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# Changing the public attitude towards psychologists

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*University of Wollongong*

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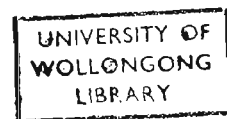
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# **CHANGING THE PUBLIC ATTITUDE TOWARDS PSYCHOLOGISTS**

A thesis submitted in partial fulfilment of the requirements for the award  
of the degree

DOCTOR OF PHILOSOPHY (Clinical Psychology)

from



UNIVERSITY OF WOLLONGONG

by

BARRY M. McNAMARA B.A.(Hons)(Psych), B.Sc.(Hons), B.Ed.

DEPARTMENT OF PSYCHOLOGY  
1993

**University of Wollongong**  
**Candidate's Certificate**

I certify that the thesis entitled "Changing the Public Attitude Towards Psychologists", and submitted for the degree of Doctor of Philosophy (Clinical Psychology), is the result of my own research, except where otherwise acknowledged, and that this thesis (or any part of the same) has not been submitted to any other university or institution.

## Acknowledgements

This study would not have been completed without the invaluable contribution of a number of people who provided me with expert comment, moral support, and continuing encouragement.

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I would also like to thank the participating organisations (who wish to remain anonymous) who enabled me to access their employees and their workplaces to implement this study. I am pleased that the exercise proved useful to them as each of them decided to continue with their EAP after the conclusion of this study.

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I dedicate this study to them.

## Abstract

The public attitude towards psychologists is, to say the least, somewhat ambivalent. Surveys of public attitude, both in Australia and internationally, have continually highlighted that the profession is poorly understood, its practitioners seen as impractical, its models of service delivery not "user friendly", its costs prohibitive and its perceived level of successful intervention dubious.

It is argued that many of these negative attitudes stem from the operation of stereotyping which, in turn, results from very low individual contact with psychologists combined with faulty media representations. Barriers to helpseeking that contribute to maintaining this low utilisation rate are discussed. Taken together, these factors have resulted in a profession suffering an identity crisis as it struggles to maintain its viability.

The present study aimed to investigate whether it was possible to positively influence the public attitude towards psychologists. It used the Employee Assistance Program (EAP) paradigm of psychological service delivery as a model designed to encourage individuals to seek psychological assistance as it addresses many of the common barriers to helpseeking.

Three organisations were chosen to participate in this study, each consisting of 330 Ss. Each participating organisation, in turn, was divided into two equal groups ( $n=165$ ) or "departments" termed A and B.

Those Ss allocated to Department A were systematically exposed to a range of strategic interventions specifically designed to positively influence their attitude towards psychologists and their work. Three

psychologists were employed to deliver the interventions in each organisation. By contrast Ss allocated to Department B received none of these interventions and thus effectively acted as the control.

In order to accurately tap the construct that is the public attitude towards psychologists a new psychometric instrument needed to be developed. The Perception of Psychologists Scale (POPS) was developed over a series of individual studies designed to initially refine and then validate the scale. The resulting instrument was a 30 item self-report measure composed of three subscales: Knowledge (of psychologists and their work), Confidence (in psychologists) and Stigma Tolerance.

Ss in both Departments A and B were requested to complete POPS on three occasions over a 12 month period: T1 (pre-test), T2 (at six months) and finally at T3 (post-test).

Data from this process was analysed using SPSS<sup>X</sup> procedure MANOVA. The three subscales of POPS - Confidence, Knowledge and Stigma Tolerance acted as the dependent variables while organisation (ORG), department (DEPT), sex of S (SEX), psychologist (PSYC) and time (TIME) acted as the independent variables of interest.

Strong main effects were found for DEPT, SEX, ORG, and TIME for department A Ss. No main effect was found for PSYC for department A Ss. Additionally an extensive range of interactions were also found. No main effects for any of the independent variables were found for any department B Ss.

The results indicated that it was possible to positively influence the public attitude towards psychologists. This finding was true for both male and female Ss from all three participating organisations and was independent of who presented the interventions.

The results are discussed in light of the independent variables, the Perception of Psychologists Scale, rate of referral to the EAP, theories of attitude change and the elusive link between attitude change and behavioural intention.

With respect to the results of this study the implications of the findings are extensive, and significant for the future viability of the profession. These implications include challenging contemporary models of psychological service delivery, the role of the EAP as a viable model of psychological service delivery, implications for professional training, the comparison of psychology with similar professional groups, the categorisation of psychologists, marketing and promotion of psychology and psychologists, and implications for models of psychological helpseeking.

Suggestions for extending the findings of the present study are discussed. A series of recommendations resulting from the present study are presented.



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## **CHAPTER 1**

### **A SURVEY OF THE PUBLIC ATTITUDE TOWARDS PSYCHOLOGISTS**

## 1.1 The Existence of a Service Gap

Although mental health problems can result in a plethora of negative social, economic, and personal repercussions (Kiesler, 1979), a substantial proportion of those who experience psychological difficulties do not seek professional help (Kessler, Brown & Bowman, 1981; Leaf & Bruce, 1987; McCaslin, 1989; Sharpley, 1986; Mechanic, 1980). An elucidation of the various factors involved in seeking psychological help is developed in Chapter 3.

Stefl & Propseri (1985) referred to this difference between those who need help and those who ultimately access it as the "service gap". Presumably, appropriate psychological treatment could bring about a significant reduction in the negative personal and societal effects of the problems experienced by many of those in the service gap (e.g., Smith & Glass, 1977; Smith, Glass & Miller, 1980).

Most estimates agree that about 15% of the United States population are in need of specialised mental health services at any given time, although only about 3% utilise these services (Regier, Boyd, Burke, Rae, Myers, Kramer, Robins, George, Karno & Locke, 1988; Myers, Weissman, Tischler, Holzer, Leaf, Vaschel, Anthony, Boyd, Burke, Kramer, & Stolzman, 1984; Shapiro, Skinner, Kessler, Von Dorff, German, Tischler, Leaf, Benham, Cotter & Regier, 1984; President's Commission on Mental Health, 1978).

On the basis of the Epidemiologic Catchment Area Survey, Shapiro et al. (1984) reported that of those who experienced at least one mental disorder in a 6-month period preceding the survey, only 17.6% also sought medical or psychological services for that problem. The

President's Commission on Mental Health (1978) similarly concluded that only about one individual in five who experiences a significant mental disorder will seek professional help for that problem.

The existence of a "service gap" in Australia has been well documented both explicitly and implicitly. A significant number of studies have consistently indicated that around 25% of Australians consulting medical practitioners present with a treatable psychological disorder. For many people their general practitioner represents the visible face of support and advice for psychologically-based problems (Mental Health Task Force, 1989).

It is estimated that the prevalence of mental disorders, including problems such as psychosocial, behavioural, sexual and alcohol-related was reported to be between 6.9% and 17% in studies undertaken between 1982 and 1987 in Sydney and Melbourne (Mental Health Task Force, 1989).

One window into this situation is an examination of the prescribing patterns of Australian medical practitioners as useful and insightful indicators of complaints presenting to general practitioners. In 1988/89, \$A58.9m was paid for pharmaceutical benefits for psychotropic medication (tranquilliser, anti-depressant, benzodiazapine, sedative and hypnotic drugs). This figure includes both Commonwealth and patient contributions (Mental Health Task Force, 1989). Illustratively most prescriptions for psychotropic medications occur in general practice (Anderson, Bridges-Webb & Chancellor, 1986). Medication profiles suggest that within the range of psychiatric disorders treated in general practice, there is a loading towards anxiety-based and depressive



conditions (Mental Health Task Force, 1989; Eisen & Wolfenden, 1988). Drugs for treatment of psychoses do not rate highly in the prescribing patterns of general practitioners. This is believed to be because psychotic patients frequently require hospitalisation where they receive bulk medications. However, antipsychotic drugs are rated in the top 100 of the most frequently prescribed drugs in Australia (Burvill, 1988).

Perhaps in an attempt to address this situation the Royal Australian College of General Practitioners actively promoted the role of the general practitioner as a counsellor (Report to the Royal Australian College of General Practitioners (1985). Ramsay (1990) expanded the idea by noting the many advantages and strengths that the general practitioner has that would make him/her an effective counsellor. These include:

1. They have the opportunity to observe and understand their patients and their patients' environment.
2. They are seen as a credible source of information and guidance by their patients.
3. They have generalist skills and a clinical approach, which allow a broad understanding of patients' problems and a multifaceted approach to treatment; for example, the general practitioner can consider whether poor diabetic control is responsible for unusual mood swings, or whether problems with mood or social circumstances are affecting their patient's compliance with diabetic control
4. They can provide treatment programs in familiar surroundings. The general practitioner's rooms are a comfortable place for patients to discuss their problems

5. They are skilled at working as a member of a professional team. The general practitioner is able to call on a wide range of other professionals to help the patient to deal with his or her problems.
6. They can follow up treatment programs in an opportunistic or a planned way as part of continuing patient care.
7. They have an intimate knowledge of the family of patients and the family dynamics.

This promotion of counselling by general practitioners is predicated on the medical model of psychological dysfunction as a "disease" and would generate vigorous argument from most professional psychologists. Ramsay (1990) reinforces this dichotomy with his definition of counselling:

"Counselling occurs when a doctor and a patient define the patient's problem then effect treatment by a process involving discussion, negotiation and education. " (Ramsay, 1990; p. 473)

## **1.2 The Public Attitude Towards Psychologists in the United States**

Why do individuals seek out their general practitioner or, indeed, avoid professional assistance altogether rather than access the services offered by a psychologist, who may be the more appropriate professional to help them. The literature suggests that one cannot avoid attributing a large part of this trend to the attitude of the general public towards psychology and psychologists.

Psychologists have, in fact, demonstrated concern about their public image since the first organisational meeting of the American Psychological Association in 1892 (Benjamin, 1986). Yet attempts to document the nature of that image (invoking the "scientific" approach of

the "scientist-professional" model) through surveys of public knowledge and opinion are relatively recent.

The first published survey of psychology's public image appeared in the *American Psychologist* in 1948 (Guest, 1948). One section of the survey compared responses to five occupations: psychologist, architect, chemist, economist and engineer. Another part of the survey compared public understanding of psychology and psychiatry. Respondents were asked whose help they would seek if they were selecting workers for a particular job. Surprisingly, economists and engineers were chosen more often than psychologists. As further evidence of respondents' confusion about psychology, Guest reported that little distinction was made between psychologists and psychiatrists. However, out of the five occupations listed, psychologists were correctly selected most often as the professionals to consult when conducting an attitude survey or deciding on a profession for one's child. These somewhat inconsistent results concerning respondent's knowledge of psychology were accompanied by an even greater inconsistency in opinions. Although the majority of respondents (61.7%) reported a positive overall impression of the field, many registered negative opinions on specific questions. When asked which of the five occupations they would least like their child to choose, respondents named psychology most often. Further, they overwhelmingly voted psychologists as the persons they would feel most ill at ease with in a social situation, and almost 40% believed psychologists are more "odd" than chemists or engineers.

As a result of this survey the public's image of psychology received considerable attention as reflected in the large number of articles appearing in professional journals. Between 1952 and 1959 there were

nine articles published (Carpenter, Lennon and Shoben, 1957; Fein, 1954; Grossack, 1954; McNeil, 1959; Newman, 1953, 1957; Nunnally & Kitross, 1958; Paterson, 1954 and Sanford, 1952). These articles noted the APA's increased activities in public relations, including publication of a booklet on the subject (APA, 1954). State psychological associations were urged to form public relations committees. Psychologists addressing various public groups were advised to spend a portion of their talks on the nature of psychology; they were urged to overcome their distaste for "selling" psychology - to realise that such activity was necessary if psychology was to reach its potential as a force for societal change.

Two of the nine articles were surveys on public attitudes (Grossack, 1954; Nunnally & Kitross, 1958). Grossack interviewed a sample of 51 Negroes in the South. The questions in this survey were so general that only the vaguest outlines of respondents' reactions to psychology were assessed. Overall, respondents appeared to have a positive opinion, with more than half of the sample believing that psychologists were helping to reduce tensions between the races. However, respondents indicated little more knowledge of the field than that psychologists work with peoples' minds, souls, and behaviour. Not surprisingly, the survey found that many people equated psychologists and psychiatrists.

Several years later Nunnally & Kitross (1958) conducted a relatively sophisticated survey. A group of central Illinois residents who, according to major demographic attributes, were similar to the total U.S. population indicated how favourably they felt towards a variety of people involved with mental health. On ratings of value and worth and on ratings of understandability or straightforwardness, general medical personnel (doctors and nurses) consistently ranked higher than psychologists, and

psychologists ranked slightly higher than psychiatrists. In absolute terms, psychologists received relatively high scores on value (a mean rating of almost 6 with 7 the highest possible value).

Subsequently, two surveys were published on the public's ability to distinguish between psychology and psychiatry (Murray, 1962; Tallent & Reiss, 1959). The respondents in the 1959 survey were non-psychology students in adult education courses, and respondents in the 1962 survey were introductory psychology students and their friends. In these surveys, the respondents' ability to distinguish between the disciplines of psychology and psychiatry was striking. For example in the 1959 survey only 15% thought that psychologists possessed an M.D. (medical) degree, whereas 70% thought psychiatrists had this degree. Overall, psychologists were believed to be teachers and scientists who study human behaviour. The majority of the sample believed that psychiatrists were trained primarily as practitioners (87%) and that they treated mental disorders (89%). A minority believed that psychologists were trained as practitioners alone (38%) or that they provided treatment for mental disorders (34%). The 1962 survey with introductory psychology students yielded similar findings.

At about the same time Witley (1959) conducted a general survey of reactions to science and found a somewhat negative view of psychology in a randomly sampled cross section of the public. Only 50% of respondents endorsed the idea that the use of a scientific approach would lead to a true understanding of human behaviour.

In 1967 the *American Psychologist* published a survey that attempted to obtain a representative sample of respondents from the St. Louis area

(Thumin & Zebelman, 1967). This survey compared reactions to a variety of occupations, including surgeon, dentist, lawyer, engineer, psychiatrist, and psychologist. As in Guest's (1948) survey, parents were asked about their preferences for their children's occupations. On this evaluative measure, the occupation of psychologist again ranked at the bottom of the list. When compared with psychology, psychiatry was preferred by twice as many people. On an open-ended question about what psychologists and psychiatrists do, respondents differentiated between the two professions, although not to the extent observed in prior studies using college students (e.g. Tallent & Reiss, 1959). For example, 31% reported that psychologists study behaviour, whereas only 3% thought psychiatrists do. When asked who they would contact for specific services, respondents reported that they would have a clear preference for psychiatrists if they were depressed, felt nervous and wanted a prescription for tranquillisers, were becoming mentally ill, or were drinking excessively. Psychologists were preferred to determine a child's intelligence or to help with marital difficulties.

Emphasising a different thrust, Dollenger & Thelen (1978) polled elementary, junior high and high school students in Columbia and St. Louis, Missouri. By far the majority of students believed psychologists provided therapy, and a surprisingly low percentage either said they did not know what psychologists did or gave an incorrect answer. However, an open-ended question revealed that only about 20% could correctly differentiate between psychologists and psychiatrists. In order to assess respondents' evaluations of psychology as a occupation, they were asked to compare it with 24 other potential occupations. Psychologist was ranked in approximately the middle range of desirability, between scientist and salesperson by boys and between farmer and banker by girls.

In 1978 a professional survey organisation, retained by the American Psychiatric Association, interviewed a cross-section of the public concerning their opinions towards psychiatry (Clark & Martire, 1978). Psychiatrists were viewed as more effective than psychologists in treating mental illness, which was defined as involving organic problems and antisocial behaviour. Yet psychologists and psychiatrists were viewed as being equally helpful in treating emotional problems, such as inability to cope with life, family problems, and depression. The perceived advantage of psychiatrists in treating mental illness appeared to be due to the respondents' recognition that psychiatrists received medical training.

McGuire & Borowy (1979) attempted to replicate Nunnally & Kitross's (1958) earlier study on attitudes towards mental health professionals. This survey polled only undergraduate psychology students, and their findings were similar to those obtained in the earlier study. Medically related occupations were evaluated most favourably, followed by psychologists then psychiatrists. Although ratings in general were less favourable than those of the previous study, psychologists were still rated highly on worth.

A more recent survey of university students and their parents found highly favourable attitudes towards psychology (Webb & Speer, 1985). Psychologists were described with more positive adjectives than physicians, scientists and teachers; only psychiatrists were viewed more favourably. Unlike prior surveys that asked specific questions about the duties of psychologists and psychiatrists, this study focussed on general attributes of the two fields and found little differentiation in responses to them.

In another more recent survey, Kabatznick (1984) polled physical and biological scientists, business people, psychologists, and a sample of shoppers at a mall in Connecticut about their opinions and knowledge concerning psychology. Attitudes towards the field were, in general, highly favourable with over 75% of the sample indicating a positive opinion about psychology. Yet this favourable opinion was, as in previous surveys, accompanied by reservations concerning specific aspects of the field. Almost half of the sample believed that findings in psychology are not as scientific as those in chemistry. Further, less than half of the respondents thought that psychotherapists help the people they are treating. Respondents did, however, demonstrate a high level of accuracy in their knowledge of the field. For example, only about 13% believed that in order to become a psychologist one must work in a hospital. Also, over 70% knew that psychologists cannot prescribe drugs. The results of this survey vary considerably from one sample to another. For example, physical and biological scientists reported significantly less favourable attitudes toward psychology than psychologists or shoppers.

Part of the problem with the variability of findings concerning the public attitude towards psychologists may rest in the way surveys are designed. Webb (1989) used three methodologies that varied on a continuum of complexity. Method 1 asked respondents to write a descriptive paragraph. Method 2 was an adaptation of the Adjective Generation Technique, asking respondents to list 5 adjectives to describe psychologists. Method 3 asked respondents to rate psychologists directly, with regard to "favourability". She hypothesised that public image would emerge consistently in all three methods, thereby justifying the use of the simplest approach. The highly indirect method 1 produced a top ranking,



whereas the direct method 3 produced the lower ranking. The findings indicated that :

"the answer you get depends on the question you ask, how you ask it and when you ask it." (Webb, 1989; p. 302).

### **1.3 The Public Attitude Towards Psychologists in Australia**

Research in the field of the public image of Australian psychologists is sparser than that in the United States. Although there was concern within the ranks of the Australian Psychological Society, from its inception in 1966 about psychology's image the first empirical study was conducted by Small & Gault (1975) who surveyed a random sample in a metropolitan shopping market and asked them which of ten professions was the most desirable. Only 1.42% listed psychologist first. In fact, psychologists tied with psychiatrists for last place in this category (behind architect, doctor, accountant, school teacher, chemist, dentist, clergyman and social worker). However, only 2.87% rated psychologists as the least desirable profession, with only two other categories (doctor and architect, respectively) rated less frequently as the least desirable profession. Small & Gault made the comment, when comparing their results with comparable findings in U.S. surveys that:

"the current situation in Australia (regarding information about psychologists) might be expected to be similar to that existing in the United States in the late 1940s and early 1950s". (Small & Gault, 1975; p.21).

In another metropolitan Australian sample Wilkinson, Cave, Flynn, Hodgson, Prouatt, Sultmann & Gardner (1978) compared the public image of clinical psychology, medicine, psychiatry, religion and social work. Psychologists were considered the least known and the least useful

of these five professions, were consulted the least, and were ranked fourth in the confidence respondents placed in them (only ahead of the clergy).

Two more recent surveys (Rogers & Sharpley, 1983; Sharpley, Rogers & Evans, 1984) investigated the public knowledge of, and attitudes to, "counsellors" in general and to marriage counsellors in particular. Generally these studies found that respondents were not aware of the nature of the counselling process, that the distinction between counselling and psychotherapy was blurred, that there was a lack of knowledge of what constituted counsellor training and that, in general, the profession as such was poorly understood.

In the most extensive Australian investigation so far in the field of the public image of psychologists, Sharpley (1986) conducted a study into the comparative public attitudes towards four mental health professionals, namely psychologists, psychiatrists, social workers and counsellors. The last group were an ill-defined category of:

"persons with some psychological training who are most often referred to as "counsellors" and enjoy wide community acceptance as informed and helpful mental health professionals." (Sharpley, 1986; p.58).

The respondents were carefully selected so that they were representative of the occupational categories of Australian society.

The results of this investigation indicated that the four professions were perceived as providing fairly distinct services to the public and fell into two subgroups: (1) psychologists and psychiatrists as private-practice and fee-demanding professionals who predominantly study human behaviour

and thoughts, and (2) social workers and counsellors as public-utility non-fee-demanding professionals who were perceived as more practical and helped the average person solve emotional problems.

In addition to these broad findings it is illustrative to examine further the public's specific attitudes towards psychologists as revealed in this study. Respondents were asked to briefly describe what they thought of each of the four professional groups did. Psychologists were predominantly described as being involved in studying behaviour, individual and group reactions, the mind and thoughts, perhaps reflecting the public's awareness of academic research psychology. A lesser percentage of subjects saw psychologists as helping and advising individuals with problems.

The data regarding responses as to where each of the four professional groups was employed (and thus could be accessed by the public) showed that psychologists were perceived as variously being in private practice (33%), public agencies (20%), hospitals (15%), community health centres (10%) and institutions (10%). When asked if they would be prepared or would expect to pay to visit a psychologist, 90% replied "yes". However 24% thought that psychological consultations were covered by Medicare. When told this was not the case then 46% responded that they ought to be.

When evaluated on their usefulness to the community psychologists scored marginally lower than the three other professions with 47% feeling that the community does not need more psychologists, but rather more social workers and counsellors. In order to understand why these data supported social workers and counsellors as more valuable and

needed by the community, respondents were asked to list the major benefits and drawbacks of each profession. All were seen as being helpful in solving problems and finding directions. Psychologists were particularly seen as providing insight (but not action) into problems. However, social workers and counsellors were perceived as (i) providing more practical help to individuals, (ii) being a benefit to the community, and (iii) regarded as caring professionals who were easy to talk to. Interestingly 31.7% of respondents either did not know of any benefits of psychologists or thought there were none, the highest percentage recorded of the four professional groups surveyed.

When respondents were asked to list drawbacks of each of the four professions, psychologists were specifically seen as being undertrained, not practically oriented, having the potential to cause more problems than they solved, too costly in money, time and taxes, and being too theoretical in their approach.

When asked if they would ever consult a psychologist or recommend that a friend do so, respondents rated psychologists last of the four professional groups. Finally psychologists were rated as second to psychiatrists in status, were thought to be difficult to talk to in a social situation and were regarded as being "odd".

It is recognised that the attitude towards psychologists may be influenced by misconceptions and stereotypes of the nature of psychologists. Schneider (1987), for example, categorised the role of therapists (psychiatrists, psychologists and counsellors) in 207 American films from 1902 to 1986. He reported that 44% were portrayed as incompetent or inept and that 22% were portrayed as nefarious. How these portrayals

affect naive viewers is not clear. There is evidence, however, that some individuals choose not to utilise mental health services because they believe such services are evil (Gardner & Hinton, 1980) or that mental health professionals are mostly incompetent (Mayer & Timms, 1970).

#### **1.4 Role of the Australian Psychological Society**

This survey paints a fairly dismal picture of the public attitude towards psychologists and psychology in Australia. Up to this point the governing professional body, the Australian Psychological Society (APS), had not seen the need to do anything tangible to improve the image of psychology. However, perhaps in response to the fact that Australia was chosen to host the XXIV International Congress of Psychology in 1988, a Working Party on Community Relations was established by the Council of the APS in 1986. The brief given to this working party was:

1. To actively promote the Society and the profession of Psychology
2. To advise the Society on community relations matters
3. To initiate and co-ordinate the preparation of community relations materials
4. To establish and maintain a referral list for specialist commentary.

(APS Bulletin, 1987)

The Community Relations Committee put into operation a number of initiatives principally aimed at promoting the profession of Psychology to the general public. Included in these initiatives were:

- establishment of Media Link, a referral service for members of the media who wish to access a psychologist who specialises in a particular area of psychology. either for background information or for direct interview.
- advertising of services on Viatel, an electronic advertising facility.

- Media Net, a press release service on matters of psychological interest
- a pamphlet entitled "Psychologists: What do they do? How can they help?" to be distributed to members of the general public; this pamphlet enjoyed such success that a second edition was released in 1989 (see Appendix 1)
- the development of a recognisable logo for the APS

Anecdotal evidence garnered in the last few years (APS Bulletin, 1989, 1990, 1991, 1992, 1993) does indicate that the profile of psychology as a profession and psychologists as credible professionals has certainly been raised through the efforts of the Australian Psychological Society. This has been achieved chiefly through the use, by the media, of the Media Link facility, to obtain commentary on psychological matters from nominated psychologists considered to be expert in a particular field.

While the trend is encouraging it is doubtful whether the attitude of the average individual has changed a great deal. Indications of this are the increasing number of articles appearing in the professional journals in Australia about raising the profile of psychology and marketing psychologists and their work more effectively. There is considerable disquiet among psychologists about the "deprofessionalisation" of psychology (APS Bulletin, 1993) and the direction that psychology is taking.

### **1.5 Aim of the Present Research**

The position remains, however, that psychologists are not well known nor is their work well understood. It is the aim of the present study to develop and then empirically investigate a strategy for effectively addressing this

situation so that the skills and abilities of psychologists will be able to be better utilised by a wider audience, thereby minimising the service gap between those who are in need of psychological help and those who ultimately seek it.

## **CHAPTER 2**

### **DEVELOPMENT OF PSYCHOLOGY AS A HELPING PROFESSION**



## 2.1 Is Psychology in Crisis?

The past decade has been marked by a professional identity crisis for Australian psychologists. This identity crisis has manifested itself in a number of areas. The first of these is an intense debate about the appropriate training model for psychologists as they face the twenty-first century bearing in mind the contention that the relationship between professional training and professional identity is a reciprocal one (Watson, 1991). Should the scientist-practitioner model continue to be promoted or is there another training model more relevant to the needs of psychologists and their clients (Franklin, 1993; Lovibond, 1993; Martin, 1989a, 1989b)?

The second public face of this crisis is one of service delivery. The rapid (and somewhat unchecked) development of psychology has generated a myriad of models of the delivery of psychological services. What is it that psychologists specifically do? What is unique about psychologists? How is the work of psychologists different from that of similar professionals such as psychiatrists, social workers, counsellors, psychiatric nurses, welfare workers, educationists? Is there a better model of service delivery than the range of models currently employed?

A third public face of this crisis is the blurring of demarcation between the various subspecialties of psychology. This is particularly evident in the area of clinical and counselling psychologies. This confusion is neatly demonstrated by the nature of job advertisements for "helping profession" positions. Is it necessary to continue the increasingly artificial boundary between these two specialties or does this demarcation merely add to the public confusion that already exists?

The inevitable consequence of this professional identity crisis is that it can't help but influence the public's attitude towards psychology and psychologists. This, in turn, leads to an under-utilisation of psychological services because potential clients do not know what psychologists can offer them. The question is, if psychologists are unsure of themselves and what they do or don't do, how can they expect the public to develop confidence in them and their professional skills and to consequently utilise their services?

In order to more clearly understand how the public attitude towards psychologists has evolved to its present state, it is necessary to trace the development of psychology both as a science and a profession.

As mentioned above an awareness of the development of psychology is integral to understanding the crisis that the profession now faces in terms of its image.

Tracing the evolution of psychology is especially important for those professional areas of psychology most closely relevant and accessible to the average member of the public. By unfolding the development of psychology it can be determined if and how psychology has adapted in response to the demands of its clientele.

The main branches of psychology most commonly associated by the general public with psychology are clinical and counselling psychology. These branches are most frequently referred to as the "helping psychologies". There are a number of reasons for this assertion:

- Most individuals would have experienced their first contact with a psychologist in the school milieu where they would have encountered, either directly or indirectly, a school counsellor.
- Clinical and counselling psychology are the branches that interface most directly with the public as they are the ones people are most commonly referred to by medical practitioners.
- Clinical and counselling psychology are the branches most commonly portrayed in the mass media as stereotypic of psychologists and the work that they do.
- Clinical and counselling psychology are the branches most closely akin to psychiatry.

The present discussion will, therefore, focus on the historical development of clinical and counselling psychology, with emphasis on both the international (particularly the United States) and Australian contexts.

## **2.2 A Brief Historical Development of Psychology**

Psychology is not a new science. There is overwhelming evidence that even in ancient times people made observations and developed and tested theories and hypotheses in order to better understand themselves and others. The need for people to understand and explain their behaviour and that of others, to account for the cause and effect of behaviour, so that we can help each other and learn from common experience is the fundamental driving force of modern psychology. However, while our curiosity about ourselves and each other may have a long past, it has but a short history.

The term "psychologist" is generally misunderstood by the public at large (Sharpley & Rogers, 1983, Sharpley 1986). To the average person "psychology" and "psychologist" is equated with the concept of "counselling". The common misapprehension is that all psychologists are counsellors and all psychologists counsel (Williams, 1978). Most people are not aware of the many divisions of the vast field of psychology or that the "helping" psychologies are but a part of this field. This confusion bears heavily on the general public's perception of psychologists, a theme that will be developed at a later stage.

The "helping" psychologies, in the sense that the general public understands the term, include the fields of clinical psychology and counselling psychology. As will be revealed later the line dividing these two fields is anything but universally agreed upon, not the least by members of the psychological profession itself. However, in order to demonstrate how the general public has become confused about psychologists and the work that they do it is essential to briefly trace the developmental history of both clinical and counselling psychology.

### **2.2.1 Development of Clinical Psychology**

To position clinical psychology appropriately in the realm of the forces which led to the establishment of psychology as we know it today is not an easy task. To fully account for its genealogical roots is beyond the scope and intent of the present discussion and, therefore, will not be attempted.

The following discussion is centred on the development of clinical psychology chiefly in the context of the United States. There are two main reasons for this concentration on one model: (a) clinical psychology

had its birth and early development almost exclusively in America and (b) the Australian model of the practice of clinical psychology is based, in large part, on the American model of the clinician as a "scientist-practitioner".

In presenting a historical development of clinical psychology the question arises concerning the most appropriate date at which to begin. Since clinical psychology as we now know it arose at the turn of the present century it is appropriate to begin with the immediate forerunners of this first generation of clinical psychologists. Thus the origins of clinical psychology are to be found in the psychometric and dynamic traditions of psychology.

The psychometric tradition was, in turn, part of the scientific tradition of the nineteenth century. With all the limitations with which it is charged today, it is to this movement that the clinical psychologist owes much of his/her scientific standing and tradition. Today whenever a clinical psychologist relies upon rigorous objectivity in assessment and the need for further research, he/she is wittingly or otherwise showing the influence of this tradition. Moving with Galton through Binet and Terman, this tradition met the demand that psychology, if it expected to be regarded as a science, must share with the other sciences their respect for quantitative measurement.

A major source of influence contributing to the growth and development of clinical psychology was the thinking and writing of the "Boston group" who promulgated "the new psychology" (Watson, 1967). Foremost in this group was William James. Although in no way could they be labelled clinical psychologists, their thinking was much closer to

the heart of the clinical psychology movement and to progressive psychiatry.

### **2.2.1.1 The Psychologist and The Psychological Clinic**

The first psychological clinic was founded by Witmer at the University of Pennsylvania in March 1896. Witmer was the first to speak of the "psychological clinic", of clinical psychology and "the clinical method in psychology" (Witmer, 1907).

Witmer made a formal report on the operation of this clinic to the American Psychological Association in 1896. He described the clinical approach in detail, making clear how his findings were based on data revealed in individual examinations of many people (Watson, 1967). In addition, Witmer demonstrated how, by application of analytic and postanalytic diagnosis, classifications of behaviour could be derived. He enlisted the aid of medical, predominantly neurologists and not psychiatrists, and paramedical specialists such as speech therapists, for both diagnosis and treatment. Finally he showed the potential for a psychological clinic as a service agency in the community - both as a research centre and as a training ground for specialists in psychological services.

The tradition of clinics as first established by Witmer began to flourish. In a survey Wallin (1914) reported that 26 such clinics were in operation in the United States by that time. The majority of these were psychoeducational clinics often operated in conjunction with departments of education.

However the fledgling clinical approach was now being applied in a number of settings including the treatment of the mentally ill and the mentally deficient. In these settings psychologists worked in tandem or under the direction of psychiatrists, but gradually established a professional autonomy by their reliance on objective assessment and observation.

### **2.2.1.2 Beginnings of Professionalisation**

From the founding of Witmer's clinic to the outbreak of World War I, clinical psychology advanced from an original concern with the educational problems of school children to the more complex problems of the mentally ill, the mentally deficient, and of delinquents. The *Psychological Clinic* was first published in 1907. Whipple prepared and published, in 1910, a compendium of available tests for clinicians, the *Manual of Mental and Physical Tests*. Trained psychologists were now beginning to concern themselves with professional standards and procedures. During World War I, psychologists developed tests and ably assisted the military in the screening and placement of draftees. By providing such vital services to the Government in a time of national crisis, psychology was able to demonstrate convincingly the vast potential of psychological techniques (Watson, 1967).

An attempt was made to form an association of clinical psychologists in 1913 but it died within two years. In 1919 the Section of Clinical Psychology within the American Psychological Association was formed. In 1921 the group lobbied for and succeeded in their quest for official certification as clinical psychologists. However this practice was abandoned in 1927 when the APA decided certification was not

practicable as it was in large part unenforceable for those psychologists who were not members of the APA.

Clinical psychology, however, continued to flourish in the period between the wars. As late as 1918 only 4% of the APA listed the field of clinical psychology as a research interest. This had risen to 19% by 1937. In the same year the newly instituted membership category of Associate showed 28% interested in clinical psychology, the largest field of interest for this class of membership.

In increasing numbers clinical psychologists were employed in hospitals, clinics, schools penal institutions, social agencies, industry and the entire gamut of agencies concerned with human welfare. In 1936 Louttit published *Clinical Psychology*, considered by many to be the earliest major attempt to present a standard text of the broad field of clinical psychology.

Ironically it was the coming of World War II that provided the impetus clinical psychologists needed to make the public at large aware of their skills and value to the community at large. About 1710 psychologists served in the armed forces of the United States during the war (Rotter, 1963, 1964). Similar contributions from psychologists were also made in the other countries engaged in the conflict. Almost half of these psychologists used clinical or counselling procedures during some part of their military work. Many psychologists were placed indiscriminately in a position where they functioned in selection and assignment, sat as members of discharge boards, worked as members of clinical teams, conducted therapeutic sessions, both group and individual, and in these and other ways used diagnostic and treatment methods. One of the



offshoots of this deployment was an increased interest among psychologists for the field of clinical psychology and a demand for better training in the field. Psychologists who previously had not been particularly receptive to the work of clinical psychologist now came to understand and appreciate the contributions of the clinical approach. This assertion is verified in a survey by Andrews and Dreese (1948) which found that three times as many military psychologists engaged in clinical work after the war as had done so in the prewar period.

The distinguished contribution to the war effort by clinical psychology led to unprecedented developments. The demands of military service had given status previously lacking to personality testing. Moreover, a significant trend was the emergence of a therapeutic role which had been created for clinicians by burgeoning demands in the armed services. These developments led to improved prestige and produced an unprecedented social demand for psychological services in this postwar period.

One of the prominent sections in a reorganised APA was the Division of Clinical and Abnormal Psychology, which later (1965) became simply the Division of Clinical Psychology. Another development was the appearance of a new and independent publication, the *Journal of Clinical Psychology*, in 1945.

Clinical psychologists were also moving in ever increasing numbers into the field of psychotherapy. Many psychiatrists felt that clinical psychologists had overextended their competence in the practice of psychotherapy. Many of the newer psychotherapies were developed by clinical psychologists. This led to the charge that clinical psychologists

were prone to accept currently fashionable theories, even though they were inadequately tested and were at times ephemeral.

The emergence of clinical psychology spurred on by the work that clinicians performed during World War II highlighted the interest that clinical psychology was generating. A symptom of this interest was the proliferation of training courses for clinicians and the deregulation that this rapid proliferation caused. If clinicians were going to harness their profession and make it truly professional some common procedures concerning training requirements were imperative.

In March 1947 the American Psychological Association's "Committee on Training in Clinical Psychology" was established. After careful study of the issues, and a review of existing facilities and programs at various universities, the Committee refrained from setting rigid guidelines and specifying a detailed program of training. Rather it worked from the point that a clinical psychologist must first and foremost be a psychologist and urged the introduction of a broad four year doctoral level training program directed towards research and professional goals. Preparation was thus focussed on three functions: diagnosis, research and therapy with special emphasis on the psychologist's contribution as a researcher. This Committee suggested a curriculum including such courses as general psychology, psychodynamics, diagnostic methods, research methods, related disciplines and therapy.

### **2.2.1.3 The Development of the Scientist-Practitioner Model**

In 1949 the American Psychological Association sponsored a conference in Boulder, Colorado in an attempt to bring order to the diversity of courses offered. The Boulder Model of clinical psychology, as it came to

be known, was adopted and is still today the foundation of many clinical psychology programs and remains relevant to how many practicing Australian psychologists see themselves today.

The model viewed the practicing clinical psychologist as a "scientist-practitioner", a term referring to:

"a clinician or practitioner who can not only directly assist people with their problems, based on knowledge developed with his or her profession, but also contribute to our collective knowledge thereby improving our practices". (Barlow, Hayes & Nelson, 1984; p.xi).

To fulfil the requirements of the Boulder model the Conference decided that all training courses were to include:

1. Preparation and proficiency in both direct service delivery and research;
2. Academic training in both general psychology and clinical psychology;
3. An integrated, extensive and uniform practical training component together with an internship at the completion of the course before certification would be granted.

The Boulder model of the clinical psychologist as a scientist-practitioner laid the foundations for the rapid growth of the profession during the 1950's. Now that the profession was generally agreed as to how it viewed its own future professional development it cleared a path for developments in other directions.

The Clinical Division of the APA was its largest division. The number of clinical psychologist in Division 12 doubled between 1950 and 1959. The U.S. Government signalled its confidence in the profession by

giving grants and contracts for psychological research which tripled between 1950 and 1959. The number of articles in *Psychological Abstracts* doubled in this period, while those relating to clinical psychology tripled.

The 1960's was a time when, in increasing numbers, clinical psychologists attempted to broaden their role by becoming more extensively involved in psychotherapy. Partly this was due to their own perception that engaging in psychotherapy with a client was merely a natural extension of their diagnostic role. Thus they were beginning to view the client wholistically rather than carry out their circumscribed role of diagnosis and then pass the client on to a psychiatrically-trained psychotherapist for treatment. This could be construed as the genesis of the blurring of roles between clinical psychologists and counselling psychologists.

The other reason for clinical psychologists becoming more involved in psychotherapy was the burgeoning number of psychotherapies being developed. The period saw significant contributions to the field of psychotherapy from the behavioural school (Eysenck, 1960; Frankl, 1963; Ullmann & Krasner, 1965) and the cognitive school (Rogers, 1959, 1961; May, 1961; Ellis, 1958, 1962; and Berne, 1958, 1961).

Clinical psychologists, partly as a rejection of the medical model, had traditionally tended to shy away from scientifically unsubstantiated psychodynamic psychotherapy and its variants and successors. Now, however, these new psychotherapies were being developed by practitioners from within the ranks of the clinical psychologists and were more acceptable to the practicing clinician who now felt they did not

need to compromise their principles in order to engage their clients in therapy.

Associated with this increase in the clinical work of the clinical psychologist was the beginnings of a movement away from the scientist-practitioner role as prescribed by the Boulder model. The practicing clinician simply did not have to become involved in research or, on the other hand, found their involvement in the clinical work more rewarding and productive than research.

Thus there was a growing reluctance to accept the Boulder model without question as indicated by a marked drop in research presentations. Research was seen as the purview of the academic clinical psychologist who possessed both the time and the resources to be able to carry out research effectively. In turn complaints were voiced about the low value attributed by some leading academic institutions to the expert work of the clinician as compared to the high value assigned to research skills.

One recommendation was to form a new profession which would draw its recruits from the fields of psychiatry, clinical psychology, and psychiatric social work. Mariner (1967), himself a psychiatrist, confessed that little of his work involved the use of medicine, and that psychotherapists, regardless of their discipline, performed similarly and with about the same effectiveness. He proposed the formation of a new field of mental health, with its own schools, outside the mantle of medicine:

"The mental health professional, then, is really working in the field of applied psychology.....That jurisdiction over his field should be claimed by a profession (psychiatry) whose basic education usually

includes not a single course in psychology is, when viewed dispassionately, little short of fantastic." (Mariner, 1967; p.279)

A second recommendation was to recognise the practitioner model as a viable training alternative to the scientist-practitioner model. This was done at the University of Illinois in 1968 when they allowed their clinical students to enrol in a PsyD (Doctor of Psychology) course, which was distinguished by less emphasis on research and by a series of "Laboratories in Clinical Psychology", which were year-long practical courses in specific treatment and assessment methods.

It was clear that clinical psychology had evolved in a direction of which Albee (1970) had warned:

"The truly crippling sources of cognitive dissonance in the professional psychologist.....are the fundamental differences between the scientist and the professional." (p. 1071)

The next major stage in the development of clinical psychology was at the 1973 Annual Conference held at Vail, Colorado. The theme of Vail was the "National Conference on Levels and Patterns of Professional Training in Psychology". The resolutions of the Conference could be summarised in the context of the following major themes (Korman, 1974): professional training models, multi-level training, desirable characteristics of professional training, doctoral level training, continuing professional training and service delivery systems.

In summary, formal training in clinical psychology has only existed for a few decades yet there has been tremendous changes in the role of the clinical psychologist and concomitant changes in the nature of their

training. One may argue that the training has not kept pace with the changing role of the clinical psychologist. Indeed, this is part of the argument put forward by advocates of increased professional training for clinical psychologists in lieu of the extensive research training required.

However the gap between training and practice extended well beyond this more general criticism. Clinical psychologists were becoming more involved in anything and everything that involved human behaviour in its normal and abnormal forms. It is this fact that makes it particularly difficult to predict the future directions of training. The field, as clinical psychologists would see it, knows no bounds.

### **2.2.2 The Development of Counselling Psychology**

The preceding account of the development of clinical psychology highlighted how the profession evolved over a period of some one hundred years to its present state of flux. Similarly, the other "helping" psychology, counselling, as a contemporary applied-scientific specialty within psychology has grown to its current status from numerous and diverse roots since the early part of the 20th. century. Thus this specialisation of applied psychology has only a short history and post-dates the development of clinical psychology as a separate entity.

A brief historical perspective on the development of counselling psychology as a profession can most effectively be organised around discrete identifiable historical periods (Whiteley, 1984). The following discussion will highlight the major themes and developments of the twentieth century in six historical periods.

The first period (1908-1950) contained diverse initial roots and seminal influences from society and organised psychology as an applied specialty.

Period	Major Themes	Main Developments
1908-1950	<div>Roots of the profession</div> <ul style="list-style-type: none"><li>• work of Parsons and the growth of vocational guidance</li><li>• development of mental hygiene movement</li><li>• study of psychometric movement and individual differences</li><li>• development of counselling and psycho therapy</li><li>• impact of social and economic forces and developments in society</li></ul>	<ul style="list-style-type: none"><li>• Parsons' (1908) work in relating occupational aptitudes and interests to vocational choices</li><li>• awareness of the deleterious conditions encountered by people committed to mental institutions</li><li>• involvement in WW11</li><li>• demand for counselling services at end of WW11</li><li>• founding of Division 17 of APA in 1946</li><li>• Binet's work on measurement of intelligence</li><li>• Rogers' (1942) <i>Counselling and Psychotherapy</i></li></ul>

Thus by the end of the Second World War a largely social and political reform movement (vocational guidance), the mental hygiene movement, three influences from organised psychology (psychometrics, the psychology of individual differences and psychotherapy), and the effects of two world wars merged to produce a field of applied-scientific psychology that had greatly outgrown its vocational guidance roots, and which provided a unique blend of service orientation and research activity.

World War II created an "unprecedented demand for psychological services" (Pepinsky, Hill-Frederick & Epperson, 1978). During the war psychologists were involved in helping create a wartime army from the ranks of civilian draftees and volunteers. After the war, psychologists



helped meet a massive demand to return veterans back into civilian life by assisting them with problems of personal and vocational adjustment.

An important perspective on the second period (1951-1954) in the history of counselling psychology may be gained from reflecting on the social forces which influenced the 1950's. Schwebel (1984) summarised them as follows:

"In the fifties, the career and interpersonal needs and problems of the many veterans and their families and the unprecedented growth in higher education created a ferment of research, especially in the area of career development and of counselling orientations. (Schwebel, 1984; p.5-6)

Super (1984) has referred to the 1950's as a time when counselling psychology applied differential psychology to the world of work and counselling processes to issues of vocational and occupational choice and adjustment.

Period	Major Themes	Main Developments
1951-1954	<ul style="list-style-type: none"> <li>• identity crisis among counselling psychologists</li> <li>• focus of intervention on individual clients</li> <li>• emphasis on "normal" behaviour and avoidance of severe psychopathology</li> </ul>	<ul style="list-style-type: none"> <li>• Northwestern Conference (1951)</li> <li>• agreement on standards of professional training</li> <li>• agreement on statement of roles and functions</li> <li>• Perls (1951) <i>Gestalt Therapy</i></li> <li>• Rogers (1951) <i>Client-centered Therapy</i></li> <li>• Skinner (1953) <i>Science and Human Behaviour</i></li> </ul>

The year 1954 marks the beginning of the third period in the history of counselling psychology. Coming immediately after a period of exceptional theoretical and scientific accomplishment and strides towards resolution of important professional issues, this was a period rife with disagreement over the central role of the specialty. It was not, however, a period devoid of long term contributions.

Period	Major Themes	Main Developments
1954-1963	<ul style="list-style-type: none"> <li>• disagreement over status and proper focus of counselling psychology</li> <li>• concern at paucity of research</li> </ul>	<ul style="list-style-type: none"> <li>• founding of <i>Journal of Counselling Psychology</i> (1954)</li> <li>• guidance clinics instituted in US schools (1954)</li> </ul>

Counselling was at the crossroads in 1963 as its fourth historical period (1963-1967) began. The membership of Division 17 had increased by 61% from 1950 to 1960.

Period	Major Themes	Main Developments
1963-1967	<ul style="list-style-type: none"> <li>• development of a common core of activities carried out by counselling psychologists</li> <li>• societal influences leading people to question personal fulfilment and exploration of potentialities</li> </ul>	<ul style="list-style-type: none"> <li>• Greyston Conference (1963) provided greater clarity on how counselling psychologists differed from other psychologists</li> <li>• growth in behaviour therapy and existential therapy</li> <li>• counselling psychologists increasingly employed in a wide range of settings</li> </ul>

However Hahn (1955) in his Presidential Address to Division 17 noted that a consequence of the rapid rise in the demand for nonmedical professional services was that organised professional groups (such as

social work, psychiatry and psychology) would stake out "zones of influence" in unclaimed territory and even attempt to claim functions considered the province of other disciplines. The competition for status, legal sanction, and advantage was particularly evident among psychiatry, social work, clinical psychology and counselling psychology.

An important legacy of the previous historical period in counselling psychology's growth was a much clearer definition of the central thrust of the profession. The fifth historical period (1968-1976) began with the release of the most comprehensive statement yet constructed on the definition of the profession (Jordaan, Myers, Layton & Morgan, 1968). Whereas the previous statements had limited circulation within the membership of Division 17, or had not been publicised at all, this statement received the imprimatur of the APA and was widely circulated.

Period	Major Themes	Main Developments
1968-1976	<ul style="list-style-type: none"> <li>• agreement on professional roles such as remedial, rehabilitative, preventive, e d u c a t i v e and developmental</li> <li>• impact of Vietnam war and Watergate on individual values and futures</li> </ul>	<ul style="list-style-type: none"> <li>• publication of the <i>Counselling Psychologist</i> (1969)</li> <li>• development and acceptance of self-help therapies</li> <li>• proliferation of "pop" psychology publications</li> </ul>

The sixth historical period (1977-1983) in the development of counselling psychology began with two elements which were different than had greeted the inaugural years of previous historical eras.

Period	Major Themes	Main Developments
1976-1983	<ul style="list-style-type: none"><li>• general consensus on professional identity</li><li>• support for the profession's preventive and developmental roles</li></ul>	<ul style="list-style-type: none"><li>• tighter definition by APA of differences between specialties especially counselling and clinical psychology</li><li>• Next Decade Project (1982) setting the future agenda</li></ul>

Thus the development of counselling psychology continues unabated. The period since (1984-present) has been marked by a blurring of the boundaries between counselling psychology and clinical psychology as both specialties struggle to establish their identities and carve a niche in the working environment. In order to address this development there has been a groundswell of support for the suggestion that the two specialties should drop their artificial demarcation of roles and functions and become one unified specialty under the banner of "health services" psychology (Levy, 1984). This theme will be developed in greater detail at a later stage.

**2.3 The Development of Clinical and Counselling Psychology in Australia**

This discussion will focus on the history of both academic psychology in Australia and its professional applications particularly in the fields of clinical and counselling psychology.

Taft (1982) makes the point that Australia was dependent, largely because of the circumstances of its foundation, on imported models for its intellectual and professional life. Thus, it is not surprising that Australia

reproduced the prevailing patterns of British and German psychology, and later American, with little added that was characteristically Australian.

There has been little written about the development of Australian psychology. This may have to do with the relative immaturity of the profession in Australia or, indeed, that the energies of the profession have tended to focus more on experimental and practical investigations. The upshot, however, is a dearth of concise, comprehensive discussion on the development of the profession in Australia comparable with that of other countries.

### **2.3.1 Role of the Australian Psychological Society**

Australian psychologists formed their first national professional association in 1945 as a branch of the British Psychological Society (BPS). In 1949 the flagship publication of the fledgling Australian association, the *Australian Journal of Psychology* appeared.

One of the offshoots of this initiative was that it encouraged Australian universities to offer four-year Honours level degrees in Psychology in order to comply with the requirements of membership of the Branch.

In 1966 the Australian Psychological Society (APS) came into existence with a constitution modelled, with some variations, on that of the British Psychological Society. There was to be a central society with regional State branches. The APS set down a six year training period for new members. This was made up of a basic four years academic study (a four-year Honours degree or in a few cases a four-year professional degree or a three-year pass degree supplemented by a one or two-year post-graduate course e.g. Diploma or Master's degree) supplemented by a

further two years supervised experience in research, teaching at a tertiary level or in some form of psychological practice.

The tensions between scientist and practitioner are mirrored in the development of the APS since 1966. It resulted in the publication of the *Australian Psychologist* in 1966, a journal with professional emphasis whereas the *Australian Journal of Psychology* was more closely concerned with experimental applications. Secondly the APS, following a model set by the BPS, established two divisions; one called the Division of Scientific Affairs, concerned with academic issues involving both basic training and research, and the other, called the Division of Professional Affairs, concerned with practitioner issues.

The Division of Professional Affairs has subsequently established eight discrete Boards (Clinical Neuropsychology, Clinical, Community, Counselling, Educational and Developmental, Sport, Forensic and Organisational Psychology) to cater to the needs of specialised aspects of practitioner-based psychology. It is illustrative to note that, in comparison, the American Psychological Society currently incorporates some 49 Boards.

Associated with this organisation of psychology was a push for public recognition and official imprimatur in the form of registration of psychologists. One of the primary reasons of this push was to prevent charlatans from claiming to be psychologists and thus bringing the profession into disrepute. In 1965, a law was passed in Victoria requiring all persons practicing as psychologists to obtain registration from a government appointed council which required minimum qualifications (which were, not coincidentally similar to those required for membership

of the APS) as a prerequisite and which holds itself responsible for policy, standards of practice and professional ethics.

Today all States require registration if an individual wishes to practice as a psychologist and have Registration Boards to oversee the operation of the profession. The last state to embrace registration was New South Wales where a Registration Bill was passed by Parliament in 1990 after much political infighting with the medical profession, particularly psychiatrists.

### **2.3.2 Development of Clinical Psychology**

The history and development of clinical psychology in Australia is, by comparison with that of the United States, relatively short and immature. Clinical psychology as a distinct specialisation of psychology has largely been a post World War II phenomenon.

The early history of clinical psychology in Australia was concentrated almost totally in the public sector. Psychological clinics, predominantly dealing with children, were opened in most States during the 1920's. These clinics were, by and large, offshoots of University Psychology departments and were thus confined to the capital cities. Clinical psychologists were to be found mainly in these outpatient child guidance clinics usually working within a team model, with a social worker and psychiatrist as professional colleagues, the latter invariably being designated the team leader.

However it must be emphasised that these child guidance clinics were more educational than clinical in their outlook. To illustrative this point the child guidance clinics were part of the School Medical Service under the control of the Department of Education until 1949.

In most States the next significant development was the appointment of clinical psychologists to mental institutions in the late 1940's and early 1950's. Employment opportunities were also to be found, in limited numbers, in correctional institutions. In addition, the Repatriation Department, charged with the welfare of returned servicemen, employed clinical psychologists from 1948.

Formal training of clinical psychologists was initially a self-help matter and of a strongly psychoanalytic flavour. Groups formed about psychoanalytically trained psychiatrists or clinical psychologists formed their own study groups such as the Rorschach Society in Victoria (formed in 1948) and the Clinical Psychology Study Group (formed in 1950).

In 1949 the University of Western Australia commenced the first formal training of clinical psychologists, a one-year full-time postgraduate course. This ultimately expanded into a three-year full-time Diploma of Clinical Psychology in 1956. It adopted the Boulder Model of the clinical psychologist as a scientist-practitioner as the basis for its curriculum.

### **2.3.2.1 Present State of Clinical Psychology**

Clinical psychology is, by all accounts, the most rapidly growing of the psychological specialties practiced in Australia (Byrne & Reinhart, 1990). Membership of the Clinical Board of the Australian Psychological Society has increased 112% in the last decade (APS Annual Report, 1989). Programs of clinical training are available at thirteen Australian universities, largely at Master's degree level but with doctoral courses now becoming more readily available (Martin, 1989a).



Clinically-based research is active, with 36% of all papers published in the *Australian Psychologist* in the period 1983-1989 bearing on clinical, counselling or health psychology (Viney, 1989). However it is illustrative to note that almost all of this clinically-based research is conducted by academic clinical psychologists. The vast majority of clinical psychologists in the public or private sector do not conduct any form of research (Maher, 1991).

In a comprehensive survey of the professional activities and theoretical orientations of Australian clinical psychologists, Byrne & Reinhart (1990) uncovered some informative trends.

Respondents reported their range of clinical activities by nominating the percentage of time in an average week spent on a broad range of possible activities. Results revealed that most time was spent on individual psychotherapy (28%). This was followed, in turn, by office-based administration (12%), teaching (10%), consultation (9%), research (8%), psychometric testing (7%), behaviour modification, clinical neuropsychology and supervision (all 6%) and group therapy (3%). Clearly the management of the individual patient or client continues to present the dominant focus of clinical psychologists' activities.

With regard to theoretical orientation, respondents nominated the following to best describe their present approach to clinical practice: behavioural (38.1%), psychoanalytic (32.6%), humanistic (7.9%) and systems (7.4%). It is interesting to note that almost one third of respondents (32.6%) said they preferred to use an eclectic approach to their clinical practice.

The affinity for the behavioural approach to clinical practice is at odds with the relatively recent trends in the United States (Garfield & Kurtz, 1976), where theoretical orientations tend to span the available breadth more evenly. Bryne & Reinhart (1990) comment that this finding perhaps

" reflects the current Australian view that the scientist-practitioner model of clinical training continues to dominate the teaching ideology of clinical courses" (p. 110)

Responses to an enquiry about the optimal level of academic qualifications seen to be necessary for clinical practice demonstrated the groundswell for increasing professionalism. Although the majority nominated the postgraduate clinical master's degree for fulfilling this function a noticeably large group (40.1%) indicated their preference for a clinical doctorate program. At the present time only four tertiary institutions in Australia offer such a course and they have only been doing so since 1988.

Responses were sought using an 11-point Likert scale to ascertain both satisfaction with and academic preparation for clinical psychology and adequacy of final training. There was a strong correlation between the two scales ( $r = 0.81$ ,  $p < 0.001$ ). Results did not indicate strong support for both satisfaction and adequacy with 45.5% rating their satisfaction between very dissatisfied and satisfied and 50.9% rating their adequacy of training between less than adequate and adequate.

Finally 73% of respondents reported themselves satisfied with clinical psychology as a career. Sixty five per cent said they would become clinical psychologists again given the same circumstances, though only 51.1% said they would choose clinical psychology if they had a completely open choice of occupational activities (6.8% would choose another area of

psychology, 31.1% would choose another profession altogether, and 2.3% would rather be relieved of the need to work). This can be compared with Byrne (1982) where 93.3% of respondents expressed some degree of satisfaction with clinical psychology as a career.

Byrne & Reinhart (1990) conclude by saying:

"It is clear that clinical psychology has not progressed in line with its scientific basis; many roles for which the clinical psychologist is well trained are assumed by other, often less well trained, professionals. The status of clinical psychology, between science and profession, will ultimately depend on perceptions of its functions and worth."  
(p.110)

In a series of studies designed to gauge the efficacy of the scientist-practitioner model with respect to clinical psychologists in Australia, Martin (1989b) found that the results clearly supported the increasingly widely held belief that the scientist-practitioner model is still the preferred one for training, but is not being implemented successfully.

"The clearest example of failure is that most clinical psychologists are not engaging in research, let alone publishing results. They appear to monitor research findings, but whether this influences their practice is debatable." (p.90)

Nonetheless the scientist-practitioner model still enjoys widespread support. This support exists in the university programs, and the employers of clinical psychologists, as well as amongst individual members of the profession.

In a study aimed at ascertaining teachers' perceptions of the work of psychologists in primary and secondary educational institutions Leach (1989) looked at teachers' perceptions of what psychologists do in schools, how well they do it and to what extent their activities are needed and valued. Results indicated that respondents had a somewhat traditional view of the role of the psychologist in the educational setting. The main finding was that psychologists were involved in cognitive testing and assessing individual children usually for placement in special classes or schools. To a lesser extent they were seen to advise teachers (and sometimes parents) on methods of managing childrens' learning and behaviour difficulties and sometimes acted as consultants and counsellors.

Respondents expressed concerns about aspects of service delivery such as the perceived lack of relevance and practicality of many classroom interventions, relatively poor written communications, non-collaborative working relationships, and a general lack of satisfaction by teachers with the services they received. Leach (1989) makes the comment that:

"[There is a] need to properly inform teachers about what psychologists do, what they can do, and what sort of training they have had."

It seems a common theme, then, that the work of psychologists is little understood or appreciated by the general public. For psychologists themselves, there is considerable disquiet about the nature and relevance of much of their training, particularly if they do not pursue an academic career but choose to become practitioners in the public or private sector.

While it is true the opportunities for psychologists are expanding it is feared that the profession may not be keeping pace with its own development.

### **2.3.3 Development of Counselling Psychology**

The search for a definable professional identity of counselling psychologists is not a new quest. Since the adoption of the title by Division 17 of the American Psychological Association in 1951, the elusive identity has been sought on both a theoretical (e.g. Domke, 1982; Fretz, 1982; Holland, 1982; Watkins, 1983, 1985; Osipow, 1977) and an empirical level (e.g. Osipow, Cohen, Jenkins & Dostal, 1979; Watkins, Lopez, Campbell & Himmell, 1986).

This search for identity is especially true in Australia where counselling psychology as a distinct branch of psychology is a relatively recent development. A division comparable to Division 17 was established within the Australian Psychological Society only in 1976.

There is a dearth of information relating to the development of counselling psychology in Australia. Only a limited number of authors have addressed this important area (Khan, 1983; Penney, 1981; Wills, 1980; Williams, 1978).

Williams (1978), in a prophetic discussion of the dilemma facing the fledgling (then) Division of Counselling Psychology, strongly emphasised:

"It is important for counselling psychology to establish its own identity, otherwise there would be no reason for the Division to exist." (p.33)

He went on to say that the fundamental problem facing counselling psychology lay in the widespread generic use of the word *counselling*:

" Not all counsellors are counselling psychologists....This situation places the field of counselling in some confusion to those of us who practice it. It must be even more confusing to the general public."  
(p.36)

To establish a separate identity for counselling psychology Williams (1978) identified, as defining attributes of prospective members, their movement towards an educational or psycho-educational model as opposed to a medical model. He posited a focus on "wellness" and a shift from remediation to development, while acknowledging that such generalisations in themselves led to confusion with other areas within the broad field of counselling psychology.

Today the Board of Counselling Psychologists is the second largest in terms of membership of the Australian Psychological Society (APS Annual Report, 1993). However, Schoen (1989) in the only comprehensive survey of counselling psychologists in Australia to date, found that 20% of her sample (N=197) were also members of the Clinical Board of the Australian Psychological Society. Further she found that less than half of the sample identified themselves primarily with the title "counselling psychologist".

## **2.4 Models and Settings of Psychological Service Delivery**

From the preceding discussion about the development of psychology as a profession in Australia it is clear that there is still much confusion among the ranks of psychologists themselves as to where they see their profession going.

One method by which the identity of a professional group may be more clearly defined is to investigate how they go about their work, the areas in which they work and how they provide their services to the general public.

In the Australian context the delivery of clinical and counselling psychological services can be, in the main, divided into two categories; (i) those offered in the public sector and (ii) those offered in the private sector with some degree of overlap between the two. Examples of these include:

Public Sector	Public/Private Sector	Private Sector
<ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Community Health Centres</li> <li>• Specialist agencies</li> <li>• Outreach services</li> <li>• Student units in educational institutions</li> <li>• Allied government departments</li> </ul>	<ul style="list-style-type: none"> <li>• Staff counsellors in organisations</li> <li>• Rehabilitation providers</li> <li>• Employee assistance programs</li> </ul>	<ul style="list-style-type: none"> <li>• Private practitioners</li> <li>• Church-based welfare agencies</li> </ul>

The growth of the "helping" psychologies (i.e. clinical and counselling psychology) in Australia has suffered somewhat because of the operation of three factors. Firstly in relation to the development of psychological services in other parts of the world, Australia is a relative neophyte. Psychology was only organised on an national level some 27 years ago

with the inauguration of the Australian Psychological Society in 1966 (although since 1945, Australian psychologists had organised themselves as a branch of the British Psychological Society). Thus, in world terms, the development of Australian psychology is still in its relative infancy.

Secondly, and somewhat as a consequence of the first reason, the development of appropriate models for the delivery of psychological services has been relatively haphazard and unstructured, with little control for efficiency or economy of service being imposed, nor much thought about the future direction of the profession. In essence psychologists have searched for niches in the market in which to establish themselves rather than setting out to establish models of service delivery unique to their skills and abilities (e.g. Thomas & Wearing, 1986; Mullaly, Kelly, & Wearing, 1985).

Thirdly, almost all the models of service delivery developed in Australia so far have been largely reactive in nature. This situation has come about largely because of a lack of both financial and manpower resources necessary to institute proactive programs. Some commentators attribute this to the lack of political influence that can be exerted by psychologists citing the relatively powerful medical lobby as an example of successful political intervention.

Table 2.1 elucidates the various models of the delivery of psychological services and work settings as presently employed in Australia together with major sources of referral, location of service delivery and associated costs. A point to be noted in the following discussion is that the term "psychologist" will be used generically in the sense that there is no legislative or statutory difference in Australia between the work of



**Table 2.1 Models of psychological service delivery and work settings**

<b>Service</b>	<b>Psychologist's Role in Service Delivery</b>	<b>Referral Source(s)</b>	<b>Work Location</b>	<b>Cost</b>	<b>Comments</b>
Community Health Centre	<ul style="list-style-type: none"> <li>• member of multidisciplinary team</li> <li>• usually work in mental health team</li> <li>• acts as a consultant to other teams</li> <li>• usually engages in short-term counselling</li> <li>• limited group work</li> </ul>	<ul style="list-style-type: none"> <li>• general public</li> <li>• medical practitioners</li> <li>• schools</li> <li>• welfare agencies</li> </ul>	<ul style="list-style-type: none"> <li>• usually office-based</li> <li>• limited home visits</li> </ul>	<ul style="list-style-type: none"> <li>• free to client</li> </ul>	<ul style="list-style-type: none"> <li>• due to heavy workloads usually long waiting list</li> <li>• pressure to "turn over" clients</li> <li>• limited resources</li> </ul>
Hospital - General	<ul style="list-style-type: none"> <li>• member of multidisciplinary team</li> <li>• usually works in mental health team</li> <li>• preference for medical model</li> <li>• may work in specialist wards such as spinal, oncology, pediatrics, orthopedic etc</li> </ul>	<ul style="list-style-type: none"> <li>• inpatient and outpatient - medical personnel</li> <li>• general public</li> </ul>	<ul style="list-style-type: none"> <li>• hospital-based</li> </ul>	<ul style="list-style-type: none"> <li>• free to client</li> </ul>	<ul style="list-style-type: none"> <li>• due to heavy workloads usually long waiting list</li> <li>• pressure to "turn over" clients</li> </ul>
Hospital - Psychiatric	<ul style="list-style-type: none"> <li>• member of multidisciplinary team</li> <li>• preference for medical model</li> <li>• assist in patient diagnosis through use of psychometric testing</li> <li>• limited opportunities for counselling</li> <li>• some group work</li> </ul>	<ul style="list-style-type: none"> <li>• inpatient and outpatient - medical personnel</li> <li>• general public</li> </ul>	<ul style="list-style-type: none"> <li>• hospital-based</li> </ul>	<ul style="list-style-type: none"> <li>• free to client</li> </ul>	<ul style="list-style-type: none"> <li>• due to heavy workloads usually long waiting list</li> <li>• pressure to "turn over" clients</li> </ul>

Specialist Agencies e.g. sexual assault, child development	<ul style="list-style-type: none"><li>• member of multidisciplinary team</li><li>• require specialised skills/training</li><li>• short-term counselling</li><li>• emphasis on diagnosis</li><li>• development of intervention programs</li></ul>	<ul style="list-style-type: none"><li>• public</li><li>• medical personnel</li><li>• Police</li><li>• legal</li><li>• Welfare agencies</li></ul>	• office-based	• free to client	<ul style="list-style-type: none"><li>• due to heavy workloads usually long waiting list</li><li>• pressure to "turn over" clients</li></ul>
Outreach Services	<ul style="list-style-type: none"><li>• member of multidisciplinary team</li><li>• working with psychiatric clients</li><li>• crisis intervention</li><li>• acts as case manager co-ordinating client's treatment program</li></ul>	<ul style="list-style-type: none"><li>• medical personnel</li><li>• Police</li><li>• legal</li><li>• Welfare agencies</li></ul>	<ul style="list-style-type: none"><li>• usually client's home</li><li>• some office-based</li></ul>	• free to client	<ul style="list-style-type: none"><li>• pressure to "turn over" clients</li><li>• psychological intervention adjunct to medication</li></ul>
School Counselling	<ul style="list-style-type: none"><li>• usually works solely on day-to-day basis</li><li>• works with students who have emotional and/or behavioural problems that impact on learning, socialising</li><li>• diagnosis of problem</li><li>• development of intervention programs to be implemented and maintained by others</li></ul>	<ul style="list-style-type: none"><li>• teachers</li><li>• parents</li><li>• allied health professionals</li></ul>	<ul style="list-style-type: none"><li>• school-based</li><li>• limited home visits</li></ul>	• free to client	<ul style="list-style-type: none"><li>• due to heavy workloads usually long waiting list</li><li>• pressure to "turn over" clients</li><li>• clients requiring long-term assistance referred on to other services</li></ul>
Tertiary Institution Counselling	<ul style="list-style-type: none"><li>• work solely or in small team of psychologists</li><li>• short-term counselling</li><li>• group work</li></ul>	• self	• campus-based	• Free to client	

Employee Counselling	<ul style="list-style-type: none"><li>• psychologist employed by organisation</li><li>• in general usually work solely</li><li>• short term counselling for personal and/or work-related problems</li><li>• problem-solving</li><li>• advice giving</li></ul>	<ul style="list-style-type: none"><li>• self supervisor</li></ul>	• work-based	• Free to client	<ul style="list-style-type: none"><li>• concerns re confidentiality and impartiality</li><li>• who "owns" client records</li></ul>
Private Practitioner	<ul style="list-style-type: none"><li>• usually work solely, in small group of psychologists or with a medical practitioner/psychiatrist</li><li>• engage in short and long term therapy but sometimes limited group work</li></ul>	<ul style="list-style-type: none"><li>• public medical practitioners</li><li>• legal</li></ul>	• office-based	<ul style="list-style-type: none"><li>• APS recommended fee</li></ul>	<ul style="list-style-type: none"><li>• not rebatable on Medicare</li><li>• limited or no rebates from private health funds</li><li>• fee can only be afforded by limited number of people</li></ul>
Rehabilitation Provider	<ul style="list-style-type: none"><li>• usually works as part of multidisciplinary team</li><li>• acts as case manager coordinating client's rehabilitation program</li><li>• some limited counselling</li></ul>	<ul style="list-style-type: none"><li>• clients' work organisation</li></ul>	<ul style="list-style-type: none"><li>• office-based</li><li>• some limited work site</li></ul>	<ul style="list-style-type: none"><li>• Free to client (work organsation pays fee)</li></ul>	<ul style="list-style-type: none"><li>• psychologist limited in extent to which client can be helped</li></ul>

Government Departments	<ul style="list-style-type: none"><li>• some Government departments provide counselling to their clients as part of their overall service (e.g DSS, DEET, CES, VA)</li><li>• crisis counselling</li><li>• short-term counselling/ advice giving</li></ul>	<ul style="list-style-type: none"><li>• clients of department</li></ul>	<ul style="list-style-type: none"><li>• office-based</li></ul>	<ul style="list-style-type: none"><li>• Free to client</li></ul>	<ul style="list-style-type: none"><li>• usually "one-off" counselling</li><li>• high turn over</li></ul>
Church/Welfare agencies	<ul style="list-style-type: none"><li>• generally telephone counselling</li><li>• some limited individual counselling</li><li>• crisis intervention</li><li>• very short-term therapy</li><li>• advice giving and referral onward</li></ul>	<ul style="list-style-type: none"><li>• public</li></ul>	<ul style="list-style-type: none"><li>• office-based</li><li>• limited home visits</li></ul>	<ul style="list-style-type: none"><li>• Free to client</li></ul>	<ul style="list-style-type: none"><li>• lack of personal contact with clients</li></ul>
Employee Assistance Program	<ul style="list-style-type: none"><li>• psychologists may be employed directly by work organisation or be contracted from a private provider</li><li>• short-term counselling for any personal and/or work-related problems</li><li>• development of workplace health promotion programs</li></ul>	<ul style="list-style-type: none"><li>• employee</li><li>• supervisor</li></ul>	<ul style="list-style-type: none"><li>• office-based</li><li>• work-site-based</li><li>• home visits</li></ul>	<ul style="list-style-type: none"><li>• Free to client (organisation pays fee)</li></ul>	

counselling psychologists and clinical psychologists and, in practical terms, their roles and functions have significant overlap.

While there is great diversity of settings in which psychologists have found employment there is a large amount of commonality between models of service delivery. An examination of this table indicates that psychologists in these different work settings generally deliver their services in much the same way i.e. in a office, using an appointment system, paid for by a third party, employing short term interventions, and with a lack of resources to encourage professional excellence.

Yet, as seen in Chapter 1, statistics reveal that psychological services are greatly underutilised. It seems logical, then, to assume that present models of service delivery are not meeting the needs of their clientele. Perhaps it is time for a new, more effective model.

## **2.5 The Present Study**

It can be seen from the preceding discussion of the development of clinical and counselling psychology, with particular emphasis on the Australian context, that the profession could be said to be at philosophical and professional crossroads.

It is generally accepted that undergraduate training in tertiary institutions in Australia does not equip new psychologists with skills that will equip them to be effective practitioners (Franklin, 1993). The adherence to the scientist-practitioner model, with emphasis on the scientist, has been found wanting in terms of preparation for a professional career.

It could be argued that, in the past, the profession has been more interested in academic affairs rather than developing the applied psychologies. Currently there is an oversupply of psychologists in Australia (DEET Report, 1992) and with limited job opportunities in both the public sector and academic fields, psychologists are increasingly being forced to find work in the private sector. It is only now that with so many psychologists becoming dependent on gaining a client base that psychologists are looking at how the public sees them.

Psychologists remain office-bound dispensers of wisdom (cf the medical model) and as such their clients, the general public, see little of them, know little about them, and consequently, do not access their services as often as they could.

In addition the proliferation of specialties within the profession, with lines marking the boundaries between them significantly blurred, adds to the public's confusion of what it is that psychologists can offer. The profession has been permitted to develop without much thought for the future.

It is an aim of the present study to investigate whether psychologists must become, to invoke a computer metaphor, "user friendly" if they are to continue as a viable force into the twenty-first century.

## **CHAPTER 3**

### **FACTORS INVOLVED IN SEEKING PSYCHOLOGICAL HELP**

### 3.1 Overview of the Literature

As has been outlined in Chapter 1 in discussion of the "service gap" most people experiencing distress do not seek help for their problems (Langner & Michael, 1963; Mechanic, 1976; Srole, Langner, Michael, Opler & Rennie, 1962). It is an aim of the present study to remedy this problem by addressing barriers to psychological helpseeking.

A large number of reasons have been suggested by the social psychological and clinical literature for this reluctance to seek help. Initially, people may be slow to ask for assistance because their problems are difficult to identify or are indeed denied (Golan, 1969; Moore, Boling & Brown, 1963; Snyder & Kahne, 1985). Once a problem has been identified, however, people may still be reluctant to seek assistance due to a number of perceived external constraints. The perception of barriers such as monetary cost, difficulty in transportation, and not being able to spare the time have been found to prevent helpseeking (Acosta, 1980). Furthermore if the help source is seen as incompetent, unable to help or unavailable, helpseeking is unlikely to occur (Gurin, Veroff & Feld, 1960; Mayer & Timms, 1970; Mechanic, 1976).

However, other factors are more psychological in nature. Greenberg (1980) has argued, on the basis of equity theory, that feelings of indebtedness towards the helper may be aversive enough in many situations to inhibit helpseeking. Consistent with this notion, experiments have indicated that feelings of indebtedness increase as the amount of help required rises (Greenberg & Frisch, 1972) and that when help cannot be reciprocated, helpseeking is less likely (Greenberg & Shapiro, 1971; Morris & Rosen, 1973).



A somewhat different theoretical framework was proposed by Fisher Nadler & Whittaker-Alagna (1982) who postulated that helpseeking is frequently threatening to the recipient's self-esteem. Consistent with this threat to self-esteem model, people have been found to seek less help for problems which are very intimate (Greenley & Mechanic, 1976; Mayer & Timms, 1970; Sweetser, 1960), stigmatising (Bergin & Garfield, 1971 Overbeck, 1977, Perlman, 1975) or imply personal inadequacy (Gross Fisher, Nadler, Stiglitz & Craig, 1979; Shapiro, 1980).

Amato & Bradshaw (1985) theorised that these reluctances to seek help appeared to represent important psychological obstacles standing between the perception of a distressing problem and the active search for help which might alleviate the problem. People's reasons for seeking help are likely to be affected by the nature of the situation, the perceived characteristics of the problem, and their personalities and attitudes. In turn the nature and strength of these reluctance motives affects the decision to seek help and the choice of help source. As such, they constitute intervening variables between situations, problems and personal characteristics on the one hand and helpseeking behaviour on the other.

Kushner & Sher (1989, 1991) strongly emphasised the role of treatment fearfulness as an important interpolated psychological barrier to seeking help. They defined treatment fearfulness as:

"a subjective state of apprehension that arose from aversive expectations about the seeking and consumption of psychological services." (Kushner & Sher, 1991: p196)

They suggested that the specific content of the fears were most likely multifaceted, culturally influenced and, in some cases, idiosyncratic.

Integrating their concerns into a helpseeking model Kushner & Sher (1991) considered the decision to seek help to be motivated in part by a conflict between approach tendencies (e.g. mental disruptions, pressure from others) and avoidance tendencies (i.e. treatment fears, cost, time commitment). Thus, in their view, an individual's tendency to seek help is influenced by competing motivational and inhibitory influences of varying strengths that constitute a classic approach-avoidance paradigm. They asserted that, ultimately, the varying strengths of the competing motivational factors, when considered together, determined whether the conflict contributed more towards helpseeking or avoidance.

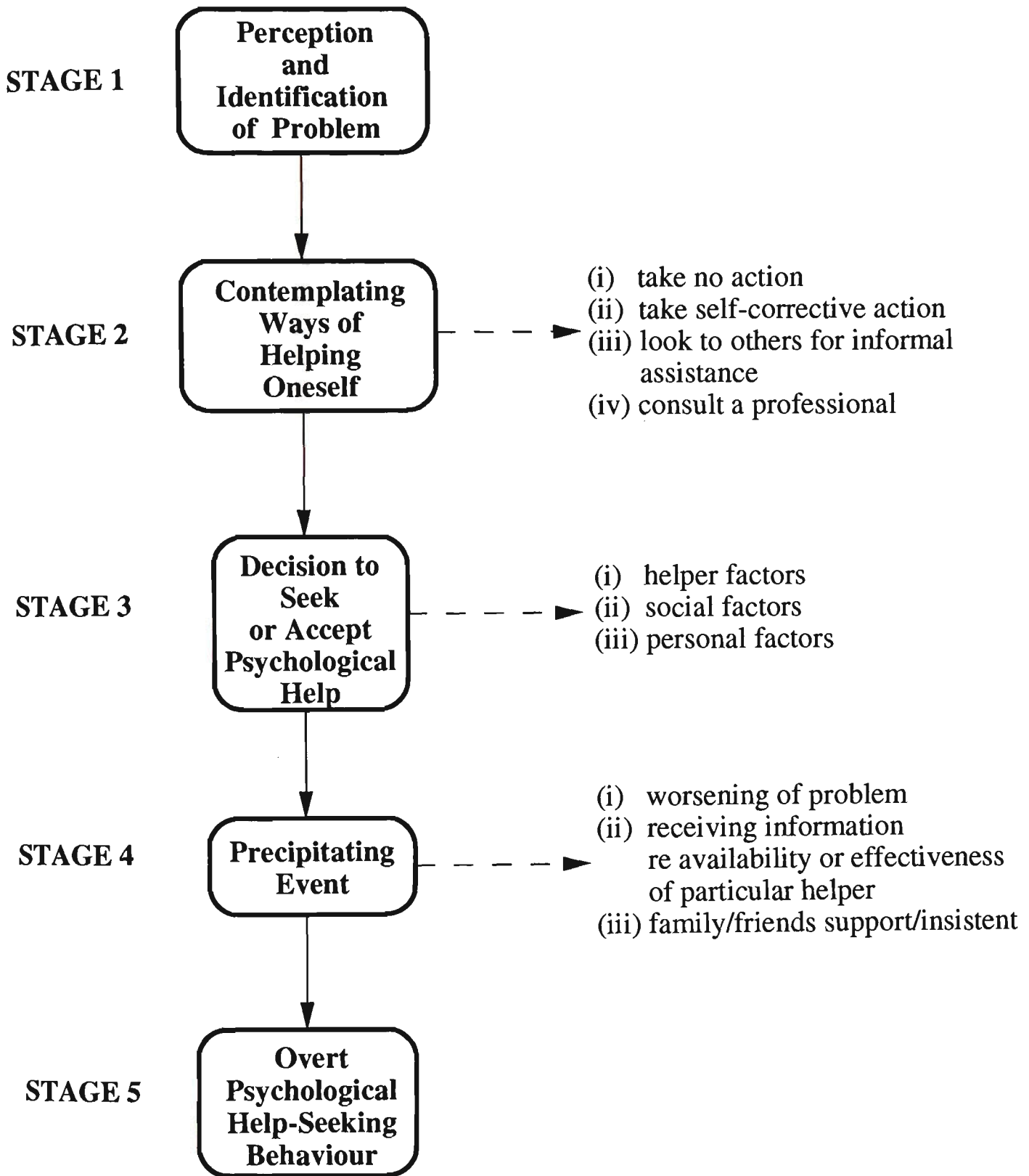
### **3.2 A Model of Helpseeking**

Fischer, Winer & Abramowitz (1983) have developed a generalized five stage model of help-seeking behaviour, applied specifically to psychological help-seeking. Their model ultimately represents a synthesis of a range of help-seeking models found in the psychological help-seeking literature (Albers & Scrivner, 1977; Gross & McMullen, 1981; Gross & McMullen, 1983, Kadushin, 1958; Rosenstock, 1974). Fischer et al. (1983) point out that although most of these models pertain to help-seeking behaviour in general, their model delineates cognitive and behavioural choice-making sequences that may be involved in psychological help-seeking as well. They suggest a range of factors that can facilitate or inhibit the person's obtaining aid at any point in a sequence. A detailed outline of this model provided in Figure 3.1.

#### **Stage 1: Perception and Identification of a Problem**

Before an individual can consider ways to relieve psychological distress, he or she must recognize that a problem exists and realise that it has, or can or will have, harmful personal consequences. Sometime during this

**Figure 3.1 A MODEL OF PSYCHOLOGICAL HELP-SEEKING**



(Adapted from Fisher, Nadler & Abramowitz, 1983)

stage the problem will probably be acknowledged as psychological, at least in some sense, by force of its quality, locus, dynamics, or personal or interpersonal effects.

## **Stage 2: Contemplating Ways of Helping Oneself**

At Stage 2, the person reviews possibilities for resolving or reducing the problem. These deliberations may include the alternatives of:

- (i) *taking no action*, merely waiting for the problem to rectify itself or to be reduced in scope, intensity, or persistence (one aspect of the problem that may be salient in early stages is its tolerability - can the difficulty be borne without any changes?;
- (ii) *taking direct, self-corrective actions* - that is, trying self help measures other than asking others for assistance, for instance searching for a new job, using drugs or medications, confronting people believed to be at the root of the problem, or developing positive mental sets;
- (iii) *looking to others for informal assistance*; and
- (iv) *consulting a professional*

## **Stage 3: Decision to Seek (or Accept) Help**

In Stage 3, the individual has formed an intention with respect to seeking professional help. That is, he or she is favourable, unfavourable or ambivalent to the idea. Several of the help-seeking models hold that the person's decision to seek help or not is contingent on the net balance of various facilitating and inhibitory elements. According to this thinking, a decision to get help stems from a (perhaps implicit) calculation that the anticipated gains from psychotherapy will surpass the total cost. Fischer et al. (1983) suggest that the following variables importantly affect one's choice to go or not to go for psychological help:

- (i) *therapist or agency factors*: the monetary cost of therapy; the quality of help available to the person; whether the available

therapist is seen as competent enough; the individual's attitudes toward and knowledge about psychotherapists (will the therapist be aloof, contemptuous, intimidating?); and the practical inconveniences of therapy (scheduling time, travel, and repeated visits),

- (ii) *social factors* : embarrassment and stigma; the anticipated reactions of key others (will they see the therapy contacts as appropriate and sensible?)
- (iii) *personal factors*: intensity and duration of the problem or symptoms; feelings of loss of self-reliance, dependency, and indebtedness; the belief that a person who solves his or her own problems is more worthy. According to the model, the gains anticipated from therapy are weighted against such negative factors.

Wills (1983) suggests that only about one- half of those who really need professional assistance finally go for help because so many disadvantages are foreseen.

#### **Stage 4: Precipitating Event**

Rosenstock's (1974) model indicates that the final act of help-seeking may require some occurrences sufficient to mobilise the individual. For psychological help-seeking this might be a significant worsening of the problem or a sudden flare-up of symptoms, receiving information about the availability or effectiveness of a particular therapist, or the realization that ones' family supports the decision to get help. An event that effectively prompts someone into action would most likely occur at a time when the person is almost, though not quite fully, committed to a decision to get help. Without the occurrence of a timely precipitant, the individual could remain in a state of indecision for a long time, perhaps for years (Fischer et al., 1983).

### **Stage 5: Overt Help-Seeking Behaviour**

In the final stage, the person is convinced of the need for professional attention, and is ready to go for help. Ostensibly, he or she would be searching for information about therapists and setting up appointments. However even though motivated to commence therapy, some might not obtain adequate help because of other obstacles. They may lack the means or knowledge necessary to locate a suitable therapist or agency, or may not be accepted into therapy, or the obtained help might be ineffective.

It must be emphasized that an individual may advance along each of the help-seeking steps in isolation, or within some particular social context (Gross & McMullen, 1983) In the latter case, the social interactions can affect the outcome of each step. For instance, in the recognition-of-the-problem stage (Stage 1), the person's family could be the main indicator of that person's own recognition of an emotional problem or, at the other extreme, may insulate the family member to the extent that he or she fails to acknowledge what outsiders perceive as a serious psychological difficulty Similarly, in one of the later stages of the help-seeking process, people close to the troubled individual may promote or prevent that individual's contact with a professional.

Gross & McMullen (1983) have pointed out that theories of help-seeking may oversimplify or distort reality by implying that peoples' help-seeking efforts follow logical, orderly, linear patterns; in reality they do not. Additionally, the theoretical oversimplification or distortion may be greater for psychological than for other modes of help-seeking (Gross & McMullen, 1983). Undoubtedly the process of seeking professional help

for a psychological difficulty has elements in common with help-seeking in other realms. But Fischer et al. (1983) submit that, compared to the person with, say, a legal or medical problem, the individual in need of psychiatric/psychological aid is more apt to experience profound helplessness, to have trouble comprehending the fundamental nature of his or her difficulty, to have trouble applying rational problem-solving steps to obtain the needed help, and to be uncertain as to whether competent help is available and where to turn for help. Hence, information about available services is very important (in fact, fundamental) to any help-seeking decision.

### 3.3 Factors Influencing Helpseeking

For the purposes of the present discussion the proliferation of relevant research on seeking help for psychological problems can be neatly divided into two types:

- (i) *attitude-based* research, including those studies concerned with how people feel about psychotherapy and other forms of psychological aid, and whether they would be inclined to obtain such help if it were needed; and
- (ii) *behaviour-outcome* research, including studies of the characteristics of people who have sought psychotherapeutic help and the circumstances that brought them to make their decision.

The chief reason for separating the two types of studies is conceptual. Most of the attitude studies surveyed here utilised a scale developed by Fischer & Turner (1970) to measure Attitude Towards Seeking Psychological Help (ATSPH). Although a considerable amount of data concerning the psychometric properties of the ATSPH has accumulated to date there have been no studies showing its ability to predict help-seeking behaviour. Notwithstanding this important distinction, there are

several areas of overlap in which results shown with attitudes are confirmed by those obtained with behavioural indices of help-seeking.

### **3.3.1 Attitude Research**

The literature involving attitude studies in turn falls into two categories: (i) those that correlate attitudes toward seeking professional psychological help with various respondent characteristics (for example, gender, social class, educational level, cultural differences, and personality factors), and (ii) those that examine the structural or dynamic properties of attitudes, such as factorial and attitude change studies.

#### **3.3.1.1 Demographic and Personality Correlates**

##### **3.3.1.1.1 Gender**

Strong sex differences in attitudes toward seeking professional psychological help are seen in most studies (for example: Fischer & Turner 1970; Fischer & Cohen, 1972; Kligfeld & Hoffman, 1979; Cook, Park, Williams, Wells, Nicholson, Schneider & Bassman, 1984; McMichael & Hetzel, 1974; Figueroa, Calhuon & Ford, 1984; Altmaier & Rapport, 1984). In all these studies, females' attitudes were overwhelmingly more favourable to help-seeking than were those of males. A few studies have found no significant effects of sex (Farber & Geller, 1977; Snyder, Hill & Derksen, 1972), but no study has found males' attitudes towards seeking help to be more favourable than those of females.

Most studies account for the strong sex difference in professional help-seeking attitudes, in terms of cultural sex role norms and socialization. Thus in our society, it has been theorised that males are brought up to be more independent and self-reliant while females are brought up more



dependent and docile (Oakley, 1972; Walum, 1977) although there is accumulating evidence that this dichotomy is being addressed. In line with this assumption, males may refrain from seeking help because of the implied dependency role for the help-recipient. For females, on the other hand, seeking help and placing oneself in a dependent position represent a lesser threat because dependency and femininity are connected in our culture (Oakley, 1972; Walum, 1977).

### **3.3.1.1.2 Social Class**

In the 1950s social class was regarded as a powerful indicator of attitudes towards seeking professional help (Brill & Storrow, 1960). However the current review of more recent research yielded few attitudinal data to support this contention. Of the few studies which examined social class effects, only one (Farber & Geller, 1977) showed the expected result, which was that upperclass respondents' attitudes were more pro-help-seeking. In the other studies there was either no effect (Lorian, 1974; Pfeiffer, 1978) or a weak interaction between social class and some other demographic variable, such as race or nationality (deBarot, 1977; Fischer & Cohen, 1972).

One possible explanation for the lack of support for social class as an indicator of help-seeking attitude, is the predominant use of tertiary level students in most current research. Any such social class differences may be broken down in the transition from school and family life, to university participation and studies.

### **3.3.1.1.3 Education and Educational Reference Groups**

Level and type of education may have more important influences on psychiatric/psychological help-seeking orientation than do other aspects

of socioeconomic status. Of all the demographic variables examined in Fischer and Cohen's (1972) study, people with higher levels of education were more favourable to seeking professional help. The finding was independent of the respondents ages. Kligfeld & Hoffman (1979) also found level of education positively correlated with attitude towards seeking psychological help among medical students.

Several studies have shown that the field of study (or major) is a significant indicator of psychological help-seeking orientation (Farber & Geller, 1977; Fischer & Cohen, 1972; McMichael & Hetzel, 1974; Altmaier & Rapaport, 1984). In these studies, students with social-science and humanities majors were more favourably disposed to seeking professional help than were those in applied programs (for example, nursing, engineering, business administration) or in the "hard" sciences (for example: physics, chemistry, mathematics).

The results pertaining to university students also fit a pattern found in previous research, namely, that social science majors generally take a liberal stance, and people in applied fields are more conservative regarding many social attitudes (Bereiter & Freedman, 1962, cited in Fischer & Cohen, 1972). The "taking of a liberal stance" aligns with Fischer and Turner's (1970) identification of two pertinent factors which they felt sampled an attitude domain of professional help-seeking attitude, that is: tolerance of stigma associated with psychological/psychiatric help and interpersonal openness regarding one's problems.

#### **3.3.1.1.4 Culture and Religion**

Dadfar & Friedlander (1982) found, from their sample of 300 international students at a large American university, that overseas born students' mean pro-help attitude scores were significantly lower than those of their American peers. Further, Dadfar & Friedlander found that European and South American born students had a significantly higher mean pro-help score than Asian and African students. Western and non-Western societies have been said to differ on dimensions of authoritarianism, restrictiveness (Levine, 1972), and acceptability of help outside the family, which may account for the more positive responses by Western students. Also contrary to Western students, sex was not uniquely significant in predicting attitudes towards seeking professional psychological help (Dadfar & Friedlander, 1982).

Investigating religious affiliation, Fischer & Cohen (1972) found that Jews had more positive help-seeking attitudes than did Protestants or Roman Catholics. The effect for religion held within each socioeconomic class but was not as robust as other demographic influences, such as education. Farber and Geller (1977) also found that Jewish respondents were more favourable toward psychotherapy than were those in other religious categories.

#### **3.3.1.1.5 Personality Factors**

A variety of studies have demonstrated the relationship between psychiatric/psychological help-seeking attitudes and either liberal-conservative orientation or authoritarianism (deBarot, 1977; Fischer & Turner, 1970; Siegman, 1974; Zeldow & Greenberg, 1979, 1980). In theoretical terms the authoritarian person

"....has been described as conventional, hypocritical, submissive to superiors, opposed to the subjective, and rigid in his beliefs.... These traits seem antithetical to the hypothesized personality of the help-oriented individual." (Fischer & Turner, 1970, p. 85)

The correlational data substantiate this hypothesis. There is a good possibility that variables such as authoritarianism and liberal- - conservative ideologies underlie some of the group distinctions found. Jewish respondents may be less authoritarian than people in other religious categories, for example, and more educated persons - especially those majoring in social-science and humanity fields - are likely to hold liberal values and thus be more open to using professional psychological help (Fischer, Winer & Abramowitz, 1983).

Fischer and Turner (1970) also investigated the relationship between attitudes towards seeking psychological help and the internal-external locus-of-control variable (Rotter, 1966), reasoning that pro-help persons should tend to be more internal, that is, believe their own actions can effect meaningful changes in their lives. This hypothesis was also substantiated. However, correlations between help-seeking attitudes and interpersonal trust or masculinity-femininity were insignificant (Amato & Bradshaw, 1985).

### **3.3.1.2 Factorial and Attitude Change Studies**

#### **3.3.1.2.1 Factorial Studies**

In Stage 3 of the help-seeking model, it was shown that a number of variables affect a person's choice to seek or not to seek professional psychological help. It has been suggested that many of these facilitating or inhibiting factors are attitudinal in nature (Fischer, Winer & Abramowitz, 1983). Through factor analysis of their data base, Fischer

and Turner (1970) isolated four interpretable factors within their overall ATSPPH scale: (1) recognition of personal need for professional psychological help; (2) stigma tolerance; (3) interpersonal openness; and (4) confidence in mental- health professionals. Fischer & Cohen (1972) identified two other factors: (5) rugged independence (in relation to a person's resistance to a person's resistance to any stigmatisation involved in help-seeking), and (6) willingness to seek help. In deBarot's (1977) study, five interpretable factors were found, coinciding with Factors 1-5, above.

### **3.3.1.2.2 Attitude Change**

Attitude change is an important topic relating to the early stages of the help-seeking process, that is, where the troubled person might be indecisive about seeking professional help but could be influenced to do so. At that point (Stage 2), the person's preconceptions, beliefs, attitudes, and intentions play a central role in guiding his or her thought-processes, decision-making, preparations for action, and actual help-seeking. In this connection the research of Farina and his associates indicates that the person's concept of the basic nature of a psychological disorder affects his or her predisposition to use interpersonal modes of help, such as counselling and psychotherapy. In those studies, an induced change in belief (through the dissemination of information) about the original psychological disorder led to an accompanying change in expressed willingness to seek help (Farina, Fisher, Getter & Fischer, 1978; Fisher & Farina, 1979).

Gelso and McKenzie (1973) and Duckro, Beal & Moebs (1976) showed that information about a counselling centre and contact with some members of its staff had a positive influence on students' help-seeking

attitudes. They theorised that exposure to the helping source served to diminish the mystique surrounding the helping process.

### **3.3.2 Behaviour-Outcome Studies**

Behaviour-outcome research on professional psychological help-seeking has been extensively reviewed by Gourash (1978), Kulka, Veroff & Douvan (1979); and Fischer, Winer & Abramowitz (1983). The major variables examined by researchers are elucidated below.

#### **3.3.2.1 Demographic Variables**

Gender, social class, and education have been the demographic variables most often examined in relationship to help-seeking. Cultural origin and religion have also received some attention

##### **3.3.2.1.1 Gender**

As in the attitude studies, gender has emerged as a reliable predictor of professional psychological help-seeking across an impressive array of samples, settings, and methodological strategies (see the literature reviews of Gourash, 1978; Kulka, Veroff & Douvan, 1979; Fischer, Winer & Abramowitz, 1983). Thus, females not only hold more favourable attitudes towards help-seeking than do males, they are also more likely to request help from professional psychological sources.

Therefore there appears to be distinct gender differences in psychological helpseeking. Two-thirds of all clients seeking psychological help are female. Furthermore, one in three women, compared with one in seven men, seek services from a mental health professional at some point during their lifetime (Collier, 1982).

One possible source of male hesitance to use counselling services is adherence to the traditional male gender role (Good, Dell & Mintz, 1989). While there is a dearth of real evidence at this point it does appear that individuals with a masculine gender role orientation are less likely to express an interest in seeking counselling than individuals with a feminine gender role orientation (Margolis, 1982; Voit, 1982).

Some specific elements of the male role have been hypothesised to result in negative consequences for men. These negative consequences have been termed "gender role conflict" by O'Neil, Helms, Gable, David & Wrightsman, (1985, 1986). Many problems, including isolation, depression and substance abuse, have been theorised to be related to men's gender role conflict and its factors.

Restrictive emotionality, for example, one factor of gender role conflict, seems to have clear implications for men's helpseeking attitudes and behaviours. Restrictive emotionality involves the reluctance and/or difficulty men have in expressing their feelings to other people (David & Brannon, 1976; O'Neil, 1986) and may be related to their hesitancy to seek help from others. In a study of help-seeking behaviours and attitudes, Fisher & Turner (1970) identified interpersonal openness as a significant aspect of positive helpseeking attitudes. The constructs of interpersonal openness and restrictive emotionality appear to be parallel but opposite concepts, both addressing one's willingness to share concerns and request assistance from others.

Values related to success, power, and competition, a second aspect of gender role conflict, may also affect helpseeking by men (David & Brannon, 1976; O'Neil, 1981). Men are traditionally socialised to seek

power and control, and to be autonomous and self-reliant. Helpseeking may thus be directly incongruent with values acquired through socialisation (Chamow, 1978; Nadler et al., 1984). That is, men experience seeking psychological assistance as admitting failure, weakness and defeat. Feeling sad or depressed and asking for help regarding these feelings is often viewed as unmanly (Warren, 1983). In addition there is evidence men may experience social sanctions (i.e. rejection and punishment) for expressing sad emotions and for asking for help (Hammen & Peters, 1977; Warren, 1983). Men may thus have strong motivation to conceal feelings of sadness and disappointment and may not be disposed to recognise or directly seek help for such problems (Warren, 1983).

The nature of the therapeutic relationship itself may also conflict with traditional male socialisation regarding power and control. The nature of the therapeutic relationship may emphasise the power differential between the therapist and the client. Thus, men may avoid entering therapy because of an aversion to being in an apparently subordinate role and hence failing to live up to the requirements of male power.

An additional reason that men may feel uncomfortable seeking help is fear of intimacy or emotional closeness (Levinson, 1978; Lewis, 1978). Further, men may be especially careful of sharing their full range of emotions or reactions with other men for fear of being considered homosexual (David & Brannon, 1976; Morin & Garfinkle, 1978; O'Neil, 1981). O'Neil (1981) and O'Neil et al., (1986) discussed traditional men's restricted affectionate behaviour with other men and noted the limitations this expectation placed on men. Therefore, men who fear affectionate feelings or behaviour with other men may be more likely to avoid



entering therapy, especially with a male therapist, because they may be more prone to equate emotional closeness with homosexuality.

### **3.3.2 1.2 Social Class and Education**

Fischer, Winer & Abramowitz (1983) note that although research over the last two decades has supported the notion that people of higher socioeconomic status are more likely to seek out professional assistance, there now exists some question as to whether the relationship is as consistent on or as strong as it once may have been. Kulka, Veroff & Douvan (1979) also state that even some of the evidence pertaining to educational level, often thought to be the most compelling social predictor, has not been supportive.

Recognizing the mounting conflicting evidence, Fischer, Winer & Abramowitz (1983) conclude that, though social position remains an important variable in help-seeking, it may be losing some of its predictive value.

Reflecting a broad and substantial literature on the use of health and welfare services (Anderson & Anderson, 1972; Mechanic, 1976, 1978) sociological studies have repeatedly shown that persons seeking help or specific types of help for psychological problems have sociocultural characteristics that differ from those of persons in their respective communities who do not seek such assistance (Greenley & Mechanic, 1976a, 1976b; Gurin, Veroff & Feld, 1960; Kadushin, 1969; Mechanic, 1975; Scheff, 1966).

Kulka, Veroff & Douvan (1979) took advantage of a unique opportunity to assess the stability of the relationship between social class and the use

of professional help for personal problems by comparing national survey data collected in 1957 (Gurin, Veroff & Feld, 1960) with comparable data obtained in a replication study in 1976. They specifically examined the influence of education and income on: (a) problem definition, (b) the decision to seek help, and (c) the choice of a particular help source. They found that in spite of a general increase in "readiness for self-referral" from 1957 to 1976 for the population as a whole, social class differences in defining a problem as relevant for professional help and in adopting a self-help position with regard to potential problems (both reported in 1957) generally persisted in 1976. Among those respondents who identified a personal problem as relevant for help, however, social class differences in the actual use of help, apparent in 1957, largely disappeared in the 1976 survey. Despite a marked increase in the use of mental health professionals in all socioeconomic strata, educational and income differences in the use of psychiatrists and psychologists found in 1957 also generally persisted in 1976, although the gap between high and low income groups appeared to be narrowing. Although perceived psychological distress was found to play a major role in seeking help, differences in professional helpseeking by socioeconomic status were largely independent of reported symptom levels.

### **3.3.2.1.3 Culture**

The research on the professional help-seeking of overseas, non-western cultures, is scant. In one of the few studies, Sue & Sue (1977) found that international students are generally reluctant to initiate a counselling relationship. Dadfar & Friedlander (1982) stress that many ethnic barriers (such as differing language, values, relation to authority) render cross-cultural counselling especially difficult. When these students do obtain

help, it is more often from a medical than a psychological service (Dadfar & Friedlander, 1982).

#### **3.3.2.1.4 Religion**

Generally speaking, religious affiliation has emerged as a more reliable correlate of participation in psychotherapy than has "religiosity" per se. Jews, who are usually found to hold relatively favourable attitudes toward professional help-seeking, have also been reported to be overrepresented among help-seeking populations in the U.S.A. (Fischer, Winer & Abramowitz, 1983).

#### **3.3.2.2 Personality Variables**

The search for personality correlates of seeking psychological assistance is complicated by several factors, including the large number of related but different concepts studied under the banner of personality and the equally diverse array of measures employed to assess those concepts (Nadler, 1983). Both of these considerations have made the comparison of findings across investigations exceedingly difficult. The same reservations unfortunately apply to comparisons with the relationships obtained between scores on certain personality inventories and scores on the Fischer-Turner help-seeking attitudes scale (Fischer, Winer & Abramowitz, 1983). Also, the cross-sectional nature of the typical research design makes it virtually impossible to rule out the possibility that any personality correlates obtained are merely aspects of the problem for which the client has sought help (Fischer, Winer & Abramowitz, 1983).

All these problems aside, some of the relevant research has found tentative linkages between the personality domain under study and

obtaining professional psychological help. For example, help seekers have been found to be less happy and less self-accepting, or to have lower self-esteem scores, than nonseekers on the California Psychological Inventory (Siegman, 1974). Results yielded by the Minnesota Multiphasic Personality Inventory (MMPI) have been mixed. Thelan and Varble (1970) found that help-seekers had higher defense and lower coping scores than did nonseekers, whereas Carr and Wittenbaugh (1968) turned up no such personality differences. Using a number of different measures of personality, Hagedorn (1977) likewise failed to identify a distinctive help-seeking profile.

### **3.3.2.3 Informal Support**

Most of the pertinent data indicate that the likelihood of seeking professional assistance is negatively related to the level of informal (non-professional) support available within one's social environment (Gourash, 1978). However, Veroff (1981) obtained the opposite result using a rigorous design and large samples. In addition, Brown (1978) failed to distinguish seekers from non-seekers on the basis of level of informal support. Consequently, any relationship between informal support and professional help-seeking would appear to be equivocal.

### **3.3.2.4 Situational Stress**

Numerous studies support the claim that the level of situational stress often precipitates help-seeking behaviour (for example: Mechanic, 1978; Brown, 1978). Moreover, the level of stress is seen as more important than the specific source of the stress. Mechanic (1978) tentatively concluded that a person's level of distress is the single most important predictor of help-seeking.

### **3.4 Theoretical Relevance of Research to Present Study**

The cumulative attitudinal and behavioural data will now be examined in light of the conceptual model of psychological help-seeking presented earlier. Given the methodological diversity of the relevant research on professional psychological help-seeking, the degree of convergence between the attitudinal and behavioural correlates is striking. Sex and religion have proven consistent predictors of help-seeking, with women and Jews holding more favourable attitudes toward, and being more likely to, request psychological assistance. Although level of education still appears, in some instances, to have implications for help-seeking, the ability of such social-class indices as occupation and income to predict relevant attitudes and behaviours has decreased appreciably in recent years (Fischer, Winer & Abramowitz, 1983).

Because the American literature on female and Jewish socialization suggest certain reliable attitudinal outcomes (Fischer & Turner, 1970; Fischer & Cohen, 1972), it seems reasonable to interpret the overrepresentation of both demographic groups among help-seekers as well as those espousing favourable help-seeking attitudes, as supporting aspects of the theoretical model (Stage 3) that emphasizes the role of personal values and beliefs in the facilitation of help-seeking behaviour.

However a glaring discrepancy exists between the theory of psychological help-seeking presented earlier and the attitudinal and behavioural research that was subsequently reviewed. The conceptual literature emphasizes the developmental nature of the process culminating in the decision to seek professional assistance, whereas the relevant research is almost entirely cross sectional rather than longitudinal. Thus, the model holds that help-seeking is a complex

function of interacting personal and social variables at each of several stages of help-seeking consideration. Investigators, however, have virtually ignored the time dimension in designing their studies, which have typically involved only a single data collection and concurrent assessment of psychological and sociocultural variables in addition to help-seeking attitudes or behaviour. The result is a database that does not permit the directional kind of inference that would constitute an adequate test of the process-oriented, stage model of psychiatric/psychological help-seeking (Gross & McMullen, 1983).

The present study attempts to address this situation by measuring, at three time periods over a period of twelve months, any changes in participants' attitudes towards psychologists and their work.

A fundamental tenet of help-seeking theory is that a favourable attitude toward securing professional assistance is associated with making the behavioural commitment to obtain it. Although the direction of effect is generally recognized to be reciprocal, with a positive help-seeking experience presumed to be capable of shifting one's attitude toward future help-seeking the primary direction of influence is thought to be from attitude to behaviour. It is one of the aims of the present study to investigate the nature and parameters of this relationship.

## **CHAPTER 4**

### **ATTITUDE THEORY AND RESEARCH: HOW ATTITUDES TOWARDS PSYCHOLOGISTS DEVELOP**

## **4.1 Introduction**

In order to gain an understanding of how attitudes towards psychologists may develop it is essential to examine attitude theory and research in general. Furthermore, if we wish to investigate the public attitude towards psychologists, as is the aim of the present study, an understanding of the theory of effecting attitude change is crucial.

The following discussion will centre on the current state of attitude theory and research and will cover areas such as the importance of attitudes, defining attitudes, sources of beliefs in the formation of attitudes, structural components of attitudes, the link between attitudes and consequent behaviour and theoretical accounts of attitude change.

Finally the threads of these theoretical underpinnings will be drawn together to enable an account for the development of public attitudes towards psychologists to be proposed and establishing a basis for how these attitudes may be influenced to change.

## **4.2 The Central Importance of Attitudes**

Why is it that psychologists have devoted a great deal of research attention to people's attitudes towards various objects, groups and issues? The central importance of understanding attitude development and change cannot be understated, particularly in today's society where the opportunities to establish and alter one's attitudes are unbounded given the increasing impact of the mass media in moulding our attitudes.

There are a number of reasons why the field of attitude development and change has been, and continues to remain, a vigorous area of ongoing research. First, it is generally assumed that attitudes are relatively



enduring. The consensus is that people's feelings towards objects and issues are probably quite stable over time. Although attitudes can and do change, such occurrences are not random or spontaneous. Something significant usually must happen to cause the change. If attitudes did indeed fluctuate substantially over short periods of time, they would have little value as predictors of future behaviour. Therefore, because people's attitudes are relatively stable over time they lend themselves to be studied, measured, and used to predict behaviour.

A second reason for ongoing interest in attitudes is that they are regarded as being phenomena that are not innate to the individual at birth but rather learned as the individual grows and develops. Consequently the processes of attitude formation and attitude change can be studied as the individual develops over the life span. If one can identify and isolate this process of formation and change then the opportunity to influence attitudes is unlimited.

A further and significant reason for studying attitudes is that attitudes are assumed to influence behaviour; that is, people's actions are believed to reflect their feelings toward relevant objects and issues and vice versa. However the link between one's attitudes and consequent behaviour is as yet not clearly delineated and, thus, is the subject of ongoing intensive research.

### **4.3 Defining Attitudes**

Unfortunately consensus about about a unitary definition of what constitutes an attitude has proved elusive and has, perhaps indirectly, maintained the interest of social psychologists in the construct. Different

researchers have used different points of departure in an attempt to circumscribe and ultimately define the construct of attitudes.

Allport (1968) defines attitude as

"....a mental and neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's response. " (p11)

Allport is eclectic in his approach to attitudes: for him, they may contain "instinct" as well as "habit" and thus may have innate as well as learned components. In his view "attitude" implies a neuropsychic state of readiness for mental and physical activity.

Proffering an alternate view Secord and Backman (1964) speak of:

"certain regularities of a person's feelings, thoughts, and predispositions to act toward some aspect of his environment". (p42)

Rosenberg and Hovland (1960) made an important addition to the affective and cognitive components of an attitude. Attitudes, they assert:

"are typically defined as predispositions to respond in a particular way towards a specific class of objects". (p34)

Such predispositions, not directly observable, are inferred from three types of indices: cognitive, affective, and behavioural. This tripartite division of an attitude will be expanded upon in later discussion.

The general confusion surrounding agreement on at least a theoretical if not operational definition of the nature of an attitude has severely hampered the efforts of researchers to isolate and measure the components of an attitude, to trace the development of attitudes and to identify the bridge between attitude change and behaviour change.

## **4.4 Sources of Beliefs**

Where do we as individuals obtain our knowledge about various objects, persons, groups, and issues? What factors influence and mould the establishment and development of our attitudinal system? The literature reveals that there are three basic sources of influence: direct personal experience, significant other individuals and influential agencies and the role of the mass media.

### **4.4.1 Direct Personal Experience**

Most of our knowledge comes from personal experiences. Fazio and Zanna (1983) discussed the importance of direct personal experience in the formation of attitudes. They have shown that the attitudes towards an object or person of someone who has had actual behavioural experience with the object or person will be more clearly defined and more confidently held. The conclusion is that knowledge gathered from personal experience can be trusted more than information obtained from other sources.

### **4.4.2 Significant Others and Institutions**

The opportunity for direct personal experience of other people, objects or issues is not always available to all people. Thus we obtain information regarding these situations from other people and institutions. For example, for many social issues such as capital punishment, abortion, nuclear power we have no personal experience with the relevant issues. Thus we depend on others for our information and beliefs. These significant influences in our lives include the family, peer groups and our interaction with a range of institutions.

#### **4.4.2.1. Familial Influence**

Parents and familial significant others have always had a profound influence on our beliefs. We generally respect, love and trust them; thus it is not surprising that we adopt many of their beliefs (and resulting attitudes) at least in the first instance. Many sociologists would argue, however, that the influence of parental and familial views is declining in today's society as children are exposed to the "global village" through exposure to the mass media. Others say that adolescence can be conceptualised as a time of challenging and evaluating the beliefs of our parents, seeing which we accept and rejecting others until we establish our own unique belief system (Collins & Harper, 1981).

#### **4.4.2.2 Peer Groups**

Another important source of information derives from friends and peers. This is especially so for adolescents, where peers serve as an important reference group - a group whose beliefs, attitudes, and behaviours provide a standard against which individuals compare themselves. Because we want to be popular and accepted, we often adopt the beliefs, behaviours, and dress of our peers.

#### **4.4.2.3 Institutions**

We have extensive contact with institutions from a very early age. Undoubtedly the most important institution for shaping our beliefs is the educational system. By its very nature as a tool of mainstream society this system socialises children into the beliefs and value systems of society. However, as both children and adults we are also influenced by our membership of other institutions such as sporting groups, churches, tertiary educational institutions and membership of various clubs.

### 4.4.3 Mass Media

In modern society perhaps the most pervasive influence on the development of our attitudes are the media. The mass media are influential in many ways, both overt and subtle. Probably most influentially they transmit a great deal of information that we would otherwise not be able to access by personal experience.

Second, the media exercise a strong editorial control by selecting events for our consumption. With editorial facilities they are able to construe events sometimes out of context. Consequently consumers may form different beliefs, attitudes and behaviours that they would have formed if they had personally witnessed the occurrence. The media, thus, define what is "reality" for the consumer.

Finally, the media can have entirely unintended effects on the beliefs, attitudes and behaviours of viewers. An excellent example of this is the role of the mass media in political elections. Thus, there is increasing evidence that the mass media have pervasive effects on our beliefs and attitudes. We rely heavily on the media for our information about the events and issues that occur outside our daily lives.

It has been repeatedly demonstrated that we implicitly trust what is portrayed to us by the media because we attribute to them expertise and integrity. By the same token it has been consistently shown that the media are capable of, and indeed are willing participants in, the careful manipulation of information.

## 4.5 The Components of Attitudes

While a consensus definition of an attitude remains elusive there has been general acceptance (with some recent dissension) that an attitude towards a person or object is the result of a tripartite interaction of three components - a cognitive, an affective and a behavioural component (Triandis, 1991). These components are not mutually exclusive but interact in a variety of ways to develop the resulting attitude.

The *cognitive* component of an attitude is the way an individual perceives an object, event, or situation - our thoughts, beliefs, and ideas about something. In its simplest form, the cognitive component is a category that we employ in thinking.

When a person is the object of an attitude, the cognitive component is frequently a stereotype - the mental picture we have of particular people or groups of people. Stereotypes exist so that we may reduce to simpler categories the myriad information contained in modern day life. It is our way of overcoming potential confusion.

The *affective* component of an attitude consists of the feelings or emotions that the object, event, or situation, or its symbolic representation, evokes within an individual. Fear, sympathy, pity, hate, anger, envy, love, and contempt are among the emotions that may be excited by a given individual or group. Although the emotional level is distinct from the cognitive, the two often appear together as one necessarily impinges on the other.

The *behavioural* component of an attitude is the tendency or disposition to act in certain ways with reference to some object, event, or situation

consistent with our cognitive and affective predispositions. The emphasis is on the tendency to act, not the action per se.

#### **4.5.1 Formation of the Components of Attitudes**

The tripartite structure of an attitude has enjoyed much support because it is possible to plausibly argue how each of the components are formed. The cognitive component of an attitude is based on the individual's attempt to achieve and maintain cognitive consistency through thoughts, beliefs and ideas about an object.

When a person is the object of an attitude the cognitive component is usually manifested as a stereotype - a set of characteristics that is assumed to fit a category of people. The development and maintenance of stereotypes is an inevitable consequence of our needs as perceivers to make sense of our complex world. It is theorised that stereotypes develop simply because we do not have the capacity to treat every new situation in its full uniqueness, nor are we able to store that uniqueness of each event in our memories.

Thus stereotypes enable us to categorise or break into smaller, more cognitively manageable components, the complexity of our world. Lippmann (1922) who coined the term "stereotype" observed that since the world is:

"..filled with so much subtlety, so much variety, so many permutations and combinations....we have to construct it on a simpler model before we can manage it." (p.16).

Although stereotypes are convenient and even important mechanisms, they lack the important virtue of accuracy. They are, in the final analysis,

unscientific and have unreliable generalisations that we make about people either as individuals or groups. In addition the broader the categorisation developed by stereotyping the more inaccurate they are likely to be.

Importantly, stereotypes are usually reserved for people or objects about whom we know very little. When we consider people close to us, for example, family and friends, we are likely to perceive a multitude of characteristics. However when we consider remote groups of people, we tend to ignore the nuances of individuality and assume that most of them share a relatively few common characteristics.

Stereotypes tend to be more rigid and less open to experience than the beliefs we develop through personal contact. To reject a long held stereotype is often cognitively distressing for the individual because it forces him into evaluating the value of his other stereotypes. For this reason we pay less attention to information that is inconsistent with our stereotypes. To put it another way the greater the degree of stereotyping of a particular group, the less likely it is that new information will challenge our stereotypes.

The accuracy of stereotypes is notoriously poor and, as such, they are inferior judgmental processes. However, it is believed that most stereotypes are persistently held because they contain a "kernel of truth". This theory proposes that once some piece of information about a stereotype is confirmed by, for example, direct contact, it reconfirms the validity of the whole stereotype for the perceiver.



The affective component of attitudes is characterised by the presence of positive or negative emotions. Physiologically, emotions involve mainly a state of arousal; it becomes positive or negative when it is cognitively interpreted.

Another process that can play a role in the formation of the affective component is classical conditioning. Classical conditioning occurs when a stimulus evokes a response that it did not previously evoke, simply by being paired with some other stimulus that evokes the response.

It is believed by some researchers that many attitudes probably include a classically conditioned affect. For example it is generally accepted that a pleasant environment leads to positive affect towards those present.

The formation of the behavioural component of an attitude is usually grounded in childhood experience, especially in the development of social norms. Social norms are ideas held by a group concerning what is correct and incorrect behaviour.

People learn the rules of social norms principally from parents and significant others in early life. Other sources of social norms are peers and ingroup influence. These, of course, are challenged during adolescence when individuals strive for independence and a will to determine their own behaviour.

#### **4.6 Attitudes As Predictors of Behaviour**

Throughout most of the history of social psychology, the study of attitudes was, in large part, motivated by the assumption that individuals tend to act in accordance with them. This assumption seemed so trite that

two of the more provocative and influential attitude theories of the 1960s and 1970s focussed instead on the reverse process, i.e. the role of experienced behaviour in determining attitudes (Festinger, 1957; Bem, 1972).

Investigators holding the assumption that individuals generally behave in accordance with their attitudes were put on the defensive, however, with the publication of a series of reviews such as Wicker's (1969) who suggested a weak relationship between measured attitudes and subsequent behaviour. Generally researchers have met this challenge in one of two ways. One group (Ajzen & Fishbein, 1977) saw the problem as largely a methodological one. They argued that an assessment of behavioural intentions would lead to the most accurate behavioural predictions.

A second group conceded that, taken in isolation, attitudes are often inadequate predictors of behaviour. Unless mediational variables and processes are taken into account, they argued, the investigator is bound to oversimplify the complex roles of experience, perception, cognition, context, and goals (Fazio & Zanna, 1981, Abelson, 1982). Because such a view assumes that the nature and impact of attitudes varies both within and between individuals and situations, it became crucial to take these individual differences into account.

#### **4.7 Theoretical Accounts of Attitude Change**

In order to examine the processes involved in creating attitude change it is germane to investigate what motivates people defend their attitudes so strongly i.e why they are resistant to attitude change. The theories put

forward to account for this defence of established attitudes are called the consistency theories.

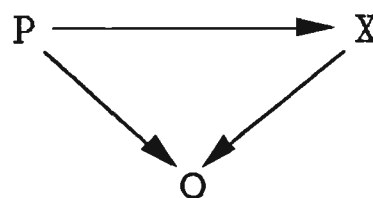
#### **4.7.1 Consistency Theories**

Attempts to change attitudes often fail. Failure is particularly likely to occur when we deal with attitudes central to the individuals' belief system. This is because we hold a coherent system of thoughts and beliefs that are subjectively and psychologically consistent. Theories stemming from this notion, the so-called cognitive consistency theories, maintain that conflicting attitudes are intolerable and that establishing inconsistency is the driving force of attitude change. As rational and rationalising animals, we are compelled to eliminate illogical or conflicting attitudes. Thus, when we believe something to be true, we convince ourselves it is also wise and desirable.

Important early work on the notion of cognitive consistency was done by Heider (1940, 1959) who proposed that there are important relationships among attitudes. Some attitudes go together harmoniously, and are said to be in balance; however, when attitudes clash a state of imbalance exists. Heider held that people have a strong psychological tendency to maintain balance in their attitudes. People are uncomfortable with imbalance and will change to achieve this balance.

Using an innovative series of "triads" Heider demonstrated that individuals will attempt to change their attitudes to achieve a state of balance (or congruency) between their attitudes. In these triads he deals with states of balance and imbalance which exist between three elements: the person (P), another person (O), and some object, idea or issue (X). What are the attitudes of two friends, P and O, towards issue X? A

balanced state exists when their attitudes towards the issue are similar i.e. they both like or both dislike the attitude object. If one of them likes X but the other dislikes it, there will be imbalance, and the resultant feelings of strain will induce pressures towards change in the direction of balance. For example, there may be a falling out between the friends, or they might try to persuade each other to adopt a common harmonious attitude towards the issue. It is important to note that there are three relations in this simple triadic system: P's attitude towards O, P's attitude towards X and O's attitude towards X. In formal terms a balanced state would exist if all three relations among P, O and X were positive, or if two were negative and one were positive.



While Heider's theory enjoyed early acceptance because it appealed on the basis of logic and simplicity, in recent times it has failed to stand up to rigorous practical application. As more research has been conducted into attitude change it has become increasingly clear that the picture is not as clear and simplistic as Heider had earlier proposed.

The most provocative of the consistency theories, especially when one reviews the extent of ensuing research, was presented by Festinger (1957) in his theory of "cognitive dissonance". According to Festinger's theory if a person has cognitions about himself or his environment that are inconsistent with each other i.e. one cognition implies the opposite of the other, a state of cognitive dissonance exists.

The state of cognitive dissonance is uncomfortable for the individual because, according to Festinger, it arouses psychological tension and therefore attempts are made by the individual to reduce this state by changing either or both cognitions or by adding new cognitions.

Dissonance becomes increasingly painful as the cognitions increase in importance. In particular, when the inconsistency challenges self-esteem or self-identity, it is likely to arouse dissonance (Cooper & Mackie, 1983). And the greater the dissonance, the greater the motivation for dissonance reduction.

The extent of research on the the theory and application of cognitive dissonance has given rise to some alternative explanations of why dissonance effects change. For example, Steele & Liu (1983) argue that the self-justificatory attitude change that follows counterattitudinal advocacy is based not upon inconsistency among cognitions but upon an ego-based need for a positive and efficacious self-image. A person who writes an essay opposed to building handicapped facilities may well feel that his or her ego identity of being a good and caring person is threatened. This is precisely the situation established in a study by Steele & Liu (1981). The authors argued that if dissonance is aroused because of such a threat, then giving subjects an expectation that they would be able to help handicapped students after the experiment was over should reduce the dissonance. Their results supported the hypothesis.

Festinger (1957) initially likened dissonance to a drive and offered several analogies to the way dissonance functioned. Hunger and thirst were the major analogues, and so it was thought that dissonance was a "drive-like state". Curiously, a close examination of Festinger's original

work finds no explicit statement that dissonance is a drive nor that it has arousal properties (Fazio & Cooper, 1983). Indeed, several investigators working within the dissonance tradition (Higgins, Rhodewalt & Zanna, 1979) have questioned whether dissonance can be conceived of as arousal at all.

In addition to one's tendency for intrapersonal consistency, there exists a desire to appear consistent in the eyes of observers. Thus, evidence for attitude-related consistency can be examined in light of possible self-presentational goals. Tedeschi and his colleagues (e.g. Tedeschi, Schenkler & Bonoma, 1971) have proposed an approach known as impression formation. The supposition behind this approach is that people try persistently to manage the impressions that other people have of them. Attitude change following counterattitudinal advocacy is conceived of as nothing more than an attempt to manipulate one's impression in the eyes of significant others and to absolve oneself from the embarrassment of appearing inconsistent.

The strength of the consistency theories in providing possible (and conflicting) accounts for why individuals either change or resist changing their attitudes is that they provide researchers with an experimental basis for investigating the field of attitude change. While no one consistency theory has achieved supremacy all have contributed to our understanding of this increasingly important field.

#### **4.7.2 Communication and Persuasion**

During the 1940s the United States government wanted to mobilise support for the war effort and persuade people to make personal sacrifices necessary for victory. Psychologists joined the effort by

developing and testing theories that might help the government influence public attitudes. The work of Hovland and his colleagues at the Yale Attitude Change Centre was foremost in this area. Their theories paid special attention to the stimulus characteristics of the persuasion process - that is, how each stimulus characteristic increases or decreases the effects of persuasion on attitudes. The key characteristics to emerge from this work fall conveniently into five classes:

1. The **source** - the personality, style and other characteristics of the person who makes the influence attempt.
2. The **message** - the content, style, and other characteristics of the communication
3. The **channel** - the medium through which the communication is presented - print, television, personal appearance
4. The **audience** - the psychological dispositions of the people to whom the communication is addressed
5. The communication **environment** - the social and physical characteristics of the communication setting - who is present and in what environment.

This analysis has provided the basis for most of the research on how to effect attitude change by providing the appropriate conditions for that change to occur.

#### 4.7.3 Central and Peripheral Routes to Persuasion

A general yet increasingly widely accepted account of how people influence each other's attitudes which incorporates the above features of the persuasion process continues to dominate the contemporary theoretical picture in persuasion research. Petty & Cacioppo's (1986) Elaboration Likelihood Model postulates that persuasion may occur via two "routes": (a) the "central route to persuasion" whose key premise is

that recipients carefully process the arguments of persuasive messages and, (b) the "peripheral route to persuasion" which emphasises factors other than argument-based thinking that may induce attitude change in persuasive contexts.

Petty & Cacioppo's (1986) Elaboration Likelihood Model (ELM) posits that careful consideration and elaboration of message arguments (i.e. systematic or central route processing) is likely to occur when recipients are both motivated and able to scrutinise the message.

The (now extensive) empirical quest continues to specify the variables that either motivate or enable recipients to process messages systematically. Enabling variables include repeated (vs single) exposures to persuasive argumentation (Cacioppo & Petty, 1989; Linskold, Han & Betz, 1986), absence (vs presence) of situational distractions (Moore, Hausknecht & Thamodaram, 1986), Smith & Shaffer, 1989), an affectively neutral (vs happy) state of mind (Worth & Mackie, 1987; Mackie & Worth, 1989), extensive (vs little) prior knowledge about the message topic (Alba & Marmorstein, 1987; Liberman, de la Hoz & Chaiken, 1988; Wood & Kallgren, 1988), and direct (vs indirect) experience with the attitude object (Wu & Shaffer, 1987).

Variables that motivate issue-relevant thinking include dispositional factors such as high (vs low) self-acceptance (Chebat & Picard, 1988), either high or low "certainty orientation" (depending on the personal relevance of the message topic; e.g. Sorrentino, 1988), and high (vs low) need for cognition (Axsom, Yates & Chaiken, 1987; Chaiken, Liberman & Eagly, 1989; Haugtvedt, Petty & Caccioppo, 1986; Petty, Caccioppo & Steidler, 1987). The motivational impetus of the latter variable is largely



independent of enabling or "ability" factors, such as verbal intelligence (Cacioppo et al 1986).

Motivating situational variables include high (vs low) personal relevance of the message topic (Axsom et al 1987; Haugtvedt et al 1986; Howard-Pitney, Borgida & Omoto, 1986; Leippe & Roamnczyk 1987), high (vs low) match between the persuasive context of the recipient's functional predispositions (DeBono, 1987; DeBono & Harnish, 1988), use of interrogative (vs assertive) formats to assess recipients' opinions (Petty, Caccioppo & Haugtvedt, 1987) and delivery of independent arguments by multiple (vs single) spokespersons (Harkins & Petty, 1987). Disagreement with the majority opinion of an important reference group induces issue-relevant thinking (Mackie, 1987), even though the consensus information from less important sources normally functions as a heuristic cue (i.e. "consensus implies correctness") to the validity of a message (Axsom, Yates & Chaiken, 1987; Chaiken, Liberman & Eagly, 1989; Wiegman 1988).

One assumption central to the Elaboration Likelihood Model is that message recipients are "economy minded" individuals who will expend only as much effort as is necessary to assess the validity of a persuasive communication or achieve other pertinent processing goals. Since processing of cognitive heuristics and other peripheral cues is presumed to be relatively effortless, message recipients who are otherwise unmotivated or unable to engage in more laborious forms of issue-relevant thinking should rely heavily on such "peripheral" information.

Consistent with this logic are the results of several recent studies demonstrating that the manipulations of superficial persuasion cues such

as source attractiveness, likeability, expertise, message length and/or number of arguments, audience reactions, consensus information often mediate persuasion when either the motivation or ability for issue-relevant thinking is low; these cues usually have less impact on attitudes when motivation and ability is high and the persuasive implications of such cues are attenuated by the recipients' systematic processing (e.g. Alba & Marmorstein, 1987; Axsom et al 1987; Chaiken, 1987; DeBono & Harnish, 1988; Haugtvedt et al, 1986, 1987; Mackie, 1987; Moore et al, 1986; Wood & Kallgren, 1988; Wu & Shaffer, 1987).

Early descriptions of central and peripheral routes to persuasion as qualitatively distinct (e.g. Petty & Cacioppo, 1981) have been interpreted by some as implying that these two processes are mutually distinct and exclusive. Chaiken, Liberman & Eagly (1989) have challenged this view, arguing that heuristic (peripheral) and systematic (central) processing can co-occur and have additive or interactive effects on recipients' attitudinal judgments.

Logically, a co-occurrence assumption allows for the possibility that heuristic/peripheral and systematic/central influences might occur independently and produce additive effects on persuasion. Several lines of evidence for the interdependence of the heuristic/peripheral and systematic/central processing modes have recently emerged. For example, blatant incongruencies between the persuasive implications of a heuristic cue (e.g. consensus information) and message content (e.g. the conclusion drawn) can induce even low-involvement recipients to engage in extensive issue-relevant thinking and to form attitudes consistent with the thoughts thus generated (Maheswaran & Chaiken, 1991). Thus people who are not ordinarily inclined to scrutinise message content may

nevertheless do so when they don't trust their heuristic processing strategies.

As noted by Petty (Petty & Cacioppo, 1986; Petty, 1987), superficial persuasion cues might routinely affect the likelihood of systematic processing whenever recipients, being unclear about whenever they can or should scrutinise a message (e.g. when their knowledge is only moderate or issue relevance is uncertain), look to the persuasive content to help them make that decision. Presumably the presence of a strong compelling cue (e.g. high source expertise) would render the message worthy of scrutiny, whereas a non compelling cue (e.g. lack of expertise) might inhibit such effortful undertakings. Consistent with this notion are the results of several studies demonstrating that, when either the motivation or the ability for systematic processing is intermediate (or uncertain), recipients carefully scrutinise the message (and are persuaded more by strong arguments than by weak ones) only if the the peripheral cues available to them (e.g. high source expertise) make it seem worthwhile to do so (Petty & Cacioppo, 1986; Petty et al, 1987; Moore et al 1986).

In the research cited above, compelling peripheral cues produced a relatively unbiased assessment of message content - i.e. they enhanced the persuasive impact of strong arguments while noticeably undermining the effectiveness of weak ones. However, peripheral/heuristic input can induce biased systematic processing if recipients who lack knowledge about a message topic are nevertheless motivated to scrutinise arguments that prove to be ambiguous (Chaiken et al 1989). For example, heuristic processing of consensus information by motivated but otherwise unknowledgeable recipients leads to highly favourable elaborations of a

majority (consensus) position but little or no systematic processing of minority views (Mackie, 1987). Ambiguous (and even weak) legal evidence against a criminal defendant is elaborated and interpreted in overwhelmingly negative ways should a salient peripheral cue (e.g. the defendant's testimonial demeanour) suggest that he/she might be acting deceitfully (Hendry & Shaffer, 1989).

#### **4.8 The Development of Attitudes To Psychologists**

The development of attitudes towards groups in general, and professional work groups in particular, follows much the same lines as attitude development generally. The professional work group assumes the role of the object to be evaluated.

In the case of psychologists it is hypothesised that attitude development occurs more through becoming aware of the experiences of others rather than through direct personal experience. When one reviews the amount of contact that individuals have with psychologists this becomes quite clear. From the limited amount of research conducted into public attitudes towards psychologists in the Australian context it is clear that individuals have little direct personal knowledge of, or contact with, psychologists. Sharpley (1986), in perhaps the most comprehensive survey conducted with an Australian sample, found that only 4.8% of his sample had ever consulted a psychologist. The other studies conducted with Australian population samples (Sharpley, Rogers & Evans, 1984; Rogers & Sharpley, 1983; Wilkinson, Case, Flynn, Hodgson, Sultmann & Gardner, 1978; Small & Gault, 1975) support a comparably limited direct rate of contact.

This rate of contact varies dramatically with the rate of contact with, for example, the medical profession. It is estimated that, in any one week, approximately 14% of Australians visit their general practitioner (Davis, 1989). Thus it is reasonable to expect that attitudes towards the medical profession would be more strongly reliant on the operation of direct personal contact.

It is proposed in this study that probably the major source of attitude development in the case of psychologists is exposure to them and their work through the mass media. This avenue for attitude development is becoming more significant as the work of psychologists gains increasing public acceptance and consequent media scrutiny. The seminal role of the media has been recognised by the Australian Psychological Society (APS) who, in 1987, established a media contact network of psychologists for members of the media wishing clarification or explanation on a point of psychological interest. The media had made available to them by the APS a list of accredited psychologists who were deemed to be expert in the area of interest, versed in media techniques and dedicated to the public advancement of psychology (APS Bulletin, 1987).

Another source of contact that influences attitude development is found in the employment of psychologists in non-traditional areas such as the workplace, sport and recreation, churches, youth groups, various government departments and schools where individuals can observe and evaluate the work of psychologists.

The relative lack of personal experience with psychologists and their work has inevitably led to the development of entrenched stereotypes as a

vehicle for attitude development towards this group. This is no more obvious than in the area of television where the prototypical psychologist is almost a caricature. Surveys consistently demonstrate the extent of misconception that the general public has about psychologists, their mode of operation and what they do to assist people. Rogers & Sharpley (1983) in an investigation into attitudes to, and knowledge of counselling in Australia concluded that:

"Overall, respondents were not aware of the nature of counselling...." (p.327)

and

"The data indicated that the profession as such was poorly understood by the general public." (p.328)

A similar survey by Sharpley (1986) some three years later found that:

"The present survey has shown that the general public remains uninformed on [the work of psychologists]" (p.66)

Attitudes towards psychologists ideally lend themselves to the notion that an attitude may be conceptualised as being composed of three elements - the cognitive, the affective and the behavioural. The cognitive element is the knowledge that the individual possesses about a psychologist and what they do. The affective element derives from the feelings that an individual has towards a psychologist and towards other individuals who seek psychological help. The behavioural element would be illustrated by the willingness or otherwise of an individual to consult a psychologist.

Attitudes towards psychologists also lend themselves to an explanation afforded by the consistency models propounded in earlier discussion. It is recognised that there remains in place a strong community stigma attached to individuals who seek help for emotional, as opposed to

physical, health problems. Surveys have consistently shown that while individuals concede that there are times when they could have used the assistance of a psychologist they did not do (Sharpley, 1986; Rogers & Sharpley, 1984; Wilkinson, Case, Flynn, Hodgson, Sultmann & Gardner, 1978). It is estimated that the prevalence of mental disorders, including problems such as psychosocial, behavioural, sexual and alcohol-related was reported to be between 6.9% and 17% in a series of studies undertaken between 1982 and 1987 in Sydney and Melbourne (Mental Health Task Force, 1989). However according to Sharpley (1986) only 4.8% of his survey sample had ever consulted a psychologist.

The need for psychological help and the consequent action of actively seeking this help illustrates the notion of cognitive consistency. The admission on the part of the individual that they need help yet they should be able to manage their own emotional problems strikes at the heart of our self-image. In order to maintain consistency about ourselves as acceptable people we deny to ourselves the need for professional assistance, minimise the significance of the problem and exhort ourselves to overcome the problem by ourselves.

#### **4.9 Attitude Change and the Present Study**

Thus, by following the development of attitudes, it has been demonstrated how public attitudes towards psychologists may develop. The present study intends to draw upon this theoretical background in attempting to positively influence the attitudes of participants towards psychologists and their work.

One of the aims of the present study is to attempt to investigate attitude change by manipulation of the various factors involved in the persuasion

process. It is hypothesised that, by appropriate management of these factors, it will be possible to positively influence the attitude of the target population towards psychologists. This approach will also permit an examination of the efficacy of the Elaboration Likelihood Model of persuasion and its ability to account for how attitudes change.



## **CHAPTER 5**

### **THE EMPLOYEE ASSISTANCE PROGRAM MODEL: AN OPPORTUNITY TO CHANGE THE PUBLIC ATTITUDE TOWARDS PSYCHOLOGISTS**

## 5.1 What is an Employee Assistance Program?

An Employee Assistance Program (EAP) is an employee support facility provided by an organisation for the benefit of its employees. It is fundamentally an effective, early and minimum intervention counselling service where employees may seek professional help for a personal and/or work-related problem they may be experiencing (Industrial Program Service, 1991).

Thus EAPs can be conceptualised as a human resource management strategy for assisting employees with these personal and/or work-related problems. In many instances these problems will be affecting the work performance of the employee. Through an EAP, employees and their immediate family members have access to free, confidential counselling provided by specially trained psychologists who are familiar with the working environment of the employee. The cost of the EAP is borne entirely by the employer organisation.

Importantly, from a legislative point of view the Employee Assistance Program fulfils requirements contingent upon employers under the Occupational Health and Safety Act of 1983 (NSW). The Act specifically enjoins employers to:

"promote an occupational environment for persons at work which is adapted to their physiological and **psychological** needs"  
[objects 5(1)(c)].

EAPs encourage self-referral by employees for assistance with personal problems before they may become work problems. In addition supervisors, who notice a decline in the work performance of the employee, can suggest that the employee may benefit from seeking

counselling and refer the employee to the EAP. However, acceptance of the offer of EAP counselling is voluntary and always remains the decision of the employee. The EAP is not part of an organisation's disciplinary procedures.

Extensive research conducted in a wide spectrum of organisations in Australia over a five year period has revealed that the following represent the most common problems (not necessarily in order of frequency of presentation) that employees bring to EAP counselling:

- family/marital/relationship problems
- interpersonal conflict at work with superiors, colleagues or employees
- drug and/or alcohol problems
- physical health problems
- financial problems including gambling and managing money
- legal problems
- emotional problems
- stress
- grief and bereavement
- depression and anxiety
- work-related problems such as promotion, transfer, dismissal, redundancy, discrimination, compensation and rehabilitation

As well as assisting with individual employee problems EAPs also provide an effective framework for workplace health promotion and preventive services and thus adopt a strongly proactive role. If the EAP psychologist detects a widespread problem within the workforce of an organisation, he/she is ideally placed to suggest that it may be appropriate to implement a program to address that problem. Such programs have

included interpersonal skills, stress management, conflict resolution, communication skills, coping with workplace trauma, time management, dealing with difficult customers, assertiveness training, supervisory skills, smoking cessation, healthy lifestyles, career planning and vocational counselling.

The return for the organisation who implements an EAP is a productive and efficient workforce. Numerous research studies have highlighted the cost saving benefits accruing to organisations who have adopted EAPs (Industrial Program Service, 1988, 1989, 1990, 1991, 1992; Indrad, 1991, 1992). Advantages accruing to organisations claimed by these studies include:

- lower staff turnover
- retention of valued employees
- decrease in absenteeism as previously ignored personal and/or work related problems are dealt with expediently before they become big problems.
- less relief staff required to replace absent workers
- decrease in sick leave
- reduced compensation payouts and, consequently, compensation insurance premiums are reduced
- decrease in industrial accidents
- more efficient rehabilitation programs meaning quicker return to work
- a more harmonious, less stressful and thus productive working environment
- morale of staff improves as they feel their organisation values them as individuals and not just employees
- greater cooperation between management and unions

- supervisors are freed to supervise not to spend valuable time dealing with the personal issues of workers
- as the EAP psychologist identifies needs within he can suggest and implement appropriate courses such as stress management, conflict resolution and team building.

By virtue of their advantages EAPs have enjoyed rapid and enthusiastic acceptance by all aspects of the Australian workforce including management and unions. EAPs are now to be found in all States and both both Territories of Australia. Their growth has been nothing less than spectacular.

## **5.2 Historical Development of the Employee Assistance Program**

In order to more fully comprehend the effectiveness of EAPs it is necessary to gain an understanding of their origins and early development.

### **5.2.1 Role of Alcohol in the Workplace**

The common use of alcohol as a mainstay of the workplace in the United States was the ground in which the first roots of job-based occupational health and well-being programs took hold. Throughout much of the first half of the nineteenth century, workers in practically all occupations drank on the job, frequently at the employer's expense, and often during specific times set aside for imbibing (Furnas, 1965).

These practices were even more evident in eighteenth century England. In London during that century it was commonplace for workers in many trades to be dependent on tavern keepers, since taverns were the employment agencies of that period.

Probably the first expression of concern for on-the-job drinking, and dealing with the problem in a nonpunitive sense, came from the Washingtonians in the United States (Fehlandt, 1904). This society - in some ways the forerunner of Alcoholics Anonymous (A.A.) in that it advocated total abstinence, groups meetings and the "carrying of the message" - flourished for a brief time in the mid-1800's, until political and religious entanglements led to its demise. It did, however, very early on set the precedent for the heavy involvement of A.A. in job-based programs during the 1940's and 1950's. It was a policy among the Washingtonians that "each one bring one" (to meetings), and working men were the primary target. Members would frequently seek out excessive drinkers from their work settings, often asking employees and co-workers for suggestions about whom to approach with their message (Trice & Schonbrunn, 1981).

All segments of American society had become caught up in the virulent anti-alcohol ethos of the Temperance Movement. Employers, in particular, were committed to the removal of alcohol in order to eliminate one of the main problems in socialising a reliable workforce. Among the most prominent examples were the employers in the steel industry (Hendrick, 1916), where all forms of persuasion including dismissal, were used to stop drinking in the workplace. By the turn of the century numerous American railroads required total abstinence, both on and off the job (Timberlake, 1963).

Equally potent was the emergence of workers' compensation laws. Under these laws, employers were held financially responsible for many of the injuries incurred by employees on the job regardless of who was actually

at fault. Thus, there was a heightened concern and fear that drinkers would injure themselves, fellow workers, or both.

Whatever the motives, a genuine concern for the effects of alcohol intoxication, of problem drinking, and of alcoholism on performance marked this period and was in sharp contrast to the long-standing encouragement or acceptance by employers of drinking on the job. Thus, impaired job performance became a major focus of concern about about on the job. Even though other personal problems were to attract much attention later in Employee Assistance Programs the origin of job-based programs was undeniably in alcohol problems within the workplace.

At this point in time three potent forces combined to capitalise on the already present and widespread concern about the effects of alcohol on job efficiency. First was the birth and rapid development of Alcoholics Anonymous (A.A.). Second , influential and dedicated medical directors of leading organisations lent their support and actually actively initiated programs during this period thus conferring a high status imprimatur on the emerging programs. Thirdly, these developments converged with the unique labour market conditions during World War II.

In 1938 there were three A.A. groups with approximately 100 members in total. By 1944 the movement had grown to 10 000 members in over 300 groups in the United States and Canada. In 1945, a film, "Problem Drinkers" was produced focusing on the work of A.A., the newly formed National Committee on Alcoholism and the Yale Centre of Alcohol Studies.

### **5.2.2 Development of Alcohol Rehabilitation Programs**

To a very large degree, the underlying motivation for rehabilitative action came from the unusual labour market conditions during World War II. The enormous production requirements of the war and limited resources resulted in a careful measurement of productivity at a time when many companies were desperately short of workers. Under this pressure significant losses of efficiency by only a few workers created a noticeable problem. As a result, many cases of problem drinking and alcoholism would otherwise have remained outside the workplace came to the attention of managers and medical directors.

There were also indications that conditions just after the war exacerbated employee drinking problems. One factor was the problem of readjustment for millions of returning soldiers. Another was the large scale readjustment of business and industry itself to peacetime conditions, culminating in the so-called "boom" period of unprecedented manufacturing during the 1950's.

### **5.2.3 From Alcohol to Generalised Problems**

A major turning point in the development of occupational alcohol programs came in 1960 when Presnall (1960) reviewed the success of such programs so far and reasoned that those programs which focused on a wide range of employee problems were more successful than those that just focused on alcoholism (Trice and Sonnesthul, 1985). Presnall (1960) recommended a change in concept by changing the title of these programs to something generic like "personnel counselling" so as to remove the stigma associated with alcoholism. (Dunkin, 1982)



In 1970, the U.S. government passed the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, better known as the "Hughes Act". This legislation was sponsored in the U.S. Congress by Senator Harold Hughes, himself a recovered alcoholic, and it led to the formation of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1971, to promote programs in the public and private sector. This law also mandated that alcoholism programs be instituted in all federal agencies and military installations. (Masi, 1984)

The NIAAA coined the term "occupational alcoholism" and its goal was to assist the "95 percent of alcoholics who were employed and not on skid row." (Roman, 1981) The Occupational Program Branch of the NIAAA offered technical assistance and guidance in implementing programs and provided impetus to the future EAP movement. This branch was established in order to promote programs created by business and labour.

Importantly the NIAAA introduced a novel element discontinuous with past efforts, which was the so-called "broad-brush approach" encompassing other behavioural and medical problems as well as focusing on alcoholism per se. The NIAAA was centrally instrumental in expanding EAPs by publishing a position paper citing its findings and endorsing more extensive treatment and referral services. It was the NIAAA that coined the term "Employee Assistance Program" to denote the new, expanded occupational programs (Roman, 1981). The proposed renaming of this field importantly excluded the word alcoholism from its title. The contention of the NIAAA was that more alcoholically-impaired employees were likely to use a program which was not wholly focused simply on alcoholics.

In 1978 the Occupational Programs Branch of NIAAA surveyed 300 companies which had a written policy on alcoholism and employee assistance. The researchers found that the most successful programs provided assistance for a broad range of problems such as marital and family, legal, financial, career, and emotional as well as alcohol and drug abuse (Carr & Hellan, 1980).

The situation today in the United States has developed dramatically. Many States have now implemented legislation making it mandatory for employers to provide their employees with access to an Employee Assistance Program. A thriving national association of EAP providers has been established to provide for accreditation, ongoing education and networking of ideas and innovations. The expansion of the EAP philosophy in the United States goes on unimpeded.

EAPs are now a world-wide phenomenon. Apart from the United States, where in some States their presence in the workplace is enshrined in legislation, they are to be found in many of the leading industrial countries such as the United Kingdom, many countries in Europe and Canada (Terry, 1990).

### **5.3 Employee Assistance Programs in Australia**

The introduction and acceptance of EAPs in Australia is, by comparison with the United States, a relatively recent phenomenon. The concept of EAPs was "exported" to Australia at about the same time as they were being developed in the United Kingdom and Europe during the late 1970's. They were brought into Australia by Australians who had attended postgraduate management schools in the United States where

they had been exposed to the concept of employee counselling. As with their early roots in the United States, EAPs in Australia initially grew out of concerns with the use of alcohol and its effects on industry.

Occupational programming commenced in earnest in February 1977 when the Federal Government made funding available for the employment of full-time Industrial Program Co-ordinators (IPCs) and support staff to promote and develop industrial alcoholism programs.

The most significant feature of these appointments was that all appointees were employed on the basis of their experience in industry i.e. management or union, rather than knowledge of the drug and alcohol field. The "industrial" nature of the occupational program was emphasised to avoid having them perceived as social welfare or socialised health schemes. Thus these chosen individuals had already established their credibility in the workplace.

A significant milestone in the controlled growth of Australian EAPs was the second national conference of occupational programs entitled Occupational Drug and Alcohol Program II (ODAP II, 1981). The basis of the conference was a five point blueprint to establish minimum requirements for future Australian workplace-based alcohol programs. The result was a standard yardstick which any organisation, adopting a program for its employees, could refer to. The blueprint had five minimum requirements:

1. joint union/management commitment and involvement
2. assessment, referral and treatment facilities.
3. a commitment to training
4. ongoing education of the workforce

## 5. evaluation of program effectiveness

ODAP II also gave birth to the Occupational Drug and Alcohol Program Association (ODAPA) in 1982. The objectives and structure of ODAPA was patterned after those of Association of Labor-Management Administrators and Consultants on Alcoholism, its sister organisation in the United States and brought together interested parties who could now share ideas and innovations.

In the beginning, ODAPs were designed to cope only with alcohol and drug dependence problems, much the same as their early U.S. counterparts. Roman (1983) in an excellent comparison of Australian and American EAPs, noted that a sharp distinction between the two models was the extent to which Australians at all levels of leadership acknowledged the severe national problems with alcohol abuse, illegal drug use and poor productivity. Indeed, one of the major thrusts in the establishment of these programs came from Robert Hawke, at that time President of the Australian Council of Trade Unions, the peak union body and, later, elected Prime Minister of Australia in 1983.

Compared with the rather haphazard development of EAPs in the United States, the development of EAPs in Australia has been much more tightly controlled and centralised. Thus, today, the concept, development, and implementation of EAPs varies little from State to State and from organisation to organisation. From the beginning the three-way coalition of Government, unions and management support has guided the planning, development and implementation of EAPs. Until recently there was only one recognised provider of EAP services in each State, which received funds from the Federal government and the fees it charged in

equal amounts. This situation has changed in the last few years as private enterprise organisations such as health funds, management consultants, and welfare organisations have entered the EAP provider field, resulting in the formation of a national association of providers, the Employee Assistance Professionals of Australia.

The growth and acceptance of EAPs in Australia has, in recent years, been exponential. The largest concentration of EAPs is to be found in New South Wales where in excess of some 100 organisations, from both the public and private sector, have implemented EAPs. It is estimated that EAP services are now available to approximately 35% of the workforce in New South Wales (Industrial Program Service, 1991). These client organisations include Federal, State and Local government departments, and private sector organisations from the heavy manufacturing, health, airline, chemical, technological, and commercial spheres.

A major innovation in the Australian adaptation of the EAP model, and a significant point of departure from its slavish adoption of the U.S. model, was the rapid acceptance of the "broad-brush" coverage of employee problems. There has been a distinct movement away from concentrating solely on drug and alcohol issues towards addressing all employee problems that may impinge on employee productivity as acceptable for referral to an EAP. A significant outcome is that this movement has reduced the stigma of attending an EAP.

This attempt to provide a broadly-based EAP is supported by statistics from representative organisations. These indicate that alcohol and other drug problems account for less than 10% of the total referrals to their EAPs (Industrial Program Service, 1992). By far the largest reason for

referral is in the broad area of family/marital/relationship difficulties. This is congruent with recent advances in the awareness of the impact that work has on the home life of employees and vice versa.

#### **5.4 Models of Service Delivery for EAPs**

Several different models for the delivery of employee assistance program services to work organisations have evolved in the Australian context. Part of the diversity comes from the variation in the size of the organisations, the availability of internal resources to devote to employee assistance services, and the willingness of organisations to expend these resources (Phillips & Older, 1981).

In terms of historical development the first model developed was based on the provision of an *Internal* program (Appendix 2.1). A person or persons who are employees of the organisation and appropriately qualified are re-assigned to provide EAP services, either on a part or full-time basis depending on the size of the organisation and other work demands. They fulfil the role generally regarded as the "staff counsellor".

The nominated person(s) has an advantage of having an intimate knowledge of how their organisation "works", the lines of communication available and who has influence. However there are also distinct disadvantages with this model. The nominated person(s) may be viewed as a tool of management and, further, there are concerns with the amount of confidentiality possible (can the counsellor refuse their "employer" information?). In addition some employees may feel uneasy being counselled by someone who they already know in a different role. Because of the way internal programs are structured the internal person is generally seconded from another position and may lack sufficient

qualifications or experience as a counsellor. Thus their skills and expertise are limited. It has been found that people who are seconded to this position are often more well-meaning than have suitable qualifications. They are often "religious" and their effectiveness suffers from this perception.

The second model, commonly called the *Service Centre* model, is where the work organisation contracts with an independent EAP service provider in the community to provide EAP services (Appendix 2.2). The service centre provides problem assessment, and may provide some short-term counselling when necessary. It is the responsibility of the service centre to provide diagnosis and a subsequent referral to treatment resources located within the community network. The service centre serves as the liaison between the EAP and the treatment network co-ordinating all client activities in the role of case manager.

The service centre model also provides EAP development for organisations as well. This model enables organisations to have access to consultation for organisational development and the clinical functions of assessment, referral, follow-up and feedback.

Referral for counselling to the external and independent service centre was designed to preserve confidentiality of treatment for employees seeking assistance. This model allows employees to receive treatment off the work site, and may enable treatment for a greater number of employees due to more extensive staff capabilities within the service centre.

The third model, called the *Comprehensive* model (Appendix 2.3), is an amalgam of the two previously described models in that the work organisation nominates an employee(s) as a "staff counsellor(s)" but, in addition, has a contractual relationship with an independent service centre. This model allows options for assistance either on or off the work site. It is up to the employee to choose which option they would prefer.

The advantages for employees are enhanced confidentiality if they choose the off-site option, with internal counsellor skills being enhanced and expanded by contact with the service centre, and clients can choose on or off site counselling.

A fourth model, the *Enhanced* model (Appendix 2.4), essentially incorporates the features of the comprehensive model but with the added refinement of the independent service centre providing employees with access to their counsellors on-site as well as off-site. Thus the service centre counsellor works closely with the staff counsellor on-site in providing services.

Different models are adopted by different organisations largely depending on their size and the availability of resources. Larger organisations tend to choose the comprehensive or enhanced models as they best suited their particular needs.

The Employee Assistance Program, as an integral part of an overall human resource management strategy, is now firmly established in the Australian work environment. Their widespread and rapid acceptance by all sections of the workforce - Government, employers and the union



movement - testify to their firm entrenchment in workplace welfare as the twenty-first century approaches.

### **5.5 EAPs and the Present Study**

The Employee Assistance Program model of service delivery presents an excellent opportunity to positively affect the public attitudes towards psychologists. As a consequence of its design the EAP encourages psychologists to come into direct contact with the potential clientele as they familiarise themselves with the workplace.

In addition the EAP encourages the psychologist to adopt a high profile within the organisation as they actively involve themselves as vital resources to assist the organisation in becoming more efficient and productive.

The present study will use the Employee Assistance Program paradigm as the vehicle for attempting to investigate attitude change towards psychologists among participants.

## **CHAPTER 6**

### **RATIONALE FOR THE PRESENT STUDY AND METHODOLOGICAL PROBLEMS ASSOCIATED WITH FIELD RESEARCH**

## 6.1 Drawing the Research Literature Together

Sir Philip Bennett, Governor of Tasmania, in delivering the Opening Address of the Twenty-Third Annual Conference of the Australian Psychological Society chose as his keynote theme "How the Public Sees You" (Bennett, 1990). Among his comments at this august gathering he said:

"...there may also be some [public] support for a point of view that suggests psychologists are slightly mad, academic and really of little practical use." (p.1)

The preceding discussion has highlighted that public attitude towards psychologists is not very encouraging. There are a number of reasons that could be posited to account for this situation, pre-eminent among them that psychologists have not promoted themselves or their services very effectively. Certainly Bennett (1990) alluded to this:

"Your collective contributions to the community are certainly not well understood by the general public. Few people outside your profession appear to comprehend the wide range of influence exercised by psychologists." (Bennett, 1990; p.2)

The very fact that the Australian Psychological Society saw fit to devote their annual conference to the theme of public image, identity and practice is indicative of the level of concern expressed by psychologists for how the public perceives them and the work that they do.

The following discussion is a summary of the preceding examination of the literature which will draw together the different themes in presenting the rationale for the present study.

### **6.1.1 Development of Attitudes**

The review of the literature of attitude formation and development and the role of attitude change in predisposing behavioural intention was superimposed on the attitude of the general public towards psychologists and their work, to provide evidence for how and why prevailing attitudes towards psychologists have evolved.

The survey demonstrated that attitudes to psychologists are predicated on the operation of entrenched stereotypes generally grounded in the prototypical "psychologist" as depicted by the media.

One of the conspicuous findings of the survey was that, because of the reported low rate of personal contact, individuals have not had the opportunity to formulate new attitudes or, indeed, challenge established attitudes through the mechanism of personal contact with psychologists.

Furthermore the survey of attitudes highlighted the advances being made into understanding the process of persuasion in leading to attitude change afforded by the Elaboration Likelihood Model. This model proposes a range of factors that operate to enable and/or motivate individuals to change their attitudes via what was called the central or peripheral route to persuasion. This model presents a range of strategies that can be experimentally manipulated to optimise the likelihood of attitude change.

### **6.1.2 Factors Involved in Helpseeking**

The survey of the help-seeking literature clearly showed that the majority of people experiencing a psychological problem do not ultimately seek appropriate professional psychological assistance for that problem.

It appears that this "gap" in the provision of psychological services is due to a number of barriers encountered by individuals between the realisation that they have a problem to eventually receiving appropriate psychological assistance for that problem. Barriers cited included: cost, time availability, stigma and fear attached to seeking help, knowledge of how to access services, availability of appropriate providers, knowledge of the therapeutic process, and confidence in the help provider.

A model was proposed to delineate the various steps involved in the helpseeking process. Additionally the helpseeking literature demonstrated that a range of demographic, personality and situational correlates may be isolated to gain a clearer picture of who uses psychological services and under what circumstances.

### **6.1.3 The Employee Assistance Model of Service Delivery**

A new model of the delivery of psychological services, the Employee Assistance Program, has been shown to be effective in addressing many of the traditional barriers to psychological helpseeking. EAPs have been in operation in Australia since the mid 1980's and are a service provided by an individual's employer. They have proved to be influential in encouraging individuals of an organisation to seek help for personal and/or work-related problems through the provision of confidential, professional assistance provided by psychologists at no cost to the individual.

An examination of the comparative referral rates of EAPs versus more traditional models of service delivery certainly indicate that EAPs are more successful in encouraging individuals to seek psychological assistance.

#### **6.1.4 Public Attitude Towards Psychologists**

The survey of the public's attitude towards psychologists clearly highlighted that psychologists and their work are not highly regarded by the general public. Survey after survey, both in Australia and overseas, has clearly shown that the public is not well informed about many aspects of the profession including such factors as the training involved; the difference between psychologists and other mental health professionals, particularly psychiatrists and counsellors; their modes of therapeutic intervention; the range of skills they possess; the types of problems they address; and their comparative position in the health industry with regard to status, fees and health fund rebates.

It is clear that, for psychologists to become more effective, these faulty attitudes need to be addressed. The Australian Psychological Society has recognised this impending need and, since 1988, has put several measures in place to improve the promotion and marketing of the profession. Thus the APS now endorses a Community Relations Committee, and provides a range of services to the mass media including Media Net, Media Link and Viatel as a conduit to better informing the public about psychologists and their work.

#### **6.1.5 Development of the "Helping" Psychologies**

The overview of the development of psychology, with specific emphasis on the "helping" specialties, clinical psychology and counselling psychology, showed how the profession has progressed to the state of crisis in which it currently finds itself.

This crisis appears to be three-fold in nature: a search for professional identity as the roles and functions of psychologists continue to be eroded away; a quest for an effective model of service delivery that meets the needs of clients and psychologists alike; and the proliferation of specialties within the profession (what is the difference between a clinical psychologist and a counselling psychologist?) leaving clients confused as to what it is that psychologists do, what is the nature of their training and how effective are they in providing professional assistance.

It is not surprising, then, that the public's view of psychologists and their work is characterised by lack of confidence, bewilderment and inaccuracy if the members of the profession are similarly confused. The situation has developed to the point where psychologists themselves are actively questioning the long-term viability of the profession.

## **6.2 Rationale for the Present Study**

The overall aim of the present study is to determine whether it is feasible to positively affect attitude change towards psychologists and their work in the target population.

To achieve this aim the present study proposed to implement an Employee Assistance Program in a range of different work organisations for a duration of twelve months. Three organisations were chosen so as to enhance the external validity of the study by demonstrating that it is possible to affect attitude change in a range of different populations.

Of the four EAP models presented, the paradigm chosen for this study is the external model. It was decided to employ this model as it would

permit the experimenter greater control over the parameters of the study thus enhancing the validity of the findings.

Within the context of the external EAP model of service delivery a range of interventions, to be given to participants, were carefully devised so as to demonstrate the effectiveness, practicality and approachability of psychologists. These characteristics were those most frequently isolated in studies of the public's attitude towards psychologists and were commonly cited as interpersonal barriers to seeking psychological help. This range of interventions was designed to enable participants to observe, at close quarters, the work of psychologists as well as affording them the opportunity of establishing personal contact with their allocated psychologist.

Three psychologists, two male and one female, were selected to deliver the interventions in each of the three participating organisations. This strategy has been chosen so as to overcome the possibility of one particular psychologist effecting change through the operation of his/her "charismatic" impact rather than through the implementation of the interventions per se. Psychologists of both sexes were used to permit assessment of any interaction between the sex of psychologist and sex of participant.

In order to critically evaluate the impact of the interventions on participant attitudes each organisation were divided into two groups of equal N. One group received the interventions (the experimental group) while the other group did not receive any interventions (the control group). Further, the experimental group in each participating organisation



was subdivided into three groups of equal N to permit each of the three psychologists to be allocated to a group.

The range of interventions specifically developed for this study drew heavily on the theoretical underpinnings of the Elaboration Likelihood Model of persuasion and included both enabling and motivating strategies. It was proposed to also test the likely route of persuasion, either central or peripheral, by conducting a follow-up study six months after the completion of the main study.

In order to accurately assess any change that occurred in participants' attitudes towards psychologists, a new psychometric instrument was needed to be developed as no instrument that focused on individuals' attitudes to psychologists and their work applicable to the Australian context currently existed. This new instrument was trialled extensively to establish its psychometric properties of validity and reliability before it was employed in the main study. It was used to assess participant attitudes to psychologists and their work at three time periods during the study: at pre-test to establish a baseline (Time 1), at six months (Time 2) and finally at the completion of the study (Time 3).

Finally data was maintained concerning the number of individuals from the experimental and control groups in each participating organisation who sought counselling through their organisation's Employee Assistance Program so that comment could be permitted about the connection between attitude change and consequent behaviour.

### **6.3 Methodological Problems Associated with Field Research**

Evaluation associated with any form of field research, as is the case with the present study, is fraught with theoretical and practical difficulties. Despite this no other form of research permits the experimenter to test his/her research question(s) in such optimum experimental conditions.

Essentially field research differs from laboratory based research in that the experimental conditions are much more difficult to control, which in turn will impact on the quality of causal inference which will be subject to influence by myriad ambiguities in interpreting the results. However the distinct advantage of field research to the population at large is that the results obtained are more likely to be held to be generalisable to the populations sampled.

#### **6.3.1 Evaluation of Field Research**

The foundations of social experimentation were laid by Campbell & Stanley (1966) in their monograph describing a conceptual framework for assessing the quality of various research methods. To this end they borrowed a concept developed in the field of psychometrics known as *validity*. They applied this concept to experimental design to indicate the equivocality or validity of the findings.

According to Campbell & Stanley (1966) there were two types of validity, which they termed internal and external validity. The former referred to the credibility of the causal relationship between treatment program and outcome while the latter was concerned with the generalisability of that relationship to other persons, locations, programs, and outcome measures. Each of these two validity types, in turn, contained a set of phenomena that could account for the observed results

and thus cloud the interpretation of the experiment. Campbell & Stanley (1966) called these phenomena "threats" to validity or "plausible rival hypotheses."

Originally there were eight such threats to internal validity and four threats to external validity. In a major revision of the validity concept (Cook & Campbell, 1979) the conceptual framework had swollen significantly. Each of the two original categories, in turn, spawned a new type of validity. Internal validity produced statistical construct validity and construct validity was split off from external validity. The former contained seven totally new threats to validity while the latter was composed of ten threats of which four remained from the original Campbell & Stanley paradigm. It is germane to briefly describe these four different types of validity and their associated violations at this point.

### **6.3.2 Factors Associated with Maintaining Internal Validity**

One of the major problems associated with field research is dealing with the concept of internal validity. A study is said to have internal validity to the extent that the data support conclusions about the hypothesis generated by the study (Stern, 1979). Judgments are made about internal validity by examining the procedural details of the study in question to decide whether the procedures used to measure and manipulate variables faithfully represent these variables.

Thus a study has internal validity when it is possible to draw conclusions about the hypothesis from the data. If this is violated and yet conclusions are still drawn it is said that the researcher has, in fact, measured an extraneous variable. An extraneous variable is a variable capable of

explaining the findings of a study without invoking the hypothesis. That is, the presence of an extraneous variable allows for alternative explanations of a set of observations; either the observed relationships are due to the variables in the hypothesis, or they result at least in part from an extraneous variable.

Some extraneous variables are almost universal problems in scientific research, while others cause difficulty when paired with particular research methods. According to Stern (1979) the present research paradigm i.e. field research, tends to raise the most universal problems. A researcher's central problem in demonstrating the internal validity of a piece of research is to achieve control over extraneous variables.

**Table 6.1 Threats to Internal Validity**

Potential Threat	Description
History	An observed effect might be due to an event which takes place between the pretest and the posttest
Maturation	An observed effect might be due to the respondent's growing older, wiser, stronger, more experienced, etc. between pretest and posttest
Testing	An observed effect might be due to the number of times particular responses are measured leading to familiarity with a test
Instrumentation	An effect might be due to a change in measuring instrument between pretest and posttest
Statistical Regression	An effect might be due to respondents' being classified into experimental groups on the basis of pretest scores where these scores may be unreliable

Subject Selection	An effect might be due to the difference between the kinds of people in one experimental group as opposed to another
Subject Mortality	An effect may be due to the different kinds of persons who dropped out of a particular treatment group during the course of the experiment
Interactions with Other Threats	An effect may be due to any of the above threats interacting with subject selection
Ambiguity about Direction of Causal Influence	An effect may be due to confusion about the actual direction of causal influence
Diffusion of Treatment	An effect may be due to the diffusion or leakage of treatment effects from the experimental group to the control group
Compensatory Equilisation of Treatments	An effect may be due to reluctance on the part of the control group to accept that they did not receive the same treatment as the experimental group
Compensatory Rivalry	An effect may be due to competition between experimental and control groups
Resentful Demoralisation	An effect may be due to resentment and/or demoralisation on the part of the no-treatment control group

Estimating the internal validity of a relationship is a deductive process in which the investigator has to systematically assess how each of the internal validity threats may have influenced the data. When all of the threats can plausibly be eliminated, it is possible to make confident conclusions about whether a relationship is probably causal.

6.3.3 Factors Associated with Maintaining Construct Validity

The notion of construct validity, as defined by Campbell & Stanley (1966), refers to the possibility that the operations which are meant to represent a particular cause or effect construct can be construed in terms of more than one construct each of which is stated at the same level of reduction.

This situation can lead to "confounding" where one E may infer a causal relationship between theoretical constructs A and B while another E may interpret the causal relationship as between constructs A and Y, or B and X or even X and Y.

The threats to construct validity as proposed by Cook & Campbell (1979) are as follows:

Table 6.2 Threats to Construct Validity

Threat	Description
Inadequate Preoperational Explication of Constructs	The choice of operations should depend on the result of a conceptual analysis of the essential features of a construct
Mono-Operation Bias	Experiments that have only one exemplar of a particular possible cause and one measure to represent each of the possible effect constructs
Hypothesis-Guessing	Occurs when Ss in one treatment group compare themselves to Ss in the other group and guess how the E expects them to behave
Evaluation Apprehension	Respondents are apprehensive about being evaluated by Es who are seen to be "experts"

Experimenter Expectancies	Es bias observations by their expectations of the outcome
Interaction of Different Treatments	Occurs if respondents experience more than one treatment which is common in laboratory research but rare in a field setting
Interaction of Testing and Treatment	Can the cause-effect relationship be generalised beyond the testing conditions from which the observed result was obtained

Much research has been carried out on the nature of the relationship between the subject and the observer or experimenter in field research and its impact on construct validity. One type of effect an observer or experimenter can produce by merely being present has been called the "on stage effect" (Agnew & Pyke, 1969). This theatrical metaphor suggests that people may begin to "act" when they are aware there is an audience. The problems associated with "putting on a act" can be expected to become more serious the more aware people are that there is an audience, the better they know what about them is being observed, and the more the subject of observation is personal and controversial. That is, the more difference it makes to people what impression they make, the more likely they are to act for the researcher.

The following are some typical types of "on stage" effects which are particularly relevant to the field research paradigm:

1. Ss sometimes tell an observer what they think they "should" say.  
When people are asked about their values, many tend to report culturally acceptable values, even when they do not hold them. Such people's responses are influenced by their perceptions of social desirability. When people's adherence to a social norm is observed,

it is reasonable to assume that the observer's presence may increase apparent conformity.

2. In some instances people believe the observer to be somehow judging their personal adequacy or mental health. This belief, called evaluation apprehension (Rosenberg, 1965, 1969), obviously becomes stronger when the observer is labelled a "psychologist". The effects of evaluation apprehension depend on the subjects' perception of what mentally healthy people are supposed to do in the situation being studied.
3. Ss of research occasionally try to make themselves look bad. This may be due to a desire to sabotage the research or because the person feels something can be gained by looking bad (Braginsky & Braginsky, 1967).
4. People sometimes try to please a researcher by doing what they think he/she wants them to do. Someone who means to please may become attuned to subtle "demand characteristics" in the interaction (Orne, 1962) that give a clue to what the researcher is looking for. Orne originally argued that Ss could be expected to accept these cues and would try to do whatever they thought the researcher wanted. However, Ss might also use these cues to sabotage the study, or to outwit the researcher. There is evidence that this is a common attitude among people coerced into being research Ss (Cox & Supprelle, 1971).

These "on stage effects" are artifacts of research in that they are created by the researcher and are not normally part of the the phenomenon the researcher wishes to study. Thus, to any extent that people are acting differently because they are "on stage", any observations of variables in their behaviour are also measuring these extraneous variables.



In summary then extraneous variables due to the presence of an observer pertinent to field research are:

**Table 6.3 Observer-Related Extraneous Variables**

<b>Extraneous Variable</b>	<b>Alternative Explanation</b>	<b>Situations where this is a problem</b>
Social Desirability	S may be saying what he/she should believe	Survey research; controversial topics; personal topics; mental health
Evaluator Apprehension	S may be trying to fake good to someone judging "mental health:, I.Q. etc	Survey research; when researcher has high status, power, influence
Faking Bad	S may be trying to sabotage research or look "sick" on mental evaluation	High status researcher; involuntary Ss
Demand Characteristics	S may be doing what he/she thinks the researcher wants	High status researcher; volunteer Ss

While "on stage" effects are serious problems for social research, the presence of the researcher can create more subtle and pervasive changes in the people being studied. This presence can, in some situations, cause people to change in ways that are more than just acting - that is, changes may occur that persist even when the subject is "off stage".

1. Workers' productivity in an industrial plant at Hawthorne, Illinois, increased every time the workers were shifted to new, experimental working conditions. As they became used to the new conditions, production levelled off, only to increase when they were shifted again, even if they were shifted to conditions in which they had

produced more slowly before (Roethlisberger & Dickson, 1939). The effect was attributed to the subjects' awareness that they were being given special treatment. The increased production was real; that is, it occurred even when no one was looking, and when there were no special rewards for it. The increased production, which came to be known generically as the "Hawthorne Effect" could be best explained as a result of either the novelty of each new situation or the attention the workers received when their jobs were changed.

2. When a person expects a treatment or experience to change her/him the person often changes, even when the "treatment" is known to be an inert or ineffective one. This effect is best known in research on drugs in which the effect of the drug must be carefully separated from the effect of the fact that the patient is being given a prescription by a competent doctor. This *placebo effect* has been offered as an explanation or partial explanation for many effects.
3. Rosenthal (1966) had Ss look at photographs and judge how successful the people in the photographs appeared to be. The experimenters in Rosenthal's studies were told either that the mean rating would be about +5 or about -5 on a scale of -10 to +10. The experimenters who were given the positive expectancy obtained more positive ratings from their Ss than did the experimenters given the negative expectancy. Rosenthal suggested that the researchers' expectancy may somehow change his/her behaviour towards Ss, and that Ss may respond to these subtle cues, creating a *self-fulfilling prophecy*. That is, the researcher's actions cause Ss to behave as expected. There is some evidence that one way a researcher can communicate an expectancy is through the tone of voice in which instructions are given (Duncan & Rosenthal, 1968; Duncan, Rosenthal & Finkelstein, 1969).

4. Jourard (1971) demonstrated that time spent in mutual self-disclosure of personal material by S and experimenter could affect the rate of learning of meaningless material by Ss. It seems that Ss' performance may be affected by their emotional reaction to an experimenter as a person. Jourard suggests further that in typical laboratory experiments, in which the experimenter attempts to be impersonal (or "control" emotional reactions) Ss may act in an atypical manner. If so, people's behaviour under these conditions may be, in part, a response to extraneous variables of a cold researcher. This source of distortion can be called a *personal relationship* effect.

All these artifacts, like the "on stage" effects, depend on some extraneous variable unintentionally introduced into the research - the element of novelty, a person's expectation of change, the researcher's expectations about the Ss behaviour, or the impersonality of the researcher-subject relationship. Each extraneous variable, if and when it may be operating, can be regarded as a potential threat to the construct validity of the research and provides for the possibility of an alternative explanation of observed behaviour.

#### **6.3.4 Factors Associated with Maintaining Statistical Conclusion**

##### **Validity**

It is frequently stated that the null hypothesis cannot logically be proven. There are two reasons posited for this. First, there is always the possibility, however remote, that statistical analysis has failed to detect a true difference. Second, it cannot be known what would have resulted if the chosen treatment had been more powerful, or a statistical test of greater sensitivity or power been used, or if the statistical analysis had

extraneous sources of respondent or setting variance which correlated with the dependent variable.

The threats to validity involving the data analytic procedures used to determine if the treatment program has a causal impact were labelled as statistical conclusion validity by Cook & Campbell (1979).

**Table 6.4 Threats to Statistical Conclusion Validity**

<b>Threat</b>	<b>Description</b>
Low Statistical Power	The likelihood of making a Type II error increases when sample sizes are small and $\alpha$ is set low
Violated Assumptions of Statistical Tests	Assumptions associated with chosen statistical tests have to be met
Reliability of Measures	Measures of low reliability such as test-retest cannot be depended upon to register true changes
Reliability of Treatment Implementation	The manner in which treatments are implemented may vary from E to E if different Es are responsible for implementation
Random Irrelevancies on Experimental Setting	Scores on the dependent variable may be affected by features of the experimental setting other than those associated with the treatment
Random Heterogeneity of Respondents	Respondents in a treatment group can differ on factors that are correlated with the major dependent variables

Any of these threats to statistical construct validity have the potential to invalidate inferences about whether two variables covary.

### 6.3.5 Factors Associated with Maintaining External Validity

A study is said to have external validity to the extent that its results can be generalised to other situations in which the same variables operate (Campbell & Stanley, 1966).

The Cook & Campbell (1979) conceptualisation of external validity is based on: (i) generalising results to particular target persons, settings and times and, (ii) generalising across types of persons, settings and times. Tests of these two propositions are essentially tests of statistical interactions.

**Table 6.5 Threats to External Validity**

Threat	Description
Interaction of Selection and Treatment	Can the cause-effect relationship be validly generalised beyond the experimental group used to establish the initial relationship
Interaction of Setting and Treatment	Can the cause-effect relationship be validly generalised beyond the setting used to establish the initial relationship
Interaction of History and Treatment	Can the cause-effect relationship be validly generalised to some other time period, either past or future, beyond the present time period used to establish the initial relationship

### 6.3.6 A Comment on the Cook & Campbell Paradigm

The four categories generated by the validity approach of Cook & Campbell (1979) have great heuristic value in sorting through the complex issues that inevitably impinge on the process of evaluation.

However, at the level of specific threats to validity a number of commentators have noted that the sheer number is both overwhelming and confusing (McSweeney, 1979; Wortman, 1983). In addition, some threats seem to be rather esoteric in nature, some seem to differ only to a small degree and still others appear to be miscategorised.

Further, some evaluators disagree with the major validity categories themselves, the priority attached to them, or the faithfulness of the adherents to this approach. For example, Judd & Kenny (1981) define external validity solely as the generalisability to other theoretical constructs where Cook & Campbell (1979) would define this as construct validity category. Cronbach (1980), for instance, argues that it is external validity that is most important.

Notwithstanding these criticisms the typology adopted by Cook & Campbell (1979) does permit the field of evaluation to be addressed in a systematic and scientific manner thus fostering a more careful approach to the temptation to generalise field experimental results to wider settings.

### **6.3.7 Addressing Field Research Problems in the Present Study**

Mindful of the potential pitfalls afforded by ignoring these threats to validity the present study has been so designed as to eliminate, control for or, at least, minimise most of these threats to internal and external validity. The major strategies specifically employed to ensure the integrity of the present study are:

#### **1. Randomisation**

When respondents are randomly assigned to experimental groups, each group is similarly constituted on the average thus controlling for the

effects of *selection*, *maturation* and *selection-maturation* interaction. Ss in the present study were not assigned on the basis of pre-test scores to experimental groups thus eliminating *statistical regression* as a problem. It is important to recognise that randomisation does not eliminate all the differences between groups but only ensures that each characteristic is equally likely to be in either group.

## 2. Use of a control

The employment of a "no-treatment" control group allows for the elimination of *history* as a problem.

## 3. Large sample size

*Low statistical power* and *random heterogeneity* have been overcome by using a large sample size.

## 4. Physical separation of experimental and control groups

The decision not to randomly assign Ss to experimental and control groups but to select them from physically distinct and separate locations for inclusion in these two groups meant that problems such as *treatment diffusion*, *compensatory equilisation of treatments*, *compensatory rivalry* and *resentful demoralisation* on the part of the control group could be minimised. Indeed it was a crucial factor in the present study that no information flowed from the experimental to the control group as this could have the effect of biasing the perceptions of both groups. *Hypothesis guessing* was eliminated by locating experimental and control groups in physically distinct areas and deliberately choosing three organisations who were located in three different cities.

## 5. Dealing with missing data

It was determined, a priori, that Ss who dropped out of the study for whatever reason would be eliminated from the analysis of results. This decision controlled for the effects of *subject mortality*.

#### 6. Using multiple experimental and control groups

Potential difficulties arose in controlling for improved external validity. To overcome this problem it was decided to use three independent experimental groups in the present study instead of one. This determination also enabled problems associated with the *interaction of testing and treatment* to be minimised.

#### 7. Using multiple experimenters

A difficulty arose in possibly attributing any observed effect to the influence of one psychologist, the so-called "charismatic effect". The employment of three psychologists to deliver the interventions to each organisation eliminated potential difficulties such as *experimenter expectancies* and *demand characteristics*. The multiple psychologists, however, were carefully instructed so they would provide consistency of delivery of the interventions. This approach controlled for *reliability of treatment implementation*.

#### 8. Extended inter-testing period

To overcome the effects of Ss becoming familiar with the testing instrument a inter-test period of six months was established thus controlling for the effects of *testing*. The same assessment instrument was employed in each of the three testing periods therefore eliminating problems with *instrumentation*.

#### 9. Informing Ss

At no time during the present study were Ss made aware that the real purpose of the study was to influence their attitude towards psychologists. This decision overcame the difficulty of *evaluation apprehension* where Ss become cautious about being evaluated by Es who were perceived as being experts.



#### 10. Use of assessment administrators

The decision to use, as assessment administrators, psychologists who were not involved in the delivery of the interventions eliminated potential problems associated with *evaluator apprehension*. This procedure also controlled for *experimenter expectancies* as assessment administrators had no intrinsic involvement in ensuring the "success" of the interventions.

Thus the design of the present study was carefully established so as to be mindful of the myriad threats to validity as explicated by Cook & Campbell (1979). The fact that these factors were taken into account, *a priori*, ensured that:

- (a) decisions to accept or reject the null hypotheses could be made with confidence
- (b) the observations were likely to be due to the interventions performed and
- (c) the results could be confidently generalised to the general population at large.

## **CHAPTER 7**

### **METHOD**

## **7.1 The Development of an Instrument to Assess the Public Attitude Towards Psychologists**

### **7.1.1 Introduction**

The matter of the public attitude towards psychologists has been a source of professional interest to researchers for some time. Psychologists, in fact, demonstrated concern about their public image at the first organisational meeting of the American Psychological Association in 1892 (Benjamin, 1986). Yet attempts to document the nature of that image through empirical investigation of public knowledge and opinion are relatively recent.

The first published survey of psychology's public image appeared in the United States (Guest, 1948). Since then a number of researchers in various countries have used a variety of methodologies with various populations in order to tap the construct of the public image of psychologists.

In Australia the level of investigation has been somewhat more circumscribed. Only two surveys have been conducted into the specific attitude towards psychologists (Small & Gault, 1975; Sharpley, 1986) while two other surveys looked at counsellors (Rogers & Sharpley, 1983) and marriage counsellors (Sharpley, Rogers & Evans, 1984) respectively. A fifth survey compared the attitude towards clinical psychologists with other members of the helping professions (Wilkinson, Cave, Flynn, Hodgson, Prouatt, Sultmann & Gardner, 1978).

However conclusions from these surveys were severely limited due to methodological flaws in survey design and procedure and analysis. These

ranged from the employment of unrepresentative populations, to the use of limited survey instruments, inadequate statistical analysis of derived data, absence of validity and reliability and lack of replicability.

The aim of the present study is to develop a robust instrument that may be used to delineate the public attitude towards psychologists in Australia with various populations by improvement of the methodological basis of previous attempts. In all, seven studies were conducted in order to progressively refine the initial survey questionnaire so that the final instrument validly and reliably measured the construct that is the public attitude towards psychologists.

## **7.1.2 Study 1**

### **7.1.2.1 Introduction**

The purpose of this study was to develop a preliminary instrument that assessed what was the the public attitude towards psychologists and their work. A large pool of potentially representative items were presented to a population and the ensuing data used to reduce this large pool of items to a succinct but psychometrically correct and workable questionnaire.

### **7.1.2.2 Method**

#### **Subjects**

329 Ss (174 male and 155 female) were drawn from a population of university students in an undergraduate organisational behaviour course. The age range was from 18 to 43 with a mean of 20.45 years. While criticism has been (validly) levelled at research which relies on university students being assumed to be representative of the general public it was the intention of this preliminary study to merely reduce the pool of items

to a manageable number rather than use the results obtained to draw hard and fast conclusions.

### **Apparatus**

A 90 statement self-report pilot questionnaire was developed for use in this study. Statements used in the construction of this instrument were drawn from an extensive review of the literature on the attitude towards psychologists in Australia, the United States and the United Kingdom (see Chapter 1). Statements were devised so as to cover key areas of perception such as knowledge of psychologists and their work, previous contact and experience with psychologists, mode of referral, confidence, trust and faith in psychologists, areas of psychological intervention, feelings towards individuals who consulted psychologists and the relation of psychologists to other members of the helping professions.

Several strategies were adopted in the construction of the pilot scale to control for aspects of response set bias. Half of the statements were constructed so as to allow for negative scoring. A number of statements were repeated so as to gauge the internal consistency of the scale. Additionally, in an effort to overcome a tendency towards social desirability, respondents were requested to complete the questionnaire anonymously.

Particular attention was paid to the construction of the representative items. The wording of the items was simple yet designed to convey the meaning of the item accurately. Each item was constituted so that it contained only one statement. Care was taken to ensure that items were not overly long nor convoluted in their narrative.

A 5 point Likert scale procedure was adopted for the response with 1 meaning "totally disagree with the statement" and 5 meaning "totally agree with the statement".

A copy of the pilot questionnaire and response sheet is included in Appendix 3.1.

### **Procedure**

Potential respondents were addressed at the beginning of class in their Organisational Behaviour course as to the purpose of the study. They were informed that involvement in the study was voluntary, that no course credit would accrue to those who participated and that no identifying data were required in completing the questionnaire. Those who agreed to participate were provided with an information sheet outlining the nature of the study, the fact that participation was voluntary and that they could terminate their involvement in the study at any time. A copy of this document appears in Appendix 3.2.

Those who agreed to participate were given a copy of the questionnaire and answer sheet, asked to complete the questionnaire in their own time without discussing it with fellow students and to return the questionnaire and answer sheet at the corresponding lecture in seven days time.

Instructions on the questionnaire asked respondents to read each statement carefully and respond on a 5 point Likert scale as to their opinion with regard to each statement. Respondents were instructed not to dwell on their response to individual items but to record their

immediate impression. They were told there were no right or wrong answers but merely how they personally felt about the statements.

### **7.1.2.3 Results**

A total of 517 pilot questionnaires were distributed and 329 were returned yielding a response rate of 63.6% considered to be adequate for this type of procedure.

In order to reduce the original 90 item sample to a more workable final scale that would, however, still accurately tap the target construct while avoiding potential response biases such as respondent fatigue a number of statistical procedures were adopted using SPSS<sup>X</sup> subprograms (SPSS Inc. 1988). Two separate statistical criteria were employed to select potential items for the refined scale as it was felt that selection by two independent procedures would increase the validity of the items chosen.

As an initial step data were analysed using subprogram FREQUENCIES. Those items yielding a variance exceeding 1.000 were selected out as this criterion indicated those items for which respondents showed the greatest range of responses and were thus likely to be items targeting the areas of greatest discrimination about the public attitude towards psychologists. This procedure yielded a pool of 37 items.

In a separate and independent analysis the original 90 item sample was reanalysed using subprogram RELIABILITY. This analysis resulted in an overall  $\alpha = 0.8664$  regarded as being an acceptable level. Items which exceeded a value of 0.35 on corrected item-total correlation were selected out forming a second pool of items. This criterion was chosen as

it indicated that representative items selected out by this procedure were correlated with the overall construct of the attitude towards psychologists. This procedure yielded a pool of 33 items.

The two pools of items resulting from these two independent procedures were then compared and items common to both pools were chosen to form the reduced scale. The rationale for this decision was that as these items had been selected by two independent procedures there was an increased likelihood that they would discriminate between Ss on the basis of their attitude towards psychologists. This process yielded 28 items in total.

The reduced pool of 28 selected items was then subjected to factorial analysis using subprogram FACTOR in an attempt to identify any major factors resulting from the data. The method of factor analysis used was principal-components analysis using varimax rotation. This procedure yielded two main factors, one comprising 15 items and the other 10 items. The results of the factor analysis are set out below.

**Table 7.1 - Results of Factor Analysis of Reduced Pool Data**

<b>Factor No</b>	<b>Eigenvalue</b>	<b>% Variance</b>	<b>Cum. Var.</b>
1	8.66	51.8	51.8
2	5.65	33.8	85.6
3	1.31	8.8	94.5
4	1.22	5.4	99.9

When this initial factor matrix was rotated using varimax rotation of axes the following factor loadings were obtained.

**Table 7.2 - Rotated Factor Matrix**



Item No.	Factor 1	Factor 2	Factor 3	Factor 4
22	.70	-.17	.18	.19
25	.70	.28	.09	.17
64	.69	.15	.13	.07
78	.67	-.11	.05	.27
56	.66	.09	.35	.11
4	.64	.07	.10	.09
58	.61	.01	.19	.16
20	.59	.06	.07	.03
21	.58	.21	-.06	.02
69	.57	.02	.06	.35
24	.53	.03	-.02	-.07
11	.51	.12	.17	.15
49	.49	.37	-.38	.11
86	.48	.42	.09	.04
3	.47.	.06	-.02	.07
40	.18	.71	.07	.03
23	.48	.68	.02	.06
42	.41	.68	.27	.07
14	.44	.64	.04	.14
31	.37	.60	.13	.01
35	-.51	.56	.19	.81
5	.27	.55	-.08	.03
63	.38	.52	.04	.02
10	.29	.52	.14	.20
75	.18	.46	-.01	.09
46	.09	.01	.64	.12
48	.23	-.15	.52	.12
26	.02	.14	.21	.71

The two major factors were found to have a statistically nonsignificant correlation ( $r = 0.34$ ) and were thus logically regarded as tapping two separate concepts of the construct of perception. The items constituting Factor 1 were 3, 4, 11, 20, 21, 22, 24, 25, 49, 56, 58, 64, 69, 78, and 86. Items constituting Factor 2 were 5, 10, 14, 23, 31, 35, 40, 42, 63, and 75.

The two major factors accounted for 85.6% of the total variance. Inspection of the content of the remaining three items which accounted for the two further factors indicated that they did not add meaning to the major two-factor model and it was decided to discard them.

The 65 items now remaining from the original pilot scale were then subjected to another factor analysis using subprogram FACTOR, again with principal-components analysis and varimax rotation, to assess whether any other meaningful and interpretable factors might be embedded in the remaining items. This procedure yielded in excess of 10 separate factors, none of which contained more than 6 items each. On close inspection by two independent judges each of these "factors" proved to be uninterpretable and thus it was decided not to include them in the reduced version of the questionnaire.

#### **7.1.2.4 Discussion**

Thus it appeared that two meaningful factors may be extracted from the factor analysis of the data obtained from the reduced item pool. An inspection of each of the representative items for each factor indicated that Factor 1 contained items that targeted an individual's feelings about their respect for psychologists and their work, their ability as competent health professionals and attitudes towards people who consult a

psychologist. This factor was termed **Confidence**. Factor 2 included items canvassing areas such as professional training, types of clients who consult a psychologist, and how one can access the services of psychologists. This factor was termed **Knowledge**.

Thus, from the original 90 item pilot questionnaire designed to assess the public attitude towards psychologists, a refined scale containing 25 items was extracted. This scale was found to subsume two factors in the public attitude towards psychologists. 15 items accounting for one factor clustered around the area of confidence in psychologists and their work while the remaining 10 items were associated with aspects of knowledge of psychologists and what is it that they do.

### **7.1.3. Study II**

#### **7.1.3.1 Introduction**

In order to establish further empirical support for the two factor model of the public attitude towards psychologists developed in Study I the reduced 25 item scale was administered to a second group of Ss.

#### **7.1.3.2 Method**

##### **Subjects**

Ss were 182 non-psychologist participants (112 male and 70 female) attending a two-day conference on Trauma in the Workplace. Age range was from 23 to 67 years with a mean of 34.6 years.

##### **Apparatus**

The refined 25 item questionnaire derived from Study I was administered. Items associated with the two factors were randomised in

the construction of the questionnaire. 12 of the items were so constructed as to allow for negative scoring.

A copy of the reduced questionnaire appears in Appendix 3.3.

## **Procedure**

Participants were addressed at the commencement of the conference as to the purpose of the study. They were informed that participation was voluntary and that no identifying data were required in completing the questionnaire. Those who agreed to participate were provided with an information sheet outlining the nature of the study, the fact that participation was voluntary and that they could terminate their involvement in the study at any time. A copy of this document appears in Appendix 3.2

Ss were asked to respond to each of the items on a 5-point Likert scale. There were no right or wrong answers but merely how the S felt about the statements. Ss were asked not to discuss the items in the questionnaire with fellow participants while completing the questionnaire. The questionnaire was then completed and returned immediately to the administrator.

### **7.1.3.3 Results**

In order to confirm whether the two factor model established in Study I was robust, data were analysed using the SPSS-X subprogram FACTOR with principal-components analysis and varimax rotation as adopted in Study I. The factor loadings resulting from the rotated factor matrix are tabulated below.

Table 7.3 - Rotated Factor Matrix

Item Number	Factor 1	Factor 2
22	.78	.07
20	.76	.19
64	.73	.02
21	.71	.20
56	.69	.19
4	.68	.16
78	.65	.18
25	.61	.19
69	.59	.21
58	.58	.28
24	.57	.27
78	.52	.12
49	.50	.21
3	.50	.13
86	.47	.26
40	.03	.81
35	.14	.78
42	.06	.70
14	.08	.69
31	.19	.69
10	.14	.68
5	.12	.62
63	.12	.58
23	.23	.52
75	.26	.44

7.3.4 Discussion

The results of Study II confirmed the two factor model of the questionnaire developed in Study I. Although the factor loadings of individual items within each factor varied slightly from those obtained in

Study I the two factors were still clearly delineated and, significantly, contained the same representative items as those obtained in Study I. Thus it appears that, in assessing what is the public attitude towards psychologists, two discrete and robust dimensions of the construct were the level of **Confidence** the public has in psychologists and **Knowledge** of their work and practice.

#### **7.1.4. Study III**

##### **7.1.4.1 Introduction**

While Study II confirmed the two factor structure of the reduced scale there was, as yet, no evidence to support the construct validity of the scale. The purpose of Study III was to establish whether this validity existed.

To achieve this Ss were asked to provide an indication of their knowledge of, and confidence in, psychologists. The reduced 25 item scale was then administered and the results of the two procedures compared to ascertain whether the reduced scale did indeed have construct validity.

##### **7.1.4.2 Method**

###### **Subjects**

Ss were 67 participants (48 male, 19 female) attending a series of health promotion workshops. Age range of Ss was from 29 to 55 years with a mean of 37.1 years.

###### **Apparatus**

In order to assess the construct validity of the scale two 9-point Likert scales were initially employed to enable participants to indicate their knowledge of and confidence in psychologists. Following the selection of Ss for the experimental group the questionnaire from Study II was employed.

## **Procedure**

Eventual Ss ( $N = 67$ ) were drawn from 144 participants attending a series of workshops concerning policies dealing with AIDS in the workplace. All conference participants were given a short presentation outlining the nature of the research they were being asked to become involved in and what would be required of them as participants. It was emphasised that Ss would not be asked to identify themselves and that their anonymity would be guaranteed. They were then told that if they did not wish to participate in the study then not to take a copy of the questionnaire. Those who agreed to participate were provided with an information sheet outlining the nature of the study, the fact that participation was voluntary and that they could terminate their involvement in the study at any time. A copy of this document appears in Appendix 3.2

Those participants who did volunteer were then given a copy of the two statement questionnaire (see Appendix 3.4) and asked to devise an identifying number which they would remember and to write this number in the space provided on the questionnaire. Ss were then asked to indicate with a (X) on the two 9-point Likert scales on the questionnaire their response as to their (i) knowledge of and (ii) confidence in psychologists. Completed questionnaires were then collected.

Based on the results of the responses to this screening procedure Ss were allocated to one of four groups. These groups were:

Group 1 - High Knowledge/High Confidence

Group 2 - High Knowledge/Low Confidence

Group 3 - Low Knowledge/High Confidence

Group 4 - Low Knowledge/Low Confidence

For the purposes of this study a score of 7 or greater on the Likert scale was regarded as a high score while 3 or less was regarded as a low score.

This procedure yielded the following results with a total N = 67:

**Table 7.4 - Self-report responses of Ss regarding Confidence in, and Knowledge of, Psychologists**

<b>Group</b>	<b>Number of Ss</b>
High Confidence/High Knowledge	18
High Confidence/Low Knowledge	17
Low Confidence/High Knowledge	13
Low Confidence/Low Knowledge	19

These 67 Ss now constituted the experimental group. They were identified by their self determined identifying number and were provided with a copy of the reduced questionnaire from Study I and asked to complete it. They were reminded to use the same identifying number as before so as to maintain their anonymity.

Completed questionnaires were collected and analysed.

#### **7.1.4.3 Results**



Group scores for the Confidence and Knowledge subscales of the questionnaire are tabulated below

**Table 7.5 - Group Means for the Confidence and Knowledge Subscales**

Group	Confidence		Knowledge	
	X	S.D.	X	S.D.
High Confidence/ High Knowledge	58.10	11.27	37.39	8.92
High Confidence/ Low Knowledge	51.28	13.72	19.33	4.85
Low Confidence/ High Knowledge	27.64	9.03	31.42	6.98
Low Confidence/ Low Knowledge	23.51	7.52	12.31	4.66

Data were analysed using the SPSS<sup>X</sup> subprogram ANOVA. The results of this analysis are tabulated below.

**Table 7.6 - Analysis of Variance of Data for the Confidence and Knowledge Subscales**

Source	df	SS	MS	F	p
Between groups	3	18460	6153.0	69.92	< 0.01
Within groups	64	9182	88.4		
Total	67	27462			

$F_{0.01\ 3,67} = 4.09$

The results indicated that  $H_0$  could be rejected and it may be concluded that there is a difference between the four groups based on their attitude towards psychologists as indicated by their responses to the reduced scale.

To explore the source of between group differences on the reduced 25 item scale, univariate analysis of variance (ANOVA) with orthogonal

planned contrasts were conducted. Groups of Ss responding either high or low with respect to confidence and knowledge on the Likert scales were compared with each other resulting in four contrasts of interest (see Appendix 17.1). No significant differences were found between any of these four comparisons, indicating that if a S initially reports they are high or low with respect to confidence in, or knowledge of, psychologists they will then proceed to score consistently with this view on the reduced 25 item scale.

#### **7.1.4.4 Discussion**

Thus the reduced scale has been shown to demonstrate construct validity in that it was shown to measure what it purported to i.e. the two factor model of the attitude towards psychologists. Those Ss who initially self-rated their knowledge of and confidence in psychologists as either high or low then proceeded to respond in a manner consistent with their position on these two dimensions when completing the reduced scale.

### **7.1.5. Study IV**

#### **7.1.5.1 Introduction**

The concepts of the attitude towards psychologists and the tendency towards helpseeking for psychological problems are closely allied. One could posit that an individual would be more likely to seek assistance from a psychologist if his/her attitude towards psychologists were positively inclined.

Inspection of the literature in the area of helpseeking revealed the existence of a scale that had been developed to assess the public attitudes of American college students towards seeking psychological help

(Fischer & Turner, 1970). This scale, the Attitude Towards Seeking Psychological Help (ATSPH), had been tested on three independent samples with ensuing results indicating that four dimensions of the construct of seeking psychological help could be isolated. These were termed: Recognition of the Need for Psychological Help, Stigma Tolerance, Interpersonal Openness and Confidence in Psychologists.

A superficial inspection of the items constituting the ATSPH revealed similarities between it and the reduced scale developed in Studies I and II. In order to assess the extent of this congruence it was decided to give both scales to the same population and compare the results.

#### **7.1.5.2 Method**

##### **Subjects**

Ss were 123 students (79 male, 44 female) sitting for an examination to qualify for the award of a first aid certificate. Age range was from 17 to 49 years with a mean of 27.2 years.

##### **Apparatus**

All Ss completed both the questionnaire developed in Study II and the Attitude Towards Seeking Psychological Help (ATSPH) scale (Fischer & Turner, 1970) (see Appendix 3.5).

In order to select items for the ATSPH scale, Fischer & Turner (1970), in collaboration with several clinical psychologists who were familiar with numerous mental health settings, generated a series of attitude statements thought to sample many of the aspects of the general orientation toward seeking professional help for psychological problems. A pool of 47 accepted statements were then randomly ordered, and then subjected to

the judgments of a panel of 14 clinical and counselling psychologists and psychiatrists. The judges rated each item as to its relevance to the hypothetical attitude domain and according to whether it reflected a positive or a negative attitude. 31 items were considered to be highly relevant, and were unanimously judged to be either "pro" or "con" statements. Two items correlated poorly with total attitude scores of 78 initially tested student subjects, and were removed from the scale. The remaining 29 items were considered the final scale.

The 29 scale items are presented in Likert-type style (see Appendix 3.5) in a four-point, agree-disagree format and scored 3, 2, 1, 0 (reversed keyed for negative items). The possible range of scores is 0 to 87, with high scores indicative of a global pro-help attitude. Internal reliability of the ATSPH scale, was computed at .86 ( $n = 212$ ) and on a later sample of 406 subjects, at .83. Five groups of students were given the scale twice, at varying intervals, to establish test-retest reliability; which ranged from .73 to .89. The scale was further found to be relatively free from social desirability bias, with correlations between help-seeking attitude and social desirability of -.08 for females and -.12 for males. Further, the scale was found to discriminate very well on known-groups (concurrent) validity, in that there was a distinct difference found between students who had sought professional psychological help and those who had no such contact. Finally, a factor analysis of item responses identified the four factors cited above.

### **Procedure**

Ss were addressed as a group at the conclusion of their having sat for the theory examination to qualify them as first aid practitioners. They were

informed about the nature of the research, that their responses would remain anonymous, that participation was voluntary and would not reflect on their performance in the first aid theory examination. Those who agreed to participate were provided with an information sheet outlining the nature of the study, the fact that participation was voluntary and that they could terminate their involvement in the study at any time. A copy of this document appears in Appendix 3.2.

Ss who volunteered were instructed to devise an identifying number that they would place on the answer sheet in place of their name so as to preserve their anonymity. They were told that, in answering the items on the two scales, there were no right or wrong answers but merely how they personally felt about the individual statements. Following these instructions Ss were randomly divided into two groups. One group was then given the public attitude towards psychologists scale developed in Study II while the other group received the Attitude Towards Seeking Psychological Help (Fischer & Turner, 1970) scale. All Ss were asked to complete the scale they had been assigned. At the conclusion of this procedure scales and completed answer sheets were collected. The procedure was then repeated with each group receiving the scale which they had not already completed. These scales and answer sheets were then collected and all data analysed.

### **7.1.5.3 Results**

All data was analysed using SPSS-X subprogram CORRELATIONS. The overall correlation between the two scales was .65. This result was

independent of the order of presentation of the scales. Further analysis was conducted to ascertain the extent of correlation between the respective subscales of the two instruments. The results of this analysis are tabulated below:

**Table 7.7 - Correlation Coefficients between the Scale from Study II and the Attitude Towards Seeking Psychological Help scale.**

		Scale from Study II	
		Knowledge	Confidence
<b>Attitude Towards Seeking Psychological Help</b>	Recognition of Need for Help	0.75	0.31
	Stigma Tolerance	0.29	0.53
	Interpersonal Openness	0.50	0.74
	Confidence in Psychologists	0.30	0.81

#### 7.1.5.4 Discussion

There were several important outcomes from this study. Firstly there was a strong correlation between the Confidence factor isolated from the attitude towards psychologists scale and the Confidence in Psychologists factor from the ATSPH scale. Similarly it appeared that the concept of Interpersonal Openness was subsumed under the concept of Confidence and Recognition of Need for Psychological Help appeared to tap the same area as Knowledge.

There was, however, only moderate correlation between Stigma Tolerance and the two factors present in the attitude towards psychologists scale. One item from this scale (item No.23) did indeed target the extent of stigma associated with consulting a psychologist.

However it seemed that the presence of a factor tapping the stigma associated with seeking psychological help may be significant in providing a more comprehensive assessment of the overall public attitude towards psychologists.

### **7.1.6. Study V**

#### **7.1.6.1. Introduction**

It was apparent from the results of Study IV that a factor tapping the notion of the perceived stigma associated with accessing the services of a psychologist may need to be included in the present scale in order to comprehensively assess what is the public attitude towards psychologists. To assess the extent of this notion a number of items constructed so as to tap this factor were developed and added to the existing attitude towards psychologists scale developed in Study II. This expanded scale was then tested on a population in order to ascertain its resultant factor structure.

#### **7.1.6.2 Method**

##### **Subjects**

Ss were 277 (232 male and 45 female) State Rail Authority employees attending a series of courses on safety procedures. Age range was from 19 to 57 years with a mean of 42.1 years.

##### **Apparatus**

The scale developed in Study II was employed. However an additional ten items constructed by a panel of three psychologists so as to assess the concept of the stigma associated with accessing the services of a

psychologist were included making a total of 35 items in this revised questionnaire. These additional items were randomised in presentation with the original items in the scale.

A copy of the expanded questionnaire appears in Appendix 3.6.

## **Procedure**

Ss were addressed as to the nature of the research and informed that participation was voluntary. Those who agreed to participate were provided with an information sheet outlining the nature of the study, the fact that participation was voluntary and that they could terminate their involvement in the study at any time. A copy of this document appears in Appendix 3.2.

Ss were instructed that no identifying data were required on the answer sheet and therefore S anonymity would be ensured. Copies of the revised scale were then distributed to Ss. It was emphasised to Ss that there were no right or wrong answers but merely how the S felt about the individual statements. Completed questionnaires were collected and data analysed.

### **7.1.6.3 Results**

Data were analysed using SPSS<sup>X</sup> subprogram FACTOR. The method of factor analysis used was principal components analysis with varimax rotation of axes as in Study II. This procedure yielded three main factors consisting of 13, 9 and 8 items respectively. These three major factors accounted for 95.7% of the total variance. Three other factors were also isolated by this procedure but they consisted of only 2, 2 and 1 items respectively. Inspection of these residual factor items revealed them to be



meaningless and uninterpretable in light of the present construct and were thus discarded.

The results of the factor analysis are reported below.

**Table 7.8 - Factor Analysis of Revised Scale**

<b>Factor</b>	<b>Eigenvalue</b>	<b>% Variance</b>	<b>Cum. Var.</b>
1	6.65	43.1	43.1
2	4.77	31.4	74.5
3	2.31	21.2	95.7

A inspection of the intercorrelations between the three factors revealed low values ( $r_{12}=.32$ ,  $r_{13}=.29$ ,  $r_{23}=.36$ ) indicating that the three resultant factors were independent and thus could be regarded as tapping three separate and distinct dimensions of the public attitude towards psychologists. The items constituting Factor 1 were 5, 6, 9, 11, 14, 16, 19, 22, 25, 26, 29, 30, and 34. Factor 2 items were 3, 8, 12, 18, 21, 24, 28, 31, and 35. Items constituting Factor 3 were 1, 4, 7, 13, 17, 20, 32, and 33.

#### **7.1.6.4 Discussion**

Thus it appeared that three meaningful and interpretable factors could be extricated from the factor analysis of the data obtained from the expanded item pool. Items that clustered to form Factor 1 were found to be targeting areas of confidence in psychologists similar to the original confidence factor from the scale developed in Study II. Items clustering to constitute Factor 2 seemed to be tapping areas of knowledge of psychologists and their practice again similar to the original knowledge factor from the scale developed in Study II. Factor 3 contained items that

had clustered together around the theme of the perceived stigma associated with accessing the services of a psychologist.

This third factor was composed of five of the ten new items added to the original questionnaire precisely for this purpose. However, and significantly, this new factor was found to also contain one item from the Knowledge dimension and two items from the Confidence dimension of the original scale developed in Study II. Inspection of the original factor analysis data of Study II revealed that these three items had, in fact, achieved the lowest factor loadings for their respective factors and were thus the "weakest" items clustering together to form the original two factors of Knowledge and Confidence.

Thus the revised and expanded scale (see Appendix 3.7) now contained three factors thought to comprehensively assess the public attitude towards psychologists. These three factors were termed Confidence, Knowledge and Stigma.

This revised scale was designated the **Perception of Psychologists Scale (POPS)**. The use of the term "*perception*" rather than attitude can be justified on a number of bases. In common useage the terms attitude, opinion, concept, image and perception are used interchangeably. Additionally a cursory perusal of the reserach literature on the development of attitude scales reveals a frequent use of the term perception in lieu of attitude (e.g. Kabatznick, 1984; Sharpley, 1986; Schindler, Berren, Hannah, Beigel,& Santiago, 1987). Finally it was believed that respondents may feel less threatened in completing a scale

that is labelled *perception* of psychologists rather than one labelled *attitude* towards psychologists.

Therefore it was decided to label the scale Perception of Psychologists although the construct being measured was, in fact, attitude towards psychologists.

## **7.1.7 Study VI**

### **7.1.7.1 Introduction**

While the revised scale had been shown to contain three distinct and independent factors subsuming the public attitude towards psychologists there was, as yet, no evidence to establish and support the validity of this new scale. Thus, using the paradigm developed in Study III, the purpose of this study was to establish whether this validity existed.

### **7.1.7.2 Method**

#### **Subjects**

Ss were 117 armed services personnel (97 male, 20 female) attending an Army camp where a skills audit was being conducted. Age range was from 18 to 51 years with a mean age of 27.7 years.

#### **Apparatus**

Three 10-point Likert scales were used to enable Ss to indicate their knowledge of, confidence in, and stigma attached to a psychologist similar to the questionnaire used to derive the experimental group in Study III. Following the selection of Ss for the experimental group the POPS developed in Study V was employed.

## Procedure

Eventual Ss (N = 117) were drawn from 212 armed services reserve personnel who were attending a skills audit assessment. Ss were informed that the present research had nothing to do with the skills audit and that S anonymity would be preserved by the use of a self-devised code number rather than their name. Participation in the survey would be voluntary. Those who agreed to participate were provided with an information sheet outlining the nature of the study, the fact that participation was voluntary and that they could terminate their involvement in the study at any time. A copy of this document appears in Appendix 3.2.

All participants were given a short presentation outlining the nature of the research and what would be required of them as participants. Those participants who did volunteer were then given a copy of the three statement questionnaire (see Appendix 3.8) and asked to devise an identifying number and to write this number in the space provided on the answer sheet. Ss were then asked to indicate with an (X) on the three 9-point Likert scales their position as to their (i) knowledge of, (ii) confidence in, and (iii) stigma attached to accessing the services of a psychologist. Completed questionnaires were then collected.

Based on the results of this questionnaire Ss were allocated to one of eight possible groups. Allocation to these groups was dependent on whether the S had scored high or low with respect to knowledge, confidence and stigma. For the purposes of this study a score of 7 or greater on the Likert scale was regarded as a high score while 3 or less was regarded as a low score. This procedure yielded the following results as shown in Table 7.9.

These 117 Ss constituted the experimental group. They were identified using their self-assigned number and were provided with a copy of the revised POPS and asked to complete it. Ss were instructed that there were no right or wrong answers but merely how they personally felt about each

**Table 7.9 - Allocation of Ss to Groups**

Group			No. Ss
Knowledge	Confidence	Stigma Tolerance	
High	High	High	9
High	High	Low	14
High	Low	High	15
High	Low	Low	10
Low	High	High	17
Low	Low	High	16
Low	High	Low	23
Low	Low	Low	13

particular statement. Ss were reminded to use the same identifying number as before so as to maintain their anonymity.

Completed questionnaires were collected and analysed.

**7.1.7.3 Results**

Data were analysed using SPSS<sup>X</sup> subprogram ANOVA. The results of this analysis are tabulated below.

**Table 7.10 - Analysis of Variance of Data for the Knowledge, Confidence and Stigma Tolerance Subscales**

Source	df	SS	MS	F	p
Between groups	7	29702	4243	7.97	< 0.01
Within groups	117	62010	530		
Total	124	91712			

$$F_{0.01\ 7,117} = 2.80$$

The results indicated that the  $H_0$  could be confidently rejected and it may be concluded that there is a difference between the groups based on their attitude towards psychologists.

To explore the source of between group differences on the revised POPS, univariate analysis of variance (ANOVA) with orthogonal planned contrasts were conducted. Groups of Ss responding either high or low with respect to confidence, knowledge and stigma tolerance on the Likert scales were compared with each other resulting in six contrasts of interest (see Appendix 17.2). No significant differences were found between any of these six comparisons, indicating that if a S initially reports they regard themselves as high or low with respect to confidence in, knowledge of, or stigma attached to accessing the services of a psychologist they will then proceed to score consistently with this view on the revised POPS.

#### **7.1.7.4 Discussion**

Thus the revised POPS had been shown to demonstrate construct validity in that it has been shown to measure what it purported to. Ss who declared themselves as high or low with respect to their confidence in,

knowledge of, and stigma attached to accessing the services of a psychologist were found to score consistently when assessed using the Perception of Psychologists scale.

### **7.1.8. Study VII**

#### **7.1.8.1 Introduction**

While the POPS has established its validity as an instrument sensitive to assessing the extent of the public attitude towards psychologists its reliability as an instrument capable of consistently measuring this construct over time had not be established. This purpose of this study was to establish this reliability by employing a test-retest procedure.

#### **7.1.8.2 Method**

##### **Subjects**

Ss were 67 (42 male, 25 female) officers of the N.S.W. Ambulance Service attending a series of monthly educational workshops in order to upgrade their qualifications. Age range was from 22 to 42 years with a mean of 31.7 years.

##### **Apparatus**

The Perception of Psychologists Scale (POPS) developed in Study V was employed (see Appendix 3.7).

##### **Procedure**

Ss were addressed as a group as to the purpose of the research. However they were not told that they would be asked to complete the scale again in the near future. Ss were informed that participation in the research was

voluntary and that no credit for their course would accrue through participation. Those who agreed to participate were provided with an information sheet outlining the nature of the study, the fact that participation was voluntary and that they could terminate their involvement in the study at any time. A copy of this document appears in Appendix 3.2.

Participants were instructed to devise an identifying number that would be used in place of their name and that this number should be something that they would remember in the future when results of the survey were returned to them. The usual instructions that there were no right or wrong answers were given to Ss. Upon completion of these instructions Ss were given a copy of the POPS and an answer sheet and asked to complete the questionnaire.

At the corresponding workshop one month later the same Ss were again requested to complete the POPS using the same identifying number that they had previously employed. Three original Ss were absent from this second meeting. Thus their data from the first administration of the POPS was eliminated from subsequent analysis making a final  $N = 64$ .

### **7.1.8.3 Results**

Data were analysed using SPSS<sup>X</sup> subprogram CORRELATIONS. The overall correlations between the two administrations of the scale was 0.84. Subscale correlations for the three factors were:

Confidence = 0.80



Knowledge	= 0.79
Stigma	= 0.86

#### **7.1.8.4 Discussion**

The results indicate that the Perception of Psychologists Scale is indeed a reliable measure of the construct of the public attitude towards psychologists.

#### **7.1.9. General Discussion of the Development of the Measuring Instrument**

A series of seven studies were devised to elucidate and refine a psychometric scale capable of assessing the nature and extent of the public attitude towards psychologists. From an initial questionnaire of ninety items covering areas such as individuals' knowledge of psychologists and their work, previous experience with psychologists, confidence and trust in psychologists, areas of psychological intervention, feelings towards individuals who consulted a psychologist, the perceived stigma attached to individuals who accessed the services of a psychologist and the relation of psychologists to other members of the helping professions, a thirty statement Perception of Psychologists Scale (POPS) was constructed. This scale was tested on a variety of populations and has been shown to demonstrate both construct validity and reliability in its application.

The three-factor model of the Perception of Psychologists Scale developed in this study is supported by recent research. Warner & Bradley (1991) in a survey of views of counsellors, psychiatrists and psychologists found that two factors discriminating between these professionals were confidence and knowledge. Confidence and

knowledge have also been shown to be predominant factors in studies tapping the attitude towards psychologists by Fisher & Turner (1970); Altmaier & Rapaport (1984); Brown (1978); Cook, Park, Williams, Webb, Nicholson, Schneider & Bassman (1984), dePaulo (1983) and Gross & McMullen (1983).

Kushner & Shaw (1991, 1989) found that fears and concerns about the seeking and consumption of psychological services significantly contributed to the avoidance of these services. They defined the concept of treatment fearfulness as a subjective state of apprehension that arises from aversive expectations about the seeking and consumption of these services. They conceptualised the decision to seek help from a psychologist as a conflict between approach tendencies (e.g. mental distress, lifestyle disruptions, pressures from others) and avoidance tendencies (e.g. treatment fears, cost, time commitment).

Kushner & Shaw (1991) went on to itemise specific treatment fears such as fear of embarrassment, fear of change, fears involving treatment stereotypes, fears associated with past experience with the mental health service system, fears of negative judgment (stigma), and fears associated with specific problem types.

In support of this contention that treatment fears are a factor in the public attitude towards psychologists Amato & Bradshaw (1985) found, surveying an Australian population, that the most important cluster of reasons given by their community sample for avoiding or delaying seeking psychological services for a personal problem involved fears associated with exposing, facing, and treating the problem, and fears of

negative judgment by the helper. Similarly, Pipes, Schwartz & Crouch (1985) developed an instrument (Thoughts About Counselling Survey; TACS) with which they demonstrated that college students who sought psychological treatment reported significantly less treatment fearfulness than did students who did not seek these services. Furthermore, they showed that the TACS tapped into two main factors which they labelled *therapist responsiveness* (e.g. fears about therapist's competence and relationship with the therapist), and image concerns (e.g. how the individuals would be viewed by themselves and others for seeking treatment).

Thus there is now an instrument that can be used to assess how the public views psychologists. Research indicates that the services of psychologists are currently either underutilised or inappropriately utilised. Up to 70% of individuals who consult their general practitioner in Australia are believed to do so for non-medical reasons i.e. they present with social or emotional problems but seek a medical solution (Mental Health Discussion Paper, 1989). If psychologists are able to improve the community's attitude towards them then it follows that psychologists will become an vital part of the community's health care system rather than a peripheral adjunct as is currently the situation.

## **7.2 Method for Main Study**

### **7.2.1 Subjects**

Three organisations, two from the private sector and one from the public sector, and differing in the nature of their work and employee

characteristics, were chosen for this study so as to enhance the external validity of the findings across a range of potential populations.

Several criteria were employed in the selection of the participating organisations. The major criteria were a commitment on the part of the management of each organisation to implement and support and Employee Assistance Program for at least twelve months, a willingness to support the present research both practically and philosophically, and to provide for ease of access to experimental Ss.

It was considered important that participating organisations were sufficiently large so as to allow for the physical separation of experimental and control groups in different locations. Organisations were also chosen on the basis on having adequate access to relatively equal populations of male and female subjects covering the range of adult working ages (18-65 years) (although this requirement proved to be somewhat difficult in practice). A further criterion was that Ss needed to be conversant in English so as to be able to respond to questionnaires.

With these requirements in mind the nature of the organisations finally chosen are outlined below. A condition of agreeing to involvement in this study was that the identity of the participating organisations was not revealed:

Organisation 1: A heavy industrial plant. A range of abilities required by employees depending on the nature of the job itself ranging from labouring to technical, scientific and professional. Approximately 8000 employees spread over a large area.

Organisation 2: An Area Health Service with several different campuses centred around three large hospitals. Again a range of abilities required by employees depending on the specific nature of the job. A higher percentage of "professional" employees (nursing medical, allied medical etc.) was present. Approximately 5000 employees.

Organisation 3: A chemical processing plant. Jobs usually required a relatively high degree of technical skill with minimal heavy physical labour involved as most work was automated. Approximately 2100 employees.

This procedure yielded a total of 990 Ss (624 M and 366 F) from the three participating organisations, each organisation providing 330 Ss. Participation of Ss in the study was strictly voluntary and no credit, either financial or work-related, accrued to participants who volunteered to participate in the study.

Due to the voluntary participation criterion of the study it was not possible to obtain equal numbers of male and female Ss for each department.

**Table 7.11 - Sex Distribution of Ss**

	Male	Female
Organisation 1	249	81
Organisation 2	180	150
Organisation 3	195	135

Percentage representation of age ranges of Ss by organisation is as follows:

**Table 7.12 - Age Distribution of Ss**

	18-25		25-35		35-45		45-55		55-65	
	M	F	M	F	M	F	M	F	M	F
<b>Organisation 1</b>	18	35	34	41	31	20	10	3	7	1
<b>Organisation 2</b>	14	33	21	44	31	19	29	3	5	1
<b>Organisation 3</b>	10	39	35	38	42	19	7	2	6	2

### 7.2.2 Design

The design selected for this study was a mixed model (within and between subjects) repeated measures design.

The 330 Ss from each participating organisation were drawn from two separate and physically distinct areas (henceforth termed "Departments") within the organisation resulting in 165 Ss from each Department. In each organisation these Departments as well as being distinct were also chosen because they were located in different areas specifically to minimise the flow of information from one to another. For the purposes of this study these were termed Departments A and B in each organisation. Because of the design of the present study where a prime consideration was the physical separation of the Departments, it was not possible to randomly allocate Ss to Departments.

In each organisation Ss in Department A only were further randomly allocated to three subgroups termed X, Y and Z, each of 55 Ss. Ss in

department B remained as one whole group of 165 Ss. Ss in Department A received the interventions (to be outlined later) while Department B Ss did not receive any interventions and acted as the "no treatment" control.

**Table 7.13 - Distribution of Ss by Organisation, Department and Subgroup**

Organisation	Subgroup	Department A	Department B
		Number Ss	Number Ss
1	X	55	165
	Y	55	
	Z	55	
2	X	55	165
	Y	55	
	Z	55	
3	X	55	165
	Y	55	
	Z	55	

Three registered psychologists (2 male, 1 female) were involved in delivering the interventions to Ss in each of the subgroups in Department A. Thus all three psychologists were involved in implementing the interventions in each of the three organisations. Only one psychologist was allocated to the Department B of each organisation as, effectively, they had no practical role. The participating psychologists were chosen on the basis of their professional experience, familiarity with the EAP model and willingness to participate in this longitudinal study.

**Table 7.14 - Allocation of Psychologists to Groups**

Organisation	Department A		Department B
	Subgroup	Psychologist	Psychologist

1	X	1	1
	Y	2	
	Z	3	
2	X	2	2
	Y	3	
	Z	1	
3	X	3	3
	Y	1	
	Z	2	

Three additional registered psychologists (1 male, 2 female), who played no part in delivering any of the interventions, were co-opted to act as "assessment administrators" responsible for administering all the questionnaires to Ss. They remained as the assessment administrator for their organisation for the three testing periods. Thus the allocated psychologists who carried out the interventions in each of the subgroups of Department A were not associated with the gathering of data at any of the testing sessions. The assessment administrators at no time revealed to Ss that they were psychologists as it was posited that this may have biased participants' perception of psychologists and their work.

As mentioned previously it was not possible to obtain, on a voluntary basis, equal numbers of male and female Ss. While this could have been achieved by co-opting Ss it was decided that, for the purposes of this study, voluntary involvement was regarded as a higher priority.

**Table 7.15 - Sex Distribution of Ss by Organisation,  
Department and Subgroup**

Organisation	Subgroup	Dept A		Dept B	
		M	F	M	F



1	X	38	17	134	31
	Y	39	16		
	Z	38	17		
2	X	31	24	87	78
	Y	28	27		
	Z	34	21		
3	X	37	18	93	72
	Y	33	22		
	Z	32	23		

The dependent variables in this study were the three subscales of the Perception of Psychologists Scale i.e. Confidence, Knowledge and Stigma Tolerance. The independent variables of interest were organisation (3 levels), department (2 levels), psychologist (3 levels), sex (2 levels) and time (3 levels). The first four independent variables were between-subjects factors while time was a within-subjects factor.

**7.2.3 Materials**

Two instruments were administered to all Ss. They were the General Health Questionnaire-30 (Goldberg & Williams, 1988) and the Perception of Psychologists Scale developed specifically for this study.

The General Health Questionnaire-30 (Goldberg, 1972; Goldberg & Williams, 1988) is a thirty item self report screening instrument aimed at detecting psychiatric disorders among respondents. It focuses on breaks in "normal" functioning rather than on lifelong traits. The GHQ-30 concerns itself with two major classes of phenomena: the inability to carry out one's normal healthy functions and the appearance of new phenomena of a distressing nature.

For these reasons the GHQ-30 is widely used as a preliminary screening instrument to assess the "normality" of the population under investigation. It has been used in over 150 studies for this purpose (Goldberg & Williams, 1988).

The GHQ-30 has both impressive reliability and validity. In terms of reliability, values of split-half = 0.95, internal consistency using coefficient  $\alpha$  ranging from +0.82 - +0.93, and test-retest reliability coefficient of 0.75 - 0.90 have been reported (Shek, 1987; Banks, Clegg, Jackson, Kemp, Stafford & Wall, 1980; Goodchild & Duncan-Jones, 1985).

The GHQ-30 also has impressive content validity. A large number of concurrent validity studies have been conducted, all of which have demonstrated the sensitivity of the GHQ-30 when compared with a range of external criteria of psychiatric disorder (Ballinger, Smith & Hobbs, 1985; Prince, Frasure-Smith & Roliz-Woloszyk, 1982; Goldmeier & Johnson, 1982).

The GHQ has a number of versions differing in the number of items contained in them. The GHQ-30 was chosen for the present study because it is the most widely used version for screening normal populations prior to treatment evaluation. The GHQ-30 consist of thirty statements to which Ss respond using a Likert-like four statement scale. Respondents are asked to "underline the answer you think most nearly applies to you over the past few weeks". A copy of the GHQ-30 appears in Appendix 4.

Items are scored "0" for statements 1 and 2 and "1" for statements 3 and 4. An overall score exceeding 5 is regarded as an appropriate threshold for the detection of any significant pathology in the individual.

The Perception of Psychologists Scale was designed specifically for use in this study (Chapter 7.1) A series of studies were carried out to establish its validity and reliability. The Perception of Psychologists Scale consists of three subscales: Confidence, Knowledge and Stigma Tolerance. A copy of the Perception of Psychologists Scale appears in Appendix 3.7.

#### **7.2.4 Procedure**

Notices were placed around the work sites in each area or "Department" (A and B) of the three participating organisations approximately two months before the commencement of the study inviting individuals to participate in the study.

The notices outlined the nature of the study, indicating that it was designed to evaluate their organisation's new Employee Assistance Program, and the commitment required on the part of participants. At no time were participants informed that the true nature of the study was to assess their perception of psychologists and their work. (It was thought that to do this would inevitably bias participants' perception of psychologists).

Potential participants were asked to contact a phone number listed on the notice to indicate their willingness to become involved. It was strongly emphasised that participation of Ss in the study was strictly voluntary,

that they could leave the study at any time without prejudice, and that no financial or work-related advantage would accrue to participants.

When each Department in the three organisations reached 165 participants no further applications were accepted. Successful Ss were then contacted by letter and told they would be informed in due course when the study commenced.

All Ss were assessed before any intervention with their nominated psychologist was commenced (pre-test). This was called Time 1 ( $T_1$ ). For the purposes of testing Ss were brought together according to whether they were allocated to Department A or Department B. Ss from Department A in each organisation were tested in their individual subgroups (X, Y and Z) while Ss from Department B were assessed as a single group.

All Ss in each of the three organisations were tested in the same room located at the Ss' workplace on the same day for each of the three testing sessions. Each S was asked to cross their name off an attendance list when they entered the testing room. In this way any absentees could be determined. Ss who missed any one testing session were excluded from the analysis of data (although they were not informed of this). No company personnel other than those who had volunteered to be Ss were allowed to be present during the testing sessions. Ss were seated individually at tables and were provided with pens to complete the Answer Sheets.

Each (co-opted) psychologist responsible for the administration of the questionnaires addressed their group about the purpose and nature of the assessment procedures. They adhered to a prepared narrative (see Appendix 5) so that all Ss received identical instructions. Ss were informed that the nature of the research was to gather data that would be used to make their Employee Assistance Program more responsive to the needs of employees and that there would be three testing periods each six months apart. It was emphasised to Ss that their answers to the questionnaires would remain confidential and, to ensure this, they were requested to devise an identifying number that only they knew but one that they would remember and use for all questionnaires over the three testing periods. It was emphasised that the questionnaires were not designed to determine right or wrong answers but merely how the S felt about the statements. They were told that the questionnaires were not speed tests but that they should consider each item carefully without dwelling too long on any one item.

Following this introduction Ss were then asked to complete a demographic survey (see Appendix 6) that had been placed on their seats before they entered. They were told that this information would be used in conjunction with the questionnaires to derive more meaning from the results of the questionnaires and that Ss were to use only their identifying number in the space provided. When these surveys were completed they were collected by the assessment administrator.

The assessment scales were administered in the same order for all Ss at T<sub>1</sub>. Each of the two scales were administered separately and was collected from Ss before the next scale was disseminated. Each

assessment administrator introduced both scales with a narrative from a prepared script (see Appendix 7), again so that all Ss received identical instructions about how to complete each questionnaire.

All Ss completed the General Health Questionnaire (Goldberg & Williams, 1988) and the Perception of Psychologists Questionnaire in that order. The Perception of Psychologists Scale was again completed by all Ss six months (T<sub>2</sub>) after the initial screening and lastly twelve months (T<sub>3</sub>) after the initial screening. The same procedure as that adopted for the first testing session was adhered to for the subsequent sessions.

**Table 7.16 - Testing Session Procedure**

Time Allocation (mins)	Assessment Activity
10	Address by Assessment Administrator about the nature of the research and rules for answering questionnaires
10	Completion and collection of demographic survey sheet
10	Distribution, completion and collection of General Health Questionnaire (*NOT included in testing sessions 2 and 3)
20	Distribution, completion and collection of Perception of Psychologists scale
10	Arrangements for next testing session

Within seven days of the initial testing session all Ss from both Departments A and B in all three organisations received a group presentation by their allocated psychologist (1, 2 or 3) about their organisation's Employee Assistance Program. Each allocated

Psychologist adhered to a prepared narrative in this presentation, a copy of which is in Appendix 8. A generic video tape and an audio tape pertaining to the Employee Assistance Program was also presented to Ss during the briefing and both were made available to Ss after the briefing session.

Following this presentation about the Employee Assistance Program those Ss allocated to Department B received no further intervention from their psychologist and did not see their psychologist for the remainder of the testing period. The exception to this was if individual Ss sought out their psychologist for counselling as part of their organisation's Employee Assistance Program. Apart from this contingency the allocated Psychologist avoided all direct or indirect contact with Ss from Department B. A record of Ss from both Departments who attended the Employee Assistance Program for counselling was maintained.

In contrast to Ss in Department B, those Ss allocated to Department A were consistently exposed to their allocated Psychologist through a comprehensive system of direct and indirect interventions over the twelve month period of the study. The thrust of these various interventions was the impress on Ss that their psychologist was an approachable, practical and credible part of their organisation who was involved in a pragmatic program (the EAP) to help them resolve personal and/or work-related problems. Thus the aim of these interventions was designed to positively influence the perception that the Ss had of psychologists by showing these Ss how useful and relevant psychologists could be to their everyday work and personal lives. There were six interventions in total and a description of each is provided below.

Firstly all Ss in Department A received two editions of a generic EAP/health promotion Newsletter specifically designed for this study, one during the first six month period of the research and the second during the next six months. This Newsletter contained information about the Employee Assistance Program together with topical articles relevant to workplace physical and emotional health, issues concerning occupational health and safety and various articles concerning the work of psychologists. It was designed to demonstrate the practical nature of the work that psychologists carried out and how this related directly to employees' everyday lives. Copies of these Newsletters appear in Appendices 9.1 and 9.2. The Newsletters were so devised that they carried no identifying information about an individual organisation and, as such, could be used in all three participating organisations. Thus all Ss in each of the three Department A's received the same Newsletters.

Secondly, in Department A the nominated psychologist became a member of the Occupational Health and Safety Committee which met on a bimonthly basis for a total of six times during the period of the research. The task of this committee was to discuss, devise and implement appropriate occupational health and safety policies for all employees. The recommendations of the Committee carried considerable weight and were carefully considered by Management. Additionally the minutes of each meeting were displayed on noticeboards for all to read. The role of the psychologist was to act as a consultant advising the committee on matters concerning employee welfare, the Employee Assistance Program and associated issues.



Thirdly, one of the (previously contrived) suggestions put by the allocated psychologist on this Committee was that all employees should undertake courses in Stress Management, Trauma Education and Assertive Communication Skills to help them cope with the rigours of work more effectively. This suggestion was aimed at again demonstrating the practical nature of the work of the psychologist.

Thus all Ss in Department A participated in three programs run by their allocated psychologist. These programs were (a) Stress Management; (b) Trauma Education and (c) Assertive Communications Skills. A outline of each of these programs is in Appendix 10.1, 10.2 and 10.3 respectively. The allocation of programs to subgroups is provided in Table 7.17.

**Table 7.17 - Allocation of Programs to Subgroups in Department A**

Organisation	Department A		
	Subgroup		
	1	2	3
1	A.C.S.	T.E.	S.M.
	T.E.	S.M.	A.C.S.
	S.M.	A.C.S.	T.E.
2	T.E.	S.M.	A.C.S.
	S.M.	A.C.S.	T.E.
	A.C.S.	T.E.	S.M.
3	S.M.	A.C.S.	T.E.
	A.C.S.	T.E.	S.M.
	T.E.	S.M.	A.C.S.

A.C.S. = Assertive Communication Skills    T.E. = Trauma Education  
S.M. = Stress Management

The final task of the allocated psychologist was to speak personally and informally to each S in Department A for a minimum of 5 minutes at least once over the twelve month period of the research. These discussions took place in the workplace and were of the nature of a structured “chat” with a previously devised format designed to establish a rapport with individual S's. Each psychologist had to mention, find out, or discuss, in the course of this conversation, at least the following:

- (i) name of the S
- (ii) psychologist's name
- (iii) psychologist's background
- (iv) what was involved in S job
- (v) how S felt about job
- (vi) how S felt about EAP and suggestions for improving it
- (vii) provide S with EAP business card with contact phone numbers

This process was designed to ensure that each S in Department A had personal contact with their psychologist, knew his/her name and something of their skills and abilities and was aware of the work that psychologists performed. After this contact Ss knew how to access their psychologist and it was hypothesised this would assist them in feeling more confident in doing this once this personal contact had been established.

**Table 7.18 - Summary of Psychologist-Generated Interventions by Department**

Psychologist Intervention	Department A	Department B
EAP Presentation	Yes	Yes

Stress Management program	Yes	No
Trauma Education program	Yes	No
Assertive Communication Skills program	Yes	No
EAP Newsletter	Yes	No
O.H.&S. Committee member	Yes	No
Individual talk with S	Yes	No

Data from the GHQ-30 and the Perception of Psychologists Scale were collected and analysed at the conclusion of each testing period.

## **CHAPTER 8**

### **RESULTS**

## 8.1 Analysis of GHQ-30 Data

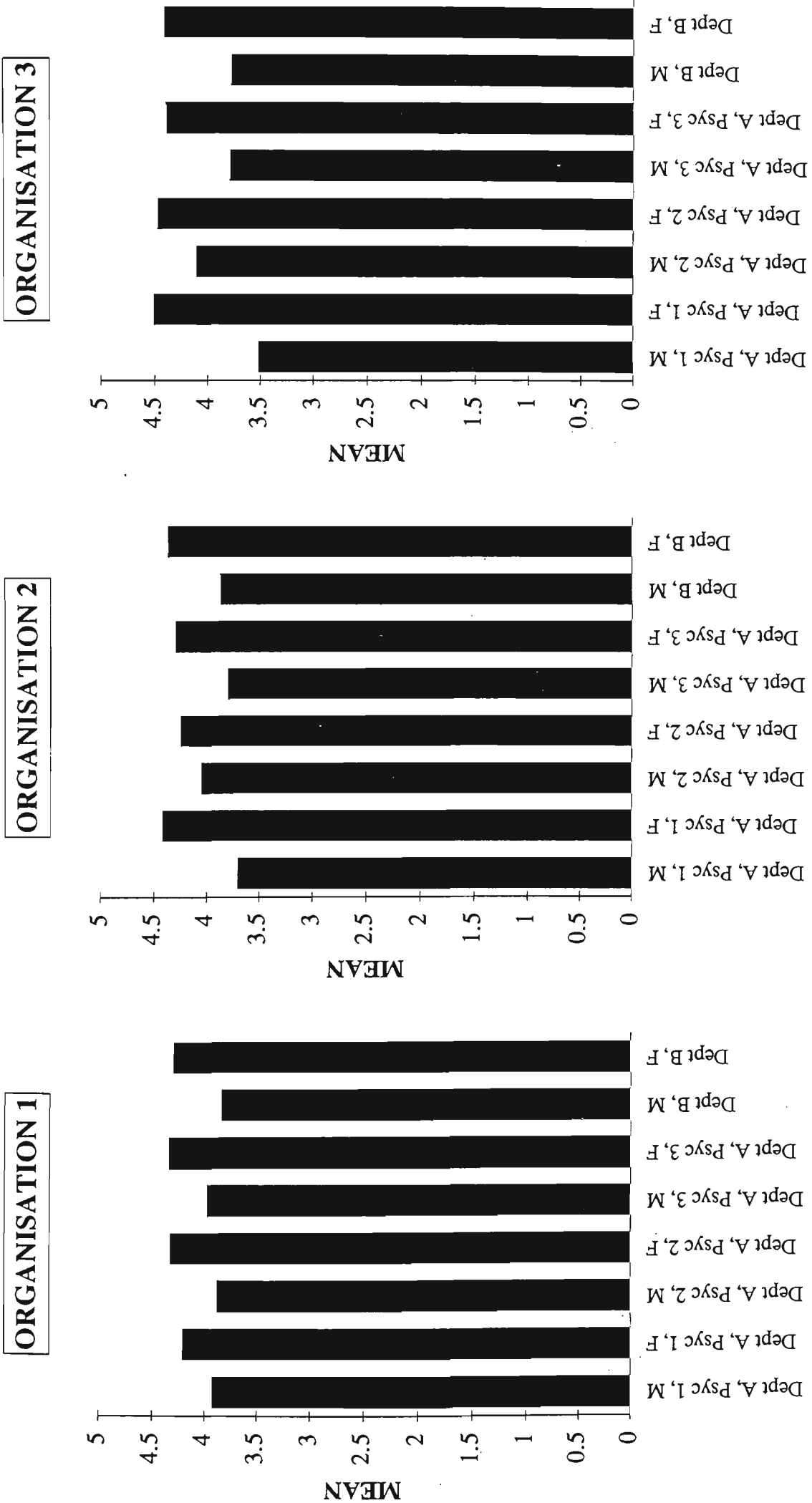
The General Health Questionnaire-30 (GHQ-30) was employed to screen for the presence of abnormal pathology in the experimental population that might render the group, as a whole, ineligible for the study. A threshold score, i.e. a score in excess of which an individual may be regarded as experiencing some level of psychological impairment, was determined to be 5 in the present study. This same threshold score has been used in a large number of similar studies where the GHQ-30 was employed as a screening instrument, similar to its role in the present study (Goldberg & Williams, 1988).

Mean scores and standard deviations for Ss in each organisation on the GHQ-30 are presented in Appendix 11. These results are depicted graphically in Figure 8.1.

Cox, Blaxter, Buckle, Fenner, Golding, Gore, Huppert, Nickson, Roth, Stark, Wadsworth & Wichelow (1987) surveyed a random sample of 6498 respondents in the British Isles using the GHQ-30. Their results showed that the mean score for males (N=2876) was 3.87 while the mean score for females (N=3622) was 4.09. In addition they reported that 31% of males and 33% of females scored above 5 on the GHQ-30.

While a score of 5 and greater may be indicative of some form of psychological impairment it would not necessarily render an individual ineligible for participation in this study. Thus no individual was eliminated from the study on the basis of their GHQ-30 score. The thrust of employing the GHQ-30 was to determine whether the group could be regarded as approximating the general population.

Figure 8.1 - Mean scores on the GHQ-30 for each organisation, as a function of department, psychologist and sex of respondent



To explore for any differences present in the GHQ-30 data univariate analysis of variance (ANOVA) with orthogonal planned contrasts were conducted (see Appendix 18.1). Significant differences with respect to sex of S were found with females reporting higher levels of psychological impairment. This finding is consistent with the profile presented by Cox et al. (1987). No significant differences were found for either sex with respect to origin of organisation or psychologist indicating that results were consistent across the three participating organisations and the three psychologists delivering the interventions.

On the basis of the findings as reported by Cox et al (1987) and given the results found in the present study (see Appendix 11 and Figure 8.1), the Ss in the three participating organisations could validly be regarded as being representative of a normal population.

## **8.2 Descriptive Statistics**

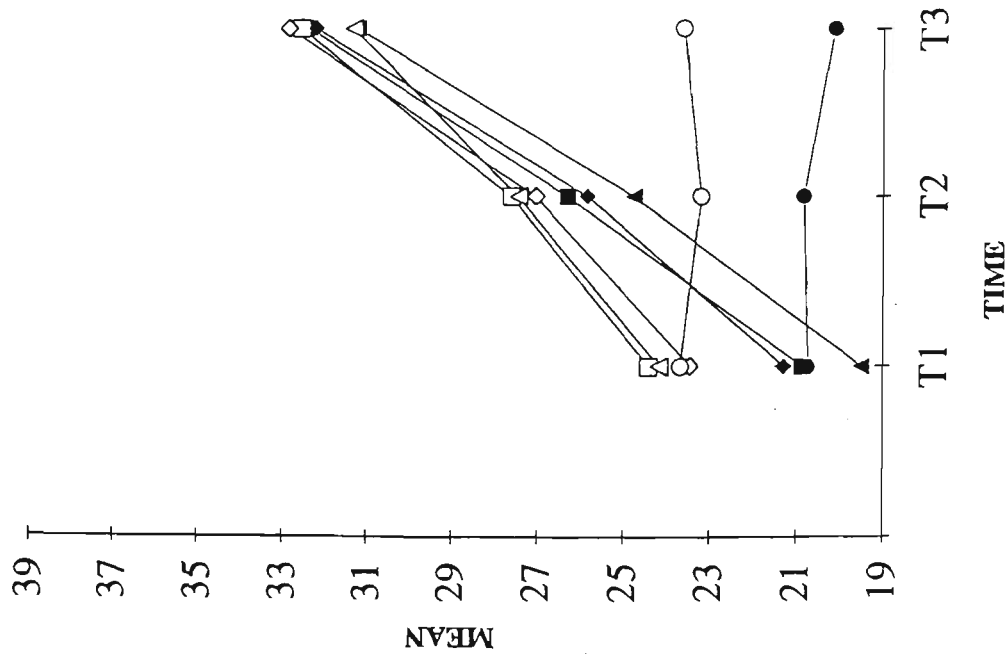
Mean scores and standard deviations for Ss in each organisation for each of the three subscales of the Perception of Psychologists Scale over the three time periods (T<sub>1</sub>, T<sub>2</sub> and T<sub>3</sub>) are presented in Appendix 12. The mean scores are presented graphically in Figures 8.2, 8.3 and 8.4.

## **8.3 Preliminary Analysis**

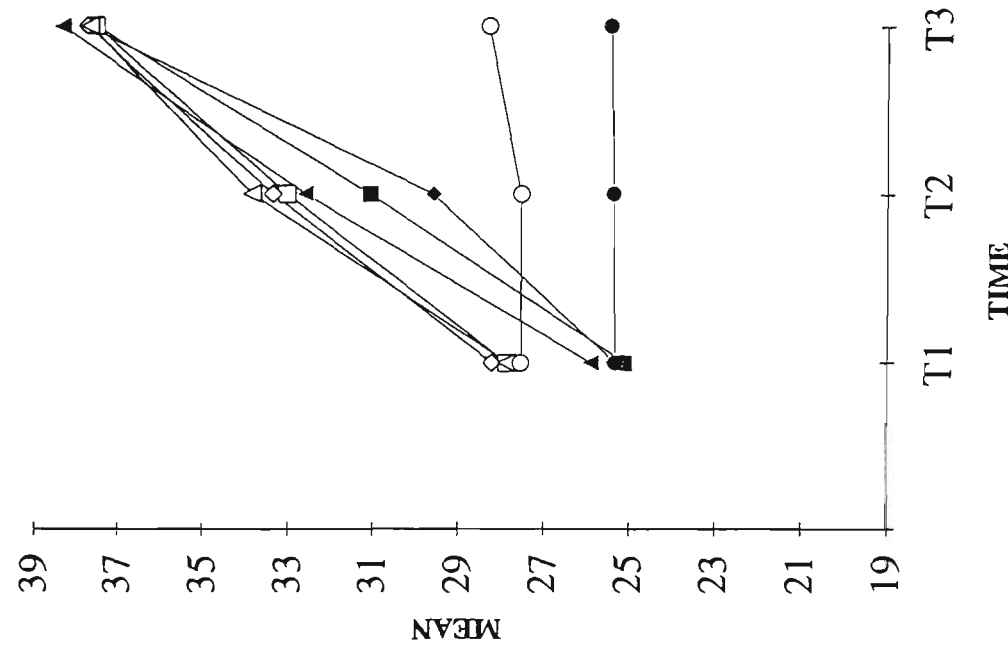
Multivariate assumptions of normality of data distribution and outliers, and homogeneity of variance-covariance matrices were satisfactorily met.

It was not possible to conduct an omnibus multivariate analysis on the entire data set as the design of the study (and hence constraints in data collection) resulted in Department B (the no-treatment control) being

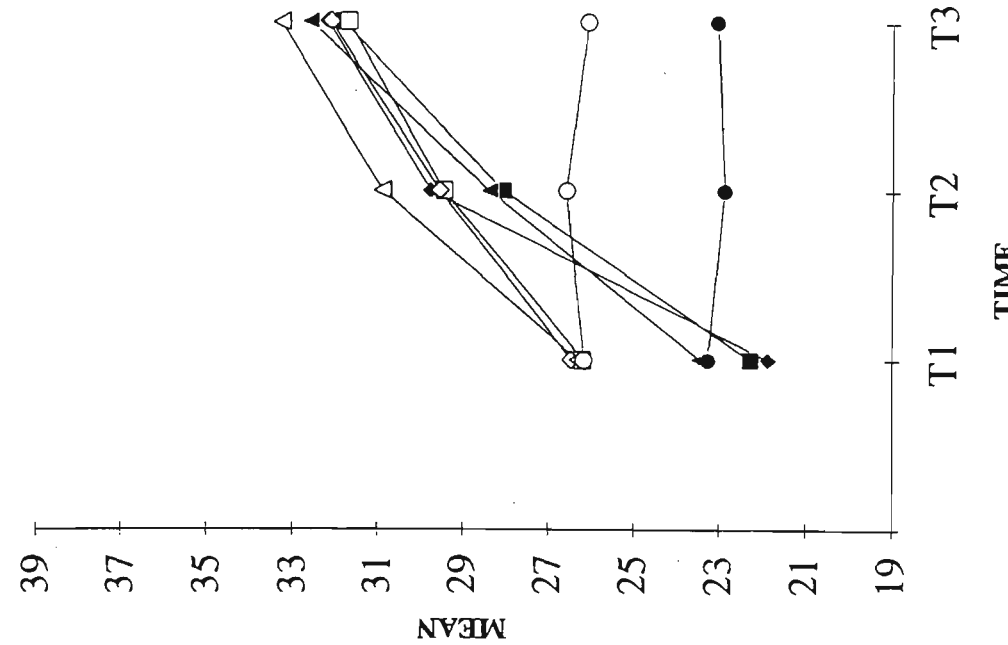
ORGANISATION 1



ORGANISATION 2



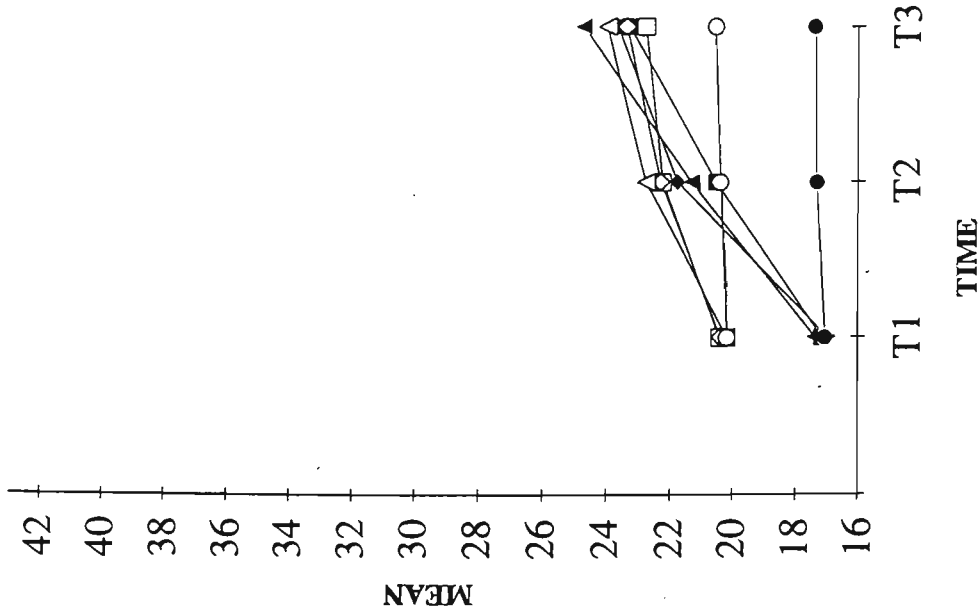
ORGANISATION 3



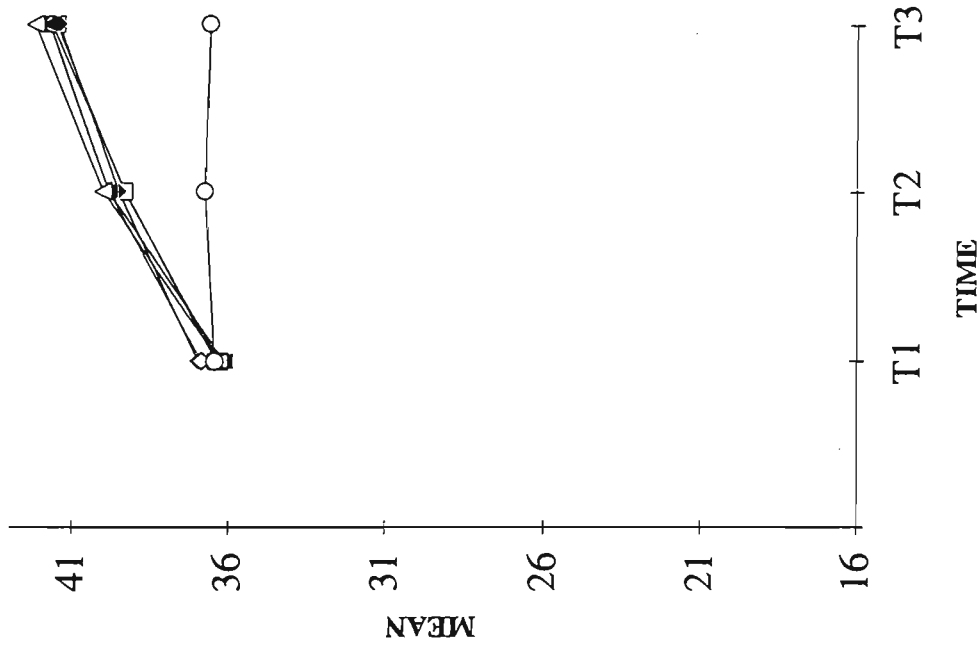
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—□— Dept A, Psyc 1, F —◇— Dept A, Psyc 2, F —△— Dept A, Psyc 3, F —○— Dept B, F



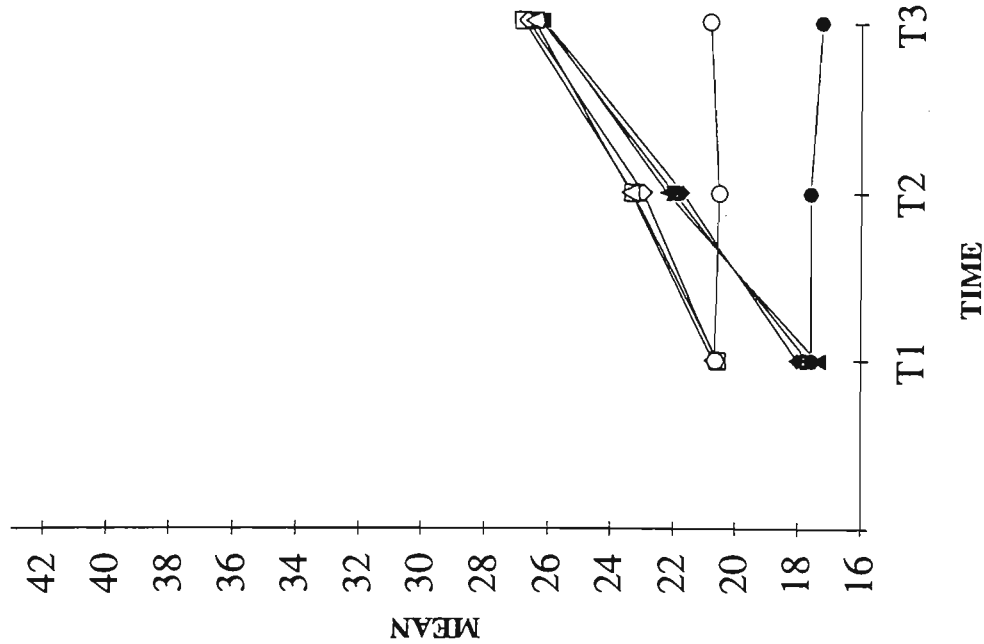
ORGANISATION 1



ORGANISATION 2

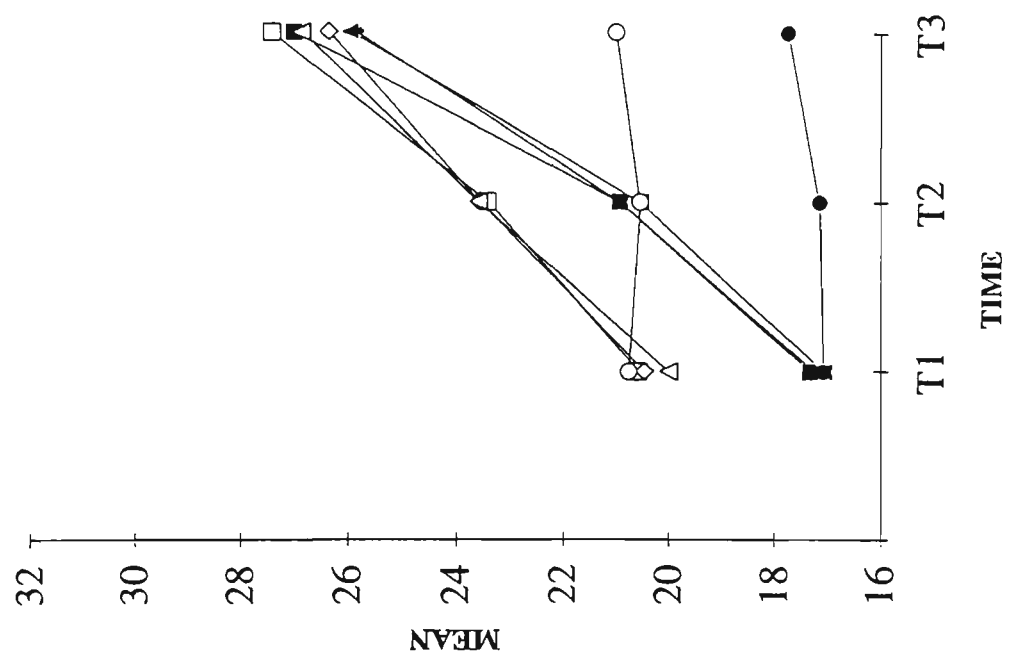


ORGANISATION 3

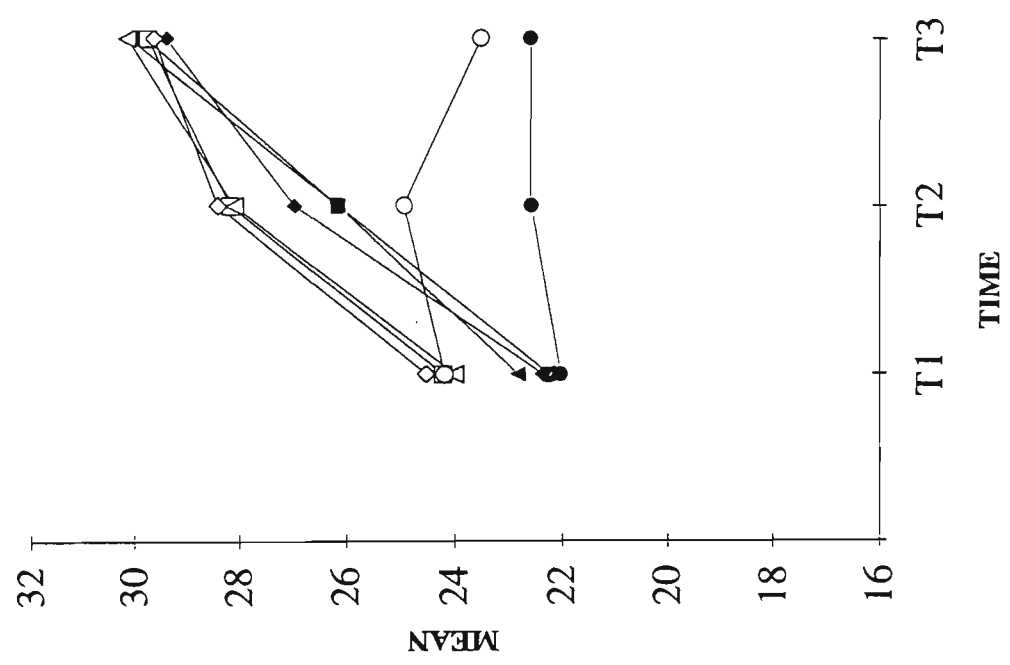


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—□— Dept A, Psyc 1, F —◇— Dept A, Psyc 2, F —△— Dept A, Psyc 3, F —○— Dept B, F

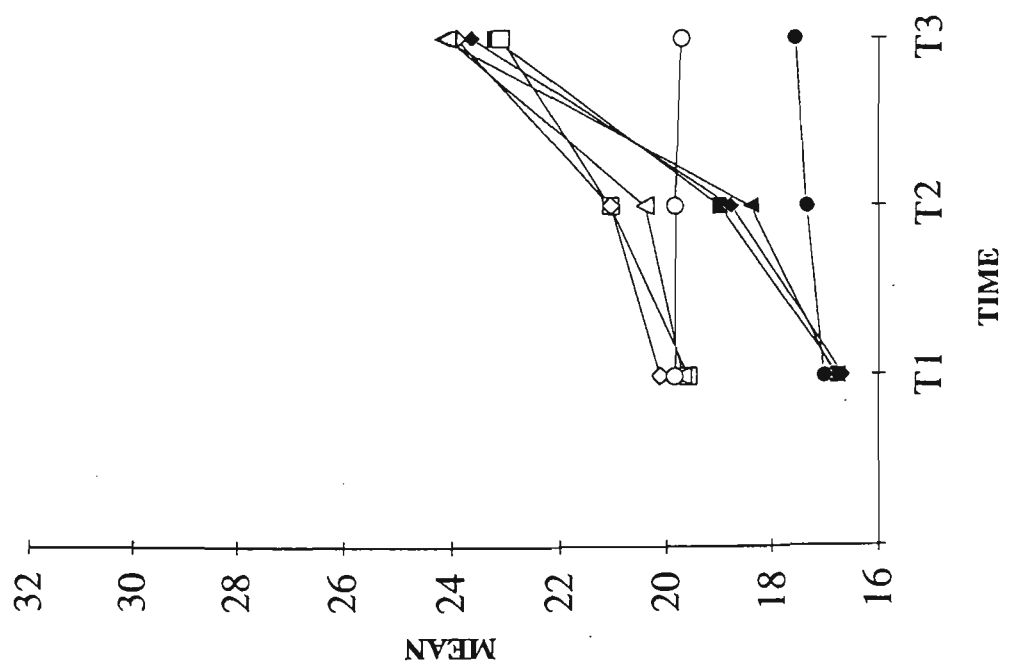
ORGANISATION 3



ORGANISATION 2



ORGANISATION 1



—■— Dept A, Psyc 1, M —◆— Dept A, Psyc 2, M —▲— Dept A, Psyc 3, M —●— Dept B, M  
—□— Dept A, Psyc 1, F —◇— Dept A, Psyc 2, F —△— Dept A, Psyc 3, F —○— Dept B, F

confounded with the independent variable PSYC in Department B where the nominated psychologist effectively had no interventionist role.

Thus an initial analysis using SPSS<sup>X</sup> procedure MANOVA with unique sums of squares was performed on data derived from Ss in Department A (the experimental group). This MANOVA was conducted with the three subscales of POPS (Confidence, Knowledge & Stigma Tolerance) acting as the dependent variables with organisation (ORG), time (TIME), psychologist (PSYC) and sex (SEX) of S acting as the independent variables. The results of this analysis of between-subjects and within-subjects effects are given in Appendix 13.

This analysis resulted in a complex set of significant two-way, three-way, four-way and five-way interactions which proved to be uninterpretable in practical terms. As well as these interactions, significant main effects being found for ORG ( $F_{2, 476} = 7474.52, p < .001$ ), TIME ( $F_{2, 954} = 3639.52, p < .001$ ) and SEX ( $F_{1, 476} = 451.46, p < .001$ ). No main effect was found for PSYC ( $F_{2, 476} = 4.19, p > .05$ ). The nature of these effects are readily observable by inspection of Figures 8.2, 8.3 and 8.4.

#### **8.4 Primary Analysis**

As a result of these interactions it was decided therefore to treat each of the three subscales by separate analysis. As well as simplifying the treatment of the data there was a logical basis for this decision. In the development of the Perception of Psychologists Scale the resultant subscales, as derived by factor analysis, were found to be largely independent (i.e. they were found to have correlations ranging from 0.29 to 0.36) (see Chapter 7.1.6). Additionally, scores achieved on each of the three subscales would allow for closer analysis and interpretation of the

differences between the independent variables in response to each of the dependent variables.

As will be shown later no significant differences with respect to any of the three subscales existed between Department A (experimental group) and Department B (control) at T<sub>1</sub>. However, at T<sub>3</sub>, significant differences did exist necessitating the data to be subsequently analysed separately for each Department (see Figures 8.5, 8.6 and 8.7).

Thus individual MANOVAs were conducted on the data sets obtained with the three subscales of POPS - Confidence, Knowledge and Stigma Tolerance - acting as the dependent variables. The data were analysed on the basis of individual departments (A and B). There were four independent variables being manipulated: ORG (with three levels), PSYC (with three levels), TIME (with three levels) and SEX (with two levels).

It is noteworthy that each of these three separate MANOVAs yielded similar results with a series of complex interactions found to be consistent among the three dependent variables (see Appendix 12). This finding led to exploration of differences within each organisation, time period, psychologist and sex of respondent. As a result of this exploration main effects were found for ORG, TIME and SEX in Department A and for ORG and SEX in Department B on each of the three dependent variables. For each of these main effects data were further analysed using SPSS<sup>X</sup> procedure ANOVA in order to more clearly identify the relationships between the respective dependent and independent variables.

### 8.4.1 Department Effects

Mean scores for male and female Ss averaged across the three psychologists for Department A were compared with mean scores for male and female Ss for Department B. The resulting averaged means for Ss in Department A and means for Department B for each subscale and each organisation over the three time periods are presented in Table 8.1.

Difference scores for male and female Ss (mean Department A - mean Department B) were then calculated for each subscale and organisation and are tabulated in Table 8.2 and depicted graphically in Figures 8.5, 8.6 and 8.7.

These differences in mean scores between Departments were analysed using SPSS<sup>X</sup> procedure ANOVA.

It is the accepted convention in this situation, i.e. where there are multiple comparisons planned before the data are analysed, to adjust the usual level of significance to accommodate violations of the Type I error rate. The procedure advised is to use the Bonferroni correction where the accepted Type I error rate is adjusted by dividing by the number of planned comparisons (Harris, 1985). In this way, the chances of obtaining statistical significance are not increased simply by performing multiple tests. However, in the case of a large number of comparisons, this procedure can lead to an unusually conservative level of significance and consequent difficulty in detecting each individual true effect (Hays, 1983). It has been argued that this puts each hypothesis test at an unfair disadvantage (Keppel, 1982; Kirk, 1982).

**Table 8.1 - Mean scores averaged across psychologist for department A and mean scores for department B**

Subscale	Time	Department A		Department B	
		Male	Female	Male	Female
CONFIDENCE					
Organisation 1	T <sub>1</sub>	20.548	24.020	20.716	23.677
	T <sub>2</sub>	25.641	27.353	20.813	23.194
	T <sub>3</sub>	31.296	32.272	20.127	23.613
Organisation 2	T <sub>1</sub>	24.768	27.651	25.322	27.526
	T <sub>2</sub>	31.107	33.423	25.386	27.538
	T <sub>3</sub>	37.863	38.650	25.425	28.295
Organisation 3	T <sub>1</sub>	22.518	26.242	23.267	26.513
	T <sub>2</sub>	28.729	29.953	22.860	26.556
	T <sub>3</sub>	32.166	32.340	23.022	26.042
KNOWLEDGE					
Organisation 1	T <sub>1</sub>	17.166	20.321	17.030	20.161
	T <sub>2</sub>	21.204	22.434	17.327	20.368
	T <sub>3</sub>	23.898	23.380	17.378	20.548
Organisation 2	T <sub>1</sub>	36.510	38.143	36.460	38.423
	T <sub>2</sub>	39.538	40.719	36.769	38.769
	T <sub>3</sub>	41.591	41.798	36.586	38.615
Organisation 3	T <sub>1</sub>	17.694	20.281	17.559	20.625
	T <sub>2</sub>	21.986	23.160	17.591	20.500
	T <sub>3</sub>	26.507	27.616	17.226	20.778
STIGMA TOLERANCE					
Organisation 1	T <sub>1</sub>	16.757	19.806	17.022	19.839
	T <sub>2</sub>	18.730	20.845	17.358	19.839
	T <sub>3</sub>	23.705	23.725	17.567	19.742
Organisation 2	T <sub>1</sub>	22.705	24.242	22.023	24.179
	T <sub>2</sub>	26.433	27.223	22.574	24.949
	T <sub>3</sub>	29.085	30.508	22.598	23.526
Organisation 3	T <sub>1</sub>	17.209	20.334	17.068	20.750
	T <sub>2</sub>	20.719	23.466	17.151	20.528
	T <sub>3</sub>	24.972	27.177	17.731	20.972

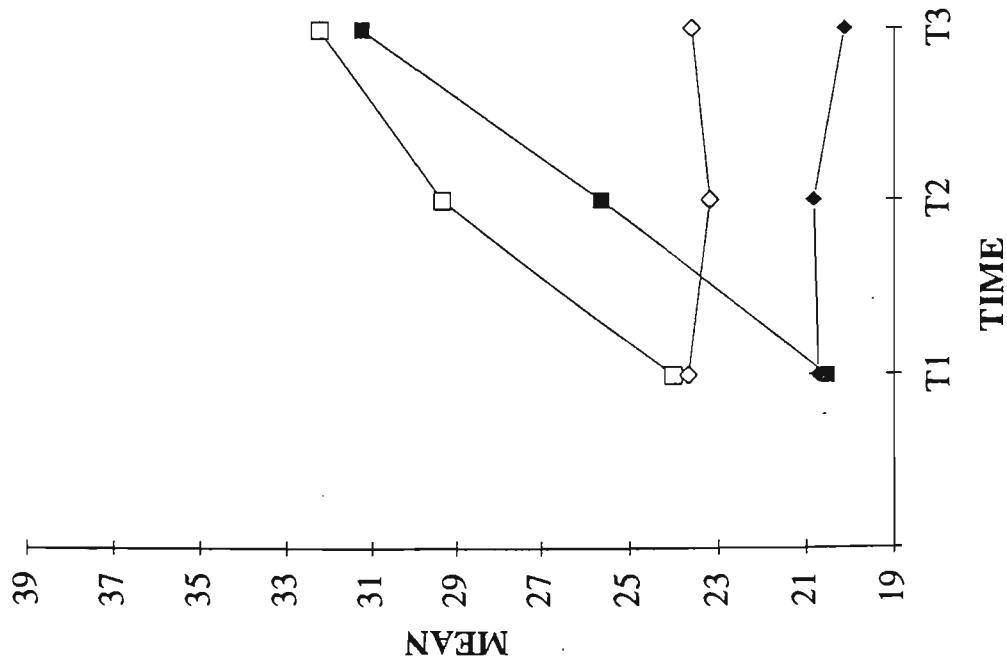
**Table 8.2 - Department Differences within each level of ORG, TIME, and SUBSCALE averaged over Psychologist.**

CONFIDENCE		Male		Female	
		( $X_A - X_B$ )	S.D.	( $X_A - X_B$ )	S.D.
Organisation 1	T <sub>1</sub>	-0.168	0.040	0.343	0.029
	T <sub>2</sub>	4.828*	0.512	2.353*	0.210
	T <sub>3</sub>	11.169*	1.212	8.659*	0.412
Organisation 2	T <sub>1</sub>	-0.554	0.095	0.125	0.045
	T <sub>2</sub>	5.721*	0.925	7.551*	0.677
	T <sub>3</sub>	12.438*	1.422	10.355*	0.692
Organisation 3	T <sub>1</sub>	-0.749	0.084	-0.511	0.045
	T <sub>2</sub>	5.869*	0.839	3.397*	0.295
	T <sub>3</sub>	9.144*	1.095	6.298*	0.578
KNOWLEDGE					
Organisation 1	T <sub>1</sub>	0.136	0.012	0.160	0.020
	T <sub>2</sub>	3.577*	0.457	1.136*	0.201
	T <sub>3</sub>	5.960*	0.518	2.832*	0.298
Organisation 2	T <sub>1</sub>	0.050	0.001	-0.280	0.031
	T <sub>2</sub>	1.769*	0.022	1.950*	0.187
	T <sub>3</sub>	5.005*	0.643	3.183*	0.270
Organisation 3	T <sub>1</sub>	0.135	0.039	-0.344	0.042
	T <sub>2</sub>	5.695*	0.875	2.360*	0.333
	T <sub>3</sub>	9.281*	0.866	6.838*	0.992
STIGMA TOLERANCE					
Organisation 1	T <sub>1</sub>	-0.265	0.009	-0.033	0.001
	T <sub>2</sub>	1.373*	0.017	1.006	0.020
	T <sub>3</sub>	6.138*	0.465	2.983*	0.199
Organisation 2	T <sub>1</sub>	0.682	0.061	0.063	0.002
	T <sub>2</sub>	3.609*	0.343	2.274*	0.313
	T <sub>3</sub>	6.487*	0.555	6.982*	0.525
Organisation 3	T <sub>1</sub>	0.141	0.040	-0.416	0.036
	T <sub>2</sub>	3.968*	0.457	3.138*	0.294
	T <sub>3</sub>	6.241*	0.702	6.205*	0.416

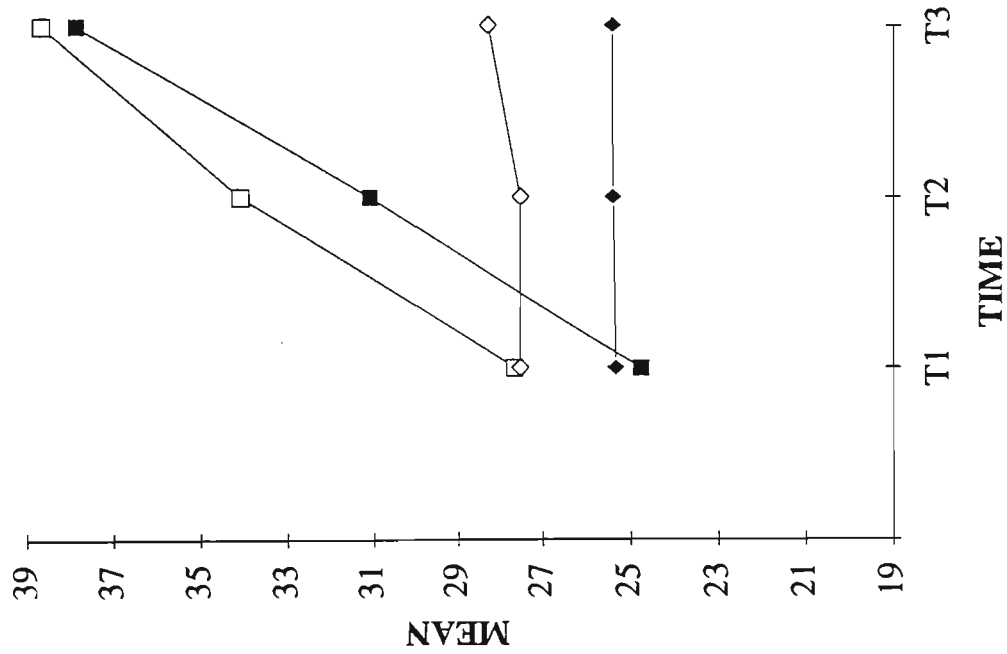
\*  $p < 0.001$

pysychologist in Department A versus mean scores for Department B  
for each organisation as a function of sex and time

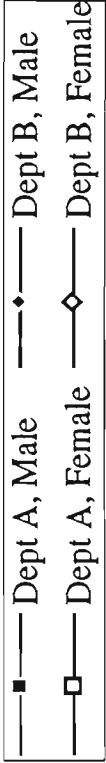
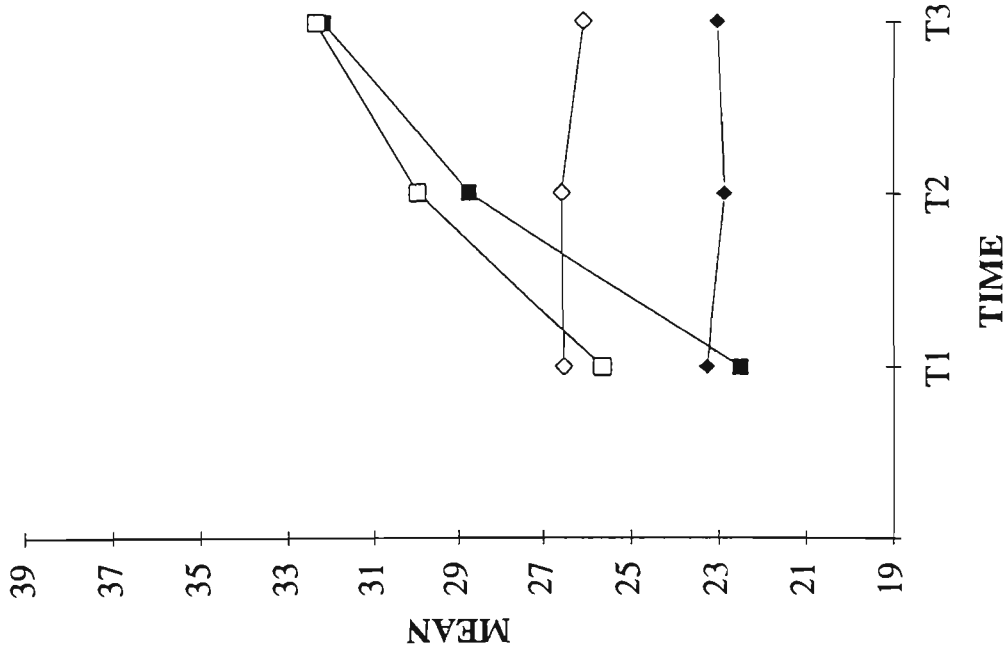
ORGANISATION 1



ORGANISATION 2



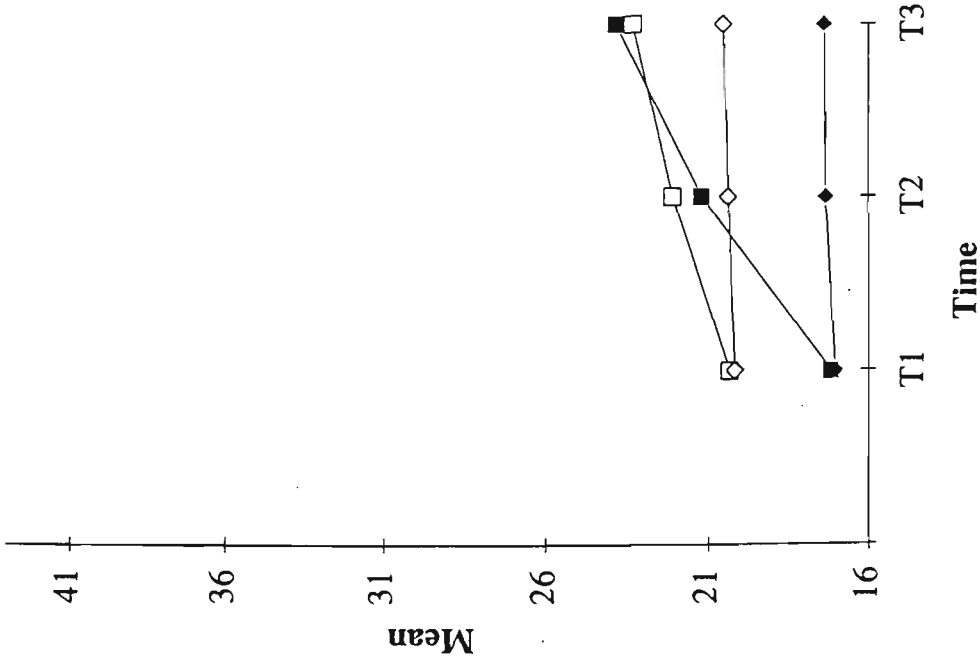
ORGANISATION 3



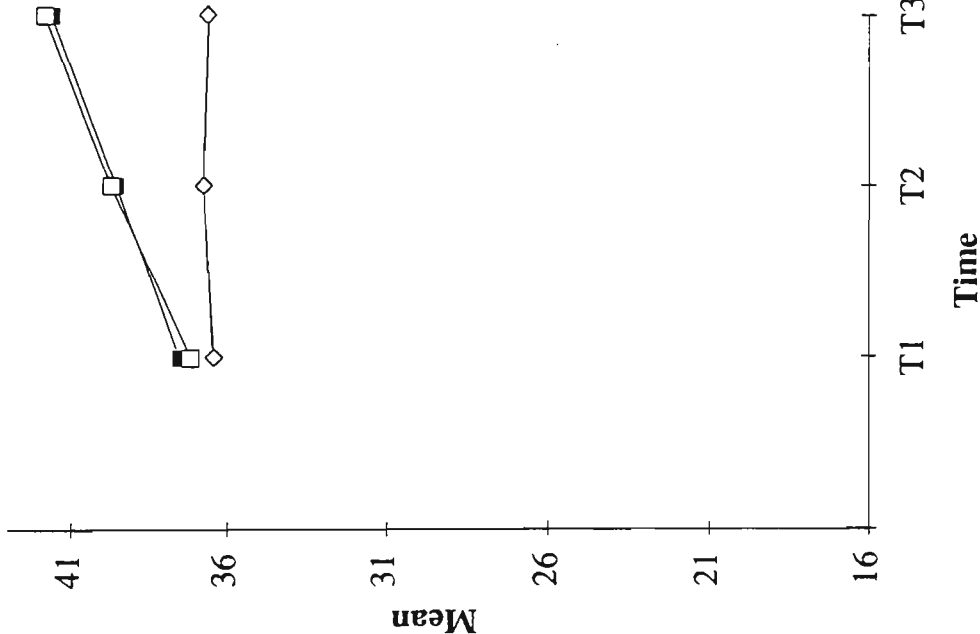


across pyschologist in Department A versus mean scores for  
Department B for each organisation as a function of sex and time

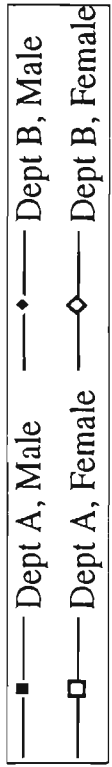
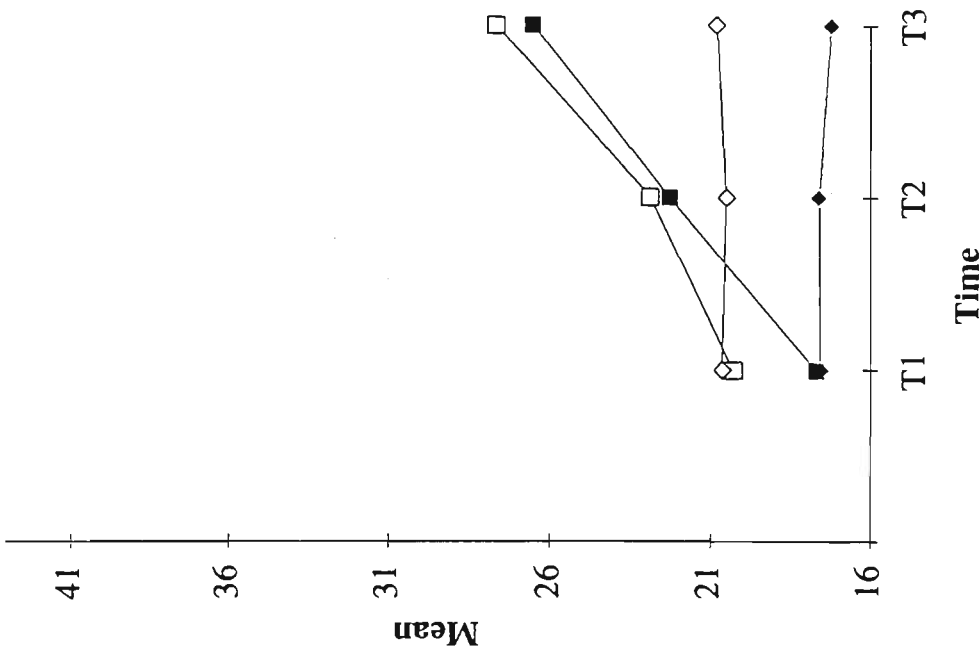
ORGANISATION 1



ORGANISATION 2

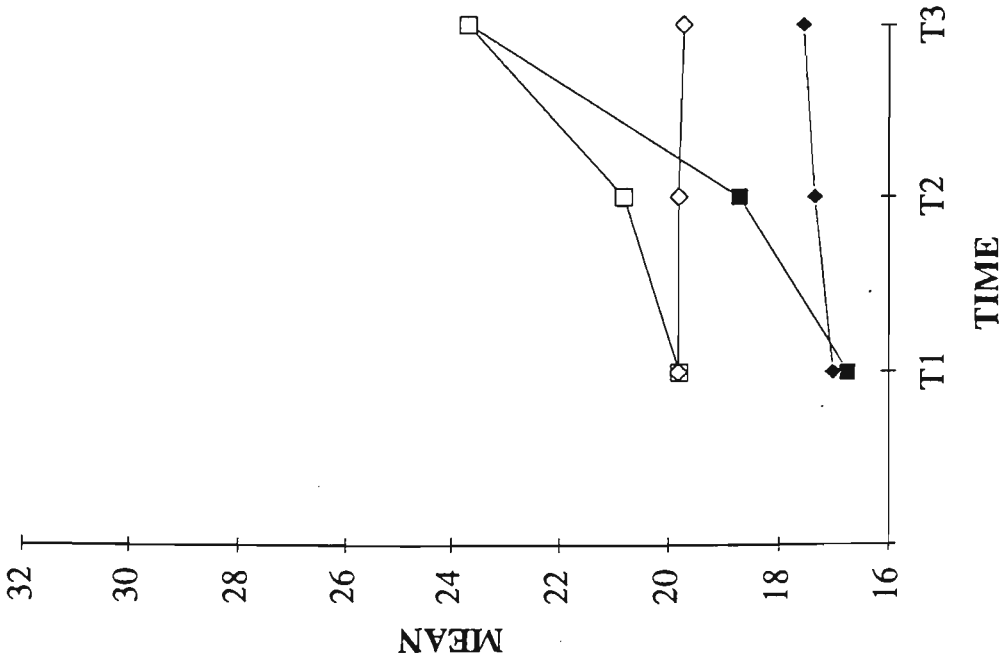


ORGANISATION 3

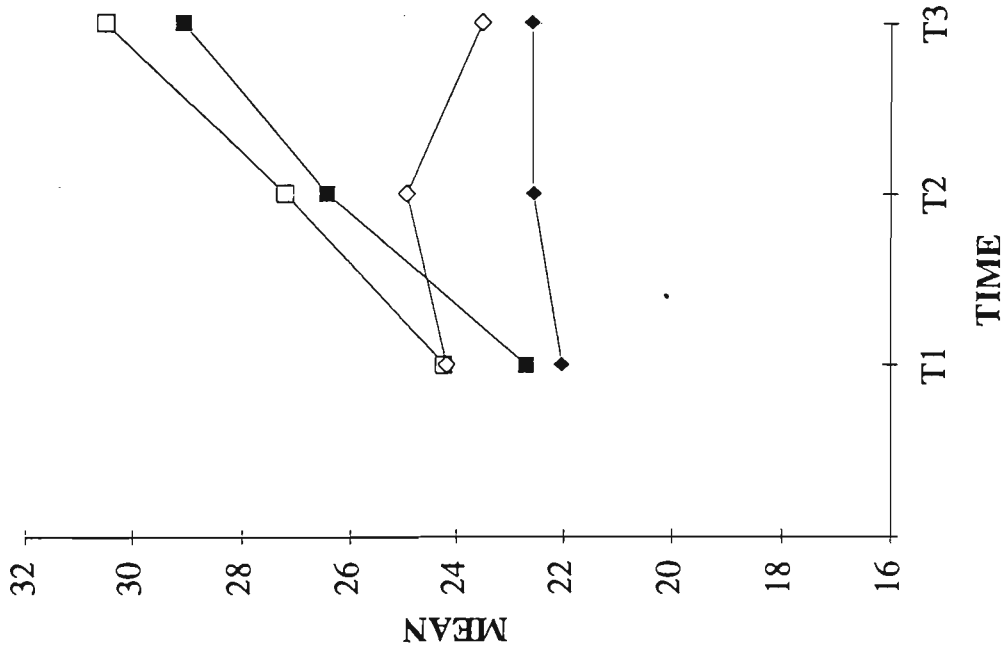


averaged across pyschologist in Department A versus mean scores  
for Department B for each organisation as a function of sex and time

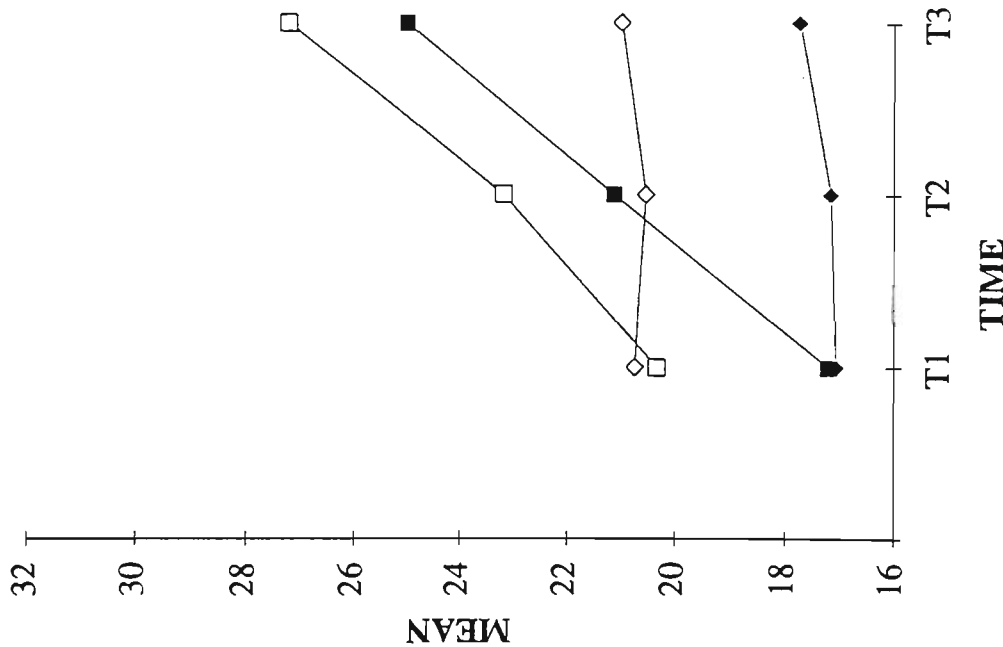
ORGANISATION 1



ORGANISATION 2



ORGANISATION 3



However, in this study greater importance was placed on the pattern of significant findings than on any individual finding as can be clearly seen in an inspection of Figures 8.2, 8.3 and 8.4. Thus it was decided to set  $\alpha = 0.001$  which is slightly higher than the level of significance that would be required using the Bonferroni procedure. Separate estimates were used in determining MS error rather than relying on the overall MS error as this would have lessened the chances of finding a significant result. Furthermore univariate comparisons were not explored unless a significant effect was firstly found in the MANOVA procedure.

As mentioned in the preliminary analysis a main effect was found for the dependent variable DEPT. Close inspection of this analysis, however, indicated that no significant difference for Department was discovered at T<sub>1</sub> for any cell combination of organisation x subscale x sex. This finding indicates the high degree of comparability of Ss in Department A and Department B despite the fact that the experimental design did not permit random allocation of Ss to each Department.

Significant differences with respect to Department were found for all cell combinations of organisation x subscale x sex at T<sub>3</sub>, indicating that the interventions conducted with Department A Ss had resulted in a polarisation of attitudes towards psychologists between Ss in the two Departments.

#### **8.4.2 Gender Effects**

Data representing within group sex differences (mean female - mean male) for each dependent variable (ORG, PSYC and TIME) for Department A and Department B and all levels of the independent variables are presented in Table 8.3.

**Table 8.3 - Mean Scores for Sex Differences by Department**

Subscale	Time	Department A			Dept B
		Psych 1 X <sub>M</sub> -X <sub>F</sub>	Psych 2 X <sub>M</sub> -X <sub>F</sub>	Psych 3 X <sub>F</sub> -X <sub>F</sub>	X <sub>M</sub> -X <sub>F</sub>
CONFIDENCE					
Organisation 1	T <sub>1</sub>	3.570*	2.156*	4.676*	3.491*
	T <sub>2</sub>	-0.066	1.217	2.708*	2.381*
	T <sub>3</sub>	0.193	0.644	0.090	3.486*
Organisation 2	T <sub>1</sub>	2.778*	4.901*	1.969*	2.204*
	T <sub>2</sub>	1.945*	3.763*	3.239*	1.382
	T <sub>3</sub>	0.026	-0.009	-0.443	2.870*
Organisation 3	T <sub>1</sub>	3.897*	4.607*	2.134*	2.886*
	T <sub>2</sub>	1.390	-0.213	2.495*	3.696*
	T <sub>3</sub>	-0.117	-0.061	0.698	3.020*
KNOWLEDGE					
Organisation 1	T <sub>1</sub>	3.254*	3.401*	2.808*	3.131*
	T <sub>2</sub>	0.709	0.544	1.449*	3.341*
	T <sub>3</sub>	-0.524	-0.292	-.0739	2.570*
Organisation 2	T <sub>1</sub>	-0.127	-0.112	-0.161	-0.017
	T <sub>2</sub>	0.043	0.324	0.176	0.002
	T <sub>3</sub>	-0.145	0.311	0.455	0.029
Organisation 3	T <sub>1</sub>	2.880*	2.561*	2.321*	3.066*
	T <sub>2</sub>	1.305	0.258	0.160	3.909*
	T <sub>3</sub>	0.535	0.515	0.279	3.552*
STIGMA TOLER.					
Organisation 1	T <sub>1</sub>	2.825*	3.458*	2.864*	3.817*
	T <sub>2</sub>	2.059*	1.294	1.991*	3.481*
	T <sub>3</sub>	-0.119	0.271	-0.093	3.175*
Organisation 2	T <sub>1</sub>	2.272*	2.162*	-2.822*	2.156*
	T <sub>2</sub>	2.002*	1.443	2.912*	2.072*
	T <sub>3</sub>	-0.024	0.237	0.055	1.922*
Organisation 3	T <sub>1</sub>	3.232*	3.202*	2.932*	3.682*
	T <sub>2</sub>	1.470	1.636	3.032*	2.872*
	T <sub>3</sub>	0.416	0.500	0.701	2.242*

\*  $p < 0.001$

As revealed in the preliminary analysis a main effect for the independent variable SEX was found for both Department A ( $F_{1,476} = 451.46$ ,  $p < .001$ ) and Department B ( $F_{1, 247} = 209.40$ ,  $p < .001$ ) for each of the three dependent variables. Following this, data for each dependent variable were analysed within each organisation, psychologist, sex and time period using SPSS<sup>X</sup> procedure ANOVA. As well as significant differences for sex on each of the three subscales there was a significant interaction of SEX x TIME for Department A for each of the three dependent variables. However no interaction of SEX x TIME was found for Department B on any of the dependent variables.

Of the 27 possible cell combinations of psychologist by sex by subscale in Department A at T<sub>1</sub> a significant difference with respect to sex was found in 24 instances with females reporting higher cell means (and thus more positive attitudes) than males in each case (see Table 8.3). The appropriate level of significance was set at  $\alpha = 0.001$  for the reasons cited previously. The three instances which was found to be nonsignificant were associated with the Knowledge subscale in Organisation 2.

In contrast at T<sub>3</sub> there were no significant differences with respect to sex in all of the 27 cell combinations (see Figures 8.2, 8.3 and 8.4).

Of the 9 possible cell combinations of SEX by SUBSCALE in Department B at T<sub>1</sub> significant differences with respect to sex were found in eight cases (Figure 8.2, 8.3 and 8.4). The exception was with Organisation 2 on the Knowledge subscale. However, in contrast to the results achieved in Department A, at T<sub>3</sub> 8 cases still resulted in significant differences. The one nonsignificant result was again associated with the Knowledge subscale in Organisation 2.

### 8.4.3 Time Effects

As revealed in the preliminary analysis a main effect for TIME was found for Department A ( $F_{2, 954} = 3693.52, p < .001$ ) for each of the three independent variables: ORG, PSYC and SEX. Data for each dependent variable in Department A were further analysed within organisation, psychologist and sex using SPSS<sup>X</sup> procedure ANOVA with planned contrasts. Analysis was carried out on comparison of time differences between scores on the dependent variable i.e. differences between means for time periods T<sub>2</sub>-T<sub>1</sub> and T<sub>3</sub>-T<sub>2</sub> for both Department A and Department B. These resulting scores for each of the three subscales and all levels of the dependent variables are presented in Table 8. 4.

Of the 108 possible cell combinations of subscale by organisation by psychologist by sex in Department A significant differences with respect to time were found in 104 cases (see Table 8.4). Again the appropriate level of significance was set at  $\alpha = 0.001$  for the reasons cited previously.

The four nonsignificant instances were all associated with the T<sub>1</sub>->T<sub>2</sub> time difference. Three instances were associated with the Stigma Tolerance subscale in Organisation 1 for female Ss with all three psychologists while the remaining instance was associated with the Knowledge subscale in Organisation for female Ss and Psychologist 2.

No significant differences with respect to time were found for Department B on any of the dependent variables, indicating that, for Ss in Department B, the attitude towards psychologists did not vary over the length of the study.

Table 8.4 Mean differences on the Confidence, Knowledge and Stigma Tolerance subscales of POPS for time periods T<sub>1</sub>->T<sub>2</sub> and T<sub>2</sub>->T<sub>3</sub> as a function of department, psychologist and sex of Ss

Subscale	Department A								Dept B	
	Psychologist 1				Psychologist 2				Psychologist 3	
	Time Period	Male	Female		Male	Female			Male	Female
CONFIDENCE										
	Organisation 1									
	T <sub>1</sub> ->T <sub>2</sub>	5.474*	1.235*		3.625*	5.263*		5.362*	3.295	-0.483
	T <sub>2</sub> ->T <sub>3</sub>	5.097*	6.941*		5.812*	6.500*		6.050*	3.882	-0.419
Organisation 2										
	T <sub>1</sub> ->T <sub>2</sub>	6.001*	5.167*		6.286*	5.148*		6.730*	9.091	-0.988
	T <sub>2</sub> ->T <sub>3</sub>	6.419*	4.500*		3.142*	1.629*		5.706*	4.810	0.757
	Organisation 3									
	T <sub>1</sub> ->T <sub>2</sub>	5.784*	3.277*		7.910*	3.090*		4.937*	6.566	0.413
	T <sub>2</sub> ->T <sub>3</sub>	3.370*	2.223*		2.394*	2.546*		4.188*	2.391	-0.524
KNOWLEDGE										
Organisation 1										
	T <sub>1</sub> ->T <sub>2</sub>	3.369*	1.823*		4.795*	1.938*		3.948*	2.589	0.807
	T <sub>2</sub> ->T <sub>3</sub>	2.763*	1.530*		1.898*	1.662*		3.423*	1.235	-0.420
	Organisation 2									
	T <sub>1</sub> ->T <sub>2</sub>	2.871*	3.041*		2.536*	0.972		1.677*	1.714	0.346
	T <sub>2</sub> ->T <sub>3</sub>	2.355*	2.167*		1.893*	1.880*		1.911*	2.190	-0.154
Organisation 3										
	T <sub>1</sub> ->T <sub>2</sub>	4.297*	2.722*		3.667*	1.364*		5.813*	3.652	-0.125
	T <sub>2</sub> ->T <sub>3</sub>	4.270*	4.500*		5.424*	5.681*		2.968*	4.087	0.278
STIGMA TOL										
Organisation 1										
	T <sub>1</sub> ->T <sub>2</sub>	2.237*	0.471		2.102*	-0.062		1.579*	0.706	0.000
	T <sub>2</sub> ->T <sub>3</sub>	4.237*	2.059*		4.898*	3.875*		5.790*	3.697*	-0.097
	Organisation 2									
	T <sub>1</sub> ->T <sub>2</sub>	3.226*	3.959*		4.607*	3.888*		1.648*	5.095*	0.770
	T <sub>2</sub> ->T <sub>3</sub>	3.613*	1.583*		1.429*	1.223*		6.912*	6.048*	-0.423
Organisation 3										
	T <sub>1</sub> ->T <sub>2</sub>	5.474*	1.235*		3.652*	5.263*		5.362*	3.295*	-0.722
	T <sub>2</sub> ->T <sub>3</sub>	3.613*	1.583*		5.912*	6.500*		6.513*	3.882*	0.944

\* p < 0.001

#### 8.4.4 Psychologist Effects

Mean scores for Ss in Department A for each of the three psychologists employed to deliver the interventions as a function of subscale, sex, time and organisation are tabulated in Table 8.5.

No main effect was found for the independent variable PSYC ( $F_{2,476} = 4.19, p > .05$ ) in the original analysis. However, as this finding could have been disguised by the complex of various interactions involving PSYC (see Appendix 12) these data were analysed within each level of organisation, sex and time using SPSS<sup>X</sup> procedure ANOVA with planned contrasts.

Analysis of the means revealed there were no significant differences between the psychologists on any of the dependent variables, indicating that the observed trends in improved attitude towards psychologists were independent of the psychologist used to deliver the interventions.

As only one psychologist was allocated to each organisation for Ss in Department B no analysis of data was carried out.

#### 8.4.5 Organisation Effects

As revealed in the preliminary analysis a strong main effect was found for the independent variable ORG ( $F_{2,476} = 7474.52, p < .001$ ). However it was not an aim of the present study to directly compare the results of each organisation as such a comparison would be meaningless. The rationale for selecting three different organisations was in order to specifically demonstrate the effectiveness of the interventions over a range of populations thus enhancing the external validity of the study.



**Table 8.5 - Mean Differences Between Psychologists in Department A**

CONFIDENCE		Psych 1		Psych 2		Psych 3	
		M	F	M	F	M	F
Organisation 1	T <sub>1</sub>	20.842	24.412	21.282	23.438	19.500	24.176
	T <sub>2</sub>	26.316	27.647	25.846	27.063	24.763	27.471
	T <sub>3</sub>	31.395	32.588	32.231	32.875	31.263	31.353
Organisation 2	T <sub>1</sub>	25.097	27.875	25.321	28.222	25.888	27.857
	T <sub>2</sub>	31.097	33.042	29.607	33.370	32.618	33.857
	T <sub>3</sub>	37.516	37.542	37.750	37.741	38.324	37.667
Organisation 3	T <sub>1</sub>	22.270	26.167	21.848	26.455	23.438	26.304
	T <sub>2</sub>	28.054	29.444	29.758	29.545	28.375	30.870
	T <sub>3</sub>	31.784	31.667	32.152	32.091	32.563	33.261
KNOWLEDGE							
Organisation 1	T <sub>1</sub>	17.158	20.412	16.974	20.375	17.368	20.176
	T <sub>2</sub>	20.526	22.235	21.769	22.313	21.316	22.765
	T <sub>3</sub>	23.289	22.765	23.667	23.375	24.739	24.000
Organisation 2	T <sub>1</sub>	36.419	36.292	36.964	36.852	36.147	36.286
	T <sub>2</sub>	39.290	39.333	39.500	39.824	39.824	40.000
	T <sub>3</sub>	41.645	41.500	41.393	41.704	41.735	42.190
Organisation 3	T <sub>1</sub>	17.676	20.556	18.030	20.591	17.375	20.696
	T <sub>2</sub>	21.973	23.278	21.697	22.956	22.188	23.348
	T <sub>3</sub>	26.243	26.778	26.121	27.636	26.156	26.435
STIGMA TOLERANCE							
Organisation 1	T <sub>1</sub>	16.763	19.588	16.667	20.125	16.842	19.706
	T <sub>2</sub>	19.000	21.059	18.769	21.063	18.421	20.412
	T <sub>3</sub>	23.237	23.118	23.667	23.938	24.211	24.118
Organisation 2	T <sub>1</sub>	22.235	24.208	22.357	24.519	22.824	24.000
	T <sub>2</sub>	26.161	28.167	26.964	28.407	26.176	28.095
	T <sub>3</sub>	29.774	29.750	29.393	29.630	30.088	30.143
Organisation 3	T <sub>1</sub>	17.324	20.556	17.242	20.445	17.063	20.000
	T <sub>2</sub>	20.919	23.389	20.909	23.545	20.531	23.565
	T <sub>3</sub>	25.973	26.389	25.818	26.318	25.925	26.826

For this reason, while acknowledging that a main effect for Organisation was found, no further analysis of the data was pursued.

### **8.5 Trends in Referral to EAP**

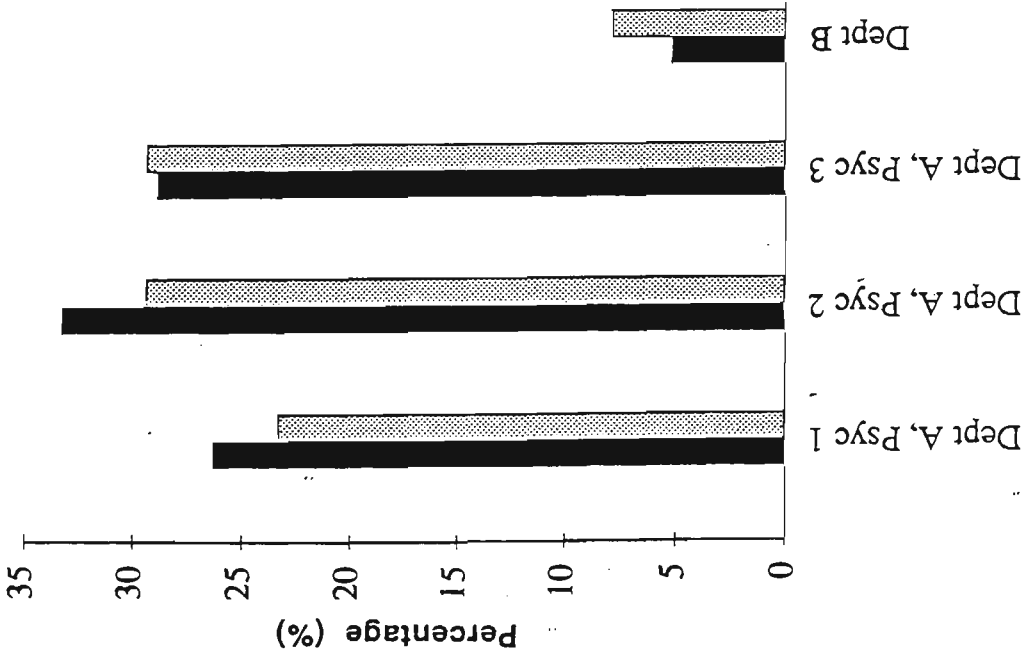
Data were collected regarding Ss who sought counselling provided by the Employee Assistance Program in their organisation. The number of Ss from each organisation who accessed counselling as a function of department, psychologist, sex and time are presented in Appendix 14. Graphical representations of total number of Ss (expressed as a percentage of N for each group) who accessed counselling for each organisation are presented in Figure 8.8.

Univariate analysis of variance (ANOVA) with planned orthogonal contrasts within each participating organisation were employed to test for differences in these data (see Appendix 18.2) The results of these analyses were consistent across the three organisations. Significant differences were found with respect to sex of individual accessing counselling and the department from which they came. The former finding is consistent with the widely accepted demographic that females universally access counselling at a greater rate than do males (e.g. Higgins, Mayer & Timms, 1991).

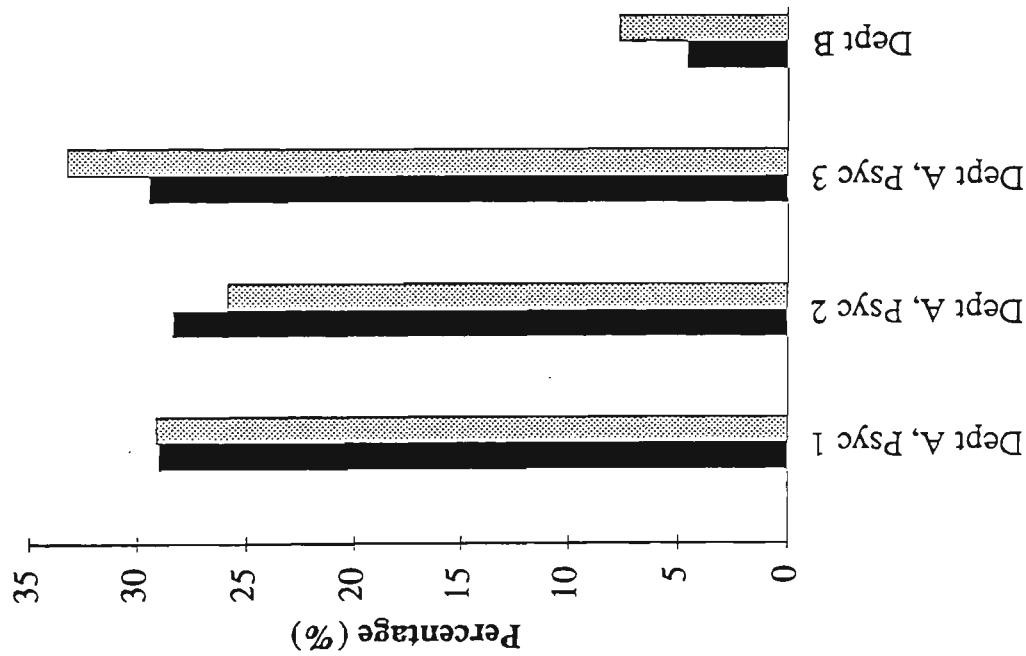
It was expected (and the study was so designed) that Ss from Department A in each organisation would access counselling at a greater rate than their counterparts from Department B and this is substantiated by the analyses. Finally there was no significant difference with respect to psychologist and rate of referral. Thus self referral to counselling was found to be independent of which psychologist "group" the individual came from.

Figure 1 - Percentage of respondents in each Organisation who referred themselves to the EAP as a function of department, psychologist and sex of respondent

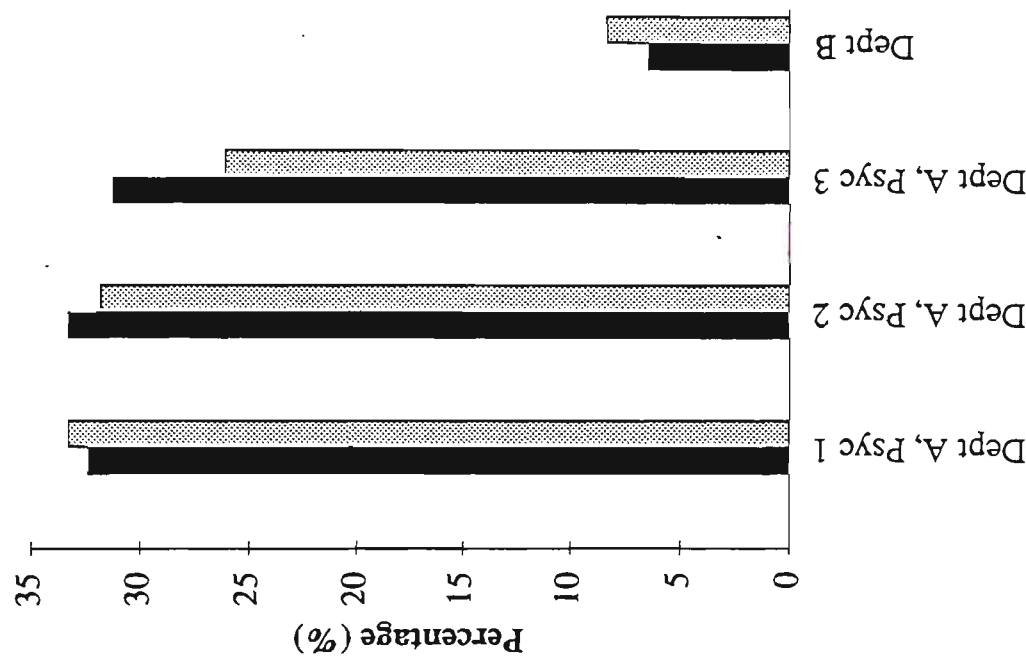
ORGANISATION 1



ORGANISATION 2



ORGANISATION 3



Male Female

Inspection of these data clearly indicate that Ss from Department A accessed counselling at a much higher rate than did their counterparts from Department B. Interestingly male and female Ss sought counselling at approximately the same rate in Department A while females maintained the tradition of being more extensive users of psychological services than males in Department B.

Finally it appears that the rate of Ss who accessed counselling in Department A was independent of the psychologist "group" from which the Ss originated.

### **8.6 Perception of Psychologists Scale**

Mean scores (minimum score = 1, maximum score = 5) derived for each of the thirty items of the Perception of Psychologists Scale for Department A and B Ss as a function of organisation, psychologist and sex over the three time periods are presented in Appendix 15.

An analysis of individual item scores was carried out to ascertain whether any individual item should be removed from the overall scale because it was failing to consistently discriminate between Ss. To this end data were analysed using SPSS<sup>X</sup> subprogram FREQUENCIES. Means obtained for each item for Department A Ss for each organisation, sex and time period were derived using this procedure. These means were then compared. Criteria for removal from the scale included any item that was consistently answered incorrectly or whose mean score decreased over the course of the study. Close inspection revealed that while there were minor fluctuations with respect to organisation or sex of Ss all items successfully met these criteria and were thus judged to be effectively discriminating.

Thus the POPS specifically developed for this study was shown to be an instrument sensitive to tapping the construct of the public attitude towards psychologists.

In order to confirm the factor structure of the Perception of Psychologists Scale developed for this study (see Chapter 7.1) a factor analysis of data derived from all Ss in all three organisations at T<sub>1</sub> was carried out. The results of this factor analysis are provided in Appendix 16.

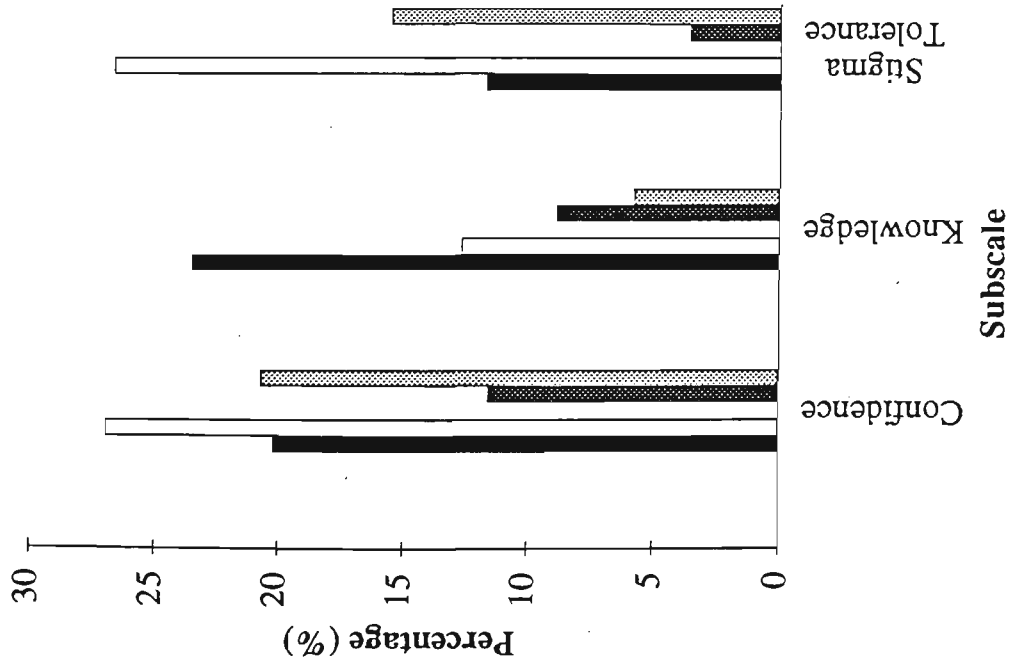
The results provide strong confirmation of the factor structure as derived in the developmental phase of POPS. The original three factor structure was supported by results in each of the organisations although some minor rearrangement of the weighting of constituent items within each factor did occur.

In order to more closely examine the changes which occurred in each of the three subscales over the period of the study data obtained at T<sub>2</sub> and T<sub>3</sub> were compared with data at T<sub>1</sub> (which provided a baseline).

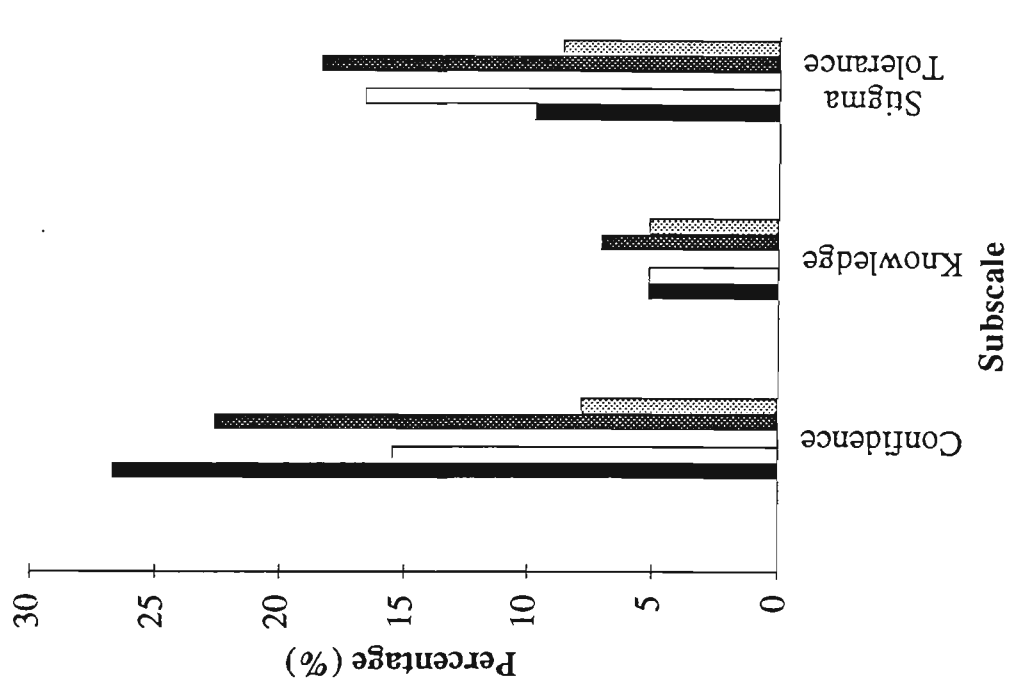
Table 8.6 indicates the percentage increase in mean scores on each of the three subscales of POPS (Confidence, Knowledge and Stigma Tolerance) from T<sub>1</sub> to T<sub>2</sub> and T<sub>2</sub> to T<sub>3</sub> as a function of sex averaged across the three psychologists for Ss in Department A. The data are presented graphically in Figure 8.9.

There was remarkable agreement in the results across the participating organisations. In each of the three organisations the Confidence subscale showed the greatest rate of increase from T<sub>1</sub> to T<sub>3</sub> while Knowledge was

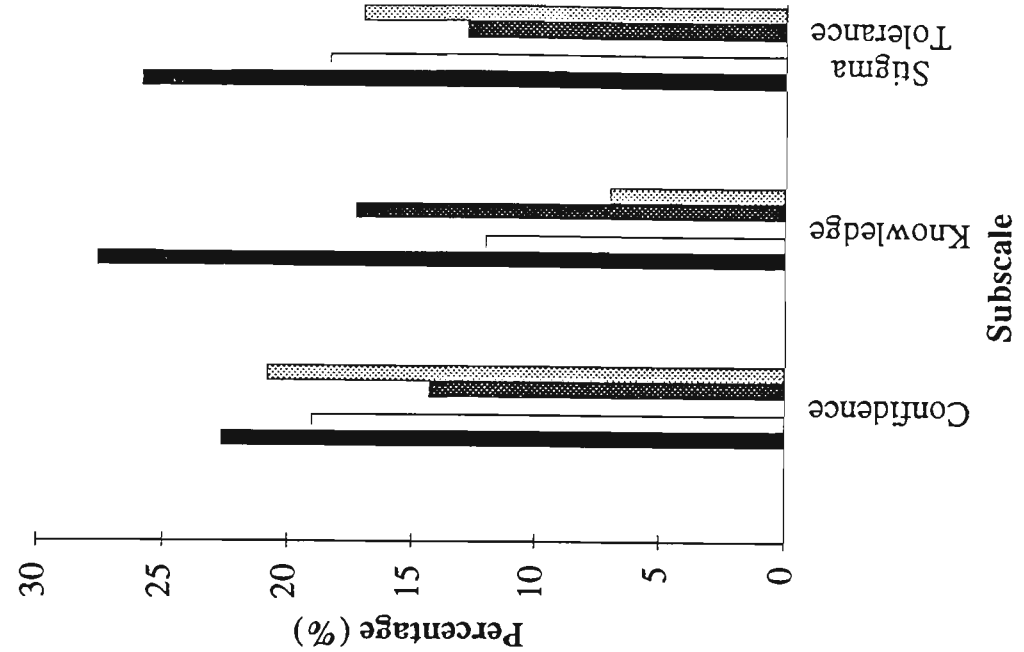
ORGANISATION 1



ORGANISATION 2



ORGANISATION 3



the subscale that showed the lowest rate of increase during the same time period. These findings were the same for both male and female Ss.

**Table 8.6 - Percentage increase in each subscale as a function of sex and time averaged across psychologist**

		Male		Female	
		T <sub>1</sub> ->T <sub>2</sub>	T <sub>2</sub> ->T <sub>3</sub>	T <sub>1</sub> ->T <sub>2</sub>	T <sub>2</sub> ->T <sub>3</sub>
ORGANISATION	Confidence	20.24	26.95	11.58	20.73
1	Knowledge	23.56	12.67	8.86	5.79
	Stigma Tolerance	11.78	26.72	3.64	15.60
ORGANISATION	Confidence	26.73	15.49	22.66	7.85
2	Knowledge	5.24	5.19	7.09	5.17
	Stigma Tolerance	9.80	16.68	18.46	8.68
ORGANISATION	Confidence	22.68	19.02	14.32	20.84
3	Knowledge	27.58	11.99	17.26	7.00
	Stigma Tolerance	25.85	18.29	12.78	16.95

No consistent trends with regard to subscale or sex were detected for changes between T<sub>1</sub> -> T<sub>2</sub> and T<sub>2</sub> -> T<sub>3</sub> apart from the finding that all organisations showed the greatest rate of increase in the Knowledge subscale occurring during the T<sub>1</sub> -> T<sub>2</sub> time period irrespective of sex of S.

## **CHAPTER 9**

### **DISCUSSION**



## **9.1 Discussion**

### **9.1.1 Introduction**

An impressive and comprehensive body of research has consistently highlighted the finding that the attitude towards psychology and psychologists held by the public in general is not favourable. Surveys conducted in many countries, and more recently in Australia (e.g. Sharpley, 1986), have found that the public possesses a somewhat distorted impression of many aspects of psychologists and their work including their training, how one goes about accessing them, their place and relative status in the health/medical world, their modes of therapeutic intervention, the costs associated with their services and their areas of expertise.

It appears that this misconception of psychologists is attitudinally based and shaped by a myriad of influences including the opportunity for personal experience, the influence of the mass media, and the operation of entrenched social and cultural norms. These factors have culminated in an unfortunate stereotyping of psychologists which, in large part, accounts for the finding that people who are experiencing a problem do not access the services of psychologists as often as they should.

Since the present study was commenced the area of the public attitude towards psychologists has received increasingly extensive exposure in the professional literature in Australia generating a great deal of vigorous debate and indicating the high level of concern currently being expressed by the profession as it struggles to define its identity and consolidate its place in the health industry milieu. Talk of the "deprofessionalisation" of

psychology is rife (Bulletin of the APS, 1993) and has led many commentators to question the long-term viability of the profession.

However the prognosis for the profession is not as hopeless as some would suggest. The present study has demonstrated that it is possible to favourably influence the public attitude towards psychologists. The results clearly indicate that attitudes can be influenced by employing appropriate strategies and, moreover, that this observed change in public attitudes towards psychologists was independent of participating organisation, sex of subject, presence of particular psychologist delivering the interventions, was robust over time and, significantly, correlated with subsequent helpseeking behaviour.

### **9.1.2 Gender Effects**

The present study demonstrated that, at T<sub>1</sub>, female Ss reported significantly more positive attitudes towards psychologists than did their male counterparts as measured by the Perception of Psychologists Scale. This finding was consistent for all three subscales of the Perception of Psychologists Scale and was independent of which organisation, psychologist "group", and Department from which Ss came.

However, when measured again at T<sub>3</sub>, there had been both an overall positive change in attitudes and a convergence of this level of attitudes to the point where there was, in the overwhelming majority of instances, no significant difference between male Ss and female Ss in their attitudes towards psychologists. Again this was true for all three subscales of POPS, and was independent of organisation, psychologist and department. Thus males' attitudes towards psychologists and their work

had improved at a greater rate than those of female Ss during the course of the study.

Strong sex differences in attitudes towards psychologists and psychological help-seeking have been consistently documented (Fischer & Turner, 1972; Fisher & Nadler, 1979; Kligfield & Hoffman, 1979; Puig, 1979; McMullen & Gross, 1983). This sex difference in attitudes has been found to be both pervasive and enduring.

Most studies account for the strong sex differences in attitudes towards psychologists and psychological help-seeking in terms of cultural sex role norms and the influence of socialisation (Amato & Bradshaw, 1985). It is argued that in our society males are socialised to be more independent and self-reliant, while females are socialised to be more dependent and subservient.

Good, Dell & Mintz (1989) have proposed that adherence to the traditional male gender role may contribute to males' attitude toward psychologists and consequent reluctance to seek psychological help. This male gender role has a number of seminal features:

- (i) the negative consequences of gender role conflict (O'Neil, Helms, Gable, David & Wrightsman, 1985, 1986)
- (ii) the concept of restrictive emotionality which theorises that men are reluctant or unable to express their feelings to other people (David & Brannon, 1976)
- (iii) conflict with male values such as success, power and competition (Braddon, 1990); men seeking psychological assistance are, implicitly, admitting failure, weakness and defeat

(iv) fear of intimacy and emotional closeness (Lewis, 1978; Kushner & Shaw, 1990)

It appears that the intervention strategies employed in the present study have been successful in overcoming males' traditionally negative attitudes to psychologists and psychological helpseeking. Definitive reasons for this finding are beyond the scope of the present study as they were not empirically investigated. However one may speculate, with some confidence, that the features incorporated into the model of psychological service delivery employed in this study, the Employee Assistance Program, played a significant role in encouraging male participants to develop more positive attitudes towards psychologists.

The Employee Assistance Program model of service delivery provides an effective paradigm for overcoming many of the traditional barriers to helpseeking. These will be discussed in greater detail at a later stage. However it is pertinent to emphasise that the EAP was promoted to employees as (just) another example of a company benefit provided to participant employees by their employers. By adopting this approach, the stigma attached to seeking counselling was minimised as measured by the improvement in the Stigma Tolerance subscale scores.

The finding that male Ss availed themselves of the EAP counselling facility at the same rate as did female Ss indicates their need for, and acceptance of, counselling when it is provided in an appropriate context. This is in contradiction to the often reported finding that women are overly represented in counselling statistics.

It is important to note that the rate of improvement of female attitudes was not circumscribed by the operation of a "ceiling" effect (Hays, 1983) causing them to "plateau" due to achieving maximum or near maximum values on POPS. The maximum scores attainable in each of the three subscales of POPS were 65, 45, and 40 for the Confidence, Knowledge and Stigma Tolerance subscales respectively. Inspection of group means for female Ss in Department A averaged across organisation and psychologist reveals that, at T<sub>3</sub>, the mean score obtained for the Confidence subscale is 52.95% of the maximum attainable score, while for the Knowledge subscale the equivalent value is 68.73% and 67.84% for the Stigma Tolerance subscale. These values indicate there is still room for improvement and that a ceiling effect was not artificially limiting the results attainable by female Ss.

Male and female attitudes were more closely matched in Organisation 2 (the Area Health Service) at each of the three time periods. In this working environment it would be expected that close contact with psychologists would facilitate less sex biasing of attitudes, because of the increasing opportunities for direct contact and observation not readily available to the general public.

A difficulty in the present study was the imbalance in the representation of the sexes in all three organisations. Due to the design of the study it was not possible to obtain equal numbers of male and female Ss. However the statistical package employed to analyse the data, SPSS<sup>X</sup> MANOVA, makes allowance for unequal N in sexes and thus the results obtained were not biased by this imbalance.

### 9.1.3 Department Effects

The present study has clearly established that it is possible to positively influence the public attitudes towards psychologists through the employment of an integrated series of carefully developed strategies designed to provide individuals with first hand knowledge of, and contact with, psychologists and their work.

The conspicuous distinction between the results obtained for Ss in Department A who were the recipients of the intervention package compared with Department B, effectively the no-treatment control group, independent of organisation and sex, provides strong evidence for the success of this study in achieving its aim to positively affect the attitude of participants to psychologists and their work by employing appropriate intervention strategies.

As the design of the study was such that the possible influence of extraneous variables (see Chapter 6) was tightly controlled, it can be confidently stated that the observed differences are attributable to the interventions carried out with Ss in Department A, which enabled them to critically evaluate and modify their attitudes towards psychologists.

An integral concern prior to the conduct of the study was the inability to randomly allocate Ss to the experimental (Department A) and control (Department B) groups. This situation came about because a higher concern was to prevent "leakage" of information about the interventions from the experimental to the control group by having Ss from each Department in close physical proximity. Thus it was decided to choose two physically distinct work locations in each organisation from which to draw participants in the study.

However, the high degree of comparability of the two groups over the three organisations indicates that *de facto* random allocation could be said to have occurred. Evidence for this statement can be found in comparisons of levels of attitude as measured by the three subscales of POPS at T<sub>1</sub>, which showed no significant differences between Ss in Department A versus Department B with regard to organisation, sex or psychologist group. Thus, to all intents and purposes, the groups could be regarded as having been randomly allocated, enhancing the external validity of the study.

No significant differences with respect to time were found for Ss in Department B in any of the three participating organisations, indicating that, in the absence of exposure to the interventions afforded Ss in Department A, the level of attitude towards psychologists reported by Department B Ss did not change. This, of course, would reflect the situation experienced by members of the general public on a day-to-day basis.

The tactic of establishing personal contact, either directly or indirectly, as a strategy for influencing peoples' attitudes towards a person or position is not novel to the present study. For example Peters (1983) in his provocative text on effective management strategies coined the term "management by walking around". Peters advocated managers abandoning their offices and, instead, getting out and moving among their employees. Peters strongly advocated this technique as a way of establishing a personal connection with one's workers thus (?subliminally) making them feel more valued and encouraging them to

be more productive because of the powerful influence of personal contact.

Politicians, also, have long known that personal contact is a most potent strategy for influencing voters to their point of view. Thus, both traditional and contemporary election campaigns are replete with personal appearances by politicians, shaking hands with electors (personal touch) and the much parodied "baby kissing" syndrome as manifestations of establishing personal contact with voters. It is known that individuals feel more comfortable in establishing their attitude towards an individual if they have the opportunity for personal contact (Fuchs & Magarey, 1988). This contact acts to provide the individual with reinforcement of his or her already established attitude or alternatively provides a basis for attitude change if the experience is incongruent with an existing attitude. Festinger (1957) recognised this phenomenon in his development of the concept of cognitive dissonance.

#### **9.1.4 Organisation Effects**

Three organisations were selected to participate in this study. The primary aim of this strategy was to enhance the external validity of the findings obtained so that may be generalised to the public at large. To achieve this aim it was decided to choose, as participants, organisations who varied on a number of key dimensions which included: representativeness of the general population, nature of core work, level of skill required, presumed knowledge of psychologists and their work, location, size and distribution of sexes. As a result of these criteria the organisations finally selected were in the fields of heavy industrial manufacturing, public health and chemical processing.



It was never an aim of the present study to directly compare and contrast the results obtained with each participating organisation, largely because such a comparison would be, in practical terms, meaningless. The interventions developed and incorporated in this study were not designed so as to work more effectively with a particular group of people. Indeed an aim of the study was to show that any group of people could improve their attitude towards psychologists if provided with the opportunity to be exposed to appropriate interventions.

With these comments in mind it was found that a positive change in the attitude towards psychologists and their work occurred for Ss in Department A of all three participating organisations, thus demonstrating that the intervention package could be effectively employed with a wide range of target populations.

Organisation 2, an Area Health Service, as would be expected, had higher relative attitudes towards psychologists as measured by POPS scores at T<sub>1</sub> than did Organisations 1 or 3. This was particularly so for the subscale Knowledge as would be predicted. Due to the nature of their work, employees in Organisation 2 variously included medical practitioners, nurses, allied health professionals such as physiotherapists, occupational therapists, social workers, nutritionists, and domestic support staff such as food preparation, clerical and cleaning staff. It would be reasonable to expect that these people would already have had, to a greater or lesser extent, the opportunity to have formed an opinion of psychologists due to their prior knowledge gleaned from working with them on a regular basis.

Notwithstanding this opportunity the attitude of Ss in Organisation 2 towards psychologists was not always favourable although it is true that it

was higher than the other two participating organisations on each of the three subscales as measured at T<sub>1</sub>. Thus the interventions were successful in improving the attitudes of a group who would have been expected to already possess positive attitudes towards psychologists.

It is illustrative to note that all three organisations demonstrated almost identical trends in the improvement of their attitudes as measured by POPS. Close inspection of the results of the three subscales of POPS over the three time periods indicates that, of each of the three organisations, the Confidence subscale showed the greatest rate of improvement while Knowledge showed the least. The most important implication of this finding is that any future campaign focussing on promoting the profession of psychology should concentrate on influencing the confidence the general public has in psychologists. This contention will be discussed in greater depth at a later stage.

### **9.1.5 Psychologist Effects**

Outcome studies have consistently shown that successful therapeutic outcome is not so much correlated with the type of therapy employed but more commonly linked with who actually carried out the therapy. In essence, it is the nature of the relationship established between the therapist and his/her client that has been found to be the best predictor of actual therapeutic improvement.

A major concern in designing the present study was that any positive improvement in Ss' attitudes could be attributed to the "charismatic" effect of a particular psychologist rather than the range of interventions employed. To overcome this difficulty three psychologists, two male and one female, were co-opted to deliver the package of interventions

designed for this study. As an additional safeguard all three psychologists were involved in delivering the interventions in each of the three participating organisations so that any positive improvement could not be attributed to a particular interaction of psychologist and organisation.

Zajonc's (1967) "mere presence" hypothesis proposes that there is an innate biologically-based mechanism which leads an individual to respond in a desired manner simply as a result of the presence of another individual. Somewhat akin to the previously discussed "on stage" effects (see Chapter 6) (Agnew & Pyke, 1969) such as social desirability, evaluator apprehension and various demand characteristics, this tendency to respond positively merely because of the presence of a psychologist was addressed by making responses to the Perception of Psychologists Scale anonymous thus eliminating the potential urge to "please" or "impress" the psychologist so as to gain their approbation.

Data analysis revealed there was no significant interaction of sex of S and sex of psychologist delivering the interventions. Thus it appears that the modelling carried out by the psychologist together with the range of intervention strategies employed alone influenced the increase noted in the attitudes towards psychologists in all three participating organisations.

#### **9.1.6 Time Effects**

A concern in the present study was that any changes observed in participants' attitude towards psychologists may be caused by the novelty of having a psychologist present together with the implementation of a novel employee benefit, the Employee Assistance Program. It was feared that the "Hawthorne effect", where individuals respond to any change in

the environment, irrespective of whether it is good or not, could operate in this situation.

To control for this possibility it was decided to conduct the present study over a twelve month period so as to minimise some potential extraneous variables. Thus attitudes were measured at the commencement of the study (T<sub>1</sub>), at six months (T<sub>2</sub>) and finally at the end of the study (T<sub>3</sub>).

Analysis of the data revealed a strong main effect for the independent variable TIME. Inspection of Figures 8.2, 8.3 and 8.4 clearly shows that over the period of the study the attitudes towards psychologists improved in Department A of all three organisations, irrespective of sex of S and psychologist group. In contrast there were no significant differences with respect to time for the corresponding Department B Ss.

Close inspection of the data revealed there was no consistent pattern of change when the time period T<sub>1</sub>->T<sub>2</sub> is compared with T<sub>2</sub>->T<sub>3</sub>. In hindsight an oversight of the present study was not to systematically manipulate the different interventions so as to ascertain if any one particular intervention or combination of interventions as differentially influential in bringing about the observed changes in attitudes.

#### **9.1.7 Perception of Psychologists Scale**

The present study has shown that the inventory specifically developed for the study, the Perception of Psychologists Scale, has proven itself to be an assessment instrument sensitive to tapping the construct of the attitude of a representative sample of people towards psychologists and their work.

This instrument has successfully filled a void in the field of measuring attitudes towards psychologists. No scale directly measures attitudes to psychologists. Furthermore the only scale remotely applicable, the Attitude Towards Seeking Psychological Help (Fischer & Turner, 1970) targets helpseeking, essentially the behavioural component of an attitude, while effectively ignoring other aspects of the attitude construct.

The successful development of POPS means there is now a tool capable of accurately and expeditiously assessing an individual's attitudes towards psychology and psychologists. POPS is an easily administered and completed psychometric instrument. It is simple to comprehend and takes only 5 minutes for a respondent to complete. It is easily scored and results in three subscale scores which allow the researcher to detect potential areas of deficiency in an individual's attitude structure towards psychologists.

A key feature of POPS is that it allows for this construct to be subdivided into three meaningful components which could be compared with the tripartite structural basis of an attitude (see Chapter 4): (i) confidence (cf affective) in and (ii) knowledge of psychologists and their work (cf cognitive) and (iii) the level of tolerance associated with the stigma attached to accessing psychological assistance (cf behavioural).

The factor structure of POPS, which led to the development of the three subscales, established in the preliminary series of studies (see Chapter 7.1) was confirmed for all three participating organisations at T<sub>1</sub>. Inspection of individual item scores revealed that all scale items were found to be discriminating effectively between Ss. Thus all items were

essential to tapping the overall construct of attitude towards psychologists and their work.

An illuminating finding was that, in each organisation, it was discovered that it was the Confidence subscale that showed the greatest rate of improvement over the period of the study while Knowledge was found to have changed the least. This consistency of response pattern underscores the efficacy of POPS as an instrument for accurately assessing public attitudes.

The practical applications of POPS are many. POPS presents itself as a useful tool for differentiating those individuals who are likely to seek psychological assistance as those that would score highly on the subscales of POPS. Thus POPS could, quite feasibly, be utilised to highlight individuals or groups in a population who are potentially reluctant to seek psychological help as likely candidates for an education program about psychologists and their work. As the present study shows it would be preferable for this program to be delivered by psychologists.

Further POPS could also be used to screen individuals, who have expressed a wish to seek psychological help, as to their attitudes towards potential help providers. Practitioners have long known that gaining the confidence of the client is positively correlated with eventual therapeutic success.

Another application of POPS could be to target referring agents such as medical practitioners, the legal fraternity, schools, and the like as to their attitudes towards psychologists. It could be that possible misconceptions

can be addressed at this level thus enhancing the chances of individuals receiving appropriate assistance.

### **9.1.8 Referral to the EAP**

A significant outcome of the present study was that Ss allocated to Department A of each participating organisation accessed the counselling provided as part of the EAP at a significantly higher rate than did those Ss allocated to Department B.

The main conclusion from this finding is that the present study has shown there is a positive correlation between enhanced attitudes towards psychologists and consequent behavioural intention to seek psychological assistance.

A design limitation of the present study was not being able to match individuals who sought counselling through the EAP with their POPS scores over the three time periods. This strategy would have enabled direct comparison of those who sought counselling with changes in their POPS scores rather than deriving a correlation between the two events as is currently the situation.

It was originally planned to obtain individuals' identification numbers (that they used when completing POPS) when they presented for counselling. However preliminary discussion with the three participating organisations indicated that this may be perceived by some Ss as compromising the confidentiality of the individual a cornerstone of the EAP. Therefore this strategy was not adopted as it was felt that maintaining the integrity of the EAP was more important than the need for collecting this data.

### 9.1.9 Theories of Attitude Change

It is germane to examine the process of the observed change in attitudes towards psychologists as shown in the present study in light of the current leading theory of attitude change, the Elaboration Likelihood Model (Petty & Cacioppo, 1986). It is important to emphasise at the outset that the present study was not designed to assess the relative merits of the Elaboration Likelihood Model of persuasion. However, several factors cited by the ELM as pivotal to persuasion were incorporated into the design of this study. This situation thus permits limited comment to be made about the operation and effectiveness of these factors in engendering the observed attitude change.

Petty & Cacioppo (Petty 1977, Petty & Cacioppo, 1978) reviewed the literature on attitude persistence and concluded that the many different empirical findings and theories in the field might profitably be viewed as emphasising just one of two relatively distinct "routes to persuasion" (as outlined in Chapter 4.6.3). The first type of persuasion was that which likely occurred as a result of a person's thoughtful and careful consideration of the true merits of the information presented in support of an advocacy. This was termed the central route to persuasion. The other type of persuasion, however, was that which more likely occurred as a result of some simple cue in the persuasion context (e.g. an attractive and/or credible source) that induced change without necessitating scrutiny of the central merits of the issue-relevant information presented. This was termed the peripheral route to persuasion.

According to the ELM theory a key tenet is that people are innately motivated to hold correct attitudes. Further, although people want to hold



correct attitudes, the amount and nature of issue-relevant elaboration in which they are willing or able to engage to evaluate a message varies with individual and situational factors. These variables can affect the amount and direction of attitude change in one of three ways:

- (a) serving as persuasive arguments
- (b) serving as peripheral cues
- (c) affecting the extent or direction of argument elaboration

As motivation and/or ability to process arguments is decreased, peripheral cues become relatively more important determinants of persuasion. Conversely as argument scrutiny is increased, peripheral cues become relatively less important determinants of persuasion.

It can be cogently argued that the present study employed a range of strategies likely to invoke both the central route and the peripheral route to persuasion in facilitating the demonstrated attitude change of participant individuals towards psychologists and their work.

The Elaboration Likelihood Model postulates a range of variables that enable the message recipient to scrutinise issue-relevant arguments in a relatively objective manner. Such "ability" factors to be found in the present study include (i) message complexity/comprehensibility, (ii) message modality, and (iii) the presence of prior knowledge.

A central enabling factor is message complexity/comprehensibility. Researchers have studied the complexity or comprehensibility of message arguments (Eagly, 1974) mostly in the context of McGuire's (1968; 1969) information-processing model. The ELM holds that the strengths of cogent arguments and the flaws in specious ones should become more apparent as complexity is reduced and comprehensibility is increased. It

can be argued that this was an underlying aim of the present study. It is posited that understanding psychology and psychologists could be construed as a complex task if dealt with on a theoretical level. The present study attempted to reduce the complexity of this task by "demystifying" psychology and psychologists through the various interventions conducted with Ss.

A further enabling factor is message modality. Research indicates that messages presented in person, or on audio or videotape may be more difficult to process than the same message presented in print (Chaiken & Eagly, 1976; Wright, 1981). It is proposed that in print, the recipient may process the message at an optimal pace, stopping to consider difficult points and elaborating at will. However with a personal delivery the pace of the message is externally controlled. Unless the message is simple, complete elaboration may not be permitted with a single exposure.

The present study attempted to overcome this impasse in three ways. Firstly it used a range of message modalities, including direct and indirect personal contact, video and audio presentations and print, to convey the message. Thus by varying message modality it could be argued that Ss had their opportunity to more comprehensively scrutinise the message enhanced. Secondly the recipients were repeatedly exposed to the message over a twelve month time period thus enhancing the chances of effective elaboration, by having time available to process the messages being presented. Thirdly Ss had access to both video tapes and audio tapes which they could listen to at their own pace again enhancing their ability to scrutinise the message.

A further enabling factor that is regarded as one of the most important variables affecting information processing activity is the extent to which a person has an organised structure of knowledge (or schema) concerning an issue (Higgins, Herman & Zanna, 1981; Wyer & Srull, 1984). It is generally regarded that although it is possible for prior knowledge to enable more objective information processing in some instances (Bobrow & Norman, 1975), because stored knowledge tends to be biased in favour of an initial opinion, more often than not this prior knowledge will enable biased scrutiny of externally provided communications (Fiske & Taylor, 1984).

In the present study Organisation 2, an Area Health Service, had significantly higher cell means for both male and female Ss in both Departments for all three subscales of POPS at T<sub>1</sub> when compared with the other two organisations. This is not a surprising finding if one accepts that Ss in this organisation would be expected to have heard of, and worked with, psychologists thus enabling them to have already formed a prior opinion of psychologists and their work. This would be unlikely to be the situation in the case of Organisation 1 (an heavy industrial plant) or Organisation 3 (a chemical processing plant) where contact with psychologists could reasonably be expected to approximate the rate of contact for the general public. Thus the presence of prior knowledge and contact may well have assisted Ss in Organisation 2 to record higher POPS scores at T<sub>1</sub>.

In addition to the operation of enabling factors the Elaboration Likelihood Model also holds that motivational variables are important in influencing the likelihood of message elaboration. According to the ELM if a person is highly able to process a message but lacks the requisite

motivation, little processing will occur (Petty & Caccioppo, 1986). Key motivational variables include (i) personal relevance of the message, (ii) personal responsibility for evaluating the message and (iii) number of message sources.

Perhaps the most important variable affecting the motivation to process a persuasive message is the personal relevance of that message. Previous psychological analyses of personal relevance have labelled this construct (or its variations) "ego involvement" (Rhine & Severance, 1970; Sherif, Sherif, & Nebergall, 1965), "issue involvement" (Kiesler, Collins & Miller, 1969), "personal involvement" (Apsler & Sears, 1968; Sherif, Kelly, Rogers, Sarup & Tittler, 1973) and "vested interest" (Sivacek & Crano, 1982). Petty & Caccioppo (1986) regard personal relevance as the extent to which an advocacy has intrinsic importance to the individual.

In terms of the ELM, Petty & Caccioppo (1979) proposed that as personal relevance increases, people become more motivated to process the issue-relevant arguments presented. As the personal consequences of an advocacy increase, it becomes more important for message recipients to form a veridical opinion since the consequences of being incorrect are greater. Because of these greater personal consequences, people should be more motivated to engage in the cognitive work necessary to evaluate the true merits of the proposal.

It is proposed, in the present study, that a shift to a more positive attitude toward psychologists is more likely to occur for those individuals who see psychologists and their work as having personal relevance for them. Indeed this was one of the strong messages being delivered to Ss throughout the study. This assertion is borne out in present findings

where subjects from Department A subsequently sought psychological help through the Employee Assistance Program at a significantly higher rate than those from Department B for all three organisations, independent of the sex of the subject and the psychologist charged with delivering the interventions.

Ss in Department A had the opportunity to be exposed to psychologists and their work over a twelve month period thus affording them the opportunity to gauge the level of personal relevance that psychologists had for them. These findings certainly seem to support the contention that the presence of personal relevance can play a strategic role in the process of attitude change.

This assertion is further supported by the finding that those subjects who sought out the assistance afforded by the Employee Assistance Program also showed significant positive change in their POPS scores. It was found that there was a high degree of correlation between those Ss who sought assistance through the EAP and positive change in POPS scores on all three subscales over the period of the study.

In the same manner that personal relevance enhances motivation to process issue-relevant arguments the ELM proposes that personal responsibility produces similar effects. The greater the personal responsibility for evaluating an issue, the more people should be willing to exert the cognitive effort necessary to evaluate the issue-relevant arguments presented (Petty & Caccioppo, 1986). For this reason, individual evaluators are expected to regard a strong version of a message more favourably and a weak version of a message less favourably than group evaluators.

It is proposed that, in the present study, there is a high degree of personal responsibility contingent upon individual Ss due to the essentially personal nature of the message being delivered. Because individuals evaluate for themselves whether psychological assistance would be beneficial for them, personal responsibility is an important factor in issue elaboration. Psychological helpseeking research indicates that it is unlikely that individuals would discuss their opinions with others and, of course, the process of seeking and gaining psychological assistance is treated as highly confidential. The decision to seek help through the EAP is usually made by the individual themselves, generally without consultation with others. This is borne out by analysis of referral data from organisations who operate an EAP. By far the largest group of referrals to EAPs is self-referrals where the client takes the responsibility for making contact with the EAP provider directly (IPS Annual Report, 1988, 1989, 1990, 1991).

A further motivational variable thought to be influential is the number of message sources employed to disseminate the message. The ELM holds that increasing the number of message sources presenting an advocacy can enhance motivation to process a message. There are a number of everyday situations in which persuasive information is provided by several sources rather than just one. For example, in debates, a number of speakers argue for or against the chosen topic. In advertising, multiple spokespersons provide testimonials for a product. In trials, several witnesses provide character evidence about a defendant.

In the present paradigm Ss in Department A were divided into three groups and allocated a "nominated" psychologist who was charged with

the responsibility of delivering the interventions designed to positively influence the attitude toward psychologists. This psychologist became the main message source. But it could also be construed that other viable message sources could include comments by fellow employees, and the newsletters, video tapes and audio tapes provided to supplement the EAP. So, in effect, while only one psychologist was allocated to each group there were a range of potential message sources.

The ELM postulates that a wide variety of variables can affect a person's motivation and/or ability to consider issue-relevant arguments in either a relatively objective or a relatively biased manner, and a number of these variables have already been discussed in the context of the present study.

However, according to the ELM, extensive issue and argument processing is only one route to persuasion or resistance. When people are relatively unmotivated or unable to process issue-relevant arguments, attitude changes may still occur if peripheral cues are present in the persuasion situation. In fact, the ELM postulates a tradeoff between argument processing and the operation of peripheral cues: as argument scrutiny (whether objective or biased) is reduced, peripheral cues become relatively more important determinants of persuasion, but as argument scrutiny (either objective or biased) is increased, peripheral cues become less important.

Several salient factors which could be construed as peripheral cues were manipulated in the design of the present study so as to enhance the prospect of attitude change for those individuals who were either unable and/or unmotivated to elaborate. These peripheral cues were (i) source

expertise, (ii) source likeability, (iii) number of message arguments, (iv) message modality, and (v) gender of source and message recipient.

It has long been known that the validity of a message can be influenced by the perceived expertise of the message source (Hovland, Janis & Kelly, 1953). In the context of the present study the psychologist was deliberately and consistently promoted as an expert in his/her field and a credible provider of psychological services. They were (accurately) portrayed as having a wide range of skills and abilities enabling them to assist individuals with any presenting problems.

In a similar manner source likeability as a peripheral cue was built into the study design. The psychologists were carefully instructed to be approachable, friendly and non-dogmatic in their dealings with Ss through training conducted before the commencement of the study aimed at instructing the participating psychologists in interpersonal skills to combat the stereotyped attitude toward psychologists (e.g. Sharpley, 1986).

Distinctions between attitude change based on source factors versus changes based on message factors have a long history in social psychology (Kelman & Hovland, 1953). In fact, studies of source cues such as those mentioned above may appear to provide evidence consistent with the distinctions others have made between source and message orientations (Eagly, 1965). However it is essential to realise that the central/peripheral distinction of the ELM is not equivalent to a source/message dichotomy. Importantly the ELM holds that both source and message factors may serve as peripheral cues.



The number of message "arguments" being presented was determined to maximise the likelihood of attitude change in the present study. The "arguments" were presently directly (through personal contact) and indirectly (via participation in the various programs and access to EAP newsletters, audiotape and videotape).

Manipulating message modality by deliberately employing a range of modalities, including direct and indirect contact, audio, video and print, to target both the central and peripheral routes was a feature of the present study. It has been found that both source credibility (Anfreoli & Worchel, 1983) and likeability (Chaiken & Eagly, 1983) have a greater impact on attitudes when a message is presented on video or audio tape (rather than in written form) where Ss had the opportunity to interpret verbal and nonverbal cues transmitted by the speaker. Ss had access to both modes of presentation.

Previous studies of sex differences in persuasion have provided some support for the view that females are more susceptible to influence than males in certain contexts (Cooper, 1979; Eagly & Carli, 1983). One explanation for this effect is based on the notion that females may have been socialised to be more agreeable (i.e. concerned with social harmony) than males (Eagly, 1978). To the extent that females have learned to be more agreeable and less dominant than males the invocation of this socialised female gender role could lead to a sex difference in influenceability. However, according to the ELM, attitude expression based on the female gender role should be more likely when women have little ability to process the issue-relevant information presented than when ability is high (Cacioppo & Petty, 1980).

The results of the present study indicated that females had significantly higher scores on each of the three subscales of POPS at T<sub>1</sub> in each participating organisation than did their male counterparts but that there was a convergence of attitudes by T<sub>3</sub> i.e. the rate of change of males' attitudes towards psychologists was greater than that of females. These findings are consistent with the finding that females generally possess a more positive attitude toward psychologists and also tend to utilise psychological services to a greater extent than do males (Greenley & Mechanic, 1976; Russo & Sobel, 1981; Veroff, 1981; Kushner & Shaw, 1991; Sharpley, 1986).

However the present study shows that if males are presented with appropriate messages about psychologists and their work in an appropriate environment there is no reason why they, too, will not be motivated to positively re-evaluate their attitude toward psychologists.

Thus, while it was not an aim of the present study to empirically assess the efficacy of the Elaboration Likelihood Model, it does appear that this model can be gainfully employed in accounting for and interpreting many of the aspects of the persuasion process in engendering the attitude change observed with participants in Department A in this study. The ELM has received much research attention since its development and holds promise as a paradigm for improving our understanding of the persuasion process.

#### **9.1.10 The Link Between Attitude Change and Behavioural Intention**

Commentators and researchers have long attempted to forge a convincing link between the process of attitude change and consequent behavioural

intention. Indeed it could be compellingly argued that the entire advertising and marketing industry is dependent upon discovering this elusive "Rosetta Stone".

In particular, arguments have specifically centred on the direction of this connection i.e. whether attitude change predisposes subsequent behaviour or whether behaviour influences attitude change. For example Fishbein & Ajzen's (1975; Ajzen & Fishbein, 1977) theory of personal action assumes that the best predictor of behaviour is intention. Behavioural intentions, in turn, are said to be a function of one's attitudes towards the behaviour and one's subjective norms.

On the other hand the attitudinal change that results from specific behaviours that individuals may be induced to perform has variously been accounted for by recourse to explanations of self-perception (Bem, 1972), dissonance reduction (Festinger, 1957), impression management (Reiss, Kalle & Tedeschi, 1981) and ego enhancement (Steele & Liu, 1983).

The present study has established the presence of a link between attitude change towards psychologists and consequent helpseeking behaviour. It was demonstrated that those Ss allocated to Department A of each participating organisation accessed the services of the Employee Assistance Program at a significantly higher rate than Ss in Department B irrespective of sex of Ss and psychologist who delivered the interventions.

The Elaboration Likelihood Model postulates that enduring attitude change is more likely to be mediated through the central route to

persuasion where the individual engages in thoughtful and analytical processing of arguments and other issue-relevant information.

The likelihood of elaboration is determined by the individual's motivation and ability to think about issue-relevant information. When an individual is motivated (e.g. by vested interest or personal responsibility) and is able (e.g. by virtue of expertise or freedom from distractions) to elaborate issue-relevant information, persuasion should follow this central route.

On the other hand attitude change mediated through the peripheral route is predicted to be relatively temporary, easy to change and not predictive of behavioural intention.

Taking into account this explanation afforded by the ELM the present study has indicated that the observed attitude change engendered is most likely to have occurred via the central route to persuasion. Evidence for this contention is found in the results of the follow-up study which was conducted 6 months after the conclusion of the main study. It was found that even after this period of time Ss in Department A remained consistently higher users of EAP counselling services than did those Ss in Department B. If attitude change had occurred via the peripheral route it is posited that utilisation of the EAP by Department A Ss would have returned to levels similar to those found in Department B Ss, as attitude change via the peripheral route is theorised to be ephemeral.

## **9.2 Implications of the Findings of the Present Study**

### **9.2.1 Models of Service Delivery**

The results of the present study have strategic implications for looking more critically at the models of service delivery presently employed by psychologists in providing professional assistance to their clients.

In their comprehensive review of the professional activities of Australian clinical psychologists, Byrne & Reinhart (1990) reported on the average time spent in the various activities that make up a typical working day for a professional psychologist. These activities ranged from individual psychotherapy, psychometric testing and research to teaching and administration, supervision and consultation.

It was illustrative to note, in light of the findings of the present study, that Byrne & Reinhart (1990) made no provision for assessing non-clinical activities such as marketing and promotion of one's services, as if these were not considered to be of sufficient importance or were not regarded as appropriate enterprises for professional psychologists.

As elucidated in the various models of service delivery (see Chapter 2.5) this position is, however, congruent with the central feature of contemporary models of service delivery that are predicated on the basis of the professional psychologist working usually in a room or office and waiting for clients to refer themselves or be referred by others for assistance. The disadvantages of this model of working have been comprehensively highlighted in the helpseeking literature. The literature has consistently indicated the large number of barriers to helpseeking thrown up by this model culminating in the fact that the vast majority of

those who need psychological help do not end up receiving it because they do not refer themselves.

It has been shown that individuals are hesitant or reluctant to access the assistance of someone who, to all intents and purposes, they do not know (even though they may have been referred, or recommended, to this person). Further the very nature of the counselling process demands the disclosure of intensely personal information. It stands to reason, then, if the potential client has prior knowledge of, or contact with, a psychologist they are more likely to feel motivated to seek their assistance.

The present study clearly indicates the efficacy of the Employee Assistance Program as a new and effective model of service delivery. This is not to suggest that there is a need to wholly discard the existing models. This would neither be practical nor advisable as they contain many important features that contribute to their therapeutic effectiveness. The key component that needs to be built into existing models is one where the psychologist has the opportunity to engage in greater direct contact with their potential client population.

The present study has shown that contact with a psychologist is sufficient to positively influence the public attitude toward psychologists. This is especially so in the area of "confidence" in psychologists and their work. There are a number of strategies psychologists can employ to improve their public profile, and these will be elucidated in detail at a later stage in the discussion.

One is mindful, of course, of ethical considerations in making these recommendations. Any change in the manner in which psychologists promote or "market" themselves and their work must be constrained within appropriate ethical guidelines, as set out by the Australian Psychological Society (APS, 1986). It is noteworthy, however, that several other professional bodies, such as accountancy and the legal profession, have recently relaxed previously stringent guidelines governing the "advertising" of their services. While there was, undoubtedly, a commercial aspect to this decision it has also led to these professions becoming better promoted in the market place by emphasising the services they have to offer.

The present study has shown that, by improving attitudes towards psychologists, there is a concomitant increase in the number of clients actively seeking and receiving psychological assistance. Thus it seems that more people are likely to seek psychological assistance if they are given the opportunity to be exposed to a psychologist and his/her work.

### **9.2.2 The EAP as a Viable Model of Service Delivery**

The key role played by the utilisation of the Employee Assistance Program (EAP) as an authentic and effective alternative model of service delivery is integral to modifying attitudes towards psychologists.

As discussed in Chapter 5 EAPs are a relatively recent human resource management strategy in Australia with barely a ten year history behind them. Their rapid acceptance by psychologists who have recognised EAPs as an effective model of service delivery is most encouraging (for a discussion of the role of psychologists in EAPs in the Australian context see Buon, 1988; Terry, 1984; Compton, 1988; for a similar discussion of

the United States context see Zedeck & Mosier, 1990; Farkas, 1989; Klarreich, DiGuiseppe & DiMattia, 1988)

Importantly, and this may account for their rapid acceptance by the profession, the EAP provides the ideal vehicle for the practicing psychologist to develop and implement a wide range of professional skills that are subsumed under the title of "psychologist". Additionally, and significantly in light of comments regarding professional training models (to be discussed later), the EAP model of service delivery draws heavily on the advantages provided by both the scientist-practitioner and the scientist-professional models of professional training.

Foremost among the professional advantages available to the EAP psychologist is the opportunity for the psychologist to develop his/her therapeutic counselling skills. Acting neither entirely in the clinical or counselling modes (if, indeed, such a distinction is operationally valid) the EAP psychologist could be regarded as the true "health services" psychologist as proposed by Levy (1984). The EAP psychologist has the opportunity to deal with exclusively work-related or personal problems but more often finds that one rarely occurs in isolation from the other.

Essentially the EAP model lends itself to short-term problem-focused intervention strategies which are goal-driven. The EAP psychologist is able to see the employee who seeks assistance through the EAP and/or members of the employees' family. Thus there is the opportunity for the psychologist to develop therapeutic skills in the area of individual, couple, marital and family therapies.



Because of the nature of the EAP model the psychologist is often called upon to provide training in the effective use of the EAP. This training may take the form of implementing programs for managers/supervisors in the workplace in how to appropriately refer employees to the EAP or it may be simply briefings for employees to inform them of the function of the EAP and how it can be relevant to their work and personal lives. Thus the educational and training skills of the psychologist are being utilised.

As the EAP is strongly proactive in its approach a key function of this model is to detect trends and/or problems areas in the workplace before they become chronic or entrenched and advise management of ways of addressing these problems. For instance the EAP psychologist may become aware of an increase in the number of referrals from a particular section of the workforce with stress being a feature of the common symptom picture. The EAP psychologist is in a key position to implement a stress management program for all employees in that section which addresses the presenting problem but does not violate the confidential nature of their work by targeting individual clients.

The ability to conduct research is also an important skill for the EAP psychologist to possess. In many organisations it is not sufficient to merely inform management of work-related problems if there is no hard evidence to support these claims. This evidence can be assembled by engaging in proper scientific research, gathering data and analysing it appropriately to create the basis for informed decision-making.

The EAP psychologist must possess well-developed management skills for he/she is charged with managing the emotional health of a large group of people. Thus the EAP psychologist must be able to plan, communicate

and provide effective leadership to both employees and the employer organisation.

The EAP model of service delivery is ideally designed to promote both direct and indirect contact between the EAP psychologist and his/her potential clients. By exposing the organisations' employees to their EAP psychologist and, as has been demonstrated in the present study, positively influencing attitudes towards psychologists, this model of service delivery optimises the diverse and extensive skills and abilities of the psychologist and maximises their professional training.

Thus the EAP model of service delivery incorporates many of the features shown to be essential in influencing the attitude of individuals towards psychologists and their work. As such it appears to be a model ideally suited to the needs of clients and practitioners alike. The rapid acceptance and impressive utilisation of EAPs is testimony to the efficacy of this model of service delivery.

### **9.2.3 Implications for Professional Training**

The findings of the present study can be construed as bringing into sharp focus the efficacy of the scientist-practitioner model as the appropriate training and practice model for psychologists. The debate on the optimum model for the training of psychologists has, for some time, been dynamic and is far from resolution (APS Bulletin, 1993). It is generally agreed that the crux of the debate currently centres around the proportion of the "practitioner" component that should be included in the overall undergraduate training regime of psychologists (Martin, 1989).

One school of thought holds that the appropriate role of tertiary institutions is the teaching of the "scientist" while the role of post-graduate work is to develop the "practitioner". O'Gorman (1993) provides support for this contention:

"The traditional undergraduate curriculum in psychology in Australian higher education institutions has stressed the study of psychology as a science and has left training in the profession of psychology to the postgraduate level. That is, the scientist-practitioner model has been put into effect by beginning the preparation of the "scientist" at the undergraduate level but delaying the preparation of the "practitioner" to the postgraduate level."  
(p.32)

Others feel that there is too much emphasis on the "scientist" aspect of training particularly in light of the relatively small number of psychologists not employed in tertiary institutions who ultimately engage in research, thus utilising their scientific skills (Byrne & Reinhart, 1990).

Montgomery (1993), coming from the point of view of a private practitioner, makes a strong case for improved skills acquisition in undergraduate training:

"There is abundant evidence, both systematic and anecdotal, to demonstrate clearly that the overwhelming majority of professional (as distinct from academic) psychologists will never conduct any research. Most of them probably don't want to, because their interests lie in the applied field and most of their employers would not support serious research, being stretched to provide applied services for their potential clientele. In practice, most professional psychologists are consumers of scientific research not producers."  
(p.39)

Montgomery (1993) asserts that undergraduate training in psychology has been "hijacked" by:

"...academic psychologists whose interests and competencies lie more in research than in practice. In my observation, tertiary teachers of psychology continue to be selected and promoted primarily on the strength of their research skills, with no consideration of, and therefore to the detriment, of their professional skills." (p.40)

Criticisms of undergraduate training are not limited to practitioners. Abell (1988), in a survey of third-year students at the University of Newcastle, found that:

1. 70% felt their knowledge of psychology at the 3rd year level was inadequate with respect to practical applications of theoretical constructs, interpersonal skills and a "real world" understanding of the role of psychology and the psychologist in the community.
2. Of the 30% who expressed satisfaction with their level of knowledge, 75% attributed their level of understanding to their having participated in work experience, vacation jobs and research projects.
3. 92% of students expressed the need for more awareness of psychology as a vocation.
4. 91% were not satisfied with the content of options available to them in 3rd year. More emphasis on undertaking practical experience with people in the community and within formal organisations was advocated.

It is too simplistic to lay the blame for inadequate training at the feet of the tertiary institutions. They have the sometimes odious job of juggling

the disparate expectations of a wide range of interested parties including the individual student, employers, the science and the profession. The Australian Psychological Society has recognised the need for an overhaul of both undergraduate and postgraduate training and is sponsoring widespread discussion of how best this can be achieved (Bulletin of the APS, 1993).

However, concerns about inadequate professional preparation directly impinge on the public image of psychologists. It appears from the results of the present study that the public attitude toward the psychologist is primarily one of the "scientist". This has been borne out by numerous studies that consistently found the psychologist being regarded as of only marginal utility to the community particularly in comparison with other members of the "helping" professions (Sharpley, 1986). The implied criticism in these studies is that psychologists are seen as largely theoretical in their approach and consequently lack pragmatism in helping individuals resolve difficulties. "Counsellors", on the other hand, are viewed as skilful and adept at assisting individuals with problems of everyday living (Clough, 1993).

Watson (1991), in a comment on the status of the scientist versus practitioner debate, makes the salient point that a reciprocal relationship exists between psychologist training and psychologist identity:

" The nature of professional identity needs to be reflected in training content and process. Changes in the training process can be expected to ultimately have effects on professional identity."

(p6)

So is there such a construct as psychologist identity? If so, how can it be defined or is it beyond definition? Attempting to define a description of psychologist identity from a list of basic competencies is not as straightforward as one would surmise. One might imagine that it would be easy to derive a description of psychologist identity from a list of basic competencies which psychologists possess.

In an attempt to do this Hayes (1989) identified a number of skills of both more or less obvious kinds. Her range of skills included literacy, numeracy, interpersonal awareness, environmental awareness, problem-solving, information-finding, critical evaluation, research, management, higher-order analysis and pragmatism. However she concluded that the range of skills acquired would equally as likely be a suitable preparation for a number of other different occupations (e.g. police work, civil service, marketing, retail management) and not merely limited to psychologists.

Thus defining a list of skills offers little consolation for anyone hoping for a definitive picture of a unique psychologist identity. Indeed, Hayes' (1989) observations imply almost the reverse since she noted that students emerged from their undergraduate training with a comprehensive lack of awareness about future careers and only a dim knowledge of the various fields in which psychologists work.

John (1985, 1986, 1988, 1990) has written extensively on the scientist-practitioner model and its connection with psychologist identity from the Australian perspective. John's (1985) analysis suggest that the model was developed not only out of a scholarly desire to give "scientific" stiffness

to professional training but also out of a desire to consolidate and maintain the hegemony of universities and of academic psychology.

It appears from the results of the present study that greater emphasis needs to be placed on training psychologists to become (to invoke an information technology metaphor) more "user friendly". To continue this metaphor this would seem to be to encourage a "hands on" approach by directly "interfacing" with the user. It is one thing to read the computer manual but quite another to put it into practice. All these approaches would lend assistance to defining more clearly the elusive psychologist identity.

#### **9.2.4 Comparing Psychology with Other Professions**

A number of other professions have, in recent times, recognised the need for their members to increase their level of contact with the general public from where their clients are drawn.

Two medical schools in Australia have broken away from the traditional pattern of medical education (Committee of Enquiry into Medical Education and Medical Workforce, 1988). The medical schools of Flinders University in South Australia and Newcastle University in New South Wales have each developed a curriculum of which interaction with the community commencing in the first year of the course is an integral feature of the undergraduate training of their students.

The rationale behind this development was the realisation that medical students completed their six years undergraduate training largely alienated from their patients. A consequence of this was that they were said to lack the ability to communicate effectively with their patients

(Sheldrake, Linke, Mensh, Newble & Rosinski, 1978). It is true they were exposed to patients as part of their training but this was invariably in the hospital setting, invoking the traditional doctor-patient power relationship. The new model of training sought to remove this barrier to effective interaction between practitioner and patient.

In a similar vein the Law Society of New South Wales has also recognised the need for its members who are completing their undergraduate training to acquire practical skills rather than a mere accumulation of theory. In a process somewhat akin to the scientist-practitioner model for psychology, Law faculties have developed a "technician-practitioner" model (McKenzie, Small & Low, 1987). The key feature of this model is that, prior to registration as a legal professional, applicants must now undergo and complete a period (currently 33 weeks) devoted to working in the community in a legal practice.

Likewise one of the concerns expressed by the New South Wales Nurses Association was the lack of "hands-on" experience being obtained by their members during their training as a consequence of the decision during the mid 1980's to "professionalise" nursing by transferring training from hospitals to tertiary institutions. While the new training model contains provision for field placements there have been calls for greatly increased hospital and community-based placements to be incorporated into the undergraduate nursing curriculum (Littlemeyer, 1992). The aim of this strategy is to expose trainees to greater patient contact, again emphasising the importance of the development of practical skills.



Thus many of the professions have recognised the necessity for their members to interact to a greater degree with the public. It is crucial for psychology to recognise these trends and follow this lead by incorporating a component of field placement into the undergraduate training curriculum.

This issue has been taken up by the APS in their review of appropriate undergraduate and postgraduate training for psychologists (Bulletin of the APS, 1993). Franklin (1993) has proposed an integrated national degree structure for psychology training with the major features being a basic four year undergraduate specialist psychology program incorporating two supervised field placements each of four weeks duration, and specialist postgraduate Master's and Doctoral level programs, again with field placements as integral components of these courses.

### **9.2.5 Subspecialties of Psychology**

It has been vigorously argued in recent times that one of the chief reasons underpinning the public's lack of a sufficient grasp of what it is that psychologists do (and thus their "professional" identity) is attributable to the myriad range of "psychologies" that currently proliferate and the consequent confusion experienced by the public over demarcation between the various branches of the "helping professions" i.e. psychologists, psychiatrists, counsellors, psychotherapists, social workers and welfare workers (e.g Wollersheim & Walsh, 1993; Warner & Bradley, 1991; Buie, 1989).

Surveys have indicated that the public is generally aware that medical specialists receive the same core training but to "specialise" they must undergo intensive post-graduate training of some years duration. A

similar perception exists for lawyers who receive the same core training but may then go on to specialise in their particular field of interests in the law such as litigation, conveyancing, commercial, industrial, international or family law, intellectual property etc.

Wearing (1993), in an excellent report of how the public sees psychologists, has argued that the term "psychologist" may be too broad for its referent to be meaningful to the general public. He advocates a position whereby psychologists would be classified on the basis of their Board membership of the Australian Psychological Society i.e. clinical, counselling, educational, forensic, neuropsychological etc. Wearing's (1993) scheme, however, does not take into account those psychologists who have dual Board memberships, those psychologists who are not members of the Australian Psychological Society, or indeed those psychologists who would wish classify themselves as "generalists".

If Wearing's (1993) scheme were to be adopted this would also necessitate educating the consumers of psychological services about the different specialties within psychology so that they could make an informed choice of what "specialist" is applicable to their situation.

As the fields of clinical and counselling psychology (the "helping" specialties) continue to develop the line marking the boundary between these two fields of psychological intervention is becoming progressively more indistinct (Watkins,. 1983, 1985). Rather than being two separate entities one can now conceive of the interrelationship as being akin to two intersecting circles with the area of commonality being increasingly proportionately larger.

A number of empirical papers and commentaries have addressed this issue in the last decade. Osipow, Cohen, Jenkins & Dostal (1979) drawing on clinical and counselling psychologists' self-descriptive listings in the 1975 Directory of the American Psychological Association found that (a) individuals with exclusive Division 17 (Counselling) affiliation described their interest as related primarily to counselling; (b) individuals with exclusive Division(s) 12 (Clinical) and/or 29 (Psychotherapy) affiliations(s) described their interests as primarily linked to therapy and behaviour disorders; and (c) individuals in both Division 17 and Division(s) 12 and/or 29 affiliations were more like the exclusive Division(s) 12 and/or 29 group than the Division 17 group. In a replication of this study, Watkins, Schneider, Cox & Reinberg (1987), using self-descriptive listings from the 1985 APA directory, obtained results that basically were consistent with these findings.

Tipton (1983) examined clinical and counselling psychologists' perceptions about their roles and functions and the areas that they saw as most aligned with their respective specialities. They saw counselling/therapy with normal to moderately disturbed clients, preventive treatment, interest testing, and vocational counselling as most consistent with counselling psychology; they saw counselling/therapy with more disturbed clients, the use of intelligence and projective tests, and writing diagnostic reports as more consistent with clinical psychology. Tipton concluded that the previously identified roles distinguish clinical psychologists from counselling psychologist. Thus the studies of Tipton (1983), Osipow et. al. (1979) and Watkins et. al. (1987) supported a clinical/counselling distinction.

Although clinical and counselling psychologists themselves may view their roles and interests differently (bearing in mind the data cited are based on self-reports), differences in their work functions may be minimal (Watkins, 1984). Rosenfield, Shimberg, & Thorton (1983) reported limited differences in the work behaviours of clinical and counselling psychologists, suggesting that the two specialities were not much different in what they do. On the basis of their occupational analysis, Fitzgerald & Osipow (1986) concluded that

"there appears to be few, if any, empirical bases on which to distinguish counselling psychologists from their colleagues in clinical psychology" (p. 543).

Watkins, Lopez, Campbell & Himmell (1986b) in summarising national survey data (Norcross & Prochaska, 1982a, 1982b, 1982c; Watkins, Lopez, Campbell & Himmell, 1986a, 1986b), reported that both groups (a) primarily provide individual psychotherapy, (b) primarily are practitioners and, (c) increasingly identify with private practice. Watkins et. al. (1986b) concluded that:

"clinical and counselling psychology have become increasingly similar over the years, and trends indicate that further convergences between them can be expected" (p.582).

In accordance with this appraisal, recent observations have suggested four interesting points: (a) counselling psychology has become more clinically orientated over the past decade; (b) counselling psychology may not be a highly distinctive psychological specialty; (c) clinical psychology, while maintaining its clinical/remedial focus, has shown an increased investment in developmental/educational/preventive interventions over the past decade; and (d) clinical and counselling

psychology may now be approaching a juncture at which they may be successfully integrated.

In support of this last point Levy (1984) has proposed the combining of all applied psychological specialities into a distinct field called *human services psychology*. This new field:

"...should be defined so as to include all professional psychological specialities concerned with the promotion of human well-being through the acquisition and application of psychological knowledge concerned with the treatment and prevention of psychological and physical disorders." (p.490).

According to Levy (1984) human services psychology would thus include clinical psychology, counselling psychology, school psychology, community psychology, health psychology and other psychological specialities to which this definition might apply.

The identity of a speciality rests upon a specific body of knowledge and a set of skills based upon that knowledge (American Psychological Association, 1981). At perhaps the grossest level, signs of clinical psychology's uncertain identity may be found in the absence of any operational definition of the essential content and skills that would distinguish it from counselling psychology.

Thus the distinction between clinical and counselling psychology in Australia is equally blurred. For example, most counselling psychologists use clinical psychometric instruments as part of their assessment armamentarium with the imprimatur of the Australian Psychological Society. Psychometric assessment has, traditionally, been the purview of the clinical psychologist and the skill that set him/her apart from his/her

professional colleagues. On the other hand there is overwhelming evidence that clinicians spend a significant amount of their time doing "counselling" (e.g. Byrne & Reinhart, 1990).

This blurred distinction between these two subspecialties is underscored by the fact that the training offered by tertiary institutions in Australia for these "specialisations" is almost identical. Indeed most of the institutions who offer both clinical and counselling programs at Master's degree level have a significant majority of common courses in their respective curricula.

Not even clinical and counselling psychologists themselves can decide what is unique about their respective specialisations. This is underscored in the literature involving studies concerning Australian psychologists. For example in a study asking respondents from the general public to choose a psychologist based on prior knowledge of fee and rebate level, Lowe, Howard & Dawson (1986) did not discern whether the "psychologist" in question was a clinical psychologist, a counselling psychologist or neither. Similarly, in a comprehensive human resources survey of registered psychologists (Thomas & Wearing, 1986), the investigators failed to discern whether respondents were counselling or clinical psychologists or neither. A survey of psychologists in private practice (Over, Parry, Geddes & Leven, 1985) provided an excellent data base but again made no attempt to indicate the specialisation of the psychologist respondents.

The point to be made is that, even when conducting research with and about their own profession, Australian psychologists tend to amalgamate all applied psychologists together into an homogeneous group. Thus there

is no tradition of recognising the differences between clinical, counselling and other psychologists.

In support of this argument, one only has to peruse advertisements for job vacancies in the field of psychology. It is becoming distressingly common for positions to be advertised for Psychologist/Social Worker/Counsellor/Psychiatric Nurse/Welfare Worker. Still others are even more vague in their requirements by offering the position to "Mental Health Worker" or even "Health Professional". Presumably there are a number of abilities that employers require and they do not see psychologists as offering a demonstrably better product.

Clough (1993), in commenting on the requisite knowledge and skills essential for psychologists to be employable, makes the point that:

"In some cases I know that Social Workers, Physiotherapists, Speech Pathologists and TAFE graduates in Social Welfare are preferred to Psychologists because all of those courses offer more in the way of applied skills." (p.43)

The ramifications of this trend are patent. If employers of psychologists are not able to decide what are the unique skills and abilities of psychologists and, thus, their consequent utility, what hope does the general public have of being able to do so.

### **9.2.6 Marketing Psychology and Psychologists**

The present study has particularly significant implications for the "re-education" of the general public concerning psychologists and their work. "Re-education" is proposed as it seems apparent the current educational endeavours have not been successful in achieving their aims.

One is mindful, of course, that in pursuing this endeavour due diligence is taken with respect to the ethical constraints imposed on the "advertising" of psychological services as set out in the Australian Psychological Society Code of Professional Conduct (1986).

Notwithstanding these constraints there has been a groundswell of interest amongst psychologists to improve the marketing of psychologists and their work. Indeed the objectives of the Australian Psychological Society are said to be four-fold: representation of members, promotion of the profession, advancement of the profession through training and research and support of members (APS Annual Report, 1993).

The objectives of Promotion subsume the following:

- to improve the status and recognition of Psychology and Psychologists
- to communicate proactively and reactively with organisations and the media on issues relevant to Psychology
- to increase awareness about Psychology and the services provided by Psychologists among current and potential employers and the community

(APS Annual Report, 1993)

To address these concerns the Australian Psychological Society, in 1992, established a Marketing Committee and charged it with the responsibility of establishing a viable marketing base for the profession (Wearing, 1993).

In order to establish a baseline the Marketing Committee surveyed 400 members of the general public and three "focus groups", consisting of



different users of psychological services: medical practitioners, medium sized employers and human resource management personnel (Wearing, 1993).

Demonstrating remarkable congruence with the findings of the present study the results of this survey were:

1. 50% of respondents would consider using a psychologist, mostly in problem related areas e.g. problems with children, learning difficulties, care of the mentally ill, stress management, counselling and personal problems.
2. However less than 10% would consider contacting a psychologist as a first port of call for assistance with a problem; most said they would first turn to their general medical practitioner
3. Psychologists were regarded as generally valuable to the community but in regard to the general practice component of psychology, the lack of rebates makes them too expensive
4. There was a low awareness of what psychologists do and how they might be accessed.
5. A profound stigma existed in seeing a psychologist ("crazy people see psychologists"); it was suggested by some respondents that psychologists should be labelled differently e.g. as counsellors, to diminish this stigma. Wearing (1993) makes the point that the term "psychologist" is so general that:

"peoples' perceptions of psychology is somewhat akin to a blind man's perception of an elephant. (p.7)"

The present study has shown that if individuals are made aware of psychologists and their work through direct and indirect contact (via the medium of "user friendly" models of service delivery) then they are more

likely to access their services. In light of the findings of present study the suggestions proposed by the APS Marketing Committee (Wearing, 1993) to market psychology more effectively are eminently supportable:

1. Market directly to referral points, such as general practitioners, medical specialists, the legal profession, schools, Government departments, and Police
2. Create a directory of psychologists and their services that would be available to potential consumers such as those listed above. Membership of this directory would need to be carefully scrutinised as willingness to participate should not be the only criterion for inclusion.
3. Raise the public profile of psychology by conducting Psychology Forums on topical issues that are widely publicised and reported in the media (similar to the annual ANZAAS Conference).
4. Prepare information kits for schools to provide resources for teachers, students and parents on the profession of psychology. Become involved in Careers Markets for senior school students to inform of psychology as a worthwhile career.
5. Prepare public information brochures about topics of general interest which can also be included in the local newspaper. The Australian Chiropractors Association and the Australian Physiotherapy Association have both done this with great success. The Australian Pharmaceutical Association has prepared a series of pamphlets on common medical problems which are distributed through pharmacies and public hospitals.
6. Increase the public visibility of psychologists by appropriate media appearances on television and radio.

7. Organise credible spokespersons to comment on a range of topics, this list being made available to media outlets. Such persons should ideally have completed a media presentation course
8. Include a section of the work of the professional psychologist in introductory tertiary psychology classes and/or have practicing psychologists from a range of different fields of endeavour speak to students. Extending this notion, practicing psychologists could lecture courses in tertiary institutions. This is akin to what currently happens in medical and legal tertiary courses.

Significantly the present study has shown that the attitude towards psychologists is largely a problem of "confidence" while most marketing strategies have been aiming more at improving the general public's "knowledge" of psychological services. Yet the present study has shown the "knowledge" subscale to be the least sensitive when attitudes towards psychologists changed for all participating organisations and both sexes, indicating that while individuals may well have some limited knowledge about psychologists and their work what they need to gain is confidence in the profession.

The proposals of the APS Marketing Committee, at this point in time, concentrate on the dissemination of knowledge about the profession. The only way that the profession can influence peoples' confidence in them is by direct contact.

Psychologists also need to make more effective use of the mass media. Wearing (1993) acknowledges that access by the media to psychologists should be appropriate:

"Psychologists should have a presence in the discussions of the important and the normal, and not be marginalised by being seen as concerned only with the rare and freakish. (p.7)"

While media coverage of psychological matters has improved dramatically in recent times due largely to the initiatives developed by the APS, it is important for the profession to continue to press for appropriate public exposure of psychologists and their work.

The initiatives of the Marketing Committee are commendable. They have recommended the establishment of a Marketing Plan Committee to oversee the development of a Marketing Plan. This decision represents a giant step forward in the effective promotion of the profession.

### **9.2.7 Helpseeking**

A number of factors have been posited to account for the reluctance of individuals to seek psychological help when experiencing a problem. Among these factors are difficulty in identifying that a problem exists (Golan, 1969; Moore, Boling & Brown, 1963; Snyder & Katane, 1985), monetary costs and allocating time (Acosta, 1980), perceived incompetence of the help source (Gurin, Veroff & Field, 1960; Mayer & Timms, 1970; Mechanic, 1976), inability or unavailability of help source (Mechanic, 1976) and treatment fearfulness (Kushner & Sher, 1991).

The present study was designed to address some of these obstacles to seeking psychological help by providing a milieu conducive to encouraging individuals to seek help. This was achieved through the utilisation of the Employee Assistance Program model of service delivery. The EAP model provides for confidential, free and voluntary counselling provided during work time and on work premises (if the

client wishes) or, more usually, off-site. These features have been found to be persuasive to individuals seeking psychological assistance through the EAP as referral rates to EAPs in general are greater than the rate of helpseeking found for the general community (Highley, 1993).

It was stated earlier that attitude change is a significant hurdle related to the early stages of the helpseeking process. In the five-stage model designed to elucidate the pathway to seeking psychological help (Fischer, Weiner & Abramowitz, 1983) presented in Chapter 3 it could be argued that the impact of attitude change would have a significant effect at the level of Stage 2 - Contemplating Ways of Helping Oneself. At this stage of the decision-making process the model hypothesises that the individual who is experiencing a problem is weighing up options that range from taking no action, taking self-corrective action, looking to others for informal assistance or seeking professional assistance.

In the present study it has been demonstrated that if an individual has developed a positive attitude toward psychologists then he/she is more likely to seek psychological help when the need arises, all other factors being equal. In light of the results of the study this may be even further refined by saying that if an individual has *confidence* in psychologists and their work they are, per se, more likely to be motivated to consider them as a viable option as a help source.

The effect of the observed attitude change was clearly reflected in the rate of subsequent referral to the EAPs in the three organisations. Ss from Department A in each of the three organisations utilised the counselling provided by the EAP to a significantly higher extent than those in

Department B, irrespective of the sex of the S or the psychologist "group" from which they came.

Further in Stage 3 of the helpseeking model - the Decision to Seek or Accept Help - it is hypothesised that the individual has, by this stage, formed an intention with respect to seeking professional help and is now confronted with the implications of that decision. The present study indicates that, for those individuals who have developed a positive attitude toward psychologists, several barriers to seeking or accepting help have been removed. Fischer, Nadler & Abramowitz (1983) identify these barriers as (i) therapist or agency factors, (ii) social factors and (iii) personal factors.

Therapist or agency factors include monetary cost, the quality of help available, the perceived competence of the therapist and the individual's attitude towards, and knowledge of, the therapist. The present study has shown that, by being accessible to his/her target population the psychologist can address these concerns through direct and/or indirect contact and permit the individual to make this decision to seek help on a more informed basis.

Social factors are said to include embarrassment and stigma about seeking help and the perception of significant others if they discover the individual is seeking help. The present study directly addresses the stigma and embarrassment attached to helpseeking by emphasising the confidentiality aspect of counselling, that no one need know the individual has sought counselling and that the counselling is available away from the workplace thus minimising the chances that anyone else will know.

This sensitivity to social barriers is revealed in the results of the Stigma Tolerance subscale scores for those Ss who sought help through the EAP. There was a significant improvement in Stigma Tolerance scores for Ss in this group.

Personal factors include the intensity and duration of the problem or symptoms, feelings of loss of self-reliance, dependency on, and indebtedness to, the helper, and an enduring belief that a person who solves his/her own problems is more worthy. By providing psychological support through the Employee Assistance Program model, counselling is actively promoted as just another in a range of employee benefits provided by participating organisations for the benefit of their employees. In briefings given to all employees about the EAP, the provision of a counselling service was linked with company-sponsored superannuation, leave entitlements and health cover as another example of a company benefit.

In adopting this approach the person who decides to access counselling does not need to feel overly indebted to an individual (the psychologist) for the provision of assistance thus serving to minimise feelings of obligation.

The present study allows for a modified model of psychological helpseeking to be proposed (see Figure 9.1).

In this modified model it is proposed that a series of intermediate steps can be interpolated into the existing model proposed by Fisher, Nadler & Abramowitz (1983). After Stage 2 it is proposed that individuals





undertake a process of evaluation of the efficacy of psychologists and psychological services mediated by their attitude toward psychologists. If this perception is positive then they decide to seek or accept psychological help (Stage 3). However if this perception is negative then the individual may decide to seek other forms of help (e.g. informal, nonprofessional or self help) or, indeed, decide to do nothing further to resolve their problem.

Furthermore, if the individual decides to seek help (Stage 3) and then proceeds on to actively obtaining this help (Stage 4), before this can occur an appropriate source of help must be available to them. Criteria contingent on this decision would include the ready availability of help, monetary cost involved, confidence in the help provider and confidentiality of the assistance. The present study has shown that these criteria are met by an effective Employee Assistance Program.

If these criteria are met then the individual proceeds on to receive psychological help. If these criteria are not fulfilled the individual may decide again to seek other forms of help or do nothing further to resolve their problem.

Thus the present study has enabled the expansion of the helpseeking model to accommodate factors relevant to the individual's attitude towards psychologists and their work.

### **9.3 Refinements in Study Design**

While the present study has proved to be very successful in achieving its desired aim of determining whether the public attitude towards psychologists can be positively influenced there are several refinements

that could be proposed to improve the design of the present study and the efficacy of the outcome.

### *1. Random Allocation of Ss to Departments*

As mentioned previously an improvement would be to use a process of random allocation to assign Ss to the experimental and control groups. This was not possible in the present study because a higher priority was considered to be the physical separation of the two groups to control for "leakage" from one to the other. However random allocation of Ss would add to the validity of the design.

### *2. Timing of Strategic Interventions*

A further improvement would be to implement the strategic interventions at specified times during the period of the study i.e. either between T1 and T2 or T2 and T3, and measure attitude fluctuations using POPS after each time period or combination of time periods. In this way one may ascertain whether any one particular intervention or combination of interventions is differentially responsible for observed changes in attitude.

### *3. Assessing Department B Participants*

Subjecting participants in Department B of each of the three organisations to the regime of interventions given to Department A Ss would enhance study validity. Thus results of Department B Ss could be compared directly with those from Department A. If the study is properly controlled the results should be largely similar.

#### *4. Assessment of Ss Who Utilise EAP Counselling*

It would be advantageous to be able to match those Ss who seek counselling assistance through the EAP with their particular POPS scores over the three time periods by gaining the S' identification number when they present for counselling. In this way a direct comparison could be made between attitude change and consequent behavioural intention. Initially it was planned to do this but concerns were raised about confidentiality and privacy and this strategy was abandoned. However, it is now believed that these concerns were largely unfounded and that Ss would be willing to disclose their identification numbers for the purposes of research.

### **9.4 Suggestions for Future Studies**

The present study has clearly established that it is possible to positively influence the attitude towards psychologists. While the present study has been successful in fulfilling its aims it is now in a position to act as the basis for further investigations that would extend and/or refine the present findings.

#### *1. Consolidating the Validity and Reliability of POPS*

While POPS has been shown to be effective in tapping the construct of the public attitude towards psychologists in the present study it needs to be exposed to further research applications to enhance its validity and reliability as a robust and effective assessment instrument.

Improving the validity of a self-report attitude measure such as POPS is particularly important, given the subjective nature of the instrument. There are several ways in which may be achieved. Further psychometric

approaches such as test-retest, split-half, and internal consistency may, and should, be pursued.

Another validation measure, and one that could be employed in the present study, is to correlate the attitude measure with measures of overt behaviour such as self-referral to the EAP.

A further alternative to validating self-report attitude measures proposed by Friedrich & Verive (1991) is based on an information-processing approach to understanding attitude formation and change, highlighting the expected correspondence between peoples' evaluation of objects of thought (e.g. attitude towards an object or issue) and the kinds of information (e.g. arguments) regarding the object or issue that they store and retrieve from memory.

To this end Friedrich & Verive (1991) focus on the explicit link the Elaboration Likelihood Model of persuasion (Petty & Cacioppo, 1986) draws between attitudes and the elaboration of cognitive content (see Chapter 4). Essentially, Friedrich & Verive (1991) propose that valid attitude measures would be expected to correlate appropriately with measures of cognitive content, such as arguments people generate or retrieve from memory when asked to think about an attitude issue. They assert that such attitude-argument consistency would support claims of validity for self-report measures of attitudes.

Friedrich & Verive (1991) propose a three stage process to validate self-report attitude measures:

1. Ss complete the self-report attitude scale.

2. At the same testing session Ss are asked to rate, using an appropriate scale, the importance of the attitude to them
3. At a subsequent testing session Ss are asked to generate a list of arguments that occurred to them - both pro and con- as they thought about each attitude issue.

These authors argue that if the self-report measure is indeed a valid measure of the target attitude then scores on the measure should be related to the proportion of attitude-consistent arguments respondents generate thus demonstrating the existence of convergent validity. Further discriminant validity can be demonstrated if the attitude measure did not correlate with the argument criteria for unrelated issues and that the argument criteria were themselves uncorrelated with each other. This procedure could readily be superimposed on POPS.

### *2. Employing POPS as a Screening Instrument*

A further study would be to assess Ss who present themselves for counselling using POPS. At the completion of their counselling these Ss could be assessed once again using POPS. By comparing pre- and post-counselling scores one could make certain statements about the direction of the connection between attitudes and behaviours. If the POPS scores show an increase one might be in a strong position to make a case for behaviour influencing attitudes.

### *3. Investigating Male Ss' Rate of Improvement*

A further study would be to ascertain what specific factors are responsible for males' observed greater rate of improvement in attitudes towards psychologists. Allied to this research generally supports the contention that males are underrepresented in counselling statistics. The

present study has shown, however that males accessed the counselling provided under the EAP at the same rate as did female Ss.

#### *4. Targeting Major Referral Agents*

An additional study would be to target key referral agents or groups and assess their attitudes towards psychologists using POPS. Typical groups may include medical practitioners, school personnel, legal practitioners, police officers, human resource personnel and the media. If it is discovered that the attitudes of these groups are not positive this may indicate they may be likely candidates for an education program provided by psychologists.

#### *5. Employing Other Assessment Instruments*

In further studies one could include a range of other assessment instruments to detect the impact of the intervention package and correlate these with changes in POPS scores. Such instruments might include

- Rotter's (1966) *Locus of Control* to indicate whether changes in attitudes to psychologists are correlated with an internal or external locus of control,
- a measure of occupational stress such as the *Occupational Stress Indicator* (Cooper, Sloan & Williams, 1988), to assess the impact of the stress management program and the implementation of the EAP
- the *Work Environment Scale* (Insel & Moos, 1974) to assess the impact of the EAP on Ss perceptions of their work environment.

#### *6. Targeting Confidence in Psychologists*

Following the finding that it was the Confidence subscale of POPS that was found to change the most during the present study, a further study

may focus on implementing strategies specifically aimed at improving the "confidence" that individuals have in psychologists and their work.

### *7. Using Other Target Populations*

Further studies could use a range of different work organisations to ascertain whether the intervention package combined with the implementation of an EAP is successful in a wider range of populations.

### *8. Cultural Influences*

It is known that different cultures respond differently when surveyed about psychological helpseeking behaviour. A further study could assess a range of cultures to compare the effectiveness of this intervention package on their attitude towards psychologists.

## **9.5 Recommendations Arising From the Present Study**

The following are a series of recommendations made in light of the findings of the present study.

Recommendation 1. *That the profession focus attention on developing new models of service delivery which foster greater contact between psychologists and their clients.*

The contemporary notion of sitting in an office and waiting for clients to come through the door fails to recognise that this does not encourage individuals who are in need of psychological help to seek out that help. The present study has highlighted this notion is proposing significant modifications to the current model of psychological helpseeking.

Recommendation 2. *That the profession needs to carefully consider the Employee Assistance Program as a viable and effective model of service delivery and use its influence to support the introduction of Employee Assistance Programs into Australian business.*

The present study has shown the efficacy of the EAP as a model that encourages the individual to access psychological services at a much greater rate than for the general public at large.

Recommendation 3. *That the profession consider redirecting its energies away from gaining Medicare acceptance and more towards the establishment of EAPs.*

It is becoming increasingly clear that successive Federal Governments of both persuasions are committed to "winding back" universal health schemes such as Medicare. In addition there is little doubt that society is moving towards a "user pays" philosophy particularly in areas of Government expenditure. If the costs of psychological assistance present a barrier to the average client then a scheme such as the EAP which allows individuals to access psychological assistance at no cost to the individual should be promoted.

Recommendation 4. *That the profession and its elected representatives recognise the value of marketing as an effective way of promoting the profession to its clientele.*

The present study has been shown that individuals are prepared to re-evaluate their attitude towards psychologists if given the appropriate opportunity to do so. This marketing should conform with the ethics of the profession and ideally should originate under the auspices of the APS.



Recommendation 5. *That any marketing strategy aimed at changing people's attitudes towards psychologists concentrate on the "central route to persuasion" as proposed by the Elaboration Likelihood Model.*

As shown in the present study the central route to persuasion is more enduring than the peripheral route, and is thus likely to produce longer lasting attitude change.

Recommendation 6. *That marketing strategies pay particular attention to tapping male attitudes.*

The present study has shown that, contrary to general expectations, males are willing to seek psychological assistance if given the appropriate opportunities to do so.

Recommendation 7 *That marketing strategies focus on engendering confidence in members of the public towards psychologists.*

The present study has demonstrated that the subscale that showed the greatest rate of change irrespective of sex of respondent or organisation was confidence. While knowledge about psychological services is important individuals need to feel that they can have confidence in psychologists.

Recommendation 8. *That undergraduate and postgraduate training needs be redesigned so as to equip new and existing psychologists with appropriate skills to deliver their services.*

It is acknowledged that this process is already somewhat in hand, albeit in the early stages. Areas of concern include the scientist-practitioner

model of training, universality of training across Australian tertiary institutions, length of training programs, nature of courses offered, qualifications awarded, provision of professional supervision, and utilisation of practicing psychologists as instructors.

Recommendation 9. *That the profession learn from the experiences of other professions the crucial importance of practical training, preferably in a work environment, as an essential component of both undergraduate and postgraduate training.*

Law, nursing and medicine have all recognised the folly of focusing only on theoretical preparation in their tertiary programs.

Recommendation 10. *That attention needs to be paid to the proliferation of finely modified specialties in the profession.*

This situation has led to confusion in the general public and artificial demarcation between the specialties. This situation, in turn, leads to fragmentation of an already complex field of human endeavour which cuts across specialty "boundaries". It also exposes a relatively small and powerless profession such as psychology to being overwhelmed by other professions encroaching on its areas of expertise if it further divides its strength.

Recommendation 11. *That key referral agents and groups be specifically targeted for assessment of their attitude towards psychologists using POPS as the assessment instrument (subject to further confirming validation and reliability studies)*

As these groups are the initial points of contact for potential clients it is important that they are supportive of the advantages of seeking psychological assistance.

Recommendation 12. *That POPS be used as an assessment instrument to enhance therapeutic effectiveness and success (subject to further confirming validation and reliability studies)*

If the therapist is aware that his/her client holds an impaired attitude towards psychologists as measured by POPS this may be addressed prior to the commencement of therapy.

## **9.6 Conclusion**

In summary, the present study has shown that it is possible to positively change the public attitude towards psychologists. Additionally the present study emphasises how important it is for psychologists to realise that they are, largely, the masters of their own destiny. If psychology is to continue as a strong, vigorous and viable force in the twenty-first century then psychologists need to recognise that the profession must adapt so as to meet the needs of its clientele.



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## **APPENDICES**

## APPENDIX 1

## PSYCHOLOGISTS

What do they do?

How can they help?

**Psychologists contribute in many ways**

Because their work covers such a wide range of areas, psychologists specialise. This ensures that a high quality service is offered:

**Organisational Psychologists** work towards the more effective functioning of organisations (public, commercial and industrial) and the people in them. This field includes psychologists working in personnel management and management consulting. Some of their activities in these fields include job analyses, organisational structure evaluation and re-design, selection, training and development of employees, and program evaluation.

**Community Psychologists** develop and evaluate community based programs which address community issues eg drug rehabilitation, parent education, vandalism and women's refuges.

**Clinical Neuropsychologists** assist in the diagnosis and rehabilitation of people affected by brain dysfunctions.

**Counselling Psychologists** help adults, children and families to explore and resolve problems in everyday living.

**Clinical Psychologists** specialise in the prevention, diagnosis or treatment of serious individual and family problems, to help people use their existing resources as effectively as possible.

**Educational Psychologists** help teachers, parents and students to maximise learning within their school community.

**Vocational Psychologists** help adults and teenagers in their choice of career and to plan changes in career.

**Industrial Psychologists** work in consumer research, advertising and marketing fields and also engineering fields where they help design roads, equipment and work areas to suit people.

**Sports Psychologists** help amateur and professional sportspeople maximise their performance.

**Media Psychologists** appear on radio, TV and the press, to popularise and take the mystery out of psychology. They also advise scriptwriters and producers on psychological matters.

**Occupational Psychologist** is a term that includes Organisational, Vocational and Industrial Psychologists.

**Psychologists also teach and undertake research in universities, colleges and teacher training institutes.**

Your local psychologist:

**The Australian Psychological Society**

National Science Centre  
191 Royal Parade  
Parkville Victoria 3052  
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\*222933# Viatel

WITH THE COMPLIMENTS OF:

THE AUSTRALIAN PSYCHOLOGICAL  
SOCIETY

### ***Psychology is a Science***

Psychologists as part of their training at university or college study people and their behaviour. They study how people:

- Develop and grow throughout their lives
- Behave in groups, organisations and communities
- See, think, hear, feel, learn and remember
- Relate and interact with partners, children and friends
- Behave at work and leisure
- Cope with anxiety, aging, depression and disability
- Respond to unemployment, death, divorce, handicap, fire, accident and other losses in their life.

Psychologists can assist you at many points and in many aspects of your life.

### ***"But I'm not crazy!"***

Psychologists' major contribution is to help people function better, whatever their life or work situation may be, and to prevent health and other problems developing.

We all experience life's difficulties and at times can benefit from the counsel of a trained psychologist. You may be surprised to learn that most people who visit psychologists are well-adjusted people experiencing stress in their lives. Psychologists help you discover and use your own resources to solve problems of everyday living.

### ***Are Psychologists and Psychiatrists different?***

Yes, psychologists are not medical practitioners and do not prescribe drugs.

### ***When should I visit a Psychologist?***

People visit a psychologist when they are planning their lives or experiencing emotional distress. There are many different reasons:

Marital and family problems, stress and tension, anxiety and panic attacks, depression, unresolved grief, sexual difficulties, fears and phobias, shyness, pain, eating and weight control problems, children's behaviour and management problems, when persons fail to come to terms with divorce or handicap, hypertension, migraines and headaches, intellectual handicap, child bed wetting and tantrums, relationship problems and addiction are some of the reasons people see psychologists.

People also visit psychologists when they have no troubles:

To make good relationships better, become better parents, personal growth, career planning, to improve sports performance and other areas where they can achieve more of their potential.

Psychologists specialise in different areas. These areas are listed in this pamphlet.

### ***How do Psychologists help?***

They help clients understand and take action to improve and enhance their lifestyle. They choose from the many available treatments the one that best suits the individual's needs, personality and circumstances. Psychologists understand the developmental and adjustment processes that clients need to go through to come to terms with their life.

Most psychologists use observations, interviews and tests to clearly identify the nature and extent of problems, and to decide upon the best form of assistance. Psychologists then assist clients, children, and families through advice, counselling and training.

### ***For how long do clients see a Psychologist?***

Some clients believe they will see immediate results. While many people can be helped with only a few visits, some problems require more extensive assistance. For example, it may be necessary to attend for one hour per week over a period of five to ten weeks, or longer.

Treatment is not an easy process, because we all find it difficult to work through emotionally painful issues and change old habits. Once we have done this, the benefits are worthwhile and long lasting.

### ***Confidentiality***

Psychologists follow strict ethical guidelines regarding client confidentiality. These are set out and supervised by the Australian Psychological Society.

### ***Cost of Service to the Public***

Most government operated psychological services are free because they are funded or subsidised by State and Federal Governments.

Private practitioner psychologists set their own fees. Hence, there can be small variations in fees from psychologist to psychologist.

Most private health insurance funds offer partial rebates of fees. To be eligible, you need to be covered by ancillary benefits insurance (extras table) and the psychologist needs

to be approved by the health insurance fund. Some insurance funds require a medical referral. It is quite easy for you to check by telephone with your fund regarding these matters prior to making an appointment.

### ***How do I find a Psychologist?***

Under PSYCHOLOGIST in the yellow pages; through a government department or private agency concerned with health, education, or social and community services; or by contacting the local Branch of the Australian Psychological Society, or through your private health insurance fund.

Most people come directly to psychologists or are referred by their medical practitioner. Some attend on the advice of teachers, social workers or friends.

### ***What is the Australian Psychological Society?***

The Australian Psychological Society is the national body through which the interests of both the science and profession of psychology are represented. It is the main organisation to which psychologists in Australia belong and has 4,500 members. Fully qualified members have the initials M.A.Ps.S. or F.A.Ps.S. after their name.

### ***Why does the APS exist?***

The purpose of APS is to advance psychology as a science, as a profession, and as a means of promoting human welfare by encouraging the practice of psychology in all its facets.

APS programs include disseminating psychological knowledge, promoting research, improving research methods and conditions, and developing the qualifications and competence of psychologists through standards of education, ethical conduct, and professional practice.

### ***Training of Psychologists***

The minimum period is six years: four years tertiary training in psychology followed by two years in which the psychologist's work is supervised by a qualified and experienced psychologist. The training of most specialist psychologists (eg clinical, counselling and neuropsychology) ranges over 7 to 8 years: six years tertiary training followed by one to two years supervised experience.

### ***Registration of Psychologists***

In most States, there is a legal requirement for psychologists to register in the same way that medical practitioners and solicitors do. For information, or to register a complaint, contact your State or Territory Registration Board.

### Psychologists contribute in many ways

Because their work covers such a wide range of areas, psychologists specialise. This ensures that a high quality service is offered.

- **Academic Psychologists** conduct research and teach in universities, colleges and teacher training institutes.
- **Clinical Psychologists** specialise in the prevention, diagnosis or treatment of serious individual and family problems, to help people use their existing resources as effectively as possible.
- **Clinical Neuropsychologists** specialise in the diagnosis and rehabilitation of people with known or suspected brain damage, assessing the effects this damage may have on mental abilities, emotions, behaviour and personality.
- **Community Psychologists** assist people to achieve their goals in areas such as health, welfare and community projects. They also research and evaluate such programs and share the information for the benefit of the relevant communities.
- **Counselling Psychologists** provide diagnosis and assessment, short and longterm counselling and therapy, to individuals, couples, families, groups and organisations. They deal with such issues as: stress in daily living, relationship issues, educational achievement, career development and rehabilitation.
- **Educational Psychologists** provide personal, educational, social and vocational assistance to students, parents and teachers in all educational settings and in the community.
- **Forensic Psychologists** research or work professionally in settings associated with the legal process, and correctional services. They usually have a clinical orientation and may assist in child and family welfare as well as criminal matters.
- **Organisational Psychologists** specialise in the areas of work adjustment, human resource management, organisation design and development, training, management effectiveness, industrial relations, technological change and the organisation-environment interface.
- **Rehabilitation Psychologists** assist people to speedily recover and resume productive lives after injury, illness and trauma.
- **Sports Psychologists** help amateur and professional sportspeople to maximise their performance.
- **Some psychologists work in consumer research, advertising and marketing fields, and also engineering fields where they help design road systems, equipment and work areas to suit people.**

The Australian Psychological Society is the national body through which the interests of both the science and profession of psychology are represented. It is the main organisation to which psychologists in Australia belong and has 5,000 members. Fully qualified members have the right to use the initials M.A.Ps.S. and F.A.Ps.S. after their name. If uncertain, members of the public can contact the Society as to whether a psychologist is a member of the Society.

The purpose of the APS is to advance psychology as a science, as a profession and as a means of promoting human welfare, by encouraging the practice of psychology in all its facets and to the highest standards.

Your local psychologist

# What do they do? How can they help?

The Australian Psychological Society

National Science Centre

191 Royal Parade

Parkville Victoria 3062

(03) 347 2622

(008) 33 3497 Toll Free

Fax: 347 4811

VIA TEL \*7079 #

**APS**  
THE  
AUSTRALIAN  
PSYCHOLOGICAL  
SOCIETY

**APS**  
THE  
AUSTRALIAN  
PSYCHOLOGICAL  
SOCIETY



### Psychology is a Science

Psychologists as part of their training at university or college study people and their behaviour. They study how people:

- Develop and grow throughout their lives.
- Behave in groups, organisations and communities.
- See, think, hear, feel, learn and remember.
- Relate and interact with spouses, children and friends.
- Behave at work, leisure and school.
- Cope with anxiety, aging, depression and disability.
- Respond to unemployment, death, divorce, disability, disaster, accidents and other losses in their life.

Psychologists can assist you at many points and in many aspects of your life.

### "But I'm not crazy!"

Psychologists' major contribution is to help people function better, whatever their life or work situation may be, and to prevent ill-health and other problems developing.

We all experience life's difficulties and at times can benefit from the counsel of a trained psychologist. You may be surprised to learn that most people who visit psychologists are well adjusted people experiencing stress in their lives or seeking help with difficult decisions.

Psychologists help you discover and use your own resources to solve problems of everyday living.

### Are Psychologists and Psychiatrists different?

Yes, psychologists are not medical practitioners and do not prescribe drugs.

Psychologists are experts in human behaviour and apply their expertise to a broad range of issues and clients. Their clients include children, couples, families, organisations and communities.

### When should I consult a Psychologist?

People consult a psychologist for many reasons.

Marital and family problems, stress and tension, anxiety and panic attacks, depression, unresolved grief, sexual and sleeping difficulties, fears and phobias, shyness, pain, eating and weight control problems, children's learning behaviour and management problems, when persons fail to come to terms with divorce or handicap, hypertension, migraines and headaches, intellectual handicap, child bed wetting and tantrums, relationship problems and addiction are some of the reasons people see psychologists.

People also consult psychologists when they are planning to enhance their lives.

To make good relationships better, become better parents, better teachers, to make better workplaces, for personal growth, and career planning, to improve sports performance and other areas where they can achieve more of their potential. Organisations also consult psychologists.

To train and develop staff, improve selection, to review organisational structure and practices, to advise on effective management of change and innovation, to improve industrial relations and occupational health and safety, to evaluate programs and to study consumer needs.

Psychologists specialise in different areas. These areas are listed in this pamphlet.

### How do Psychologists help?

They help clients understand and take action to improve and enrich their lifestyle and effectiveness. They choose from many available treatments the one that best suits the client's needs, personality and circumstances. Psychologists understand the developmental and adjustment processes associated with change.

Most psychologists use observation, interviews and tests to clearly identify the nature and extent of problems, and to decide upon the best form of assistance. They then assist adults, children, families, organisations and communities through advice, counselling, consultation, therapy or training.

### For how long do clients see a Psychologist?

Some clients who attend for counselling or therapy believe they will see immediate results. While many people can be helped with only a few visits, some problems require more extensive assistance. For example, it may be necessary to attend for one hour per week over a period of five to ten weeks, or longer.

Psychological tests require at least one to two hours to administer, score and interpret. Testing may require several attendances.

In other settings such as organisations and communities, clients and consulting psychologists decide upon the extent and duration of the psychologist's involvement after discussion.

### Confidentiality

Psychologists follow strict ethical guidelines regarding client confidentiality. These are set out and supervised by the Australian Psychological Society.

### Cost of Service to the Public

Most Government operated or funded psychological services are usually free.

Private practitioners charge fees. The Australian Psychological Society reviews its recommended fee annually. There can be small variations in the fees charged by different psychologists.

Many private health insurance funds offer partial rebates of these fees. To be eligible, you need to be covered by ancillary benefits insurance (extras table) and the psychologist needs to be approved by the health insurance fund. Some health funds require a medical referral. It is quite easy for you to check by telephone with your fund regarding these matters prior to making an appointment.

### How do I find a Psychologist?

Under PSYCHOLOGIST in the yellow pages; through a Government department or private agency concerned with health, education or social and community services; by contacting the local Branch of the Australian Psychological Society, or through your private health insurance fund.

Some people come directly to psychologists or are referred by their medical practitioner. Some attend on the advice of teachers, social workers, parents or friends.

### Training of Psychologists

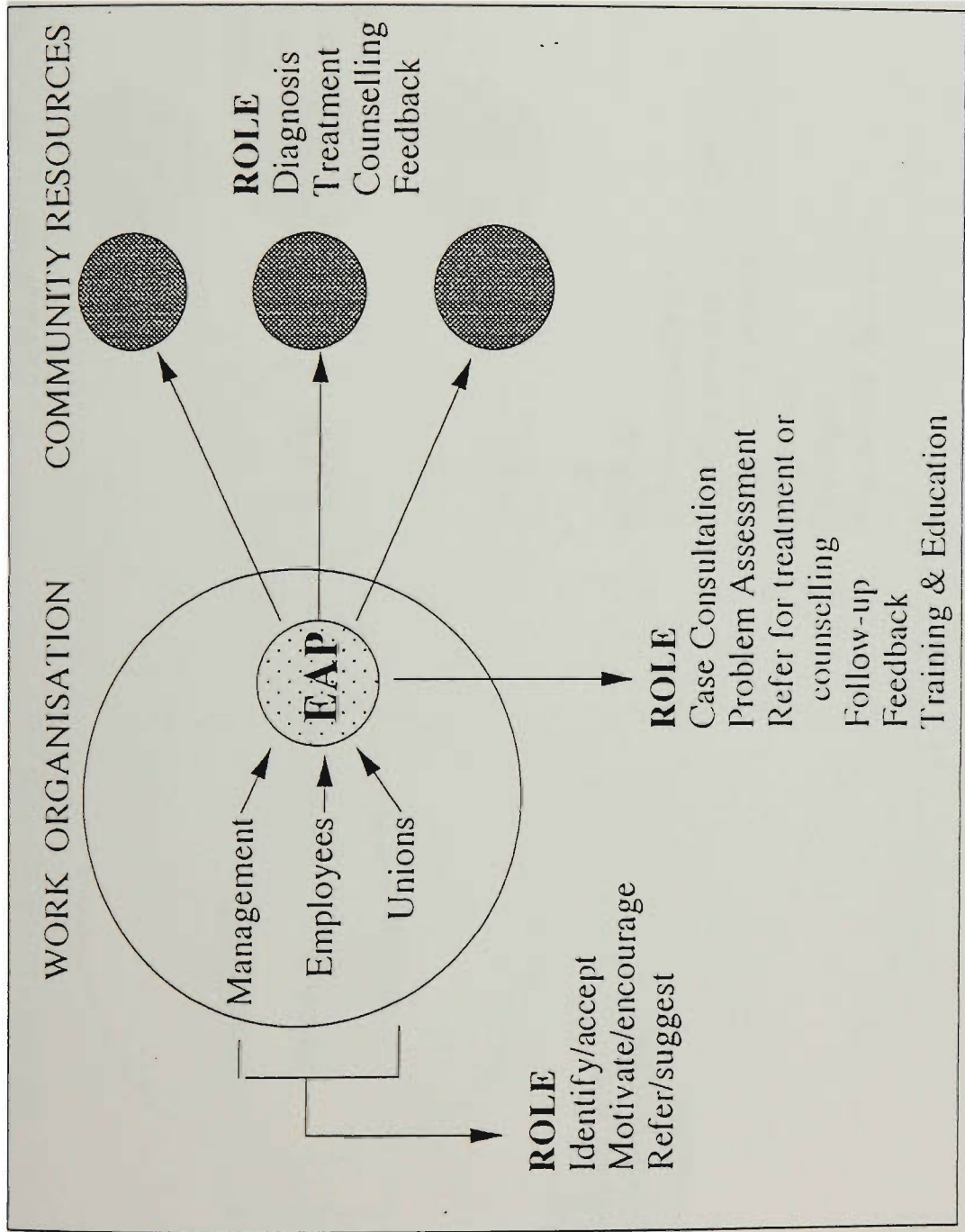
The minimum period for basic training is six years: four years tertiary training in psychology followed by two years in which the psychologist's work is supervised by a qualified and experienced psychologist. Many psychologists have additional training. Specialists undertake specific post-graduate training and supervision within the particular area of specialisation.

### Registration of Psychologists

In most States, there is a legal requirement for psychologists to register in the same way that medical practitioners and solicitors do. For information, or to register a complaint, contact your State or Territory Registration Board.

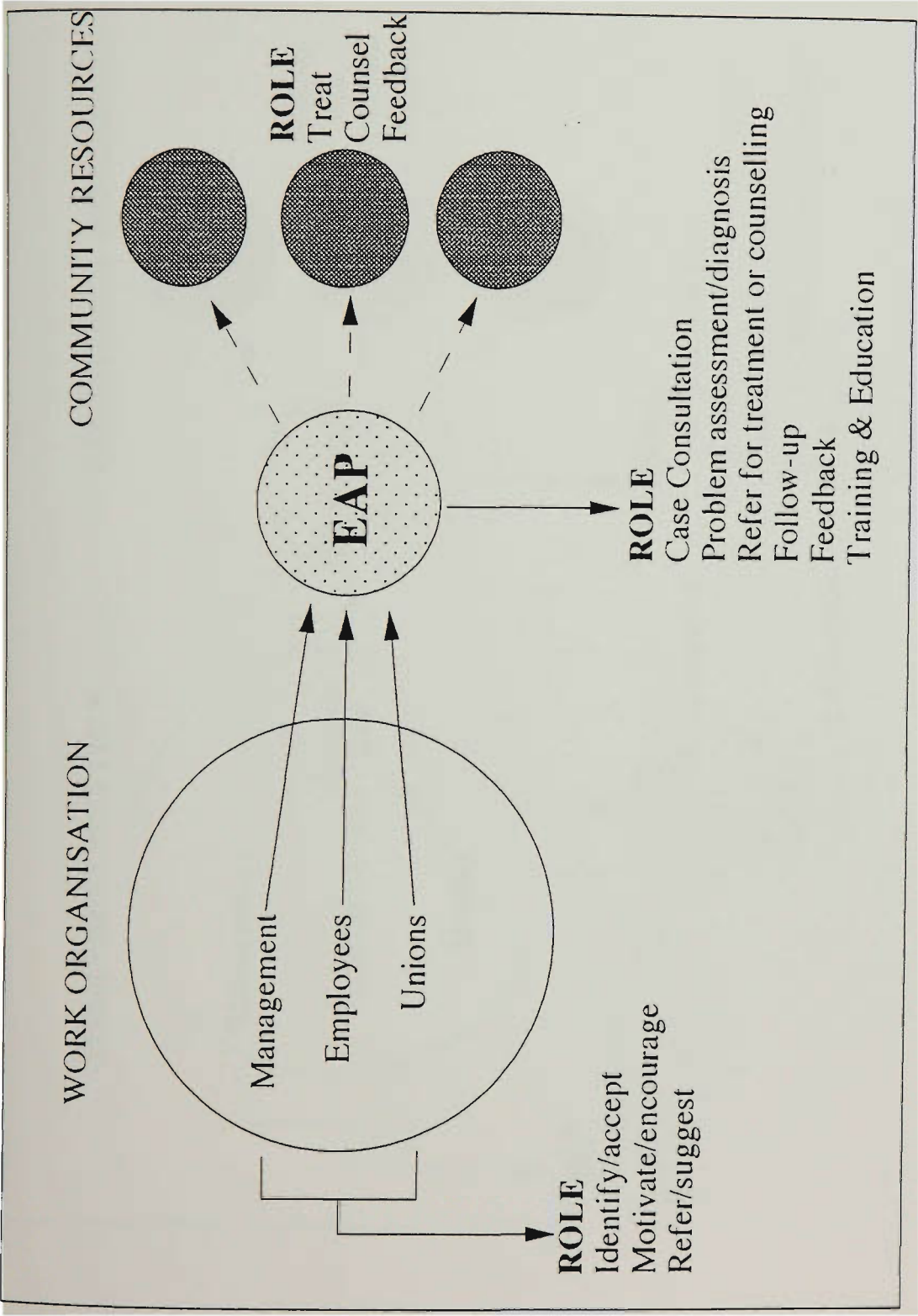
APPENDIX 2.1

INTERNAL MODEL



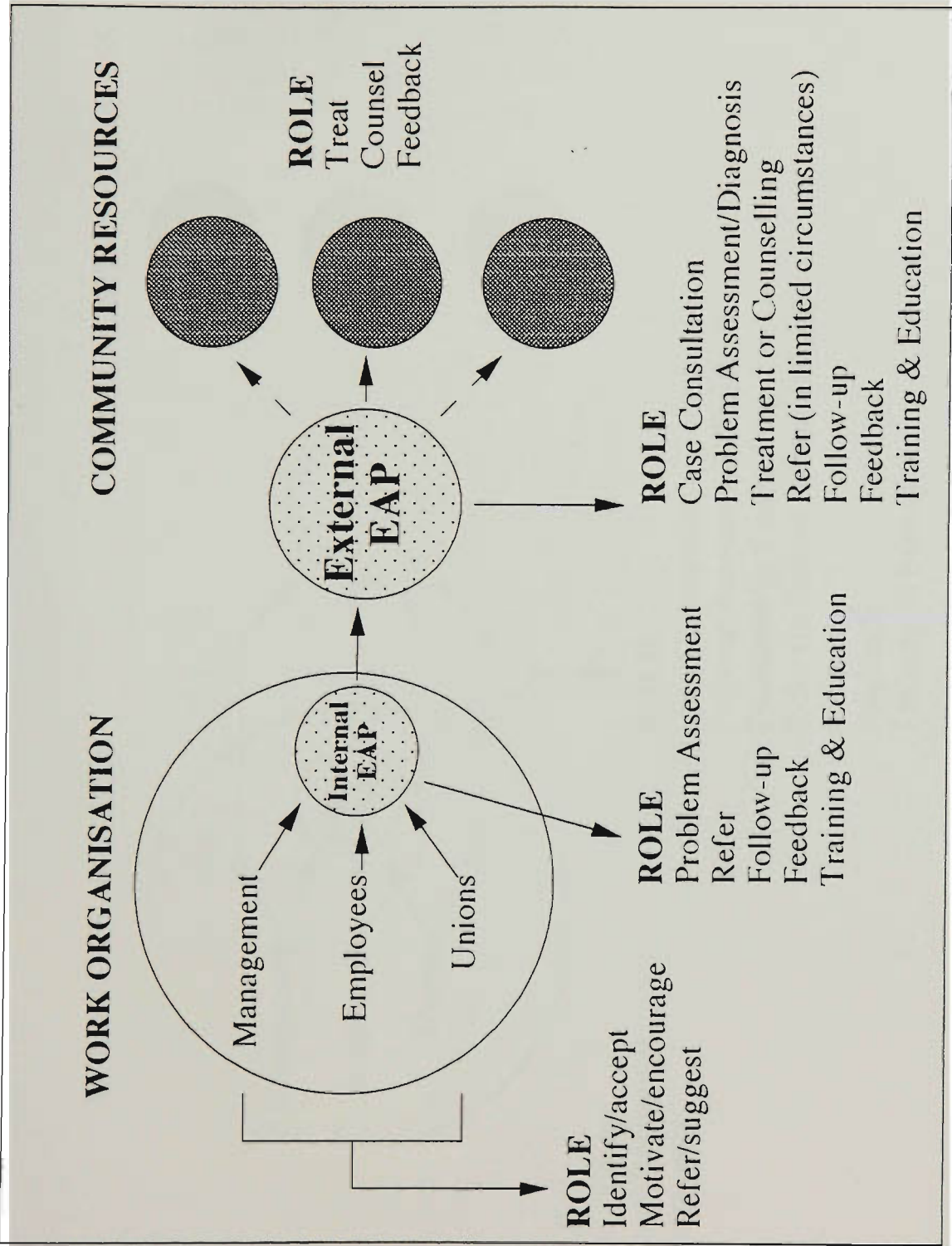
APPENDIX 2.2

| SERVICE CENTRE MODEL |



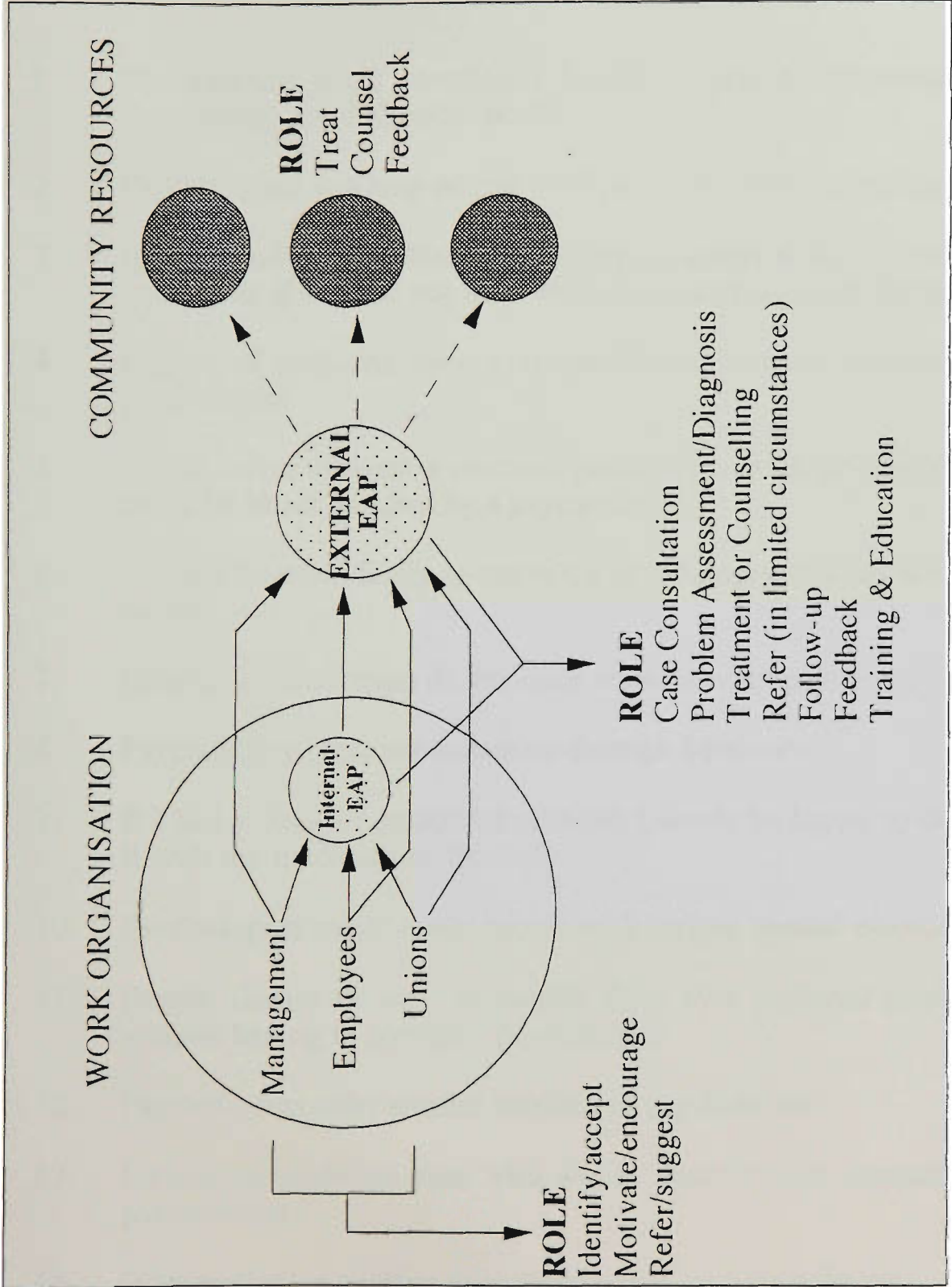
APPENDIX 2.3

COMPREHENSIVE MODEL



APPENDIX 2.4

ENHANCED MODEL



## APPENDIX 3.1

### ORIGINAL ITEM POOL

1. Maintaining good emotional health is just as important as maintaining good physical health
2. Psychologists can help people with problems they are having
3. It would adversely affect my feelings towards a family member or a friend if I found out they were consulting a psychologist
4. I know of someone now who would benefit from consulting a psychologist
5. People often consult a medical practitioner with problems that could be better handled by a psychologist
6. I would be more likely to consult a psychologist if I did not have to pay
7. Clinical psychologists do the same work as other psychologists
8. Psychologists' fees are rebatable through Medicare
9. If I had a difficult emotional problem I would be happy to discuss it with my medical practitioner
10. Psychologists mainly help people with serious mental disorders
11. People should be able to handle their own personal problems without having to consult a psychologist
12. Psychologists offer similar services to psychiatrists
13. I know of someone now who would benefit from consulting a psychologist
14. "Counsellor" is another acceptable name for psychologist
15. In order to consult a psychologist I first need a referral from a doctor

16. Psychologists help people with social problems such as financial difficulties
17. Psychologists help people solve problems
18. Psychologists are generally aloof and detached people
19. Discussion between a psychologist and his/her client is always strictly confidential
20. Psychologists are of benefit to the community
21. I would be prepared to pay to consult a psychologist
22. There should be more psychologists to help people
23. I feel that psychologists are generally "odd" people
24. I would feel comfortable in talking with a psychologist in a social situation
25. I would feel confident in suggesting a family member consult a psychologist
26. When a person consults a psychologist it usually involves a large number of sessions
27. Psychologists' fees are rebatable through private health funds
28. Psychologists are particularly interested in the childhood of their clients
29. Most psychologists work in hospitals
30. If I am experiencing problems at work my employer should be prepared to pay for me to consult a psychologist
31. Psychologists are medical practitioners who have specialised in psychology
32. I would not feel comfortable in talking with a psychologist because he/she may ask me embarrassing questions
33. Psychologists solve problems for people



34. Most people would be embarrassed if their friends found out they were consulting a psychologist
35. I am generally well-informed about psychologists
36. People who consult a psychologist run the risk of becoming emotionally dependent on the psychologist
37. Psychologists offer their clients practical advice
38. I would be more likely to consult a psychologist of the opposite sex
39. If I was having a problem with my boss I would consider talking about it with a psychologist
40. Psychologists are generally approachable people
41. If I was consulting a psychologist I would prefer that no one know about it
42. I would not know how to go about finding a psychologist to consult
43. If I had a problem that was worrying me I would be more likely to talk it over with a family member or a friend rather than consult a psychologist
44. I believe that small problems can become big problems unless something is done early on to solve them
45. Problems I am having at home often affect my performance at work
46. Psychologists are practical people
47. Psychologists study people's behaviour and reaction
48. Psychologists are university-trained graduates
49. I would feel confident in suggesting a friend consult a psychologist
50. All psychologists must be registered with the Government



51. It would affect my feelings towards a family member or a friend if I found out they were consulting a psychologist
52. All psychologists include some form of "counselling" in their work
53. Psychologists offer the same services as psychiatrists but do not prescribe drugs
54. Psychologists sometimes conduct physical examinations if the situation warrants it
55. A good psychologist should be a good listener
56. Psychologists should have the same community acceptance as medical practitioners
57. I know of someone now who would benefit from consulting a psychologist
58. Consulting a psychologist is a sign of weakness and/or inadequacy in a person
59. Psychologists are able to predict how people will react
60. If something is worrying me at work I often become preoccupied and lose concentration
61. Psychologists can help people with alcohol or drug problems
62. If I am having a problem with my spouse/partner I would be more likely to talk about it with my medical practitioner rather than a psychologist
63. Psychologists should promote their services more effectively
64. I have never considered consulting a psychologist
65. Consulting a psychologist may lead to a person having more problems than they initially realised
66. It is better to talk with a friend rather than psychologist when you have a problem because a friend knows you and understands you better
67. Problems I am having at work can affect my home life.

68. People I know who have consulted a psychologist have generally been pleased with the result
69. I would feel confident in consulting a psychologist
70. Because of their training and experience psychologists can help people solve problems that they could not have solved themselves.
71. Psychologists offer similar services to social workers
72. Most problems will fix themselves in time without having to ask others for help
73. I would be more likely to consult a psychologist if they were more readily available and easily accessible.
74. I would be more likely to consult a counsellor rather than a psychologist
75. There is no stigma attached to someone consulting a psychologist
76. People who consult a psychologist must feel like they are going mad
77. Psychologists undergo at least six years study and training before they are allowed to practice
78. If I consulted a psychologist I would have faith in their opinion
79. School counsellors are not really psychologists
80. Psychologists should be able to advertise their services
81. In today's increasingly stressful world there is an increasing need for psychologists
82. Clinical psychologists do the same work as counsellors
83. I would be happy to have a psychologist for a neighbour
84. People who can't work out their own problems have something wrong with them
85. Consulting a psychologist may stir up old memories that would be better forgotten

86. I would only consult a psychologist as a last resort
87. Psychologists are generally friendly people
88. Psychologists use tests to help them work out what problems a client has.
89. More women than me consult a psychologist
90. If I had a problem I would be more like to consult of minister of religion rather than a psychologist

## APPENDIX 3.2

### Information to Participants

Thank you for agreeing to participate in this research project.

I am carrying out this research as part of the course requirements for the Doctor of Philosophy in Clinical Psychology at the University of Wollongong.

By agreeing to participate in this study you are reminded that your participation is entirely voluntary and that no reward, either work-related or financial, will accrue to you.

You are also reminded that you may choose to leave this study at any time without prejudice.

Any information disclosed by your participation in this study will be treated as strictly confidential and will not be divulged to any other individual.

Thank you once again for your participation.

(Barry M. McNamara)

### APPENDIX 3.3

#### AMENDED TWENTY FIVE ITEM SCALE

1. It would adversely affect my feelings towards a family member or friend if I found out they were consulting a psychologist
2. People often consult a medical practitioner with problems that could be better handled by a psychologist
3. I know of someone now who would benefit from consulting a psychologist
4. People should be able to handle their own problems without having to consult a psychologist
5. "Counsellor" is another acceptable name for a psychologist
6. Psychologists are of benefit to the community
7. I would be prepared to pay to consult a psychologist
8. Psychologists mainly help people with serious mental disorders
9. There should be more psychologists to help people
10. I would feel comfortable in talking with a psychologist in a social situation
11. I would not know how to go about finding a psychologist to consult
12. I would feel confident in suggesting s friend consult a psychologist
13. I feel that psychologists are generally "odd" people
14. Consulting a psychologist is a sign of weakness or inadequacy in a person

15. Psychologists are generally approachable people
16. I have never considered consulting a psychologist
17. If I consulted a psychologist I would have faith in their opinion
18. Psychologists are medical practitioners who have specialised in psychology
19. I would feel confident in suggesting family members consult a psychologist
20. Psychologists should have the same community acceptance as medical practitioners
21. Psychologist should promote their services more effectively
22. I would only consult a psychologist as a last resort
23. There is no stigma attached to someone consulting a psychologist
24. I would feel confident in consulting a psychologist
25. I am generally well-informed about psychologists

APPENDIX 3.4

Indicate by placing an (X) on the scale below your opinion concerning your **CONFIDENCE** in psychologists

1

2

3

4

5

6

7

8

9

No confidence  
at all

Average  
Confidence

Total  
Confidence

Indicate by placing an (X) on the scale below your opinion concerning your **KNOWLEDGE** of psychologists and their work

1

2

3

4

5

6

7

8

9

No knowledge  
at all

Average  
Knowledge

Total  
Knowledge

APPENDIX 3.5

ATTITUDE TOWARDS SEEKING PSYCHOLOGICAL HELP  
SCALE (ATSPH)

Instructions

On the next pages are a number of statements pertaining to psychology and mental health issues. Read each statement carefully and indicate your opinion by circling one of the following:

- (1) agreement,
- (2) probable agreement,
- (3) probable disagreement, or
- (4) disagreement.

For example, if I have "probable agreement" with the following statement, I would circle number ' 2.'

\* A person studies better at home ..... 1    2    3    4  
than at the library

Please express your frank opinion in rating the statements. There are no "wrong" answers, and the only right ones are whatever you honestly feel or believe. It is important that you answer every item.

**Please note: Your answers are strictly confidential.**



1. Although there are clinics for people with mental troubles, I would not have much faith in them
2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.
3. I would feel uneasy going to a psychiatrist because of what some people would think.
4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.
5. There are times I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.
9. Emotional difficulties, like many things, tend to work out by themselves.
10. There are certain problems which should not be discussed outside of one's immediate family.
11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

13. Keeping one's mind on a task is a good solution for avoiding personal worries and concerns.
14. Having been a psychiatric patient is a blot on a person's life.
15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.
16. A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help.
17. I resent a person - professionally trained or not - who wants to know about my personal difficulties.
18. I would want to get psychiatric attention if I was worried or upset for a long period of time.
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
20. Having been mentally ill carries with it a burden of shame.
21. There are experiences in my life I would not discuss with anyone.
22. It is probably best not to know *everything* about oneself.
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears *without* resorting to professional help.
25. At some future time I might want to have psychological counseling.

26. A person should work out his or her own problems; getting psychological counseling would be a last resort.
27. Had I received treatment in a mental hospital, I would not feel that it has to be "covered up."
28. If I thought I needed psychiatric help, I would get it no matter who knew about it.
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.

### APPENDIX 3.6

#### REVISED THIRTY FIVE SCALE INCLUDING TEN ITEMS TARGETING STIGMA TOLERANCE ASSOCIATED WITH PSYCHOLOGISTS

1. Family member or friend if I found out they were consulting a psychologist
2. People who consult a psychologist must feel like they are going mad
3. People often consult a medical practitioner with problems that could be better handled by a psychologist
4. Most people would be embarrassed if their friends found out they were consulting a psychologist
5. I know of someone now who would benefit from consulting a psychologist
6. People should be able to handle their own problems without having to consult a psychologist
7. If I was consulting a psychologist I would prefer that no one knew about it
8. "Counsellor" is another acceptable name for a psychologist
9. Psychologists are of benefit to the community
10. I would feel more uneasy about visiting a friend in a psychiatric hospital rather than a general hospital
11. I would be prepared to pay to consult a psychologist
12. Psychologists mainly help people with serious mental disorders

13. I would not tell anyone if I was consulting a psychologist
14. There should be more psychologists to help people
15. Most people jump to the wrong conclusions when they find out someone is consulting a psychologist
16. I would feel comfortable in talking with a psychologist in a social situation
17. It should be OK to say you have consulted a psychologist
18. I would not know how to go about finding a psychologist to consult
19. I would feel confident in suggesting a friend consult a psychologist
20. One of the barriers to psychologists being more widely accepted is the stigma attached to it
21. I feel that psychologists are generally "odd" people
22. Consulting a psychologist is a sign of weakness or inadequacy in a person
23. It should be OK to ask for professional psychological help with emotional problems
24. Psychologists are generally approachable people
25. I have never considered consulting a psychologist
26. If I consulted a psychologist I would have faith in their opinion
27. Only people who are mad need to consult a psychologist

28. Psychologists are medical practitioners who have specialised in psychology
29. I would feel confident in suggesting family members consult a psychologist
30. Psychologists should have the same community acceptance as medical practitioners
31. Psychologists should promote their services more effectively
32. I would only consult a psychologist as a last resort
33. There is no stigma attached to someone consulting a psychologist
34. I would feel confident in consulting a psychologist
35. I am generally well-informed about psychologists

## APPENDIX 3.7

### PERCEPTION OF PSYCHOLOGISTS SCALE (POPS)

1. It would adversely affect my feelings towards a family member or friend if I found out they were consulting a psychologist
2. People often consult a medical practitioner with problems that could be better handled by a psychologist
3. Most people would be embarrassed if their friends found out they were consulting a psychologist
4. I know of someone now who would benefit from consulting a psychologist
5. People should be able to handle their own problems without having to consult a psychologist
6. If I was consulting a psychologist I would prefer that no one knew about it
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23. Psychologists are medical practitioners who have specialised in psychology
24. I would feel confident in suggesting family members consult a psychologist
25. Psychologists should have the same community acceptance as medical practitioners
26. Psychologists should promote their services more effectively
27. I would only consult a psychologist as a last resort



28. There is no stigma attached to someone consulting a psychologist
29. I would feel confident in consulting a psychologist
30. I am generally well-informed about psychologists

APPENDIX 3.8

Indicate by placing an (X) on the scale below your opinion concerning your **CONFIDENCE** in psychologists

1	2	3	4	5	6	7	8	9
_____  _____  _____			_____  _____  _____			_____  _____  _____		
No confidence			Average			Total		
at all			Confidence			Confidence		

Indicate by placing an (X) on the scale below your opinion concerning your **KNOWLEDGE** of psychologists and their work

1	2	3	4	5	6	7	8	9
_____  _____  _____			_____  _____  _____			_____  _____  _____		
No knowledge			Average			Totally		
at all			Knowledge			Knowledgeable		

Indicate by placing an (X) on the scale below your opinion concerning the **SITGMA** attached to psychologists and their work

1	2	3	4	5	6	7	8	9
_____  _____  _____			_____  _____  _____			_____  _____  _____		
No stigma			Average			A large amount		
at all			Stigma			of Stigma		

## APPENDIX 4

# GENERAL HEALTH QUESTIONNAIRE



Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, *over the past few weeks*. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past. It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

## HAVE YOU RECENTLY:

1 — been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2 — lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3 — been having restless, disturbed nights?	Not at all	No more than usual	Rather more than usual	Much more than usual
4 — been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
5 — been getting out of the house as much as usual?	More so than usual	Same as usual	Less than usual	Much less than usual
6 — been managing as well as most people would in your shoes?	Better than most	About the same	Rather less well	Much less well
7 — felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
8 — been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
9 — been able to feel warmth and affection for those near to you?	Better than usual	About same as usual	Less well than usual	Much less well
10 — been finding it easy to get on with other people?	Better than usual	About same as usual	Less well than usual	Much less well
11 — spent much time chatting with people?	More time than usual	About same as usual	Less time than usual	Much less than usual
12 — felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
13 — felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable

PLEASE TURN OVER

## HAVE YOU RECENTLY:

14 — felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
15 — felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
16 — been finding life a struggle all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
17 — been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
18 — been taking things hard?	Not at all	No more than usual	Rather more than usual	Much more than usual
19 — been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
20 — been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
21 — found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
22 — been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
23 — been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
24 — been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
25 — felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
26 — been feeling hopeful about your own future?	More so than usual	About same as usual	Less so than usual	Much less hopeful
27 — been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual
28 — been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
29 — felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
30 — found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual

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## APPENDIX 5

### ADMINISTRATOR'S SCRIPT FOR TESTING SESSIONS

Good morning. My name is [.....] Thank you for agreeing to take part in our research project concerning your Employee Assistance Program. You will be hearing more about the Employee Assistance Program soon. I hope that being part of this research will be beneficial to you. When the research is completed the final report will be made available to you.

Today I will be asking you to complete several questionnaires which will take about [...] hours in total. It seems a long time but we will have breaks in between. [.....] has agreed to release you from your work commitments for this time and of course, you will not lose any pay.

I will be returning in six months time to give you these questionnaires again and again six months after that. So you will be asked to complete them on three occasions.

It is very important for you to realise that all the information from the questionnaires you complete will be treated as strictly confidential. To show you that I mean this I do to want you to put your name on any of the Answer sheets. Instead I am going to ask you to use an identifying number that only you will know. I suggest you use one of the following:

1. Your car registration number
2. Your driver's licence number
3. Your date of birth

All I ask is that you use the same number on all the answer sheets for today and the next sessions in three and six months time. So use a number you will remember. I will give you a minute to decide what number you will use. Now don't tell anyone else. Has everyone thought of their identifying number? Good. Is everyone satisfied that by using this number the information they complete on the questionnaires will be strictly confidential?

To start off with I would like you to fill out the survey that you found on your seat when you came in. Don't forget, do not use your name but your identifying number. This information will be used by our researchers to give us a better picture of how the Employee Assistance Program can best serve you. If anyone has any questions please put your hand up and I will come and help you. Is everyone finished? Please pass them to the ends of the row and I will collect them. Thank you

Today I am going to ask you to complete two questionnaires. With each of these questionnaires there are no right or wrong answers but merely how you feel that is the most important thing. There are no prizes for finishing first. What I ask is that you work through each of them steadily and answer all questions.

Does anyone have any questions before we commence?

**APPENDIX 6****DEMOGRAPHIC SURVEY**

Please complete the following demographic survey.

You are reminded that any information disclosed in this survey will be treated as strictly confidential

Identification No.: \_\_\_\_\_

Organisation Name: \_\_\_\_\_

Age: \_\_\_\_\_

Sex: \_\_\_\_\_

Thank you for your co-operation.

**APPENDIX 7****ADMINISTRATOR'S SCRIPT FOR  
COMPLETING for GHQ-30 and POPS**

You have just be provided with [name questionnaire]. Could you write your identifying number in the space provided on the Answer Sheet. Please turn to the instructions on page [..] and I will read through them with you.

Read through instructions.

Does anyone have any questions?

Remember there are no right or wrong answers, simply how you feel. Please ensure you answer all questions. Do not dwell on any one question. This questionnaire will take you about [...] minutes to complete. When you have completed all the questions please remain seated. All answer sheets and question papers will be collected when everyone has finished. If you have any questions from now on please raise your hand and I will come to you. You may now commence.

**COMPLETION OF QUESTIONNAIRE PROCEEDS**

Is there anyone who is still working? I will now collect both the Answer Sheet and the question paper. You may talk quietly while I collect these. There will be a five minute break before the next questionnaire.



## APPENDIX 8

# EAP PRESENTATION

### General Aim

To provide participants with a clear understanding of their Employee Assistance Program and to assist with the clarification of their role within the Program

### Objectives

At the completion of the briefing, participants will be able to:

- Define the scope and purpose of the Employee Assistance Program
- Explain the referral process by which employees gain access to counselling
- Describe the roles of personnel in the Program
- Outline other services provided by the Employee Assistance Program

### Content

1. What is an Employee Assistance Program?
2. How EAPs are established
3. Key elements of EAP
4. Typical presenting problems
5. What is counselling?
6. Where is the counselling available?
7. Who has access to the counselling?
8. Who provides the counselling?
9. Video presentation

### Duration

30 minutes

# EMPLOYEE ASSISTANCE PROGRAM

## NEWSLETTER

### NUMBER 1

BROUGHT TO YOU IN THE INTEREST OF BETTER HEALTH

## RULES OF THUMB

☐ Shopping for groceries while you're *hungry* will triple the cost of the trip.

☐ Don't travel with anything you can't carry for a kilometre, while running.

☐ If you say, "I'll *hate* myself in the morning for doing this," you're probably right.

☐ If you can't figure out what you want to eat, you're not hungry.

☐ In any group, the person doing the *least* talking is the one with the most power.

☐ If you don't know what you want to do, what you probably want to do is sleep.

☐ If your fiancé does something that bothers you *before* your married, it will bother you ten times more *after* you're married.

☐ You lose 1/2 kilogram (1 pound) of fat for every 7350 kilojoules (3500 calories) you burn or don't eat.

☐ If you're too busy to use hot air hand dryers in public restrooms, your lifestyle's too hectic for your own health.

☐ It's generally easier to ask forgiveness than permission.

☐ A child will become as you describe him to others.

☐ When you use the time-out method to discipline a child, impose one minute for each year of the child's age.

Source: "Rules of Thumb" by Tom Parker

### AMAZE YOUR FRIENDS HEALTHY TRIVIA

● You can't catch a cold or the flu at the North Pole in winter. The temperature there is so low that the germs can't survive.

● The custom of serving lemon with fish dates back to the Middle Ages. At that time lemon was served with fish because it was believed that if you swallowed a fish bone, the lemon juice would dissolve it.

● In Ancient China, doctors were paid when their patients were kept well. Chinese doctors paid the patient if the patient lost his health. Each time a patient died, a special lantern was hung outside the doctor's house; too many lanterns would slow his practice.

*"The only reason some people get lost in thought is because it's unfamiliar territory"*

# How the EXPERTS Rate the Exercises

In the USA, seven "experts" were asked to rate 14 different exercises according to how much or how little each exercise contributed to different health/fitness benefits.

The experts chosen were all doctors who were prominent either in cardiovascular (heart and lung) medicine or sports medicine. Each doctor was

allowed to give each of the exercises from 0 to 3 points for the different benefit categories.

The sums of the doctors scores are shown below. The highest possible score was 21 points; that is, 3 points given by all seven of the doctors.

Source: Presidents Council on Physical Fitness and Sports

BENEFITS	EXERCISES													
	Jogging	Bicycling	Swimming	Skating (Ice or Roller)	Squash	Skiing - Cross country	Skiing - Downhill	Basketball	Tennis	Callisthenics	Walking	Golf	Softball	Bowling
<b>Physical Fitness</b>														
Cardiorespiratory fitness	21	19	21	18	19	19	16	19	16	10	13	8	6	5
Muscular endurance	20	18	20	17	18	19	18	17	16	13	14	8	8	5
Muscular strength	17	16	14	15	15	15	15	15	14	16	11	9	7	5
Flexibility	9	9	15	13	16	14	14	13	14	19	7	8	9	7
Balance	17	18	12	20	17	16	21	16	16	15	8	8	7	6
<b>General Well-Being</b>														
Weight control	21	20	15	17	19	17	15	19	16	12	13	6	7	5
Muscle definition	14	15	14	14	11	12	14	13	13	18	11	6	5	5
Digestion	13	12	13	11	13	12	9	10	12	11	11	7	8	7
Sleep	16	15	16	15	12	15	12	12	11	12	14	6	7	6
<b>Total Score</b>	<b>148</b>	<b>142</b>	<b>140</b>	<b>140</b>	<b>140</b>	<b>139</b>	<b>134</b>	<b>134</b>	<b>128</b>	<b>126</b>	<b>102</b>	<b>66</b>	<b>64</b>	<b>51</b>

## Q. IS IT OK TO EXERCISE IF I HAVE HIGH BLOOD PRESSURE?

A. Not only is it all right to exercise if you have high blood pressure, it is recommended! Work up gradually to a point where you can get in at least 30 minutes of non-stop aerobic exercise at least every other day. The most popular aerobic exercises include walking,

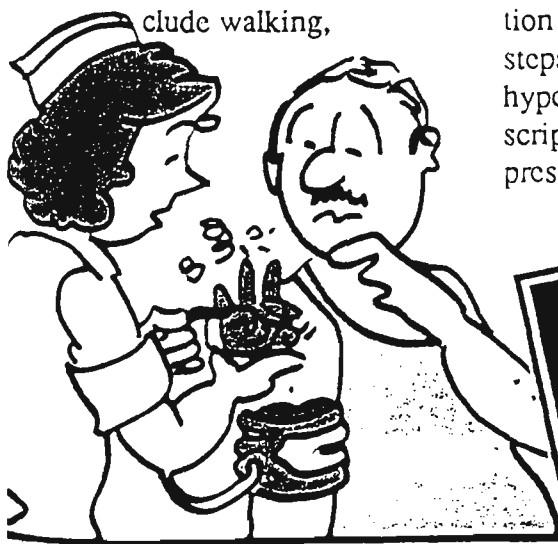
jogging, cycling and swimming. Regular exercise can skip to lower the blood pressure into the normal range for those who have borderline or mild hypertension.

The prescription of regular aerobic exercise, weight loss and with restriction of dietary salt should be the first steps prescribed for patients with mild hypertension. Only if these two prescriptions don't work should drugs be prescribed.

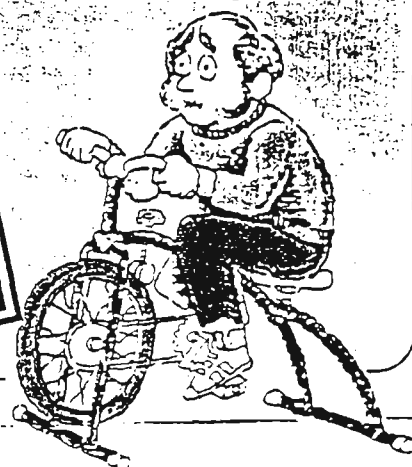
## BLOW WITH THE FLOW

For whatever reason, some people hold their breath during exercise, and on exercise machines. This halt in respiration results in a build-up of pressure in the chest, which conflicts with the circulation of your blood. That's not good, so when you exercise:

- Breathe out/exert force.
- Breathe in/complete the exercise.
- Breathe out. . .
- Breathe in. That's good!



A lot of people call life "The Survival of the Fittest". You know, a lot of people are right.



By Doctor Stephen R. Yarnall

# What's your opinion about

## CELLULITE?

For your interest, none of my standard medical texts even acknowledge the existence of cellulite. Nonetheless, many people (women in particular) feel they are plagued with "dimply ripples of fat and indented skin" on the thighs and buttocks. I did find one excellent source which I can recommend to you: *Getting Firm - Shaping and Toning* (Time Life Fitness Books). This book points out what you already know: special lotions, creams, pills, and massage treatments are not effective in altering cellulite, no matter what their advertising may claim.

Cellulite is basically ordinary fat that has accumulated under hormonal control in the hip and buttock areas of females, predominantly. (I suspect this is why your accumulation of body fat (cellulite) in your thighs occurred during pregnancy.)

You are correct in saying that cellulite is "stubborn fat," and that it takes a combination of kilojoule restriction and exercise to show improvement.

Muscle toning exercises alone are not effective in slimming thighs and buttocks, but they certainly can improve

firming and shaping of the underlying muscles as you lose body fat (fat sits on top of muscles).

Body fat lost through a combination of sensible, kilojoule restricted eating - plus regular aerobic (brisk, sustained) exercise - is the answer for

most people.

You note that you have been doing exercises for a few months - and have taken inches off and have improved your energy level - but have not yet seen improvement in cellulite. Don't give up: this is one of the most stubborn and last to go areas of fat. If you have changed your shape and have not lost weight, don't be discouraged. This is because you have been adding muscle which is denser and heavier than fat for the same amount of space. Now that you have added the muscle, the fat loss will come next.

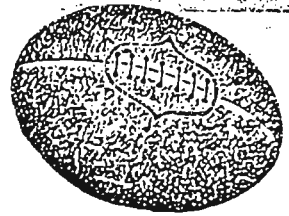
Finally, when you have achieved an ideal body weight and have toned yourself through aerobic exercise\* and muscle toning exercises - if you still have what you consider to be an unacceptable amount of unsightly dimpling of your sub-cutaneous fat (cellulite), you can consult a plastic surgeon for liposuction and plastic surgery advice.

In any case, your "slow and steady" approach is the right one, and I'm pleased you're not wasting your money on useless creams and treatments.

*\* I suggest at least 20 minutes a day of steady aerobic exercise (e.g. brisk walking or cycling), four to six days a week, for people who are serious about losing weight.*

*Before increasing your activity level, check with your doctor if you're over 35, or haven't had a checkup recently.*

Source: Hope Health Letter



# RED

## FOR THE HOME TEAM

### DOES THE COLOUR OF A ROOM AFFECT ONE'S STATE OF MIND?

The University of Mexico thinks so. The home team's locker room is painted red to stimulate and excite the players; the visiting team's locker room is painted blue to put them into a restful kind of mood.

## EXERCISE:

### A 'MINI-VACATION'

"Attitude is everything. People tend to resent having to do exercise, but it should be regarded as a mini-vacation from all the stresses of life."

- Rachel McLish, author and winner of two Ms. Olympia bodybuilding titles.

## COCAINE Saps Energy

According to a study published in the *Journal of Applied Physiology*, cocaine reduces endurance. In the Brigham Young University study, rats given cocaine before running on a treadmill quit exhausted after 29 minutes. Rats who had not been given cocaine were able to run nearly 75 minutes.

## ILLNESS on the TUBE

TV medical dramas don't reflect real life, says Purdue University communications professor Joseph Turow. He cites the following examples:

- ◆ Most illnesses on TV are acute, rather than chronic (long-term), the opposite is true in real life.
- ▷ Children and old people rarely get sick on TV.

- △ TV patients are always treated in big hospitals by specialists.
- △ Family doctors are rarely portrayed on TV.
- △ When TV patients live, they are cured completely.
- △ TV patients never worry about their medical bills.

Source: *Hope Health Letter*

## 13 CAUSES OF ON THE JOB STRESS

1. Inadequate time to complete a job to one's satisfaction.
2. Lack of a clear job description, or chain of command.
3. Absence of recognition or reward for good job performance.
4. Inability or lack of opportunity to voice complaints.
5. Many responsibilities, but little authority or decision making capability.
6. Inability to work with superiors, co-workers, or subordinates because of basic differences in personality, values, and/or goals.
7. Lack of control or pride over the finished product.
8. Job insecurity due to pressures from within the organisation, or the possibility of take-over or merger.
9. Prejudice and bigotry due to age, gender, race, or religion.
10. Unpleasant environmental conditions: cigarette smoke and other air pollution, crowding, noise, exposure to chemicals, commuting difficulties, or inadequate/non working equipment.
11. Not being able to use personal

talents or abilities effectively or to their full potential.

12. Problems at home: family worries, financial problems, alcohol/drug/gambling problems, etc.

13. The "FUD Factor": fear, uncertainty and doubt.



Source: adapted from U.S. Department of Health and Human Services literature.

## You know you're in trouble when...

- You get to work and find a 60 Minutes news team in your office.
- You turn on the evening news and they are showing emergency routes out of the city.
- Your twin sister forgets your birthday.
- Your horn sticks on the freeway behind 32 Hell's Angels.
- You have to sit down to brush your teeth in the morning.
- Everyone avoids you the morning after the company party.
- Your mother approves of the person you are dating.

## MORE MEDICAL MYTHS TRUE OR FALSE?

Try this quick quiz about some common medical misunderstandings, then check your answers on page 8.

1. Penicillin or other antibiotics are 'good medicine' for viruses, like colds and 'flu.  
True..... False.....
2. Extra-strength pain relievers are more effective than regular-strength.  
True..... False.....
3. You should whisper, not talk aloud, if you are hoarse or have laryngitis.  
True..... False.....
4. Nasal decongestant sprays can actually result in the user becoming more congested.  
True..... False.....
5. Certain people get headaches from eating certain foods.  
True..... False.....
6. Bed rest is the best cure for backache.  
True..... False.....



## DOES QUITTING MEAN GAINING WEIGHT?

So, quitting means you've made one of the most important health decisions of your life. But you may gain a few kilos as your metabolism changes with the withdrawal of nicotine. If you become noticeably overweight, you are probably substituting food for cigarettes.

Here are ten tips to help you maintain your weight (or maybe lose a few kilos) while your body is returning to normal: If you find you are using food as an oral substitute for cigarettes, keep several non fattening snacks handy ...carrots, mushrooms, apples, oranges or plain popcorn.

Eat fewer high kilojoule foods like meats, whole milk products and sweets. Substitute with fish, poultry, low fat or skimmed milk and whole grain products.

Reduce kilojoules by eating smaller servings at regular meals.

Eat more fruits and vegetables. They are generally low in kilojoules. A high intake seems to produce a less acid urine, increasing the possibility of an easier withdrawal from nicotine.

Watch your alcohol intake. It has a lot of kilojoules and tends to stimulate the body's craving for nicotine.

Avoid highly spiced foods since they seem to increase the craving for nicotine.

Drink cold water whenever you can. It helps like eating or smoking. Aside from providing temporary gratification, it also helps flush the toxins out of your body.

If you feel unsatisfied at the end of a meal because you're craving a cigarette, don't eat more or light up.

Instead, leave the table, wash the dishes, take a walk, water your plants, do something to divert your attention from what you want to do it before you begin.

Start exercising. It will not only keep you busy, it burns kilojoules, reduces the tension and increases your energy. Recent studies suggest that

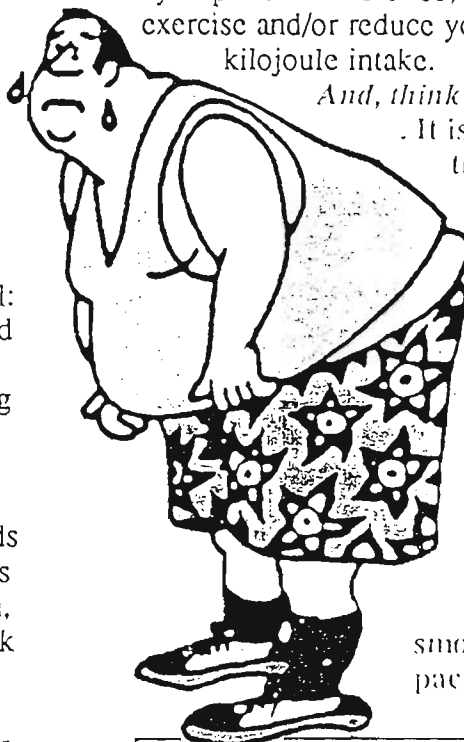
regular aerobic workouts help to speed up the ex-smokers metabolic adjustment.

(An aerobic routine consists of non-stop exercise for at least 15 minutes daily or 30 minutes every other day within your training heart rate range.)

**10.** Weigh yourself every few days. If you put on a kilo or so, get more exercise and/or reduce your kilojoule intake.

And, think about this.

It is estimated that you would have to be approximately 50 kilos overweight to tax your heart as much as you do by smoking just a pack a day.



## So You'd Believe a Used Car Salesman

A survey commissioned by the WA Department of Health has revealed that those surveyed are more likely to believe statements made by used car salesmen than statements by tobacco industry representatives.

Nearly 75% of those surveyed found that statements by tobacco industry sources were "not at all believable", compared with a figure of 69% for used car salesmen, 21% for stockbrokers, 10% for teachers and 7% for doctors.

The survey asked both smokers and non smokers how believable they found statements made by people in different professions. Doctors were rated as the most likely to be believed, with 64% of those surveyed describing them as "very believable". In contrast, only 4% of people so described tobacco industry representatives.

Source: *Consuming Interest*

## WAS YOUR MUM OR DAD AN ALCOHOLIC?

Alcohol is an "equal opportunity destroyer," and it's impossible to grow up unaffected when alcoholism is present in a family. So say Herbert L. Gravitz and Julie D. Bowden, authors of *Recovery: A Guide for Adult Children of Alcoholics* (Simon & Schuster paperback).

In homes where one or both parents are actively alcoholic, childhood is like a warzone, say the authors, and kids who survive the experience come out "shell shocked." Life in an alcoholic home is inconsistent, unpredictable, and chaotic, and kids of alcoholics learn not to talk, not to trust, and not to feel.

Researchers and counsellors say adult children of alcoholics tend to fit into one of three categories:

➊ Children who take charge of the household when their parents are drinking grow up to become overly

responsible, overly serious and overly self reliant adults who are unable to trust and unable to relax. They also have a compulsive need to be in charge of everything and everyone so that life is as predictable, ordered, and controlled as possible.

➋ Adult children of alcoholics who survive childhood by "rolling with the punches" grow into adults who have difficulty taking charge and making decisions.

➌ Kids who take care of and "parent" their alcoholic parents become "people helpers" as adults; their tendency is to give and give, while ignoring their own physical and emotional needs.

If there's a scared child still hiding inside of you, take a look at Gravitz' and Bowden's book.

This may be the time for healing.

Source: *Hope Health Letter*



## Hunting Hidden

# FAT

Careful reading of product labels will aid

in keeping dietary fat to a minimum, but what if you're buying food that is unlabelled or eating in a restaurant? Here are some clues to help you ferret out hidden fat:

1. Does the food coat your mouth with a film?
2. Is the food slippery or shiny?
3. If you put the food in a paper bag, does the grease come through?
4. Is the food crunchy or crispy (and it's not a carrot!)?
5. Do you need to wipe off greasy hands after you touch the food?

### MENU DECODING

1. "Au gratin" means with cheese, and most cheeses have a high fat content. (Exceptions are part skim mozzarella, ricotta and cottage cheese).
2. "Stuffed" usually means fat holds the item together.
3. "Breaded" - breading acts as a sponge for grease
4. "Twice baked" means butter or fat was added between bakings.
5. "Tempura", "battered" are other words for "fried".

## FAT CHANCE OF PIGGING OUT

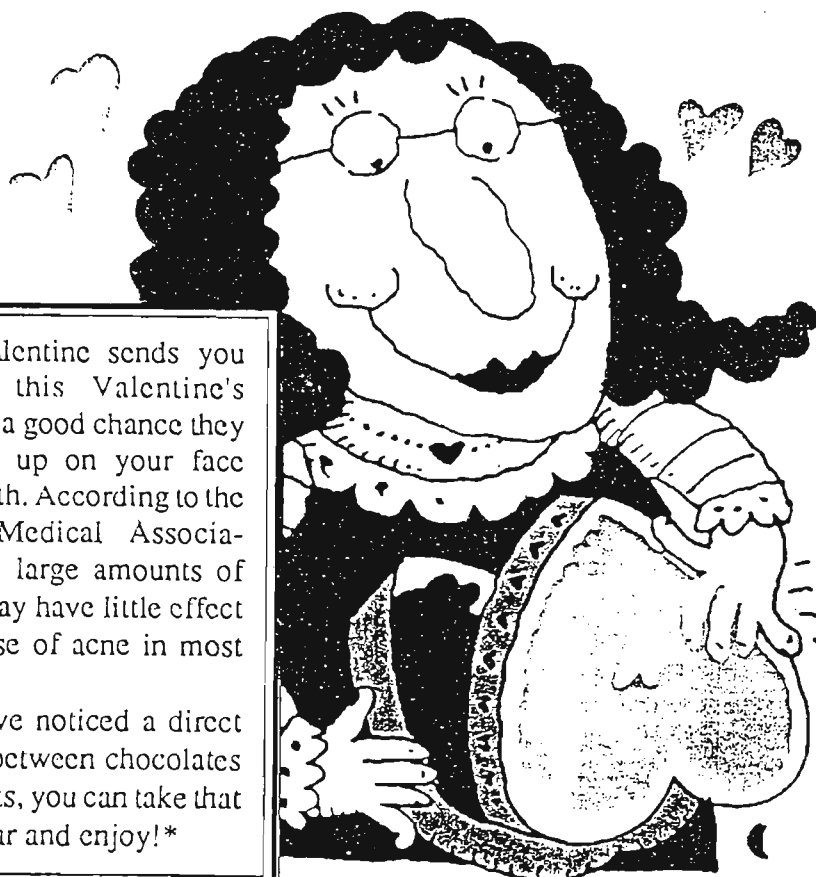
Not everyone is pleased with the reduction of fat in our meat. A letter in the Weekend Australian says:

"What has happened to the pigs of Australia? On Christmas Eve I barbecued a large leg of pork as the centre piece of my Christmas dinner and was met with widespread cheers from my guests... but I was sorely disappointed with the joint.

The day before I had visited half a dozen butchers around Sydney trying to find a leg from a nice fat pig that had a layer of fat to fuel the crackling and keep the meat moist. Find a fat pig... you may as well search for one that flies!

The pigs on offer had less body fat than Lisa Curry. These were pigs that had trained for a marathon or that went to a couple of aerobic classes a day."

# CHOCOLATES DON'T CAUSE BREAKOUTS



If your Valentine sends you chocolates this Valentine's Day, there's a good chance they won't show up on your face February 15th. According to the American Medical Association, "even large amounts of chocolate may have little effect on the course of acne in most people."

Unless you've noticed a direct correlation between chocolates and breakouts, you can take that as an all clear and enjoy!\*

*\* Is this news letter suggesting that it's okay to eat chocolates? Of course! In moderation. It isn't the chocolates on Valentine's Day that get us in trouble; it's the chocolates on the other 364 days that are the problem.*

The information in this publication is meant to educate readers about ways to help themselves avoid illness & live a longer, healthier life - not to provide medical advice for individual problems. For advice and treatment, consult your doctor or health care professional.

## Meat Bites Back

The meat you eat today certainly isn't the same as the meat you or your parents ate in the 1930's. Meat today is leaner, because, firstly, farmers produce meat which is lower in fat, and secondly, retailers and consumers are trimming more fat from meat.

This table shows the average fat content of nine cuts of beef from 1938 to 1987

Date	Fat gm/100 gm	% Fat Reduction since 1938
1938	17.0	
1987 (as purchased)	10.7	37%
1987 (lean)	5.9	77%

## Symptoms of the

# CANCER

one likes to talk about

Cancers, only cancer of the lung, men, and cancer of the breast in men, kill more people than cancer of the colon and rectum. You don't hear too much about colorectal cancer, though, because of the "sensitive nature" of its location. The good news is that almost three out of four people can expect to be cured of this cancer if the disease is detected and treated early.

Symptoms of colorectal cancer:

**Rectal bleeding.** Bleeding is the most common symptom.

Bright red blood may signal a lesion in the rectum; dark red stools, a tumour in the colon. However, blood of any description needs a thorough investigation.

**Change in bowel habits.**

Constipation, haemorrhoids, increasing constipation alternating with diarrhoea, decreased calibre of stools, sensation of

incomplete evacuation, or increasing flatulence (gas) are signals of possible cancer. Each calls for an examination.

**Pain.** Early cancer of the rectum and colon is painless, except for cancer involving the anus which is often painful even at an early state. Locally obstructing tumours of the colon may also give rise to ill-defined abdominal discomfort or mild cramps.

What should you do:

If you are over 40 and have a regular medical exam, you may wish to discuss with your doctor any requirements for colorectal cancer screening. If you have relatives with this cancer you will also be at increased risk so regular screening may be advisable. However if you notice blood in the toilet after a bowel movement, you should immediately seek medical advice.

Source: *Hope Health Letter*

## COLORECTAL CANCER Risk Factors

- ◇ Age (over 40 years old)
- ◇ Low fibre/high animal fat diet
- ◇ History of ulcerative colitis
- ◇ History of polyps
- ◇ Presence of adenomatous polyps

Source: Charles A. Berry, MD, MPH; *Good Health for Employees and Reduced Health Care Costs for Industry.*



## REAGAN

President Reagan, interviewed on his health after his colon surgery, told reporters that he was "a little embarrassed talking boldly about all of his plumbing secrets." A question comes to mind - why is talking about colon surgery any more "embarrassing" than talking about dental surgery?

Everyone has "plumbing".

Everyone needs to eat food, digest it, and get rid of the by products of metabolism. Our 8 metre long digestive system isn't an embarrassment, it's an incredible chemical "factory" that puts man made chemical plants to shame. We all would do well to think about it in those terms and to give it the respect and care it deserves.

This includes eating moderate amounts of wholesome foods, having check-up examinations appropriate for our age and medical history, and boldly seeking medical advice if we ever notice anything out of order.

## How does the doctor make a diagnosis?

*There are a number of tests that may be done.*

**Digital Rectal Examination.** The doctor inserts a gloved finger into the rectum to feel irregular or abnormally firm areas that may be malignant. Some bowel cancers can be detected this way.

**Sigmoidoscopy.** This is a simple inspection of the rectum and lower colon with an illuminated instrument called a sigmoidoscope. Cancers of the rectum and the lower colon can be detected with this instrument.

**Colonoscopy.** This is an inspection of the bowel using a flexible tube. This instrument makes it possible for

the doctor to view the whole of the colon. Polyps (small growths) can be removed during this procedure.

**Barium Enema.** In this x-ray test, the bowel is first filled with a mixture of air and liquid barium compound so that the colon is outlined on the x-ray film which helps to show up any abnormalities.

**Occult Blood Test.** This is a simple chemical test for blood which cannot be seen in the bowel motion. Occult blood tests are not specific for diagnosing bowel cancer.

Source: *NSW Cancer Council*



# WHY GIVE YOURSELF A HEART ATTACK?

MORE THAN 30,000 AUSTRALIANS DIE OF A HEART ATTACK EACH YEAR.

Many thousands of these deaths occur amongst people in their most productive years — men and women with responsible jobs, with children still at school and mortgage payments still due.

Heart disease is a family affair. A few simple changes to your family's lifestyle will benefit everyone — children as well as adults. Children stand to gain the most if they are encouraged from the start in eating and living patterns that will help protect their hearts from premature disease in adult life.

## HERE ARE THE RISK FACTORS!

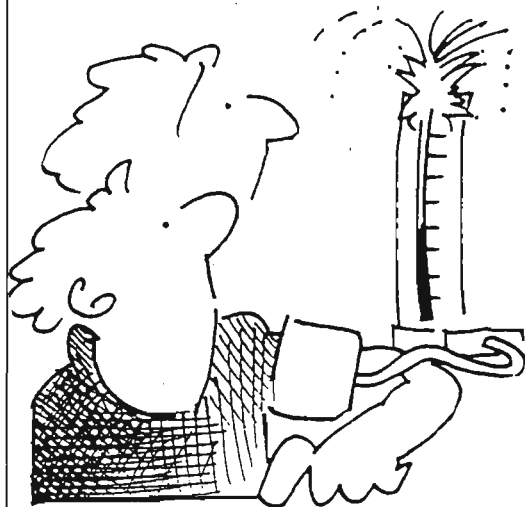
- High blood pressure
- High blood fats
- Cigarette smoking
- Excess weight
- Lack of physical activity

If you have a combination of risk factors and are between the age of 30 and 60 years, your potential of developing heart disease, angina and heart attack within 5 years is as high as 1 in 6. But by eliminating some of or all of these risk factors, you can reduce your chance of having a heart attack to 1 in 70.

This is what you can do:

### ● Check Your Blood Pressure

High blood pressure often gives no warning signs and it is necessary to have it checked regularly by your doctor.



### ● Reduce Blood Fats

A high level of blood fats (cholesterol and/or triglycerides) increases the risk of heart attack. With moderate changes in your diet, your blood fats can be reduced to a safer level. This means reducing your total fat intake.

### ● Give up smoking!

Smoking greatly increases your risk of heart attack. It is never too late to stop, as evidence shows that damage can be very quickly reversed.

### ● Maintain Normal Weight

If you or your children are overweight, the chances of developing health problems are increased. Ask your doctor for a sensible weight reducing diet.

### ● Improved Physical Activity

Exercise should be fun not a chore. Choose a physical activity you enjoy.

### ● Have Regular Check-Ups

Regular check-ups enable your doctor to detect and treat conditions that can lead to heart attack and other forms of heart and circulatory disease.

From The National Heart Foundation.



# EMPLOYEE ASSISTANCE PROGRAM

## NEWSLETTER

### NUMBER 2

BROUGHT TO YOU IN THE INTEREST OF BETTER HEALTH

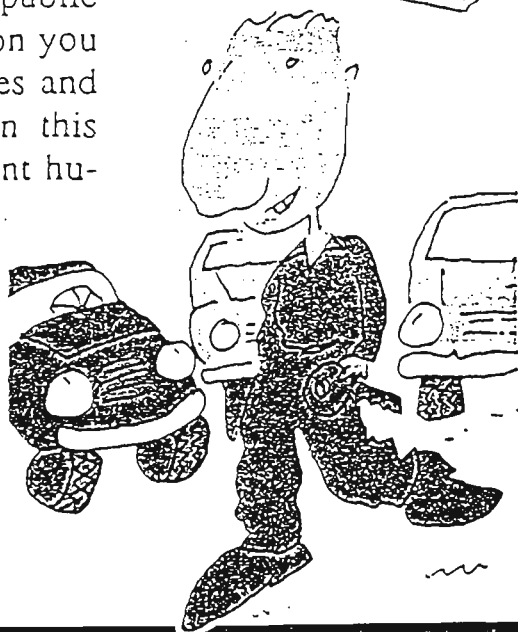
# HOW TO OUT-THINK THUGS

There's no need to be paranoid about walking down the street, waiting for a bus, or using a public car park. Contrary to the impression you might get from newspaper headlines and the evening news, most people in this world are moral, upright, and decent human beings.

It makes sense, though, to think about personal safety, and not to expose yourself to potentially dangerous situations.

## CAR PARK SMART

- Try to park in a well-lit area of the car park.
- Don't use the stairways in car parks.
- Lock your car doors so no one can get into and hide in your car.
- If you have to put money into a pay slot, prepare the money while you're in your locked car so you don't have to fumble with your wallet outside.
- Have your car key in your hand before you return to your car so you don't have to fumble for your keys in the car park.
- Be alert when entering your car. If anything or anyone looks suspicious, leave immediately and come back with security escort or with friends.
- Lock your car doors as soon as you're in your car.



## STREET SMART

- Remember that thugs don't always wear black hats. A criminal can look like your kindly next door neighbour. Don't trust someone just because he or she "looks nice" or is well-dressed.

- Walk or wait at a bus stop with a friend whenever possible. (Note: some companies and hospitals provide security escorts after dark.)

on "automatic pilot."

Be alert. Always look a block or two ahead; look to the sides. Be aware of who's behind you and what's going on around you.

If anyone moves too close to your "personal space," confidently move away.

- Anticipate and avoid potentially dangerous situations. Plan your route to avoid poorly lit and/or poorly maintained areas, parks, alleys, and "hang outs".

- Walk with purpose. Your body language should say "Don't mess with me," instead of "I'm vulnerable" or "I'm not paying attention."

- If a car approaches and beckons, don't approach it. Walk quickly in the opposite direction.

A common ploy thugs use is asking for directions or the time of day. Best bet is to say you don't know or to ignore the request, and walk away.

- Women who have some walking and/or waiting to do should change out of their high-heels before leaving work. Tennis shoes or flats make women look less vulnerable, and allow quick movement, if necessary.

- Wallets and handbags should be kept under the arm, close to the body.

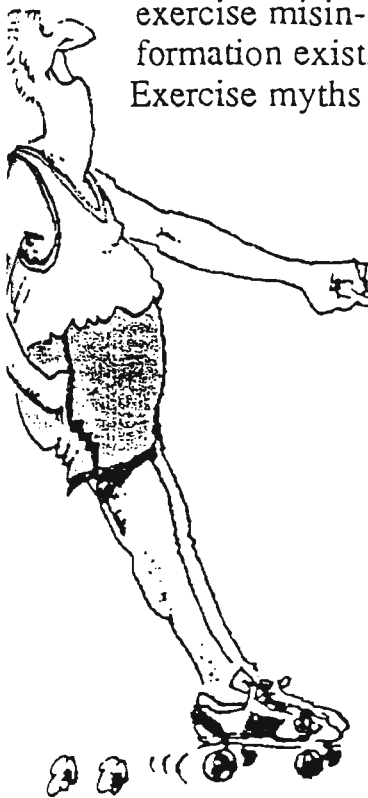
- Keep your keys in a pocket, not in your purse. (In case your purse is lost or stolen, your address won't be with your house keys.)

Source: Hope Health Letter

# aerobic exercise

## A Lot of Huff and Puff about EXERCISE MYTHS

With more than a million Australians engaging in regular aerobic activity, experts say it's amazing how much exercise misinformation exists. Exercise myths



range from promises of quick fixes for figure flaws and weight problems to wrong advice that may lead to injury.

Knowing the truth about aerobic activity may save you a lot of trouble and pain.

Here are the facts about some popular exercise myths.

### HOW FAST SHOULD YOU EXERCISE?

When you walk, jog, cycle, or do any other kind of aerobic exercise - be sure to exercise at a pace that produces a slight shortness of breath and/or a slight sweat, *without* producing any sense of strain or discomfort.

If your exercise pace causes you to huff-and-puff (if you can't carry on a conversation), your pace is too fast.

Concentrate on finding a *steady, rhythmic* pace that you can maintain throughout your exercise period.

Ignore the people who go faster than you. Either they're in much better shape, or they don't know what they're doing.

### GETTING FIT WON'T MAKE YOU GORGEOUS

Don't fall for the line that losing excess weight and toning your muscles will make you beautiful. You're already beautiful by virtue of the fact that you're a unique human being of infinite wonder and potential.

What getting in shape *can* do for you is to help you feel better which, in turn, can help you realise this potential.

*Source: Hope Health Letter*

☆ Spot reduction exercise works. Although spot reduction exercises may help tone the muscles which they work - fat belongs to the entire body, not to one area. Exercise burns fat all over your body. Toning exercises build muscle but can't get rid of fat deposits in specific areas.

☆ Cellulite is a special kind of fat. "Fat is fat," Cellulite's bumpy appearance comes from the connective tissue that separates fat into compartments. Generally, women have more cellulite because they have thinner skin and larger, more rounded fat compartments. And unfortunately, even once you are in shape, some cellulite may remain.

☆ Women shouldn't lift weights because they will develop large muscles. Most women have low levels of testosterone, which affects muscle size and prevents them from building large muscles.

☆ The more you sweat, the more you burn. The myth that sweat leads to weight loss has encouraged people to work out in extreme heat or wear layers of clothes in the hope of sweating fat off. Unfortunately, what they lose is water, not fat.

☆ No pain, no gain. It is not only unnecessary to suffer to improve your fitness level, it's probably harmful.

☆ When you stop exercising, muscle turns to fat. Unused muscles may atrophy or lose their tone, but they won't turn to fat.

☆ Eat protein when you're weight training. Eating a well-balanced diet should make protein supplements unnecessary. Excess protein calories will just be converted to fat and stored.

☆ Exercise increases appetite. Unless you exercise vigorously for more than an hour, your appetite shouldn't increase. In fact, your body temperature rises during exercise which reduces the hormonal signal for hunger.

What Women Should Know About.....

## Premenstrual Syndrome

As many as 8 out of 10 women have physical and emotional symptoms of premenstrual syndrome, or PMS. While the symptoms can be uncomfortable and upsetting, PMS can be easily managed in many cases. A healthy diet and self-care can result in more comfort and less stress every month.

### RECOGNISE SYMPTOMS

You may have PMS if you have these physical symptoms up to two weeks before your period: exhaustion, sleep disturbances, breast swelling, bloating, weight gain, acne, cravings for sweets, constipation, then diarrhoea. Common emotional symptoms include irritability, depression, anxiety, confusion and feeling out of control.

### DIET MAKES A DIFFERENCE

For many PMS symptoms, your diet can make a big difference. Try these suggestions for a week or two before your period:

#### Eliminate

☛ Sugar, caffeine (in coffee, chocolate, and cola drinks), artificial sweeteners, cigarettes and alcohol.

#### Emphasise

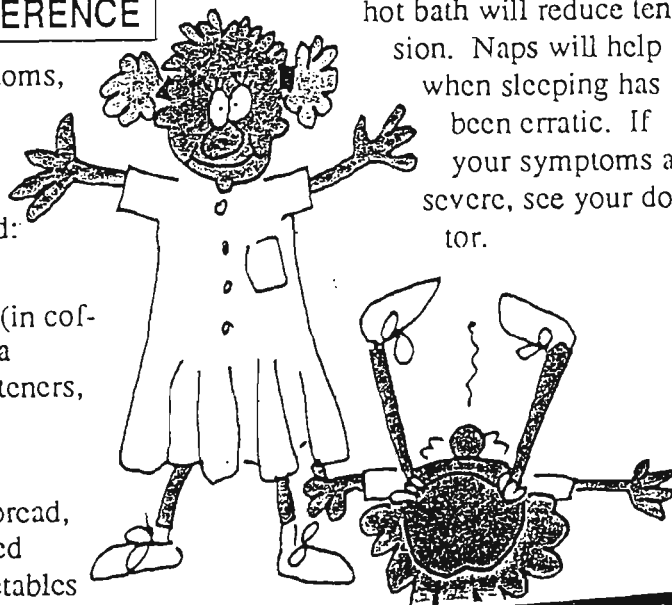
☛ Whole grains (bread, pasta, brown rice), dried beans, nuts, fresh vegetables (especially spinach), and fruit.

### Avoid

☛ Salty and smoked foods, and dairy products. If bloating is a problem, limit fruit and eliminate fruit juices. Your doctor may suggest supplements including a basic multivitamin with minerals (including Vitamin B6 and E, calcium and magnesium); evening primrose oil (available in health food stores); or L-tryptophan, an amino acid.

### MORE HELP

These are other things which will help reduce PMS. Most importantly, take steps to manage your stress levels. Vigorous exercise will reduce both physical and emotional symptoms. Relaxation through meditation, deep breathing, walks, massage, or a hot bath will reduce tension. Naps will help when sleeping has been erratic. If your symptoms are severe, see your doctor.



## MENOPAUSE STRIKES SMOKERS EARLY

A consultant gynaecologist at Kings College Hospital, London told the *National Osteoporosis Society's* conference that women who smoke experience menopause up to five years earlier than those who do not. Dr John Studd also said that: "Women who smoke produce less oestrogen. This makes them more prone to osteoporosis and fractures."

Oestrogen maintains the collagen which forms the basic structure of both skin and bone. As less collagen is produced in older women, particularly after the menopause, the skin becomes thinner and the bones more porous. Thinning of the skin causes the face to become noticeably aged in appearance.

## NATURAL FIBRES EASE FEMININE ITCHING

Each year, thousands of women suffer from vaginitis, commonly referred to as yeast infections. These infections are characterised by vaginal discharge with odour, burning and itching. They often are aggravated by trapped moisture in the vaginal area.

A contributing factor is tight, restrictive clothing - especially clothes without cotton crotches, such as nylon leotards and pantyhose made of synthetic fibres which trap moisture when worn during exercise. Natural fabrics, such as cotton or silk, are better because they allow the vaginal area to "breathe".

### Steps to Avoid Infection

In addition to restrictive, moisture trapping clothing, factors such as birth control pill use, diabetes, recent childbirth, and being overweight are associated with a tendency toward repeated yeast infections. Some steps women can take to reduce the chance of suffering from vaginitis include:

○ Clean the vaginal area thoroughly, and keep it as dry as possible.

○ Avoid irritating agents - harsh soaps or detergents, feminine hygiene sprays, perfumed toilet paper, perfumed tampons.

○ Avoid using tampons exclusively throughout your menstrual period.

○ Thoroughly clean diaphragms and spermicide applicators.

○ Avoid douching. Symptoms of vaginitis should be reported to your doctor. Yeast infections will not go away by themselves and must be treated with medications.

Relieving everyday stress...

# 'Contents Under Pressure'

## STRESS REDUCER FOR NEGOTIATORS

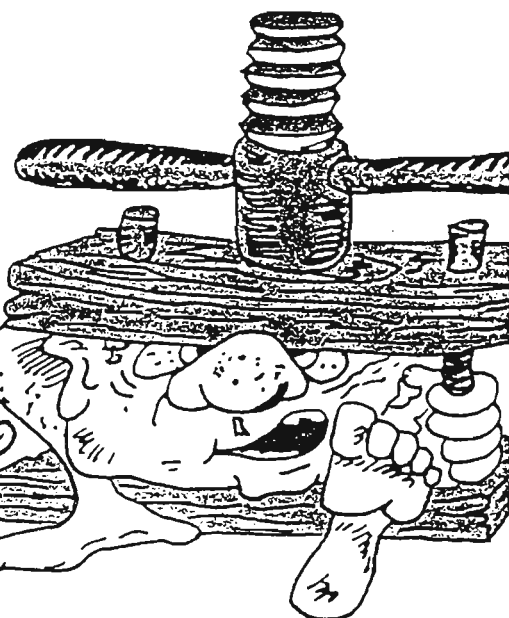
If you sit on the same side of the table as your opponent, you'll significantly undermine the me-against-you approach to negotiating, and you'll get a feeling of cooperation from the start. So says Gerard Nierenberg, president of The Negotiation Institute.

The same thing might work at home, too.

## TIP FOR BOSSES AND SECRETARIES

Bosses can reduce their secretaries' stress if they save up small, non-urgent tasks and assign them once or twice a day, rather than interrupting their secretaries every time something comes along.

In the same way, secretaries can save several items to present at one time so their bosses have blocks of uninterrupted time to work.



## DO YOU LIKE YOUR JOB ?

There's no question that job satisfaction is important to health.

As Hans Selye, the world's greatest authority on stress, has pointed out, If you do what you like, you never really work; your work is your play."

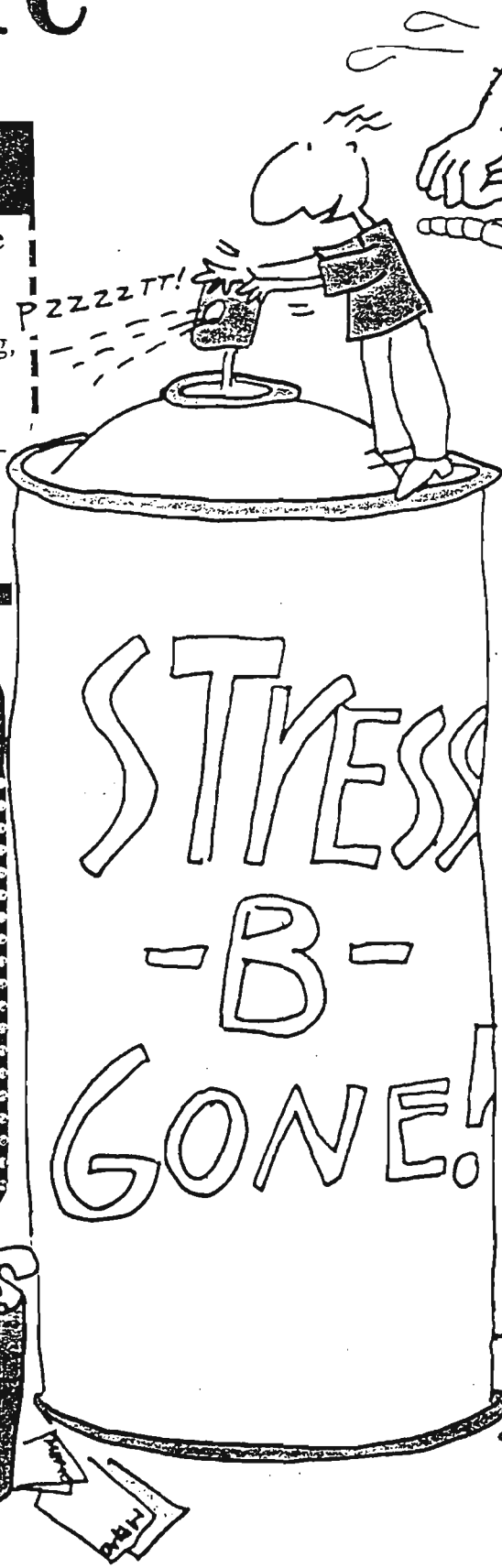
Somebody once came upon George Halas, owner of the Chicago Bears football team, sitting in his office on a weekend. He asked Halas, then in his 80's, "George, at your age, what are you doing here working?" Halas replied, "It's only work if there's someplace else you'd rather be."

## HIT HERE

How did you read the above line? If you saw "Hit Here" instead of "Hi There" maybe it's time to take a break and relax. ■

"Never mistake motion for action."

-Ernest Hemingway





STRESSED OUT?

# HUMOUR CAN HELP

"Stress" and "burn-out" became household words in the 1980's, but humour can be a powerful antidote - moving us from a "grim and bear it" mentality to a "grin and share it" way of thinking.

This notion is captured well by George Burns (who may outlive 90% of us reading this article).

George says you can't help growing older, but you can help growing old.

By using humour, we can prevent "hardening of the attitudes," he says. If you stand rigidly in the face of stress, you are easily knocked off-balance. If you are flexible, you are in a much better position to "roll with the punches" that life throws you.

This shows up over the long haul, too. In his longitudinal study of Harvard College graduates, Dr. George Vaillant found that humour was one of the key coping mechanisms used by healthy and successful Harvard graduates. Hu-

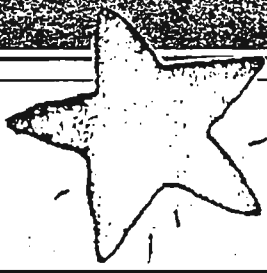
mour can add years to your life, and life to your years.

There's a story about a businessman who ordered flowers to be sent to the opening of his friend's new branch office. When the businessman got there himself, he was delighted to see a beautiful floral arrangement had been delivered. However, when he looked at the card that had accompanied the flowers, he read: "Rest in Peace."

Furious, the businessman made a bee-line to the flower shop and began chewing out the florist. After the shouting had subsided, the florist reassured him, saying "Hey, don't worry! Just think - somewhere in this city someone was buried beneath flowers with a card that read, "Good luck in your new location!"

Regardless of whether we're six feet under, six feet over, or somewhere in between, *humour* can help.

Source: *Laughing Matters*



## TV stars have to talk fast, *you don't*

One of the dangers of watching too much TV is that our conversations may start to sound like those on TV.

Because TV conversations *have* to move right along, there are rarely any patient pauses. As soon as one person stops talking, someone else takes off.

In real life, it's often helpful to allow a person to stop, reflect, and develop his thoughts slowly and carefully - without interruption.

TV stars don't have to think before they speak - their scripts are written for them.

Real people have to think; give them time.

### With too little stress, we are:

- ☐ bored
- ☐ tired
- ☐ frustrated
- ☐ unhappy
- ☐ prone to illness

### With too much stress, we are:

- ☐ irritable
- ☐ exhausted
- ☐ overwhelmed
- ☐ unable to make decisions quickly
- ☐ prone to illness

### With just the right amount of stress, we are:

- ☐ happy
- ☐ creative
- ☐ motivated
- ☐ productive
- ☐ healthy

## WHEN A JOKE'S NOT FUNNY

- \* when someone blushes with embarrassment
- \* when someone is hurt by the joke
- \* when someone's weakness provides the laughter
- \* when profanity is required to make it funny
- \* when a child (or an adult) is brought to tears
- \* when everyone can't join in the laughter.

## Wisdom from the WORLD'S SMARTEST PERSON

**Q:** Is there a more important decision in life than the choice of a career or the choice of a spouse?

**A:** Yes. The choice of which one is going to come first.

Marilyn vos Savant, listed in the Guinness Book of World Records under "Highest IQ"



## NEXT TIME YOU HAVE A 'PROBLEM'

The next time you think you have a *problem*, try telling yourself that you have an "opportunity" or a "challenge," instead.

Redefining the situation as an opportunity or a challenge can reduce a whole lot of stress, and allow you to come up with a creative solution.

## DO YOU REALLY KNOW WHAT YOU'RE EATING?

If you thought baked beans were just that - baked beans - take a look at the label next time you open a can. You may be surprised at what you find inside: Navy beans, tomato puree, sugar, thickener, salt, spices, food acid (296), natural colour (150, 160c), water . . . .

Most ingredients are recognisable but did you know that (296) is malic acid, (150) is caramel and (160c) is B-apo-8'. carotenal.

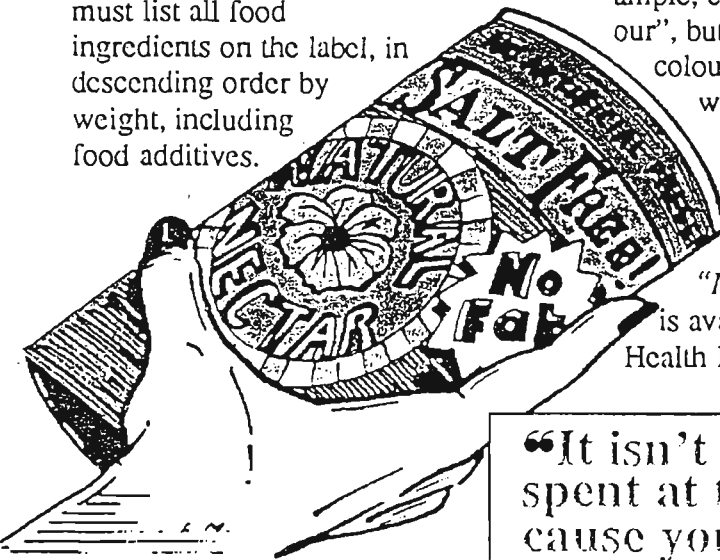
A packet of instant soup contained flavour enhancers, (621) monosodium L-glutamate, (627) disodium guanylate and (631) disodium inosinate. A bottle of soft drink contained (33) citric acid, colours- (102) tartrazine, (110) sunset yellow FCF, (122) azorubine, (133) brilliant blue FCF (all of these in a red coloured soft drink!)

Almost every manufactured food product contains one or more food additives, many of which perform useful and necessary functions: preservatives, anti-oxidants (to prevent fats and oils becoming rancid), emul-

sifiers (to prevent oil and water mixtures breaking up), humectants (to stop foods drying out), anti-caking agents (to ensure food flows easily out of packets) and so on. The vast majority of people are unaffected by food additives but others have found that additives either aggravate or produce negative reactions such as hyperactivity, allergies, skin conditions etc.

### APPROVED ADDITIVES

In Australia, food manufacturers must list all food ingredients on the label, in descending order by weight, including food additives.



The National Health and Medical Safety Council has, as at June 1988, approved 277 food additives for use, most identified by a number. Additives which have no number must be named on the label. Food additives must pass a number of tests before they are approved for use: Is it safe? Could it be used to disguise inferior quality food or faulty processing? Could the intended function be performed more efficiently in another way?

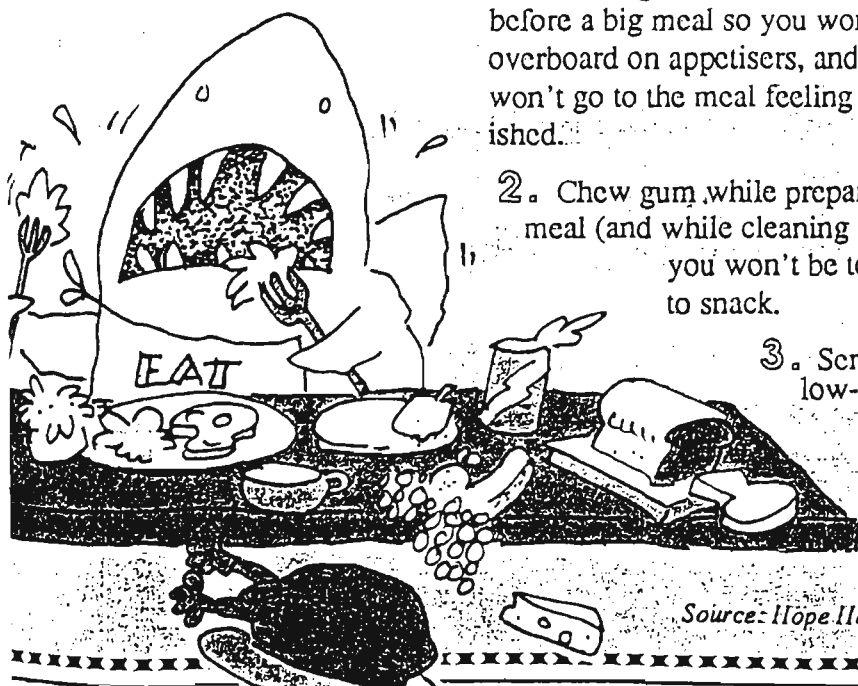
The Australian numbering system is based on an international system and means that tartrazine, for example, can't be listed as just "colour", but either as colour (102) or colour (tartrazine). Someone who wants to avoid tartrazine can then do so.

For people who want to know exactly what they are eating, a pamphlet entitled "Identifying Food Additives" is available from the NHMRC or Health Departments in every state.

**"It isn't the minutes spent at the table that cause you to gain weight, it's the seconds."**

## License to Fill...

## 007 WAYS TO AVOID A STUFF-A-THON



1. Eat a light breakfast and lunch before a big meal so you won't go overboard on appetisers, and so you won't go to the meal feeling famished.

2. Chew gum while preparing a meal (and while cleaning up) so you won't be tempted to snack.

3. Serve a low-fat soup

for the first course. This will slow people down and take the edge of appetites.

4. Allow people to serve themselves, and allow them to choose not to have something.

5. If serving dishes are placed on a side-table, conversation will be the focus of the meal - and seconds and thirds will take a back seat.

6. Don't eat anything unless you really love it (do you really love frozen peas?)

7. Eat dessert two hours after the main meal; this will replace the 1000 calorie snack you usually have.

Source: Hope Health Letter

## SMOKING CUTS BLOOD SUPPLY TO THE HEART



### New Study

Smokers have more and longer episodes of *ischemia* (an inadequate supply of blood to the heart muscle) than nonsmokers, according to a study recently published in the *Journal of the American Medical Association*.

Ischemic episodes can damage the heart muscle and lead to heart attack and sudden death.

In the study, the first of its kind, men and women with heart disease (smokers and nonsmokers) wore a portable heart monitor while going about their daily activities.

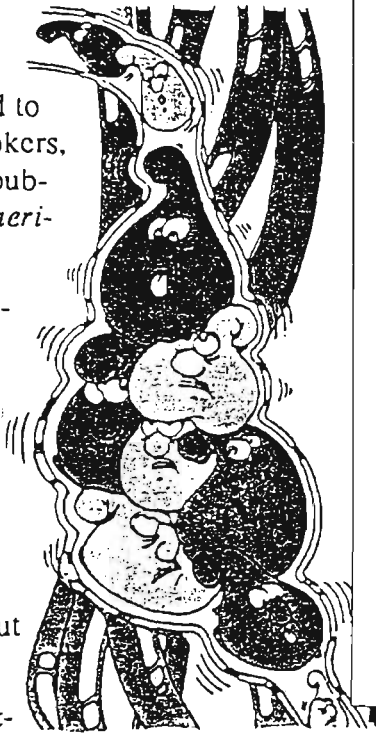
It was discovered that smokers had an average of *three* ischemic episodes a day that averaged 24 minutes each in length. *Nonsmokers* had an average of *one* ischemic episode that averaged just two minutes.

Another finding: 92% of ischemic episodes were not accompanied by chest pain. This means a person could have relatively extensive heart damage without having any distinguishable pain.

The researchers also linked the frequency and duration of ischemic episodes with the number of cigarettes smoked.

Source: *Hope Health Letter*

The information in this publication is intended to educate readers about ways to help themselves avoid illness & live a longer, healthier life - not to provide medical advice for individual problems. For advice and treatment, consult your doctor or health care professional.



## KID'S MEDICINE

Most children have already taken one or two medications for the treatment of viral or bacterial infections by age two. Yet almost half of all children fail to take their medicines correctly, even for serious illnesses.

As a result, many children do not fully recover from their illnesses, and that can lead to other health problems.

What can parents do to help their children understand and use medicines properly?

- Start explaining medicines to children early on. Even preschoolers can understand basic concepts about the benefits and importance of taking medicines as prescribed.
- Teach your children the difference between legitimate medicines and illegal drugs. Use the term "medicine" to talk about prescription and over-the-counter medicines.
- Remind preschoolers and young children that they should never take medicines without adult permission and supervision. Never allow children to use medicines for play.
- Store medicines properly, and keep them out of reach of young children. Safely dispose of outdated or unneeded medications. Use safety caps on all medicine bottles if young children live in or visit your home.
- Encourage your children to listen to their doctor's or pharmacist's instructions for taking medicines.

## The Caffeine in Your Cuppa

Drinks containing caffeine are all right - in moderation. But taken before bedtime, they usually delay sleep and shorten the time you're asleep.

Adults who drink up to six average cups of coffee a day (that's more than 600 mg of caffeine) do not usually suffer any toxic effects. If you drink more, you risk chronic insomnia, persistent anxiety, depression and stomach upset.

If you regularly drink four or five average cups of coffee a day (more than 350 mg of caffeine) you're likely to be "hooked." Without a regular caffeine "top up" you may have withdrawal symptoms - the most conspicuous is severe

headache.

If you now drink large amounts of caffeinated beverages, it's wise to cut down slowly.

CAFFEINE CONTENT	
Coffee	80-100mg/cup
	100-150mg/cup
	100-150mg/cup
	100-120mg/cup
	2-4mg/cup
80-90mg/cup	
Cola Drinks	30mg per 250ml serving
	50-70mg/cup





# SPORTS INJURIES

The football, soccer and hockey season are underway again and while sport is a healthy part of our life, it may also cause injuries, many of which can be prevented.

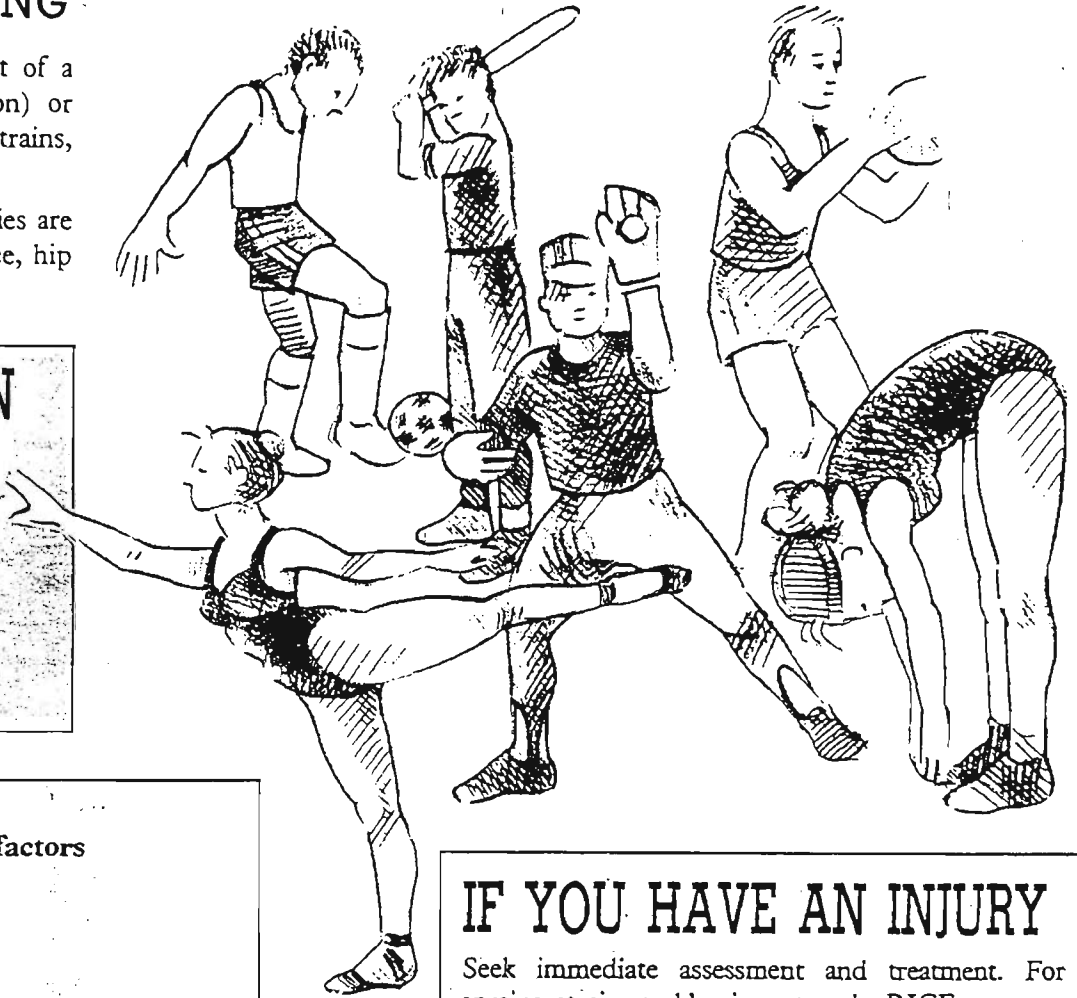
## WHAT GOES WRONG

Most sports injuries are a result of a direct blow (bruise or contusion) or indirect dynamic force (sprains, strains, tears).

An increasing number of injuries are due to overuse stresses (foot, knee, hip and shoulder injuries).

### SOME COMMON INJURIES ARE

- Bruises
- Ligament sprains and tears
- Muscle and tendon strains
- Joint injuries
- Overuse injuries
- Stress fractures



Avoid any of the **HARM** factors

- H** Heat increases bleeding
- A** Alcohol increases swelling
- R** Running or exercising too soon makes an injury worse
- M** Massage in the first 24 hours increases swelling and bleeding

Don't presume an ice pack and strapping will do the trick — especially if you then stand around drinking while 're-living your glories'. Rest, compression and elevation are most important.

## IF YOU HAVE AN INJURY

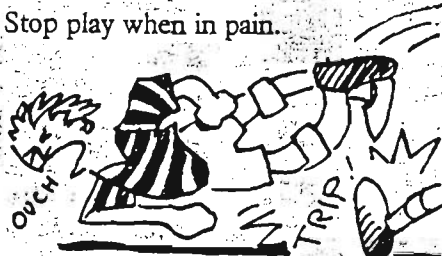
Seek immediate assessment and treatment. For sprains, strains and bruises, start the RICE program;

- R** Rest (injured tissues must have a period of rest to heal)
- I** Ice (10 mins frequently is better than one long application)
- C** Compression (moderately firm bandage to control swelling)
- E** Elevation (elevate the injured part to help drainage)

## HOW YOU CAN PREVENT IT

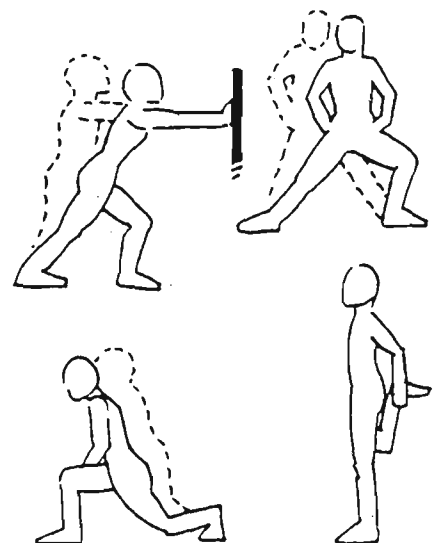
- Correct warm-up and warm-down exercises
- Proper stretching exercises for flexibility
- Protective strapping for support
- Correct footwear
- Specific conditioning for a particular sport
- Good general and aerobic fitness

- Avoid heat stress — maintain fluid intake
- Take it easy at the start of the season
- Stop play when in pain.



(from the Australian Physiotherapy Association)

## STRETCHING EXERCISES



## **APPENDIX 10.1**

### **Stress Management Course Outline**

Session No. 1		Relaxation And Stress Management		(1½ hours)
OBJECTIVES. 1. To help members feel welcome in group setting. 2. To detail objectives of course and why relaxation could be helpful. 3. To introduce a simple relaxation technique, and discuss how group members can use it.				
TIMING	SESSION PLAN (ACTIVITIES, TOPICS, ETC.)	MANUAL REFERENCE	PAGE	
15	Welcome Introductory exercise	Appendix D		
5	Discussions of aims and expectations			
20	What is Relaxation? What is Stress?	Theory of Relaxation & Stress	7	
20	Introduce Muscle Relaxation. Practice of this	Analysis of Practice 3	17	
10	Introduce and Describe Simple Meditative Relaxation	Notes on Practice 1	11	
10	Practice 1	Tape and Script of Practice 1	12	
10	Home assignment — daily practice	Points in Presenting Relaxation	10	
		Notes on obstacles and difficulties	23	

Session No. 2		Relaxation And Stress Management		(1½ hours)
OBJECTIVES: 1. To encourage feedback and discussion on home practice. 2. To reinforce last week's practice. 3. To increase understanding of value of relaxation. 4. To help group members lower general level of tension.				
TIMING	SESSION PLAN (ACTIVITIES, TOPICS, ETC.)	MANUAL REFERENCE	PAGE	
5	Opening discussion and warm-up			
25	Detailed discussion on home practice, or any obstacles, problems or difficulties, and on choice of mental device	* Problems and Difficulties Medical Complaints	23 25	
20	Further background on value of relaxation; discussion on different methods of relaxation	Notes on Practice 1	11	
15	Practice 1	Script and Tape, Practice 1	12	
5	Discussion and feedback			
15	Check Muscle Relaxation — Differential Relaxation	Notes on Practice 3(c) Tape and Script Practice 3(c)	19	
5	Home assignment — contract with each group member for daily practice			

Session No. 3		Relaxation And Stress Management		(1½ hours)
OBJECTIVES: 1. To check out home practice and reinforce daily routine. 2. To introduce a 2nd deep relaxation technique. 3. To introduce concept of A.B.C. of Stress Management — A for Awareness.				
TIMING	SESSION PLAN (ACTIVITIES, TOPICS, ETC.)	MANUAL REFERENCE	PAGE	
10	Opening discussion and warm-up			
15	Practice 1			
5	Discussion on this			
30	A.B.C. of Stress Management	A.B.C. of Stress Management	33	
		Awareness of Stress Symptoms	34	
5	Introduce Practice 2	Notes on Practice 2	16	
20	Do Practice 2 (without Resolve)	Tape and script — Practice 2	15	
5	Discussion on this practice — home assignment to practice this daily			
COMMENTS: Leader may choose to omit Practice 1 to allow more time for Practice 2.				

Session No. 4		Relaxation And Stress Management		(1½ hours)
OBJECTIVES: 1. To discuss home practice of 2 techniques and the advantages and disadvantages of both. 2. To reinforce relaxation with more practice. 3. To further increase awareness of stress. 4. To provide information on the Resolve and suggestion on how this can be used.				
TIMING	SESSION PLAN (ACTIVITIES, TOPICS, ETC.)	MANUAL REFERENCE	PAGE	
10	Opening discussion and warm-up			
10	Practice 1			
5	Feedback			
30	Further Awareness of Stress — recognising situations where we feel stressed	Sources of Stress Sheet	34	
10	Understanding the Resolve	Notes on Practice 2: Resolve	16	
20	Practice 2 including Resolve		15	
5	Closing discussion and home assignment			
COMMENTS: Depending on group needs, leaders can choose to do two relaxation practices or one only, to allow more time for stress management discussion.				

Session No. 5		Relaxation And Stress Management		(1½ hours)
OBJECTIVES: 1. To continue reinforcing value of practice. 2. To increase understanding of Stress Management — B for Balance. 3. To discuss use of relaxation in relation to sleep.				
TIMING	SESSION PLAN (ACTIVITIES, TOPICS, ETC.)	MANUAL REFERENCE	PAGE	
10	Opening discussion and feedback			
20	Practice 1 or 2 and feedback			
30	Stress Management — B — Balancing Stress; Exercises on this	Diagram — Balancing Stress	35	
10	Relaxation in Relation to Sleep	Notes on Sleep	27	
20	Practice 2			
5	Closing Discussion and home assignment			
COMMENTS: Depending on group needs, leaders can choose to do two relaxation practices or one only, to allow more time for stress management discussion.				

Session No. 6		Relaxation And Stress Management		(1½ hours)
OBJECTIVES: 1. To continue reinforcing practice of relaxation. 2. To continue understanding of managing stress. 3. To promote correct breathing and an awareness of the connection between breathing and instant stress reduction.				
TIMING	SESSION PLAN (ACTIVITIES, TOPICS, ETC.)	MANUAL REFERENCE	PAGE	
10	Opening discussion and feedback			
20	Any practice of choice and feedback			
30	Stress Management — Balance — "Changing Perception of Stress"	Diagram — Balancing Stress Handout Sheets "Worry Shrinkers", "Habit Breakers" "Style of Living"	35 40-41	
15	Correct Breathing — How to Reach Optimum Stress Level by Instant Stress Reduction	Notes on Practice 3	17	
15	A 2nd practice — feedback Closing — home assignment			
COMMENTS: Depending on group needs, leaders can choose to do two relaxation practices or one only, to allow more time for stress management discussion.				

**Session No. 7****Relaxation And Stress Management****(1½ hours)**

**OBJECTIVES:** 1. To reinforce understanding and practice of relaxation techniques.  
 2. To look at Time Planning as an aspect of Stress Management.  
 3. To look at relaxation in relation to setting goals.

TIMING	SESSION PLAN (ACTIVITIES, TOPICS, ETC.)	MANUAL REFERENCE	PAGE
10	Opening discussion and feedback		
20	A practice and feedback		
25	Stress Management — discuss importance of Time Planning — exercise on this	Time Planning Handout	37
20	Goal Setting — using relaxation to reinforce aims by using the resolve and/or imagery	Goal setting Handout	37
		Notes on Practice 2 — Resolve	16
10	Optional: Practice 4 — Imaginary achievement or health aim	Notes on Practice 4	21
5	Closing discussion and home assignment	Tape and Script Practice 4(a) or 4(b)	21

**COMMENTS:** Any topics in which group has shown an interest can be scheduled for sessions 7 and 8 in order to provide motivation for attending these last 2 sessions.

**Session No. 8****Relaxation And Stress Management****(1½ hours)**

**OBJECTIVES:** 1. To reinforce understanding and practice of relaxation techniques.  
 2. To help group members recognise the value of attending to their general health to lessen their vulnerability to stress.  
 3. To provide an overview of the eight weeks' course.

TIMING	SESSION PLAN (ACTIVITIES, TOPICS, ETC.)	MANUAL REFERENCE	PAGE
10	Opening discussion and feedback		
20	A practice		
30	Attention to General Health. Nutrition/Exercise/Rest etc.	Notes on Nutrition	41
		Notes on Sleep	27
		Notes on Exercise	38
15	Stress Management — C — Control	"Managing Strategies" Handout	43
15	Overview and rounding off	"Using the Small Group Approach" Appendix	37

**COMMENTS:** If this course is part of a total Lifestyle Programme, referring group members on to other courses of value to them is appropriate in this final session.

**APPENDIX 10.2**

**Trauma Education Course Outline**

## SEMINAR

## TRAINERS' GUIDE

INTRODUCTION:

Welcome to participants. Introduce topic, trainer and participants, and state expected finishing time.

If the group is not from one section, make sure that everybody knows each other. Name tags may be worn, or allow participants to introduce themselves briefly.

ORIENTATION  
TO THE PROGRAM

10 minutes

Overhead #1



Put up Overhead #1.

*The purpose of this seminar is to consider the effects of trauma in the workplace. Many occupations face a higher than average risk of trauma. Occupations such as security and banking face the risk of armed hold-ups, violence and robbery: police, emergency, casualty, rescue services face human suffering, violence, injury, and death; train drivers face the risk of track fatalities through accident or suicide; airline industries face hijacks and accidents (add others as appropriate).*

*Trauma has become a common occupational problem and the effective management of it has been recognised to be of great importance to both the individual and organisation. This program looks at how individuals and organisations can deal with trauma at work.*



## INTRODUCING TRAUMA AT WORK

15 minutes



Open up discussion to the group with the question:

*What types of events would you see as potentially "traumatic" in this particular occupation or workplace?*

Refer to the occupation of the group you are dealing with. Call for group feedback of the range and frequency of traumatic events in the workplace. Ask for the amount of experience amongst group members with these events with the question:

*How many people have experienced a traumatic event at work?*

*What other occupations may experience trauma at work?*

*What sort of events might they be experiencing?*

Generate group ideas.

Call for a range of occupations and events. Focus on traumatic situations, not the reactions individuals may have had.

*What do these traumatic incidents have in common?*

*What makes an event traumatic? In other words, what is trauma?*

Generate group ideas.





TRAUMA - DEFINITIONS

5 minutes

Overhead #2



Put up Overhead #2.

*Traumatic events involve an extremely dangerous or distressing situation where there is:*

- . threat of violence, death or severe injury to self or others*
- . unnatural, unexpected or innocent death*
- . human degradation, suffering, violence or loss (eg warfare or natural disaster).*

*These types of events can disrupt our usual belief that we are safe, secure and that life is fairly predictable and to a large extent within our control.*

*Examples: death of a child - innocent, unexplained, unfair (use for emergency services workers); being threatened with a gun - unpredictable, insecure, unsafe (use for cash handling, security services).*

*A traumatic event threatens our life, security, challenges our sense of invulnerability, and does not accord with our sense of what is fair or just, and can leave us distressed, confused or angry, even for just a short time.*

*Traumatic events generally cause acute stress reaction after a period of initial "shock". This reaction, called "TRAUMATIC STRESS" occurs in most people and can be immediate or delayed, mild or severe, and can last for hours, days or weeks. Where traumatic events occur frequently in certain occupations, we may notice less severe shock reactions over time. This is called "habituation".*



## PERSONAL EXPECTATIONS

Experience,  
attitudes and beliefs  
15 minutes

In this section participants are encouraged to relate personal experiences regarding trauma. Trainers should treat such self-disclosures carefully.

Ask the group:

*Would anyone like to share their own experiences with trauma? Do you know of anyone who has experienced any sort of trauma in their working or personal lives?*

If the group experiences trauma frequently, you may wish to ask:

*What has been the most traumatic incident for you and why?*

Group feedback - briefly relate incidents.

The next task of the group is to generate discussion around their own beliefs about the impact of trauma on themselves or others.

For those group participants who have experienced a traumatic event of some sort (at work or elsewhere), encourage them to discuss whether they had thought about ever experiencing trauma and if they had, how they thought they would be able to handle the incident emotionally?

Trainers may wish to ask:

*What did you expect your reaction to trauma to be like?*

Group feedback.

Often these are different, quite unexpected reactions to distressing situations, which although perfectly normal, we find unfamiliar and uncomfortable. Often there are pressures for us to react in certain ways, or expectations that either we build up of ourselves, or that others have of us, that can influence our belief about what is normal, acceptable, and how we should react.

Ask participants:

*Did you react the way you expected, or were you surprised by your reaction in some way?*

Group feedback.

It is now quite well known that people who expect that they will have a reaction to trauma, but also believe they will survive and cope with it, cope better than those who believe it will not affect them at all, or others who believe they will fall apart and fail to cope. The trainer may wish to discuss this with the group using examples.

Different examples will need to be given to different audiences. Trainers may need to refer to the Reference Article for more information, but some common examples of the differences between "occupational" and "incidental" trauma are given below:

Examples:

Ambulance Officers may expect that they should not be affected by trauma especially if they have previously dealt with incidents quite effectively that would be regarded by most people as "traumatic".

It may be appropriate to point out that there are, at times, peculiarities about events which do make them significant for individuals, and also at different times there will be an unusual number of incidents involving infant deaths, so the last traumatic incident, while not being unique will be the "straw that breaks the camel's back".

Banking personnel, or others who may not expect trauma as a normal part of their job, may overestimate the impact of a hold up, having very negative expectations of their own abilities to handle the effects of such an incident if it should occur.

*Whether or not you have experienced a traumatic incident in the past, an important part of managing, coping and dealing with traumatic events is preparation.*

*Preparation involves gaining an understanding of what trauma is, what the reactions to it are, what we expect of ourselves and others, what makes the reactions worse or better, and how to assist recovery. Our own preparation also helps us to help others handle trauma.*



## TRAUMATIC STRESS

15 minutes

Having talked about what trauma is, the next section explores what the different reactions to trauma are.

*A set of reactions to trauma, called "TRAUMATIC STRESS", does seem to occur in most people after experiencing a traumatic event. For people who experience trauma daily, this reaction may only last a few hours. For others it may last much longer.*

*The set of physical and psychological reactions normally appears after an initial shock.*

Ask participants who have experienced a traumatic event, or know someone who has, whether there were any physical or psychological reactions?

Ask how it made them feel and whether the reactions occurred straight away, or a few hours or days later.

For example, for the fire fighter where trauma is a normal "part of the job", the reaction will probably be delayed such that they will not feel 'shock' on the scene and will perform duties and operations competently. Reactions may, however, become apparent when they return to the station. For occupations where trauma is not characteristic, eg a train driver, an immediate reaction following a railway accident may be seen, where the individual experiences shock in the situation itself.

Group feedback.

Whiteboard and  
flip chart

As the group responds, you may wish to write the reactions onto the whiteboard or flip chart, dividing the responses into columns of physical and psychological reactions.

Examples of reactions which may be generated by the group are:

#### PHYSICAL

tension  
headaches  
illness  
nausea  
diarrhoea  
loss of appetite  
sleep disturbance  
nervousness  
poor  
coordination  
lethargy  
slowed reflexes  
restlessness  
sexual difficulties  
easily startled

#### PSYCHOLOGICAL

nightmares about  
event  
flashbacks  
preoccupied thoughts  
feelings of panic  
anxiety and  
depression  
irritability  
anger/guilt  
fear in response to  
triggers or  
reminders  
poor concentration/  
memory  
lack of confidence  
in job  
withdrawal from  
people and  
relationships  
problems  
communicating  
increased drinking,  
smoking, taking  
medication

Overhead #3



Put up Overhead #3.

Compare the group's list with the common reactions listed on Overhead #3. Point out and discuss similarities between the lists.

Although a common set of traumatic stress reactions can be outlined, there is individual variability in terms of which reactions will be present and the degree to which these reactions will be shown. Some or all of these components will be evident in most people after a traumatic event.

Even though they are uncomfortable and unpleasant, these reactions are all perfectly normal and can be expected. There are, however, some people who become further distressed by their own reactions such as the nightmares, flashbacks, or feelings of helplessness and confusion.

If we understand what we can expect in ourselves and others after a traumatic event, we are already in a better position to deal with that reaction in a positive fashion.



RECOVERY CYCLE

5 minutes

Overhead #4



*The traumatic stress reaction normally follows a recovery cycle over a period of time. How severe the reaction is and how long it lasts differs between individuals according to their preparation and their experience.*

Put up Overhead #4.

*Most people do, however, go through a cycle of recovery beginning with the initial stage of shock.*

*Where a person reacts with shock (Stage 1) they feel numb, disbelieving, unable to comprehend the situation, startled, aroused and tense. This can last a few hours or even days.*

*The initial shock phase is often followed by the acute stress reactions listed earlier, where the awareness of the event increases (Stage 2). Thoughts "intrude", or come into the person's mind involuntarily, there may be nightmares or unexpected and unexplained feelings of anxiety or other strong emotions.*

*Here, temporary changes in behaviour may also be seen (e.g. drinking, irritability, inability to concentrate, relate to others, or perform). This phase may last for several days or even weeks.*

*Finally, there is a period of acceptance and recovery (Stage 3), where the event is able to be dealt with and accepted, so that physical and psychological well-being is restored.*

*This pattern of recovery is normal and to be expected, and is part of the body and mind's way of adjusting to shock or severe disturbance and disruption.*

Ask if any participants have experienced this cycle of recovery, or seen it in someone else? If the group has had no experience with trauma, participants may describe a grief reaction.

Group feedback.





*A traumatic stress reaction is only different to any other stress reaction in its severity or acuteness. The signs and symptoms of the reaction are exactly the same as the commonly understood "stress" response.*

*In any stress reaction, once a threat has been perceived by the brain, messages are sent to the adrenal glands to release the "emergency" or "stress" hormones of adrenaline and cortisol.*

*Adrenaline is responsible for all the familiar and instant "rush" feelings of increased heart rate, increased respiration rate, sweating, muscle tension, blood flow changes away from face, hands and feet (leaving us cold and pallid) into the large muscle groups. Our "attention range" is broadened, and no longer focussed and the digestive processes are suspended for a while. Simultaneously, cortisol is facilitating an energy surge into the bloodstream.*

*These normal, instantaneous changes prepare us for "fight or flight" ie, to run away from the threat, or to fight it. This response evolved to help man cope with threats in his environment.*

*If, however, this stress reaction is extreme, or if it occurs repeatedly, it is not difficult to envisage how the symptoms and signs of "traumatic stress" eg, nausea, tension, headaches, sleep disturbance, restlessness, startle reactions, and poor concentration and memory may result. It will be useful to keep the concept of the stress response and its relationship to "traumatic stress" in mind throughout this seminar, particularly when we come to consider how to cope best with the traumatic stress reaction.*

*It is common and perfectly normal to experience changes in the way we feel and think after trauma. These thoughts and feelings are often strong, unfamiliar and fairly distressing.*

**BREAK**

5 minutes

VIDEO

"Trauma at Work"  
Video (17 minutes)

20 minutes



Summary of video



*Now may be a good opportunity to break and look at the video, which covers some of the points raised so far.*

*The video is called "Trauma at Work", and was made in Australia by Industrial Program Service for use with different types of organizations whose employees are at risk of experiencing "traumatic stress".*

*Although the types of traumatic events people face are different, the reactions and recovery cycles are similar.*

*Some people will identify with these feelings and reactions, others will not have experienced them.*

*The video outlines ways in which we can start to prepare ourselves psychologically for the trauma, and cope with it after it occurs.*

(Show video here)

Ask for reactions and feedback to and feedback the video.

The important messages in the video which should be emphasised are:

- (1) That the reactions are normal. Even though we may not feel, think or behave as we normally do, these reactions are signs that the normal recovery process is taking place.
- (2) That a normal recovery process following the initial shock period, can be expected.



RECOVERY:FOR WORSE OR FOR BETTERPart 1: Avoiding the  
worst

10 minutes

Overhead #5



*Problems can, however, occur if the recovery process fails to take its normal course. In some people, the reactions do not steadily improve. In fact, the "traumatic stress" reactions can be worsened or prolonged by a variety of factors, and can become quite damaging to physical and psychological health.*

*These may be characteristics of the event itself, of the person, or how we deal with the trauma at the time or afterwards, and can be grouped into factors before, during and after the event.*

Put up Overhead #5.

1. Before - disclose "Before" on the overhead.

*Many of these factors are qualities that the individual brings into the situation, potentially worsening the reaction, hindering recovery.*

Ask the group to call out ideas.

Examples here might be:

- . existing stress levels
- . fatigue
- . illness
- . financial and family problems
- . incomplete recovery from the last event
- . lack of preparation for traumatic incidents
- . lack of awareness about trauma on the job
- . lack of understanding of the reactions to trauma
- . unrealistic expectations of yourself, your performance, or how you will cope.

2. During - Disclose "During" on the overhead

*There is also a group of factors from in or around the event which may worsen the reaction.*

Again ask the group to call out ideas.

Examples may include:

- . expectations from others (e.g. pressure from other staff or managers to react in a particular way)
- . heavy demands during, or shortly after, the event (remembering faces, details, procedures reporting to media or police)
- . identification with the victim (e.g. same name or age as your child or yourself)
- . not having a clear, realistic set of procedures or plan to follow.

3. After - Disclose "After" on the overhead.

*Certain things which we do or which happen after the event also affect recovery:*

The group should once again be encouraged to come up with ideas.

Examples are:

- . external triggers or reminders (e.g. in the paper, on TV, objects, times, scenes)
- . another event happening in quick succession
- . other life stresses occurring around that time
- . poor methods of coping e.g. using prescription drugs or alcohol
- . "bottling-up" feelings, or lack of opportunity to talk it through with a caring person

- . lack of understanding and support from family, friends, or work
- . getting back to work too quickly or too slowly
- . performance demands at work after the event, when we are still confused and distressed
- . pressure from others telling you how to cope with the situation
- . implicit pressure from self or others to appear invulnerable, encouraging denial of these effects.

. Encourage participants to use their own experience, the experiences of their peers, ideas from the video, or general thoughts and impressions they may have, to consider what might make their own reaction worse. Add participants ideas to the list. Discuss.



FOR WORSE OR FOR BETTERPart 2: Making it better

10 minutes

Overhead #6



*Looking at these three groups of factors, are there any implications for assisting ourselves and others through the recovery process?*

Put up Overhead #6.

After the event - Disclose "After" on overhead.

*Beginning with after (point to this category on overhead) what can be done here to hasten the recovery process?*

Before disclosing the points on the overhead encourage the group to generate some of the following ideas:

- accept reactions, and be aware of the likelihood of flashbacks and the effect of triggers  
Key word: **awareness**
- engage in normal social and leisure routines  
Key word: **routines**
- engage in regular and vigorous exercise, and attend to diet  
Key words: **diet and exercise**
- carefully monitor and minimise other personal stresses  
Key words: **control personal stress**
- talk to - peers, family, work colleagues or formal groups where possible  
Key words: **talk - share feelings**
- learn meditation or relaxation techniques, or yoga and maintain a healthy, relaxing lifestyle.  
Key words: **stress management**

- seek help, such as counselling, where appropriate. Counselling is able to assess problems and guide people through a normal recovery cycle. Specific skills can be learned and other stresses managed.  
Key word: **counselling**
- assess carefully the correct time for returning to work. Counselling can help individuals make this decision.  
Key word: **timing**
- allow yourself time to progress through the recovery cycle.  
Key word: **patience.**

(In early stages of shock immediately after the event, it is extremely difficult to remember to use self-protective strategies. Workmates and Supervisors should encourage individuals to engage in the above strategies.)

During the Event - Disclose "During" on overhead.

*What can be done during the event to hasten recovery?*

The likelihood of a quick recovery can be increased by:

- making sure procedures for what to do in the situation are clear  
Key word: **procedures**

Prior to the event - Disclose "Before" on overhead.

*Before the event, how can resistance be increased?*

Prior to the event each individual can maximise their own resistance to the impact of trauma by:

- adequate preparation and rehearsal of procedures  
Key word: **preparation**
- understanding more about the nature of trauma and its reactions  
Key word: **understanding**

- adopt a healthy lifestyle, through improved diet and exercise  
Key word: **health**
- schedule regular relaxation and leisure activities  
Key word: **relaxation**
- improved communication of feelings and emotions with family, peers and co-workers  
Key word: **communication**
- analyse the attitudes and expectations we may have of ourselves and others for coping with trauma  
Key words: **attitudes and expectations**
- encourage realistic expectations from others through information and education  
Key word: **education**

#### Handout 1



Distribute Handout 1 to participants.

*A normal recovery process can be anticipated if some of these strategies are attended to and practised.*

*In order to facilitate the recovery process, each of us can begin to prepare ourselves right now. We would like to encourage each of you to examine what changes you could make or steps you could take to help yourself prepare for trauma. Make a commitment to yourself to take at least one step over the next few weeks and write it down now.*

Allow 2 minutes.

*Would you like to share your personal commitment with the group?*

Feedback from the group.



If the Trauma Workshop is being held immediately following the Seminar, conclude Seminar here. Otherwise, proceed with summary over.





SUMMARY

10 minutes

*The messages we hoped to convey from this seminar were:*

- a. That trauma at work does impact upon each of us. The impact may be small or large, immediate or delayed and may be seen to take many forms.*
- b. Despite the variability between individuals in signs and symptoms of traumatic stress, there is a recognisable recovery course which can be observed.*
- c. Certain measures can be taken which ensure that the recovery course proceeds as normal and is not blocked or hampered in any way.*
- d. These measures include things we can do now to increase our awareness and preparedness.*

Trainers may wish to distribute copies of overheads as handouts now. Encourage each participant to examine their ideas further, by themselves, with their colleagues and families.

Thank participants for their attendance.



**APPENDIX 10.3**

**Assertiveness in Communications Course Outline**

# ASSERTIVENESS in COMMUNICATION

## SELF ASSERTIVENESS

Many people are unable to respond to situations with sufficient skills to enable them to feel comfortable with their response.

Some people respond aggressively and are domineering whilst others are often apologetic and non-assertive.

When this lack of a rational and comfortable response persists a low self-worth develops.

This workshop has been designed to teach you basic communication skills so that you can respond to situations in an honest, direct and assertive manner that gains you the respect of your peers and enhances your own self-esteem.

We hope you enjoy this workshop and find it useful in your everyday lives.

**PLEASE DO NOT TURN THE PAGES OF THIS  
WORKBOOK UNTIL INSTRUCTED TO DO SO BY  
THE WORKSHOP LEADER**

## RATHUS ASSERTIVENESS TEST

The Rathus Assertiveness Test assesses your usual response style when dealing with potentially difficult situations.

Some questions on the test may not be relevant to your immediate situation. However please respond as you imagine you would if placed in that situation.

**Directions:** Using the code below indicate how characteristic or descriptive of you each of the following statements is.

+ 3	very characteristic, extremely descriptive
+ 2	rather characteristic, quite descriptive
+ 1	somewhat characteristic, slightly descriptive
- 1	somewhat uncharacteristic, slightly nondescriptive
- 2	rather uncharacteristic, quite nondescriptive
- 3	very uncharacteristic, extremely nondescriptive

1. Most people seem to be more aggressive and assertive than I am
2. I have hesitated to make or accept dates because of "shyness"
3. When the food served at a restaurant is not to my satisfaction, I complain about it to the waiter or waitress
4. I am careful to avoid hurting other people's feelings, even when I feel I have been injured
5. If a salesman has gone to considerable trouble to show me merchandise that is not quite suitable, I have difficulty in saying "No"
6. When I am asked to do something I insist on knowing why
7. There are times when I look for a good vigorous argument
8. I strive to get ahead as well as most people in my position
9. To be honest, people often take advantage of me
10. I enjoy starting conversations with new acquaintances and strangers
11. I often don't know what to say to attractive persons of the opposite sex
12. I will hesitate to make phone calls to business establishments and institutions
13. I would rather apply for a job or admission to a college by writing letters rather than going through a personal interview
14. I find it embarrassing to return merchandise
15. If a close and respected relative were annoying me, I would smother my feelings rather than express my annoyance

16. I have avoided asking questions for fear of sounding stupid
17. During an argument I am sometimes afraid that I will get so upset that I will shake all over
18. If a famous and respected lecturer makes a statement that I think is incorrect I will have the audience hear my point of view as well
19. I would avoid arguing over prices with shop assistants
20. When I have done something important or worthwhile, I manage to let others know about it
21. I am open and frank about my feelings
22. If someone has been spreading false and bad stories about me, I see him/her as soon as possible and "have a talk about it"
23. I often have a hard time saying "No"
24. I tend to bottle up my emotions rather than make a scene
25. I complain about poor service in a restaurant and elsewhere
26. When I am given a compliment, I sometimes don't know what to say
27. If a couple near me in a theatre or lecture were conversing rather loudly, I would ask them to be quiet or to take their conversation elsewhere
28. Anyone attempting to push ahead of me in a line is in for a good battle
29. I am quick to express an opinion
30. There are times when I just can't say anything.

**My Score:**\_\_\_\_\_

**My Response Style is Often:**\_\_\_\_\_

## RECOGNITION EXERCISE

The following exercise is designed to evaluate your ability to distinguish between an assertive, aggressive or non-assertive response style.

In the right hand column mark each response as either assertive, aggressive or non-assertive.

Situation	Response	Your Answer
The date is being set for the next meeting of the committee of which you are a member. You are keen to attend but the proposed date accepted by everyone else means you cannot attend. When the chairman says "Is that OK for everyone then?" You say:	"Well, all right, as it seems to be convenient for everyone else".	
A colleague asks you for a lift home. It's inconvenient to you, as you are late already and the drive will take you out of your way. You say:	"I'm about 20 minutes late so I won't be able to take you home. If it helps I can drop you off at the nearest bus stop."	
You're having trouble getting started on a report. You can't see a logical starting point. You say to a colleague:	"I'm pretty useless at writing reports. I can't really see how to even start. I must be getting old."	
Your boss asks what went wrong when you were installing a new machine for a customer. You say:	"You wasted a lot of my time! You never told me he didn't have the area ready."	
A subordinate interrupts you when you are making an important call to a supplier. You say:	"I'd like to finish this phone call, then I'll be happy to answer your question"	
Your secretary is arranging your diary for the day. She asks you "What time will you be back in the office?" You answer:	"When you see me walk in."	

A colleague hears you dealing with an awkward parent. Afterwards he praises the way you handled it. You say:	"Well, I only really came in at the end".	
You sat in on a presentation given by one of your staff. You felt it was highly successful. You say:	"I think that was a really good presentation. I particularly liked the way you made the material interesting."	
A colleague has just produced a good work plan for his department. You'd like his help with one for your department. You say:	"That work plan you produced is a good approach. Will you be able to spend half an hour working on one for me with my department."	
A member of staff tells you she is wanting to take responsibility for some of the enquiries. You say:	"What on earth for? You know jolly well you're struggling to keep up with the filing - without doing extra work."	
A salesman has been pushing hard for you to buy a piece of equipment. You are not too sure; besides, you had thought of looking at several makes before deciding. You say:	"Well, I suppose it's more or less what I am looking for. I was going to look at other makes, but perhaps this will be OK."	
A colleague agreed to come to a special meeting and then failed to turn up. You ring him and say:	"Dave, I understood you were coming to the meeting. I would have liked you to be there. What happened?"	
A subordinate has asked for time off to visit a sick relative at a time when things are very busy. You say:	"I hope you won't think I'm being mean, but Mr. Cross will not like you taking time off tomorrow. I'm very sorry."	



Your boss asks you to attend a meeting. The last time you went it wasn't relevant to your department so you don't want to go. You say:	"I'm really busy this week with lots of work. I don't think I'll have time to go."	
You're about to do some photocopying when a fellow employee who often asks you to do her copying says: "Can you just run off 30 of these for me". You say:	"I'm usually happy to help out, but I don't want to spend time on extra copying this morning."	

## WHAT IS AGGRESSION?

Standing up for your own rights in a way that:

- violates the rights of others
- ignores the opinions, needs and feelings of others
- is inappropriate i.e. loud, angry, rude, derisive, arrogant

## WHAT IS NON-ASSERTIVENESS

Failing to stand up for your rights because:

- you fail to express your opinions at all or
- you express your opinions in a way that is apologetic, weak or self-effacing so that others can easily disregard them

## WHAT IS ASSERTIVENESS?

Standing up for your own rights in a way that is :

- direct
- honest
- appropriate
- and does not violate the rights of others

## ROLE PLAYS

### SITUATION 1 - PARENT/TEACHER MEETING

Teacher	Parent
The teacher wants to inform the parents that the child is often disruptive in class and, despite having ability, is at times disorganised	Parent was unaware there was a problem but is prepared to discuss it

Teacher is AGGRESSIVE

### SITUATION 2 - AFTER SCHOOL

Sue	Jane
Sue asks Jane at short notice to do her bus duty as a "favour" because she wants to get to the hairdresser before she goes out tonight. Sue is known to be manipulative and persistent	Jane wants to refuse because she would like to finish preparing tomorrow's lessons before going home to her family

Jane is NON-ASSERTIVE

### SITUATION 3 - TEAM TEACHING

Teacher 1	Teacher 2
Teacher 1 arrives late for school again and, as she has not prepared her lessons, asks Teacher 2 for his notes to get her through the day's classes. This is the third time this term that this has occurred. Teacher 1 is persuasive and is used to getting her own way.	Wants to assert his rights and refuse.

Teacher 2 is ASSERTIVE

**DISCUSSION OF ROLE PLAYS**

**1. In Situation 1**

(a) How do you feel the parent was treated?

---

---

(b) Describe the teacher's behaviour

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(c) Was the situation resolved satisfactorily?

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(d) How do you think the teacher felt afterwards?

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**2. In Situation 2**

(a) What was your opinion of Jane?

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(b) How was Jane treated?

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(c) How do your think Jane felt about the outcome of the situation?

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**3. In Situation 3**

(a) Who had control over the situation?

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(b) What was your opinion of teacher 2?

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(c) Was the situation resolved satisfactorily?

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## **PREPARING YOURSELF TO BE ASSERTIVE**

Responsible assertion rests on the two beliefs set out below.

Read them over and think about how they apply to you.

The first belief is a straightforward observation but it is important because it is ultimately your motivation for putting in the effort to be assertive.

### **ASSERTIVE BELIEF 1**

**ASSERTION, RATHER THAN SUBMISSION,  
MANIPULATION OR AGGRESSION, LEADS  
TO MORE SATISFYING AND SUCCESSFUL  
INTERPERSONAL RELATIONSHIPS AND SO  
ENRICHES YOUR LIFE**

The second belief looks obvious and some people are surprised it rates a mention but in practice you will find many people who act as if certain groups, like children, adolescents, women or employees, should not be asserting themselves.

If you are going to be responsibly assertive, that means you expect others to be assertive with you.

### **ASSERTIVE BELIEF 2**

**EVERYONE IS ENTITLED TO ACT  
ASSERTIVELY AND TO EXPRESS HIS OR  
HER HONEST THOUGHTS, FEELINGS AND  
BELIEFS.**

If you find the idea of behaving assertively daunting or even frightening, or if your first few attempts at being assertive were not as successful as you would have hoped, then strengthen your assertive frame of mind by practicing the self statement below.

You will find it a good preparation to read through before entering a situation in which you may expect a confrontation.

### POSITIVE SELF-STATEMENT

I EXPECT TO FEEL ANXIOUS WHEN I ASSERT MYSELF BECAUSE MOST PEOPLE DO. I WOULD FEEL DISAPPOINTED IF IT DOESN'T WORK, AND I MIGHT FEEL EMBARRASSED OR FRIGHTENED IF THE OTHER PERSON OVERREACTS, BUT I CAN COPE WITH ANY OF THOSE FEELINGS, AND THE CHANCE OF THEM HAPPENING IS NOT A GOOD REASON FOR ME TO SURRENDER MY RIGHTS.

I WILL CONSIDER THE RIGHTS AND FEELINGS OF OTHERS IN ANY SITUATION BEFORE I ASSERT MYSELF.

IT IS IMPORTANT FOR MY OWN SELF-ESTEEM TO ASSERT MYSELF REASONABLY AND RESPONSIBLY BECAUSE IN THIS WAY I WILL GAIN THE RESPECT OF OTHERS.

## **THE FOUR STEPS TO BECOMING ASSERTIVE**

**STEP 1: LISTEN TO OTHERS**

**STEP 2: BE FLEXIBLE**

**STEP 3: ASSERT YOURSELF**

**STEP 4: REVIEW THE SITUATION**

## **SELF-ASSERTIVENESS IN COMMON SITUATIONS**

### **MAKING REQUESTS**

1. Don't apologise profusely
2. Be direct
3. Keep it short
4. Don't justify yourself
5. Don't sell your request
6. Don't play on people's good nature/friendship
7. Give a reason
8. Don't take a refusal personally
9. Respect the other person's right to say "No"

### **REFUSING REQUESTS**

1. Keep the reply short
2. Simply say "No"
3. Give a reason
4. Avoid "I Can't" phrases
5. Don't apologise profusely
6. Acknowledge the request
7. Honestly state limitations/possibilities
8. Ask for clarifications
9. Ask for more time
10. Non-verbal behaviour

### **THE PERSISTENT REQUESTER**

1. Repeat your refusal
  - add the reason if you didn't before
  - leave it out if you did
2. Slow down
3. Emphasise repeated words
4. Don't search for better reasons
5. Continue to use "broken record" technique



## **DISAGREEING and STATING YOUR VIEWS**

1. State disagreement clearly
2. Express doubts in a constructive way
3. Use "I" statements
4. Change your opinion
5. Give reasons for your disagreement
6. State areas of agreement and disagreement
7. Recognise other points of view

## **GIVING PRAISE**

1. Maintain eye contact
2. Keep it brief and clear
3. Use "I" statements
4. Make it specific

## **RECEIVING PRAISE**

1. Keep the response short
2. Simply thank the giver
3. Agree with/ accept praise
4. Qualify your reply

## REFUSING REQUESTS; THE PERSISTENT REQUESTER

Stan: Uh.....hello, Genevieve.

Gen: Hi. Stan. What's new?

Stan: Well, Gen, I'm here to give you a chance to help your fellow man.  
(*Uses a cliché*)

Gen: Really. How can I do that? (*Asks for details*)

Stan: Well, as you know, I collect for the Red Cross every year.

Gen: Wait a minute, Stan, and I'll get my purse.

Stan: Genevieve, I need a little more help this year. I'm going to be away on vacation during the collection drive.

Gen: Oh, that's too bad, Stan.

Stan: You could do a good turn and really help me out of a jam if you'd collect from the neighbours in my place.

Gen: Gee, Stan, you're right in saying it would be a good turn and it would help you out, but I'd rather not collect from the neighbours.  
(*Agrees with truth and self-discloses*)

Stan: And it would give the opportunity to keep in touch with Meg, Liz and Veronica and all your friends. Besides, you said you wanted to meet more people in the neighbourhood. Well, Gen, here's your chance.

Gen: Yes, Stan, it would be a good opportunity to see my friends and meet new neighbours, but I'd rather not collect from the neighbours. (*Agrees with the truth and uses broken record*)

Stan: I'm sure you'd be very good at it. Everyone in the neighbourhood likes you.

Gen: It's nice of you to say that, but I'd rather not collect from the neighbours. (*Broken record*)

Stan: You know, of course, that it would only take an hour of your time.

Gen: I'm sure it would only take an hour, Stan, but I'd rather not collect from the neighbours. (*Agrees with truth and uses broken record*)

Stan: You know, the Red Cross does a lot of good for people.

Gen: They certainly do, but I'd rather not collect from the neighbours.  
(*Agrees with truth and uses broken record*).

Stan: Why don't you want to do it, Genevieve.? I don't understand.

Gen: I know it makes no sense to you, but I'd rather not. (*Agrees with the critic's right to an opinion and uses broken record*)

Stan: It doesn't sound like you care all that much for your fellow man, Genevieve.

Gen: I can see how you might think that, but I'd rather not collect from the neighbours. (*Agrees with the critic's right to an opinion and uses broken record*)

Stan: I don't think you're going to do this little favour for me.

Gen: You're right, Stan. I'm not. (*Agrees with the truth*)

# EVALUATION

Please complete the following evaluation of the workshop so that we may gauge if it has been successful in meeting your needs. Circle the number appropriate to your response

1. **How would you rate your overall enjoyment of this workshop**

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Average	Satisfied	Very Satisfied

2. **How would you rate the usefulness/practicality of this workshop to your needs**

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Average	Satisfied	Very Satisfied

3. **How would you rate the relevance/pertinence of this workshop to your needs**

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Average	Satisfied	Very Satisfied

4. **How would you rate the clarity and ease of understanding of the material presented in this workshop**

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Average	Satisfied	Very Satisfied

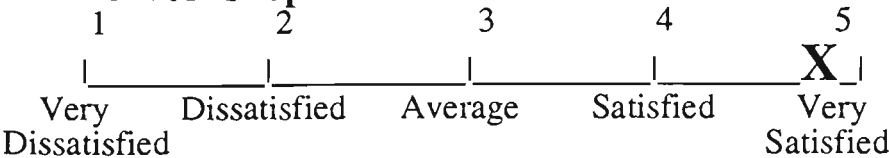
5. **Do you think you will put into practice what you have learnt today**

1	2	3	4	5
Not at all	In limited circumstances	Average	In most circumstances	Very much so

6. **Please rate the workshop leader**

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Average	Satisfied	Very Satisfied

7. Please rate the workshop overall



Do you have any comments to make or suggestions to assist us in improving this workshop

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Thank you for your participation in this workshop.  
We hope you have enjoyed it and it has been of  
benefit to you.



APPENDIX 12

Mean scores and standard deviations on each of the three subscales of the Perception of Psychologists Scale for each participating organisation as a function of department, psychologist sex of S, and time.

Mean scores and standard deviations on the Confidence subscale of POPS from Organisation 1 participants as a function of department, psychologist, sex and time

Organisation	1
Subscale	Confidence

Time	Department A												Department B			
	Psychologist 1				Psychologist 2				Psychologist 3							
	M		F		M		F		M		F		M		F	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
T <sub>1</sub>	20.842	2.272	24.412	1.326	21.282	1.638	23.438	1.209	19.500	1.180	24.176	2.351	23.716	2.175	23.677	2.151
T <sub>2</sub>	26.316	1.561	27.647	0.702	25.846	1.615	27.063	1.526	24.763	1.532	27.471	1.125	22.813	2.308	23.194	2.286
T <sub>3</sub>	32.395	1.443	32.588	1.326	32.231	1.404	32.875	1.088	31.263	1.589	31.353	0.998	24.127	3.111	24.613	3.556

Mean scores and standard deviations on the Confidence subscale of POPS from Organisation 2 participants as a function of department, psychologist, sex and time

Organisation	2
Subscale	Confidence

Time	Department A												Department B			
	Psychologist 1						Psychologist 2						Psychologist 3			
	M		SD		F		M		SD		F		M		SD	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
T <sub>1</sub>	25.097	2.006	27.875	2.328			25.321	2.161	28.222	1.209			25.888	1.351	27.857	2.351
T <sub>2</sub>	31.097	1.557	33.042	1.517			29.607	1.397	33.370	1.735			32.618	2.349	33.857	2.287
T <sub>3</sub>	37.516	1.208	37.542	1.318			37.750	1.602	37.741	1.873			38.324	2.396	37.667	1.354
													25.425	2.613	28.295	2.654



Mean scores and standard deviations on the Confidence subscale of POPS from Organisation 3 participants as a function of department, psychologist, sex and time

Organisation	3
Subscale	Confidence

Time	Department A												Department B			
	Psychologist 1				Psychologist 2				Psychologist 3							
	M		F		M		F		M		F		M		F	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
T <sub>1</sub>	22.270	2.479	26.167	1.855	21.848	2.123	26.455	2.385	23.438	3.058	26.304	3.211	23.267	2.132	26.153	2.060
T <sub>2</sub>	28.054	1.353	29.444	1.464	29.758	1.542	29.545	1.654	28.375	2.459	30.870	3.321	22.860	1.798	26.556	2.276
T <sub>3</sub>	31.784	2.123	31.667	2.449	32.152	3.492	32.091	3.085	32.563	2.078	33.261	2.454	23.022	2.828	26.042	2.816

Mean scores and standard deviations on the Knowledge subscale of POPS from Organisation 1 participants as a function of department, psychologist, sex and time

Organisation	1
Subscale	Knowledge

Time	Department A												Department B			
	Psychologist 1				Psychologist 2				Psychologist 3							
	M		F		M		F		M		F		M		F	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
T <sub>1</sub>	17.158	1.717	20.412	2.063	16.974	1.513	20.375	2.247	17.368	1.601	20.176	2.069	17.030	2.951	20.161	3.216
T <sub>2</sub>	20.526	2.023	22.235	1.985	21.769	2.096	22.313	1.922	21.316	2.042	22.765	1.522	17.327	1.689	20.368	1.329
T <sub>3</sub>	23.289	1.575	23.765	1.562	23.667	2.062	23.375	2.062	24.739	1.841	24.002	1.768	17.378	2.916	20.548	2.827

Mean scores and standard deviations on the Knowledge subscale of POPS from Organisation 2 participants as a function of department, psychologist, sex and time

Organisation	2
Subscale	Knowledge

Time	Department A												Department B			
	Psychologist 1				Psychologist 2				Psychologist 3							
	M		F		M		F		M		F		M		F	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
T <sub>1</sub>	36.419	1.501	36.292	1.601	36.964	1.071	36.852	1.292	36.147	1.184	36.286	0.902	36.460	2.271	36.423	2.282
T <sub>2</sub>	39.290	1.488	39.333	1.404	39.500	1.374	39.824	1.715	39.824	1.749	40.000	1.643	36.769	2.082	36.769	2.144
T <sub>3</sub>	41.645	1.142	41.500	1.251	41.393	1.198	41.704	1.171	41.735	1.880	42.190	1.537	36.586	1.722	36.615	1.684

Mean scores and standard deviations on the Knowledge subscale of POPS from Organisation 3 participants as a function of department, psychologist, sex and time

Organisation	3
Subscale	Knowledge

Time	Department A												Department B			
	Psychologist 1				Psychologist 2				Psychologist 3							
	M		F		M		F		M		F		M		F	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
T <sub>1</sub>	17.676	2.829	20.556	2.662	18.030	2.663	20.591	2.404	17.375	3.150	20.696	3.267	17.559	3.595	20.625	3.698
T <sub>2</sub>	21.973	1.658	23.278	1.602	21.697	2.663	22.955	2.011	22.188	1.655	23.348	1.229	17.591	1.670	20.500	1.583
T <sub>3</sub>	26.243	2.087	26.778	1.665	26.121	1.916	26.636	2.083	26.156	2.579	26.435	0.945	17.226	2.968	20.778	2.878

Mean scores and standard deviations on the Stigma Tolerance subscale of POPS from Organisation 1 participants as a function of department, psychologist, sex and time

Organisation	1
Subscale	Stigma Tolerance

Time	Department A												Department B			
	Psychologist 1				Psychologist 2				Psychologist 3							
	M		F		M		F		M		F		M		F	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
T <sub>1</sub>	16.763	2.272	19.588	1.417	16.667	1.638	20.125	1.088	16.842	1.180	19.706	1.961	17.022	2.175	19.839	2.035
T <sub>2</sub>	19.010	1.831	21.059	1.144	18.769	1.662	21.063	1.692	18.421	1.718	20.412	1.004	17.358	1.509	19.839	1.594
T <sub>3</sub>	23.237	2.307	23.118	1.409	23.667	1.883	23.938	1.526	24.211	1.436	24.118	1.111	17.567	2.773	19.742	2.768

Mean scores and standard deviations on the Stigma Tolerance subscale of POPS from Organisation 2 participants as a function of department, psychologist, sex and time

Organisation	2
Subscale	Stigma Tolerance

Time	Department A												Department B			
	Psychologist 1				Psychologist 2				Psychologist 3							
	M		F		M		F		M		F		M		F	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
T <sub>1</sub>	22.235	1.731	24.208	1.668	22.357	1.283	24.519	1.805	22.824	1.696	24.100	1.449	22.023	2.151	24.179	2.124
T <sub>2</sub>	26.161	1.881	28.167	1.971	26.964	1.732	28.407	1.845	26.176	1.866	28.095	3.032	24.574	2.496	24.049	2.438
T <sub>3</sub>	29.774	1.477	29.750	1.482	29.393	1.423	29.630	1.391	30.088	2.050	30.143	3.275	23.598	1.434	23.526	1.430

Mean scores and standard deviations on the Stigma Tolerance subscale of POPS from Organisation 3 participants as a function of department, psychologist, sex and time

Organisation	3
Subscale	Stigma Tolerance

Time	Department A												Department B			
	Psychologist 1				Psychologist 2				Psychologist 3							
	M		F		M		F		M		F		M		F	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
T <sub>1</sub>	17.324	1.973	20.556	2.229	17.242	2.372	20.445	3.035	17.063	2.031	20.012	2.419	17.068	1.930	20.750	1.798
T <sub>2</sub>	20.919	1.862	23.389	1.614	20.909	2.983	23.545	2.283	20.531	2.676	23.565	3.355	17.151	0.999	20.528	1.021
T <sub>3</sub>	25.973	2.166	26.389	1.685	25.818	3.025	26.318	1.756	25.925	1.238	26.826	1.800	17.731	1.973	20.972	1.986

Table 1 - Tests of Between-Subject Effects

Source of Variation	SS	df	MS	F	p
Within cells	2300.12	476	4.83		
Regression	1.50	1	1.50	.31	>.05
SEX	2181.56	1	2181.56	451.46	<.05
ORG	72236.46	2	36.118.23	7474.52	<.05
PSYC	40.46	2	20.23	4.19	>.05
SEX x ORG	97.01	2	48.51	10.04	<.05
SEX x PSYC	2.10	2	1.05	.22	>.05
ORG x PSYC	211.71	4	52.93	10.95	<.05
SEX x ORG x PSYC	33.49	4	8.37	1.73	>.05

Table 2 - Tests Involving TIME Within-Subjects Effect

Source of Variation	SS	df	MS	F	p
Within cells	4622.39	954	4.85		
TIME	35268.97	2	17634.49	3639.52	<.05
SEX x TIME	513.27	2	256.63	52.97	<.05
ORG x TIME	327.80	4	81.95	16.91	<.05
PSYC x TIME	185.56	4	46.39	9.57	<.05
SEX x ORG x TIME	332.27	4	83.07	17.14	<.05
SEX x PSYC x TIME	199.27	4	49.82	10.28	<.05
ORG x PSYC x TIME	374.55	8	46.82	9.66	<.05
SEX x ORG x PSYC x TIME	177.37	8	22.17	4.58	<.05



Table 3 - Tests Involving SUBSCALE Within-Subjects Effect

Source of Variation	SS	df	MS	F	p
Within cells	3694.54	954	3.87		
SUBSCALE	27912.30	2	13956.15	3603.74	<.05
SEX x SUBSCALE	205.61	2	102.81	26.55	<.05
ORG x SUBSCALE	35129.40	4	8782.35	2267.77	<.05
PSYC x SUBSCALE	408.03	4	102.01	26.34	<.05
SEX x ORG x SUBSCALE	210.05	4	52.51	13.56	<.05
SEX x PSYC x SUBSCALE	18.24	4	4.56	1.18	>.05
ORG x PSYC x SUBSCALE	731.74	8	91.47	23.62	<.05
SEX x ORG x PSYC x SUBSCALE	38.64	8	4.83	1.25	>.05

Table 4 - Tests Involving SUBSCALE BY TIME Within-Subjects Effect

Source of Variation	SS	df	MS	F	p
Within cells	5783.35	1908	3.03		
SUBSCALE x TIME	1817.45	4	454.36	149.90	<.05
SEX x SUBSCALE x TIME	97.13	4	24.28	8.01	<.05
ORG x SUBSCALE x TIME	1043.67	8	130.46	43.04	<.05
PSYC x SUBSCALE x TIME	263.86	8	32.98	10.88	<.05
SEX x ORG x SUBSCALE x TIME	118.99	8	14.87	4.91	<.05
SEX x PSYC x SUBSCALE x TIME	53.05	8	6.63	2.19	<.05
ORG x PSYC x SUBSCALE x TIME	523.27	16	32.70	10.79	<.05
SEX x ORG x PSYC x SUBSCALE x TIME	205.80	16	12.86	4.24	<.05

Number of participants and percentage for each group for Organisation 1 who referred themselves to the EAP for as a function of department, psychologist, time and sex of S

Organisation	1
	Referral to EAP

Time Period	Department A										Department B			
	X			Y			Z							
	M	%	F	%	M	%	F	%	M	%	F	%	M	%
T <sub>1</sub> -T <sub>2</sub>	4	10.52	1	5.88	4	10.25	2	12.50	3	7.89	0	0	2	1.49
T <sub>2</sub> -T <sub>3</sub>	3	7.89	2	11.76	5	12.92	2	12.50	4	10.53	3	17.65	5	3.73
Follow-up	3	7.89	0	0	4	10.25	1	6.25	4	10.53	2	11.76	3	2.23
TOTAL	10	26.32	3	17.64	13	33.3	5	29.41	11	28.94	5	29.41	10	7.46
														3
														7.90

Number of participants and percentage for each group for Organisation 2 who referred themselves to the EAP for as a function of department, psychologist, time and sex of S

Organisation	2
	Referral to EAP

Time Period	Department A										Department B			
	X					Y					Z			
	M	%	F	%	M	%	F	%	M	%	F	%	M	%
T1-T2	2	6.45	1	4.16	0	0	2	7.41	2	5.88	2	9.52	1	1.15
T2-T3	3	9.68	4	16.66	4	14.20	3	11.10	3	8.82	4	19.02	2	2.30
Follow-up	2	6.45	2	8.33	4	14.21	2	7.41	3	8.82	1	4.76	2	2.30
TOTAL	7	22.58	7	29.16	8	28.41	7	25.92	8	23.53	7	33.30	5	5.75
														6
														7.70

Number of participants and percentage for each group for Organisation 3 who referred themselves to the EAP for as a function of department, psychologist, time and sex of S

Organisation	3
	Referral to EAP

Time Period	Department A												Department B			
	X						Y						Z			
	M	%	F	%	M	%	M	%	F	%	M	%	M	%	F	%
T <sub>1</sub> -T <sub>2</sub>	2	5.41	2	11.10	1	3.03	3	13.64	3	9.38	3	13.04	1	1.08	1	1.39
T <sub>2</sub> -T <sub>3</sub>	5	13.49	2	11.10	6	18.15	4	18.16	2	12.49	4	8.70	2	4.32	2	2.78
Follow-up	5	13.49	2	11.10	4	12.12	0	0	1	9.38	3	4.34	4	4.32	3	4.16
TOTAL	12	32.40	6	33.30	11	33.3	7	31.80	6	31.25	10	26.08	19	9.68	6	8.33

APPENDIX 15

**Individual item mean scores on the Perception of Psychologists Scale as a function of organisation, department, psychologist, sex of S, and time.**

Item Number	1
Subscale	Stigma Tolerance

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.00	3.71	2.19	2.89	3.67	3.99	1.77	2.96	2.67	2.97	3.71	4.01	1.37	2.43	2.66	3.03	3.64	3.66
	2	1.79	3.88	2.77	3.01	3.51	4.01	1.32	3.00	2.79	3.12	3.79	3.96	1.33	2.54	2.91	2.98	3.52	4.00
	3	1.47	3.35	2.54	3.10	3.79	3.92	1.54	2.01	2.87	3.04	3.88	3.92	1.34	2.24	2.89	3.14	3.88	4.03
B		2.36	2.10	2.34	2.20	2.27	2.15	2.02	2.45	2.23	2.30	2.23	2.29	2.07	2.30	2.13	2.34	2.19	2.31

Item Number	2
Subscale	Knowledge

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.88	2.62	2.21	2.83	3.16	3.14	1.54	2.50	2.00	2.69	3.32	3.56	1.77	2.96	2.34	3.10	3.31	3.86
	2	1.91	2.76	2.48	3.45	2.78	3.25	1.24	2.68	1.92	2.87	3.24	3.72	1.32	2.45	2.47	3.01	3.29	3.39
	3	1.62	2.28	1.86	3.26	3.56	3.45	1.90	2.54	2.07	2.78	3.45	3.45	1.67	2.54	2.49	2.99	3.20	3.54
B		2.22	2.22	2.28	2.23	2.43	2.36	2.03	2.05	2.25	2.13	2.35	2.10	1.99	2.02	2.20	2.16	1.99	2.08

Item Number	3
Subscale	Stigma Tolerance

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.01	3.08	2.45	3.14	2.63	3.47	1.81	2.85	2.57	2.89	3.69	3.99	1.57	2.44	2.59	2.99	3.74	3.61
	2	1.92	3.85	2.69	3.07	3.55	3.99	1.30	2.97	2.83	3.21	3.80	3.86	1.43	2.51	2.89	3.01	3.57	4.02
	3	2.07	3.27	2.56	3.14	3.83	3.94	1.51	2.04	2.74	3.11	3.79	3.89	1.64	2.20	2.78	3.09	3.78	3.97
B		2.33	2.09	2.21	2.22	2.23	2.19	1.99	2.39	2.31	2.29	2.19	2.41	2.06	2.29	2.24	2.38	2.27	2.11

Item Number	4
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.88	2.75	2.23	2.91	3.19	3.23	1.61	2.56	2.13	2.77	3.21	3.66	1.81	2.79	2.29	3.08	3.39	3.84
	2	1.81	2.78	2.39	3.41	2.79	3.20	1.47	2.86	2.21	2.83	3.40	3.71	1.54	2.44	2.43	3.13	3.47	3.52
	3	1.60	2.40	1.95	3.28	3.62	3.39	1.49	2.52	2.33	2.78	3.42	3.50	1.63	2.51	2.37	3.19	3.35	3.59
B		2.29	2.16	2.33	2.25	2.34	2.30	2.12	2.12	2.20	2.19	2.10	2.37	1.91	2.09	2.25	2.11	1.96	2.14

Item Number	5
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.77	2.73	2.10	2.94	3.05	3.25	1.45	2.49	2.02	2.73	3.23	3.65	1.83	2.78	2.43	3.01	3.19	3.79
	2	1.80	2.87	2.37	3.56	2.67	3.36	1.42	2.86	1.94	2.78	3.42	3.74	1.71	2.54	2.70	3.16	3.41	3.54
	3	1.51	2.39	1.75	3.37	3.54	3.46	1.91	2.45	2.02	2.87	3.54	3.54	1.67	2.45	2.61	2.92	3.25	3.59
B		2.11	2.33	2.17	2.34	2.32	2.47	2.12	2.11	2.30	2.21	2.23	2.01	2.03	2.19	2.18	2.25	1.98	2.13

Item Number	6
Subscale	Stigma Tolerance

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.12	3.19	2.54	3.23	2.56	3.43	1.91	2.64	2.53	2.83	3.59	3.91	1.58	2.47	2.61	3.13	3.72	3.63
	2	2.03	3.44	2.59	3.18	3.55	3.68	1.54	2.97	2.73	3.11	3.82	3.96	1.48	2.71	2.83	3.07	3.52	3.98
	3	2.18	3.21	2.56	3.29	3.79	3.69	1.51	2.34	2.71	3.17	3.62	3.82	1.68	2.23	2.79	3.21	3.78	3.97
B		2.21	2.21	2.27	2.20	2.22	2.12	2.03	2.27	2.30	2.22	2.13	2.31	2.11	2.32	2.31	2.32	2.17	2.23



Item Number	7
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Subscale	Knowledge
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Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.81	2.57	2.32	2.89	3.29	3.33	1.62	2.52	2.34	2.72	3.22	3.46	1.69	2.74	2.35	3.12	3.42	3.92
	2	1.92	2.68	2.41	3.09	2.99	3.24	1.65	2.78	2.41	2.73	3.46	3.72	1.66	2.49	2.37	3.17	3.44	3.60
	3	1.69	2.50	2.22	3.02	3.42	3.41	1.57	2.63	2.29	2.71	3.35	3.54	1.51	2.46	2.43	3.23	3.31	3.67
B		2.01	2.21	2.31	2.21	2.31	2.32	2.03	2.23	2.27	2.34	2.23	2.41	1.95	2.14	2.31	2.15	1.99	2.20

Item Number	8
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Subscale	Knowledge
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Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.12	3.79	2.27	2.79	3.61	3.95	1.79	2.86	2.62	2.98	3.73	3.96	1.57	2.33	2.54	3.10	3.65	3.62
	2	1.91	3.96	2.81	3.05	3.52	4.06	1.30	3.00	2.74	3.16	3.82	3.89	1.53	2.51	2.79	3.05	3.55	3.91
	3	1.60	3.27	2.62	3.12	3.73	3.97	1.51	2301	2.86	3.09	3.84	4.01	1.54	2.34	2.77	3.21	3.85	4.06
B		2.12	2.28	2.61	2.29	2.24	2.18	2.02	2.34	2.28	2.35	2.21	2.27	2.17	2.36	2.24	2.41	2.29	2.19

Item Number	9
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.12	3.19	2.54	3.23	2.56	3.43	1.91	2.64	2.53	2.83	3.59	3.91	1.58	2.47	2.61	3.13	3.72	3.63
	2	2.03	3.44	2.59	3.18	3.55	3.68	1.54	2.97	2.73	3.11	3.82	3.96	1.48	2.71	2.83	3.07	3.52	3.98
	3	2.18	3.21	2.56	3.29	3.79	3.69	1.51	2.34	2.71	3.17	3.62	3.82	1.68	2.23	2.79	3.21	3.78	3.97
B		2.21	2.21	2.27	2.20	2.22	2.12	2.03	2.27	2.30	2.22	2.13	2.31	2.11	2.32	2.31	2.32	2.17	2.23

Item Number	10
Subscale	Knowledge

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.01	3.08	2.45	3.14	2.63	3.47	1.81	2.85	2.57	2.89	3.69	3.99	1.57	2.44	2.59	2.99	3.74	3.61
	2	1.92	3.85	2.69	3.07	3.55	3.99	1.30	2.97	2.83	3.21	3.80	3.86	1.43	2.51	2.89	3.01	3.57	4.02
	3	2.07	3.27	2.56	3.14	3.83	3.94	1.51	2.04	2.74	3.11	3.79	3.89	1.64	2.20	2.78	3.09	3.78	3.97
B		2.33	2.09	2.21	2.22	2.23	2.19	1.99	2.39	2.31	2.29	2.19	2.41	2.06	2.29	2.24	2.38	2.27	2.11

Item Number	11
Subscale	Stigma Tolerance

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.88	2.62	2.21	2.83	3.16	3.14	1.54	2.50	2.00	2.69	3.32	3.56	1.77	2.96	2.34	3.10	3.31	3.86
	2	1.91	2.76	2.48	3.45	2.78	3.25	1.24	2.68	1.92	2.87	3.24	3.72	1.32	2.45	2.47	3.01	3.29	3.39
	3	1.62	2.28	1.86	3.26	3.56	3.45	1.90	2.54	2.07	2.78	3.45	3.45	1.67	2.54	2.49	2.99	3.20	3.54
B		2.22	2.22	2.28	2.23	2.43	2.36	2.03	2.05	2.25	2.13	2.35	2.10	1.99	2.02	2.20	2.16	1.99	2.08

Item Number	12
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.77	2.73	2.10	2.94	3.05	3.25	1.45	2.49	2.02	2.73	3.23	3.65	1.83	2.78	2.43	3.01	3.19	3.79
	2	1.80	2.87	2.37	3.56	2.67	3.36	1.42	2.86	1.94	2.78	3.42	3.74	1.71	2.54	2.70	3.16	3.41	3.54
	3	1.51	2.39	1.75	3.37	3.54	3.46	1.91	2.45	2.02	2.87	3.54	3.54	1.67	2.45	2.61	2.92	3.25	3.59
B		2.11	2.33	2.17	2.34	2.32	2.47	2.12	2.11	2.30	2.21	2.23	2.01	2.03	2.19	2.18	2.25	1.98	2.13

Item Number	13
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.88	2.75	2.23	2.91	3.19	3.23	1.61	2.56	2.13	2.77	3.21	3.66	1.81	2.79	2.29	3.08	3.39	3.84
	2	1.81	2.78	2.39	3.41	2.79	3.20	1.47	2.86	2.21	2.83	3.40	3.71	1.54	2.44	2.43	3.13	3.47	3.52
	3	1.60	2.40	1.95	3.28	3.62	3.39	1.49	2.52	2.33	2.78	3.42	3.50	1.63	2.51	2.37	3.19	3.35	3.59
B		2.29	2.16	2.33	2.25	2.34	2.30	2.12	2.12	2.20	2.19	2.10	2.37	1.91	2.09	2.25	2.11	1.96	2.14

Item Number	14
Subscale	Stigma Tolerance

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.81	2.57	2.32	2.89	3.29	3.33	1.62	2.52	2.34	2.72	3.22	3.46	1.69	2.74	2.35	3.12	3.42	3.92
	2	1.92	2.68	2.41	3.09	2.99	3.24	1.65	2.78	2.41	2.73	3.46	3.72	1.66	2.49	2.37	3.17	3.44	3.60
	3	1.69	2.50	2.22	3.02	3.42	3.41	1.57	2.63	2.29	2.71	3.35	3.54	1.51	2.46	2.43	3.23	3.31	3.67
B		2.01	2.21	2.31	2.21	2.31	2.32	2.03	2.23	2.27	2.34	2.23	2.41	1.95	2.14	2.31	2.15	1.99	2.20

Item Number	15
Subscale	Knowledge

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.00	3.71	2.19	2.89	3.67	3.99	1.77	2.96	2.67	2.97	3.71	4.01	1.37	2.43	2.66	3.03	3.64	3.66
	2	1.79	3.88	2.77	3.01	3.51	4.01	1.32	3.00	2.79	3.12	3.79	3.96	1.33	2.54	2.91	2.98	3.52	4.00
	3	1.47	3.35	2.54	3.10	3.79	3.92	1.54	2.01	2.87	3.04	3.88	3.92	1.34	2.24	2.89	3.14	3.88	4.03
B		2.36	2.10	2.34	2.20	2.27	2.15	2.02	2.45	2.23	2.30	2.23	2.29	2.07	2.30	2.13	2.34	2.19	2.31

Item Number	16
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.01	3.08	2.45	3.14	2.63	3.47	1.81	2.85	2.57	2.89	3.69	3.99	1.57	2.44	2.59	2.99	3.74	3.61
	2	1.92	3.85	2.69	3.07	3.55	3.99	1.30	2.97	2.83	3.21	3.80	3.86	1.43	2.51	2.89	3.01	3.57	4.02
	3	2.07	3.27	2.56	3.14	3.83	3.94	1.51	2.04	2.74	3.11	3.79	3.89	1.64	2.20	2.78	3.09	3.78	3.97
B		2.33	2.09	2.21	2.22	2.23	2.19	1.99	2.39	2.31	2.29	2.19	2.41	2.06	2.29	2.24	2.38	2.27	2.11

Item Number	17
Subscale	Stigma Tolerance

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.12	3.79	2.27	2.79	3.61	3.95	1.79	2.86	2.62	2.98	3.73	3.96	1.57	2.33	2.54	3.10	3.65	3.62
	2	1.91	3.96	2.81	3.05	3.52	4.06	1.30	3.00	2.74	3.16	3.82	3.89	1.53	2.51	2.79	3.05	3.55	3.91
	3	1.60	3.27	2.62	3.12	3.73	3.97	1.51	2301	2.86	3.09	3.84	4.01	1.54	2.34	2.77	3.21	3.85	4.06
B		2.12	2.28	2.61	2.29	2.24	2.18	2.02	2.34	2.28	2.35	2.21	2.27	2.17	2.36	2.24	2.41	2.29	2.19

Item Number	18
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.81	2.57	2.32	2.89	3.29	3.33	1.62	2.52	2.34	2.72	3.22	3.46	1.69	2.74	2.35	3.12	3.42	3.92
	2	1.92	2.68	2.41	3.09	2.99	3.24	1.65	2.78	2.41	2.73	3.46	3.72	1.66	2.49	2.37	3.17	3.44	3.60
	3	1.69	2.50	2.22	3.02	3.42	3.41	1.57	2.63	2.29	2.71	3.35	3.54	1.51	2.46	2.43	3.23	3.31	3.67
B		2.01	2.21	2.31	2.21	2.31	2.32	2.03	2.23	2.27	2.34	2.23	2.41	1.95	2.14	2.31	2.15	1.99	2.20

Item Number	19
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.12	3.19	2.54	3.23	2.56	3.43	1.91	2.64	2.53	2.83	3.59	3.91	1.58	2.47	2.61	3.13	3.72	3.63
	2	2.03	3.44	2.59	3.18	3.55	3.68	1.54	2.97	2.73	3.11	3.82	3.96	1.48	2.71	2.83	3.07	3.52	3.98
	3	2.18	3.21	2.56	3.29	3.79	3.69	1.51	2.34	2.71	3.17	3.62	3.82	1.68	2.23	2.79	3.21	3.78	3.97
B		2.21	2.21	2.27	2.20	2.22	2.12	2.03	2.27	2.30	2.22	2.13	2.31	2.11	2.32	2.31	2.32	2.17	2.23

Item Number	20
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.77	2.73	2.10	2.94	3.05	3.25	1.45	2.49	2.02	2.73	3.23	3.65	1.83	2.78	2.43	3.01	3.19	3.79
	2	1.80	2.87	2.37	3.56	2.67	3.36	1.42	2.86	1.94	2.78	3.42	3.74	1.71	2.54	2.70	3.16	3.41	3.54
	3	1.51	2.39	1.75	3.37	3.54	3.46	1.91	2.45	2.02	2.87	3.54	3.54	1.67	2.45	2.61	2.92	3.25	3.59
B		2.11	2.33	2.17	2.34	2.32	2.47	2.12	2.11	2.30	2.21	2.23	2.01	2.03	2.19	2.18	2.25	1.98	2.13

Item Number	21
Subscale	Knowledge

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.12	3.79	2.27	2.79	3.61	3.95	1.79	2.86	2.62	2.98	3.73	3.96	1.57	2.33	2.54	3.10	3.65	3.62
	2	1.91	3.96	2.81	3.05	3.52	4.06	1.30	3.00	2.74	3.16	3.82	3.89	1.53	2.51	2.79	3.05	3.55	3.91
	3	1.60	3.27	2.62	3.12	3.73	3.97	1.51	2.301	2.86	3.09	3.84	4.01	1.54	2.34	2.77	3.21	3.85	4.06
B		2.12	2.28	2.61	2.29	2.24	2.18	2.02	2.34	2.28	2.35	2.21	2.27	2.17	2.36	2.24	2.41	2.29	2.19

Item Number	22
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.00	3.71	2.19	2.89	3.67	3.99	1.77	2.96	2.67	2.97	3.71	4.01	1.37	2.43	2.66	3.03	3.64	3.66
	2	1.79	3.88	2.77	3.01	3.51	4.01	1.32	3.00	2.79	3.12	3.79	3.96	1.33	2.54	2.91	2.98	3.52	4.00
	3	1.47	3.35	2.54	3.10	3.79	3.92	1.54	2.01	2.87	3.04	3.88	3.92	1.34	2.24	2.89	3.14	3.88	4.03
B		2.36	2.10	2.34	2.20	2.27	2.15	2.02	2.45	2.23	2.30	2.23	2.29	2.07	2.30	2.13	2.34	2.19	2.31



Item Number	23
Subscale	Knowledge

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.88	2.75	2.23	2.91	3.19	3.23	1.61	2.56	2.13	2.77	3.21	3.66	1.81	2.79	2.29	3.08	3.39	3.84
	2	1.81	2.78	2.39	3.41	2.79	3.20	1.47	2.86	2.21	2.83	3.40	3.71	1.54	2.44	2.43	3.13	3.47	3.52
	3	1.60	2.40	1.95	3.28	3.62	3.39	1.49	2.52	2.33	2.78	3.42	3.50	1.63	2.51	2.37	3.19	3.35	3.59
B		2.29	2.16	2.33	2.25	2.34	2.30	2.12	2.12	2.20	2.19	2.10	2.37	1.91	2.09	2.25	2.11	1.96	2.14

Item Number	24
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.77	2.73	2.10	2.94	3.05	3.25	1.45	2.49	2.02	2.73	3.23	3.65	1.83	2.78	2.43	3.01	3.19	3.79
	2	1.80	2.87	2.37	3.56	2.67	3.36	1.42	2.86	1.94	2.78	3.42	3.74	1.71	2.54	2.70	3.16	3.41	3.54
	3	1.51	2.39	1.75	3.37	3.54	3.46	1.91	2.45	2.02	2.87	3.54	3.54	1.67	2.45	2.61	2.92	3.25	3.59
B		2.11	2.33	2.17	2.34	2.32	2.47	2.12	2.11	2.30	2.21	2.23	2.01	2.03	2.19	2.18	2.25	1.98	2.13

Item Number	25
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.88	2.62	2.21	2.83	3.16	3.14	1.54	2.50	2.00	2.69	3.32	3.56	1.77	2.96	2.34	3.10	3.31	3.86
	2	1.91	2.76	2.48	3.45	2.78	3.25	1.24	2.68	1.92	2.87	3.24	3.72	1.32	2.45	2.47	3.01	3.29	3.39
	3	1.62	2.28	1.86	3.26	3.56	3.45	1.90	2.54	2.07	2.78	3.45	3.45	1.67	2.54	2.49	2.99	3.20	3.54
B		2.22	2.22	2.28	2.23	2.43	2.36	2.03	2.05	2.25	2.13	2.35	2.10	1.99	2.02	2.20	2.16	1.99	2.08

Item Number	26
Subscale	Knowledge

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.81	2.57	2.32	2.89	3.29	3.33	1.62	2.52	2.34	2.72	3.22	3.46	1.69	2.74	2.35	3.12	3.42	3.92
	2	1.92	2.68	2.41	3.09	2.99	3.24	1.65	2.78	2.41	2.73	3.46	3.72	1.66	2.49	2.37	3.17	3.44	3.60
	3	1.69	2.50	2.22	3.02	3.42	3.41	1.57	2.63	2.29	2.71	3.35	3.54	1.51	2.46	2.43	3.23	3.31	3.67
B		2.01	2.21	2.31	2.21	2.31	2.32	2.03	2.23	2.27	2.34	2.23	2.41	1.95	2.14	2.31	2.15	1.99	2.20

Item Number	27
Subscale	Stigma Tolerance

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	2.01	3.08	2.45	3.14	2.63	3.47	1.81	2.85	2.57	2.89	3.69	3.99	1.57	2.44	2.59	2.99	3.74	3.61
	2	1.92	3.85	2.69	3.07	3.55	3.99	1.30	2.97	2.83	3.21	3.80	3.86	1.43	2.51	2.89	3.01	3.57	4.02
	3	2.07	3.27	2.56	3.14	3.83	3.94	1.51	2.04	2.74	3.11	3.79	3.89	1.64	2.20	2.78	3.09	3.78	3.97
B		2.33	2.09	2.21	2.22	2.23	2.19	1.99	2.39	2.31	2.29	2.19	2.41	2.06	2.29	2.24	2.38	2.27	2.11

Item Number	28
Subscale	Stigma Tolerance

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.88	2.75	2.23	2.91	3.19	3.23	1.61	2.56	2.13	2.77	3.21	3.66	1.81	2.79	2.29	3.08	3.39	3.84
	2	1.81	2.78	2.39	3.41	2.79	3.20	1.47	2.86	2.21	2.83	3.40	3.71	1.54	2.44	2.43	3.13	3.47	3.52
	3	1.60	2.40	1.95	3.28	3.62	3.39	1.49	2.52	2.33	2.78	3.42	3.50	1.63	2.51	2.37	3.19	3.35	3.59
B		2.29	2.16	2.33	2.25	2.34	2.30	2.12	2.12	2.20	2.19	2.10	2.37	1.91	2.09	2.25	2.11	1.96	2.14

Item Number	29
Subscale	Confidence

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.88	2.75	2.23	2.91	3.19	3.23	1.61	2.56	2.13	2.77	3.21	3.66	1.81	2.79	2.29	3.08	3.39	3.84
	2	1.81	2.78	2.39	3.41	2.79	3.20	1.47	2.86	2.21	2.83	3.40	3.71	1.54	2.44	2.43	3.13	3.47	3.52
	3	1.60	2.40	1.95	3.28	3.62	3.39	1.49	2.52	2.33	2.78	3.42	3.50	1.63	2.51	2.37	3.19	3.35	3.59
B		2.29	2.16	2.33	2.25	2.34	2.30	2.12	2.12	2.20	2.19	2.10	2.37	1.91	2.09	2.25	2.11	1.96	2.14

Item Number	30
Subscale	Knowledge

Dept.	Psych	Organisation 1						Organisation 2						Organisation 3					
		T1		T2		T3		T1		T2		T3		T1		T2		T3	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
A	1	1.81	2.57	2.32	2.89	3.29	3.33	1.62	2.52	2.34	2.72	3.22	3.46	1.69	2.74	2.35	3.12	3.42	3.92
	2	1.92	2.68	2.41	3.09	2.99	3.24	1.65	2.78	2.41	2.73	3.46	3.72	1.66	2.49	2.37	3.17	3.44	3.60
	3	1.69	2.50	2.22	3.02	3.42	3.41	1.57	2.63	2.29	2.71	3.35	3.54	1.51	2.46	2.43	3.23	3.31	3.67
B		2.01	2.21	2.31	2.21	2.31	2.32	2.03	2.23	2.27	2.34	2.23	2.41	1.95	2.14	2.31	2.15	1.99	2.20

Factor Analysis of Scores on the Perception of Psychologists Scale at T1 as a function of organisation

Item Number	Factor 1			Factor 2			Factor 3		
	Org 1	Org 2	Org 3	Org 1	Org 2	Org 3	Org 1	Org 2	Org 3
29	.79	.81	.81	.02	.03	.14	.17	.09	.06
22	.74	.78	.80	.07	.12	.18	.11	.07	.12
24	.76	.79	.74	.12	.16	.08	.10	.12	.17
16	.70	.74	.77	.21	.18	.09	.09	.20	.19
20	.69	.71	.71	.28	.09	.13	.13	.18	.09
12	.68	.71	.76	.13	.04	.15	.15	.13	.14
18	.68	.69	.63	.26	.24	.23	.20	.26	.23
5	.63	.68	.68	.12	.22	.20	.21	.14	.22
9	.59	.64	.66	.17	.22	.17	.16	.17	.21
4	.57	.63	.64	.09	.19	.18	.18	.09	.19
25	.56	.56	.60	.21	.14	.21	.24	.17	.14
13	.51	.55	.53	.21	.23	.26	.25	.20	.22
19	.50	.51	.54	.28	.26	.21	.22	.29	.30
30	.14	.17	.23	.78	.80	.83	.13	.17	.20
15	.08	.13	.12	.81	.77	.80	.19	.20	.09
7	.19	.08	.12	.71	.70	.76	.07	.13	.12
10	.21	.07	.19	.69	.71	.69	.11	.09	.16
23	.13	.20	.26	.66	.66	.70	.12	.10	.17
2	.12	.22	.14	.57	.61	.64	.20	.21	.14
26	.12	.14	.03	.56	.55	.63	.21	.19	.12
8	.15	.10	.04	.52	.56	.56	.16	.06	.12
21	.09	.10	.10	.50	.51	.52	.14	.14	.17

Item Number	Factor 1			Factor 2			Factor 3		
	Org 1	Org 2	Org 3	Org 1	Org 2	Org 3	Org 1	Org 2	Org 3
14	.20	.20	.09	.17	.09	.21	.66	.70	.68
11	.07	.13	.07	.09	.07	.10	.65	.66	.70
3	.16	.09	.16	.12	.11	.15	.62	.65	.64
17	.12	.10	.17	.16	.12	.14	.64	.61	.61
6	.17	.11	.14	.20	.21	.18	.58	.56	.54
1	.22	.09	.14	.11	.06	.12	.56	.53	.49
27	.07	.06	.11	.10	.06	.09	.51	.47	.48

## APPENDIX 17.1

**Planned contrasts for Organisation, Sex of Respondent and Psychologist on GHQ-30 variable.**

Contrast	Variable	F	p
Org 1 vs Org 2 vs Org 3	GHQ-30	2.59	.583
Male vs Female	GHQ-30	7.64	.039
Psych 1 vs Psych 2 vs Psych 3	GHQ-30	2.89	.441

Note: GHQ-30 = General Health Questionnaire-30

**Planned contrasts for Sex, Department and Psychologist for each organisation on rate of referral to EAP counselling acting as the variable**

**Organisation 1**

Contrast	Variable	F	p
Male vs Female	Referral Rate	9.22	.021
Dept. A vs Dept. B	Referral Rate	11.01	.009
Psych 1 vs Psych 2 vs Psych 3	Referral Rate	2.24	.103

**Organisation 2**

Contrast	Variable	F	p
Male vs Female	Referral Rate	12.36	.043
Dept. A vs Dept. B	Referral Rate	11.92	.039
Psych 1 vs Psych 2 vs Psych 3	Referral Rate	1.88	.233

**Organisation 3**

Contrast	Variable	F	p
Male vs Female	Referral Rate	9.71	.025
Dept. A vs Dept. B	Referral Rate	10.80	.036
Psych 1 vs Psych 2 vs Psych 3	Referral Rate	2.02	.179



## APPENDIX 18.1

Pairwise contrasts for the four groups based on high or low responses to Likert scales conducted on reduced scale scores with the CONFIDENCE and KNOWLEDGE subscales as variables

Contrast	Variable	t	p
High C/High K vs High C/Low K	Confidence	3.44	.222
Low C/High K vs Low C/Low K	Confidence	2.72	.196
High C/High K vs Low C/High K	Knowledge	2.51	.158
High C/Low K vs Low C/Low K	Knowledge	3.89	.245

Note: High C = High Confidence response on Likert scale  
 Low C = Low Confidence response on Likert scale  
 High K = High Knowledge response on Likert scale  
 Low K = Low Knowledge response on Likert scale

Planned contrasts for the six groups based on high or low responses to Likert scales conducted on revised POPS scores with the CONFIDENCE, KNOWLEDGE and STIGMA TOLERANCE subscales as variables

Contrast		Variable	F	p
High C/High K/High ST vs High C/High K/Low ST vs High C/Low K/High ST vs High C/Low K/Low ST	K/High	Confidence	5.46	.287
High C/High K/High ST vs High C/High K/Low ST vs Low C/High K/High ST vs Low C/High K/Low ST	K/High	Knowledge	4.02	.341
High C/High K/High ST vs Low C/High K/High ST vs High C/Low K/High ST vs Low C/Low K/High ST	K/High	Stigma Tolerance	4.89	.402
High C/High K/High ST vs Low C/High K/Low ST vs Low C/Low K/Low ST	K/High	Confidence	5.11	.457
High C/Low K/High ST vs Low C/Low K/ High ST vs High C/Low K/Low ST vs Low C/Low K/Low ST	K/Low	Knowledge	5.40	.286
High C/High K/Low ST vs Low C/High K/Low ST vs High C/Low K/Low ST vs Low C/Low K/ Low ST	K/Low	Stigma Tolerance	4.48	.392

Note: High C = High Confidence response on Likert scale  
 Low C = Low Confidence response on Likert scale  
 High K = High Knowledge response on Likert scale  
 Low K = Low Knowledge response on Likert scale  
 High ST = High Stigma Tolerance response on Likert scale  
 Low ST = Low Stigma Tolerance response on Likert scale