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A Portfolio of Theory, Practice & Research

in a Primary Care Setting

By

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Submitted for the degree of

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CONTENTS

Page No.

List of Tables	3
List of Figures	5
Acknowledgements	6
Key of Abbreviations	7
<i>SECTION A Introduction</i>	8
<i>SECTION B Research</i>	
Primary Care Counselling: The Perceptions & Experiences of General Practitioners	14
Abstract	15
Chapter 1 – Introduction & Literature Review	16
1.1 The Development of Counselling within Primary Care	
1.2 The GP & Mental Health Issues	
1.3 The Medical Model vs the Psychological Model	
1.4 Models of Collaboration	
1.5 Research	
1.6 Professional Issues in Counselling	
1.7 Summary & Aims	
1.8 Methodological Issues	
Chapter 2 - Methodology	79
2.1 Semi-structured Interviews	
2.2 Questionnaire Design, Pilot & Amendment	
2.3 Meeting with Local GPs	
2.4 Method of Data Analysis Chosen for Study	
Chapter 3 – Results	98
3.1 Semi-structured Interviews	
3.2 Questionnaire Results	
3.3 Meeting with Local GPs	
Chapter 4 – Discussion	136
4.1 Summary of Findings for each stage of Research	
4.2 Themes	
4.3 Predicting Variables	
4.4 Model to Show Processes Involved in GPs’ Perception of Primary Care Counselling	

4.5 Interventions	
4.6 Methodological Critique	
4.7 Chapter Summary	
4.8 Implications	
Chapter 5 – Conclusion	204
References	208
Appendix B (1) – Information Relating to GP Interviews	220
Appendix B (2) – Information Relating to Questionnaire	224
 <i>SECTION C</i>	
Case Study of a Male with a Sexual Compulsion	265
 <i>SECTION D</i>	
The Etiology & Treatment of Domestic Violence: A Critical Review	267
Introduction	
The Etiology of Domestic Violence	
The Treatment of Domestic Violence	
Measurement of Violence	
Violent Women	
Substance Abuse & Domestic Violence	
Summary	
Implications	
Conclusion	
References	292

List of Tables

Tables in Section B

TABLE 2.01 To Show Gender of Respondents

TABLE 3.01 To Show Inter-Rater Reliability of Interviews

TABLE 3.02 To Show GPs' Experience of Primary Care Counselling Service

TABLE 3.03 To Show GPs' Perception of Counselling

TABLE 3.04 To Show When Decision to Refer for Counselling is Made

TABLE 3.05 To Show Influential Factors in Referring

TABLE 3.06 To Show Factors that make Collaboration Difficult

TABLE 3.07 To Show Appropriate Presenting Problems for Practice Counsellor

TABLE 3.08 To Show Inappropriate Presenting Problems for Practice Counsellor

TABLE 3.09 To Show Important Factors in Employing a Counsellor

TABLE 3.10 To Show Differences Between Counsellor & other Mental Health Professionals

TABLE 3.11 To Show Age Bands of GPs

TABLE 3.12 To Show Age Bands of Counsellors

TABLE 3.13 To Show Orientation of Counsellors

TABLE 3.14 To Show GP Interest in Primary Care Counselling

TABLE 3.15 To Show Skewness of Sample from 'Total Score' on Rating Scale

TABLE 3.16 To Show Questions on Rating Scale where Statistically Significant Difference was obtained in Scores between GPs & Counsellors

TABLE 3.17 To Show Descriptive Statistics for each Group on 'Total Score' from Rating Scale

TABLE 3.18 To Show Percentage of Respondents Indicating Ways to Improve Counselling Service

TABLE 3.19 To Show Percentage of Respondents Experiencing Funding Difficulties in Counselling Service

TABLE 3.20 To Show GP Service Satisfaction by Group

TABLE 3.21 To Show Percentage of Respondents indicating Appropriateness of each Presenting Problems

TABLE 3.22 To Show Responses to Question, ‘Do Patients Return to GP after Counselling with Little Improvement?’

TABLE 3.23 To Show Percentage of Respondents Ticking each Role

Tables in Appendix B (2)

TABLE A.01 To Show Number of Years Respondents have Been in their Profession

TABLE A.02 To Show Employment Status of Counsellors

TABLE A.03 To Show Number of Years GP Practice has had Counselling

TABLE A.04 To Show Hours a Week of Counselling input by Counsellor in Primary Care

TABLE A.05 To Show Counsellors’ Qualifications

TABLE A.06 To Show Responses to Rating Scale

TABLE A.07 To Show Mann Whitney Scores for 21 Statements on Rating Scale

TABLE A.08 To Show Other Ways to Improve Counselling Service for each Profession

TABLE A.09 To Show Reasons Given by GPs for Patients Returning to GP after Counselling Showing Little Improvement

TABLE A.10 To Show Reasons Given by Counsellors for Patients Returning to GP after Counselling Showing Little Improvement

TABLE A.11 To Show Responses to Open Question

TABLE A.12 To Show Cross Tabulation of GP Responses to Question 1 by Gender

TABLE A.13 To Show Cross Tabulation of GP Responses to Question 1 by Age

TABLE A.14 To Show Cross Tabulation of GP Responses to Question 26 by Years Practice has had Counselling

List of Figures

Figures in Section B

Fig 3.01 Bar Chart to Show Age Bands for Counsellors

Fig 3.02 Bar Chart to Show Age Bands for GPs

Fig 3.03 Pie Chart to Show Orientation of Counsellors

Fig 3.04 Bar Chart to Show Distribution of 'Total Score' for Counsellors

Fig 3.05 Bar Chart to Show Distribution of 'Total Score' for GPs

Fig 3.06 Pie Chart to Show Counsellors' Perception of Counselling

Fig 3.07 Pie Chart to Show GPs' Perception of Counselling

Fig 3.08 Bar Chart to Show Problems considered Appropriate for Treatment by Practice Counsellor

Fig 3.09 Bar Chart to Show Views of Counsellor Role within the Practice

Fig 4.01 Model to Show Processes Involved in GP's Perception of Primary Care Counselling

Fig 4.02 Model to Illustrate Interventions (suggested by Study) Aimed at changing unhelpful/negative GP Perceptions

Figures in Section D

Fig 1.0 Model of Antecedents for Battering

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Declaration

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Key of Abbreviations

BACP – British Association for Counselling & Psychotherapy

CBT – Cognitive-behaviour therapy

CPC – The professional body ‘Counsellors in Primary Care’

CPN – Community Psychiatric Nurse

DSM – Diagnostic & Statistical Manual

GP – General Practitioner

NHS – National Health Service

PCG – Primary Care Group

PHCT – Primary Health Care Team

UKCP – United Kingdom Council for Psychotherapists

SECTION A

Introduction

This study presents different aspects of my work as a counselling psychologist. In this section, I shall discuss how these aspects relate to my career development as a counselling psychologist. I shall also discuss how these areas of work are linked together, firstly by the primary care setting and secondly through linking research, theory and practice.

My career as a counselling psychologist has developed in the most part, through working as part of a primary care counselling service and this study reflects my interest in this area. Primary care is a topical theme given recent government initiatives aimed at primary care health services. For example, the introduction in April 1999 of Primary Care Groups and later the development of Primary Care Trusts to replace health authorities; and the trend towards the de-centralisation of many health services to primary care level (following on from the Tomlinson Report of 1992). Primary care is therefore an exciting area in which to be working given these changes. It is an area where counselling psychologists are employed (particularly in providing psychological input to GP practices) and have a role to play in effecting some of these changes. Counselling psychologists are well placed to offer a range of services in primary care. For example, counselling psychologists may be involved in primary care at an organisational level as well as in the area of research and evaluation of services in primary care, teaching and training as well as the provision of psychological help to GP patients. Such a setting, therefore, offers counselling psychologists the opportunity to demonstrate their range of skills.

Through my work as a primary care counselling psychologist I became aware of the unique nature of this setting. Working in a GP surgery one is providing a service to clients as well as to the GP(s) in the practice. I became interested in the different dynamics within each practice in which I worked, in particular the different perceptions each GP had about the service I offered the practice and my role as a primary care counselling psychologist. I formed a different relationship with each GP and became aware of how this relationship developed over time and through different clients I worked with. It was through my interest in exploring these experiences that lead me to conduct the research presented in this study. The study looks at the GP – therapist relationship and reflects that facet of working in primary care.

My interest in the area of domestic violence (presented in the critical review of the study) also developed through my work in primary care. The primary care setting offers a ‘front line’ service and the GP surgery is often the first port of call for people in distress. Through offering a counselling service in GP practices I encountered several women who were victims of domestic violence, I also became involved in risk assessment for children caught up in violent relationships. This work raised ethical issues for me and involved collaboration with social services and health visitors. Through my work with a male victim of domestic violence I became aware of and interested in the often hidden issue of violent women.

The case study presents clinical work in primary care and reflects the diverse nature of presenting problems encountered in this setting. It highlights the limitations of providing a service at primary care level for complex difficulties and how this may impact on therapy. The case study reflects another facet of primary care work; the client – therapist relationship.

The mission statement for the division of Counselling Psychology states its aims as being to “...*promote, protect and advance best practice and openness, research and theory in counselling psychology..*” (Division of Counselling Psychology Strategic Plan Revised/2001, Counselling Psychology Review, vol. 16, page 30).

The areas of study presented are also linked together as they highlight some of these different areas (research, theory and practice) that form an integral part of the profession of counselling psychology. The relationship between research, theory and practice is topical given recent government initiatives for evidence based practice that are driving many services (including psychological services) within the health service.

SECTION B – Research

Section B focuses on research and reflects the importance of research skills that form a central part of the training of a counselling psychologist.

The research investigates the perceptions and experiences of general practitioners of primary care counselling. Counselling services in GP practices have grown rapidly over

recent years. However, difficulties working together between GPs and counsellors have been documented. GPs' perceptions of primary care counselling are interesting to explore from a theoretical perspective as they can provide an insight into why a GP may develop a particular perception of counselling. They are also important to explore from a service perspective as they may help in our understanding of the difficulties that may arise (for GP, counsellor and patient) when two professionals from such different backgrounds try to work together.

The research aims to explore, both qualitatively and quantitatively, the perceptions and experiences of GPs of primary care counselling. A related aim is to compare these perceptions and experiences with those of primary care counsellors, the purpose being to try to better understand the difficulties both professions may encounter when working together. The objective being to better understand why some GPs may form negative/unhelpful perceptions of primary care counselling, this can lead to a consideration of how one may intervene to change such perceptions. Such an investigation can also provide ideas about interventions that may be developed aimed at minimising difficulties between the GP and primary care counsellor and promoting collaborative working. The research uses a range of different methodologies to address the aims of the study, and highlights how different methodologies may be used to complement each other and enrich a study.

The research re-inforces the complexity of social perception and demonstrates the importance of the GP-counsellor relationship.

SECTION C – Case Study

The case study highlights the area of clinical practice that forms a fundamental part of the role of an applied counselling psychologist. It explores the author's work with a male client who presents with a sexual compulsion. The therapy offered to the client was short term cognitive-behavioural therapy. The case study explores how psychological interventions from a cognitive-behavioural perspective can be usefully applied to such a presenting problem within the time constraints of a primary care setting. The case study also explores the difficulties within the therapeutic relationship that arose in the course of therapy and highlights how cognitive-behavioural therapy (not usually associated with issues concerning the therapeutic alliance) is now

addressing this important area of therapy. However, the case study highlights the need not only to monitor the therapeutic relationship, but also to actively intervene if difficulties arise.

The case study also highlights the importance of working as a reflective practitioner, that is, to reflect on one's way of working (supervision and personal therapy may be a useful way of doing this) and to use this process to inform one's practice. The importance of adopting a non-judgemental and empathic approach when working with clients is crucial. Reflection on our practice allows us to 'step back' and critically evaluate our work and to learn from this process.

SECTION D – Critical Review

This section explores current literature on the area of domestic violence. Given the prevalence of domestic violence, it is an area that counselling psychologists may be involved in either through working with victims or perpetrators of violence or through conducting research in this area. Domestic violence is also an area of concern to society as a whole. The review explores current psychological perspectives around the etiology and treatment of domestic violence. Through doing so, the review highlights certain areas of controversy. In particular it explores the appropriateness of couple therapy where domestic violence is present. Is such a form of therapy a useful (and necessary) intervention for couples where violence is present? Or does couple therapy compromise the therapeutic alliance and safety of the victim?

The review also highlights the area of women who are perpetrators of domestic violence. This area appears to have been neglected by researchers and writers but now seems to be receiving more attention. The review asks whether services can respond appropriately to the needs of men who are physically abused by their female partners. The review ends by discussing the implications of these findings for counselling psychologists in terms of their training and practice in this area as well as the need to be aware of how our own beliefs and experiences may influence therapy.

Section D highlights the area of critical review. Such critical review is an important way of keeping counselling psychologists updated on research and theory within

psychology. This can help inform our general knowledge about developments within our profession as well as our clinical practice.

In this sense these diverse but related areas of practice integrate the scientist and practitioner aspects of the role of an applied counselling psychologist. There has been discussion recently (e.g. Pelling 2000) about the dichotomy between the branches of research and practice within the field of psychology and the apparent resistance of integrating research and practice. Within the training of a counselling psychologist the scientist practitioner model is emphasised. It is important to recognise and value both research and practice to the work of a counselling psychologist; this study attempts to promote both aspects.

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SECTION B

Primary Care Counselling: The Perceptions & Experiences of General Practitioners

Abstract

Counselling is a growth area in primary care. Difficulties providing a psychologically based service within the medical domain of the surgery have been documented, in particular the difficulties when two professionals from differing backgrounds come together to provide a service to patients. This piece of research aims to explore (both qualitatively and quantitatively) the perceptions and experiences of GPs of primary care counselling. A second aim is to compare GP's perceptions and experiences to those of primary care counsellors themselves. The objective being to help understand these difficulties (from the perspective of both professionals) as well as the factors involved in shaping a GP's perception of primary care counselling.

The study focuses on the GP-counsellor relationship, GP satisfaction with the service, GPs' perceptions of counselling and the role of the counsellor in the practice. The research aims are addressed through using three different formats and combining qualitative and quantitative methods of analysis. A small group of GPs were interviewed on their experiences of a counselling service. These findings helped to shape the development of a survey looking at perceptions and experiences of primary care counselling. The survey was sent to a larger group of GPs and also to primary care counsellors. The third stage of the study involved meeting with a group of GPs to hear their views on primary care counselling services.

The results obtained from the study suggest that overall GPs value their counselling service but they seem to view counselling as a passive process. There is no consensus among GPs or among counsellors as to what counselling is. The role of the counsellor within the practice does not appear to be clear to the GP and there are differences between the counsellors' perceptions of their role and the GPs' perceptions. Issues of GP power emerge from the study and many GPs believe they offer counselling to their patients. These results are developed into a model showing the factors involved in a GP's perception of primary care counselling and what factors might lead a GP to form a negative or unhelpful perception of practice based counselling. From this model interventions are suggested aimed at changing unhelpful/negative perceptions that GPs may hold and interventions designed to promote good collaborative practice. These interventions are aimed at both GPs and primary care counsellors.

The study has implications for the training of both GPs and primary care counsellors as well as implications for service users. The study highlights the importance of collaborative working and the GP-counsellor relationship. Such research can help increase our understanding of inter-professional relationships.

CHAPTER 1

INTRODUCTION & LITERATURE REVIEW

Counselling is becoming a growth area in primary care. The purpose of this study is to explore and measure the experiences and perceptions of GPs who work with a counsellor (or group of counsellors) in their practice.

In considering the relevant literature, the background and development of counselling within primary care will be discussed, as will current changes within primary care. The advantages and disadvantages to offering counselling within general practice will be considered. Some background to the work of the GP will be helpful in understanding some of the issues the study hopes to address, particularly considering the ability of GPs to deal with the psychological problems of their patients. The question of whether GPs should offer counselling to patients will also be discussed.

There is evidence that counsellors have encountered difficulties working in primary care. A considerable part of this is to do with the different cultures of the GP (& Primary Health Care Team) and the counsellor. This issue will be explored through discussion of psychological research on group processes and the specific difficulties encountered by GPs and counsellors. This leads on to a consideration of how these difficulties might be addressed through collaborative working.

Finally, relevant research in the area of primary care counselling will be reviewed and gaps in current research highlighted. Potential ways to research these issues will be discussed and the aims of the study stated. This will include a consideration of the theoretical aspects of perception, particularly social perception leading on to a discussion about attributions. This is helpful in understanding from a theoretical perspective, the perceptions of GPs and counsellors and the attributions a GP might make about the practice counsellor.

1.1 THE DEVELOPMENT OF COUNSELLING WITHIN PRIMARY CARE

Research in general practice repeatedly shows a high proportion of patients presenting with emotional distress (Small & Conlon 1988). It is estimated that approximately 40% of GP consultations involve such problems (Goldberg & Huxley 1992). In considering the presentation of psychological problems in general practice, there appears to be a wide variation in reported prevalence and incidence (Markus, Murray Parkes, Tomson & Johnston 1989). However, there is consensus that a significant proportion of patients consult their GP over issues such as family problems, anxiety, financial difficulties, insecurity and sexual problems (Cohen & Halpern 1978). Often the GP is not trained to deal with these issues and receives little support in doing so (Cohen & Halpern 1978).

Balint in the 1950's showed GPs the value of listening to their patients and being aware of their patients' feelings (Salinsky & Curtis-Jenkins 1994). However, there came a realism that with the increasing demands placed upon them, GPs would be unable to offer many patients the time they needed to address their concerns. Many GPs have voiced their unhappiness with the quality and quantity of psychological care available to their patients (Broome & Kat 1981). When this is considered with the GPs' reluctance to involve themselves in this type of work (Balint 1964), a role for counsellors within a general practice setting becomes apparent.

The reasons for the emergence of counselling within primary care, suggest Shillitoe and Hall (1997), are to be found in changes in society, changes within the NHS and changes within the professions.

Nurses and health visitors have been attached to GP practices for many years. 1959 saw the introduction of social worker attachments. Despite its success such attachments developed slowly (Brook & Temperley 1976). However the policy from 1960's onwards of the closure of psychiatric hospitals meant the shifting of mental health services into the community (Goldberg & Jackson 1992). The Trethowan Report (1974) suggested that studies be carried out of GP referrals to clinical psychology and envisaged psychologists extending their role into primary care. Other health policy, particularly the Tomlinson Report (1992) continued this further by emphasising the

importance of the decentralisation of health services. This has speeded the shift of services (including mental health services) to primary care and community settings (Tomlinson 1992). This policy has led to the increasing influence of GPs on the provision of health care (Day & Wren 1994). Funding changes in the NHS also make it easier for GPs to employ staff, like counsellors, themselves.

The development of counselling within general practice may also be viewed within the context of a changing public perception about mental illness. The public are now more exposed to the concept of counselling particularly by the media in response to major tragedies or disasters (Shillitoe & Hall 1997). Counselling has become less stigmatising as a result. Cohen and Halpern (1978) argue that the need to curtail health costs, to provide better community care and to keep people out of hospital is encouraging the GP to consider a more holistic approach to medicine. The shifting of philosophy by the medical establishment and their willingness to consider non-traditional and non-pharmacological treatments to the management of psychological problems has allowed for the development and increasing acceptance of counselling within primary care.

Finally, from an economic perspective, a shortage of clinical psychologists and the lesser costs involved in employing counsellors has allowed counsellors to be 'accepted' into the NHS to provide a service that was once the domain of clinical psychologists.

Counsellors are now firmly established within the NHS (Shillitoe & Hall 1997). Studies indicate that approximately a third of general practices in England and Wales have a counsellor (Kendrick, Sibbald, Hall et al 1993; Sibbald, Hall, Brenneman & Freeling 1993). This figure has recently increased to just over 50% (Curtis-Jenkins 1998). The distribution of counsellors and the hours they work in practices varies widely across the country (Salinsky & Curtis-Jenkins 1994). Some counsellors provide 2-3 hours a week in a practice, others work as part of a counselling team in a practice and may offer a comprehensive service with little or no waiting time for appointments (Salinsky & Curtis-Jenkins 1994). Counsellors may be employed directly by the practice or may be 'attached' to the practice through the local NHS provider. Some counsellors remain employed on a voluntary basis, although this appears to be changing as counselling develops to offer a more 'professional' image. Although some research (e.g. McLeod 1988) indicates that the image of the counsellor as a non-professional voluntary worker lingers on. Counsellors in general practice work with a wide range of problems from

issues relating to loss and bereavement to more complex difficulties of phobias, obsessive compulsive disorder, anxiety and depression (Salinsky & Curtis-Jenkins 1994). Other presenting problems may include relationship or sexual difficulties, post traumatic stress disorder, eating disorders or substance abuse (Salinsky & Curtis-Jenkins 1994). Research looking at problems referred to a practice counsellor by the GP indicates that anxiety, relationship problems, sexual problems, psychosomatic symptoms are common referrals (Waydenfeld & Waydenfeld 1980; Marsh & Barr 1975; St. George 1976; Cohen 1977; Meacher 1977; Heisler 1979; McLeod 1988).

Counsellors may vary in their training and the type of therapy they offer in the surgery. For example; long term therapy, short-term therapy, one-to-one counselling, group work. McLeod (1988) found that of her sample of counsellors, 3 were nurses, 2 were psychiatric nurses, one was a health visitor and another a social worker. Her sample also varied in the type of counselling they offered as some were trained in marriage guidance, others in transpersonal therapy. A recent survey of primary care counsellors (Curtis-Jenkins 1998), with a sample size of 800, found a variation in training standards with 90% of counsellors having a minimum of a diploma or certificate level qualification in counselling and of these 34% hold a first or masters degree in counselling and seemingly 10% of respondents do not hold a relevant counselling qualification.

Research appears to suggest the benefits of short-term therapy in primary care (Hemmings 2000), although there may be a need amongst some patients for longer term therapy (Hudson-Allez 2001). Some counsellors are trained in family therapy or marital therapy and this will be reflected in the type of patients they see. Although research suggests it is not counsellor orientation, but non-specific factors (e.g. the therapeutic relationship) to be a major predictor of outcome in therapy (Clarkson 1996). Group work can be useful in general practice especially for teaching self-help methods. It is also cost effective, although not widely used in general practice (McLeod 1988). It has been suggested that a counsellor works 35 hours a week in a practice with a patient list size of 7000 – 9000 patients; spending approximately 60% of the time on one-to-one counselling and the remaining time on administration, supervision and consultancy (Curtis-Jenkins 1995).

When the Labour Party came into government in 1997 they made several major changes to the organisation of primary care services through their white paper 'The New NHS Modern & Dependable' (NHS Executive 1998). April 1999 has seen the introduction of Primary Care Groups and clinical governance. This means that GPs and *not* health authorities are responsible for purchasing health care on behalf of their patients. Local GP practices are grouped together to form a Primary Care Group formed mainly of GPs and practice nurses. The group has a combined patient list size of about 100,000 patients (Curtis-Jenkins 1998). Together, as a group they decide which services to purchase. This change has lessened very considerably the role of local health authorities. These changes may impact on the provision of counselling in primary care (this will be discussed later). Another new development with the formation of Primary Care Groups is the concept of clinical governance in primary care (and throughout the NHS). This means that GPs and the rest of the PHCT will be responsible for providing high quality care and for developing ways of monitoring quality (Roland 1999).

The Advantages of Offering a Practice-Based Counselling Service

In considering the potential benefits offered by providing counselling within the surgery, four main areas can be considered;

- benefits to the patient
- benefits to the GP
- benefits to the PHCT
- cost benefits

It has been argued (e.g. Brook & Temperley 1976) that many patients obtain help with their psychological problems at a much earlier stage through offering practice-based counselling. Also a substantial number of patients are able to obtain help who would not have accepted a referral to a psychiatric service or another, outside agency (Brook & Temperley 1976). These are commonly cited advantages to offering such a service; patients feel secure being seen on familiar premises that are easily accessible. A practice-based service allows for continuity and evaluation of patient care (Wyld 1981). Being practice-based also lessens the stigma associated with receiving psychological help and offers the opportunity for an early intervention (Brunning & Burd 1993). A psychological model of care can offer the patient an opportunity to learn and develop

effective ways of managing their problems beyond the therapy (Brunning & Burd 1993), therefore lessening the chances of their difficulties returning. A referral to a practice counsellor can also show the patient the willingness of their doctor to recognise emotional distress behind a somatic symptom (Waydenfeld & Waydenfeld 1980).

It has been suggested that, particularly for GPs who are not interested in psychological issues, the patients in their care would benefit from a counsellor attachment (Rowland, Irving & Maynard 1989). Whether such GPs would request and value a counselling service is another matter. Studies have indicated that doctors value the expertise the counsellor can bring to the practice particularly in helping the GP to distinguish between problems that can be dealt with in the practice and those that require a specialist referral (Brook & Temperley 1976). The counsellor can therefore facilitate the work of the GP, leading to an earlier identification of problems, fewer inappropriate referrals and an overall reduction in consultation time and medication offered (Rowland & Irving 1984). Having a counsellor in the practice can also reduce GP stress (Brunning & Burd 1993) and increase awareness of mental health issues (Campbell 1995). It offers the GP a way of helping the patient without recourse to medication (Cohen & Halpern 1978) and puts them under less pressure to prescribe (Waydenfeld & Waydenfeld 1980).

The benefits of having a counsellor in the practice may spread to all the PHCT, not just the doctors. The counsellor can heighten awareness of psychological issues within the team and encourage team members to develop their counselling skills (Rowland et al 1989). This may foster an increase in skills sharing across the team (Irving 1988), encourage case discussion and ease of referral (Rowland et al 1989). The counsellor may help with team building (Brunning & Burd 1993), bring a division to the workload and enhance mutual respect (Winter & Whitfield 1980). He/she may also be an additional support for the team (Breese 1994). The combination of which may be an overall increase in knowledge, improved working relations within the team and improved quality of patient care.

In 1980 nearly 39 million prescriptions for psychotropic drugs were issued (Health & Personal Social Services Statistics 1980). As Rowland and Irving (1984) argue, this figure does not reflect the cost in GP time, in pharmacists' salary, in administration and packaging, not to mention the cost of hospitalisation for patients who abuse or overdose

on their prescribed medication. However, the presence of a counsellor in the surgery has been shown in some studies to reduce the demand on GP time and reduce the prescribing of psychotropic drugs (Marsh & Barr 1975; Anderson & Hasler 1979; Law 1984).

Cohen and Halpern (1978) cite potential benefits for a counsellor working in a general practice setting, namely the support from other team members, the contact and reassurance offered. The practice setting provides the counsellor with easy access to medical notes and prompt medical help if necessary (Waydenfeld & Waydenfeld 1980). The counsellor can feel satisfied seeing the improvement, tolerance and acceptance of the patients helped.

The Disadvantages of Offering a Practice-Based Counselling Service

There can be disadvantages as well as difficulties to offering a practice-based counselling service. These disadvantages may be considered in three broad areas

- is the counsellor the most appropriate professional to offer counselling in the practice?
- The accessibility of a practice-based counselling service
- A centralised versus a practice-based counselling service

In considering whether or not the counsellor is the most appropriate professional to offer a practice-based counselling service an immediate disadvantage may be the counsellor's lack of medical knowledge (McLeod 1988). This may leave the counsellor feeling inadequate and isolated from the rest of PHCT. Arguably other professionals (e.g. community psychiatric nurses) with a medical background may feel more at ease working within the medical domain of the GP practice. However, this issue may be addressed through improving the training of primary care counsellors (as will be discussed more fully further on in the study). A practice-based counsellor may also find it difficult to compromise over methods of working (McLeod 1988), this may be less of an issue for other mental health professionals.

Corney (1999) found a considerable degree of overlap between mental health professionals in their training, techniques employed and range of problems referred. Cape and Parham (2001) also found the case mix of practice counsellors and clinical

psychologists to be broadly similar. One may ask, therefore, whether counsellors are duplicating services offered by other mental health professionals. If so, is there a need for a practice-based service? However, although some overlap may exist, the demand for primary care counselling and the reported rates of patient satisfaction with the service (e.g. Meacher 1977, Anderson & Hasler 1979, Wyld 1981) strongly suggest that there is a need for a practice-based counselling service.

Although the accessibility of the GP practice may be seen as a strength of a primary care counselling service, such a service is only accessible to those registered at the practice. This could exclude certain vulnerable groups such as the homeless or refugees. Such groups could benefit from the services of counsellors but may not be registered at a practice. The Government in the National Service Framework for Mental Health (NHS Executive 1999) has highlighted the mental health needs of the homeless as views them as a vulnerable group. A centralised counselling service may overcome these problems by accepting referrals from a wider source than just the PHCT.

Approximately two thirds of practice-based counsellors are employed directly by the practice (Curtis-Jenkins 1998a). This may be a disadvantage to a practice-based counselling as it could create difficulties for both the GP and the counsellor. Brunning and Burd (1993) argue that if a GP is effectively paying for the counselling sessions, he/she may feel they can dictate the use of sessions. This could cause considerable problems for the GP, the patient and the counsellor and may undermine the effectiveness of the counselling service. This problem could be overcome or minimised by having counsellors 'attached' to GP practices and employed by the local mental health trust (as happens in some primary care counselling services). Counsellors themselves are pushing for this and a move away from direct employment by the practice.

The service structure of a practice-based counselling service may be viewed as a disadvantage of such a service. Would, for example a centralised counselling service, (that is, not located within the GP practice but at a central location servicing a number of GP practices) be more advantageous? Such a service structure may address a number of potential disadvantages of a practice-based service. For example, problems can arise from having no specific room in which to work in the practice, this can be disruptive for both the counsellor and the patient (McLeod 1988). Many GP practices may not have a

room available that can be regularly used by the counsellor or that provides the therapeutic environment that is appropriate for counselling.

A centralised counselling service may have other advantages over a practice-based counselling service. Arguable a team of counsellors may minimise the professional isolation that McLeod (1988) speaks of with respect to the practice counsellor. A centralised service consisting of a team of counsellors may offer the patient more choice in relation to what counsellor they see and what type of therapy they are offered. For example, some patients may prefer to see a counsellor of a particular gender or ethnic background (following on from the NHS Executive 1997 paper, “Working Together: Securing a Quality Workforce for NHS” this will become increasingly important). That choice is unlikely to be offered at a practice-based counselling service. Likewise a patient may present with a particular problem that best responds to a particular intervention. This issue is very relevant given recent Department of Health (2001) guidelines on treatment of choice for psychological problems. For example a patient presenting with panic disorder to a practice-based counsellor may not be offered the treatment of choice (i.e. CBT) if the counsellor is not trained to offer this. Arguably a centralised service may be better able to get around this issue by having a team of counsellors offering a mix of therapies.

A further disadvantage of a practice-based counselling service may be that the GP surgery is a setting where the patient can bump into friends or neighbours, and so the patient may prefer to see the counsellor somewhere more anonymous. Also some patients may be concerned about information from the sessions or the referral appearing in their medical notes. This may prompt some patients to seek counselling elsewhere.

The difficulties of providing a primary care counselling service will be discussed further on in this chapter. A final disadvantage of such a service may be that the difficulties are so overwhelming that they offset the potential advantages of a practice-based service.

Despite these disadvantages, the idea of offering counselling through the NHS to patients in a familiar and accessible setting appears, in principle, to provide a potentially useful service to both GPs and patients.

When considering the perceptions and experiences of GPs of primary care counselling it is useful to think about the role of the GP as this will influence a GP's perception. The role of the GP will have a bearing on the GP-counsellor relationship. The GP and mental health issues is also relevant when considering whether GPs should offer counselling to their patients.

The role of the general practitioner today is a complex and often stressful one. GPs work in comparative isolation from specialists, hospitals and community services (Mansfield 1991). Although with the recent development of Primary Care Groups this isolation may be lessened but there may be increased stress with the increased responsibilities. GPs wish for increased respect and recognition (Bowling, Jacobson, Southgate et al 1991). Doctors are one of the professional groups at greatest risk of depression, marital breakdown, alcoholism and suicide (Zigmond 1984). This may lead one to consider how wise is it for doctors who are unprepared and untrained to take on patients' feelings as well as their medical problems (Breese 1994).

The Ability of GPs to Detect Psychological Problems

Medical training is notoriously lacking in helping doctors address their own needs and feelings and few opportunities exist for the well established GP to increase his/her self-awareness (McLeod 1988). Many GP trainees comment on the inappropriateness of their hospital based psychiatric training to prepare them for dealing with the emotional problems of their patients (Markus et al 1989). It has been suggested that the GP needs help not with the small number of severely mentally ill patients referred to psychiatry, but the other 90% of the emotionally disturbed population (Lesser 1983). Early detection and treatment of the emotional problems results in symptom relief without 'medicalising' the problem and with cost benefits (Johnson & Goldberg 1976). Without adequate training a patient's psychological problems may go unrecognised and untreated. Or the possibility of unnecessary medical treatment, inappropriate referral and the potential for chronicity (Grol 1983; Melville 1987; Wilkinson, Smeeton, Skuse and Fry 1988).

GPs vary widely in their reported rates for psychiatric disorder among their patients (Goldberg & Kessel 1975). In trying to account for this wide variation two factors have been identified as important. They are GP 'interest (in psychiatry) and concern (about the patient)' and GP 'conservatism' (Marks, Goldberg & Hillier 1979). This study also supports the view that GPs who ask their patients about family life or possible problems at home and who frequently use questions with a psychiatric content are very much more likely to be accurate raters of psychiatric problems (Marks et al 1979). A more recent study carried out in Australia (Davenport, Hickie, Naismith, Hadzi-Pavlovic & Scott 2001) also found a large variation in GP reported rates of psychological problems. The study found the rates at which GPs made psychological diagnoses varied between practices from 12% and 52% (median 27%).

About 40% of GPs undertake a 6-month hospital attachment in psychiatry during their training (Paykel, Tylee, Wright, Priest, Rix and Hart 1997). This means that 60% of GPs will have had no specialist training in psychiatry and yet are required to identify, and in most cases treat, patients presenting with a wide range of psychiatric and psychological problems.

In January 1992 the Defeat Depression Campaign was launched by the Royal College of Psychiatrists and the Royal College of General Practitioners. It ran for 4 years (from 1992 – 1996) and its aim was to educate GPs to recognise and manage depression. Research has indicated varying attitudes and knowledge about depression among GPs (Botega, Blizzard, Wilkinson & Mann 1992; Kerr, Blizzard & Mann 1995). The outcome of the campaign is that GPs who were aware of it expressed greater confidence in their ability to treat depression (Rix, Paykel, Lelliott, Tylee, Freeling, Gask & Hart 1999). Interestingly the campaign had the highest impact among younger GPs and those who had undertaken a 6-month training post in psychiatry (Rix et al 1999). Other controlled studies (e.g. Howe 1996) have also demonstrated that using a brief, self-directed educational intervention focusing on the detection of psychological distress can improve the GPs performance in this area significantly. The Royal College of General Practitioners is educating GPs about mental illness by developing a new network of over 60 teachers to teach GPs (Burd, Chambers, Cohen, King, Lloyd, Maxwell, Robson, Tudor-Miles, Tylee & Wright 1999).

Waydenfeld and Waydenfeld (1980) argue that the inclusion of the subject area of counselling in the postgraduate syllabus of general practitioners would be useful and report that the Royal College of General Practitioners has recognised this need (Home Office 1979). However, over 20 years on from their paper, counselling is still not widely available in postgraduate training for GPs (personal communication from GP).

The GP as a Counsellor

When faced with a significant number of patients presenting themselves with psychological problems; can, and should, GPs counsel their patients?

Many GPs use counselling skills during the course of their work (Rowland, Irving & Maynard 1989). Through listening and asking appropriate questions the GP can encourage the distressed patient to open up and talk about his/her difficulties. However, an important distinction needs to be made between using counselling skills (for example, listening, offering empathy) and offering counselling. Many professionals may use counselling skills in the course of their work, for example, teachers, nurses, personnel officers, but they are not offering *counselling* as this involves a greater level of expertise on the part of the professional and a formal arrangement with the client. Although counselling skills may be extremely useful to the GP, the focus of his/her work is different from that of the counsellor (Rowland et al 1989).

There are many difficulties for GPs considering offering formal counselling to their patients. Firstly, patient expectations may present considerable barriers. The patient will not expect to see his/her doctor in this role and may find it confusing (McLeod 1988). The GP-patient relationship may be a mixing of social and professional contact and could compromise any counselling relationship (Rowland et al 1989). Probably the biggest constraint on the GP would be time and the emotional pressure involved in counselling patients. However, research has shown that without taking extra time, GPs can use counselling skills instead of prescribing benzodiazepines (Catalan & Gath 1985). There is a role for the use of counselling skills by GPs, but formal counselling may not be the most efficient or cost effective use of practice time (Rowland et al 1989).

Rowland et al (1989) argue that students selected for medical training are not usually selected for their counselling potential and their education produces a professional with a different orientation from that of a counsellor. Medical training is designed to produce doctors and not counsellors. However, Newsome (1980) suggests that medical training and practice can produce an arrogance and distance within the doctor, which conflicts with a counselling approach.

Some GPs who tried to offer formal counselling to their patients found that they worked late, that their family life suffered and that the emotional demands made by offering counselling in addition to their other work, were too great (McLeod 1988).

Referral Issues

GPs vary widely in their referral rates to their services (Newton, Hayes & Hutchinson 1991). Due to the expense and limited resources of using NHS services, there has been an incentive to try to explain and understand these differences.

Newton et al (1991) attempted to address this issue in a different way from previous research by considering referring as a type of social interaction, best understood by interpreting the meanings and motives of those involved. Through their qualitative analysis of interviews with 15 GPs they concluded that a large number of referral decisions are not only difficult to make from a clinical perspective but are further complicated by the personal values, skills and experiences of those involved in the process as well as the nature of the relationship between them (Newton et al 1991). The researchers identified 4 factors that influence the referral process; doctor associated factors, patient associated factors, case specific factors and structural factors. They also emphasize that a good GP-patient relationship may facilitate open communication, so enabling the GP to reassure a patient if the GP feels a referral is not necessary.

In terms of referring for psychological problems, many GPs do still want to deal with many cases themselves and rarely see psychologists as essential (Gordon 1987).

1.3 THE MEDICAL MODEL vs THE PSYCHOLOGICAL MODEL

Despite the potential advantages in offering a practice based counselling services, difficulties can arise for the counsellor and the GP working in primary care from the clash of cultures between the GP (who is trained in a medical model) and the counsellor (whose training is from a psychological model). The medical model in this sense refers to models of treatment that emphasise the dominance of biological processes in health and illness. The psychological model refers to models of treatment that emphasise the role of psychological processes in health and illness. Eastman and McPherson (1982) carried out a study looking at GPs' perceptions of psychological problems and the relevance of clinical psychologists. They found that a significant proportion of "sympathetic" GPs (i.e. those GPs interested in clinical psychologists becoming involved at a primary care level) anticipated that difficulties may arise in collaboration between the GP and the clinical psychologist. The main problems often cited in research in this area are; differences in training and working between the GP and the counsellor; differences in power; communication difficulties; differences in the use confidentiality; and a different relationship with patients.

Before we consider these specific difficulties in relation to GPs and primary care counsellors, it may be helpful to consider theories about group processes. These theories may help explain some of the difficulties for the GP and/or primary care counsellor when working together.

Group Processes

The GP and primary care counsellor are both members of their own respective professional groups, as well as being members of the same group (The Primary Health Care Team). Theories about groups and group processes may be helpful to consider in our understanding of the perceptions the GP and counsellor may have about each other, this in turn will impact on their relationship.

Group Structure

This refers to the system of roles, relationships and norms among group members and as such it provides a framework for the group's functioning (Deaux & Wrightsman 1988).

Group cohesiveness has been found to be important in influencing people, their productivity and providing job satisfaction (Pennington 1986). Little past experience of groups has been shown to be a disadvantage to the member as they will be unfamiliar with group processes and norms (Deaux & Wrightsman 1986).

Role & Role Expectation

An individual's behaviour within a group is influenced by his/her role. Shaw (1971) made a helpful distinction between expected role, perceived role, and enacted role. The expected role refers to the behaviours thought appropriate by others in the group, the perceived role is the behaviour the individual thinks he/she should enact and the enacted role refers to the actual behaviour of the individual. Where these three factors show little, if any difference, conflict between the individual and rest of the group will be low. However, where these differ, group conflict may result (Pennington 1986). In this situation Pennington (1986) suggests there are three options; the person occupying the role may be put under pressure to conform to group expectations, may be asked to leave the group or the individual may attempt to change the expectations of other group members.

In his research on roles and group processes, Schachter (1951) found that the role a person adopts within a group affects communication patterns. If a group member holds an extreme and different view from the rest of the group and does not shift in his/her position, other group members will dramatically lessen their communication to that group member.

Status & Power

The role of a group member will often have a status ascribed to it. With status comes power. A theory on status development within groups has been developed (Berger, Rosenholtz & Zelditch 1980; Humphreys & Berger 1981). According to this theory (*"status characteristics theory"*), differences in evaluations and beliefs about types of individuals form the basis for inequalities within the group. Certain expectations are attached to the performance of those who differ in status. Some of these expectations are formed from the specific tasks for the group (a specific status characteristic), others are not directly linked to the group task but may be based on race or gender, for

example (a diffuse status characteristic). These characteristics may be used to form expectations about the performance of a group member.

Research on power within groups suggests that members of high power groups tend not to treat those with less power very well (Brown 1988). Sachdev and Bourhis (1985) demonstrated in-group favouritism and showed that as groups became more powerful they sought to consolidate their power still further. Interestingly, the research suggests that groups with 'absolute power' may tend to moderate this bias slightly. This is possibly because they are so secure in their position they can afford to treat less powerful groups a little better (Brown 1988).

Group Attributions

Issues of attribution will be explored further on in this chapter. In a group situation, research seems to suggest that group behaviour shows similar biases to individual behaviour when we consider attributions. Pettigrew (1979) highlighted biases within one's own group (the in-group) relative to another group (the out-group). Negative behaviour by out-group members was seen as dispositionally caused while the same behaviour from in-group members was explained as being due to external causes. That is, attributions are made that favour the in-group (Brown 1988).

Minority Group Influences

From the perspective of PHCT, the counsellor, in many instances, may be viewed as a minority member of the group (firstly, a minority as possibly the only group member whose training is psychological in orientation and secondly, a minority, as possibly the newest addition to the group).

Research suggests that in certain circumstances it is possible for a minority group member to influence the majority. A minority member can be most effective in influencing the group when its members have higher status or greater ability, when they are closer to the majority in space or time, and when minority numbers are larger (Deaux & Wrightsman 1988). A minority that states its position consistently may be more successful in influencing the majority (Nemeth 1979). However, if the minority are perceived to be too rigid they may alienate the majority (Di Giacomo 1980).

Gender Differences

In determining attitudes, research on group processes has found gender differences in certain areas. Women have been found to be better able to judge the affective or emotional state of others (Hall 1984; 1986). This may account for why the counselling profession is female dominated.

The particular difficulties cited by GPs and primary care counsellors who work together will now be considered.

Mind/Body Dualism

The mind/body dualism is a dichotomy that views our experience as two disparate entities. It could be argued this is the single conceptual element that most characterises Western culture (Seaburn et al 1996). Issues of mind-body dualism are relevant as this study is exploring the provision of a psychologically based service (i.e. a service that focuses on the ‘mind’) within the medical domain of the GP surgery (i.e. where the focus is on the ‘body’). Health care has been divided into care for the mind and care for the body. It has been argued that this is a false dichotomy that artificially separates how people think, feel and exist (Brown & Zinberg 1982) and that it should be discarded as patients do not come in compartmentalised form but whole. Therefore a holistic approach to patient health care is optimal (Brown & Zinberg 1982). Research suggests that other cultures hold a more integrated view of illness. For example, Shapiro (1990) looked at the views of the people in Bali on the mind-body relationship and found an integrated view of mind-body-spirit; Ekblad (1996) studied the views of Chinese people on these issues and Hyun (1996) looked at the Korean community on issues of mental health. These studies suggest a different view of illness from Western culture.

Possibly some of the difficulties between the GP and counsellor are related to their different conceptualisation of health and illness, with the GP focusing on biomedical processes and the counsellor focusing on psychological processes. However, it can be seen that both psychological and physical processes are involved in the development and maintenance of a wide range of health issues. A whole area of health research is devoted to illnesses that may be viewed as psycho-physiological. This term refers to physical symptoms or illnesses that “result from the interplay of psychosocial and

physiological processes” (Sarafino 1990 p134). Another frequently used term for these illnesses is psychosomatic and such illnesses are linked with stress. Examples include ulcers, inflammatory bowel disease, asthma, eczema and tension headaches (Sarafino 1990).

It is therefore useful to consider how GPs and counsellors may approach the problems of their patients with a common understanding. Models of illness that integrate both psychological and physical processes will be explored further on in this chapter.

Different Training and Ways of Working

In Western culture the mind-body dichotomy can be seen in the different training and ways of working between the GP and the counsellor and the difficulties that can arise from it. GP training focuses on the body; the counsellor’s training focuses on the mind.

Medical training focuses on the application of concrete scientific findings and emphasises well-defined assessment and treatment protocols (Pace et al 1995). The emphasis is goal oriented (as against process oriented), the model attaches less importance on the *process* of becoming or feeling ill (Brown & Zinberg 1982). Psychologists and counsellors tend to think in terms of methods and processes, whereas physicians typically seek specific facts and concrete solutions (Schon 1987). The process orientation of the psychological practitioner involves understanding the patient’s life experiences, internal psychological conflicts and character structure (Brown & Zinberg 1982). To a busy medical practitioner such approaches that value inclusive thinking and try to make psychological processes more explicit are often seen as unaffordable luxuries (Brown & Zinberg 1982).

It could be argued that medical practitioners value action. The focus on diagnosis reflects this attitude, in that diagnosis implies action or suggests future action (Brown & Zinberg 1982). A psychological training and way of working tends to be more accepting of relative inaction and uncertainty or delayed accomplishment. This may be seen in the context of an emphasis on subjective experience and motives rather than on disease or diagnosis (Brown & Zinberg 1982).

The degree of training and expertise in the biological, psychological and social bases for behaviour, health and illness differs between GPs and counsellors with the biomedical model continuing to serve as the dominant theoretical perspective for GPs (Pace et al 1995), although this may be changing (Campbell, McDaniel & Seaburn 1992).

Language

The differences in training and theoretical perspectives discussed above between the GP and the counsellor can be seen in the different language and technical jargon used by the two professions. This can lead to difficulties as it can limit clear communication and understanding of the issues for both the GP and the counsellor (Stabler 1988; Wales 1978; Wood 1991). Pace et al (1995) suggest that these differences may contribute to the GP lacking the appropriate skills or confidence to implement psychological recommendations effectively. So no action may be taken by the GP towards helping a patient in psychological distress or inappropriate or ineffective treatment may be provided. Such inadequate care could have economic and treatment implications (Pace et al 1995).

The language differences could also leave the counsellor feeling isolated working in an environment and within a team where the medical model and medical language pervades.

Confidentiality

The issue of confidentiality may cause difficulties in the GP- counsellor relationship. The GP, through his/her work, is used to sharing information about the patient with other GPs in the practice or to a specialist. Many patients are aware that this occurs and may even expect it to happen and that it is done so in their best interest. For the counsellor confidentiality may be perceived differently. It is seen as part of the therapeutic relationship that what is discussed in the session remains confidential between the counsellor and the patient (unless the patients' life or that of another person is perceived to be in danger). This is usually made explicit to the patient at the beginning of therapy. For many counsellors, disclosures to the GP are only made with the patient's knowledge and agreement (McLeod 1988). Doctors can find it difficult and

frustrating to accept that there may be some areas in a patient's private life that the patient does not wish the doctor to know about (McLeod 1988). This perceived reluctance to share information may be perceived by the GP that the counsellor is not willing to be fully part of the PHCT.

Here is an example where mutual understanding of each other's roles is vital. For the GP to understand and respect the working of the counsellor and the importance of confidentiality in the counsellor-patient relationship. For the counsellor to be willing to let go of ways of working which were suitable in other contexts (Henderson 1996). Within a private practice setting the absolutes of confidentiality maybe rigidly adhered to, however, within an NHS culture where information sharing is the norm, this may cause difficulties. It requires the counsellor to tread a fine balance in maintaining a collaborative relationship with his/her GP whilst also remaining true to his/her role as a counsellor. The two are not mutually exclusive.

Communication

Good communication between the GP and the counsellor is vital to the success of a counselling service in a primary care setting (McLeod 1988). The difficulties that can exist in this area have been well-documented (McLeod 1988; Groot 1985). Some of the communication problems may be seen in the context of the setting itself, usually a busy and hectic environment. If the counsellor uses the GP's room to see patients, he/she may never actually see the GP; this will obviously inhibit good communication. McLeod (1988) suggests that some GPs may be ambivalent about the work of the counsellors and may be more used to directing and acting than to consulting on a peer level.

GPs and counsellors appear to have differing expectations regarding communication. For the GP, time spent with a patient is of central importance; liaison is less of a priority. For the counsellor liaison is important to keep others in touch and to improve the quality of the service (Small & Conlon 1988). For the counsellor, supervision is essential; for most GPs there is no supervision.

The counsellor can have a useful role within the practice to facilitate good communication. They can help the GP and other members of the team to make

appropriate referrals and also to offer new insights with patients with whom the GP may be experiencing difficulties (McLeod 1988). This may reduce the stress of the GP and enable the counsellor to feel less professionally isolated (McLeod 1988). It also provides the opportunity for the counsellor to learn more about the working of the doctor, this can only enhance mutual understanding of each other's roles and improve the GP- counsellor relationship.

Power, Identity & Role

As has been discussed earlier, issues of power and roles within a group are of central importance to both the group and the individual members. One difficulty that may arise for the GP and the counsellor concerns their different roles and associated power. What Huntington (1981) describes as the problems encountered when different occupations meet on the home ground of one of them. By working in a GP practice, the counsellor is effectively working on the GP's territory; this creates a power differential between the GP and the counsellor. This may be reinforced by the fact that in many practices the counsellor is dependant upon the GP for referrals and therefore, upon the GP's definition of what is valid work for him/her to do (Small & Conlon 1988).

Reason (1991) has explored the difficulties in multidisciplinary collaboration in terms of power and power conflicts in the context of group processes. Within the PHCT power struggles may be viewed where those within the group reach out to the most similar other and away from those they experience as dissimilar. The different pairings may join together and vie for control. This struggle may be important for the effective life of the group (Reason 1991), but this phase may develop into a structure within the group where all the members have an acceptable position within the group. From this comes a deep understanding of each other's needs within the group.

Issues of power, identity and role may be understood within the context of the traditional role of the GP as the professional in charge of health care (Kingsbury 1987; Ross & Doherty 1988). This may extend from making decisions controlling a patient's access to other health care services or to other professionals (Pace et al 1995). This power the GP has (and indeed the medical model has) is maintained by systems within the health service (e.g. prescribing medication). This creates a hierarchical structure that may make it a difficult environment for the counsellor to work in and is certainly one

where the counsellor's skills and expertise are not given the same status as that of the GP. Another difficulty is that GPs may be unsure about what counsellors are trained to do (Hughes 1994), thus creating some confusion about the role of the counsellor in general practice.

Some authors see a clear concept of managerialism with general practice with the assumption that the doctor exerts authority over the other members of the PHCT who occupy lower levels and assist in the main task of serving the doctor (Small & Conlon 1988).

Relationship with Patients

The GP and the counsellor, due to their different ways of working and different status tend to relate to patients in a qualitatively different way that is also, in part, due to the different expectations patients may have of each professional.

Small and Conlon (1988) cite several important differences between the GP-patient relationship and the counsellor-patient relationship. Some GPs may have known their patient (and indeed the patient's family) for many years. They may see the patient frequently or occasionally. Whilst with the patient, the GP may be interrupted by the receptionist or on the telephone. The consultation will probably last 5-10 minutes and absences or holidays would not usually be communicated to the patient. The GP takes overall responsibility for the patient's medical (physical and mental) care.

The counsellor is unlikely to have known the patient for many years and would not usually know the patient's family. The relationship is negotiated and, for a limited period, there is regular and ongoing contact at a fixed time and date. There would not usually be interruptions to sessions (although in a primary care setting this is sometimes unavoidable). Appointments are often 50-60 minutes and absences or holidays are usually communicated to patients in advance.

These differences in relating to the patient engender different patient expectations towards each professional. The GP acts in an executive capacity ("the expert") and the (passive) patient is relatively dependent upon the doctor to identify the problem and propose treatment (Brown & Zinberg 1982). The patient may see the counsellor

differently, less as “the expert”. This may lead to more equity in the relationship, with the patient being an active participant in the therapy. Brown and Zinberg (1982) suggest that the locus of responsibility tends to lie nearer the patient in psychological work. However, they qualify this by adding that medical practitioners do not view their patients as passive or ignorant and there is mutual responsibility in the GP-patient relationship (Brown & Zinberg 1982).

1.4 MODELS OF COLLABORATION

As can be seen, there are many differences between the GP and the counsellor that can create difficulties for *both* professionals when working together. One way to address these differences is through collaboration. Collaboration has been defined as, “*to work together*” (American Heritage Dictionary).

The potential importance of a collaborative approach is illustrated in the following quote;

“Each member of the collaboration should gain something in the process, and the product (of collaboration) should be better than either of the separate parts can provide”
(E Perrin 1999 p.58).

The importance of interdisciplinary collaboration in primary care has been recognised by the medical profession (Hart 1993). That in order to survive within an ever-changing environment, organisations must be able to constantly renew themselves. One element of change can be seen in interdisciplinary collaboration. Hart (1993) argues that “...*increasingly general practitioners recognise that success in primary care means being deadly serious about team working*” (p1024). What will be considered now are proposals or models of how the difficulties encountered by counsellors and GPs working together might be addressed through collaboration.

The Biopsychosocial Model

One well-known model proposing an inclusive approach to health care is the biopsychosocial model of medical care as initially proposed by George Engel (1977, 1980, 1987). This model emphasises the interplay among biological systems,

psychological systems and social systems (Ramsey 1989). It is argued that all of these systems operate simultaneously in health events and health care, but that focusing only on one, the biological system (as traditional medicine does) represents a cultural bias disguised as scientific theory (Baird & Doherty 1990). This model makes several assumptions that challenge the commonly accepted biomedical approach (as taught and practised by many doctors).

Firstly, the assumption is made that understanding the context of the patient is sometimes as important as understanding the main medical problem (Baird & Doherty 1990). This involves consideration by the doctor of issues like social difficulties, unemployment, family history, lifecycle events etc.

Secondly, the context of the doctor needs to be understood. Many issues can affect and influence how the doctor will respond to the patient. For example, the doctor's own tiredness, anger, marital problems or lifecycle issues (Baird & Doherty 1990). This is an issue rarely discussed openly. The assumption is that the doctor's decision is solely based on his /her experience or on relevant medical literature.

Thirdly, the context of health care environment is important (Doherty & Baird 1987; Glenn 1984; Doherty & Burge 1987). It can overwhelm or support the doctor and determine how he or she responds to the patient (Baird & Doherty 1990).

In terms of implementing the biopsychosocial model of health care through a family systems approach, a number of strategies have been suggested by proponents of this model to help doctors create change when a family or medical system seems stuck (Baird & Doherty 1990).

Firstly, it can be helpful to consider that medical diagnosis and/or treatment is not always useful (Bloch 1985; Beahrs 1986). A systems approach can teach the doctors that they may be only one of many people involved with a patient. For example, the patient's family, friends or employer may also provide more or less benefit to the patient than the doctor. This may be particularly true if the doctor fails to consider the context of the patient's medical complaint (Baird & Doherty 1990).

It can be helpful to get feedback from the patient (and family) for chronic illnesses if the doctor feels stuck. It can be useful for the doctor to take a different perspective on the issues; for example to consider who has defined this condition as a problem?

Other models of illness have been proposed that view illness in an integrated way and may therefore be helpful to both GPs and primary care counsellors in promoting a common understanding between them. One particular model will be explored.

Model of Cognitive Representation of Illness

This model (Leventhal & Cameron 1987; Leventhal et al 1992) explores how we develop certain ideas or beliefs about illness from our direct experiences as well as what we read or hear about illness. This model suggests that some of these beliefs may be correct and others may not be. The model may be viewed as a comprehensive model of the cognitive, emotional and behavioural responses to a health-threatening situation. It suggests that health-related behaviours are influenced by a person's health threat representation. This representation consists of an interplay between cognitive and emotional parts (Decruyenaere, Evers-Kiebooms, Welkenhuysen, Denayer & Claes 2000). This in turn affects our behaviour.

The model suggests that an individual constructs a mental representation of a health threat and possible action plans for managing the threat (e.g. seeing their GP, seeking information about their symptoms). Appraisal processes evaluate whether the coping strategies reduce the health threat (Decruyenaere et al 2000). These representations can change in the light of new information. Leventhal et al (1992) suggests 5 different cognitive attributes for the illness representation; identity, consequences, causal beliefs, course of the disease and cure. This model has been supported by research, for example Bishop and Converse (1986) studied students' knowledge of actual symptoms; Kaden et al (1985) studied mothers' understanding about their infant's congenital heart disease.

The cognitive representation of illness is a useful model as it views illness (even those illnesses seemingly rooted in physical processes) in an integrated way. For example, Decruyenaere et al (2000) use the model to help explore how women may understand and cope with information concerning genetic predisposition to breast cancer. Such an integrated view of illness helps us understand the complexity of illness and the interplay

of different factors. This may increase the understanding of both the GP and counsellor and help them work in a more integrated and collaborative manner with their patients.

Collaborative Working in Primary Care

The biopsychosocial model of health care discussed above has been developed further to a model for collaborative working between mental health workers and GPs (Seaburn, Lorenz, Gunn, Gawinske & Mauksch 1996). The aim of this model is to create a “culture of collaboration” to treat illness (mental & physical) and facilitate health. That is, a system of interaction that is created when GPs, mental health professionals, patients and their families work together over time to treat illness. Each person brings his or her own beliefs, values and experience to try to resolve the problem and stimulate change. Through this process relationships are formed that affect each participant and through which the potential for change is made apparent (Seaburn et al 1996).

Unlike the previous model, this model of collaboration includes the mental health professional and is, therefore, particularly relevant to primary care counselling.

The authors of this model suggest 3 basic tenets of collaboration that make it possible to create a culture of working together. These are:

1. An integrative paradigm regarding health and mental health problems.
2. An ecological perspective on the interaction between the professionals who collaborate.
3. The treatment of patients and families as partners in care. (Seaburn et al 1996).

1. The Integrative Paradigm

The paradigm suggested is the biopsychosocial model discussed earlier. However, for a culture of collaboration to develop this not only needs the GP to move from a purely biomedical to a biopsychosocial perspective, is also requires that the mental health professional make changes (Seaburn et al 1996). For some such professionals their training may leave them unfamiliar with or hostile to the medical illness itself (Seaburn et al 1996). This may be particularly true of many primary care counsellors who are often trained through courses with little, if any component on working in a medical setting. It has been suggested that mental health professionals may have a distorted view

of illness as a concept, seeing it as “reductionist”, “pathologising”, “disempowering” and “stigmatising” (Wynne, Shields & Sirkin 1992, p4). It is argued for mental health professionals to have a broader view of illness. Thus the collaborative approach allows the GP and the mental health professional to view problems in an integrated manner.

2. The Ecological Approach

The second tenet of a collaborative culture is an ecological approach on behalf of the professionals. When professionals come together to address a problem each professional uses only his or her own framework of origin with which to view the problem. For example, the counsellor stays within a psychological perspective and the GP within a medical perspective. Seaburn et al (1996) argue that the problem is not that each professional has a different perspective but that each professional stays within that perspective and does not communicate adequately with those from other disciplines. Each professional, therefore, takes “only those concepts which pose, no serious challenge or language difficulties”, (Auerswald 1968, p204).

The ecological approach

“invites professionals involved in collaboration to focus on the process of interaction between the professional, the patient and the family. By focusing on the process of communication among the parties involved, each collaborator minimises the risk of maintaining too narrow a vision of the problem. Instead each is invited to see with the eyes of the other participants. The collective viewpoint is then enriched” (Seaburn et al 1996, p20).

The aim of the ecological approach is to focus on the *process* as well as the content of communication between different people.

3. Partners in Care

This third tenet for collaborative working builds on the work of Baird and Doherty (1990) discussed earlier, in the triangular model of medicine. The aim is to move away from the doctor-patient dyad to the doctor-patient-family triad. In the model of collaborative working, the patient and the family are an important part of the conceptualisation of collaboration.

The Components of a Collaborative Relationship

Several, so-called key ingredients have been identified as necessary for effective collaboration between doctors and mental health professionals (Seaburn et al 1996).

These ingredients are:

1. Relationship
2. Common purpose
3. Paradigm
4. Communication
5. Location of service
6. Business arrangement

These components will be considered in turn, with particular reference to a primary care counselling service.

1. Relationship

The relationship between a GP and counsellor is central when considering collaborative working. Without a good relationship there cannot be effective collaboration. The building of a good working relationship between two professionals takes time. Seaburn et al (1996) suggest that collaborative relationships go through the stages of self-disclosure, checking each other out and building trust. The self-disclosure may be indirect and occur through case discussion between the GP and the counsellor.

The relationship may develop further and trust deepens. Discussion may be less patient focused and more focused on the GP and the counsellor. This becomes a “second order collaboration” (Seaburn et al 1996), where the professionals care for each other and grow together. Within this process there may be particular “collaborative moments” when the goals of the GP, the patient and the counsellor are all united and all work together to produce change.

Within a collaborative relationship mutual respect is necessary. Each collaborator must respect and value the expertise and perspective of the other (Seaburn et al 1996) whilst also being aware of his/her limitations.

A good working relationship between the GP and the counsellor implies recognising and sharing influence as a function of mutual respect (Seaburn et al 1996). It also allows for a flexible hierarchy and recognition that in some situations the GP may be the perceived expert and in others it may be the counsellor. This is a useful approach as it challenges the idea of the GP as being at the top of the hierarchy and the obvious imbalance in power that this creates in the GP-counsellor relationship. This idea of power sharing may also be applied to patients, allowing them to be more involved and more responsible for their health.

Seaburn et al (1996) also make a point that many counsellors may identify with. As mental health professionals the counsellors will probably have more expertise in the area of relationships and interpersonal skills. This enables the counsellor to facilitate a collaborative relationship with the GP but may also mean that the counsellor has to initiate this and may feel that they are doing all the work.

2. Common Purpose

The GP, the counsellor and the patient are working together to help the patient – this is their common goal. Schrage (1990) says, “*at the very heart of collaboration is a desire or need to solve a problem, create or discover something*” (p36). It is this common purpose that draws the professional and patient together. Even when the short-term goals of the patient, GP and counsellor may differ and could potentially cause conflict, it can be helpful for each party to review their goals to see that their common purpose may still be the same.

3. Paradigm

For effective collaboration it is not necessary for the professionals to share the same paradigm as long as there is a good relationship and a common purpose (Seaburn et al 1996). However, a shared paradigm does make collaboration easier. In considering collaboration between a GP and a counsellor, the paradigm in many cases will be different due to different training and orientation. However, the GP can still consider the patient’s psychological and social factors whilst focusing on their medical needs. Likewise, a counsellor may still consider the patient’s medical problems whilst focusing on their psychological issues. Thus effective collaboration between the GP and the

counsellor can still occur as they share a common purpose, although their paradigms may be different, they are not mutually exclusive.

4. Communication

As discussed earlier, good communication is essential for effective collaboration and can be a source of difficulty between the GP and the counsellor. Seaburn et al (1996) consider collaborative working in 5 aspects of communication.

Language

There are differences in language between the two professionals, which can inhibit good communication. Learning the meaning of symbols within the medical profession can be extremely useful for the counsellor and vice versa. Through doing so, each professional has the opportunity to learn about the culture of the other. It is also important to learn the language of the other professional in order to understand the rules for communication (Seaburn et al 1996). Clarifying these issues early on will certainly improve communication and the GP-counsellor relationship, thus enhancing collaboration.

Frequency & Duration

The GP's and the counsellor's sense of time is different. The pace at which they work and the duration and frequency of their contact with patients reflects their own professional culture. Given these differences, it is still possible for effective collaboration to take place but flexibility is required in the frequency of communication and will often be affected by the individual patient (Seaburn et al 1996). Sometimes intense and frequent communication between the two professionals will be required, and other times it may be less frequent.

Form

There are many different ways in which communication may take place between two professionals. An onsite counselling service will usually lend itself well to face-to-face communication between the GP and the counsellor. This can be a very effective form of communication as it allows for discussion and immediate feedback and is seen by some (e.g. Seaburn et al 1996) as the most effective form of communication. However, some GPs may never be in the surgery when the counsellor is there and this can make

communication more difficult. Meetings can be scheduled to allow for communication. Alternatively communication can be made through phone calls or letters. Letter writing is more permanent and allows for considered thought and is probably the most usual form of communication (Seaburn et al 1996). However, it does not allow for feedback and general discussion and due to its permanence a professional may feel more inhibited in what can be written.

From her study McLeod (1988) found that counsellors had reasonably easy, although brief contact with GPs and felt free to make contact to discuss patients. However, some counsellors wished to meet GPs more frequently but most GPs were reluctant to have any further meetings.

Content

For effective collaboration certain pieces of information need to be exchanged between professionals (Seaburn et al 1996). For example when referring a patient to the counsellor, the GP should mention the reasons for the referral and any important information about the patient. At the end of therapy the counsellor should mention what the outcome of therapy has been.

Confidentiality

This can be a difficult area for GPs and counsellors to negotiate. Doctors frequently complain that they hear nothing back from the mental health professional after referral (Seaburn et al 1996). However, if this issue can be discussed between the professionals early on and clarified this will certainly enable both the GP and the counsellor to know what is expected of them and each other. This may help to resolve some of the problems this issue can cause. Likewise it is good practice for the counsellor to clarify boundaries of confidentiality with the patient from the outset.

5. Location of Service

Collaboration is easier the closer the proximity the professionals are (Seaburn et al 1996). Three different types of location may be considered.

The Separate Model

This is the traditional model of mental health services whereby the mental health professionals are working in separate locations from the medical professionals.

This model is not applicable to primary care counselling services as the GP and counsellor are located in the same place.

The Together-but-Separate Model

This model may be applicable to some GPs and counsellors. The different professionals work within the same setting, the GPs “territory” (i.e. the surgery) but there is a fixed hierarchy usually with the doctor at the top. In this case sharing space is not equivalent to collaboration (Seaburn et al 1996). However, even within this model, collaboration can happen and co-location can allow for regular communication between professionals.

The Together Model

In this model the hierarchy is flexible and allows both professionals to work closely together. It is not assumed that the doctor will always lead, but the professional with the most expertise (this could be the patient in some circumstances). This model may apply to many GPs and primary care counsellors – particularly if the counsellor is not employed by the practice and therefore has more autonomy. This model facilitates effective collaboration between GP, counsellor and patient. It promotes the concept of an equal partnership (Bloch 1988).

6. Business Arrangement

The financial arrangement between professionals can affect collaboration. This is not applicable to those counsellors who are employed by an NHS Trust and attached to a GP practice. Some counsellors, however, are employed by a surgery and the business arrangement can raise issues of money, power and hierarchy (Seaburn et al 1996). In order for effective collaboration to occur within the arrangement, it is argued that these issues must be explicitly recognised and accommodated (Seaburn et al 1996).

It can be seen that in many different ways and at many different levels effective collaboration can occur between GPs and counsellors. The counsellor can play an important role in facilitating this. The counsellor may have different roles within the

practice, which can each promote collaborative working. Waskett (1996) identifies 3 ways in which the counsellor can encourage collaboration within the practice. Through consultancy, being proactive and through education/facilitation.

Consultancy

Waskett (1996) suggests that the counsellor's neutrality and curiosity are the most valuable assets in consultation. Through them the counsellor can help the members of the PHCT consider how they interact with each other and their patients.

Being Proactive

The counsellor will almost always have to be proactive within the PHCT (Waskett 1996) as the other team members may be used to working alone or only with professions from their own discipline. The counsellor can be proactive through sharing information, explanation and emotions (Waskett 1996). This involves the counsellor being aware of the differences between members of PHCT and attempting to bridge these differences. For example, by finding out more about the disease process and treatments. Waskett (1996) suggests that the counsellor will seek out collaborative work with the team members more directly through case discussion or possible joint work with patients.

Education / Facilitation

The counsellor may have a useful role in helping the team explore their interdependency and functioning. This needs to be approached within a manner of mutual respect by all team members and a shared objective of closer and collaborative working (Pritchard & Pritchard 1992). Team processes may be addressed in the following order (adapted by Pritchard & Pritchard, from Rubin et al 1975):

1. Goals – what are we here for?
2. Roles – who does what?
3. Procedures – how do we go about it?
4. Interpersonal relations – how do we get on together?

Action Learning

Another method of promoting collaboration between the GP and the counsellor is through the use of action learning (Curtis-Jenkins & White 1994). Action learning

usually involves the coming together of a group consisting of 8-10 individuals from different professions who meet regularly over several months to address different problems each group member may have which individually they have been unable to resolve. The members of the group try to help each other there and then to find a solution that is then tried out and reported back at the next meeting (Curtis-Jenkins & White 1994). Curtis-Jenkins and White (1994) used this model of learning to help counsellors and GPs address some of their difficulties working together. Two groups were set up consisting of 4 GPs and 4 counsellors in each group and arranged to meet 6 –7 times at 4 – 6 week intervals. One group completed 6 meetings, the other group terminated after 4. The groups looked at 9 work related areas; collaboration, patient referrals, confidentiality, waiting lists, support for GPs and counsellors, training, funding, evaluation of services, GPs as counsellors.

It was found that the safety of the action learning set allowed members to voice concerns they had not felt able to say before (Curtis-Jenkins & White 1994). For example, regarding referrals issues, it was found that GPs used different referral criteria and often failed to tell patients about the referral or what to expect from counselling. Some GPs felt that the counsellor failed to give feedback on patients. One solution suggested by the set was to give leaflets to patients explaining the counselling service and a way was suggested for the counsellor to give feedback to the GP without compromising confidentiality (Curtis-Jenkins & White 1994). It was found that the action learning set improved collaboration and interprofessional working between GPs and counsellors. The quality of the counselling service improved and may also be more cost effective as a result (Curtis-Jenkins & White 1994).

Although these suggestions for teamwork and teambuilding within the PHCT may be useful, teamwork appears to be rare within the surgery (Waskett 1996). This may be partly because of the time it requires to implement such strategies within an already overworked and overstretched team and maybe the idea of collaboration is unfamiliar to health service staff (Waskett 1996).

Thomas and Corney (1992) carried out a study aiming to obtain an estimate of the extent to which collaborative schemes exist between GPs and mental health professionals in England. They found that professional links were likely to be concentrated in certain GP practices. That some practices had many links with a range

of mental health professionals (e.g. psychologists, psychiatrists, social workers, CPN) while other practices (often smaller practices) have few, if any, links with such professionals. The authors raise the issue of equity from these findings – why should some patients be able to receive a wider range of services at the expense of other patients? The authors also raise the interesting question of whether interdisciplinary collaboration necessarily means a better service for patients. However, their study was unable to examine the quality of the relationship between mental health professionals and GPs and therefore, whether a good collaborative relationship existed or merely a “link”.

It can be seen that collaboration will be affected by each professional’s perception of the other. A GP with a negative perception of primary care counselling may find it more difficult to work collaboratively with the counsellor than a GP with a positive perception. Likewise, the process of collaboration itself may alter or reconfirm existing perceptions.

1.5 RESEARCH

Evaluative Studies

As the area of counselling within primary care has grown rapidly over the last 10 years so has the need to evaluate the effectiveness of primary care counselling.

Corney (1990) suggests 4 reasons why evaluative studies are so essential:

1. Some studies have suggested that some patients benefit more than others do from counselling. With limited resources available it is useful to identify which patients can benefit most from counselling.
2. To identify those patients who may be harmed through counselling.
3. To identify which type of therapy (e.g. cognitive-behaviour therapy or psychodynamic) might benefit the patient most and that the patient will find most acceptable.

4. To identify what level of skills, training and expertise are needed for change to occur. This is important when limited resources are available as some types of input (e.g. a self- help group) require less resources than others (e.g. one-to-one counselling).

A randomised control study evaluating counselling in primary care was carried out recently and published in the British Journal of General Practice (March 1998). In this study (Harvey, Nelson, Lyons, Unwin, Monaghan & Peters 1998) the interventions compared were access to counselling with usual GP care. The counselling evaluated was short-term (6 sessions), involving a person-centred approach. Nine practices were involved in the study and 162 patients participated with a range of mental health problems. Evaluation was measured by administering a questionnaire (the Hospital Anxiety & Depression Scale) to the patient at the start of treatment and 4 months after randomisation. Results indicated a significant improvement in both groups at follow-up, but no significant difference between each randomised group. The authors concluded there was no difference in functional or mental health outcome at 4 months between patients offered counselling and those seeing their GP.

Being published in a prestigious journal widely read by GPs and one used by potential purchasers of counselling services in allocating services makes this study an influential one. However, the Harvey et al (1998) study has been criticised for its methodology. For example, Curtis-Jenkins & Tylee (1998) comment that it is not clear what the primary outcome measure of the study is and secondly for the small sample size of GPs and counsellors used in the study; only 9 general practices participated in the study. It is difficult to make generalisations about the effectiveness of primary care counselling from such a small group of practices.

Studies evaluating the effectiveness of counselling or psychology in primary care paint a mixed picture. In their study of clinical psychology in general practice, Earll and Kincey (1982) found that patients referred for psychological treatment received significantly less psychotropic medication than the control group. However, this difference was not maintained at follow up. The researchers also found no difference in GP consultation rates between the two groups.

Some studies rely on patient self-report to assess the effectiveness of primary care counselling. Anderson and Hasler (1979) used self-report from patients and GPs and also consulted medical records. They studied 80 patients receiving counselling in one GP practice. They found an improvement after counselling as measured by the patients' and GPs' questionnaires. Some patients showed a lower GP consultation rate and use of psychotropic drugs. A more recent and larger study looked at the effectiveness of a new counselling service introduced throughout Dorset (Baker, Allen, Gibson, Newth & Baker 1998). This aimed to evaluate the impact of counselling on patient symptomatology, self-esteem and quality of life. It also addressed the effect on drug prescribing, referrals to other mental health professionals, and patient and GP satisfaction with the service. The study found that counselling significantly reduced the number of psychiatric symptoms and their severity. They found that the presence of a counsellor did not affect referrals to other mental services neither was there a significant difference in prescribing of psychotropic medication between practices with and those without a counsellor. The study found that both GPs and patients highly valued the service.

Some studies have failed to show which type of counselling is most effective in general practice (e.g. Ashurst & Ward 1983). This has led some to suggest that it is not the orientation of the counsellor that effects the outcome, but rather the non-specific aspects of therapy, for example the patient-counsellor relationship (Truax & Carkhuff 1967).

Methodological Problems

Much of the research looking at primary care counselling services has methodological problems. These difficulties or limitations need to be highlighted so the results of the studies can be interpreted realistically. Corney (1990) in her analysis of research in this area discusses several methodological weaknesses.

Firstly there is the difficulty in trying to assess effectiveness and improvement. Can it be measured by assessing the amount of GP involvement and a reduced drug bill or by a change in the patient's physical or mental health? Corney (1990) argues that outcome measures should include objective ratings (for example, criminal offences, health records, attendance rates, and psychotropic drug taking). Also that health changes in

other family members may be important and that changes in prescribing rates are not valid measurements of change. Corney (1990) suggests that the initial patient assessment should be thorough in order not to miss the subtle changes that may occur through counselling. This requires the instruments of measurement (usually questionnaires) to be sensitive to this.

Many outcome studies rely on patient satisfaction questionnaires. However, it is important to recognise that many patients may be anxious to please (Breese 1994). Also the response rate for these types of studies may be biased in that patients satisfied with the counselling may be more likely to respond than those who are not, there is also the problem of using an adequate sample size.

Many studies follow up patients after counselling. It is difficult to know the best time to follow-up patients after counselling. A short term follow up may not pick up the changes that take longer to emerge and more lengthy follow ups often yield a higher drop out rate (Corney 1990). Corney (1990) recommends researchers carry out more than one follow up.

Studies looking at cost effectiveness of primary care counselling services can be problematic. Focusing solely on reduced prescribing and less GP time spent on a patient is a narrow definition of cost effectiveness but, in practice, are often the only outcomes considered (Corney 1990). Measurements of improved (mental and physical) health should also be considered but are very difficult to measure in terms of cost (Corney 1990).

Corney (1990) stresses the need for studies carried out evaluating counselling to use a control group. Many patients recover spontaneously from their problems. In many studies the control group used is patients on the waiting list for counselling or those receiving GP care, as yet there is no suitable placebo for counselling (Corney 1990).

Much research carried out in this area can be considered in 2 broad areas; patient views on primary care counselling; GPs' views on primary care counselling.

Research on Patients' Views on Primary Care Counselling

A large number of studies have been carried out looking at the views of patients about the counselling they have received in their surgery. The majority of these studies are carried out by sending the patient a questionnaire to complete at a specified interval (or intervals) after the counselling has finished.

In one study 75% of patients reported that counselling had helped and 82% were said by their GPs to have improved after counselling (Meacher 1977). Another study recorded 35 out of 54 patients who responded to a questionnaire said the counsellor had lessened their demand of medical attention and reported a 'general improvement' (Anderson & Hasler 1979). Wyld (1981) carried out a review of patient satisfaction studies and concluded that 75% of patients can be expected to show some improvement after receiving counselling from a non-medical professional in the surgery.

However due to the methodological difficulties associated with patient satisfaction studies (as discussed earlier) one has to be cautious about conclusions drawn from such studies. Although patient satisfaction (when measured reliably) is obviously important in assessing the impact of primary care counselling, it highlights only one facet of service efficacy.

Corney (1981) looked at 50 clients of social workers attached to a GP practice and compared their perspectives with those of the social workers. Although the majority of clients were well satisfied with the service, there was disagreement between the social worker's assessment of the problems and interventions and that of the client.

More recent studies have been favourable towards primary care counselling. Gordon and Wedge (1998) followed up 41 clients 2 years after receiving short-term counselling at their practice. Many of the gains were maintained 2 years on and GP consultation rates fell (although the research relied on the patients recalling this). 87% of respondents reported that the counselling was helpful. But it was found that the more chronic the problem, the less likely the counselling was seen to have been effective.

A study by Booth, Goodwin, Newnes and Dawson (1997) showed a reduction in GP consultations after counselling and a significant decrease in referrals to other mental

health agencies. They did not find a reduction in prescribing of psychotropic medication as a result of counselling. However, the patients surveyed found the counselling successful in that it achieved significant change. Although the sample size analysed was relatively small for this part of the study (51 patients) and depended upon patients responding to a questionnaire.

Research on GPs' views on Primary Care Counselling

Fewer studies have been carried out looking at the views of GPs.

One major study looking at the work of counsellors on general practice (McLeod 1988) and published by the Royal College of General Practitioners focused, in part on the views of GPs. McLeod (1988) interviewed GPs and concluded that doctors valued a readily accessible and known source of skilled help. McLeod goes on to suggest that appropriate referrals for counselling depend on the GP's understanding of and belief in counselling and also on his/her ability to detect emotional problems. She also argues that whether the GP knows and trusts the counsellor can be conveyed to the patient and this will also affect referrals for counselling (McLeod 1988).

Radley, Cramer and Kennedy (1997) looked at the experience and preferences of GPs on primary care counselling. A postal questionnaire was sent to 484 Leicestershire GPs. The researchers were interested in comparing GPs who could refer for counselling with those who could not in terms of their views on counselling. They found that the size of the practice and fundholding status, as well as the inclusion of a female GP, were all related to the employment of a counsellor. GPs in rural practices gave counselling a lower priority than those in urban practices. The authors hypothesise that this may be because patients from economically and socially deprived city areas may see their GP for advice rather than for medical treatment. It was also found that practices serving predominantly ethnic minority groups were more likely to provide counselling provision (Radley et al 1997).

In asking those GPs why they did not employ a counsellor, the responses were that limited NHS funds could be better spent on more important services of proven efficacy, which could benefit a greater number of patients than could be seen by a practice counsellor. The researchers found that this group of GPs felt that counselling is carried

out for social rather than medical reasons, i.e. that it is a “want” rather than a “need”. Some of these GPs had reservations about the training, selection and supervision of counsellors. The authors suggest that this perception resulted from some GPs’ lack of knowledge about counselling (Radley et al 1997).

Those GPs with a practice counsellor cited convenience and ease of feedback as the main benefits. Other benefits were reduced demands on GP time, learning about appropriate referrals and the reduced medicalisation of some problems (Radley et al 1997). 6% of respondents mentioned disadvantages in having a practice counsellor. This was to do with the conflict between the medical model and the psychological model. Some GPs mentioned that because the counsellor had to deal with a wide range of problems, he/she offered less specialist advice than particular outside agencies (Radley et al 1997). GPs who employ a counsellor have reported an increased awareness of mental health issues (Marsh 1993).

Research has suggested a variation amongst GPs in their approach to psychological problems (Eastman & McPherson 1982) and their views on the involvement of other professions in primary care. In considering GPs’ perceptions of clinical psychologists one study found over a third of GPs asked did not want psychologists working within their practice (even in the absence of financial and other constraints). These GPs envisaged problems arising from psychologists working in this area. These problems were clinical responsibility and different working practices; issues of confidentiality and ‘general friction’ were also mentioned.

One GP writing about primary care counselling services from a GP’s perspective sees the counsellor as

“ ..the appropriate professional to deal with many of the mild to moderate mental health problems seen in primary care, often with short-term focused counselling”
(Cocksedge 1997, page 23).

The importance of a team approach is emphasised to increase communication and understanding amongst the professions involved and so improve the service to the patients (Cocksedge 1997).

The Leeds CORE System Research

In 1995 the Psychological Therapies Research Centre at Leeds University designed a system for standardising the audit and evaluation of primary care counselling services. Initially working with over 120 counsellors and many GPs, the researchers identified the criteria for “quality” counselling from which tools were designed for routine data collection (Mellor-Clark 1997). With these tools have been designed short, standardised assessment and outcome measures to be completed by patients. The measures address well being, symptoms, functioning, risk, goal attainment and alliance (Mellor-Clark 1997). It is hoped that from this large scale audit and evaluation will come profiles on service provision, presenting problems for counselling, coping strategies and ultimate outcomes (Mellor-Clark 1997).

Preliminary results from over 1200 cases indicate that the average wait for a first counselling appointment is 4.5 weeks, with 38% of patients on medication when initially seen. Presenting problems for counselling were commonly; relationship problems (41% of patients), depression (32%), anxiety (often with depression) (10%) and behavioural issues (18%). Results of the study show that counsellors felt 82% of GP referrals were appropriate and that half of all patients seen completed an agreed number of counselling sessions. Looking at outcome measures, the researchers found a significant difference in patient scores between pre-counselling and post-counselling Health of the Nation Outcome Scales (Mellor-Clark 1999).

The CORE system data is on going and will hopefully provide an accurate picture of the efficacy of primary care counselling. It is certainly the largest audit and evaluation of its kind ever carried out in counselling in primary care. It emphasises the importance of practice-based evidence to measure the efficacy of counselling.

Evidence Based Counselling

In the government review of NHS psychotherapy services in England (NHS Executive 1997) the importance of evidence based services and cost effective services is stressed.

By evidence based services, the government suggests the use of service agreements, outcome bench marking, research based clinical guidelines, audit, improved professional training and dissemination of research findings that can all enhance clinical effectiveness and should be carried out by therapy services (NHS Executive 1997). The NHS Executive stresses the importance of therapy services being cost effective. By this they mean the intervention to be “at the least complex, costly and intrusive level consistent with effective treatment” (NHS Executive 1997). They see well-targeted treatments that are based on research evidence to be the most cost effective and call for more research on cost-effective treatments. The need for technologies to enable therapies to make judgements on duration and frequency of sessions is also requested.

When considering the cost effectiveness of a primary care counselling service, this has to be seen in a much wider context than merely money. One US research study quoted in Pulse (Aug 1996) offered all patients with thick notes counselling. 85% of patients took up the offer and saved the practice 30% in health costs in one year.

1.6 PROFESSIONAL ISSUES IN COUNSELLING

The term profession may be viewed as

“...a form of employment obtained after a particular education and training, professionalism represents recognition for those demonstrating high standards.”
(Charles-Edwards, Dryden & Woolfe 1989, page 402)

These issues may affect the public image of primary care counselling, not only a GP’s perception of the profession, but that of the public as a whole. As counsellors become increasingly employed by the NHS or GP practices issues of professionalisation, training and standards are being raised. Cohen and Halpern (1978) refer to counsellors as ‘non-professionals’ and they are perceived as being ad hoc in terms of availability, selection and lack of standardisation (Rowland & Irving 1984). But this perception may be shifting.

The need for primary care counsellors to be accepted as professionals is clear both for the GP and the client. However, a GP or purchaser’s lack of knowledge about standards and their search for a cheap option can lead to the use of under-qualified and unsupervised ‘counsellors’ working in primary care (Hall 1997). Research has indicated

a lack of knowledge amongst GPs about the qualifications of the counsellors they employ (Mutale 1995). GPs may find it confusing to distinguish the skills and specialities of the counsellor from those of other mental health professionals. Doctors are unclear about the goals of counselling and have reservations about the training, selection and supervision of counsellors (Radley et al 1997). If the training and working aims of counsellors are made clear and easily accessible GPs may be more inclined to employ them (Rowland & Irving 1984).

The different issues of professionalism will be considered.

Recognition & Accreditation

The granting of professional status is often dependent upon some form of registration by a professional body (Charles-Edwards et al 1989). For counsellors, the main body is the British Association for Counselling and Psychotherapy (BACP). The BACP (formerly the BAC) was formed in 1977.

To become an accredited counsellor with BACP an individual goes through a process of accreditation. BACP accreditation offers a direct route to registration as an independent practitioner with the United Kingdom Register of Counsellors. To achieve accreditation an individual member of BACP will have already completed a BACP accredited counselling training course over a specified time limit (or met other specified requirements regarding formal training and supervised practice) and have had over 450 hours of supervised counselling practice. In addition an individual must; meet the agreed minimum arrangement for formal supervision, provide evidence of on-going professional and personal development, remain a member of BACP, provide evidence of at least one core theoretical model, adhere to BACP code of ethics and practice, provide evidence of at least 40 hours of personal counselling and be committed to working with issues of difference and equality in counselling practice (BACP website 2001).

The other main professional body for counsellors is the UK Council for Psychotherapy (UKCP) set up in 1993. To register with UKCP (i.e. to practice as a fully qualified psychotherapist) an individual has to undergo 5 years of specialist, intensive training in

psychotherapy (Tholstrup 1999). Currently over 4000 individuals are registered with UKCP.

Another route to BACP accreditation is through the grandparenting scheme. To become an accredited counsellor through this scheme, an individual must meet 10 specified criteria. These criteria include; BACP membership; a minimum of 450 hours of supervised counselling; to account for their practice with reference to a counselling knowledge base; to demonstrate an ethical and competent working relationship with clients; to demonstrate reflective practice and to demonstrate professional development.

However, the accreditation procedure that currently operates with BACP is optional. This contrasts with doctors where there is statutory registration through the General Medical Council. In theory any individual could today set themselves up as a counsellor with little, or no training. Without adequate accreditation procedures counsellors may have difficulty being fully ‘accepted’ into the health service where all professionals are increasingly required to be registered with a recognised professional body.

The BACP’s accreditation process has been criticised as “weak” (Charles-Edwards et al 1989). More recently Curtis-Jenkins (2001 p5) justifying the need to set up a new professional body for counsellors in primary care states that “*..membership of national counselling bodies has failed to confer an adequate guarantee of competence. Registration and accreditation was a hit and miss procedure... The disciplinary procedures were often lacking in power to control unsafe practitioners..*”

Psychologists do not (yet) have statutory registration (although this issue is being looked at by the profession and department of health at the moment) but a psychologist cannot call themselves a Chartered psychologist without satisfying criteria laid down by their professional body. This enables psychologists to become a better-established profession with a much stronger system of registration than counsellors (Charles-Edwards et al 1989).

As counselling in primary care is growing the profession is recognising the need to address the important issue of standards and qualifications within the profession. The BACP has a division for members who work in medical settings, although this would include counsellors working in primary care, the division is not exclusive to this group.

The need for primary care counsellors to form an organisation to address their particular needs and concerns has led to the recent formation of a new professional body for primary care counsellors called, Counsellors in Primary Care (CPC). This body aims to see counselling established as part of statutory NHS provision, with every GP practice to be offered a counsellor (Counselling in Practice, February 1999). This body hopes to eventually represent all counsellors working in primary care.

Ethics

The formation of a professional organisation and the requirement of members to register is for the protection of clients, to ensure that members agree to a code of ethics and there are disciplinary procedures in place to deal with unsafe or incompetent practitioners (Tholstrup 1999).

The BACP has established explicit standards in counselling for all its members. However, because there is no statutory registration of counselling this sanction is not a legal bar on individuals continuing to practice as a counsellor. The BACP code of ethics addresses issues of responsibility, competence, management of work, confidentiality and advertising. The difficulty is to have a code of ethics that covers all the different counselling groups within BACP whilst also ensuring high standards for its members.

Training

Counselling training involves 4 components;

1. Theory
2. Skills practice
3. Counselling under supervision
4. Personal development

(From Charles-Edwards et al 1989).

In practice training varies in length, depth, and breadth (Charles-Edwards et al 1989).

The BACP have tried to address this problem and maintain high standards in the training of counsellors by accrediting courses that meet their criteria. Ten years ago no course was BACP accredited; in May 1998 Tholstrup (1999) reports seeing 12 courses

advertised as BACP accredited. BACP states that counselling courses should follow certain guiding concepts and assumptions. These include; 8 basic elements, admission, staff development, client work, supervision, skills training, theory, professional development and assessment. BACP also state that counselling courses should provide grounding in one core theoretical model and encourage students to develop as reflective practitioners (BACP website 2001).

A more recent training development is the formation of National Vocational Qualifications (NVQ) in counselling (Miller 1997). The variety of training courses available can make the selection of an appropriate counsellor difficult for GPs (McLeod 1988).

Over ten years from McLeod's ground breaking research, the situation in the health service has changed considerably and the need for (proven) qualifications is more pressing now for counsellors. The Psychotherapy Review (1997) devoted much time to the issue of training and standards in psychotherapy. The review states;

"It follows from the capacity of psychological therapies to cause harm that NHS employers have a responsibility to ensure that those offering these treatments are properly trained and qualified to do so and that clinical management processes are in place to ensure safe practice as a minimum requirement."

(NHS Psychotherapy Services in England 1997 p71)

McLeod (1988) suggests that for counsellors working in primary care specific training is required. This issue is focused on by the newly formed CPC and training courses for counsellors wanting to work in primary care are continuing to grow. Primary care counsellors are requesting that their training reflect their setting. They wish for modular courses on psychological assessment, psychotropic medication and on using DSM IV (Curtis-Jenkins 1998 b).

Employment Status

Most primary care counsellors today are either employed directly by a GP practice, or are part of a local NHS Trust and are attached to the practice. The latest figures indicate almost a third of primary care counsellors are employees of managed services, NHS Trusts, Health Authorities and other agencies (Curtis-Jenkins 1998 a).

The type of employment can impact on the GP-counsellor relationship as GPs paying for sessions may feel they can dictate the use of sessions (Brunning & Burd 1993). With the formation of PCGs from April 1999, the employment of many primary care counsellors has been threatened. Particularly for those counsellors directly employed by a GP practice, these changes have created insecurity and uncertainty about their future survival (Counselling in Practice, Dec 1999).

1.7 SUMMARY & AIMS

Recent years have seen a surge in growth in primary care counselling from a third of practices in 1993 to over 50% of practices today offering a counselling service in the surgery. The reasons for this growth are many. It has long been recognised that a large proportion of GP consultations involve patients with emotional/psychological problems. The GP does not have the time (or the training) to deal with some of these problems. Also the last 10 years have seen the decentralisation of health services, including mental health services, to primary care. This move has co-incided with a shift in medical practice towards a more holistic approach and a willingness to consider less traditional treatments in the management of psychological problems. A counsellor can offer the skills and expertise necessary to deal with a range of problems commonly encountered in primary care. The public attitude towards counselling has shifted to being more aware and accepting of counselling.

A practice based counselling service offers the patient, the GP (and the counsellor) many benefits. Patients can receive help at a much earlier stage in a familiar and accessible environment. A referral to the practice counsellor carries less stigma than a referral to a mental health service and so a substantial number of patients can access the counselling service who may not accept a referral to a community mental health team. For the GP, having a counsellor can reduce his/her stress and workload. The counsellor can facilitate the GP's work and increase his/her awareness of mental health issues. The counsellor can offer support to the whole PHCT and improve working relations among team members. Such a service lends itself well to collaborative working and regular liaison between the counsellor and the GP that can improve the quality of patient care.

However, difficulties can arise when two professions with such differing training and ways of working come together in the same setting. If we consider the PCHT as a group, theories on group processes may help in understanding these difficulties. In particular the issues of group structure, roles and status of group members and the evolution of groups over time. There are also issues that are specific to the GP and the counsellor that can explain some of these difficulties. The medical training of the GP is goal oriented, focusing on concrete scientific facts in order to make a diagnosis. The counsellor is process focused and interested in subjective experience. These, quite fundamental differences may create difficulties, in that communication and understanding may be limited between the professions. Other differences between the two professions that can be problematic are associated with the relative power of the GP compared to the counsellor. Because of his/her different way of working, the counsellor may be perceived as 'separate' from the rest of the PHCT.

Attempts have been made to address these issues and to find a way that the GP and counsellor might work together. The way forward appears to be through collaboration. The biopsychosocial model can provide a framework for a more inclusive approach to health care. Leventhal's model of the cognitive representation of illness (Leventhal & Cameron 1987; Leventhal et al 1992) gives an integrated view of illness addressing the behavioural, emotional and cognitive components. Such an integrated view of illness helps us understand the complexity of illness and the interplay of different factors. This may increase the understanding of both the GP and counsellor and help them work in a more integrated and collaborative manner with their patients.

The biospsychosocial model has been developed further to address how the GP, the patient, the family and the mental health professional can work together to address the patient's problems in a primary care setting. This model is very relevant to primary care counselling. It emphasises the need for both the GP and the counsellor to shift from their relative positions and take a different (i.e. integrated) approach to the problem. The components of a collaborative relationship are discussed – the relationship is key when considering collaborative working. Without a good relationship there cannot be effective collaboration. This requires both parties to work at the relationship and it may take some time to develop. It is often the counsellor who will initiate collaboration. A good relationship can also be sought through effective communication and liaison

between the two professionals. Action learning sets may also be a useful tool in promoting collaboration. The extent to which collaboration takes place may be affected by the GP's and counsellor's perceptions of each other. Likewise, collaboration provides an opportunity to challenge or reconfirm pre-existing perceptions

Research in the area of primary care counselling has tended to focus on evaluative studies of practice based services. Results have been mixed and such studies are often fraught with methodological problems. Some evaluative studies have looked at patient satisfaction with the counselling service, which overall, appears to be positive. Or they have focused on an improvement in patient symptoms after counselling, the results of which have not been conclusive. A few studies have asked GPs their views on practice based counselling services but have not focused on the GP-counsellor relationship but have tended to address more "objective" issues; e.g. practice size, gender of GP. A major on-going research project is currently underway at Leeds University looking at the efficacy of primary care counselling from a number of angles. It is hoped that from this, the criteria for "quality" counselling will be developed. Cost effectiveness is an issue facing many NHS services. For primary care counselling there is an increasing need to show that the service is not only cost effective but evidence that it works.

Current research indicates that GPs value a practice based counselling service, in particular its convenience and ease of feedback. Such a service can reduce their workload and increase their awareness of mental health issues. GPs' understanding of counselling can affect referrals. Trust in the counsellor is important. Some GPs question the efficacy and cost effectiveness of such a service. GPs also report a lack of feedback from counsellors about patients referred. Common presenting problems for counselling are; depression, anxiety and relationship difficulties. The orientation of the counsellor does not appear to be the main factor in therapeutic change. Some GPs are aware of the different ways of working between themselves and counsellors and feel this could present problems when working together.

As counselling has developed in recent years to become part of many GP surgeries, the profession has to address issues of quality and standards. These issues may be central to the GP's and the public's perception of the profession. Such issues were less pressing for the profession when outside the NHS. This is in part due to the increasing need for *all* NHS professions to address these issues for the protection of the public. However,

for counsellors, being relatively new to the health service, this issue is particularly apparent. Some GPs seem uncertain, and even suspicious of the training and qualifications of counsellors. This issue is not helped by counsellors having several professional bodies representing them, rather than a unitary body. There is also no statutory registration for counsellors and the registration procedures that do exist are optional and seen as weak. A new professional body Counsellors in Primary Care has recently been established and hopes to become *the* professional body for primary care counsellors and to establish counselling as part of statutory NHS provision. With the recent formation of Primary Care Groups, many counselling services face an uncertain future through lack of funding.

Rationale

Through my work as a counselling psychologist in primary care I have become aware of and interested in the perceptions of different GPs of primary care counselling. There appears to be a gap in current research that this study hopes to address. Research focusing on GPs' perceptions or satisfaction with a counselling service have either formed a small part of the main study (e.g. McLeod 1988) or have been concerned with how objective issues like practice size affect a GP's perception of counselling. The literature highlights the central importance of collaborative working between the GP and the counsellor. The relationship is a key factor in collaborative work, yet research has not addressed in any depth the GP-counsellor relationship and how the quality of this relationship might impact on a GP's perception and experience of primary care counselling.

The rationale for the present research is that counselling is a growth area in primary care. It is an area where counselling psychologists are, and may continue to be, employed. Although primary care counselling as an area has, and is, being researched, some of these gaps in current research need to be addressed. In particular to explore both qualitatively and quantitatively the GP's perception and experience of working with a counsellor and a wide range of issues associated with a practice based counselling service. Some of these issues are more objective; for example, funding difficulties, but most are subjective; for example, the GP-counsellor relationship, GP satisfaction with the service, GPs' perception of counselling. These issues are interesting to explore within themselves as they provide an insight into how a GP

develops a perception of primary care counselling. However, the implications for researching such areas are also important and relevant. The findings from such research may help us understand what factors play a role in shaping a GP's perception of counselling. This may help explain some of the difficulties that arise for the two professions when working together. This in turn may lead to the development of interventions designed to alter unhelpful or negative perceptions. Such interventions may impact on areas such as training and practice for both primary care counsellors and GPs. Given that GPs are becoming increasingly influential in purchasing services on behalf of their patients it is important to be aware of their views on these issues as GPs unhappy with the counselling service may not continue to purchase it. The research may also have implications for patients and the quality and effectiveness of the service they are receiving.

It would also be useful to consider these issues from a counsellor's point of view. To see if, and to what extent, their perceptions of primary care counselling differs from GPs' perceptions of this. This can give a fuller understanding of the issues involved, rather than only considering the view point and experience of either professional. Inclusion of counsellors' perceptions can also give an indication of the extent of agreement or disagreement between the two professions on issues concerning primary care counselling. This is important as such disagreements may impact on the quality or effectiveness of the service.

The present study does not focus directly on the patient. This is because a number of studies are, and have, addressed patient satisfaction with primary care counselling services or address outcome measures concerning themselves with the efficacy of counselling services. The present study is concerned with the perceptions and experiences of GPs of primary care counselling and comparing this with the perceptions and experiences of primary care counsellors. However, the findings from the study will be very relevant for patients/service users as ultimately any issues raised from the study may impact on the service they receive.

Aims

The broad aim of this study is to provide a snapshot of what is currently happening

in primary care counselling by using a representative sample of GPs who work with counsellors and also primary care counsellors themselves. More specifically to;

1. Explore, both qualitatively & quantitatively, the perceptions and experiences of GPs working with counsellors. Focusing on the GP-counsellor relationship, how GPs perceive counselling and their satisfaction with a practice based service.
2. Compare the perceptions and experiences of these GPs with the perceptions and experiences of counsellors working in primary care.

As the study involves designing a questionnaire, a further aim is to see if discrete factors exist within the rating scale of the questionnaire. This may be helpful in identifying whether a GP's (or counsellor's) overall perception of primary care counselling is composed of separate, but related, elements.

The researcher was also interested to see if, and to what extent, a relationship exists between different variables (both GP variables and counsellor variables) and experience of primary care counselling. More specifically;

- i. Is the orientation of the counsellor related to his/her view on collaboration?
- ii. Is the orientation of the counsellor related to the quality of the GP-counsellor relationship?
- iii. Is the gender of the GP related to how highly he/she values the counselling service?
- iv. Is the age of the GP related to how highly he/she values the counselling service?
- v. Does the number of years a practice has a counsellor relate to a GP's satisfaction with the counselling service?
- vi. Is GP satisfaction with the counselling service related to the quality of the GP-counsellor relationship?
- vii. Is GP satisfaction with the counselling service related to a GP's interest in primary care counselling?

The Psychology of Social Perception & Attributions

A central aim of the study is to explore the perceptions of GPs of primary care counselling. It may be useful, therefore, to consider relevant theoretical aspects of social perception at this point.

Perception is of central importance as it helps us to make sense of our world and to interpret the vast amount of stimuli and information we contend with each day. In social cognition the role of perception is considered in the social context. People are viewed as processors of information. Thus interpretation plays a central role in perception and we interpret things in the light of what we already know (Pennington 1986). Perception in a social context may be best viewed as an active and constructive process defined as;

“..a complex response to a sensation (where a sensation is an immediate experience of stimuli) in the light of past experience (and) expectations”
(Pennington 1986 page 105)

People are not passive respondents but active interpreters of the environment. Social psychologists have demonstrated that people select different behaviours to attend to and that interpretation of the same behaviour may be different (Hastorf & Cantril 1954). Motivation is an important factor in perception, as is commitment and affiliation (Pennington 1986). People are more likely to attend to something that interests them. Past experience plays a role in perception by directing what information we attend to and also by possibly blinding us to other interpretations (Pennington 1986). Perception of others is often a two way process. That is, how we may perceive and behave towards another person is influenced by how that person perceives and behaves towards us.

Individual Differences in Perception

There are also individual differences in perception. These individual differences have been found to be partly environmental (Segall et al 1966), with personality also playing a role (Witkin et al 1962). People may look for different types of information in a social situation and this will result in different impressions being formed (Pennington 1986).

Attributions

How might a GP explain or infer his/her own behaviour or the behaviour of the counsellor? Theories on causal attribution may shed some light on this process.

Attribution theories are concerned with understanding and explaining how people attribute causes to their own and other people's behaviour (Pennington 1986).

The process of attributing behaviour is important to us as it helps to reduce uncertainty about ourselves and about others. We use attributions to help predict behaviour.

Attribution is affected by perception. How we perceive the behaviour of another person will affect how we interpret the cause of the behaviour and this may also have consequences for the degree of responsibility attributed to the person for his/her actions (Pennington 1986).

Differences, or discrepancies in attributions also frequently occur (Pennington 1986). and may be explained by people's different perspectives on a situation. Heider (1958) suggests that perceptions of the causes of behaviour depend upon the characteristics of the perceiver, the features of the behaviour perceived and the social context in which the behaviour takes place.

Different models have been developed looking at the process of attribution and three of them will be briefly commented upon as may be relevant to the research findings. These three theories do not offer different explanations of behaviour, but offer an explanation depending upon the information available to the perceiver and the kind of explanation the person is interested in (Pennington 1986).

The Causal Schemata Model

This model was proposed by Kelley (1972) and is useful in explaining attributions when we have only very limited information available to us. In situations where the only information available to us is observing a person in one situation, Kelley suggests that we rely on general beliefs (or schemata) to make attributions. Sometimes this means that in the absence of information about a person or the situation, we may use mental short cuts (or heuristics) to make sense of the behaviour. This may mean we sometimes rely on stereotypes in attributing behaviour.

The Covariation Model

Proposed by Kelley (1967), this is a model of attribution applicable when we have sufficient information on the other person and the situation. He suggests that in such circumstances we look for a systematic pattern of relationships and we infer cause and effect from that pattern (Deaux & Wrightsman 1988).

Kelley suggests that we use 3 types of information when making an internal or external attribution in these circumstances.

1. Consensus – information based on our knowledge about the behaviour of other people in the same situation.
2. Consistency – information based on our knowledge about that person's behaviour on other occasions.
3. Distinctiveness – information based on our knowledge about that person's behaviour towards other people.

Kelley suggests that whether we perceive each of these types of information as being high or low will give us an overall picture that will determine the attribution we make. Research has shown some support for this model, but also its limitations. Research suggests we do not use the 3 types of information equally, but the most important may be distinctiveness, followed by consistency and finally consensus (McArthur 1972). Research also suggests that we use other types of information in forming attributions, for example, personality traits (Garland et al 1975).

Correspondence Inference Model

This model, proposed by Jones and Davis (1965) considers the factors behind making an internal attribution. This model emphasises the importance of the consequences of an action when making an attribution. The suggestion is that when we observe the behaviour of another person we consider not only the effects of that behaviour but also the effects of possible alternative behaviours (Deaux & Wrightsman 1988). This model considers two factors behind making an internal attribution about another person's behaviour. Firstly, we consider the non-common effects of that person's behaviour, that

is, the distinctive features of the behaviour. Secondly, we consider the social desirability of their behaviour.

The model asserts that we make an internal attribution about a person's behaviour when the behaviour is both low in social desirability and there are few non-common effects (Pennington 1986).

Self-Attribution

Research has demonstrated that when we attribute causes to our own behaviour we tend to emphasise external or situational factors (Pennington 1996). There is also evidence (e.g. Johnson et al 1964) to suggest that when attributing causes to our own behaviour we tend to make attributions that will enhance our own skills or self-esteem, this has been termed a self-serving bias.

In summary, research on social perception suggests that how we perceive others is influenced by our interpretation of a situation and this in turn is influenced by our prior knowledge and experience. Past experience may direct our attention to certain information and/or exclude other information. Individual differences have been found with regard to social perception. Perception is affected by motivation, commitment, affiliation and interest.

Attributions help us explain and understand our own and other people's behaviour. This is affected by perception. Attributions may be dispositional, situational or a combination of the two. Theories have been developed to help explain how, and under what circumstances we may make a particular attribution.

How do psychological theories on social perception and attributions help when considering a GP's perception of counselling? From the research mentioned, one may suggest that

1. A GP's perception of counselling is a complex process that is not static.
2. There may be individual differences among GPs about their perception of counselling (even among GPs who have the same counsellor).

3. A GP will have a perception of primary care counselling *before* the introduction of the service, based on what he/she already knows or expects about counselling and his/her beliefs about counselling. Other factors may also influence this perception; for example, the training of a GP may influence his/her beliefs about counselling.
4. The GP's perception of the counsellor may be influenced by how the counsellor perceives and behaves towards the GP.

Theories on causal attributions are helpful in explaining how a GP might infer the behaviour of the counsellor. It can be seen that the attribution(s) made will be dependent upon the information the GP has available to him (information about the counsellor as an individual, information about counsellors in general and the specifics of the situation). This suggests that in the light of new information attributions may change. Attributions made by a GP concerning the counsellor are affected by the characteristics of the GP and the primary care setting. In any given situation concerning the behaviour of the practice counsellor, the GP may make a causal attribution that is internal (behaviour determined by the individual counsellor) or external (behaviour determined by the situation) or a combination of the two. Causal attributions have implications in terms of responsibility for behaviour and how much control one perceives one has in altering undesirable behaviour.

Hypotheses

In light of the research discussed in this chapter predictions were made regarding the nature of the relationship between some of the variables described earlier (please refer to page 62). Namely, it was predicted that;

1. Female GPs would value the counselling service more highly than their male colleagues. This is from previous research (Radley et al 1997) that found the inclusion of a female GP increased the likelihood the practice employed a counsellor.
2. Younger GPs would be more likely to value the counselling service than older GPs due to their increased exposure to counselling, their different training from their older colleagues and the likelihood they would adapt to changes in their working practice more easily than older GPs.

3. The longer a practice has a counsellor, the more likely the GP is satisfied with the service. This is because over time, the two professionals can develop a working relationship; the GP can learn about the work of the counsellor and can obtain feedback from patients.
4. The stronger the GP-counsellor relationship, the more likely the GP will be satisfied with the counselling service. This prediction follows on from Seaburn et al's (1996) model of collaboration where the quality of the GP-mental health professional relationship is central when considering effective collaboration.

Predictions were not made about the relationships between the other variables.

1.8 METHODOLOGICAL ISSUES

In considering the ways in which this subject area might be explored, a variety of methods might be suggested. Previous research has used a number of methods. McLeod (1988) conducted her research with GPs through interviews. Radley et al (1997) used questionnaires to access the information from a large number of GPs. The study by Small and Conlon (1988) was a single case design focusing on the experience of one social worker attached to a GP practice.

Quantitative Research

This form of research uses numbers as the tool of measurement. The advantages of a quantitative approach (as suggested by Barker, Pistrang & Elliott 1994) are:

1. Greater precision through using numbers
2. Well established statistical tests to analyse the data.
3. Comparison amongst data is easier.
4. This method of research fits with hypothesis testing. Predictions can be made about the experiment and it can be seen how well the data fits the prediction.
5. Sampling theory can be used to estimate how well the results can be generalised from the sample studied to the general population.

It has been argued that a quantitative approach does not lend itself well to studying many aspects of psychological research. For example, feelings, values and meanings are highly subjective (Barker, Pistrang & Elliott 1994). A purely quantitative approach can reduce a person's experience to numbers thereby missing the depth and richness of the experience. This type of research has also been criticised in that researchers emphasise aspects that are easily measured and ignore more intangible aspects that do not lend themselves well to a quantitative approach (Barker et al 1994). Examples of quantitative research are, experimental design and questionnaires.

Qualitative Research

This approach to research is primarily based on language as opposed to figures. The main advantages of this form of data are;

1. Subjects can be studied in depth and issues not amenable to quantitative research can be explored.
2. Fewer restrictions are imposed on the data, the simplification of quantitative data can be avoided.
3. The data may be more readable.
4. This approach lends itself well for hypothesis generation and exploration.
5. The participants are freer to express themselves.

(From Barker et al 1994).

However, a qualitative approach has been criticised that it reflects the research's own opinions and biases which are not easily disentangled from the data (Barker et al 1994). Examples of this type of research are observation, single case design and interviews.

Both qualitative and quantitative approaches have their uses and their limitations. However, it is possible to conduct research combining both methods. Some researchers argue that it is unwise to rely solely on one approach (Campbell & Fiske 1959; Cronbach & Meehl 1955; Patton 1990). Using a combined approach can illustrate how the two approaches complement each other (Barker et al 1994). Such integration of approaches can

"...retain the richness of the data from the qualitative tradition with the precision of assessing the phenomena gained in the quantitative tradition."

(Hill & Corbett 1993, page 16)

As the area of GPs' perceptions and experiences of primary care counselling has not been explored in depth – a qualitative approach allows for initial exploration of the issues amongst a small number of participants. This can generate themes that a quantitative approach can be applied to using a larger number of participants. The research, therefore, can be a rich exploration of the subjective experience of GPs (and counsellors) but can also generate data which can be analysed and compared between the two groups (GPs and counsellors).

In considering the different forms the research may take common approaches are interviewing and questionnaires.

Interviews

Interviews can be a useful tool in research. They allow rapport to be established between the interviewer and respondent, follow up questions can be asked and complicated instructions can be given which may be too difficult to follow using a questionnaire format (Barker et al 1994). Interviews can be used at different stages of research; initially to identify areas for more detailed exploration; as the main tool of research; or as a final stage to check the data (Breakwell 1995). Interviews are commonly semi-structured but may be structured or conversational. They may vary in length from a few minutes to many hours and may take place on one or many occasions (Barker et al 1994). Interviews are a flexible tool in research. Questions asked should be clear and unambiguous and without assumptions. Complex words should be avoided, as should leading questions (Breakwell 1995). Interviewing style should be empathic and non-judgemental, giving the interviewee plenty of time to think and talk (Barker et al 1994). Like other forms of research, the reliability and validity of interviews can be affected. The respondent may be untruthful, or may be embarrassed to answer correctly (Breakwell 1995). The validity may be affected by researcher variables. The characteristics of the interviewer may affect the respondent's willingness to answer (Breakwell 1995). It is recommended that interviews be recorded (or videotaped) as this can help to minimise interviewer bias and also means the interviews can be scrutinised by other researchers (Breakwell 1995).

Questionnaires

Questionnaires are probably the most common research tool in social science (Fife-Shaw 1995). The advantages of using this form of measurement is that it

standardised, it allows the respondent to complete it in their own time and privacy and confidentiality can be ensured (Barker et al 1994). However, a major disadvantage is that unless a measure already exists, the difficulty in constructing a questionnaire can be enormous. So much so that Barker et al (1994) strongly advise researchers to use an existing measure. Questionnaires can also suffer from a low response rate. It is recommended that a 60% response rate be aimed for (Barker et al 1994). However, GPs are notoriously poor responders to postal surveys (Kaner, Haighton & McAvoy 1998). Questionnaire design can vary from open-ended questions (yielding qualitative data) to closed questions (yielding a yes/no response), to multiple-choice questions or rating scales.

Open ended questions give respondents freedom to answer, but they can produce enormous amounts of data, great variability across respondents and many respondents may leave the question blank as it requires more effort to answer (Barker et al 1994). Closed questions can be restricting for the respondent but are easier to analyse. However, respondents may understand the question differently (Barker et al 1994). A rating scale offers respondents a choice of answers. As with interviews, it is essential that questions are clear, unambiguous and not leading the respondent to a particular answer.

Research Format

Taking account of the research approaches discussed above, an approach format for the study was designed. The following points were taken into consideration; a suitable approach for exploratory, qualitative research is through using semi-structured interviews on a small number of GPs. The interviews may generate themes or patterns that may be measured on a greater number of respondents. An efficient way of reaching this larger group of GPs is through the use of a questionnaire.

As there was no existing questionnaire measuring the experiences and perceptions of GP of primary care counselling services, a questionnaire was designed and piloted.

This approach was complimented by meeting with a number of GPs together. This is another way of looking at the same issue using a different research method.

In Summary

The format used in the study was;

1. Semi-structured interviews with a small number of GPs.
2. A questionnaire was designed and piloted and sent to a number of GPs who have a counsellor and also to primary care counsellors themselves. Once piloted and amended, the questionnaire was sent to a larger number of GPs and counsellors.
3. A meeting with a group of local GPs in which their experiences of a primary care counselling service were discussed.

The following chapter looks at the research methodology and the data analysis used for the study.

CHAPTER 2

METHODOLOGY

The methodology is divided into 4 parts

- 2.1 Semi-structured interviews
- 2.2 Design, piloting, amending and sending out the questionnaire
- 2.3 Meeting with local GPs
- 2.4 Method of data analysis chosen for the study

Ethics Committee

Before commencing the research, ethical approval was sought and obtained from City University and The Bethlem & Maudsley NHS Trust (now South London & Maudsley NHS Trust).

2.1 SEMI STRUCTURED INTERVIEWS

Aim

This stage of the study was exploratory. The aim being to measure qualitatively the perceptions and experiences of GPs of primary care counselling.

Eligibility

GPs who have a counsellor (or group of counsellors) in their practice.

Participants

Ten local GPs were randomly selected and contacted. Of these, 9 GPs took part in the study although all 10 initially agreed to do so. 1 GP refused to take part in the interview when the interview was about to commence. The GPs who participated came from 7 different practices and represented a range of practices throughout London Borough of Croydon:

Of the 9 GPs;

- 4 were male, 5 were female.

- 2 GPs were from single handed practices, the others were from group practices ranging in size from 3 to 8 partners.
- The location of their practices ranged from being situated in affluent areas in the south of the borough to situated in socially deprived and ethnically mixed areas in the north of the borough.

The Interview Guide

The framework of the interview was broad as this was the initial and exploratory stage of the study.

The areas addressed in the interview were the GP's;

- perception of counselling
- presenting problems for counselling
- referrals for counselling
- collaboration with the practice counsellor
- individual experience of the counselling service
- role of the counsellor

Considerations for the Interview:

- 1 The length of interview. The interview had to be fairly short. GPs are busy, with little time to spare. If they feel the interview is too long, they will not agree to participate.
- 2 The questions should not be too intrusive in a face-to-face interview as GPs may feel uncomfortable and not respond to the questions.

Interview Design

The interview design was semi-structured to allow the interviewee to feel free to respond whilst also allowing the interviewer to ask each GP the same set of questions. The questions and order of the questions were the same for each GP.

In considering the types of questions to ask covering the framework, the following guide (adapted from Breakwell 1995) was considered.

Questions should *not*;

1. Be double-barrelled.
2. Make assumptions.
3. Use jargon or complex words.
4. Be leading.
5. Include double negatives.

In considering the order of questions, the interview started with broader and historical questions (e.g. “why did your practice consider having a counsellor?”) and narrowed down ending with considering the GP’s experience of working with a counsellor.

In considering the time to complete the interview (aiming for approximately 10 to 15 minutes), the interview consisted of 13 questions (See Appendix B (1), page 223).

The Interview Process

All interviews were conducted face-to-face by the same interviewer and took place in the GP surgery. Most interviews were conducted in the GP’s room where it was quiet and uninterrupted. 1 interview took place in the practice staff room which was noisy and there were frequent interruptions.

7 GPs were interviewed on their own; 2 GPs were interviewed together at their request. Before the interview each GP was given an Information Sheet outlining the purpose of the study and their participation in it (see Appendix B (1), page 221). They were then asked to read and sign a Consent Form agreeing to take part in the study (see Appendix B (1), page 222). The form stated that the interview would be tape recorded and issues of confidentiality were outlined. This form was then counter signed by the interviewer.

The time taken to complete each interview ranged from 10 to 20 minutes. All interviews were tape recorded.

Interviewing Style

The interview style adopted was empathic and non-judgemental, giving the respondent time to answer. All interviews were tape recorded as this is a more reliable and less distracting method of recording than note-taking.

Follow up questions were asked by the interviewer if the question was not answered or if clarification was needed.

Confidentiality

Issues of confidentiality are important to ensure that the respondent feels comfortable in the interview and feels able to answer as openly and honestly as possible. All GPs were assured of complete confidentiality and told that they could withdraw from the study at any time without giving a reason and without incurring a penalty. GPs were also assured that their responses would not affect their current (or future) primary care counselling service provision.

Reliability

Reliability is a statistical measure of how reproducible a questionnaire's data is (Litwin 1995).

Reliability of the interviews was addressed through **consistency**.

The same interviewer conducted each interview. This minimised researcher effects. The interviewer was not known to the GP but was employed by the local NHS Mental Health Trust as a psychologist. This was known to the interviewee.

There was consistency in question presentation. All interviews were tape recorded offering a permanent and accessible record of the interview.

Interviewer Bias

The interviewer was part of the local NHS Trust and also a counselling psychologist. This could present bias in the interview. But GPs appeared to be open and honest in their responses and not afraid to be critical of their counsellor or primary care counselling service in general if they felt if necessary. Being assured of confidentiality may have enabled the GPs to do this.

The inter-rater reliability of the interviews was assessed using Cohen's Kappa (please see Chapter 3 - Results page 100).

Validity

The interview schedule was shown to one GP (not participating in the study) to check the questions were;

1. Clear
2. Unambiguous
3. Easily understood (i.e. no jargon).
4. Not leading

Also to ensure that the overall interview was structured logically and the aim and purpose of the interview was clear to the interviewee.

2. 2 QUESTIONNAIRE DESIGN, PILOT & AMENDMENT

Aims of the Questionnaire

1. To quantitatively measure the perceptions & experiences of GPs of primary care counselling through a questionnaire.
2. To compare this with the perceptions & experiences of counsellors working in primary care.
3. To see if discrete factors exist within the rating scale of the questionnaire.
4. To see if, and to what extent, relationships exist between different variables measured in the questionnaire. More specifically;

- Is counsellor orientation predictive of other variables?
- Is GP gender predictive of how highly a GP values the counselling service?
- Is GP age predictive of how highly the GP values the counselling service?
- Is the number of years a practice has had a counsellor predictive of GP service satisfaction?
- Is GP satisfaction with the counselling service related to the GP-counsellor relationship?
- Is GP satisfaction with the counselling service related to a GP's interest in primary care counselling?

Hypotheses

Predictions were made regarding the nature of the relationship between some of the variables described above. Namely, it was predicted that;

- 1 Female GPs would value the counselling service more highly than their male colleagues. This is from previous research (Radley et al 1997) that found the inclusion of a female GP increased the likelihood the practice employed a counsellor.
- 2 Younger GPs would be more likely to value to counselling service than older GPs due to their increased exposure to counselling, their different training from their older colleagues and the likelihood they would adapt to changes in their working practice more easily than older GPs.
- 3 The longer a practice has a counsellor, the more likely the GP is satisfied with the service. This is because over time, the two professionals can develop a working relationship, the GP can learn about the work of the counsellor and can obtain feedback from patients.
- 4 The stronger the GP-counsellor relationship, the more likely the GP will be satisfied with the counselling service. This prediction follows on from Seaburn et al's (1996) model of collaboration where the quality of the GP-mental health professional relationship is central when considering effective collaboration.

Predictions were not made about the relationships between the other variables.

Eligible Participants

1. GPs who have a counsellor (or group of counsellors) in their practice.
2. Counsellors working in a general practice setting. (Counselling and clinical psychologists were not included in the study).

Considerations

- 1 GPs are busy and are notoriously poor responders to surveys (Kaner et al 1998). Therefore, the survey needed to be fairly short.
- 2 As both GPs and counsellors were to complete the same survey, some of the questions needed to be worded in the third person.

Questionnaire Design

The design was shaped by the findings of the interviews. The design was cross-sectional, to determine the perceptions and experiences of GPs and counsellors at one point in time.

Stage 1 Making a Blueprint for the Questionnaire

A blueprint is a grid structure consisting of content areas along the horizontal axis and manifestations along the vertical axis. Content areas cover everything that is relevant to the questionnaire (Rust & Golombok 1989). Manifestations are the ways in which the content areas may show themselves (Rust & Golombok 1989).

The content areas decided upon were;

1. Perception of counselling
2. Experience of a primary care counselling service.
3. The GP-counsellor relationship
4. Referral issues

The manifestations were:

- Beliefs
- Behaviour

- Feelings
- Context of respondent

This led to the construction of a grid consisting of a number of questions in each content area covering:

- Interest in primary care counselling
- Priority & commitment to the service
- How referrals are made
- Types of problems appropriate for primary care counselling
- Attitudes about collaboration
- Difficulties encountered
- Beliefs about counselling
- Understanding of each other's roles
- Communication
- Joint working
- Security of the service
- Effectiveness of the service
- Role of the counsellor in the practice

Stage 2 Types of Questions

A mixed design was used (that is, a design with a mix of different styles of questions). It was felt that a mixed design allows for maximum information to be obtained from a short questionnaire. The questionnaire consists of;

1. A 5 point Likert scale consisting of a number of statements. Respondents can feel able to express themselves with such a scale (Rust & Golombok 1989).

These statements were designed around 4 main areas:

Respondent's perception of primary care counselling

Respondent's experience of a primary care counselling service

The GP-counsellor relationship

Issues around referrals

2. Respondents were asked to rate each statement. Responses ranged from strongly agree to strongly disagree. The questionnaire consisted of 21 such statements (this was amended from 22 statements following piloting).
3. Alternate questions requiring a yes/no/don't know response. These questions are quick to answer and easy to measure and can be useful for a survey that needs to be short.
4. One open question. An open question allows the respondent to make comments. Information can therefore be gained that would be missed through the constraints of closed questions or a rating scale.
5. Demographic information. This was placed at the end of the survey so the respondent can start with the subject questions. The demographic information sought from the GPs differed from that sought from the counsellors.

For an example of the Pilot Questionnaire please refer to Appendix B (2), page 227 (for questionnaire sent to GPs) and Appendix B (2), page 231 (for questionnaire sent to counsellors).

Procedure for Piloting the Questionnaire

The questionnaire was piloted on 70 eligible GPs and 20 eligible counsellors. These participants were from the Croydon area and the Basildon area. These areas were selected for the pilot stage as the researcher had information on primary care services for these areas. The questionnaires were posted to each participant with a covering letter (see Appendix B (2), page 225 & 226) and a stamped addressed envelope. The questionnaires were anonymous and were not precoded.

The response rate for the pilot stage was;

GPs	55.7%	<i>n</i> =39
Counsellors	55.0%	<i>n</i> =11
Overall	55.6%	<i>n</i> =50

Reliability of Pilot Questionnaire

The reliability of the questionnaire was assessed by looking at the homogeneity of the questionnaire. This was assessed by measuring the **internal consistency**. This is a form of reliability that looks at how well different items in a questionnaire measure the same issue (Litwin 1995). Once the pilot questionnaire was sent out and the responses returned, all the data was analysed using SPSS. Cronbach's alpha analysis was carried out on items 1 - 22 (the rating scale) and found to be;

For all respondents $\alpha = 0.1359$

For GPs $\alpha = 0.1200$

For counsellors $\alpha = 0.4503$

A good reliability is considered to be 0.70, therefore, the pilot questionnaire shows poor reliability for both groups, particularly for the GPs on the rating scale.

Validity of Pilot Questionnaire

This considers how well a questionnaire measures what it sets out to measure (Litwin 1995). In this instance validity was measured by:

1. Face Validity

This is a subjective view of how well an item or group of items appear to fit together. This was done by showing the questionnaire to a number of 'non-experts' for their opinions.

2. Content Validity

This is a subjective measure of how appropriate the items in a questionnaire seem to a set of 'experts' who have knowledge of the subject matter. This was carried out by giving the questionnaire to a panel consisting of;

- 1 GP
- 1 academic tutor
- 1 counselling psychologist
- 1 counsellor

The comments of all the panel members were noted. This stage was carried out *before* the pilot questionnaire was sent out to respondents.

Other methods of validity, i.e. construct and criterion validity were not applicable in this instance. Construct validity measures how meaningful a questionnaire is and is usually determined after years of experience with the questionnaire (Litwin 1995). Criterion validity measures how well a questionnaire correlates with an existing questionnaire measuring a similar subject area (Litwin 1995). As no such existing questionnaire is available this form of validity cannot be assessed.

Amendments following Piloting

Given the poor reliability of the questionnaire several amendments were made. Most of these amendments were to make the questions clearer or to change the order of the questions. Some questions were dropped as respondents were unable to answer properly or failed to understand the instructions.

For specific changes to questions made after piloting please refer to Appendix B (2), page 237. For an example of the amended questionnaires, please refer to Appendix B (2), pages 240 (for amended questionnaire sent to counsellors) and 245 (for amended questionnaire sent to GPs).

Reliability of Amended Questionnaire

In this instance reliability was measured by,

Internal consistency

Once the questionnaire had been sent out and responses returned, the data from the amended questionnaire was analysed using SPSS. Cronbach's alpha analysis was carried out on items 1 - 21 (the rating scale) and found to be;

For all respondents $\alpha = 0.7858$

For GPs $\alpha = 0.8152$

For Counsellors $\alpha = 0.7116$

These results indicate reliable standardised Cronbach's alpha for these items across both groups and a very considerable improvement from the pilot questionnaire.

Validity of the Amended Questionnaire

The validity was assessed by:

1. Face Validity

This is a subjective view of how well an item or group of items appear to fit together. This was done by showing the questionnaire to a number of 'non-experts' for their opinions.

2. Content Validity

This is a subjective measure of how appropriate the items in a questionnaire seem to a set of 'experts' who have knowledge of the subject matter. Given the amendments to the questionnaire, it was decided to give the questionnaire to a larger panel than previously for their comments. The panel consisted of;

- 3 GPs
- 3 academic tutors
- 3 counselling psychologists
- 3 counsellors

As with the pilot study, the comments of the panel were noted. This stage was carried out *before* the amended questionnaire was sent out.

Factor Analysis

This will be discussed in the following chapter.

Participants in the Survey

These were randomly selected from data supplied from a number of sources. As health authorities do not appear to hold information on which GP practices have a counsellor, the researcher had to contact several mental health trusts with a counselling service for information on local GPs. Information on GPs and primary care counsellors was also

supplied from the database of the Counselling in Primary Care Trust (a charity that aims to promote the work of counsellors in primary care).

From these sources the names of the participants covering Britain were randomly selected. All participants were sent the questionnaire with a covering letter and stamped addressed envelope. As for the pilot stage, all questionnaires were anonymous and were not pre-coded.

Response Rate

The questionnaire was sent to 215 GPs and 102 counsellors throughout Britain. Due to limited resources it was not possible to send the questionnaire to any more GPs or counsellors. More GPs were sent the questionnaire than counsellors as there are more GPs with a practice counsellor than there are practice counsellors (most practices have more than 1 GP but usually have only 1 counsellor).

13 questionnaires were returned uncompleted. Of these, 8 had been sent to the wrong address or the participant had moved (in each case this participant was a counsellor).

Excluding these 8 questionnaires the response rate was;

$$\begin{aligned} \text{GPs} &= 55 \% \quad n = 119 \\ \text{Counsellors} &= 70 \% \quad n = 66 \\ \text{Overall} &= 58 \% \quad n = 185 \end{aligned}$$

TABLE 2.01 To Show Gender of Respondents

	Male		Female		Missing	
GP	64.7 %	<i>n</i> =77	33.6 %	<i>n</i> =40	1.7 %	<i>n</i> =2
Counsellor	13.6 %	<i>n</i> =9	80.3 %	<i>n</i> =53	6.1 %	<i>n</i> =4
Total	46.5 %	<i>n</i> =86	50.3 %	<i>n</i> =93	3.2 %	<i>n</i> =6

2. 3 MEETING WITH LOCAL GPs

Aim

The objective of this stage of the study was to meet with a group of local GPs to find out their views and experiences of their primary care counselling service.

Background to the meeting

The researcher and a colleague (a counsellor) approached the Chairperson of the local Primary Care Group to ask to meet with local GPs. The researchers were attending the meeting as representatives of a local primary care counselling service, but also as researchers. They were invited by the Chairperson to attend a locality Primary Care Group meeting where they were given the opportunity to meet with a considerable number of GPs and other primary health care staff. The researchers were offered a 20 minute slot at the meeting to discuss the issues.

As time was very limited, the researchers decided to structure the meeting around 3 specific areas concerning primary care counselling. They wished to obtain feedback from the GPs on their experience and satisfaction with the counselling service. It was hoped that by doing so to also tap into their views and perceptions of primary care counselling generally. The 3 areas discussed at the meeting were;

1. Waiting times to see the practice counsellor.
2. Communication between the GP and the counsellor
3. Overall service satisfaction.

The Setting & Participants

The meeting was part of the locality Primary Care Group general meeting at which different issues are discussed and feedback and updates are given to GPs and practice staff by the Chair. All GPs and practice staff within the locality are invited to attend the meeting. At this meeting approximately 40 –50 people were present. They included; GPs, practice nurses, health visitors and practice managers. This is a larger group than is usual for focus groups. The whole meeting was scheduled to last 1.5 hours of which the researchers' allocated slot was 20 minutes at the beginning. The meeting was held in a local community hall.

The Role of the Researchers

According to Millward (1995), the role of the moderator within a focus group is of central importance. *“The best facilitator guides the proceedings in an unobtrusive and*

subtle way, intervening only to the extent of maintaining a productive group”, (Millward p282; in Breakwell et al 1995). However, the role of the researchers at the meeting was slightly different. The role was a dual role, on the one hand they facilitated the discussion (as moderators), but were also present at the meeting as representatives of the local counselling service. The style adopted was to facilitate the process with minimal control over the content area aside from ensuring the three areas were covered. However, both researchers had to answer certain points that were raised and directed at them at the meeting in their capacity as representatives of their service.

The Format

The researchers were introduced by the chairperson to the audience and told they would be discussing the issues for 20 minutes. Both researchers addressed the audience. The meeting was not tape recorded as it was felt that this would require the consent of all present and some may feel uncomfortable about this. Therefore, notes were taken by both researchers throughout the meeting.

2.4 METHOD OF DATA ANALYSIS CHOSEN FOR STUDY

Semi-Structured Interviews

As the aim of this stage was exploratory, a qualitative and quantitative approach to analysis was adopted (for more detail, please refer to Results chapter). An appropriate form of analysis for interview data is content analysis.

Content analysis has been defined as;

“...a research technique for making replicable and valid inferences from data to their context.” (Krippendorff 1980 p21)

There are several different forms of content analysis. As the interviews were only one part of the study a method of analysis was chosen that would not be too time-consuming.

The technique used was to transcribe the text of the interviews, to break the responses up into units and to record and rank the frequency of GPs’ responses to the units.

Patterns or themes were also selected that appeared to emerge from the interviews, and appropriate quotes were selected from the text that highlighted issues raised from the interviews.

Questionnaires

The method of analysis was primarily quantitative, statistical analysis.

Questionnaire scoring

As there were a range of questions used, there were different types of scoring applied to different questions.

The rating scale

Respondents answered the 21 questions by rating each statement from ‘strongly agree’ to ‘strongly disagree’. The scoring given for each question was from 1 to 5. Questions were either worded positively or negatively. A positive question was one where the statement gives a positive view of primary care counselling. A negative statement is one where the statement gives a negative view of primary care counselling.

For the positive questions the scoring was as follows;

Strongly disagree = 1

Disagree = 2

Neither agree nor disagree = 3

Agree = 4

Strongly agree = 5

For the negative questions the scoring was as follows;

Strongly disagree = 5

Disagree = 4

Neither agree nor disagree = 3

Agree = 2

Strongly agree = 1

All questions were positive questions with the exceptions of questions 8, 13, 14, 15, 16, 19 & 21.

The reason the negative questions were reverse scored was so that all questions went in one direction. That is, the respondent's overall score was a reflection of their overall experience of primary care counselling out of a total possible score of 105 (i.e. scoring 5 for every question). The higher the respondent's score, the more positive their perception and experience. The lower the respondent's overall score the less positive their perception and experience of primary care counselling.

All scores on the rating scale were treated as **interval** data for the purpose of analysis.

Other questions in questionnaire

A number of other questions in the questionnaire required a yes/no/don't know response. Others required respondents to tick an appropriate response (or responses) from a selection of responses. These questions were scored as;

0 = no/not ticked

1 = yes/ticked

2 = don't know (if applicable)

All scores on these questions were treated as **categorical** data for the purposes of analysis.

Open questions

The questionnaire ends with an open question and two other questions (questions 24 & 29) ask for the respondent to specify another response if their chosen response is not given. The responses to these questions were coded and treated as **categorical** data for the purposes of analysis.

Demographic Information

Most of the demographic was treated as categorical data. The only exception being the age bands which were treated as **ordinal** data for the purposes of analysis.

Questionnaire Analysis

All statistical data was analysed using the SPSS software package.

Factor Analysis

Factor analysis was carried out to see if discrete factors exist within the rating scale of the questionnaire. Factor analysis is concerned with exploring the underlying structure of a set of variables (Hammond 1995). In this case, the variables are the 21 questions constituting the rating scale. Factor analysis is concerned with the relationship between the items in the scale. A correlation matrix is constructed and chunks of variance are extracted to represent each underlying factor sequentially (Hammond 1995). This is a complex procedure requiring SPSS. There are different methods of factor analysis and different ways of rotating the correlation matrix. Two common methods of rotation are; orthogonal rotation and oblique rotation. Orthogonal rotation involves a transformation that forces the underlying factors to be uncorrelated with each other; oblique rotation allows factors to be correlated (Hammond 1995).

Descriptive analysis

This was used to report on the data. For example, the frequency of responses, the mean score etc. This data was also displayed visually through bar charts and pie charts.

Comparative Analysis

A range of parametric and non-parametric tests were conducted on the data to compare the responses of the GPs with the responses of the counsellors. The tests used were; t-tests (for interval data), chi-square (for categorical data) and Mann Whitney (for ranked data).

Predictive Analysis

To consider relationships between the variables, correlations were carried out; Pearson's correlation (for parametric data, i.e. interval & ordinal data) and Spearman's rank correlation (for non-parametric data, i.e. categorical data).

To assess whether variables could be predicted from one another, regression techniques were used. Regression is the prediction of unknown values of one variable from known values of another (Miller 1984). The regression analysis carried out was linear regression.

Meeting with Local GPs

For this part of the study, the issues reported upon were;

- what was said by the GPs on waiting times, communication between the GP and counsellor, and overall service satisfaction.
- group issues

These three areas were reported, presented and commented upon. No formal analysis was carried out on the data.

The following chapter will present the results of the study.

CHAPTER 3

RESULTS

This chapter presents the results of the study. The chapter is divided into 3 parts;

3.1 Results from semi-structured interviews with GPs

3.2 Results from questionnaire responses from GPs and counsellors

3.3 Report on meeting with local GPs

3.1 SEMI-STRUCTURED INTERVIEWS

This part of the study was the initial, exploratory stage. Nine local GPs were interviewed on their experiences and perceptions of primary care counselling.

Once the interviews were completed the tapes were transcribed. The method of assessment used was a form of content analysis.

The process for the analysis took the following steps;

- A. The 9 interviews were transcribed
- B. The data was cleaned to remove errors or irrelevancies.
- C. Units were established. These were based on the six areas upon which the interview was designed from the 13 interview questions (please refer to Appendix B (1), page 223);
 - 1. GP experience of the counselling service (based on responses to questions 12 & 13).
 - 2. Perception of counselling (based on responses to questions 3 & 4).
 - 3. Referrals for counselling (based on responses to questions 5 & 6).
 - 4. Collaboration between the GP & counsellor (based on responses to questions 9 & 10).
 - 5. Presenting problems for counselling (based on responses to questions 7 & 8).
 - 6. Perception of the practice counsellor (based on responses to questions 2 & 11).

Question 1 was not allocated to a unit as it was treated as a ‘warm up’ question. Some GP responses did not fit neatly into the prescribed unit but into another unit. For example, some GP’s perception of counselling came from their response to question 11 (asking about the difference between a counsellor and other mental health professionals).

- D. The data were re-ordered into the above units. This process allows for the emergence of themes from the data.
- E. Themes were identified for the units. This process was conducted by two independent coders.

GP responses were coded and allocated to a unit. For each unit a frequency count of responses was taken by the 2 coders.

Themes were then identified by the two coders for 5 of the 6 units. The presenting problems unit was not analysed into themes as the responses did not lend themselves to this type of analysis.

Finally, an overall impression of the interviews was noted by each researcher. This allowed the researcher to step back and consider general points and issues that could be missed by a frequency count.

Reliability

This was assessed by measuring inter-rater reliability for each of the 6 units. This was obtained by calculating the level of agreement between the two coders. Responses to each unit for coder 1 were correlated with responses to each unit for coder 2. The reliability (as calculated by Cohen’s Kappa using SPSS) for each unit can be seen in Table 3.1

It was found that for some units e.g. presenting problems there was almost total agreement between the 2 coders as the GP responses were clear and unambiguous. For other units e.g. perception of counselling, there was less agreement between the 2 coders as the GP responses were more open to individual interpretation.

However, all units showed good inter-rater reliability (that is, $r = 0.70$ or above).

TABLE 3.1 To Show the Inter-Rater Reliability of the Interviews

Unit	Cohen's Kappa
Experience of service	$r = 0.70$
Perception of counselling	$r = 0.70$
Referrals (when are referrals made?)	$r = 0.78$
Referrals (influencing factors)	$r = 0.70$
Collaboration	$r = 0.79$
Presenting problems	$r = 0.89$
Perception of counsellor (employment of counsellor)	$r = 0.70$
Perception of counsellor (difference with other professionals)	$r = 0.72$

1. GP's Experience of Counselling Service

When asked about their experience of having a counsellor in their practice (question 12) and what had they learnt from having a counsellor (question 13), the GPs gave the following responses;

These responses were divided into the theme of positive/ negative/neutral experience of counselling service by the coders.

TABLE 3.2 To Show GPs' Experience of Primary Care Counselling Service

Responses of GPs	Number of GPs Responding	Response Rating
Values counselling service	6 (inc 1 highly value)	positive
Makes a big difference to practice	3	positive
Difficulties with the counsellor	3	negative
Not learnt from the counsellor	3	negative
Learnt a lot from the counsellor	2	positive
A mixed experience	2	neutral
Finds service expensive	2	negative
Questions the value of counselling	2	negative
Can share problems with another professional	2	positive
Caused conflict with partners	1	negative
Eases GP workload	1	positive
Broadens available treatments	1	positive
Confirms importance of talking about problems	1	positive
Funding issues	1	negative
Long term counselling not effective in primary care	1	negative
Little contribution	1	negative
Saves GP time	1	positive

Of the 33 responses identified by the coders, 17 were assessed as positive, 14 were identified as negative and 1 was identified as neutral experience of counselling service.

2. *GPs’ Perception of Counselling*

When asked the question, ‘how do you think counselling may help a patient?’ (question 3) and ‘how does it achieve this?’ (question 4), the GPs gave the responses in Table 3.3.

The theme identified for this unit was whether the response gave an active or passive (or neutral) view of counselling. Responses were allocated to one of these categories. Two responses have been included which were not amenable to categorisation as they were not strictly responses on perception of counselling, but the GP’s opinion on the merits of counselling. However, they have been included in the table as they may be of interest.

TABLE 3.3 To Show GPs’ Perception of Counselling

GPs’ Responses	Number of GPs Responding	Response Rating
Offers time	5	Passive
Offers insight	3	Active
Gives a different perspective	3	Active
Is non-directive	2	Passive
Opportunity to talk things over	2	Passive
Is a process	1	Active
Helps a person to help themselves	1	Active
Offers non-specific skills	1	Passive
Cognitive therapy	1	Active
Offers empathy	1	Passive
Introspection	1	Active
Normalise problems	1	Active
Offers neutrality	1	Passive
Unstructured	1	Passive
Offers safety	1	Passive
Opportunity to ventilate feelings	1	Passive
Chance to make changes	1	Active
Not a cure	1	n/a
Fashionable	1	n/a

It can be seen that the responses are varied, but that the majority of these GPs feel that counselling offers the patient time. 16 of the responses may be considered passive;

viewing counselling as offering time, safety, empathy, opportunity to talk etc. Fewer of the responses view counselling as an active process (11 responses). Other responses appear to be specific to a particular type of counselling e.g. cognitive therapy; this may reflect the orientation of the GP's particular counsellor. One GP found this a difficult question to answer, saying that there are many different types of counsellors and counselling and that it was difficult to generalise.

3. *Referrals*

This unit was divided into two categories (one for each question).

The GPs were asked, 'How do you decide whether or not to refer a patient to the counsellor?' (question 5) and 'what factors may influence your decision?' (question 6). The themes identified for this unit was where the decision to refer lay (i.e. with the GP, the patient or both) and where the influential factors in referring were attributed (i.e. the patient, the GP, the counsellor, the service).

When discussing who makes the decision to refer for counselling, a significant number of GPs ($n = 4$) stated that the decision could be either GP led or patient led. Three GPs stated that the decision is usually, or always GP led, one GP stated that the patient usually makes the decision to seek counselling and one GP stated that the decision to refer is always a joint decision between the GP and the patient.

TABLE 3.4 To Show When Decision to Refer for Counselling is Made

Responses of GPs	Number of GPs Responding
Patient asks for counselling	4
Patient needs more time	2
After medication, still problems	1
GP feels stuck	1
GP lack of expertise	1

TABLE 3.5 To Show Influential Factors in Referring

Responses of GPs	Number of GPs Responding	Factor
Patient motivation	3	patient
Waiting list	2	service
No factors	2	neither
Patient history	1	patient

In considering the factors that influence the GP’s decision to refer to the practice counsellor, the most common factor is patient motivation, followed by consideration of the waiting list. Two GPs could not think of any influential factors. It can be seen that patient factors appear to be the most common reasons when considering a referral for counselling.

4. *Collaboration*

When asked, ‘Do you think collaboration and liaison with the counsellors is important?’ (question 9), all 9 GPs felt that collaboration with the practice counsellor was important and of these, 2 GPs felt that that it was very important.

GPs were than asked, ‘what, if any, obstacles do you think exist to closer collaboration?’ The theme identified for this unit was the attribution made by the GP regarding the obstacles to collaboration. The possible attributions were; the counsellor, the setting, the GP. Most of the GPs (8 out of 9) had experienced obstacles when trying to work collaboratively with the counsellor. None of these obstacles are attributed to the GP alone, 7 responses attribute the obstacles to the primary care setting, 6 responses attribute the obstacle to the counsellor alone and 1 response attributes this to both the GP and counsellor. The obstacles given by the GPs can be seen in Table 3.6

TABLE 3.6 To Show Factors that Make Collaboration Difficult

GPs’ Responses	Number of GPs Responding	Attribution
Lack of time	5	Setting
Confidentiality	4	Counsellor alone
Different ways of working	1	Counsellor & GP
Lack of feedback from counsellor	1	Counsellor alone
Separateness of counsellor	1	Counsellor alone
Waiting lists	1	Setting

However, some of these ‘obstacles’ were also seen as positive aspects of the counselling service. For example, one GP reported that it was useful that the counsellor worked separately from the rest of the PHCT as this gave the counsellor some distance from the GP and that some patients may value this. Another GP stated that although the issue of confidentiality may be problematic at times for the GP, patients valued the

confidentiality between themselves and the counsellor.

Some GPs ($n= 5$) went on to say that talking is the best form of communication and makes collaboration possible; another GP spoke of the importance of a shared approach between the two professions.

5. *Presenting Problems*

When asked about appropriate and inappropriate problems to refer to the practice counsellor (questions 7 & 8), the GPs gave the following responses;

**TABLE 3.7 To Show Appropriate Presenting Problems for
Practice Counsellor**

GP Responses	Number of GPs Responding
Depression	4
Bereavement	3
Relationship difficulties	3
Family Problems	2
Low self-esteem	2
Anger management	1
Anxiety	1
Life cycle issues	1
Difficulty coping	1
Phobias	1
Personality problems	1
Self doubt	1
Stress	1
Termination	1

**TABLE 3.8 To Show Inappropriate Presenting Problems for
Practice Counsellor**

GP Responses	Number of GPs Responding
Psychotic illness	4
Lack of insight	2
Endogenous depression	2
Schizophrenia	2
Personality problem	2
Childhood sexual abuse	1
Drug dependency	1
Depression	1
Long term problem	1
Alcohol dependency	1

Some of these responses do not relate specifically to a presenting problem, rather a factor of the patient. For example, lack of insight. However, they have been included in the table as they were cited by the GPs as relevant problems that would make a referral inappropriate for the practice counsellor. It is interesting to see that depression features as both an appropriate and an inappropriate problem for primary care counselling.

6. *Perception of the Practice Counsellor*

This issue was addressed by two different questions and was, therefore, divided into two sub-units.

1. Factors in employing a counsellor

When asked what they would look for in employing a counsellor in their practice (question 2), the GPs gave the responses in Table 3.9. The responses were allocated to one of three categories that were identified for this unit. These were; personal factors of counsellor, external factors and qualification/experience factor.

TABLE 3.9 To Show Important Factors in Employing a Counsellor

Responses of GPs	Number of GPs Responding	Factor
Good rapport	3	Personal
Appropriate qualifications	2	Qualification
Primary care experience	2	Qualification
Supervision	2	Qualification
Flexibility	1	Personal
Maturity	1	Personal
Appropriate management	1	External
Offers short-term counselling	1	Qualification
Team approach	1	Personal

It is interesting to note that the most frequent response is concerned with personal factors concerning the counsellor. Issues of qualification/experience are also important, particularly experience of working in primary care.

2. Difference between a Counsellor and other Mental Health Professionals.

When asked about the difference between a counsellor and other mental health professionals working in primary care (e.g. a CPN or clinical psychologist) the GPs gave the responses in Table 3.10.

The responses were allocated to three categories; according to whether the perceived difference was associated with

- 1. training/knowledge
- 2. style/way of working
- 3. types of patients seen

TABLE 3.10 To Show Difference Between Counsellor & Other Mental Health Professionals

Counsellor	Other Mental Health Professionals	Factor
Non-directive	Directive	Style
Little medical knowledge	More medical knowledge	Training
Non chronic patients	Chronic patients	Patient
Good counselling ability	Less counselling ability	Training
See patients short term	See patients longer term	Style
Less severe patients	More severe patients	Patient
Less structured	More structured	Style
Non-behavioural approach	Behavioural approach	Training
Patient's pace	Less at patient's pace	Style
Less monitoring	More monitoring	Style

Cognitive therapy was given by one GP as something that counsellors offered that made them different from other mental health professionals. This response was also offered by another GP as something that counsellors did *not* do.

A number of GPs stated their confusion about the differences between the professions.

Summary of Part 3.1 – The Semi-Structured Interviews

Nine GPs took part in the interviews. They indicated a mixed experience of their counselling service. When asked about their perception of counselling, again a mixed response was obtained, but overall counselling was perceived to be a passive process. In terms of referrals to the practice counsellor, the decision to refer is sometimes taken by the GP (if it is felt the patient needs more time or the GP feels stuck), or counselling may be requested by the patient. The decision to refer may be influenced by patient motivation and the waiting list for counselling. Depression, bereavement and relationship difficulties were the most commonly identified appropriate presenting problems for counselling. Psychotic illness, personality problems, schizophrenia,

endogenous depression and lack of patient insight were given as inappropriate presenting problems for counselling.

All nine GPs felt collaboration and liaison with the practice counsellor is important. Obstacles to closer collaboration were commonly identified as, lack of time and issues of confidentiality. In considering employing a counsellor, GPs identified both personal qualities of the counsellor as well as his/her experience. The GPs gave a range of differences between a counsellor and other mental health professionals in primary care. A number of GPs stated their confusion about the differences between the mental health professions.

3.2 QUESTIONNAIRE RESULTS

Aims of the Questionnaire

1. To quantitatively measure the perceptions & experiences of GPs of primary care counselling through a questionnaire.
2. To compare this with the perceptions & experiences of counsellors working in primary care.
3. To see if discrete factors exist within the rating scale of the questionnaire.
4. To see if, and to what extent, a relationship exists between different variables measured in the questionnaire

More specifically;

- i. Is the orientation of the counsellor related to his/her view on collaboration?
- ii. Is the orientation of the counsellor related to the quality of the GP-counsellor relationship?
- iii. Is the gender of the GP related to how highly he/she values the counselling service?
- iv. Is the age of the GP related to how highly he/she values the counselling service?
- v. Does the number of years a practice has a counsellor relate to a GP's satisfaction with the counselling service?
- vi. Is GP satisfaction with the counselling service related to the quality of the GP-counsellor relationship?
- vii. Is GP satisfaction with the counselling service related to a GP's interest in primary care counselling?

Hypotheses

Predictions were made regarding the nature of the relationship between some of the variables described above. Namely, it was predicted that;

1. Female GPs would value the counselling service more highly than their male colleagues. This is from previous research (Radley et al 1997) that found the inclusion of a female GP increased the likelihood the practice employed a counsellor.
2. Younger GPs would be more likely to value to counselling service than older GPs due to their increased exposure to counselling, their different training from their older colleagues and the likelihood they would adapt to changes in their working practice more easily than older GPs.
3. The longer a practice has a counsellor, the more likely the GP is satisfied with the service. This is because over time, the two professionals can develop a working relationship; the GP can learn about the work of the counsellor and can obtain feedback from patients.
4. The stronger the GP-counsellor relationship, the more likely the GP will be satisfied with the counselling service. This prediction follows on from Seaburn et al's model of collaboration where the quality of the GP-mental health professional relationship is central to effective collaboration.

Predictions were not made about the relationships between the other variables.

The results of the questionnaire will be subdivided into three parts:

- 3.2.1 Descriptive results.
- 3.2.2 Comparative results
- 3.2.3 Predictive and related variables.

3. 2.1 Descriptive Results

This section presents descriptive data including factor analysis and demographic information on respondents.

Factor Analysis of The Rating Scale

The study was interested to see if discrete factors existed within the rating scale of the questionnaire. To this end a factor analysis was carried out for each group on the scores from the rating scale of the questionnaire.

As discussed in the previous chapter, there are a number of methods of factor analysis. The method of factor analysis used in the present study was the generalised least squares method. The extractions were rotated using several different rotation methods; quartimax rotation, equamax rotation, varimax rotation & oblimin rotation. Separate analyses were carried out for each group. However, no discrete or stable factors emerged from the factors analyses for either the GPs or the counsellors.

The Sample

Of the total sample of 185 respondents, 119 were GPs and 66 were counsellors.

Age

Both groups were asked to indicate their age group. As they were given different age bands it is not possible to report on their ages in one table.

TABLE 3.11 To Show Age Bands of Counsellors

Age Group (in years)	Frequency	Percent
31 – 40	5	7.6
41 – 50	32	48.5
51 – 60	22	33.3
Over 60	3	4.5
Missing data	4	6.1
Total	66	100

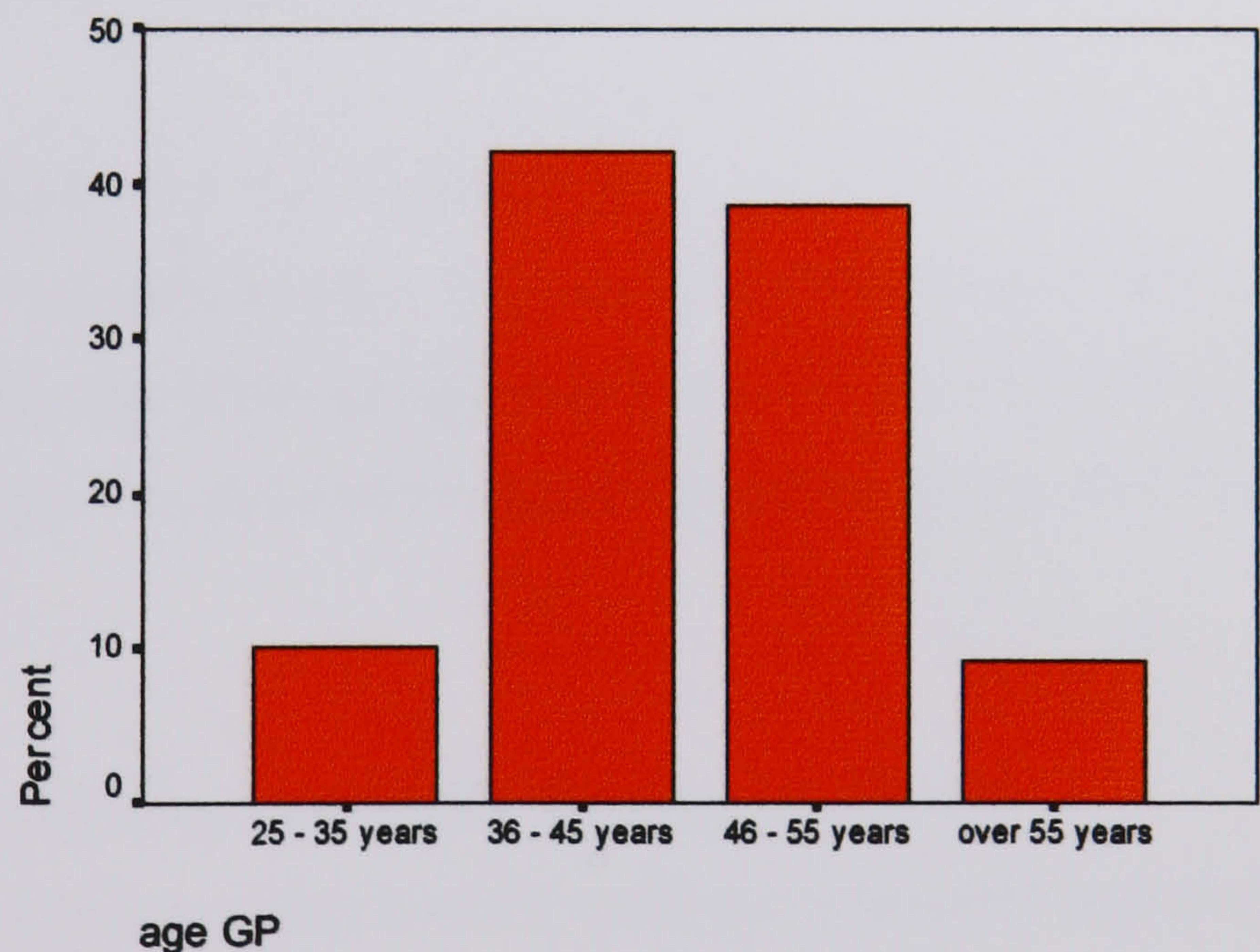
TABLE 3.12 To Show Age Bands of GPs

Age Group (in years)	Frequency	Percent
25 – 35	12	10.1
36 – 45	50	42.0
46 – 55	46	38.7
Over 55	11	9.2
Total	119	100

Fig 3.01 Bar chart to show age bands for counsellors



Fig 3.02 Bar chart to show age bands of GPs



It can be seen that as a group, the counsellors appear to be older than the GPs. Only 7.6% of counsellors are 40 years or younger. However, it is difficult to make direct comparisons as the age groups are different for the two professions.

Gender

As reported earlier, 33.6% of GPs and 80.3% of counsellors are female.

Years in their Profession

Both groups were asked to indicate the numbers of years they have been in their respective professions from a list of year groups. Although older than the GPs, the counsellors, as a whole have been in their profession for fewer years than the GPs. 67.3% of the GPs have been in their profession over 10 years compared with only 21.2% of the counsellors. A third of the counsellors have been in working as counsellors for 5 years or less, compared with only 13.4% of the GPs working in general practice. For detailed results please refer to Appendix B (2), Table A.01, page 250.

Employment Status of Practice Counsellor

Both groups were asked to indicate the employment status of the practice counsellor. For both groups the vast majority of counsellors are employed by the practice (60.2%), NHS Trust employment was second. Only one GP and one counsellor indicated that the counsellor works in the practice on a voluntary basis. For detailed results, please refer to Appendix B (2), Table A.02, page 250.

Number of years Practice has had Counselling

The GP sample were asked how many years there had been a counselling service at their practice. The majority of the sample (70 %) have had a counselling service for between 2 and 10 years. For detailed results please refer to Appendix B (2), Table A.03, page 250.

Hours a Week of Counselling input by the Practice Counsellor

Both groups were asked how many hours a week the counsellor sees patients at the surgery. 60% of counsellors reported to see patients for over 10 hours a week, compared to just 27% of GPs reporting the same number of hours for their counsellor. Eight GPs did not know how many hours the practice counsellor sees patients. For detailed results, please refer to Appendix B (2), Table A.04, page 251.

Orientation and Qualification of Counsellor

Counsellors were asked to indicate their primary theoretical orientation from a list of orientations given. The results can be seen in the pie chart (Fig 3.03) and Table 3.13

Pie chart to show

orientation of counsellors

Fig 3.03

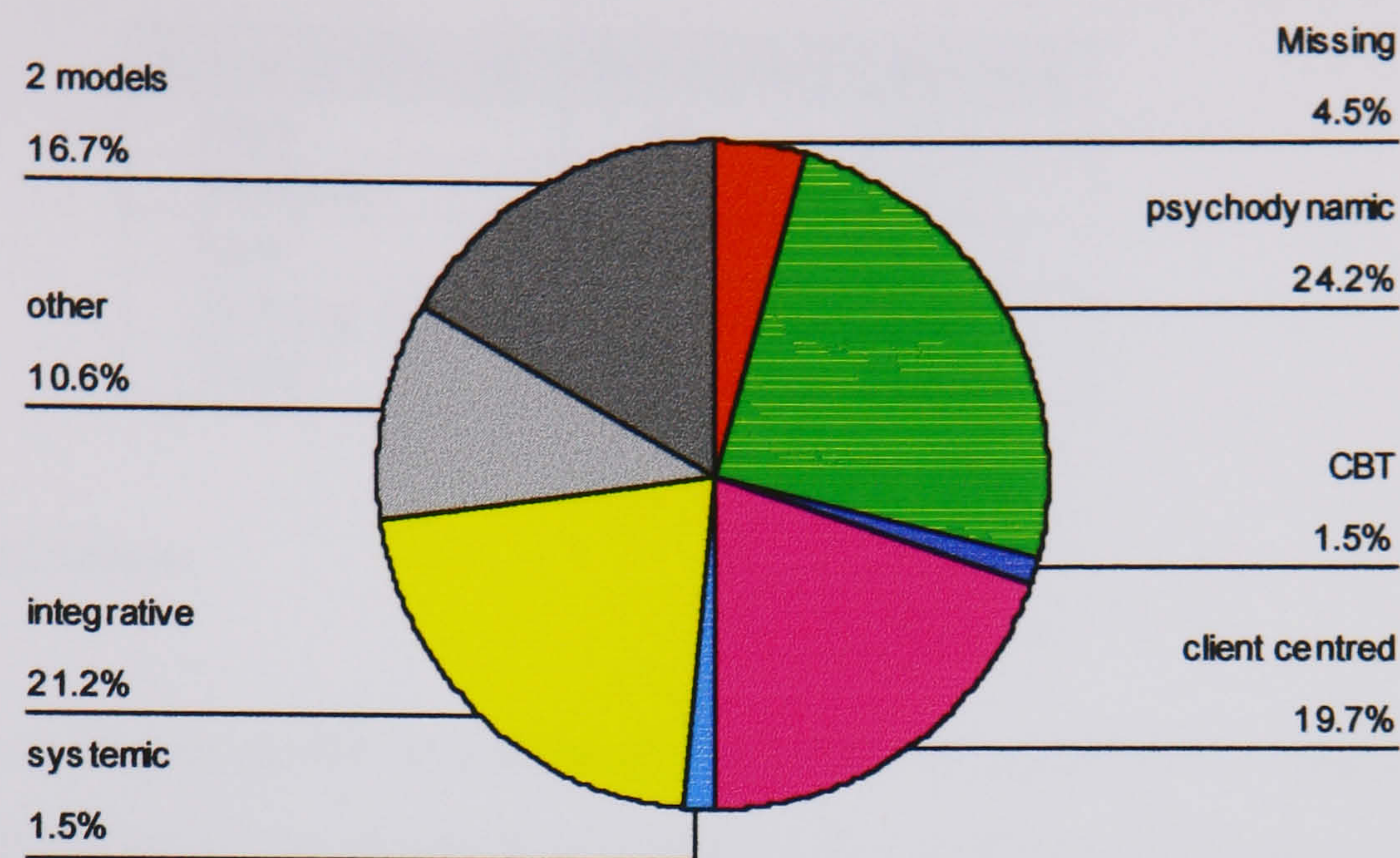


TABLE 3.13

To Show Orientation of Counsellors

Orientation	Frequency	Percent
Psychodynamic	16	24.2
Integrative	14	21.2
Client centred	13	19.7
Combination of the above	11	16.7
Another approach	7	10.6
Systemic	1	1.5
Cognitive-behavioural	1	1.5
Missing data	3	4.5
Total	66	100

Counsellors were also asked as an open question to give their qualification (s). Some counsellors did not state a qualification as such, but that they were BAC or UKCP accredited. To reach this level of accreditation would require a recognised level of qualification. The most popular qualification held by the counsellors was a diploma in counselling (45.4% of respondents). The newer qualification of a masters degree in counselling is held by 19.7% of the group. For detailed results on counsellors’ qualifications, please refer to the Appendix B (2), Table A.05, page 251.

GP Interest in Counselling

All GPs were asked to indicate their interest in the subject area of primary care counselling as high interest, medium interest or low interest.

The responses given can be seen in Table 3.14.

TABLE 3.14 To Show GP Interest in Primary Care Counselling

Level of Interest	Frequency	Percent
High	62	52.1
Medium	50	42.0
Low	5	4.2
Missing data	2	1.7
Total	119	100

Distribution of Scores

Analysis was carried out on the responses of the sample to questions 1 – 21 (the rating scale). The distribution of the scores for the sample was analysed to see how closely the scores on the rating scale approximate a normal curve. A normal curve is one that is symmetrical about the mean and where the mean, median and mode are equal (LoBiondo-Wood & Haber 1998).

The distribution of scores for each group can be seen in Fig 3.04 & Fig 3.05

It can be seen from viewing the graphs that the distribution of scores appears to be nearing a normal distribution.

This was investigated further by measuring the skewness graph for the total sample and for each profession. Skewness is a measurement of the shape of a frequency distribution. For a perfect symmetrical distribution (that is, a normal distribution), the skewness is zero.

Fig. 3.04 Bar Chart to Show Distribution of ‘Total Score’ for Counsellors

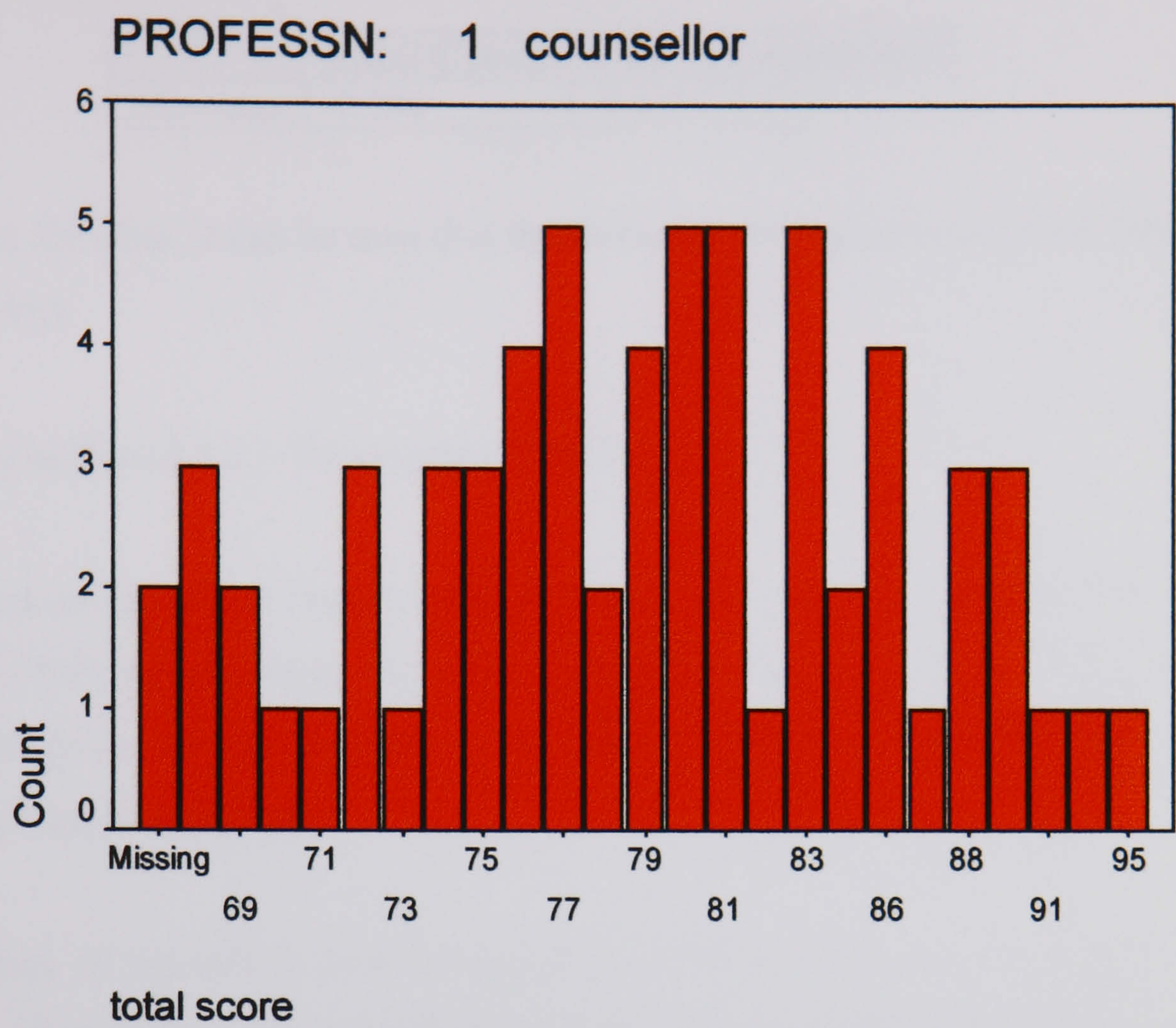


Fig 3.05 Bar Chart To Show Distribution of ‘Total Score’ for GPs

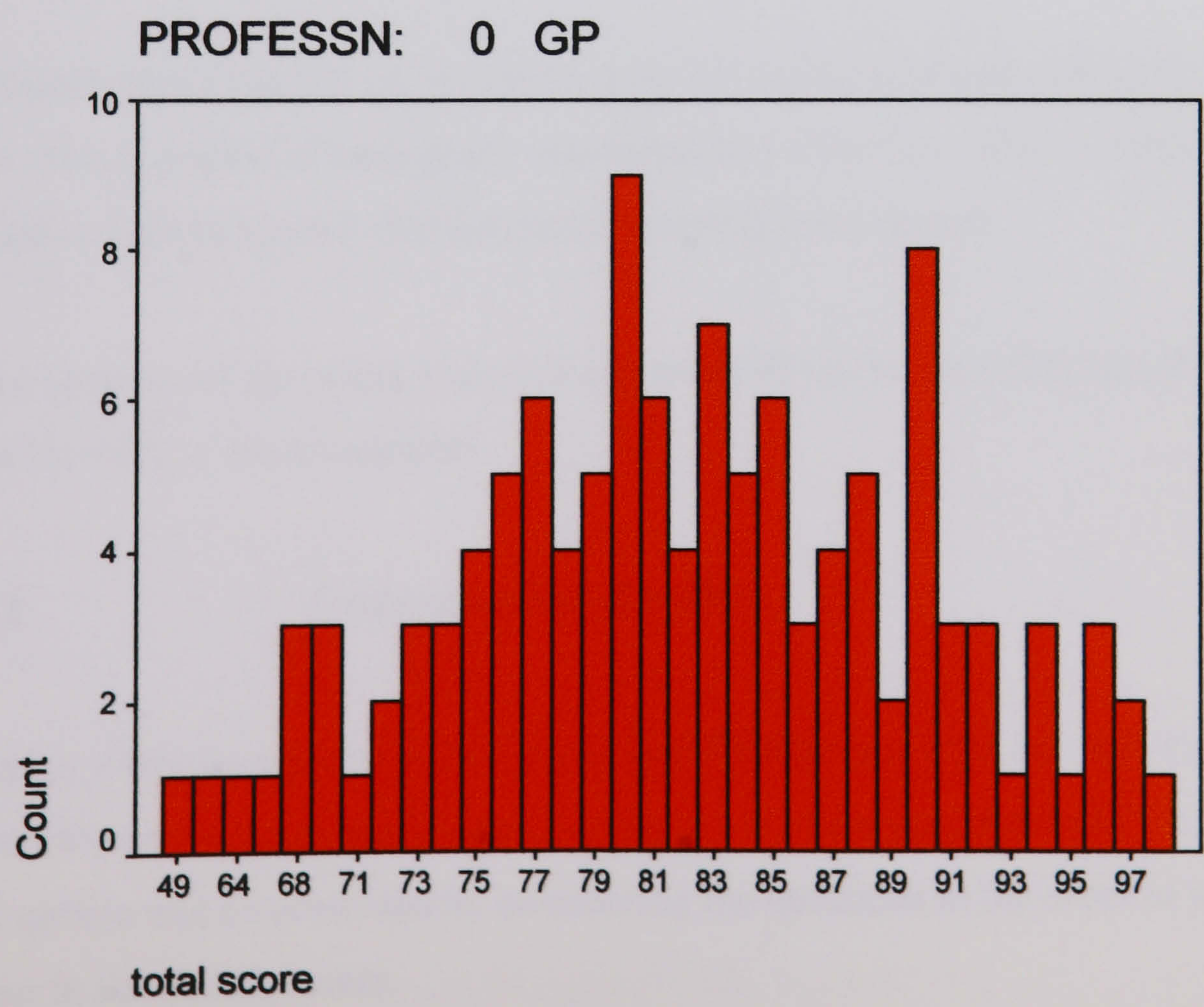


TABLE 3.15 To Show Skewness of the Sample From Total Score on Rating Scale

	Total Group	GPs	Counsellors
Skewness	-0.306	-0.535	0.115

Looking at the table, it can be seen that the skewness for both groups is low (that is, it is close to zero).

Summary of Part 3.2.1 – Descriptive Results

Of the total sample of 185 respondents, 119 were GPs and 66 were counsellors. The majority of GPs were between 36 and 55 years of age and have been in their profession for over 10 years. The vast majority of the sample expressed a medium or high interest in primary care counselling.

The majority of counsellors were between 41 and 60 years of age and had been working in their profession for fewer years than the GPs. Most counsellors were employed by the practice and offered over 10 hours a week seeing patients in primary care. The most common orientations cited among this group were psychodynamic (24.2%) and integrative (21.2%).

The distribution of scores on the rating scale for each group approximated a normal curve. The skewness of each graph was found to be low (i.e. close to zero). This suggests a near to normal distribution of scores for each group.

Factor analyses of the rating scale did not reveal the presence of discrete factors for either the GPs or the counsellors.

3.2.2 Comparative Results

Analyses were carried out on the data to see if differences exist between the responses of the GPs to the questionnaire and the responses of the counsellors to the questionnaire. This section will be presented by considering the questions in the order in which they appear in the questionnaire.

A test was carried out to measure the difference in responses to the 21 questions in the rating scale between the GPs and the counsellors. A Mann Whitney test was conducted on the sum of the ranks of each question. (For the responses of each group to the 21 questions on the rating scale, please refer to Appendix B (2), Table A.06, page 252). The results of the Mann Whitney test for each of the 21 questions can be seen in Appendix B (2), Table A.07, page 259.

To test for significance on these results, it was first necessary to carry out a Bonferroni adjustment. As there are 21 questions to be tested, using a significance level of 0.05 (that is, 1 in 20) it would be expected that at least one of these 21 questions would throw up a significant result purely by chance. Therefore, an adjustment is needed to find a new significance level. This adjustment is obtained by a simple calculation;

Significance level

No. of questions

=

new level of significance

0.05

21

=

0.002

With this new level of significance, a number of questions in the scale were found to show a statistically significance difference in responses between the GPs and the counsellors. That is, the GPs and the counsellors differed significantly in their responses to these questions. These questions are shown in Table 3.16

TABLE 3.16 To Show Questions in Rating Scale where a Statistically Significant Difference was obtained in Scores Between the Two Groups

Question	Level of Significance
Many GPs regularly provide some form of counselling themselves, to their patients.	$p = 0.000$
If GPs had more time to spend with their patients there would be less of a need for counselling	$p = 0.000$
The GP & the counsellor have different views about confidentiality	$p = 0.003 \#$
The counsellor can learn about medical practice from the GP	$p = 0.007 \#$
The counsellor likes to work separately from the rest of the team	$p = 0.007 \#$
The counsellor needs to develop a more collaborative working style with the team	$p = 0.007 \#$

= level of significance that is approaching statistical significance

One question (question 1) showed a highly non-significant level ($p = 0.846$), indicating that for this question there was considerably agreement between the two groups. This question states, ‘the counselling service in this practice is highly valued by the GP’. 89.9% of GPs agreed or strongly agreed with this statement and 92.4% of counsellors agreed or strongly agreed with this statement.

Looking at the responses to the rating scale, the total score on the scale was considered for each respondent. The higher the total score the more positive the experience of the primary care counselling service. The mean total score and range of scores for each group can be seen in Table 3.17

TABLE 3.17 To Show Descriptive Statistics For Each Group on ‘Total Score’ from Rating Scale

Profession	n	Range	Minimum	Maximum	Mean	Std. Deviation
GP	119	52	49	101	81.90	8.42
Counsellor	64	28	67	95	79.53	6.57

The mean total score for the GP sample is higher than for counsellors.

A t-test analysis was carried out to see if the difference in mean total scores for each profession was significant. The result obtained ($t = 1.952$) was found to have a level of significance of 0.052. This is not statistically significant but is approaching significance. Looking at the Range of scores for the 2 groups, it can be seen that the GP group have a much wider range of scores than the counsellor group.

Perception of Counselling

Respondents were asked to indicate their view and understanding of counselling by ranking (from 1 – 6) 6 statements describing a view of counselling (Question 22). However, a large proportion of respondents (37.9% of counsellors & 38.7% of GPs) did not answer this question correctly. As this was such a large number of respondents it was not possible to carry out any analysis on this data. However, the difference in responses between the two groups can be seen in the pie charts below that indicate the percent of respondents from each profession that ranked each statement first.

Pie chart to show counsellors'

perceptions of counselling

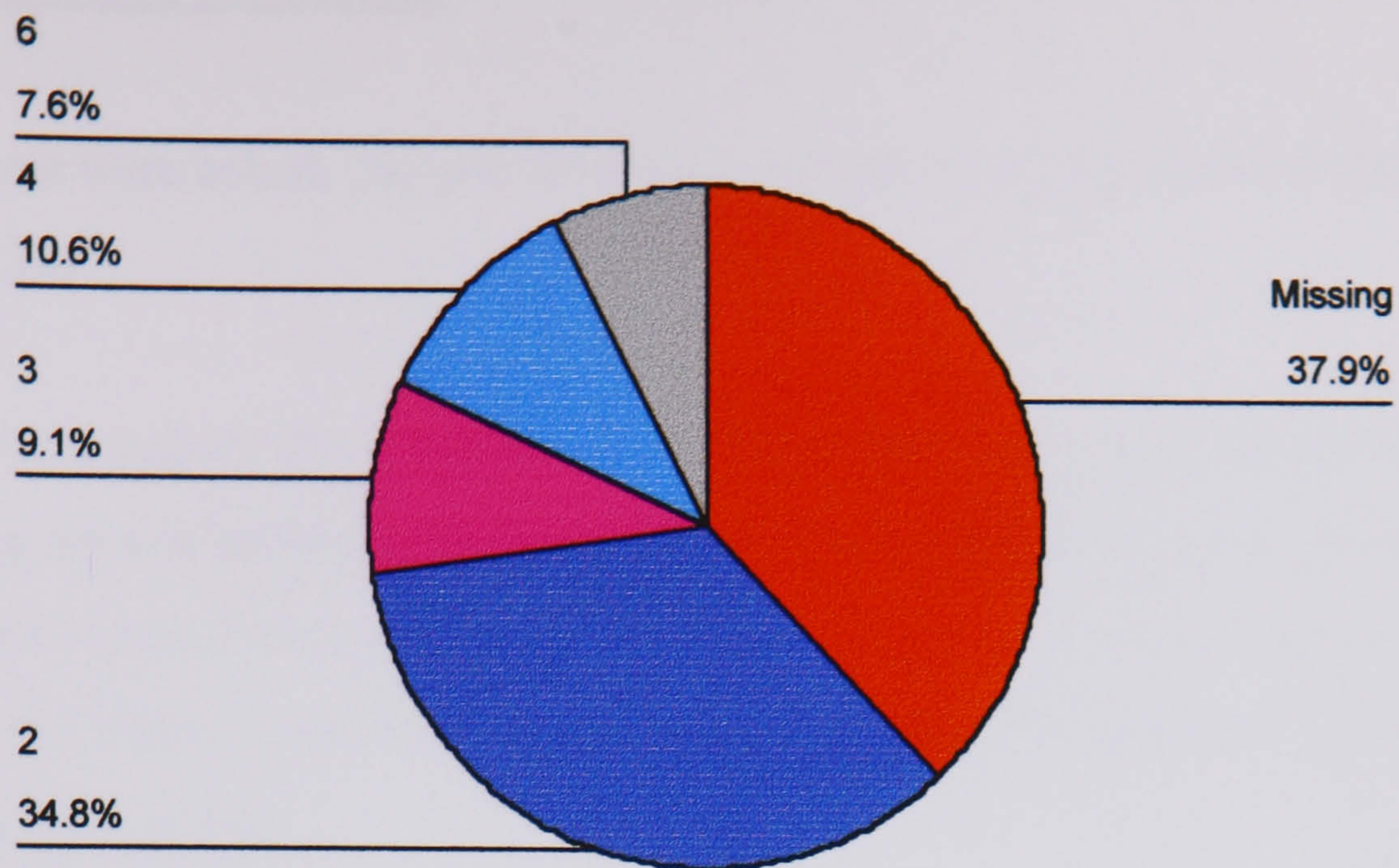


Fig 3.06

Pie chart to show GPs' perceptions of counselling

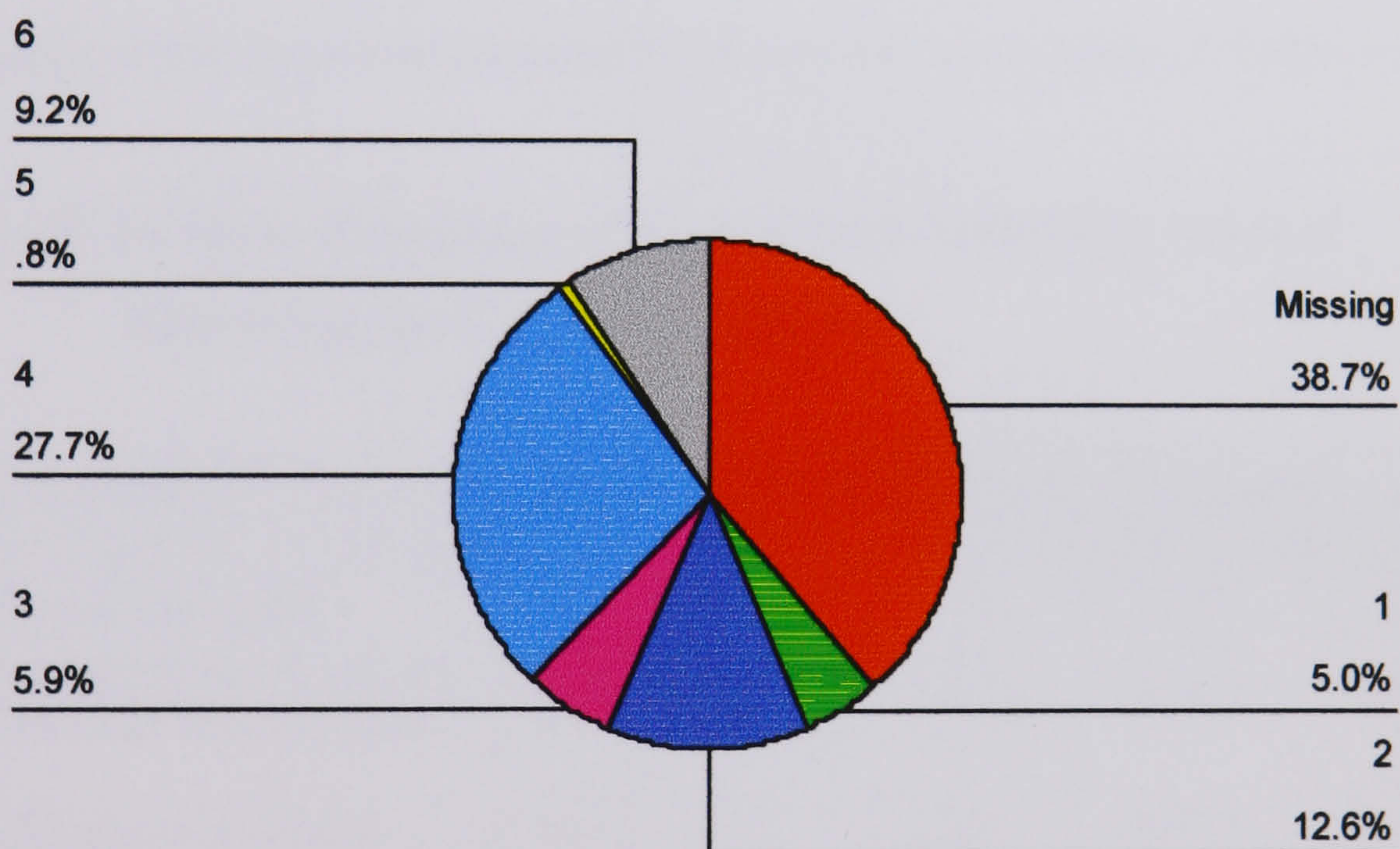


Fig. 3.07

Key to Pie Charts

- 1 = statement 1 "counselling primarily offers a patient time to talk".
- 2 = statement 2 "counselling is primarily an active process involving self exploration"
- 3 = statement 3 "counselling primarily helps a patient to use their own coping resources".
- 4 = statement 4 "counselling primarily offers patients an opportunity to identify & solve their own problems".
- 5 = statement 5 "counselling primarily offers a patient a listening ear".
- 6 = statement 6 "none of the above".

Improvements to the Service

Respondents were asked, ‘do you think the counselling service could be improved?’, (question 23).

85.5% of GPs and 95.4% of counsellors (89% of all respondents) felt that the counselling service could be improved. A chi-square analysis was carried out on this result to see if there was a significant difference between the two groups on this question. The result obtained ($\alpha = 4.199$) gives a level of significance that is statistically significant ($p = 0.040$).

Respondents were then asked, ‘if yes, how could the service be improved?’, (question 24). Respondents could select from a number of responses given or specify their own response. A chi-square analysis was carried out on these responses to see if there was a statistically significant difference between the scores of each group.

The frequency of the responses selected by the sample can be seen in Table 3.18

TABLE 3.18 To Show Percentage of Respondents Indicating Ways of Improving the Counselling Service

Response	GP	Counsellor	Total	Chi-square $\alpha =$	Significance level
Using a different counsellor	10.1	4.6	8.2	1.679	$p = 0.195$
Offering more sessions per patient	22.7	27.7	24.5	0.570	$p = 0.450$
Increasing hours of counselling in practice	69.7	80.0	73.4	2.261	$p = 0.133$
Other ways to improve service	26.1	47.7	33.7	8.813	$p = 0.003^*$

* = statistically significant level

N.B. The percentage given in the table is the percent of respondents from the total sample of respondents who were eligible to answer this question. That is, respondents who answered ‘yes’ to question 23.

The most popular response for both groups, by a long way, was the suggestion that increasing the hours of counselling in the practice would improve the counselling service. The least popular response for both groups was the suggestion that using a different counsellor would improve the counselling service.

It can be seen that for the response ‘offering more sessions per patient’ there was considerable agreement between the GPs and the counsellors. However, for the response, ‘other ways to improve the service’ a statistically significant difference was obtained between the number of GPs who responded ‘yes’ and the number of counsellors who responded ‘yes’.

Respondents who replied that the counselling service could be improved by other ways were asked to specify what these other ways were. The responses for both groups can be seen in Appendix B (2), Table A.08, page 260. The most popular response given for both groups was ‘more collaboration between the two professionals’ as a way of improving the counselling service. 19.4% of GPs who responded to this question and 18.8% of counsellors who responded to this question gave this suggestion. This was followed by ‘having more specialist counsellors’ (9.7% GPs & 15.6% counsellors) as a suggestion for improving the counselling service. After this, the numbers become too small to be able to draw any conclusions from.

Funding Difficulties

Respondents were asked, ‘are you aware of funding difficulties for the counselling service?’, (question 25).

The results obtained (given as percentages) can be seen in Table 3.19

TABLE 3.19 To Show Percent of Respondents Experiencing Funding Difficulties for Counselling Service

Profession	Yes	No	Don’t know
GP	80.7	16.0	2.5
Counsellor	80.3	12.1	7.6
Total	80.5	14.6	4.3

It can be seen that the vast majority of respondents from both professions indicate that there are funding problems with the counselling service.

GP Service Satisfaction

Respondents were asked, ‘are the GPs sufficiently satisfied with the counselling service to want it to continue at this practice?’ (Question 26).

The responses can be seen in Table 3.20

TABLE 3.20 To Show GP Service Satisfaction by Group

Profession	Satisfied	Not Satisfied	Don't Know	Missing Data
GP	92.4 %	5.0 %	1.7 %	0.8 %
Counsellor	98.5 %	0 %	1.5 %	0 %

A chi-square analysis was carried out on the responses of both groups to see if there was a significant difference in the responses of both groups. The result obtained ($\alpha = 3.488$) has a significance level ($p = 0.175$) that is not statistically significant.

Presenting Problems

Respondents were asked ‘which presenting problems may be appropriate to refer to a counsellor working in primary care?’ (Question 27). They were asked to select as many presenting problems as they wished from a list of 14 problems.

The responses of both groups are shown in Fig. 3.08

It can be seen that for most problems there appears to be agreement between the two groups as to their appropriateness for primary care counselling.

The most popular choices among both groups were; anxiety (all counsellors ticked this response), bereavement, depression, family problems, relationship difficulties and somatisation.

The least popular choices among both groups were; drug abuse; personality disorder and psychosis. That is, these presenting problems were considered by the majority of respondents to be inappropriate for the practice counsellor.

A chi-square analysis was carried out on each presenting problem to see if a significant difference exists between the responses of each group. The results can be seen in Table 3.21

Problems considered appropriate for treatment by practice counsellors

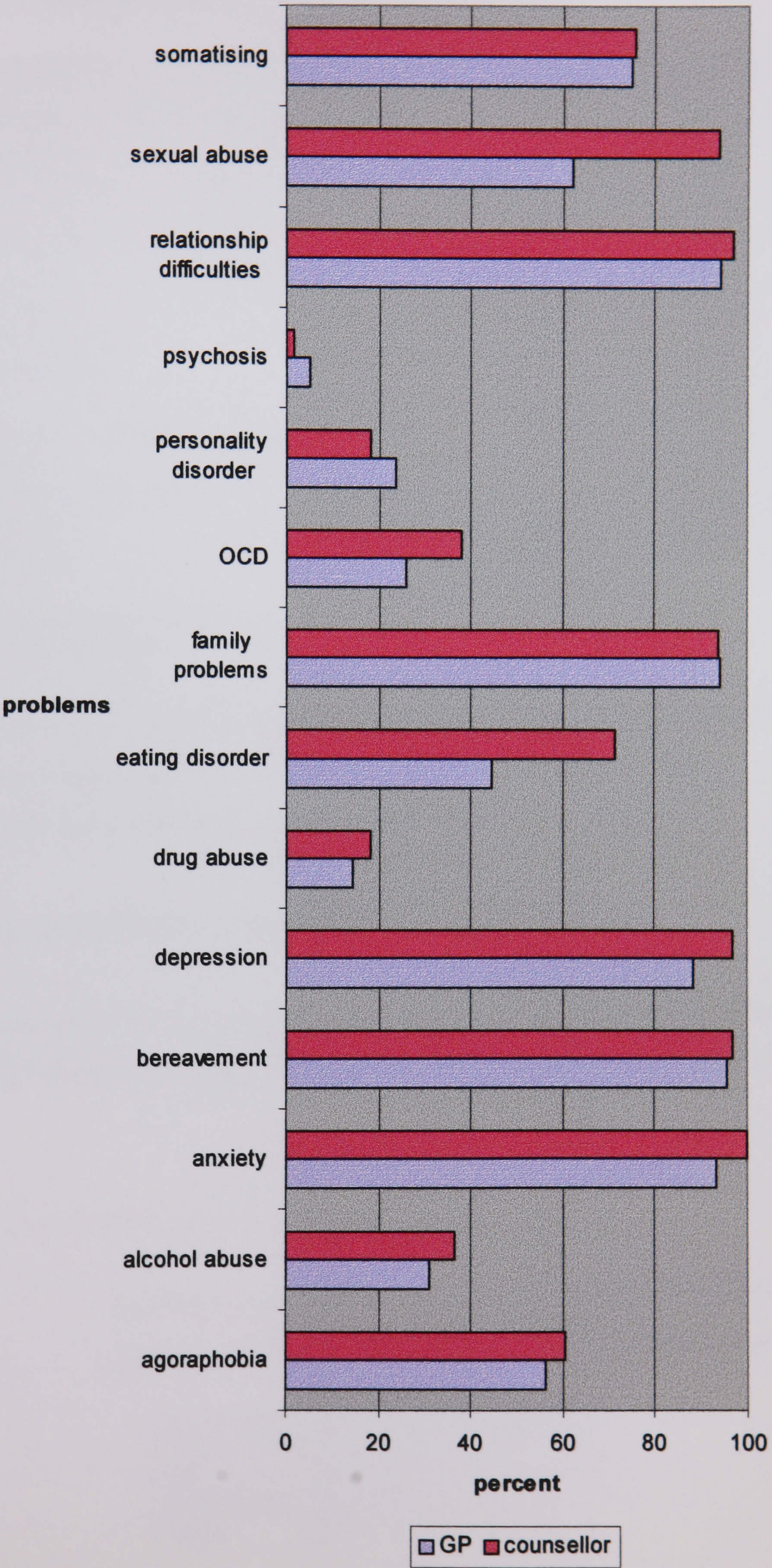


Fig 3.08

TABLE 3.21 **To Show Percentage of Respondents indicating**
Appropriateness of each Presenting Problem

Presenting Problems	GP	Counsellor	Chi-square $\alpha =$	Significance level
Agoraphobia	56.8	60.6	0.255	$p = 0.614$
Alcohol abuse	31.4	36.4	0.479	$p = 0.489$
Anxiety	94.1	100	-----	$p = 0.051^*$
Bereavement	96.6	97.0	-----	$p = 0.895$
Depression	89.0	97.0	3.606	$p = 0.058$
Drug abuse	14.4	18.2	0.454	$p = 0.500$
Eating disorder	44.9	71.2	11.797	$p = 0.001^{**}$
Family problems	94.9	93.9	0.078	$p = 0.779$
OCD	26.3	37.9	2.694	$p = 0.101$
Personality problems	23.7	18.2	0.765	$p = 0.382$
Psychosis	5.1	1.5	-----	$p = 0.225$
Relationship difficulties	94.9	97.0	-----	$p = 0.512$
Sexual abuse	62.7	93.9	21.406	$p = 0.000^{**}$
Somatising	75.4	75.8	0.003	$p = 0.960$

* = value approaching statistical significance
** = statistically significant value

For *anxiety, bereavement, psychosis and relationship difficulties*, it was not possible to carry out a chi-square analysis as at least one cell contained less than 5 values. Therefore a Fishers exact test was carried out on these items.

Patients Returning to GP after Counselling

Respondents were asked, ‘in your experience, do patients sometimes return to the GP after seeing the counsellor, showing little improvement in their difficulties?’, (question 28).

The responses given (as percentages) can be seen in Table 3.22

TABLE 3.22 **To Show Responses in Percent to Question, ‘Do Patients**
Return to GP after Counselling with Little Improvement?’

	No	Yes	Uncertain
GP	14.3	77.3	8.4
Counsellor	10.6	62.1	27.3
Total	13.0	71.9	15.1

It can be seen that most respondents indicate that sometimes the patient returns to the GP after counselling showing little improvement. A chi-square analysis was carried out to see if there was a significant difference in responses between the two groups. The value obtained ($\chi^2 = 11.793$) gives a significance level of $p = 0.003$. This value of p is statistically significant.

However, this significance level appears to be due to the proportion of counsellors who responded to this question by saying they are uncertain. When these ‘uncertain’ responses are screened out and a chi-square analysis is carried out, the result obtained ($\chi^2 = 0.026$) is not statistically significant ($p = 0.871$).

Respondents were asked, “if yes (to question 28), what do you consider to be a common explanation for this?” Respondents were offered four possible explanations and a fifth option “other factors” which was left open. Respondents could tick no more than two statements.

The detailed responses given by both professions can be seen in Appendix B (2), Table A.09, page 261 & Table A.10, page 262.

As respondents could give more than one explanation, the percentages given add up to more than 100.

It can be seen that the most popular responses for GPs were;

Lack of patient motivation	74.4 %
Lack of patient insight	41.1 %
Inappropriate referral	38.9 %

The most popular responses for counsellors were:

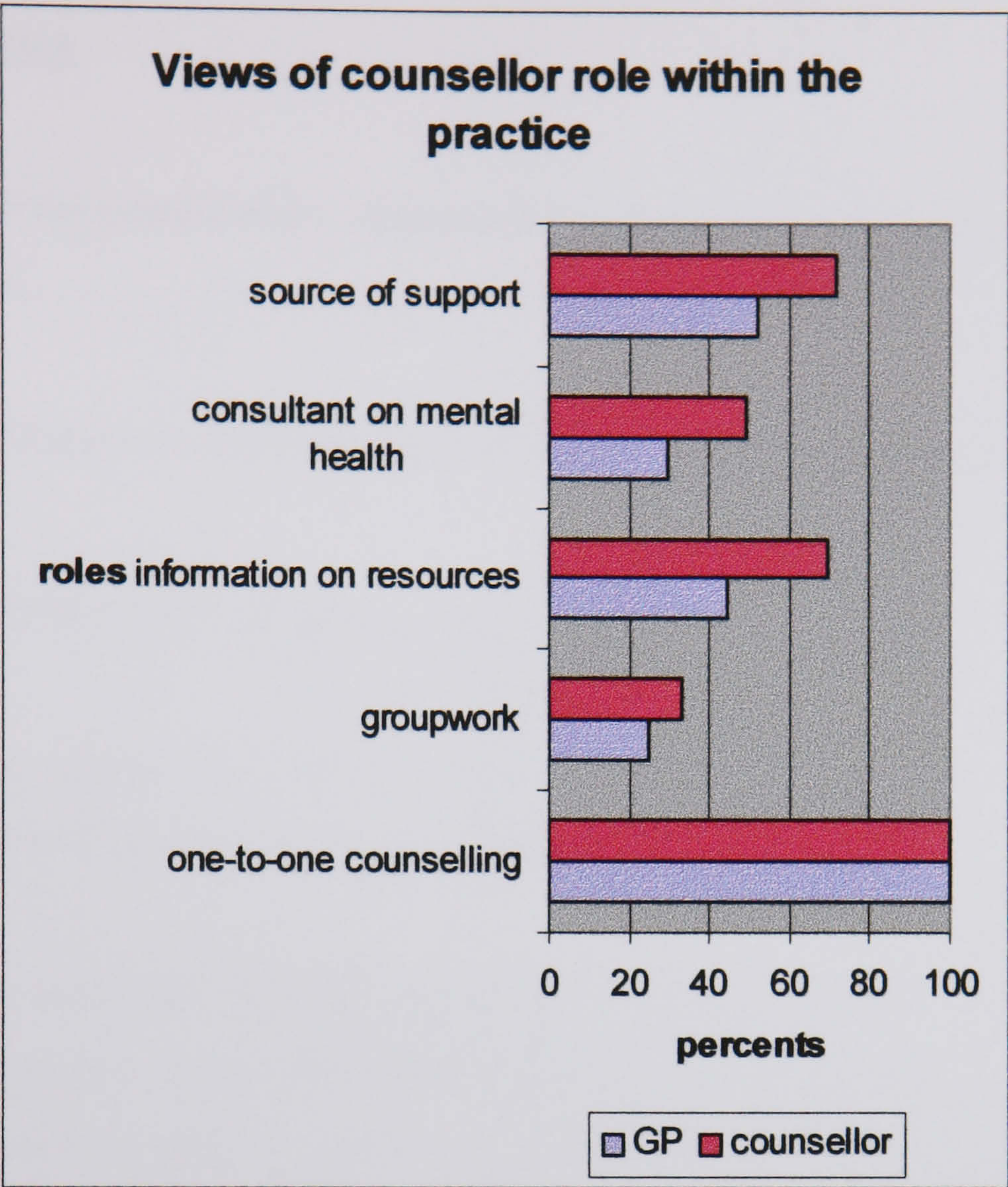
Lack of patient motivation	63.6 %
Inappropriate referral	52.3%
Lack of patient insight	40.9 %

Role of the Counsellor within the Practice

Respondents were asked, ‘which statement below describes the role of the counsellor within the practice?’, (question 30). Respondents were given 5 statements and could tick as many statements as they wished. The results may be seen in Fig 3.09.

All respondents said the practice counsellor provided one-to-one counselling.

Fig 3.09



A chi-square analysis was carried out on the responses for each group to see if there is a significant difference in the responses of each group. The results of the chi-square analysis for each role can be seen in Table 3.23

TABLE 3.23 To Show Percentage of Respondents Ticking each Role

Counsellor Role	GP	Counsellor	Chi-square	Significance Level
1-1 counselling	100	100	$\alpha = 0$	$p = 1$
Groupwork	25.2	31.8	$\alpha = 1.348$	$p = 0.246$
Information on Resources	44.5	66.7	$\alpha = 10.596$	$p = 0.001^*$
Consultant on Mental Health	29.4	47.0	$\alpha = 6.983$	$p = 0.008^*$
Support to Team	52.1	68.2	$\alpha = 6.351$	$p = 0.012^*$

* = a statistically significant difference

For three of the five roles; information on available resources, consultant on mental health issues and a source of support to the team, there is a significant difference

between the responses of each group. That is, the GPs and counsellors differ significantly on whether these are roles performed by the practice counsellor.

Open Question

At the end of the questionnaire, respondents were asked to add any comments they felt were relevant.

The range of responses given can be seen in Appendix B (2), Table A.11, page 262.

Summary of Part 3.2.2 – Comparative Results

Analyses were carried out to see if there was a difference in response to the questionnaire between the GPs and the counsellors.

On the rating scale, significant differences were found between the two groups in response to two questions relating to whether GPs provide counselling and if GPs had more time with their patients would counselling still be needed. Differences were also found on questions relating to the working style of the counsellor and views on confidentiality. There was a considerable amount of missing data on the question asking about perception of counselling, so it was not possible to carry out analysis on this question. Most respondents felt the counselling service could be improved and there was general agreement between the GPs and counsellor about how the service may be improved (the most popular response being to increase the counselling input to the practice). The vast majority of both professions reported funding difficulties for the counselling service.

In terms of presenting problems for counselling, there was broad agreement between the two groups about the appropriateness for counselling of a range of problems. Differences were found between the GPs and the counsellors concerning the appropriateness of anxiety, eating disorders and sexual abuse for primary care counselling. The majority of both groups agreed that patients sometimes return to the GP after counselling showing little improvement in their difficulties. The reasons for this were cited as patient motivation, lack of patient insight and an inappropriate

referral. In considering the role of the practice counsellor, with the exception of providing counselling and group work, there were differences between the two groups about what the role of the counsellor is. Most counsellors indicated that the primary care counsellor's role is to provide information on resources and to support the PHCT and, to a lesser extent, to act as a consultant on mental health issues. The majority of GPs disagreed with this view. Both groups felt that, overwhelming, the GP was satisfied with the counselling service.

3.2.3 Predictive Results

This section presents the results on analyses carried out looking for predictive variables and the relationship between different variables measured in the questionnaire.

Counsellor Orientation

Analyses were carried out to see if the counsellor's orientation was related to other variables. No hypotheses were made about these relationships, therefore, the value of p was two-tailed (bi-directional) for all correlations with counsellor orientation.

Spearman's correlations were carried out on counsellor orientation and the following variables.

View on joint working between GP and counsellor (question 10).

Quality of GP-counsellor relationship (question 12)

View on differences in confidentiality between GP and counsellor (question 8).

View on counsellor being team orientated (question 13).

Counsellor orientation was *not* found to be a predictive factor for any of the above variables.

Gender of GP

Analyses were carried out to see if GP gender was related to how highly the GP values the counselling service.

A Spearman's correlation was carried out to see if GP gender is a predictive factor of how highly the GP values the counselling service. It was hypothesised that female GPs may value the counselling service more than male GPs (from previous research – Radley et al 1997). Therefore, the significance value (p) was one-tailed (unidirectional).

The result obtained ($r = 0.217$) was found to be highly significant ($p = 0.009$). That is, gender was found to be related to how highly the GP values the counselling service.

Looking at a cross-tabulation of GP gender and how highly the service is valued (please refer to Appendix B (2), Table A.12, page 264), confirms that female GPs appear to value the counselling service more highly than male GPs.

GP Age

Analyses were carried out to see if the age band of the GP is related to how highly the GP values the counselling service. The analysis carried out was a Spearman's correlation.

It was hypothesised that younger GPs may value the counselling service more than older GPs, therefore the significance level was one-tailed.

The result obtained ($r = -0.156$) was found to be significant ($p = 0.045$). That is, GP age group is related to how highly the GP values the counselling service. Looking at a cross tabulation of GP age band with how highly the GP values the counselling service (Q1) (please refer to Appendix B (2), Table A.13, page 264), confirms that the younger GPs appear to value the counselling service more highly than older GPs.

Number of Years the Practice has had a Counsellor

Analyses were carried out to see if the number of years a practice has had a counsellor is related to GP service satisfaction. A Spearman's correlation was carried out.

It was hypothesised that the longer a practice has had a counselling service, the more likely the GP would be satisfied with the service. Therefore, the value of p was one-tailed.

The result obtained ($r = 0.146$) was found to be significant ($p = 0.05$). That is, the number of years a practice has had a counsellor is related to GP service satisfaction. Looking at a cross-tabulation of these two variables (please refer to Appendix B (2), Table A.14, page 264), confirms that the longer a practice has had a counsellor the greater the probability the GP will be satisfied with the service.

GP service satisfaction by GP-counsellor relationship

A correlation was carried out on the results to question 26 (*Are the GPs sufficiently satisfied with the counselling service to want it to continue at this practice?*) and question 12 (*In this practice the counsellor & the GP have a good working relationship*) for the GP sample. It was predicted that there would be a positive relationship between these two variables. Therefore, the significance value (p) was one-tailed (unidirectional).

$$\text{Spearman's } \rho = 0.221$$

$$p = 0.016 \quad \text{significant}$$

Service satisfaction was found to have a positive relationship to the quality of the GP-counsellor relationship.

GP service satisfaction by GP interest in primary care counselling

A correlation was carried out to see if a relationship exists between GP service satisfaction and GP interest in primary care counselling. No predictions were made about the nature of this relationship. Therefore, the significance value, (p) was two tailed. The following result was obtained;

$$\text{Spearman's } \rho = 0.056$$

$$p = 0.552 \quad \text{non-significant}$$

GP service satisfaction was not found to be related to GP interest in primary care counselling.

Summary of Part 3.2.3 – Predictive Results

The analyses looking for predictive variables or relationships between variables, found that counsellor orientation is not a predictive variable for quality of GP-counsellor relationship or view on issues relating to collaborative working. A female GP is more likely to value a counselling service than a male GP, as is a younger GP more likely to value the service than an older GP. The longer a practice has had a counsellor, the more likely the GP is to be satisfied with the service.

GP satisfaction with the counselling service was found to be positively related to the strength of the GP-counsellor relationship, but was not found to be related to GP interest in primary care counselling.

3.3 MEETING WITH LOCAL GPs

The two researchers had a dual role at the meeting. Firstly, they were present as researchers interested in the views and experiences of this group of GPs. Secondly, they were present at the meeting as counsellors and representatives of the local primary care counselling service. This meant that there were certain points or issues raised at the meeting that the researchers had to answer in their capacity as a service representatives.

The purpose of the meeting with the local GPs was, therefore, different from each perspective.

From a Research Perspective

The purpose of the meeting was to obtain an insight into the perceptions and experiences of a group of GPs about primary care counselling using a different approach from stages 1 and 2. To see how these findings may link to findings from the other parts of the study. The research perspective is a more generalised perspective than the service perspective. That is, one group of GPs is being researched to try to obtain an overview. The researchers, therefore, are not involved in justifying the service, but are more interested in hearing what the GPs have to say. This involves the researchers stepping outside their role as counsellors and trying to understand where the GPs are coming from.

From a Practice Perspective

The purpose of the meeting was for two representatives from the counselling service to obtain feedback on their service and address any problems the GPs (and others) may be experiencing about their particular service. This is a less generalised and more specific perspective than the research perspective. From a service point of view, the counsellors are less interested in the perceptions of GPs on primary care counselling in general, but more interested in their experiences of this particular counselling service and whether the service can be improved. The role of the counsellor is, therefore, different from the role of the researcher. In this role, the counsellors had to answer certain points that the GPs raised at the meeting.

In the meeting, the GPs (and others present) were asked to consider and discuss 3 main areas affecting their primary care counselling service. These areas were;

1. Waiting times to see the counsellor
2. Communication between the counsellor and the GP
3. Overall service satisfaction

The results from the meeting will be presented under headings for these 3 areas.

However, the discussion often flowed from one area to another and did not always stay within the area under discussion.

For the purposes of the study, the results will be presented from a research perspective.

Waiting Times

The following comments were made by the group when discussing the issue of waiting times for counselling:

DNA ("Did Not Attend") Rates

One GP mentioned that non-attenders were a waste of limited resources and because counselling sessions were usually one hour long, they represented a significant waste of

time. This led on to a discussion about how to address DNA rates particularly if a counsellor offers three hours a week to a practice, as one non-attender represents one third of the counsellor's time in the practice.

Another GP suggested that the counsellor or receptionist phone the patient the day before the appointment to check that the person would attend.

Assessments

It was suggested by one GP that the counsellor assess all patients shortly after referral thereby quickly sifting out those patients who are not appropriate for counselling and so reducing the waiting time for everybody.

Urgent Referrals

Many in the group felt that current waiting times for counselling were far too long in their practice. Some GPs asked about urgent referrals. How quickly could the counsellor see someone whom the GP felt needed help urgently?

Shortening sessions

One GP suggested that the counsellor shorten the length of sessions thereby offering more sessions to the practice. This point was brought up later in the discussion by another GP as a way of reducing waiting lists. However, another GP responded to this point by saying that this would not be appropriate as counselling is about offering time and space to the patient and this would be seriously jeopardised by shortening the counselling session.

Collaboration

One GP commented that in her practice with a very long waiting list for counselling, the counsellor works collaboratively with the practice CPN. Where appropriate they refer to each other and this is helping to reduce the waiting list.

Voluntary Sector

It was noted by a GP that waiting lists within the voluntary sector counselling services are also long. Therefore the long waiting times experienced at his practice appear to be representative of counselling services generally.

Communication between the GP and the Counsellor

When the group were asked to discuss this issue the following comments were made:

Reports

One GP felt that the standard 4 week post discharge for a report from the counsellor was too long as the patient may have returned to see the GP by then. Another GP told the group that he does not fully read the pages of reports, but tends to scan through them.

Technology

One GP commented that the counsellor should communicate with the GP by computer. That is, to write notes on the computer as many GPs are now doing.

Verbal Communication

Other members of the group commented that a primary care service, such as the counselling service, lends itself well to verbal communication between the GP and counsellor because the counsellor is on site.

Overall Service Satisfaction

The group were asked how satisfied they were with the counselling service and what improvements, if any, did they feel the service could make?

One GP commented that he no longer refers patients to his practice counsellor because of the very long waiting times. This GP felt the service was not effective because of the waiting time. Another GP stated about the counselling service, *“We would like a Rolls Royce, but are getting a fiesta”*.

Lack of resources

The main issue from the GPs’ perspective and the practice staff appeared to be a lack of resources for expanding the service. This meant that the counselling input to each practice was limited and in most practices there were long waiting lists. The Chairperson of the PCG was asked by a GP if there were any more funds to expand the service and the Chair replied that there was not. One GP stated:

“Why don’t (the Mental Health Trust) tell us (the PCG) what services cost and we can give them the resources to fund them? Instead of it happening the other way round.”

Appropriate referrals

The two counsellors were asked by the group if the referrals the counsellors receive from GPs are appropriate. The counsellors replied that it is an on-going process of feeding back to the GP about patients so the GP can learn which referrals are most appropriate for our service.

Service equity

The issue of service equity was raised by a number of GPs. It appeared to be an issue that the group felt strongly about. Some GPs at the meeting had a counsellor in their practice, others at the meeting had a counsellor and a CPN, yet some GPs present had neither professional in their practice. Many of the GPs appeared to be unaware of this discrepancy until the meeting was held and they wanted this issue addressed in the near future.

One GP without a counsellor stated to another GP, *“You’re complaining that your patients have to wait a long time to see a counsellor. At least they will be seen!”*

The group briefly discussed how this issue might be addressed. One option was to increase resources so all practices in the PCG had access to a counsellor. This seemed unlikely, due to limited resources. Another option mentioned was to restructure the counselling service. That is, for the counsellor to see patients at the larger practices in the PCG and the smaller practices to refer their patients to these practices.

Outcome of the Meeting

The discussion was brought to a close by the Chairperson after half an hour. The group and the counsellors agreed to meet again to discuss these issues further. The meeting ended by both parties thanking each other.

Group issues

As a group, these members know each other reasonably well. They attend regular meetings together, work near each other and are now part of a primary care group making joint decisions about the health care needs of the local population.

The group interactions varied slightly for different questions. Some issues generated quite a heated discussion, particularly the issues on waiting lists and service equity. During these discussions the group spoke without any prompting. The other issue of communication, the discussion flowed less easily. This could suggest that either this is a less important issue for these GPs or it is a more difficult issue to talk about.

As in most groups, some members were very dominant and others were quiet. The vocal members tended not to allow the other group members to speak. The same GPs tended to speak throughout the meeting.

One GP in particular was very attacking of the counselling service.

Summary of Part 3.3

The meeting raised a number of important issues concerning primary care counselling; the demand for counselling which cannot be met, a lack of resources for counselling services, service equity, non-attendance for appointments.

These issues will be discussed further in the following chapter.

In the next chapter the results from the study will be discussed.

CHAPTER 4

DISCUSSION

The broad aim of the study is to provide a snapshot of what is currently happening in primary care counselling by using a representative sample of GPs who work with counsellors and also primary care counsellors themselves. More specifically to;

1. Explore, both qualitatively and quantitatively, the perceptions and experiences of GPs working with counsellors. Focusing on the GP-counsellor relationship, how GPs perceive counselling and their satisfaction with a practice-based service. The aim being to help explain what factors may be influential in shaping a GP's perception of counselling. This may increase our understanding of some of the difficulties the two professions may encounter when working together.
2. Compare the experiences and perceptions of these GPs with the experiences and perceptions of counsellors working in primary care. The purpose of this is to see if, and to what extent the perceptions of primary care counselling differ between the two professions.

This chapter begins with a summary of the findings for each of the three stages of the research; the GP interviews, the questionnaires and the meeting with local GPs. The main bulk of this chapter will, however, discuss the findings of the study according to the main themes and issues emerging. These themes/issues are perceptions, attributions, group processes, GP & counsellor role, and collaboration. This will lead to a consideration of possible interventions to address any difficulties raised.

This chapter ends with a summary of the main findings from the study, a methodological critique and the implications of the study.

4.1 SUMMARY OF RESEARCH FINDINGS FOR EACH STAGE OF RESEARCH

GP Interviews

Nine GPs from one geographical area were interviewed on a range of issues concerning their primary care counselling service. (For specific interview questions, please refer to Appendix B (1), page 223). The aim of this initial stage of the study was exploratory; to look for patterns or themes from the interviews to develop into a questionnaire for use in the next (main) stage of the study.

The interviews showed a mixed experience of a local counselling service from a group of 9 GPs. Overall, the GPs value the counselling service, although they tend to perceive counselling as a rather passive process. However, a significant number did not value the service. This finding is worrying for primary care counselling and suggests the need for regular liaison between the two professions to address service satisfaction and any difficulties at an early stage. Some GPs emphasised that they offer counselling to their patient. The role of the counsellor is not always clear to GPs or distinguishable from the role of other mental health professionals working in primary care. Referrals appear to be decided not only by the presenting problem of the patient but other ‘patient factors’ or service issues. The GPs recognise the importance of liaison and collaboration with the counsellor but a number of issues make collaboration difficult (particularly lack of time and issues of confidentiality). A few of these GPs had encountered difficulties with the counsellor. These difficulties appear to be around different ways of working and the perceived inflexibility of the counsellor to adapt to the primary care setting. Some GPs, together with the counsellor, had resolved these problems. In other practices the difficulties had not been resolved and the GPs questioned the value of a primary care counselling service. In considering employing a counsellor, the GPs were interested in the personal qualities of the counsellor as well as his/her training and experience. Experience as a counsellor in a primary care setting was seen by some GPs as an important criteria for a potential primary care counsellor.

The implications from these findings are that more needs to be done to clarify the role of the counsellor and raise the profile of the profession so the distinct skills and

expertise of the counsellor can be seen. In order for counselling services to continue to improve it is important to listen to what GPs say about their experiences and the difficulties they have encountered working with counsellors. More needs to be done to address those areas where GPs are not happy with the service they and their patients receive from the counsellor. GPs unhappy with the service are unlikely to continue to purchase it. These findings also raise issues about the training of both primary care counsellors and GPs; these issues will be discussed further on in the chapter.

The Questionnaire

The Sample

The sample size for both groups was relatively small (particularly for the counsellors). Therefore caution must be used extrapolating from this study to a wider group. The distribution of scores for both professions, the graph of these scores and the skewness of the graph suggests that both samples had a near to normal distribution.

Demographics

As professions the two groups were different in their gender, age and years working in their profession. Counselling is predominantly a female profession, and has tended to attract older women, possibly entering the profession as a second career. This may explain why, although a little older than the GPs, the counsellors have been working in their respective career for fewer years than the GPs. General practice, on the other hand is less likely to attract older people as a second career simply because of the length of training involved. The gender mix for GPs is more balanced as is the age spread. In considering why the counselling profession tends not to attract younger people or men (or possibly those from ethnic minorities, although information on ethnicity was not sought), a number of possible explanations may be considered. The training courses for counselling are expensive. Counselling may be perceived by society as a female profession, this may be off putting for many men. The profession may not be perceived as high status and as has been seen, in primary care counselling, jobs are not always secure.

The questions about GP and counsellor demographics are relevant to the study and important to ask. It is important to have a balanced profession with as many sectors of society represented within it. This gives the patient more choice in terms of what

counsellor they can see. For example, some patients may prefer to see a counsellor from their own ethnic group, or gender. Presently that choice is not available to most patients. A more diverse profession can only add to the richness, in terms of what ideas and experiences these people may bring to the profession. The findings have implications for the counselling profession. The profession needs to consider what can be done to attract more men, younger people (and those from ethnic minority groups) to the profession. The starting point is probably to encourage these groups to want to enter the profession and to ensure the training courses are as accessible as possible to as wide a group of people as possible.

As a sample, the GPs are biased in favour of those interested in primary care counselling (92.1% of the sample expressed a medium or high interest in the subject). This is not surprising as those GPs uninterested in the subject area would be less likely to respond to the questionnaire. However, it does mean that caution has to be exercised when interpreting the results.

When asked how many hours a week the counsellor sees patients, the counsellors reported a much higher number of counselling hours than the GPs. The most probable explanation for this difference is that many of these counsellors work at more than one practice, and so gave a higher figure as they were calculating their total counselling input at all their practices.

In terms of their employment status, just over 60% of the counsellors stated they were employed by the practice. This compares with data from the Counselling in Primary Care Trust where it was found that approximately a third of counsellors are employed by NHS Trusts or managed services (i.e. not employed by the practice) (Curtis-Jenkins 1998 a). In terms of their counselling qualifications, the vast majority of counsellors hold basic or advanced qualifications in counselling. Only one respondent did not appear to have a counselling qualification. A recent survey of 800 primary care counsellors carried out by the Counselling in Primary Care Trust found 34 % held a counselling qualification at certificate, diploma or masters level (Curtis-Jenkins 1998 a); the finding from the present study suggests that the sample of counsellors used in this study may be better qualified than the profession as a whole.

Summary of Questionnaire Findings

The questionnaire findings suggest that, overall the GPs highly value the counselling service. However, many GPs believe they themselves offer counselling to their patients. The importance of collaboration and a good GP-counsellor relationship was supported by most GPs. Some GPs perceive the practice counsellor as working separately from the rest of the team but report mutual understanding regarding each other's roles. The presenting problems for counselling, cited by GPs, support previous research findings. Most GPs felt the counselling service could be improved by increasing the amount of counselling to the practice, a very high number also reported funding difficulties for the service. Many GPs cited lack of patient insight and poor patient motivation as possible reasons why some patients do not appear to benefit from counselling as well as the referral being inappropriate.

The questionnaire was also concerned with different or similar perceptions between the GPs and the counsellors. Similarities were found between the two groups on the importance of the GP-counsellor relationship. Both groups also reported GP service satisfaction to be high but also reported funding difficulties. With regard to presenting problems for counselling, there was broad agreement between the two groups on this issue. However, differences were found on whether sexual abuse is an appropriate or inappropriate presenting problem for practice counselling. Problems of anxiety and eating disorders also caused some disagreement between GPs and counsellors. A very significant difference was found on the issue of whether GPs provide counselling to their patients, with the majority of counsellors saying "no" and the majority of GPs saying "yes". The role of the practice counsellor also caused some discrepancies in perceptions to emerge between the two groups, in particular whether the practice counsellor is a consultant in mental health issues and a source of information to the GP.

The questionnaire found that female GPs are more likely to value the counselling service than male GPs. Also the length of time a practice has had a counsellor and the age of the GP is related to service satisfaction. The theoretical orientation of the counsellor and GP interest in primary care counselling were not found to be related to other variables.

Meeting with Local GPs

Two counsellors, representing a local primary care counselling service met with a group of local GPs at their PCG meeting. The purpose of the meeting was to hear from the GPs their experience of their local counselling service and through doing so to gain an insight into their perceptions.

The meeting highlighted a number of areas of concern for these GP regarding their primary care counselling service. The issue of long waiting lists for counselling was a cause of concern for many GPs who also made a number of suggestions about how to address these issues. Some of these suggestions provide an insight into their perceptions of counselling in primary care and also highlighted differences between the medical and psychological models. Verbal communication appears to be favoured over written reports for some GPs and the issue of communicating via computer was mentioned.

Lack of resources for counselling services and the apparent lack of equity of the service is a major problem for these GPs and is a cause of considerable dissatisfaction.

The meeting was difficult for the two researchers to manage in terms of their dual role.

However, the meeting allowed the researchers insight into how the GPs operate as a group and provided a way of gaining their views and perceptions that otherwise might not have been obtained whilst also supporting previous findings from the study. In this way the meeting had been extremely useful and stressed the need for service representatives to meet regularly with GPs.

Comparison with Findings from the GP Interviews, the Questionnaire & the Meeting with GPs

In comparing the findings from the questionnaire with those from the interviews, and the meeting; a number of similarities can be seen. Overall the questionnaire results appear to support the interview results.

In both the interviews and the survey a significant number of GPs said they offer counselling to their patients. Other similarities include the importance of collaboration and the difficulties cited that make collaboration difficult to implement, for example, differences between the GP and the counsellor on issues of confidentiality. There were similarities between the interviewed and surveyed GPs regarding the appropriateness of particular presenting problems for primary care counselling and the inappropriateness of others. The GPs interviewed seem to regard counselling overall as a passive process. Although analysis could not be carried out on this question in the survey, a significant number of those GPs who did respond to the question seem to also view counselling as a passive process. The interviews suggest that GPs are looking for personal qualities in a counsellor when considering employing one. The questionnaire has supported this by finding that the quality of the GP-counsellor relationship is related to GP satisfaction with the counselling service. Some of the interviewed GPs expressed some confusion about the role of the counsellor in primary care. This is supported by the questionnaire findings, although the issue does not appear to be straightforward. The majority of surveyed GPs indicated that they and their counsellor understand each other's roles. This appears to contradict the findings from the interviews. However, when asked more specifically about the role(s) of the counsellor, there is disagreement between the counsellor and the GP. This may suggest there is confusion about the role of the counsellor in the practice.

One area where the interview findings do not appear to have been supported by the questionnaire is regarding the GP's overall experience of the counselling service. Although this question was not directly replicated in the questionnaire, it was asked indirectly through a number of questions. The GPs surveyed seem to report a more positive experience overall than the GPs interviewed. They also appear to be more emphatic in their support of the service. This difference may be due to the different sample used for each part of the study or it may be due to the different method used.

The value of face-to-face communication and the scanning of written reports, as stated by one GP at the meeting is supported by the interviews where a similar sentiment is expressed.

At the meeting the GPs stated quite strongly that the issue of referrals to the practice counsellor is affected by waiting times. This finding is supported by the results of the

interviews where two GPs reported that their referral process to the counsellor is influenced by the waiting list. The issue of waiting times also concerns the surveyed GPs, a significant number of whom felt the counselling service could be improved by increasing the counselling input to the practice. This suggests that at present the service is unable to meet the demands placed upon it. The issue of time, although discussed in a slightly different context by the GPs at the meeting (i.e. waiting times), is raised by the GPs interviewed and surveyed (in terms of their lack of time).

Another similarity between the different sections of the study, is the issue of funding. At the meeting, it was apparent that lack of resources is a major difficulty for this group of GPs in trying to expand and improve their existing counselling service. This supports the results of the survey where 81% of GPs stated that their counselling service has funding difficulties.

At both the interviews and at the meeting, the researcher had the opportunity to see and hear the GPs face-to-face. In the interviews this was in a one-to-one situation (apart from two GPs who wished to be interviewed together) and at the meeting in a group setting. Some differences were observed between the two formats. The GPs at the meeting were observed to be more assertive and directly critical than the GPs interviewed. The GPs appeared more confident in the group setting than in an individual setting. The ‘safety’ and possibly the ‘power’ of the group may have allowed them to feel more comfortable doing so, and make more “risky” comments. This may be an example of in-group bias (Brown 1988). Or it may be to do with the different personalities concerned. Another possibility for the observed difference in behaviour is that the interviews were tape-recorded, but the meeting was not. The GPs interviewed may, therefore, have felt a little more restrained than the GPs at the meeting.

4.2 THEMES

The themes that emerged from the study will be discussed. For this purpose, and to avoid duplication, the three sections of the study (GP interviews, questionnaire and meeting with local GPs) will be considered together.

The themes discussed are under three main headings;

4.21 Perceptions

- 1) Experience and satisfaction with primary care counselling service
- 2) Perceptions of the GP
- 3) Perceptions of counselling
- 4) Perception of role of primary care counsellor
- 5) Referrals for counselling
- 6) Presenting problems for counselling
- 7) Issues of funding & cost effectiveness

4.22 Attributions made

4.23 Issues of collaboration and the GP-counsellor relationship.

4.21 PERCEPTIONS

A central part of the study was to assess GPs' perceptions of primary care counselling. As this was a major issue touching on most aspects of the study it will be broken down into the subsections given above.

Measure of overall Perception

The rating scale of the questionnaire was used to provide an overall measure or score of a GP's perception of his/her primary care counselling service covering various aspects of the service (e.g. referrals, GP-counsellor relationship, issues of collaboration, communication, whether the service and counsellor was valued). Each respondent (counsellor and GP) had an overall score on the rating scale. The mean total scores for both groups were similar and high. This implies that the majority of respondents report an overall positive perception and experience of their primary care counselling service.

Although the mean total score was similar for both groups, the range of scores was different for each group. The counsellor range was much narrower than the GP range. This difference may imply that the counsellor group were more homogenous than the GP group. This could be an effect of the small sample size in the study (particularly the small sample of counsellors). Another possible explanation is that the perceptions of GPs' (as a whole group) appear to be broader than those of counsellors'. As cognitive theories suggest, perceptions are dependent upon the perceiver's knowledge, experience and information about the subject being perceived. One might expect that, as a group,

the GPs would have a wider *range* of knowledge, experience and information about primary care counselling (ranging possibly from very little to considerable knowledge, experience and information) than the primary care counsellors who would be more likely, as a whole, to have more experience, more knowledge and more information about primary care counselling (that is, a narrower *range*).

Another possibility for this observed difference in scores between the two professions is that the questionnaire may not be sophisticated enough for counsellors and is, therefore, giving a less accurate picture of their perceptions and experiences.

1. Experience of Counselling Service

The GPs interviewed were asked directly about their experience of their primary care counselling service. Experience is an important factor in determining perceptions.

There was a wide variation in responses to this question among such a small group of GPs. This is illustrated by the different views of two interviewed GPs on this issue,

“... (it has) been quite nice to be able to download some problems of mental health to another professional and to benefit the patient by giving them a great amount of time.”

“The only contribution (the counsellor) really makes is .. (to) save us time. I’m not sure how valuable the counsellor has been on the whole.”

There appears to be a perception (shared even by two GPs who attach different values to the service) that the counsellor offers the patient (and so the GP) more time; time which the GP does not have.

Such a wide variation in experiences is surprising given such a small number of GPs and also that this group came from the same geographical area. These responses imply that there are individual ‘counsellor factors’ (which may not be stable from one counsellor to another) or ‘GP factors’ that may determine whether or not the GP reports a positive experience of the counselling service. As psychological research suggests, social perception is a two –way process, the perceptions a GP may have about the primary care counselling service, may be partly determined by the behaviour of the counsellor. This interaction between GP and counsellor may differ from GP to GP even among GPs with the same counsellor, as illustrated by the comments of one interviewed

GP. Interestingly for this GP, the counselling service has caused conflict with partners at the practice. This GP highly values counselling and considers the service a high priority, but the other partners feel differently. This finding shows that exposure to the same service and the same counsellor can still give different experiences for different GPs. This fits with the theory that perceptions of the same behaviour/situation may be different for different people. The finding suggests that other factors may be influential in determining the GP's perception of primary care counselling over and above what the particular counsellor is/is not doing. These other factors may be a GP's previous experience of counselling or their belief about such a service. These beliefs may determine what information a GP attends to form his/her perception. Thus two GPs with the same counsellor are making different interpretations about the value of the service.

This point is also underlined by the comments of one GP who was satisfied with his previous counsellor but not his present counsellor (this also supports theories suggesting our perceptions can shift in the light of new experiences).

Research has shown a wide variation among GPs in reported rate of psychiatric disorder among their patients (Goldberg & Kessel 1975) and one factor suggested for this wide variation is GP interest (in psychiatry) and patient concern. Likewise the variation seen here, in experience of the service may be partly accounted for by the possible variation in interest in counselling among this group of GPs.

It appears that many GPs value the addition of another professional:

"I very much welcome having a counsellor here. That quick conversation about a patient is worth two sides of A4, which one tends to scan these days anyway."

"I actually feel that talking about things is more useful than medicating".

This supports previous findings (Cohen & Halpern 1978).

Issues of cost and funding of counselling services are factors for some GPs in considering their overall experience of a counselling service and this will be discussed further on in this chapter.

The question '*The counselling service in this practice is highly valued by the GP*' (question 1) showed a very high level of agreement between the two professions. This high level of agreement suggests that the counsellor's perception of how highly the GP values the service is pretty close to how highly the GP is saying he/she values the service. That the counsellors seem able to perceive quite accurately the GP's value of the service correctly (regardless of how highly the service is valued), implies that this is communicated to them by the GPs, either directly or indirectly.

However, this finding must be interpreted cautiously due to the sample size used and the possible sample bias within the GP group. This finding compares favourably to the results of the interviews where six of the nine GPs interviewed stated that they value (or highly value) the counselling service and other research (e.g. McLeod 1988).

GP Satisfaction with the Service

Issues of GP satisfaction with the counselling service provide an insight into their perceptions and expectations of the service. It also has implications for service provision, as unhappy GPs may be reluctant to continue to purchase a counselling service if they are not satisfied with it. Their dissatisfaction may have implications for the standard of patient care.

Overall, service satisfaction among GPs appears to be high. This is good news for primary care counselling services. However, this high result could be a function of the sample. Those who respond to postal questionnaires tend to be more motivated than non-responders (Barker, Pistrang & Elliott 1994). Motivation is an influential factor in perception. The sample of GPs used in this study could be biased in favour of GPs who support and value counselling services and are, therefore, more likely to respond favourably to this question. The majority of these GPs are interested in primary care counselling and report a good relationship with the counsellor. Therefore, this finding is not surprising, but fits with other findings from the questionnaire.

All of the counsellor group (except one) responded 'yes' to the question "*Are the GPs in the practice sufficiently satisfied with the service to want it to continue?*" This result appears to be very high. It may be that some counsellors' perceptions of GP service satisfaction are slightly inaccurate and overly positive. This may be to do with the

influence of the counsellors' *own* perceptions of how well *they* feel the service is doing. However, without a larger sample size it is difficult to say.

It may have been useful to have paired the GPs and counsellors at the outset, particularly for this question. This would have allowed for direct comparison of the response of a GP and counsellor who work at the same practice. That is, does the counsellor perceive GP service satisfaction accurately (i.e. as the GP perceives it)? This may have allowed a more reliable measure of discrepancies in perceptions between the two professions.

The primary care counselling service has become totally ineffective for one GP at the meeting because of excessive waiting times. However, in some cases dissatisfaction may come about due to an unrealistic expectation of the service. At the meeting, some GPs appeared to want a service where patients can be seen immediately, in some circumstances. Is this reasonable and practical? Do these GPs have a distorted perception of primary care counselling? This may have implications for both counsellors and GPs, and supports the case that some GPs may benefit from on-going training/education about primary care counselling.

Both GPs and counsellors felt that the counselling service could be improved and a significantly greater number of counsellors felt this to be the case than GPs. In considering why a greater number of counsellors replied 'yes' to this question, a possible explanation is that primary care counselling is the counsellors' subject area, so counsellors may see more potential for the counselling service. For some GPs where practice counselling may be a new, and possibly unfamiliar service, they may be less able to gauge whether or not the service could be improved.

The most popular suggestion for service improvement, by a huge margin, was to increase the counselling input in the practice. Both professions appear to be saying that there is a need for more counselling in the practice. This suggests that many primary care counselling services are unable to meet the demands placed upon them. However, it may also be seen as a positive endorsement of practice counselling by the GPs that they wish for more of it.

There is a suggestion from the results that GPs and counsellors feel time limited counselling in general practice is preferable to long term counselling. Two GPs interviewed spoke of the withdrawal of their counselling service due primarily to the counsellor offering long term counselling which the GPs concerned felt was an ineffective use of very limited resources. There appears to be a general perception among GPs that short term counselling is more appropriate in primary care. This is supported by research (Hemmings 2000).

Other suggestions offered by respondents to improve the counselling service were “more collaboration between GP and counsellor”. This may suggest that a significant number of GPs and counsellors recognise the value of collaborative working. This supports findings from the questionnaire asking about collaboration, discussed further on in this chapter. However, another (less optimistic) interpretation of this response may be that collaboration between the GP and counsellor is not happening, or certainly not as much as both professions would like.

A number of counsellors suggested that offering a specialist counselling service (e.g. alcohol. or drug counselling) may improve the service. This finding supports the research carried out by Radley et al (1997) on the views of GPs about counselling. Offering such a service would broaden the available treatments offered within the practice. However, this may also be costly in terms of additional training required or the employment of an additional counsellor to provide such a service.

The different responses given by each profession reflects their own perspective and role. A number of GPs (and to a lesser extent counsellors) are concerned with the type of counselling offered and how this may improve the service. Responses given by GPs include; offering cognitive counselling, short term behavioural counselling, psychoanalytic counselling and different counselling. The counsellors, on the other hand tend to be more concerned than the GPs with issues of training and salary. These differences in emphasis between the two groups may reflect their different priorities and roles within the PHCT. For GPs employing counsellors (as most GPs in this sample do) they appear to be concerned with cost effectiveness and are they getting a ‘good’ service from the type of counselling offered by their counsellor. For the practice counsellor as an employee of the GP (as the majority of these counsellors are), the issues raised are around their needs as employees, e.g. wanting more training, an increase in salary etc.

Thirteen years on from McLeod's study (1988), it appears that issues of pay are still apparent for primary care counsellors.

However, the numbers responding to this open question are small (31 GPs and 32 counsellors). Therefore, one has to be cautious in drawing conclusions from such small numbers.

Other suggestions offered to explain why some patients do not improve after counselling are; relationship difficulties between the counsellor and the patient, the patient requiring long term counselling and that the patient was not ready for counselling. However, the numbers of respondents offering these explanations are small. Mention of the counsellor-patient relationship supports research suggesting this to be an important predictor of outcome (Clarkson 1996).

Some GPs appear to have 'used' the interview and survey as a sounding board to express their unhappiness with the counselling service and may have gained some relief through this opportunity. It may be that these GPs felt unable to express their dissatisfaction through the appropriate channels. Or the appropriate channels may be non-existent or inaccessible.

2. Perception of the GP

Although the focus of this study is on perceptions of primary care counselling, as Heider (1958) stated, perceptions of the causes of behaviour depend upon the characteristics of the perceiver (in this case, the GP). Thus the study provides insight into GPs' self-perception. This issue will be considered from the perspective of two emerging themes from the study; GP omnipotence & the GP as counsellor.

GP Omnipotence and Issues of Power

One theme to emerge about GPs' self-perception regards some GPs' sense of omnipotence and issues of power.

A number of GPs interviewed stated that they had not learnt anything from their practice counsellor, although they valued the counselling service. This may be seen as GP omnipotence and may be related to the relative power of the GP compared to the counsellor. Issues of power between the GP and counsellor have been noted in previous research (e.g. Small & Conlon 1988). Indeed one GP interviewed in the study stated that he had not learnt anything from his counsellor as he is on several mental health committees already and therefore has little more to learn about mental health issues. This finding is important because firstly it suggests that issues of power are still very apparent within primary care (and probably within the health service generally) despite the efforts of government to address this (e.g. trying to raise the status of nurses). More specifically for primary care counselling, this suggests that the GP-counsellor relationship is not one based on equality in many instances. In terms of perceptions, it appears that some GPs are saying, "I have nothing more to learn about primary care counselling". This is an unhelpful perception, as the GP is not open to new ideas or possibilities. Some GPs seem to perceive themselves as all knowing, this is possibly reinforced by their training, as suggested by Newsome (1980) who speaks of the arrogance and distance the medical training can produce within the doctor.

Why do some GPs need to assert their power in this way? Do they feel threatened by the presence of a counsellor in their practice? Possibly some GPs feel their power base may be under threat not necessarily only through the presence of counsellors within PHCT but also the increased role and status of the practice nurse. Their comments, therefore, may be an attempt to reassert their dominance.

This perception of the all knowing GP may be seen in the following quote from an interviewed GP,

"Patients perceive that (counselling) is a good thing, but it isn't necessarily a good thing, or better than medication. There's a lot of them that medication is the best option".

This issue was also highlighted when discussing referrals for counselling. The GPs highlighted different approaches to the referral process and provided an insight into their perception of the GP-patient relationship.

Some GPs always make the decision themselves whether or not to refer to the counsellor (this may imply the GP perceives him/herself as the expert, as the GP

quoted). Such an attitude of “I know what’s best for my patient” could be very unhelpful to the patient in certain circumstances, particularly when considering psychological treatments as the success of such treatments depends to some extent upon the motivation and insight of the patient. Some GPs appear to perceive themselves as being the expert. This self-perception may come at some cost to the GP.

Other GPs discuss the referral with the patient and reach a decision together (this may imply a more equitable relationship with both parties working together), for some GPs the patient decides (this may imply the GP perceives the patient as the expert).

Obviously for many GPs these styles can shift depending on individual patients, but for some GPs the decision to refer is always made by them and only them. These differing and changing styles show different perceptions among the GPs about their role and relative power compared to the patient. Their role is one that carries high status and with that status comes power.

GP as Counsellor

A second theme to emerge regarding a GPs’ self-perception is the GP as a counsellor. Two questions on the rating scale of the questionnaire showed a highly significant difference between the responses of the counsellors and the responses of the GPs. These two questions were the statements, *‘many GPs regularly provide some form of counselling themselves, to their patients’* and *‘if GPs had more time to spend with their patients there would be less of a need for counselling’*. On both these questions, the majority of GPs tended to agree with the statement and the majority of counsellors tended to disagree with the statement. This suggests a strongly held perception among GPs as a whole that they act as counsellors. This supports the findings of Rowland, Irving and Maynard (1989) that many GPs use counselling skills during the course of their work.

The vast majority of GPs agreed or strongly agreed with the first statement. This fits with the results of the interviews where a number of GPs stated, “we do counselling”. As one GP interviewed stated, *“We don’t have as much time to counsel as we used to”*. These GPs suggest that if the GP had more time s/he too could offer counselling to his/her patients. Of course many GPs do use counselling skills in their work. The 40% or so of GP-patient consultations that deal with emotional/psychological problems are

mainly handled by the GP alone. However, the number of these GPs who stated that they offer counselling to their patients could also be interpreted as saying that the counsellor does not offer any specific skills. This fits with the overall perception of a number of GPs that counselling is a passive process (as will be discussed later in the chapter). This perception is not shared by counsellors who possibly interpret the question differently, as de-skilling them.

Such findings provide an insight into the GPs' self- perception and perception of the counsellor.

This finding is important as it may suggest firstly, a lack of understanding among GPs about what counselling is. Secondly, it may suggest that GPs feel overwhelmed by their work- load and feel they do not have enough time with their patients. This has implications for the general practice profession in terms of the stress GPs are under (as shown by previous studies e.g. Zigmond 1984), possible additional support they may require and the issue of supervision for GPs who spend a considerable amount of their time dealing with the emotional difficulties of their patients largely unaided.

The very high number of GPs agreeing to these statements may be explained by possible sample bias – these GPs are overwhelmingly interested in counselling, therefore they may be more likely to use and be aware of using counselling skills in their work.

The difference in responses between the GPs and the counsellors to these questions may be explained by considering the interpretation of '*some form of counselling*'. The counsellors may interpret this as formal counselling provided by an appropriately trained professional. The GPs may have interpreted this as meaning the use of counselling skills, e.g. active listening and empathy, which many GPs probably use with patients. It appears there is little clarity about what counselling is. This finding is reinforced by differing perceptions about the role of the counsellor between GPs and counsellors (as will be discussed later) – this is not surprising if there is uncertainty about what counselling is.

The other statement that showed a highly significant difference in responses between the two professions was, '*if GPs had more time to spend with their patients, there would*

be less of a need for counselling' (question 6). As with the previous statement, the majority of GPs tended to support this statement and the majority of counsellors tended not to support this statement.

Both these statements may have been interpreted by some counsellors as de-valuing counselling by possibly suggesting that counselling offers little more than time (question 6), and that it is something that others without training in counselling can also provide (question 3). However, the reality of general practice today is that it is a busy and hectic environment, with GPs under increasing pressure. The average consultation time is now about 7½ minutes (personal communication from GP). This obviously leaves very little time for the GP and patient to talk. If the GP does become involved in a discussion about the emotional problems of the patient, he/she risks delaying other patients and the whole clinic could run late.

It may be a reality of general practice today, that counselling services are needed whereas years ago there was less of a need. This is not to devalue the skills of the counsellor. Some presenting problems do require the specialist skills of the counsellor that the GP cannot offer. However, for some patients referred to the practice counsellor, it may be that had the patient been able to see their GP more regularly than the allocated few minutes, the support received from a professional whom the patient trusts may have been enough to help them with their difficulties.

Both these themes may partly explain the high stress levels of GPs. GPs may not be acknowledging their limitations and may have unrealistically high expectations of themselves. When this is considered with the comparative isolation and lack of support in their work and high levels of responsibility, one can see why doctors are at such a high risk of stress, alcoholism and suicide (Zigmond 1984).

3. Perception of Counselling

A central part of measuring a GP's perception of primary care counselling is to look at their perception of counselling. GPs' perceptions of counselling are important as they will influence their expectations of the counselling service and their relationship with the counsellor. Their perception of counselling may also influence a patient's perception

of counselling. It is also important to determine the extent of discrepancies in perceptions of counselling between the two professions. A significant discrepancy could have major implications for primary care counselling services as the GP may expect counselling to offer something quite different from what the counsellor feels counselling may offer. This may influence which patients are referred for counselling.

This issue was addressed through the interview and one question in the questionnaire directly addressed perception of counselling (question 22). However, many respondents did not follow the correct instructions when answering. (Possible reasons why this question was not well answered will be discussed further on in the Methodological Critique).

Due to the huge amount of missing data from this question, it was not possible to carry out any analysis on the results or compare these findings with those from the interviews. However, from studying the pie charts of the data, it can be seen that for those respondents who answered the question according to the instructions, some differences in perception do emerge between the two professions. None of the counsellors who responded correctly to the question perceive counselling to be primarily a time to talk, although a number of GPs do (as did some of the interviewed GPs). In a similar way, no counsellors perceive counselling to primarily offer patients a listening ear, although some of the GPs did. What these findings may suggest (although no analysis was carried out and the numbers of respondents are small), are that GPs, overall, tend to view counselling as a more passive process than the counsellors do. What is also apparent, is that there does not appear to be agreement among or between the two professions as to what counselling is.

The GPs interviewed gave a varied response on this issue but overall their perception of counselling also confirms this view. Many of the responses listed by the GPs are skills that counsellors use but a number of other professionals may also use and are not specific to counselling. The views of some interviewed GPs supports the findings of Radley et al (1997), that some GPs feel counselling is used because patients 'want' rather than 'need' it. One GP interviewed felt that counselling is fashionable at present, therefore, many patients want it.

Knowledge of counselling, exposure to counselling, beliefs about counselling will be significantly different between the two professions. These are important factors in determining perceptions. Therefore, some difference in perceptions of counselling might have been expected. Possibly a large discrepancy in perceptions between counsellors and GPs suggests very different beliefs about counselling. Looking at these findings suggests that there is not an agreed perception of counselling *within* either group. This suggests that counsellors are not united in their perception and within the counsellor group there are discrepancies in perception. These different perceptions within the counsellor group may be due to the variety of orientations and training these counsellors have had. Each orientation will have a different interpretation and application of counselling and will be a major influence in the counsellor's perception of counselling.

The different suggestions offered at the meeting provide an insight into GPs' perspectives and priorities. For example, the suggestion made by at least two GPs at the meeting to shorten the counselling session to 30 or 45 minutes, therefore to offer the practice more counselling appointments. The issue of time is one area where the psychological and medical models differ. In the medical model, time is of the essence. Doctors are often busy, running late; anyone familiar with a GP practice will be aware of this. The experience of seeing a counsellor is different from the experience of seeing a GP in a number of respects, one of these being the time offered. This issue was very apparent from the GP interviews and the questionnaire and it appears to be one aspect of counselling that the GPs value. Therefore, the suggestion that the counselling session be significantly shortened to accommodate more patients may imply that some GPs are unclear about what counselling offers. However, when there are limited resources (as there clearly are in primary care counselling) and waiting lists; the suggestion that the counselling session is shortened to allow more patients to be seen may have some value.

However, there is some agreement between and within the two groups on issues concerning their perception of counselling. The majority of GPs (77.3%) and a smaller majority of counsellors (62.1%) report that sometimes patients return to the GP after counselling showing little improvement in their difficulties. This high figure is not surprising given that most GPs and counsellors support the view, "*some patients, whatever their difficulties, may not benefit from counselling*" (question 2). There is a perception within both professions that some people do not benefit from counselling

regardless of their difficulties. This perception may arise from their direct experience of the service. It appears that GPs and counsellors have a similar perception of why patients may not improve from counselling. This ‘shared view’ may imply some shared ideas of what counselling is and who is likely to benefit from it. This fits with what Seaburn et al (1996) termed a shared paradigm, or shared perspective.

The findings reported here suggest there is considerable work to be done to address GPs’ perception of counselling if GPs are to view counselling as an active and interactive process which requires specialist skills and training. These findings have implications for both GP and counsellor training, as both professions may not be doing enough to address misconceptions that they may have about each other. From a service perspective, it is important that GPs have an accurate perception of counselling in order to know what to expect from the service, which patients to offer it to and for the counsellor and GP to be able to work together (albeit from differing perspectives) to treat the patient. This issue is also important from a patient’s perspective. A GP with an accurate perception of what counselling is will be more likely to offer it to patients most likely to benefit, this enables the service to be as efficient as possible and so cost effective. This issue is also important from the point of view of the counselling profession; few professions wish to be misrepresented. However, given the difficulty of the profession itself answering this question is it surprising that GPs are not completely sure, or agreed upon what counselling is? This finding, however, may be a reflection of the generic term that “counselling” is. It may be more helpful, therefore to consider the issue at an individual practice level and to consider how an individual GP may form an accurate perception of what his/her counsellor may offer.

Overall these findings suggest that GPs’ perceptions of counselling is a complex process made up of a number of factors. As suggested earlier, every GP will have a perception of primary care counselling even before they have contact with the service. These initial perceptions may exist at different levels according to the particular interests and experience of different GPs. The results suggest that these perceptions are varied and this fits with theories suggesting that there are individual differences in perception, these differences may be partly personality based. Cognitive psychology suggests that we form basic beliefs about a subject/object which can alter in the light of new information. For example, a GP who previously valued counselling service may shift his perceptions when a new counsellor arrives. Others even in light of new

information may not alter their beliefs about primary care counselling, as research has shown that past experience can blind us to other interpretations (Pennington 1986). Attention plays a role in this process in determining what we select out as important information and thus how we form perceptions. One GP may attend to the fact that his counsellor works well with patients the GP finds difficult and this may influence his/her perception of the service in a positive way. Another GP may not consider this information relevant or important and may not, therefore, attend to it and so not have his/her perceptions influenced by it.

According to theories on perception, time is an important factor in forming perceptions of other people. This has been born out by the study as results suggest that time (as in length of time practice has had counselling service) is a predicting variable in GP satisfaction with the service. This may also explain individual differences as some of the GPs studied have had a counselling service for many years, others for much less. GPs' perceptions of counselling will be influenced by behaviour of the counsellor. This underlines the importance of the counsellor "fitting in" and recognition of the importance of their relationship. With a good GP-counsellor relationship, the GP may be more likely to have positive perception of the counselling service.

As the study has found, there are some gender differences in perceptions. Female GPs appear to value a counselling service more highly than male GPs (this issue will be explored in more detail further on this chapter), this may also account for the variety of perceptions measured.

To summarise, some differences have been found between and within the groups on what counselling is. However, there is agreement between and within groups that not everyone benefits from counselling and what factors are influential in determining why a patient may not benefit from counselling.

4. Perception of the Practice Counsellor

Consideration of a GP's perception of his/her practice counsellor can provide an insight into the perceived role and status of the counsellor within the PHCT.

The interviews suggest that some GPs perceive the counsellor as inflexible. This assessment that the GP makes (consciously or unconsciously) of his/her counsellor appears to be around how the GP and counsellor interact and much less to be about the actual work the counsellor is doing. This appears to be a less important factor for GP satisfaction than how they (the GPs) relate to their counsellor. This finding fits with the work of Seaburn et al (1996) suggesting the importance of the GP – mental health professional relationship.

Role of the Counsellor

Research has suggested that the addition of a counsellor to a practice may foster an increase in skills sharing across the team (Irving 1988), encourage case discussion and ease of referrals (Rowland et al 1989). As discussed earlier, people in groups are often ascribed a role. The role will impact on the expected behaviour of that individual. This study was interested in GPs' perceptions of the practice counsellor and whether this matched practice counsellors' self-perception.

The role of the counsellor within the practice is an important area to consider for a number of reasons. Firstly, it provides an insight into what the counsellor is perceived as doing in the practice and does this match what the services were set up for? Is the role(s) of the counsellor clear? Is it one or several roles? Could these roles be provided by other staff? What do these roles bring to the practice? This raises the issue of whether the counsellor is seen as having more than one skill area and whether his/her skills are transferable into other areas in primary care. Secondly, a level of agreement between the two groups is important as significant differences may impact on the GP-counsellor relationship and may imply different expectations about the counselling service. Thirdly, the perception of the role of the counsellor also has implications for the counselling profession. Issues of roles within groups also provide an insight into the functioning and dynamics of the group.

The vast majority of both professions perceive the counsellor to be an important member of the PHCT. This suggests that the role of the primary care counsellor has some status attached to it, but, as discussed earlier, not as much status (in the eyes of many GPs) as the GP's role.

In considering the potential role(s) of the primary care counsellor suggested in the questionnaire, the most popular role selected, by a huge margin, was one-to-one counselling. This is not surprising given that this is the core role of the primary care counsellor and probably takes up more of his/her time than any thing else. This role would be seen by many (probably including the counsellors themselves) as their *raison d'être*.

Looking at the findings from the questionnaire, all five suggested roles scored more highly by the counsellors than the GPs. This suggests the self-perception of counsellors as being more skilled (or performing more roles) than the GPs' perception of them.

However, for three of the five roles there were significant discrepancies in perception between the two professions. These roles were; 'a source of information for the GP on local services', 'a consultant for the GP on mental health issues', and 'a source of support to others in the practice'.

The role of consultant on mental health issues scored quite low for both groups (counsellors = 47.0% and GPs = 29.4%). Of all the five roles, this is probably the role with the most status attached. The word consultant (obviously used in the medical profession) implies an expert. Perceptions are based upon interpretations, GPs and counsellors may have different interpretations of word consultant. It appears that many of these GPs do not see the counsellor as being "the expert" when it comes to mental health issues. This finding fits with the theme of the GP as being the expert across all situations (not just those concerning medical matters). It highlights issues of power mentioned earlier. Many GPs do not perceive (and may not feel comfortable with) the counsellor as having more expertise than them in a particular field. As has been discussed earlier the GP role is far more powerful than the counsellor's within the medical setting of the surgery (and within society as a whole). For successful collaboration it is helpful to have a relationship based on equality and a flexible hierarchy (Seaburn et al 1996). That is, a relationship where the two professions recognise and respect the expertise of the other. It may be considered unfortunate that many of the GPs do not see the counsellor as someone the GP can consult on mental health matters. This finding may fit with the interviews when a number of the GPs said they had not learnt anything from the practice counsellor. If some GPs do not expect to learn from the counsellor, they will be less likely to attend to what the counsellor is

saying. However, the vast majority of GPs responding to the questionnaire do feel that they can learn about psychological treatments from the practice counsellor. So there appears to be a perception among some GPs that they can learn from their counsellor, but the majority are not wishing to ascribe the potentially high status role of consultant to the counsellor (as are half the counsellors).

Most GPs do not perceive their counsellor as a potential source of information on local counselling services, but two thirds of counsellors perceive this as part of their role as practice counsellor. Given this role may be considered more tangible than the other roles, e.g. the counsellor can physically give the GP the information on local services, whereas the other roles (such as showing support to other team members) are more covert, this difference in perceptions is surprising. One explanation may be that the GP and counsellor may be attending to different things. Expectations will play a role in these perceptions. If a GP is not expecting the counsellor to fulfil a particular role, he/she may not attend to behaviours that suggest otherwise.

The role of 'source of support to others in the practice' scores well among counsellors (68.2%) and fairly well among GPs (52.1%), although there is a significant difference between the two professions. This is probably a less contentious role. Support may be a part of what counsellors are traditionally perceived as offering their patients in counselling. So this skill can be transferred to others in PHCT. GP expectations regarding this role may be different from their expectations regarding other roles. There may be a greater expectation that the counsellor fulfils this role. This expectation may be partly determined by a stereotypical view of the counsellor. Is there any evidence of GPs stereotyping counsellors? From McLeod's study (1988) there is evidence of the image of the counsellor as the non-professional lingering on. Possibly some GPs still have this image or stereotype of counsellors. With stereotypes, people tend to seek out information that confirms rather than refutes the stereotype (Pennington 1986). The GPs may, therefore, attend to counsellor behaviours that strengthen their preconceived view.

It is unfortunate that groupwork scores lowly for both counsellors and GPs. This may be to do with the lack of space in the surgery to offer such treatment. Or it could be the lack of training or confidence of the counsellor to offer groupwork in the practice. Groups offer an alternative form of counselling that may be particularly appropriate for some patients and broadens the range of treatments available in the surgery. Also,

groups can be a cost-effective way of treating a large number of patients at the same time. In her study, McLeod (1988) also found groupwork was not widely used in general practice.

Thinking about these results in relation to research by Shaw (1971). These results seem to suggest a difference between the *perceived* and *expected* role of the primary care counsellor. In this instance the expected role of the counsellors refers to what the GP (& PHCT) expects the counsellor's role to be and the perceived role is what the counsellor thinks his/her role is. Such differences in a group between the perceived and expected role of a group member can cause conflict within the group (Pennington 1986). The expected role of the counsellor could be determined by a stereotypical view (although it is not possible from the results to show this).

Studying the important factors, cited by the interviewed GPs, in employing a counsellor provides an insight into their perception and expectation of the practice counsellor. Both personal qualities of the counsellor as well as his/her qualifications and experience feature highly. Good rapport between the GP and the counsellor is also important, as is the maturity, the flexibility of the counsellor and a team approach to working. This underlines that many GPs consider the working relationship they have with the counsellor is of central importance. The GPs appear to be looking not only at qualifications, as one might expect, but also those factors that may help determine whether the counsellor 'fits in' at the practice and how the counsellor and GP might relate to each other. This supports the findings of Seaburn et al (1996) underlining the importance of GP-counsellor relationship. Primary care experience is considered important by two GPs, this suggests that GPs perceive that the role of a primary care counsellor is somewhat different from a counsellor's role in another setting.

These findings also give an insight into the group processes of PHCT. The mention by GPs of counsellors having previous experience of working in primary care supports research suggesting that little past experience of groups may be a disadvantage for the member (Deaux & Wrightsman 1988). The mention of flexibility would fit with the implicit view given by some GPs that some counsellors are rigid in their approach and this can cause difficulties for the GP. These issues are important as they suggest that GPs are looking for a person who will be accepted within the PHCT. A person has more

chance of acceptance if he/she is perceived as not too different from the other group members (Deaux & Wrightsman 1988).

Research has suggested that GPs find it difficult to distinguish the work of the counsellor from other mental health professionals (Radley et al 1997). This is supported by the findings from the interviews and can be seen in the following quotes from GPs:

“I suppose I’m not clear in my own mind when sometimes it would be more appropriate to use (the CPN).”

“(the distinction between professions) is very blurred.”

These findings may be a result of the implementation in NHS of multi-disciplinary working, blurring the distinction between some professional roles. However, if the GPs are confused about the counsellor’s role it will affect their expectations of a counselling service. It may also cause conflict within PHCT. Why employ a counsellor, if the CPN can do the same work? If the GP is confused, it may also be confusing for the patient. The findings are also of concern as they imply that the skills of the counsellor are not distinct from those of other mental health professionals.

However, despite these differences and confusion, the majority of both GPs and counsellors feel that there is mutual understanding of each other’s role. Both professions are saying they understand the role of the other. This understanding may help resolve differences or lessen the chances of these differences occurring. Mutual understanding is important in collaborative working. Seaburn et al (1996) speak of an ecological approach to working. This is about each professional “see(ing) with the eyes of the other participant” (Seaburn et al 1996, p20). An understanding of each other’s roles can allow this to happen. This seems to contradict the previous findings. It may be that some GPs and counsellors *think* they understand each other’s roles, but on closer inspection this does not appear to be the case. Or it may be that there are *certain areas* of the counsellor’s role where there is confusion. The findings also suggest that differences exist among different counselling services and raise the question of whether counselling services should be more homogenous providing a uniform service throughout practices or whether these observed differences reflect the different needs of each practice and should therefore not be challenged?

There appears to be a perception amongst some GPs that the counsellor likes to work separately from the rest of the team (18.4% of GPs and 9.2% of counsellors agreed or strongly agreed with this statement – question 15). A slightly higher proportion of GPs and counsellors perceive the counsellor as not being as team orientated as the other professionals working in primary care (28.6% of GPs and 36.3% of counsellors agreed or strongly agreed with this statement - question 13). However, the majority of both professions do not perceive this to be the case. One reason for this sense of separateness of the counsellor may be a practical one. For a counsellor ‘attached’ to a practice and employed by a local NHS trust it may be more difficult to integrate into the PHCT than a counsellor employed by the practice, simply because the counsellor has less contact with the practice and may be less likely to be perceived as part of the practice than a counsellor employed by the practice. However, this sense of separateness may also be to do with the different working styles of the counsellor and GP. Schachter (1951) found that if a group member is perceived to hold an extreme and different view from the rest of the group, other group members may lessen their communication dramatically with that individual. So the separateness of the counsellor may, in part come about because of the difference between the counsellor and the rest of PHCT. This could become self-fulfilling.

This issue around the working style of the counsellor and the GP’s perception of this is important as it can indicate whether the GP perceives the counsellor as accessible. A professional perceived as inaccessible may become isolated and have only distant relationships with other professionals, possibly for the reasons mentioned earlier. The issue of the professional isolation of the primary care counsellor has been acknowledged (Cohen & Halpern 1978). The findings here suggest that a significant minority of GPs perceive the counsellor as somewhat inaccessible. This perception may significantly impact on the group dynamics within PHCT and on the GP-counsellor relationship. As Di Giacomo (1980) found, if the minority member of a group is perceived to be too rigid they may alienate the majority. The GP as employer and the counsellor as employee immediately suggests a power differential. This power differential may affect the role of each professional and also the relationship between them.

In summary, these findings on the role and perception of the primary care counsellor suggest that,

1. The role of the counsellor is not clear (as suggested by the GPs interviewed).

2. There is a difference between expected and perceived role of the practice counsellor. Such discrepancies may lead to conflict between the counsellor and PHCT.

5. Referrals for Counselling

The GPs were asked about referrals and the referral process for counselling as this can give an insight into the GPs' perception of which patients may benefit from counselling and also insight into the working style of individual GPs reflecting issues of power and the GP-patient relationship.

The issue of GP referrals has been studied and research suggests the referral process to be a complex one made up of patient factors, GP factors, service factors and the interplay between them (Newton et al 1991). Referral issues have implications for service efficiency (are those patients most likely to benefit from counselling able to access the service?) and ultimately service cost effectiveness.

For some GPs a referral to the practice counsellor is a response to a patient request. This may be seen as a straightforward referral. However, it is evident from the GPs' responses that in a number of cases, consideration is also made of the waiting time for counselling and/or patient history. In other situations where the patient does not request counselling but the GP is considering a referral, another influential factor is patient motivation. The implication being that if the patient is not motivated to attend counselling the GP will be less likely to refer. This suggests that GPs perceive counselling to be a process where the patient is involved.

The findings thus suggest, that for a number of GPs there is an interplay between patient factors (presenting problem, motivation), GP factors (do *I* think the patient will benefit?) and service factors (the waiting time for counselling). This supports Newton's research. Interestingly there is no mention among the GPs of 'counsellor' factors in the referral process. For example, does the GP consider, 'is this patient likely to get on with the counsellor?' Research has suggested the therapeutic relationship to be a strong predictor of outcome in therapy (Clarkson 1996) and, as will be discussed in the following section, problems in the patient-counsellor relationship are cited by some GPs

are reasons why the patient did not benefit from counselling. The GP-counsellor relationship may have a bearing on the referral process. A GP with a good working relationship with the counsellor may be more inclined to discuss a possible referral with the counsellor before referring.

The findings of the present study support McLeod (1988) who found that the understanding of the GP about counselling affects referrals. Both GPs and counsellors tended to share this view. The study suggests that both the GP and counsellor recognise the importance of discussing the referral with the patient. It is also empowering the patient to involve him/her as much as possible in discussion about treatments.

So the issue of referring has implications for service effectiveness and efficiency. These findings have highlighted different referral criteria and styles of referring among this group of GPs and issues of power discussed earlier in this chapter.

6. Presenting Problems for Counselling

Looking at the presenting problems considered appropriate for primary care counselling provides an insight GPs' perceptions of counselling. This issue is important to ensure appropriate patients can access the counselling service. It is also important that there is some level of agreement between GPs and counsellors about presenting problems as it would be difficult to provide a good service for the patient if GPs and counsellors do not agree about which patient problems may benefit from counselling. Disagreement on this issue is likely to impact on the GP-counsellor relationship.

In considering the spread of these problems across both groups, it can be seen that some 'high risk' problems e.g. psychosis, alcohol abuse and drug abuse tend not to be considered appropriate referrals for primary care counsellors. This is not surprising given that these problems may be seen as typical secondary care referrals and tend to require a team or specialist approach. The most popular referrals are for anxiety, bereavement, depression, family problems, somatic disorders and relationship difficulties. These findings compare favourably with previous research e.g. Salinsky & Curtis-Jenkins (1994), Waydenfeld & Waydenfeld (1980), Marsh & Barr (1975), St. George 1976), Cohen (1977), Meacher (1977), Heisler (1979) & McLeod (1988). The

Leeds CORE evaluation study found similar results, from their initial research. These findings are also supported by the findings from the interviews.

For most presenting problems, GPs and counsellors feel similarly about their appropriateness for primary care counselling. The only exceptions to this appear to be with regard to sexual abuse, eating disorders and, to a lesser extent, anxiety. The primary care counsellors feel these problems are appropriate for them but significantly fewer GPs consider them appropriate. With regard to sexual abuse, the difference in responses between the two groups is highly significant. This finding is supported by the interviews. One GP interviewed stated that she/he did not consider sexual abuse to be an appropriate referral for the primary care counsellor. This GP refers such patients to the psychologist. It appears that a significant number of GPs perceive the counsellor does not have the necessary expertise to deal with such problems. It is difficult to hypothesise where this may come from. There may be a belief among GPs that issues of sexual abuse demand a level of skill that a primary care counsellor does not possess. This belief can become self-fulfilling if GPs never refer such issues to the counsellor their belief can never be challenged.

It would be interesting to explore this further as issues of sexual abuse probably form a significant proportion of the work of a practice counsellor either directly as a presenting problem or indirectly emerging during the course of counselling.

With regard to anxiety, the difference between the two groups (although not statistically significant, is approaching significance) seems surprising. This difference may be a function of the small sample size or that 100% of counsellors feel it is an appropriate presenting problems. However, the vast majority of GPs questioned (94.1%) feel anxiety is an appropriate referral for the counsellor. It is interesting to note that agoraphobia (which is a common form of anxiety) is considered appropriate by a smaller number of respondents (GPs = 56.8%, counsellors = 60.6%). This may be to do with the treatment for agoraphobia which is often seen as cognitive-behavioural therapy. Many primary care counsellors do not appear to use cognitive-behavioural therapy, certainly not as their primary orientation. Patients presenting with agoraphobia, therefore, may be referred by the GP to a psychologist. There may be a perception (arguably an accurate perception) that agoraphobia is more successfully treated by a psychologist.

Eating disorders is considered by a number of counsellors to be an appropriate referral to their service, but a significant number of GPs disagree. This finding may be in part, determined by whether the problem and treatment is perceived as medical or psychological or both. Due to the potential 'high risk' associated with some eating disorders, e.g. anorexia, the GP may feel such a presenting problems requires a team approach within possibly a hospital setting. The GP may not feel the apparent isolation of the primary care counsellor an appropriate setting to treat an eating disorder. Some counsellors wrote on the questionnaire that this may be an appropriate problem for them to treat if they were part of a team treating the patient or if the eating disorder was mild.

As with all these presenting problems, some degree of interpretation is needed on the part of the respondent. Obviously the interpretation the respondent attaches to the question will determine how he/she will respond. This interpretation may be particularly applicable to the term 'depression' which covers a broad range and degree of symptoms. This difference in interpretation may account for some of the difference in responses.

It is interesting to see from the interviews, depression feature as both an appropriate and inappropriate referral for counselling. This is not supported by research, where depression has been found to be a common referral for a practice counsellor. However, as only one interviewed GP sees depression as an inappropriate referral, this finding may reflect his/her individual experience.

To summarise; there is general agreement between GPs and counsellors about the appropriateness of certain presenting problems for counselling. These problems support previous research. However, there is considerable disagreement between GPs and counsellors concerning the appropriateness of referring patients with issues of sexual abuse to the counsellor. This appears to raise issues of the GP's perception of the skill level of the practice counsellor.

7. Issues of Cost Effectiveness & Funding Difficulties

Issues of cost effectiveness seemed to emerge at the interviews, the questionnaire and the meeting with GPs.

One GP interviewed stated,

“I’m not sure whether we could really justify the expense of (counselling) for the benefit it gives. I think there is a stronger case to invest in cases of more proven value such as clinical psychology.”

Another stated,

“The counsellor we’ve had has been costly to the practice in terms of administrative support. I don’t think I would employ a counsellor over other specialities”.

The perception is that primary care counselling is an expensive service. This perception is important given the current climate in the NHS for evidence based practice. Services such as clinical psychology may be seen to lend themselves more easily to evidence based practice than counselling. Is there a place for services where it may be more difficult to measure outcome or effectiveness? These findings raise the issue of how can counselling services show their effectiveness to service providers and remain in the competitive NHS market? Counselling services and organisations are aware of these issues and the setting up of the Leeds CORE evaluations system was, in part, as a response to such concerns. CPC are also advising their members to carry out research and audit showing the efficacy of their service.

The issue of resources is a major problem for GPs. There was a strong sense of frustration among the GPs at the meeting as they would like to improve or expand the counselling service, but are unable to. The lack of service equity and accessibility is causing them dissatisfaction. They are frustrated that some patients do not have access to the service. This is probably more of an issue now that GPs are part of PCG and work together as a collective; such discrepancies between practices go against the principles of PCG. This issue could potentially be quite stressful for the GP if their patient requests or requires counselling but the GP is unable to refer them.

Funding is an important area because costs drive services. The questionnaire assessed the state of funding for primary care counselling. Funding difficulties can lead to instability, insecurity and uncertainty.

The number of respondents indicating that their counselling service has funding difficulties is worryingly high. Primary care counselling appears to face an uncertain future in many practices. This supports the findings reported by Counselling in Primary

Care Trust (Counselling in Practice, December 1999). The uncertainty and insecurity funding difficulties can create makes primary care counselling a difficult environment for many counsellors to work in. Issues of funding also have implications for service planning and development. The results may suggest difficulties for both the GP and counsellor to plan and develop the service.

Lack of funding may partly explain some of the suggestions given by the GPs and counsellors to improving the service. If resources are scarce, issues such as counsellor training, research or audit may not be financially viable for some practices. Although a number of suggestions were put forward by GPs and counsellors to improve the service, lack of resources may partly explain why they have not been implemented and remain suggestions or ideas. It appears that although counselling is a growth area in primary care it is going through an uncertain period. Four GPs commented through the open question at the end of the survey on funding problems in their practice.

The high number reporting funding problems for the service may be, in part, a reflection of the timing of the study. The questionnaires were sent out over the summer period of 1999. This was just a few months after one of the biggest changes within primary care; the introduction of primary care groups (April 1999). Particularly for those counsellors employed by a practice (as distinct from those attached to a practice and employed by an NHS trust), these few months were a worrying time as no one was sure how counselling services would fit into these changes and some counsellors have lost their jobs.

What do these findings tell us about perception? There appears to be a perception among a significant number of GPs that primary care counselling is not a cost effective service and it is difficult to prove its efficacy. For the question on funding there was very little discrepancy in perception between the two professions. This may be because this question required less interpretation than other questions and was more objective or factually based with, therefore, less room for interpretation which can lead to error.

We make attributions all the time in order to make sense of and predict our behaviour and the behaviour of other people. This lessens our uncertainty about how a person is likely to behave in the future. Several questions from the study provide an insight into the attributions GPs and counsellors may make about themselves, each other and their patients.

When asked how they felt the counselling service could be improved, both GPs and counsellors suggested increasing counselling input. In this case, the potential limitations of the service are attributed externally to funding/resources issues. The attribution made is situational.

For some GPs, difficulties in the primary care counselling service are attributable to the counsellor. One GP interviewed stated,

“When our counsellor first came it was all very secretive...but that’s inappropriate when we’re both trying to improve the patient’s health...so she had to change and to realise that we had to have access to what she said.”

In this instance, it is interesting to note that the attribution is not situational (e.g. caused by the potential difficulties of two very different professionals trying to work together), rather it is internal (i.e. caused by the counsellor’s behaviour). The Correspondence Inference Model (Jones & Davis 1965) may help explain why this attribution is made. This model suggests that when we consider the behaviour of another person we consider not only the effects of the behaviour, but also the effects of possible alternative behaviours. As attributions are affected by perception, the counsellors’ behaviour (i.e. the “secrecy”) may be perceived by the GP as socially undesirable and the behaviour may also be perceived to have few non-common effects (i.e. the behaviour is distinctive – “inappropriate”). Under these conditions, according to the model, an internal attribution is made.

In the interview, the GPs were asked what they saw as obstacles to closer collaboration with the counsellor. Of the 13 explanations given, 6 were situational (lack of time and waiting lists), 6 were dispositional and one was a combination of counsellor, GP and situational factors (different ways of working). The GPs did not tend to attribute these difficulties to themselves. This supports research suggesting we tend to make external

attributions when considering behaviour we are involved in (Nisbett et al 1973). It also suggests that the GPs, in this situation are behaving in a way to preserve their own self-esteem and enhance their abilities (i.e. they are exhibiting a self-serving bias).

When a patient returns to the GP after counselling and counselling has not been successful to whom or what do GPs and counsellors attribute this to? A high proportion of counsellors responded 'uncertain' to the question (*In your experience, do patients sometimes return to the GP after seeing the counsellor, showing little improvement in their difficulties?* 27.3% of counsellors and 8.45% of GPs), and therefore did not make an attribution. The question asks about patients returning to the GP after counselling. Therefore, one interpretation is that a significant minority of counsellors felt they did not have the available information in order to make an attribution. Another interpretation may be that some counsellors are minimising the number of patients who return to the GP after counselling showing little improvement in their difficulties. Arguably many counsellors *would* have enough information to make a judgement as to whether or not the counselling had been helpful. Some counsellors may be minimising this number as they may feel that it does not reflect well on the counselling service.

The three most common explanations given by both GPs and counsellors as reasons for patients not benefiting from counselling are the same for both groups and these explanations score far more highly than other reasons given. These explanations are lack of patient motivation, lack of patient insight and an inappropriate referral. Of these three explanations two may be seen as a 'patient' attribution (lack of patient motivation and lack of patient insight) and the third explanation as a 'GP' attribution (inappropriate referral). These results support the findings from the interviews where some GPs mentioned lack of patient motivation as an influential factor in making a referral to the counsellor; lack of patient insight was also cited by GPs as an inappropriate referral for the counsellor. It appears that both the interviewed and surveyed GPs (as well as the surveyed counsellors) are attributing an unsuccessful outcome in counselling to the patient.

Why are the vast majority of respondents attributing this chiefly to the patient, rather than the GP or practice counsellor? One possible explanation for the GP and counsellor, in a sense, coming together to blame the patient may lie in in-group out-group processes. In this instance the GP and practice counsellor may be seen as members of

the in-group (the PHCT) and the patient is part of the out-group. According to the theory of 'ultimate attribution error', in-group members may attribute the negative behaviour of an out-group member dispositionally (i.e. to the individual out-group member) and attribute positive behaviour situationally. In this instance, the negative outcome may be the patient not benefiting from counselling. This is, therefore attributed by the in-group to the patient, rather than to the situation (or to the in-group, i.e. the counsellor or the GP).

A significant proportion of GPs and counsellors indicate that a patient inappropriately referred for counselling will show little improvement in their difficulties. This is not surprising to report as a factor of poor outcome, but does show a certain degree of honesty on the part of the GPs in admitting that they inappropriately refer to the practice counsellor. In this instance a minority of GPs are attributing the negative outcome to themselves. One possible reason why some GPs may be attributing a poor outcome in counselling to themselves is because of their relative power compared to the counsellor and the patient. Brown (1988) suggests that groups with considerable power (as arguably GPs are) are more secure within their power base and may, therefore, feel less uncomfortable challenging their behaviour than groups with less power (e.g. counsellors and patients).

None of these attributions are directly associated with the counsellor's behaviour. This is interesting as the implication is that both GPs and counsellors are saying the main reasons why a patient may not benefit from counselling is not to do with the behaviour of the counsellor. This is surprising given research suggesting the therapeutic relationship to be a major factor in therapy outcome (Clarkson 1996).

The suggestion offered in the question of 'poor counselling skills' as an explanation scored lowly for both groups (5.6% of GPs and 2.3% of counsellors). Both counsellors and GPs scored lowly on the suggestion of "using a different counsellor" as a way of improving the counselling service. In terms of attribution theories, what do these findings tell us? Counsellors are not attributing a poor outcome in counselling directly to themselves. This provides an insight into the self-perception of counsellors. Most of us probably like to think that we are doing sufficiently well at our job. We tend to attribute negative outcomes externally, rather than internally (self-serving bias). It appears this is what the counsellors are doing in this instance. However, if the

counsellors believe that other (external) factors are responsible for the outcome and do not consider their own behaviour/skills as a common explanation, they are unlikely to change their behaviour. It also suggests that as a group, counsellors are possibly less able than some GPs to take responsibility for a poor outcome in counselling, this may be to do with their insecure power base relative to GPs.

In summary, when considering a negative scenario involving the behaviour of themselves and the counsellor, GPs tend to make situational and dispositional (i.e. directed at the counsellor) external attributions. When the patient, counsellor and GP are involved in the scenario, we see in-group out-group behaviour as the attribution tends to be made to the out-group member (the patient). There appears to be a clear tendency on the part of both GPs and counsellors to exhibit self-serving bias (but not all GPs behaved in this way, a small number of GPs attributed a poor outcome from counselling to an inappropriate referral). The outcomes and behaviours considered here are negative; it would have been interesting to have a question that considered a positive outcome (e.g. the success of the counselling service or when counselling has a positive outcome) and what attributions the counsellors and GPs made about this.

4.23 ISSUES OF COLLABORATION

The issue of collaborative working is important as collaboration promotes a good working relationship between two professionals and can increase service efficiency and provide a higher standard of patient care. Contrary to the findings of Small and Conlon (1988), this study suggests that GPs *do* feel that liaison and collaboration with the counsellor is important, although accepting that collaboration is not easy. It is particularly encouraging that all nine interviewed GPs perceive collaboration and liaison as important and for one GP it is very important. This suggests that the profession may have shifted in their views on this issue since the study by Small and Conlon (1988).

However, in practice, liaison and collaboration are not easy to implement. GPs appear to be aware of these difficulties, as one interviewed GP stated,

“(Collaboration) is (important) although it doesn’t happen very often. It would be nice if it did, but usually the counsellor is doing their own thing. It’s very separate.”

This supports the findings of Eastman and McPherson (1982) who found a significant proportion of GPs envisaged difficulties working with a clinical psychologist. Some GPs saw these as problems which they and the counsellor had to address together, others saw these as the counsellor's problems which he/she had to address to fit in with the GP's way of working. The problems mentioned, for example, different ways of working, issues of confidentiality, are commonly cited difficulties (Eastman & McPherson 1982; McLeod 1988; Small & Conlon 1988). Not surprisingly, lack of time was frequently mentioned by GPs and appears to be the biggest barrier to collaboration for this group of GPs. From these interviews it is not clear whether the lack of time is attributed to the GP, the counsellor or to both professionals. It may have been of interest to ask the GPs whether they or the counsellor had attempted to address any of these obstacles.

From the questionnaire a difference between the two professions was observed that is nearing significance is, *'the counsellor needs to develop a more collaborative working style with the PCHT'* (question 16). Interestingly it is the counsellors who tended to agree with this statement more than the GPs. Counsellors may be more aware of issues of collaboration than GPs are.

The issue of collaboration was raised at the meeting. How, when two professionals work together the service provided can become more efficient as a result. In this case, the GP was commenting on collaboration between a counsellor and CPN working in the same practice. This supports the findings from the interviews, indicating that GPs value collaborative working.

The GP-Counsellor Relationship

As a key component of collaborative working, the GP-counsellor relationship is important (Seaburn et al 1996). The questions asked on this issue are of importance to the study as they may indicate whether or not collaborative working is happening between GPs and counsellors and provide an insight into the GP-counsellor relationship.

In considering the GP-counsellor relationship, it appears that the vast majority of both professions recognise the importance of the relationship they have with each other. The

majority also report a good relationship. These findings are important as the quality of the GP-counsellor relationship will have a bearing on the quality of the counselling service. With the formation of primary care groups, GPs are playing an increasingly powerful role in the provision of primary care services. GPs with a good working relationship with the practice counsellor are more likely to fight to retain the service. A good GP-counsellor relationship is also likely to benefit the patient as there is likely to be a shared approach to the patient's care and communication between the two professionals about the patient rather than having two professionals working separately with the same patient and communicating very little.

Confidentiality

The issue of confidentiality appears to be potentially problematic for a number of GPs and counsellors. It is an issue where there appears to be an acknowledged discrepancy in perceptions between the two professions.

Four of the nine GPs interviewed stated that issues of confidentiality create an obstacle to collaboration between the GP and practice counsellor and a quarter of surveyed GPs felt that the counsellor's view of confidentiality is different from their own. This supports previous research (Eastman & McPherson 1982; Seaburn et al 1996; Radley, Cramer & Kennedy 1997; McLeod 1988). However, one GP valued the confidentiality of the counselling service (this finding supports theories suggesting that the same behaviour may be interpreted differently).

What is particularly interesting is that the counsellors tended to agree more strongly than the GPs with the statement – *“The GP & the counsellor have different views about confidentiality”* (44.0% of counsellors agreed or strongly agreed with this statement). This implies that nearly half of the counsellors sampled feel that they have a different view of confidentiality from the GP. One counsellor's comments on this issue support the findings of McLeod (1988);

“I would sometimes like to have more... meetings with GPs about the progress of clients, but issues of confidentiality cause problems.”

It appears that the counsellors are just as aware of differences in views of confidentiality. GPs whose training and career are within the NHS will be used to

working within a culture where information sharing is the norm. For many counsellors, working in the relatively new environment of general practice can mean a significant adjustment. This adjustment the counsellors may have to make may explain why more of them see a difference in views on the issue of confidentiality between themselves and the GP, than the GPs do.

This finding has implications for the training of primary care counsellors and adds support to the view that primary care counselling is a specialist form of counselling. Therefore, counsellors considering working in this area should be required to have training to address the issues (e.g. multi-disciplinary team working) that may be specific to working in primary care.

Communication

The issue of communication between the GP and counsellor is important for patient care and service effectiveness. It is also important in terms of collaborative working between the two professionals and can allow the building and development of a working relationship. Communication can also highlight issues of group function and is a potential source of information through which perceptions may be altered or re-inforced.

From the interviews it appears that some GPs value patient discussion with the counsellor as the best form of communication, *“That quick conversation with the GP is worth two sides of A4, which one tends to scan these days anyhow.”* This supports previous research emphasising the value of face-to-face communication (Seaburn et al 1996). This was seen as a strength of an on-site service. The possibly greater benefit of face-to-face communication is highlighted by a comment made by a GP at the meeting that he tends to scan through the reports from the counsellor. However, it does appear that some of these GPs value feedback from the counsellor, as they wish to have heard from the counsellor by the time they next see the patient. This implies they find such feedback useful.

The mention of communicating by computer is interesting. Firstly, it shows the changing environment of the surgery where many GPs (and other members of PHCT) are now using a computer rather than written notes. Secondly, the suggestion by one GP

that counsellors also communicate this way, could imply the desire to fully integrate the counsellor within the PHCT, by homogenising the practice of all members of the PHCT. The vast majority of GPs feel that the counsellor gives helpful feedback to them about patients seen. This feedback is important for several reasons. It is important in terms of educating the GP about counselling. Information can alter perception. Communication is an effective source of information for GPs and a good way of altering unhelpful or negative perceptions. If the counsellor feeds back to the GP about patients, the GP can learn which referrals are appropriate for counselling and which are inappropriate and can learn which patients are likely to benefit from seeing the practice counsellor.

Communication has implications for service efficiency and patient care. Although the patient may have finished with the counsellor, he/she will continue to have contact with the GP. If the GP has some awareness of the issues raised in counselling it could help the GP understand the patient a little more and may improve their relationship and the quality of GP patient care.

This finding may seem to contradict the previous finding that issues of confidentiality can cause problems between the GP and the counsellor. It appears that for the majority of GPs they do receive helpful feedback from their counsellor about patients seen, but for a quarter of the GP sample, issues of confidentiality are problematic.

Importantly communication is an obvious way for the two professions to build and maintain a good working relationship. The less contact the GP and the counsellor have with each other, the harder it will be for them to relate to form a relationship (Seaburn et al 1996).

Another aspect of a good working relationship is mutual learning. Both GPs and counsellors felt they could learn from each other. However, slightly more counsellors than GPs tend to feel that both professions can learn from each other. A similar, high, proportion of counsellors responded to both question 4 (*The GP can learn about psychological treatments from the counsellor*) and 11 (*The counsellor can learn about medical practice from the GP*) in a positive way. That is, the vast majority of counsellors perceive that both professions can learn from each other. Equally a high number of GPs supported both these statements, although slightly more GPs feel that the counsellor can learn from the GP than the other way around. This response differs

slightly from the interviews where there was a stronger sense of the GPs saying they had not learnt from their practice counsellor. Seaburn et al (1996) see mutual respect as an important aspect of the GP-mental health professional relationship because without this respect is more difficult to develop a relationship. From the results of the questionnaire, it would appear that the vast majority of both professions feel they can learn from their colleague. This reflects another benefit of communication.

Mutual learning is also important because it can also enhance the sense of what Seaburn et al (1996) term 'a shared paradigm'. A shared paradigm between the two professions can make collaborative work easier. This means, for the GP to consider the psychological aspects of the patient and for the counsellor to consider the medical aspects. That is, each professional does not stay within the narrow focus of his/her own professional issues. Through learning about the work of the other, the GP and counsellor will be adopting a broader (more holistic) approach to the care of the patient. The implication being that the quality of patient care will be higher as a result.

4.3 PREDICTING VARIABLES

The study did not find counsellor orientation to be related to GP service satisfaction or the quality of the GP-counsellor relationship. This finding may relate to research suggesting that counsellor orientation is not predictive of outcome in therapy rather the patient-counsellor relationship is. In a similar way, the orientation of the counsellor may not affect GP service satisfaction, rather the nature of the GP-counsellor relationship may and that the nature of this relationship depends on other factors than the orientation of the counsellor.

The prediction that a female GP is more likely to value the counselling service than a male GP is supported by the study. Radley et al (1997) found the presence of a female GP within a practice increased the likelihood of the practice employing a counsellor. Why is this the case? Possibly as women present themselves for counselling more frequently than men, they may, as a group feel more comfortable with the idea of seeing a counsellor than men do. The GP profession may reflect this gender difference. It may also be that the female partner 'attracts' more counselling referrals than her male partners and therefore, has more contact with the counselling service than her male

colleagues, this may be a contributory factor in valuing the service more highly. This appears to support previous research suggesting that women are better able to judge the affective state of others (Hall 1984; 1986).

The prediction that the number of years the practice has a counsellor is related to GP service satisfaction, was supported by the study. This finding is not surprising if one considers that over time the GP-counsellor relationship can develop and also over time the GP can observe the counsellor at work and receive feedback from patients about the service. Perceptions are not static and shift over time. The longer the practice has had a counselling service, the more information the GP has on which to base his/her perceptions and they are less likely to be based on stereotypical views.

The prediction that GP age is related to GP service satisfaction was supported by the study. This finding is not surprising given that counselling is a new area within primary care and that society as a whole is now more exposed to and possibly more accepting of counselling. Younger GPs have probably experienced quite different training and exposure to counselling than their older colleagues, with possibly more emphasis on psychological approaches to treatment. These GPs may be more open and accepting of counsellors working alongside them in general practice. However, this does have implications for those older GPs whose training may have been quite different as to whether further training is required. This finding could suggest that older GPs have different perceptions or expectations of counselling than younger GPs due to their different beliefs and experiences.

Service satisfaction was positively related to the GP-counsellor relationship. This finding supports the view (echoed by some of the GPs interviewed) that the relationship between the two professionals is important (Seaburn et al 1996). Also, that when employing a counsellor, GPs are looking for someone they feel they can work with and establish a relationship with. The perception GPs have regarding importance of relationship is borne out by previous research (e.g. Seaburn et al 1996). This is an important finding as it suggests that the GP-counsellor relationship may be an effective vehicle for improving GP service satisfaction.

4.4 MODEL TO SHOW PROCESSES INVOLVED IN GPs' PERCEPTION OF PRIMARY CARE COUNSELLING

Bringing these findings together, provides an insight into the perceptions of GPs of primary care counselling. This can lead to the development of a model or framework to show the process of a GP's perception of primary care counselling highlighting the influential factors in this process (please refer to Fig 4.01). Some of the factors in the model are derived from previous research on social cognition (e.g. the influence of experience, knowledge, beliefs and schemata on perceptions); other factors emerge from the findings of the present study (e.g. the influence of GP gender, GP age, GP training, time, counsellor behaviours and the GP-counsellor relationship on perceptions).

From this model, based upon the findings from the study and previous research on social cognition, one may predict what factors may increase the likelihood of a GP having a positive perception of primary care counselling and what factors may increase the likelihood of a GP having a negative perception of primary care counselling.

Positive perception more likely if GP.....

- Female
- Younger
- Realistic expectations of service
- Previous experience of service good
- Had counselling service for several years
- Good relationship with practice counsellor
- Collaboration frequently takes place with counsellor
- Role of counsellor clear to GP

Negative perception more likely if GP.....

- Male
- Older
- Unclear/unrealistic expectations of service
- Previous experience of service not good
- Counselling service new
- Poor relationship with counsellor

- Collaboration with counsellor happens infrequently/not at all
- Role of counsellor not clear to GP

4.5 INTERVENTIONS

What can be done to challenge negative or unhelpful perceptions that some GPs may hold regarding primary care counselling and strengthen positive perceptions? As has been demonstrated the formation of perceptions is a complex process made up of many influential factors. Research suggests that perceptions can be shifted. Some factors that influence perception may not be amenable to change, e.g. age, gender, previous experience. Other factors such as time, experience, schemata, information can shift perceptions. This leads to a consideration of what interventions can be developed to target particular factors that may influence a GP's perception of his/her primary care counselling service (as illustrated in Fig 4.02).

Perceptions are dependent upon the behaviour of both the perceiver and the person being perceived. Therefore, these interventions will target both GPs and counsellors.

Target Variables

1. GP-counsellor relationship
2. Counsellor factors
3. GP factors

GP-Counsellor Relationship

This study suggests that the quality of the GP-counsellor relationship is influential in forming the GP's perceptions of the service. For those practices where the GP-counsellor relationship is poor, the GP's perceptions may be altered through collaborative working. This provides the opportunity to strengthen the GP-counsellor relationship. Examples of collaborative working are provided in the opening chapter of the study, but may include increased communication between GP and counsellor, case discussion, trying to appreciate where the other professional is coming from, showing respect to each other. Thus increasing what Seaburn et al (1996) term a shared paradigm.

Fig 4.01 Model Showing Processes involved in GP's Perception of Primary Care Counselling



Through collaboration the GP-counsellor relationship may be strengthened and unhelpful perceptions may be altered in the light of increased knowledge on both the part of the GP and counsellor.

Counsellor factors

The study has highlighted some difficulties for counsellors around confidentiality, team working, communication, audit and evaluation. These issues affect the behaviour of the counsellor and may be contributing to negative or unhelpful perceptions that the GP may have. The role of the counsellor is not clear to many GPs and differences exist between their perceived and expected role.

These issues may be targeted through counsellor training. Training provides an opportunity for counsellors to alter their practice in certain areas and form a clearly defined role. Role definition is important, to the counsellor, GP, PHCT and the patient. These issues need to be addressed from the outset in training. For example, for training courses to address issues of team working and communicating within teams. This could help to alter the perception of the counsellor as separate from the PHCT. Counsellors could undergo placements within primary care to increase their understanding of the surgery environment and to learn first hand about the work of the GP. This will help develop the counsellor's knowledge about the work of the GP. Issues of confidentiality need to be addressed and a way found for the counsellor not to be perceived as secretive. Counsellors could be encouraged to negotiate with their individual GP(s) on this issue early on in their practice, to find out the needs and expectations of their GPs on this issue.

Currently counsellors working in primary care come from a range of counselling schools, professional bodies and orientations. This is undoubtedly contributing to the confusion about the role of a primary care counsellor. Role definition may become clearer once more specialist training courses are established as there will be more homogeneity to the training. The issue of the homogeneity of primary care counselling services is important as it has implications for the future development of the profession and counselling services. Historically primary care counselling services have

developed in a rather ad hoc way. More uniformity among services would allow for the development of a set of counselling service standards and referral criteria for GPs for use in all surgeries. For example, such standards may include strict referral criteria for primary care counselling, minimum training requirements for practitioners and mandatory professional development. Such a move could improve service standards and lessen the confusion among GPs. However, this may be difficult to implement in practice for several years due to the widely differing training and working practices of primary care counsellors (as highlighted by this study).

Such a change in the training of primary care counsellors may allow both GPs and counsellors to have a clearer idea of the counsellor's role and may help to alter the discrepancy observed between the perceived and expected role of the counsellor. Counsellor training may also shift counsellor behaviours that are contributing to negative and unhelpful perceptions that GPs may have regarding primary care counselling. Increasing a counsellor's knowledge about the work of the GP may shift unhelpful perceptions counsellors may hold about GPs and promote collaborative practice.

GP factors

The study has highlighted issues of power for some GPs as well as negative perceptions about counselling and confusion about the role of the counsellor. Some of these factors may be targeted through counsellor training, as discussed. Others may be targeted through GP training. For example, for GPs considering employing or purchasing a counselling service, it is important to know what to expect from that service. Most other services that GPs may consider purchasing (e.g. physiotherapy, chiropody) would be primarily medical in orientation, counselling is not. Therefore the GP needs some knowledge about the work of a primary care counsellor and what such a service may provide in order that the service may be used effectively.

GP training focuses very little on psychological methods of treatment and it is therefore not surprising that some GPs know little about counselling. GP training needs to address this so that GPs can fully utilise counselling services and make appropriate referrals.

For example, GP training could address such issues as multi-disciplinary team working and counselling in primary care. The issue of GP training has been raised before (Waydenfeld & Waydenfeld 1980) but little appears to have been done. However, as counselling is developing further in primary care, the need for such training becomes even greater.

Even with such training, there will always be individual differences and preferences among GPs and counsellors. It is important that the GP is aware of what his/her particular counsellor can offer. This awareness can lessen confusion between the two professions and modify any unrealistic expectations each professional may have about the other. This should be addressed early on through discussion between the GP and counsellor. This issue was raised by one GP interviewed in the study, she stressed the importance for her of finding out which types of patients/presenting problems her counsellor works well with and the orientation of the counsellor.

The study has also raised issues of GP power and the dominance of the medical model and hierarchy within general practice. Power issues and abuse of power can cause difficulties for other professionals working with the GP and also for the patient. GPs may not be used to working so closely with another professional from such a different orientation and this is an issue that could be addressed through on-going training (even multi-disciplinary training courses) with possibly less emphasis on the GP as the dominant professional within primary care.

GP training, including multi-disciplinary training may help alter unhelpful perceptions GPs may hold about primary care counselling. It is also an opportunity to try to address issues of power and how that power may be inappropriately used.

Perceived success of Service

The study suggests that GP satisfaction with the primary care counselling service is influential in forming their perceptions about the service.

The study also highlights that many GPs are questioning whether counselling is cost effective. Both these issues may be addressed through on-going audit and evaluation of the counselling service. This may help provide the necessary information to GPs

questioning the cost effectiveness of their service. Such research (if favourable) may also increase their satisfaction with the service, this may help to alter negative perceptions and strengthen positive perceptions of the service.

4.6 METHODOLOGICAL CRITIQUE

This section discusses the methodological strengths and weaknesses of the study and considers possible ways these may be addressed.

The GP Interviews

One critique of the interviews may be the researcher's role. The researcher, although not known to any of the GPs interviewed, was known to be a counselling psychologist and part of their local primary care counselling service on which they were being questioned. This may have created bias in the GP responses. A person unconnected with the service may have been more appropriate in this role. Due to limited resources this was not possible. However, some GPs agreed to be interviewed stating their feedback may be helpful to the primary care counselling service. These GPs may not have agreed to be interviewed by a person unconnected with the service.

The number of GPs interviewed was small. However, for an exploratory stage of a researcher study, this number seems appropriate. The analysis of the interviews, although thorough, was not as in depth as other forms of content analysis. However, due to limited time, and as this was the initial stage of a larger study, it was felt that this form of analysis was sufficient.

Model to Illustrate Interventions (suggested by Study) Aimed at Changing Unhelpful/Negative GP Perceptions

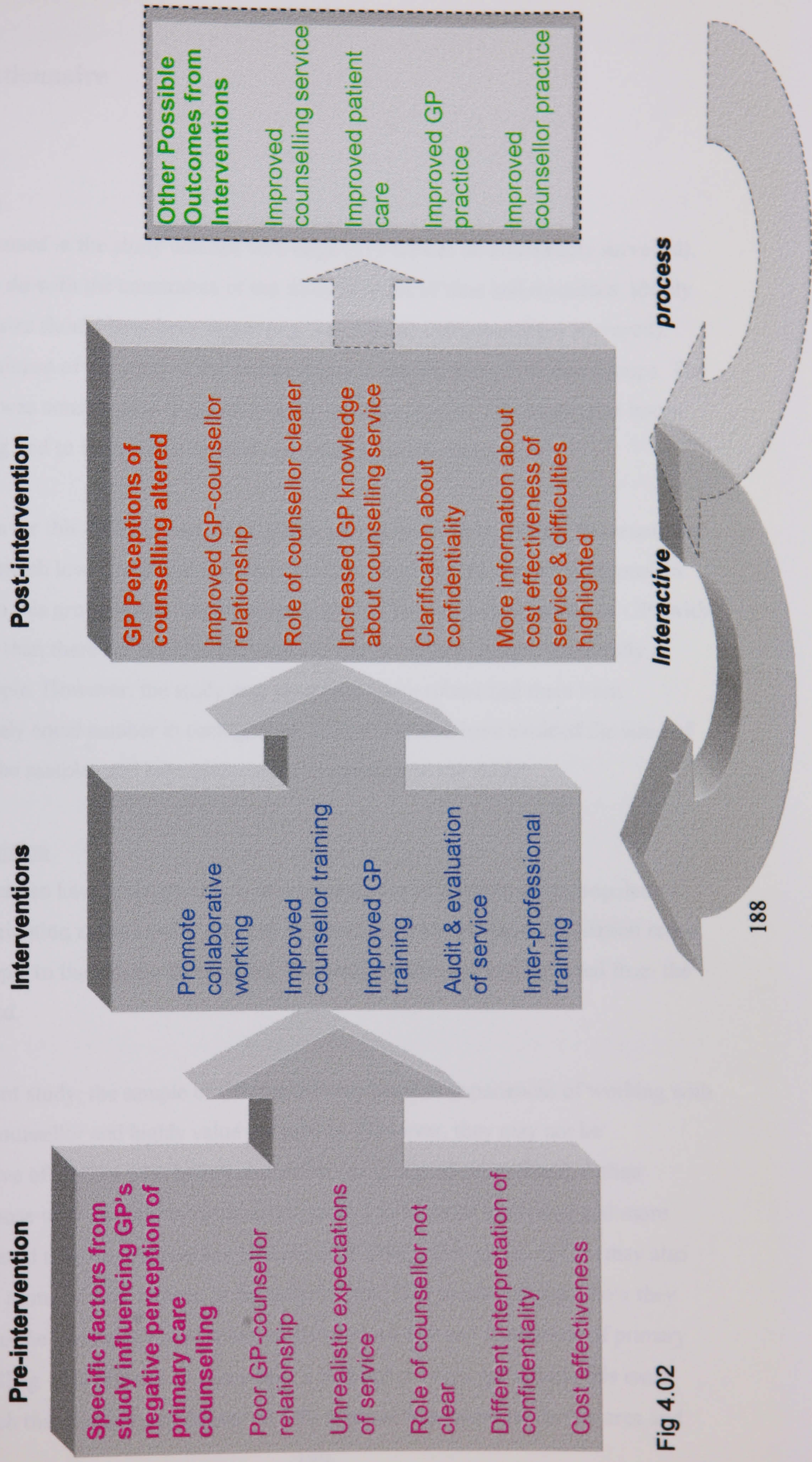


Fig 4.02

The Questionnaire

Sample

Sample size

The sample used in the study was not very large (119 GPs & 66 counsellors surveyed). This was to do with the constraints of the study in terms of time and resources. Ideally the sample size should have been larger (e.g. 150 GPs & 150 counsellors surveyed). Another criticism of the study is the inconsistency in sample size of the two groups. The GP sample was considerably larger than the counsellor sample. This meant that issues of weighting had to be considered when carrying out some analysis.

The reasons for this difference between group size were two fold. Firstly, the researcher expected a much lower response rate from the GPs, therefore far more questionnaires were sent to this group than to the counsellor group. Secondly, there are more GPs with counsellors than there are practice counsellors. The counsellor sample is naturally a smaller sample. However, the study may have been more robust had there been approximately equal number in each groups. This would also have avoided the issue of weighting the samples and have given more consistency to the study.

Sample selection

It is important to have a sample that is as representative as possible of the population under investigation as the results can then be generalised to the whole population rather than just apply to the sample investigated. The sample was randomly selected from the data supplied.

In the present study, the sample of GPs report very positive experiences of working with a practice counsellor and highly value the service. However, they may not be representative of all GPs who have a counsellor (or group of counsellors) at their practice. Those who respond to questionnaires tend to be more motivated and more highly educated than non-responders (Barker et al 1994). This group of GPs may also be biased in terms of their interest in the subject area. This would influence how they responded to the questionnaire in terms of their knowledge and experience of primary care counselling. It is difficult to know how a researcher might get around this issue. How to reach that 'hidden population' of GPs who are less interested in this area and

who may report less positive experiences, yet whose views are of as much interest as other GPs' views.

Matched pairs

In retrospect it would have been useful to match the GPs and counsellors who worked in the same practice. Such matched pairs could have produced very interesting data in terms of comparing GPs' and counsellors' experiences. Such a sample would allow direct comparison between the experiences of professionals who are known to work in the same practice.

However, this may have meant sending out larger numbers of questionnaires as it would have required *both* the GP and counsellor in a practice to respond for the questionnaires to be included in the study. This may not have been practical.

Power Analysis

The statistical power of a study is the likelihood that the study will detect an effect that is actually present (Barker et al 1994). This statistical measure can be used to estimate the appropriate sample size to use in a study. In this study, the appropriate sample size to use in the survey could have been calculated at the pilot stage from using the standard deviation from the results of the pilot survey. From the standard deviation the standard error could have been measured. Using this figure with an appropriate power level selected (0.8 is often recommended as the standard level for power [Cohen; 1988, 1992]) and the standards for an appropriate effect size; the sample size needed to produce such an effect size could be obtained.

An estimate of the sample size could have been a very useful guide for the survey and if the suggested sample size could be obtained it would have added considerably to the robustness of the research findings

The Instrument

Instrument development

An initial difficulty emerged in designing a questionnaire to be used on two different populations. That is, how to design a questionnaire to be pitched at the right level for both professions. In this study this was particularly difficult as the subject area of the

questionnaire was obviously more familiar to one population than the other population. The questionnaire may not have been sophisticated enough for the counsellors but was probably at the right level for the GPs. This was apparent by the comments made by some counsellors about the questionnaire or the way some counsellors answered the questions. Another possible indication of this was that the questionnaire appears to be a more reliable instrument for GPs than counsellors as seen by the higher internal consistency for the questionnaire among the GP sample compared to the counsellor sample.

The feedback from respondents about the questionnaire generated the most responses. Four GPs and five counsellors commented on the questionnaire. Here are a selection of their comments from the open question at the end of the questionnaire;

“I would query the value of the survey when you have asked for subjective responses about our own experience but the statements are mostly broad and impersonal. These statements do not relate to specific experience or situation and could be answered in a variety of ways. Also, since most practices are groups practices considering one GP could give a variety of results.” (Counsellor)

“I don’t know what you mean by view. Do you mean ‘knowledge of’ or ‘an attitude towards’? I don’t know how reliable your proposed comparison between GPs’ returns and counsellors’ returns will be.” (Counsellor)

“It is very difficult to generalise in the way requested by this document – please bear in mind that an individual GP, 1) probably does not see enough of each case to justify generalisation, 2) is very geared towards individual differences which frequently cannot be categorised.” (GP)

“(The) questionnaire is a very spartan tool for this kind of research. Sorry, but I think there is material you could access which a questionnaire cannot.” (GP)

Questions

Some respondents did not understand the instructions. The counsellors were asked to consider only one GP when responding to the questionnaire. This was requested to give a consistency to the responses. However, several counsellors pointed out that their GPs are all very different and questioned the value of only considering one GP when responding.

In considering why there was such a huge amount of missing data for question 22 asking respondents about their perception of counselling (see questionnaires in Appendix B (2), pages 240 & 245) a number of possible explanations arise.

This question required more thought than the previous questions. Therefore, many respondents may not have wanted to give the question this amount of time. Although this may be true for some of the GPs, many of the counsellors (& a proportion of GPs) spent considerable time answering the questionnaire. This could be deduced by the number of respondents (59.5%) who gave comments at the end of the questionnaire. Therefore, this explanation cannot fully account for the large number of respondents who did not answer this question correctly. Another possible explanation for the missing data could be that the cognitive load of the question was too high. That is, a large proportion of respondents did not understand the point of the question. A third possibility is that the wording and/or the layout of the question made it unclear and difficult to answer. This explanation could be applicable to both groups. Indeed a few counsellors wrote comments next to this question on their questionnaire. For example some wrote that their definition of ‘counselling’ is different in primary care from their private work.

Another option would be to have this as an open question. This was considered, but the researcher felt that many respondents would not bother to answer, as it may be too difficult for them to think of an appropriate response. The problems with this question may be seen as a weakness of the study. If the questionnaire is to be used again, this question would have to be amended.

The open question provided a rich source of material. It enriched the data and gave the researcher access to views and ideas not accessible through the questionnaire.

Questions Not Asked.

It may have been interesting to ask respondents to indicate their ethnicity. Firstly, to see the spread of ethnic groups within both samples and secondly to see if ethnic group is a predicting variable of other factors, e.g. service satisfaction.

It may have been useful to ask GPs to indicate the list size of their practice to see if there is any difference in terms of perception and experience of primary care

counselling in different size practices. One counsellor commented that there was not a question about the counsellor's room and he/she felt this was an important issue.

Another area that was not fully explored in the questionnaire was communication between the GP and counsellor. Although respondents were asked about feedback from the counsellor and about information sharing, there were no questions about frequency and form of communication. Such questions may have been helpful in exploring a possible relationship between GP-counsellor communication and service satisfaction or GP-counsellor relationship.

Reliability

The reliability of the pilot questionnaire (as measured by the internal consistency) was very low suggesting that the original design needed quite major changes. This may have been influenced by the comparatively small sample used in the pilot. However, this could not account for all the error as the pilot sample of counsellors was much smaller than the pilot sample of GPs, yet the pilot questionnaire appeared to be more reliable for the counsellors. Such a low reliability for the pilot questionnaire among the GPs could be seen as a weakness of the questionnaire.

It appears that much of the error may have been caused by the questions seeming unclear to respondents (particularly the GPs). This was addressed by changing the wording of most of the questions. Given such a low reliability score on the pilot, the questionnaire should have been piloted a second time, (after making the amendments) to measure the reliability before sending out such a large number of questionnaires. This was not done, but the reliability for the amended questionnaire was very high, although the researcher had no conclusive way of knowing this would be the case. Had the reliability of the amended questionnaire been low, it would have been necessary to carry out more amendments and send out the questionnaire again. This would have wasted considerable time, effort and resources. It may also have been difficult to find another sample of GPs and counsellors to use for the study who had not already been tested. Therefore, a second pilot stage would have been useful.

The internal consistency of the rating scale of the amended questionnaire was higher for the GPs than for the counsellors (although for both groups there was good reliability). This suggests that the survey is a more reliable instrument for GPs than for counsellors.

This maybe because the GPs responded to the survey in a cruder way than the counsellors did. Obviously their knowledge of the subject area is less than the counsellors. The survey, therefore, may not be sophisticated enough for counsellors. This, of course, is one of the difficulties in designing a reliable and valid instrument for two different groups. Or the difference in internal consistency may be a reflection of real differences in the homogeneity of the two professions.

Validity

As the questionnaire was addressing an area of research where no known instrument existed, the researcher was limited in the type of validity criteria that applied. Given more time, it may have been possible to explore further the validity of the questionnaire. For example, the predictive validity of the questionnaire could be studied by comparing the results from this study with previous studies. However, given the time constraints of the study, this was not possible.

The study by Radley, Cramer and Kennedy (1997) used a questionnaire to survey GPs about their views on primary care counselling. Although the emphasis and sample differed from the present study, their questionnaire may have been compared to the present one as a test of validity. However, the author was not aware of their research until the present study had started.

Factor Analysis

Factor analysis was carried out to see if discrete factors existed in the rating scale of the questionnaire. Several methods of analysis were used, none of which produced a clear or stable factor structure. Therefore, it can be concluded that the rating scale of the questionnaire does not consist of clear discrete factors, but may be seen as one factor. That is not necessarily to say that the issue of a GP's or a counsellor's overall experience of counselling service is not made up of different elements or variables, merely that these elements could not be found through the factor analysis carried out. It may be that the relationship between the different elements is particularly complex and therefore outside the scope of the present study.

Another issue to consider is the sample size. The smaller the sample size, the greater the chance of sample error. Hammond (1995) suggests a minimum sample of 200 for factor analysis. The sample of GPs and counsellors was considerably smaller than this and this

may also account for the absence of discrete factors. It may be considered a weakness of the scale that discrete factors did not emerge as such factors may have given an insight into different elements of a respondent's experience of a primary care counselling service.

However, due to the high internal consistency of the scale as a whole, it can be concluded that the perception and experience of the counselling service is a stable factor, even if, at this stage, it is not clear what the relationship is between the elements making up this experience.

Response rate

The response rate for the questionnaires was high for both groups. GPs are poor responders to questionnaires, therefore, the rate obtained of 55% for GPs was much higher than expected. This may imply that the questionnaire was interesting and/or attractive to respondents. The high response rate may be due to the subject area, both GPs and practice counsellors may not have been asked their opinion on this subject before and may therefore, have been more motivated to respond. Enclosing a stamped addressed envelope probably increased the response rate, making it as easy as possible for respondents. The covering letter was personally addressed in most cases (although in some cases this was not possible) and all letters were individually signed by the researcher on headed paper. It was not sent as a photocopied standard letter, as happens in some studies. This extra effort in terms of presentation may have helped increase the response rate.

Despite its flaws and limitations, the questionnaire generated a considerable amount of very interesting data.

Meeting with GPs

No analysis was carried out on this part of the study; the meeting was simply reported.

The dual role of the researchers at the meeting, acting as both groups moderators and representatives of the local counselling service may be seen as a weakness of the study. This may have created bias in their reporting of the meeting. It may also have created bias in the comments of the GPs at the meeting.

However, the meeting proved a useful addition to the study and complimented the other sections of the study. It would have been useful to have more time with the GPs and to have a follow up meeting (this was agreed at the end of the meeting but the researchers are awaiting an invitation to attend a second meeting with the PCG).

4.7 CHAPTER SUMMARY

The aim of the present study is

1. To examine the perceptions and experiences of GPs of primary care counselling.
2. To determine if their perceptions differ from those of primary care counsellors themselves.

The study consisted of 9 GP interviews, a survey of 119 GPs and 66 primary care counsellors and a meeting with a local PCG.

The study found that, overall, the majority of GPs have a positive perception of primary care counselling and highly value the counselling service. GP service satisfaction appears to be high, but most GPs and counsellors feel the service could be improved. However, the majority of GPs also believe that they offer counselling to their patients and most feel that if they had more time to spend with their patients, there would be less of a need for counselling in their practice.

In terms of GP's self-perceptions, the study suggests that GPs perceive themselves as offering counselling to their patients. This perception is not shared by counsellors. Issues of power and a sense of omnipotence were detected among some GPs who indicated that they have nothing to learn from the practice counsellor. This is also evident from the referral process, that some GPs perceive themselves as the expert at all times with the patient. The implications of such perceptions are discussed namely, how the GP may not be open to new ideas or possibilities if he/she holds such a perception. Such a perception may make it more difficult for a GP to ask for or receive support and

suggests that some GPs may have unrealistic expectations of themselves. These perceptions may partly explain why GPs are at such high risk of stress and suicide.

No clear perception of counselling was obtained from the study. There appears to be a wide variation of perceptions among and between the two groups. One theme to emerge, however, is that GPs appear to perceive counselling as more of a passive process than counsellors do. Both professions agree, however, that not all patients benefit from counselling. Important factors in outcome were reported as patient motivation, patient insight and if the referral was appropriate. Perceptions were shown to be affected by time, GP gender and GP age. This finding is supported by theories on social perception.

The practice counsellor is perceived by some GPs as inflexible and separate. Such perceptions could have a major effect on how other group members behave towards and communicate with the counsellor. The role of the practice counsellor is not clear to many GPs and there is a discrepancy between the perceived and expected role of the counsellor. Such discrepancies in perception have been shown to lead to conflict within a group. Few counsellors seem to offer group work in the practice. When considering employing a counsellor, GPs appear to be looking for personal characteristics in the counsellor that suggest he/she will fit it well at the practice. GPs also feel that previous primary care experience is important for potential counsellors.

The referral process for counselling appears to be an interplay of patient factors, GP factors and service issues. The study showed different referring styles among GPs reflecting their self-perception and perception of the patient.

For most presenting problems there appears to be agreement among GPs and counsellors as to their appropriateness for counselling. High risk problems (e.g. psychosis, drug/alcohol abuse) tend not to be considered appropriate. The presenting problems considered appropriate support many previous studies. There was, perhaps surprisingly, a perception among GPs that issues of sexual abuse are not appropriate issues to refer to the practice counsellor. Counsellors overwhelmingly disagree. This raises the issue of a GP's perception of the skill level of primary care counsellors.

The study highlights issues of cost effectiveness with some GPs questioning the use of a counselling service which some perceive to be expensive and of unproven efficacy. Both GPs and counsellors overwhelmingly report funding difficulties in their practice. The implications of such findings are discussed.

Both GP and counsellor attributions were studied across a range of situations. In some situations the counsellors and GPs appear to perceive themselves and each other as members of two separate professional groups and evidence of in-group out-group dynamics are observed. The use of self-servicing bias to enhance one's own skills was found by both GPs and counsellors. In other situations where the GP, counsellor and patient are involved, the group dynamics appear to shift, in that the GP and counsellor possibly perceive themselves as being members of the same group (PHCT) and the patient is the out-group member. In such situations, the attributions are made to the patient. These findings are supported by research in social cognition.

An exception to this is the findings that a small number of GPs attribute a poor outcome in counselling to themselves for referring inappropriately. Their security in their position and their relative power compared to the counsellor or patient, may have allowed some GPs to do this.

The vast majority of GPs feel the relationship is important and most report a good GP-counsellor relationship. They also recognise the importance of collaboration and liaison with the counsellor but in practice this is difficult to implement for several reasons. Lack of time is cited as a major factor, as is different ways of working between the GP and counsellor. Issues of confidentiality appear to be problematic for a number of GPs. In considering the issue of communication between the two professions, the GPs reported that the counsellor gives them helpful feedback about patients. GPs recognise that a primary care counselling service lends itself well to face-to-face communication and the value of this form of communication is commented upon by a number of GPs. Both GPs and counsellors feel they can learn from each other.

In considering why some patients may not benefit from counselling, the GPs tend to perceive this as being due to 'patient' factors or that the referral was inappropriate. The vast majority of GPs did not cite 'counsellor' factors as a possible reason why some patients do not improve following counselling. These 'patient' factors are seen as lack

of patient motivation and lack of patient insight. Such patients are perceived by the GPs as unlikely to benefit from counselling.

The study also found that female GPs were more likely to value the counselling service than male GPs and the longer the practice has a counsellor the more likely the GP will value the service. This supports previous research and theories suggesting that perceptions can shift over time. Gender has been shown to affect perceptions and females are arguably able to detect emotional distress in others more easily than males. The age of the GP was also found to relate to how much the GP values the counselling service. Counsellor orientation was not found to predict GP service satisfaction or other variables. GP interest in counselling was not found to affect GP service satisfaction.

These findings lead to the formation of a model showing the processes involved in a GP's perception of the primary care counselling service. From this model interventions can be developed targeting variables that are influential in GPs forming negative or unhelpful perceptions. The target variables that may be amenable to change are individual counsellor factors, individual GP factors, the GP-counsellor relationship and the perceived success of the service. These variables may be targeted through collaborative working between GP and counsellor, training processes and evaluation and audit. Through such interventions, unhelpful or negative perceptions may be altered and positive perceptions strengthened.

These findings need to be interpreted cautiously due to a number of methodological problems with the study. Namely sampling weaknesses, difficulties with the development, reliability and validity of the questionnaire. There were also problems with individual questions and useful data that may have been obtained if certain questions had been included in the survey. However, the response rate for the survey was high and a high level of internal consistency was obtained. The different research methods used appear to have complimented each other and added to the richness of the data.

4.8

IMPLICATIONS

The main implication from the study is in terms of training for both GPs and primary care counsellors, as discussed earlier. This includes the importance and potential benefit of on-going multi-disciplinary training so the GP and counsellor (and PHCT) can learn and train together. This idea links with current government policy for NHS staff training. For example, the policy of NHS staff working together outlined in the government paper ‘Working together: Securing a Quality Workforce for the NHS’; the National Service Framework for mental health emphasises partnership working and training in team development; in May 2001 the government issued a paper entitled ‘Development in Multi-Professional Education’.

The issue of specialist training for primary care counsellors has been raised by the study. Current training for both GP and counsellors re-inforces the mind/body split. If primary care counsellors have more understanding of the physical components of a client’s difficulties it could not only enhance the therapy they offer the client but may also deepen their understanding of the work of the GP. For example, some patients with medical problems (e.g. diabetes, multiple sclerosis, cancer) may be referred for counselling. Some knowledge of the medical condition may be helpful for the counsellor in understanding the patient’s psychological difficulties. Another way such knowledge may be useful for the practice counsellor is in understanding the medical terminology often used in the surgery or written in the referral.

Some of the difficulties cited by GPs and counsellors in the present study (e.g. differences in confidentiality, the perceived separateness of the counsellor) may be partly attributed to counsellors working in primary care who are not prepared for the specific demands and difficulties working in this area. There is a strong case for specialist training for primary care counsellors to better equip them for work in a surgery. This is an issue being considered by Counsellors in Primary Care as many counsellors themselves feel the need for further and specialist training. For example, to set up specialist training courses in primary care counselling (as some colleges now offer) and to make this a mandatory requirement for *all* counsellors working in this area. Such training may include issues such as knowledge of DSM criteria, sitting in on GP

consultations (to gain knowledge of the working practice of the GP, this will enhance mutual respect and understanding of each others ways of working), developing skills in research and audit (in the author's experience, these issues are not addressed in many counselling courses) and how to work within the information sharing culture of NHS. Particular attention needs to be paid to the issue of confidentiality, how the counsellor can maintain confidentiality, whilst also working with the GP to treat a patient. The difficulty may be addressed through negotiation between the GP, counsellor and patient to determine what information the patient is willing for the counsellor to disclose to the GP. This may vary from patient to patient, but training may help the counsellor to feel more comfortable about sharing information with the GP. This may also have the effect of increasing the confidence of counsellors to speak effectively with GPs.

The study also raises the issue of the accessibility of counselling training. The demographics of the counsellors surveyed in the study suggest that the counselling profession may not be representative of all sections of society (as shown by the age and gender imbalance of the sample). This issue may be addressed, for example, through offering bursaries or scholarships to students on lower incomes and so reaching out to a wider group of prospective counsellors who may presently be turned off entering the profession because of the costs involved in training.

The present study suggests that some GPs may be struggling to cope with the demands of their work as suggested by the very little time they have with their patients or to meet with the counsellor. It is widely acknowledged that GPs are at a higher than average risk of alcoholism and suicide (Zigmond 1984), therefore issues of support and clinical supervision for GPs need to be considered.

The study has highlighted areas of concern for some primary care counsellors, such as poor pay, isolation, poor administrative support and lack of funding for training. These findings support the case for a unified professional body representing primary care counsellors. Such a body could address these concerns and raise the profile of the profession as a whole. However, in practice this may be difficult to implement given the widely different training and professional bodies covering counsellors working in primary care.

Although the focus of the present study was on GPs and primary care counsellors, the findings from the study have implications for patients and those using primary care counselling services. The study suggests that many primary care counselling services are experiencing funding difficulties. This will affect the service in terms of its stability, security and future development and will impact therefore on the quality of the service the patient receives. It was beyond the scope of the study to consider how the differences found between the two professions on issues of perception of counselling and the role of the counsellor affects the service the patient receives. However, one may hypothesise that such differences could potentially be at least confusing for the patient and at most damaging to the patient if the two professions do not have a shared idea of the patient's problems and are not communicating with each other.

The issue of service equity was powerfully demonstrated at the meeting with GPs. Clearly not all patients have access to a counsellor at their surgery and among those that do, are there widely differing standards? It was beyond the scope of the present study to determine this, but the study has found a range of experiences reported by GPs.

What about patient empowerment? Although the study was not addressing this issue directly, it seems that in many instances, it would be helpful to involve the patient more in the decision making process, thus promoting collaborative practice not only between GP and counsellor but GP and patient. The increased power of the patient in relation to the GP should shift the GP-patient relationship to a more equitable status. Some primary care counselling services already try to involve the patient more in the referral process by asking all patients referred to the service by their GP to also 'opt in' to the service (e.g. to fill in a form confirming they wish to attend counselling and patients who do not opt in are not offered an appointment), thereby the patient is making an active decision to be referred. However, this example concerns the counsellor's efforts to involve the patient and not the GP's efforts.

A range of research formats were used in the present study (interviews, questionnaires and a meeting). This appears to have strengthened the study by addressing the issues through a variety of means, sometimes arriving at a similar answer and sometimes not. The study is strengthened by the richness of data such methods, when used together, can generate. This supports the view that using both qualitative and quantitative research methods can enhance research and shows there are different, and equally valid ways of

looking at an issue. Such an approach can provide a more comprehensive picture and supports the call for methodological integration advocated by Hill and Corbett (1993).

CHAPTER 5

CONCLUSION

This study set out to explore the experiences and perceptions of GPs of primary care counselling. This was achieved through interviewing, surveying and meeting with GPs who have a counsellor in their practice and also through surveying primary care counsellors. The experiences of GPs were compared with the experiences of primary care counsellors.

On the whole, the findings may be interpreted optimistically. GPs overwhelmingly value a primary care counselling service. However, there are clearly difficulties providing a psychological service within a medical practice. For the service to work effectively both the GP and the counsellor will need to modify areas of their practice and behaviour. Added to this there are external pressures, namely a service with funding difficulties and a government requirement to prove its effectiveness.

The findings highlight the group processes at work within the primary care setting. Of particular relevance are issues of role, identity and power. The study clearly demonstrates the power of the GP and this affects how the GP behaves towards the counsellor and the patient. The counsellor, it appears is still struggling to clarify his/her role, and therefore, status and position within PHCT. These issues will have a major effect on how each professional is perceived within PHCT. In keeping with these findings, the GP-counsellor relationship may be seen as pivotal in shaping the perceptions of both GP and counsellor. As such it also offers the opportunity for both professionals to learn more about the work of the other, thus lessening misunderstanding, poor communication, role confusion and negative perceptions about the other.

This study found that GPs' perceptions of primary care counselling are made up of a number of factors, which may at times seem contradictory. These perceptions appear to be influenced by, age, gender, time, information, behaviour of the counsellor and past experience. A model illustrating this process is offered. Although perceptions exist

among GPs that may be viewed as unhelpful or negative perceptions of primary care counselling, these perceptions may be altered.

This paper argues that collaboration and team working among professionals is the way forward in the changing environment of primary care (and the health service generally) and supports the ideas of Seaburn et al (1996). Health care, although still dominated by the “medical model” (i.e. the medical profession and the medical philosophy emphasising the role of biological processes in health and illness), is shifting to become more holistic in its approach. So-called complementary medicines are being more widely used by patients (e.g. acupuncture, herbal remedies) who possibly find the medical model of care does not fully address their needs. Such forms of treatment are becoming more acceptable within the medical establishment and the emphasis upon patients’ rights is greater. Therefore, the medical profession is being forced to consider the benefits of a more holistic approach to treatment. This has implications firstly for the continuing dominance of the medical model and the power of the doctor and secondly the increasing multi-disciplinary nature of health care. In primary care this has meant the expansion of the primary care team to include non-medical professionals (e.g. counsellors). If such treatments are to be offered in primary care and to work effectively in this context for the benefit of the patient, there needs to be a good working relationship between the GP and the counsellor. This means recognition, mutual respect and an acknowledgement and validation of each other’s way of working.

Future Research

Where does this study leave the issue of primary care counselling? The study has raised many important issues (e.g. GPs believe they offer counselling, differences in perception of confidentiality between the two professions). However as the experiences and perceptions of GPs of counselling have not been well researched, the present study may be seen as an initial study. Therefore, future research may address some of the difficulties and gaps within the present study. For example, the methodological difficulties discussed earlier. Further areas to explore could be the impact on patient care when there are difficulties between the GP and counsellor. The GP-counsellor relationship could be explored further, to consider what constitutes a good GP-counsellor relationship. Also, what makes some GPs satisfied with a service, but other GPs receiving the same service dissatisfied? This may help in terms of the development

of good practice and particularly for developing service standards in primary care counselling. Areas that the present study has raised but not addressed could be explored further. For example, looking at the issue of service equity. The study has shown a wide range of experiences reported by GPs. Therefore one needs to consider whether all patients have access to the same type of counselling service, and the implications of this in terms of service quality. The study has also highlighted that some counsellors are employed by a practice, others are attached to a practice. How do these different types of service structure impact on the counsellor, the GP, the patient and the overall quality of the counselling service?

Issues of counselling effectiveness and outcome are being addressed through the ongoing CORE evaluation study at Leeds University and will, hopefully help to answer some of the critics on this issue. However, it is also important to continue to listen to the views and experiences of GPs.

The conclusion of the study appears to be the central importance of the GP-counsellor relationship. Interestingly, in terms of outcome in therapy the relationship is seen to be one of the most important factors, possibly, then, within the context of a primary care counselling service the same may apply. The relationship is also an important vehicle for change

The focus of this study has been on counsellors (not psychologists) working in primary care. Can any conclusions be drawn for counselling psychologists, a number of whom work in primary care? Through their extensive training in therapeutic and research skills, counselling psychologists are well placed to effectively offer a counselling service to GPs and their patients. Some of the difficulties cited by GPs may be less applicable to counselling psychologists. For example, the training of counselling psychologists is more homogenous than that of counsellors, with a clearly identified benchmark of qualification (chartering). Counselling psychologists can use their research skills to enhance their practice (they can carry out audits and evaluations of their work). Counselling psychologists frequently work in NHS placements during their training. They are, therefore, familiar with the culture of the NHS. There may be more clarity about the role of the counselling psychologist within primary care. However, other issues may be equally applicable to counselling psychologists as they are to

counsellors (for example, issues of power and hierarchy that feature in general practice). Counselling psychologists may also offer a useful role in the training of both GPs and counsellors in the area of collaborative working and also at an organisational level, counselling psychologists may be involved in looking at the overall effectiveness of a primary care counselling service.

Finally, this study reinforces the complexity of social perception. How we perceive others and ourselves is a complex process made up of a number of factors many of which we are not consciously aware of. However, our perceptions have a major influence on how we behave towards others and how others behave towards us. Through studying these processes we can better understand the dynamics of inter-professional relationships and actively intervene to change them.

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APPENDIX B (1)

Information Relating to GP Interviews

**A STUDY EXAMINING GPs' PERCEPTIONS & EXPECTATIONS
OF COUNSELLING & THEIR PRACTICE-BASED COUNSELLOR**

Information Sheet

You have been asked to participate in a study examining the perceptions and expectations GPs have of counselling. You will be asked some questions about your experiences of working with a counsellor and also your views about counselling. This will be in the form of a semi-structured interview. The interview will be tape-recorded and is expected to last approximately 10 – 15 minutes. The information collected from the interview will be kept strictly confidential.

Contact name:

Maria Geoghegan
Primary Care Counselling Service
Psychological Therapies Service
Lennard Lodge
3 Lennard Road
Croydon CRO 2UL.

0181 700 8832

**A STUDY EXAMINING GPs’ PERCEPTIONS & EXPECTATIONS
OF COUNSELLING & THEIR PRACTICE- BASED COUNSELLOR**

Consent Form

I acknowledge that I have read and understood the description of the investigation given in the information sheet and I give my consent to take part in the study. I also understand that all information collected about me will be kept strictly confidential and will not be transmitted to third parties without my further consent in writing. I also understand that I may withdraw from the study at any time without giving a reason and without incurring a penalty.

Signed.....

Name.....

Date.....

I confirm that I have fully discussed the nature of the study with the participant and that he/she has freely consented.

Signed.....

Name.....

Date.....

APPENDIX B(1)

Interview Questions

1. Why did your practice consider having a counsellor?
2. In considering employing a counsellor, what might you be looking for in the counsellor?
3. How do you think counselling may help a patient?
4. How do you think counselling achieves this?
5. How do you decide whether or not to refer a patient to the counsellor?
6. What factors may influence your decision?
7. Are there particular problems for which counselling is likely to benefit a patient?
8. Are there particular problems for which counselling is unlikely to benefit a patient?
9. Do you think collaboration and liaison with the counsellor is important?
10. If 'yes' – what, if any, obstacles do you think exist to closer collaboration?
11. What do you consider to be the differences, if any, between a counsellor and other mental health professionals who may work in primary care, for example, a clinical psychologist or a CPN (community psychiatric nurse)?
12. What contribution, if any, do you think the counsellor makes to the practice as a whole?
13. What have you learnt as a result of having a counsellor at your practice?

APPENDIX B (2)

Information Relating to Questionnaire

APPENDIX B (2) Covering Letter sent to Surveyed GPs

THE MAUDSLEY
Advancing mental health care

Primary Care Counselling Service
Psychological Therapies Service
Lennard Lodge
3 Lennard Road
Croydon CR0 2UL

Tel No: 0181 700 8832
Fax No: 0181 700 8809

July 1999

Dear Dr

A study is currently being undertaken looking at GPs' views on counselling in primary care. Little is known about the thoughts and experiences of GPs on this issue although counselling is a growth area in primary care. Your involvement in this study is, therefore, important as your views on this issue need to be known in order to help evaluate and improve such services. You have been selected to participate in this study as you have a counsellor at your practice. Participation involves completing the enclosed questionnaire.

It is hoped that through such research will come a better understanding of GPs' experiences of counselling in primary care and working with counsellors. This will enable such services to be improved thus benefiting the patients, the GP and the practice as a whole.

The enclosed questionnaire should take, on average, **5 minutes to complete**. *The questionnaire is anonymous and all responses will be treated in the strictest confidence.* Please return the questionnaire as soon as possible, in the stamped addressed envelope provided.

If you have any questions about this letter or the study, please contact;
Ms Geoghegan on 0181 700 8832.

May we take this opportunity to thank you for your participation and co-operation.

Yours sincerely

Maria Geoghegan
Chartered Counselling Psychologist

Dr Miriam Burke
Consultant Clinical Psychologist

APPENDIX B (2) Covering Letter sent to Surveyed Counsellors

THE MAUDSLEY
Advancing mental health care

Primary Care Counselling Service
Psychological Therapies Service
Lennard Lodge
3 Lennard Road
Croydon CR0 2UL

Tel No: 0181 700 8832
Fax No: 0181 700 8809

July 1999

Dear

A study is currently being undertaken looking at GPs' views on counselling in primary care. Little is known about the thoughts and experiences of GPs on this issue although counselling is a growth area in primary care. Part of the study involves eliciting GPs' views through a questionnaire. In order to gain a fuller understanding of their views of counselling in primary care, it is necessary to compare them with the views and experiences of counsellors who work in this area. You have been selected to participate in this study as you work in primary care. Participation involves completing the enclosed questionnaire.

It is hoped that through such research will come a better understanding of GPs' experiences of counselling in primary care and working with counsellors. A further stage of the study is aimed at intervening to address any misconceptions GPs may have about counselling in primary care. This will enable such services to be improved thus benefiting the patients and the practice as a whole.

The enclosed questionnaire should take, on average, **5 minutes to complete**. *The questionnaire is anonymous and all responses will be treated in the strictest confidence.* Please return the questionnaire as soon as possible, in the stamped addressed envelope provided.

If you have any questions about this letter or the study, please contact;
Ms Geoghegan on 0181 700 8832.

May we take this opportunity to thank you for your participation and co-operation.

Yours sincerely

Maria Geoghegan
Chartered Counselling Psychologist

Dr Miriam Burke
Consultant Clinical Psychologist

QUESTIONNAIRE MEASURING GPs’ VIEWS & EXPERIENCES OF COUNSELLING IN PRIMARY CARE

Below are a number of statements relating to counselling in primary care. Each statement is followed by a series of possible responses: strongly disagree, disagree, neither agree nor disagree, agree or strongly agree. Read each statement carefully & decide which response best describes your view & experience of counselling in primary care. Then circle the corresponding response. Please respond to every statement. If you are not completely sure which response is more accurate, put the response which you feel is most appropriate. Do not spend too long on each statement.

	strongly agree	agree	neither agree nor disagree	disagree	strongly disagree
1. The counselling service in this practice is valued by the GP	SA	A	N	D	SD
2. The counsellor is an important member of the Primary Health Care Team.....	SA	A	N	D	SD
3. Some patients, whatever their difficulties, may not benefit from counselling.....	SA	A	N	D	SD
4. Many GPs regularly provide counselling, themselves, to their patients.....	SA	A	N	D	SD
5. The GP can learn from the counsellor.....	SA	A	N	D	SD
6. Counselling may sometimes be more effective than medication in helping a patient.....	SA	A	N	D	SD
7. It is the time offered to the patient that is important, not which professional is offering it; whether an hour is spent with the GP or the counsellor makes little difference to the patient.....	SA	A	N	D	SD
8. Collaboration & liaison between the GP & the counsellor is important.....	SA	A	N	D	SD
9. The GP & the counsellor have different views on confidentiality.....	SA	A	N	D	SD
10. Joint working between the GP & the counsellor can be difficult.	SA	A	N	D	SD
11. The counsellor can learn from the GP.....	SA	A	N	D	SD

- | | | | | | |
|---|----|---|---|---|----|
| 12. In this practice the counsellor & the GP have a good working relationship..... | SA | A | N | D | SD |
| 13. The counsellor is not as team orientated as the rest of the Primary Health Care Team..... | SA | A | N | D | SD |
| 14. The GP & the counsellor have little understanding of each other's roles. | SA | A | N | D | SD |
| 15. The counsellor likes to work separately | SA | A | N | D | SD |
| 16. The counsellor needs to develop a more collaborative working style | SA | A | N | D | SD |
| 17. There is adequate information sharing between the GP & the counsellor... .. | SA | A | N | D | SD |
| 18. The referral process is affected by a GP's understanding of counselling..... | SA | A | N | D | SD |
| 19. The decision to refer for counselling should be jointly made by the GP & the patient..... | SA | A | N | D | SD |
| 20. It is important that the GP & the patient discuss the referral with each other..... | SA | A | N | D | SD |
| 21. The counsellor gives useful feedback to the GP about referrals..... | SA | A | N | D | SD |
| 22. Some patients do not understand why they have been referred for counselling..... | SA | A | N | D | SD |
23. Here are some statements describing counselling, please indicate by ticking the appropriate box(es) which statement most closely describes your view of counselling.
Please do not tick more than 2 statements.

- | | |
|---|--------------------------|
| a) Counselling primarily offers a patient time to talk. | <input type="checkbox"/> |
| b) Counselling is primarily an active process involving self-exploration. | <input type="checkbox"/> |
| c) Counselling primarily helps a patient to use their own coping resources. | <input type="checkbox"/> |
| d) Counselling primarily offers patients a solution to their problems. | <input type="checkbox"/> |
| e) Counselling primarily offers a patient a listening ear. | <input type="checkbox"/> |
| f) None of the above. | <input type="checkbox"/> |

Please circle the appropriate response for the following 3 questions

24. Do you think the counselling service could be improved?
Yes / No

25. Does the counselling service have a secure future at the practice?

Yes / No / Don't know

26. Would you like the counselling service to continue at the practice?

Yes / No / Don't mind

27. Which presenting problems may be appropriate to refer to a counsellor working in primary care?

Please tick any presenting problems you feel are relevant.

Agoraphobia	<input type="checkbox"/>	Personality disorder	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	Psychotic depression	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	Relationship difficulties	<input type="checkbox"/>
Bereavement	<input type="checkbox"/>	Sexual abuse	<input type="checkbox"/>
Moderate depression	<input type="checkbox"/>	Somatising	<input type="checkbox"/>

28. What priority *should* be given, in your view, to the following services in primary care.

*Please rank from 1 – 5 where,
1 = highest priority service
2 = lowest priority service*

Physiotherapy	_____
Counselling	_____
Midwifery	_____
Clinical Psychology	_____
Chiropody	_____

29. In your experience, do patients sometimes return to the GP after seeing the counsellor, showing little improvement in their difficulties? **Yes / No**

30. If yes, what do you consider to be a common explanation for this:

Please tick no more than 2 statements.

The patient was inappropriately referred for counselling	<input type="checkbox"/>
The patient lacked insight into their problems	<input type="checkbox"/>
The patient lacked motivation to address their problems	<input type="checkbox"/>
The counsellor showed poor counselling skills	<input type="checkbox"/>
Other factors (please specify) _____	

31. Which statement below describes the role of the counsellor within the practice?
You may tick as many statements as you wish.

- a) providing one-to-one counselling sessions ☐
- b) facilitating groups ☐
- c) a source of information for the GP on available resources. ☐
- d) a consultant for the GP on a variety of mental health issues. ☐

Below are a number of general questions about you, your practice and your counsellor. Please answer each question by putting a circle around the appropriate response.

Date..... Sex male / female

Your age group	25 – 35	No of years in general practice .
	36 – 45	0 - 5
	46 – 55	6 - 10
	over 55	10 - 20
		more than 20

Is your counsellor; a. employed by the practice
 b. employed by a local NHS Trust
 c. don't know
 d. other (please specify)_____

How many years has your practice had a counsellor? 0 – 1
 2 – 5
 6 – 10
 more than 10
 don't know

How many hours a week does your counsellor see patients at the practice?

1 – 3
4 – 6
7 – 10
more than 10 hours
don't know

Please rate your interest in the area of primary care counselling by ticking the appropriate box;

- I am particularly interested in this topic ☐
- I am fairly interested in this topic ☐
- I am not interested in this topic ☐

If you have any other comments you would like to add which you feel have not been addressed in this questionnaire please do so here.

Thank you for your co-operation

Please return this questionnaire in the SAE provided to:

**Maria Geoghegan
Primary Care Counselling Service
Psychological Therapies Service
Lennard Lodge
3 Lennard Road
Croydon CRO 2UL.**

QUESTIONNAIRE MEASURING COUNSELLORS' VIEWS & EXPERIENCES OF COUNSELLING IN PRIMARY CARE

Below are a number of statements relating to counselling in primary care. Each statement is followed by a series of possible responses: strongly disagree, disagree, neither agree nor disagree, agree or strongly agree. Read each statement carefully & decide which response best describes your view & experience of counselling in primary care. Then circle the corresponding response. Please respond to every statement. If you are not completely sure which response is more accurate, put the response which you feel is most appropriate. Do not spend too long on each statement.

Some questions ask about your experiences of working with your GP; if you work at more than one practice, or with more than one GP, please consider just one practice and one GP when answering.

	strongly agree	agree	neither agree nor disagree	disagree	strongly disagree
1. The counselling service in this practice is valued by the GP	SA	A	N	D	SD
2. The counsellor is an important member of the Primary Health Care Team.....	SA	A	N	D	SD
3. Some patients, whatever their difficulties, may not benefit from counselling.....	SA	A	N	D	SD
4. Many GPs regularly provide counselling, themselves, to their patients.....	SA	A	N	D	SD
5. The GP can learn from the counsellor.....	SA	A	N	D	SD
6. Counselling may sometimes be more effective than medication in helping a patient.....	SA	A	N	D	SD
7. It is the time offered to the patient that is important, not which professional is offering it; whether an hour is spent with the GP or the counsellor makes little difference to the patient.....	SA	A	N	D	SD
8. Collaboration & liaison between the GP & the counsellor is important.....	SA	A	N	D	SD
9. The GP & the counsellor have different views on confidentiality.....	SA	A	N	D	SD
10. Joint working between the GP & the counsellor can be difficult.	SA	A	N	D	SD

11. The counsellor can learn from the GP.....	SA	A	N	D	SD
12. In this practice the counsellor & the GP have a good working relationship.....	SA	A	N	D	SD
13. The counsellor is not as team orientated as the rest of the Primary Health Care Team.....	SA	A	N	D	SD
14. The GP & the counsellor have little understanding of each other's roles.	SA	A	N	D	SD
15. The counsellor likes to work separately	SA	A	N	D	SD
16. The counsellor needs to develop a more collaborative working style	SA	A	N	D	SD
17. There is adequate information sharing between the GP & the counsellor... ..	SA	A	N	D	SD
18. The referral process is affected by a GP's understanding of counselling.....	SA	A	N	D	SD
19. The decision to refer for counselling should be jointly made by the GP & the patient.....	SA	A	N	D	SD
20. It is important that the GP & the patient discuss the referral with each other.....	SA	A	N	D	SD
21. The counsellor gives useful feedback to the GP about referrals.....	SA	A	N	D	SD
22. Some patients do not understand why they have been referred for counselling.....	SA	A	N	D	SD

23. Here are some statements describing counselling, please indicate by ticking the appropriate box(es) which statement most closely describes your view of counselling. *Please do not tick more than 2 statements.*

- a) Counselling primarily offers a patient time to talk.
☐
- b) Counselling is primarily an active process involving self-exploration.
☐
- c) Counselling primarily helps a patient to use their own coping resources.
☐
- d) Counselling primarily offers patients a solution to their problems.
☐
- e) Counselling primarily offers a patient a listening ear.
☐
- f) None of the above.
☐

Please circle the appropriate response for the following 3 questions

24. Do you think the counselling service could be improved?
Yes / No

25. Does the counselling service have a secure future at the practice?
Yes / No / Don't know

26. Would you like the counselling service to continue at the practice?
Yes / No / Don't mind

27. Which presenting problems may be appropriate to refer to a counsellor working in primary care?
Please tick any presenting problems you feel are relevant.

Agoraphobia	<input type="checkbox"/>	Personality disorder	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	Psychotic depression	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	Relationship difficulties	<input type="checkbox"/>
Bereavement	<input type="checkbox"/>	Sexual abuse	<input type="checkbox"/>
Moderate depression	<input type="checkbox"/>	Somatising	<input type="checkbox"/>

28. What priority *should* be given, in your view, to the following services in primary care.

*Please rank from 1 – 5 where,
1 = highest priority service
2 = lowest priority service*

Physiotherapy	_____
Counselling	_____
Midwifery	_____
Clinical Psychology	_____
Chiropody	_____

29. In your experience, do patients sometimes return to the GP after seeing the counsellor, showing little improvement in their difficulties? **Yes / No**

30. If yes, what do you consider to be a common explanation for this:
Please tick no more than 2 statements.

- The patient was inappropriately referred for counselling** ☐
- The patient lacked insight into their problems** ☐
- The patient lacked motivation to address their problems** ☐
- The counsellor showed poor counselling skills** ☐
- Other factors (please specify)** _____

31. Which statement below describes the role of the counsellor within the practice?
You may tick as many statements as you wish.

- a) providing one-to-one counselling sessions

d) facilitating groups

e) a source of information for the GP on available resources.

d) a consultant for the GP on a variety of mental health issues.
- ☐

☐

☐

☐

Below are a number of general questions about you and the practice where you work. Please answer each question by putting a circle around the appropriate response.

Date.....

Sex male / female

Your age group

20 – 30

31 – 40

41 – 50

51 - 60

over 60

No of years working as a counsellor in
general practice

less than 1

1 – 5

6 – 10

more than 10

Are you;

a. employed by the practice

b. employed by a local NHS Trust

c. working as a volunteer at the practice

d. other (please specify)_____

How many hours a week do you see patients in a GP setting?

1 – 3

4 – 6

7 – 10

more than 10

How would you describe your primary theoretical orientation?

Psychodynamic

Cognitive-behavioural

Client centred

Systemic

Integrative

None of the above (please specify)_____

If you have any other comments you would like to add which you feel have not been addressed in this questionnaire please do so here.

Thank you for your co-operation

Please return this questionnaire in the SAE provided to:

**Maria Geoghegan
Primary Care Counselling Service
Psychological Therapies Service
Lennard Lodge
3 Lennard Road
Croydon CRO 2UL.**

APPENDIX B (2)

Amendments made after Piloting

1. Question 1 was amended from “The counselling service in this practice is valued by the GP” to “The counselling service in this practice is *highly* valued by the GP”. This was inserted for stronger emphasis.
2. Question 4 was amended from “Many GPs regularly provide counselling, themselves, to their patients” to “Many GPs regularly provide *some form of* counselling, themselves, to their patients”. This was amended for clarity. This question became Question 3 in the amended questionnaire.
3. Question 5 was amended from “The GP can learn from the counsellor” to “The GP can learn about *psychological* treatment from the counsellor”. This was amended for clarity. This question became Question 4 in the amended questionnaire.
4. Question 6 was amended from “Counselling may sometimes be more effective than medication in helping a patient” to “Counselling can be more effective than medication in helping a patient in some circumstances”. This question was amended to add more emphasis and clarity. This question became question 5 in the amended questionnaire.
5. Question 7 was amended from “It is the time offered to the patient that is important, not which professionals is offering it; whether an hour is spent with the GP or the counsellor makes little difference to the patient” to “If GPs had more time to spend with their patients there would be less of a need for counselling”. This question was amended because it was felt that the original version was too long and clumsy and so the respondent may lose the thread of the question. This question became Question 6 of the amended questionnaire.
6. Question 8 was amended from “Collaboration & liaison between the GP & the counsellor is important” to “A close working relationship between the GP & the counsellor is important”. This question was amended to be more specific about one aspect of collaborative working. This question became Question 7 of the amended questionnaire.
7. Question 11 was amended from “The counsellor can learn from the GP” to “The counsellor can learn *about medical practice* from the GP”. This was amended to be more specific.
8. Question 13 was amended from “The counsellor is not as team orientated as the rest of the Primary Health Care Team” to “The counsellor is not as team orientated as *the other professionals working in the practice*”. This was amended to make the question read more easily.
9. Question 15 was amended from “The counsellor likes to work separately” to “The counsellor likes to work separately *from the rest of the team*”. This question was amended for clarification.
10. Question 16 was amended from “The counsellor needs to develop a more collaborative working style” to “The counsellor needs to develop a more

collaborative working style *with the team*". This question was amended for clarification.

11. Question 17 was amended from "There is adequate information sharing between the GP & the counsellor" to "There is adequate sharing of information *about patients* between the GP & the counsellor". This question was amended to be more specific.
12. Question 18 was amended from "The referral process is affected by a GP's understanding of counselling" to "a lack of understanding on the part of the GP can lead to inappropriate referrals". This question was amended to be less abstract and more concrete.
13. Question 19 "The decision to refer for counselling should be jointly made by the GP & the patient" and question 20 "It is important that the GP & the patient discuss the referral with each other" were combined as both questions were asking similar things. The amended question 19 was turned into a negative question (to increase the number of negative questions) and became "The GP sometimes makes referrals without discussing it with the patient".
14. Question 21 was amended from "The counsellor gives useful feedback to the GP about referrals" to "The counsellor gives *helpful* feedback to the GP about *patients seen*". This question was amended as *helpful* reads better than *useful* and *patients seen* reads better than *referrals*. This question became Question 20 in the amended questionnaire.
15. Question 23 was amended in two ways. Firstly, the instructions were amended from;
"Here are some statements describing counselling, please indicate by ticking the appropriate box(es) which statement most closely describes your view of counselling. *Please do not tick more than 2 statements.*"
To
"Here are some statements describing counselling. Please indicate your view and understanding of counselling by ranking the following statements from 1 – 6 where;
1 = the statement that most closely describes your view of counselling
6 = the statement that least closely describes your view of counselling"
These amendments were made as in the pilot study, many respondents did not answer this question correctly, it was felt that changing the instructions may make the question more user friendly.

Secondly, statement d) was amended from;
"Counselling primarily offers patients a solution to their problems."
To
"Counselling primarily offers patients an opportunity to identify and solve their own problems." This statement was amended as the original statement was possibly crude.
This question became Question 22 in the amended questionnaire.
16. Question 24 in the amended questionnaire was added after piloting, as all respondents in the pilot study had indicated that the counselling service could be

improved. It was felt that it would be useful to ask respondents *how* the service could be improved.

17. Question 25 was amended from “Does the counselling service have a secure future at the practice?” to “Are you aware of funding difficulties for the counselling service?” This question was amended to be more specific about funding.
18. Question 26 was amended from, “Would you like the counselling service to continue at the practice?” to “Are the GP sufficiently satisfied with the counselling service to want it to continue at this practice?” This question was amended as all the counsellors responded ‘yes’ to the question when piloted, this was to be expected and was not giving particularly useful information. The question was, therefore, amended so the counsellors had to consider whether the *GPs* wished for the service to continue.
19. The list of presenting problems was extended to offer respondents more choice and to, therefore, offer more useful information. The four problems included after piloting were; drug abuse, eating disorders, family problems and obsessive compulsive disorder.

The names of some problems were also amended for clarity; alcoholism became alcohol abuse; moderate depression became depression; psychotic depression became psychosis.

20. Question 28 in the pilot questionnaire was omitted from the amended questionnaire as many respondents did not answer correctly and were not clear on how to answer, other respondents felt it was impossible to compare such different services, others respondents seemed annoyed by the question.
21. Question 29 was amended to include the response “uncertain” as well as yes/no, to give respondents more choice. This question became Question 28 in the amended questionnaire.
22. Question 31 was amended to offer respondents more choice. This list of responses was increased to include the response, “a source of support to others in the practice”.
The response, “a source of information for the GP on available resources” was amended to, “a source of information for the GP on available resources, *e.g. local voluntary or statutory services offering counselling*”. This question was amended for clarity as the available resources had not been specified.
This question became Question 30 in the amended questionnaire.

QUESTIONNAIRE MEASURING COUNSELLORS' VIEWS & EXPERIENCES OF WORKING IN PRIMARY CARE

Below are a number of statements relating to counselling in primary care. Each statement is followed by a series of possible responses: strongly disagree, disagree, neither agree nor disagree, agree or strongly agree. Read each statement carefully & decide which response best describes your view & experience of counselling in primary care. Then circle the corresponding response. Please respond to every statement. If you are not completely sure which response is more accurate, put the response which you feel is most appropriate. Do not spend too long on each statement.

Some questions ask about your experiences of working with your GP; if you work at more than one practice, or with more than one GP, please consider just one practice and one GP when answering.

	strongly agree	agree	neither agree nor disagree	disagree	strongly disagree
1.The counselling service in this practice is highly valued by the GP	SA	A	N	D	SD
2. Some patients, whatever their difficulties, may not benefit from counselling.	SA	A	N	D	SD
3. Many GPs regularly provide some form of counselling, themselves, to their patients.	SA	A	N	D	SD
4. The GP can learn about psychological treatments from the counsellor	SA	A	N	D	SD
5. Counselling can be more effective than medication in helping a patient in some circumstances.....	SA	A	N	D	SD
6. If GPs had more time to spend with their patients there would be less of a need for counselling	SA	A	N	D	SD
7. A close working relationship between the GP & the counsellor is important.....	SA	A	N	D	SD
8. The GP & the counsellor have different views about confidentiality.....	SA	A	N	D	SD
9. The counsellor in this practice is an important member of the Primary Health Care Team.	SA	A	N	D	SD
10. Joint working between the GP & the counsellor can be difficult.	SA	A	N	D	SD

11. The counsellor can learn about medical practice from the GP.....	SA	A	N	D	SD
12. In this practice the counsellor & the GP have a good working relationship.....	SA	A	N	D	SD
13. The counsellor is not as team orientated as the other professionals working in the practice.	SA	A	N	D	SD
14. The GP & the counsellor have little understanding of each other's roles.	SA	A	N	D	SD
15. The counsellor likes to work separately from the rest of the team.	SA	A	N	D	SD
16. The counsellor needs to develop a more collaborative working style with the team	SA	A	N	D	SD
17. There is adequate sharing of information about patients between the GP & the counsellor.....	SA	A	N	D	SD
18. A lack of understanding about counselling on the part of the GP can lead to inappropriate referrals....	SA	A	N	D	SD
19. The GP sometimes makes referrals without discussing it with the patient.....	SA	A	N	D	SD
20. The counsellor gives helpful feedback to the GP about patients seen.....	SA	A	N	D	SD
21. Some patients do not understand why they have been referred for counselling.....	SA	A	N	D	SD

22. Here are some statements describing counselling. Please indicate your view and understanding of counselling by ranking the following statements from 1 – 6 where;

1 = the statement that most closely describes your view of counselling
6 = the statement that least closely describes your view of counselling

- a) Counselling primarily offers a patient time to talk.
- b) Counselling is primarily an active process involving self-exploration... ..
- c) Counselling primarily helps a patient to use their own coping resources.....
- d) Counselling primarily offers patients an opportunity to identify and solve their own problems.
- e) Counselling primarily offers a patient a listening ear
- f) None of the above.

Please circle the appropriate response for the following questions

23. Do you think the counselling service could be improved?
Yes / No

24. If yes, how could the service be improved?
Please tick any relevant responses

- ☐ **By using a different counsellor**
- ☐ **Offering more sessions per patient**
- ☐ **Increasing the number of hours of counselling offered to the practice.**
- ☐ **In other ways (please specify) _____**

25. Are you aware of funding difficulties for the counselling service?
Yes / No / Don't know

26. Are the GPs sufficiently satisfied with the counselling service to want it to continue at this practice?
Yes / No / Don't know

27. Which presenting problems may be appropriate to refer to a counsellor working in primary care?
Please tick any presenting problems you feel are relevant.

- | | | | |
|-------------------------|--------------------------|--------------------------------------|--------------------------|
| Agoraphobia | <input type="checkbox"/> | Family problems | <input type="checkbox"/> |
| Alcohol abuse | <input type="checkbox"/> | Obsessive Compulsive Disorder | <input type="checkbox"/> |
| Anxiety | <input type="checkbox"/> | Personality disorder | <input type="checkbox"/> |
| Bereavement | <input type="checkbox"/> | Psychosis | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | Relationship difficulties | <input type="checkbox"/> |
| Drug abuse | <input type="checkbox"/> | Sexual abuse | <input type="checkbox"/> |
| Eating disorders | <input type="checkbox"/> | Somatising | <input type="checkbox"/> |

28. In your experience, do patients sometimes return to the GP after seeing the counsellor, showing little improvement in their difficulties? **Yes / No/ Uncertain**

29. If yes, what do you consider to be a common explanation for this:
Please tick no more than 2 statements.

- The patient was inappropriately referred for counselling** ☐
- The patient lacked insight into their problems** ☐
- The patient lacked motivation to address their problems** ☐
- The counsellor showed poor counselling skills** ☐
- Other factors (please specify) _____**

30. Which statement below describes the role of the counsellor within the practice?
You may tick as many statements as you wish.

- a) providing one-to-one counselling sessions _____
- f) facilitating groups _____
- g) a source of information for the GP on available resources, eg. local voluntary or statutory services offering counselling _____
- d) a consultant for the GP on a variety of mental health issues. _____
- e) a source of support to others in the practice _____

Below are a number of general questions about you and the practice where you work. Please answer each question by putting a circle around the appropriate response.

Date..... Sex male / female

Your age group	20 – 30	No of years working as a counsellor in general practice	
	31 – 40		
	41 – 50		less than 1
	51 – 60		1 - 5
	over 60		6 - 10
			more than 10

Are you;

- a. employed by the practice?
- b. employed by a local NHS Trust?
- c. working as a volunteer at the practice?
- d. other (please specify)_____

How many hours a week do you see patients in a GP setting?

- 1 – 3
- 4 – 6
- 7 – 10
- more than 10

How would you describe your primary theoretical orientation?

Psychodynamic
Cognitive-behavioural
Client centred
Systemic
Integrative
Humanistic
None of the above (please specify)_____

What counselling qualifications do you have?

If you have any other comments you would like to add which you feel have not been addressed in this questionnaire please do so here.

Thank you for your co-operation

Please return this questionnaire in the SAE provided to:

**Maria Geoghegan
Primary Care Counselling Service
Psychological Therapies Service
Lennard Lodge
3 Lennard Road
Croydon CRO 2UL.**

APPENDIX B (2) Amended Questionnaire sent to GPs

QUESTIONNAIRE MEASURING GPs' VIEWS & EXPERIENCES OF COUNSELLING IN PRIMARY CARE

Below are a number of statements relating to counselling in primary care. Each statement is followed by a series of possible responses: strongly disagree, disagree, neither agree nor disagree, agree or strongly agree. Read each statement carefully & decide which response best describes your view & experience of counselling in primary care. Then circle the corresponding response. Please respond to every statement. If you are not completely sure which response is more accurate, put the response which you feel is most appropriate. Do not spend too long on each statement.

	strongly agree	agree	neither agree nor disagree	disagree	strongly disagree
1. The counselling service in this practice is highly valued by the GP	SA	A	N	D	SD
2. Some patients, whatever their difficulties, may not benefit from counselling.	SA	A	N	D	SD
3. Many GPs regularly provide some form of counselling, themselves, to their patients.	SA	A	N	D	SD
4. The GP can learn about psychological treatments from the counsellor	SA	A	N	D	SD
5. Counselling can be more effective than medication in helping a patient in some circumstances.....	SA	A	N	D	SD
6. If GPs had more time to spend with their patients there would be less of a need for counselling	SA	A	N	D	SD
7. A close working relationship between the GP & the counsellor is important.....	SA	A	N	D	SD
8. The GP & the counsellor have different views about confidentiality.....	SA	A	N	D	SD
9. The counsellor in this practice is an important member of the Primary Health Care Team.	SA	A	N	D	SD
10. Joint working between the GP & the counsellor can be difficult.	SA	A	N	D	SD
11. The counsellor can learn about medical practice from the GP.....	SA	A	N	D	SD

12. In this practice the counsellor & the GP have a good working relationship.....	SA	A	N	D	SD
13. The counsellor is not as team orientated as the other professionals working in the practice.	SA	A	N	D	SD
14. The GP & the counsellor have little understanding of each other's roles.	SA	A	N	D	SD
15. The counsellor likes to work separately from the rest of the team.	SA	A	N	D	SD
16. The counsellor needs to develop a more collaborative working style with the team	SA	A	N	D	SD
17. There is adequate sharing of information about patients between the GP & the counsellor.....	SA	A	N	D	SD
18. A lack of understanding about counselling on the part of the GP can lead to inappropriate referrals....	SA	A	N	D	SD
19. The GP sometimes makes referrals without discussing it with the patient.....	SA	A	N	D	SD
20. The counsellor gives helpful feedback to the GP about patients seen.....	SA	A	N	D	SD
21. Some patients do not understand why they have been referred for counselling.....	SA	A	N	D	SD

22. Here are some statements describing counselling. Please indicate your view and understanding of counselling by ranking the following statements from 1 – 6 where;

1 = the statement that most closely describes your view of counselling
6 = the statement that least closely describes your view of counselling

- a) Counselling primarily offers a patient time to talk.
- b) Counselling is primarily an active process involving self-exploration.
- c) Counselling primarily helps a patient to use their own coping resources.
- d) Counselling primarily offers patients an opportunity to identify and solve their own problems.....
- e) Counselling primarily offers a patient a listening ear.
- f) None of the above.

Please circle the appropriate response for the following questions

23. Do you think the counselling service could be improved?

Yes / No

24. If yes, how could the service be improved?

Please tick any relevant responses

- ☐ **By using a different counsellor**
 - ☐ **Offering more sessions per patient**
 - ☐ **Increasing the number of hours of counselling offered to the practice.**
 - ☐ **In other ways (please specify)**
-

25. Are you aware of funding difficulties for the counselling service?

Yes / No / Don't know

26. Are the GPs sufficiently satisfied with the counselling service to want it to continue at this practice?

Yes / No / Don't know

27. Which presenting problems may be appropriate to refer to a counsellor working in primary care?

Please tick any presenting problems you feel are relevant.

- | | | | |
|-------------------------|--------------------------|--------------------------------------|--------------------------|
| Agoraphobia | <input type="checkbox"/> | Family problems | <input type="checkbox"/> |
| Alcohol abuse | <input type="checkbox"/> | Obsessive Compulsive Disorder | <input type="checkbox"/> |
| Anxiety | <input type="checkbox"/> | Personality disorder | <input type="checkbox"/> |
| Bereavement | <input type="checkbox"/> | Psychosis | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | Relationship difficulties | <input type="checkbox"/> |
| Drug abuse | <input type="checkbox"/> | Sexual abuse | <input type="checkbox"/> |
| Eating disorders | <input type="checkbox"/> | Somatising | <input type="checkbox"/> |

28. In your experience, do patients sometimes return to the GP after seeing the counsellor, showing little improvement in their difficulties? **Yes / No/ Uncertain**

29. If yes, what do you consider to be a common explanation for this:

Please tick no more than 2 statements.

- The patient was inappropriately referred for counselling** ☐
- The patient lacked insight into their problems** ☐
- The patient lacked motivation to address their problems** ☐
- The counsellor showed poor counselling skills** ☐
- Other factors (please specify)** _____

30. Which statement below describes the role of the counsellor within the practice?
You may tick as many statements as you wish.

- a) providing one-to-one counselling sessions
- h) facilitating groups
- i) a source of information for the GP on available resources, e.g. local voluntary or statutory services offering counselling
- d) a consultant for the GP on a variety of mental health issues.
- e) a source of support to others in the practice

Below are a number of general questions about you, your practice and your counsellor. Please answer each question by putting a circle around the appropriate response.

Date.....

Sex male / female

Your age group	25 – 35	No of years in general practice .
	36 – 45	0 - 5
	46 – 55	6 - 10
	over 55	10 - 20
		more than 20

Is your counsellor; a. employed by the practice
 b. employed by a local NHS Trust
 c. don't know
 d. other (please specify)_____

How many years has your practice had a counsellor?	0 – 1
	2 – 5
	6 – 10
	more than 10
	don't know

How many hours a week does your counsellor see patients at the practice?

1 – 3
4 – 6
7 – 10
more than 10 hours
don't know

Please rate your interest in the area of primary care counselling by ticking the appropriate box;

- I am particularly interested in this topic☐
- I am fairly interested in this topic☐
- I am not interested in this topic☐

If you have any other comments you would like to add which you feel have not been addressed in this questionnaire please do so here.

Thank you for your co-operation

Please return this questionnaire in the SAE provided to:

Maria Geoghegan
Primary Care Counselling Service
Psychological Therapies Service
Lennard Lodge
3 Lennard Road
Croydon CRO 2UL.

TABLE A.04

To Show Number of Years Respondents have been in their Profession

TABLE A.01 To Show Number of Years Respondents have been in their Profession

Years in profession	Counsellors	GPs	Total
0 – 5	22 (33.3%)	16 (13.4%)	38 (20.5%)
6 – 10	25 (37.8%)	19 (16.0%)	44 (23.8%)
More than 10	14 (21.3%)	80 (67.2%)	94 (50.8%)
Missing data	5 (7.6%)	4 (3.4%)	9 (4.9%)
Total	66 (100%)	119 (100%)	185 (100%)

TABLE A.02 To Show Employment Status of Counsellors

Employed by	Counsellor sample	GP sample	Total Sample
Practice	48 (72.7%)	85 (71.4%)	133 (71.9%)
Local NHS Trust	10 (15.2%)	29 (24.5%)	39 (21.1%)
Volunteer	1 (1.5%)	1 (0.8%)	2 (1.1%)
Other	2 (3.0%)	3 (2.5%)	5 (2.7%)
Missing	5 (7.6%)	1 (0.8%)	6 (3.2%)
Total	66 (100%)	119 (100%)	185 (100%)

TABLE A.03 To Show Number of Years GP Practice has had Counselling

Years	GP Sample
0 – 1	1 (0.8%)
2 – 5	42 (35.3%)
6 – 10	42 (35.3%)
More than 10	30 (25.3%)
Don't know	3 (2.5%)
Missing	1 (0.8%)
Total	119 (100%)

TABLE A.04 To Show Hours a Week of Counselling Input by Counsellor in Primary Care

Hours per week	Counsellor sample	GP sample	Total
1 – 3	2 (3.0%)	11 (9.2%)	13 (7.0%)
4 – 6	7 (10.6%)	32 (26.9%)	39 (21.1%)
7 – 10	16 (24.2%)	33 (27.7%)	49 (26.5%)
More than 10	38 (57.6%)	31 (26.1%)	69 (37.3%)
Don't know	0 (0%)	8 (6.7%)	8 (4.3%)
Missing	3 (4.5%)	4 (3.4%)	7 (3.8%)
Total	66 (100%)	119 (100%)	185 (100%)

TABLE A.05 To Show Counsellors' Qualifications

Qualification	Number	Percent
Diploma in counselling	30	45.5
Masters in counselling	13	19.6
Certificate in counselling	4	6.1
Adv. diploma in counselling	7	10.6
Other counselling qualification	4	6.1
No qualif. given – BAC accredited	5	7.6
No qualif. given – UKCP registered	1	1.5
No counselling qualification	1	1.5
Missing	1	1.5
Total	66	100

TABLE A.06 To Show Responses to Rating Scale

1 The counselling service in this practice is highly valued by the GP

		Profession		
		GP	Counsellor	Total
strongly disagree	Count	1	0	1
	% within profession	0.8	0	0.5
disagree	Count	4	1	5
	% within profession	3.4	1.5	2.7
neutral	Count	7	4	11
	% within profession	5.9	6.1	5.9
agree	Count	28	19	47
	% within profession	23.5	28.8	25.4
strongly agree	Count	79	42	121
	% within profession	66.4	63.6	65.4
Total	Count	119	66	185
	% within profession	100	100	100

2 Some patients whatever their difficulties may not benefit from counselling

		Profession		
		GP	Counsellor	Total
disagree	Count	2	2	4
	% within profession	1.7	3.0	2.2
neutral	Count	5	3	8
	% within profession	4.2	4.5	4.3
agree	Count	70	43	113
	% within profession	58.8	65.2	61.1
strongly agree	Count	42	18	60
	% within profession	35.3	27.3	32.4
Total	Count	119	66	185
	% within profession	100	100	100

3 Many GPs regularly provide some form of counselling themselves to their patients

		Profession		
		GP	Counsellor	Total
strongly disagree	Count	0	2	2
	% within profession	0	3.0	1.1
disagree	Count	2	11	13
	% within profession	1.7	16.7	7.0
neutral	Count	7	13	20
	% within profession	5.9	19.7	10.8
agree	Count	59	37	96
	% within profession	49.6	56.1	51.9
strongly agree	Count	51	3	54
	% within profession	42.9	4.5	29.2
Total	Count	119	66	185
	% within profession	100	100	100

4 The GP can learn about psychological treatments from the counsellor

		Profession		
		GP	Counsellor	Total
strongly disagree	Count	1	1	2
	% within profession	0.8	1.5	1.1
disagree	Count	4	2	6
	% within profession	3.4	3.0	3.2
neutral	Count	20	5	25
	% within profession	16.8	7.6	13.5
agree	Count	64	38	102
	% within profession	53.8	57.6	55.1
strongly agree	Count	30	20	50
	% within profession	25.2	30.3	27.0
Total	Count	119	66	185
	% within profession	100	100	100

5 Counselling can be more effective than medication in helping a patient in some circumstances

		Profession		
		GP	Counsellor	Total
disagree	Count	1	0	1
	% within profession	0.8	0	0.5
neutral	Count	5	3	8
	% within profession	4.2	4.5	4.3
agree	Count	54	26	80
	% within profession	45.4	39.4	43.2
strongly agree	Count	59	37	96
	% within profession	49.6	56.1	51.9
Total	Count	119	66	185
	% within profession	100	100	100

6 If GPs had more time to spend with their patients there would be less need for counselling

		Profession		
		GP	Counsellor	Total
strongly disagree	Count	4	9	13
	% within profession	3.4	13.6	7.0
disagree	Count	35	35	70
	% within profession	29.4	53.0	37.8
neutral	Count	28	11	39
	% within profession	23.5	16.7	21.1
agree	Count	41	9	50
	% within profession	34.5	13.6	27.0
strongly agree	Count	11	2	13
	% within profession	9.2	3.0	7.03
Total	Count	119	66	185
	% within profession	100	100	100

7 A close working relationship between the GP & the counsellor is important

		Profession		
		GP	Counsellor	Total
disagree	Count	2	0	2
	% within profession	1.7	0.0	1.1
neutral	Count	17	6	23
	% within profession	14.3	9.1	12.4
agree	Count	55	25	80
	% within profession	46.2	37.9	43.2
strongly agree	Count	45	35	80
	% within profession	37.8	53.0	43.2
Total	Count	119	66	185
	% within profession	100	100	100

8 The GP and the counsellor have different views about confidentiality

		Profession		
		GP	Counsellor	Total
strongly agree	Count	4	4	8
	% within profession	3.4	6.1	4.3
agree	Count	26	25	51
	% within profession	21.8	37.9	27.6
neutral	Count	27	17	44
	% within profession	22.7	25.8	23.8
disagree	Count	46	15	61
	% within profession	38.7	22.7	33.0
strongly disagree	Count	16	5	21
	% within profession	13.4	7.6	11.4
Total	Count	119	66	185
	% within profession	100	100	100

9 The counsellor in this practice is an important member of the PHCT

		Profession		
		GP	Counsellor	Total
strongly disagree	Count	2	1	3
	% within profession	1.7	1.5	1.6
disagree	Count	3	2	5
	% within profession	2.5	3.0	2.7
neutral	Count	6	10	16
	% within profession	5.0	15.2	8.6
agree	Count	46	25	71
	% within profession	38.7	37.9	38.4
strongly agree	Count	62	28	90
	% within profession	52.1	42.4	48.6
Total	Count	119	66	185
	% within profession	100	100	100

10 Joint working between the GP & the counsellor can be difficult

		Profession		
		GP	Counsellor	Total
strongly agree	Count	3	3	6
	% within profession	2.5	4.5	3.2
agree	Count	40	24	64
	% within profession	33.6	36.4	34.6
neutral	Count	15	10	25
	% within profession	12.6	15.2	13.5
disagree	Count	50	26	76
	% within profession	42.0	39.4	41.1
strongly disagree	Count	11	3	14
	% within profession	9.2	4.5	7.6
Total	Count	119	66	185
	% within profession	100	100	100

11 The counsellor can learn about medical practice from the GP

		Profession		
		GP	Counsellor	Total
strongly disagree	Count	1	0	1
	% within profession	0.8	0	0.5
disagree	Count	1	1	2
	% within profession	0.8	1.5	1.1
neutral	Count	17	5	22
	% within profession	14.3	7.7	12.0
agree	Count	85	40	125
	% within profession	71.4	61.5	67.9
strongly agree	Count	15	19	34
	% within profession	12.6	29.2	18.5
Total	Count	119	65	184
	% within profession	100	100	100

12 In this practice the counsellor & the GP have a good working relationship

		Profession		
		GP	Counsellor	Total
strongly disagree	Count	1	0	1
	% within profession	0.8	0	0.5
disagree	Count	1	0	1
	% within profession	0.8	0	0.5
neutral	Count	4	5	9
	% within profession	3.4	7.7	4.9
agree	Count	53	30	83
	% within profession	44.5	46.2	45.1
strongly agree	Count	60	30	90
	% within profession	50.4	46.2	48.9
Total	Count	119	65	184
	% within profession	100	100	100

13 The counsellor is not as team oriented as the other professionals working in the practice

		Profession		
		GP	Counsellor	Total
strongly agree	Count	4	2	6
	% within profession	3.4	3.1	3.3
agree	Count	30	22	52
	% within profession	25.2	33.8	28.3
neutral	Count	23	9	32
	% within profession	19.3	13.8	17.4
disagree	Count	41	22	63
	% within profession	34.5	33.8	34.2
strongly disagree	Count	21	10	31
	% within profession	17.6	15.4	16.8
Total	Count	119	65	184
	% within profession	100	100	100

14 The GP & counsellor have little understanding of each others roles

		Profession		
		GP	Counsellor	Total
strongly agree	Count	1	0	1
	% within profession	0.8	0	0.5
agree	Count	7	2	9
	% within profession	5.9	3.1	4.9
neutral	Count	14	0	14
	% within profession	11.8	0	7.6
disagree	Count	66	43	109
	% within profession	55.5	66.2	59.2
strongly disagree	Count	31	20	51
	% within profession	26.1	30.8	27.7
Total	Count	119	65	184
	% within profession	100	100	100

15 The counsellor likes to work separately from the rest of the team

		Profession		
		GP	Counsellor	Total
strongly agree	Count	1	1	2
	% within profession	0.8	1.5	1.1
agree	Count	21	5	26
	% within profession	17.6	7.7	14.1
neutral	Count	30	10	40
	% within profession	25.2	15.4	21.7
disagree	Count	49	32	81
	% within profession	41.2	49.2	44.0
strongly disagree	Count	18	17	35
	% within profession	15.1	26.2	19.02
Total	Count	119	65	184
	% within profession	100	100	100

16 The counsellor needs to develop a more collaborative working style with the team

		Profession		
		GP	Counsellor	Total
strongly agree	Count	2	2	4
	% within profession	1.7	3.1	2.2
agree	Count	18	16	34
	% within profession	15.1	25.0	18.6
neutral	Count	27	19	46
	% within profession	22.7	29.7	25.1
disagree	Count	49	22	71
	% within profession	41.2	34.4	38.8
strongly disagree	Count	23	5	28
	% within profession	19.3	7.8	15.3
Total	Count	119	64	183
	% within profession	100	100	100

17 There is adequate sharing of information about patients between the GP & the counsellor

		Profession		
		GP	Counsellor	Total
strongly disagree	Count	5	0	5
	% within profession	4.2	0	2.7
disagree	Count	8	4	12
	% within profession	6.7	6.2	6.5
neutral	Count	27	5	32
	% within profession	22.7	7.7	17.4
agree	Count	65	45	110
	% within profession	54.6	69.2	59.8
strongly agree	Count	14	11	25
	% within profession	11.8	16.9	13.6
Total	Count	119	65	184
	% within profession	100	100	100

18 A lack of understanding about counselling on the part of the GP can lead to inappropriate referrals

		Profession		
		GP	Counsellor	Total
strongly disagree	Count	2	3	5
	% within profession	1.7	4.6	2.7
disagree	Count	9	9	18
	% within profession	7.6	13.8	9.8
neutral	Count	11	6	17
	% within profession	9.2	9.2	9.2
agree	Count	83	36	119
	% within profession	69.7	55.4	64.7
strongly agree	Count	14	11	25
	% within profession	11.8	16.9	13.6
Total	Count	119	65	184
	% within profession	100	100	100

19 The GP sometimes makes referrals without discussing it with the patient

		Profession		
		GP	Counsellor	Total
strongly agree	Count	0	3	3
	% within profession	0	4.6	1.6
agree	Count	2	4	6
	% within profession	1.7	6.2	3.3
neutral	Count	7	3	10
	% within profession	5.9	4.6	5.4
disagree	Count	44	33	77
	% within profession	37.0	50.8	41.8
strongly disagree	Count	66	22	88
	% within profession	55.5	33.8	47.8
Total	Count	119	65	184
	% within profession	100	100	100

20 The counsellor gives helpful feedback to the GP about patients seen

		Profession		
		GP	Counsellor	Total
strongly disagree	Count	4	1	5
	% within profession	3.4	1.5	2.7
disagree	Count	5	1	6
	% within profession	4.2	1.5	3.3
neutral	Count	19	7	26
	% within profession	16.0	10.8	14.1
agree	Count	69	43	112
	% within profession	58.0	66.2	60.9
strongly agree	Count	22	13	35
	% within profession	18.5	20.0	19.0
Total	Count	119	65	184
	% within profession	100	100	100

21 Some patients do not understand why they have been referred for counselling

		Profession		
		GP	Counsellor	Total
strongly agree	Count	3	4	7
	% within profession	2.5	6.2	3.8
agree	Count	28	21	49
	% within profession	23.5	32.3	26.6
neutral	Count	21	10	31
	% within profession	17.6	15.4	16.8
disagree	Count	55	26	81
	% within profession	46.2	40.0	44.0
strongly disagree	Count	12	4	16
	% within profession	10.1	6.2	8.7
Total	Count	119	65	184
	% within profession	100	100	100

TABLE A.07 TO SHOW MANN WHITNEY SCORES FOR 21 STATEMENTS ON RATING SCALE

The counselling service in this practice is highly valued by the GP	3870	0.85
Some patients whatever their difficulties may not benefit from counselling	3585.5	0.25
Many GPs regularly provide some form of counselling themselves to their patients	1787.5	0.00
The GP can learn about psychological treatments from the counsellor	3526.5	0.20
Counselling can be more effective than medication in helping a patient in some circumstances	3674	0.41
If GPs had more time to spend with their pts there would be less of a need for counselling	2368	0.00
A close working relationship between the GP & the counsellor is important	3251	0.03
The GP and the counsellor have different views about confidentiality	2927.5	0.00
The counsellor in this practice is an important member of the PHCT	3402	0.10
Joint working between the GP & the counsellor can be difficult	3560	0.26
The counsellor can learn about medical practice from the GP	3102.5	0.01
In this practice the counsellor & the GP have a good working relationship	3665	0.51
The counsellor is not as team oriented as the other professionals working in the practice	3621.5	0.46
The GP & the counsellor have little understanding of each others roles	3291	0.06
The counsellor likes to work separately from the rest of the team	2989	0.01
The counsellor needs to develop a more collaborative working style with the team	2925	0.01
There is adequate sharing of information about pts between the GP & the counsellor	3072	0.01
A lack of understanding about counselling on the part of the GP can lead to inappropriate referrals	3678.5	0.52
The GP sometimes makes referrals without discussing it with the pt	2935.5	0.00
The counsellor gives helpful feedback to the GP about pts seen	3505.5	0.23
Some pts do not understand why they have been referred for counselling	3297	0.08

TABLE A.08 To Show Other Ways to Improve Counselling Service for each Profession

		GP	Counsellor	Total
more collaboration	count % within profession	6 19.4	6 18.8	12 19.0
specialist counselling	count %within profession	3 9.7	5 15.6	8 12.7
brief counselling	count % within profession	3 9.7	0 0	3 4.8
managed service	count % within profession	2 6.5	1 3.1	3 4.8
supervision & consultancy	count % within profession	1 3.2	2 6.3	3 4.8
appropriate referrals	count % within profession	1 3.2	2 6.3	3 4.8
offering groups	count % within profession	0 0	3 9.4	3 4.8
cognitive work	count % within profession	2 6.2	0 0	2 3.2
more contact with phct	count % within profession	2 6.2	0 0	2 3.2
seeing children	count % within profession	1 3.2	1 3.1	2 3.2
audit	count % within profession	1 3.2	1 3.1	2 3.2
paid admin.	count % within profession	0 0	2 6.3	2 3.2
training	count % within profession	0 0	2 6.3	2 3.2
securing funding	count % within profession	1 3.2	1 3.1	2 3.2
quicker assessments	count % within profession	1 3.2	0 0	1 1.6
medium term counselling	count % within profession	1 3.2	0 0	1 1.6
reducing waiting time	count % within profession	1 3.2	0 0	1 1.6
s. term behavioural	count % within profession	1 3.2	0 0	1 1.6
psychoanalytic counselling	count % within profession	1 3.2	0 0	1 1.6
developing psychology	count % within profession	1 3.2	0 0	1 1.6
different counselling	count % within profession	1 3.2	0 0	1 1.6
infrequent referrers refer	count % within profession	0 0	1 3.1	1 1.6
co-ord. with othertherapists	count % within profession	0 0	1 3.1	1 1.6

gender of counsellor	count	0	1	1
	% within profession	0	3.1	1.6
research	count	0	1	1
	% within profession	0	3.1	1.6
illegible	count	0	1	1
	% within profession	0	3.1	1.6
box ticked – no explanation	count	1	1	2
	% within profession	3.2	3.1	3.2
Total	count	31	32	63
	% within profession	100	100	100

TABLE A.09 To Show Reasons Given by GPs for Patients Returning to GP after Counselling Showing little Improvement

Reason	Number	Percent
Lack of patient motivation	67	74.4
Lack of patient insight	37	41.1
Inappropriate referral	35	38.9
Poor counselling skills	5	5.6
Relationship difficulties	4	4.4
Patient too anxious	2	2.2
Various	1	1.1
Other, not specified	1	1.1
Patient not ready	1	1.1
Patient too damaged	1	1.1
Counsellor unavailable	1	1.1
Ignorance of counselling	1	1.1
Unrealistic expectations	1	1.1
Poor attendance	1	1.1

TABLE A.10 To Show Reasons Given by Counsellors for Patients Returning to GP after Counselling Showing little Improvement

Reason	Number	Percent
Lack of patient motivation	28	63.6
Inappropriate referral	23	52.3
Lack of patient insight	18	40.9
Requires long term counselling	4	9.1
Unrealistic expectations	2	4.5
Poor counselling skills	1	2.3
Patient too damaged	1	2.3
Relationship difficulties	1	2.3
Patient not ready	1	2.3

TABLE A.11 To Show Responses to Open Question

		Profession		Total
		GP	Counsellor	
no response	Count	77	33	110
	% within profession	64.7	50	59.5
importance of service	Count	4	0	4
	% within profession	3.4	0	2.2
funding issues	Count	4	0	4
	% within profession	3.4	0	2.2
their own service	Count	7	5	12
	% within profession	5.9	7.6	6.5
DNA rate	Count	1	1	2
	% within profession	0.8	1.5	1.1
difficulty meeting	Count	2	2	4
	% within profession	1.7	3.0	2.2
counsellors' qualifications & standards	Count	3	0	3
	% within profession	2.5	0	1.6
about questionnaire	Count	4	5	9
	% within profession	3.4	7.6	4.9
comments about counselling	Count	3	1	4
	% within profession	2.5	1.5	2.2
GP with counselling qualifications	Count	4	0	4
	% within profession	3.4	0	2.2
info/feedback on study	Count	3	5	8
	% within profession	2.5	7.6	4.3

importance of teamwork	Count	1	2	3
	% within profession	0.8	3.0	1.6
married to clinical psychologist	Count	1	0	1
	% within profession	0.8	0	0.5
research on counselling	Count	1	0	1
	% within profession	0.8	0	0.5
illegible	Count	1	0	1
	% within profession	0.8	0	0.5
use service carefully	Count	1	0	1
	% within profession	0.8	0	0.5
cost effectiveness	Count	1	0	1
	% within profession	0.8	0	0.5
interest in subject	Count	1	0	1
	% within profession	0.8	0	0.5
importance of counsellors' support	Count	0	1	1
	% within profession	0	1.5	0.5
involve counsellor in decisions	Count	0	1	1
	% within profession	0	1.5	0.5
pay for admin	Count	0	1	1
	% within profession	0	1.5	0.5
different roles of counsellor	Count	0	2	2
	% within profession	0	3.0	1.1
provide service by team	Count	0	1	1
	% within profession	0	1.5	0.5
counsellors with medical background	Count	0	1	1
	% within profession	0	1.5	0.5
importance of the room	Count	0	1	1
	% within profession	0	1.5	0.5
flexibility of service	Count	0	1	1
	% within profession	0	1.5	0.5
primary care vs other counselling	Count	0	1	1
	% within profession	0	1.5	0.5
lowers referrals to psychiatry	Count	0	1	1
	% within profession	0	1.5	0.5
variation among GPs in approach	Count	0	1	1
	% within profession	0	1.5	0.5
Total	Count	119	66	185
	% within profession	100	100	100

TABLE A.12 To Show Cross Tabulation of GP Responses to Question 1 by Gender

“The GP in this practice highly values the counselling service”

GP Gender	strongly disagree	disagree	neutral	agree	strongly agree	Total
male	1	4	6	19	47	77
female	0	0	0	8	32	40
Total	1	4	6	27	79	117

TABLE A.13 To Show Cross Tabulation of GP Responses to Question 1 by Age

“The GP in this practice highly values the counselling service”

GP age band	strongly disagree	disagree	neutral	agree	strongly agree	Total
25 - 35 years	0	0	2	1	9	12
36 - 45 years	0	4	1	8	37	50
46 - 55 years	0	0	3	15	28	46
over 55 years	1	0	1	4	5	11
Total	1	4	7	28	79	119

TABLE A.14 To Show Cross Tabulation of GP Responses to Question 26 by years Practice has had Counselling Service

“Are the GPs sufficiently satisfied with the counselling service to want it to continue at this practice?”

No years practice has counselling service	Yes	No	Don't know	Missing	Total
0 –1 year	1	0	0	0	1
2 – 5 years	37	4	1	0	42
6 – 10 years	40	2	0	0	42
More than 10 years	29	0	1	0	30
Don't know	3	0	0	0	3
Missing data	0	0	0	1	1
Total	110	6	2	1	119

SECTION C

Case Study of a Male with a Sexual Compulsion

For reasons of confidentiality, the Case Study will not be presented in this volume.

SECTION D

The Etiology and Treatment of Domestic Violence: A Critical Review

INTRODUCTION

Domestic violence is the leading cause of injuries to women aged 15-44 years in the US (Novello, Rosenberg, Saltzman & Shosky 1992). It is estimated that 1.8 to 4 million women are assaulted by their current or former male partners each year (Horton 1992; Straus & Gelles 1990). Browne (1993) estimated that between 21% and 34% of all women will be physically assaulted during adulthood by a male partner. A woman is more likely to be assaulted and injured, raped or killed by a former partner than by all other assailants combined (Browne & Williams 1989). Findings indicate that domestic violence cuts across race, ethnicity and religion (Feldman & Ridley 1995).

Rationale

Looking at these figures it can be seen just how prevalent domestic violence is. The rationale for reviewing this area of counselling psychology is that due to the high incidence of domestic violence it is an area that counselling psychologists may often be faced with in their clinical work, either working with perpetrators of violence or their victims. The issue of domestic violence is, therefore, a particularly relevant area for counselling psychology and topical too, given recent government initiatives in this area (e.g. Ten Point Plan to Tackle Domestic Violence, March 2000). It is important that clinicians are aware of the issues involved with these client groups and available treatments in order to be able to offer clients the most appropriate and beneficial treatments. Such a review, therefore, may have implications for the training and practice of counselling psychologists in this area.

Aim

The aim of the review is to consider where psychology is now in relation to domestic violence in terms of theory and practice. The focus of the review will be on domestic violence between adult partners. The definition of domestic violence considered for the review is a definition given by Dutton (1992 p192) where it is viewed as “any physical act of aggression by a man against a woman with whom he is in an intimate relationship”. The limitations of this definition will be discussed. The different theories proposing to explain what causes a man to be violent towards his partner will be

critically reviewed. Treatments currently available to help such men (and sometimes their partners too) will be considered, as will the formats of such treatments. Efficacy of treatment will also be discussed as will the issue of female perpetrators of domestic violence. Due to the high incidence of domestic violence where substance abuse is involved, this issue will be discussed. The review will end with a summary and the implications for clinicians and researchers working in the area of domestic violence.

THE ETIOLOGY OF DOMESTIC VIOLENCE

Theories focusing on explaining the causes of domestic violence, although many, can be considered under three main categories;

1. Individual, psychopathology theories
2. Psychosocial theories
3. Sociocultural theories.

Each group will be considered in turn.

Individual Psychopathology Theories

This perspective proposes that intrapsychic dysfunction is the primary cause of male violence against women (Stordeur & Stille 1989). Such dysfunctions may be due to poor impulse control, passive aggressive tendencies, dependency and pathological jealousy (Feldman & Ridley 1995).

Of the three groups of theories, this group has probably received the most criticism for tending to shift the focus away from actual abusive behaviour and viewing it as a symptom of deep-rooted psychological illness (Bryant 1994). Other criticisms cited are that these theories fail to specify which abnormal personality traits or disorders are associated with, or predictive of, family violence (Straus 1980). Gelles (1993) argues that psychopathology theories are guided by circular reasoning where characterisations are used as both description of the behaviour and as an explanation for it.

Research also fails to support these theories as a cause of domestic violence. Hotaling and Sugarman (1986) found that few abusive men evidence diagnosable psychological problems, and for those who do, there is no consistent pattern of pathology. Other studies also support the above findings (e.g. Gelles 1974; O’Leary & Jacobson 1992; Parke & Colmer 1975). Psychopathology theories are also undermined by statistics that show a much higher prevalence of domestic violence in the population relative to the prevalence of significant pathology (Feldman & Ridley 1995).

Although no particular psychopathology profile exists, some characteristics are observed to be common to violent men and risk factors have also been cited that increase the probability for the occurrence of abuse (Bryant 1994). For example, low self-esteem; past history of abuse; alcohol abuse.

Theories of psychopathology have also attempted to profile abused females. It is suggested that such women are depressed, suicidal and masochistic (Kleckner 1978; Rosewater 1988). However, these symptoms may be present as a result of the violence rather than character traits (Rosewater 1988). Therefore, the relationship between domestic violence and psychopathology remains unclear. O’Leary (1993) states that

“...as the level of physical aggression increases, the greater the likelihood that some personality style, trait or disorder will be associated with physical aggression” (page 25).

Psychosocial Disorders

The psychosocial theories on domestic violence tend to focus on the relationship between the violent individual and his environment or on the relationship between the abuser and his partner. Systems theory emphasises that violence stems from a dysfunctional relationship, proposing that pathology lies in the relationship itself rather than in either individual (Hansen & Harway 1993). However, this theory has been criticised for minimising the severity of the problem and implying an equal distribution of power in the relationship. Such theories may also be seen to excuse male violence (Orme, Dominelli & Mullender 2000).

In this group of theories can be placed the social learning theory of domestic violence. This theory proposes that aggressive and violent behaviour are learned responses, acquired and maintained by direct experience and the observation of others. This theory

asserts that individual differences in behaviour patterns may be explained by prior experience, reinforcement patterns and cognitive patterns (Bandura 1973, 1986; Patterson 1982). This theory has probably had the most global impact on both research and treatment within this field (Feldman & Ridley 1995). The social learning theory stresses the importance of determinants in the individual's environment and also that reactions to events are cognitively mediated (Feldman & Ridley 1995).

The theory of social conflict can be placed within this group. This theory (Dahrendorf 1968; Sprey 1969) proposes that social conflict is an inevitable and even necessary part of social relationships as we seek to further our own interests. The emphasis is on how to resolve conflict. Violence may be seen as a powerful way of resolving conflict when other ways of pursuing individual or group interests break down due to faulty conflict management processes, skills or options (Dahrendorf 1968; Sprey 1969). However, this theory has yet to be empirically supported (Margolin, John & Gleberman 1988).

Sociocultural Theories

Stordeur and Stille (1989) propose that the sociocultural context in which domestic violence occurs is at the root of the problem. Men who abuse women, it is suggested, are living up to a particular cultural expectation regarding male dominance, aggression and female subordination coupled with an unequal distribution of power between the sexes (Bryant 1994). Feminist based explanations view the problem of partner violence as a microcosm of the relationship between men and women in society (Feldman & Ridley 1995).

Sociocultural theories have been criticised on several grounds. As a 'single factor' theory it does not provide a useful explanation for family level behaviour, which appears to be determined by multiple factors (Gelles 1993). These theories, it is argued, fail to account for violence by females. Some studies (Arias & Johnson 1986; Riggs, Murphy & O'Leary 1989) have shown that violence against women is viewed by men as socially *undesirable*, this evidence directly challenges feminist theories that argue the opposite is the case. Finally, these theories fail to account for the large number of men living within a patriarchal society who are not violent (Feldman & Ridley 1995).

Therefore, although it is generally accepted that societal and cultural factors do have a role in the acquisition and maintenance of domestic violence – in themselves they may not be a sufficient risk factor.

The different theories attempting to provide an explanation for the causes of domestic violence, while striking stimulating debate and discussion on this issue, have not generally served as a strong guide for empirical research (Riggs & O’Leary 1989). Feldman and Ridley (1995) suggest several reasons why this may be. Firstly, there is a consensus amongst researchers in this area that domestic violence is multi-determined and involves the interaction of a large number of factors and cannot be explained by a single factor. Secondly, research supporting one theory over another has often reported moderate or inconsistent association for potential correlates of violence. These factors have led to a difficulty for researchers in distinguishing among causes, maintaining factors and consequences of domestic violence.

THE TREATMENT OF DOMESTIC VIOLENCE

In this section issues around the type of treatments offered for perpetrators of domestic violence will be reviewed as will issues around treatment format.

Treatment Format

The format of treatment for those involved in domestic violence has been the subject of substantial debate (Feldman & Ridley 1995). Three treatment formats shall be considered; one-to-one therapy, group therapy, and couple therapy.

One-to-one Counselling

This is a treatment format available for one or both partners where domestic violence is present. For the violent male, the type of counselling offered may be behavioural/cognitive behavioural or it may be insight orientated and follow a psychodynamic model. Whatever the model of counselling offered, the male is usually expected to assume total responsibility for his violence regardless of any participation or provocation by his partner (Feldman & Ridley 1995).

Individual therapy for the female victim of the abuse often focuses on her victimisation, safety and absolution of responsibility, providing her with support, guidance and empowerment and to help her effectively use police intervention (Feldman & Ridley 1995).

It has been argued (e.g. Stordeur & Stille 1989) that individual counselling creates an adversarial climate in which the abuser views the counsellor as an arbitrator and counselling is perceived as persecution and not treatment. However, if the counsellor is suitably trained to work with this client group and these issues can be openly addressed in the counselling, this form of treatment may be used effectively and viewed in a positive way by the abuser. Another criticism of individual therapy for domestically violent men, is that it can be restrictive and may reinforce feelings of shame and guilt as well as feelings of isolation in the abuser (Bryant 1994). However, it could be argued that the abusive male needs to work through such feelings in order to fully address his behaviour and the effect it has on others.

Group Treatment

The treatment of domestically violent men through short term (10-16 weeks) group programmes represents the majority of treatment programmes available (Dutton & McGregor 1991; Ganley 1981; Gondolf 1985). The research suggests that group therapy offers a therapeutic climate that is particularly effective and amenable to working with violent men. Stordeur and Stille (1989) state that such treatment has been proven to be the most effective and highly recommended approach for treating domestically violent men.

Brand (1989) states three principles that guide his group approach with this client group. Firstly, that violence is always the issue to be addressed. Secondly, a man's violence is always the man's responsibility. Thirdly, while his behaviour is violent, the issue is the man's need to have power and control over others, particularly his wife and family.

The content of treatment programmes varies from group to group but is often based on psycho-educational techniques. It is argued that this approach is more effective for a

group intervention than a psychotherapeutic approach (Bryant 1994), as the violence is viewed as a learned behaviour that can be unlearned, rather than as an “illness” (Edleson 1992). A group setting for treatment can allow for non-judgemental feedback from others in the group and men can learn to express their emotions other than anger with the help of the group members (Bryant 1994). Men in groups have the opportunity to role play and rehearse domestic disputes and to identify and challenge distorted beliefs (Pence & Paymar 1993). Some groups have a closed membership in which members begin and end their group experiences in a limited number of sessions. Other groups are open-ended and have the advantage of senior group members using their understanding to challenge and support incoming members (Edleson 1992). A number of men are placed in group programmes by the court. They may be defiant and hostile. Therefore, Bryant (1994) argues, the group facilitator must project a directive, yet non-authoritarian style when leading these groups. Such groups need to maintain an atmosphere within them that fosters critical thinking and avoids any collusion with the negative attitudes of the violent men.

There is some evidence, although scarce, that indicates that group treatments are effective in decreasing violent behaviour in male abusers (e.g. Dutton 1986; Tolman & Bennett 1990). This issue shall be addressed more fully when discussing treatment efficacy.

Couple Treatment

In couple therapy both partners are seen together. This form of therapy is usually based on a behavioural approach or on a systemic approach to treatment. In behavioural couple therapy the main components of the therapy are; behavioural exchange (providing each other with more reinforcers); communication (assertiveness and listening); and problem-solving training (Jacobson & Margolin 1979). The systemic approach focuses on the dysfunction within the relationship.

Whichever approach is adopted, conjoint therapy may imply there is a mutual problem to be solved and this almost inevitably slides into the implication of mutual responsibility for it (Goldner, Penn, Sheinberg & Walker 1990). This is the major criticism levelled at couple therapy as a treatment format for domestically violent men and their partners.

Feminist clinicians have strongly recommended against couple therapy citing reasons of a compromised therapeutic alliance and lack of safety for the woman. They also argue that it is an intervention that blames the woman and gives reduced leverage to work with the abuser (Bograd 1992). This point is strongly contested by proponents of couple therapy, advocates of behavioural or systemic couple therapy argue for the increased attention couple therapy gives to the family as a focus of intervention and that it draws our attention to the prevalence and nature of mutual abuse (Margolin 1979; Neidig & Freidman 1984; Stacey, Hazlewood & Shupe 1994; Taylor 1984).

Approaches to Treatment

In this section the treatment approaches offered for perpetrators of domestic violence shall be reviewed. Debate has often focused on the goals and content of treatment, particularly who should be the subject of treatment (the abuser, the partner, or both) (Feldman & Ridley 1995). The different interventions currently available may be considered in three groups; the behavioural approach to treatment, the systemic approach and the psychodynamic approach. There is, of course common ground between these approaches. Finally, treatment efficacy shall be considered.

The Behavioural Approach

This treatment is based on behavioural theory. It focuses on the dynamics of domestic violence from within this framework, looking at the antecedents, the behaviour and the consequences of domestic violence. Escape and avoidance of verbal abuse and physical assault are important in controlling a woman's performance of housework and for her to be sexually compliant (Myers 1995). Similarly, punishment controls a woman's assertion and refusal and a man may receive positive reinforcement for using verbal and physical aggression (Myers 1995). These contingencies are seen to maintain the man's violence whilst keeping the woman in a subservient position (Myers 1995).

Intervention programmes for domestically violent men based on this approach may take the form of one-to-one therapy, couple therapy or group therapy. All interventions, taking whichever format are based on the social learning concepts.

“Men batter because their culture devalues women, it teaches men to batter, it fails to teach alternatives to controlling and battering and it fails to provide behaviour reducing consequences for battering” (Myers 1995, p 500).

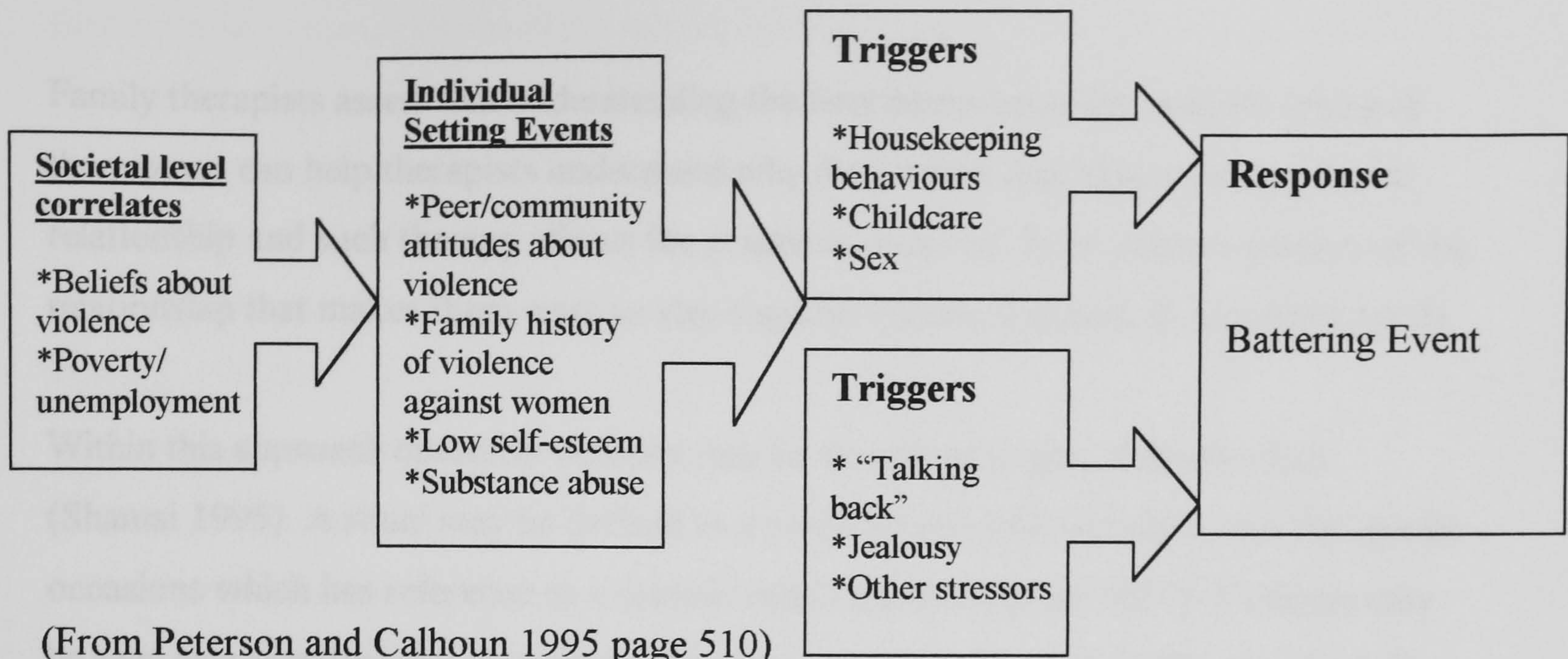
Such an intervention may use cognitive- behavioural and psycho-educational techniques and the learning of well established behavioural practices. The violent man may be asked to monitor his behaviour and to identify the antecedents, describe his feelings to the therapist or other men in the group or his partner in an assertive, non-coercive way. The man may learn to articulate the effects of his abuse on his partner, make regular contacts with other participants (if in a group) to discuss non-violence. The development and use of a safety plan if the man is in a stressful or anger provoking situation, stress management, anger management and assertiveness training may also be used (Myers 1995).

Peterson and Calhoun (1995) present their model (Fig 1.0, page 277) of the antecedents for battering and argue that it is important to consider different levels of analysis and they propose to extend the existing behavioural model of domestic violence based chiefly on the work of Myers.

Peterson and Calhoun (1995) argue that any intervention should reflect these different levels and that some behavioural approaches only focus on the male abuser's behaviour but that *his* behaviour is the least likely to change voluntarily. They argue that any approach should not address the abuser and the beaten woman in isolation but they should be considered as mutually dependent (this is a view shared with systemic therapists). The individual most motivated for behaviour change is the woman, they argue. They feel what is necessary is an intervention based on identification of relevant avenues for behaviour change and a diagnostic process to identify those couples (if any) for whom behavioural marital therapy may be effective and those women who need to leave the relationship.

The biggest criticism levelled at behavioural-based approaches to treatment (be they one-to-one therapy, couple therapy or group therapy) is that they do not address the underlying problems that may be driving the violence (Gauthier & Levendosky 1996). Simply changing behaviour alone, it is argued, without helping the man to understand why he chooses to be violent, does not fully address the causes that will likely lead to

Fig. 1.0 Model of Antecedents for Battering



further violence (Gauthier & Levendosky 1996). Similarly, feminist and pro-feminist writers have criticised behavioural-based interventions as too narrowly focused on overt behaviour change and not sufficiently addressing the abuse and violence as a social problem embedded in a sexist, patriarchal social structure (Gondolf & Russell 1986; Walker 1979).

However, some behaviourists are attempting to address these criticisms and state that it is important for behavioural analysts to do more than treat violence (Peterson & Calhoun 1995). The model presented by Peterson and Calhoun (1995) is a recognition that certain individual histories (e.g. that punishment will be used to control behaviour); skills deficits; and societal conditions (e.g. poverty), can be risks factors for domestic violence and that these issues must all be considered when treating those involved in domestic violence.

The Systemic Approach

This treatment approach is based on the systemic model and is usually in the form of couple therapy. The focus of treatment is on the relational patterns of the couple and violence is seen as a symptom of a larger, shared, systemic problem (Gauthier & Levendosky 1996). Reciprocities and complementary patterns in the couple’s relationship are implicated in the cycle of violence (Goldner, Penn, Sheinberg & Walker 1990). This approach rejects the feminist assumption that only the male ever needs

counselling to halt violent tendencies and that it is solely his problem (Shupe, Stacey & Hazlewood 1986).

Family therapists assert that understanding the interdependence between the man and the woman can help therapists understand why the woman may choose to stay in the relationship and such therapy allows the couple to focus on those positive aspects of the relationship that makes them want to stay together (Sirles, Lipchick & Kowalski 1993).

Within this approach domestic violence may be viewed as a type of family ritual (Shamai 1995). A ritual may be defined as a prescription of formal behaviour for special occasions which has reference to a specific belief system (Turner 1967). Violence may be seen as a repetitive process which is known to members of the family and which fits a certain set of beliefs and meanings within the family (Bograd 1988). The violent episode can be seen to function as a means by which the hierarchy and roles in the family are clarified or redefined (Shamai 1995). The therapist must, therefore, try to empower the family with substitute rituals which might replace the cycle of violence without ignoring the couple's belief systems. In order to achieve this, the therapist works with multiple meanings on behavioural, cognitive and emotional levels (Shamai 1995). The couple may be asked to sign a contract promising to immediately end the violence. The continuation of couple therapy is often contingent upon the man signing the contract. The contract the woman signs is different, emphasising that she is not responsible for the violence.

The systemic approach to treatment has been subject to fierce criticism. As a form of conjoint therapy it is subject to the criticisms already cited, namely that the abuser and the abused are seen to be mutually responsible for the violence. However, family therapists argue strongly against this. Rosenbaum and O'Leary (1986 p390) state that while the couple is "mutually responsible for the marital discord, the husband alone is responsible for his violent behaviour".

Walker (1995) asserts that family systems therapy is not recommended as the initial treatment for domestic violence because of the inequality of power in the male-female relationship. Abused women who have not yet moved from being victims to survivors are frequently unable to perceive the neutrality necessary in family therapy (Walker 1995). This is an often cited criticism against family therapy, that 'neutrality' may be

inappropriate in dealing with domestically violent men and may undermine the process of healing from the trauma of the abuse (Feldman & Ridley 1995). Some family therapists have also questioned the appropriateness of neutrality when working with this client group (e.g. Bograd 1992). Ganley (1989 p221) states that a neutral stance “*may be therapeutic on some issues but not in the cases of family violence... (as it) seems to ignore the power of the violence*”.

Bograd (1992) also argues that family therapists must not remain neutral on the issue of domestic violence because silence about our values on this issue may be viewed as consent to violent actions. Bograd (1992) goes on to say that in facing the issue of domestic violence, family therapists must grapple with the limitations of their familiar and comfortable theories that were not originally conceived to deal with these issues.

Another criticism of family therapy as a treatment choice, that comes from family therapists themselves, is that they are not well equipped to detect marital violence amongst couples they work with (Aldarondo & Straus 1994). Aldarondo and Straus (1994) cite several possible reasons, some client based, others therapist based, why violence may not be detected. For example, the fear and perceived risk of victimisation may prevent a couple from disclosing abuse or the therapist may fail to directly ask about violence. The authors argue that family therapists must face the problem of domestic violence with the same rigor and imagination that characterises their treatment of other conditions.

Although there are several criticisms about the use of a family systems approach to the treatment of domestic violence (both from within and outside the systemic school), there is a sense that family therapists are becoming increasingly aware of the limitations of their way of working with this client group. Some of the aforementioned criticisms are being addressed and, in some cases, therapists are trying to adapt their ways of working. For example, Goldner et al (1990) present a model of treatment based on systemic thinking which also incorporates a feminist stance. Meth (1992 p261) states,

“...a treatment programme that holds a man accountable for his behaviour... is not necessarily incompatible with a systems perspective. I strongly believe that what makes a treatment modality systemic is not simply the unit of treatment”.

The Psychodynamic Approach

This treatment approach is based on psychodynamic theories where acts of violence may be viewed as the manifestation of complex intrapsychic and interpersonal behaviour and may be a repetition of earlier childhood experiences (Rosen 1991). This treatment approach is insight orientated and focuses on the man's violence and on underlying problems that lead to violence. These approaches tend to look to the recognition of and adjustment of, impaired internal (ego) functions such as low self-esteem and poor impulse control, as a way of diminishing violence (Myers 1995).

The psychodynamic approach to treatment can be used in an individual counselling context or in a group setting. As its strengths, this approach can enable the man to see a connection between his violence and past experiences as a child and it can give him a greater understanding of why he is violent. Also, the exploration and understanding of childhood history gives the therapist the opportunity to empathise with the abusive man as once having been an abused or neglected child (Gauthier & Levendosky 1996). However, the main criticism of this approach is that environmental or societal and cultural influences are largely ignored. Also, whilst giving the abuser a greater insight into his behaviour – this treatment approach does not focus on strategies or techniques to help the violent man deal directly with his violence.

The Efficacy of Treatment

The majority of outcome studies on available treatments for domestic violence have evaluated group interventions for men (Feldman & Ridley 1995). The results obtained are of limited value as some studies did not employ control or comparison groups (Edleson 1990; Rosenfeld 1992). However, studies carried out so far do suggest that a group intervention for male perpetrators of domestic violence can be effective. During the first 6 – 12 months after treatment, between $\frac{1}{2}$ to $\frac{2}{3}$ of men seem to stop violence completely, other men substantially reduced their frequency of violence (Feldman & Ridley 1995).

A limited number of studies comparing treated subjects with untreated controls also suggest that some treatments can significantly reduce recidivism compared to no treatment (Feldman & Ridley 1995).

Edleson and Myers (1991) compared men on a structured, educational programme with men on a less structured self-help programme. They found that 18 months post treatment fewer men on the self-help programme were violent than men on the more structured programme. These findings seem to contradict a study carried out by Edleson, Miller, Stone and Chapman (1985) where violent men were randomly assigned to one of three treatment models; educational, self-help or a combined model. Six months post treatment, their partners reported that the structured educational and the combined models both significantly reduced the recidivism rate for direct violence or threats.

Overall, the studies carried out so far do seem to suggest that treatment for these men can significantly reduce their levels of violence. However, for many men treatment does not stop violence altogether. Therefore, due to the small number of studies carried out results should be interpreted with caution. Clearly more evaluative studies are needed in this area.

MEASUREMENT OF VIOLENCE

Therapists have available to them different measurement instruments for use in assessing levels of domestic violence. The three most commonly used scales shall be reviewed.

The most widely used scale to measure domestic violence is The Conflict Tactics Scale (CTS) (Straus 1990). This scale consists of three verbal report scales measuring;

1. Reasoning. For example; “discussed an issue calmly”, “got information to back your side”.
2. Verbal aggression. For example; “insulted or swore at other”, “threatened to hit or throw something at other”.

3. Physical aggression. For example; “minor violence: punched, slapped”, “severe violence: beat up, choked”.

This scale has been used in three studies of nationally representative samples of US couples and has detailed normative tables by age and gender (Kaufman, Jasinski & Alarondo 1994; Straus & Gelles 1990; Straus, Gelles & Steinmetz 1980). A test manual with over 200 references to the CTS and documentation of its validity and reliability is available (Straus 1989).

Apart from empirical support for the CTS, it also has practical advantages. It takes only a few minutes to administer within an interview or as a self-administered questionnaire. It targets specific behaviour and so minimises the possibility that respondents must first recognise their behaviour as violent in order to respond (Aldarondo & Straus 1994). The questionnaire can be completed by either or both partners.

The most frequently cited criticism of the scale is that it measures only the frequency and severity of the attacks and not the extent of the injury (Aldarondo & Straus 1994). Myers (1995) makes the point that, so called, “minor” violence and some verbal aggression items involve physical aggression and intimidation, and also that the same violent act may have a different effect when done by a man than a woman. Despite these criticisms, the CTS does provide a useful assessment tool for the therapist to determine the frequency and severity of violence between a couple.

Two other scales used in the assessment of domestic violence shall be briefly discussed. The Index of Spouse Abuse (Hudson & McIntosh 1981) measures both physical and non-physical abuse. The 30 items in the questionnaire also address issues such as sexual coercion, intimidation and domination. Aldarondo and Straus (1994) argue that the scale, although providing useful information, mixes physical violence with other forms of violence. A woman could, therefore, receive a high score on the ‘violence’ subscale without ever having been physically assaulted.

The Wife Abuse Inventory (Lewis 1983, 1985) was designed to identify abused women or women at risk of being abused. The woman rates her partner and herself on a number of ‘family management matters’. Only two items measure physical violence. A criticism of this questionnaire is that the questionnaire focuses on the risk of abuse rather than

detecting whether violence has occurred or is occurring (Sedlak 1988). However, this may also be seen as a strength of the questionnaire, as it may allow the therapist to intervene in a situation to prevent violence from occurring.

Although each inventory has its potential uses, it is important that the therapist is also aware of their limitations. The inventories may best be viewed as a useful aid to assessment and are only part of the assessment process.

VIOLENT WOMEN

There has been little discussion in research papers about treating women who are perpetrators of domestic violence (Hamberger & Potente 1994). Hamberger and Potente suggest two main reasons why this may be. Firstly, the actual rates at which women batter their male partners are low compared to male battering of female partners 5% vs 95% (Pagelow 1984 & 1992). However, this large difference in reported rates may be partly affected by the under-reporting of female violence by males due to the stigma attached to male victims and the lack of services able to respond to, and believe, male victims. Secondly, the injuries inflicted by women seem to be less severe than those inflicted by men (Straus & Gelles 1986). Another possibility for the lack of attention in this area, is that for historical reasons men have been viewed as violent and the women's movement have suggested this reflects the sexist society in which we live. Consideration of female perpetrators of domestic violence does not fit neatly with this view.

Yet two national surveys in USA have shown that the rate of increase of physical assaults on men by their female partners is equal or slightly higher than rates of increase of male-to-female violence (Steinmetz 1977, 1978; Straus & Gelles 1986; Straus, Gelles & Steinmetz 1980). It has been proposed that abuse and traumatic experiences increase the likelihood that females may demonstrate aggressive behaviour in interpersonal conflict situations (White & Humphrey 1994). Pollock (1996) concludes from his clinical work with this group of women that dissociative states may be an influential factor in the commission of violent acts in some cases of adult survivors of sexual abuse.

This leads on to the question of whether or not domestic violence by women can be viewed as being different from that perpetrated by men. Mason and Blankenship (1987)

propose that in husband battering the type of women who are likely to inflict abuse are those who are highly stressed, have a high need for power and a low inhibition of activity. This would fit with the views held about male perpetrators and may initially suggest that there is little difference between male and female violence. However, the authors also found that when women struck out they were usually struck in return.

Hamberger and Potente (1994) also question whether domestic violence is a 'two way street' and whether traditional socio-political views on domestic violence are inaccurate, as some have suggested. They conclude that the context of female violence *is* different from men's, recognising women's powerlessness and victimisation and they suggest that women are often violent towards their male partners through self-defence. Any intervention with such women must, therefore, reflect these differences. Saunders (1986) found that among women in shelter, 71% who used violence did so in self-defence. However, using women in a shelter as the sample will bias the sample towards women who have been abused by their partners. Barnett and Thelen (1992) compared the motivations of male batterers and battered females who had used violence. They found that women were more likely to identify self-defence as their primary motive for violence, whereas men identified control and punishment.

The widely held view among professionals and researchers in this area is that domestically violent women are a group of battered women who have become caught up in a pattern of violence that, in most cases, they did not initiate and do not control (Hamberger & Potente 1994).

Any intervention with this group of women would be based on this view. Although the woman is said to be "responsible" for the violence, she is not "blamed" for it (Hamberger & Potente 1994). Although an immediate goal is to stop the violence and protect the women and children, the literature pays little attention to the needs of the children who may require protection from their mother as well as her partner and for the woman to recognise the impact of her actions on her children.

The other goals of intervention may include empowering women to break through their isolation, to identify their resources and to assess immediate safety. This may be achieved through developing assertiveness and self-esteem, through cognitive-behavioural strategies and anger management techniques (Hamberger & Potente 1994).

However, there remain a number of women who are the primary perpetrators of domestic violence. That is, these women are not acting in self-defence when they batter their partner. For these women, it is suggested they follow a similar treatment programme to men (Hamberger & Potente 1994). There may be situations where it is not clear who is the primary perpetrator of the violence and it may be difficult for the therapist to assess this.

Research carried out on gay women who have been violent in their relationships with other women found that violent gay women showed similar personality and psychological characteristics as heterosexual male abusers (Fortuna 1999).

The issue of male abuse by females appear to be gaining a slightly higher profile in the media and recent research appears to directly challenge previously held assumptions about male victims and female perpetrators, particularly the assumption that the female is always acting in self-defence when violent to her partner. Following a successful documentary on domestic violence by *Dispatches* (Channel Four), the programme makers were approached by men to address the issue of violent women. In January 1999 a documentary on this issue was aired by *Dispatches* (Channel Four). A survey, the first of its kind on the subject of female abuse was carried out. One hundred questionnaires completed by male victims were analysed (situations where the man was the aggressor and the woman was responding in self-defence were excluded from the study).

Dispatches found one area of difference between female and male battering being how the violence was carried out. Most of the men surveyed were bigger and stronger than their partners, but the women compensated for this by using a weapon (half the men surveyed indicated this), or attacking the man when he was vulnerable (e.g. many men reported to being attacked whilst asleep). Three quarters of the men reported not retaliating, fearing that if they did they would kill their partner. The male victims reported feeling trapped and controlled by their female partner. Another similarity with female victims was the finding that many of these men had low self-esteem, were socially isolated, had high levels of depression and some were suicidal. The response of the police was found to be poor. Most of the men questioned who contacted the police found the police offered them no protection and frequently did not believe them. Such reporting on television of this issue is clearly important to raise the profile of female

violence in the public's awareness. Since the Dispatches programme, daytime TV has also addressed this issue (Kilroy, BBC1 1999).

Although female violence is an area that is beginning to be addressed, more research is needed to look at which types of interventions may be useful for which types of women. The issue of the etiology to female violence needs to be explored and issues of working with male victims of such abuse.

SUBSTANCE ABUSE & DOMESTIC VIOLENCE

There is general consensus amongst researchers in this area that alcohol is the drug most commonly associated with violence (Maiden 1996). Research has shown that an average of 60% of domestically violent men were intoxicated at the time they were violent and an average of 53% of such men were assessed to have a drug and/or alcohol problem (Tolman & Bennett 1990). Alcohol has been shown to play a role in the occurrence of violence among newly married couples and the presence of alcohol (particularly amongst men) is associated with the occurrence of physical, rather than verbal, aggression (Leonard 1999).

Apart from a statistical association between alcohol abuse and domestic violence, families where such abuse occurs often share characteristics (Bennett 1995). For example, they show frequent crisis states, isolation of the non-abusive partner and poor emotional development in the family (Bennett 1995). Many practitioners assume that substance abuse is the primary cause of violence towards women. However, most men who abuse alcohol and/or drugs are not violent towards women and many episodes of violence do not involve alcohol or drug use by the perpetrator or the victim. Therefore, other factors must account for the relationship between substance abuse and domestic violence (Bennett 1995).

Different theories have been put forward to explain the link between alcohol abuse and domestic violence. The disinhibition model proposes that alcohol acts to "release" many forms of constrained behaviour (Feldman & Ridley 1995). Despite its popularity, this model is often discredited as research shows that expectation of intoxication is a better predictor of aggression than intoxication itself (Lang, Groekner, Adesso & Marlatt

1975). Another model proposes that cognitive disruption can explain the relationship (Leonard & Jacob 1988; Pernanen 1991). It is argued that substance abuse can impair functioning by reducing the users ability to process information (Bennett 1995). Violent men, more than non-violent men, misinterpret the actions of their partners as abandonment or engulfment (Dutton 1988) and alcohol and/or drug abuse can exacerbation this distortion. A third model asserts that the alcohol-aggression relationship is conditioned by individual power concerns (McClelland, Davis, Kalin & Warner 1972). A large quantity of alcohol for social drinkers, or any quantity for problems drinkers, increases their sense of personal power over others. Also a man concerned with personal power and control is more likely to drink heavily and to be aggressive (Bennett 1995).

Alcohol or substance abuse may not be confined to the perpetrator of violence. Alcoholic women receive greater levels of physical and verbal abuse than non-alcoholic women (Miller, Downs & Gondoli 1989). A woman using drugs or alcohol increases the likelihood she will be a victim of domestic violence, increases the likelihood that her partner will be also be drinking when he abuses her and increases her chances of personal injury (Bennett 1995). Research has suggested a relationship between the severity of abuse and alcohol use among battered women (Clark & Foy 2000).

Substance abuse is a strong predictor of violent abuse recidivism and non-compliance with treatment (Bennett 1995). Due to the strong relationship between the two, one might predict that if substance abuse were treated there would be less likelihood of domestic violence (Maiden 1996). In his study of alcoholics engaged in treatment for alcohol abuse, Maiden (1996) found that such treatment reduced the incidence of domestic violence, but did not eliminate it. This research supports the view that alcohol abuse, whilst exacerbating domestic violence, does not cause it.

Looking at treatment issues, Bennett (1995) asserts that therapists working with this client group should not send the client to specialist agencies but must recognise the complexity of the situation. Instead, practitioners must assess and evaluate the extent of both the violence and the substance abuse. Bennett (1995) suggests that substance abuse treatment should, ideally, precede treatment for violence or if not, the programmes should run concurrently. Intensive community care management is essential to ensure

that such men do not fall between the cracks but receive appropriate treatment addressing both problems.

SUMMARY

This review has looked at the area of domestic violence focusing particularly on etiology and treatment. Different theories have been presented and criticised. Available treatments seem to fall into three main groups, each approach with its strengths and limitations.

The way forward may be to consider treatment for violent men/women that draws on the strengths of the different therapies currently available, i.e. an integrated model of treatment. Such a model is argued for by Gauthier and Levendosky (1996). They argue that there is currently a rift between the different approaches to treatment, particularly between the systemic and the feminists approaches. The authors state that none of these models alone provides a complete enough framework for treatment. Professionals in this area using a single treatment approach are becoming increasingly aware of the limitations of doing so and seem to be drawing on the strengths of other approaches. For example, the model put forward by Peterson and Calhoun (1995), although based on behavioural principles, also considers ecological factors and individual histories as important determinants for domestic violence.

Systems therapists – whose approach to treatment has received the most criticism – are beginning to clarify their position on the issue of mutual responsibility. Many such therapists seem to be saying that the man alone is responsible for his violence, but that the couple are mutually responsible for the difficulties in the relationship. This clarification seems to answer some of the criticism levelled at them, particularly by feminist theorists.

The focus of treatment should, as far as possible be multi agency. A number of families where domestic violence is present may have several agencies involved, e.g. the police, social services, mental health professionals or voluntary agencies. Where this is the case, there should be close collaboration between professionals.

Outcome studies carried out to date have failed to show consistent support for one form of treatment. This may support the view that an integrated treatment approach is most successful. Further research is clearly needed and also a way to overcome present methodological problems, e.g. with case control and outcome measurement criteria and assessment; also heavy reliance on self-report which may not be entirely accurate. Much research has tended to focus on group interventions for violent men, more is needed to evaluate other forms of treatment and on individual and couple therapy.

There is increasing public and media awareness that women can, and do, perpetrate domestic violence. Although current research suggests that in the majority of cases violence is used in self-defence. Hopefully, as this area receives more attention from researchers, more treatment approaches tailored to the particular needs of women will be developed and outcome studies carried out to evaluate them. Highlighting this issue should make it possible for more male victims of domestic violence to come forward for help and for available services e.g. the police and health professionals to be able to respond appropriately. A broadening of the definition of “domestic violence” is needed, as most current definitions see the perpetrator as male and the victim as female, and therefore need updating.

That there is a link between domestic violence and alcohol is unquestionable but the type of relationship remains contentious. Although research seems to support the assertion that alcohol does not cause domestic violence. Again, particular treatment approaches tailored to the particular needs of clients with the dual diagnosis of alcohol or drug misuse and violent behaviour are needed.

IMPLICATIONS

The implications from this review appear to centre on how counselling psychologists (as well as other professionals e.g. the police, social services) may review and improve their practice in the area of domestic violence. There are also implications in terms of research.

Firstly, the review suggests that the issue of domestic violence may be best considered as a complex one. Therefore, a single model theory in terms of etiology and treatment does not appear to be appropriate. The various models reviewed all appear to offer a

partial explanation for the causes of domestic violence. This has implications for practitioners in that there needs to be a flexible approach to treatment and one that best fits the particular needs of the client. For example, some clients may benefit from one-to-one counselling, others may benefit from group counselling. In terms of the issue of couple therapy for those involved in a violent relationship, it seems that such therapy may not be appropriate for some couples. For example, in a situation where one partner may feel unsafe discussing the violence in the presence of the other. It seems to depend on where the couple is in addressing their problems. For a couple where there is mutual abuse and both partners seem willing and able to look at their role in the violence, such therapy may be extremely useful.

The issue of male victims of domestic violence has implications for clinical practice. This requires counselling psychologists to be aware that women can and do perpetrate violence to their male partners. This may mean some practitioners challenging previously held views and assumptions on this issue. It will also mean training for all practitioners in this area on how to work with male victims as more men begin to come forward and seek help.

Counselling psychologists also need to be aware of the particular needs of men/women who are violent and also abusing drugs or alcohol. The review suggests that the needs of many of these clients are not being addressed and they easily fall through the net of different services. Also that such clients tend not to comply well with treatment. Therefore attention needs to be paid to how to address this problem. This requires different agencies working together to ensure that such clients do not fall through the net or end up being transferred from one service to another.

The importance of collaboration between the various agencies involved in the area of domestic violence (e.g. the police, social services, mental health professionals) is stressed. This requires practitioners to liaise regularly for the benefit of the client; research suggests that this is not happening as much as it should. Counselling psychologists have a role to play in promoting good collaborative practice. Another related issue concerns the safety of practitioners when working with violent people. It may be appropriate to consider training for counselling psychologists to help us deal with potentially dangerous situations.

In terms of research, clearly, more needs to be done in researching male victims of domestic violence, so that the extent of this problem may be assessed. From such research appropriate help may be made available to such men. The review has highlighted gaps in present research. Namely the need to research what types of treatments may work best for which client groups. This is important for efficacy and cost effectiveness of treatment.

CONCLUSION

This review set out to consider where psychology is now in relation to domestic violence in terms of theory and practice. Through doing so this paper has raised important issues for counselling psychologists.

This paper argues for an integrated approach to working with men and women involved in domestic violence due to the complex nature of this problem. This also involves counselling psychologists considering each case on an individual basis. Our work with such clients may be influenced by our own experiences in relationships and our assumptions about what is right for the person being abused. We need to be aware of how these beliefs may unduly influence therapy. It is also important to recognise our ethical obligations as well, for example, in situations where, as practitioners, we may need to override the wishes of the client if children are at risk.

The literature reviewed is diverse and at times controversial. The prevalence and potential consequences of domestic violence ensure that it is an area where psychology will hopefully continue to contribute (in both research and clinical practice) as psychology (particularly counselling psychology) still has much to offer in advancing our knowledge about domestic violence.

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