CHAPTER ONE

Introduction to the research paper

1.1 Introduction

The stresses of contemporary society and their associated impact on the individual have led to the process of counselling becoming more closely scrutinised. For professionals who are responsible for the delivery of counselling and for educational facilities that deliver counsellor training, the perceptions of counsellors have become topical. Additionally, current trends toward partnerships between medical practitioners and allied health professionals indicate that the perceptions and knowledge of medical practitioners of counsellors have major significance.

Public perceptions and attitudes toward mental health professionals have been investigated in various studies over the last 50 years. From the first published survey conducted by Guest (1948), to the most recent Australian survey conducted by Sharpley (1986), data have been collected regarding what the public think of helping professionals, what is known about the activities of helping professionals and what value is placed on helping professionals. Studies that have focused specifically on the perceptions and knowledge of counsellors have concluded that the public generally hold the counselling profession in high regard. However, all of these studies also reported confusion and misinformation regarding the nature of counselling and the activities of counsellors.

Studies regarding the opinions of the medical profession toward counselling date from Nunnally (1961) to Radley, Kramer and Kennedy (1997). These studies reflected differences in opinion amongst medical practitioners regarding counsellors.

The current status of the counselling profession in contemporary Australian society has not been investigated since the study by Sharpley (1986), and there have been no Australian studies regarding the perceptions and knowledge of medical practitioners of counsellors. Therefore, it is significant to the future development of counselling and relevant to re-examine the current perceptions and knowledge of counsellors as they are perceived by the general public and by medical practitioners.

The purpose of this research was to assess whether or not attitudes toward counsellors continue to be positive and whether or not the confusion and misinformation reported in previous studies still exists. Additionally, this research sought to determine whether or not the general public could differentiate between counsellors, psychologists, psychiatrists and social workers. Comparative data were also collected between the perceptions and knowledge of the general public regarding counsellors, versus the perceptions and knowledge of medical practitioners regarding counsellors. Furthermore, the perceptions of medical practitioners in relation to patient referrals to counsellors and their willingness to have a counsellor working in their practice was examined in this research. Finally, a second study was conducted in order to assess the accuracy of the reported perceptions of the general public and medical practitioners regarding the accessibility of counsellors.

This research includes ten chapters. The first chapter introduces the research and explores definitions of counselling. The second chapter details the historical development of counselling. The relevant literature regarding issues for counselling and perceptions and knowledge of counselling is reviewed in the third chapter. Chapters four, five and six include the methodology, results and discussion of Study I,

while chapters seven and eight describe the methodology and report the results of Study II respectively. Chapter nine includes a discussion on the results for Study II. An overview of the research is presented in chapter ten.

1.11 Definition of counselling

In introducing this research, it is relevant to briefly explore how counselling has been defined. The definition of counselling used influences the determination of where in history counselling began and impacts on how counselling is perceived. Dictionary definitions of counsellors state that they are: "adviser; person trained to advise others on personal problems" (Garmonsway, 1965, p. 172). According to this definition, counselling dates far back in history to when humans first sought advice from another. However, giving advice is not how counsellors currently perceive themselves, and therefore other definitions by authors concerned with clarifying the nature of counselling have been documented. Rogers (1940) described a counsellor as "… a skilled therapist whose purpose is to release and strengthen the individual, rather than to intervene in his life…" (p. 163). Rogers (1940) further clarified that the counsellor does not suggest, advise or persuade, but rather encourages the client to take responsibility for making new choices. Tyler (1969) described the purpose of counselling as being "… to facilitate wise choices of the sort on which the person's later development depends" (p. 13). Similarly, Shertzer and Stone (1974) described counselling as "… the endeavour, by interaction with another person, to contribute in a facilitating, positive way to his improvement" (p. 5). Gladding (1996) summarised the definitions of counselling according to the American Counseling Association and Division 17 of the American Psychological Association as:

> … a relatively short-term, interpersonal, theory-based process of helping persons who are basically psychologically healthy resolve developmental and situational problems … A practitioner must complete a required course of study on either the master's or doctoral level to be licensed or certified as a professional (p. 8).

However, inspite of efforts by the above-mentioned authors to define counselling, counselling is a word that is mentioned frequently in a variety of organisations and contexts. Cracknell (1987) wrote "It appears to be an 'in word' used to describe a number of different processes; consequently, the exact meaning is difficult to establish" (p. 307). The issues of counsellor identity, counsellor expertise and training, counsellor professionalism and counsellor associations are detailed in the next chapter of this research.

CHAPTER TWO

History of counselling

2.1 Introduction

The parameters of the evolution of counselling are difficult to determine because its beginnings are inextricably linked to how it is defined. As counselling has advanced over the years the meaning it has been given, and its status as a profession, have undergone substantial change. This chapter documents the most notable events, movements, theories and individuals that contributed to the emergence of counselling as a profession. According to Shertzer & Stone (1974):

> Landmarks or 'firsts' in the history of counseling, such as who the first counselor was, are hard to establish with any degree of certainty. Resolving the issue of 'first' depends on how counseling is defined. If its traditional definition – 'giving of advice' – is accepted, then the point at which one person first sought and received verbal aid or instruction from another marked the advent of counseling (p. 21).

It could, therefore, be argued that elements of counselling evolved from Greek philosophers and early religious teachers.

The literature available detailing the history of counselling is scarce. Therefore, the sources relating to events, factors and forces that influenced counselling are largely dependent on such authors as Shertzer and Stone (1974), Shertzer and Stone (1980), Gibson and Mitchell (1990), Vaac and Loesch (1994), Gladding (1996), Kaplan and Saccuzzo (1997), and Blocher, (2000). However, primary sources are more readily

available for constructs and individuals that helped shape contemporary counselling and these have been included here accordingly.

2.2 Historical development

2.21Greek Philosophers and religious teachers

Since the beginning of civilisation people have sought to understand the human condition. Religious leaders such as Moses (100 B.C.), Buddha (500 B.C.), and Mohammed (600 B.C.) presented teachings to enhance the quality of life of the individual and to explain the struggles and conflicts people were experiencing (Neukrug, 1999). In terms of current counselling theories and practice, it is not so much the content of these religious teachings that is significant, but rather the process of individuals seeking counsel or advice from those who are perceived to have knowledge. However, some of the humanistic ideals purported by religious societies have provided the basis for later counselling theories. For example, the concepts of kindness, compassion and the ethics of social relationships that are central to Buddhist practice (Warren, 1987), are incorporated in contemporary counselling ideology.

Similarly, philosophers such as Lao-Tzu (600 B.C.), Confucious (500 B.C.), Socrates (450 B.C.), Plato (400 B.C.), and Aristotle (350 B.C.) issued advice and recommendations regarding how to live and think. For example, Socrates pointed to the differences between what is essential and what is not essential, and was concerned with the 'good' or aim of life. Plato's writings were a series of dialogues that incorporated theories of knowledge being relative to perceptions, and was also concerned with the desire of human beings for 'good' (Wilbur & Allen, 1979). Aristotle was concerned with 'Ethics', which incorporated concepts of friendship, justice,

community, self-love and self-sacrifice (Thomson, 1953). These theories and concepts are evident in counselling approaches such as existentialism.

Hence, throughout history there have been both religious and philosophical writings which have reflected on the nature of people and the understanding of self. All could be argued to be significant to the origins of the counselling field (Neukrug, 1999). However, the general consensus amongst authors who have documented the historical development of counselling is that the constructs and events that have largely shaped counselling, and the individuals who have had most influence upon it, are from more recent history. Shertzer and Stone (1974), Shertzer and Stone (1980), Vacc & Loesch (1994), Gladding (1996), and Blocher (2000), all agree that contemporary counselling had its most significant origins in the beginning of the 20th century in the United States of America. As Blocher (2000) states:

> …it seems more reasonable to commence with a brief account of the events that were shaping the nature of American society around the beginning of the 20th century. These were the forces and events that energized the "spirit of the times" from whence came the ideas and ideals of the pioneers of what eventually became counseling psychology (p. 4).

2.22 The American Influence

The emergence and development of counselling in America was the result of a combination of influencing factors. According to Shertzer and Stone (1974), the reason for America being the forerunner in the origins of counselling is not clearly apparent. Nevertheless, they cite a number of conditions existing in America at the time as influential. The influence of the American social environment, which included the

concept of the importance of the individual, the rejection of rigid class distinctions, and the philosophy of individuals realising their full potential, provided an atmosphere conducive to the rise of counselling. The American economy and the emphasis on the welfare of children were also certain contributors to an increased demand for counselling (Shertzer & Stone, 1974).

At the beginning of the 20th century, American society was in a state of change. Conflict began to develop between American idealism and "…feelings of derealization, moral confusion, and a lack of a sense of meaning and a place in society" (Freedheim, 1992, p. 36). As events and forces continued to have social and economic impact, individuals sought advice, counsel and guidance to assist with the adjustments and conflicts that emerged (Gibson & Mitchell, 1990).

Therefore, the origins of counselling can, in a general context, be seen to have evolved from the ancient Greek philosophers and early religious teachers. However, counselling became more clearly defined around the beginning of the 20th century, and over the ensuing decades emerged as a professional and distinct movement. Central to the development of counselling were a series of historical events and movements, and these will be briefly described below.

2.3 Historical events, factors and forces

2.31 The American Civil War and the industrial revolution

At the turn of the 20th century, the impact of the American Civil War was prominent. Economically and socially the nation flourished. Blocher (2000) has described this period of time as "…the amassing of great fortunes, of breathtaking

technological advances, and of dramatic conquests and ruthless exploitation of natural and human resources" (p. 4). The nation was in a state of transformation psychologically, as well as economically. Population growth expanded dramatically and resulted in movement towards urbanisation (Blocher, 2000). Furthermore, the Civil War had highlighted moral conflict over the issues of slavery versus the ideal of a free labour system in the North (Cramer, 1965). Thus, the aftermath of the American Civil War created significant social, psychological, economic and moral issues that facilitated the advent of social reform movements.

The effects of the Industrial Revolution were similarly profound during the early 1900's. The importance of the cottage industry became secondary to the emerging industry of steel and technological advancement. Subsequently, there emerged a "…concentration of wealth and consequent political and economic power in the hands of giant corporations and the relative handful of people who controlled them" (Blocher, 2000 p. 6). Hence, the abundance of wealth resulting from the Civil War did not benefit a considerable portion of the growing population. Unskilled labourers, factory workers, recent immigrants, and farmers became displaced in the new industrial movement. There was very little put in place to ensure the safety and protection of workers and child labour was an acceptable part of life (Blocher, 2000). These changes challenged the traditional notion of the work ethic and the associated concepts of fair remuneration for labour. Blocher (2000) argues that:

> It was the conflict between these sharply differing views of what constituted a just and healthy society that set the stage for the social reform efforts out of

which the Guidance Movement, the forerunner of today's counseling psychology, first emerged (p. 6).

2.32 Social reform, the progressive movement, and vocational guidance.

Between 1900 and 1920 there emerged an increasing number of individuals and groups of people who sought to bring about social reform to address the negative consequences of the Civil War and the Industrial Revolution. This period of time has been labelled "The Progressive Era" (Blocher, 2000). Organised charities and settlement houses were established, as were government bureaus for corrective services (Shertzer & Stone, 1980). However, the primary focus of the Progressive Movement was the welfare and needs of youth. It was prioritised that children needed to be prepared during their education for work in the new industrial world (Blocher, 2000).

The emphasis on education as a means of preparing children and youth for the nature of work in the industrial world led to vocational guidance. According to Shertzer and Stone (1980) "Most authorities identify the emergence of vocational guidance as the beginning of modern-day counseling" (p. 27). The efforts of Jesse B. Davis resulted in a systemised guidance programme in public schools for the first time (Gladding, 1996). He was further instrumental in the formation in 1913 of the National Vocational Guidance Association (NVGA) (Vaac & Loesch, 1994). The NVGA was significant in that it united professionals, established a formal association, and offered guidance literature for the first time (Gladding, 1996).

Additionally, the work of Frank Parsons had a major influence on the development of vocational guidance. He is regularly referred to as the "Father of Guidance", and was responsible for the institutionalisation of vocational guidance when

he founded Boston's Vocational Bureau in 1908 (Gladding, 1996). Parson's experience in vocational guidance led him to maintain that, in assisting youth in selecting a vocation, there were three major steps involved. These steps included an understanding of the individual in terms of interests, temperament and abilities, an analysis of job opportunities and requirements, and what he called 'true reasoning'. In 1909, the book *Choosing a Vocation*, written by Frank Parsons, was published and became influential in vocational guidance within many school systems (Parsons, 1909). Hence, it can be argued that: "Counseling originated to help individuals choose, enter and progress in an occupation." (Shertzer & Stone, 1980, p. 27).

2.33 Influence of Mental Health Movement.

During the early 1900's, the Mental Health Movement was similarly emerging as a reform measure. This was instigated primarily by the personal experiences and observations made by Clifford Beers in his book *A Mind That Found Itself* (1908). This book exposed the sub-standard states of mental institutions, and inspired the beginning of an organised mental health movement by way of the formation of the Connecticut Society for Mental Hygiene in 1908. Beers further facilitated the emergence of the National Committee for Mental Hygiene in 1909 (Shertzer & Stone, 1980). This movement initiated and advocated for legislative reform, aftercare and free clinics for the mentally ill. It further sought to educate the general public, schools and parents in prevention and early treatment of mental illnesses (Shertzer & Stone, 1980).

Additionally, support began to emerge for a new type of institution to deal with the mentally ill at a local level (Gibson & Mitchell, 1990). Located within the community, these institutions were to be focused on treatment involving the support

networks of the patient (Gibson & Mitchell, 1990). The rationale for a treatment facility to treat mental illness in the community was of lasting significance, as Gibson and Mitchell (1990) wrote: "This institution was to become the forerunner of our present-day community mental health center. It was called a psychopathic hospital" (p. 17). Therefore, the Mental Health Movement contributed to the incorporation of counselling programmes in schools and public clinics to address in a compassionate and humane manner the needs of the mentally ill (Shertzer & Stone, 1980).

2.34 World War I and the psychometric and child study movements

The impact of World War I on the historical development of counselling was twofold. Firstly, it facilitated the origins of rehabilitation counselling (Gibson & Mitchell, 1990). The Civilian Vocational Rehabilitation Act (Public Law 236) was passed in 1920, followed by Public Law 47 in 1921 (Gibson & Mitchell, 1990). From this legislation the Veteran's Bureau was created and, according to Gibson & Mitchell (1990) "…provided, among other benefits a continuation of vocational rehabilitation services for veterans, including counseling and guidance" (p. 17).

Secondly, World War I resulted in the development of a number of psychological instruments, commissioned by the United States Army to screen its personnel. Among these tests were the Army Alpha and Army Beta intelligence tests (Gladding, 1996). Additionally, the Personal Data Sheet was a personality test devised by Robert Woodworth for the selection purpose of the Army. These screening measures were implemented to reveal those who were mentally ill and to identify those of superior intelligence for officer training (Shertzer & Stone, 1974). At the end of the

war, some of the psychometrics used by the army were adapted to civilians. Hence, psychological testing became a popular movement (Gladding, 1996).

The testing movement had a number of influences on counselling. As Shertzer and Stone (1974) state:

> …it (1) led to the objective study of individual differences, such as sex, race, and social status differences; (2) served as a base for development of the trait-and-factor concept of personality; (3) enabled scientific investigations to be made of problems like the rate of growth of intelligence and the constancy of intelligence measures over a period of time; (4) focused attention on the diagnosis and evaluation of maladjustment; (5) facilitated prediction, classification, and placement of individuals; and (6) resulted in the formulation and publication of a code of ethics to be used as a guide for responsible testing practices" (p. 28).

These benefits of the testing movement provided the cornerstone for the ongoing development of psychometrics.

Although the testing movement flourished in America following World War I, it has origins dating back over 4000 years ago to China where examinations were given as part of a civil service testing program and the results were used to make decisions about work promotions and for work evaluations (Kaplan & Saccuzzo, 1997). Throughout the Han Dynasty and the Ming Dynasty, test batteries became common, more refined, and more widely used (Kaplan & Saccuzzo, 1997). The English East India Company emulated the Chinese system in 1832 and used tests to determine suitability of employees for overseas employment (Kaplan & Saccuzzo, 1997). Due to

the efficacy of these testing programmes, in 1855 the British government adopted testing for its civil service, and the German and French governments copied this testing system soon afterwards (Kaplan & Saccuzzo, 1997).The theories and writings of Charles Darwin in the mid 1800s influenced Sir Francis Galton to begin to develop ways of determining and understanding individual differences (Kaplan & Saccuzzo, 1997). James McKeen Cattell extended the works of Galton, and in 1890 "… coined the term mental test" (Kaplan & Saccuzzo, 1997, p. 14). Wilhelm Wundt in Germany established the first psychological laboratory in 1879, and other laboratories were soon developed as research was undertaken to assess intelligence (Shertzer & Stone, 1974). In 1905, Albert Binet and Theophile Simon developed a standardised scale for measuring general intelligence. Binet and Simon modified this scale in 1908 and 1911 and further revisions occurred in America (Shertzer & Stone, 1974).

Following the intelligence tests came the development of personality, interest, and special aptitude tests. Robert Woodworth developed the forerunner of personality tests with the Personal Data Sheet, and the Strong Vocational Interest Blank emerged in 1927 as one of the initial interest inventories (Shertzer & Stone, 1974). In 1937 Walter Bingham published what was to be for many years a standard reference, *Aptitudes and Aptitude Testing* (Shertzer & Stone, 1980). From 1945 to 1960 test “batteries” and large-scale testing programmes came into being (Shertzer & Stone, 1974). Hence, the history of the psychometric movement paralleled the development of the need to measure and quantify human characteristics. Psychometrics continues to be an integral part of contemporary counselling.

Another movement significant to the development of counselling was the Child Study Movement. The primary impact of this movement, influenced by G. Stanley Hall, was to place emphasis on the child as an individual (Shertzer & Stone, 1980). The formative years of child development were acknowledged as the basis for personality development. More analytical and precise methods of child studies were introduced with the highlighted need for reliable knowledge about children (Shertzer & Stone, 1980). The counselling developments that were influenced by this movement are chronicled by Shertzer and Stone (1974) as the following:

> During the 1920's and 1930's child study centers in some states … and scientific journals and organizations designed to promote the well-being of children came into existence. The questionnaire method of inquiry, popularised by Hall, resulted in the rapid accumulation of data relating to different phases of the mental life of all ages (p. 24).

2.35 The Depression and World War II

The stock market crash of 1929 motivated further development in the counselling process. Mass unemployment led university and vocational settings to prioritise helping strategies and counselling methods that were pertinent to employment (Shertzer & Stone, 1980). Subsequently, the United States Employment Service was established to provide counselling, placement services, and testing. Additionally, Abraham and Hannah Stone established the first marriage and family centre in New York. Edmund Griffin Williamson and colleagues at the University of Minnesota developed the first theory of counselling. They used a modification of Frank Parsons hypothesis to work with students and the unemployed (Shertzer & Stone, 1980).

Williamson's approach emphasised directive, counsellor-centred techniques, and his theory has been known as the Minnesota point of view and trait-factor counselling (Williamson, 1939). Gladding (1996) explains the approach of Williamson as the following:

> His pragmatic approach emphasized the teaching, mentoring, and influencing skills of the counselor. One premise was that persons had *traits* (such as aptitudes, interests, personalities, and achievements) that could be integrated in a variety of ways to form *factors* (constellations of individual characteristics) (p. 11).

This theory of counselling was a scientific, empirical method that focused on problem solving and accommodating the individual needs of each client with a view to eliminating non-productive thinking and facilitating effective decision making (Williamson, 1939). There are elements of this philosophy in current counselling practice.

Finally, the work of John Brewer facilitated change, in that his book *Education as Guidance* (1932) challenged the notion that the primary focus of counselling was vocational assistance. His book suggested that every school should be involved with preparing students for life after education, and that all teachers should be counsellors. Brewer (1939) further proposed that guidance be included in the school curriculum as a subject. He argued that vocational guidance was one part of a range of responsibilities of a counsellor.

Thus, from the depression of 1929, there emerged important shifts in counselling development. The associated human needs that were products of this time in history resulted in a move away from the previous focus of vocational guidance. Counselling was starting to diversify.

World War II saw further refinement of the selection, training and placement procedures that began during World War I. Both the Army General Classification Test (1941) and the United States Employment Service General Aptitude Test Battery (1945) were products of this time (Shertzer & Stone, 1980). Counselling was made available to disabled veterans and eventually to all veterans, and centres were established to facilitate this (Shertzer & Stone, 1980). In 1952 the civil service position of "Counseling Psychologist" was created and the establishment of the Office of Vocational Rehabilitation occurred in 1954 (Shertzer & Stone, 1980).

The Second World War further challenged stereotyped occupational sex roles, as women began to work outside of the home (Gladding, 1996). Subsequently, previously held ideas about vocational guidance began to change. Therefore, World War II highlighted the need for counsellors and provided further impetus for developmental change. Again, the demands of the time reflected a further refining and expansion of the roles, responsibilities, and expertise of counsellors.

2.36 Post War Developments

After the war, the American Veterans Administration (VA) financed the training of counsellors and psychologists by providing grants (Gladding, 1996). The VA was further influential in that it coined the term ‘counseling psychologist’ (Gladding, 1996). The introduction of the National Defence Education Act in 1958

contributed to counselling by providing further funds for the training of counsellors (Gladding, 1996). Also, as a result of the Act, counselling and guidance institutes were established. As funding sources and government Acts supported the development of counselling, a number of organisations were established that reflected the evolution process (Gladding, 1996).

From 1935-1951 the American Council of Guidance and Personnel Association (ACGPA) was developed (Gladding, 1996). However, it lacked structural organisation, and in 1952 the American Personnel and Guidance Association (APGA) was established to create a more formal group (Gladding, 1996). Initially, it was an interest group rather than a professional organisation as it did not have any regulations on standards for membership (Gladding, 1996).

Additionally, in 1952 the Division of Counseling Psychology (Division 17) was formalised within the American Psychological Association (APA). This division sought to make a clear distinction between counselling psychology and clinical psychology (Gladding, 1996). Donald Super contributed largely to establishing an identity for counselling psychology, although this was difficult to achieve from within the APA (Gladding, 1996). Nevertheless, the existence of the division was another milestone in the development of counselling.

Leona Tyler published *The Work of the Counselor* in 1953 as a teaching aid for psychology students and for those expecting to work in colleges or high schools. This book outlined the general principles of counselling such as listening, warmth and responsiveness (Tyler, 1969).

In 1962 Gilbert Wrenn published his book *The Counselor in a Changing World*. His focus was on counselling as a developmental profession, and his book was influential throughout the 1960s as he emerged as a strong advocate for counselling. However, the Vietnam War, the civil rights movement, and the women's movement all lessened the impact of the developmental model as needs and issues arose from these key events (Gladding, 1996). Crisis counselling and short-term intervention strategies became focal points as counsellors sought to address the specific needs that were emerging (Gladding, 1996).

From the turmoil of the Vietnam War, and the lasting consequences of the civil rights movement and the women's movement, the diversity and professionalism of counselling continued to develop through government acts and established organisations (Gladding, 1996). The Community Mental Health Centers Act of 1963, created opportunities for counsellors to be employed outside the educational setting (Gladding, 1996). This diversification of counselling resulted in the development of new counselling concepts. In 1977 Lewis and Lewis created the term 'community counselor,' used to describe the emerging multifunctional role of counsellors (Gladding, 1996). During the 1980s and 1990s there was an increased emphasis on human growth and development issues within the counselling profession (Gladding, 1996). A new focus emerged on the issues of adults and the elderly, exemplified by the formation of the Association for Adult Aging and Development (AAAD), (Gladding, 1996). Gender and sexual preference issues were given increased attention, as were multicultural issues.

A ‘sound code of ethics for counselors’ was published by the APGA in 1961, and in 1973 a division of the APGA, the Association of Counselor Educators and Supervisors (ACES), outlined the standards for a masters degree in counselling (Gladding, 1996). They further approved guidelines for doctoral preparation in counselling in 1977 (Gladding, 1996). The APGA also sought to move toward state and national licensure, and in 1976 the first counsellor licensure law was adopted in Virginia (Gladding, 1996). During the 1980’s it became apparent within the APGA that the words ‘personnel and guidance’ no longer adequately described the roles of counsellors. Hence, in 1983 it was renamed the American Association for Counseling and Development (AACD). In 1992, another decision was made to modify its title, and it became the American Counseling Association (ACA), and remains so today (Gladding, 1996). Other efforts to expand and develop proficiency occurred in 1969 when Division 17 of the APA began to publish a professional journal, *The Counseling Psychologist* (Gladding, 1996).

Additionally, the ERIC Clearinghouse on Counseling and Personnel Services (ERIC/CAPS) was established in 1966, and was to have a lasting impact (Gladding, 1996). According to Gladding (1996) “Through the years ERIC/CAPS would become one of the largest and most used resources on counseling activities and trends in the United States and throughout the world” (p. 15). Hence, new focus, new legislation, and new organisations all assisted in providing the counselling profession with credibility and identity.

A new emphasis also began to emerge on the training and skills of counsellors. Basic counselling skills began to be taught within helping-skills programmes

(Gladding, 1996). In 1981, training programmes sought accreditation, and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) was established to facilitate this (Gladding, 1996). This organisation was responsible for standardising masters and doctoral education programmes in the areas of school, community agencies, mental health, and relationship counselling (Gladding, 1996). Similarly, the National Board for Certified Counselors (NBCC) was formed in 1983 and began to certify counsellors on a national level. A standardised test was developed defining eight major subjects in which counsellors should be conversant before becoming certified (Gladding, 1996).

Hence, counselling was evolving as a distinct mental health profession. As Gladding (1996) quotes, the "role statements, codes of ethics, accreditation guidelines, competency standards, licensure, certification and other standards of excellence" (p. 17), are the characteristics that distinguish a profession. Complementary to the role of events, factors, and movements in the development of counselling was the influence of constructs and individuals.

2.4 Constructs and individuals

2.41 The Psychoanalytical Approach

2.41.1 Sigmuend Freud

According to Vacc & Loesch (1994), the psychoanalytical model was the first counselling model. The focus for this model included the past history of the client, the client's personality and the relationship between the client and the counsellor. According to Freudian psychology, the role of the unconscious, the concept of repression of memories, an understanding of human 'instinctual drives,' human

sexuality, the 'Oedipus Complex', and the concept of 'the Ego' and the 'Id', are key factors in understanding the human condition (Freud & Freud, 1986). Although Freudian ideology is not widely utilised in contemporary counselling, the significance of this approach lies in that individuals and therapeutic approaches that developed after Freud modified his concepts and procedures. Corey, (2001) writes that Freudian ideology "…called attention to psychodynamic factors that motivate behavior, focusing on the role of the unconscious and developing the first therapeutic procedures for understanding and modifying the structure of one's basic character" (p. 68). Furthermore, other models for counselling have emerged as extensions of and reactions against, Freudian theories.

2.41.2 Erik Erikson

Erik Erikson extended the theories of Freud by highlighting the psychosocial influences on individual growth. He focused many of his studies, teachings and consultations on problems of young adulthood. Later in his life he extended his studies to investigate the problems with productivity in the middle aged (Erikson, 1993). In terms of impact on the development of counselling he "…is often credited with bringing an emphasis on social factors to contemporary psychoanalysis" (Corey, 2001, p. 73).

2.41.3 Carl Jung

A former colleague of Freud, Carl Jung also made contributions to contemporary counselling. His works placed significant importance on changes that occur during middle age. In contrast to Freud, Jung placed less focus on human

sexuality in relation to psychological issues. He also developed a spiritual approach, which emphasised the importance of individuals finding meaning in life (Jung, 1970).

2.42 The Adlerian Approach

Following an irreconcilable conflict with Freud, Alfred Adler developed an approach to therapy that he called "individual psychology." What is notable about the Adlerian Approach is that it shifted the focus from the sexual nature of Freud's theory to an understanding of the broader family and background forces at work. Although the Adlerian philosophy was called Individual Psychology, the concentration on the individual was in a social context (Adler, 1964).

At the end of World War I, Adler's interest in children led to the establishment of the first of 30 child-guidance clinics in the Viennese school system. He advocated strongly for school reforms and an improvement in child-rearing behaviours. He spent a large part of his time giving lectures to and writing for the general public, and as such was the first individual to endeavour to present a psychological theory in a language that could be understood by non-professionals (Prochaska & Norcross, 1994).

The Adlerian approach also initiated ideas that had implications for multiculturalism. By focusing on the importance of the cultural context, emphasising health rather than pathology and seeking to understand individuals according to their goals and purposes, this approach could be utilised by numerous cultures (Corey, 2001). Furthermore, by placing importance on the development of a theory to practically deal with problems, and by purporting a holistic perspective on life, the Adlerian philosophy sought to be sensitive to cultural issues (Corey, 2001).

The contributions of Adler are summarised by Corey (2001) as "elementary education, consultation groups with teachers, parent education groups, marriage counseling, family counseling, and group counseling" (p. 131).

2.43 The Existential Approach

Corsini & Wedding (1995) argue that the prescursors to the existential movement were the beliefs of Plato, Sartre, and Augustine regarding human existence, and truth versus reality. Beginnings of existentialism can also be found in the writings of other prominent philosophers such as Kierkegaard and Nietzsche, both of whom further elaborated on the dichotomy between truth and reality (Corsini & Wedding, 1995). However, the Existential Approach in counselling became formalised in the 1940s and 1950s. Existentialism was not founded by any one individual or group, but arose in different parts of Europe from different schools of philosophy, psychology and psychiatry. It emerged as a means to understand the human experiences of isolation, alienation and meaninglessness. Although absent of any founding figures, there were individuals whose contributions to the existential movement were notable (Corey, 2001).

2.43.1 Victor Frankl

Viktor Frankl developed logotherapy which, when translated means therapy through meaning. Additionally, his writings have been translated into over 20 different languages and his book *Man's Search for Meaning*, (1959) has been a contemporary best seller. This book details Frankl's personal experiences in a German Nazi concentration camp during World War II and focuses on the freedom of the individual to find value and meaning despite external circumstances (Frankl, 1959).

2.43.2 Rollo May

Rollo May was instrumental in bringing the existential movement to America. He was further responsible for translating the key concepts of the movement into therapeutic practice (May, 1975). He espoused the importance of seeking 'the inner reality.' He argued that a connection with inner values was the remedy for "…feelinglessness, the despairing possibility that nothing matters, a condition very close to apathy" (May, 1969, p. 27).

In terms of impact on the development of counselling, the existential movement most notably provided a new view of death as a positive force, rather than an event to be feared (Corey, 2001). It also added a new understanding of guilt, frustration, anxiety, loneliness and alienation, and emphasised the importance of humanness in the therapeutic relationship (Corey, 2001). As Prochaska and Norcross (1994) state: “Core existential concepts – meaning, freedom, responsibility, individuality, authenticity, choice – have been incorporated into most contemporary systems of psychotherapy” (p. 123).

2.44 Gestalt Therapy

Fritz Perls and his wife Laura developed Gestalt therapy in the 1940s. The primary goal of this therapy is for the client to gain an awareness of what they are experiencing. Accordingly, Gestalt techniques are experiential and are designed to focus the client on the here and now, and their associated thoughts, feelings, and actions. These techniques facilitate the client to emotionally experience their conflicts and struggles, and then from a heightened awareness to become able to make decisions for change (Perls, Hefferline & Goodman, 1951).

The contributions of the Gestalt approach to counselling lie in its development of new creative methods of moving the client from talk to action and experience within the counselling session. Additionally, Gestalt therapy provided a new perspective on dream analysis. It subscribed to a unique pathway for awareness, whereby each aspect of the dream is seen as a projection of the person (Corey, 2001).

2.45 Person-Centred Therapy

Many of the currently used micro-skills for counselling such as empathy, unconditional positive regard, and genuineness, evolved from Person-Centred Therapy (Nelson-Jones, 1995). This approach, established by Carl Rogers, developed as a reaction to the existing theories that espoused the philosophy that the 'counsellor knows best.' Person-Centred Therapy assumes that people have the potential to identify and resolve their own problems without direct intervention, and that they are capable of self-directed growth (Rogers, 1980).

During the 1940s, Rogers developed what was called nondirective counselling. He challenged the commonly held assumption that advice, direction, suggestion, teaching, persuasion, diagnosis, and interpretation were valid counselling procedures. He rejected the use of diagnostic tools, and saw them as prejudiced, inadequate and misused. The primary focus of the Rogerian theory was reflecting and clarifying the verbal and non-verbal communications of the client (Rogers, 1980).

In the 1950s Rogers renamed his model Client-Centred Therapy to highlight the focus on the importance of the client’s frame of reference in the therapeutic relationship. During the 1970s and 1980s he again renamed his theory to the Person-Centred Therapy, as an acknowledgement of the expansion of his works into industry

and education (Rogers, 1980). Hence, Rogers pioneered a significant shift in perceptions of the counselling process from one of procedures, techniques and directives to a focus on the therapeutic relationship.

2.46 Transactional Analysis

Another theory of counselling that developed in reaction to the psychoanalytical movement was transactional analysis (TA). Eric Berne formally presented his first paper outlining TA in 1957. The focus of TA is that human personality can be defined by three ego states, that of Parent, Adult and Child (PAC). Understanding these ego states, their associated functions, and identifying which one is operational during any interaction, are the main therapeutic goals of TA (Berne, 1964). Although it was a popular therapy during the 1970's, transactional analysis is no longer a prominent counselling theory. However, TA has significance in the development of counselling in that it brought focus to interpersonal interactions and the therapeutic value in the analysis of these interactions (Prochaska & Norcross, 1994).

2.47 Reality Therapy

William Glasser was another individual who developed a theory of counselling after rejecting the psychoanalytical approach. In 1962 he founded what was known as Reality Therapy which, by 1996, had incorporated what Glasser called Choice Theory. As the name suggests, the main theoretical philosophy was that individuals have the power of choice. Successful counselling outcomes could occur providing the client was motivated to change and believed that change would occur by making different choices (Glasser, 1964). The focus on self-evaluation by the clients, having a plan of

action and the brief nature of Reality Therapy are its most valuable contributions to the development of counselling (Corey, 2001).

2.48 The Behavioural Approach

Just as individuals who predated the emergence of a formalised approach shaped existentialism, Behaviour Therapy had similar precursors. Ivan Pavlov contributed to the behavioural movement with the experiments he performed on dogs (Nelson-Jones, 1995). He discovered and wrote about conditioned reflexes and the learning or unlearning of the same (Nelson-Jones, 1995). This experimental work laid the foundation for what is known in behaviour therapy as classical or respondent conditioning (Nelson-Jones, 1995).

In the early 1900s John Watson emerged as a strong advocate for behaviourism (Watson, 1931). As Corsini & Wedding (1995) state "Watson's emphasis on the importance of environmental events, his rejection of covert aspects of the individual, and his claim that all behavior could be understood as a result of learning became the formal bases of behaviorism" (p. 201).

Similarly, Burrhus Skinner made a distinctive contribution to the behavioural approach. Apart from writing numerous books about behaviourism, he developed and highlighted the concept of consequences for behaviour, arguing that: "Behavior is shaped and maintained by its consequences" (Skinner, 1971, p. 23). This principle became known as operant conditioning.

The works of Albert Bandura have had a notable impact on the development of counselling. His study of observational learning "… has made a significant contribution to understanding how clients learn helpful and harmful ways of thinking

and behaving" (Nelson-Jones, 1995, p. 290). He further expanded on cognitive concepts such as self-regulation and self-efficacy and, in 1958, he published a book concerning social learning, *Principles of behaviour modification*. Additionally, he was concerned with the concepts of incentive and vicarious motivators (Bandura, 1986). These contributions are evident in contemporary counselling.

Joseph Wolpe further pioneered behavioural methods that remain in current practice. Using cats in laboratory experiments, he developed a method based on 'reciprocal inhibition' for 'deconditioning neurotic fear responses.' This theory involved finding a number of incompatible or competing responses to inhibit anxiety responses. The primary competing response used by Wolpe was relaxation as a part of a process called systematic desensitisation. This entailed creating a hierarchy of anxiety-provoking events, and dealing with each one separately, beginning with the least anxiety-proving event (Wolpe, 1958). These methods are an integral part of contemporary behaviour therapy.

In the 1950s and early 1960s, the behavioural approach emerged as a radically different approach to the dominant psychoanalytical perspective (Corey, 2001). It offered behavioural conditioning techniques as a viable alternative to psychotherapy. The two notable influences during this time were firstly the publishing of John Krumboltz's book (1964) *Behavioural Counseling Theory and Practice*, and the introduction of biofeedback in 1968, by Joseph Kamiya (Shertzer & Stone, 1980). However, it was not until the 1970s that behaviour therapy made a significant impact on education, counselling, psychotherapy and psychiatry (Corey, 2001).

Unique to the behavioural approach is its adherence to the principles of the scientific method. As Corey (2001) states "Concepts and procedures are stated explicitly, tested empirically, and revised continually. Treatment and assessment are interrelated and occur simultaneously" (p. 282). Therefore, a comprehensive and systematic approach to counselling evolved that had accountability.

Behaviour therapy contributed to the development of counselling in numerous other ways. It introduced the notion of identifying specific goals for treatment at the beginning of the therapeutic process (Corey, 2001). Additionally, central to the philosophy of behaviour therapy is collaboration with the client about what behaviour will be changed (Corey, 2001). Subsequently, a wide variety of techniques and procedures from a number of therapeutic systems were employed to achieve goals.

Furthermore, behaviour therapy challenged the global approach to counselling by focusing on specifics (Corey, 2001). It also placed importance on being proactive rather than simply talking about problems, and introduced behavioural methods and exercises to facilitate active change (Corey, 2001). The variety of techniques and tools used by behaviour therapists has been extended comprehensively to other areas of human functioning. A major development from this was the use of behavioural techniques in the prevention and treatment of medical disorders. According to Corey (2001) "Behavior therapy is deeply enmeshed in medicine, geriatrics, paediatrics, rehabilitation programs, and stress management. This approach has made significant contributions to health psychology, especially in the areas of helping people maintain a healthy lifestyle and in managing illness"(p. 283).

An additional contribution of behaviour therapy is the focus on research into and evaluation of treatment results (Corey, 2001). If progress is not made, then the treatment plan is reviewed and acknowledgement is made that what is effective for one person may not be helpful to another (Corey, 2001). Hence, treatment of clients is individualised and flexible.

Finally, behaviour therapy has influenced counselling by stressing the importance of ethical accountability (Corey, 2001). At the beginning of the counselling session, the client is told about the nature of counselling, what techniques may be used, and the associated benefits and risks. Clients are informed and consulted about their treatment, and as such a partnership is formed between the counsellor and the client (Corey, 2001).

2.49 The Cognitive Approach

2.49.1 Albert Ellis

Albert Ellis developed Rational Emotive Behaviour Therapy (REBT) after rejecting the philosophies of psychoanalysis. Central to Ellis' theory and of significant impact on counselling is the A-B-C theory of personality. According to this theory, A signifies the activating event, B denotes the belief about the event, and C represents the emotional and behavioural consequences. Therefore, the focus of rational emotive therapy is concentrating on and challenging the belief system of the client. Ellis further developed the concept of identifying and reframing what he called irrational thoughts. Client's monitoring their self-talk, and modifying language that is of an absolute nature, such as using generalisations, is central to this theory (Ellis, 1962).

Providing clients with homework, and suggesting that they read self-help books, listen to tapes and/or attend workshops to supplement the counselling process is another contribution of REBT. It highlighted the emphasis of converting insights that other theories had similarly espoused into action. Lastly, REBT was the forerunner to the development of other cognitive behaviour therapies (Corey, 2001).

2.49.2 Aaron Beck

Aaron Beck both modified and extended REBT to develop Cognitive Therapy. Beck's research and approach impacted largely in the treatment of anxiety, phobias, and depression. His pioneering efforts led to Cognitive Therapy being expanded to the treatment of drug and alcohol abuse, eating disorders, personality disorders, and relationship counselling. He additionally developed assessment tools for depression, suicide risk, anxiety, personality, and self-concept (Beck, 1976).

2.491 Truax & Carkhuff

Just as the above-mentioned approaches, theories and constructs contributed to the development and evolution of counselling, so too did a number of individuals. One of the most valuable skills for a counsellor is that of empathy. This skill, highlighted in its importance initially by Carl Rogers, came under closer scrutiny in 1961 when Truax developed a nine-point rating scale to measure empathy. Carkhuff later revised this in 1969 into a five-point scale (Truax & Carkhuff, 1967).

The development of a tool to measure empathy had a major input into counselling. For the first time the empathic skills of the counsellor could be assessed and the impact on therapeutic outcomes of empathy could be determined (Truax &

Carkhuff, 1967). Research studies that followed showed that progress in therapy was related to the degree of empathy demonstrated by the counsellor (Neukrug, 1999).

During the 1970s and 1980s, the Carkhuff scale was central to the training of counsellors. Although it has not been used extensively in later years, the scale provided a platform for similar microcounselling skills training (Neukrug, 1999).

2.492 Kagan

In 1965 Kagan started video-taping counselling interviews to gain further insights into what ingredients were significant for change to occur for recipients of counselling. By observing closely any change processes in the therapeutic sessions, a greater understanding of the efficacy of counselling techniques became apparent (Kagan, 1973). The initiatives of Kagan led to the Interpersonal Process Recall Studies (Shertzer & Stone, 1980). These involved collating information from the clients about when something of importance occurred for them in the counselling session and how those incidents felt for them (Kagan, 1973).

2.493 Ivey

The information gathered from videotapes, client feedback and other research, facilitated changes in the training of counsellors. A training programme to teach basic skills for counselling was developed by Ivey in the early 1980s. This programme was originally called microtraining, and later developed into Modern Rogerian Encounter Skill Pattern (MRESP) (Ivey & Authier, 1978). While similar to the skills outlined by client-centred therapy, Ivey's training programme was more specific in its definition of counselling skills. Each skill was defined one at a time and evaluation of learning was assessed by videotape (Ivey, 1994). Hence, use of counselling skills and related

training programmes were becoming more refined and measured, and this research continues to influence the effective use of specific counselling microskills.

2.494 Egan

As the skills of the counsellor and the counselling styles used in therapeutic sessions became prolific and subsequently related to the outcomes of counselling, the importance of the process of counselling emerged. Pioneers in developing appropriate methods for optimum counselling outcomes were focused on the microskills of counselling. The writings of Egan reflected this emphasis. The counselling skill of attending was summarised by Egan as involving five non-verbal skills, and forms the acronym SOLER. The S represents facing the client squarely indicating interest in and involvement with the client. The O denotes open body posture, not crossing arms or legs, and the L signifies leaning towards the client, not too far forward to be intrusive, but not too far back to indicate disinterest. The E alludes to appropriate eye contact with the client, and the R represents being relaxed and comfortable (Egan, 1994). Therefore, the behaviours, body language, and skills of the counsellor came under scrutiny, and tools and principles became developed to promote quality counselling styles. These principles of effective counselling continue to be utilised by counsellors and are incorporated in counsellor education.

2.5 Overview

Beginning as a vague notion of providing advice and philosophising, counselling emerged with a clear identity as it progressively evolved according to the needs and demands of society. Hence, over a span of centuries and more recently decades, philosophers, religious teachers, events, factors, movements, constructs and

individuals, have all contributed to and moulded counselling into the dynamic profession of today. Table 1 shows these recent major milestones in chronological order.

TABLE 1

Milestones: a chronology of counselling historical events

Date	*Individual*	*Event*
1878	Wilhelm. Wundt	Established first psychological laboratory in Leipzig, Germany.
1883	G. Stanley Hall	Initiated child study movement and child guidance clinics.
1890	James McKeen Cattell	The term mental tests first used.
1900	John Watson	'Founder' of behaviourism
1905	Alfred Binet	First individual intelligence scale.
1908	Frank Parsons	Established Vocational Bureau of Boston.
1909	Frank Parsons	Published *Choosing a Vocation.*
1909	Sigmund Freud	Recognition of psychoanalytic theories.
1909	Clifford Beers	Published *A Mind That Found Itself* , and was impetus for formation of the National Committee for Mental Hygiene, forerunner of National Association for Mental Health.
1910	Alfred Adler	Development of the Adlerian Approach.
1912	Carl Jung	Theory of psychoanalysis develops independent to Freud.
1913	Jesse B. Davis	Founding of the National Vocational Guidance Association, forerunner of the American Personnel and Guidance Association (APGA).
1914	Robert Woodworth	Development of Personal Data Sheet - prototype of the personality test.

Table 1 continued from page 35

Milestones: a chronology of counselling historical events

Date	*Individual*	*Event*
1917		Use of Army Alpha and Army Beta, forerunner of group tests of mental ability.
1921		Veterans' Bureau established.
1927	E. K. Strong, Jr.	First edition of Strong Vocational Interest Blank.
1929	Ivan Pavlov	Investigates conditional reflexes using dogs.
1929		Depression, resulting in establishment of United States Employment Service.
1929	Abraham & Hannah Stone	Establishment of first marriage and family centre in New York.
1932	John M. Brewer	*Education as Guidance* published.
1937	Walter V. Bingham.	Published *Aptitudes and Aptitude Testing*.
1938	Victor Frankl	Formulation of logotherapy.
1938	Burrhus Skinner	Developed a reputation for his contribution to behaviour therapy.
1939	Edmund Williamson	Development of trait-factor counselling.
1940		Existential Approach formalised.
1941		Army General Classification Test developed.
1942	Carl R. Rogers	Published *Counseling and Psychotherapy.*
1945		United States Employment Service General Aptitude Test Battery developed.
1950	Erik H. Erikson	First edition of *Childhood and Society,* describing stages of development.
1950	Joseph Wolpe	Systematic desensitisation gaining influence.

Table 1 continued from page 36

Milestones: a chronology of counselling historical events

Date	*Individual*	*Event*
1951		Founding of the American Personnel and Guidance Association.
1951	Carl R. Rogers	Published Client-Centered Therapy.
1951	Fritz Perls	Gestalt Therapy published, starting of movement.
1952		Civil Service position of Counseling Psychologist created.
1952		Division of Counseling Psychology (Division 17) formalised.
1953	Leona Tyler	Publication of *The Work of the Counselor.*
1954		Establishment of the Office of Vocational Rehabilitation.
1954	C. Gilbert Wrenn	One of the founders and first editor of the Journal of Counseling Psychology.
1957	Eric Berne	Presentation of first paper outlining Transactional Analysis.
1957	APGA	Forerunner of the International Association of Counseling Services created to approve counselling agencies.
1958	Albert Bandura	Published *Principles of Behavior Modification*, emphasising social learning.
1958	U.S. Congress	Passed the National Defence Education Act, providing funds for programs and training counsellors.
1959	Aaron Beck	Development of Cognitive Therapy.
1960	Rollo May	Co-founder of the Association for Humanistic Psychology.

Table 1 continued from page 37

Milestones: a chronology of counselling historical events

Date	*Individual*	*Event*
1961	APGA	Code of ethics for counsellors published.
1962	C. Gilbert Wrenn	Published *The Counselor in a Changing World*
1962		Community Mental Health Centers Act.
1962	William Glasser	Foundered Reality Therapy.
1962	Albert Ellis	Published *Reason and Emotion in Psychotherapy*, start of rational emotive therapy.
1964	John Krumboltz	Publication of *Behavioral Counseling Theory and Practice.*
1965	C, B. Truax and Robert Carkhuff	Measures of empathy and other facilitative conditions.
1965	Norman Kagan	Started video taping of interviews that led to The Interpersonal Process Recall studies.
1966		ERIC/CAPS established.
1968	Joseph Kamiya	Introduction of biofeedback.
1969	Division 17	Initial Publication of *The Counseling Psychologist*
1973	ACES	Standards outlined for Master's Degree in counselling.
1976	State of Virginia	Passed first state counsellor licensure law.
1977		Guidelines for Doctoral Preparation in Counselor Education approved by Association for Counselor Education and Supervision.
1980	Allen Ivey	Developed training programme, teaching basic counselling skills.
1981		CACREP established.

Table 1 continued from page 38

Milestones: a chronology of counselling historical events

Date	*Individual*	*Event*
1983	NBCC	National Board for Certified Counselors established.
1983	APGA	Renamed American Association for Counseling and Development (AACD).
1990	Egan	Published *The skilled helper* - development of micro-skills for counselling.
1992	AACD	Modified title to American Counseling Association (ACA).

Note. Adapted from Fundamentals of Counseling 3rd Edition, by Bruce Shertzer and Shelley C. Stone, 1980, p. 24-26.

2.6 Australian counselling history

There is very little literature documenting the evolution of Australian counselling. However, counselling has emerged in Australia in a manner similar to that of the United States, beginning with vocational and guidance counselling. The history of counselling and psychological services in schools dates back to the 1920's (Barletta, 1996). In the late 1940's the focus of primary school counsellors was assessments, placements and programme developments. In secondary schools vocational and career guidance counselling were the main roles of the counsellor. However, similar to the American experience, counselling in educational facilities had a broader role which included individual and group counselling, interventions with students, teachers and parents, as well as vocational and career guidance (Barletta, 1996).

In 1982 the Queensland Guidance Officers' Association was established. This was renamed in 1988 to the Queensland Guidance and Counselling Association.

Following the state initiative, the national Australian Guidance and Counselling Association was formed in 1984 (Barletta, 1996).

Marriage counselling emerged in Australia in the mid 1950's, although due to the relative infancy of psychology and social work professions, the training of marriage counsellors was reliant on support from the churches. Subsequently, a selection of individuals were trained as marriage counsellors using the principles of Rogers person-centred therapy (Fox & Miller, 2000). Throughout the 1980's marriage counselling continued to evolve with other secular organisations and other professionals entering the field of marital and more general relationship counselling. In March 2000, the Australian Association of Marriage and Family Counsellors was accepted as a member of the newly formed Psychotherapy and Counsellors Federation of Australia (PACFA) (Fox & Miller, 2000).

The development of the Vietnam Veterans Association (VVAA) in 1979 was also influential in the development of counselling in Australia. In 1981, a new counselling service was established due to the recognition that a percentage of Vietnam veterans had problems that could not be adequately managed within normal departmental arrangements. By 1982 counselling services for Vietnam veterans had opened in Adelaide, Sydney, Perth, Hobart, Darwin, Melbourne and Brisbane (Vietnam veterans Association of Australia web site,2002).

Thus, similar to the United States, Australian counselling emerged from vocational and guidance counselling, was influenced by social need (marriage counselling), and was responsive to issues arising from war. The current status of counselling in Australia will be discussed in the next chapter.

CHAPTER THREE

Literature Review

3.1 Introduction

Historically, to counsel has meant to advise (Shertzer & Stone, 1974), and this perception has prevailed in contemporary society, according to studies conducted by Rogers and Sharpley (1983), Sharpley, Rogers and Evans (1984) and Sharpley (1986). This notion of counselling being advisory in nature directly conflicts with what counsellors would describe as their role in the counselling process.

While the last chapter documented the historical background of counselling, this chapter will seek to address the issues confronting counselling in contemporary society and review the relevant literature. Firstly, the current issues from the available literature will be discussed and the past studies that have focused on these issues will be reviewed. Additionally, the issues that, while not included in recent studies, have emerged from past literature as pertinent concerns, will be mentioned in this chapter. Studies that have assessed the perceptions of sections of the public regarding counsellors will also be reviewed. Finally, literature that has compared public perceptions of counsellors, psychologists, psychiatrists and social workers will be discussed and the purpose and rationale for Study I will be outlined.

3.2 Contemporary Issues

3.21 The need for counsellors

3.21.1 Statistical evidence

Current trends in Australia have suggested a number of social and economic influences that indicate the relevance of counselling today. Data compiled by the

Australian Bureau of Statistics (ABS) showed that approximately 43% of all marriages are likely to end in divorce (ABS web page, Population Divorces, 2001). One third of households had some degree of financial stress in 1998-99, with 46% of all Australian homes repaying one or more loans (ABS web page, Australian Social Trends, 2002). Further statistics collected in 1998 by the ABS found that one in five 15-64 year olds with a disability were in need of help for one of the following - thinking through problems, making decisions, maintaining relationships, making friends, interacting with others, and coping with emotions (ABS web page, People with a disability, 2002).

Data compiled by the Australian Bureau of Statistics in 1996 found that 23% of women who had ever been in an intimate relationship had been a victim of domestic violence (ABS web page, Domestic Violence, 1996). According to the ABS, in 1995 there were over 101,000 cases of criminal assault recorded by the police. Between 1995 and 2001 the number of victims of assault increased by 49%. This statistic is of recorded crime trends, therefore it is important to acknowledge that many other cases of assault might not be reported to the police (ABS web page, Recorded Crime, 2001).

The 1997 National Survey of Mental Health and Wellbeing of Adults, conducted by the ABS, found that almost 18% of Australian adults had experienced a mental disorder at some time during the year prior to the survey. The survey further indicated that, of those with mental disorders, 38% used a health service for assistance, while 29% consulted a general practitioner. Of those who used a health service, 60% received counselling, 60% were given medication and 32% were given information about mental illness and treatments. Approximately 24% of those who received

counselling reported that they needed more. Therefore, according to data from the Australian Bureau of Statistics regarding current trends in Australian society, there exists a continuing need for counselling services (ABS web page, National Survey of Mental Health and Wellbeing, 1997).

A report from the Centre of Policy Studies at Monash University further supports the statistics that there is a growing need for counsellors. The report forecast that the health, welfare and education sector, out of 21 employment sectors, would experience the greatest employment growth between the years 1999 and 2010. From this sector, welfare had the highest projected annual employment growth of 6.6%. When subdivided to the level of specific occupations, the report showed that the greatest employment growth was in counselling with a growth rate of 5.7% per annum (Adams & Meagher, 1999).

Finally, data collected by staff at the School of Health Sciences at Bond University indicated that there has been a consistent local need for counsellors. Information was gathered from three major newspapers *The Australian*, *The Courier Mail*, and the *Gold Coast Bulletin* regarding the number of vacancies per annum and the salary ranges for various employment areas. The information taken from these newspapers was from the years 2000 to 2002. The findings from this study have been reproduced in table 2 on page 44, and indicate that there was a consistent need for counsellors to fill positions over the years studied. With an average of approximately 224 vacancies per year, counselling was the most advertised position following child care (School of Health Sciences, 2002).

Table 2

Recently advertised employment opportunities taken from *The Australian*, *The Courier Mail* and the *Gold Coast Bulletin*.

Employment area	Vacancies			Salary range
	2000	2001	2002	
Child Care	1397	1192	1534	$27 000-$ 75 000
Retirement & Ageing	111	109	105	$30 000-$ 69 000
Behaviour Management	245	263	133	$30 338-$ 87 108
Mental Health	169	94	122	$28 000-$100 000
Counselling	263	146	263	$24 500-$ 79 640
Sports Coaching/Management	N/A	239	472	$25 000-$100 000

Note. Copied from Graduate Employment Opportunities in Health Sciences, by Bond University, School of Health Sciences, 2002, p. 1.

3.21.2 Breakdown of traditional support, less stigma and legal requirements

Apart from the statistical data that have suggested there is a need for counsellors within the community, Barletta (1999), also attributed the demand for counselling to "the breakdown of the family, community, and church contacts in conjunction with the greater stressors in our society" (p. 70). Bareltta (1999) argued that these factors have led to more people seeking professional help, rather than having access to traditional support systems such as family, community and church associations.

Furthermore, the stigma of utilising professional services to assist with personal problems has diminished in current Australian society. It has become acceptable and considered valuable to deal with issues by accessing professional help (Barletta, 1999). Central to the acceptance of counselling has been the widespread mention of mental

health issues in everyday life circumstances, and through media communications. Johnson (2002) wrote: "…terms such as Depression, Stress, Psychological Trauma, Post Traumatic Stress Disorder, Anxiety…have become household phrases. We hear them on the news, read them in the newspapers, and use them repeatedly … in conversation" (p. 2).

Counselling has also, in some contexts, gone beyond being desirable to being a societal requirement. Within the court system, counselling has, in some instances, become mandatory as part of an individual's rehabilitation process. Many employment organisations have implemented counselling in their protocols for employee rehabilitation and disciplinary action. Employee Assistance Programmes are routinely used for employees to access counselling services to deal with any issues that affect work performance, with no cost to the employee. These services are also often offered to the families of employees (Johnson, 2002). Governments are taking further initiatives to encourage the use of counselling. A Victims Referral and Assistance Scheme has been established by the Victorian government, whereby any individual who can demonstrate, either directly or by witnessing, that they have been a victim of a crime, will receive ten fully funded counselling sessions (Johnson, 2002). Related to the issue of the need for counsellors is the issue of counsellor identity,

3.22 Identity

With the growing need for counselling there has been a parallel growth in the role of counsellors being incorporated into existing positions. The job descriptions of other professionals have been expanded to include counselling components. Johnson (2002) comments that "…masseurs, nurses, rehabilitation workers, psychiatric nurses,

geriatric workers, teachers, administrators, managers…seem to be looking for more ways to be more effective, more competent and confident in their counselling roles" (p. 2). Hence, the identity of counsellors is becoming diluted by the concept of multi-skilling in other work disciplines. Counselling is not exclusive to the domain of counsellors, rather it is becoming a recognised role within many other employment areas.

In her article *COUNSELLING PSYCHOLOGY: is there a FUTURE?* Drever (1999) described the development of counselling in other work areas, as a "crisis." While acknowledging that social trends have indicated a growing need for counsellors, Drever (1999), suggested that with no Medicare rebates offered and with widespread economic hardship, counselling will become a luxury that the general public will not be able to afford. Therefore, a number of other health providers are incorporating counselling into their services and competing with the counselling profession in the marketplace. According to Drever (1999),

> … just about every discipline in health offers counselling to clients as an 'extra' - herbalists do it, dieticians do it, spiritualists do it and so do psychics. A physiotherapist will give advice about lifestyle and a masseuse will teach relaxation techniques… (p. 18).

Compounding the dilemma of counsellor identity is the growing number of medical practitioners who offer counselling to their patients, whether they have had extra training or not (Drever, 1999). Hence, counselling is becoming a generic term that could refer to the practice of a multitude of professionals, paraprofessionals, or individuals that simply believe that they are good listeners. The issue of blurred

identity raises the question of what qualifications and expertise a counsellor should have.

3.23 Counsellor expertise and training

According to the *Directory of Postgraduate Study* (2002), different States and different universities have diverse counselling courses. This can be seen from table 3.

Table 3

Available counselling degrees

State	University	Degree Offered
ACT	University of Canberra	G. Certificate in Community Counselling
		G. Dip. in Community Counselling
		Master of Arts in Community Education (Counselling)
NSW	Charles Stuart University	G. Dip. of Pastoral Counselling
	Macquarie University	Master of Counselling Psychology
		PG. Certificate in Counselling
		PG. Dip. in Counselling
		PhD/Master of Counselling Psychology
	University of New England	Bachelor of Counselling
		Master of Counselling
		Master of Counselling Honours
	University of Western Sydney	Master of Counselling

Table 3 continued from p. 47

State	University	Degree Offered
QLD	Bond University	Doctor of Counselling
		G. Dip. in Counselling
		Master of Counselling
		Bachelor of Health Sciences (Counselling)
	Qld. University of Technology	Master of Counselling
		Master of Counselling Psychology
SA	Flinders University	G. Certificate in Loss, Grief and Trauma Counselling
	University of SA	G. Dip in Social Science (Counselling)
		Master of Social Science (Counselling)
TAS	University of Tasmania	G. Dip. of Rehabilitation Counselling
VIC	LaTrobe University	Master of Counselling and Human Science
	Monash University	Master of Psychology (Counselling)
	Swinburne University	G. Dip. of Social Sciences (Human Services-Counselling)
		Master of Arts (Counselling Psychology)
	Victoria University	G. Dip. in Counselling
		Master of Counselling
WA	Curtin University	G. Certificate in Art in Counselling and Community Practice
		G. Dip in Human Services (Counselling)
		Master of Health Counselling
	Notre Dame University	Master of Counselling

The above-mentioned courses vary in length of time from three semesters of full time study at the Notre Dame University for a Master of Counselling degree to four years of full time study at Macquarie University for a PhD/Master of Counselling

Psychology. Therefore, a diversity of training programmes exists for counsellors, with a range of prerequisites for entry into them. Additionally, unless the counsellor has chosen to join a counselling association, there are no standardised requirements for counsellor training, leading to confusion regarding the necessary qualifications to be a counsellor.

Further to the dilemma of counsellor expertise and training is the fact that currently anyone, qualified or not, can call themselves a counsellor. Barletta (1999) wrote " Consumers are guaranteed that their Psychologist, Psychiatrist, and Social Worker are qualified and regulated, but for their Counsellors, no such mechanism exists" (p. 70). Hence, the public, when seeking out the services of a counsellor, unless they ask, will never know whether the service provider has any qualifications, minimal training, or tertiary qualifications. This presents to the counselling profession the issue of public safety and professional accountability.

3.24 Counselling professionalism

Pertinent to the current issues facing counsellors is the question of whether or not counselling can be considered a profession. Barletta (1999) sought to investigate the question of counselling as a profession by relating the current state of counselling to documented characteristics of a profession. Although there has been subsequent documentation regarding what constitutes a profession, McCully (1962), and Emener and Cottone (1989), Barletta (1999) referred to the work of Lieberman (1956) as a framework for appraising the professional status of counselling. Lieberman (1956) examined the criteria for a profession in the context of education. According to his

work an occupation could be considered to be a profession if it met eight specific criteria. These criteria are as follows:

1. A unique, definite and essential social service.
2. An emphasis upon intellectual techniques in performing its service.
3. A long period of specialised training.
4. A broad range of autonomy for both the individual practitioners and for the occupational group as a whole.
5. An acceptance by the practitioner of broad personal responsibility for judgements made and acts performed within the scope of professional autonomy.
6. An emphasis upon the service to be rendered, rather than the economic gain to the practitioners, as the basis for the organisation and performance of the social service delegated to the occupational group.
7. A comprehensive self-governing organisation of practitioners.
8. A code of ethics which has been clarified and interpreted at ambiguous and doubtful points by concrete cases (Lieberman, 1956, p. 2-6).

In regard to the requirements of the first criteria, Barletta (1999) argued that, while counselling involves a number of interventions and programmes that create definition and has value and an identified need in society, it is not unique in nature. According to the second criteria, counselling does fulfill the conditions. As Barletta (1999) correctly acknowledged, counselling is not a manual occupation and does involve knowledge and awareness of various theories and approaches. The services

provided by counsellors have an emphasis on possessing a wide range of intellectual techniques and strategies, and involve reasoning and problem solving abilities.

However, the stipulations of the third criteria are of some concern for counselling as a profession. In his analysis of counsellors meeting the criteria for a profession, Barletta (1999) stated that: "For entry into a career in counselling, an individual must first complete a recognised graduate-level program. Core requirements and a comprehensive program at university ensures individual competencies in a range of areas" (p. 72). If this were the case, counselling would certainly meet the third criteria. However, as has already been mentioned in the preceding section on counsellor training, unless a counsellor belongs to a professional association, there are no mandatory minimum educational requirements for an individual to practice counselling. Therefore, Barletta's (1999) analysis is the ideal rather than the reality. He does qualify his statement to suggest that accreditation of courses would be desirable, and that professional counselling associations could be instrumental in facilitating minimum standards for course accreditation. Nevertheless, in terms of the current situation of counsellor education, counselling does not meet the third criteria.

The qualifying factors for the fourth, fifth and sixth criteria for a profession are incorporated within current counselling practice. Counselling does posses autonomy both on an individual level and an organisational level. Furthermore, counsellors are becoming more accountable for the welfare of their clients and more prepared to take responsibility for their actions. Professional indemnity insurance is becoming an essential part of any counselling practice as litigation becomes more prominent in Australian society (Barletta, 1999). Finally, while a number of motivating factors may

inspire an individual to become a counsellor, the primary incentive is not financial remuneration. Barletta (1999) wrote, "It is more likely that Counsellors are drawn to become members of the occupational group almost like a vocation" (p. 72).

The provisions included in criteria seven and eight involve issues that are prominent for current counselling. There are a number of associations which counsellors could belong to, and they each have related documents regarding ethics and standards. However, there is no mandate to belong to an association in order to be able to practice counselling. Additionally, each association has its own standard of requirements for membership, and the ethics documented in those memberships vary accordingly. The issue of counselling associations will be discussed later in this chapter.

The conclusion that Barletta (1999) drew from his analysis of counselling as a profession according to the criteria of Lieberman (1956), was an ambiguous "… my response is an unequivocal 'probably.' I do however acknowledge that the profession is still in it's [sic] infancy, but the development thus far has been good" (p. 73). Barletta further qualifies his conclusion by acknowledging that there is no current legislation that legally recognises counselling, nor do any laws exist to regulate the practice of counselling. Therefore, although counselling has evolved to a standard that meets most of Lieberman's (1956) criteria for a profession, there are pertinent issues of uniqueness, accountability, regulation, standardised ethics and a recognised association that need to be developed.

3.25 Counsellor associations

The establishment of the Australian Board of Certified Counsellors (ABCC) has provided formal national recognition of counsellors. Those who are certified by the ABCC are identifiable to the public and other professionals as meeting nationally recognised professional standards. The requirements for a counsellor to be certified by the ABCC involve an accredited qualification from a tertiary college or university and work experience that has been documented and supervised for a minimum of twelve months following graduation. Certification further requires two professional references that testify to professional competency and good character, one from a supervisor and one from a counsellor educator or counselling colleague. Additionally, a counsellor must be a member of a professional organisation that is reflective of their interests and expertise, and endorses a standard code of ethics. Finally, to be considered for certification by the ABCC, a counsellor must provide a Professional Disclosure Statement outlining professional details and the extent of their counselling practice. If the application for certification is approved, it is valid for a three-year period, after which re-certification is contingent on the applicant fulfilling a further two requirements: a minimum of 45 hours of continuous education relevant to counselling, and continuing practicing counselling according to a recognised code of ethics (ABCC web page, 2002).

The requirements and standards of the ABCC provide a solution for the issues of counsellor identity and professionalism. However, whether or not a counsellor becomes certified by the ABCC is currently left to the conscience of the individual rather than being compulsory to practicing counselling.

The Australian Counselling Association (ACA) is another organisation that counsellors can join. The primary purpose of the ACA is "To provide a single unified voice and promote public confidence and trust in the counselling profession" (ACA web page, 2002, p. 1). Closely related to their purpose is a clearly defined mission statement "To be recognised as *the* Association for Counsellors in Australia" (ACA web page, 2002, p.1). Having both national and international recognition, the ACA has several thousand members throughout Australia as well as a percentage of international members. According to information provided about the ACA, it was also the first counselling association to be recognised by a private health fund for rebates. The objectives and standards of the ACA do address the above-mentioned issues of professionalism for counselling. They are as follows:

To provide an industry based Association for persons engaged in counsellor education and practice.

To be a self-regulatory body to provide for registration of members and to provide a mechanism for dealing with complaints about members.

To liaise with Government for the benefit of members and the public.

To provide a consistent Code of Conduct and set of Practitioner Standards.

To promote the professional development and growth of practicing counsellors.

To provide a National Complaints Tribunal.

To assess, review and recognise counsellor education courses.

To maintain a register of, and to certify practicing counsellors.

To identify to the public at large counsellors that meet nationally approved standards of practice.

To make the general public at large more aware of the counselling profession and the availability of reputable counsellors" (ACA web page, 2002, p. 1).

Hence, the Australian Counselling Association incorporates the criteria of autonomy, self-regulation, certification of its members and a standard code of ethics within its stated objectives. It does not, however, address the issues of counsellor uniqueness, nor is it mandatory to be a member before practicing counselling. Furthermore, the primary criterion for membership is providing proof of undertaking or having undertaken professional supervision. There is ambiguity regarding the training and qualifications necessary to become a member.

Similarly, The Psychotherapy and Counselling Federation of Australia (PACFA) was established from an acknowledgement that there is a need for a cohesive national association for counsellors. However, as has already been noted of other associations, their eligibility criteria for membership are not definitive. The minimum requirements that they list are as follows:

Relevant Degree (as defined by the Applicant's Professional Association)

+ Specialist Training in Psychotherapy or Counselling (2 years – 250 hours minimum)

+ 750 hours' client contact with 65 hours' post-training supervision (minimum) over two years (minimum)

OR

3 years' Training in Psychotherapy or Counselling (2 years – 250 hours min)

+ 750 hours' client contact with 75 hours' post-training supervision (minimum) over two years (minimum)

OR

+ 150 hours' additional professional training which was completed after the Specialist Training, and which was more advanced and/or more specialized that the Applicant's previous Specialist Training. Any course included here must have been successfully completed (PACFA web page, 2002, p. 1).

There are other alternatives listed as criteria for membership to PACFA, which further highlights the issue of a lack of succinct, defining and clear requirements. There is also no mandate for practicing counsellors to belong to this association.

Members of the Australian Guidance and Counselling Association (AGCA) include school counsellors, guidance offices and school psychologists. To be eligible for membership an individual needs to be a person who has teacher training and a major study in psychology. They further need to have undertaken accredited post-graduate training that is recognised as suitable training for guidance and counselling activities. However, what is recognised as suitable training differs according to the State in which the individual works. Additionally, if a person has other training or personal experience recognised as suitable, they may be considered eligible for membership. Thus, the requirements for becoming a member of the AGCA are ambiguous and dependent on what is deemed suitable by the current executive board. The AGCA does have a comprehensive code of ethics, and has a general principle that its members "strive to acquire and maintain the highest standards of professional competence and ethical behaviour" (The Australian Guidance & Counselling Association Ltd, 1971, p. 3). However, as has been noted of other associations, it is not compulsory for practitioners to be members of the AGCA.

The above-mentioned associations are the national Australian counselling organisations. However, there exist a number of other associations that pertain to counselling. Many of the national associations have State branches and there are many individual therapies that have associations to which the practitioners of those therapies belong. Gestalt therapists can belong to Gestalt Australia and New Zealand (GANZ); those who practice psychoanalysis have an option for membership to the Psychoanalytic Psychotherapy Association of Australia; and followers of Jung can belong to the Australian and New Zealand Society of Jungian Analysts. These kinds of associations and societies for membership are numerous (PACFA web page, member associations, 2002).

The disciplines in which counsellors practice also have associations. Counsellors that specialise in marriage counselling or family therapy can belong to the Australian Association of Marriage and Family Counsellors and career counsellors can belong to the Australian Association for Careers Counselling (PACFA web page, member associations, 2002). Again, the list is too extensive to mention all of the related organisations. Therefore, the enormous range of associations available for counsellors to apply for membership means that there is no unifying, governing organisation to which counsellors are accountable. None of the current associations are mandatory and this issue facilitates the dilemma of counsellor expertise, training and identity. By comparison, in order to be able to practice psychology, an individual must have completed a four- year psychology degree, and have received two years of clinical supervision before they can be registered with the relevant state board as a psychologist. To be employed as a social worker, the individual must be eligible to

belong to the Australian Association of Social Workers. To practice psychiatry, the practitioner must be registered, have both a medical degree and a degree in psychiatry, as well as belonging to The Royal Australian and New Zealand College of Psychiatrists (RANCZP). Doctors who are elected as Fellows of the Royal Australian and New Zealand College of Psychiatrists (FRANCZP) can achieve recognition as consultant psychiatrists and can practice in Australia and New Zealand. There is no equivalent for counsellors. Therefore, the issue of counsellor associations is a contemporary issue that recent literature has acknowledged and sought to address. Finally, the issue of counsellor gender as an influence on clients' perceptions within the counselling relationship has been an issue discussed in recent literature.

3.26 Gender Issues.

Henderson and Lydon (1997) sought to examine the effects of counsellor gender, client gender, and client gender role attitude, on clients' perceptions of counsellors. They made three propositions. Firstly, they proposed that client perceptions of counsellor expertness, attractiveness, and trustworthiness would differ depending on the gender of the counsellor. Henderson and Lydon (1997) therefore predicted that both male and female clients would rate female counsellors either significantly higher or lower than male counsellors. Secondly, they hypothesised that client perceptions of counsellor characteristics would differ depending on the gender of the client. This hypothesis was specifically based on the prediction that female clients would rate both male and female counsellors either significantly higher or lower than male clients would. Thirdly, they proposed that the ratings of female counsellors would be relative to the respondents' attitude toward women. A sample of 57 clients

seeking counselling services at outpatient facilities were asked to participate in a counselling session and then to complete a Counsellor Rating Form and the Attitudes Toward Women Scale. However, the results and discussion in the article did not indicate whether or not the first two hypotheses were supported by the data. Only the third proposition was mentioned in relation to the results of the survey. Henderson and Lyddon (1997) discussed the results as indicating that female clients rated their counsellors significantly more positively than did male clients. The implications of this finding were twofold. Firstly, women may be more likely to experience a positive outcome from counselling, and secondly, there may be a greater need for extra time to be spent establishing a rapport with male clients. While these results are relevant to gender issues they do not relate to the first and second hypotheses of the study. Gender role attitude of the client was found to influence perceptions of female counsellors, therefore indicating that female counsellors may need to spend more time establishing rapport and credibility with clients who have a stereotypical view of women. This result supported the third hypothesis. Limitations of this study included the fact that the respondents were not representative of the general population, and the fact that the majority of subjects were mostly young college students. Additionally, the counsellors used in the research were predominantly female, outnumbering their male counterparts by more than two to one.

The issue of counsellor gender was further explored by Beauchamp and Shaw (2002) in a study specifically focused on female counsellors engaging and retaining men in relationship counselling. They surveyed men's experience of counselling in the context of those who had accessed the organisation that both authors worked for,

Relationships Australia. Of the 26 respondents who participated, approximately half had attended counselling with a partner, and the other half had attended alone.

The results from the questionnaire used indicated that eight respondents expressed a pre-counselling preference. Of those, six indicated a preference for a female counsellor and two preferred a male counsellor. The remaining 18 subjects had no gender preference for a counsellor. Following the experience of counselling, the reported preferences of those surveyed did not significantly alter. Therefore, conclusions from this study were that there were no significant counsellor gender preferences by male clients, although Beauchamp and Shaw (2002) recommended that "female therapists must be aware of the influence of gender socialisation upon their clients and upon themselves, this is essential in order to work with male clients around stereotypical attitudes and behaviours, mutual responsibility, power imbalances and affective expression" (p. 3-4). Possible limitations of this study include the small representative sample and the fact that those being surveyed may have been influenced in their responses by the fact that they were seeking some form of assistance from the organisation where the survey took place. However, the data collected in the above-mentioned literature suggested that the gender of the counsellor did not significantly impact on the choices made by the public when accessing counselling.

The current issues mentioned above regarding the need for counsellors, counsellor identity, counsellor expertise and training and gender issues, have all been incorporated into studies that, although not current, are nevertheless pertinent to the literature review of this paper. Therefore, the nature of these studies and their associated conclusions and limitations, if any, will be reviewed.

3.3 Past literature relevant to contemporary issues

3.31 The need for counsellors

Rogers and Sharpley (1983) found from their survey of 504 residents of Queensland and New South Wales that 62% of respondents thought that more counsellors were needed. Of that percentage, 37% attributed the need for more counsellors to the belief that there are a number of people who have problems that they cannot solve themselves. A further 20% indicated that the stresses and complexities of modern living were reasons for more counsellors, while 11% thought that counsellors should be plentiful so that accessing one was routine practice. A need for more counsellors in specific areas was indicated by 14% of respondents. These areas included the disadvantaged, the unemployed, small towns, vocational guidance, social issues and drug and alcohol problems. Counselling was considered to be of general value by approximately 12% of those surveyed, because it improved life in the community, provided an objective listener, or was a sounding board for those who have no-one to talk to. Some respondents reported that more counselling services could relieve the strain on the medical profession.

Data from that study further reported what issues respondents had seen a counsellor for or would see a counsellor for if the need arose. Thirty two percent of those surveyed indicated that they had received counselling predominantly for vocational issues (35%) and usually within a school setting. Marriage counselling had been accessed by 5% of the respondents, while the remainder "… had received counselling from occupational therapists, university counsellors, child guidance counsellors, youth counsellors, legal counsellors, or what they considered to be

counselling from doctors, lawyers, priests, a hypnotherapist and an astrologer" (Rogers & Sharpley, 1983, p. 325). Fifty-seven percent of respondents reported that they had not received counselling but would consider accessing counselling services if necessary. Of those, 12% specified that the type of problem they would seek help for was marital issues, 9% indicated they would seek help for vocational problems, and 6% specified family and personal problems respectively. Other problems mentioned "…included drinking and gambling, legal, business/financial, spiritual, relationship, bereavement, study, weight, and stress control, work, social and decision-making problems" (Rogers & Sharpley, 1983, p. 325).

Rogers and Sharpley (1983) also assessed the value placed on counselling as a service to the community in general. Participants were asked to give a rating between 1 (very low) and 5 (very high), with nearly half of the sample indicating that they thought counselling was valuable (4) and 17% reporting it was very valuable (5). Therefore, the survey indicated that the majority of respondents not only felt that there was a need for more counsellors, but that counselling was a valuable service.

Similarly, Sharpley, Rogers and Evans (1984) sought to evaluate the need and value of marriage counsellors as a part of their survey. Of the total of 658 persons surveyed, 625 respondents stated that they had not experienced marriage counselling. When asked if they would ever consider seeing a marriage counsellor, 57% said that they would, while 43% stated that they would not. Those who indicated they would seek marriage counselling were then asked what specific problems they thought a marriage counsellor could help with. The results were defined by four categories " (1) 72% general (e.g., meeting partner's needs, communication problems); (2) 15% specific

couple problems (e.g., jealousy, infidelity, drinking, sex, finances, abuse); 4% specific child-rearing problems (e.g., insolence, drugs, pregnancy); and (4) 11% don't know" (Sharpley et al., 1984, p. 132). In response to the question of need for more marriage counsellors, 58.5% indicated that there was such a need, and their primary reason for believing this need exists was the current high divorce rate and the need to save marriages.

In 1986 Sharpley re-evaluated the public perceptions of the need for and value of counsellors. Data collected from a representative sample of 502 found that 57% thought there was a need for more counsellors. When asked to rate the value of counselling to the community on a 5-point scale where 1 represented of little value and 5 indicated very valuable, counselling scored a mean of 3.7.

Therefore, the relevant literature has indicated that the majority of the general public perceived a need for more counsellors, and placed considerable value on counselling as a service to the community. There is also a correlation between the statistical data from the Australian Bureau of Statistics regarding the current social issues and what the public indicated they would see a counsellor for. Similar to the above-mentioned studies, there have been earlier studies conducted and literature written regarding counsellor identity.

3.32 Identity

McCully (1961) wrote about the blurred identity of school counsellors. His discussion explored the perpetuating idea that school counsellors are teachers, and are distinctive only in the manner in which they spend their time, rather than by the service they provide or the training required to deliver their service. This lack of a distinct and

unique identity for school counsellors, according to McCully (1961), has jeopardised the rationale for counsellor certification.

Williams (1978) attributed counsellors' willingness to share their knowledge and skills as a contributing factor to the widespread use of the word counselling. Williams (1978) stated that "too many persons whom counsellors have helped to acquire counselling skills have tended to believe that formal training in an academic discipline is unnecessary" (p. 37).

Further identity issues have been documented as the result of changes in the focus of counselling and the subsequent shift from the traditional psychological paradigm. According to Williams (1978) there has been a movement away from the medical model as a framework for counselling towards a psycho-educational model, therefore making a clear distinction between counselling and clinical psychology. This shift has reflected a focus on "wellness" rather than sickness and emphasised learning life skills. However, while this development may have provided clarity regarding counselling versus other disciplines of applied psychology it has led to confusion with other areas within the field of counselling. This shift of emphasis was not derived from psychology, but from other sources involved in human welfare. Williams (1978), cited the following as influential "…the human potential movement, growth groups, social work, various philosophies based on eastern rather than western traditions…" (p. 35). These forces have shared with counselling the aim of fostering self-fulfillment through taking personal responsibility for development and growth. The dilemma for counsellors, as described by Williams (1978), lies in that many of the above-mentioned forces are associated with individuals without any formal qualifications at all.

Therefore, the use of the word counsellor has become indiscriminate, leading to some confusion not only for those who practice it, but also for the general public. The results of a survey of doctoral level counsellors in the United States suggested that the lack of cohesion in the field of counselling was not isolated to Australia. Krauskopf, Thoreson, and McAleer (1973) concluded from their survey that "In answer to our question of identity, we are a loose mixture of guild members becoming increasingly more divergent in our training, skills, and goals" (p. 71).

Furthermore, a counsellor's employment situation has been argued as contributing to their identity. The settings where counsellors are employed were predominantly in educational and community health settings, with a few involved in vocational and marriage counselling, according to Khan (1983). More specifically, Khan (1983) listed four public service domains in which counselling personnel were employed. The first two of these domains were the labour department and the field of rehabilitation. The primary focuses for counsellors in these areas of employment were vocational guidance, psychological assessments and behaviour modification. The third domain was the largest single employer of counsellors and incorporated schools, colleges and universities. In a primary school setting the main role of the counsellor was psychological testing, with little involvement in treatment. High school counsellors were primarily involved with the developmental issues of students, as well as vocational guidance. Their role was broadened to also encompass personal counselling. Counselling in tertiary institutions had a wider range of options for the counsellor and subsequently was less restraining on theoretical approaches or interventions. The fourth domain of counsellor employment was entitled by Khan

(1983), as 'other settings.' Included in this domain were community health clinics and marriage counselling services. As part of a multi-disciplinary team within the community health setting, Khan (1983) stated that the dominant theoretical approach of counsellors was eclectic. Marriage counsellors primarily utilised a communications or systems approach, as well as teaching conflict resolution and negotiation skills. Therefore, both the theoretical orientation and the role of the counsellor were largely defined by the place of employment of the counsellor. Additionally, the confusion of the public regarding counsellor identity has been documented by relevant studies.

A survey by Rogers and Sharpley (1983) was aimed at determining public responses to specific questions regarding counselling. From 504 respondents the conclusion was made that, while the public attitude to counsellors was generally favourable, there did exist a widespread ignorance of what counselling services offered to recipients, leading to the conclusion that the counselling profession was “poorly understood by the general public perhaps because of a lack of information from counsellors” (Rogers & Sharpley, 1983, p. 328-329).

Similarly, in 1984 Sharpley, Rogers, and Evans sought to explore public attitudes to, and knowledge of marriage counsellors. Again, while that research indicated an overall positive attitude towards marriage counsellors, there was evidence to suggest ignorance regarding the function and role of the counsellor. “That marriage counsellors were seen as advice-givers by nearly one-fifth of the sample is of concern, and may suggest a lack of knowledge of the specific non-advising role which underlies traditional counselling” (Sharpley et al., 1984, p. 135). Linked to literature regarding counsellor identity is the associated literature that examined counsellor training.

3.33 Counsellor expertise and training

Venables (1974) argued that, until there was some consensus amongst counsellors regarding identity and role definitions, it was unlikely that there would be an agreement on essential ingredients for counsellor training. Khan (1983) noted a diverse range of training programmes, both within universities and in other less formal settings. Variety also existed in the nature of studies taken. Some studies resulted in a certificate, others diplomas, bachelor's degrees, or masters and doctoral degrees (Khan, 1983). Therefore, an individual with a certificate in counselling, obtained by correspondence from a TAFE programme, and an individual who had graduated from a university doctoral programme, could both classify themselves as counsellors. Khan (1983) concluded that the field of counselling in Australia was hindered by the lack of leadership at the national level. Khan (1983) further argued that:

> A strong national association could help raise the academic and professional standing of the field, provide a clearer sense of identity, establish standards for training programs and minimum job entry level qualifications, and focus attention on the relatively untouched issues of accountability, research, and systematic program evaluation (p. 472).

Additionally, the work-setting of the counsellor was found to affect the amount of training that was required, according to the study by Khan (1983). Vocational and school counsellors were required to have a degree in teaching, and either another qualification in counselling or psychology, or some were required to attend in-service training on counselling. Other private agencies only required attendance of a non-

credit training course (Khan, 1983). Thus, ambiguity existed regarding counsellor qualifications and requirements within employment agencies.

A survey of counsellor training programmes in Australia and New Zealand found that, of 19 counselling programmes offered in Australia, 5 were taught in universities and 14 in colleges of advances education (McWhirter, 1987). The emphasis on programme content varied between colleges and universities. According to McWhirter (1987) college courses had particular focus on vocational counselling and the practical use of specific skills, whereas the university programmes had greater focus on research, theoretical knowledge, and postgraduate work. McWhirter (1987) further found that the counsellor training programmes available within Australian institutions offered 28 different courses. Accreditation of the counselling programmes was also different for colleges and universities. McWhirter (1987) wrote:

> All programs in the CAEs must be approved by postsecondary commissions or tertiary education authorities of the various states. Furthermore, all CAE programs are listed nationally with the Australian Council on Awards in Advanced Education. Programs operating in Australian universities are free from this approval process because of the autonomy that universities enjoy in Australia (p. 82).

In his article *Mental Health Counselor Education in Australia,* Hershenson (1990) reviewed the context and preparation of counsellors, and developed the study of McWhirter (1987). He also compared the counsellor education programmes in Australia with the specified standards for mental health counsellor preparation studies as identified by the Council for Accreditation of Counseling and Related Educational

Programs (CACREP), in America. Hershenson (1990) conducted interviews at three Australian educational institutions to gather data for his survey. The mental health counsellor education programmes at Macquarie University, the Royal Melbourne Institute of Technology (RMIT), and Curtin University of Technology were the focus of the survey. Although his study concluded that a number of Australian counsellor education programmes did parallel the CACREP-approved mental health counsellor preparation programmes in America, Hershenson (1990) found that "the programs all differ in the academic unit in which they are housed, the title of the degree or diploma awarded, and the length of the program" (p. 178). Differences that were found between the Australian and American programmes included less emphasis than their American counterparts in Australian programmes on environmental interventions or on social and cultural factors, and more emphasis on psychotherapeutic function. Hershenson (1990) further suggested that a potential weakness for Australian counselling lies in that there is not a defined and unique role that differentiates counsellors from other mental health fields. Possible limitations of this study were primarily its narrow focus of only three educational facilities and their associated programmes. Several studies have highlighted the major confusion the general public has regarding the amount of training undertaken by counsellors.

3.33.1 Public perceptions

According to Rogers and Sharpley (1983), when asked about counsellor training, one quarter of the sample surveyed did not know enough to answer, 38% replied that tertiary education was required, with some mentioning psychology, sociology or social studies, and others were more vague. There were a few respondents

who thought that counsellors took a short course "and a few thought that common sense is the major element of the counsellor's qualifications. Eighteen respondents tersely replied that counsellors have insufficient training" (Rogers & Sharpley, 1983, p. 324).

Similarly, Sharpley, Rogers, and Evans (1984) data indicated a wide range of responses to the question of counsellor training, with 42.9% of responses in the 'don't know' category. Sharpley (1986), reported that, when compared to other helping professions, training for counsellors was the least readily classified, with 65.1% of respondents in the 'no special training needed,' 'other training,' or 'don't know' categories. Just as the issue of counsellor training has been documented by earlier literature, so too has the issue of the professionalism of counselling been included in past studies.

3.34 Counselling professionalism

The characteristics of what constitutes a profession have been documented by Vollmer and Mills (1966), Moore (1970), Pavalko (1971), and Elliott (1972). More specifically, examining how counselling meets the criteria for a profession has been assessed by the following authors. McCully (1962) used the criteria for a profession established by Lieberman (1956) to determine the professional status of school counsellors. He concluded that school counsellors did not meet the criteria for a profession in the areas of legal recognition, professional autonomy and self-regulation (McCully, 1962). Emener and Cottone (1989) sought to determine the professional status of rehabilitation counsellors, and similarly found that rehabilitation counsellors were in the process of professionalisation. An assessment of counselling in general and

as a profession was conducted by Ritchie (1990). His assessment was based on ten criteria for a profession established by McCully (1962). These criteria and the associated analysis of Ritchie (1990) were as follows:

1. A profession is primarily service orientated and the service it provides is of great social value.
2. Performance of the specified social service rests primarily upon intellectual techniques.
3. Members of a profession possess a strong commitment or calling to the profession, view it as a life-long career, and are engaged in the profession full-time (McCully, 1962, p. 18).

Ritchie (1990) found that these three criteria were met by counselling.

4. A profession is based upon a common body of knowledge, theory, and skills that is not generally known to the public, is based on scientific research, and is unique to the profession.
5. The service provided to society is unique and society has delegated to qualified members of the profession exclusive authority to provide the specified social service (McCully, 1962, p.18).

The issue for counselling with regards to these two criteria is one of uniqueness. The knowledge, theories and skills utilised by counsellors are not unique to them, nor are the services provided by counsellors exclusive. A further issue for counsellors from the fourth criteria was the " Lack of a research-driven theoretical base for counseling techniques…" (Ritchie, 1990, p. 222).

6. Entry into the profession requires an extensive period of specialized training in institutions of higher education. There are explicit and uniform standards for training. Admission into training is highly selective. The training standards are controlled by the profession.
7. Members must exhibit minimum competency by examination and supervised apprenticeship or internship prior to entry into the profession (McCully, 1962, p. 18).

As has previously been discussed, these two criteria are being met by some counsellors and not by others. An adoption of universal, minimum standards is necessary to qualify in these criteria.

8. The profession is legally recognized by virtue of certification, licensure laws, or both.
9. Members of the profession are bound by an ethical code that defines both ethical and unethical conduct and services, and provides for strict enforcement of its rules and regulations (McCully, 1962, p. 18).

Again, counselling does not, to date, meet these criteria.

10. Individual members of the profession possess broad authority over the practice of their services, and the profession as a whole possesses broad autonomy over internal operations (McCully, 1962, p.18).

While Ritchie (1990) acknowledged that counselling does have, in a broad sense, autonomy he suggested that counsellors work together with insurance companies and other regulatory bodies to maintain professional autonomy. Therefore, the areas of research, training and legal recognition are the central issues that need to be addressed

if counselling is to be considered a profession according to the criteria established by McCully (1962).

Although there are no current studies that address the issue of counsellor fees, Medicare rebate, the accessibility and approachability of counsellors and the perceived benefits and drawbacks of counselling, these issues have been included in past literature. Despite the lack of current acknowledgement of these issues, they are by their nature relevant to both contemporary counselling and the future development of counselling.

3.4 Issues emerging from past literature

3.41 Counsellor Fees

There appear to be conflicting data regarding the impact that fees have on the public's perception of, and willingness to access counselling services. According to the sample population surveyed by Rogers and Sharpley (1983), 50% indicated that they would be willing to pay to see a counsellor, while 47% indicated that they would not. Of those willing to pay, a reasonable fee was considered to be between five dollars and seventy dollars.

Similarly, the findings of Sharpley, Rogers, and Evans (1984), indicated that 49.3% of the respondents thought that marriage counselling should be free. The amount they were prepared to pay varied up to sixty dollars, with only 1% willing to pay any more for marriage counselling services. These results indicate that there was a large variability in the perceived worth of a counselling session.

Two studies were published in 1986 relevant to the issue of counselling fees. Results from Sharpley (1986) reported that 28% of respondents indicated that they

would be willing to pay for a counselling consultation. Additionally, Lowe, Howard and Dawson (1986) focused on three pertinent questions. Firstly, they considered if there was a correlation between payment of fees and a perception of higher quality of service. From this consideration they secondly sought to determine if there was an assumption by the public that the quality of a counselling service directly varied with the level of fees charged. Thirdly, they asked the question "…are psychologists and counsellors considered equally competent (or incompetent) regardless of fee?" (Lowe et al., 1986, p. 300).

In order to address these questions Lowe, Howard and Dawson (1986) collated data from a total of 243 students attending the Mitchell College of Advanced Education. Respondents were given a questionnaire that included a fictitious scenario in which the respondent was in urgent need of several sessions of therapy. They were then given a choice of four hypothetical practitioners whom they could consult. For the purposes of a more specific focus to their study, the authors used the profession of a psychologist, rather than counsellor or therapist. The potential psychologists were presented as equally qualified and well-known, only differing in the fees charged and their place of work. The first psychologist worked in a community health centre and was free; the second, third, and fourth were in private practice and charged $45, $25, and $35 per session respectively. The survey was further divided into three groups, and respondents were assigned to one of these. The groups differed in the amount of health-fund rebate that was available. The three levels of rebate were categorised as nil, 50% and 100%. Results indicated that the majority of respondents preferred the psychologist offering free services. Although, as the authors acknowledged:

> The degree of preference for free treatment was not consistent in the groups but varied inversely with the anticipated level of rebate: for the nil, 50% and 100% rebate groups respectively, the percentages of subjects choosing free service were 70.9, 57.3 and 45.1. (Lowe et al., 1986, p. 303).

However, as the real cost of a therapy session diminished, respondents indicated that they were more willing to pay for the services. In the 100% rebate group 54.9% reported that they would pay, although only 9.8% of subjects chose the highest fee level ($45). Therefore, the results of this study do not reflect the assumption that the higher the fee paid for counselling the greater is the quality of service provided. The authors do acknowledge that the study has limitations, primarily the lack of any analysis of the reasons for the choices made by respondents, and the exclusive use of tertiary students as a representative sample.

Conoley and Bonner (1991) attempted to directly address the issue of fee structure relative to counsellor desirability. From a study of 60 female undergraduates attending a southwestern university, three levels of fee were compared– high fee, low fee and sliding scale. Results of this research indicated a tendency of the public to view counsellors on the high fee scale as more credible, expert, and attractive than those on the lower fee levels. However, the authors themselves acknowledge that a sample of college students may not be a true representation of the general public and subsequently these conclusions are somewhat limited. For a more comprehensive understanding of how fee structure affects the public's view of counsellors, wider research was recommended by Conoley and Bonner.

A more recent study conducted by Waehler, Hardin and Rogers (1994) found that higher fees charged by counsellors were viewed negatively. Three hundred and ninety-six students from psychology classes at the University of Akron were asked to view a videotape and then complete a related survey. The study design involved a three-tier fee structure – free, prepaid, or $70.00 per session, relative to the severity of the problem being experienced – mild, moderate, or severe. Waehler et al. (1994) concluded that, while it would be expected that people would be more willing to pay higher fees as the level of distress escalated, this was not found with the student population they surveyed. Contrary to other studies, students in this survey were affected by a high fee, although the authors suggested that this may be attributed to the economic status of students, who view a $70.00 fee as a significant expense. However, Waehler et al. conceded that the conclusions drawn from their studies were limited in so far as the sample population may not have been a true representation of the general population. Additionally, responses to a simulated problem may not accurately portray how respondents would react if they were in an actual help-seeking situation. Relevant to the issue of fees is the issue of whether or not counselling should be covered by Medicare.

3.42 Medicare rebate

Currently in Australia there are limited avenues for financial reimbursement for counselling services. A few private health insurance funds have recently provided some financial remuneration for counselling for their members. Conversely, in America most states have a process whereby those accessing the services of a counsellor are partially refunded for payment through third party insurance

(Richardson & Handal, 1995). However, Medicare rebates are available to patients who consult a psychiatrist, and fees incurred by a session with a psychologist can be claimed from most private health insurance companies in Australia.

Sharpley (1986) sought to determine if the general public had knowledge of which of the four professions' services – psychiatry, psychology, counselling, and social work – were covered by Medicare. Results from this survey found that 24% believed that services provided by a psychologist were covered by Medicare, 60% identified that services provided by a psychiatrist were covered by Medicare and 6% and 5% thought that services provided by social workers and counsellors respectively were covered by Medicare. Additionally, Sharpley (1986) further asked respondents whether or not they thought that the professions whose services were not covered by Medicare should have those services covered. While 46% considered that psychologists' services should have Medicare coverage, 59% thought that social workers' services should not and 56% stated that Medicare should not cover counsellors' services. Hence, the issue of Medicare rebate for counselling services was found to be an issue, on which those surveyed held divided opinions. The issue of counsellor accessibility and approachability was also the focus of earlier studies.

3.43 Accessibility and approachability

The issue of where to find a counsellor and how readily accessible they are once found is not an issue that has been extensively explored in previous research. However, Rogers and Sharpley (1983) noted that, while people were reluctant to seek help for psychological problems, they would see a medical practitioner for even mild concerns. Whether or not the reason for this reluctance was a lack of knowledge or a

belief that counselling has nothing to offer, was an issue Rogers and Sharpley (1983) sought to address. This has been, and continues to be a concern for those who seek to offer counselling services.

Sharpley (1986) asked respondents where they thought the four professions of psychiatry, psychology, counselling and social work were employed and therefore able to be accessed by the public. The results indicated that counsellors were thought to work in community health centres (29%), public agencies (27%) and education and church institutions (23%). Central to the issue of counsellor accessibility is the issue of how approachable counsellors are thought to be.

Sharpley (1986) specifically sought to determine how the public perceived the approachability of psychiatrists, psychologists, counsellors and social workers. Results from this study indicated that 61% of respondents thought that they would consult a counsellor for a problem, and 78% stated that they would recommend a counsellor to a friend. The respondents were further asked to rate (out of five) the perceived status, the degree of comfort talking to in a social setting and the perceived oddness of each of the four professionals. Regarding status (1 representing low and 5 indicating high), the counsellor's rating was 2.9. In terms of the degree of comfort respondents indicated they would feel when talking with a counsellor in a social situation, counsellors rated 4.1, with 1 being "not at all comfortable" and 5 demonstrating "very comfortable." Finally, counsellors received a rating of 1.5 with regards to "perceived oddness," where 1 indicated "not odd at all" and 5 suggested "very odd." Therefore, although not rating highly on the question of status, this study indicated that, in relation to approachability, counsellors were considered to be comfortable to talk with socially and not excessively

'odd.' Just as the perceptions of counsellors' approachability and accessibility are important issues, of similar relevance to counsellors is the issue of what the public perceive to be the benefits of counselling.

3.44 Benefits of counselling

The major benefit of counselling reported by respondents in the survey by Rogers and Sharpley (1983), was having access to talk to an uninvolved and objective person. Other benefits indicated included helping people solve their problems and helping people to gain a better understanding of their problems. Similar results were evident in the study by Sharpley, Rogers and Evans (1984), where respondents reported a number of benefits of counselling. These included having a confidential and objective viewpoint, consulting a trained listener, having help to solve problems and make decisions, saving marriages, increasing self and other awareness, and assisting with effective communication. Furthermore, data compiled by Sharpley (1986) showed that 46% of respondents believed that counselling would help to solve problems and find directions. Having a caring person and someone to talk to were considered benefits by 14.9%, and 8% thought counselling was beneficial in that it helped the community and was practical. The benefits of insight and confidentiality were reported by 3.8%, while 2.6% stated that being affordable was a benefit, and 0.2% thought counselling would ease the pain of mental illness. Of some concern in this study were the 23.5% of respondents who either did not know of any benefits of counselling or thought that there were none. However, in order to obtain a balanced view of the regard in which counsellors are held, the perceived drawbacks of counselling need to be assessed.

3.45 Drawbacks of counselling

Dependency on the counsellor was considered the main drawback of counselling according to Rogers and Sharpley (1983). Other concerns of respondents of that survey were that the counsellor might give the wrong advice or provide misleading information, or that the client may misconstrue the input from the counsellor.

Similar concerns were expressed by respondents from the study conducted by Sharpley, Rogers and Evans (1984). Over-reliance on the counsellor was again reported by many as a drawback. Further perceived drawbacks recorded were lack of counsellor credibility, invasion of privacy, lack of client co-operation with the counsellor, and some saw marriage counselling as potentially doing more harm than good.

Of those surveyed by Sharpley (1986), 32.1% of respondents did not know of any drawbacks of counselling, while 20.1% stated that there were none. Lack of training, being too theoretical and only giving personal opinions was reported by 14.1%. A further 8% thought that counselling was not practical and caused more problems, 6.4 % stated that counsellors were underpaid, not given enough government support and did not have enough time and 6.2% believed that counselling was costly in terms of time, money and taxes. The drawback of causing emotional dependence was reported by 5.6%, and 5.1% thought that counselling was impersonal, intimidating and bureaucratic. Two percent believed that public stigma was a drawback.

Therefore, from the literature reviewed, there are a number of perceived drawbacks of counselling that are prominent issues for those who offer counselling

services. Since the perceptions of the public regarding counselling are paramount to the utilisation of counselling services, issues that might influence an individual when accessing a potential counsellor are relevant. Cultural issues have been explored by a number of studies. However, since cultural issues were not included in the current research, the relevant literature will not be extensively reviewed. Existing literature that has considered cultural issues as pertinent to counselling have included: an examination of the effects of counsellor cultural sensitivity, counsellor ethnicity, participant acculturation and gender on perceived counsellor credibility and cultural competence (Gim, Atkinson, & Kim, 1991), an examination of the effects of counsellor ethnicity and counselling style on Japanese Americans' perceptions of counsellor credibility (Atkinson & Matsushita, 1991), an assessment of the perceptions of Asian students who had received counselling, compared to Caucasian students who had received counseling (Lee & Mixson, 1995).

3.5 Other relevant literature

There is very little literature that specifically addresses the question of general public perceptions of counsellors. However, there is literature that has focused on public perceptions of counsellors within specific sections of the community. These sections included the education system, medical practices and professional employees.

3.51 Perceptions of counselling within the education system.

Evaluating the effectiveness of pre-enrollment counselling conferences at a University in Milwaukee was the focus of a paper written by Blum and Sullivan (1953). A checklist to determine the impressions of counselling of college students was issued

to 335 Freshmen. Results indicated that the majority of Freshmen found the pre-enrollment counselling to be a positive experience and helpful with vocational issues.

Grant (1954) conducted two studies regarding the perceptions of counsellors within the education system. The first study focused on the perceptions of senior students from nine different high schools in New York regarding the role of the school counsellor. While mention was made that each high school that participated in the study had a senior class of over 100 but less than 150, the author did not include in his paper the number of students who participated in the study. An open-ended questionnaire, consisting of nine situations was distributed to the students. Each situation listed on the questionnaire required participants to nominate, in order of preference, who they would like to assist them in a given situation: 1) counsellor, 2) other school personnel, or 3) non-school people. The nine situations were grouped into the following areas: vocational planning, educational planning and personal-emotional issues. Results indicated that students perceived counsellors as providing competent assistance with vocational and educational planning (62%). However, only 4% reported that they would access the school counsellor for personal or emotional issues. The majority of respondents (75%) indicated a preference for non-school people for assistance with personal and emotional situations. Grant (1954) recommended the promotion of counsellors and counselling services to school personnel and potential clients.

The second study conducted by Grant (1954) was to determine whether or not the perceptions of the students in his first study regarding the role of counsellors was a reflection of attitudes and perceptions of the counsellors role held by school

administrators, teachers and by the counsellors themselves. A similar open-ended questionnaire was distributed to school personnel and counsellors, as was completed by the students in the first study. The situations listed in the questionnaire were again categorised into the areas of educational planning, vocational planning and emotional or personal issues and participants were asked to prioritise whether they believed that a counsellor, other school personnel or non school personnel would be best suited for handling the situations listed. Randomly selected from schools in New York State, participants included 82 counsellors, 76 administrators and 200 teachers. Similar to the results of the first study, the participants of Grant's (1954) second study indicated a perception that a counsellor was their first preference for vocational and educational planning issues. However, approximately 70% of school administrators and teachers perceived that someone other than a counsellor should work with students in the areas of emotional and personal issues. Additionally, the counsellors themselves seemed unclear as to their ability to effectively assist students with emotional or personal issues with nearly 50% indicating that other sources could be of greater assistance in these areas. Grant (1954) concluded that the results of this study supported his hypothesis that the perceptions reported by students regarding the role of a counsellor, from his previous study, were reflecting the perceptions of school administrators, teachers and the counsellors themselves. He further recommended that training programmes for counsellors provide a higher level of competency in the managing of emotional and personal issues.

Jenson (1955) sought to determine how students from grades nine to twelve felt about counselling they had received. Results represented the responses of a 20%

random sampling of approximately 8000 students. Over 60% of participants reported positive feedback towards the counselling they had received. Jenson (1955) further sought to assess which individuals the participants would prefer to help them with certain problems. The choice of individuals given to participants included parents, counsellors, teachers, deans and friends. For all of the problems presented to the participants, counsellors were the preferred individuals to approach for help, although parents were a close second preference for two thirds of the problems. Hence, the results of this study showed that the students surveyed perceived counsellors as their primary source of assistance.

Similar to the results of Grant (1954), King and Matteson (1959) concluded that the students they had surveyed perceived their counselling centre as most able to manage educational problems. Vocational problems were reported as the next issue the students believed they would take to the counselling centre, followed by social problems and personal problems. King and Matteson (1959) surveyed 390 Michigan State University students in order to determine the preferences of the students in taking different types of problems to the counselling centre.

Wilcove and Sharp (1971) surveyed students, parents or legal guardians of students, faculty, counsellors and student services personnel in a study to determine the perceptions of a college counselling centre. The results of that study indicated that the counsellors who worked at the college saw their role differently to the community they served. All groups indicated that the counselling centre was appropriate for issues of vocational choice and routine college problems. However, while counsellors stated that adjustment problems were appropriate for their services, the other groups reported to

the contrary. The authors of that study concluded that re-educating the public regarding the role of the counsellor and their associated expertise was necessary.

Similarly, Resnick and Gelso (1971) sought to determine whether or not counsellors had reduced the communication gap between themselves and others within the Ohio State University community. This study surveyed counselling centre professional staff (n = 13), student personnel staff (n = 105), the teaching faculty (n = 68), counselling centre clients before (n = 58) and after (n = 38) counselling, and students enrolled in an undergraduate course in psychology (n = 70). A checklist consisting of 66 student problems was distributed and the respondents were asked to indicate the appropriateness of the counselling centre for each of these problems. Conclusions from this survey were that counsellors had not been successful in reducing the communication gap between themselves and other relevant campus groups. Counsellors indicated that personal and social problems were more appropriate for them to deal with than did the other groups surveyed.

The discrepancies between what counselling services offer and what the community they serve believes they offer was an issue that Gelso and McKenzie (1973) sought to address. The purpose of their study was to determine whether or not the perceptions of students regarding what was appropriate to discuss with a counsellor and their willingness to access counselling services could be altered by providing written and verbal information about counselling services. They further sought to compare the efficacy of providing only written information about counselling services with information presented both verbally and in writing. The survey included two experimental groups comprising of 260 female students each, and a control group of

161 students. None of the participants in the survey had previously accessed counselling. A 10-15 minute oral presentation discussing the appropriateness of students seeking counselling support for personal problems was delivered to one of the experimental groups. The following day written information was distributed to both of the experimental groups. The written information made the same points as the oral presentation. The control group was not provided with any information about the counselling services available at the university. Approximately seven weeks later all of the participating groups were post-tested. They were asked to rate the appropriateness of discussing 66 student problems with a counsellor. Willingness to access counselling services was also analysed. The results of this study were that printed information, even though it was specifically written to correct misconceptions, was largely ineffective in altering the perceptions of the students toward counselling. However, the information presented both orally and in writing did modify the perceptions of the respondents. Both of the experimental groups indicated that they would be more likely to access counselling than the control group that received no information reported. Gelso and McKenzie (1973) concluded that while written information increased help-seeking in general, it did not alter the perceptions of the students regarding the appropriateness of counselling for personal problems, nor did it alter the willingness of the respondents to seek help for these problems. Therefore, the authors recommended that for counsellors to effectively change misperceptions they needed to consider alternative education methods than simply written information. The main limitation of this study was that it only surveyed female students from one university campus, and therefore may not be representative of the general population.

Fullerton and Potkay (1973) sought to determine the perceived 'pressures and helps' of 341 undergraduate students at a mid-western state university. Respondents reported that their main pressures were 'grades and money.' Hence, despite 91% of respondents indicating a positive perception of counselling services, the use of counselling was not perceived as useful to themselves, but rather as somewhere that friends who had other pressures could be referred. Most of the respondents indicated that they would manage the pressures of grades and money themselves with some assistance from their friends.

The perceptions of 50 male undergraduate students of a large mid-western university campus regarding counsellors, guidance counsellors and counselling psychologists were the focus of a study conducted by Getsinger and Garfield (1976). Results of this study showed that, while the respondents did not perceive the three professionals as different in value and power, they did make differentiation between the types of problems they perceived each professional would most effectively address. Respondents reported that they would be most likely to seek out a counsellor or guidance counsellor for problems dealing with occupational choice, than a counselling psychologist. However, they further reported a greater willingness to access a counselling psychologist for personal and emotional problems than a counsellor or guidance counsellor. Getsinger and Garfield (1976) recommended that helping professionals working within the education system clarify the types of problems they are able to assist with. Counsellors and guidance counsellors may need to promote their ability to manage emotional and personal problems and counselling psychologists may need to ensure that students understand that vocational assistance is available from

them. Limitations of this study include the small sample surveyed and its focus on the male student population only.

The perception of black students towards counselling at a predominantly black university was the purpose of a study by Johnson (1977). The representative sample of this survey included 186 males and 241 females from a cross-section of schools and departments within the university. A questionnaire was divided into two parts. The first part sought to assess the respondents attitudes to the value of counselling, with responses being based on a 5-point scale ranging from strongly agree to strongly disagree. The second part of the questionnaire included 50 items that described problems that could be categorised as vocational, college routine or personal adjustment. Results of the survey found that 49.7% of respondents would seek counselling if the need arose, 31.2% were uncertain, and 19.1% of respondents indicated that they would not use a counselling service. In response to the question of whether they would recommend counselling to a friend, "… 45.2% said they would, 43.6% were uncertain, while 11.2% said they would not" (Johnson, 1977, p. 163). Respondents were further asked if they thought that counsellors probed too deeply into people's lives. The results indicated that 48.5% of respondents thought that counsellors did not probe too deeply, 19.9% believed they did and 31.6% were uncertain. A minority of 7.8% stated they believed that counsellors were a part of a system that oppressed third-world people. The second part of the survey found that respondents were most likely to see a counsellor for vocational and educational problems, whereas a friend was the preferred choice for consulting with regard to personal concerns. Johnson (1977) concluded that there was no 'strong negativism' toward counselling

indicated from the survey results, rather, the utilisation of counselling depended on the nature of the problem. Another conclusion of the study was that there was no significant difference between black students and white students regarding perceptions of counsellors.

Tryon (1980) wrote a paper reviewing the literature regarding the perceptions of and preferences for student counselling services. She concluded that, although studies have shown that students view counselling centres as more appropriate for discussing personal problems than they did twenty years ago, "…students will go more readily to a counseling center with an educational-vocational problem than they will a social-personal problem" (Tryon, 1980, p. 309). Family and friends have continued to be the reported preferable source of help with personal problems. Tryon (1980) concluded that while concerns about confidentiality and negative perceptions regarding help-seeking behaviour may contribute to the lack of use of counselling services for personal problems, the main issue is a lack of knowledge about what counselling centres offer.

The perceptions of students regarding personal problems, appropriate help sources and attitudes towards counselling was the focus of a study conducted by Cook, Park, Williams, Web, Nicholson, Schneider and Bassman (1984). A sample of 738 students from a mid-western urban campus, comprised of 350 men, 384 women and 4 respondents who did not specify gender. Results showed that the preferred source of help was 1) self-reliance, 2) friends and relatives and 3) counsellors. Counsellors were seen as the most helpful for career choice issues, stress or anxiety problems. The items of the questionnaire that pertained to positive attitudes toward counselling were endorsed by over one third of respondents and 83% agreed that counselling could be

helpful for a variety of problems. Therefore, despite an overall positive attitude toward counselling reported by respondents, the preferences for help were not the utilisation of a counselling service. The authors concluded that this result could, in part, be attributed to a lack of information regarding the counselling process and its availability.

Johnson, Nelson and Wooden (1985) investigated the student knowledge and knowledge of faculty members of a university counselling centre. A total of 88 faculty members and 79 students returned a one-page questionnaire. Results indicated that the majority of respondents had heard of the counselling centre before they received the questionnaire (73% of students and 86% of faculty members). However, the authors found "…the lack of knowledge about actual services and other facts about the CC is striking" (Johnson et al., 1985, p. 30). The student sample believed that they had more knowledge about the counselling centre than they actually did, while the faculty members were 'uninformed rather than misinformed.' Students reported a belief that the counselling centre was a guidance service, offering a range of academic support, whereas the faculty members had an understanding of the comprehensive mental health services being incorporated in the counselling centre. The area of least knowledge reported by respondents was the qualifications of the staff working in the counselling centre. Very few respondents were aware that the counselling staff were highly qualified professionals and consistently underestimated the level of qualifications. The authors concluded that the lack of knowledge and associated inaccuracies would play a significant role in influencing perceptions of counsellors.

Hassan and Hasssan (1991) explored whether or not attitudes towards counselling services within the education system could be changed by increasing the knowledge of school staff regarding these services. A sample of 60 school personnel were randomly selected for the study. Fifty percent of the sample comprised principals and vice-principals, and the remaining 50% were classroom teachers. Half of the subjects were given a verbal presentation on the advantages of school counsellors and the general work of a counsellor, and the other half were given a presentation on the role of teachers. The authors expected there to be no difference between the perceptions of principals and those of other school personnel, nor did they expect that knowledge of counselling practice would change people's attitudes towards counselling services. The results recorded a higher attitudinal change within classroom teachers than the principals and vice-principals. Furthermore, the group which received the information about counselling displayed more positive changes in attitudes than the other group. This further supports the notion that providing information about the role of counsellors is of paramount importance to the facilitation of positive public perceptions of counselling services.

Similarly, Kaczmarek and Jankowicz (1991) sought to investigate college students' perceptions of counsellors, specifically addressing the issue of counsellor approachability. Two groups of students were used for the research. The first group comprised of 15 freshmen students taking introductory undergraduate courses, while the second group involved 22 students in their first year of a Masters Degree in Counselling. The results of the survey indicated substantial disparity between the participating groups with regards to their view of the approachability of counsellors.

"The contrast in preference for helpers in the two groups was well established: freshmen prefer friends, while post graduates prefer counsellors, as people to approach for assistance" (Kaczmarek & Jankowicz, 1991, p. 326). Recommendations from the authors of that study included raising the awareness of the counselling process and the associated expectations of this process to perspective clients. Because the freshmen in the survey reported a strong belief that counselling involved 'advice-giving', Kaczmarek & Jankowicz (1991) further recommended that education specific to the nature of counselling could reduce such misconceptions.

The school system is not the only professional area in which confusion exists regarding counsellors. The medical profession also reported divided opinions when asked about the value they would place on having a counsellor operating in their practice. A sample of the literature is reviewed in the next section.

3.52 Medical Opinion.

Nunnally (1961) sought to assess the opinions and attitudes of general practitioners toward mental health professionals from a representative sample of 431. Almost all of the participants (91%) stated that psychiatrists were available for case referrals. However, the study found that when patients required treatment for mental health issues, the general practitioners often treated the patient themselves. Of those patients that they would refer, the respondents indicated that most of the time they would refer to a psychiatrist. If another resource was used, the general practitioners surveyed indicated that the clergymen would be their next preferred choice of professionals for referral. When asked to rate the perceived effectiveness of various treatment methods for those with mental illnesses, the respondents favoured shock

treatment above the other options. Although rated considerably lower, psychoanalysis was the second preferred treatment method. Differences noted among the opinions of the general practitioners were that younger doctors were more likely to treat patients with symptoms of mental illness themselves, and that doctors from smaller communities were more likely to believe in the efficacy of psychiatric services to which they referred their patients. Nunnally (1961) concluded that, although the results of this survey indicated that general practitioners evaluated themselves and their own institutions more highly than they did other mental health specialists and methods, their overall attitude toward mental health facilities could be described as 'not bad.' Nunnally (1961) stated: "They placed moderately high evaluations on psychiatrists, mental hospitals, psychoanalysis, psychotherapy, and other related concepts" (p. 105).

In 1976 Anderson and Hasler sought to measure the effects of a counselling service that was established in a medical practice in South Oxfordshire. A questionnaire was sent to the first 80 patients who utilised the counselling service and their treating doctor completed a shorter questionnaire. Fifty-five of the patients returned completed questionnaires and forty-eight of these reported that: "…they would not have preferred to continue to see their own doctor about their problems." (Anderson & Hasler, 1979, p. 355). Similarly, the doctors reported a belief that the majority of their patients that were referred to the counselling service had an improved ability to manage their problems and improved interpersonal skills. Additionally, there were indications that counselling reduced the use of psychotropic drugs, although the authors cautioned that more time was needed to accurately assess the decline in use of medication. Anderson and Hasler (1979) concluded that, based on the results of their

survey, counselling was a valuable service to both patients and doctors in a general practice setting.

Koch (1979) further sought to evaluate the perceived efficacy of behaviour therapy intervention in general practice. A total of thirty patients with psychological problems who consulted with general practitioners from a medical surgery were surveyed over one year and comparisons were made between the patients' reliance on both psychotropic drugs and their general practitioner, before and after contact with psychological services. This study assessed the involvement of clinical psychologists in the treatment of "…anxiety states, stress reactions, psychosomatic disorders, obsessional states, habit disorders of eating, smoking, and drinking, and problems of social, marital, or sexual dysfunction" (Koch, 1979, p. 337). The results of the study indicated that the frequency of doctor consultations for advice and the use of psychotropic drugs were substantially reduced in patients following psychological intervention. Recommendations for further research by the author was to monitor a control group of patients that did not receive psychological help and to assess whether or not psychological help effectively reduced the number of presentations to hospital based psychiatric services.

Ives (1979) found similar results in a study conducted of a clinical psychologist working in two medical practices in Sheffield. From a total of 238 patients who were seen by the psychologist over a period of 26 months, results showed that visits to the surgeries and prescriptions written for psychotropic drugs decreased. Ives (1979) also acknowledged that the lack of a control group was a limitation of the study.

A survey conducted by Waydenfeld and Waydenfeld (1980) in North London involved 35 general practitioners, nine counsellors and 88 patients who were counselled. This study sought to determine the success rate of counselling in general practice according to the counsellor, the doctor and the patient. The study further sought to assess the effects of counselling on the general practice workload, on the cost of prescription drugs and on referrals to other agencies. Data were collected by questionnaires distributed to the patients and the counsellors, and interviews were conducted with the doctors. According to the results from the counsellors' questionnaires, 79% of patients 'welcomed' the referral, 15% 'accepted it for the doctor's sake,' and 5.8% needed to be persuaded about the possible benefits of counselling. Twenty-four percent of participants indicated that they would access counselling outside of the medical practice, while 76% stated that they would not. However, according to the results from the patients' questionnaires, 78.7% indicated that they would access counselling again and 90% stated that they would recommend counselling to others. A decline in the number of prescriptions issued for psychotropic drugs was cautiously reported by the study, with the qualification that there were only complete data regarding this issue from 60 patients. All of the interviewed doctors reported highly valuing the direct accessibility of a counsellor working from their practice. However, of the nine doctors interviewed, five indicated that the inclusion of a counsellor in their practice had not altered their workload, while two reported that they had experienced some workload relief and two believed that their workload had increased by more involvement personally and by liaison with the counsellor.

In another study designed to determine the effects of counselling from a medical practice in Bedfordshire, England, Martin and Martin (1985) found no major changes reported regarding the number of prescriptions written for psychotropic drugs or in the frequencies of consultations with the general practitioner. This survey involved two samples. The first sample consisted of 300 patients, randomly selected, who had been continuously attending the practice since 1974. The medical notes for these patients were reviewed and the number of prescriptions written for psychotropic drugs and the number of recorded psychosocial problems were noted for the years 1975, 1979 and 1982. The second sample comprised of 87 patients who had attended counselling at the practice at least a year before the survey and 87 patients from a control group. Martin and Martin (1985) concluded that, although three years after receiving counselling more than 75% of patients from that sample were receiving no medical treatment for psychiatric problems, these results could reflect either the natural history of the problems patients were being counselled for or the benefits of counselling over a period of time.

Corney (1987) studied the perceptions of marriage counsellors and general practitioners regarding the efficacy of the marriage counsellors working as allied health professionals in general practice. From a list of general practitioners who were known to have marriage guidance counsellors attached to their practices, questionnaires were mailed to 38 doctors from nine of the practices. Additionally, questionnaires were sent to 10 counsellors working in medical surgeries. The questionnaires were completed and returned by all of the counsellors and 28 of the general practitioners. Results from the general practitioners showed that all would refer to the counsellor for marital

problems, 17 indicated they would also refer other types of relationship difficulties and 10 stated that they would refer patients with emotional problems, or who were depressed or anxious. However, referrals depended on whether or not there were other health professionals attached to the surgery. In those surgeries where psychiatrists, psychiatric nurses and psychotherapists were attached, the general practitioner tended to only refer to the counsellor for marriage guidance. Twenty of the general practitioners reported that they found the services of the marriage guidance counsellor valuable and that it decreased their workload, while six indicated that their workload had increased due to extra discussions and meetings. All of the counsellors were positive in their feedback regarding working from a medical surgery. Therefore, while the results indicated general satisfaction with the working relationship between counsellors and general practitioners, a major limitation of this study (acknowledged by the author) lies in the fact that the general practitioners surveyed were not typical of the wider population. The general practitioners who participated in this study often had a special interest in counselling and had close friends or partners who were counsellors. Corney (1987) stated: "These specific interests do not apply to medical practitioners in general: the majority of general practitioners have little or no training in counselling, no specific expertise, no time available and possibly no inclination" (p. 55).

McLeod (1988) wrote a paper evaluating the work of counsellors in general practice, based on her discussion with counsellors and general practitioners from 14 different surgeries scattered across England. She found that all of the counsellors saw patients with relationship and marital problems, anxiety, depression and stress-related problems, and those with bereavement issues. However, the proportion of patient

problems varied, depending on the field of expertise of the counsellor. One counsellor was trained in behaviour therapy and therefore most of their caseload involved patients with phobias or drug and alcohol dependencies. Additionally, crisis intervention was part of the work of counsellors from ten of the general practices examined. McLeod (1988) listed the advantages and disadvantages of counsellors working in general practice according to her study. Advantages for the counsellor were found to include a ready source of referrals, easy access to medical information, consultation with other helping professionals, and a place to work with limited overhead costs. The patient was considered to benefit by having access to a counsellor in a familiar setting, and being referred to someone that their doctor knew and trusted. There was some evidence that the number of prescriptions required was reduced by the easy access to counselling for patients. A perceived advantage for the general practitioners was in learning to identify the real needs underlying the presenting symptoms of the patient, although it was acknowledged that it took time for the doctors to appreciate and understand the methods and skills of counsellors. McLeod (1988) found that it was tempting for some of the general practitioners to refer to the counsellor in the practice those patients who either presented with long-term problems or who left them feeling angry or helpless. The appropriateness of referrals was noted to improve as the counsellor became known and their work was better understood. Both counsellors and doctors indicated that a major benefit for them was in gaining insight from collaborative discussions. The disadvantages identified by McLeod (1988) were that counsellors lacked medical knowledge and were unfamiliar with the way general practitioners worked. There were also difficulties regarding fees, with

counsellors charging for services in an environment where patients were not required to pay for services offered by other professionals. There was a feeling reported by counsellors of professional isolation and sometimes hostility and misunderstanding from other staff. Furthermore, amongst the general practitioners the non-professional image of the counsellor as a volunteer worker still lingered and the issue of counsellor training being greatly varied was considered a drawback. From the information gathered from her enquiries, McLeod (1988) concluded that the practices that she visited were providing comprehensive patient care and that the introduction of a counsellor to the practices was viewed as an extension of a multidisciplinary team. She wrote:

> the doctors who decided to appoint a counsellor were often interested in or trained in psychotherapy and were usually open to the possibilities of working with other professions. These doctors were aware of their own limitations in terms of time and counselling skills (McLeod, 1988, p. 8).

Balestrier, Williams and Wilkinson (1988) conducted a meta-analysis of specialist mental health treatment in general practice. Their analysis included eleven studies, only two of which were focused on counsellors in general practice. Ashurst and Ward (1984) and Martin and Martin (1985) were the two studies included that were specific to counsellors in general practice. Results of this analysis indicated that counselling, behaviour therapy and general psychiatry were almost identical in their overall superiority over 'usual general practitioner treatment.' Additionally, counselling was reported as the most effective treatment in improving social functioning, while behaviour therapy appeared to be the most effective in reducing contacts with outside

psychiatric services. Hence, according to the analysis by Balestrieri, Williams and Wilkinson (1988), counsellors in general practice were believed to be of equal impact to that of psychologists, social workers and psychiatrists.

Martin (1988) wrote in an article in the British Medical Journal about the confusion regarding the efficacy of counsellors in general practice. The article discussed the issue of counselling services being delivered by specialist counsellors, or being delivered by general practitioners themselves. The article did not provide an opinion or recommendation regarding the author's preference, although Martin (1988) did express a caution against a widespread adoption of counsellors in general practice until there is more consistent evidence supporting its efficacy over a period of time. Martin (1988) criticised some of the studies that have been conducted about counsellors in general practice as not having the longevity to substantiate their claims.

Similarly, the efficacy of counselling in general practice was the focus of a discussion paper by Corney (1990). According to this paper, the number of counsellors working in general practice had substantially increased, with subjective feedback suggesting that there had been considerable consumer and medical practitioner satisfaction from this working arrangement. However, the paper sought to determine if clinical studies reported similar favourable outcomes. Of the twelve studies that Corney (1990) evaluated, five studies indicated that there were no major differences in the outcomes for patients treated only by their general practitioner, versus those who were treated by a counsellor as well. A study that evaluated the treatment of patients suffering from phobias and habit disorders by a nurse therapist versus those who received routine care from their doctor, found that the experimental group had a better

outcome after a one year follow-up. Similarly, the treatment of patients suffering from post-natal depression by counselling was compared to the treatment by general practitioners, with a greater psychiatric improvement reported in the experimental group after three months. When the interventions of a psychologist were compared to the treatment of a general practitioner, the experimental group was found to improve more quickly, although there were no major differences between the outcomes of the two treatment interventions after one year. A similar study found that the experimental group used fewer psychotropic drug prescriptions during therapy treatment, versus the treatment only by a general practitioner. The use of cognitive therapy in the treatment of major depressive disorder (as opposed to treatment by a general practitioner) showed that, while the experimental group were reportedly less depressed at the end of treatment, this was not the case after three months. Conversely, when cognitive therapy was used in the treatment of depression, versus routine general practitioner treatment, the experimental group had better outcomes according to a three month follow-up. Corney (1990), rewrote her paper for the *International Review of Psychiatry* (1992) and drew the same conclusions as those from her original paper that "the results of these studies give tentative support to the value of counselling in general practice" (p. 336).

An article written in the editorial section of the Journal of the Royal College of General Practitioners (1990) entitled, *Is counselling the key?* explored the importance of counselling for the future framework of general practice. However, the focus of the editorial was on general practitioners providing the counselling for their patients and

did not incorporate the idea of liaison with counsellors for managing the psychological issues of patients.

Thomas and Corney (1992) sought to investigate the existence of collaboration between general practitioners and mental health professionals in six randomly selected health districts in England. A questionnaire was sent out to the surgeries operating within the selected health districts, with a return of 75% (261 practices). The results from this study showed that 47.9% of practices surveyed reported a link with a community psychiatric nurse, 21% reported an association with a social worker, 16.9% reported collaboration with a counsellor, while 15.7% and 14.9% indicated links with a psychiatrist and a clinical psychologist respectively. Hence, a number of general practitioners surveyed in this study indicated a positive attitude toward counselling, evident by their professional collaboration with other mental health workers.

In an article in the British Medical Journal, Pringle and Laverty (1993) wrote about the perceptions of general practitioners toward counsellors in general practice. "Despite the lack of convincing evidence of its efficacy many general practitioners believe in the value of counselling and of counsellors in general practice" (Pringle & Laverty, 1993, p. 2). However, they argue for caution, citing concerns of the cost of employing a counsellor in a general practice and the issue of counsellor training. Pringle and Laverty (1993) concluded that the current demand for counsellors should be tempered with the need to ensure that counsellors working in primary care are properly trained and supervised.

Sibbald, Addington-Hall, Brenneman and Freeling (1993) sought to provide an accurate picture of the views of general practitioners of counsellors working in general

practice and the services they provide, by conducting a survey of counsellors working within English and Welsh practices. Sibbald et al. (1993) acknowledged the conflicting results of previous literature. Some studies have indicated that patients and general practitioners believe that counselling has improved the patients' feelings of well being, has reduced the use of psychotropic drugs, has reduced the number of consultations with the general practitioner and has reduced referrals to psychiatric services. However, other studies have indicated that counselling in general practice may not be cost effective and has little impact on both the prescribing of psychotropic drugs or the workload of the general practitioner. Sibbald et al. sought to address the limitations of the other studies by surveying a larger representative sample. Questionnaires were mailed to doctors and telephone interviews were conducted with those who did not respond to the postal questionnaire. The total of completed questionnaires able to be used in the survey was 1542. Results of this survey showed that 31% (484) of general practices employed a 'counsellor.' The professional backgrounds of these 'counsellors' included 181 community psychiatric nurses, 134 practice counsellors and 95 clinical psychologists. Of the general practitioners who did not have a counsellor working for them, 413 said that they would, 85 reported opposition to a counsellor working in their practice, 144 were uncertain and 25 did not respond to the question. The barriers to providing a counsellor reported by those general practitioners who had indicated that they would like to have a counsellor on staff included financial constraints, lack of space and time, difficulties with staffing, low demand for counselling and doubts about the value of counselling. Only 197 of the counsellors working in the general practices surveyed had counselling qualifications

and general practitioners did not know the qualifications, if any, of 85 counsellors. A further 145 counsellors whose qualifications were known to the general practitioner, had no training in counselling. Sibbald et al. hypothesised that, because there was no accepted accreditation scheme for counsellors and counsellor training varied greatly, general practitioners may rely more on their personal knowledge of an individual rather than on formal qualifications. The referral patterns reported by general practitioners reflected the perceptions of the skills of the counsellors. Community psychiatric nurses were often referred patients with affective and psychotic disorders. Patients with psychosexual difficulties, phobias, eating disorders and obsessive compulsive disorders tended to be directed to clinical psychologists, while practice counsellors often received referrals regarding grief and loss. Sibbald et al. concluded that, while counselling services were becoming widespread in general practices, the lack of counselling qualifications of individuals providing a counselling service should be monitored by general practitioners and their referral policies should be more discriminating.

The 'use and uptake' of counselling in a London general practice was the focus of a study conducted by Webber, Davies and Pietroni (1994). A retrospective analysis of 92 patients referred by general practitioners for counselling onsite over a twelve - month period was conducted. Results showed that the mean referral rate by the general practitioners to the onsite counsellor was substantially higher than the mean referral rate to psychiatric outpatient services (13.5 referrals per 1000 general practitioner consultations versus 1.7 referrals per 1000 general practitioner consultations). However, a quarter of the patients referred to the counsellor in the general practice did not keep their original appointments or did not complete the counselling contract.

Webber et al. (1994) concluded that, although general practitioners were willing to refer patients to counselling, preparation of the patient regarding the nature of counselling and the reason for the referral was necessary for the uptake of counselling.

Another survey conducted by Sibbald, Addington-Hall, Brenneman and Freeling (1996) challenged the perceived efficacy of counsellors in general practice. Using data collected from their 1993 study, Sibbald et al. (1996) compared the prescription rates of psychotropic drugs of 126 practices that had counsellors versus 88 practices that did not have a counselling service. The results of this survey indicated no significant differences between practices with or without counsellors in the prescribing of psychotropic drugs. However, Sibbald et al. acknowledged that the results needed to be taken in context of the limitations of the study. These limitations included the following: uncertainty that the participants were representative in their prescribing behaviour, the counselling may have reduced drug consumption of patients but the numbers may have been of a small proportion comparative to the overall practice population, counselling may have been used to supplement prescribed medication, counselling may have primarily targeted patients who were not on prescribed medication and the quality of the counselling services may not have been high, thereby limiting any beneficial effects on prescribing. Sibbald et al. acknowledged that more indepth studies of counsellors in general practice needed to be conducted to investigate these limitations.

The views and perceptions of counsellors held by general practitioners and their subsequent decision to refer to, or incorporate within their practice a counsellor were investigated by Radley, Kramer, and Kennedy (1997). Their paper surveyed 136

general practitioners from a total of 152 medical practices in the English County of Leicestershire. The study indicated that 15% of the practices surveyed employed a specialist, trained counsellor. Additionally, the survey indicated that provision for counselling was a relatively low priority for rural practices, whereas practices serving predominantly ethnic minorities were more likely to prioritise having a counsellor. In follow-up interviews there were indicators that "some doctors saw counselling as not having clear goals, and that they had reservations about the training, selection and supervision of counsellors" (Radley et al., 1997, p. 172). The authors concluded that this opinion was a result of either lack of knowledge about what counselling offers, or an expectation of an information-based advisory service rather than a therapeutic alliance.

A number of studies have been conducted that have specifically related to clinical psychologists, social workers, or psychiatrists and the associated perceived efficacy of liaisons between these health professionals and general practitioners. However, the focus of this paper is the attitudes toward and perceptions of counsellors and therefore studies that have focused exclusively on the other health professionals have been excluded from this literature review.

Thus, the research conducted to date appears to reflect a difference of opinion between medical practitioners regarding counselling. "Where general practitioners with counsellors emphasised improved working relationships and convenience for patients, those without tended to focus upon doubts about the efficacy of the technique and upon reservations about the legitimacy of counselling within medical practice" (Radley et al., 1997, p. 172). Again, it could be concluded that education is central to

counselling services being considered viable. Further division regarding perceptions of counsellors was evident when the attitudes of professional employees' were assessed.

3.53 Professional employees' perceptions

A study by Powell and Kotschessa (1995) sought to determine the factors that would influence professional employees' willingness to access company-sponsored counselling services. They surveyed 120 MBA students who were enrolled in a programme that involved a professional work component. Seventy-nine percent of the respondents had already obtained work experience and 20% indicated that they had previously seen a counsellor. The survey asked 60 questions regarding the willingness of the respondents to seek counselling in a series of hypothetical scenarios. The type of problem was classified as a serious personal problem, a serious work problem, a minor career problem, or a desire for career counselling. The location of the counsellor was indicated as either on company premises or elsewhere. Payment for the counselling was specified as by the employer, by the employee's insurance company, or by the employee directly. Willingness to seek counselling was indicated by yes, not sure, or no answers. Results of this survey found that respondents would go to counselling for 52% of the hypothetical scenarios, they would not go to a counsellor for 27% of the scenarios, and were not sure for 21%. The respondents indicated that they would most likely seek counselling when they had a desire for career counselling (60%) and were least likely to access counselling for minor career problems (34%). For both serious personal and work problems the 'yes' response rate was 55%. Additionally, 67% of respondents were willing to seek counselling if their employer paid for it, 62% if their

insurance company paid for it, and only 26% indicated that they would seek counselling if they had to pay for it themselves. However, the authors of the study acknowledge that the students surveyed may not be representative of the population of professional employees and answers to hypothetical problems may not be reflective of the respondents' actual behaviour. As the literature regarding the perceptions of specific populations of the community is relevant to this thesis, so too are the studies that compare public perceptions of counsellors, psychologists, psychiatrists and social workers.

3.6 Comparative Studies

There have been numerous studies that have compared the public perceptions of different helping professionals and sought to determine whether or not the public could make distinctions between various disciplines. Some of these comparative studies do not include counsellors. However, since perceptions of psychologists, psychiatrists and social workers are included in the present study, the literature that compares these disciplines has been included here. Furthermore, while Australian literature is the most relevant to this paper, comparative studies are limited in numbers. A sample of Western literature and studies have been included in this review because the demographics of the countries are very similar in culture and socio-economic factors. Also, Australian studies have used their western counterparts as references to their studies.

3.61 Australian studies

Small and Gault (1975), sought to determine the perceptions of the public of psychologists, relative to the perceptions of accountants, architects, chemists,

clergymen, dentists, doctors, psychiatrists, school teachers and social workers. Based on the findings of other studies, Guest (1948), Nunnally (1961), and Thumin and Zebelman (1967), Small and Gault (1975) developed four hypotheses. Firstly, they theorised that the public would be better informed about the roles of psychiatrists than psychologists when presented with the concept of one of the two disciplines. Secondly, they hypothesised that the public would be able to distinguish between psychologists and psychiatrists more accurately when the two disciplines were presented together. The third hypothesis was that psychologists and psychiatrists would be perceived as less desirable by the general public than the non-mental health disciplines. Hence, Small and Gault (1975) predicted that when confronted with a list of professionals including: accountant, architect, chemist, clergyman, dentist, doctor, psychiatrist, psychologist, school teacher and social worker, respondents would nominate psychologists and psychiatrists amongst the least desirable of the professions. The fourth hypothesis of the study was that the general public would prefer to consult professionals other than psychologists for services which psychologists were skilled to deliver. Three hundred and sixty members of the general population were interviewed in shopping centres from the metropolitan Sydney area. The subjects of the survey were randomly sampled, with an equal distribution from low, middle and high socio-economic backgrounds, an equal number of males and females, and an equal distribution of the age categories 20-35, 36-50 and 50+ years. The results of the study found that the first hypothesis was rejected. The respondents were no better informed about psychiatrists than psychologists when presented with one of the two professions. The answers of the respondents indicated substantial confusion:

> …most respondents considered that a qualified psychologist required a medical degree and that his task is primarily to help the mentally ill. Psychiatrists, on the other hand, were often attributed with the tasks of administering intelligence tests and conducting attitude surveys" (Small & Gault, 1975, p. 23).

However, the second hypothesis was accepted, with respondents indicating a more accurate differentiation between psychologists and psychiatrists when presented with both professions and forced to identify the distinctions. Some respondents gave incorrect verbal responses, referring for example to the psychologist as a physiologist, sociologist or pathologist, or the psychiatrist as a physicist or physiotherapist. Similar anomalies were present when respondents were asked to differentiate between the roles of a clinical psychologist, an industrial psychologist and a professor of psychology. Most of the respondents could correctly identify the different roles of the associated disciplines. However, again, some gave incorrect verbal responses, such as naming a clinical psychologist a clinical psychiatrist. The primary source of gaining information about a psychologist was from reading, with television viewing and talking with friends indicated as the next most likely sources of information. Of the professions surveyed, architecture and medicine were considered to be the most desirable professions for males and school teaching and social work were indicated as the most desirable professions for females. Partially supporting the third hypothesis was that neither psychologists nor psychiatrists were considered to be the most desirable professions, although they were not indicated as the least desirable either. When asked which profession they would consult for various services, 74.44% indicated that they would

consult a social worker to assist a migrant family struggling to adjust to a new country, more than a third of respondents would consult a social worker for assistance to improve factory conditions, while 22.92% would see a social worker for marital problems. Over a third of the respondents indicated that they would prefer to consult a psychiatrist if they had a child constantly stealing, 28.61% for a cure for excessive drinking and 26.27% preferred a psychiatrist if they were feeling depressed or despondent. A psychologist was preferred by 27.32% for helping with a child constantly stealing and by 21.63 % for assisting with the improvement of factory conditions. For career guidance, over one half of the respondents indicated that they would consult with a school teacher. Since the results showed that a psychologist was selected by only a minority of respondents as the profession most likely to be consulted, the fourth hypothesis was accepted.

Small and Gault (1975) conducted a second survey from twenty members of the groups of general practitioners, clergymen and secondary school teachers and compared their perceptions to psychologists to those of the general public. Findings from this study showed that the professional groups were significantly better informed about the activities of a psychologist than were the general public. However, they indicated misinformation regarding the academic background and the professional affiliations of psychologists. The professional group who reportedly saw the largest number of emotionally troubled people per week was the general practitioners, who were also the professional group least likely to refer these individuals to another service.

The knowledge of and attitudes to various help-giving professions in Australia was investigated by Wilkinson, Cave, Flynn, Hodgson, Prouatt, Sultmann and Gardner (1978). Although this study did not include counsellors specifically, the results regarding the public perception and knowledge of psychiatrists and psychologists are relevant to this paper. A representative sample of 126 members of the Brisbane metropolitan area were interviewed using a five-item questionnaire. The professions of clinical psychology, social work, psychiatry, medical practitioner and clergy were singled out for the study. The results of this study indicated that the roles of a psychiatrist and a clinical psychologist were the least understood by respondents. Furthermore, there was uncertainty regarding the location of these two services, as there was for the social worker. The respondents of the survey rated the perceived usefulness and degree of confidence in the clinical psychologist as low. The authors concluded that there were major gaps in the knowledge and use of services provided, and recommended an education programme, directed toward the community, the media, and medical practitioners as a possible remedy.

Sharpley (1986) sought to determine the public perceptions and knowledge of psychologists, psychiatrists, social workers and counsellors in a study of 502 respondents representative of Australian society, as per Congalton's (1969) eight occupational categories. When asked to describe what they thought each of the four professionals did, 26.1% of respondents described psychologists as "people who study human behaviour and reactions" (Sharpley, 1986, p. 60), while 22.9% thought that they helped and advised with problems. Psychiatrists were predominantly described (60%) as being involved in study of the mind and thoughts, while 45% of respondents

similarly classified social workers as studying mind and thoughts. Counsellors were seen by 32.9% as helping with emotional problems and personal disorders. Furthermore, respondents were asked to rate on a scale of 1 to 5 (1 = “poorly” and 5 = “very well”), how well-informed they were about each profession, and to indicate how they had learnt about that profession. Psychiatrists and counsellors rated 2.6 respectively, social workers were rated 2.9 and psychologists were rated 2.5 regarding the respondents' informedness. The source of information about the four professionals was the same, with 37.42% stating general knowledge and 12.19% indicating that they had previously consulted one of the four professions and therefore knew about them from that experience. Sharpley (1986) concluded that the public perceived the four professions as providing distinct services that fell into two sub-groups:
"(1) psychologists and psychiatrists as private-practice and fee demanding professionals who study human behaviour and thoughts, and (2) social workers and counsellors as public-utility non-fee-demanding professionals who are more practical and help the average person solve emotional problems" (p. 57).

Adults and adult clients of psychologists were surveyed from a random sample of the Sydney metropolitan area to determine their knowledge of and attitudes toward mental health and physical health professionals (Hopson & Cunningham, 1995). The non-client sample comprised of 62 adults and the client-sample included 10 males and 30 females who were currently consulting psychologists. The survey compared the public perceptions of psychologists with perceptions of counsellors, doctors, nurses, physiotherapists, psychiatrists and social workers. In total, the respondents indicated some general knowledge about each of the mental health professions. They reported

the least knowledge about psychologists, and similarly very little knowledge of social workers. Conversely, well over half of the respondents indicated some general knowledge of counsellors. Non-clients reported specific knowledge of psychiatrists, stating that they treated serious mental disorders, and the client-sample specified the medical training and ability to administer medication for psychiatrists. In response to the question of how professional they considered the professions to be, participants rated doctors and nurses the highest, closely followed by physiotherapists. Counsellors and psychologists were rated next, while social workers were rated as the lowest in terms of professionalism. When asked about which profession provided a useful service to the community, doctors and physiotherapists were rated the highest. The client sample rated counsellors and psychologists higher than the non-client sample did, although both samples rated these professions as of higher than average value. Confusion between counsellors and psychologists was evident from responses to the question of what the participants thought of when they heard the word psychologist. Most of the client sample indicated that they associated the word psychologist with the thought 'provider of counselling services.' However, 45% of the client sample who were in treatment with psychologists believed that they were seeing counsellors. When asked the question whether they would see another professional instead of a psychologist, most of the client sample stated that they would prefer a counsellor or alternative health practitioner, while the non-client sample indicated that they would prefer to see a doctor. Hopson and Cunningham (1995) concluded about psychologists that, comparative to the other professions included in their survey, "it seems that the

public are not well informed about the nature of the profession and the areas of interest and expertise that it encompasses" (p. 216).

3.62 Western studies

The first published survey regarding the pubic opinion of psychologists was Guest (1948). This study sought to determine what was known about psychologists, what attitudes existed and where they came from, and whether or not the public could differentiate between psychologists and psychiatrists. A representative sample of 311 members of the general public were personally interviewed from areas of New York, Pennsylvania, New Jersey and Illinois. The interviews were divided almost equally between males and females. The results indicated that, compared to a career as an architect, chemist, engineer or economist, almost one third of the respondents stated that they would prefer that their children did not pursue psychology as a career. There were also a large proportion of respondents who indicated that they would feel uncomfortable with a psychologist in a social setting. In response to another question, 37.9 % of subjects thought that psychologists as a group were more unusual and odd than the other professions surveyed. When asked to indicate what they thought the different categories of professionals did, many respondents thought that psychologists dealt with mental problems, both intellectual and personal. However, the results further indicated that the respondents thought that psychologists only dealt with abnormal people and therefore did no work with normal individuals. The majority of respondents thought that they would find a psychologist from a doctor or the telephone directory, and had formulated their opinions of and attitudes toward psychologists from what they had read and from listening to others talk. Finally, respondents of this survey made

little or no distinction between psychologists and psychiatrists. Guest (1948) concluded that there was a need for education and information to increase the public's knowledge of psychologists and to alter undesirable attitudes.

Nunnally and Kittross (1958) sought to determine the public attitudes toward a number of mental health professionals, compared with medical professionals. The occupational categories included in this study were doctor, physician, nurse, psychiatrist, psychoanalyst, psychologist, clinical psychologist, research psychologist, mental hospital attendant and social worker. The sample comprised of 207 members of the Opinion Panel of the Institute of Communications Research in central Illinois. Results indicated that while overall the public held all professionals included in the study in high esteem, there was a more favourable attitude toward those professionals that were identified as medical professionals. Furthermore, there were no significant distinctions made by respondents between the various mental health professionals included in the study.

How well informed the public was with regard to the functions of psychiatrists and psychologists and how much was known about the academic background and training of these professions, was the subject of a study by Tallent and Reiss (1959). They conducted a survey of 143 students, none of whom were enrolled in psychology. Respondents were given a form to complete which included a series of statements. The respondents were then told that each statement might pertain to a psychiatrist, a psychologist, to both, or to neither. A 'don't know' category was also included. Results of the data indicated confusion regarding the academic background and training of the two professions. Similarly, some of the unique roles and functions of the two

professions were not correctly identified by the respondents. Tallent and Reiss (1959) concluded from their study that both professions had a need to educate the public.

Nunnally (1961) included a chapter assessing the public attitudes toward 'the experts and treatment' in his book *Popular Conceptions of Mental Health*. Specifically, that study included the professionals of doctor, physician, nurse, psychiatrist, psychoanalyst, psychologist, clinical psychologist, research psychologist, mental hospital attendant and social worker. From a representative sample of 207 members of the general public residing in or within the vicinity of Illinois, 45% of the respondents were male and 55% were female. The results of the survey indicated that, while the public reported a moderately high regard toward the mental health professionals, they placed a higher regard on those professionals who treated physical disorders. The survey further found that the public did not make any distinctions between the sub-groups of the mental health profession in terms of differentiating between clinical and research psychologists, psychoanalysts and psychiatrists, and psychologists and psychiatrists.

Similarly, Murray (1962) assessed college students' perceptions of psychologists and psychiatrists, and compared whether or not the accuracy of the responses was affected by previous exposure to studies in psychology or psychiatry. Results suggested that there was little difference in responses between those who had college courses or work experience in psychology and those who had neither. From a representative sample of 137, Murray (1962) summarised the survey findings as:

> Some reasonably accurate delineations of the role and background of psychiatrist and psychologist emerge from testing a group of college students, but there are strange overlaps of the two, and prominent functions of the psychologist, especially, are denied to him (p. 168).

Thumin and Zebelman (1967) sought to ascertain whether or not the public could differentiate between psychology and psychiatry. A representative sample of 200 males and 200 females was randomly selected from a telephone directory. The results indicated that, regarding descriptions of psychologists and psychiatrists, respondents were able to make distinctions between the two. However, the responses to the estimated income of the two disciplines and the number of years of required training for psychologists and psychiatrists indicated some confusion and error in perception. Thumin and Zebelman (1967) further sought to assess the desirability of psychology as a profession. When asked which profession they would prefer their son to enter into from a choice of psychiatry, psychology, surgeons, engineering, law and dentistry, psychology was the least preferred profession. Psychiatry was only the preferred profession by respondents over psychology.

Conclusions of that study were that, although there was some evidence of an increase in clarity of the roles and functions of psychologists and psychiatrists since the study by Guest (1948), both professions were rated as relatively undesirable compared to other professions. The authors of the study recommended a continuous and systematic programme of research be conducted to remain aware of the public perceptions and to begin to address the discrepancy between actual and desired public image.

A comparative study of college students' perceptions of counsellors, advisors, and psychiatrists was conducted by Strong, Hendel and Bratton (1971). A sample of 67 female students were asked to describe either a counsellor, an advisor, or a psychiatrist according to 100 adjectives provided, and then asked to indicate how likely they were to discuss nine topics with the assigned professional. Data collected suggested that the respondents saw little difference between counsellors and advisors. However, there were marked differences in how counsellors were perceived as opposed to psychiatrist. The respondents indicated that they perceived counsellors to be warmer, friendlier and more polite than psychiatrists, whereas they described psychiatrists as more intelligent, decisive and analytic. Subsequently, respondents indicated that counsellors were valuable resources for assisting with educational and vocational problems, and in achieving personal growth. However, as the problems became more difficult and severe, respondents indicated that the services of a psychiatrist would be more appropriate and helpful than those offered by a counsellor.

Gelso and Karl (1974) sought to extend the study of Strong, Hendel and Bratton (1971) by making a comparison of psychology students' perceptions of three titles within counselling - high school counsellor, college counsellor and counselling psychologist. They further sought to compare psychology students' perceptions of the disciplines of adviser, psychiatrist and clinical psychologist. Gelso and Karl (1974) argued that a major limitation of the study by Strong et al. (1971) was the use of the generic label "counsellor" and hence sought to address this limitation in their survey. The results of that study indicated that more differences occurred in students' perceptions of the three counselling disciplines than in any other profession studied.

The only difference that was reported between counselling psychologists and psychiatrists was that counselling psychologists were perceived to be more casual than psychiatrists. Contrary to the findings of Strong et al., results from the study by Gelso and Karl (1974) did not find that any of the counselling specialities were warmer, friendlier and more polite than psychiatrists. Additional findings of the study were that counselling psychologists were perceived to be more knowledgeable, inquisitive and analytic than college counsellors, yet were also perceived as more “flighty” and “casual” than their counterparts. Counselling psychologists were further reported as being a more likely source of assistance for a variety of personal problems than were college counsellors. As a result of their findings, Gelso and Karl (1974) recommended that counselling psychologists and clinical psychologists that work in counselling centres, inform the public of their titles as these elicit a favourable perception and may therefore increase the likelihood of their services being accessed. If college counsellors are not counselling psychologists or clinical psychologists, Gelso and Karl (1974) recommended that these professionals need to "more effectively inform students that they are legitimate sources of help for a variety of personal concerns" (p. 247). As has previously been mentioned, that study has limitations in that the representative sample comprised of students enrolled in psychology.

McGuire and Borowy (1979) sought to assess the attitudes toward various mental health professionals. The categories of professionals included physician, counselling psychologist, nurse, social worker, clinical psychologist, psychiatrist, mental health attendant, psychiatric nurse, school psychologist, psychoanalyst and marriage counsellor. Respondents comprised of 41 males and 44 females who were

enrolled in an introductory psychology course. The study developed and modified the survey conducted by Nunally and Kittross (1958). The results of this study indicated an overall positive perception of professionals in the mental health field, although it was noted that every occupational category received a higher mean score for perceived value than for understandability of professional role. Similar to the results of Nunally and Kittross (1958), McGuire and Borowy (1979) found that the medical professions were rated more favourably than the psychological professions, although the category of counselling psychologist was viewed in nearly as equal regard as were the medical professions. Marriage counsellors were reported as the least valuable and only reported as more understandable as a profession than the psychoanalysts. The authors speculated that this result may have been a consequence of the wide disparity in the credentials of marriage counsellors. This study concluded that all mental health professionals needed to improve the education of the public regarding the nature and process of their service delivery.

The perceptions held by college students of psychiatrists, psychologists and social workers were the subject of a comparative study by Alperin and Benedict (1985). A representative sample of 180 students was divided into three groups of 60. Each group was randomly assigned to describe either psychiatrists, psychologists, or social workers. Two questionnaires were distributed to the respondents. The first questionnaire included 85 adjectives with which respondents were asked to rate their assigned professional on a five-point scale where 1 equalled “not at all descriptive” and 5 represented “very descriptive.” The second questionnaire asked respondents to indicate how likely they were to discuss seven problem areas with their assigned

professional on a five-point scale in which 1 indicated “very unlikely” and 5 equalled “very probably.” The results indicated "that social workers were viewed as warm and easy to relate to but not particularly intelligent while the psychiatrists were viewed antithetically, as bright and intellectual but rather cold and reserved" (Alperin & Benedict, 1985, p. 548). The psychologists were rated as more studious and clever than the social workers, and more responsive and appreciative than psychiatrists. Furthermore, psychologists were the professionals that respondents indicated would be the most likely to be consulted for assistance with the majority of their problems. However, the main limitation of this study was the use of students from different psychology classes of a university as a representative sample. Apart from the fact that students may not be representative of the general public, the question of potential bias of the students towards their chosen profession may have influenced the results.

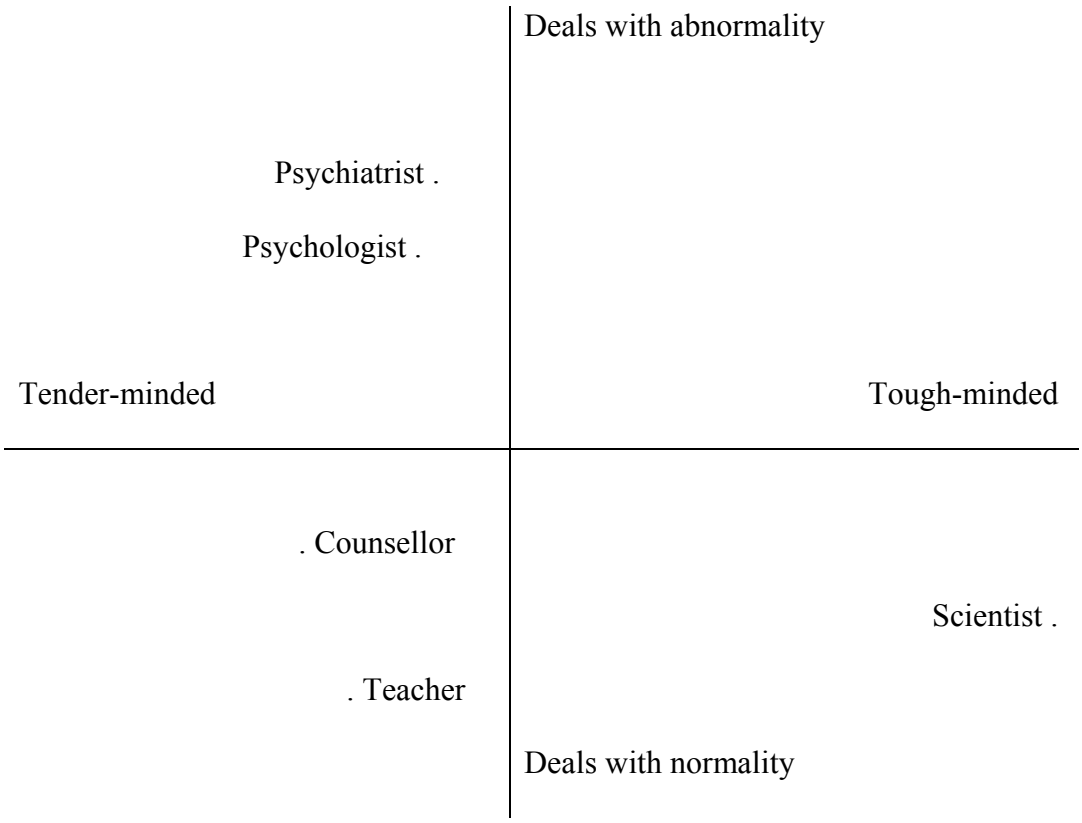
A survey of 201 residents from four metropolitan areas in the United States was conducted by Wood, Jones and Benjamin (1986). Although this study was primarily concerned with the public image of psychology, participants of the study were asked whether psychologists and psychiatrists routinely performed certain activities. Results of this survey found that a larger percentage of respondents believed that psychologists rather than psychiatrists surveyed attitudes and predicted behaviour. Whereas most respondents indicated that psychiatrists rather than psychologists prescribed drugs for mental illness, evaluated mental disorders and provided counselling.

Similarly, in 1986, Webb and Speer sought to determine the public image of psychologists relative to perceptions of psychiatrists, physicians, counsellors, teachers and scientists. Fifty-four undergraduate students were asked to write a paragraph on

each of the above-listed professions. From these paragraphs, three judges correlated the descriptive features of the professions. That study provided results that were specific to psychologists, and did not provide findings of the perceptions of the other professions. However, the authors did provide a diagrammatic summary of their findings, and this has been reproduced in figure1 below.

Figure 1

Summary of findings from study by Webb and Speer, 1986.



Note. Copied from Webb and Speer, 1986, Prototype of a Profession: Psychology's Public Image. Professional Psychology: Research and Practice, 17, No. 1, p. 7.

Data from Figure 1 indicated that psychiatrists and psychologists were perceived as tender-minded and primarily concerned with dealing with abnormalities. Counsellors and teachers were perceived to be tender-minded and dealing with

normality, and scientists were considered to be tough-minded professionals who were concerned with normality. Furthermore, in their discussion, Webb and Speer (1986) reflected that the survey had found that there was some confusion regarding the differentiation between psychologists and psychiatrists, with 15% of respondents indicating that they would describe the two professionals in an identical manner. Additionally, as can be seen from Figure 1, the rating of psychologists and psychiatrists on the graph was close together.

Schindler, Berren, Hannah, Beigel, and Santiago (1987) conducted a study of 119 patients attending two community mental health centre outpatient clinics, and 114 non-patients. The purpose of the study was to determine how the public perceived psychiatrists, psychologists, non-psychiatric physicians and members of the clergy. The results of this study that are relevant to this thesis were those regarding perceptions of psychologists and psychiatrists. Psychologists were reported as being warmer and more caring than psychiatrists, and were rated as most effective in dealing with adjustment and relationship problems. However, psychiatrists were perceived to be considerably more educated and qualified to treat severe emotional disorders. Hence, the authors concluded that the results of their study indicated that there remained amongst the public "a hint of the inaccurate and stereotypic image of the psychologist as one who treats milder psychological disorders, and of the psychiatrist as a treater of more severe mental illnesses" (Schindler et al., 1987, p. 374-375). Acknowledged limitations of this study lay in the nature of the sample. No information was obtained regarding the non-patients' previous exposure to any of the disciplines of the study, which may have influenced their responses. Additionally, patients were only recruited

from two outpatient clinics, and therefore may not be representative of patients receiving treatment in other settings.

The perceptions of undergraduate psychology students of counsellors, psychiatrists and psychologists were assessed in a study conducted by Warner and Bradley (1991). The sample included 60 males and 60 females enrolled at the University of Montana in an introductory psychology course. The authors acknowledged that the sample may have been biased in their viewing of psychologists as academics and researchers rather than clinicians, given the current studies of the sample. Results showed that respondents viewed counsellors as 'helpful, caring, friendly, and good listeners,' more so than psychologists. Psychiatrists were described by statements such as 'deals with mental problems', 'studies the mind', 'studies behaviour.' The reported knowledge of treatments provided by the three disciplines was as follows: psychiatrists treat severe disorders, psychologists respond to middle-range problems and counsellors manage mild disorders. Respondents were ambiguous about the nature of middle-range problems. Overall, counsellors were preferred in the treatment of five clinical problems presented in the survey to respondents, except in the treatment of a major depression with psychotic features. The authors concluded that the respondents:

> …(a) lacked information about psychologists' clinical functions, (b) lacked confidence in psychologists to treat the five cases presented, (c) viewed psychiatrists to be researchers just as much as they viewed psychologists to be researchers, and (d) viewed counselors as more 'caring' than psychologists (Warner & Bradley, 1991, p. 140).

A thirteen-year comparative study of attitudes toward counselling was conducted by Rule and Gandy (1994). In 1976, 117 students were surveyed from a university in Atlantic City. Thirteen years later the same survey was conducted from a representative sample of 143 students from the same university and a comparison of the results of the two surveys was made. The gender distribution in both samples was approximately the same. In response to the question regarding the likelihood of seeking counselling, the results of both surveys found that females were more likely to access counselling than males, although over the thirteen-year time span there were no significant reported changes for either gender in their willingness to seek counselling. Respondents were given the choice between a close friend, a family member, a professional counsellor, a psychologist, a minister, priest or rabbi, or a psychiatrist as the individual that they would most likely seek out for help. The results showed that, for both samples, a close friend was the preferred helper, while the preferences for a professional counsellor, a psychologist and a psychiatrist were unchanged over the thirteen years of the study.

Richardson and Handal (1995) examined the relative efficacy (as perceived by the public) of psychiatrists, clinical psychologists, counselling psychologists, counsellors, marital and family therapists, general practitioners, self-help groups and social workers. This study sought to overcome the limitation of other studies by using a general public population rather than a student or client population, and by including a wider range of disorders to seek help for. The 26 disorders that were included in the study were: depression, marital and family problems, delinquency or conduct disorder, drug and alcohol abuse, academic problems and learning disabilities, obsessive-

compulsive disorder, anxiety, panic attacks, schizophrenia, manic depression, physical and sexual abuse, phobias, divorce problems, sexual dysfunction, promoting personal growth, loss, child behaviour and emotional problems, paranoia, eating disorders, insomnia and hypersomnia, work related problems, personality disorders, antisocial behaviour, psychosomatic illness, suicidal thoughts or attempts, and multiple personality. The representative sample included 173 respondents, of whom 56.3% were female and 43.7% were male. Results indicated that respondents perceived counselling to be moderately effective for the aggregate of disorders listed. However, counselling psychologists and clinical psychologists were perceived as significantly more effective than counsellors for 18 of the 26 disorders investigated, while for the remaining eight disorders there was no significant difference reported between psychologists and counsellors. Despite being perceived as significantly more effective for only two of the 26 disorders, psychiatrists were generally preferred by respondents for 22 out of 26 disorders. Psychiatrists were consistently followed by clinical and counselling psychologists, who were closely followed by counsellors as preferred effective treatment options. The exception to these results was the acknowledgement of the efficacy of marriage and family therapists for the categories of marital difficulties and divorce issues, and self-help groups were perceived as the most effective treatment of drug and alcohol abuse. However, while the authors stated that the list of disorders used was collated from statistical information regarding the most frequently reported disorders that the public sought treatment for, at least half of the disorders used in the study were psychiatric in nature, and may have influenced the respondents answers accordingly.

Sydow and Reimer (1998) analysed 60 studies that were published between 1948 and 1995 regarding attitudes toward psychotherapists, psychologists, psychiatrists and psychoanalysts. Results of their analyses that are relevant to this thesis indicated that the relative status of psychologists, psychiatrists, psychoanalysts, psychotherapists, and counsellors were ambiguous. According to Sydow and Reimer (1998), "Laypersons do not seem to differentiate very much between the different academic mental health professions, and there exist no, or only slight, differences in status" (p. 467-469). In regard to the roles, responsibilities and expertise of the various mental health professionals, Sydow and Reimer (1998) found the following: forty percent of respondents of the studied surveys conducted during the 1940s did not know what problems a psychologist should be recommended for; during the 1950s, 3-8% of students surveyed believed that psychologists or psychiatrists were able to read thoughts, and even by the 1970s the public were not able to differentiate between psychology and psychiatry. At the time Sydow and Reimer (1998) wrote their analysis, they found that psychologists were considered to be involved with research, diagnostics, counselling and work with children. Psychiatrists were perceived as clinical practitioners who attempted to cure mental disorders by psychoanalysis, psychotherapy, hypnosis, medication and electroconvulsive therapy. Counsellors were found to be preferred for the treatment of marital problems. The profession with the most perceived expertise was psychiatry, followed by psychologists and counsellors, with social workers having the least perceived expertise. The authors concluded from their analysis of the 60 studies that there existed a public image problem for psychotherapists.

The issue of public image has not only been the focus of comparative studies. According to Wood, Jones and Benjamin (1986): "Psychologists have been interested in their public image since the organization of the American Psychological Association nearly 100 years ago" (p. 947). However, surveys documenting the public attitudes to and knowledge of psychologists have not been conducted until more recent years. While there have been numerous surveys regarding the public perceptions of psychologists and other mental health professionals, counsellors are the primary focus of this thesis. Therefore, the studies pertaining exclusively to psychologists psychiatrists or social workers have not been reviewed. It is, however, noteworthy that studies have been conducted in countries other than Australia and the western world regarding the perceptions of counsellors.

These studies have included an assessment of attitudes toward counselling in the Middle East (Day, 1983), studies of guidance counselling in India (Fletcher & Riddle, 1962) and in Russia (Gass, 1959), the introduction of guidance counselling into the education system in Norway (Hansen, 1965), recent trends in vocational guidance counselling in Japan (Nishigaki, 1957), and studies regarding vocational guidance counselling in Belgium (Ostlund, 1981) and in France (Ostlund, 1958). However, because the focus of this paper is on Australian attitudes and awareness, these studies have not been reviewed in this chapter.

3.7 Summary

In conclusion, it is evident that a number of issues have emerged for contemporary counsellors. Many of these issues are interwoven and impact on each other. The statistical evidence, the breakdown of traditional support systems, the

reduction of stigma associated with receiving counselling and the emergence of legal requirements to attend counselling by the courts all testify to the need for counsellors in contemporary Australian society. However, the issues of counsellor identity, training, professionalism and the lack of a uniform, mandatory association for counsellor membership, if not addressed, have potential consequences of promoting public confusion regarding counsellors, and facilitating the loss of professional credibility. It is noteworthy that these consequences were included in the drawbacks listed by the respondents in studies that were reviewed. Also incorporated in perceived drawbacks of counselling were the issues of fees, accessibility and approachability, suggesting that these issues and the issue of Medicare rebates are similarly important for counsellors to seek to address. However, the number of considered benefits of counselling, according to the reviewed literature, was encouraging for counsellors. The issues of the gender of the counsellor was not identified as significant to the potential client's selection of a counsellor according to the literature reviewed.

Therefore, it can be concluded from the literature reviewed that public attitudes to counsellors have been generally positive. However, lack of informed knowledge and the existence of confusion regarding the value, role and nature of counsellors permeated all reviews to some extent. Since Sharpley's (1986) survey there has not been an Australian research paper that comprehensively addresses these issues. Hence, the following research is designed to determine whether or not any change in public knowledge of counsellors has occurred, and to explore whether or not attitudes to counsellors have improved or deteriorated in the ensuing years. Limitations noted from other studies, such as students and small samples will be addressed here.

3.8 Purpose and rationale of the present study

The current study was designed to investigate the issues raised in the literature reviewed, in the context of contemporary perceptions and knowledge of the general public and medical practitioners on the Gold Coast. The issues included in the current study were as follows:

1. Need for counsellors. This was apparent from the statistical evidence collated from the Australian Bureau of Statistics, the Centre of Policy Studies at Monash University and the School of Health Sciences at Bond University. Furthermore, studies by Barletta (1999) and Johnson (2002) correlated an increasing demand for counsellors with the breakdown of traditional support systems, less perceived stigma regarding seeking counselling, and the emergence of legal requirements for counselling by the courts. Past studies conducted by Rogers and Sharpley (1983), Sharpley, Rogers and Evans (1984) and Sharpley (1986) sought to evaluate the perceived value and need for counsellors by the general public. Hence, the present study sought to clarify whether the need for counsellors suggested in the literature was mirrored by a perceived need for counsellors by the general public and medical practitioners.
2. Counsellor identity and the associated confusion surrounding this issue. This was included in studies by McCully (1961), Krauskopf, Thoreson and McAleer (1973), Williams (1978), Khan (1983), Rogers and Sharpley (1983), Rogers, Sharpley and Evans (1984) and Drever (1999). The present research was designed to determine whether or not the public and the medical profession on the Gold Coast were any

better informed about the activities of and problems dealt with by counsellors than respondents from the above-mentioned studies.

3. Counsellor expertise and training. The lack of clarity and uniformity regarding this issue was evident in the courses listed by the *Directory of Postgraduate Study* (2002). Additionally, studies that investigated this issue included Venables (1974), Khan (1983), McWhirter (1987), Hershenson (1990), Barletta (1999). The perception of the public regarding the issue of counsellor training and education was incorporated into studies by Rogers and Sharpley (1983) and Sharpley, Rogers and Evans (1984). Hence, the current study sought to determine what education and training the public and the medical profession believed that a counsellor should have.
4. Counsellor professionalism. This was documented by McCully (1969), Emener and Cottone (1989), Ritchie (1990) and Barletta (1999). Investigating the perceived professionalism of counsellors compared to that of social workers, psychologists and psychiatrists was a further aim of the present research.
5. Lack of a single uniform representative association for counsellors. This was evident from the number of "national" counselling organisations present in Australia. These associations included the Australian Board of Certified Counsellors (ABCC), the Australian Counselling Association (ACA), the Psychotherapy and Counselling Federation of Australia (PACFA), and the Australian Guidance and Counselling Association (AGCA). The existence of State branches for these associations, associations for individual therapies, and associations for the disciplines in which counsellors practice were further evidence

of the lack of a unifying, governing organisation to which counsellors are accountable. This study sought to determine if the general public and medical practitioners believed that counsellors should be registered members of a government-approved association, in order to practice as counsellors.

6. Counsellor gender preferences by clients. Henderson and Lydon (1997) and Beauchamp and Shaw (2002), have documented the issue of whether or not counsellor gender influences the public perceptions of counsellor competence or influences counsellor preferences by their clients. Whether or not the respondents of the present study had a preference for a counsellor of the same gender, opposite gender, or had no gender preference was also investigated.
7. Fees paid for counselling services. This was included in studies by Rogers and Sharpley (1983), Rogers, Sharpley and Evans (1984), Sharpley (1986), Lowe, Howard and Dawson (1986), Conoley and Bonner (1991) and Waehler, Hardin and Rogers (1994). Therefore, this study sought to determine whether or not the general public and medical practitioners were prepared to pay for counselling services and what fee they considered appropriate for a counselling consultation.
8. The related issue of whether counselling services should be covered by a Medicare rebate was contentious in the previous literature (Sharpley, 1986). This issue was also included in the present study to investigate whether or not opinions have remained divided over the ensuing fourteen years.
9. Accessibility and approachability of counsellors. This was discussed in literature by Rogers and Sharpley (1983) and Sharpley (1986). From the documented evidence demonstrating a current need for counselling, the perceived accessibility

and approachability of counsellors was considered an important issue to explore. Thus, the collection of data on the perceptions and knowledge of the public and medical practitioners regarding where they would access counsellors, and how comfortable they believed they would feel consulting a counsellor was a further aim of this study.

10. Perceived benefits and drawbacks of counselling. These issues were investigated by Rogers and Sharpley (1983), Sharpley, Rogers, and Evans (1984) and Sharpley (1986) and were included in this study to determine the current perceptions of the value of counselling.
11. Perceptions of counsellors from specific population groups was included in a number of studies. The perceptions of counselling within the education system was the focus of studies by Blum and Sullivan (1953), Grant (1954), Jenson (1955), King and Matteson (1959), Wilcove and Sharp (1971), Resnick and Gelso (1971), Gelso and McKenzie (1973), Fullerton and Potkay (1973), Getsinger and Garfield (1976), Johnson (1977), Tryon (1980), Cook, Park, Williams, Web, Nicholson, Schneider and Bassman (1984), Johnson, Nelson and Wooden (1985), Hassan and Hassan (1991) and Kaczmarek and Jankowicz (1991). Similarly, the perceptions of professional employees, was the focus in studies by Powell and Kotschessa (1995). The current study sought to extend the representative sample of a specific population group and encompassed the perceptions of the general public of eight distinct occupational categories, classified according to Congalton (1969). The knowledge and perceptions of counsellors by the medical profession was the subject of studies conducted by Nunnally (1961), Anderson and Hasler (1976),

Koch (1979), Ives (1979), Waydenfeld and Waydenfeld (1980), Martin and Martin (1985), Corney (1987), McLeod (1988), Balestrier, Williams and Wilkinson (1988), Martin (1988), Corney (1990), Corney (1992), Thomas and Corney (1992), Pringle and Laverty (1993), Sibbald, Addington-Hall, Brenneman and Freeling (1993), Webber, Davies and Pietroni (1994), Sibbald, Addington-Hall, Brenneman and Freeling (1996) and Radley, Kramer and Kennedy (1997). The current study was designed to further explore the knowledge and perceptions of medical practitioners of counsellors, and further sought to determine the willingness of medical practitioners to refer to counsellors and to incorporate counsellors within their general practice. Additionally, comparisons were made between the knowledge and perceptions of the general public and those of medical practitioners regarding counselling to determine if there were any differences in opinions.

12. Comparative studies of health professionals have been conducted in Australia and overseas. The studies reviewed in this paper made comparisons that involved counsellors, psychologists, social workers and psychiatrists. The relevant Australian studies included Small and Gault (1975), Wilkinson, Cave, Flynn, Hodgson, Prouatt, Sultmann and Gardner (1978), Sharpley (1986) and Hopson and Cunningham (1995). Studies conducted in western countries that focused on comparing knowledge and perceptions of different health professionals, specifically counsellors, social workers, psychologists, or psychiatrists were Guest (1948), Nunnally and Kittross (1958), Tallent and Reiss (1959), Nunnally (1961), Murray (1962), Thumin and Zebelman (1967), Strong, Hendel and Bratton (1971), Gelso and Karl (1974), McGuire and Borowy (1979), Alperin and Benedict (1985),

Wood, Jones and Benjamin (1986), Webb and Speer (1986), Schindler, Berren, Beigel and Santiago (1987), Warner and Bradley (1991), Rule and Gandy (1994), Richardson and Handal (1995) and Sydow and Reimer (1998). From all of the above-mentioned studies that were reviewed, it was evident that the ability of the samples surveyed to differentiate between counsellors, psychiatrists, social workers and psychologists was limited to varying degrees. Therefore, again in light of the documented need for counselling in contemporary Australian society, it was considered pertinent to determine the clarity amongst the general public and medical practitioners regarding the perceived roles of counsellors comparative to social workers, psychologists, and psychiatrists. This study aimed to determine what confusion has continued to exist since the last Australian study (Sharpley, 1986) that specifically focused on comparing perceptions and knowledge of these four health professionals.

3.9 Implications of outcomes for the practice of counselling

The proposed research could raise the awareness of the potential client market to target for counselling services. The study could further provide indications of where it would be best to advertise and therefore strengthen marketing options. Responses to the questionnaire regarding fee structures may provide counsellors with a gauge to determine what fees the public are willing to pay for counselling services, and may assist in constructing a scale of fees relative to client income. Furthermore, responses to the issues of counsellor education and training, and professional registration may provide indications for practicing counsellors as to the preferences of the public. Additionally, data collected from the research may provide educational requirements or

information necessary for clients to maximise the effectiveness of counselling and to dispel any myths currently in existence. Counsellors may also receive feedback as to how they are perceived compared to psychiatrists, psychologists, and social workers. The survey could be a precursor to a community education campaign that may be necessary to raise awareness of counsellor roles and functions of counselling services. Finally, data collected from the medical practitioners may indicate the likelihood of potential partnerships with the medical profession or for counsellors to be employed in a medical practice as a professional colleague.

CHAPTER FOUR

Method - Study I

4.1 Introduction

The chosen research design and its associated validity issues will be discussed in this chapter. The sample recruited, demographic information, the development of the questionnaire, the materials used in the research, and the collection of the data will also be outlined. A brief description of each questionnaire item is further included in this chapter.

4.2 Research design

The selected research design was a Qualitative Descriptive Survey. Anticipated validity issues that may have arisen from this research design, and the subsequent safeguards put in place to address these issues were as follows:

4.21 Statistical conclusion validity

4.21.1 Type 1 and Type 11 errors

By ensuring that the sample surveyed was a true representation of the general population these errors in validity were minimal. The sample comprised of respondents identified as representative by Congalton's (1969) eight distinct occupational categories.

4.21.2 Low statistical power

Insufficient power most often results from using too few participants. This research design incorporated a total of 331 participants, and therefore reduced this threat to statistical conclusion validity.

4.21.3 Random irrelevancies in the experimental setting

Due to the fact that the respondents filled out the questionnaire in their own environment rather than a controlled environment setting, the statistical conclusion validity was threatened. The large variability in responding greatly increased the error variance. In an attempt to decrease the possible error variance, it was requested that respondents found a quiet place, free from distractions to fill out the questionnaire. Whether or not the respondents complied with this request was unable to be controlled. Hence, random irrelevancies remained a validity issue.

4.21.4 Random heterogeneity of respondents

The differences in participants may have led to further variability in responses and thus influenced validity. In terms of age, occupation, and gender, the structure of the questionnaire and the securing of a representative sample was an effort to exercise an element of control.

4.22 Internal validity

4.22.1 History

If the respondent had any stressful events going on in their lives, or were experiencing any physical illness, this may have affected their responses to the questionnaire, or how much time they invested in the survey. The only means of addressing this issue was to suggest to respondents that they filled out the questionnaire in a relaxing setting.

4.22.2 Selection

The selection of participants for this survey was controlled, as has already been mentioned, according to distinct occupational categories as outlined by Congalton

(1969). Therefore, the issue of selection as a threat to validity was diminished. Other known threats to internal validity such as maturation, testing, instrumentation, statistical regression, attrition, interactions with selection, ambiguity about the direction of the causal influence, diffusion or imitation of treatments, compensatory equalisation of treatments, compensatory rivalry by participants receiving less desirable treatments, and resentful demoralisation of participants receiving less desirable treatments were not considered to be areas of concern for this research design.

4.23 Construct validity

4.23.1 Inadequate pre-operational explication of constructs

This was the only considered threat to construct validity. In order to overcome this issue, every effort was made to develop a clearly defined questionnaire, carefully worded, in order to ascertain exactly what was intended.

4.24 External validity

4.24.1 Interaction of selection and treatment

Ensuring that the population sample was adequate in numbers and truly represented the stated occupational categories minimised this threat to external validity. Thus, the research design chosen had minimal threats to the external validity due to the population study being taken directly from the occupational categories outlined.

4.25 Dependent and independent variables

The questionnaire items represented the dependent variables. Independent variables included occupation, gender, age and location.

4.3 Representative sample

The research involved two samples. The first included 226 adult men and women from the Gold Coast region, selected from eight distinct occupational categories determined by Congalton (1969). These categories included professionals, proprietors and managers, office and sales, skilled, semi-skilled, unskilled, unemployed and retired. The utilisation of Congalton's occupational categories rather than other sources of occupational definitions such as the Australian Bureau of Statistics, was to facilitate a comparative analysis of data from the present study to that from Rogers and Sharpley (1983). A further sample of 105 medical practitioners was included in the study to determine whether there were any differences between the perceptions and knowledge of the general public and the perceptions and knowledge of medical practitioners. This sample was recruited from the yellow pages telephone directory.

4.4 Demographic Information

Participants of the survey were selected from suburbs of the Gold Coast and northern New South Wales region according to the Australian Bureau of Statistics demographic data. This area encompassed suburbs from Murwillumbah in northern New South Wales to Beenleigh in Queensland. The questionnaire asked that only those over the age of 18 years complete the study. Respondents were further asked to record their postcode, age, occupation and gender for data collection purposes.

4.5 Materials/Instruments

A questionnaire and an introductory letter were the materials used in the research. The questionnaire was self-reporting and confidential. It was designed from

issues raised, and questions asked, in previous research studies by Rogers and Sharpley (1983), Rogers, Sharpley, and Evans (1984), Sharpley (1986).

Comprising of two sections, the questionnaire sought to determine the knowledge of and attitudes toward counsellors, of the general public and of medical practitioners. The first section of the questionnaire consisted of 24 open and closed questions and the second section, consisting of seven questions, was completed only by the sample of medical practitioners. The final page of the questionnaire asked respondents to complete contact details if they were willing to participate in an extension of the research paper. However, due to a very small number of respondents completing the section, this extension of the research could not be done. A copy of the questionnaire appears in Appendix A.

The introductory letter was included with the questionnaire in an envelope that was given to respondents who had expressed willingness to complete a questionnaire. Included in the letter was an assurance of confidentiality for respondents, except if they were willing to possibly participate in further research and therefore chose to provide their name and a contact number. The letter further provided details of the researchers, their supervisor, and the university from which the study was being undertaken. Information was also included about the aims of the research, and the appropriate contact details for any complaints regarding the manner in which the research was conducted. The letter additionally clarified the voluntary nature of the survey and the issues of safekeeping and disposal of the data collected. The estimated time thought by the researchers to complete the questionnaire (thirty minutes) was also included in the letter. A copy of this letter appears in Appendix B.

4.6 Procedure

Questionnaires for the representative sample of the general public were hand-delivered to and collected from businesses, hospitals, community agencies, clubs, learning institutions and farming supply centres. Attendance at Rotary meetings was another initiative to recruit participants. Questionnaires for the sample of general practitioners were similarly hand-delivered and collected by the researcher. Medical surgeries, hospitals and rehabilitation institutions were included in the delivery of the questionnaires. Further efforts to recruit medical practitioners were made by delivering questionnaires to divisional meetings of general practitioners.

Upon delivery of the questionnaire, participants were asked if they could set aside some quiet time to fill in the questionnaire in an effort to address the previously mentioned validity issues. The time of collection of the completed questionnaire was confirmed on delivery. It was estimated that a two-week period would be sufficient.

Some difficulties emerged regarding the collection of data from medical practitioners. Frequently, the questionnaires were collected uncompleted, with an explanation that medical practitioners did not have the time to read and complete the questionnaire.

The collected data were analysed using SPSS for Windows 11.0. Open questions were classified into value labels by a panel of three, consisting of the researcher, a fellow counselling student and the research supervisor.

4.7 Development of the questionnaire

4.71 Collaborative input

The questionnaire items were designed by the researcher, a fellow counselling student, and the research supervisor. Questions asked from previous surveys such as Rogers and Sharpley (1983), Sharpley, Rogers and Evans (1984), and Sharpley (1986), were developed and extended for this study.

4.72 A pilot questionnaire

Following the design of the questionnaire, a pilot study was conducted to identify any errors in the format, to determine whether or not the questions clearly reflected the information sought, to asses the adequacy of the questionnaire instructions, and to invite constructive comments from the participants. Ten questionnaires were delivered, with eight being completed on collection. Of the eight respondents, six were representative of the general public and the remaining two were medical practitioners. Amendments and adjustments were made to the questionnaire according to the results of the pilot study. A copy of the pilot questionnaire and the associated results appears in Appendix C.

4.73 Questionnaire items

4.73.1 Part one

The first part of the questionnaire was completed by both the general public and medical practitioners. Question 1 sought to determine what knowledge participants had about the activities of counsellors, and required the respondents to write a brief description about what they thought a counsellor does. Question 2 asked the respondents to indicate, by circling yes or no, whether they knew of any counsellors,

while question 3 was designed to determine the place of work of the known counsellor. Participants were asked to tick a box from a selection of possible employment areas. These areas included private practice, medical practice, community health, community agency, hospital, and schools and educational institutions.

Additionally, respondents were asked to specify whether or not they had ever seen a counsellor for help, and if they would consider seeing a counsellor for a personal problem by circling yes or no to questions 4 and 5 respectively. The issue of gender preference was addressed in question 6, requiring respondents to tick a box indicating their preference for a counsellor of either the same gender or the opposite gender or no preference. The purpose of question 7, requiring a yes or no response, was to determine whether or not the respondents thought that there was a need for more counsellors in the community.

The perceived benefits and drawbacks of counselling were the issues addressed by questions 8 and 9 respectively. Each question asked the respondents to list three relevant answers. In order to determine the perceived value of counsellors in helping with personal problems, question 10 asked respondents to provide a rating on a scale from 1 (little value) to 10 (high value). Similarly, questions 11 and 12 asked respondents to rate the level of comfort they would feel with a counsellor in a social setting and with consulting a counsellor for a personal problem. Both questions were scales of 1(most uncomfortable) to 10 (very comfortable).

The issue of what training a counsellor should have was the focus of question 13. Respondents were asked to tick the boxes they believed indicated the appropriate training for a counsellor. The list of potentially desirable qualifications included

undergraduate university degree, postgraduate university degree, T.A.F.E college qualification, correspondence course, certificate course, and life experience. Question 14 was an extension of the issue of counsellor training, asking respondents to identify, in a few lines, what types of problems they believed counsellors should be trained to deal with. Similarly, question 15 sought to determine what combination of counsellor training and life experience was considered by respondents to be the most beneficial. The combinations that respondents were asked to rate were: a) counsellor with formal recognised training and little life experience, b) counsellor with informal training and personal life experience, c) counsellor with formal training and personal life experience, d) other. Each of these combinations was rated on a scale of 1 (little or no benefit) to 10 (extreme benefit).

Respondents were asked to indicate in question 16 whether they agreed or disagreed with three statements regarding the expertise of counsellors by circling yes or no responses. The first of these statements addressed the issue of whether counsellors should be registered members of a government-approved association in order to practice as counsellors. The second statement was that counsellors should be tertiary-trained, and the final statement related to the professionalism of counsellors comparative to psychologists, psychiatrists and social workers.

Question 17 provided respondents with lists of people, organisations and advertising agencies. Participants were asked to indicate which of the listed sources they would use to find a counsellor by ticking the relevant box. The issue of fees was addressed in questions 18 and 19. For question 18 respondents were asked to circle yes or no to indicate if they would pay to see a counsellor. If a ‘no’ response was recorded,

participants were further asked to list reasons why they would not pay for counselling. Question 19 required respondents to indicate by ticking the box they considered most reflected the fee they would pay for a fifty-minute consultation with a counsellor. The payment options listed were $25, $50, $75 and $100. Additionally, whether or not respondents believed that counselling should be covered by Medicare rebates was the content of question twenty. This question required respondents to circle a yes or no answer.

The perceptions and knowledge of counsellors relative to other professionals, specifically psychiatrists, social workers and psychologists, was the focus of questions 21 – 24. Question 21 asked respondents to rate the degree to which they felt the most able to communicate with each of the four health professionals in a therapeutic relationship. Ratings were indicated on scales of 1 (not very well) to 10 (very well). Which of the four health professionals the respondents would refer a friend in need of help to was the content of question 22. Provision was made in this question for the respondents to nominate another professional or individual, with the option of 'other.' Question 23 provided a table for respondents to indicate which of the professionals – counsellor, psychologist, psychiatrist or social worker, they would consult for a given list of problems. The problems included in the table were: depression, domestic violence, phobias, sexual abuse, grief and loss, hypnotherapy, eating disorder, anxiety, rape, learning difficulty, marriage problem, drug problem, alcohol problem, stress reduction, vocational assessment, panic attack, mental health problem, sexual dysfunction, financial difficulties and child behavioural problems. Respondents were given the option to tick as many responses as they wished. Question 24 asked

participants to reflect on the problems they had indicated in question 23 and to write a brief description of what sort of treatment they believed each of the four professionals would provide for those problems. The respondents were instructed to list the treatments for the problems rather than the problems themselves.

4.73.2 Part two

The second part of the questionnaire comprised of seven open and closed questions and was completed by medical practitioners only. The first question required respondents to indicate by circling yes or no whether they would consider referring a patient to a counsellor, while question 2 asked that they qualify a 'no' response with a brief description of why they would not refer to a counsellor. Similarly, question 3 required circling yes or no to the issue of whether or not the respondents would refer a patient having difficulty accepting the diagnosis of a specific health problem to a counsellor. Again, they were asked to qualify a 'no' response. Questions 4, 5 and 6 were focused on the issue of counsellors working in close association with medical practitioners, and all three questions asked participants to respond by circling yes or no. Question 4 sought to determine whether the respondents had a counsellor working in their practice, and question 5 asked if they would consider employing a counsellor to work as a team member in their practice. Question 6 was designed to discover if respondents believed there were any benefits in having a counsellor on staff in a hospital setting. The table used in question 23 of the first part of the questionnaire was duplicated in question 7 and required the respondents to indicate which of the four professionals - a counsellor, a psychologist, a psychiatrist, or a social worker, they would refer a patient to for the listed problems.

4.8 Ethical approval

The questionnaire, the explanatory letter and procedures were approved by the Bond University Human Research Ethics Committee (BUHREC) in February 2000.

4.9 Conjoint design and data collection

The design of the questionnaire and the collection of data were done in collaboration with fellow researcher Janice Bond. However, all analyses and writing of this thesis was done individually.

CHAPTER FIVE

Results – Study I

5.1 Introduction

This chapter reports the analyses of data collected from questionnaires completed by the general public and medical practitioners regarding the perceptions and knowledge of counsellors on the Gold Coast and Northern New South Wales. The data were collected from the general public during the period 2000 to 2001 and from the medical practitioners from the period 2000 to 2002.

5.2 Data collection - general public

5.21 Response rate

A total of 500 questionnaires were distributed to the general public, with 226 being completed and collected. Reluctance to fill out the questionnaire was expressed by a number of respondents who indicated that they believed that they did not have enough knowledge of the subject matter, or that they found the size of the questionnaire and the length of time required to complete the questionnaire daunting. Male respondents indicated a particular reluctance to complete the questionnaire, inspite of a number of attempts to target male-dominated work areas for distribution and collection of the questionnaires.

5.3 Data collection - medical practitioners

5.31 Response rate

From 640 questionnaires distributed to medical practitioners, 105 were returned. The reluctance of medical practitioners to participate in the survey was due to reported time constraints of working in a 'busy practice.' Many questionnaires did not come to

the attention of the medical practitioner at all, and were returned by reception staff or practice managers uncompleted.

5.4 Demographic information - general public and medical practitioners

The demographic information required from respondents included their postcode, occupation, gender and their age group. The age groups were divided into periods from 18-24 years, 25-34 years, 35-54 years and 55years and over. The notable absence of medical practitioners from the 18-24 year age category is a reflection of the number of years of study required to complete a medical degree. A summary of the demographic information for the general public and medical practitioners is outlined in Table 4.

Table 4

Demographics of respondents

Data	General Public n	General Public Percentage	Medical Practitioners n	Medical Practitioners Percentage
Postcode Areas				
Gold Coast Qld	184	81.4	77	73.2
Northern NSW	42	18.6	28	26.8
Age Groups				
18 – 24	25	11.1	-	-
25 – 34	58	25.6	23	21.9
35 – 54	110	48.7	61	58.1
55 & over	33	14.6	21	20.0
Gender				
Male	76	33.6	62	59.0
Female	150	66.4	43	41.0
Occupation				
Professional	29	12.8	-	-
Managers/Proprietors	27	11.9	-	-
Office & Sales	41	18.3	-	-
Skilled Workers	27	11.9	-	-
Semi-skilled Workers	24	10.6	-	-
Unskilled Workers	26	11.5	-	-
Unemployed	29	12.8	-	-
Retired	23	10.2	-	-
Medical Practitioners	-	-	105	100.0

Note. Data represent frequencies (n) and percentages. General Public N = 226.
Medical Practitioners N = 105.

5.5 Major activities of a counsellor reported by the general public

When asked what they thought the major activities of a counsellor were, 56.2% of respondents listed listening, 43.3% indicated supporting, and 25.2% stated that counsellors helped people solve problems. Giving advice was reported by 21%, empathising and guidance by 16.4% respectively, exploring client options by 11.1%, and empowering the client to help himself or herself by 9.7% of respondents. Helping to clarify problems, referral, mediation, providing information, providing assessment, providing homework and helping a client achieve a positive outcome, were further counsellor activities listed by respondents. Two of the respondents indicated that they believed that counsellors were unhelpful. The perceptions of the general public regarding the major activities of counsellors are outlined in Table 5 on page 154.

5.6 Major activities of a counsellor reported by medical practitioners

Similar to the general public, the majority of medical practitioners (69.5%) indicated that listening was a major activity of counsellors. Empowering the client to self-help was reported as a major activity of counsellors by 62.9% and 57.1% listed supporting. A further 47.6% and 43.8% reported empathising and problem solving respectively. Thirty-nine percent of respondents indicated guidance as a major activity and 38.1% thought that counsellors helped clients clarify problems/issues. Additionally, 29.5% of respondents stated exploring options was a major activity of counsellors, while 22.9% indicated that providing assessment was a function of counselling. Twenty percent of respondents included advising and providing coping mechanisms in their responses and 10.5% thought that educating was a major counselling activity. Remaining responses included reflecting and summarising

thoughts, helping to achieve positive outcomes, dealing with life crises and source of referral. The response rates that reflect the perceptions of the activities of counsellors, by this sample are summarised in Table 6 on page 155.

Table 5

Counsellor activities and response percentage of the general public

Category of comment	n	Percentage
Listening	127	56.2
Supporting	91	40.3
Problem Solving	57	25.2
Advising	48	21.2
Empathising	37	16.4
Guidance	37	16.4
Explores options	25	11.1
Empowers client to self-help	22	9.7
Other	84	16.8

Note. Data indicate response percentage and frequencies (n). Because multiple answers were given, totals vary from 100%. N = 226.

Table 6

Counsellor activities and response percentage of medical practitioners

Category of comment	n	Percentage
Listening	73	69.5
Empowers client to self-help	66	62.9
Supporting	60	57.1
Empathising	50	47.6
Problem Solving	46	43.8
Guidance	41	39.0
Helps clarify	40	38.1
Explores options	31	29.5
Provides Assessment	24	22.9
Provides coping mechanisms	21	20.0
Advising	21	20.0
Educates	11	10.5
Other	21	20.0

Note. Data indicates response percentage and frequencies (n). Because multiple answers were given, totals vary from 100%. N = 105.

5.7 Counsellors known and their workplace reported by the general public

Respondents were asked if they knew of a counsellor, and if they did, where they thought they were employed. When asked whether they knew any counsellors, 66.4% of those surveyed indicated that they did. Those who knew a counsellor were

further asked to indicate where the counsellor worked. The results showed that 32.3% of respondents knew a counsellor in private practice, 24.3% knew a counsellor in a community health setting and 17% stated that they knew a counsellor in a community agency. Schools or educational institutions were listed by 17% as being workplace settings for known counsellors, while 11.5 % worked in hospitals and 6.6% were identified as working in a medical practice. Two respondents indicated that they knew a counsellor who worked in a church. Some participants marked more than one response to the known workplace of counsellors. Table 7 shows the frequency and percentage of respondents who reported that they knew of a counsellor, while table 8 on page 157 summarises the response rates to the different possible workplace environments of counsellors.

Table 7

Counsellors known - general public

Counsellors known	n	Percentage
Yes	150	66.4
No	75	33.2
Missing	1	0.4

Note. Data represent frequencies (n) and percentages. N = 226.

Table 8

Counsellors workplace reported by general public

Counsellors' workplace	n	Percentage
Private Practice	73	32.3
Community Health	55	24.3
Educational Institutions	39	17.3
Community Agency	36	15.9
Hospital	26	11.5
Medical Practice	15	6.6
Other (Church)	2	0.9

Multiple answers were given, therefore totals vary from 100%. Data indicate frequencies (n) and response percentages. N = 226

5.8 Counsellors known and their workplace reported by medical practitioners

Of the total of 105 respondents, 99 (94.3%) indicated that they knew a counsellor. The results showed that 72.4% knew a counsellor from a community health setting, 43.8% knew of a counsellor in private practice, 24.8% knew of a counsellor in schools and educational institutions, 19% reported that they knew a counsellor that worked in a hospital, 16.2% indicated that they knew of a counsellor in a community agency and 11.4% of respondents stated that they knew of a counsellor working in a medical practice. Table 9 demonstrates the percentage of respondents that reported

knowing a counsellor and Table 10 indicates the workplace where respondents knew a counsellor.

Table 9

Counsellors known - medical practitioners

Counsellors' known	n	Percentage
Yes	99	94.3
No	6	5.7

Note. Data represent frequencies (n) and percentages. N = 105.

Table 10

Counsellors workplace reported by medical practitioners

Counsellors' workplace	n	Percentage
Community Health	76	72.4
Private Practice	46	43.8
Educational Institutions	26	24.8
Hospital	20	19.0
Community Agency	17	16.2
Medical Practice	12	11.4

Multiple answers were given, therefore totals vary from 100%. Data indicate frequencies (n) and response percentages. N = 105.

5.9 Recipients and potential recipients of counselling - general public

From a sample of 226, 49.6% stated that they had been to a counsellor for personal help, while 77.9% indicated that they would consider seeing a counsellor if the need arose.

5.10 Recipients and potential recipients of counselling - medical practitioners

In response to the question of whether they had ever been to a counsellor for personal help, 90.5% of respondents indicated that they had not received counselling before. However, 83.8% reported that they would consider counselling if the need arose. The collective responses of the general public and medical practitioners are summarised in table 11.

Table 11

Recipients and potentials for counselling - general public and medical practitioners

Responses	General Public n	General Public Percentage	Medical Practitioners n	Medical Practitioners Percentage
Have you ever been to a counsellor for personal help				
Yes	112	49.6	10	9.5
No	114	50.4	95	90.5
Would you consider going to a counsellor for personal problems				
Yes	176	77.9	88	83.8
No	47	20.8	17	16.2
Missing	3	1.3	-	-

Note. Data indicate frequencies (n) and percentage responses. General Public N = 226 and Medical Practitioners N = 105.

5.11 Gender preference - general public

Almost 75% of respondents did not have a preference regarding the gender of a counsellor they would consult, while 21.7% preferred a counsellor of the same sex and 2.2% indicated that they would prefer a counsellor of the opposite sex. One respondent indicated that their gender preferences for a counsellor would depend on their presenting issue. However, a possible limitation of this study, which may have influenced the results of the survey especially regarding gender issues, was the disproportionate number of females to males. Of the 226 respondents, 150 were females.

5.12 Gender preference - medical practitioners

The sample of medical practitioners comprised of 62 males and 43 females. Results indicated that 54.3% had no preference regarding counsellor gender, while 29.5% reported a preference for a counsellor of the same gender. A preference for a counsellor of the opposite sex was reported by 5.7% of respondents and the same percentage indicated that their preference of counsellor gender would depend on the issue for which they were receiving counselling. A further 4.8% of respondents did not answer this question as they had indicated in the questionnaire that they would not consult with a counsellor. As outlined in table 12, the response rate from both samples indicated that counsellor gender was not an issue for the majority of respondents.

Table 12

Counsellor gender preference - general public and medical practitioners

Counsellor Gender	General Public n	General Public Percentage	Medical Practitioners n	Medical Practitioners Percentage
No preference	169	74.8	57	54.3
Same sex	49	21.7	31	29.5
Opposite sex	5	2.2	6	5.7
Depends on issue	1	0.4	6	5.7
Irrelevant	-	-	5	4.8
Missing	2	0.9	-	-

Note. Data indicate response percentages and frequencies (n). General Public N = 226 and Medical Practitioners N = 105.

5.13 Need for more counsellors in the community - general public

When asked if they thought that there was a need for more counsellors in the community, 71.4% of respondents indicated that there should be more and 16.8% thought that there should not. A further 1.8% of respondents were unsure about the need for more counsellors in the community and 22 participants did not provide a response to the question at all.

5.14 Need for more counsellors in the community from - medical practitioners

Results from the medical practitioners indicated that 86.7% believed that there was a need for more counsellors in the community. Table 13 demonstrates the frequencies and responses of both the general public and medical practitioners regarding the issue of need for more counsellors.

Table 13

Need for more counsellors - general public and medical practitioners

Response	General Public n	General Public Percentage	Medical Practitioners n	Medical Practitioners Percentage
Yes	162	71.7	91	86.7
No	38	16.8	14	13.3
Unsure	4	1.8	-	-
Missing	22	9.7	-	-

Note. Data indicate frequencies (n) and response percentages. General public N = 226. Medical Practitioners N = 105.

5.15 Benefits of counselling - general public

Respondents were asked to list three major benefits of counselling, and table 14 on page 164 shows the reported responses. Three lines labelled a, b, and c were provided for participants to list their answers. Some of the respondents chose not to list three benefits of counselling, recording only one or two perceived advantages, while others did not record any benefits at all. The missing data from the a, b, c categories were as follows: Answer A, 21 missing responses; Answer B, 32 missing

responses; and Answer C, 55 missing responses. The associated benefits rated highly by respondents were having someone who listens, being impartial, support, help with clarification of problems, and assisting with problem-solving. Personal benefit was also listed as a major benefit, with respondents including stress relief, a happier life, hope for the future, self-esteem and self-awareness in this category. Other benefits mentioned were release of feelings, empathy, having a safe and confidential environment to express problems, suicide reduction, confidence building, finding a better behaviour, goal setting and non-judgemental regard. One respondent expressed the belief that there was less stigma involved in consulting a counsellor than a psychologist or a psychiatrist, while another respondent reported that seeing a counsellor might assist to 'get rid of' his wife.

5.16 Benefits of counselling - medical practitioners

As indicated in table 15 on page 165, the most frequently considered benefits of counselling reported were problem solving, helps clarify and support. The totals listed in this table are cumulative from answers a, b and c. Catharsis, personal empowerment and achievement of realistic goals were also frequently perceived as benefits of counselling by respondents. Similar to the general public, some medical practitioners did not report any advantages of counselling, while others listed only one or two benefits.

Table 14

Benefits of receiving counselling - general public

Respondent comments	n	Percentage
Personal benefit	113	50.1
Listening	75	33.2
Support	72	31.9
Helps clarify	71	31.4
Problem Solving	61	27.0
Impartial person	40	17.8
Catharsis	32	14.2
Advice / Guidance	32	14.2
Empathy	28	12.4
Confidential / Safe	23	10.2
No longer feel alone	14	6.2
Benefit to society	5	2.2
Referral	3	1.3

Note: Data indicate frequencies (n) and percentages. N = 226. Because multiple answers were given totals vary from 100%.

Table 15

Benefits of receiving counselling - medical practitioners

Respondent comments	n	Percentage
Problem Solving	31	29.5
Helps clarify	30	28.6
Support	30	28.6
Catharsis	25	23.8
Personal empowerment	24	22.9
Achievement of realistic goals	18	17.2
Impartial person	15	14.4
Confidential / Safe	15	14.4
Self-awareness	11	10.5
Positive Outlook for future	10	9.5
Ventilation	10	9.5
Long-term coping strategies	10	9.5
Models communication style	8	7.7
Crisis intervention	8	7.7
Advice/Guidance	8	7.7
Accepting losses/illnesses	8	7.7
Personal Benefit	7	6.8
Listening	7	6.8
Empathy	6	5.8
Case management	6	5.8
No medication	5	4.8
No longer feel alone	3	2.9
Education	2	1.9
Self-help	2	1.9
Shorter duration of symptoms	2	1.9
Referral	2	1.9
Professional development	1	1.0

Note. Data indicate frequencies (n) and percentages. N = 105. Because multiple answers were given, totals vary from 100%

5.17 Drawbacks of counselling - general public

The category of personal issues was the largest recorded drawback found. Incorporated within this category were issues such as the fear of confronting, expressing and reliving experiences that were sources of emotional pain, the availability and accessibility of the counsellor, time, the realisation that counselling is required, finding the courage to attend, and the potential for creating rifts and resentment within the family possibly resulting in an unfavourable outcome. Questions around the competency of the counsellor was another reported drawback and included concerns about choosing the wrong counsellor, inadequate training of the counsellor and the possibility of lack of accreditation. Other drawbacks mentioned were the cost of counselling, counsellor bias, and the lack of empathy or life experience of the counsellor. Some respondents simply thought that counselling was unhelpful, while feelings of embarrassment and inadequacy concerned others, and issues of trust, confidentiality and stigma were also considered drawbacks. Table 16 on page 167 illustrates the above-mentioned drawbacks of counselling reported by the general public.

5.18 Drawbacks of counselling - medical practitioners

As is evident in table 17, the competency of the counsellor was the greatest perceived drawback recorded by medical practitioners. Time was a further major concern for respondents. The possibility of forming a dependency on the counsellor and the issue of cost were also reported drawbacks. Other concerns that were considered to be negative about counselling included the potential for transference, reliving traumatic experiences, personal embarrassment and having a poor rapport with

the counsellor being consulted. Table 17 on page 168 summarises the listed drawbacks reported by medical practitioners. Some respondents did not record three major drawbacks as asked, with many listing only one or two perceived problems with counselling. Two respondents indicated that they did not think that there were any drawbacks to counselling.

Table 16

Drawbacks of counselling - general public

Respondent comments	n	Percentage
Personal Drawback	121	53.5
Cost	56	24.8
Counsellor Competency	49	21.6
Unhelpful	44	19.5
Dependence on Counsellor	29	12.9
Issue of Confidentiality	16	7.0
Trusting another	16	7.0
Stigma	15	6.7
No Drawbacks	13	5.8
Feeling Inadequate	12	5.3
Self-awareness	12	5.3
Embarrassment	9	3.9

Note: Data indicate frequencies (n) and percentages. N = 226. Because multiple answers were given, totals vary from 100%

Table 17

Drawbacks of counselling - medical practitioners

Respondent comments	n	Percentage
Counsellor Competency	61	58.0
Time	55	52.4
Dependence on Counsellor	37	35.3
Cost	28	26.7
Transference	15	14.3
Relive traumatic experience	14	13.4
Embarrassment	12	11.5
Poor rapport with counsellor	10	9.6
Feeling inadequate	9	8.6
Expectations too high	8	7.7
Unable to medicate	8	7.7
Exploitation of vulnerable	5	4.9
Requires motivation	4	3.9
Stigma	4	3.9
Issue of confidentiality	3	2.9
Accessibility	3	2.9
No drawbacks	2	1.9
Taking sides with couples	2	1.9
Trusting another	1	1.0
Unhelpful	1	1.0
Superficial attention, not Sophisticated	1	1.0

Note: Data indicate frequencies (n) and percentages. N = 105. Because multiple answers were given, totals vary from 100%.

5.19 Counsellor approachability - general public

Three questions were asked specifically relating to counsellor approachability. The first question asked respondents to rate a counsellor according to the value they thought the counsellor would be in helping with personal problems. On a scale of 1 to 10, with 1 being of little value and 10 equalling of high value, the mean score was 6.3. The second question required respondents to rate a counsellor according to the degree of comfort they would feel relating to a counsellor in a social setting. Again on a scale of 1 to 10, 1 represented most uncomfortable and 10 indicated very comfortable. The mean for this question was 6.11. The third question examined the degree of comfort that respondents would feel consulting a counsellor about a personal problem. The mean calculated from the ten-point scale was 6.44. As was the case for the second question, 1 equalled most uncomfortable and 10 suggested very comfortable.

5.20 Counsellor approachability - medical practitioners

In contrast to the general public, medical practitioners rated both the ability of a counsellor to assist them with their personal problems and the degree of comfort they would experience consulting a counsellor as lower. The mean calculated for the former question was 5.78, while the latter question had a mean score of 5.03. However, medical practitioners indicated that they were relatively comfortable talking to a counsellor in a social setting, with a mean score of 7.14 being calculated for this question. All three questions were 10-point scales, presented in the same format as for the general public. Table 18 outlines the associated mean and standard deviation calculated for the responses of the general public and medical practitioners regarding the approachability of counsellors.

Table 18

Counsellor approachability on a 10-point scale-general public and medical practitioners

Category	General Public			Medical Practitioners		
	n	M	SD	n	M	SD
Counsellor in social setting	225	6.11	2.73	105	7.14	2.19
Comfort consulting counsellor	224	6.44	2.55	105	5.03	2.11
Help with personal problems	219	6.30	2.36	105	5.78	1.75

Note. Data represent respondents (n), mean (M), and standard deviation SD. General Public N = 226. Medical practitioners N = 105.

5.21 Counsellor training - general public

A majority of 86.7% believed that counsellors should have a postgraduate (45.1%), or an undergraduate (41.6%) university degree. Additionally, 71.7% of respondents indicated that a counsellor should have both formal qualifications and life experience. TAFE college training was preferred by 8.8%, a certificate course by 7.5% and 0.9% indicated that they thought a counsellor should have completed a correspondence course.

5.22 Counsellor training - medical practitioners

The preferred counsellor training recorded by medical practitioners (80.0%) was a post-graduate university degree, while 58.1% indicated a preference for an undergraduate degree. Most respondents nominated more than one preference, with 71.4% stating they would prefer a counsellor with formal qualifications combined with life experience. A T.A.F.E. College course was nominated by 13.3% of respondents

and 2.9% included a certificate course in their responses. One respondent wrote a question mark, followed by the statement " I didn't know there was any." Table 19 lists the responses of preferred counsellor training of the general public and medical practitioners.

Table 19

Preferred choice of counsellor training – general public and medical practitioners

Training	General Public n	General Public Percentage	Medical Practitioners n	Medical Practitioners Percentage
Postgraduate degree	102	45.1	84	80.0
Life Experience	162	71.7	75	71.4
Undergraduate degree	94	41.6	61	58.1
TAFE College	20	8.8	14	13.3
Certificate Course	17	7.5	3	2.9
Correspondence Course	2	0.9	-	-

Note. Data indicate frequencies (n) and percentages. Because multiple answers were given, totals vary from 100%. General public N = 226. Medical Practitioners N = 105.

5.23 Counsellor most beneficial to needs - general public

Respondents were also asked to rate on a scale of 1 to 10 which of three combinations of training and personal experience they would find most beneficial. On the rating scale 1 indicated of little benefit and 10 represented extreme benefit. Counsellors who had formal training and life experience were rated as extremely valuable by 85.8% of respondents, with a mean of 8.71. The combination of informal

training and personal life experience was rated on the scale between 4 and 8 by 72.7%, with a mean of 5.63, and formal recognised training with little personal life experience had a mean of 3.89, with 77.4% of respondents marking the scale between 1 and 5. The scale titled "other" was completed by 22 respondents, five of which stated they had a preference for a counsellor who had personally experienced a problem, for example addictions. A further two respondents stated that they would prefer a counsellor with maximum training complimented with life experience, while others indicated a preference for life experience combined with the right attitude; a counsellor who specialises in a specific area; an honorary, supervised counsellor; and a counsellor who had done "self work." Additional responses to the "other" scale included a counsellor who was qualified and already known to the client, a Christian counsellor, and a compassionate but firm counsellor. The age of the counsellor was mentioned as important to one respondent and the ability to be a good listener was stated as important to another. Two respondents indicated that assistance from a friend would be of greater benefit to them and one respondent stated that they would prefer to consult with a police officer. Table 20 shows clearly the preference of the majority for a counsellor with formal training and personal life experience.

Table 20

Counsellor training and life experience most beneficial - general public

Scale category	n	M	SD	Range	Percentage
Formal training and personal life experience	221	8.71	1.56	8-10	85.8
Informal training and personal life experience	216	5.63	2.07	4-8	72.7
Formal recognised training and little personal life experience	215	3.89	2.06	1-5	70.9

Note. Data indicate n = respondents, M = mean, SD = standard deviation. Range = most frequently chosen numbers on scale of 1 to 10. N = 226.

5.24 Counsellor most beneficial to needs - medical practitioners

Similar to the general public, medical practitioners were asked to rate the counsellor they considered would be most beneficial to their needs on a 10-point scale. The combination of formal education and personal life experience was the counsellor considered the most beneficial by the majority of respondents. As table 21 demonstrates, 96.2% of respondents marked the range between 7 and 10, when reporting the perceived benefits of a counsellor with qualifications and life experience, with a mean of 8.66. Additionally, 89.5% of respondents, with a calculated mean of 3.25, marked the scale between 1 and 5 when reporting their perceived value of counsellors with formal training and little personal life experience. Whereas, counsellors with informal training and personal life experience had a mean of 4.7, with 65.7% marking the 4 to 6 range on the scale. Twelve respondents marked the category

titled "other." Over half of these (6) rated a specialist counsellor in a specific area as 9 on the 10-point scale, and four of the remaining respondents marked between the range of 8 to 10 their stated preference for a more qualified professional, for example a psychologist or a psychiatrist. One respondent placed moderate value on a counsellor who had the right attitude and experience, and another respondent rated a counsellor with little life experience and informal training as not at all beneficial. Table 21 summarises the data analysed from the medical practitioners regarding what combination of training and personal life experience they perceived to be most beneficial to their needs.

Table 21

Counsellor training and life experience most beneficial - medical practitioners

Scale category	n	M	SD	Range	Percentage
Formal training and personal life experience	105	8.66	1.09	7-10	96.2
Informal training and personal life experience	105	4.70	1.75	4-6	65.7
Formal recognised training and little personal life experience	105	3.25	1.67	1-5	89.5

Note. Data indicate n = respondents, M = mean, SD = standard deviation. Range = most frequently chosen numbers on scale of 1 to 10. N = 105.

5.25 Problems counsellors should be trained to deal with - general public

The associated problems that respondents of the survey thought counsellors should be trained to deal with was varied, and respondents usually indicated more than one problem. The majority, 53.5% stated relationship problems, with 51.8% believing that counsellors should be trained to deal with all problems. A further 32.7% listed personal problems which included self esteem issues, anger management, medical health issues, financial problems, career options, social and sexual problems, pregnancy issues, mental health and cultural issues. Dealing with addictions was considered to be important by 27% of respondents, and 25.7% thought that counsellors should be skilled in handling grief and loss issues. A further 19.5% indicated stress, anxiety and trauma problems, 17.3% listed general and sexual abuse, 15.9% specifically mentioned depression and mental health problems, 14.6% thought child and adolescent problems, and 7.5% mentioned suicide.

5.26 Problems counsellors should be trained to deal with - medical practitioners

Similarly, medical practitioners recorded a variety of problems that they believed counsellors should be trained to deal with and many respondents listed more than one problem. The most frequently listed problems, as is clearly shown in table 22, included addictions (74.3%), relationship issues (69.5%) and grief and loss (63.8%). A further 29.5% of participants included stress/anxiety/trauma in their responses, and 26.7% indicated that counsellors should be trained to deal with domestic violence and anger management respectively. General and sexual abuse was recorded by 24.8% of respondents, while a further 23.8% listed depression and mental health, adjustments and low self-esteem respectively as issues they believed that counsellors should be

trained to manage. Child and adolescent problems were accounted for by 22.9% of respondents and sexual disorders was listed by 21%. Additionally, 19% of respondents indicated that they believed counsellors should be trained to assist with Post Traumatic Stress Disorder (PTSD), while 13.3% believed that counsellors should be trained to deal with all problems. Suicide and vocational problems were reported by 11.4% of respondents. Other issues listed as important for counsellors to be able to assist with included panic attacks (9.5%), psychological impact of disease (8.6%), financial problems (6.7%), dietary issues (3.8%) and palliative care (1.9%). Table 22 on page 177 summarises the data collected from the general public and medical practitioners regarding problems counsellors should be trained to deal with.

5.27 Registration, tertiary training and professionalism - general public

When asked about counsellor registration requirements 83.7% of respondents believed that counsellors should be registered members of a government-approved association. Similarly, the majority of respondents (75.3%) reported that counsellors should be tertiary trained. The opinions of the general public regarding the professionalism of counsellors indicated that counsellors were considered to be as professional as psychologists, psychiatrists and social workers by 67.4% of respondents. One respondent who reported that counsellors were not as professional as psychologists due to possible lack of training, qualified their response to state that the work of the counsellor was equally important as other professionals. The reported responses to the yes/no questions relating to counsellor registration, tertiary training and professionalism are summarised in table 23 on page 178.

Table 22

Problems counsellors should deal with – general public and medical practitioners

Category of Problem	General Public n	General Public Percentage	Medical Practitioners n	Medical Practitioners Percentage
Addictions	61	27.0	78	74.3
Relationships	121	53.5	73	69.5
Grief and Loss	58	25.7	67	63.8
All Problems	117	51.8	14	13.3
Personal	74	33.7	-	-
Stress/Anxiety/Trauma	44	19.5	31	29.5
Domestic Violence	-	-	28	26.7
Anger Management	-	-	28	26.7
General/Sexual Abuse	39	17.3	26	24.8
Depression/Mental Health	36	15.9	25	23.8
Adjustments	-	-	25	23.8
Low self-esteem	-	-	25	23.8
Child & Adolescent	33	14.6	24	22.9
Sexual Disorders	-	-	22	21.0
PTSD	-	-	20	19.0
Suicide	17	7.5	12	11.4
Vocational	-	-	12	11.4
Panic Attacks	-	-	10	9.5
Impact of disease	-	-	9	8.6
Financial	-	-	7	6.7
Dietary	-	-	4	3.8
Palliative Care	-	-	2	1.9

Note. Data indicate frequencies (n) and percentages. Because multiple answers were given, totals vary from 100%. General public N = 226. Medical Practitioners N = 105.

Table 23

Responses to registration, tertiary training and professionalism – general public

Question category	n	Percentage
Counsellor registration		
("All counsellors should be registered members of an association to practice as counsellors")		
Yes	190	84.1
No	34	15.0
Missing	2	0.9
Tertiary training		
("Counsellors should be tertiary-trained")		
Yes	171	75.7
No	42	18.6
Missing	13	5.7
Professionalism		
("Counsellors are not as professional as psychologists, psychiatrists & social workers")		
No	153	67.7
Yes	63	27.9
Missing	10	4.4

Note: Data indicate percentages and frequencies (n). N = 226.

5.28 Registration, tertiary training and professionalism - medical practitioners

Table 24 outlines the responses to three yes/no questions regarding the registration, tertiary training and professionalism of counsellors respectively. As is evident in table 24, nearly all of the sample population believed that counsellors should be both registered members of a government-approved association (93.3%) and tertiary trained (92.4%) before they can practice as counsellors. Although the percentage was not as high as for the first two questions, there was a majority of 71% of respondents who indicated that they believed that counsellors were equally as professional as psychiatrists, psychologists and social workers. A further 22% reported that it would depend on the qualifications of the counsellor as to whether or not they were as professional as their colleagues.

Table 24

Responses to registration, tertiary training and professionalism - medical practitioners

Question category	n	Percentage
Counsellor registration		
("All counsellors should be registered members of an association to practice as counsellors")		
Yes	98	93.3
No	7	6.7
Tertiary training		
("Counsellors should be tertiary-trained")		
Yes	97	92.4
No	8	7.6
Professionalism		
("Counsellors are not as professional as psychologists, psychiatrists & social workers")		
No	71	67.6
Yes	12	11.4
Depends on qualifications	22	21.0

Note: Data indicate percentages and frequencies (n). N = 105.

5.29 Resources to find a counsellor - general public

Respondents were asked to indicate firstly which people they would consult if they needed to find a counsellor, secondly which organizations they would consult to find a counsellor and thirdly what advertising they would read to find a counsellor. Respondents usually indicated more than one source. The three most frequently indicated responses for the categories of people, organisations and advertising were as follows. Of people sought to help find a counsellor, a doctor was mentioned by 82.3%, 61.5% stated they would ask a friend, and a family member would be consulted by 40.7%. The organisations most likely to be contacted for help to find a counsellor were community services (65%), hospitals were believed to be able to assist by 57.1% and 40.7% reported that they would consult the health department. Other organisations mentioned by respondents as being helpful in finding a counsellor included rehabilitation units, health funds, support groups, religious groups and Lifeline. The advertising sources that people stated they would read to find a counsellor included the telephone book (48.2%), a medical directory was listed by 32.7% and a community services magazine was mentioned by 31%. Other advertising sources listed by respondents were brochures, word of mouth, health awareness classes, their place of work, or a women's centre. Therefore from the results of this study the three major sources that people would seek to help find a counsellor from the three categories of person, organisation and advertising, were doctors, community services and the telephone book respectively. These three sources will be the focus of a mini-survey later in this research. Table 25 provides a more detailed outline of the participants' responses to this question.

Table 25

Referral sources to find a counsellor - general public

Sources	n	Percentage
People		
Doctor	186	82.3
Friend	139	61.5
Family member	92	40.7
Work colleague	61	27.0
Teacher	41	18.1
Police	34	15.0
Telephone operator	26	11.5
Lawyer	22	9.7
University professor	17	7.5
Chemist	11	4.9
Other	7	3.1
Organisations		
Community services	147	65.0
Hospital	129	57.1
Health department	92	40.7
Church	74	32.7
School	36	15.9
University	23	10.2
Local council	18	8.0
Other	5	2.2
Advertising		
Telephone book	109	48.2
Medical directory	74	32.7
Community services magazine	70	31.0
Internet	32	14.2
Newspaper	31	13.7
Television	17	7.5
Magazines	16	7.1
Radio	9	4.0
Other	7	3.1

Note. Data represent response percentage, and frequencies (n). Because multiple answers were given, totals vary from 100%. N = 226.

5.30 Resources to find a counsellor - medical practitioners

As shown clearly in table 26, all of the respondents from this sample included doctors in their response to the question regarding what people they would consult with to find a counsellor. The next two most frequent responses were for a friend (52.4%) and a work colleague (51.4%). Similar to the general public, respondents often indicated more than one answer, and a few respondents (10) specified in the option for 'other' that they would consult with a health professional from another workplace to find a counsellor. Regarding the question of which organisations would be used to locate a counsellor, the results were as follows. Seventy-nine percent of respondents indicated that they would prefer to locate a counsellor through contacting community services. A further 55.2% recorded the health department as a likely source of where to find a counsellor and 51.4% believed a hospital would be a helpful source. Other organisations reported were Lifeline and private practices. The majority of responses (73.3%) to the issue of which advertising source would be utilised to find a counsellor favoured a medical directory. The telephone book was reported by 68.6% of respondents as a preferred resource for locating a counsellor, while 29.5% nominated a community service magazine as a likely resource. Table 26 provides a summary of all of the reported responses to this question.

Table 26

Referral sources to find a counsellor - medical practitioners

Sources	n	Percentage
People		
Doctor	105	100.0
Friend	55	52.4
Work colleague	53	50.5
Family member	35	33.3
Teacher	16	15.2
Police	13	12.4
Lawyer	7	6.7
Chemist	4	3.8
Telephone operator	2	1.9
University professor	-	-
Other	10	9.5
Organisations		
Community services	83	79.0
Health department	58	55.2
Hospital	54	51.4
Church	26	24.8
School	17	16.2
University	9	8.6
Local council	4	3.8
Other	9	8.6
Advertising		
Medical directory	77	73.3
Telephone book	72	68.6
Community services magazine	31	29.5
Internet	17	16.2
Newspaper	5	4.8
Television	2	1.9
Radio	2	1.9
Magazines	1	1.0

Note. Data represents response percentage, and frequencies (n). Because multiple answers were given, totals vary from 100%. N = 105.

5.31 Counsellor fees - general public

Responses to the question of whether or not they would be prepared to pay for a 50-minute counselling session indicated that 78.8% of respondents would be prepared to pay to see a counsellor. The 20.3% of respondents who indicated that they would not pay for counselling services, were asked why they would not pay. The main reason given by 13.7% was that they could not afford to pay. Of the remaining respondents, three stated that because they did not need counselling they would not pay, three more indicated that they would rather talk to friends, four answered that they believed that counselling would not be helpful, and the final two respondents attributed their reluctance to pay to personal reasons. The author noted that there was incongruence in some respondents answers, in that after indicating they would not pay for counselling, they marked a box nominating how much they would be prepared to pay. The usual amount elected was the $25 to $50 fee range. This anomaly might suggest that some of those who stated they would not pay for counselling actually would if the need arose.

The percentage that indicated that they would pay for counselling, were further asked to report the fee they would be prepared to pay. The options given were $25, $50, $75 or $100. The data found that 43.8% were prepared to pay $50, 33.2% nominated $25, 15.9% marked $75 and 5.3% stated they would pay $100 for counselling services. Two respondents qualified their answers, with one reporting that what they were prepared to pay would depend on the seriousness of the problem and the qualifications of the counsellor, the other respondent stated that any fee charged would be reasonable if the counsellor was 'good.' The responses to payment for

counselling and the associated fees that the respondents indicated they would pay for counselling are outlined below in table 27.

Table 27

Willingness to pay for counselling and nominated fees - general public

Response category	n	Percentage
Payment for counselling		
Yes	178	78.8
No	46	20.3
Missing	2	0.9
Fees Nominated		
$50	99	43.8
$25	75	33.2
$75	36	15.9
$100	12	5.3
Missing	4	1.8

Note. Data indicate response percentages and frequencies (n). N = 226

5.32 Counsellor fees - medical practitioners

Of the 105 respondents, 100 indicated that they would pay to see a counsellor (95.2%). Of the remaining five respondents who reported that they would not pay to see a counsellor, three stated that they would not need counselling, or if they did they would not consult with a counsellor. Two respondents did not qualify their "no"

answer. The majority of respondents who indicated that they would pay to see a counsellor (49.5%) nominated that they would be prepared to pay $50. A further 32.4% reported that they would pay $75, while 8.5% were willing to pay $100 for a 50 minute counselling consultation. Twenty-five dollars was the preferred counselling fee for 4.8% of respondents. The inconsistencies apparent with the general public were not evident with the medical practitioners. As table 28 shows, the 100 respondents who indicated that they were willing to pay for counselling, consisted of the total responses for preferred counselling fees.

Table 28

Willingness to pay for counselling and nominated fees - medical practitioners

Response category	n	Percentage
Payment for counselling		
Yes	100	95.2
No	5	4.8
Fees Nominated		
$50	52	49.5
$75	34	32.4
$100	9	8.5
$25	5	4.8
No payment	5	4.8

Note. Data indicate response percentages and frequencies (n). N = 105

5.33 Medicare rebate - general public

Data indicated that 92.5% of respondents thought that counselling fees should be covered by Medicare. One respondent believed that "effective preventative counselling would save the health system a huge amount of money, with less physical illness, time off work, suicide, etc." Data was missing from four questionnaires.

5.34 Medicare rebate - medical practitioners

Respondents were divided regarding the issue of counselling fees being covered by Medicare. Fifty-six of the respondents (53.3%) believed that counselling fees should not be covered by Medicare, with 49 respondents (46.7%) indicating that they thought Medicare should cover the fees. Some of those who responded in the negative felt strongly about the issue and added comments that reflected this. One respondent wrote, "You've got to be joking!" Another stated that there were other priorities, "psychologists first." A further response was "you're kidding! Opening Medicare access to counsellors would mean all other allied health providers would have a right as well. Clinical psychologists will probably get some access for a limited number of sessions." One respondent stated "not in my lifetime!"

Of those who responded in the affirmative, some qualified their response with "only if tertiary qualified" and "with limitations/reviews in place." Table 29 summarises the responses of the general public and medical practitioners regarding the issue of Medicare covering counselling fees.

Table 29

Medicare rebate for counselling fees - general public and medical practitioners

Should fees be covered by Medicare	General Public n	General Public Percentage	Medical Practitioners n	Medical Practitioners Percentage
Yes	209	92.5	49	46.7
No	13	5.8	56	53.3
Missing	4	1.7	-	-

Note. Data represent percentages, and frequencies (n). General public N = 226. Medical Practitioners N = 105.

5.35 Counsellors and other professionals

5.351 Communication within therapeutic relationship - general public

Respondents were asked to rate on a 10-point scale the degree to which they would feel the most able to communicate with four health professionals: counsellors, psychologists, psychiatrists, and social workers. Each professional corresponded with a scale rating the degree respondents felt able to communicate them, where 1 equalled not very well, 5 represented moderately and 10 indicated very well. As table 30 demonstrates, counsellors were rated most frequently as the professional the respondents believed they could communicate with in a therapeutic relationship. Psychologists and social workers were rated next as professionals that respondents thought they could communicate with in a therapeutic relationship, whereas psychiatrists were most frequently rated as the professionals that respondents indicated they would feel the least comfortable communicating with in a therapeutic relationship.

Table 30

Respondents' ability to communicate with therapists - general public

Health professional	M	SD
Counsellor	7.23	2.06
Psychologist	6.68	2.30
Social Worker	6.22	2.51
Psychiatrist	5.87	2.54

Note. Data show the mean, M and standard deviation SD. N = 226.

5.352 Communication with therapists - medical practitioners

In contrast to the general public, medical practitioners indicated that they would be most able to communicate with a psychiatrist in a therapeutic relationship. With a mean of 7.56, a majority of 76.2% of respondents marked the scale in the 6 to 9 range. Psychologists were rated as the next group of health professionals that respondents believed they would be comfortable communicating with in a therapeutic relationship, with a mean of 7.17. Counsellors rated very closely to psychologists with a mean score of 7.02, while social workers were rated as the health professionals that respondents would feel the least comfortable communicating with in a therapeutic relationship. Table 31 summarises the reported perceptions of medical practitioners regarding the degree of comfort they would feel communicating with counsellors, psychologists, psychiatrists and social workers during therapy.

Table 31

Respondents ability to communicate with therapists – medical practitioners

Health professional	M	SD
Psychiatrist	7.56	1.61
Psychologist	7.17	1.59
Counsellor	7.02	1.66
Social Worker	5.91	1.97

Note. Data show the mean, M and standard deviation SD. N = 105.

5.353 Recommended professional for friend - general public

When asked which of the four health professionals - counsellor, psychiatrist, psychologist, social worker - respondents would prefer to recommend to a friend, 77.9% indicated that they would choose to refer their friend to a counsellor. As indicated in table 32, psychologists and social workers were the next two preferred professionals, with 40.3% and 39.8% nominating these disciplines respectively. The least preferred health professional for recommendation to a friend in need of help was the psychiatrists, with 23.5% of respondents recording this group of health professionals as a choice. Some respondents indicated more than one health professional as preferences, while others nominated all four disciplines, indicating no preference at all. One respondent reported that she did not know the difference between a psychiatrist and a psychologist.

Table 32

Preferred professional recommended for a friend - general public

Health Professional	n	Percentage
Counsellor	176	77.9
Psychologist	91	40.3
Social Worker	90	39.8
Psychiatrist	53	23.5

Note. Data represent frequencies (n) and percentages. Because more than one answer was given totals vary from 100%. N = 226.

5.354 Recommended professional for friend - medical practitioners

Similar to the general public, the majority of medical practitioners (78.1%) indicated that they would prefer to recommend a counsellor to a friend who needed help. However, the percentage of respondents who nominated psychologists and psychiatrists as preferences was significantly higher for medical practitioners than the general public. Psychologists were preferred by 73.3% of respondents and psychiatrists were chosen by 63.8% of respondents as desirable to recommend to a friend. The least preferred health professional reported by medical practitioners was social workers, with 36.2% nominating this discipline. As was the case for the general public, many respondents indicated more than one health professional as a potential referral for a friend. However, 23.8% reported that their preference for a health professional would depend on the nature of the problem, while a further 12.4% indicated that they would recommend a doctor to a friend in need of assistance. Table 33 summarises the above-mentioned responses of medical practitioners.

Table 33

Preferred professional recommended for a friend - medical practitioners

Health Professional	n	Percentage
Counsellor	82	78.1
Psychologist	77	73.3
Psychiatrist	67	63.8
Social Worker	38	36.2
Depends on problem	25	23.8
Doctor	13	12.4

Note. Data represent frequencies (n) and percentages. Because more than one answer was given totals vary from 100%. N = 105.

5.355 Professional consulted for specific problem - general public

The responses of the general public regarding which of four health professionals, counsellor; psychologist; psychiatrist; or social worker, they would consult for a series of 20 listed problems, were favourable to counsellors. Overall, the majority of respondents indicated they would consult counsellors for 13 of the 20 problems. Respondents frequently indicated more than one health professional as desirable to consult for each problem. The highest number of responses for consulting a counsellor was for grief and loss (187), with a further 169 respondents indicating marriage problems as an issue they would prefer to consult a counsellor for. Alcohol problems and drug problems were reported by a majority of 167 and 165 respondents respectively. Rape was another issue considered to be most likely dealt with by

consulting a counsellor by 157 respondents and 150 thought the same about financial difficulties. Additionally, 149 respondents reported that they would consult a counsellor for sexual abuse issues, while 148 indicated stress reduction as a problem they would consult a counsellor about. Other problems that counsellors were most frequently nominated as desirable to consult for included domestic violence (146), child behavioural problems (131), depression (119), vocational assessment (91) and learning difficulties (87). Anxiety was the problem that was most frequently reported (115) as being managed by consulting with a psychologist. Psychologists were further preferred only marginally over psychiatrists in the treatment of phobias (113 versus 112). Eating disorders (107) and panic attacks (103) were also primarily perceived as problems that respondents would consult a psychologist for. Sexual dysfunction was the other problem that respondents (99) preferred to consult with a psychologist about. Psychiatrists had the highest response rate for being the health professional consulted for mental health problems (158) and for hypnotherapy (101). Although social workers were not reported by the majority of respondents as preferable for any of the health problems, they did rank second to counsellors for the following problems: financial difficulties, sexual abuse, rape, drug problem, alcohol problem, domestic violence, grief and loss, and marriage problems. Table 34 summarises the respondents preferences for which of the four health professionals they would consult for the listed personal problems.

Table 34

Professional most likely to consult for a specific problem - general public

Category of problem	Health professional			
	Counsellor	Psychologist	Psychiatrist	Social Worker
Grief & Loss	187	61	23	66
Marriage Problem	169	57	8	64
Alcohol Problem	167	74	39	91
Drug Problem	165	75	49	101
Mental Health Problem	43	99	158	21
Rape	157	75	56	102
Financial Difficulties	150	22	5	110
Sexual Abuse	149	80	57	102
Stress Reduction	148	95	37	32
Domestic Violence	146	34	30	68
Child Behavioural Problem	131	114	61	77
Depression	119	111	94	26
Anxiety	111	115	78	20
Phobias	40	113	112	9
Eating Disorder	64	107	98	19
Panic Attack	88	103	89	21
Hypnotherapy	24	85	101	5
Vocational Assessment	91	71	21	52
Sexual Dysfunction	90	99	82	24
Learning Difficulty	87	84	25	62

Note. Data represent frequencies (n). _ indicates highest frequency for each problem. Because multiple answers were given, totals vary from 100%.

5.356 Professional consulted for specific problem - medical practitioners

Responses from medical practitioners regarding the professional most likely to consult for a series of 20 listed problems, were not as favourable for counsellors as were responses from the general public, with counsellors being ranked the highest for 9 out of the 20 problems. Grief and loss (99) was again the most frequently perceived issue that a counsellor would be consulted for, closely followed by marriage problems (98). Consulting a counsellor for alcohol problems and drug problems was considered preferable by 93 and 92 respondents respectively. Rape was a problem that 85 respondents reported they would prefer to consult with a counsellor about, while 83 respondents thought that stress reduction was an issue that they would be most likely to consult a counsellor for. A further 79 respondents indicated that they would consult a counsellor for sexual abuse and financial difficulties. Vocational assessment was also reported as an issue that a majority of 69 respondents would prefer a counsellor handled.

Similar to the general public, the majority of respondents (92) preferred to consult with a psychiatrist for mental health problems, while 87 reported that they would most likely see a psychiatrist for depression. Both an eating disorder and anxiety were problems that 84 respondents thought that psychiatrists were the preferred health professionals to consult. Eighty-three respondents indicated psychiatrists as their preferred choice to manage panic attacks, and 77 reported they would consult a psychiatrist for phobias. A further majority of 59 respondents indicated that sexual dysfunction was a problem they would prefer to see a psychiatrist about.

Psychologists were rated the highest for managing learning difficulties (83), child behavioural problems (80) and hypnotherapy (70). Social workers were only the preferred choice of the majority in the management of domestic violence (75). Four respondents made the distinction of clinical psychologist in their responses, another four indicated that they would consult a doctor for depression, while 5 respondents also reported that they would consult a doctor for sexual dysfunction, rather than the four listed health professionals. Table 35 on page 198 summarises the frequency response of medical practitioners regarding the professional they would most likely consult for a specific problem.

Table 35

Professional most likely to consult for a specific problem - medical practitioners

Category of problem	Health professional			
	Counsellor	Psychologist	Psychiatrist	Social Worker
Grief & Loss	99	30	15	12
Marriage Problem	98	38	3	23
Alcohol Problem	93	27	25	16
Drug Problem	92	26	28	14
Mental Health Problem	26	42	92	10
Depression	25	49	87	-
Rape	85	53	42	50
Eating Disorder	40	58	84	4
Anxiety	48	64	84	-
Learning Difficulty	38	83	25	4
Stress Reduction	83	62	18	4
Panic Attack	33	68	83	-
Child Behavioural Problem	45	80	53	11
Sexual Abuse	79	51	60	35
Financial Difficulties	79	-	-	67
Phobias	16	69	77	-
Domestic Violence	72	17	10	75
Hypnotherapy	12	70	50	-
Vocational Assessment	69	64	-	8
Sexual Dysfunction	41	55	59	-

Note. Data represent frequencies (n). _ indicates highest frequency for each problem. Because multiple answers were given, totals vary from 100%.

5.357 Treatment provided by health professionals

5.357.1 Counsellor - general public

Responses regarding the perceived treatment provided by counsellors for problems were diverse. There were missing data from 30% of questionnaires returned from this sample. One respondent reported that they did not know what treatment counsellors provided, while another respondent indicated that there were too many open questions in the survey. Of those who recorded answers to this question, 46.9% indicated that they believed counsellors provided listening, clarification and identification of problems. A further 34.1% perceived that providing options and strategies was a major treatment of counsellors, while 14.2% reported that they thought counsellors referred to other health professionals and self-help groups. Support was listed as a treatment option by 12.8% and 11.5% believed counsellors provided therapy and mediation. Other treatments that were mentioned by respondents included empathy (9.7%), empowering client to self-help (6.6%), education and guidance (5.3%) and group therapy (3.5%).

5.357.2 Counsellor - medical practitioners

There were no missing data from the medical practitioners. Similar to the general public, the majority of medical practitioners (81%) recorded listening, clarification and identification of problems as the major treatment provided by counsellors. Support was thought to be a treatment provided by 66.7% of respondents and just over half of the respondents (50.5%) believed counsellors provided therapy and mediation. An additional 41.9% reported problem solving, 38.1% stated providing options, strategies and advice as a major treatment and 35.2% thought that empathy and

empowering clients to self-help were integral counselling treatments. Group work and behaviour modification were both treatments mentioned by 27.6% and cognitive behaviour therapy was perceived as a counselling treatment by a further 16.2%. Other treatments nominated by respondents included education and guidance (8.6%), goal setting (4.8%) and one respondent thought that referral was a treatment provided by counsellors. Table 36 on page 201 outlines the responses from the general public and medical practitioners regarding their perception of treatment provided by counsellors.

Table 36

Treatment provided by a counsellor - general public and medical practitioners

Treatment Categories	General Public n	General Public Percentage	Medical Practitioners n	Medical Practitioners Percentage
Listen and clarify to identify problems	106	46.9	85	81.0
Provides options and strategies	77	34.1	40	38.1
Referral	32	14.2	1	1.0
Support	29	12.8	70	66.7
Behaviour Modification	-	-	29	27.6
Therapy & Mediation	26	11.5	53	50.5
Empathy	22	9.7	37	35.2
Cognitive Behaviour Therapy	-	-	17	16.2
Empowers client to self-help	15	6.6	37	35.2
Education & guidance	12	5.3	9	8.6
Group Therapy	8	3.5	29	27.6
Goal Setting	-	-	5	4.8

Note. Data indicate response percentages and frequencies (n). Because multiple answers were given totals vary from 100%. General public N = 226. Medical Practitioners N = 105.

5.357.3 Psychologist - general public

Similar to responses regarding treatment provided by counsellors, there were missing data (37%) from the general public in relation to what treatment they believed a psychologist provided. Some respondents indicated that they did not know or "had no idea," while others simply left the section blank. The most frequently listed treatment option by the remaining respondents was providing analysis (31.9%) and 28.8% reported providing options and strategies as a treatment they thought psychologists provided. A further 14.6% thought listening was provided by psychologists, while 9.6% of respondents thought that psychologists educated clients to achieve solutions. Providing medication, referrals, hypnotherapy, testing and behaviour therapy were other treatments reported by respondents.

5.357.4 Psychologist - medical practitioners

Again there were no missing data from medical practitioners, although some respondents wrote "as above," indicating that they believed that counsellors and psychologists provided the same treatment options. Behaviour modification was the most frequently recorded response 49.5% and testing was the next most frequently listed treatment (41%) believed to be provided by psychologists. Psychologists were thought to provide listening by 33.3% of respondents, analysis by 19% and therapy by 13.3%. Providing options, strategies and advice was listed by 12.4% of respondents while 11.4% thought that psychologists delivered specific treatment programmes for various issues such as phobias and were professionals who were empathic towards their clients. Educating clients to find solutions was further listed by 8.6% of respondents as

a treatment provided by psychologists. Table 37 outlines the different responses of the general public and medical practitioners regarding psychologist's treatment options.

Table 37

Treatment provided by a psychologist - general public and medical practitioners

Treatment Categories	General Public n	General Public Percentage	Medical Practitioners n	Medical Practitioners Percentage
Behaviour Modification	-	-	52	49.5
Testing	9	4.0	43	41.0
Listening	33	14.6	35	33.3
Analysis	72	31.9	20	19.0
Provides options strategies and advice	65	28.8	13	12.4
Therapy	-	-	14	13.3
Specific treatment Programmes	-	-	12	11.4
Empathy	-	-	12	11.4
Education for solution	22	9.6	9	8.6
Medicates	16	7.1	-	-
Provides referral	14	6.2	-	-
Hypnotherapy	10	4.4	-	-
Behaviour Therapy	5	2.2	-	-

Note. Data indicate response percentages and frequencies (n). Because multiple answers were given totals vary from 100%. General public N = 226. Medical Practitioners N = 105.

5.357.5 Psychiatrist - general public

Again missing data were apparent from the general public (35%), with respondents indicating that they didn't know. Of those who did provide a response, 37.2% indicated medication as the primary treatment provided by psychiatrists. A further 29.2% listed psychoanalysis and 13.7% of respondents thought that psychiatrists provided clients with options. Listening accounted for 6.2% of responses, 5.3% stated hospitalisation, while 3.1% believed hypnosis was a psychiatric treatment.

5.357.6 Psychiatrist - medical practitioners

As shown in table 38, medication was clearly the most frequently listed treatment considered to be provided by psychiatrists by both the general public and medical practitioners with ninety-nine percent of medical practitioners nominating this treatment. Another 48.6% believed that psychiatrists provided psychoanalysis and cognitive therapy. Behaviour modification was recorded by 29.5% of respondents and 26.7% indicated that psychiatrists were involved in hospitalising patients when necessary. Other treatments that psychiatrists were thought to deliver included providing options, strategies and support (15.2%), listening (14.3%) and tests were listed by 4.8% of respondents. One respondent, rather than writing the treatments provided by psychiatrists, stated that psychiatrists were "highly trained clinicians." The responses of the general public and medical practitioners regarding the above-mentioned treatment options provided by psychiatrists are outlined in table 38.

Table 38

Treatment provided by a psychiatrist - general public and medical practitioners

Treatment Categories	General Public n	General Public Percentage	Medical Practitioners n	Medical Practitioners Percentage
Medicates	84	37.2	104	99.0
Psychoanalysis	66	29.2	51	48.6
Cognitive Therapy	-	-	51	48.6
Behaviour modification	-	-	31	29.5
Hospitalisation	12	5.3	28	26.7
Provides options strategies and advice	65	28.8	13	12.4
Listening	14	6.2	15	14.3
Testing	-	-	5	4.8
Hypnotherapy	7	3.1	-	-
Highly trained clinician	-	-	1	1.0

Note. Data indicate response percentages and frequencies (n). Because multiple answers were given totals vary from 100%. General public N = 226. Medical Practitioners N = 105.

5.357.7 Social Worker - general public

As was the case for the other responses from the general public regarding treatment provided by health professionals, there were missing data from 38% of respondents as to the treatment provided by social workers. Providing referrals to other health professionals, community agencies and self-help groups was the treatment most frequently listed as given by social workers (27.0%). Nineteen percent of respondents thought that social workers provided listening as a treatment, while 17.3% indicated providing options, strategies and advice, and practical assistance as treatment options. Social workers were also thought to provide child, family and social welfare by 9.7% of respondents and support by 9.3%. Education and guidance was recorded by 4.4% of respondents, while liaison with other agencies and professionals was nominated as a treatment performed by social workers by 4.0%. Eight respondents (3.5%) indicated that they did not believe that social workers provided any helpful treatment and 1.3% thought that social workers did home visits.

5.357.8 Social Worker - medical practitioners

Similar to the general public, medical practitioners recorded 'referral' as the primary treatment provided by social workers (49.5%). Practical assistance was listed by 44.8% and 34.3% believed social workers liased with other health professionals and community agencies. Twenty percent of respondents indicated support as a treatment option, while 18.1% stated that social workers provided options, strategies and advice. An additional 11.4% of respondents nominated listening as a treatment. Other listed treatments provided by social workers included problem solving (2.9%), home visits (1.9%) and education and guidance (1.0%). Table 39 summarises the responses of the

general public and medical practitioners regarding the treatment perceived to be provided by social workers

Table 39

Treatment provided by a social worker - general public and medical practitioners

Treatment Categories	General Public n	General Public Percentage	Medical Practitioners n	Medical Practitioners Percentage
Referral	61	27.0	52	49.5
Practical Assistance	39	17.3	47	44.8
Liaison with other professionals	9	4.0	36	34.3
Support	21	9.3	21	20.0
Listening	43	19.0	12	11.4
Provides options strategies and advice	39	17.3	19	18.1
Provide child, family and social welfare	22	9.7	-	-
Education & guidance	10	4.4	1	1.0
No helpful treatment	8	3.5	-	-
Problem Solving	-	-	3	2.9
Home Visits	3	1.3	2	1.9

Note. Data indicate response percentages and frequencies (n). Because multiple answers were given totals vary from 100%. General public N = 226. Medical Practitioners N = 105.

5.36 Medical practitioners only

The remaining items of the questionnaire were answered by medical practitioners only. The associated response rates are summarised in the following text and outlined in tables 40, 41 and 42.

5.361 Patient Referral

All of the 105 respondents indicated that they would consider referring a patient to a counsellor.

5.362 Referral of patient with difficulty accepting diagnosis

Although 100% of respondents had recorded that they would consider referring a patient to a counsellor, almost one third indicated that they would not refer a patient to a counsellor for assistance in accepting a specific health problem. Respondents who stated that they would refer a patient under the above-mentioned circumstances accounted for 68.6% of responses. Of the remaining 31.4% of respondents, 21.9% indicated that they would deal with the issue themselves. A further 5.7% stated that they would refer the patient to a specialist and 2.9% suggested that the reason they would not refer a patient experiencing difficulty in accepting a specific health problem to a counsellor was due to the lack of health training of counsellors. One respondent mentioned the cost of counselling as the reason for his reluctance to refer to a counsellor. Table 40 demonstrates the response rates regarding the referral of a patient to a counsellor for assistance in accepting a medical diagnosis.

Table 40

Responses for referral of patient with difficulty accepting a specific health problem

Responses	n	Percentage
Yes	72	68.6
No	33	31.4
Why not		
Deal with by self	23	21.9
Refer to specialist	6	5.7
No health training	3	2.9
Cost	1	0.9

Note. Data represent frequencies (n) and percentage responses. N = 105.

5.363 Counsellors employed, potential employment & counsellors in hospitals

Only 8 of the 105 (7.6%) respondents stated that they currently had a counsellor employed in their medical practice. However, of some encouragement to counsellors, 73 of the respondents (69.5%) indicated that they would consider having a counsellor working as a team member of their practice. Some respondents did underline the word 'consider' when recording their answer, suggesting that they were not committed to their affirmative response. A further positive indicator for counsellors was the return of 99 responses (94.3%) indicating a belief that counsellors were beneficial within a hospital setting. The response rates described above are summarised in table 41.

Table 41

Counsellors employed, potential employment and value of counsellor in hospitals

Responses	n	Percentage
Do you currently have a counsellor in the practice in which you are employed		
Yes	8	7.6
No	97	92.4
Would you consider employing a counsellor to work as a team member in your practice		
Yes	73	69.5
No	32	30.5
In a hospital setting would you consider it beneficial to have a counsellor on staff		
Yes	99	94.3
No	6	5.7

Note. Data represent frequencies (n) and percentage responses. N = 105

5.364 Professionals respondents would refer a patient to for problems

The overall rating for counsellors regarding the respondents preferred professional to refer a patient to for a series of 20 problems was the same as the overall responses from this sample regarding their preferred professional to consult for themselves. Counsellors were rated as the most likely professionals to refer a patient to for 9 of the 20 problems. Respondents frequently indicated more than one professional as likely to be the recipient of a patient referral. The statistics reported in the following text reflect the majority of responses given. A marriage problem was the most

frequently nominated issue by respondents (102) for referring a patient to a counsellor, while 98 indicated that they would refer a patient to a counsellor for grief and loss, a drug problem and an alcohol problem. A further 89 respondents believed a counsellor would be beneficial to refer a patient to for both domestic violence issues and sexual abuse. Additionally, rape and stress reduction were problems that 88 respondents indicated they would refer to a counsellor and 84 preferred a counsellor for referral for financial difficulties. Not surprisingly, psychiatrists were the preferred professional group for a mental health problem (99), depression (98), anxiety (93), panic attacks (89), an eating disorder (88) and phobias (87). Sexual dysfunction was also a problem that a majority of respondents (60) indicated that they would refer a patient to a psychiatrist for. Eighty-seven respondents preferred to refer to a psychologist for child behavioural problems and 86 indicated that they would refer to a psychologist for learning difficulties. Vocational assessment was another problem that 76 respondents rated psychologists as being the profession most likely to refer to, while 70 believed the same about hypnotherapy. Social workers were not the preferred profession to refer a patient to for any of the listed problems, although they were rated second to counsellors for domestic violence issues (79) and financial difficulties (78). The number of responses for each professional regarding the respondents preference for patient referral for 20 listed problems is summarised in table 42.

Table 42

Professional most likely to refer a patient for a specific problem

Category of problem	Health professional			
	Counsellor	Psychologist	Psychiatrist	Social Worker
Marriage Problem	102	58	3	26
Mental Health Problem	23	48	99	5
Grief & Loss	98	45	29	13
Alcohol Problem	98	29	28	15
Drug Problem	98	27	29	14
Depression	30	67	98	-
Anxiety	47	78	93	4
Domestic Violence	89	24	8	79
Sexual Abuse	89	58	67	44
Panic Attack	36	78	89	-
Eating Disorder	47	69	88	8
Rape	88	66	54	52
Stress Reduction	83	62	18	4
Phobias	27	75	87	-
Child Behavioural Problem	42	87	60	17
Learning Difficulty	39	86	33	7
Financial Difficulties	84	2	-	78
Vocational Assessment	71	76	-	3
Hypnotherapy	17	70	54	-
Sexual Dysfunction	45	57	60	-

Note. Data represent frequencies (n). _ indicates highest frequency for each problem.

5.37 Differences between the general public and medical practitioners

Some of the results reflected similar perceptions and knowledge of counsellors of the general public and the medical practitioners. However, other results demonstrated substantial differences in opinions. Figures two to eight summarise these differences of perceptions. The results each figure pertains to are as follows:

Figure 2 on page 214 reflects the differences between the general public and medical practitioners regarding the counsellors known by each respective sample.

Figure 3 on page 215 summarises the percentage of the general public who had been recipients of counselling versus the medical practitioners who had received counselling.

Figure 4 on page 216 corresponds with question six of the questionnaire, which asked if respondents had a preference of gender when choosing a counsellor. Again data are comparative between the general public and medical practitioners.

Figure 5 on page 217 demonstrates the differences between the general public and medical practitioners regarding the willingness to pay to see a counsellor.

The nominated fees ($25, $50, $75 or $100) that the general public and medical practitioners reported they would pay for a 50 - minute counselling consultation is summarised in figure 6 on page 218.

The different responses between the general public and medical practitioners regarding the question of whether or not counselling fees should be covered by Medicare, is highlighted in figure 7 on page 219.

Figure 8 on page 220 compares the preferred professional that the general public and medical practitioners reported they would recommend to a friend.

CHAPTER SIX

Discussion – Study I

6.1 Introduction

The results of study one reflected the knowledge of and attitudes toward counsellors recorded by a cross section of the general public and medical practitioners on the Gold coast and in northern New South Wales. An overview of these results, plus a discussion regarding the correlation between the issues raised from the literature review and the reported findings from the current survey and the purpose and rationale for study two, will be discussed in this chapter.

6.2 Summary of results

From the data collected, it was apparent that the reported public confusion and misinformation about the counselling profession from the study conducted by Rogers and Sharpley (1983) was not reflected in the present study. According to the results of the present study, the perception of counsellors as "giving advice to people" (Rogers & Sharpley, 1983, p. 322), has been replaced with the more accurate belief that counsellors are primarily engaged in activities such as listening, providing support and problem solving. Further evidence to support an increased knowledge of counsellors by respondents in the present study was the two-thirds of the general public and almost all of the medical practitioners who indicated that they knew of a counsellor. The three most frequently reported workplace areas for counsellors were community health centres, private practices and educational institutions, again indicating an increased awareness of respondents from this survey regarding the nature of the work performed by counsellors and where they can be located. Thus, the general public and medical

practitioners who participated in this survey reported a greater knowledge of the activities and roles of counsellors than the respondents of previous studies (McCully, 1961; Krauskopf, Thoreson & McAleer, 1973; Williams, 1978; Khan, 1983; Rogers & Sharpley, 1983; Rogers, Sharpley & Evans, 1984; and Drever, 1999).

Although only approximately half of respondents from the general public had personally consulted a counsellor, and almost all of the medical practitioners had not personally experienced counselling, the majority from both samples indicated that they would be prepared to consider accessing a counsellor if the need arose. Hence, a perceived value in the nature of counselling in times of need was suggested by this result. The value of counselling was further reinforced with most of the respondents from the general public and the medical practitioners indicating that they believed that there was a need for more counsellors in the community. Therefore, the need for counsellors suggested in the literature reviewed was mirrored by the data collected from this study. However, this result may also suggest a difficulty in accessing already existing counsellors.

The gender of the counsellor was not reported as an issue for the majority of the respondents from both samples. However, there were indications from a few responses that the nature of the problem for which counselling was sought may influence the preferred gender of the counsellor.

The benefits of counselling listed by respondents were numerous, with the most frequently reported response by the general public being personal benefit, and having an impartial person to listen. Both samples reported a high response rate for listing benefits of counselling as including receiving support, clarification of issues and

problem solving. Again, the shift in perceptions away from the previous data that indicated counsellors being advice-givers was reflected in the reported benefits of receiving counselling, with receiving advice/guidance being listed as an advantage of receiving counselling by only a few respondents.

The most frequently recorded drawback of counselling reported by the general public was personal issues, which included issues such as the trauma of reliving painful experiences, where to find a counsellor, time required and the possibility that counselling may not help, whereas counsellor competency was the main concern for medical practitioners. Inadequate training and registration, counsellor bias, little life experience and lack of empathy were reported concerns of the general public regarding the competency of the counsellor. The cost of counselling and forming dependencies on the counsellor were also reported drawbacks of counselling by both samples. These results correlate with the reported preferred choice of counsellor training from the general public and the medical practitioners. Both samples clearly indicated by consensus that a counsellor with tertiary qualifications and personal life experience was considered the most beneficial and valuable. In contrast to the lack of clarity and uniformity regarding the issues of counsellor expertise and training evident in the previous literature reviewed, the respondents from this survey were clear about what education and training they believed a counsellor should have.

Similarly, regarding the issue of counsellor registration, the majority of respondents from both samples clearly indicated that they believed that counsellors should be registered members of a government-approved association. Although the percentages were lower, a majority of respondents indicated that they believed that

counsellors were just as professional as psychologists, psychiatrists and social workers. Some respondents from the medical practitioners qualified their answer by writing that the considered professionalism of the counsellor would depend on the qualifications of the counsellor.

The perceptions of the general public regarding the approachability of counsellors socially and professionally were consistently above average, reflecting a positive attitude of the general public toward counsellors. However, while the medical practitioners recorded a high degree of comfort when relating to a counsellor in a social setting, the degree of comfort dropped to average when consulting a counsellor for personal problems or according to the value they thought a counsellor would be in helping with personal problems.

The problems most frequently listed as issues that counsellors should be trained to deal with included relationship problems, all problems, addictions, and grief and loss. Perhaps the variety of problems listed by respondents indicates that the respondents of this survey were not any clearer about the problems dealt with by counsellors than respondents from previous studies by McCully (1961), Krauskopf, Thoreson and McAleer (1973), Williams (1978), Khan (1983), Rogers and Sharpley (1983), Rogers, Sharpley and Evans (1984) and Drever (1999).

When seeking access to a counsellor, the person nominated by the general public and medical practitioners as the most likely source of referral to a counsellor was a doctor. The organisation indicated as the most likely to be contacted for assistance in finding a counsellor by both samples was community services. The advertising sources that respondents indicated that they would read to find a counsellor

were the telephone book and a medical directory. These results regarding the accessibility of counsellors will be the foundation for study II.

The majority of all respondents indicated that they would be prepared to pay for a 50-minute counselling session, with $50 being the most popular fee nominated by both representative samples. This result demonstrated a marked increase in the percentage of respondents prepared to pay for counselling in this survey compared to the survey by Rogers and Sharpley (1983). Furthermore, the amount respondents were prepared to pay in the current study was almost double the amount respondents were prepared to pay from the Rogers and Sharpley (1983) study. This also reiterates the positive attitude towards counsellors, and the value placed on counselling services, by the general public and the medical profession.

The related issue of whether or not counselling fees should be covered by a Medicare rebate found contrasting responses between the general public and medical practitioners. An overwhelming affirmative response (92.5%) from the general public indicated that perceptions have changed from those reported in previous literature (Sharpley, 1986), in which the issue of Medicare rebate for counselling fees was contentious. However, the responses from the medical practitioners were divided, with the slight majority believing that Medicare should not cover counselling fees.

Results from this study further indicated that the confusion that was reported in the last Australian study that focused on comparing perceptions and knowledge of counsellors, psychologists, psychiatrists and social workers (Sharpley, 1986), had greatly diminished. The reported ability of the general public to communicate in a therapeutic relationship with each of the four health professionals favoured counsellors

followed by psychologists and social workers. Psychiatrists were reported as the profession the general public felt the least able to communicate with in a therapeutic relationship. However, the medical practitioners indicated that they believed that they would feel most comfortable communicating with a psychiatrist in a therapeutic relationship. Psychologists and counsellors were rated next and social workers were the professionals that medical practitioners stated they felt the least comfortable with in a therapeutic relationship.

The professional that both samples indicated that they would recommend to a friend in need of help was a counsellor. This suggests some incongruence in responses from the medical practitioners. It would appear that they would feel most comfortable personally with a psychiatrist in a therapeutic relationship, but would refer a friend of theirs in need of help to a counsellor.

Further favourable results for counsellors were shown from the data collected from the general public regarding which of the four health professionals they would most likely consult for a series of problems. The majority of respondents indicated that they would consult with a counsellor for 13 out of the 20 listed problems. Results from the medical practitioners remained favourable to counsellors with respondents indicating that they would consult with a counsellor for 9 of the 20 listed problems, although the preference was only marginally higher for counsellors than for psychiatrists.

Perceptions of what treatments were provided by counsellors from the general public and medical practitioners included listening, clarification and identification of problems, support and therapy and mediation. Providing analysis was the treatment

option most frequently reported by the general public as pertaining to psychologists, while medical practitioners recorded behaviour modification and psychological testing as treatments they believed psychologists performed. Psychiatrists were perceived to be associated with the medical model, with the majority of respondents from both samples listing medication and psychoanalysis as the main treatments provided by psychiatrists. This perception is similar to the findings of Thumin and Zebelman (1967) regarding the association of psychiatry to the medical model. However, medical practitioners from the current study also included cognitive therapy as a treatment most likely used by psychiatrists. As found by Sharpley (1986), social workers remained as the health professionals perceived by respondents as providing practical assistance in the current study. Providing referrals to other health professionals and community agencies was the treatment most frequently listed as being provided by a social worker. Therefore, greater clarity was apparent amongst the respondents of the current study regarding the perceived roles of counsellors comparative to social workers, psychologists and psychiatrists, than was evident from the results of previous studies in the literature review. A few of the general public reported that they were confused as to the differences between psychiatrists and psychologists and this was reflected by responses that recorded medication as a treatment provided by psychologists. However, those who did respond to the question of what treatments each health professional provided were reasonably accurate and demonstrated an ability to differentiate between counsellors, psychiatrists, psychologists and social workers. All of the medical practitioners reported knowledge and clarity of the four health professionals.

The items of the questionnaire that were answered by the medical practitioners only returned results of further encouragement to counsellors. One hundred percent of respondents indicated that they would consider referring a patient to a counsellor, although one-third of respondents reported that they would not refer a patient that was experiencing difficulty accepting a diagnosis to a counsellor, mainly because they would prefer to handle the problem themselves. While there were very few respondents who reported currently having a counsellor in the medical practice where they were employed, the majority indicated that they would be prepared to consider employing a counsellor as a team member in their practice. Additionally, there was an overwhelming affirmative response regarding the considered value and benefit of having a counsellor on staff in a hospital setting. Consistent with their responses to the problems they would personally consult a counsellor for, the medical practitioners indicated that they would refer a patient to a counsellor for 9 out of the 20 listed problems, with psychiatrists again rating a close second.

6.3 Limitations of the study

Possible limitations of the current study include the confinement of the demographic area to the Gold Coast and Northern New South Wales region. Furthermore, the substantially higher ratio of females (n = 150) to males (n = 76) in the sample of the general public, may be a possible limitation, as could the relatively small number of medical practitioners surveyed. (n = 105).

6.4 Recommendations for future research

Future research could address the above-mentioned limitations and explore a wider demographic region. There is potential for a survey of capital cities throughout

Australia to determine a national perception and knowledge of counsellors and to compare data between the States. Additionally, future research could attempt to collect a more balanced ratio of males and females as a representative sample. Also, when targeting a specific group as a representative sample (such as medical practitioners), future studies could be mindful of the length of any questionnaires used and determine whether the time being asked of respondents to complete the questionnaires is a realistic request.

6.5 Purpose and rationale for study II

Study II was designed to investigate whether or not the perceptions and beliefs of respondents from study I were accurate regarding the *accessibility* of counsellors. From study I (p. 181 - 184), respondents indicated that they believed they could most readily access a counsellor from:

1. A doctor.
2. A community health organisation.
3. The telephone book.
4. Medical directory.

Study II sought to determine if counsellors could be readily accessed from the above-mentioned sources and addressed the issues of the qualifications of the potential counsellor, the fees charged, rebates available, and experience in the field.

CHAPTER 7

Method – Study II

7.1 Introduction

The development of the questionnaire, the materials used in the study and the collection of the data will be outlined in this chapter. Additionally, a brief description of each questionnaire item will be included.

7.2 Representative samples

Study II involved three samples. The first included 60 randomly selected medical surgeries listed in the Gold Coast region and Northern New South Wales telephone book. A further sample of 25 counsellors listed in the yellow pages of the telephone book was also included in Study II. The third sample included 6 community agencies on the Gold Coast and Northern New South Wales, also listed in the yellow pages telephone directory.

7.3 Materials

Two questionnaires were the materials used for study II. They were designed from the results collated from Study I regarding the perceptions of the general public and medical practitioners about the availability and accessibility of counsellors.

Both questionnaires sought to determine the accuracy of the *reported sources* that participants from study I indicated were the places that counsellors could be accessed. The questionnaires were further designed to determine the *cost of counselling* and the *qualifications and experience of counsellors*.

The first questionnaire included eight open and closed questions designed for the medical practices and community agencies, with an additional question being added

for the medical practices only. The second questionnaire comprised five open and closed questions and was designed for counsellors in the telephone directory.

7.4 Procedure

Data were collected by way of telephone interviews with participants of all three samples. Sample one included 60 receptionists working in medical practices. The receptionists were the identified respondents for sample one, as they would be the first point of contact for anybody seeking a counsellor through their local doctor. Sample two comprised of 25 counsellors and sample three included 6 community agencies.

7.5 Development of the questionnaire

The questionnaire was designed by the researcher and the research supervisor. The items included were developed from the results of study I.

7.51 Questionnaire items

7.51.1 First questionnaire

Question 1 sought to determine whether medical practices and community centres *had a counsellor working with them*. This question required a yes or no response. If there was not a counsellor working in the environment of those surveyed, a further question asked respondents if they knew *where a counsellor could be accessed*. Where respondents indicated that a counsellor was working within the facility, question three was designed to determine *how that counsellor could be accessed*. Questions 4 to 8 sought to establish *the waiting time* to see a counsellor, *the cost* of seeing a counsellor, whether or not consultation with the counsellor was *covered by health insurance*, *the qualifications of the counsellor* and *the experience of*

the counsellor. The purpose of question 9 was to determine whether or not *a medical directory* existed in the medical practices surveyed, which provided lists of practicing counsellors and their contact numbers. A copy of the questionnaire appears in Appendix D.

7.51.2 Second questionnaire

The five items in the second questionnaire sought to determine the *waiting time*, *cost*, *health insurance cover*, *qualifications* and *experience* of counsellors that were in the telephone directory. A copy of this questionnaire appears in Appendix E.

7.6 Ethical approval

The Bond University Human Subjects Research Committee (BUHREC) approved the method and procedures of Study II in February, 2000.

CHAPTER EIGHT

Results - Study II

8.1 Introduction

This chapter reports the findings of data collected from the two questionnaires regarding the accessibility and availability of counsellors working in medical practices, community centres and listed in the telephone directory on the Gold Coast and Northern New South Wales. Data regarding the cost of counselling and the qualifications and experience of counsellors have also been reported. The data were collected during the period of January to March, 2003.

8.2 Availability of counsellors in medical practices

As demonstrated by table 43 below, only 20% of medical practices surveyed had a counsellor working from the premises. Of those who did report having a counsellor employed, four of the medical practices employed the same counsellor, who was available one day per week at each practice.

Table 43

Counsellors accessible in medical practices

Counsellors	n	Percentage
Yes	10	16.7
No	50	83.3

Note: Data indicate response percentages and frequencies (n). N = 60

8.3 How medical practices accessed a counsellor

Of the 50 medical practices that did not have a counsellor working for them, 20 (40%) recommended looking in the phone book for a counsellor, while 12 (24%) referred the researcher to Lifeline. A further 10 (20%) suggested making an appointment to see the doctor and 8 (16%) thought that a community health centre would be helpful in finding a counsellor. Those who recommended seeing a doctor from the medical practice indicated that a referral to a counsellor was necessary from the doctor, or alternatively the doctors themselves often did their own counselling. Table 44 summarises the responses of medical receptionists regarding where a counsellor could be accessed in lieu of the absence of one working in the medical practice.

Table 44

Medical practices referral source to find a counsellor

Location	n	Percentage
Telephone Book	20	40
Lifeline	12	24
Medical Practitioner	10	20
Community Health	8	16

Note: Data indicate response percentages and frequencies (n). N = 50

8.4 Information about counsellors working in medical practices

Of the 10 medical practices that indicated that they had a counsellor working for them, four were able to give an approximate waiting time of one to four days to consult with the counsellor. A further four reported that it would depend on how busy the counsellor was on the day they attended the surgery, and that the counsellor would make contact to provide an appointment time. One surgery could not give any indication of the waiting time to see the counsellor and stated that the counsellor themselves would be in contact with those details. The other medical practice suggested that an appointment would need to be made initially with a doctor from the practice to get a referral to see the counsellor.

The cost of consulting with a counsellor ranged from $50 per hour to $100 per hour with only one counsellor offering health insurance cover. The counsellors consulting from two of the medical practices had psychology qualifications and it was one of these clinicians that had health insurance cover. The remaining counsellors had either a diploma in counselling or a bachelor of counselling and two clinicians had both a diploma of counselling and a diploma of psychotherapy. The experience of the counsellors ranged from 5 to 19 years. Table 45 outlines the information gathered about the counsellors who consulted in medical practices.

Table 45

Information about counsellors allied with medical practices

Health Insurance Cover	Qualifications/ Profession	Waiting Time	Cost per hour	Experience
No	Dip Psychotherapy Dip Counselling	1 Day	$60	10 Years
Yes	B Arts Psychology (Honours)	4 Days	$100	7 Years
No	Dip Psychotherapy Dip. Counselling	-	$60	15 Years
No	B Counselling	Depends	$50	5 Years
No	B Counselling	Depends	$50	5 Years
No	B Counselling	Depends	$50	5 Years
No	B Counselling	Depends	$50	5 Years
No	Psychologist	Receptionist said to get referral from doctor		
No	Dip Counselling	3 Days	$60	12 Years
No	B Counselling	4 Days	$80	19 Years

8.5 Accessibility of counsellors in community centres

Accessing a counsellor in the community health centres that were listed in the Yellow Pages of the Gold Coast Telephone Directory (Tweed Heads Community Health Centre, Palm Beach Community Health Centre and Bundall Community Health Centre) involved waiting for an intake officer to return the phone call. This usually took one or two days. The intake officer then collected brief details and referred to another counsellor from an appropriate discipline such as child and family services, sexual assault services, drug and alcohol services, depending on the nature of the counselling required. The counsellor from the specific discipline could take up to a week to return the phone call with an appointment time in two or three weeks. When Kingscliff Community Health Centre and Murwillumbah Community Health Centre were contacted, the researcher was referred to the intake officer in Tweed Heads Community Health Centre. Bethel Community Centre was also listed in the yellow pages of the telephone directory. However, that centre advised that no counsellors were available for consultation and that they only ran workshops. If individual counselling was required they referred to Lifeline.

There was no cost involved in consulting with any of the counsellors from the community health centres. However, the qualifications of the counsellors employed in these organisations and their years of experience were unknown by the receptionists and the intake officer. It was not until the counsellor themselves contacted the researcher that this information could be determined. Many of the clinicians who were employed as counsellors were either psychologists or social workers, a few had counselling degrees, and some had no formal qualifications. All of the clinicians who

were contacted had at least 5 years of working experience, and some had up to 25 years of practical experience.

8.6 Information about counsellors in the telephone book

Under the heading 'counsellors' in the yellow pages there were 24 listed psychologists, two life coaches, a counselling phone line costing $3.30 per minute and an advertisement for a Diploma of Counselling with the Australia Institute of Professional Counsellors. Additionally, a variety of counselling organisations were listed that included the following: Lifeline, Sexual Assault Support, Break-Thru Communications, Relationships Australia, Gold Coast Gestalt Centre, Centacare, Australian Association of Marriage and Family Counsellors, Compassion Connection, Interrelate, New Life Care Inc., Broadbeach Counselling Centre, Affinity Counselling Centre, Change Alliance, Conflict Resolutions, Stillbirth and Neonatal Death Support, The Human Response Centre, The Chesterfield Centre for Counselling, Professional Counselling and Consulting Centre, Vietnam Vets Counselling, Marriage Guidance Qld., Marriages made in Heaven, Gold Coast Centre of Counselling and Psychology.

Some of the remaining names in the telephone book had telephone numbers that had been disconnected, with those that were current numbers for individuals totalling 25. Of the 25 names contacted, ten were psychologists. All of these clinicians stated that they were available for a counselling consultation within a week, except for one who had a waiting time of two to three weeks for an appointment. This waiting time may be attributed to the low fees payable for a consultation, ranging between $5 and $20, depending on the income of the person seeking counselling. The fees charged by the other psychologists ranged from $50 to $125. The reported years of experience

varied from one year to 22 years, with one psychologist stating they had "between five and thirteen years" experience.

Another individual listed as a counsellor in the telephone book had two social work degrees and 25 years experience. The reported waiting time for a consultation was one day and the cost per hour was $80.

Ten of the people contacted actually had counselling qualifications and one of these was an addictions counsellor and gestalt therapist. Of the remaining nine, four had "diplomas of counselling," three had a "bachelor of counselling" and one individual had a "master of counselling degree." One of the counsellors with a diploma was also a registered nurse and had a "master of hypnotherapy degree." The waiting time for the counsellors ranged from one or two days to two or three weeks. The fees payable for a counselling consultation were $45, $40 to $60, $50, $55, $66, $70, $80 and $85 respectively, while two counsellors charged $90 per hour. Similar to the counselling psychologists, the experience of the counsellors widely ranged from three to 30 years.

Three of the remaining four individuals listed as counsellors had the following qualifications: "masters degree in mental health," "masters degree in family therapy and hypnotherapy/psychotherapy." The receptionist for the remaining individual was unable to give the qualifications or experience of the 'counsellor' and stated that there was approximately one week to wait for an appointment and the fee would be $55 per hour. The mental health worker could offer an appointment the following day, charged $70 per hour for employed clients and $50 per hour for unemployed clients and had 20 years experience. The family therapist had 21 years experience and had an

appointment time after one day for $100 per hour. The hypnotherapist/ psychotherapist reported a waiting time of one week for an appointment and had 17 years experience. Tables 46, 47, and 48 summarise the data collected from the listing of counsellors in the telephone directory.

Table 46

Counsellors listed in the yellow pages with psychology and social work qualifications

Health Insurance	Qualifications/ Profession	Waiting Time	Cost per hour	Experience
No	B. Psych	2 Days	$125	22 Years
*Yes	Clinical Psychologist	1 Week	$95	16 Years
*Yes	BA (Psychology)	1 Week	$100	Unknown
No	Psychologist Social Worker	2 to 3 Weeks	$5 - $20 Depending on income	4 Years
Yes	Psychologist	1 to 3 Days	$100	Unknown
Yes	BA Psychology	1 to 7 Days	$50	5 Years
*Yes	Psychologist	4 Days	$80	10 Years
*Yes	Psychologist	5 Days	$70	20 Years
No	BA (Social Science) Psychologist	1 Day	$85	1 Year
Yes	Psychologist	2 Days	$90	5-13 Years
*Yes	Mstrs Social Work BA (Social Work) PACFA Member	1 Day	$80	25 Years

Note: * represents ultimate health cover required to receive benefits.

Table 47

Counsellors listed in the yellow pages with counselling qualifications

Health Insurance	Qualifications/ Profession	Waiting Time	Cost per hour	Experience
No	Certified Addiction Counsellor Gestalt Therapist	2 Weeks	$70	8 Years
No	R.N. Dip Counselling Mstrs Hypnotherapy	3 Days	$66	3 Years
No	Dip Counselling	3 Days	$45	7 Years
*Yes	Dip Counselling	1 Week	$55	4 Years
*Yes	BA Counselling	2 Weeks	$90	19 Years
*Yes	BA Counselling	1 Week	$85	7 Years
No	Dip Professional Counselling Dip Relationship Counselling Runs centre for men affected by sexual abuse	1 Week	$40-$60	5 Years
*Yes	BA Counselling Hons	3 Days	$90	21 Years
No	Mstrs Counselling	2 Weeks	$50	27-30 Years
No	Dip Counselling	1 Week	$80	10-15 Years

Note: * represents ultimate health cover required to receive benefits.

Table 48

Counsellors listed in the yellow pages with other reported qualifications

Health Insurance	Qualifications/ Profession	Waiting Time	Cost per hour	Experience
No	Masters Degree Mental Health	Tomorrow	$70 employed $50 unemployed	20 Years
No	Mstr Family Therapy	1 Day	$100	21 Years
No	Hypnotherapist Psychotherapist	1 Week	$105	17 Years
Yes	Unknown	1 Week	$55	Unknown

8.7 Medical Directory Results

The demographic region covered in Study II included two General Practice Divisions. The Tweed Valley Division of General Practice had a resource entitled *Health Services Directory.* This directory included a section with lists of allied health professionals. The table of contents for allied health professionals included dental surgeons, dentists, optometrists, physiotherapists, podiatrists, psychologists, rehabilitation services, speech pathologists and sports medicine practitioners. An additional section for psychiatrists was also included. However, there were no listings for counsellors in the entire directory.

The medical surgeries on the Gold Coast had a medical directory that included only medical professionals and specialists. There was not a resource that listed counsellors.

CHAPTER NINE

Discussion - Study II

9.1 Introduction

The results of Study II demonstrated the actual availability and accessibility of counsellors that work in medical practices, community centres and are listed in the telephone directory. An overview of these results and the correlation between the results of Study I which reflected the main sources that the general public and medical practitioners would seek in order to access a counsellor, and the reality of how readily accessible counsellors were from contacting these sources, will be summarised in this chapter. Additionally, the results of Study II identified the cost, qualifications and experience of practicing counsellors. These results, comparative to what was reported as desirable from the results of Study I, will also be discussed in this chapter.

9.2 Summary of results

The availability of counsellors in medical practices was consistent with the results of Study I. Of the 105 medical practitioners surveyed in Study I only eight (7.6%) reported having a counsellor working with them. Similarly, the results of Study II showed that 16.7% of medical practices surveyed had direct access to a counsellor. The remaining 83.3% of medical practices referred primarily to the telephone book as an alternative source for locating a counsellor. The receptionists from the medical practices could not provide the name and phone number of an individual counsellor and, in order to speak to a doctor regarding referral to a counsellor, an appointment needed to be made with the doctor. Therefore, these results would suggest that, despite doctors being reported as the most likely referral source to find a counsellor from

Study I (82.3% of general public and 100% of medical practitioners), counsellors were not as readily accessible from the majority of medical surgeries. Even medical practices that did have a counsellor employed with them could not provide an appointment for the counsellor. The phone number for the potential client was taken and the counsellor would then contact them with an appointment time.

Of the ten medical practices who employed the services of a counsellor, four used the same counsellor. This counsellor's qualifications were of a tertiary level (as was the reported preference of 75.7% of general public and 92.4% of medical practitioners from Study I). Additionally, the counsellor had five years experience. The results from Study I indicated that a counsellor with formal training and experience was considered the most beneficial by 85.8% of the general public and 96.2% of medical practitioners. Therefore, the counsellor working from four of the medical practices in Study II had the qualifications and experience deemed desirable by the participants of Study I.

Furthermore, the cost per hour of the counsellor working in the four medical practices ($50) was the amount the majority of participants from Study I (43.8% general public and 49.5% medical practitioners) indicated they would pay for a counselling consultation. However, no health insurance cover was available and the waiting time to see the counsellor could not be determined.

Two of the 'counsellors' working from two of the remaining medical practices were, in fact, psychologists. One of these had seven years experience, charged $100 per hour, and had approximately 4 days waiting time for an appointment. They did offer some health insurance cover, although they could not indicate how much that

would be and recommended that clients contact their health insurance company. The other counselling psychologist was not available without a referral from the doctor (according to the medical receptionist) and no information regarding their qualifications, cost, or experience was available.

The remaining four medical practices employed counsellors with tertiary qualifications and reported an approximate waiting time of one to four days to access the counsellor. The experience of the counsellors was 10 years, 12 years, 15 years and 19 years respectively. Three of the four counsellors charged $60 per hour and the other required a fee payable of $80 per hour. There was no health insurance cover available for consultation with any of these counsellors.

Hence, counsellors that were employed to work in medical practices were generally accessible once contact had been made directly with them. They all had tertiary qualifications and some years of experience as counsellors. However, the cost per hour for six of the counsellors was more than participants from Study I indicated they would pay for a counselling consultation, although this conclusion must be taken in context with the fee scales nominated in the questionnaire for participants in Study I (i.e., $25, $50, $75 and $100). Therefore, the willingness of participants to pay $60 and $80 per hour was not reported.

The organisation that the majority of respondents from Study I (65% general public and 79 % medical practitioners) indicated as the most likely referral source to find a counsellor was Community Services. However, the results from Study II indicated that a counsellor was <u>not</u> readily accessible from these organisations. All of the community health services had an intake system, whereby a potential client was

required to wait until the intake worker called back to get details. Following contact from the intake worker, a potential client was then required to wait for the appropriate counsellor (referred by the intake worker) to telephone them. A further waiting time of two or three weeks for an appointment with the counsellor was then necessary. The services of counsellors working for these organisations were free. However, the qualifications and experience of the counsellors were unknown by the receptionists and often the intake worker. When contact was made with the 'counsellor,' the majority were actually social workers or psychologists.

According to the results of Study I, the telephone book was reported as the referral source that 48.2% of the general public and 68.6% of medical practitioners would use to access a counsellor. A medical directory was reported by a further 32.7% of the general public and 73.3% of medical practitioners as an advertising source most likely used to access a counsellor.

However, looking for a counsellor in the telephone directory could be a confusing experience. The majority of the listings included counselling organisations and psychologists. A total of ten individuals listed in the telephone directory had counselling qualifications, with nine of these having tertiary level qualifications. Hence, 90% of the counsellors from study II possessed the preferred educational experience reported by the participants of Study I. Eight of the ten counsellors in Study II reported having experience of five years or more. This result indicates that these counsellors reflect the combination of education and experience reported as most desirable by the participants of Study I. Additionally, the counsellors listed in the

telephone book, once identified, were relatively accessible, with a minimum waiting time of three days and a maximum waiting time of two weeks for a consultation.

The preferred fee payable for a counselling consultation by participants from Study I ($50) was the fee charged by three of the counsellors in Study II, although one counsellor charged only $5 more than this. As mentioned previously, the fees charged by the other counsellors did not match the options of fees provided in the questionnaire distributed in Study I. Therefore, the willingness of the participants of Study I to pay the fees of $66, $70, $80, $85 and $90 was not reported. However, the percentages of participants from Study I willing to pay $75 for a counselling consultation (15.9% general public and 32.4% medical practitioners) was considerably less than the percentages prepared to pay $50 (43.8% general public and 49.5% medical practitioners). Hence, those counsellors charging more than $75 per hour for a consultation were in a price range outside of that which the majority of participants from Study I indicated they would pay.

Four of the eight counsellors listed in the telephone directory offered some rebate from private health insurance. However, the counsellors did not know the amount that would be refunded and this information was left for the potential client to pursue. Additionally, a refund was only available from private health insurance companies if the individual client had maximum health cover.

Of concern for counsellors is the finding that, while the telephone directory was a main advertising source indicated by participants from Study I as a means of accessing a counsellor, actually locating a counsellor from the telephone directory was

difficult. Counsellors were not as available from the telephone directory as was perceived by the participants of Study I. If a member of the general public or a medical practitioner were to seek a counsellor in the telephone directory, they would not be able to distinguish between the counsellors and the psychologists. Both professions were listed in the yellow pages under the heading of 'counsellor' and it would be more likely that a psychologist would be accessed this way than a counsellor as there were 24 psychologists listed and a further 10 who did not advertise their qualifications. There were no apparent correlations between the qualifications, experience or fees charged by the health professionals and their associated waiting time.

A Medical Directory was the other main advertising source of accessing a counsellor reported by participants of Study I. However, data from Study II found that counsellors were not listed in the resource directories located in the medical surgeries surveyed.

Therefore, while the results of Study I indicated that the general public and medical practitioners were more knowledgeable and better informed about counsellors than participants from previous studies, the results of Study II indicated that, when attempting to access a counsellor, there was potential for confusion based on the following:

1. Very few medical surgeries had a counsellor working for them and two of those that did so employed psychologists, yet referred to them as counsellors.
2. The medical surgeries that did not employ a counsellor could not provide names or telephone numbers of counsellors as an alternative, the majority referring to the telephone directory.

3. The majority of 'counsellors' working from community organisations were psychologists or social workers.
4. The majority of individuals listed in the telephone directory under 'counsellors' were psychologists.
5. The medical directories available to doctors from Tweed Heads to Murwillumbah only list psychologists and psychiatrists, not counsellors.
6. The medical directories available to doctors on the Gold Coast only listed medical professionals, not counsellors.

CHAPTER TEN

Overview

10.1 Introduction

The following chapter will summarise the contents of this thesis and discuss the potential limitations, recommendations for future research and implications for counselling. Final conclusions will also be included.

10.2 Overview of results

The summary of the literature review on pages 131 to 133 concluded that there was a need for counsellors in contemporary Australian society. However, the issues of counsellor identity, training, professionalism and the lack of a uniform mandatory association for counsellor membership were documented concerns. Additionally, the issues of counselling fees, accessibility and approachability of counsellors and the lack of Medicare rebates for counselling consultations were raised in the literature reviewed as potential drawbacks for counselling. Throughout the literature reviewed, however, there was generally a positive attitude reported by the public toward counsellors, although a lack of informed knowledge and the existence of confusion regarding the value, role and nature of counselling were also evident.

The current study sought to investigate the issues raised in the literature review, in the context of perceptions and knowledge of counsellors of the general public and medical practitioners on the Gold Coast and Northern New South Wales. The results of Study I indicated that the general positive regard for counsellors remained and that the confusion and lack of knowledge evident in the last Australian study conducted by Sharpley (1986) had greatly improved.

Study II sought to investigate the accuracy of reported responses from Study I regarding the *accessibility* of counsellors. The results of Study II showed that the sources for accessing counsellors, (nominated by the respondents of Study I) were not actually sources for ready access to a counsellor and some were not a source for finding a counsellor at all. Furthermore, results from Study II indicated that listings of and references to counsellors were, in reality, listings of and references to psychologists or social workers. Hence, the results from Study II suggested that the confusion reported by the previous literature, and reportedly overcome by respondents of Study I, could be generated again when the public seek to access a counsellor.

10.3 Limitations of Study

In addition to the mentioned limitations of Study I (page 228) regarding the disproportionate number of females (n = 150) to males (n = 76) in the general public sample and the relatively small sample of medical practitioners, other possible limitations include the localised nature of the sample, being drawn from the Gold Coast and nearby New South Wales. In addition, although a representative sample of the general public was ensured via reference to Congalton's (1969) categories of occupation, the actual generalising of these data to the wider Australian population remains uncertain.

10.4 Possibilities for future research

Addressing the above-mentioned limitations could be the focus of future research. A survey of a wider demographic region would establish whether or not the Gold Coast and Northern New South Wales is representative of the Australian public, as would the use of other reference sources such as the Australian Bureau of Statistics

(ABS) occupation, age and gender statistics. Additionally, most of the literature reviewed regarding the efficacy and perceptions of counsellors working in medical practices reported studies conducted in England. Australian studies regarding counsellors working in medical practices are recommended for future research, if medical practitioners are to be encouraged to include a counsellor within their practice. Some specific aspects of the methodology that might bear revision in future studies include:

1. Respondents were not asked for their specific age and occupation so that comparative analyses could be made.
2. The fees that respondents would be prepared to pay could be presented in increments of $5, rather than $25 in order to more accurately correlate what the public would be prepared to pay with what counsellors' are currently charging.
3. Doctors rather than medical receptionists could be a representative sample for Study II, to determine if they have a greater knowledge of accessing a counsellor than their receptionists.
4. The counselling qualifications, if any, of psychologists and social workers surveyed in Study II could be determined.

10.5 Implications for counselling

A number of issues for counsellors have emerged from this study.

1. Both the general public and the medical practitioners surveyed reported a positive attitude toward counsellors. However, in order to maintain this positive regard, counsellors need to ensure they have a tertiary qualification and belong to a reputable, recognised professional counselling association.

2. The affordability of counselling remains an issue that concerned both the general public and the medical practitioners. Counsellors may need to investigate pathways to provide some form of health insurance rebates for clients.
3. The lack of accessibility from the identified sources for finding a counsellor by respondents of this survey suggests that counsellors need to: a) consider promoting themselves to medical practitioners, b) seek to clarify their qualifications when advertising in the telephone directory, and c) endeavour to educate staff in community centres as to the distinctions between themselves and other health professionals.

10.6 Conclusion

In conclusion, this thesis has shown that the public perceptions of counsellors have greatly improved in terms of willingness to consult a counsellor, the belief that there is a need for more counsellors in the community and an increased willingness to pay for counselling services, since the last survey conducted by Sharpley (1986). The confusion and misinformation regarding counsellors as 'giving advice to people' and regarding the nature of the work performed by counsellors and where they can be located reported by Sharpley (1986) and in previous studies, were not apparent from this research. Furthermore, respondents from this study were generally able to differentiate between counsellors, psychologists, psychiatrists and social workers. Similarly, medical practitioners reported favourable perceptions of counsellors and a willingness to consider partnerships with counsellors. However, it would appear from the present data that counsellors are not as readily accessible as the general public and

medical practitioners perceived. Therefore, while a positive perception toward counselling currently exists, some misinformation remains regarding the accessibility of counsellors. Education and clear advertising could remedy the misinformation and assist in preserving the positive regard that the general public and medical practitioners have for the counselling profession.

REFERENCES

Adams, P. D., & Meagher, G.A. (1999). Australia's workforce trends to 2010: Forecasts from the Monash model. Monash University, Centre of Policy Studies.

Adler, A. (1964). Social Interest: A Challenge to Mankind. New York: Capricorn Books.

Alperin, R. M., & Benedict, A. (1985). College Students' Perceptions of Psychiatrists, Psychologists, and Social Workers: A Comparison. Psychological Reports, 57, 547-548.

Anderson, S., & Hasler, J. C. (1979). Counselling in general practice. Journal of the Royal College of General Practitioners, 29, 352-356.

Atkinson, D. A., & Matsushita, Y. J. (1991). Japanese-American Acculturation, Counseling Style, Counselor Ethnicity, and Perceived Counselor Credibility. Journal of Counseling Psychology, 38, 473-478.

Australian Board of Certified Counsellors. (1999). Who are these counsellors? [Brochure]. Barletta, J: Author.

Australian Board of Certified Counsellors. (2002). Certification Process [Online]. Available: http://www.abcc.com.au/process2.html

Australian Board of Certified Counsellors. (2002). Requirements [Online]. Available: http://www.abcc.com.au/process2.html

Australian Bureau of Statistics. (1996). Domestic Violence [Online]. Available: http://www.abs.gov.au/ausstats

Australian Bureau of Statistics. (1997). National Survey of Mental Health and Wellbeing [Online]. Available: http://www.abs.gov.au/ausstats

Australian Bureau of Statistics. (2001). Population Divorces [Online]. Available: http://www.abs.gov.au/ausstats

Australian Bureau of Statistics. (2001). 4510.0 Recorded Crime, Australia [Online]. Available: http://www.abs.gov.au/ausstats

Australian Bureau of Statistics. (2002). Australian Social Trends 2002: Family - Family Services: People with a disability: Need for Guidance [Online]. Available: http://www.abs.gov.au/ausstats

Australian Bureau of Statistics. (2002). Australian Social Trends 2002: Income and Expenditure – Expenditure: Households in financial stress [Online]. Available: http://www.abs.gov.au/ausstats

Australian Counselling Association (2000). Information [Online]. Available: http://www.theaca.net.au/onfo.htm

Australia Guidance and Counselling Association Limited (1991). [Memorandum]. Australia: Author.

Bandura, A. (1986). Social Foundations of Thought and Action. New Jersey: Prentice-Hall Inc.

Balestrieri, M., Williams, P., & Wilkinson, G. (1988). Specialist mental health treatment in general practice: a meta-analysis. Psychological Medicine, 18, 711-717.

Barletta, J. (1996). An examination of the professional status and identity of school counseling in Australia. Unpublished doctoral dissertation, University of Ohio, Athens.

Barletta, J. (1999). The counselling bug: How to help prevent the crash of the profession in the next millennium. In K. Glasgow, R. Slee, S. Houghton, & G. Douglas (Eds.). School psychology: Partners in education, (p. 70-75). Perth: Australian Guidance and Counselling Association.

Beauchamp, J., & Shaw, E. (2002). Engaging and retaining men in therapy: issues for female therapists working with men in relationship counselling [Online]. Available: http://law.gov.au/aghome/commaff/lafs/frsp/mensforum/people/38.htm

Beck, A. (1976). Cognitive Therapy and the Emotional Disorders. New York: International Universities Press.

Berne, E. (1964). Games People Play. New York: Penguin Books Ltd.

Blocher, D. H. (2000). The Evolution of Counseling Psychology. New York: Springer Publishing Company.

Blum, L. P., & Sullivan, B. A. (1953). What Do College Students Think of Counseling? Journal of Higher Education, 24, 262-264.

Brewer, J. M. (1939). Education as guidance. New York: Macmillan.

Congalton, A. (1969). Status and prestige in Australia. Melbourne: Cheshire.

Conoley, J. C., & Bonner, M. (1991). The effects of Counselor Fee and Title on Perceptions of Counselor Behavior. Journal of Counseling and Development, 69, 356-358.

Cook, E. P., Park, W., Williams, G. T., Webb, M., Nicholson, B., Schneider, D., & Bassman, S. (1984). Students' Perceptions of Personal Problems, Appropriate Help Sources, and General Attitudes About Counseling. Journal of College Student Personnel, 25, 139-145.

Corey, G. (2001). Theory and practice of counseling and psychotherapy. (6th ed.). California: Brooks/Cole.

Corney, R. H. (1987). Marriage Guidance Counselling in General Practice in London. British Journal of Guidance and Counselling, 15, 50-58.

Corney, R. H. (1990). Counselling in general practice - does it work? Discussion paper. Journal of the Royal Society of Medicine, 83, 253-257.

Corney, R. H. (1992). The effectiveness of counselling in general practice. International Review of Psychiatry, 4, 331-338.

Corsini, R. J., & Wedding, D. (Eds.). (1995). Current psychotherapies. (5th ed.). Illinois: Peacock Publishers.

Cracknell, E. (1987). What is Counselling? British Journal of Occupational Therapy, 50, 307-308).

Cramer, K. C. (1965). The Causes of War. Illinois: Scott, Foresman and Company.

Day, R. C. (1983). Attitudes Toward Counselling in the Middle East. International Journal for the Advancement of Counselling, 6, 143-152.

Directory of Postgraduate Study (2002). [Online]. Available: http://postgrad.grad.com.au./

Drever, P. (1999). Counselling Psychology: is there a Future? INPSYCH, February, 18-19.

Egan. G. (1994). The Skilled Helper (5th Ed.). California: Brooks/Cole Publishing Company.

Elliott, P. (1972). The sociology of the professions. New York: Macmillan Publishing.

Ellis, A. (1962). Reason and Emotion in Psychotherapy. New York: Lyle Stuart.

Emener, W. G., & Cottone, R. R. (1989). Professionalization, Deprofessionalization and Reprofessionalization of Rehabilitation Counseling According to Criteria of Professions. Journal of Counseling and Development, 67, 576-581.

Erikson, E. (1993). Childhood and Society. New York: W. W. Norton and Company, Inc.

Fletcher, F. M., & Riddle, C. W. (1962). The guidance movement in India. Personnel and Guidance Journal, 40, 807.

Fox, D., & Miller, N. (Ed.). (2000). An Oral History of Marriage Counselling in Australia From Meaning Well to Doing Well. Canberra: Panther Publishing and Printing.

Frankl, V. (1959). Man's Search for Meaning. Boston: Beacon Press.

Freedheim, D. K. (Ed.). (1993). History of Psychotherapy: A century of change. Washington: American Psychological Association.

Freud, S., & Freud, A. (1986). The Essentials of Psychoanalysis (J. Strachey, Trans.). England: Penguin Books Ltd.

Fullerton, J. S., & Potkay, C. R. (1973). Student Perceptions of Pressures, Helps, and Psychological Services. Journal of College Student Personnel, 14, 355-361.

Garmonsway, G. N. (Ed.). (1991). The Penguin Concise English Dictionary (3rd ed.). London: Bloomsbury Books.

Gass, G. Z. (1959). Guidance in Russia. Personnel and Guidance Journal, 38, 34-39.

Gelso, C. J., & Karl, N. J. (1974). Perceptions of 'Counselors' and Other Help-Givers: Whats in a Label. Journal of Counseling Psychology, 21, 243-247.

Gelso, C. J., & McKenzie, J. D. (1973). Effect of Information on Students' Perceptions of Counseling and Their Willingness to Seek Help. Journal of Counseling Psychology, 20, 406-411.

Getsinger, S. H., & Garfield, N. J. (1976). Male Students' Perceptions of Counselors, Guidance Counselors, and Counseling Psychologists. Journal of College Student Personnel, 17, 7-10.

Gibson, R. L., & Mitchell, M. (1990). Introduction to Counseling and Guidance (3rd ed.). New York: Macmillan Publishing.

Gim, R. H., Atkinson, D. R., & Kim, S. J. (1991). Asian-American Acculturation, Counselor Ethnicity and Cultural Sensitivity, and Ratings of Counselors. Journal of Counseling Psychology, 38, 57-62.

Gladding, S. T. (1996). Counseling a comprehensive profession (3rd ed.). New Jersey: Prentice-Hall.

Glasser, W. (1964). Reality Therapy. New York: Harper.

Grant, C. W. (1954). How Students Perceive the counselor's role. Personnel and Guidance Journal, 32, 386-388.

Grant, C. W. (1954). The Counselor's Role. Personnel and Guidance Journal, 33, 74-77.

Guest, L. (1948). The public's attitudes toward psychologists. American Psychologist, 3, 135-139.

Hackney, H. L., & Cornier, L. S. (1996). The professional counselor: A process guide to helping. (3rd ed.). Massachusetts: Allyn and Bacon.

Hansen, L. S. (1965). Norway adapts guidance into new educational structure. Personnel and Guidance Journal, 44, 244-247.

Hassan, T., & Hassan, M. (1991), Principals and Teachers' Change in Attitudes Toward Counselling: A Function of the Knowledge of Counselling Services. Nigerian Journal of Guidance and Counselling, 4, 64-70.

Henderson, W. J., & Lyddon, W. J. (1997). Client Gender Role Attitudes and Perception of Counselor Characteristics. Journal of Mental Health Counseling, 19, 182-190.

Hershenson, D. B. (1990). Mental Health Counselor Education in Australia. Journal of Mental Health Counseling, 12, 175-185.

Hopson, K., & Cunningham, J. D. (1995). Community and client perceptions of psychologists and other health professionals. Australian Psychologist, 30, 213-217.

Ives, G. (1979). Psychological treatment in general practice. Journal of the Royal College of General Practitioners, 29, 343-351.

Ivey, A. E. (1994). Intentional Interviewing and Counseling (3rd Ed.). California: Brooks/Cole Publishing Company.

Ivey, A. E., & Authier, J. (1978). Microcounseling: Innovations in interviewing, counseling, psychotherapy and psychoeducation (2nd ed.). Illinois: Thomas Books.

Jenson, R. E. (1955). Student Feeling about counseling help. Personnel and Guidance Journal, 33, 498-503.

Johnson, D. (2002). ASOCHA in a broader Perspective: Counselling as an evolving profession in Australia [Online]. Available: http:ampersandaus.com.au/about/asocha/perspective.htm

Johnson, D. H., Nelson, S. E., & Wooden, D. J. (1985). Faculty and Student Knowledge of University Counseling Center Services. Journal of College Student Personnel, 26, 27-32.

Johnson, H. N. (1977). A Survey of Students' Attitudes Toward Counseling at a Predominantly Black University. Journal of Counseling Psychology, 24, 162-164.

Journal of the Royal College of General Practitioners (Editorials). (1980). Is counselling the key? Journal of the Royal College of General practitioners, 30, 643-645.

Jung, C. G. (1970). Freud and Psychoanalysis (2nd Ed.). New Jersey: Princeton University Press.

Kaczmarek, P. G., & Jankowicz, A. D. (1991). American college students' perceptions of counsellor approachability: Professional implications. International Journal for the Advancement of Counselling, 14, 313-324.

Kagan, N. (1973). Can technology help us toward reliability in influencing human interaction? Educational Technology, 13, 44-51.

Kaplan, R. M., & Saccuzzo, D. P. (1997). Psychological Testing (4th ed.). California: Brooks/Cole Publishing Company.

Khan, J. (1983). The evolution of counseling and guidance in Australia: Or, as yet no counseling kangaroos? The Personnel and Guidance Journal, 61, 469-472.

King, P. T., & Matteson, R. W. (1959). Student Perception of Counseling Center Services. Personnel and Guidance Journal, 37, 358-364.

Koch, H. C. H. (1979). Evaluation of behaviour therapy intervention in general practice. Journal of the Royal College of General Practitioners, 29, 337-340.

Krauskopf, C. J., & Thoreson, R. W. (1973). Counseling Psychology: The who, what, and where of our profession. Journal of Counseling Psychology, 20, 370-374.

Lee, W. M., & Mixson, R. J. (1995). Asian and Caucasian Client Perceptions of the Effectiveness of Counseling. Journal of Multicultural Counseling and Development, 23, 48-56.

Lieberman, M. (1956). Education as a Profession. New Jersey: Prentice-Hall Inc.

Lowe, R., Howard, J., & Dawson, R. (1986). Choice of psychologist based on prior knowledge of fees and level of rebate. Australian Psychologist, 21, 299-306.

Martin, E. (1988). Counsellors in general practice. British Medical Journal, 1, 637-638.

Martin, E., & Martin, P. M. L. (1985). Changes in Psychological Diagnosis and Prescription in a Practice Employing a Counsellor. Family Practice, 2, 241-243.

May, R. (1969). Love and Will. New York: W. W. Norton and Company, Inc.

May, R. (1975). The Courage to Create. New York: Norton and Company, Inc.

McCully, C. H. (1961). A rationale for Counselor Certification. Counselor Education and Supervision, 1, 3-9.

McCully, C. H. (1962). Challenge for change in Counselor Education. In The School Counselor: Strategy for Professionalization, (p. 16-26). Minneapolis: Burgess Publishers.

McGuire, J. M., & Borowy, T. D. (1979). Attitudes Toward Mental Health Professionals. Professional Psychology, 10, 74-79.

McLeod, J. (1988). The Work of Counsellors in General Practice. London: The Royal College of General Practitioners.

McWhirter, J. J. (1987). International perspective: Counselor preparation in Australian and New Zealand. Counselor Education and Supervision, 27, 77-88.

Moore, W. (1970). The professions: Roles and rules. New York: Russell Sage Foundation.

Murray, J. B. (1962). College Students' Concepts of Psychologists and Psychiatrists: A Problem in Differentiation. The Journal of Social Psychology, 57, 161-168.

Nelson-Jones, R. (1995). Counselling and personality: theory and practice. St. Leonards: Allen and Unwin.

Neukrug, E. (1999). The World of The Counsellor: An Introduction to the Counseling Profession. California: Brooks/Cole Publishing Company.

Nishigaki, M. (1957). Vocational guidance: Recent trends in Japan. Personnel and Guidance Journal, 36, 118-120.

Nunnally, J. C. (1961). Popular Conceptions of Mental Health. New York: Holt, Rinehart and Winston, Inc.

Nunnally, J., & Kittross, J. M. (1958). Public Attitudes Toward Mental Health Professionals. American Psychologist, 13, 589-594.

Ostlund, L. A. (1957). Vocational Guidance in Belgium. Personnel and Guidance Journal, 35, 456-459.

Ostlund, L. A. (1958). Vocational guidance in France. Personnel and Guidance Journal, 3, 566-570.

Pavalko, R. (1971). Sociology of occupations and professions. Illinois: Peacock Publishers Inc.

Perls, F., Hefferline, R. F., & Goodman, P. (1951). Gestalt Therapy. United States of America: The Julian Press, Inc.

Powell, G. N., & Kotschessa, B. (1995). Factors that Influence Professional Employees' Willingness to Seek Counseling. Psychological Reports, 77, 872-874.

Pringle, M., & Laverty, J. (1993). A counsellor in every practice? Reasons for caution. British Medical Journal, 306, 2-3.

Prochaska, J. O., & Norcross, J. (1994). Systems of Psychotherapy (3rd ed.). California: Brooks/Cole Publishing Company.

Radley, A., Cramer, D., & Kennedy, M. (1997). Specialist counsellors in primary care: the experience and preferences of general practitioners. Counselling Psychology Quarterly, 10, 165-173.

Resnick, H., & Gelso, C. J. (1971). Differential Perceptions of Counseling Role: A Reexamination. Journal of Counseling Psychology, 18, 549-553.

Richardson, P., & Handal, P. (1995). The public's perception of psychotherapy and counseling: Differential views on the effectiveness of psychologists, psychiatrists and other providers. Journal of Contemporary Psychotherapy, 25, 367-385.

Ritchie, M. H. (1990). point/counterpoint: a response, Counseling is not a Profession - Yet. Counselor Education and Supervision, 29, 220-227.

Rogers, C. R. (1980). A Way of Being. Boston: Houghton Mifflin Company.

Rogers, C. R. (1992). The process of therapy. Journal of Consulting and Clinical Psychology, 60, 163-164.

Rogers, H. J., & Sharpley, C. F. (1983). Attitudes to and knowledge of counselling in Australia. Australian Psychologist, 21, 321-329.

Rule, W. R., & Gandy, G. L. (1994). A thirteen-year comparison in patterns of attitudes toward counseling. Adolescence, 29, 575-589.

Scherzer, B., & Stone, S.C. (1974). Fundamentals of counseling (2nd.ed). Boston: Houghton Mifflin Company.

Scherzer, B., & Stone, S. C. (1980). Fundamentals of counseling (3rd.ed). Boston: Houghton Mifflin Company.

Schindler, F., Berren, M. R., Hannah, M. T., Beigel, A., Santiago, J. M. (1987). How the Public Perceives Psychiatrists, Psychologists, Nonpsychiatric Physicians, and Members of the Clergy. Professional Psychology: Research and Practice, 18, 371-376.

School of Health Sciences. (2002). Graduate Employment Opportunities in Health Sciences. Bond University: Author.

Sharpley, C. F. (1986). Public perceptions of four mental health professionals: A survey of knowledge and attitudes to psychologists, psychiatrists, social workers and counsellors. Australian Psychologist, 21, 57-67.

Sharpley, C. F., Rogers, H. J., & Evans, N. (1984). 'Me! Go to a marriage counsellor! You're joking!': A survey of public attitudes to and knowledge of marriage counselling. Australian Journal of Sex, Marriage & Family, 5, 129-137.

Sibbald, B., Addington-Hall, J., Brenneman, D., Freeling, P. (1993). Counsellors in English and Welsh practices: their nature and distribution. British Journal of General Practice, 306, 29-33.

Sibbald, B., Addington-Hall, J., Brenneman, D., Freeling, P. (1996). Investigation of whether on-site general practice counsellors have an impact on psychotropic drug prescribing rates and costs. British Journal of General Practice, 46, 63-67.

Skinner, B. F. (1971). Beyond Freedom and Dignity. New York: Alfred A. Knopf.

Small, J., & Gault, U. (1975). Perceptions of psychologists by the general public and three professional groups. Australian Psychologist, 10, 21-31.

Strong, S. R., Hendel, D. D., & Bratton, J. C. (1971). College Students' Views of Campus Help-Givers: Counselors, Advisers, and Psychiatrists. Journal of Counseling Psychology, 18, 234-238.

Sydow, K. V., & Reimer, C. (1998). Attitudes toward Psychotherapists, Psychologists, Psychiatrists, and Psychoanalysts. American Journal of Psychotherapy, 52, 463-488.

Tallent, N., & Reiss, W. J. (1959). The public's concepts of psychologists and psychiatrists: A problem in differentiation. Journal of General Psychology. 61, 282-285.

The Psychotherapy & Counselling Federation of Australia. (2002). About PACFA [Online]. Available: http://www.pacfa.org.au/scripts/

The Psychotherapy & Counselling Federation of Australia. (2002). Member Associations [Online]. Available: http://www.pacfa.org.au/scripts/MembersAssociation.asp

Thomas, R. V. R., & Corney, R. H. (1992). A survey of links between mental health professionals and general practice in six district health authorities. British Journal of General Practice, 42, 358-361.

Thoreson, R. W. (1974). The evolution of counselling. British Journal of Guidance and Counselling, 2, 171-181.

Thumin, F. J., & Zebelman, M. (1967). Psychology versus psychiatry: A study of public image. American Psychologist, 22, 282-286.

Truax, C., & Carkhuff, R. (1967). Toward effective counseling and psychotherapy: Training and practice. Hawthorne, New York: Aldine.

Tryon, G. S. (1980). A Review of the Literature Concerning Perceptions of and Preferences for Counseling Center Services. Journal of College Student Personnel, 21, 304-311.

Tyler, L. (1969). The work of the counselor. (3rd ed.). New York: Appleton-Century-Crofts.

Vacc, N., & Loesch, L. (1994). A Professional Orientation to Counseling. (2nd.ed). Indiana: Accelerated Development Inc. Publishers.

Venables, E. (1974). Theorising About Counselling. British Journal of Guidance and Counselling, 2, 41-54.

Vietnam Veterans Association of Australia. (2002). Vietnam Veterans' Counselling Service [Online]. Available: http//www.vvaa.org.au/vvcs2.htm

Vollmer, H., & Mills, D. (Eds.). (1966). Professionalization. New Jersey: Prentice-Hall.

Von Sydow, K., & Reimer, C. (1998). Attitudes toward psychotherapists, psychologists, psychiatrists, and psychoanalysts. American Journal of Psychotherapy, 52, 463-488.

Waehler, C. A., Hardin, S. I., & Rogers, J. R. (1994). College Students' Perceptions of the Relationship Between Fee and Counseling. Journal of Counseling and Development, 73, 88-93.

Warner, D. L., & Bradley, J. R. (1991). Undergraduate Psychology Students' Views of Counselors, Psychiatrists, and Psychologists: A Challenge to Academic Psychologists. Professional Psychology, 22, 134-140.

Warren, H. C. (1987). Buddhism in Translations. Delhi: Motilal Banarsidass.

Watson, J. B. (1931). Behaviourism. London: Paul Kegan, Trench and Traubner.

Waydenfeld, D., & Waydenfeld, S. F. (1980). Counselling in general practice. Journal of the Royal College of General Practitioners, 30, 671-677.

Webb, A. R., & Speer, J. R. (1986). Prototype of a Profession: Psychology's Public Image. Professional Psychology: Research and Practice, 17, 5-9.

Webber, V., Davies, P., Pietroni, P. (1994). Counselling in an inner city general practice: analysis of its use and uptake. British Journal of General Practice, 44, 175-178.

Wilbur, J. B., & Allen, H. J. (Ed.). (1979). The Worlds of Plato and Aristotle. New York: Prometheus Books.

Wilcove, G., & Sharp, W. H. (1971). Differential Perceptions of a College Counseling Center. Journal of Counseling Psychology, 18, 60-63.

Wilkinson, I., Cave, K., Flynn, A., Hodgson, G., Prouatt, M., Sultmann, W., & Gardner, J. M. (1978). The public and the help-giving professions in Australia. Professional Psychology, 9, 692-699.

Williams, C. (1978). The Dilemma of Counselling Psychology. Australian Psychologist, 13, 33-39.

Williamson, E. G. (1939). How to counsel students: A manual of techniques for clinical counselors. New York: McGraw-Hill.

Wolpe, J. (1958). Psychotherapy by Reciprocal Inhibition. Stanford: Stanford University Press.

Wood, W., Jones, M., & Benjamin, L. T. (1986). Surveying Psychology's Public Image. American Psychologist, 41, 947-953.

Appendix A

Questionnaire - Study I

Appendix B

Introduction letter to participants - Study I

Appendix C

Pilot questionnaire - Study I

Appendix D

First Questionnaire - Study II

Appendix E

Second questionnaire - Study II