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Editorial

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Welcome to the second issue for 2018 – just in time to wish all our authors and readers a very happy Christmas and New Year. We have five great manuscripts for this issue.

Firstly, James Yu from Hong Kong has a very interesting article on Phenomenology in Clinical Practice. He highlights the implications of phenomenology in counselling and psychotherapy practice, in particular in understanding the client's presenting issues and concerns.

Judy Boyland and Tanya Fisher discuss the importance of collegial support for counsellors arguing how such strong support can aid in professional growth and professional identity. Judy and Tanya are part of a strong ACA counselling group in Queensland and have just celebrated 20 years of collaboration and support for their group.
From Sultan Qaboos University, Lawati and Alrajhi examine the quality of student counselling services and the perceptions of the students themselves.

Christine Cresswell presented the following paper at the ACA conference in September this year looking at stepping stones for resilience in children and young people whose lives are beset with family violence.
The final paper is by Josie Larkings from the University of Canberra who studied Mental Health Professionals' causal beliefs and whether these beliefs impacted their work with consumers.

Early next year we will be presenting a special issue on expressive and creative therapies in counselling and psychotherapy. You are most welcome to contribute manuscripts for this issue. Please do note the instructions for authors on the website: http://www.acrjournal.com.au/journals and please present you article in Word format, New Times Roman size 12 font.
We look forward to your contributions.

Dr Ann Moir-Bussy
Editor

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Phenomenological concepts in clinical practice: From presenting problems to case formulation

James Yu[1]

The present atricle highlights the implications of phenomenology in counselling and psychotherapy practice, specifically concerning understanding the client's presenting problems and conducting an initial case formulation. These routine activities in clinical practice are shaped by the clinician's philosophical and theoretical backgrounds. Phenomenology, as an alternative philosophical tradition to Cartesian dualism, offers cornerstone concepts such as the lived-world, the lived-body, intersubjectivity, Befindlickeit and a horizonal perspective on the unconscious. Their implications to clinical understand will be illustrated with a case study.

Keywords: *phenomenology; case formulation; presenting problems; unconscious; bracketing; descriptive; contextualization*

Phenomenology is one of the unique big-picture philosophical movements emerged from continental thoughts (Nisbett, 2003). Although phenomenology is not an alternative psychological theory and different scholars in the phenomenological tradition have vastly different propositions, its implications on clinical practice have not been systematically explored in the literature.

In the practice of counselling and psychotherapy, the clinician generally conducts two routine activities, implicitly or explicitly (as in written forms), on which subsequent interventions or treatments are predicated. These include a detailed profile of the client's presenting problems and a case formulation based on available clinical data. The primary purpose of this paper is to propose and illustrate how phenomenological concepts can concretely shape and inform these activities.

According to Mearleau-Ponty (1962, 1964), phenomenology fundamentally challenges the Cartesian dualistic view of reality which allegedly obscures our understanding of human experience. As clinical practice is always based on implicit viewpoints on human existence and reality, an alternative non-dualistic perspective should bring about different views on psychopathology. Stolorow and colleagues (2002) argue that a phenomenological approach to psychopathology should be "unencumbered by objectifying images of mind, psyche, or psychical apparatus and is therefore free to study experience without evaluating it for its veridicality with respect to a presumed external reality" (p.144). Hence, preoccupations with the distinctions between inner and outer, real and unreal, and subjective and objective, are counterproductive to the clinician's attempt to understand the experience of clients.

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The Lived-world: Primordial Dimension of Experience

In contrast to the dualistic notion of an inner mind or psyche standing at odd with an outer world, Merleau-Ponty (1962) proposes a more fundamental and experience-near notion of the lived-world which transcends the conceptual separation of the mind and the reality. The lived-world is a first-order experiential world, which is historical, temporal, emergent, and nonsubstantial. It is more primordial and fundamental than the second-order scientific and theoretical constructs such as the mind and the reality. Dualistic concepts such as the mind, the psyche or the outer world are viewed as abstractions of the first-order experiential world.

A phenomenological approach to clinical practice advocates that the clinician must endeavour to bypass the limitations of dualistic thinking and focus instead on the first-order level of experience. Rogers (1961, p.23) also emphasises that "it is to experience that [the clinician] must return again and again, to discover a closer approximation to truth." Translating this principle into practice, the clinician should be committed to understanding the level of experience as close as it is lived first-hand by the clients. Accordingly, diagnostic categories and psychological theories should be treated only as the preliminary tools to facilitate this process of understanding.

Intersubjectivity, Befindlickeit and the Lived-Body

In phenomenology, the lived-world should not be conceived as an isolated territory, but as a field or "a system composed of differently organized, interacting subjective worlds" (Stolorow et al., 1987, p.ix), otherwise known as intersubjectivity. Intersubjectivity refers to the fact that the primordial context of human existence is a communal world. Hence, meanings of existence must be understood in their intersubjective contexts.

Dreyfus (1989) borrows Martin Heidegger's notion of Befindlickeit in German to describe how temperament, affect, mood, and emotion can potentially "colour" a person's experiential world. Befindlickeit refers to human emotions and moods as a kind of disposition that is intertwined with how one is situated in the world. When a little boy experiences humiliation from his parents, his emotional reaction (i.e., embarrassment) is not only capable of magnifying the situation, but also engulfing his total experience to become an ontological dimension in his lived-world. If this is a prominent feature of the boy's intersubjective contexts—that is, he experiences such embarrassment on a regular basis, his emotion can be arrested in its course and gradually transform into a dimension of his lived-world. Extreme intensity of singular emotional experience can also engulf a person's experience to become an ontological dimension, which is exemplified in cases where trauma is present.

The lived-body, as Merleau-Ponty (1962, 1964) suggests, corresponds with the lived-world. The boy's experiences associated with the humiliation gradually become sedimented, forming the foundation of his habitual postures and bodily gestures in ways that make his life embarrassment-prone, thus reinforcing a sense of self that is built upon an organising principle of anticipating and avoiding humiliation.

Phenomenological Reconceptualization of the Unconscious

Distinct from classical psychoanalytic notions of the unconscious, phenomenology advocates for experience-near concepts to capture the commonly observed clinical phenomenon that most human beings are not aware of their deepest motivations. For example, the horizonal notion of the unconscious (Husserl, 2001) allows clinicians to explore the underlying meanings and motives of their clients' behaviour without making reference to any unobservable psychic entities. This phenomenological notion is a type of metaphoric characterisation which seeks to describe the conscious-unconscious phenomenon with common-sense metaphors.

The horizonal unconscious suggests that a person's issue would fall outside of his or her awareness if it has transformed into a dimension of the context in which all future objects and events are encountered. The issue is no longer experienced as a dated moment or event in life, but as a general manner of existence like an atmosphere.

The past is spread out in front of this person as an atmosphere of the present. If this dimension becomes a core one in his or her whole existential context, it will show up in this person's habitual and rigid ways of relating to objects and other people in the world (Dreyfus, 1989).

Stolorow and colleagues (2002) propose three interrelated realms of the unconscious based on the notion of horizon. The prereflective unconscious refers to emotional convictions and organising principles that shape and thematise a person's experiences but operate outside the realm of reflective self-awareness. Similar to the phenomenological notion of atmosphere, it pervades everywhere in the person's horizon such that it cannot be identified as a perspective with anything to contrast with it. The dynamic unconscious refers to experiences that were denied of articulation because they were perceived to threaten significant relationships from which one's sense of self emerged. . Such experiences are faded into the background of the horizon but continue to shape our conscious experiences in powerful ways. Lastly, the invalidated unconscious refers to experiences that could not be articulated because they never evoked the necessary validating responsiveness from the environment. These experiences are like fragments of a gestalt floating in the empty space along the horizon but loaded with strong emotional forces that also significantly shape our conscious experiences and relational strivings.

Stolorow and colleagues (1992) provide an alternative concept of "organizing principles" of experiential world, which guides clinicians to explore how our clients' experiential world is organized in ways that give rise to distinctive meaning and themes in life. In terms of psychoanalytic practice, the clinician would focus on the more or less unconscious and invariant organising principles that underlie their patients' recurrent themes in life.

Tools to Understand Experience: Bracketing, Description, and Contextualization

The phenomenological approach to counselling and psychotherapy refutes the concepts of "decontextualized absolutes or universals…neutral or objective analysts…God's-eye views of anything or anyone" (Stolorow et al., 2002, p.76). From a phenomenological perspective, clinical understanding is built upon genuine respect of the client's utterances, an expansion from the contents into contexts (e.g., historical, relational, and dynamic), and a continuous reflection of an evolving therapeutic relationship. Bracketing, description, and contextualization are three interrelated intellectual exercises for clinicians inspired by phenomenology.

Bracketing allows clinicians to suspend their taken-for-granted beliefs in abstract theories and mechanisms underlying their clients' problems. It is a crucial mental maneuver that helps clinicians to shift toward an emphasis on understanding and describing their clients' experience as fully as possible. Contextualization refers to a committed exploration into the various contexts of the experience of clients. Their psychological and affective difficulties should be understood in terms of relevant historical and interpersonal contexts. The above epistemological tools are foundational to the phenomenological endeavour to understand human experience.

Application I: Understanding the meaning of our clients' presenting problems

Presenting problems are only the client's initial attempt to articulate an aspect of his or her lived-world that precipitates the pursuit for counselling. Phenomenology suggests that human beings are always in meaningful relationships with the world. Even in so-called disordered conditions, there are meanings in what would generally be regarded as negative, maladaptive, or pathological in the client's presenting problems. Clinicians can move beyond the judgement categories, namely, normal or pathological, adaptive or maladaptive, rational or irrational, by focusing on the uniquely sophisticated ways in which clients interact with their surroundings. The traditional practice of psychotherapy emphasises the contents of presenting problems. In contrast, phenomenology calls for a continuous expansion of contents into contexts in clinical practice.

The Case of Jenny: Presenting Problems

Jenny was a twenty-year-old female college sophomore student. She self-referred to the psychology clinic at her University in order to gain a better understanding about her negative emotions, thoughts and memories, which were essentially her presenting problems at the time. She complained about having repeated

episodes of uncontrollable emotional outburst in her social life, experiencing difficulties with meeting new friends in college, and suffering from a heightened level of anxiety. These presenting problems were considered by her parents as adjustment issues in college and possibly a biological-based emotional disorder. Jenny was in between consulting with a psychiatrist for medication advice and finding a psychotherapist to understand herself better.

To understand Jenny's lived-world, it is important to explore the historical and interpersonal contexts of her presenting problems. Jenny first began to experience an elevated level of hurtfulness, anger, and fear after a car accident that took place during the senior year of high school. On the night of the accident, she was one of the four passengers in the car with a driver who was under the influence of alcohol. She stated that the car had slipped on the icy road, hit a snow pile and flipped over. The impact immediately knocked her out of consciousness until her friends pulled her out of the car. She began feeling very disoriented and decided to walk home which was not far away from the accident site. At the door, Jenny recalled staring at her mother and said, "I am dead." Because she departed from the accident site, only her friends were present when the police arrived and investigated the scene. She later learned that her friends blamed her for the alcohols found in the car. Charges were pressed against her for illegal possession of alcohol and distributing alcohols to minor, which resulted in a yearlong parole and community service. Since then, she suffered from sustaining injuries on her back and legs. She also experienced occasional nightmares and a heightened level of anxiety about being in a car while imagining various kinds of disaster that could have happened. Interpersonally, she felt extremely angry and upset about her close friends' betrayal. Although Jenny began to meet new friends in college, her enduring and intense emotions made it difficult for sustaining and enjoying these new relationships.

As the above illustration shows, presenting problems can lead clinicians to an enriched understanding of the contexts in which their clients construct meanings in their lives. It also reveals how the meanings of the presentation problems are co-constructed by the client and the therapist, which is essentially an intersubjective clinical phenomenon participated by two human beings. The interplays between two embodied beings are what determine and shape the meanings of therapeutic communication, such as whether or not something can be expressed or made aware of. Highlighting that both the client and the clinician are embodied beings calls attention to the therapeutic exchanges at the level of bodily gestures, affect, and temperament.

It should be reminded that it is easy and tempting for clinicians to unintentionally dehumanise their clients by diagnosing, categorising, and theorising about them. Viewing the therapeutic situation as an intersubjective clinical phenomenon, the clinician's stance plays a central role in how the presenting problems are conceived. Generally, one can adopt many different stances when listening to the client's narratives such as introspective, empathic, problem-solving, and sceptical.
A sceptical stance, for instance, translates into paying a lot of attention to the truthfulness of the client's utterances as well as the motivation behind them. Hence, the presenting problems should always be understood as an interplay between the clinician's therapeutic stance, theoretical convictions and personal backgrounds, andthe client's backgrounds and motivations. It is in this intersubjective context in which Jenny's presenting problems was understood initially by her clinician as a narrative in which she was a victim of an unfortunate event and its aftermath. However, this initial understanding was only the beginning of an ongoing interplay between them.

Application II: Case Formulation from a Phenomenological Perspective

Traditionally, case formulation is defined as a distinctive activity where clinicians provide a written conceptualisation of clients based on initial clinical data gathered from diagnostic interviews and psychological assessments. From a phenomenological perspective, case formulation is not viewed as an isolated clinical activity independent of the ongoing process of clinical exchanges. Regardless of the theories adopted by clinicians, all the presenting problems, symptoms, and assessment data should be thoroughly contextualised.

A Brief Case Formulation of Jenny

As counselling continued, the intersubjective contexts in which Jenny's problems emerged in life began to unfold. She was raised in a family in which her father was emotionally withdrawn, and her mother was mentally unpredictable partly due to multiple sclerosis. In Jenny's lived-world, she never experienced validation from her father who always disapproved of her decisions. She experienced some caring and love from her mother but in inconsistent and unpredictable ways, which led to immense feelings of ambiguity and uncertainty throughout her upbringing. She was also strongly convinced that her mother's "bad genes" were passed onto her. She perceived her brother as a very negative figure who never cared for and protected her when she needed most. She felt that he had been a bystander in all of her emotional and social struggles. Specifically, he never helped and protected her when she was constantly teased and bullied by his peers in the neighbourhood. Jenny's extended family was characterised by a long history of serious medical illnesses and deaths, which is a major theme in the historical and interpersonal contexts of her traumatic reactions toward the car accident. She talked about her unsettling feelings of having to anticipate and deal with the deaths and losses of close family members as she was growing up.

Jenny repeatedly talked about being the target of teasing and verbal abuses in her neighbourhood. The perpetrators were a group of young boys who were his brother's friends, and they often made fun of her appearance and weight and sometimes even threw hard objects at her. Jenny's victimisation was highlighted by an incident that took place when she was seven years old. One of the neighbourhood boys choked her on the neck until she almost fainted. Although she reported to her parents immediately afterwards, she felt that they did not take her seriously and downplayed her emotional reactions. Hence, she suffered not only from this traumatic experience but also a combination of her brother's betrayal and her parents' negligence.

In counselling, Jenny gradually acquired the insight that she was becoming more of an angry and hostile person after this incident. On the other hand, she increasingly despised any feelings and expressions of sadness and disappointment which were perceived as signs of weakness. To safeguard herself from being overwhelmed by strong feelings of vulnerability, she gradually became gravitated toward adopting a tough-girl identity which is her way of saying "I will rely on no one but myself." This identity was helpful in terms of regaining a sense of control in life, but it was loaded with intense anger, hurtfulness and disappointment. As such, she often found herself lashing out on those who had hurt her even in minor ways.

From an intersubjective perspective, Jenny's presenting problems were rooted in a rigid relationship with the world in which most significant individuals in her life were readily failing or hurting her in some ways. Although her symptoms and difficulties were directly related to the car accident as well as its legal and interpersonal aftermath, the major invariant principles of her lived-world were beginning to unfold. As a seven-year-old little girl, she felt that she had no choice but to depend on harbouring a "tough" identity to ward off her sadness and hurtfulness. However, the colossal intensity of those emotions associated with the accident and its aftermath were too overwhelming for this habitual defensive self-identity to handle.

As time passed, Jenny gradually moved on and rebuilt a new social network in college. She also fell back on her tough-girl identity when facing new challenges in her social life. She reacted strongly with anger whenever she felt betrayed or belittled by others, as it gave her a sense of control and reinforced her toughness. Furthermore, her easily irritated mood and vigilant body gestures created a lot of interpersonal problems in college. Her lived-world was still one inhabited by individuals who were readily failing, betraying, disappointing and hurting her in some ways. Her traumatic and disappointing past, so to speak, was still living in the presence, as she was unable to free herself from these painful intersubjective experiences. Moreover, up till the point when she entered counselling for the first time, she had no alternative resolution but to rely on being an angry, tough girl in order to maintain a sense of control and power in a frustrating interpersonal world.

Conclusion

For counsellors and psychotherapists, the presenting problems of clients are often the first organised set of narrative information gathered from beginning sessions, whereas an initial case formulation is generally their first attempt to integrate all the available clinical information and observations at a later stage. Both are considered important milestones in clinical practice that lay the foundation for effective counselling interventions. This paper illustrates how phenomenological concepts, despite its philosophical roots, can directly and concretely inform how clinicians can conduct these two foundational activities in routine practice.

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Collegial support for counsellors

Judith R Boyland[1] & Tanya Fisher[2]

The present paper identifies what Australian counsellors across State borders believe to be the benefits of collegial support: not the least being the growth and development of a professional identity. It also identifies counsellors' perceptions of what behaviours they expect of themselves and of their colleagues in adhering to principles of ethical practice as befit an authentic professional identity. The context embraces all facets of collegial support and while investigation was initially focused on collegial interaction within Member Associations and Association Chapters, individual respondents chose to broaden the identified scope by making reference to additional aspects of collegiality and a variety of different collegial scenarios. Additions to initially intended collegiate scope include professional and peer supervision; agency, multi-disciplinary, and private practice workplaces; city, regional, and remote locations; and pitfalls and problems as well as values and benefits.

Keywords: *camaraderie, colleague, collegiality, collegiate, Dialogical Self Theory (DST), needs gratification, non-violent communication, professional accountability, professional identity, Professional Learning Communities (PLCs)*

Nellis and Roberts (2009/2014) remind us that "collegiality", as a term, has its roots deep in religious and academic history. However, it could be said that the notion of collegiality is as old as human existence: for, have not human beings always moved in twos and tribes?

In linguistic terms, collegiality dates back to political protocol adopted during the era of the Roman Republic (509-27 BCE) where collēgiālis was the practice of having at least two people (and always an even number) in each magisterial position of the Senate. The practice was later replicated in organisational structures adopted and adapted into protocols of the Roman Catholic Church, where a collegiate of bishops was set up by the papacy for the purpose of sharing the tasks of administration and organisation within the early Church (Oakley & Cunningham, 2018). This notion of a "collegiate" is still adhered to by Pope Frances who, in his Address to the Leadership of the Episcopal Conferences of Latin America during the General Coordination Meeting of 2013, called for those who work with him to "work in a spirit of solidarity and subsidiarity to promote, encourage and improve collegiality" (2013).

With an added touch of Mid-French influence in the 14th century CE, collégialité has evolved to refer to the modern day relationship between colleagues: defined by AskDefine (n.d.) as being those explicitly united in a common purpose and respecting of each other's abilities while working towards the fulfilment of that purpose. Thus, as postulated by AskDefine, the word collegiality implies respect for the commitment of persons to the common purpose and their ability to work toward it. In like turn of phrase, the word "colleague" can connote an associate in a professional, academic, ecclesiastical, or civil office.

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Context

Coming at collegiality from a back-door perspective, Caesar (2006) suggests that while nobody may know exactly what collegiality is, everybody knows what it is not. His suggestion is that for collegiality to be, it needs to be actively promoted and free from political connotation. He also suggests that breaches need to be defined and addressed.

The value of collegiality is explored by Bennett (1998) who, with focus on ethical practice, gives significant voice to the social constructs of isolation and individualism within educational settings. Reflecting the importance of developing positive relationships with colleagues, he proposes a model of collegial support that values an environment of collegial professionalism: a model where professional ethics and professional growth are pivotal to the development of a supportive environment. The concept that professional persons perform more effectively and efficiently with collegial support is grounded in principles underpinning organisational theory as espoused by Covey (1991) and Senge (1990).

Jones (1997) wrote that for true collegiality to occur it needs to be between like-minded professionals who must "be aware of one another's strengths to capitalize on them, be willing to learn from one another, trust one another, treat one another with respect and courtesy, and behave ethically" (p. 164). For counsellors, this may be seen in the effective interactions occurring within peer review and group supervision exchanges and also in gatherings of the collective where, to be effective, there must be collegial relationships of equality, with no person holding a position of authority over the other while each adheres to the responsibilities associated with role and function. Furthermore, as noted by Fraser and Horrell (2018), these types of relationships are pivotal to providing professional support and growth between counsellors as well as providing emotional, academic, and professional support in managing the demands of professional practice.

Counsellors need opportunities to gather as colleagues and to chat with each other with a vision to (a) maximising the flow-on benefits to clients through energising/re-energising the tired brain; (b) transforming working in the field of emotional and mental health from a place where there is a focus on mental illness to a place where there is a focus on mental wellness; and (c) making their every-day work with people who are hurting more meaningful, more "normal", more relevant, more respectful, more sensitive, and more empathic. In his book, A possible dream: Retaining California teachers so all students learn, Futernick (2007) highlighted the notion that strong collegial support systems promote positive morale. He also pointed to the critical role that relationships play in practitioners' attitudes towards their work. While Futernick's research was positioned in the education arena, his findings ring true across disciplines and are deemed to be particularly relevant in any field of human service.

From an Australian perspective, The Australian Institute of Teaching and School Leadership Limited (AITS) references the development of what they term as "Professional Learning Communities" (n.d.). It is stated that a Professional Learning Community (PLC) involves collaboration, sharing, and ongoing critical interrogation of practices in line with professional standards. It is also stated that PLCs should be learning oriented and promote the growth of teachers and students. Transferring the construct of the PLC into a counselling context, it could be said that a Collegial Support Group (CSG) involves collaboration, sharing, and ongoing critical interrogation of clinical and therapeutic practices in line with professional standards as outlined in codes of ethics and practice and scope of practice documents published by industry related professional associations.

According to Woo et al. (2004, p. 13) as cited by Moir-Bussy, Andrews, and Smith, (2016), "Survival of the counselling profession depends on counselling's quest for establishing a clear, common professional identity" and there is no better platform for achieving this quest than through commitment to the development of professional collegiality reflecting the model of the CSG. Drawing from the findings of the study undertaken by Moir-Bussy et al., it is noted that among counsellors, there is a shared understanding of the relationship between the concept of collective identity, the core philosophy of counselling, and the methodological approach of counselling: that is, how counsellors perceive and engage with clients is directly related to their sense of professional identity.

Nellis and Roberts (2009/2014) suggest that one of the most personally enjoyable aspects of one's career may be developing close relationships with colleagues; and while the context to which they refer is academia, one might well ask, "Is this not true for any profession or any field of interest or any career path that one chooses to follow?" Herein lies the very foundation of the ultimate goal of collegial support that is deemed to be professional, ethical, committed, socially enjoyable, and truly valued: and that foundation is a focused integration of experience that strengthens the professional identity of the counsellor and produces a flow-on benefit to the clients who are supported by professional engagement and therapeutic intervention.

December 10, 2018 heralds the 20th birthday of Australian Counselling Association. A significant achievement across these 20 years is the network of collegial support that has grown across region, state, country, and beyond our shores.

Nowhere is this more evident than in the growth and development of Member Associations and Association Chapters across the States, as well as international networking across borders. This paper identifies what Australian counsellors across State borders believe to be the benefits of collegial support. It also identifies counsellors' perceptions of what behaviours they expect of themselves and of their colleagues in adhering to principles of ethical practice as befit an authentic professional identity.

The context embraces all facets of collegial support and while investigation was initially focused on collegial interaction within Member Associations and Association Chapters, individual respondents chose to broaden the identified scope by making reference to additional aspects of collegiality and a variety of different collegial scenarios. These additions included professional and peer supervision; agency, multi-disciplinary, and private practice workplace environments; city, regional, and remote locations; and pitfalls and problems as well as values and benefits.

Research Aims

It is hoped that the findings of this study may;

(a) Strengthen the collective professional identity of counsellors;

(b) Prompt counsellors to join their local Member Association or Association Chapter;

(c) Encourage counsellors who may be feeling the impact of isolation and individualism to explore ways of finding a colleague or three with whom to connect for the purpose of mutual support, encouragement, and enjoyment;

(d) Invite counsellors who are not living in remote places, yet are distanced from centralised Chapters, to consider co-ordinating a Chapter in their own constituency or region: with the help and support of their Association and experienced co-ordinators, so as to ensure that relevant guidelines are ethically and constitutionally adhered to.

Method

Design

A combination of guided reflection with a focus group and individual invitation to respond to a single open-ended prompt was presented to potential respondents. The guided reflection posed eight questions for discussion:[1] one question presented to each of eight sub groups. The prompt simply asked respondents to consider what they believed to be the benefits of collegial support from the perspective of their own individual experience.

Respondents

In total, 68 respondents from Queensland, New South Wales, Australian Capital Territory (ACT), and Victoria chose to share their thoughts. All were professional counsellors, eight were educators, and 15 were professional supervisors. Identifying characteristics were representative of the broad community. There were recent graduates and clinicians who have been practising for well in excess of a quarter of a century. There were male and female counsellors and there was a mix of cultural background, religious faith, and sexual orientation. Seven respondents participated in both activities.
2000/2015).

Procedure

The focus group was a Group Supervision Session, facilitated by a certified and registered Professional Supervisor. The theme of the session was underpinned by Article 2, clause (a), item ix of the Code of ethics and practice of the association for counsellors in Australia (Australian Counselling Association, 2000/2015).[2] As questions were discussed, a collaborative portrait was composed by working through a process of reflective practice. At the conclusion of discussion, a spokes-person for each group presented the group's response to the whole group. Group responses to the collegiality focused questions together with individual responses to the prompt, profiled a broad landscape featuring the findings of the collective.

Findings

Benefits of collegial support as considered by respondents are diverse and numerous and are thematisised across three key headings – Benefits, Making It Happen, and Pitfalls and Problems. Sub-themes within the broad framework of "Benefits" include Personal perspective, Professional perspective, Making connections and finding supports, Fun and enjoyment, Private practice perspective, Collegial support in the workplace, Perspective of the rural clinician, Response to loneliness and isolation, and The role of Professional Supervision as a model of collegial support. Sub-themes in relation to "Making It Happen" include Responding to need, Creating a supportive environment, and Expectations of Self and Other. The theme of Pitfalls and Problems is addressed as a single entity.

Benefits

Personal perspective

From a personal perspective, collegial support is said to give the unique opportunity to listen, learn, and share skills, knowledge, and experiences with peers in an informal yet supportive environment. It is seen as providing a powerful model for caring for one another within a professional context and is noted as being an important adjunct to formal professional supervision while also being a conduit to feeling supported and connected. It means having the ability to network with like-minded colleagues while also having a safe space within which to debrief one's thoughts while safely reflecting on practice.

There are the benefits implicit in sharing information and making new friends and there are also opportunities for sharing life experience and being listened to with respect and empathy. Counsellors express that they have found going to Chapter gatherings has been "such a gift" in their lives and they state that "it is so good to be able to mix with people who get you: people who have an intrinsic understanding of what you do and why you do it". There is also appreciation and a knowing that if one is having a tough time, "there is someone to encourage you on when you may feel like quitting".

Professional perspective

From a professional point of view, value and benefit encompass what is referred to as "the easy and economical access" to shared and experiential Ongoing Professional Development activities and professional input. As counsellors learn from the experiences of others in relation to particular topics and techniques, they feel supported in their own work.

Having opportunity to share one's own my experiences in relation to particular topics and techniques also helps counsellors to feel validated in the way they work and to realise that as a collegiate, "we are all striving to convey understanding with clients". There are times when being able to get a second opinion on a challenging situation can be a big help as there are times when another can see a pain free way of handling a difficult situation when one has become so deeply involved in the situation to the point of being stuck.

Through engagement in these shared opportunities, counsellors state that they feel humbled by their learnings. It is also expressed that collegial support helps to process things, whereby ensuring a balanced service. As stated:

We are in an era where as technology changes, so too, do patterns of communication; thus creating a forum to explore the pros and cons to ensure that what we do in therapeutic intervention is grounded in principles of ethical practice. It is noted by respondents that in the present environment, the professional identity of counsellors has very mixed reviews and can be denigrated by others. This is a point that was also identified in the study of Moir-Bussy et al. (2016) and it is again acknowledged that to have the support of other counselling colleagues can validate one's sense of purpose and professional identity. It is further stated that the issues of professional identity and professional accountability walk hand-in-hand and that knowing one is part of a network of supportive colleagues can be a motivator not to let the others down. As shared by one respondent, "Knowing that if I stumble I may bring others down with me can give me resolve to continue to do a professional job".

Then there is "inspiration": not to be confused with "professional development". Described as making a far broader and deeper connection, it is noted that while one can get professional development from an anonymous webinar, Inspiration is said to better describe "the sense of awe at what colleagues are doing and experimenting with, while discovering which can inspire me to want to stretch and grow".

Making connections and finding supports

What is highly valued is the sense of camaraderie: "knowing that someone else understands what I'm experiencing". There is also the encouragement and support given by colleagues and the sharing of knowledge, so freely given, and found to be so helpful when struggling with difficult cases.

As noted by the respondent who started attending Chapter gatherings while studying on-line, "It's never too early to connect". What was found to be missing when studying alone was sharing thoughts and having discussions with people who were studying something similar. Coming to Chapter gatherings and hearing some of the same terms being used in discussion as were being taught in course work, and observing that what was being discussed at Chapter was grounded in theory being explored in study units, was said to be "wonderful": reinforcing that what was actually happening in practice was what was being taught in course work. As stated, "It was interesting to pick up new tidbits to check out".

What was also observed was that things do not always go according to "textbook formulas" and that counsellors need to be "switched on" to what is happening for their client while also being flexible in having the knowledge and ability to "mix and match modalities" so as to best support every client in the way that is right and best for that client: "so many needs; so many clients; and there is not one hat that fits all".

As counsellors move further along their career pathways, their hope to embrace making connections and finding supports continues. Sharing knowledge and developing structures and programs to help transfer what is learned into best practice, while building a professional service of which they can be proud, are highly valued aspect of collegiality.

Fun and enjoyment

As expressed by one respondent, "It's more fun with collegial support. Who wants to fly solo?" It is also highlighted that by definition of function, the counselling profession generally deals with the less than fun aspects of clients' lives and collegial support sometimes just makes one laugh and smile.

Wanting to "fit in" and having opportunity to connect with colleagues is truly valued. The enjoyment associated with connection is found not only in learning but also in having one's own thoughts confirmed as one engages in ongoing professional development and group supervision activities as presented and facilitated at Chapter gatherings.

Private practice perspective

From the viewpoint of the "therapist" in private practice,3 there is the support of the friendly, accepting, and welcoming atmosphere of fellow counsellors. While the professional dream is to build a practice from which one can make a reasonable living and hopefully have some influence on the world by reducing violence, abuse, and disrespect, there is also the prophetic vision of encouraging hope and the growth of a more positive, successful place for all to live. For such a dream to be fulfilled and for the vision to take pedestrian formation, collegial support is not an option: it is a necessity. Also deemed to be a necessity is practising with others who share a common professional identity and are proud to call themselves "professional counsellors".

Benefit of collegial gatherings for the counsellor in private practice is said to flow from having the time to meet and talk with the new and the known, while getting to know what they are up to and making ongoing professional friendships. Having input from a platform that profiles a wide range of approaches and styles and finding out different contexts across which counsellors are working to support a client base managing similar issues is also highly valued: for example, the chid presenting with behavioural or learning difficulties; the child ascertained with having an intellectual disability; persons whose perception processes are ranked on the autism spectrum; those who are living with incidence of family violence; children who have witnessed and experienced abuse; caregivers; persons with Post Traumatic Stress Disorder (PTSD); persons with suicide ideation; persons with drug and alcohol dependency; adult survivors of childhood sexual abuse; persons presenting with diagnosis of clinical depression; persons who are displaced.

What is said to be "great", is having opportunity to get some fresh perspectives of practice while learning new skills and collecting new ideas. Further value is encapsulated in exposure to the diverse variety of perspectives and modalities used by experienced counsellors and this aspect of collegial shared experience is described as being "fascinating" while also opening up possibilities for further study, connection, and referral bases.

Working in a private practice is also noted as being sometimes very lonely; and it is stated that mixing with other counsellors in a collegial setting and sharing stories is not only helpful, but is also heart-warming.

For those working alone, opportunity to meet with colleagues at events such as Chapter gatherings is something to look forward to and something that is very much valued. As stated:

> *It is lovely and it feels so good to be part of something bigger. It is wonderful to know that supportive caring people are there if you ever needed them. I imagine I would feel a little lost without the connection I get at the monthly ACA meetings.*

From the viewpoint of the "person" in private practice,[4] there is the reassurance of having one's own insecurities normalised:

> *It's OK to be human and my insecurities become acceptable around the challenges of being in private practice and the challenges of counselling in general. Mixed with the challenges of my colleagues, they become more normal and I become less insecure.*

> *As I reflect on counselling as being a humanistic and imprecise science inspired by compassion and the desire to be of genuine service to our fellow humans, I also become consciously aware that I must first own my identify as human before I can identify as counsellor and as one counsellor in a collegiate of counsellors.*

Collegial support in the workplace

Reference is made to the many life roles and "hats" that one carries into the workplace. In concert with Hermans' Dialogical Self Theory (DST) (Hermans, 2001, 2012, 2016; Hermans & Dimaggio, 2016; Hermans & Hermans-Konopka, 2012),[5] there is recognition of the many "I" positions that each "Self" has: each being governed by time and circumstance. As stated:

> *When I come to work, I bring with me all that has been happening at home and on the news and with my family and friends and it is so good to be able to share and offload before the start of a new day.*

Similar sentiments are expressed in relation to the closing of the day: "When I leave work, I like to become the mother, grandmother, or wife. So if I need to, I stay back and debrief before getting in the car so that what happens at work stays at work". For one respondent, the best experience of collegial support is said to be collaborating with colleagues who voluntarily meet on a weekly basis to share classroom management strategies with a view to achieving best practice. It was noted that the teachers were from all disciplines so the different ways of thinking and implementing various strategies to engage adolescent students became almost a fun time as, together, there was collaborative reflection on both successes and not so good outcomes. It was also stated that support from colleagues was found to be transformative in ways that led to change in practice, bringing one to a place of being consciously aware of methods, strategies, and techniques used; so as to make sure students were "engaged" rather than merely being present in a controlled space. It was further stated that by inviting staff from all disciplines to participate in collegial discussion, focused reflection made the students, and not the departments, the centre of attention.

In addition, the appreciation of each other's disciplines increased the positive collegiality in the staff room in a way not experienced before; "and the stress of trying to survive separately in one's own cocoon became a thing of the past".

Perspective of the rural clinician

For the counsellor working in a rural area, support of colleagues is deemed to be "very important". While working in a rural region is quite isolating, having a few significant colleagues one can call on in times when a quick debrief or just an occasional check-in is needed, is noted as being "great".
While support in work is said to be "very helpful", supervision is found to be "essential" – particularly in small and remote communities where anonymity is a rare commodity. What respondents find most helpful with professional supervision is the dual focus on the clinical aspects of case work and the holistic elements that embrace the well-being of the clinician. It is observed that having regular supervision with a "good" and "experienced" professional supervisor minimises risk of client emotional safety being compromised by dual relationships that could lead to conflicts of interest, and/or development of issues related to transferences and counter-transferences, or issues that could pose potential risk associated with developing feelings and/or actions framed by dependency and co-dependency.

What applies for the regional and/or rural counsellor is even more significant for the "remote" counsellor who defines Self as being the "I am it" of mental and emotional support for the community. It is stated that even while remote locations may have access to "fly-in: fly-out" services, practitioners are from different domains of health care and the continuity of practitioner presence "on the ground" is simply not there in a way that promotes collegial connection: for, as stated, "collegial relationship takes trust; and trust takes time to build".

Response to loneliness and isolation

While those in remote areas intimately know loneliness and live with isolation, a point very clearly stated is that one does not need to be situated in a remote location to feel lonely and isolated. What is noted is that the profession of counselling can be a very lonely one in any place. Explanation given is that counsellors rarely work in collaborative teams where they can draw encouragement and motivation from those around; and it is stated that even in a workplace that has a multi-disciplined approach to holistic client well-being, one may well be the only counsellor in the midst of many other allied health practitioners. In such a practice, the reflection is that "collegial support can just be a word of encouragement from a fellow worker in the bigger game of helping".

For the counsellor who is the only counsellor in the work environment, Chapter gatherings (where accessible) are said to provide a space for feeling less isolated and more able to connect with people who are also in the same type of situation. Chatting with colleagues in the collegial setting is also said to give opportunity to discuss what career paths and further education colleagues are pursuing; and then taking time to reflect so as to see if they are, or could be, beneficial options to explore in relation to future career moves and/or further study.

The role of professional supervision as a mode of collegial support

Respondents speak of often being faced with difficult situations and the constancy of hearing stories of difficulty day after day. This is where the collegial support that comes with professional supervision provides the permission to off-load the day or the week that was, or to discuss potential scenarios for future learning.

What is also spoken of is the struggle that accompanies the thought of colleagues who don't attend supervision and say they are OK. It is stated that excuses given for not participating in supervision include the belief that by not having professional supervision, they are saving the organisation funds. It is also stated that it is these same counsellors who display a sense of being "all over it" because they have worked so long in the industry, have so much experience, and therefore, do not need professional supervision.

This is deemed to be not OK and is believed to ultimately reflect badly on the individual counsellor, other professional counsellors, the agency, and the industry. Above all else, what is stated as being worrying to respondents is the potential impact on clients when there is no perceived need for collaboration and learning on the part of the counsellor who "knows it all".

As stated above (Perspective of the rural clinician), a significant aspect of "good" professional supervision is collegial connection. The role of the professional supervisor in being the collegial connection between supervisee and industry cannot be underestimated when it is not only the "tyranny of distance" that impacts the supervisee's professional well-being, but also the whims and turns of nature that bring flood, fire, loss of all communication with the outside world, and destruction of access roads, landing strips, and seaway docks. For professional supervisors who support clinicians in remote locations, collegiality reverts to the root notion of walking in twos and the responsibilities associated with duty of care are compounded. These supervisors are "It", and they need to be consciously aware of the significance of responsibility in providing holistic supervision where there is a multi-dimensional focus on personal and professional support that leads to best practice in the delivery of therapeutic support and intervention with flow-on benefit to the counsellor's clients.

Making it Happen

As counsellors in the focus group reflected on the notion of "collegial support" and what that really looks like in practice, a wide range of thoughts, expectations, and needs were tabled. The need to "step up and step out" of comfort zones was deemed to be a key component of collegiality – particularly in support of those just beginning their career and taking their first footsteps into the world of professional counselling. Collegial support is said to be all about authenticity and encompasses the sharing of ideas, listening, and responding with interest and respect.

Responding to need

In order to know the needs of colleagues the expressed sentiment is simply to ask: so succinctly stated in the words, "How can I expect others to know that I am interested in what is happening for them, if I don't ask?" The corollary is also posed – "If we're all listening and asking, who's doing the talking and the telling?"

So enters the element of trust in both asking and acknowledging. For trust to be there, all need to work together to create an atmosphere where there is a sense of emotional safety: a place where nothing is too "silly" or too "awful" to talk

about: a place where a listening ear and a compassionate heart can always be found. It is deemed to be the responsibility of all to observe, to identify, and to be willing to take time over and above formal and structured activities at collegial gatherings so as to chat casually over a meal or a coffee after the formalities have concluded.

Providing a supportive environment

By way of providing a supportive environment within which professional development may be enhanced, the suggestion is that given the difficulties encountered by colleagues in the work environment, there needs to be a concerted effort to "normalise" the industry – to appreciate that what clients bring to the counselling room is their "normal" and to acknowledge the need to recognise and own our own humanness in response. The need is to accept with a conscious awareness that it is OK to feel and to hurt in an empathic connection with the hurting of another human being and it is said that, as an aspect of professional identity, counsellors need to own the fact that we are not "super-human" without empathy and emotion. What is emphasised is the need for positive encouragement, networking, and connection; and in acknowledging the duality of the human and the professional states of our being, the expressed thought is that, "We all need to come along to collegial gatherings with an attitude and intention of being 100% involved and active".

So, what does a supportive environment look like? Defined in words that reflect the essence of simplicity, a supportive environment is first and above all else, a "safe space". Within that safe space, people talk and are listened to and shared information is not exploited. It is stated that when colleagues feel supported, they can allow their vulnerability to come through. People say to each other, "How can I help you?" and they feel respected. There is non-violent communication[6] and there is laughter as people "simply check-in with each other".

Expectations of Self and Other

By way of expectations, counsellors in the focus group suggested that first and foremost, peers could respond to the needs of each other by simply saying, "Hello" and by respecting the confidentiality of anything that is shared in a professional, collegial space. There is an expectation of being listened to and it was stated that if one expects to be listened to by Other, there also needs to be an expectation of Self to speak with honesty and to allow oneself to be vulnerable within a place that projects an ethos of being be safe, respectful, and non-judgemental. There is expectation that colleagues listen respectfully with no side chatting or sniggering or putting-down or texting while someone is presenting. There is also expectation that colleagues will listen with compassion, will attend, and will be curious in a place where there is emotional support and unconditional positive regard. There is further expectation that colleagues will "listen with intentionality" – a concept that reflects Heidegger's notion of "presence" (Heidegger, 1927/1962, p. 47): Being "present-at-hand" or Being "present-in-the-world" (p.245): "concernfully absorbed" with Other (p.247).

Echoing the words of Dr Philip Armstrong (2015), "You cannot expect more from others than they are prepared to do for themselves", respondents reflected on what each can contribute to providing a supportive environment for the professional development of peers and colleagues.

There is intent to help create an environment where one can observe and talk to those around. There is intent to listen with respect, be curious, and make the time to chat over lunch so as to really get to know colleagues.

A most significant aspect of collegiality is posed in the comment, "Respect others and expect respect". It is about being open to giving and receiving and being both trusting and trustworthy. It is about recognising the vulnerabilities of others and allowing Self to be vulnerable and to reach out to colleagues. In keeping with the transactional construct inspired by Berne (1966), the feeling is expressed in terms of, "I'm OK. You're OK. We're OK."

Pitfalls and Problems

While the benefits of collegial support are significant, not all collegial encounters lead to joyful experiences, collaboration, sharing of ideas and experiences, knowledge enhancement, and professional friendships. It is suggested that while there are those who are very generous and authentic in their support and sharing, the trouble is finding those with whom one can establish a professional bond, as some colleagues can be very self-focused and tend to be "a bit precious" about their ideas and thoughts on a subject, or their supposed exclusive territory, or body of work. Others, it is said, can be "a bit snobby". As mentioned above (The role of professional supervision as a mode of collegial support), there are also those who believe that they are "all over it"; and having no need either to give or to receive collegial support, any attempt to develop a collegiate can be easily sabotaged.

It is also found that, at times, it can be difficult to sustain an on-going commitment to participate in formalised collegial gatherings (for example: Chapter gatherings), due to other commitments, distance, or having gatherings hijacked by a participant attendee. Elaborating on the concept of "hijacking", reference is made to attendees who do not participate and disrupt presentations and there are also those people who try to "outdo each other". The expressed sentiment is that:

It can be uncomfortable when there are some Narcissistic personalities fighting for attention – what they do is the best and nobody else matters. It also worries me when there is unethical use of confidential information that is shared or when that information is used subversively by someone to wave their own flag.

What I want and what I value in collegial gatherings is a platform for communicating with like-minded people and a place to gather where there is fun and respect and where I can get new ideas and learn what techniques other people are using in a relaxed atmosphere with just the right amount of structure to keep it flowing. Unfortunately, to get all this, we also have to put up with the pitfalls and the breakdowns, as well.

It is suggested that guidelines for the ethical and professional, and the effective and efficient operation of Association Chapters and Member Associations is "absolutely necessary". It is also suggested that there needs to be balance and the expression is:

If operational structures become too rigid and too business like (like having to register to attend), there is risk of losing the warmth and friendliness that define the very essence of why we come together as colleagues; and to this end, we must never lose site of the fact that we are a collegiate and not a business.

It is stated that "an organisation is only as strong as those within; and if those within are supporting one another, then they,

as a collegiate, are very strong indeed!" While acknowledging that there can be difficulties, the final claim is that "all things considered, and at the end of the day, any benefits from the collective far out-weigh the cost of not having the support of some individuals".

Conclusion

This study was initiated in response to the shared vision of counsellor colleagues relating to the relevance and importance of professional collegiality. What was found was that professional collegiality is highly valued and that the place of professional collegiality is significant in supporting the growth of a professional identity from both an individual position and a broader industry perspective.

Collegial support is found in the workplace, in casual collegiate gatherings, in professional supervision, and in more structured gatherings that are convened in collaboration with the parent body of professional associations. It is found in the city, in the suburbs, in regional areas, and in remote locations.

Involvement in collegial activities provides needs gratification on personal and professional levels. Counsellors participating in collegial activities experience a sense of connection. There is fun, enjoyment, and learning. There is an expressed sense of freedom to be one's self with no pretence: "it's OK to be human and allow my vulnerabilities to be seen while knowing that I am not being judged and that I will be supported". With that freedom, there is also reflected a sense of responsibility to Self and Other to grow and develop personally and professionally and in that growth, there is expressed a sense of achievement.[7]

Perhaps the most significant point of value to permeate all responses is the opportunity for counsellors to develop a professional identity that each and every one can wear with pride while walking tall as an individual, as a collegiate, and as an industry. As professional identity is strengthened so too is the flow-on benefit to clients. Subsequent contribution to the broader community is the profiling of a landscape of therapeutic intervention where the focus is mental wellness and where clinical practice that focuses on mental illness is destines to become a concept associated with generations past.

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Appendix

Appendix A: Questions for reflection: Collegial and professional peer support

Questions posed for discussion employing a process of reflective practice in response to Code of ethics and practice of the association for counsellors in Australia – article 2, clause (a), item ix. (2000/2015):

2. Code of Ethics

(a) The helping relationship constitutes the effective and appropriate use of helper's skills that are for the benefit and safety of the client in his or her circumstances. Therefore as members (regardless of level) of the Australian Counselling Association we will:

ix. Be responsive to the needs of peers and provide a supportive environment for their professional development.

Question 1: How am I, as a member of Australian Counselling Association, responsive to the needs of my peers?

Question 2: How do I know the needs of my peers?

Question 3: What does being responsive to the needs of my peers look like?

Question 4: How do I expect my peers to respond to my needs?

Question 5: What could my peers do by way of providing a supportive environment within which my professional development may be enhanced?

Question 6: What does a supportive environment look like?

Question 7: What do I contribute towards providing a supportive environment for the professional development of my peers?

Question 8: How can I contribute to providing a supportive environment?

Footnotes

[1]Refer Appendix A, Questions for reflection: Collegial and professional peer support

[2]2.(a) ix - 2. Code of Ethics; (a) The helping relationship constitutes the effective and appropriate use of helper's skills that are for the benefit and safety of the client in his or her circumstances. Therefore as members (regardless of level) of the Australian Counselling Association we will; ix. Be responsive to the needs of peers and provide a supportive environment for their professional development.

[3]As opposed to the "person" in private practice.

[4] As opposed to the "therapist" in private practice.

[5]Dialogical self/Dialogical Self Theory (DST): A dynamic multiplicity of I-positions in the society of the mind; intrinsically bound to particular positions in time and space, positioning and repositioning, and interacting like characters in a story (Hermans, 2001, 2012, 2016; Hermans & Dimaggio, 2016; Hermans & Hermans-Konopka, 2012).

[6]As a model of communication developed by Rosenberg (1999/2015), non-violent communication (NVC) is a simple method of empathic communication –stating (1) observations, (2) feelings, (3) needs, (4) requests. NVC aims to find a way for all parties to express what they really want without the use of guilt, humiliation, or shame. It is postulated as being an effective pro-cess for resolving conflict, connecting with others, and living in a way that is conscious, present, and attuned to the genuine, living needs of Self and Other.

[7]Psychological needs gratification based on William Glasser's model of choice and control (Glasser, 1984; 1999; Glasser & Glasser, 1989).

Quality of Student Counseling Centre's Services at Sultan Qaboos University: Students' Perceptions

Suad M. AL.Lawati[1] & Marwa N. Alrajhi[2]

The current study aimed to examine the quality levels of counseling services provided by the Student Counseling Centre (SCC) at Sultan Qaboos University (SQU). The researchers developed a self-report questionnaire consisting of three main parts - the centre's general conditions, the counseling services, and reasons for not-benefiting from the services. The sample used in the study consisted of 1200 university students. Statistical differences were found between students in terms of their academic experience and the benefit they gained from the services. All services were assessed by the students and high to very high levels of quality were recorded for them all. Reasons behind students not reporting benefits from the services were also reported.

Keywords: *counseling, counseling services, quality, university, students*

Introduction

For a very long time, awareness of the benefits people gain from speaking to each other about societal or personal issues have been widespread. Close friends or family members are the individuals with whom people usually prefer to share their problems and seek help. However, as nations have developed and many social, economic and educational changes have occurred, people have started to encounter an increased variety of problems, which cause many difficulties in their lives. One of the consequences of all these changes is that the practice of sharing problems with friends and family has become less common. As a result, it is important to offer help to students which involves interaction with experts in a semi-formal setting in order to supplement interactions with friends and family. The rapid economic development that has occurred in Muslim countries over the past twenty years and the liberalizing of Islamic principles has created different types of mental health problems and stress, and, as a consequence, the need for counseling has increased (Brinson & Al-Amri, 2005).

For more than fifty years, college counseling centres have been offering different mental health services to students to help them grow and deal with late adolescence/early adulthood developmental issues and changes (McEneaney & Gross, 2009). These services have become more complicated over time (Meilman, 2016) and there are now many effective professional services that universities offer which can help students make informed decisions, resolve problems and deal with various issues. Recently, university counseling centres have started to appear in various Arab countries in order to provide services to the community.

This study aims to explore students' perceptions about counseling services provided by the Student Counseling Centre (SCC) at Sultan Qaboos University (SQU) in Oman. Counseling, as a profession started in Oman through the SCC at SQU, when it was established based to a US model of college counseling centres, but as an independent body, during the 1999-2000 academic year (Sulaiman, 2006). The SCC provides information about counseling services that are available to university students and deals with student's mental health issues and those of the community in general (Sulaiman, 2004).

The Importance of Counseling Services for Students

As students start their university life, they can encounter a form of a cultural shock due to the massive differences they experience when compared to life during their school years. This shock may hinder students' adjustment and success. For example, Saleem, Mahmood and Naz (2013) found that, among university students, 31% of the study sample was suffering from "severe" mental health problems, while 16% suffered from "very severe" problems. Those problems were described as "lack of self-regulation," "loss of confidence," and "anxiety proneness" (p., 124). The researchers concluded that knowing the problems university students suffer from would be very helpful in planning counseling services. In addition, Alkayumi and Aldhafri (2015) explored the common problems that first year students at SQU experience, and the findings revealed that the students suffered from a great deal of problems. The most prevalent issues were lack of concentration, eating disorders and health problems.

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Consequently, there is a great need to establish student counseling centres that offer a range of services to help students to adjust personally and academically to university life and promote improved mental health. According to Sulaiman and Aldhadha (2007), counseling centres provide counseling services for students who suffer from problems such as, anxiety, indecisiveness and an inability to adjust to university life. Moreover, they offer study skills support which enables students to overcome obstacles to successful study.

In a study exploring the needs of students who attend a counseling centre, Lucas and Berkel (2005) found that students suffered from depression and anxiety symptoms, and feelings of isolation in their social relationships. In addition, Yi, Lin, and Kishimoto (2003) mentioned that counselees reported major concerns related to 'anxiety', work/course grade' and 'depression' in addition to being "worried" or "extremely worried" about their future, p.337,339). Other findings showed that anxiety was the most common complaint by university students, as reported by counselors, followed by depression (Centre for Collegiate Mental Health, 2016). It is crucial to assess counselees' ability to deal with such issues, since personal and social lives are strongly tied with vocational and educational concerns (Lucas & Berkel, 2005), which then affect students' academic success at university.

Moreover, counseling services were found to be significantly related to students' academic performance. Yang, Yon and Kim's (2013) conducted a longitudinal study of the effect of a mandatory counseling program on the academic performance of college students who had been under probation. The authors revealed that, over three semesters, the students who attended five or more counseling sessions, beyond the two mandatory sessions, showed greater improvement in their GPA than the students who did not attend the mandatory sessions. Students in Turner and Berry's (2000) study reported that the counseling centre helped them maintain or improve their academic study. In addition, the researchers found that clients of counseling centres showed higher retention (i.e., re-enrollment) rates than students who did not receive counseling. In addition, Wilson, Mason, and Ewing (1997) found that students who received six counseling sessions continued their education longer than those who did not attend such sessions. The researchers also reported that additional sessions beyond six, did not have much impact on student retention. Similarly, a positive relationship between attending counseling sessions and students' GPA and retention rates was supported by other researchers (e.g., Lee, Olson, Locke, Michelson, & Odes, 2009; Wlazelek & Coulter, 1999).

Types of Services Provided in Counseling Centres

Counseling centres around the world provide different kinds of services. The main types of individual and group counseling services are commonly found in any typical counseling centre. Research has been conducted to explore the important types of counseling services provided by counseling centres. Individual counseling is a core service that is assumed to be provided by all counseling centres. Through investigating the perspectives of members in two college counseling associations (AUCCCD and ACCA) in the USA, Brunner, Wallace, Reymann, Sellers and Mccabe (2014) found that participants rated individual counseling as the most important service provided by counseling centres. All the counselors who participated in this study reported providing individual counseling.

In addition, most counseling centres offer group counseling along with individual counseling (Brunner et al., 2014). According to McEneaney and Gross (2009), the use of group psychotherapy has increased markedly in counseling centres as a way of effectively meeting the rapidly increasing demand for counseling. Examples of college centres providing group counseling are University of Kentucky (USA), Kean University (USA), and the University of Iowa (USA). Group counseling services are also provided by counseling centres in Arab universities such as, Qatar University and United Arab Emirates University. Beside these typical and commonly known types of counseling, counseling centres have started to develop different types of supportive counseling services which can assess and help students indirectly. Examples of these services include, developmental counseling, consultation, outreach counseling and workshops. Based on the work of Brunner et al. (2014), 97% of members of Association for University and College Counseling Center Directors (AUCCCD) and American

College Counseling Association (ACCA) reported consultation as a supportive service provided in their centres and that counseling centre staff work as the main consultants for almost all staff, parents and students in a college or university. They provide consultation on different issues, such as how to deal with students who are at academic or different forms of psychological risk. Examples of college centres providing consultation are the University of Kentucky (UK) (2015) and the University of Iowa (2016). Similarly, counseling centres in some Arab universities provide consultation as a counseling service. Examples of these universities are Brince Sattam Bin Abdulaziz University (Saudi Arabia) (2014) and United Arab Emirates University (2014).

Brunner et al. (2014) stated that almost all directors rated outreach programs and preventive counseling as important or extremely important services provided by their counseling centres. Moreover, other services, such as workshops and development counseling were reported as supportive services provided by different counseling centres all over the world (e.g., Michigan State University; University of Kentucky; United Arab Emirates University).

Students' Perceptions about Counseling Services

For the purpose of improving counseling services offered in any centre, it is important to know clients' perceptions of the quality and the usefulness of these services. In universities and colleges most of the counseling centres' clients are students, and their opinions should be highly valued and considered in any developmental process. Much research has been conducted to explore students' perceptions of counseling services. Bundy and Benshoff (2000) found that 70% of participating students thought that having a centre for personal counseling on campus would be "very helpful or helpful" and 34% reported that they would be "very likely or likely" to visit such a centre. Similarly, Gaughf, Smith and Williams (2013) found that about (54%) of the students believed that academic counseling is very necessary to their academic life and (60%) indicated that they may seek counseling services if needed. Moreover, Russell, Thomson, and Rosenthal (2008) stated that college students who received counseling services held positive perceptions about their experiences and did not feel uncomfortable about the process.

Several studies have been conducted regarding the perceptions of Arab students regarding counseling services. For example, in a study conducted for Arab students in the UAE, Brinson and Al-Amri (2005) found a high level of agreement among students that the counseling profession is important. Many students reported that they would seek counselor support, much in the same way as they would ask for help from a friend or family. In addition, most of the participants indicated that they wished more counseling services were offered for people who needed them and, even if the students did not frequently use counseling services, they believed in the importance of making these services available to the community.

Only one study has been conducted to examine the quality of counseling services provided by the Student Counseling Centre (SCC) at Sultan Qaboos University (SQU). Almashhadani and Alfazari (2009) looked at students' perspectives of the service quality and found that counseling services provided at the centre (individual counseling, group counseling and consultation) were rated as being of high quality. Moreover, the counseling services provided outside the centre (i.e., outreach counseling, developmental counseling, and social services) as well as the centre's environment (e.g., location, organization, library) were perceived to be of moderate quality by the students. Also, the research findings did not show any significant differences with regard to the variables of gender, benefiting from the services, and academic discipline (i.e., science or humanities).

Students' Unwillingness to Visit Counseling Centres

While some students find counseling crucial, some others did not believe in the importance of counseling. Yi, Lin and Kishimoto (2003) stressed the importance of advertising and marketing counseling services for students such as these. Students who perceived counseling as an essential service, usually had a positive experience with counselors or they appreciated the vital role of this profession (Xie, 2007).

Research has examined the obstacles or reasons behind students' unwillingness to visit counseling centres. Many reasons can explain students' avoidance of counseling services, among which are the location of the centre, students' beliefs and lack of awareness about counseling, and lack of recommendations from friends or faculty.

First, the location of any counseling centre should be given some attention. Bundy and Benshoff (2000) indicated that the students may not find it affordable or practical to seek counseling outside their college. Also, in rural areas, students may have to drive long distances to find a good counseling centre in the city. Moreover, the 'stigma' that can be linked with seeing a counselor may be reduced when the students are able to see counselors who are part of their college staff.

Students' beliefs, 'misperceptions' or lack of awareness about counseling services can be additional obstacles towards seeking counseling (Kahn, Wood, & Wiesen, 1999). Many students associate counseling only with mental health problems. In a study of students' views on counseling, Xie (2007) found that participants viewed clients who sought counseling as having mental health problems, which they cannot solve themselves. Many of the students stated that they did not know what counseling was, or how the process worked. Some of the students imagined that a counseling session was similar to a medical visit, that is, a client is lying on a couch and speaking to the counselor (Xie, 2007). It is clear that some students might not be aware that counseling services are not meant only for mental health problems, but also for developmental and personal growth issues (Kahn et al., 1999; Xie, 2007). Moreover, a lack of knowledge about how to make an appointment, and access services could be reasons behind students not counseling services (e.g., Gaughf et al., 2013; Russell et al., 2008).

In Arab societies in particular, the idea of seeing a counselor remains hard to accept by many students. Brinson and Al-Amri (2005) claimed that Islamic beliefs are the reason why mental health counseling is not popular in Arab culture. People believe that everything that happens to them is connected with God's will. If an individual suffers from any problem, it is more likely to be viewed as a consequence of a religious deviation and, thus, if a person is reconnected to God's principals, he or she can live a better life. Another reason why Arabs do not show a great interest in using counseling services is their belief that counseling is a western practice and therefore should be automatically rejected. Supporting this claim, Al-Darmaki (2011) found that the majority of Emirates' college students preferred to rely on themselves to deal with their problems, rather than seeking help. Moreover, most students who sought the help of others reported preferring family or friends over academic staff or advisors. Also, students often consider seeking out advice from academic advisors or faculty help for academic and career problems rather counselors.

Finally, students are more likely to benefit from counseling services if they are recommended by teachers or friends. Research found that having friends who already benefited from counselling meant students were more likely to visit the counseling centre (e.g., Russell et al., 2008). Gaughf et al. (2013) suggested that if faculty lacks knowledge about the available academic counseling services and they do not recommend these services to students, then students will rarely benefit from or seek these services. The researchers recommended that faculty should be better prepared to encourage and refer students with academic difficulties to seek academic counseling. Bundy and Benshoff (2000) suggested that, with encouragement, many college students would likely seek personal and group counseling and attend workshops.

The Student Counseling Centre at Sultan Qaboos University

The Student Counseling Centre (SCC) at Sultan Qaboos University (SQU), launched in 1999, is one of the centres that provide support services for college students to help them adjust to university life. The SCC is a member in the world association of counseling centers and it works according to internationally accredited ethics and principles (Almashhadani & Alfazari, 2009). The centre offers many different counseling services classified into the primary internal services (i.e., at the centre), which are individual counseling and group counseling, and external support (i.e.,outside the centre) services represented by developmental counseling, outreach counseling, discussion sessions and student workshops. Brief definitions for each service are as follows:

1. Individual counseling "is conducted between two persons, the guidance and counseling specialist and the counselee, in a special place according to the walk-in counselee's requests or based on an arranged appointment for a period of time. Individual counseling session aims to discuss and deal with personal issues that cannot be implemented or discussed in group counseling sessions. Counseling relationship is a pro-

professional relationship based on privacy and confidentiality of the counselees' information during the counseling session in order to achieve specific and private goals". (Student Counseling Centre, p.5, 2016a).

2- Group counseling "is a social dynamic organized process in which a group of counselees meet and work in co-operation with a guidance and counseling specialist to achieve common goals. The focus of these meetings is to discuss common academic, behavioral, psychological, or social concerns. Group counseling consists of pre-prepared and organized sessions that take place once a week". (Student Counseling Centre, p.5, 2016a).

3- Developmental counseling is provided through specialized and purposeful lectures or through workshops, which last for about one hour and can address academic, educational or psychological issues. The lectures are presented by one of the specialized counselors in the centre or by specialized staff from one of the university colleges.

4- Outreach counseling is provided through specialized lectures and can address academic, educational or psychological issues. They are presented by counselors and last for two hours. These lectures are held in places outside the centre, such as students' dormitories inside or outside the university.

5- Discussion sessions are organized by the SCC in cooperation with some professionals or academics in the different university colleges. These seminars focus on a variety of students' academic, developmental or social concerns.

6- Student workshops are purposeful activities that aim to develop certain academic or life skills. They are conducted once a week throughout the semester for not more than 30 students (Student Counseling Centre, 2016b).

Study Aim and Context

As evident from the reviewed literature, there are very few studies, to the researchers' knowledge, that have evaluated the quality of counseling services offered in college counseling centres in Arab contexts. More specifically, only one study (Almashhadani & Alfazari, 2009) was conducted to assess the quality of counseling services provided by the Student Counseling Centre (SCC) at Sultan Qaboos University (SQU). Hence, the current study adds to the existing literature generally, and the earlier study examining SCC services in particular.

The purpose of this study is to examine the quality of counseling services provided by the SCC at SQU from students' perspectives. Specifically, the study attempts to explore students' perceptions about the quality of counseling services by focusing on, first, the centre's environment and general conditions, for example, the location of the centre, the waiting area, the library, advertising of the centre's services, making appointments and the website of the centre). Second, the quality of each service provided in the centre, for example, individual counseling, group counseling, developmental counseling, outreach counseling, discussion sessions, and student workshops.

In addition, the study investigates the reasons behind students' unwillingness to access the counseling services. Specifically, the study utilizes a descriptive design to answer the following questions:

1- What are the most frequent sources used by stu-dents to find out about SCC services?

2- Are there statistically significant differences regarding the levels of student benefit from counseling services, based on stu-dents' gender and their academic year?

3 -What are the quality levels of the SCC environment and the counseling services provided?

3-Are there statistically significant differences in stu-dents' perceptions of the quality of counseling services based on gender and academic year?

4-What are the most important reasons preventing students from benefiting from the counseling services?

Method

Study Population and Sample

The population of the study included all registered students at SQU in the fall of 2015 who were enrolled in all undergraduate and postgraduate programs (High Diploma, Masters and PhD). The total number of students was 17,952, based on the Dean of Admission and Registration's (2015) statistics. The sample comprised 6.68% of the population (n=1200), and females represented 53% of the sample.

Instrument

The researchers developed a "Counseling Services' Quality Questionnaire" (CSQQ) after reviewing some of the existing instruments in this field such as the Counseling Centre Student Satisfaction Survey developed by Queens Borough Community College; and the SMU Counseling Centre Client Satisfaction Survey by the Samuel Merritt University Counseling Centre (2013). In addition to these questionnaires, the researchers reviewed Almashhadani's and Alfazari's (2009) questionnaire for evaluating SCC services, as perceived by prospective graduate students.

The CSQQ consisted of three main parts in addition to the demographic variable part. After providing some personal information such as gender, college, academic year, and subject area, participants indicated whether they had already benefited from SCC services or not. Based on this, participants who had benefited from the services answered the first two parts. The first part (23 items) related to the centre's environment and general conditions (waiting area, receptionists, library, location), and the second part asked participants to evaluate only the service(s) they benefited from, whether it was individual counseling (18 items), group counseling (21 items), developmental programs (14 items), outreach programs (14 items), discussion sessions (15 items) or student workshops (16 items). On the other hand, participants who had not benefitted from SCC services answered the third part of the questionnaire, in which they revealed the reasons for not benefiting from the services. All items were scored using a 4-point Likert Scale ranging from strongly agree to strongly disagree.

Face validity of the CSQQ was assessed by reviewers specialized in the area of psychology and evaluation and measurement. Moreover, reliability coefficients were derived for each of the CSQQ domains using Cronbach's alpha. Coefficients ranged from 0.61- 0.93 (see table 5).

Evaluation Criteria for data analysis

The researchers developed an evaluation criteria to be used in the data analysis. The criteria were used to distinguish Weak, Medium, High, or Very High levels of quality. Since the items were scored using a 4-point Likert scale, the range was 3 (i.e., 4-1 = 3) and, thus, interval length for the 4 categories equals 0.75 (i.e., 3-4 = 0.75). Table 1 represents the evaluation criteria used in this study.

Table 1. *Evaluation criteria used for measuring services' quality levels*

Means	Levels
1.00-1.74	Weak
1.75-2.49	Medium
2.50-3.24	High
3.25-4.00	Very high

Procedures

First, the questionnaire was sent by Planning and Statistics Department at SQU to all registered students during the fall of 2015. Students were assured of the confidentiality of their information and were informed that all data would be used only for research purposes. A total number of 1053 online filled questionnaires were retrieved. Second, students were reached in different sites, such as student dormitories and at the locations of the centre's activities or workshops. Hard copies of the questionnaire were distributed to them in order to increase the number of participants. A total of 147 hard copies were retrieved for a grand total of 1200 students participated in this study.

After data collection, the questionnaire forms were classified into two groups; Group1 were the students who had benefited from the SCC services and Group 2 were students who had not benefited from the services. The total number of students who had benefitted was 232 and of those who had not benefited was 968.

Results

Prior to the data analysis, data were screened for outliers and none were identified. Some missing data were found due to items being left blank. Research questions were answered based on the two groups - benefited students and non-benefited students. Hence, questions 1 and 2 were answered using data from the whole study sample, questions 3 and 4 were answered using benefited students' responses (Group 1), and question 4 was based on non-benefited students' responses (Group 2).

Descriptive statistics were utilized to answer the first question, "What are the most frequent sources used by the students to find out about SCC services?", and these are presented in Table 2.

Table 2. *Sources used by students to learn about the SCC*

No.	Methods	Number	Percentage
1	Student orientation week	466	38.90
2	SCC advertisement	348	29.00
3	Friends	191	15.90
4	Social Media	78	6.50
5	SCC website	70	5.80
6	SCC publications	36	3.00
7	More than one method	11	0.90
Total		**1200**	**100%**

The findings showed that the highest frequency sources used by the students to learn about the counseling centre and its services were "student orientation week" and "SCC advertisements" respectively. The source used least, on the other hand, was "SCC publications". In addition, some students reported that they knew about the centre through more than one method.

Now to examine the second question - "Are there statistically significant differences in the levels of students' benefits from counseling services based on students' gender and their academic year?". First, to examine gender differences, an independent sample t-test was utilized (presented in Table 3). The results showed no statistically significant differences regarding gender in the levels of students' benefits from the counseling services (p= 0.239).

Table 3. *Gender differences in levels of students' benefits from counseling services*

Gender	*n*	Mean	Std. Dev.	*t*	*p*
Male	564	0.18	0.38	1.17	0.239
Female	636	0.21	0.40	-	-

Regarding the second part of this question related to differences in students' benefits from counseling services based on academic years - these were examined through one way ANOVA and presented in Table 4. The findings showed that there were statistically significant differences in the levels of students' benefits from counseling services based on their academic years (F= 2.81, p = 006). A Post Hoc test showed that the highest levels of benefit from counseling services was among students enrolled in 3rd - 6th academic years. However, students with 1st 2nd and 7th, or more, academic years benefitted less from counseling services.

Table 4. *One way ANNOVA for differences in benefits based on the academic year*

Sum of Squares	Mean Square	*F* Staistic	*p*
3.04	0.43	(7, 1191)	0.006
183.45	0.15	2.82	

Constant: Benefit from services

To answer the third question, "What are the quality levels of SCC environment and the counseling services provided?", descriptive statistics were calculated at the item level and service level based on the responses of students who benefited from the services only (Group 1). Table 5 shows descriptive statistics at the service level and the quality level of each service according to the evaluation criteria justified in the methodology. (Note: descriptive statistics at the item level are included as a supplementary material in appendix 1).

As is clear from Table 5, student workshops and individual counseling had the highest quality levels ("very high") based on students' perceptions. The rest of the services showed "high" quality levels. Regarding the SCC environment, Table1 in appendix 1 reveals results related to the environment. The highest means ("very high") were found for the two items - "The location of the SCC ensures privacy to students," and "Receptionists in the counseling centre meet students with amiability and gentleness". On the other hand, the lowest means ("medium level") were found for "I have visited the SCC library and benefited from its services," and " The SCC website is not known to me.

Regarding the fourth question, "Are there statistically significant differences in students' perceptions about the quality of counseling services based on gender and academic experience?", an independent sample t-test was used to examine differences based on gender.

Table 5. *Reliability coefficients, descriptive statistics, and quality level of services (n= 232)*

Variable	No.	*a*	Mean	Std. Dev.	Quality Level
Student workshops	16	0.85	3.66	0.89	Very high
Individual Counseling	18	0.89	3.15	0.43	Very high
Discussion Sessions	15	0.85	3.12	0.40	High
Group Counseling	21	0.91	3.08	0.41	High
Developmental Counseling	14	0.85	2.97	0.42	High
Outreach Counseling	14	0.93	2.90	0.57	High
SCC environment	23	0.82	2.75	0.36	High
Reasons for not benefiting*	11	0.61	2.57	0.37	---

*Note: Quality level is not provided for this dimension as it measures different reasons for not benefiting from the services and not a single service. It is included only to demonstrate Cronbach's Alpha value.

As is clear from Table 5, student workshops and individual counseling had the highest quality levels ("very high") based on students' perceptions. The rest of the services showed "high" quality levels. Regarding the SCC environment, Table1 in appendix 1 reveals results related to the environment. The highest means ("very high") were found for the two items - "The location of the SCC ensures privacy to students," and "Receptionists in the counseling centre meet students with amiability and gentleness". On the other hand, the lowest means ("medium level") were found for "I have visited the SCC library and benefited from its services," and " The SCC website is not known to me."

Table 7 presents the one way ANOVA results which also demonstrates no statistically significant differences in students' perceptions of services' quality based on their academic year.

Finally, to answer the last question related to the most important reasons which prevent students from benefiting from counseling services, the responses of students who did not benefit (Group 2) were analyzed. Descriptive statistics (i.e., means, standard deviation, and the quality level of each item based on the evaluation criteria) concerning the reasons scale are presented in Table 8.

As shown in Table 8, the most important reasons hindering students from coming to the centre and benefiting from its services were "I am not aware of the student counseling centre's services," "Student counseling centre's services are not clear to me," and "I don't know student counseling centre's location". The least important reasons were "Asking for counseling help means that I suffer from a mental disorder," "A friend has advised me not to seek student counseling centre's services," and "The information in the student counseling centre's website is not useful"

Table 6. *Gender differences in students' perceptions about counseling services' quality (n=232)*

Services	Gender	No.	*Mean*	*Std. Dev.*	*t*	*p*
SCC environment	Male	88	2.73	0.32	0.79	0.425
	Female	97	2.77	0.39		
Individual counseling	Male	38	3.06	0.43	1.88	0.064
	Female	33	3.25	0.41		
Group counseling	Male	13	3.03	0.43	0.55	0.585
	Female	19	3.11	0.40		
Developmental counseling	Male	11	2.89	0.52	0.78	0.439
	Female	21	3.02	0.37		
Outreach Counseling	Male	4	2.87	0.66	0.16	0.877
	Female	1	3.00	-		
Discussion session	Male	35	3.04	0.40	2.63	0.012
	Female	10	3.40	0.27		
Student Workshops	Male	11	2.85	0.50	0.36	0.721
	Female	5	2.76	0.28		

Table 7. *Differences in students' perceptions about counseling services' quality based on their academic experience (n=232)*

Variables	Source	Sum of squares	*df*	Mean square	*F*	*p*
SCC environment	Between groups	0.86	7	0.12	0.92	0.491
	Within groups	23.81	177	0.13		
Individual counseling	Between groups	1.78	7	0.11	0.58	0.769
	Within groups	12.23	63	0.19		
Group counseling	Between groups	1.42	5	0.28	1.94	0.121
	Within groups	3.81	26	0.14		
Developmental counseling	Between groups	1.22	5	0.24	1.43	0.246
	Within groups	4.43	26	0.17		
Outreach Counseling	Between groups	0.69	2	0.34	1.09	0.479
	Within groups	0.63	2	0.31		
Discussion session	Between groups	0.780	5	0.15	0.98	0.440
	Within groups	6.015	38	0.15		
Student Workshops	Between groups	1.20	4	0.30	1.90	0.180
	Within groups	1.73	11	0.15		

Table 8. *Reasons for not benefiting from the counseling services (n=968)*

No.	Items	*Mean*	*Std. Dev.*	Level
1	I am not aware of the student counseling centre's services.	3.18	0.75	Very high
2	Student counseling centre's services are not clear to me.	3.07	0.75	Very high
3	I don't know student counseling centre's location.	2.89	0.94	High
4	The centre's announcements haven't attracted my attention.	2.86	0.83	High
5	I face difficulty arriving to the student counseling centre.	2.78	0.83	High
6	I prefer to solve my problems by myself rather than consulting somebody else.	2.72	0.89	High
7	I feel shy to seek counseling services.	2.72	0.89	High
8	I don't trust the confidentiality of information I reveal to the counselor.	2.53	0.91	High
9	The information in the student counseling centre's website is not useful.	2.41	0.73	Medium
10	A friend has advised me not to seek student counseling centre's services.	1.68	0.85	Weak
11	Asking for counseling help means that I suffer from a mental disorder.	1.64	0.67	Weak
10	A friend has advised me not to seek student counseling centre's services.	1.68	0.85	Weak
11	Asking for counseling help means that I suffer from a mental disorder.	1.64	0.67	Weak

Discussion

The current study aimed to primarily explore the quality of counseling services provided in the Student Counseling Centre (SCC) at Sultan Qaboos University (SQU). Secondly, it aimed to examine the most significant reasons that prevented the students from benefiting from the services.

The findings suggested that regarding the ways by which the students became familiar with the counseling services, "student orientation week" and "SCC advertisement" were the most frequent sources utilized by the students. This finding supports the vital role that student orientation week plays at the beginning of each semester. Students who attended activities organized during this week have the chance to gain awareness of all aspects of university life such as the facilities, services, laws… etc. The SCC prioritizes advertising its services and support activities to the students during this week, which according to this study contributes a great deal towards the students' awareness of the centre. This indicates a need to continue providing and strengthening the quality of these two methods, so as to familiarize the students with SCC services. SCC publications were found to be the least frequently mentioned source used by the students, which could be attributed to students being more influenced by people speaking directly with them about the services (i.e., in orientation week) and through advertisements on the internet and social media, which are brief and capture the attention and passion of today's generation better than printed publications. Yet, the SCC staff need to find a better advertising plan to encourage students' to read publications, since they include a lot of important information regarding students' adjustment to university life such as dealing with anxiety, dealing with emotions, self-development and studying strategies.

No gender differences were found in the levels of benefits from the SCC services, however, statistical differences based on years of academic experience were found. Students in their 3rd to 6th academic years benefited from the services more

than those enrolled in the 1st, 2nd and 7th or more academic years.

This could be due to several reasons: students who enrolled in the 1st and 2nd years might be less aware about the centre than those who have been studying longer as they were more familiar with the university and services provided. In addition, as students in the first year often have to study English at the Centre for Preparatory Studies, they may feel less engaged with university life until they become more integrated when they start attending their colleges in their second year. Moreover, students first starting university life are coming from a home environment where they are used to receiving social support through speaking with parents, relatives or friends about problems that they may face. It could be difficult for them to become accustomed to the culture of counseling and thereby benefit from its services. As suggested by Brinson and Alamri (2005) the idea of seeing a counselor was rejected by Arabs, who believe that the solution to any problems they face is to be found in their faith in God. This idea still exists among students currently, although to a lesser extent, especially in those who are newly enrolled and those needing some time to realize the importance of counseling.

Regarding the more experienced students, there were very few students enrolled in their 7th year or higher since most colleges at SQU entail only 4-6 years of study, which could be a reason why students enrolled in these years benefit less from the centre. The university years (3rd to 6th), on the other hand, are the years when students are generally in the midst of their busiest period of study and, therefore, may face many challenges which make them more likely to benefit from counseling services. These results are inconsistent with Tahhan and Abu Eitah (2002) who found that first and second year students revealed a greater usage of counseling services than fourth year students. However, in the current study, it cannot be assumed that 3rd to 6th year students have higher counseling needs than their 1st and 2nd year counterparts, because they might have benefitted from counseling services since their first year. However, by the time the study was conducted they were enrolled in their 3rd to 6th years. There was no question included in the questionnaire that asked the students in which academic year they benefited from the SCC services. As a result, future studies will need to examine when students have higher needs of counseling services.

Regarding the main purpose of the current study, in general, all counseling services were found to have high levels of quality. Student workshops and individual counseling were rated the highest level of quality ("very high") and the remaining services were rated as being "high" in terms of quality. These results are consistent with Almashadani and Alfazri's findings in relation to SCC services in 2009. In their research, counseling services were rated as being moderate to high quality as perceived by graduate students. These consistent results reinforce the notion that SQU students believe in the necessity and the quality of counseling services which SCC provides for them. These findings are also in line with other studies (e.g., Brinson & Alamri, 2005; Bundy & Benshoff, 200; Thomson & Rosenthal, 2008).

Regarding the SCC environment, most students agreed that the centre's location ensured they could maintain their privacy. Furthermore, the students agreed that the reception staff that greeted them were affable and relaxed, which are essential qualities of receptionists in any counseling centre so as to attract students to the centre and make them feel comfortable and welcome.

Many reasons which could inhibit student from accessing and benefiting from the counseling services were examined in the current study. The participants who did not benefit from the services said the main reasons they did not access the centre were that they were not aware of the counseling services, that the role of the counseling services were not clear to them, and that they were unaware of the SCC location. This result is in agreement with findings by Xie (2007), who found that students who were not aware about counseling sessions and had no idea about how they worked. As mentioned earlier, counseling, as a profession, only started in Oman after the establishment of the Student Counseling Centre at SQU (Al-Darmaki, & Sulaiman, 2008). Private counseling centres have just recently opened in some major Omani cities and, hence, many students are not aware of or familiar with counseling services. The centre has made great efforts to make the students aware of its services through different mediums and activities such as orientation week, social media, advertising campaigns, outreach programs, and presentations at colleges and other places, however, despite these efforts, some students still do not know about these services either because they do not care to know about them or because they sincerely do not know.

This result suggests that staff at the SCC need to diversify the activities they organize and the channels they use to reach students. It is also recommended that the centre tries to reach all students at SQU through a mandatory course, which all students should take in their first year at SQU called "Life Skills" or "Study Skills". These courses would contribute to raising students' awareness towards university life, how to adjust to the university environment, the kind of problems they may face and how they can overcome them alone or with the help of SCC services. Yang et al. (2013) showed the positive results of a mandatory counseling program on the academic performance of students who were under probation. Moreover, recommendations from staff, faculty and friends to access and benefit from counseling services are very effective tools to raise students' awareness, as shown by research by Gaughf et al. (2013), and Russel et al., (2008). Moreover, the students themselves should also take some responsibility to find out about SCC services and seek them when needed.

The findings of the present study demonstrated that, based on the perspectives of students who benefitted from counseling (Group1), the current location of the SCC at SQU ensures privacy which is perceived as an advantage. On the other hand, non-benefited students perceived the SCC location as "unknown to them" and being difficult to find. These findings seem to contradict each other; while benefited students liked the location of the centre and liked to be able to access it anonymously, it remained unknown to those who had not benefitted from the services. The reason might because the current location of the SCC is near a small botanical garden which may make the centre look somewhat isolated to some students. It is recommended that either a new building is established in a place that is visible to all students, or an intensive awareness plan needs to be conducted to familiarize students with the centre's location. Currently, efforts to raise awareness of the existing site are underway by all staff in the SCC. The centre has been working to advertise its location to all students, either through social media, or the centre's publications and announcements. Bundy and Benshoff (2000) addressed the importance of student familiarization with the location of a counseling centre, and further studies may be needed to investigate the impact of the SCC location on students

benefiting from counseling services.

The least important reason for not benefiting from the SCC services was " Asking for counseling help means that I suffer from a mental disorder". This finding is quite remarkable, since it shows that most students at SQU were aware of the role of counseling and they could recognize the difference between the counseling provided for students by the SCC and that provided by mental health medical services. The efforts that were made by the SCC staff to strengthen students' awareness concerning the meaning of counseling and its goals, have led to positive results in students' understanding. This is a very promising finding which could result in an increase in the number of students benefiting from counseling services in the future.

Limitations of the Study

As with any research, the current study is not without limitations. First, utilizing a larger sample size in the study of students who benefited from SCC services, could have helped ensure a more accurate evaluation of the SCC. Second, in the current study, the quality of SCC services was assessed based only on the students' point of view. Further studies could also assess the quality of these services from the perspectives of SCC counselors. Third, this study focused only on the services provided for students, but there are also some counseling services that are provided for SQU staff and the community. The quality of these services could be evaluated from the perspectives of counselees as well. Fourth, a self-report scale was used that might be affected by social desirability and bias, and, thus, students may tend to overestimate or underestimate the quality of the services provided. Thus, a qualitative design could be utilized, using open-ended questions or interviews.

Conclusion

In conclusion, the current study has given an insight about the quality levels of services provide currently by the SCC. The results have indicated "high" to " very high" level of quality to all services which highlights the study's sample satisfaction about the center's services. However, the researchers emphasized the importance of continuing with improving counseling services provided by the SCC and with evaluation of their qualities.

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Stepping stones to resilience: Supporting children and young people through a life marked by family violence

Christine Cresswell[1]

The present paper shows how significant counselling is to children and young people who have been subjected to experience of ongoing violence within the family circle. The modality of Three-In-One-Concepts, used in conjunction with expressive therapies, has the potential to be a powerful therapeutic approach for bringing children and young people to a level of resilience where they are able to cope and distance themselves from the intensity of the impact of family violence.

Keywords: *Anterior Deltoid muscle, Attention Deficit Hyperactivity Disorder (ADHD), autism, resilience, family violence, Three-In-One-Concepts, One Brain Approach, vicarious trauma*

Family violence hurts kids, too - even if they don't see it. Evidence shows that living in a family where there is violence - physical or emotional - may have significant traumatic effects on children (Devaney, 2015; Domestic Violence prevention Centre, 2018; The Australian Domestic & Family Violence Clearinghouse, 2015). As noted by Campo (2015), in the past two decades, empirical evidence about the extent to which children are exposed to domestic and family violence and the negative effect this has on their development has created an impetus for policy responses to this issue. This is reflected in the recognition that exposure to family violence is a form of child abuse in some state and territory child protection frameworks - for example Queensland Child Protection Act 1999, (Office of the Queensland Parliamentary Council, 2005), the Australian Government's National Framework for Protecting Australia' Children 2009 - 2020 (Council Of Australian Governments [COAG], 2009/2014, and the federal Family Law Act 1975 (Office of Legislative Drafting and Publishing, Attorney-General's Department, 1975/2012).

As a result of family violence, children can experience powerful mixed and confusing feelings that may be difficult for them to express. However, despite the horrific emotional, psychological, and somatic impact that family violence has on children and young people, the effects on the individual are not irreversible if early and effective intervention occurs. A review of the literature profiles the effectiveness of counselling in providing a safe space where children and young people can express their feelings and come to acknowledge their thoughts and life experiences.

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As referenced by Irwin, Waugh, and Wilkinson (2002), children who have experienced domestic violence are more likely to:

- Exhibit aggressive behaviour;
- Experience anxiety;
- Exhibit symptoms of depression;
- Demonstrate diminished self-esteem;
- Tell lies, act disobediently, and act destructively;
- Reveal reduced social competence skills;
- Exhibit emotional distress;
- Demonstrate somatic complaints.

One Avenue of Support

Children impacted by domestic violence can find support at The Centre for Women & Co. which is a Non-Government Organization (NGO) based in Queensland with branches in Logan and Redland City. The vision at the Centre for Woman & Co. is to deliver responsive, high quality and holistic women's services to the Logan and Redlands Regions. The mission of this NGO is to encompass domestic and family violence support services and women's health and wellbeing support services (personal communication, September21, 2018).

When an intake is done for children and young people, it is established that they have been witness to abusive relationships within the family system. A child's experience of family violence may be through the witnessing of violent acts and the consequences of physical violence: such as broken bones, blood, bruises or broken objects. They may become indirectly involved in the violence by being in close proximity to their mother when she is being abused or when they are intervening to protect her. They may also be the subject of abuse by the perpetrator.

For some, there may be responsibility of calling the ambulance or they may react in the moment by trying to stop the perpetrator from hurting the other parent. It is usually noted that the abuse has been on-going for many years and even though the family relationship may have broken down, the abuse is still continuing in some form. Children tend to become the scapegoat and can be very much caught up in a triangulated web where one parent is judging the other parent to the child and projecting their thoughts and emotions onto them.

It has been found that children in this situation can be very vulnerable when it comes to taking on those emotions which can send them into feeling confused and overwhelmed by the whole scenario. They have been traumatised enough over the years with the violence and now they have the separation and the triangulation to try to work through. Many children make the comment, "I like both parents and I don't know which side to take or who to choose". On the other hand, there can be children who are caught up emotionally in a battle where the court has given both parents equal share of responsibility for their children but the children do not want to go to the other parent. Young people quite often present this as a huge dilemma in their lives.

Research in Situ

Empirical data gathered over a period of 12 months testify to the effectiveness of Three-In-One-Concepts processes when working with children and young people who have experienced vicarious trauma through witnessing family violence. Unsolicited comments from children, mothers or primary caregivers, and teachers have been manually recorded. Evidence is embodied in statements that collectively portray an image of the power of therapeutic support and the impact this can have of the well-being of children and young people.

Young people refer to muscle testing as a "lie detector". They explain that while they might be telling the counsellor that their presenting issue is one thing, the muscle indicates something different. Children and young people often say to their Mum and the receptionist, "How does she get all that information from my muscles? This is so cool. When am I coming again?" Children will also thank the counsellor for "fixing" them using the muscles.

Before the counselling session with children and young people, it is normal for the Mum to express, "[Johnny] is acting just like his Dad. He is aggressive at home and at school. The teacher says he is not concentrating and is becoming very disruptive in the class room". After follow-up communication in the immediate days following sessions, mothers report how relaxed and calm their child is as compared to how they were acting before counselling. In addition, mothers whose children have a diagnosis of high functioning autism report that their children are having fewer meltdowns and are able to cope with the anxiety associated with going to school and participating in other general activities where there is potential for separation anxiety and their Mum is not present to give support and a much needed sense of security.

After receiving positive feedback from mothers, it is the counsellor's understanding that children tend to feel "very good" and "balanced" after sessions. Therefore, it is noticeable at home and at school when the stress is beginning to mount and they are not "feeling good". This is an indicator that the child needs to have another session. Also, after communicating with the child's teacher, mothers will speak to the counsellor about how much the child's behaviour and focus has improved in the classroom.

One reported incident relates to the situation where it was suggested to a mother that her son might have Attention Deficit Hyperactivity Disorder (ADHD). The mother stated that she was advised by school authorities to "get him tested and onto medication". As an alternative to this radical measure, the mother chose to bring her son with her to counselling; as she knew that her child may find the support he needed. After one session using the Three-In-One-Concepts process, a change in behaviour was observed and remarked on by the teacher who is said to have asked the mother if she had been to the doctor to get medication, as her son's behaviour had greatly improved.

Three-in-one Concpets: An Overview

Three-In-One-Concepts was founded and created by Gordon Stokes (1929-2006): and while Three-In-One-Concepts, also referred to as "Three-In-One-Concepts 'One Brain' Stress Management Approach to Counselling", uses muscle testing, it is to be noted that muscle testing is not testing muscles. It is testing the brain's hemispheres. In 1976, Stokes officially created Three-In-One-Concepts, Inc. and in 1983, with his partners, Daniel Whiteside (1933-2013) and Candace Callaway (1949-2005), he began to fashion Three-In-One-Concepts\ into its current form: infusing the "One Brain" method with everything that peaked his interest throughout his life time - from Parent Effectiveness Training to Personology.

The "One Brain" stress management approach is gentle and non-invasive. The individual personhood of the client is respected with ethical consideration focused on integrity as related to achieving the highest good of oneself and the highest good of all. Three-In-One-Concepts developed and expanded to become a multidimensional therapeutic modality, focusing on the integration of Body, Mind, and Spirit as forming the "One Brain". The modality was further developed to assist people resolve their personal experiences of emotional stress overwhelm in all areas of their life (Three In One Concepts, n.d.).

Three-in-one Concpets: The Process

By placing hands on the outer wrist, the clinician can feel a wakening or a strengthening of the wrist muscle. While the clinician feels the movement in the wrist, it is actually the Anterior Deltoid muscle in the upper arm that is reacting. A weak response indicates that there is a stress source being held within the body.

When right and left arms are used simultaneously both cerebral hemispheres are activated to achieve whole brain response. As Stokes & Whiteside explain (1996), "With both brains working equally an honest read-out of how emotion affects the body is established" (p. 12). The body runs on an electrical system pouring through the body and fires the brain. The same system can be used through muscle testing to find out from the body what is causing the stress. When the client thinks of something that causes stress, the arms start to give way, causing a negative muscular response (Ainley, M, 2009). It is a safe and gentle way to identify and defuse old belief patterns, phobias and traumatic experiences that may have been stored in the memory bank for many years.

This gentle process allows biofeedback from the body/brain to identify and defuse suppressed negative emotions that wilfully destroy the positive changes that clients want in their lives. Stokes and Whiteside (1996), define the "One Brain" process as "dealing with all levels of awareness - body, mind, and spirit - at both conscious and subconscious levels; while getting more into what is hidden in the sub conscious, rather than what we think we know on the conscious level" (p. 10). According to Stokes and Whiteside (1996), when all levels of awareness are dealt with, right brain and left brain begin to communicate with each other allowing for integration of the right creative brain and the left logic brain. As a result, body, mind, and spirit are empowered to deal directly with self-doubt on any issue as well as the stress-overwhelm that hampers clear thinking and decreases freedom of choice.

Three-in-one Concpets: In the Field

When working with young people, the counsellor may often "go with the flow" connecting with the child's reality incorporating complementary therapeutic approaches, and while working with the presenting issue the counsellor is also working with what the muscle indicates at the time. Quite often the young person will say, "Oh yes, that's right! That is what I would like to get the stress off". The stress may not be to do with the trauma they are experiencing at present, but could be related to something they have experienced in the past and which may feel very similar to the somatic sensation that is happening in the present. However, what is the same, is that there is a contributing critical incident that triggers a stress response that could be either traumatic in the moment or could present as secondary trauma (Wyder & Bland, 2014).

When using the muscle as the indicator, the counsellor will "age recess" (in counselling terms, more commonly referred to as age regression). This evokes release of a stored memory back to where the muscle response indicates an appropriate age for healing past trauma. This will be the age at which stress will be released and the brain re-balanced into thinking differently about the emotional experience at that age. The muscle determines the type of healing the body and mind require (Stokes & Whiteside, 1996)

A fundamental belief in working with children and young people is that each one is their own unique person. What they share is a life over shadowed with the trauma associated with family violence. Therefore, while Three-In-One-Concepts may be the primary "go to", it is, in practice the primary modality underpinning an over arching eclectic framework. Modalities incorporated in this structure include, reframing, visual association picture and word cards, non-directive sand play, directive sand tray, painting, drawing, feeling faces, visualization, child-centred play, power animals and positive affirmations. The muscle is again used to round off the process.

Response to Therapy

It has been found that when working with children and young people, the way they acknowledge their traumatic experience can be very different. Some demonstrate extraverted behaviour and like to talk about the whole experience. Others can become quite withdrawn and do not like to talk about anything: they may even move into a state of selective muteness. A significant feature of the muscle testing approach is that the client does not need to engage verbally. The body knows. Experience demonstrates that children and young people love to be muscle tested. They love becoming aware of how much stress they are actually carrying and how the muscle helps them to tell their story. The muscle remembers what the brain may choose to forget: or as Bessel van der Kolk (2014) might say, "The body keeps the score".

This process keeps the brain in the present rather than focussing on experiences that have happened in the past and there seems to be no fixed rule on how many sessions a child or young person would require for keeping the brain in the present. Under general circumstances an affective timeframe has proved to be eight fortnightly sessions with a tapering down process.

Conclusion

Healing can be an ongoing process. Therefore, the purpose of counselling is to bring children and young people to a level of resilience where they are able to cope and distance themselves from the ongoing impact of critical incidents in this life span. For so many, it is highly likely they are still living in an environment where abusive behaviour is the norm and where they are still caught in the web of family violence. It could be said that an eclectic approach, incorporating the "One Brain" Stress Management and muscle testing, combined with expressive therapies has potential to be the greatest gift in helping young people acknowledge their experience, and the emotions attached to the experience: even if they choose to not talk about it.

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"It helps us to understand that it's not particularly a patient's fault": Mental health professionals discuss their causal beliefs and perceptions of mental illness

Josie Larkings[1]

Mental health professionals' beliefs about the causes of mental illness are thought to impact their stigma and perceptions towards mental illness; however, there has been little research exploring this topic. This study aimed to examine the causal beliefs of mental health professionals and how these beliefs have developed, along with the impact that these beliefs have on perceptions of consumers. A thematic framework guided the analysis of semi-structured interviews with 17 mental health professionals. Multiple causes of mental illness were endorsed simultaneously, with most endorsing a combination of biogenetic, psychological and environmental factors. Causal beliefs influenced factors such as blame, compassion, empathy, and understanding. Mental health professionals identified that their causal beliefs impacted their perceptions of consumers with both positive (e.g., increasing empathy and compassion) and negative consequences (e.g., increase blame and frustration). Mental health professionals thought their beliefs were influenced primarily by their clinical experiences. Further research is needed to understand how mental health professionals' causal beliefs and perception towards consumers may impact the treatment process.

Keywords: *causal beliefs; mental health professionals; mental illness; stigma; professional experience; thematic analysis*

Reducing the stigma associated with mental illness is an important endeavour, given that stigma has been found to dramatically decrease the quality of life of people living with mental illness (Corrigan, Sokol, & Rüsch, 2013; Kvaale, Gottdiener, & Haslam, 2013). The bulk of research on mental illness stigma has focused on the general public, with the attitudes of mental health professionals receiving minimal attention by comparison (Blinded for review, 2017; Schulze, 2007). It is often assumed that mental health professionals have positive attitudes towards mental illness and, as such, they have played an important role in the fight against stigma (Adewuya & Oguntade, 2007). However, mental health professionals can still exhibit negative attitudes and stigma towards people with mental illness, such as viewing people with mental illness as being dangerous and having a desire for increased social distance (Kopera et al., 2015; Scholz, Bocking, & Happell, 2017; Wahl & Aroesty-Cohen, 2010). These negative attitudes may adversely impact the effectiveness of mental health promotion efforts and are likely to have a negative impact on treatment (Overton & Medina, 2008). Therefore, it is essential to understand what influences mental health professionals' attitudes, in order to reduce stigma and improve services provided.

Contact is one factor thought to impact stigma (Allport, 1954; Amir, 1969; Pettigrew & Tropp, 2006), with some stigma reduction programs based on the idea that interacting with people from the out-group (i.e., people with mental illness) will help to reduce stigma and improve attitudes (Corrigan, Larson, Sells, Niessen, & Watson, 2007). Lauber and colleagues (2006) found mental health professionals with more professional experience had a more positive attitudes towards people with mental illness, but that hours of working (part-time versus full-time) did not appear to influence stereotypical attitudes. However, contact alone does not seem to guarantee stigma reduction given that some mental health professionals, who have regular contact with consumers, still exhibit aspects of attitudes which reflect stigma. Consumer refers to an individual who has received or are receiving treatment for mental illness. This term was developed and used by people with mental illness and advocacy groups to encourage empowerment (Anthony, 1993; McLean, 1995).

Another factor thought to influence stigma are beliefs about the causes of mental illness, or causal beliefs (Haslam & Kvaale, 2015; blinded for review, 2012, 2017; blinded for review, 2017c). Over the past few decades, efforts to understand the psychopathology and aetiology of mental illness have increased, with a particular focus on understanding the biogenetic causes of mental illness (Kvaale et al., 2013; Lebowitz, 2014). In this paper, we place causal beliefs into three categories influenced by definitions provided by Ahn and colleagues (2009).

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Biogenetic refers to genetic or psycho-physiological factors that contribute to mental illness such as genetic predisposition, hereditary, brain structures/abnormalities, and chemical imbalances. Psychological causal beliefs refer to factors such as thoughts, emotions, behaviours, or identity-related factors such as stress, anxiety, or temperament. Environmental causal beliefs include current or past environmental factors such as early childhood experiences, trauma, and substance use.

Several anti-stigma campaigns have promoted biogenetic causes, with the hope that endorsement of biogenetic causes would help to reduce the blame associated with mental illness and thus reduce the stigma towards it in the general public (Wiesjahn, Jung, Kremser, Rief, & Lincoln, 2016). Schomerus and colleagues (2012) conducted a meta-analysis and found that endorsement of biogenetic causes, regarding schizophrenia and depression, increased significantly between 1990 and 2006. However, research that focused on the general public, suggests that endorsement of biogenetic beliefs does not guarantee a reduction in stigma (Angermeyer, Holzinger, Carta, & Schomerus, 2011; Kvaale et al., 2013; Read, Haslam, Sayce, & Davies, 2006).

Two opposing paradigms have generally been used to understand the relationships between causal beliefs (particularly biogenetic causes) and stigma. Attribution theory (Weiner, Perry, & Magnusson, 1988) predicts that causes perceived as outside an individual's control (e.g., biogenetic causes) will elicit emotions such as pity, and thus reduce blame and discrimination (Rüsch, Todd, Bodenhausen, & Corrigan, 2010). Alternatively, through a genetic essentialism lens, endorsing biogenetic factors would result in people with mental illness being viewed as having "bad genes" which are unchangeable (Dar-Nimrod & Heine, 2011). Thus, this perspective argues that endorsement of biogenetic causes would result in little or no improvement in attitudes and decreased optimism around recovery (Haslam, 2011). More recently, Haslam and Kvaale (2015) conducted two comprehensive meta-analyses investigating the impact of biogenetic causal beliefs on perceptions towards mental illness. Their findings prompted the proposal of the mixed-blessing model. This model provides a synthesis between attribution theory and genetic essentialism, and suggests that biogenetic explanations may contribute to reduced blame (as mental illness is viewed as outside an individual's control), but would also encourage essentialistic thinking (i.e. genes are unchangeable) and lead to an increase in stigma and prognostic pessimism.

Relatively little research has been conducted which explores the nature of causal beliefs endorsed by mental health professionals and the relationship between their causal beliefs and perceptions of mental illness (Blinded for review, 2017). Ahn and colleagues (2009) asked mental health professionals to rate the causes of 445 mental disorders, and concluded that mental health professionals place mental disorders on a continuum from strongly biological (and weakly psychological/environmental) to strongly psychological/environmental (and weakly biological). Our previous research, which explored causal beliefs and stigma in potential mental health professionals (psychology students), found that while a combination of beliefs were endorsed, potential mental health professionals endorsed biological causal explanations more than psychological and environmental factors. Moreover, results indicated that causal beliefs do impact mental illness stigma, with different causal beliefs having varying impacts on different elements of stigma. For instance, participants who endorsed biogenetic and environmental factors more strongly, viewed people with mental illness as inferior and more threatening (blinded for review, 2012). Grausgruber and colleagues (2007) found a non-significant relationship between mental health professionals' genetic causal beliefs and desire for social distance from people with schizophrenia. There are several implications associated with mental health professionals' causal beliefs, which could have a considerable impact on treatment outcomes and recovery. For example, mental health professionals' causal beliefs have been found to: influence their choice of treatment modality and perceived effectiveness of the treatment they recommend; and, affect emotional responses to consumers, such as empathy and blame (Goldstein & Rosselli, 2003; Hansson, Jormfeldt, Svedberg, & Svensson, 2013; Iselin & Addis, 2003; Blinded for review, 2012 Blinded for review, 2017a; Lebowitz & Ahn, 2014; Miresco & Kirmayer, 2006). T

The purpose of the current study is to examine the causal beliefs about mental illness that mental health professionals endorse, and factors that influence the development of these beliefs. In addition, this study aims to explore how mental health professionals' causal beliefs may influence their perceptions of people with mental illness. A qualitative approach was chosen as there is limited research on this topic and such an investigation should provide a more in-depth understanding of the mental health professionals' perspective.

Method

Recruitment

Approval for this project was received from the University of Canberra Committee for Ethics in Human Research. The first author conducted all the recruitment and interviews. The first author is a psychologist who works in the public mental health sector in Canberra. She used professional contacts and approached a number of mental health professionals regarding potential participation in this project, and recruitment was by means of snowballing. Potential participants were provided with information about the project and were asked to contact the first author if they wanted to take part in the study. Potential participants were also asked to distribute study information to other mental health professionals who may be interested in participation. Face-to-face individual interviews were then organised with the mental health professionals interested in participation at a location convenient to them – all participants chose their workplace. Informed consent was obtained prior to the interview and participants were aware that they could withdraw from the study at any time. Participants received movie ticket vouchers as a token of appreciation for their time.

Participants

This study included 17 mental health professionals, who were employed in the public mental health system in Canberra, Australia. There were 14 females (82%) and three males (18%), aged between 26 and 59 years (M = 36.71, SD = 10.15). Years of experience working with people with mental illness ranged from one year to 29 years (M = 11, SD = 7.60). Mental health clinicians came from a range of different disciplines including: Psychiatry (n = 3), Psychology (n = 5), Nursing (n = 3), Occupational Therapy (n = 3), and Social work (n = 3).

Data Collection

A semi-structured interview schedule was developed to explore mental health professionals' causal beliefs (see Table 1). Demographic information was collected along with questions which aimed to explore participants' beliefs about the causes of mental illness, the nature of these causal beliefs, factors that influenced the development of these causal beliefs and how these beliefs influence perceptions towards people with mental illness. The first author, who conducted all of the interviews, had a professional relationship with all the participants. As such, the interviews were conversational, attempting to be non-leading, curious, and non-judgemental to minimise the influence of social desirability. Following Hill (2005), mental health professionals were consulted in the development of the interview protocol and questions were modified as a result of feedback received. In addition, two pilot interviews were conducted, however, the interview protocol was not modified significantly as a result of these pilot interviews and data from these interviews were included in the study. The interviews yielded an abundance of rich data some of which was not analysed in the current study.

Data Analysis

Transcripts of the interviews were analysed using thematic analysis, a method for identifying and analysing patterns and themes that emerge in qualitative data (Braun & Clarke, 2006). The first stage of analysis involved immersion in the data which included reading each transcript several times and then identifying possible codes. Next, similar codes were grouped together and explored in detail; these were then grouped into themes. Data were coded with a synthesis of inductive and deductive principles. Initially, coding followed an inductive approach, in which the author made no attempt to fit data into any preconceived codes or themes, but rather grouped similar data together. Then a deductive approach was used to explore causal beliefs in more detail and a "theory-driven" approach was used to code the causal beliefs into three categories (biogenetic, psychological, and environmental) guided by definitions presented by Ahn, et al. (2009). Finally, transcripts were reviewed to identify quotes that best represented the themes which had been identified. Coding consistency and inter-rater reliability were conducted to test coding reliability. Initially, coding of all transcripts was completed by the primary author, who then re-coded six clean (i.e., un-coded) transcripts to assess coding consistency over time (Richards, 2005). A second independent researcher also coded the same six (clean) transcripts, and then inter-rater reliability was assessed. Coding assignment was compared between coders with a calculated Kappa coefficient of .93, with values greater than .75 generally considered excellent (Landis & Koch, 1977).

For part of the analysis, mental health professionals were split into two groups based on their years of professional experience. The median years of experience (8 years) was used to divide the clinicians into two groups; eight years and below was considered to have less professional experience (n = 9), and above eight years was considered to have more professional experience (n = 8). The median split method to dichotomise data to form low and high groups is a common method used (MacCallum, Zhang, Preacher, & Rucker, 2002), and thus was thought to be appropriate for this analysis. Making comparisons between these groups was appropriate given the overall size on the sample was large enough that the size of each subgroup was still within the recommended size for qualitative research (Hill et al., 2005). The less professional experience group comprised of: a nurse (n = 1), occupational therapists (n = 2), social workers (n = 2), and psychologists (n = 4). The more professional experience group comprised of: an occupational therapist (n = 1), a social worker (n = 1), a psychologist (n = 1), nurses (n = 2), psychiatrists (n = 3). In line with the Consensual Qualitative Research Method (Hill et al., 2005), the frequency of participants responses were labelled to help determine the level of representativeness of responses and themes. Four frequency levels were used: few (less than 10%), some (10% to 50%), most (51% to 90%), and all (91% to 100%).

Table 1. Semi-structured interview schedule

Research Area	Interview Question	Prompts/follow-up questions
Demographics	What is your age & gender? What discipline are you from? How many years of experience do you have?	
Own causal beliefs	What do you believe the causes of mental illness are?	You may believe there are many different causes of mental illness, what are some of the possible causes? Do you think there are certain factors which are the main causes of mental illness? Do you think different mental illnesses are caused by different causes?
Development of causal beliefs	What do you think has influenced the development of your causal beliefs?	Where you taught about the causes of mental illness in your training? Has your clinical experience influenced your causal beliefs? How?
Causal beliefs and perceptions	Do you think that your beliefs about the causes of mental illness influence your view of people with mental illness?	In what ways? Do your beliefs around the causes of mental illness impact any of your behaviours? Do you think your beliefs have an impact on your prognosis?

Please note that not all data from the semi-structured interview were included in this paper, and thus only the section of the interview schedule that pertains this is paper is presented in this table.

Findings

There were four aspects prominent to the understanding mental health professionals' causal beliefs: the first related to the type of causal beliefs mental health professionals endorsed; the second focused on how these causal beliefs had developed; the third explored the impact that causal beliefs had on perceptions of mental illness; and, the final theme looked that how professionals' experience influenced causal beliefs and perceptions towards mental illness.

Causal Beliefs

All mental health professionals identified a range of factors that contributed to mental illness, with each clinician mentioning an average of 7.88 causes (SD = 3.95). There were 58 distinct causes within the data that were coded into three types of causal beliefs: biogenetic, psychological, and environmental. All mental health professionals suggested more than one type of causal belief, with most participants mentioning biogenetic causes first when discussing their causal beliefs. It is possible that participants mentioning biogenetic causes in the first instance reflects the previous research which shows that there has been an increase in endorsement and awareness of biogenetic causes (Schomerus et al., 2012), and may also reflect training in a medical model framework.

All participants endorsed both biogenetic and environmental causes, with most clinicians endorsing a combination of biogenetic, psychological, and environmental causal beliefs, as the participant in Extract 1 discusses.

Extract 1

Probably before studying mental health I couldn't, I don't know what I would have said then. But now I definitely say biopsychosocial. For all people there's some type of really strong biological component. Others have like a psychological predisposition/psychological experiences. And then social being the, what's going on in their life at that given time, and the social influences in the environment. Yeah, a combo [combination], and some are heavier [more significant] than others, but they're all interlinked to me.

While the results clearly indicate that mental health professionals endorse more than one type of causal belief ("they're all interlinked"), most participants thought that there was a main cause or a stronger causal factor. Biogenetic causes were the most commonly reported main cause, for example, one participant simply stated: "I think the main cause is biological!". Most participants thought that different types of mental illness were caused by different factors or that the causal factors had differing weightings depending on the type of illness. For example, one participant stated, "If you just look at the amount of, or the significance, that genetics plays in different illnesses, you can clearly see that some of them [mental illnesses] are more genetic than others". Some participants thought that mental illness resulted from differences between individuals "it can be different for everyone", rather than particular causal factors resulting in a particular type of mental illness, with one participant stating:

Extract 2

I think there's different things for everybody. I've seen older people who have a psychosis without any drug and alcohol use, other people who have been perfectly fine, use some drugs and then become unwell. So I think it can be different for everyone, but definitely that genetic factor probably contributes to that a lot. I mean, of course you see trends there, such things as trauma and then a personality disorder. There's definitely trends, but I think its individual at the end of the day.

Previous research has suggested that mental health professionals' causal beliefs are on a continuum ranging from psychological to biological causes (Ahn et al., 2009). Our findings are not consistent with this research, and show that participants identified a wide range of causes and endorsed multiple causes simultaneously (see Extract 1). Despite endorsing a combination of causal beliefs, most participants tended to think that there was a main cause of mental illness "the main cause is biological" and that different mental illnesses were caused by different factors, "some of them [mental illnesses] are more genetic than others". Therefore, mental health professionals could put more emphasis on a particular cause depending on the diagnoses consumers presented with. This is consistent with previous research which has shown that mental health professionals believe that different mental illnesses are caused by different factors (Ahn et al., 2009).

Development of Causal Beliefs

All participants were able to identify factors that influenced the development of their causal beliefs. Most participants thought that their causal beliefs were a result of a combination of their formal training and their clinical experience. Clinical experience was the most commonly reported influencing factor, with one participant explaining:

Extract 3

Look, I mean, it's hard to unlearn what you've learned throughout your degree. I guess being taught about the biopsychosocial model really did influence my beliefs. I guess pre that, just seeing people around me who suffered from depression or anxiety, I could just, I guess, see from those examples that it's not just any one factor that leads to it. Then, in the work we do every day, I guess I can just see that it's not so simple as one factor causing any particular mental illness. I would say it's a whole combination of things that have led to me believing that it's [mental illness is caused by] a mix of factors.

Some mental health professionals reported that they had received little or no training around the causes of mental illness, with participant saying "I really haven't had much training about the causes. It's always been about the treatment of, but yeah, not a lot around the causes". In the following extract, another participant expands on their understanding of mental illness causes.

Extract 4

I think every family has mental illness within it. You'd have your own ideas about mental illness growing up. I think it touches every family. I think the thing that's majorly influenced my belief, sort of views on mental illness, is working in it, seeing friends as I've grown up develop it, and seeing family members suffer from it.

As in Extract 4, some participants identified that contact in their personal life with mental illness influenced their understanding and causal beliefs. Relevant to more participants, however, were ongoing professional development activities that influenced their understanding and beliefs around what causes mental illness. Indeed, most participants reported that clinical experience had had the biggest impact on their causal beliefs, with one participant stating "My patients are my best teachers... I attend conferences. I speak with my colleagues. I do all of those professional bits, but still, my patients are still my best teachers". In addition, most mental health professionals explained that their clinical experience had changed their causal beliefs in some way with the majority of these participants explaining that through their clinical experience they had started to put more weighting on environmental factors, with the following participant explaining "The increased weight I put on trauma and life events has been through my experiences working with clients and spending time with them". As in Extract 5, some participants talked about how certain populations that they had worked with had increased their endorsement of certain causal factors.

Extract 5

[Particularly] working with young people, seeing the influence of peers and how those environmental factors paired with particular periods of schooling, you know, when exam period comes on, that those are the times that I can see young people particularly suffering from anxiety or depression.

The finding that not all participants' received training around the causes of mental illness "I really haven't had much training" is concerning, given the potential impact that causal beliefs have on stigma and treatment outcomes (Lebowitz & Ahn, 2014; Phelan, 2005). The majority of participants thought that the development of their causal beliefs was primarily influenced by their clinical experiences. Therefore, it seems likely that mental health professionals' working in different settings and with different populations may endorse different causal beliefs (see Extract 5). Overall, these findings highlight the need for further investigation into mental health professionals' causal beliefs, in order to explore how training and experience influence the development of causal beliefs and if there are differences across disciplines and work settings in regard to what causal beliefs are endorsed.

Causal Beliefs and Perceptions of Mental Illness

Most mental health professionals identified that their beliefs about what causes mental illness have an impact on their perceptions towards people with mental illness, with one participant remarking "I probably like to say it [causal beliefs impacting perception] doesn't, but I think it probably does". Some mental health professionals felt as though their beliefs about the causes of mental illness did not influence their perception towards people with mental illness, with one occupational therapist saying "I don't think it [my causal beliefs] influences my view [of people with mental illness]". Some participants thought that their causal beliefs had a positive impact on how they viewed people with mental illness. Specifically, in line with attribution theory (Weiner et al., 1988), some participants reported that their causal beliefs helped to reduce the blame they placed on the individual, increased compassion and empathy, and increased understanding. For example, in Extract 6, a participant discusses his thoughts in response to being asked if causal beliefs had an impact on his perception towards people with mental illness.

Extract 6

I guess they do, but I would hope not in a negative way. Umm, I suppose if you think everything's genetic then you adopt a very fatalistic response to everything. Whereas if you think everything's environmental, if causes are all environmental, then you think, well this person has made some choices that have led them to this. I think having a balance of both, which is probably more consistent to where mental disorders do originate from, it is a balance of both, it helps us to understand that it's not particularly a patient's fault. We don't choose our parents, as much as we'd like to [laughs]. Seeing that they [consumers] had no choice about that, so we can't blame, I think it helps us adopt a non-judgmental style of practice, understanding that causality, it clearly is beyond the patient's choice or willpower.

The participant in Extract 6 thought that his causal beliefs had an overall positive influence, however, some participants reported that their causal beliefs at times had a negative impact on how they viewed people with mental illness (see Extract 7). Specifically, that at times their frustration with consumers increased and they would make assumptions about factors that contributed to the development of mental illness in their client (e.g., drug use).

Extract 7

I'd like to say no [that causal beliefs don't influence my perception], but I think it probably does... I guess depending on the illness. You know, it's sometimes hard not to carry your own judgements about people and judgements about, you know, say if you've got a consumer with schizophrenia that has IV ice use and that sort of thing, your capacity to feel like your treating them well and treating them compassionately, it sort of diminishes a bit... I guess you sort of feel that they play a role in their own demise in many ways. That can be really frustrating.

Extract 7 demonstrates that attributions of responsibility appear to increase blame and decrease compassion. Another factor that is thought to be influenced by causal beliefs is prognostic pessimism. Some participants thought that their causal beliefs did not influence their perception of prognosis, with one participant explaining "I don't think that my causal beliefs impact on prognosis. I think my own observation of working with people who experience schizophrenia might. I look at that being a lifelong hardship that people experience." However, some participants, such as the participant in Extract 8, thought that their causal beliefs had in impact on their perceptions of prognosis.

Extract 8

Sometimes the cause may make me feel like, you know, it kind of doesn't matter what I do or say, this [mental illness] is just going to continue as it is, and not much is going to change it. Or, other causes I guess might make me feel a bit more hopeful about prognosis, or feel like there is definite steps [to take in treatment], and a distinct or a particular time frame that things could really improve.

In general, these findings suggest that mental health professionals' causal beliefs have an impact on perceptions towards consumers. However, our findings suggest that these relationships may be complex, with causal beliefs appearing to have both positive and negative consequences and which influence a range of variables. For instance, the participants in Extract 6, Extract 7, and Extract 8, highlight that, strong endorsement of environmental factors, may lead to viewing consumers as responsible for their illness and thus result in increased blame and reduced compassion, while strong endorsement of biogenetic factors appears to increase prognostic pessimism.

Professional Experience, Causal Beliefs and Perceptions of Mental Illnesss

It was found that the more professional experience group mentioned more causal beliefs (M = 8.13, SD = 5.47) than the less professional experience group (M = 7.67, SD = 2.24). Given that participants commonly attributed the development of their causal beliefs to their clinical experience (see Extract 3), it would appear that with more clinical experience participants are exposed to a wider range of consumers who may present with different causal factors. Thus, mental health professionals' experience may increase the number of/types of causal factors that they endorse, and their beliefs may become more complex and varied over time. When looking at the types of causal beliefs endorsed, the groups did not appear to differ greatly, with most participants in each experience group endorsing a combination of biogenetic, psychological, and environmental causal beliefs and some participants in each group just endorsing biogenetic and environmental factors.

While participants endorsed multiple causal beliefs, most of the participants in the less professional experience group reported that they thought there was likely to be a main cause of mental illness, while most of the participants in the more professional experience group did not think that there was a main cause of mental illness (i.e., thought the causes were more complex). As previously mentioned, biogenetic causes were the most commonly reported main factor in this study. The increase in awareness and promotion of biogenetic causes over the past few decades has seen a rise in the endorsement of biogenetic causes in the general public (Schomerus et al., 2012). It is likely that mental health professionals go into their training and career endorsing similar causal beliefs to the general public, and then are likely taught a mental medical model of illness, and thus may view biogenetic causes as the main or stronger causal factor. It then appears that with more clinical experience mental health professionals endorse more causes and no longer view mental illness to be caused by a main factor.

When considering whether causal beliefs had an impact on perceptions towards people with mental illness, there appeared to be differences between the less professional experience and the more professional experience groups. In the less professional experience group, some participants thought that their causal beliefs had a positive impact on their perception towards people with mental illness, some participants reported that their causal beliefs had a negative impact on their perceptions towards people with mental illness, and most participants did not think that their causal beliefs influenced their perceptions towards people with mental illness. In the more professional experience group, most participants thought that their causal beliefs had a positive impact on how they view people with mental illness, with some participants reporting that they did not think their causal beliefs influenced their perceptions towards people with mental illness, and no participants reporting that their causal beliefs had a negative impact on how their view people with a mental illness. These results suggest that participants with more professional experience feel that their causal beliefs have less of a negative impact on their attitudes towards people with mental illness. A possible explanation of these findings is that endorsing a wider range of causal beliefs, without believing that there is a "main" cause which may improve perceptions and attitudes towards people with mental illness. Alternatively, it is possible that contact (in this case more professional experience), may act as a moderating factor between causal beliefs and attitudes towards people with mental illness.

Discussion

This study explored mental health professionals' beliefs about the causes of mental illness and expands the current understanding of the relationships between causal beliefs and perceptions towards mental illness. First, we found that participants endorsed a range of causal beliefs simultaneously with the majority of participants endorsing a combination of biogenetic, psychological, and environmental causes. Despite endorsing a combination of causal beliefs, participants tended to believe there is a "main" cause of mental illness (with biogenetic causes being the most commonly reported main cause), and that different mental illnesses are caused by different factors. Second, participants thought that their causal beliefs were a result of a combination of their formal training and their clinical experience. However, several participants thought that they did not receive significant training around causes, with clinical experience having the biggest impact on the development of causal beliefs. Third, we found that participants thought that their causal beliefs influenced their attitudes and perceptions towards people with mental illness, and participants identified both positive and negative consequences of their causal beliefs. Last, participants who had more professional experience seemed to have a more complex belief system and endorsed a wider range of causal beliefs and were less likely to think that there was a "main" cause (compared to those with less professional experience). Participants with more professional experience also tended to think that their causal beliefs did not have a negative impact on their perceptions towards people with mental illness.

Attribution theory, genetic essentialism, and the mixed-blessing model (Dar-Nimrod & Heine, 2011; Haslam & Kvaale, 2015; Weiner et al., 1988), all propose that causal beliefs will have an impact on perceptions towards mental illness, in particular, stigma. Our results mirror this sentiment, with the majority of participants identifying that their causal beliefs impact their attitude towards people with mental illness. While this study was not designed to test the validity of different models, it does appear that results are more in line with the mixed-blessing model, as causal beliefs seemed to have both positive and negative consequences. The mixed-blessing model suggests that endorsement of biogenetic causal beliefs would reduce blame but would have a negative impact on other components of stigma such as prognostic pessimism (Haslam & Kvaale, 2015). In our study, participants often commented on how their causal beliefs reduced blame towards consumers and increased feelings of compassion and empathy. However, participants noted that their causal beliefs often had a negative impact on their view of prognosis.

Our study focused on causal beliefs in general rather than focussing only on biogenetic causes (as per mixed-blessings model). Further research is needed to explore the role that different types of causal beliefs have on perceptions of mental illness and to further explore the validity of the mixed-blessing model by controlling for the impact that other causal beliefs may contribute.

There are several clinical implications associated with our finding that mental health professionals' causal beliefs influence their view of consumers. Causal beliefs appear to impact mental health professionals' emotional response to consumers. For example, participants in our study stated that their causal beliefs shaped their feelings of compassion and empathy towards their consumers, which would likely have an impact on the therapeutic relationship. This conclusion is consistent with some of the previous limited research which also suggests that causal beliefs can have an impact on mental health professionals' emotional responses, such as empathy and blame (Lebowitz & Ahn, 2014; Miresco & Kirmayer, 2006). Empathy has previously been found to be an important factor which helps to enhance and build a therapeutic alliance, and also predicts therapeutic outcomes (Elliott, Bohart, Watson, & Greenberg, 2011). Therefore, it is important for mental health professionals to be aware of their own causal beliefs and to reflect on how these beliefs may influence important treatment factors such as therapeutic alliance. Consumers' causal beliefs have been found to influence their self-stigma and approach to treatment (blinded for review, 2017b; blinded for review, 2017c). Moreover, mental health professionals' causal beliefs would influence how they explain mental illness to their clients, which would play a role in shaping consumers' causal beliefs (Ahn et al., 2009; Lam, Salkovskis, & Warwick, 2005). Understanding the impact that mental health professionals' causal beliefs have on the therapy journey and the development of consumers' causal beliefs are important in future research.

Participants with more professional experience thought their causal beliefs had a more positive impact on their perceptions towards people with mental illness, suggesting that experience influences perceptions towards mental illness. Alternatively, it is possible that mental health professionals with negative perceptions of mental illness may stop working in the field, and thus people remaining (i.e., with more experience) may have more positive views. Contact and experience have previously been found to influence mental health professionals' perceptions towards people with mental illness (Lauber et al., 2006). Unfortunately, contact and experience are often difficult to control, as many mental health professionals have little control over the quantity or quality of contact they have with people with mental illness in their work environment. Contact may offer limited utility in trying to reduce stigma or improve perceptions towards people with mental illness in this context. On the other hand, causal beliefs may be easier to influence in training, thus if more attention is placed on causal beliefs in training, it may be helpful in the efforts to improve mental health professionals' perceptions towards people with mental illness.

It appears that participants adhere to the biopsychosocial model of mental illness (Engel, 1977), which has dominated the mental health field since it's conception in the 70's and argues that clinicians must attend simultaneously to biological, psychological, and social factors (Borrell-Carrió, Suchman, & Epstein, 2004). It is likely that some participants were taught the biopsychosocial model in their formal education, and the finding that most participants endorse a combination of biogenetic, psychological, and environmental factors suggests that they are still influenced by their formal education (see Extract 3). However, several mental health professionals identified that they received little or no training on causes of mental illness. Thus, more attention should be placed on learning about causes of mental illness and how to address these with consumers, during mental health professionals' formal education. In particular, formal education should focus on presenting information on a range of causes and encourage individuals to reflect on how their beliefs about causes may impact their view of people with mental illness. If mental health professionals receive training later in their career, it is likely that they will have already have formed strong views regarding causality and, as a result, attitudes may be harder to modify (Lam & Salkovskis, 2007).

While this study provides important insight into mental health professionals' causal beliefs, it is not without limitations. Past research has shown that there can be a difference in causal beliefs endorsed between different professional groups, and that different professional groups may have different levels of stigma (Kent & Read, 1998; Lauber et al., 2006). It is possible that results were influenced by the fact that we included a range of professional groups. However, we chose to include multiple disciplines to reflect community mental health services which are generally multidisciplinary. Future research would benefit from exploring differences between professional groups to help understand whether the type of training received influenced their causal beliefs. Another limitation of this study is that the primary researcher had a professional relationship with all the participants and knew them prior to conducting the interviews. As such participants would have been aware that they would have an ongoing professional relationship with the first author and this may have influenced the results. It is possible that participants gave responses that were more socially desirable than they would have been, if they had not known the interviewer or were responding to a questionnaire. As a result, negative perceptions of mental illness may have been under-reported. However, the results did imply that negative perceptions towards mental illness differed between the more and less professional experience groups. The division into more or less professional experience was not random, with different professional groups representing in the two groups, suggesting that participants may have been forthcoming with their responses and not influenced by knowing the primary researcher. Although the primary researcher having a professional relationship with participants may have also contributed to the depth and detail of data, participants all appeared comfortable and forthcoming with information during the interviews.

This study contributes to the very limited research on mental health professionals' causal beliefs and how these beliefs influence attitudes and perceptions towards consumers. Our results show that mental health professionals endorse a range of causal beliefs and that these beliefs are formed primarily through their clinical experiences as opposed to formal training. Most importantly, the results of this study show that mental health professionals' causal beliefs influence perceptions towards consumers and at times influence factors such as blame and prognosis which are likely to have an impact on treatment outcomes. These relationships should continue to be explored

in future research, and consideration should be given to how this knowledge could be utilised to help improve mental health professionals' attitudes and perceptions towards consumers. Moreover, an increased understanding of how mental health professionals' causal beliefs influence treatment-related factors is important for improving the treatment and services provided to consumers. It would also be important to explore consumers' causal beliefs and their experiences of causal beliefs in the treatment process.

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