchers to conduct the study. Clients were given a package containing a Letter of Information and the Baseline Questionnaire. Two Research Assistants (Master’s-level students) were available in the waiting area to answer questions about the study and to assist anyone who requested help in completing the Questionnaire.

Hoping to recruit a comparison group of clients who were similar to those coming to the walk-in clinic, we also asked the receptionists to provide information about the research to clients who came for a previously scheduled first session of ongoing counselling, and to invite them to complete a similar questionnaire prior to their first session. Research Assistants were not available to answer these clients’ questions because the appointments were scheduled throughout the week. A locked box was placed in the waiting room throughout the duration of the study and research participants were asked to place their completed questionnaires in the box.

The study was approved by the Research Ethics Boards of Wilfrid Laurier University and the University of Waterloo. To protect confidentiality, questionnaires were identified only by a research ID number; at the end of the questionnaire, participants were asked if they consented to receive two follow-up questionnaires by mail, at one and two months after the walk-in session. Clients sent the completed surveys by mail directly to the researchers. One agency staff member at the agency was selected to keep a list of participants’ addresses and corresponding research IDs; she signed an oath promising to keep confidential the identity of clients who participated (or
not) in the study. When it became clear that the follow-up response rate was low, we requested permission from the Ethics Boards to conduct a third mailing at four months post baseline and to offer an incentive for completion. In the letter accompanying the four month follow-up questionnaire, we offered participants who completed the final questionnaire a ten-dollar gift certificate to Tim Horton’s.

**Measures**

Outcome measures were:

1) the 12-item version of the *General Health Questionnaire (GHQ-12)* (Goldberg 1972), a standardized instrument that assesses level of psychological distress;

2) the number of self-reported contacts with health services and other social service agencies over the previous month;

3) the number of days clients were unable to work and/or undertake normal activities over the previous month.

4) the 18 item *Stages of Change Questionnaire (SOCQ)* (Bellis, 1994).

**Data analysis**

Mean scores were calculated for the GHQ-12 and the four stages of the Stages of Change Questionnaire. Paired samples t-tests examined whether the differences between scores on the outcome measures at baseline and the two follow-up points were statistically significant. Correlation coefficients were computed among the mean scores of the four stages of change, age, gender and the difference in scores in GHQ-12 from baseline, at each of the two follow-up points.

**Results**

*Response Rate*
Of 362 walk-in clients, 225 (62.5%) completed the baseline questionnaire. Of this group, 146 consented to receive follow-up questionnaires. For the one-month follow-up, only 28 participants returned the follow-up data by mail. For the two-month follow-up, only 8 returned the completed questionnaire. When the incentive was offered for return of the four-month follow-up data, 24 questionnaires were returned; 15 of these clients had previously returned follow-up data, and nine were new follow-up respondents.

Of 70 clients in the comparison group who received a research package at the time of their first scheduled session, only 14 (20%) completed the baseline questionnaire, of which seven indicated consent to receive a follow-up mailing. None of this group returned the follow-up questionnaires. Clearly, more resources and different procedures to recruit potential members of a comparison group are necessary.

*Description of the walk-in clinic sample at baseline*

At baseline, 121 (54%) clients were female, 102 (45%) identified as male (two did not provide this data) and the mean age was 33 years (range 16-63). Thirty-six percent were employed full-time, 15% worked part-time, 24% were unemployed, 11% were receiving disability benefits, 5% were in school and 1% worked in the home. For 44% of the sample, household income was below $19,999, 26% reported income between $20,000 and $39,000, 13% reported income between $40,000 and $59,000 and 16% reported income of $60,000 or more. Thirty-six percent were married or living common-law, 41% were single, 15% were separated or divorced, and the remainder was widowed or “other”. Ninety percent of the sample indicated that English was their first language, 1% indicated French, and the remainder indicated “other”, with Spanish and Arabic being most common.
Source of Referral and Presenting Concern

Responses to a question about source of referral to the Walk-in service revealed that 17% indicated the agency web-site, 15% said a friend, another 15% said a family member, and 10% named their physician. Thirty nine percent indicated “other” and specified sources such as Court, Ontario Works, hospital, other counselling agencies and co-workers.

When clients were asked to circle “the problem that concerns you the most” and were given five options, the largest proportion indicated depression/anxiety (27.5%) followed by problems in the couple relationship (21.6%). Family conflict and parent-child conflict accounted for smaller proportions (3.7% and 4.6% respectively), while 11.7% indicated “other” problems. For 15.6%, what brought them to the walk-in clinic involved depression/anxiety plus one other problem category and 13.8% indicated that the concern involved depression/anxiety plus two or more of the other problem categories. Finally, 1.8% indicated two or more problems but not including depression.

Severity of psychological distress

As would be expected, the mean GHQ-12 score for the subgroup of clients that reported their presenting concern as depression/anxiety plus other problems (mean = 8.94, SD= 3.4, n= 64) was higher than for the subgroup that indicated other problems but not depression/anxiety (mean =6.04, SD = 3.8, n=93). The mean GHQ-12 score for the subgroup that reported depression/anxiety only was 8.67, (SD= 3.1, n= 58). A one-way ANOVA indicated that the three groups differed significantly (F=16.82, df = 2, p = .001) and the Boniferroni post-hoc test indicated that the score on psychological distress for the group with concerns other than depression was significantly lower than both of the other groups.
Improvement at Follow-up

Table 1 allows the reader to compare the characteristics at baseline of four client subgroups: those who responded to the initial survey, those who agreed to receive follow-up questionnaires, and those who actually returned data at one month and four months post baseline. The four subgroups were not significantly different except the subgroup that returned the one-month follow-up data were more likely to have reported that their health prevented usual activities in the month prior to attending the walk-in clinic compared to the entire group that completed baseline data.

Table 2 compares those clients who responded after one month with themselves at baseline, and the client subgroup who responded after four months with themselves at baseline. The subgroup that returned one-month follow-up data showed a significant improvement on the GHQ-12 score ($p = .001$), and the improvement on this score compared with baseline was even greater for those who returned four month follow-up data ($p = .001$). A significant decrease in the proportion of clients who reported their health prevented usual activities in the previous month at both follow-up points was also reported. Although the differences did not reach statistical significance, the numbers of days lost per employed person decreased suggesting a trend towards improvement on this measure. Notably, the proportion that had used community services increased. We speculate that, in some cases, this increase may be because the visit to walk-in counselling informed them of community services of which they were not previously aware. Referral to other support services is often part of the “plan” at the single session. The improvement reported at follow-ups may have been associated with services received from these organizations in addition to the single session received at the walk-in clinic.
Relationship between Stage of Change and Improvement at Follow-up.

At baseline, the mean score was 3.6 on Precontemplation, 8.5 on Contemplation, 7.8 on Action, and 7.3 on Maintenance (maximum was 10 for all scores). The TTM would predict that clients who scored highly on the Contemplation, Action and Maintenance scales of the SOCQ would be more likely to demonstrate improvement at the follow-up time points. Table 3 illustrates that at one-month follow-up, scores on the Contemplation and Maintenance scales but not Action were significantly correlated with improvement on the GHQ-12, partially supporting the TTM.

A significant negative correlation between age and the Action and Contemplation scales indicates that older clients were less likely to be thinking about making a change or actively trying to change. Significant positive correlations among the Stages of Change scores indicate that those scoring high on Contemplation were also very likely to be high on Action and Maintenance; Action was also significantly correlated with Maintenance. This suggests that a larger sample may have yielded the expected significant correlation between Action and improvement. Correlations at four months were similar, but slightly less likely to be significant.

Discussion

Perhaps the most important result from this pilot study is a greater appreciation of the difficulty involved in studying outcomes associated with SST delivered in a walk-in counselling clinic. Also important is the finding that the clients attending this walk-in clinic are considerably distressed with a mean GHQ-12 score of 7.5 (SD=3.8), comparable to a study of adult (primarily women) patients commencing group psychotherapy in a psychiatric hospital in Brazil. The mean
GHQ-12 score for the patients in the psychiatric setting was 9.4 (SD= 3.5) (Blay, Fucks, Barruzi, Dipietro, Gastal, Neto et al., 2002).

A low response rate is not unique to this study. Miller (2008) reported that only 22.5% of adults attending the Eastside Family Center in Calgary for walk-in single-session therapy returned client satisfaction questionnaires following the single session. The questionnaires in Miller’s study were given to clients by the therapist and could have been completed immediately or returned by mail. Derisiley and Reynolds (2000), in their study of stages of change and psychotherapy attendance, reported that only 22% of clients of two outpatient mental health services returned questionnaires mailed to them prior to the first session.

The findings regarding the association between stage of change and improvement in psychological distress provide partial support for the Transtheoretical Model of Change. Initial high scores on Contemplation and Maintenance predicted reduction in distress after one month, as did that on Action (the latter not being significant). Initial high scores on Precontemplation were negatively associated with improvement. Results were similar at four months but no longer significant. The small sample size may be responsible for these mixed findings.

Because the majority of clients attending the walk-in service were in the Contemplation stage, TTM would suggest that the optimal therapeutic stance with these clients is the role of a Socratic teacher. Socratic dialogue has been described as structured discourse involving doubt and systematic questioning (Tredway, 1995). Further research would, however, be desirable.

The use of the GHQ-12, a frequently used standardized measure, is a strength of this study. Another strength is the use of research assistants to collect data, minimizing the potential bias when therapists are involved in recruiting clients and collecting data for research studies. The small samples at the two follow-ups and the lack of a control or comparison group are
significant limitations. However, the findings of the study have value in that they suggest that at least some proportion of the people attending the walk-in counselling clinic are finding it helpful in a way that decreases distress and use of health services.

The pilot study has helped us to recognize that clients who attend an agency for ongoing counselling do not constitute the best comparison group for a study of the clinical effectiveness of SST in walk-in counselling clinics. Because this model is thought to be an improvement over wait lists, the most appropriate clients for comparison would be individuals and families on a wait list. If future studies of SST in walk-in counselling clinics are to meet adequate standards of methodological rigour, sufficient resources will be required to recruit a comparison group from agencies that maintain wait lists. Collecting follow-up data by mail clearly does not yield an adequate response rate; we believe that collecting follow-up data by telephone would likely yield a better response. In planned future work we intend to use the Brief Child and Family Phone Interview (Cunningham Cunningham, Harrison, Knight, McHolm, Pollard et al., 2007) such that we can include children and youth. We also plan to employ a mixed methods design involving in-depth interviews with a purposively selected subsample of clients, to enhance the research design and our understanding of the clients’ perspectives on SST and walk-in counselling.

References


http://www.wlu.ca/documents/46045/Walk_In_Inventory_-June_6_final.pdf


Table 1. Characteristics of participants at baseline, for all participants, those who agreed to follow-up (FU), those who returned questionnaire at 1 month FU, and those who returned questionnaire at 4 months FU.

<table>
<thead>
<tr>
<th>Variable (past month)</th>
<th>Responded at Baseline</th>
<th>Agreed to Follow-Up</th>
<th>Returned one-month FU</th>
<th>Returned four month FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size</td>
<td>225</td>
<td>146</td>
<td>28</td>
<td>24</td>
</tr>
<tr>
<td>% female</td>
<td>54%</td>
<td>55%</td>
<td>71%</td>
<td>54%</td>
</tr>
<tr>
<td>Mean age</td>
<td>33</td>
<td>35</td>
<td>40</td>
<td>36</td>
</tr>
<tr>
<td>GHQ-12**</td>
<td>7.5 (3.8)</td>
<td>7.7 (3.8)</td>
<td>8.1 (4.0)</td>
<td>7.5 (3.6)</td>
</tr>
<tr>
<td>Health prevented usual activities</td>
<td>55%</td>
<td>55%</td>
<td>79%*</td>
<td>63%</td>
</tr>
<tr>
<td>Health prevented work***</td>
<td>32%</td>
<td>42%</td>
<td>38%</td>
<td>20%</td>
</tr>
<tr>
<td>Days lost/person***</td>
<td>2.5</td>
<td>3.2</td>
<td>3.1</td>
<td>2.0</td>
</tr>
<tr>
<td>Visited emergency</td>
<td>15%</td>
<td>16%</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Saw doctor</td>
<td>44%</td>
<td>48%</td>
<td>61%</td>
<td>52%</td>
</tr>
<tr>
<td>Used community services</td>
<td>45%</td>
<td>43%</td>
<td>46%</td>
<td>29%</td>
</tr>
<tr>
<td># of community services used ++</td>
<td>3.8</td>
<td>4.0</td>
<td>3.0</td>
<td>3.0</td>
</tr>
</tbody>
</table>
*denotes a significant difference (p < .05) from the largest sample, i.e. all those who completed the baseline questionnaire.

**score ranges from 0 – 12 (0=best, 12=worst)

*** averaged over all those employed

+ includes those who went to a medical walk-in clinic

++ mean for all those using
Table 2. Before and after comparison for those who returned one month and four month follow-up questionnaires: means (standard deviations)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Baseline</th>
<th>1 month Followup</th>
<th>Baseline</th>
<th>4 months Followup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size</td>
<td>28</td>
<td>28</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>GHQ (0=best, 12=worst)</td>
<td>8.1 (4.0)</td>
<td>3.3**(4.0)</td>
<td>7.5 (3.6)</td>
<td>2.8** (3.9)</td>
</tr>
<tr>
<td>Health prevented usual activities</td>
<td>79%</td>
<td>36%*</td>
<td>63%</td>
<td>33%*</td>
</tr>
<tr>
<td>Proportion employed at baseline</td>
<td>29%</td>
<td></td>
<td>42%</td>
<td></td>
</tr>
<tr>
<td>Health prevented work (if employed)</td>
<td>38%</td>
<td>13%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Days lost/employed person</td>
<td>3.12</td>
<td>0.25</td>
<td>2.0</td>
<td>0.2</td>
</tr>
<tr>
<td>Used emergency</td>
<td>11%</td>
<td>7%</td>
<td>8%</td>
<td>13%</td>
</tr>
<tr>
<td>Saw doctor/walk-in medical clinic</td>
<td>61%</td>
<td>50%</td>
<td>52%</td>
<td>50%</td>
</tr>
<tr>
<td>Used community services</td>
<td>46%</td>
<td>61%</td>
<td>29%</td>
<td>50%</td>
</tr>
<tr>
<td># of other community services used (only users)</td>
<td>3.0</td>
<td>3.8</td>
<td>3.0</td>
<td>3.7</td>
</tr>
</tbody>
</table>

** Differences are significant (p < .001) from the scores for the same individuals at baseline; * Same, (p < .05)
Table 3. Correlation Coefficients for Stages of Change, Age, Gender and Change on GHQ-12 at one-month n=28 (four months n=24) post-baseline

<table>
<thead>
<tr>
<th></th>
<th>Precontemp</th>
<th>Contempl</th>
<th>Action</th>
<th>Maintenance</th>
<th>Gender</th>
<th>Age</th>
<th>Change on GHQ</th>
</tr>
</thead>
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<tr>
<td>Precontemp</td>
<td>1.00</td>
<td></td>
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<tr>
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<td></td>
<td></td>
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<tr>
<td>Contempl</td>
<td>.201</td>
<td>1.00</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(-.674**)</td>
<td>(1.00)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>.179</td>
<td>.840**</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(-.433*)</td>
<td>(.456*)</td>
<td>(1.00)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td>.202</td>
<td>.838**</td>
<td>.814**</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(-.450*)</td>
<td>(.451*)</td>
<td>(.783**)</td>
<td>(1.00)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>-.242</td>
<td>.047</td>
<td>.019</td>
<td>.120</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(-.266)</td>
<td>(.215)</td>
<td>(.264)</td>
<td>(.307)</td>
<td>(1.00)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.038</td>
<td>-.378*</td>
<td>-.481**</td>
<td>-.365</td>
<td>-.002</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.156)</td>
<td>(.240)</td>
<td>(.091)</td>
<td>(-.052)</td>
<td>(-.115)</td>
<td>(1.00)</td>
<td></td>
</tr>
<tr>
<td>Change on GHQ</td>
<td>-.202</td>
<td>.458*</td>
<td>.302</td>
<td>.479**</td>
<td>.168</td>
<td>.048</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>(-.389)</td>
<td>(.382)</td>
<td>(.224)</td>
<td>(.162)</td>
<td>(-.202)</td>
<td>(.145)</td>
<td>(1.00)</td>
</tr>
</tbody>
</table>

*Correlation is significant at the .05 level (2-tailed)

**Correlation is significant at the .01 level (2-tailed)