THE CREATION OF THE PUBLIC IMAGE OF PSYCHOLOGISTS: AN
APPLIED PSYCHOLOGICAL INVESTIGATION

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I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary education institution.

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ABSTRACT

The public image of psychologists has been thrown into sharp focus recently due to the increasing importance of mental health care in the community. Recent changes to the Medicare system in Australia that have increased psychologists’ involvement in the provision of mental health interventions, and debate in the profession regarding the training of future psychologists have intensified this focus. The current thesis is an applied psychological investigation presenting four separate but thematically connected studies investigating the issue of the public image of psychologists.

This thesis begins from the premise that the public perception of psychologists is formed by the interaction of many different sources of information and experience; it explores how intersecting perspectives, agendas, and sources of information work together in the formation of shared social understandings of what psychology is. Using a methodological approach based on social representations theory, the thesis addresses the issue of public perception of psychologists and psychology in a range of different sites, in order to produce a multifaceted, contextually sensitive understanding of the construct.

The first study investigated possible methodological approaches that can be used when examining public perception and recommended the qualitative approach as an adjunct to the previously employed quantitative studies. Previous quantitative studies have outlined the confusion that exists in understanding the roles of psychologists and psychiatrists, and the first study in this thesis confirmed this finding from a qualitative perspective. The second study presented an analysis of the role of psychology’s major professional
association in Australia, the APS, on the public image of psychology. A number of prominent themes on the APS website including the difference between psychologists and psychiatrists, the accessibility of psychologists, and the effectiveness of psychological interventions were discussed and a range of extracts were analysed to show some of the ways in which the APS actively manages the public image of psychologists in order to promote and advance the profession. The third study provided a contrasting example of the APS tailoring their message to a very specific audience by analysing a series of written submissions to the Australian federal government to advocate on behalf of psychologists for the inclusion of psychological interventions on the Medicare rebate. The final study investigated General Practitioners’ (GPs’) perceptions of psychologists, particularly in light of the recent Medicare changes in Australia. The data suggested that GPs find the current system cumbersome, and that these major ‘gatekeepers’ of mental health care often lack a clear understanding of the specific skills and training of psychologists.

One of the major themes surrounding the public perception of psychologists revealed in this thesis was the interplay between the already existing confusion in the public mind about the role of psychologists, and the efforts of the APS to actively promote a broad role for psychologists as providers of both general counselling and specialist mental health services. These findings were used to argue for further investigation into the issue of public perception of psychology, and to engage with current debates within psychology in Australia about the importance of finding a balance between presenting a flexible public face of psychology (resulting in a broad referral base), and propagating a more tightly drawn public face of the profession (potentially restricting market share but
helping to sharpen the somewhat indistinct public image of the profession) (Littlefield, 2009).
ABSTRACT .................................................................................................................................................. III

ACKNOWLEDGEMENTS .......................................................................................................................... X

CHAPTER 1: INTRODUCTION ................................................................................................................... 1

1.1 OVERVIEW .............................................................................................................................................. 1

1.2 INVESTIGATING THE PUBLIC IMAGE OF PSYCHOLOGISTS: WHAT DO MEMBERS OF THE PUBLIC SAY ABOUT PSYCHOLOGISTS? ........................................................................................................................... 5

1.3 HOW IS THE PUBLIC IMAGE OF PSYCHOLOGY ACTIVELY MANAGED BY PSYCHOLOGICAL PROFESSIONAL ASSOCIATIONS? ..8

1.4 WHAT DO REFERRING AGENTS THINK OF PSYCHOLOGISTS? ................................................................. 10

1.5 SUMMARY AND OVERVIEW OF THE THESIS STRUCTURE ..................................................................... 11

CHAPTER 2: LITERATURE REVIEW ........................................................................................................... 14

2.1 OVERVIEW OF THE CHAPTER ............................................................................................................. 14

2.2 THE ROLE OF ATTITUDES AND SOCIAL REPRESENTATIONS IN PUBLIC PERCEPTION ......................... 15

2.2.1 Overview ........................................................................................................................................... 15

2.2.2 The role of attitudes in public perception .......................................................................................... 16

2.2.3 The role of social representations in public perception ................................................................. 17

2.2.4 Summary ........................................................................................................................................ 21

2.3 HISTORY OF PERCEPTIONS OF PSYCHOLOGY .................................................................................... 22

2.3.1 Overview ........................................................................................................................................ 22

2.3.2 A brief history of applied psychology ............................................................................................. 23

2.3.3 A brief history of psychology in Australia ....................................................................................... 25

2.3.4 A brief history of the APS in Australia ............................................................................................. 26

2.3.5 Summary ........................................................................................................................................ 29

2.4 MAJOR CURRENT ISSUES IN PUBLIC PERCEPTION OF PSYCHOLOGY ..................................................... 30

2.4.1 Overview ........................................................................................................................................ 30

2.4.2 The effectiveness and efficacy of psychological interventions .......................................................... 31

2.4.2.1 Meta-analysis ................................................................................................................................. 33
2.4.2.2 Absolute versus relative efficacy ................................................................. 37
2.4.2.3 Specific versus generalised effects .................................................................. 39
2.4.3 The difference between psychologists and psychiatrists ....................................... 42
2.4.4 Summary ............................................................................................................ 44
2.5 The role of communications in influencing public perceptions ................................. 45
2.5.1 Overview ........................................................................................................... 45
2.5.2 Stakeholders in psychological health care ............................................................. 47
  2.5.2.1 The consumer ............................................................................................ 47
  2.5.2.2 The competitors ...................................................................................... 49
  2.5.2.3 The government ....................................................................................... 50
  2.5.2.4 The APS ................................................................................................ 53
  2.5.2.5 The referring agent ................................................................................. 54
2.5.3 Constructing a persuasive message ....................................................................... 54
  2.5.3.1 The role of cognitions in constructing a persuasive message ...................... 55
  2.5.3.2 The role of mode of communication in constructing a persuasive message .... 59
  2.5.3.3 The role of presentation in constructing a persuasive message .................... 60
2.5.4 Summary ........................................................................................................... 62

CHAPTER 3: METHODOLOGY AND OVERVIEW OF EMPIRICAL STUDIES ...................... 64
3.1 Overview ................................................................................................................ 64
3.2 Introduction ............................................................................................................. 65
3.3 Background to thematic analysis ............................................................................ 69
3.4 Empirical phase one: General public’s perception of psychologists ......................... 71
3.5 Empirical phase two: The active management of psychology’s public image ............ 72
3.6 Empirical phase three: GP perceptions of psychologists ........................................ 74
3.7 Summary ................................................................................................................ 75

CHAPTER 4: THE PUBLIC PERCEPTION OF CLINICAL PSYCHOLOGISTS: A DISCURSIVE ANALYSIS ...... 77
MEETING AUSTRALIA’S MENTAL HEALTH NEEDS: INCREASING COMMUNITY ACCESS AND DECREASING HEALTH WORKFORCE SHORTAGES. A SUPPLEMENTARY SUBMISSION TO THAT SENT TO THE PRIME MINISTER, CHAIR OF THE COUNCIL OF AUSTRALIAN GOVERNMENTS (NO DATE). .................................................................................................................................................................................. 393

APPENDIX G: CONSENT FORM FOR QUESTIONNAIRE CHAPTER 4 .................................................................................. 407
APPENDIX H: CONSENT FORM FOR INTERVIEW CHAPTER 4 ................................................................................................. 409
APPENDIX I: INFORMATION FLYER FOR INTERVIEW CHAPTER 6 .......................................................................................... 411
APPENDIX J: CONSENT FORM FOR INTERVIEW CHAPTER 6 ................................................................................................. 413
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CHAPTER 1: INTRODUCTION

1.1 Overview

The public image of psychologists is a complex construct and the profession of psychology has invested a good deal of time and energy trying to define and measure it (Fall, Levitov, Jennings & Ebets, 2000; Von Sydow & Reimer, 1998). The profession of psychology has experienced significant growth over the last century and particularly over the last several decades. As a result of this growth, and the subsequent prevalence of psychologists in the community, it could be expected that the public image of psychology and psychologists would be well formed and unambiguous. However this is not necessarily the case and the literature which addresses this topic has to date been surprisingly scant. Nevertheless, interest in the debate about the professional image of psychology in Australia has recently intensified and the profession is starting to engage in a meaningful discussion. For example, a recent article in the InPsych Bulletin written by the Executive Director of the Australian Psychological Society (APS) (Littlefield, 2009) addresses the issue of public perception of psychologists and the delicate balance between the provision of specialised services which attract significant funding, versus the provision of an eclectic range of services which cultivate a wide referral base. Since the introduction of the Better Access mental health initiative in 2006, the ability of psychologists to provide specialised mental health services has been rewarded with significant funding in the form of Medicare rebates. However, the potential disadvantages of this, including a decreased referral base, if the general public comes to
view psychologists as only providing mental health services, have been outlined. This has prompted the APS Executive Director to state that “it is essential to address the threat to the diversity of the psychology profession that has resulted from the increased focus on mental health within both the community and the Society since the introduction of the Better Access initiative” (Littlefield, 2009, p.7). This overview will expand on these issues and outline a range of reasons why the public image of psychologists is an important construct, some of which are related to the health of the profession and others that are related to the health of the consumers.

First, it is important for the profession to have a clear perception of the public’s understanding of psychology. Throughout its history, the profession of psychology has conducted research with the goal of understanding individuals, couples and groups and the way they interact and relate to each other (Freedheim & Weiner, 2004). These individuals, couples and groups are members of the public and so some understanding of the public perception of psychology becomes important. Inherent in this objective is the notion that certain methodological approaches yield certain outcomes, while other methodological approaches may yield different outcomes. Previous attempts at analysing data around the public perception of psychologists have employed quantitative methodology which provides a particular perspective. However the possibility of employing a qualitative approach to provide an alternative perspective is worth considering due to the potential for collecting highly specific and meaningful data and the subsequent opportunity to engage in a more focused analysis.
Second, the profession of psychology has a broad and eclectic base which employs a wide range of different philosophies, interventions, and approaches. Therefore, for reasons of marketing (Boonekamp, 2004) and distinctive competence (Andrews, 1971; Selznick, 1949), it becomes important for the profession to portray a clear message about its boundaries as compared with other professions, and the effectiveness of psychology in general. The profession of psychology clearly has a vested interest in portraying psychology and psychologists in a positive light. However, closer consideration of the nature of that interest shows this to be a more complex task than might at first be imagined. Psychology is a broad umbrella covering a large number of professionals with a wide range of (not always compatible) philosophies, priorities and practices. Establishing the interests of such a disparate group is far from straightforward, and the nature of the public image aspired to by this group is likely to be far from consensual. In addition to any internal dissent among psychologists as to what psychology is and how it should be portrayed is the ambiguity surrounding the demarcation between psychologists and other mental health professionals. For example, there is a long history of confusion between the roles of psychologists and psychiatrists (Grossack, 1954; Guest, 1948; Nunnally & Kinross, 1958; Sharpley, 1986; Thumin & Zebelman, 1967; Von Sydow & Reimer, 1998; Webb & Speer, 1986), and hence psychology’s self image, and the role it plays in creating that self image is a crucial aspect of the development of the public image of the profession.

It is also important for the profession to have an understanding of how it is perceived by various relevant health practitioners with whom it engages in the health care market.
Although psychology is increasingly accepted in the community and many people self refer for psychological assistance, referrals from other health care providers are still a major pathway by which members of the public access psychological services. In light of the new Medicare changes introduced in Australia in 2006 which provide a structural basis for General Practitioners (GPs) making the bulk of referrals to psychologists, it seems likely that GPs’ perceptions of psychologists will partly determine the extent to which they refer their patients to psychologists. Hence a clear understanding of these factors will contribute to the health and growth of the profession of psychology.

It will be noted thus far that the stated objective of this thesis has been to examine the profession of psychology as opposed to the science of psychology. This is an intentional and considered approach in light of the majority of psychologists being employed in an applied setting. However, an understanding of the public perception of the science of psychology is fundamentally related to the public’s understanding of the practice of psychology and should be considered in future research. With this caveat in mind therefore, the overarching purpose of this thesis is to investigate some of the varied aspects of the public image of professional psychology in Australia. The status of the profession of psychology in Australia’s contemporary health care market is fluid and dynamic which provides a range of opportunities as well as a number of potential threats. Psychological services have recently been made available on the Medicare schedule which propels the profession of psychology firmly into the forefront of the public consciousness. However, despite the current need for clarity around the
professional role and image of the profession, the construct of the public perception of psychologists remains a complex and largely misunderstood phenomenon.

This thesis plans to investigate a number of aspects of the public perception of psychologists by addressing three key questions. The first question addresses the issue of the public perception of psychologists and recommends the use of qualitative methodology as an adjunct to the traditional methodological approaches. The second question taken up by this thesis addresses the active management of the public image of psychology by professional organisations and outlines the role of a major professional organisation in Australia in actively promoting a positive and professional image of psychologists using two different types of media. The final question in this thesis takes into consideration recent changes to the health system in Australia resulting in the introduction of GP mental health care plans designed to provide Medicare rebated services for some psychological conditions, and consequently investigates GPs’ understanding of the skills and qualifications of psychologists, and the factors they take into consideration when making referrals to psychologists. The remainder of this chapter will outline these three questions in greater detail.

1.2 Investigating the public image of psychologists: What do members of the public say about psychologists?

The opinions of consumers of psychological services and other mental health professionals will in part contribute to the public image of psychologists. However, in addition to this, a central component of the public image of psychologists will be made
up of the judgements and attitudes of the general public. There are a number of different eras in the measurement of the public image of psychologists beginning in the late 1940s and continuing through until the current day. The process of investigating the public image of psychologists was initiated by Guest (1948) who created a fixed alternative questionnaire designed to capture public opinion at the time. Results of this survey administered to 311 individuals showed that “the public seems to think that the psychologist deals only with abnormal individuals” (p. 137) and that public opinion about psychologists was derived from an unrepresentative sample and was influenced by “such questionable sources as movies, newspaper columns, and even the funny papers.” (p. 135). In the mid 1980s however, this approach was superseded by Webb and Speer (1986) who stated that “the popular fixed-alternative questionnaire format is inherently self-limiting because it may reflect the investigator’s pre-conceptions” (p. 5). Hence, Webb and Speer (1986) began their investigation by asking a wider population to generate spontaneous descriptive paragraphs about psychologists from which a set of dimensions describing psychologists (and other professionals) was derived, and then employed the statistical process of factor analysis to structure the data. Webb and Speer (1986) asked 98 undergraduate participants to write spontaneous descriptive paragraphs deemed to be typical of psychologists, psychiatrists, physicians, counsellors, teachers and scientists. Adjectives in the spontaneous paragraphs were then grouped according to frequency of appearance resulting in a list of 40 descriptive features. Twenty students then sorted the list of 40 descriptive features into groups according to similarity of meaning and these groups underwent cluster analysis which ultimately resulted in 11 final adjective clusters which are listed in Table 1 (in Chapter 4) with the summary
constructs used by Webb and Speer (1986). Following this, another sample of subjects consisting of 128 undergraduates rated each of the six professions on how typically they were described by each of the 11 adjective clusters. Finally, a fourth group of undergraduates (N=50) made favourability ratings on each of the 11 adjective clusters and their accompanying summary constructs. Webb and Speer (1986) found that the public had a generally positive perception of psychologists, even though their understanding of the role was unclear and psychologists were often seen as similar to psychiatrists.

There are advantages and disadvantages to the use of factor analysis as employed by Webb and Speer (1986). Advantages include the reduction of the overall number of variables, or the identification of similar variables into a set of factors inside a particular statistical analysis (Williams, Zimmerman, Zumbo, & Ross, 2003). For example, the variables which include being bossy, hostile, greedy and egotistical might be combined into a single factor labelled with the descriptor “arrogant”. The gains in simplification achieved by reducing the data in this way are offset against the potential loss of meaning and capacity for capturing ambivalence and internal inconsistency in representations of psychologists. These nuanced and flexible aspects of public perception of psychologists may be more fully grasped by employing qualitative methods. For example, discourse analysis and thematic analysis might be more useful when examining the spontaneous descriptive paragraphs analysed by Webb and Speer (1986) because the descriptive approach of qualitative analysis seems better suited than a factor analytic approach to managing the semantic issues of labelling (bossy, hostile, greedy and egotistical versus
the construct of arrogance, or intelligent, studious and wise versus the construct of scholarly) as outlined in Webb and Speer, (1986). This issue is pursued in detail in the first empirical study presented in this thesis (Chapter 4).

Several attempts have been made outside Australia to ascertain the public perception of psychologists (Nunnally & Kinross, 1958; Tallent & Reiss, 1959; Thumin & Zebelman, 1967; Warner & Bradley, 1991). The results of these studies show a lack of understanding of the role of psychologists and in particular, confusion between the roles of psychologist and psychiatrist. Similarly, some Australian authors have employed a quantitative approach to investigate this phenomenon and give an account of the public perception of psychologists in Australia (Donovan, 1985; Hopson and Cunningham, 1995; Sharpley, 1986). However, each of these studies has employed a quantitative approach, and one of the tasks of Chapter 4 will be to provide a contemporary, Australian, view of the public perception of psychologists using a qualitative approach.

1.3 How is the public image of psychology actively managed by psychological professional associations?

The role of professional organisations in managing the public image of psychology has received little attention in the literature and the profession of psychology clearly has a vested interest in portraying psychology and psychologists in a positive light. Strategic reasons for this may include: a desire to increase the number of individuals self referring to the profession; a desire to increase the number of groups (such as GPs) referring to the profession; a desire for the government of the day to have psychologists at the
forefront of their mind as providers of specialist mental health services in the public system; and a desire to encourage prospective students to enter into psychology as a profession. However, similar to the profession of psychology which is a diverse field encompassing themes of a clinical, academic, and organisational nature (just to name a few), these interests are eclectic and somewhat divergent in nature and contain inherent tensions which need to be managed. One example is the tension that needs to be managed between ensuring that psychologists and psychiatrists are seen as distinct professions in their own right, while still ensuring that psychology is not seen as inferior to, or less effective than psychiatry (given the higher social status of medical doctors).

The public image of psychologists is a complex and shifting construct, and there are many sources of information about psychology including media coverage, personal experiences, and reports from others of their experiences that can all contribute to people’s understandings of what psychology is and what it can offer them. In addition to this, the various professional bodies associated with psychology distribute information which contributes to the public understanding of psychology. For example, the mission of the Australian Psychological Society is ‘to represent, promote and advance psychology and psychologists within the context of improving community well-being and scientific knowledge’, and one of its goals is ‘to enhance the profile of APS psychologists and psychology and increase public access to and utilisation of psychological services’ (Australian Psychological Society, n.d.). The focus of Chapter 5 is on analysing the impact of psychological associations in shaping and influencing community and government attitudes and knowledge about psychology. Chapter 5A
focuses on the APS website and argues that this shaping and influencing is designed to subtly promote a positive and professional image of psychology and encourage people with mental health concerns to seek help from psychologists. Chapter 5B provides a contrasting example by focusing on a range of written submissions to the APS. Using these documents, the APS are seeking to positively influence the government’s perception of psychologists while arguing for the inclusion of psychological interventions on Medicare.

1.4 What do referring agents think of psychologists?

While self referral to psychological services has always been an option, recent changes to the Medicare system now provide a financial incentive (in the form of a Medicare rebate) to accessing psychological services through a GP referral. One of the primary reasons that referring agents’ perceptions of psychologists is important is because of the increased likelihood that a referring agent will utilise the services of a psychologist if they are familiar with the profession of psychology. GPs have historically been at the centre of primary health care provision (Verhaak, 1993) and regularly refer their patients to mental health care specialists, making GPs a particularly important reference group in which to explore perceptions of psychologists. Moreover, recent changes to the Medicare system in Australia have led to the creation of a number of mental health care items which are now available on the Medicare Benefits Schedule, further highlighting the importance of GPs to the profession of psychology. These changes have been designed to assist GPs to engage in the early detection, assessment and intervention of patients with mental health problems, and generate referrals to psychologists and other
allied mental health service providers. Under the scheme, as part of a GP Mental Health Care Plan, patients can receive a significant rebate following consultation with a psychologist for a diagnosed mental health disorder. Consequently, there seems to be a clear relationship between the extent to which GPs are aware of the role of psychologists and the likelihood that they will refer their patients to them, emphasising the importance of the perception of psychology and psychologists with regard to new referrals.

This potential changing of the guard, from GPs to psychologists, with respect to the primary provision of mental health care and psychological services raises two interesting questions about the public image of psychologists. The first question focuses on the factors that GPs take into consideration when making referrals to psychologists, and how this has changed with the introduction of the Medicare rebates for psychological services. The second question investigates the extent to which GPs are aware of psychology as a profession and the skills and qualifications which psychologists possess to enable them to take on the brunt of mental health care provision. Both of these questions are explored in Chapter 6.

1.5 Summary and overview of the thesis structure

In summary, this thesis will investigate the question of the public perception of psychologists using three questions which address issues of methodology, the active management of the image of psychologists, and GPs’ understanding of the training and skills of psychologists.
This thesis is comprised of seven chapters. Chapter 1 has just provided a brief précis of the importance of studying the public image of psychologists outlining a number of relevant issues including how the public image of psychologists is created, different methodology for investigating the public image of psychologists and referring agents’ perceptions of psychologists. Chapter 2 is a comprehensive literature review encompassing areas such as the history and nature of the public perception of psychology, and some of the relevant public health and funding issues. Chapter 3 outlines the methodology used throughout the thesis.

The empirical work in this thesis is presented as a series of papers that have been published or submitted for publication. Chapter 4 is a journal article published in the *Australian Psychologist* in 2007 which presents initial information from an undergraduate population about the public perception of psychologists and critiques the methodology previously used to ascertain the public image of psychologists, suggesting an adjunctive approach. Chapter 5A is a manuscript that has recently been submitted to *Computers in Human Behavior*. This paper analyses a number of excerpts from the APS website to examine the ways in which the APS actively manages the public image of psychology and psychologists. In particular, issues concerning the management of the diverse interests of psychologists, and the relationship between the professions of psychology and psychiatry are addressed. Chapter 5B provides a further example of the APS tailoring their message inside a different medium; namely a series of APS submissions to government written between 2003 and 2005 to advocate on behalf of
psychologists and psychology for the inclusion of psychological interventions on the Medicare rebate. Chapter 6 is also a journal article, published in the *Australian Psychologist*, outlining GP responses to the new Medicare changes and the impact of these changes on the public image of psychologists. Finally, Chapter 7 contains a general discussion and conclusion section which ties together some of the relevant points and makes a series of recommendations for future research.
CHAPTER 2: LITERATURE REVIEW

2.1 Overview of the chapter

The purpose of this chapter is to highlight and develop a number of ideas relating to the public perception of psychologists which will then be expanded on throughout the course of this thesis. When thinking about the question of public perception, there are various ways of conceptualising the construct. Previous methodology has employed an individualistic, aggregational approach to gain insight into the attitudes held by the public about psychologists. However, an alternative approach involves the use of social representations which take into consideration existing beliefs and value systems, and can be used to unpack the attitudes that are held towards an object of representation (such as psychologists). Therefore, the first part of this chapter will expand upon the role of social representations in public perception.

Chapters 5 and 6 of this thesis investigate specific domains of the question of the public perception of psychologists by focusing on both the contemporary views the profession itself displays about psychologists, and the understanding that GPs have of the training and expertise of psychologists. However, public perceptions arise over time and in order to provide a background for these empirical chapters, the second part of this chapter will present a brief history of the profession of psychology and its major professional body in Australia, the APS. Similarly, the third part of this chapter will provide background contextual information to two of the major issues which the profession of psychology is currently managing. The first of these is the effectiveness and efficacy of psychological
interventions and the second is the difference in public perception between psychologists and psychiatrists. Both of these issues impact on the public perception of psychologists, and the issues surrounding this influence will be drawn out in this chapter.

Finally, it will be argued throughout this thesis (particularly in Chapter 5) that the development of public perception is a two way process which takes into consideration the views of the perceiver, as well as the influences of the referent object (in this case the profession itself). Consequently, the final part of this chapter will do two things. First it will highlight a range of strategies employed by the profession to portray a particular image of the profession of psychology including the various elements involved in the creation of a persuasive message, and second it will outline the assorted stakeholders involved in psychological health care in the current market.

2.2 The role of attitudes and social representations in public perception

2.2.1 Overview

When discussing the topic of the public image of psychologists, it is useful to consider two of the many available theoretical stances. The first stance which will be considered is based on social psychology literature which addresses the construct of attitudes and which will be referred to as the “attitudinal stance”. The second stance is based on the more recent literature around social representations (Moscovici, 1988; Potter & Edwards, 1999). This section of Chapter 2 will argue that the attitudinal stance on public perception is internally driven and individually evaluative in nature and as such is
inherently limited in its ability to provide a convincing and coherent account of the creation of the public image of psychologists. In contrast to this, it will be argued that the social representations approach is externally driven, socially constructed and resides predominately in the culture or environment. Hence it is suggested that the social representations approach is a potentially more useful way of investigating the public image of psychologists. A brief discussion of the relevance of each of these approaches to the public image of psychologists will be outlined.

2.2.2 The role of attitudes in public perception

Social psychology spent much of its early years studying attitudes which at the core, are tools for evaluating referent objects (Weber, 1992). Initial research focused on the ABC model of attitudes which suggested that attitudes were a tripartite construct consisting of an affective component (I feel a certain way about the referent object), a behavioural component (I behave a certain way towards the referent object), and a cognitive component (I think a certain way about the referent object). However, more recently, attitude researchers have found that attitudes require effort and engagement. For example Augoustinos, Walker and Donaghue (2006) note that “Attitudes are evaluations. They convey what we think and how we feel about some object, or attitude referent” (p. 2). Moreover, these authors argue that the activation of a non-automatic attitude requires some cognitive effort and engagement. Although attitudes are certainly social, in that they develop from the experiences (both direct and indirect) that a person has with the attitude object, once developed they are considered as properties of the individual. As a result of their different experiences with the attitude object, individuals
are expected to vary in their attitudes towards particular objects. Collective constructs, such as public perceptions of certain objects (such as the profession of psychology) are based on the aggregation of the individual attitudes held by each member of the relevant population.

Social representations have an internal component similar in some aspects to the traditional psychological attitude, but the individual level of analysis is not privileged over the social. In contrast to the attitudinal stance, social representations theory suggests that public opinion is best understood as being located in the social environment. Therefore it can be seen that the attitudinal stance primarily suggests that attitudes belong to the individual and can be investigated by probing the individual. This is in contrast to the social representations stance which acknowledges the role of the individual and indeed of the cognitions of the individual, but extends the theory to encompass the public domain. Social representations theory is a particularly appropriate methodology for investigating the public perception of psychologists which, it is argued, is created in the social spaces or the public domain. Social representations are developed in the social world and provide a framework for highlighting the role of communication in creating a shared or common reality. It is to the role of social representations in public perception to which we now turn.

2.2.3 The role of social representations in public perception

“Social representations, as I have already mentioned, concern the contents of everyday thinking and the stock of ideas that gives coherence to our religious
beliefs, political ideas and the connections we create as spontaneously as we breathe. They make it possible for us to classify persons and objects, to compare and explain behaviours and to objectify them as parts of our social setting. While representations are often to be located in the minds of men and women, they can just as often be found ‘in the world’, and as such examined separately. Representations can be preserved on parchment or stone in some forgotten places without having left a trace as such in anyone’s mind for thousands of years”. (Moscivici, 1988).

The term social representation was coined in the 1960s by Serge Moscovici and is generally understood to be the joint elaboration or understanding of a social commodity (such as mental illness or psychologists) by a particular community which provides guidance around issues of behaviour and communication. The understanding of social representations originated from Durkheim’s notion of collective representations which Evans-Pritchard outlined as being “common to all, or most members of society” (1981, p. 124). However, as a theoretical approach it has developed significantly in the last 50 years undergoing a series of evolutions, changes, progressions and transformations as a result of the robust debate it has engendered.

Social representations are not constructed in isolation, but rather arise from the connections between individuals. For example, Markova (1987) notes that social representations consist of a collection of ideas and images, and Moscovici (1988) observes that they link a cognitive notion to a collective group.
Because social representations are mental entities which take into account existing beliefs and value systems, they can be used to explain attitudes and actions towards an object of representation and allow for a more complex and holistic understanding of the object. Some of the complexity of this theoretical approach is highlighted by Abric (1993) who advocated for the existence of a two tiered structure to social representations comprised of the central core and peripheral elements of social representations. Abric (1993) came to this conclusion after noting that social representations were both “stable and moving, rigid and flexible” (p. 75). He consequently proposed that the central core and peripheral components of social representations function in a complementary fashion with the central core components being more stable, consistent and resistant to change, and the peripheral components being more flexible, sensitive and tolerant to contradiction.

Wagner (1995) notes that Moscovici examined the construct of psychoanalysis across different strata of French society and found that the understanding and interpretation of the psychoanalytic process was contingent on the individuals’ “pre existing ideological frameworks and interests” (p. 11). He noted that each subgroup of French society had a different view of psychoanalysis and that each of these different sub groups’ representations needed to be examined, amalgamated and combined to constitute a meaningful overall social representation of psychoanalysis: “it is the total of these group specific ‘sub-representations’, including the professional psychoanalysts themselves which assures complex social interaction, which only in toto constitutes the object of
psychoanalysis in French social discourse” (Wagner, 1995, p.11). Likewise it could be argued that various subgroups in Australia including consumers of psychological services, other mental health providers, the government of the day, as well as psychologists themselves, may have overlapping but not interchangeable views of psychologists which need to be scrutinized and integrated in order to come to a comprehensive understanding of the public perception of psychologists in Australia.

Similarly, Jodelet (1991) studied residents in a village in France to try and ascertain their understanding of mental illness. However to create a meaningful social representation of mental illness, Jodelet had to take into consideration the other relevant groups associated with mental illness in the village including the nurses, administrative staff and doctors. Again the importance of working from the bottom up and taking into consideration a number of different perspectives in the construction of the overall social representation is highlighted, making it clear that the public perception of a particular construct, mental illness in this case, is a fundamentally social process which takes place in a social context and resides in the culture rather than being the sum of individuals’ privately formed and held attitudes.

When thinking about the role of social representations in public perception, it is useful to ask if and why the concept of social representations is a better way of thinking about public perceptions than the alternative notion that different groups simply have different (and often contradictory) attitudes towards, and opinions about things. Moscovici (1988) provides some insight into this when he says “there has been a disregard for the
infinitely varied nature of the things with which we have been dealing, a blind faith that
condensing them in a formula is all that is needed to bring them under control” (p. 213).
Here, Moscovici is suggesting that while the attitudinal approach may allow for some
degree of analysis and scrutiny of the issues surrounding public perception, it ultimately
considers public perception as the aggregation of the stable attitudes held by individuals,
and does not allow for a truly social level of analysis. In contrast to this, the theory of
social representations encompasses and accommodates for the existence of the
contestations and contradictions, both within people and between groups, which are
inextricably linked with any analysis of public perception. For this reason, in this thesis
I use social representations theory as a framework for conceptualising the multiple
points of view about psychology and psychologists in order to achieve an authentic,
valid and theoretically compelling analysis.

2.2.4 Summary

It seems then that there are at least two possible ways of conceptualising the construct of
public perception. On the one hand there is the attitudinal approach which suggests that
public perception can be understood inside a framework which uses the construct of
attitude formation. In this view, an attitude is a mental construct which arises from an
individual’s experiences and which is located within the individual person. Public
perceptions are simply the aggregation of these individually held attitudes across a
relevant population. In contrast there is the social representations approach which
emphasises the role of action and interaction and the actively constructed, socially
influenced nature of public perception. Social representations are the subject and
product of social processes and although they contain a core of consensually agreed material, they are able to encompass, and are energised by, some contested elements and understandings. Although social representations are considered to be available in the minds of individuals, these representations are also easily found in the social world and it is contended that approaches such as this provide a more integrated, holistic, and mature methodology for studying public perception. Social representations emphasise the historical and social context in which current perceptions exist. Therefore, this next section will provide a brief discussion of the development of the profession of psychology in Australia.

2.3 History of perceptions of psychology

2.3.1 Overview

When a group of people attempt to portray a particular image of themselves, they will often draw on the history of their institution, their achievements, their ideology, their successes and sometimes their failures. For example, the Australian Labour Party (ALP) draws on its history as a political party committed to representing the working class of Australia in the late 19th century to establish its credentials as a political party which uses industry policy to regulate the economic markets and thus ensure stable economic conditions for the working class of today (Clarke, 1996). In simple terms, we judge ALP politicians today partly according to the history of the institution to which they belong. Similarly, in order to better understand the public image of psychologists, it is first necessary to gain an understanding of the history of psychologists, psychology in
general, and the major professional body which represents the interests of psychologists; namely the APS. This section will outline a brief history of applied psychology on an international level, a brief history of psychology in Australia, and a brief history of the Australian Psychological Society which is the major professional association for psychologists in Australia.

2.3.2 A brief history of applied psychology

The public image of psychology has been of interest to psychologists since the beginning of the profession (Wollersheim & Walsh, 1993). Benjamin (1986a) gives an outline of the history of psychology’s public image beginning with the 1850 Webster’s dictionary definition of psychology as “a discourse or treatise on the human soul; or the doctrine of man’s spiritual nature” (cited by Benjamin, 1986a, p. 941).

In North America, Benjamin (1986a) outlines the somewhat dubious associations of early psychology with clairvoyance, spiritualism and general chicanery. However, this image was ameliorated to a degree with psychology’s entrance into applied settings and particularly its association in the 1890s with the North American education system. This proved to be something of a turning point and the discipline of psychology became very popular in the 1920s, partly as a result of the perceived role it played in the military success of the First World War. Despite this early change of fortune, the popularity of psychology plateaued in the 1930s and entered its own “minor depression” mirroring the major economic depression of the times.
However, the economic recovery, which was largely due to the Second World War, was again mirrored in psychology’s fortunes when psychologists found a proliferation of new jobs focusing on psychometric testing which resulted in a much improved public image. Benjamin (1986a) notes that:

“war work changed the face of psychology forever, essentially establishing psychology as a profession that could thrive outside the halls of academe. Further, the praise psychologists received from government, industry, and the military provided a tremendous boost for the public image of psychology.”

(p. 945).

This improvement in the public perception of psychologists was further highlighted by Wood, Jones and Benjamin (1986b) who compared their own survey results from 201 individuals in the United States with the results of eight surveys completed in the United States in the preceding 38 years. While previous surveys had noted significantly negative reactions to the profession of psychology, this was in contrast to the results of Wood, Jones and Benjamin’s (1986b) whose results indicated a marked improvement in favourability towards psychologists. However, these authors did note the lack of correlation between knowing about psychologists and actually liking psychologists with the correlation of only 0.14 between number of psychology courses taken and positive impression of psychology (Wood, Jones, & Benjamin, 1986b).
2.3.3 A brief history of psychology in Australia

Psychology in Australia got off to a relatively sluggish start particularly in academia. Indeed Australia’s first 3 year psychology course commenced in 1925 producing a total of five graduates in 1929 and increasing to just 21 graduates by 1938. However, in Australia as in North America, the Second World War provided the perfect opportunity for the burgeoning profession to expand its reach. Unlike their North American counterparts who were heavily involved in providing services in the clinical arena during the Second World War, Australian psychologists focused on psychometric testing providing information to the armed forces on appropriate recruitment and selection procedures (Benjamin, 1986a).

Outside the realm of the war effort, psychology also challenged old forms of authority such as corporal punishment, by providing a range of alternative, psychological motives for previously unacceptable behaviour. Hence, the previously wayward and ill disciplined youth who engaged in anti social behaviour, were in the 1940s beginning to be perceived as sufferers of medical symptoms requiring psychological intervention. In addition to challenging old forms of authority, the profession of psychology was also functioning as a new social commentator on issues as diverse as relationships, the psychology of the German army, and contemporary dances such as the “jitterbug” and “boogie woogie” (Cooke, 2000).

This boom in social relevance and applied work was reflected in the number of people who had applied for registration as psychologists in 1943 which was recorded at a total
of 1424 applicants. However, Cooke (2000) notes that only 695 of these people had two or more years of psychological training, with the remainder applying for registration apparently on the basis of two or more years of psychological experience. Nevertheless, nearly 700 registered psychologists in the country was enough to prompt the establishment of a society to protect and advocate for the interests of the profession.

2.3.4 A brief history of the APS in Australia

Cooke (2000) notes that planning for the Australian Branch of the British Psychological Society (BPS) began in Sydney in February 1943. Two options were open for consideration to the inaugural members. The first was the establishment of an independent Australian Society and was based on issues of the different needs and geographies of the two countries. The examples of other professions such as pharmacists (The Australian Institute of Chemists) and engineers (The Australian Institute of Engineers) were invoked. However the BPS with its already established levels of membership and strong historical links with Australian psychology was seen as the more favoured option. The BPS was supportive and held a special meeting in October 1944 to form the new branch with the first meeting of the Australian Branch being held three days later. Following this, the growth of the newly formed Australian Branch of the BPS was rapid. Per head of population, the proportion of psychologists in the Australian community increased from less than one person per 100,000 in 1945 to eight people per 100,000 in 1965 (almost 1000 members).
The Australian Branch of the BPS developed a number of initiatives to facilitate a sense of community and foster the development of a truly Australian profession. One of these was the annual conference which provided a clinical, academic and social forum for psychologists to meet and discuss issues around clinical practice, and academic and research pursuits.

A second initiative to foster a sense of psychological community was the publication of the Australian Journal of Psychology (AJP) in 1949. A dearth of material submitted for publication led to a delay in the first issue, and the survival of the AJP was initially in question which prompted the Branch to introduce mandatory subscription to the journal. However over time, the culture of research which flourished in the 1950s led to an excess of material suitable for publication and the AJP became an important part of the development of an Australian community of psychologists.

However, the diverging interests of both parties became evident, with the BPS and the Australian Branch of the BPS ultimately having different expectations. The BPS expected “to see the Society a fully British organisation” (Cooke 2000, p. 26) whereas the Australians were clearly counting on the distance between the two countries to provide them with a suitable buffer zone from Britain allowing greater autonomy and independence.

Throughout the 1960s, increased globalisation and the chance of easier travel afforded Australian members of the Branch the opportunity to travel to Britain and observe the
birth place of their professional body. However there was a sense of disappointment and anti climax. For example, Cooke (2000) cites one figure saying:

“Having looked to London as one’s Mecca for a number of years it is not easy to adopt a realistic view but one gradually comes to appreciate the fact that not all people who lecture at BPS or in Universities are necessarily “BIG MEN” and that piffle can be talked here just as it is at home”. (p. 65).

Cooke (2000) notes the sense of disillusionment citing the same individual’s opinion on British universities: “If I may say so with all humility – I consider our course was superior to anything I have seen or heard of over here” (p. 65).

Necessarily, the issue of an independent Australian Society remained bubbling away on the agenda for the next 10 years until January 1966 when the transition from Australian Branch of the BPS to Australian Psychological Society was made complete. It was a relatively trouble free conversion with the BPS offering no objections, and the vast majority (82%) of Branch members joining the APS (Cooke, 2000). History was made when the Australian Branch of the BPS closed for business on the 22 December 1965, and the same office opened for business on 6 January 1966 with the new name of Australian Psychological Society.
2.3.5 Summary

In summary it can be seen that applied psychology started to take a foothold in North America towards the end of the 19th century when it was associated with the education system and later the military. However, psychology in North America really flourished as a result of the Second World War which provided psychologists with the opportunity to establish themselves as specialists in the provision of clinical services.

Similarly in Australia, psychology began to flourish as a result of the Second World War. However in this case, Australian psychologists were seen as specialists in psychometric testing. Moreover, psychologists in Australia also found a niche for themselves in commenting on societal norms and customs and providing clinical services, particularly to the disaffected youth of the day. This dual role further cemented their place in the community as social critics and providers of clinical services.

In addition to this, the evolution of the APS from being a branch of the British Psychological Society to an independent Australian Society in its own right has been briefly described. This was a relatively uneventful transition which was facilitated by the Australian Branch of the BPS organising regular conferences in Australia, the establishment of the Australian Journal of Psychology, and the attendance of members of the Australian Branch of the BPS at international conferences.

Although a relatively new science, the profession of psychology is gradually becoming an institution (much like the ALP), and as such, individuals’ judgements and
perceptions about psychology will be partly based on the history of the profession and
the professional and institutional status it has achieved. This brief history of psychology
and its most prominent professional association, the APS, provides a background and
framework for understanding the public perception of psychology and psychologists.
Nevertheless, there are a number of issues in the public perception of psychology which
warrant further attention in order to provide an adequate context. Two of these include
the effectiveness and efficacy of psychological interventions, and the differences
between psychologists and psychiatrists in the eyes of the public. The following section
will address both of these issues.

2.4 Major current issues in public perception of psychology

2.4.1 Overview

Over the history of the profession, psychology has developed a broad repertoire of
distinct and sometimes contradictory approaches to therapeutic treatment resulting in an
extensive range of therapies which are in use today. While representing one of the
strengths of the discipline, this professional and therapeutic eclecticism also presents a
potential threat to psychology which, along with other professions such as nursing and
physiotherapy (Britt Pipe, Wellik, Buchda, Hansen & Martyn, 2005; Turner &
Whitfield, 1997), has focused heavily in recent years on promoting evidence based
practice. There is a natural tension between the notions of therapeutic eclecticism with
its multiple, sometimes contradictory treatments, and the philosophy of evidence based
practice. This is because ambiguity and disagreement about which psychological
treatments are effective under which particular circumstances potentially makes it
difficult for the profession to claim expertise as providers of specialist therapeutic interventions, and thus affects the public perception of psychologists. In addition to this, disparate cultural representations of psychologists (such as those that appear in the media), or confusion between the roles of different mental health clinicians (such as psychologists and psychiatrists), further confuses and complicates the public perception of psychologists. Hence it becomes important for the profession to have clear and credible claims about the efficacy of psychological interventions, and unambiguous parameters about the role of psychologists.

Consumers of psychology will be interested in having some understanding of the role of their psychologist (both in its own right and compared to other mental health professionals), and a reliable assurance that the treatment they engage in will be effective. This next section will focus on these two issues: the effectiveness and efficacy of psychological interventions and the difference between psychologists and psychiatrists. It is hoped that focusing on these two current issues will draw attention to some of the many internal conflicts, tensions and contestations which exist generally in psychology, highlighting the complex issues that need to be attended to in any discussion around the creation of the public image of psychologists.

2.4.2 The effectiveness and efficacy of psychological interventions

The complexity of some of the issues involved in understanding the effectiveness or efficacy of psychotherapy is summarised in the opening pages of Wampold (2001) who notes the existence of more than 250 different psychotherapeutic approaches. With
specific regard to the effectiveness of psychotherapy Wampold (2001, p. 1) also notes that “tens of thousands of books, book chapters, and journal articles have reported research conducted to understand psychotherapy and to test whether it works”. Establishing the efficacy and effectiveness of psychotherapy is not a simple matter.

The distinction between effectiveness and efficacy is important because the two terms are often used interchangeably with psychologists sometimes referring to effectiveness when using the term efficacy would be more appropriate. Wampold (2001) notes that efficacy can be defined as the effect of a particular treatment or intervention in a clinical trial such as a randomised, placebo controlled trial. This is in comparison to the notion of effectiveness which can be defined as the effect of a particular treatment in a real life setting such as when a client is being seen on an individual basis by a psychologist.

Hans Eysenck (1952) initiated much of the discussion surrounding the efficacy of psychological interventions with his seminal paper which reported a higher rate of improvement in the no treatment group (70% improved) compared to the treatment group (60% improved). While these figures were subsequently revised, significantly reducing the improvement rate in the no treatment group down to approximately 40% (Bergin, 1971), debate about the efficacy of psychological treatments has nevertheless persisted throughout the literature.

There are a number of specific issues inherent in the debate around the effectiveness and efficacy of psychological interventions including the statistical technique known as a
meta analysis, the various types of efficacy (absolute and relative), and the specific versus the generalised effects of psychological intervention. These issues will now be outlined.

2.4.2.1 Meta-analysis

In response to Eysenck’s (1952) diatribe damning psychotherapy as ineffective at best and harmful at worst, Smith and Glass (1977) employed a relatively new statistical technique known as a meta-analysis to try and settle the issue of efficacy. A meta-analysis is essentially one overarching statistical analysis of a number of different studies about a similar topic for the purpose of integrating the findings. Its modus operandi is to aggregate individual sets of experimental data from different studies that address a particular research topic resulting in an overall finding. The overall objective therefore, is to argue for the efficacy of psychotherapy which ultimately has clear implications for the perception of the profession of psychology. Smith and Glass (1977) employed a meta-analysis to analyse 375 separate studies with results showing that in approximately 75% of cases, psychotherapeutic intervention led to improved outcomes for clients.

Cox, Swinson, Morrison and Lee (1993) conducted a meta-analysis on the results of different treatments for obsessive compulsive disorder and associated low mood. They compared treatment efficacy of two medication based interventions (clomipramine and fluoxetine) and one non-medication based treatment (exposure and response prevention). The outcome variables were overall severity, anxiety and depression. Their
findings revealed that all three treatments produced significant improvement overall, but that the exposure and response prevention treatment was effective for the anxiety component but not specifically for the mood component.

They were able to make these conclusions because conducting a meta-analysis allows for the assessment of similarities and differences between studies and tries to control for the effects of the differences in design and population. There are some advantages and disadvantages to this approach. One of the advantages of employing a meta-analysis is that it allows the researcher to combine a significant amount of the research on a particular topic and analyse the data with more power. For example, Cox et al (1993) integrated and summarised 25 empirical studies to provide more a more rigorous examination of the data on the effects of treatment on obsessive compulsive disorder. However one of the disadvantages of employing a meta-analysis is that aggregating large sets of data from different studies can reduce the clarity of the constructs being defined. For example, Cox et al (1993) were studying effects of treatment on obsessive compulsive disorder symptoms, mood disorder symptoms and anxiety symptoms which some clinicians might argue are constructs of questionable clarity in the first place. Additionally, some authors have also argued that aggregating large data sets is problematic. For example, Millon and Davis (1996) use the term “person-population paradox” which refers to the problem of applying the clinical data obtained from large population studies to the individual. They note that researchers are often faced with large numbers in their studies and that they then argue for the validity of their studies based on the results of these sample based statistics. However, Millon and Davis (1996)
also note that clinicians are generally faced with much smaller numbers. Typically they see individuals, or at most some type of a family system of maybe up to five or six people. This is problematic because in large population studies, the individual differences across the population are filtered out in the statistical process and accounted for as “noise” or “error”. In contrast to this, in the clinical situation, or a research situation using case studies where N=1, these individual differences can be interpreted as understandable, explicable, rational and legitimate individual differences. The question then becomes; can we really reconcile the use of mass collected data based on what is the same about people, with the individual situation which so often demands that we take into consideration what is unique about the individual?

In addition to this, there are also a number of specific difficulties associated with the use of this statistical procedure including issues of data quality, selection bias, and commensurability (Glass, McGaw and Smith, 1981). With regard to data quality, it has been argued by Glass, (1976) that regardless of their quality, as many studies as possible should be included in a meta-analytical review to allow for the possibility that many weak studies might be legitimately amalgamated to form a strong finding. However some critics of this philosophy argue that the inclusion of poor quality studies lowers the quality of the meta-analysis thus giving a poor indication of overall treatment efficacy (Mintz, 1983; Rachman & Wilson, 1980).

With regard to selection bias a number of authors have argued that the inclusion of studies in any one meta-analysis must be performed in a discriminating way with some
studies being included and other studies being excluded (Rachman & Wilson, 1980; Strube and Hartman, 1982). The inevitable conclusion of this approach is that the results of any one meta-analysis will be shaped partly on the basis of what studies the researcher decides to include or exclude. Again, this affects the construct of treatment efficacy because even though there are principles guiding what studies are included, there will always be researcher discretion regarding the final choice of studies to be incorporated into a meta-analysis.

With regard to commensurability, Glass et al (1981) argue that some types of data can be conceptually amalgamated in a meaningful and legitimate way. In essence, Glass et al (1981) suggest that even if you are comparing apples with oranges, they are both at least fruit and as such could be considered part of the same subset. However, some authors (Cook & Leviton, 1980; Mintz, 1983) note that aggregating different studies can lead to an overall degradation of the data and subsequent suspicious findings with regard to treatment efficacy.

In addition to this, Chow (1987) has also argued that many of the different studies included in a meta-analysis have been originally designed to test the various aspects of a particular theoretical problem. Similar to the spokes of a wheel which come from many different angles but which all meet in the middle, Chow argues that different studies of a particular issue such as obsessive compulsive disorder, are designed to test different aspects of a particular theory. Strictly speaking therefore, they are not replicated experiments. In summary Chow (1987, p.268 ) states “By their very nature, properly
designed experiments forming a series of converging operations for corroborating a theory are different experiments. Consequently, they are not commensurable in the way required by meta-analysis”. Hence it can be seen that there are a range of difficulties with using meta-analyses to determine treatment efficacy.

2.4.2.2 Absolute versus relative efficacy

Wampold (2001) notes a general level of acceptance in the current environment that psychotherapy is efficacious however it is important to note there is still some dissent in the literature around this issue (Andrews, 1999; Chambless & Ollendick, 2001; Dawes, 1994). However Wampold (2001) delves deeper into the debate to also raise questions about absolute efficacy versus relative efficacy, and the specific ingredients of psychotherapy which make it effective versus some generalised features which may be responsible.

Wampold (2001) notes that “Absolute efficacy refers to the effects of treatment vis-à-vis no treatment and accordingly is best addressed by a research design where treated participants are contrasted with untreated participants” (p. 59). It can be seen therefore that absolute efficacy is concerned with the overall effect of a particular intervention rather than the specific effects; the “whether it works” rather than the “how it works”.

In contrast to absolute efficacy which is measured by comparing a treatment group with a no treatment group, relative efficacy is ascertained by comparing two different treatment groups against each other (de Maat, Dekker, Schoevers, & de Jonghe, 2007).
For example, a researcher might be interested in whether a behavioural therapy such as exposure and response prevention is more or less efficacious for obsessive compulsive disorder than a pharmacological therapy such as a selective serotonin reuptake inhibitor. In this instance a comparative research design is employed to pit one intervention against the other in an attempt to establish which results in the better outcome for the individual. Sometimes a control group is also included to ensure that the active interventions are superior to no treatment at all. However, strictly speaking, the control group is not required to answer the questions around comparative efficacy of the two treatment groups.

Therefore, it can be seen with regard to the public perception of psychologists that absolute efficacy gives consumers an indication as to whether psychological interventions are efficacious at all (for example, is cognitive behavioural therapy effective as a stand alone treatment). This is in comparison to relative efficacy which gives an indication as to which treatment works best in a particular situation (for example is cognitive behaviour therapy as good as, or even better, than medication). In the current climate where the overall efficacy of psychotherapy is generally accepted in the community, it seems likely that the construct of relative efficacy is particularly important for the profession of psychology which is trying to establish its interventions as valid and efficacious compared to other interventions such as medication based treatments.
2.4.2.3 Specific versus generalised effects

Keeping in mind dissenting viewpoints, (Andrews, 1999; Chambless & Ollendick, 2001; Dawes, 1994), the question of overall psychotherapeutic effectiveness has shown a clear finding for the superiority of treatment over non-treatment (Liechsenring & Rabung, 2008; Seligman, 1995; Wampold, 2001). However, while some authors argue for the efficacy of certain specific treatments (Huppert, Fabbro, & Barlow, 2006), Wampold (2001) concludes there is a lack of evidence for specific effects. This has potentially negative implications for the profession of psychology which may be able to claim that it makes a difference, but remains incapable of outlining exactly how this difference is achieved. Nevertheless, it seems likely that if the specific effects of therapy cannot be identified as being responsible for treatment gains, there may be generalised effects of therapy which are effective. Indeed the case of the therapeutic alliance between clinician and client can be used to illustrate the point because, despite the opinions of various proponents of particular treatments, the literature clearly identifies that the type of psychotherapeutic intervention (cognitive behavioural therapy, or interpersonal therapy, or client centred therapy to name a few) matters less than the therapeutic relationship between the client and clinician. Hence, the therapeutic alliance has been consistently implicated as a generalised effect in the efficacy of psychotherapy (Burns and Nolen-Hoeksema, 1992; Horvath & Symonds, 1991; Martin, Garske & Davis, 2000).

There are a range of research designs which have been used to examine the specific effects of a particular psychotherapy. The first of these is component designs which
compare an entire treatment containing the critical specific ingredient, all the other specific ingredients, and the incidental aspects with another group containing just the other specific ingredients and the incidental aspects (Wampold, 2001). Any effect therefore can be directly attributed to the critical specific ingredient. Wampold (2001) argues that a component design is one of the more rigorous research designs which can be employed to examine the specific effects of an intervention.

A second potential research design is the double blind randomised control trial (RCT) which is designed to encompass all the non-specific features of a treatment without any of the specific features (Lachin, 1988). However, one of the shortcomings of this approach is the difficulty ensuring placebo control groups contain all the universal factors of therapy (Wampold, 2001). The public perception of psychology and psychologists has been largely influenced by RCTs which are generally accepted by the research community as the most pure, impartial, and pragmatic scientific methodology available (Kaptchuk, 2001). However, considering the potential limitations of this approach, it seems possible that the public perception of psychologists has been partly constructed on a somewhat unsteady and artificial platform which further establishes the relevance of the efficacy and effectiveness of psychological interventions to the debate around the public perception of psychologists.

Finally, Wampold (2001) suggests that specificity can be examined by observing the link between individual symptoms (such as hyperactivity) and the effects of medication (such as dexamphetamine). It is argued that if the hyperactive symptoms improve, then
the intervention can be seen as specific to that problem. However, he also notes the paucity of literature supporting this method of measuring specificity.

In summary, there are a number of reasons for highlighting the relevance of the effectiveness and efficacy of psychological interventions to the debate around the public perception of psychology and psychologists. First, it can be seen that a lack of agreement on the effectiveness and efficacy of psychological interventions constitutes a potential threat to the image of the psychology as a discipline which is scientific, grounded in an evidence based approach, and which carries a high degree of expertise and competence. Second, as a result of this and a number of other less direct factors including subsequent representations in the mass media, the implementation of government policy and communication with trusted sources such as GP’s, the profession of psychology could then be perceived by the public as ineffectual and unscientific. Consequently, potential consumers of psychology may be less inclined to engage in the therapeutic treatments offered by the profession. It seems likely that the eclectic nature of psychotherapy constitutes a threat to the image of psychologists as expert, scientific and competent, and consequently that this could undermine the public’s perception of psychotherapy as effective and worthwhile. It appears evident that the profession of psychology is aware of some of these problems and is attempting to manage them by making a case for the efficacy of psychological interventions. An investigation into the subtle methods employed by the profession to manage the image of psychology with regard to the efficacy of psychological interventions will be the focus of Chapter 5A of this thesis.
2.4.3 The difference between psychologists and psychiatrists

Before we can talk meaningfully about a public perception of psychologists, psychologists have to be identified as a distinct group in the public’s mind. Although professional and disciplinary distinctions are clearly visible from within, to members of the public, psychologists, psychiatrists, counsellors, and perhaps to a lesser extent social workers occupy much of the same ground. Therefore a second current issue related to psychology in general, and which is specifically relevant to the creation of the public image of psychologists is the difference between psychologists and psychiatrists. While there have been many international studies on the public image of various health professionals and mental health professionals including doctors, nurses, psychologists, psychiatrists, counsellors and social workers (Fall et al, 2000; Hopson & Cunningham, 1995; Warner & Bradley, 1991), some authors have focused specifically on the perceived similarities of psychologists and psychiatrists and noted some of the problems associated with the seeming interchangeability of psychologists and psychiatrists in the eyes of the public. For example, one of the earliest commentators on the perceived similarity between psychologists and psychiatrists was Guest (1948) who concluded that people didn’t distinguish between the two professions to any significant degree.

Grossack (1954) interviewed a group of African-Americans in the United States and found that the majority of the sample was unable to distinguish between a psychologist and a psychiatrist. Soon after this, Nunnally and Kinross (1958) surveyed the public image of a number of health professionals including doctors, nurses, physicians,
psychiatrists, psychologists and social workers and found evidence to support Grossack’s findings of a limited distinction in the eyes of the public between psychologists and psychiatrists. Thumin and Zebelman (1967) followed this with an investigation into the similarities between psychologists and psychiatrists and they cite Amrine (1965) who stated that with regard to a congressional inquiry into testing at the time “a dissonant note in the hearings was the recurring confusion of psychology and psychiatry…Apparently these remain almost ‘hopelessly’ mixed up in the public mind” (p. 869).

With regard to the Australian context, Sharpley (1986) also commented on the perceived similarity between psychologists and psychiatrists with his review of four types of mental health workers. Sharpley (1986) found that the public categorised psychologists and psychiatrists into one distinct sub-group, and social workers and counsellors into another distinct sub-group. His data revealed that psychologists and psychiatrists were viewed by the public as “fee-demanding professionals who study human behaviour and thought” (p. 57), as distinct from social workers and counsellors who were viewed as “public-utility non-fee-demanding professionals who are more practical and help the average person solve emotional problems” (p. 57).

It can be seen therefore that from at least 1948 onwards, the public perception of psychologists and psychiatrists has been characterised by a number of factors such as resemblance, interchangeability, and similarity. There are a number of reasons why this is problematic for both professions. For example, Wollersheim and Walsh (1993) have
argued that an increasing group of mental health providers competing for a decreasing pot of available money is a compelling reason for the development of clarity and distinction around professional boundaries, job descriptions and services provided. Moreover, Hall (1997) has argued for intergroup distinction and difference as being the initial ingredient required for one group to exert power over the other group. Therefore, it would seem likely that psychologists and psychiatrists would have a vested financial and professional interest in establishing and propagating the perceptions of higher authority and superior competence in their respective philosophies.

2.4.4 Summary

This brief introduction to just two of the current debates relevant to the creation of the public image of psychology highlights some of the complexities and the inherent potential for debate and contestation which resides in these issues. The issue of the effectiveness of psychological interventions is crucial to the public image of psychologists. For example, it could be argued that if psychological interventions are seen to be highly effective this would likely reflect favourably on the public image of psychologists. In addition to this, some of the issues discussed in this section include the difference between efficacy and effectiveness, the construct of absolute efficacy versus relative efficacy, and the difference between the specific and generalised effects of psychotherapeutic interventions. These issues are important because part of the validity of psychology as a scientific profession rests on its ability to argue convincingly for both the effectiveness of its interventions, and a clear understanding of how these interventions work. Therefore an investigation into efficacy and effectiveness, absolute
efficacy versus relative efficacy and the specific and generalised effects of interventions appears warranted as it addresses both these issues. Similarly, the confusion between psychologists and psychiatrists appears to have been a long standing discussion in the literature around the public perception of psychologists. Consequently, it seems likely this is also an issue that the profession of psychology needs to address in putting forward information designed to promote its public perception.

2.5 The role of communications in influencing public perceptions

2.5.1 Overview

Having argued for the benefits of conceptualising the public image of psychologists using a social representations framework, in which attention is drawn to the dynamic, multifaceted and contextual nature of shared public understandings, I now turn to a discussion of some of the contextual issues which are relevant when considering the public image of psychologists. In particular, this section will look at the notions of how and why the APS has a vested interest in influencing the public perception of psychologists. Representations of social objects exist in societies at various levels, but particular groups have a specific interest in providing particular types of representations and will consequently engage in persuasive activities in order to attain their goals. While not intending to provide a comprehensive review of all the literature pertaining to this area, the discipline of marketing contributes something to this debate and this next section will review some of the relevant arguments that are specific to the marketing and branding of psychology.
It is my contention that the image of psychologists and the public perception of psychology are integral factors in the allocation of funding (in the form of a Medicare rebate), the allocation of referrals (from General Practitioners and psychiatrists) and the overall likelihood of public engagement with the expertise and services provided by psychologists. As the peak body for the profession, the APS therefore has a special interest in promoting psychologists as providers of specialised mental health services. It is important to consider some of the mechanisms by which the APS negotiates the complexities of professional advocacy, government guidelines and control, and the ultimate provision of psychological services to clients. When considered from this more holistic perspective, psychology is not purely a clinical enterprise; rather, it takes into consideration issues of communication, marketing and network management. This view is supported in a pivotal paper by Boonekamp (1994) that brings together the constructs of health care and marketing and which notes that:

“In the health-care market, the allocation of scarce resources is not the mere result of the match between supply and demand. Instead, the functioning of the market depends on the behaviour of various parties, the formal and informal rules and the availability of information about the different options to choose from” (p. 11).

There are at least two obvious points being made here. It seems clear from this quote that just because psychologists might offer a service which is potentially useful, there is no guarantee or certainty that this service will be taken up by the public, or sanctioned
by the governmental health authorities of the day. A second point which follows from this is that the necessary manoeuvring and negotiations to ensure the required service finally makes it to the general public, need to be viewed from a socio-political perspective which considers the market as a network of stakeholders which have rules and relationships. Moreover, it is suggested that as part of managing the issues of communication, marketing and the dissemination of information, various stakeholders may choose to present their message in a way that is persuasive to their particular audience. For example, the APS as a stakeholder in the marketing of psychology might choose to deliver their message about the role of psychologists and psychology in a way that persuades government to provide additional funding, and in a way that persuades the general public to use psychological services. This next section will do two things: first it will examine some of the rules and relationships that exist in the network of psychological health care marketing by examining exactly who the stakeholders are; and second it will identify and discuss some of the major factors at play in constructing a message that is persuasive to an audience.

2.5.2 Stakeholders in psychological health care

2.5.2.1 The consumer
One of the primary stakeholders in the business of psychology is the consumer who is usually identified as an individual, a couple or a group requiring psychological services. Without the existence of this group, the profession of psychology would arguably have less societal relevance as much of the focus of applied psychology, as well as the academic pursuits of research and theoretical developments, is directed towards
understanding or providing interventions for individuals, couples or groups. It was identified approximately 25 years ago that organisations are able to create their own environments inside which they interact with consumers and other stakeholders according to an intricate set of rules and inside a set of complex competing forces (Smircich & Stubbart, 1985). The importance of the consumers of psychological services can be illustrated with the distinction between the constructs of selling and marketing. The notion of “selling” a product was most commonly associated with the early to mid 20th Century and paid little attention to the needs of the consumer, focusing solely on the research, development and implementation associated with the product itself. Over time, this gave way to the “marketing” phase towards the end of the 20th Century which focused more on the consumers and used them as a central tenet in the construction of client companies and their products. This transition from selling to marketing was part of a pivotal shift in perspective from the “survival of the fittest” mentality, to a mindset which emphasized the role of the consumer and encouraged the development of networks, interdependence, and business relationships (Boonekamp, 1994). Similarly, the APS have embraced the notion of marketing and emphasized the importance of the consumer by creating an environment in cyberspace with specific links on their website catering to the needs and questions of consumers and potential consumers.

The APS website is one forum which allows for some communication between the seller of the service (in this case represented by the APS), and the consumer. On the one hand, the website provides information specifically directed at the consumer or potential
consumer, while on the other hand it offers opportunities for the general public to find a registered APS psychologist or for the media to make contact with a member of the APS. Hence the website provides a space for mutual communication, with the APS simultaneously giving pre-emptive information to the public as well as responding to enquiries from the public.

2.5.2.2 *The competitors*
A second collective of stakeholders in the public image of psychologists can be referred to as the competitors. For example, there are other potential providers of mental health care services besides psychologists including psychiatrists, counsellors, social workers and various other psychotherapeutic clinicians. A major task of psychology’s marketing effort is to create a distinct image of itself in the public eye. The discipline of marketing makes reference to the construct of distinctive competence which is a term first used by Selznick (1949) and then extended by Andrews (1971). In essence it can be defined as an organisation’s set of capabilities that they perform particularly well compared to their competitors (Snow & Hrebinia, 1980). For example, with regard to an individual seeking assistance with a neck injury, the distinctive competence of a chiropractor who can perform spinal manipulations may be preferred to the services of a physiotherapist who cannot. According to Boonekamp (1994), “attaining distinctive competence compared to competitors is an important means for guaranteeing the independence of organisations” (p. 17).
There is however, a potential downside to achieving distinctive competence with your competitors. For example, psychologists who have established their distinctive competence as compared to psychiatrists may have marked themselves as being able to perform some tasks that psychiatrists don’t perform (such as psychometric testing). However, they also run the risk of being unfavourably compared to psychiatrists and perceived as a lower status competitor who can do some things that psychiatrists can do (such as talking therapies and mental health interventions), but not all things that psychiatrists can do (such as prescribe medications). Hence, while the differentiation between psychologists and psychiatrists may be seen as important to the profession of psychology, it can also be seen to contain inherent risks such as being negatively evaluated in comparison to psychiatrists who are frequently perceived as higher status competitors in light of their medical degree.

2.5.2.3 The government
Boonekamp (1994) also acknowledges the government of the day as another central stakeholder and notes that in a deregulated market environment, the government influences the level of competition and therefore goes on “playing a role in health-care networks by influencing the rules of the game” (p. 18). There are various strategies for influencing government including lobbying; however Boonekamp (1994) also notes the importance of an organisation clearly demonstrating their value and significance to society at large mostly through the establishment of undeniable distinctive competence. If an organisation is seen by the government of the day to have an irrefutable claim to expertise in a particular domain, this will provide a compelling reason for them to pay
attention to the arguments and expectations of this organisation. If the APS can convince the government of the day that they have an incontestable understanding of, and expertise in, the discipline of psychology, it will make the government more likely to consult the APS with regard to issues relevant to the profession.

Boonekamp’s (1994) observation that the government has a role in the provision of health care, and thus mental health care, raises questions surrounding the government’s precise stake in the provision of psychological health care which will now be addressed.

One of the major responsibilities of government is the provision of access to health care, including mental health care, for all citizens. The Council of Australian Governments (COAG) produced a document in 2006 titled National Action Plan on Mental Health 2006 – 2011 which outlined their view of the government’s stake in mental health. This document observes that the effects of mental illness reverberate across the nation and then goes on to outline the prevalence of mental illness in Australia stating that it affects nearly twenty percent of individuals in any one year. This statistic is qualified with the observation that “severe mental illnesses are less prevalent and affect around two and half percent of the population at any one time” (p.1). The yearly cost of mental illness in Australia taking into account the effects on workplace productivity is estimated at $20 billion. The plan then goes on to recommend a “strategic framework that emphasises coordination and collaboration between government, private and non-government providers in order to deliver a more seamless and connected care system, so that people with mental illness are able to participate in the community” (p. i).
The specific outcomes of the plan are aimed at reducing the prevalence of mental illness; reducing the prevalence of risk factors that cause mental illness; encouraging early intervention and the provision of appropriate community services for people who have an emerging or established mental illness; and improving access to accommodation, community participation, employment and education.

The plan then outlines that these outcomes will be achieved by the expansion of funding to private mental health providers such as psychiatrists, psychologists, mental health nurses and allied health professionals. In addition, the plan outlines the provision of employment programs for people with mental illness, and scholarships and extra training opportunities for mental health professionals.

Hence the stated objectives and the recommendations to achieve these objectives, give a clear indication that the government considers itself to have a significant stake in the issues of mental illness and the provision of mental health services. This is important for the profession of psychology which needs to ensure that the government sees psychological services as an important part of the mental health care services that should be available to members of the public. Chapter 5B provides an investigation into a range of submissions made to Government by the APS arguing for the relevance of psychologists and psychological services in achieving some of the objectives of the National Action Plan on Mental Health 2006 – 2011.
2.5.2.4 The APS

The role of the APS as a stakeholder in the public perception of psychology must be acknowledged. The APS provides an environment in cyberspace which allows for mutual communication between their organisation and the general public (see Chapter 5A). Moreover, it lobbies government with submissions designed to emphasise the distinctive competence of psychologists compared to other providers of mental health services including psychiatrists (see Chapter 5B). The APS engages in these activities because it has a stake in the recognition, professional acceptance, and proliferation of the profession throughout the public and private sectors. The APS is invested in portraying the profession of psychology as dynamic, competent, and scientific. Hence it can be seen that the APS is another important stakeholder with regard to issues of mental health care and it can be argued that the APS has a vested interest in influencing the way that the government of the day and the general public perceives the profession of psychology.

The recent focus on psychologists as specific providers of mental health interventions for Medicare scheduled items has, according to the APS, narrowed the perception of psychologists as simply being involved in mental health. In response to this, the APS has recently argued for encouraging diversity within the profession of psychology. For example, Littlefield (2009) has suggested that “there are many opportunities outside mental health to raise the profile of what psychology can offer across diverse fields” (p. 7). This highlights the importance to the APS of balancing the benefits (both with regard to status, and financially) of psychologists being seen as specialised mental health
providers, with the potential difficulties associated with the profession being perceived as limited and engaged only in the specialised practice of mental health.

2.5.2.5 The referring agent
Finally, the role of referring agents, specifically GPs who refer their patients to psychologists for psychological services, must be considered. Due in part to funding structures which have allowed patients to obtain a significant rebate for health care provided by a GP compared to other health service providers, GPs have historically had a substantial role in delivery of mental health care services and are significantly invested in not having their own credibility and authenticity as mental health care providers diminished. In the absence of being able to provide mental health care themselves (due to expertise or time constraints) GPs also have a vested interest in having a reliable, affordable, and accessible profession to whom they can refer their patients who require mental health care. Psychologists have long argued for a larger role in the provision of publicly funded mental health services and this has now been provided following the Medicare changes introduced in November 2006. The history and context surrounding the development of these policies is covered clearly in other documents (Moulding et al., 2007; Perkins et al., 2007, van Gool, 2007). Therefore, it seems clear that GPs are now an important stakeholder for psychologists who are likely to receive a greater number of referrals in light of the recent Medicare changes.

2.5.3 Constructing a persuasive message
As the peak organisation representing psychologists in Australia, the APS has a clear role in promoting the public profile of psychologists and the profession of psychology.
In attempting to present a particular view of psychology, the APS needs to form its messages in a way that takes into account the multiple audiences and their different levels of interest and investment in mental health issues.

It is my contention that public image is less a fixed and static snapshot taken by a camera, and more a fluid, dynamic construct which is continually constructed, developed and modified. In other words, the creation of the public image of psychologists is a process not an event. Hence it will also be argued that the public perception of psychologists is influenced by the information provided by the APS and that the messages put out by the APS are themselves flexible and responsive to audience, context, and emerging social concerns. The nature of the information that the APS conveys about psychology, and the way it is presented, is the subject of two empirical studies which form Chapters 5A and 5B. The extant literature surrounding the issue of persuasion in public perception is expansive and will be briefly summarized.

2.5.3.1 The role of cognitions in constructing a persuasive message

Part of the objective of this thesis is to illuminate some of the ways in which the public perception of psychologists is created by particular parties through the use of an active and intentional agenda. There are various factors which influence the construction of a persuasive message and the first of these is the role of cognitions.

One important theoretical model which attempts to explain the role of cognitions in persuasion is the cognitive response model (Wright, 1980) which suggests that
individuals are persuaded (or not) depending on the outcome of their reflection and elaboration of a message. Moreover, it is suggested that new information presented in a message is judged for its compatibility with pre-existing knowledge before it is adjudged as either favourable or unfavourable. There is some literature which supports this notion (Keller, 1987; Keller and Aaker, 1992) however it has also been noted that persuasion may still occur in the absence of the required cognitive processes. For example, Petty and Cacioppo (1981) note that we can learn a message but not be persuaded by it, but we can also be persuaded by a message even when we have not learnt or paid attention to the content. As a result of this anomaly other researchers have suggested a second model of persuasion, known as the dual process model, which argues for the existence of two routes to persuasion (Chaiken, 1980; Eagly & Chaiken, 1993; Petty & Cacioppo, 1981). First is the schematic or algorithmic route to persuasion which is a low effort approach using instinctive responses to easily processed cues such as the level of expertise or attractiveness of the source. In contrast to this, the systematic route to persuasion is a higher effort approach and is thought to result in more long lasting decisions following strict, systematic and more thorough analysis of the data. The choice between these two possibilities depends on issues such as the salience of the message, the degree of previous information, investment in the accuracy of the judgement, and the amount of time available to process the data. A third model of persuasion referred to as resource matching theory (Anand & Sternthal, 1989) argues that the degree of persuasion achieved is dependent on the balance between the cognitive resources demanded by the message and the cognitive resources available to
the recipient. Somewhat predictably, the degree of persuasion is hypothesized to be higher if a reasonable balance exists between these two factors.

Recent literature explicitly supports the notion of public perception as the contingent, ever revisable product of an open ended, dynamic process. For example, some authors have examined the possibility that judgments may be refined or adjusted in the light of new information after the initial formation has been made (Alba, Marmorstein & Chattopadhyay, 1992; Schmitt & Zang, 1998). This is relevant for the APS as it suggests that despite initial opinions, the public perception of psychologists can change direction either from negative to positive, or from positive to negative. The issue of context is important in this model with data showing a familiar context leads to increased accessibility of the data and a subsequent increased likelihood of persuasion.

The literature is still unclear with regard to a definitive theoretical understanding of the cognitive processes involved in persuasion; however it is posited that any meaningful theory must take into account an episode of judgment formation and an episode of judgment correction. This is important for the APS to take into consideration with regard to their stake in the creation of the public image of psychologists, and suggests that any attempts to shift or extend public perception of psychologists needs to pay careful attention to the nature of existing perceptions.

As people interpret new information on the basis of their pre-existing or old information, if a consumer were to read the APS website and be engaged in the
schematic or algorithmic route to persuasion, it is contended that the ultimate impression formed is somewhat cumulative and that their previous knowledge of psychologists would contribute to the final judgment. Hence, opening statements and initial knowledge of psychologists is crucial with regard to impression formation. Even though the APS provides more thorough and detailed information about psychology than any other source in the Australian context, it is not the only source of information about psychologists. Moreover, the information received by members of the public from the APS is unlikely to be their first encounter with psychology and psychologists. On the contrary, information about the profession of psychology is available to the public from a range of cultural sites including film and television characters, magazine and newspaper articles, and via everyday interactions with other people. Hence, the APS is highly unlikely to be influencing people's first impression of psychologists and thus needs to take into account the probability that people have existing ideas about psychologists, in order to extend, modify or contradict these impressions to produce the public image it desires. This is highly supportive of the notion of public image as a social representation, multiply determined and subject to a process of continual information gathering, assessment, reflection and ongoing modification, rather than a static snapshot taken at a particular period in time.

The APS must also consider the importance of judgment correction. For example, Martin, Seta and Crelia (1990) note that the consumer must have adequate cognitive resources to engage in authentic judgment correction and that if these cognitive resources are not present, it is likely that the consumer will maintain their initial
judgment. So it seems that existing impressions are important and can influence the likelihood of a change of mind or an upgrade of a judgment. This provides further support for the notion of public image as an open ended process which is subject to amendment and alteration.

2.5.3.2 The role of mode of communication in constructing a persuasive message

A second factor which influences the construction of a persuasive message is the mode of communication. Communications to influence public perception come in various forms including, but not limited to, television, radio, print media (newspapers, magazines, books) and the various forms of information available via the internet. Similarly, the information provided by the APS to its various audiences comes in the form of pamphlets, brochures, books, newsletters, journals, tip sheets, position papers and statements, radio interviews, conferences and its website. The internet is a particularly interesting site of information exchange, as the consumer initiated nature of its use means that the vast majority of people accessing the APS website will do so when they are explicitly seeking information about psychology. A potential consequence of this is that individuals actively seeking information through the APS website will most likely have formed an initial judgment about psychologists which may ultimately influence the ongoing course of their perceptions. With regard to the APS website, it is timely to examine how the use of the internet as a form of message presentation affects the ways in which the APS goes about the task of presenting its message about psychologists and the services they provide.
The internet, and subsequently corporate websites, are relatively new phenomena, and as such research on this topic is developing. However, Topalian (2003) has observed that corporate websites have become an increasingly important means for disseminating corporate information and allowing customers to communicate with the organisation. In addition there are a number of authors who have broached the topic of corporate websites and made some pertinent observations. For example, Sharp (2001) has commented on the range of audiences attracted by the internet including customers and potential customers, employers and employees, students and academics, and the public in general. Some advantages of the internet over the traditional media include increased control over, and more thorough processing of the information presented (Esrock & Leichty, 1998; Gallagher et al, 2001), and the benefits of the interactive nature of the internet allowing a discourse between the company and those who use the website have been noted by Hurme (2001). Finally, Pollach (2003; 2005) has addressed issues of corporate self presentation and corporate ethics in the realm of the World Wide Web (WWW).

2.5.3.3 The role of presentation in constructing a persuasive message

The APS have a stake in creating and influencing the public image of psychologists and they distribute much of their information about psychologists through public statements on their website and in their various other journals, bulletins and newsletters. These publications necessarily have a particular style or interface with which the reader must engage to absorb the message.
Pollach (2005) cites Halliday (1978) who noted the categorization of language into three functions including the textual function, the ideational function and the interpersonal function. Pollach (2005) notes that while this system of classification was originally devised for “linear, written texts or oral communications, they equally apply to WWW-mediated communication” (p. 290). The three functions of text can be seen to be fundamental to an organisation’s ability to construct a positive image of itself, hence these text functions will be described and discussed with regard to the APS website.

Pollach (2005) suggests that the textual, ideational and interpersonal functions of language as text are inextricably intertwined. With the textual function of web based language being about building, arranging and organizing the style or interface of the actual message to be delivered. For example, the APS website uses a particular logo, set of colours, and style of fonts throughout its various publications presumably designed to instil in the reader a sense of familiarity and dependability. The use of a logo and a predictable interface is common business practice (Klein, 2000) with some authors suggesting that “in today’s sensitive business milieu, a firm’s ultimate survival may well depend on developing and maintaining a recognizable image” (Gray & Balmer, 1998, p. 695). In contrast to the textual function of web based language which focuses on the style of the message, the ideational function of web based language is about establishing the content of the message by highlighting the processes, events and details of the message. In essence, the ideational function of web based language is focused on what the message says; what it is attempting to get across. Finally, Pollach (2005) suggests that the interpersonal function of web based language is designed to build relationships
and disseminate the corporate attitude and outlook. The interpersonal function of web based language is also about providing a space for interaction and dialogue between the producer and the consumer of a particular product which further cements the relationship, and if it is managed well, increases the level of trust between both parties (Stillar, 1998).

2.5.4 Summary

This final section of Chapter 2 has examined the role of communication and some of the socio-economic issues which are relevant when considering the creation of the public image of psychologists. This is important because it appears evident that the public image of psychologists and psychology is associated with the degree of funding received, the number of referrals received, and the likelihood that the public will engage with the service.

The different types of stakeholders which are engaged in these socio-economic relationships were identified: first were the consumers; second the competitors; third the APS; fourth the government of the day; and finally the primary referring agents in the form of GPs. It appears evident that the APS have, recognised the importance of the consumer and through the use of their website, established a dialogue with the Australian public on the nature of the profession. Moreover, the construct of distinctive competence was introduced which is an important concept to keep in mind when discussing some of the issues related to the similarities and differences between psychologists and psychiatrists. The government’s precise stake in the provision of
psychological health care, and the relationship between the APS and government, was also outlined with particular attention being paid to the role of APS submissions to government on mental health care policy (discussed in detail in Chapter 5B), and the importance of government taking psychology seriously as potential providers of the bulk of mental health care services. To a certain extent, these two bodies have a dependent relationship with the government requiring the presence of a reliable and accessible mental health workforce, and psychologists requiring validation about their expert status from a legitimate body to ensure they are seen as reliable in the eyes of the public. The role of the GP as an important stakeholder was also outlined with GPs having a vested interest in either providing quality mental health care, or having a reliable source to which they can refer their patients who require mental health care.

Finally, it was argued that the APS sees part of its role as promoting the profile of psychologists by presenting psychologists and psychology in a particular way. The literature around constructing a persuasive message was also briefly outlined with the roles of cognition, the mode of communication and the type of presentation of the message all being implicated. The importance of taking into account existing impressions when attempting to shift or extend public perceptions was outlined. Moreover, the dynamic and fluid nature of judgment formation was noted, as was the importance of the information provided by the APS to the public, which could then potentially be used as a platform for the construction of future perceptions about psychology and psychologists.
CHAPTER 3: METHODOLOGY AND OVERVIEW OF EMPIRICAL STUDIES

3.1 Overview

As outlined in Chapter 1, the profession of psychology has invested a good deal of time and energy trying to define and measure the public perception of psychologists and psychology. In extending research on this issue, this thesis asks a series of questions and makes a series of choices in answering these questions. The first empirical study which makes up Chapter 4 of this thesis examines the public perception of psychologists providing some data on the similarities between psychologists and psychiatrists, and arguing for the use of qualitative methods when investigating this phenomenon. The second empirical study which makes up Chapter 5A of this thesis is aimed at illuminating some of the ways in which the APS are invested in actively managing a particular image of psychologists. Chapter 5B presents a comparative analysis of statements made by the APS about psychology to a different audience; the Australian Federal Government. Submissions made to the Federal Government by the APS arguing for greater public funding of psychological services to treat mental health problems are analysed. Taken together, Chapters 5A and 5B allow a comparison of the informational focus and style of presentation used by the APS when promoting the value of psychology to different audiences. The final empirical study, which makes up Chapter 6 of this thesis, examines the relationship between GPs and psychologists in light of the recent changes to the Medicare system in Australia which have placed some psychology services on the Medicare rebate. The present chapter will outline some of the
methodological decisions made throughout the writing of this thesis which have contributed to the overall shape and direction of the empirical work presented.

3.2 Introduction

In analysing issues around the public perception of psychologists, it seems pertinent to begin with identifying the particular methodologies which are, and are not, able to manage some of the inherent ambiguities and contestations which exist in the area of public perception. The use of social representations theory as a way of conceptualising the multiple sources of information and the dynamic and flexible way in which they combine to form socially shared perceptions of social objects, in this case psychologists, lends itself to a method which is able to capture the flexible, contextual and sometimes contradictory impressions that form an overall perception of psychologists. The value of a qualitative approach which allows for the gathering of detailed and individual data has been argued for in Chapter 2. The first questions posed by this thesis are based on matters relating to the measurement of the public perception of psychologists, and some of the issues that arise from what people have to say about psychologists. Specifically the questions asked in Chapter 4 are: What are some previous methods that have been used to measure or gauge the public perception of psychologists; are those methods valid; and what did the respondents actually say about psychologists? It seems relevant to commence the investigation of this question with a review of the methods previously employed to ascertain the public perception of psychologists. This literature review yielded two main psychometric approaches which will be discussed in detail in Chapter 4 (Warner and Bradley, 1991; Webb and Speer, 1986; Wollersheim & Walsh, 1993).
The rationale behind the questions which are posed in Chapter 4 is that a purely quantitative approach may not necessarily capture from respondents a complete sense of their beliefs and feelings about psychologists. In essence the main psychometric approach previously used to measure the public perception of psychologists has employed factor analysis to create a cluster of adjectives from spontaneously written descriptive paragraphs (Webb & Speer, 1986). However, this approach has the potential to misinterpret some of the data which started out as individualised and specific descriptive sentences, but which ended up as clusters of adjectives. Chapter 4 thus takes a qualitative approach to examine participants’ beliefs and feelings about psychologists and the services provided by them.

A second question which is crucial to understanding current public perceptions of psychology concerns the ways in which the profession itself might try to create or influence its public perception. Chapter 5 is an investigation into the ways that the major representative body for psychologists in Australia, the APS, presents information and focuses on differences between audiences. Specifically, the questions asked in Chapters 5A and 5B are: How does the APS actively manage the public image of psychology and under what circumstances might it do this?

As the major professional association for psychologists in Australia, the APS are explicitly and implicitly involved in the creation of the public image of psychology and psychologists. They engage in a range of interactions with various stakeholders using
strategies such as the production of a website, television advertisements, radio interviews, submissions to government, and public statements. It is suggested that these interactions are active and instrumental, being aimed at promulgating a particular view of psychologists to a range of different audiences. For example, the APS website contains detailed and diverse information about the profession of psychology and the role of psychologists, and as such constitutes valuable data around the image of psychology that the APS would like to disseminate to the general public. Hence in Chapter 5A, the APS website was chosen as a data source for the analysis of relevant themes including the effectiveness of psychological interventions and the impact of this on the public perception of psychologists, and the public’s understanding of the difference between psychologists and psychiatrists.

In contrast to the APS website which provides information to the general public, the APS also write submissions to government. Chapter 5B highlights the role of the audience in influencing the style and content of the APS message by presenting and analysing a range of submissions to government which argue for the introduction of psychological services to Medicare. As the ways in which arguments were formulated and the context in which information was presented were important to the analysis (rather than simply classifying the content), both of these data sets were examined using thematic analysis.

As discussed in Chapter 1, the ultimate importance of public perceptions of psychology is in terms of their role in influencing the uptake of psychological services by those who
can benefit from them. Although the perceptions of psychology held by potential consumers of psychological services are of clear importance, many people who access psychological services are referred by a third party. In many cases, this third party is the person’s GP and thus understandably, the perception of psychology held by GPs is of particular interest. The question of GPs’ perception of psychology has become even more important in recent years since changes to the funding of mental health care in Australia have resulted in patients receiving a government rebate for some services provided by psychologists if they are accompanied by a GP mental health care plan.

In recognition of the gaps in mental health care between government and non-government agencies, while also acknowledging that the specialised services of psychologists are under-utilised, the Australian Government has recently developed policies to better integrate mental health care services and facilitate referrals to psychologists under the new Medicare scheme. Specifically, the Australian Government has recognised that the majority of people utilise GPs as their primary practitioner for help with mental health issues and has introduced psychological services onto Medicare in 2006. These changes require GPs to write mental health care plans and place GPs firmly at the centre of mental health care, outlining their importance with regard to referrals to psychologists, and making their perceptions of psychologists even more important. This has prompted the third question asked in this thesis which is: how do GPs view psychologists particularly in light of the recent Medicare changes which have been introduced in Australia in November 2006?
Hence the decision was made to gather data from GPs regarding their perception of psychologists. A semi-structured interview process was chosen to allow individual GPs to respond to a series of questions which facilitated the overall emergence of themes in the data. These themes were then identified using a thematic analysis (Braun & Clarke, 2006) which will be discussed in the following section.

### 3.3 Background to thematic analysis

Chapter 4 argues for the use of a qualitative approach as an adjunctive methodology for ascertaining the public perception of psychologists based on the limitations of the nomothetic, aggregational approach. It has been argued that a purely quantitative approach to measuring complex constructs such as public perception may result in a simplistic and one dimensional interpretation of the data. As noted in Chapter 2, social representations consist of an assortment of ideas, images and shared understandings and as such can be somewhat resistant to analysis using only traditional quantitative methods. According to Braun and Clarke (2006, p. 77), thematic analysis “offers an accessible and theoretically flexible approach to analysing qualitative data”. I argue that the use of thematic analysis to analyse the data pertaining to the social representations of psychologists is a useful and valid approach. A brief outline of some of the major characteristics of thematic analysis as they pertain to the empirical studies presented in this thesis will now be described and discussed.

Braun and Clarke (2006) argue that thematic analysis is often poorly demarcated from other qualitative methods. They outline the fundamental characteristics, advantages and
disadvantages of thematic analysis, describing it as “a foundational method for qualitative analysis” (p. 78). To set the scene and provide some useful definitions, Braun and Clarke (1986) note that the term data corpus (or data body) refers to the sum total of all the data collected. This is in comparison to the data set which refers to that section of the data body which is selected for use in a particular analysis. Breaking it down even further, these authors note that a data item is a singular unit of data such as an interview with one of the participants, and a data extract is a particular section of the interview which has been individually coded from a data item and which may or may not be included in the final analysis. For example, in Chapter 6, the data body consisted of all the talk (including introductions, explanations about the project etc) that took place between the interviewer and the interviewees; the data set consisted of the specific talk on the topic of GPs and psychologists between interviewer and interviewees which was transcribed; the data items consisted of each of the interviews that took place with each of the interviewees and finally the data extracts are the actual extracts that were included in the final analysis.

Braun and Clarke (2006) note that the process of thematic analysis allows for the identification and organisation of data in order to facilitate a thorough analysis. They also note that researchers often report on themes which “emerged” in the data. However, this language is passive and does not acknowledge the active role played by the researcher who approaches the data with a predetermined set of thoughts, beliefs and notions which ultimately shape the analysis and interpretation. As Braun and Clarke state “any theoretical framework carries with it a number of assumptions about the
nature of the data, what they represent in terms of ‘the world’, ‘reality’, and so forth. A good thematic analysis will make this transparent” (p. 81). Therefore the aim of this section is to discuss the fundamental elements of thematic analysis in relation to the data collection and analysis for the empirical chapters of this thesis. As with any empirical project, there have been a number of implicit and explicit decisions which have been made throughout the conduct of the studies and the construction of this thesis and this chapter will seek to expound on these decisions giving the reader an understanding of some of the assumptions which have ultimately shaped the interpretation and analysis of the data. Each empirical chapter will be addressed in turn.

3.4 Empirical phase one: The public’s perception of psychologists.

Chapter 4 effectively asks two questions. The first question is about the methods psychology has used in the past to measure or gauge the public perception of psychologists, and the second question is about the perceptions that some individuals have about psychologists. These are useful questions to ask when conducting an overall investigation into the public perception of psychologists because they provide some background to the debate and give a context to the methods which have previously been employed.

In order to answer the first question a literature search was conducted and the primary method identified in the literature was found to be that developed by Webb and Speer (1986) who employed a complex four phase statistical approach which will be described in detail in Chapter 4. While this approach allowed Webb and Speer (1986) to distil the
spontaneously generated responses of participants into adjective clusters and subsequently analyse the responses, the use of factor analysis to devise a uniform set of measures did not allow the participants to contribute their original, complete and intact responses regarding their perception of psychologists. Similarly, while later work on the public perception of psychologists (Warner & Bradley, 1991; Wollersheim & Walsh, 1993) allowed researchers to utilise aspects of Webb and Speer’s (1986) approach, their condensing of the full process employed by Webb and Speer (1986) into a significantly abridged version did not allow for participants to contribute spontaneously generated descriptors in the first instance, thus imposing some limitations on the overall validity of the investigation.

Braun and Clarke (2006) make the distinction between an inductive thematic analysis and a theoretical thematic analysis. They note that an inductive thematic analysis is a bottom up, data focused approach which does not try and identify pre-constructed themes and fit them into a pre-arranged format to answer specific questions. In contrast to this is the theoretical thematic analysis which focuses specifically on points in the data which relate to a specific question. The methodology used in this thesis employs elements of both these approaches.

**3.5 Empirical phase two: The active management of psychology’s public image.**

Chapter 5 investigates some of the ways in which the peak body for the profession of psychology has shaped and contributed to the public perception of psychologists. In doing this the initial question “how does the APS actively manage the public image of
psychology?” is posed. The APS is the self-identified major professional association for psychologists in Australia and as such is considered to be an appropriate source of data when taking into account questions around the public image of psychology.

In Chapter 5A, relevant extracts from the APS website are presented as evidence that the major professional association for psychology in Australia is actively engaged in managing the public image of psychology. To highlight the multifaceted nature of investigating public perception and the role of the audience in shaping the message, Chapter 5B presents and analyses a series of government submissions designed to support the introduction of psychological services to Medicare. Both of these data sets are analysed using thematic analysis as espoused by Braun and Clarke (2006) who note the ability of thematic analysis to identify themes across a whole data set such as a website. This means that it is an appropriate methodology to employ when looking at public data sets such as the APS website or submissions to government. Braun and Clarke (2006) also note that the presence or absence of a theme is partly based on the judgement of the researcher and can depend on factors such as prevalence and relevance to the research question. This is important because it explicitly states that the parameters of the thematic analysis are partly constructed by, and subject to, the biases of the individual researcher. For example, one of the assumptions in Chapter 5A is that the APS set out to portray psychology and psychologists in a favourable light. This would seem to be a reasonable assumption given the role of the APS in representing psychology in Australia. However, one of the implications of this assumption is that the APS may also choose to portray non-psychologists (for example psychiatrists) in a less
favourable light. Hence one of the questions guiding the analysis concerned the extent of positive self presentation and negative other presentation with regard to psychologists and psychiatrists respectively. Of course, these assumptions are tested against the data, and are only confirmed to the extent that there is evidence in support of them in the data. The resultant analysis is thus a co-production of the expectations and concerns brought to the analysis by the researcher, and the “raw” content of the data set.

3.6 Empirical phase three: GP perceptions of psychologists

General practitioners have historically been at the centre of primary health care delivery in Australia, including delivery of mental health care services. However, recent changes to the funding of these services by the Australian federal government have led to the creation of a number of mental health care items provided by psychologists which are now available on the Medicare Benefits Schedule. In furthering research on the public perception of psychologists, Chapter 6 asks the question: What do referring agents think of psychologists, particularly in light of the recent Medicare changes which have been introduced in Australia in November 2006?

Referring agents are just one group of stakeholders out of the many identified in Chapter 2, and GPs are just one type of referring agent with referrals also being made by other health professionals and the clients themselves. However, the relevance of GPs as providers of mental health care has been thrown sharply into focus with the recent changes to the Medicare system. These changes mean that GP perceptions of psychologists may carry more significance and have a greater impact on the marketing
of psychology and psychological services. Moreover, it has previously been noted (in Chapter 2) that the image of psychology, and GPs perceptions of psychologists are integral factors in the allocation of referrals from GPs.

Another characteristic of thematic analysis as outlined by Braun and Clarke (2006) is the distinction between the identification of themes using either a semantic or a latent approach. The use of a semantic approach to identify themes in the data is portrayed as a descriptive approach which addresses the surface characteristics of a particular theme. In any given data extract, a semantic approach might describe and give some basic insight into what is said or written. In contrast to this is the latent approach to identifying themes, which adds a deeper level to the analysis and attempts to give some insight into why something has been said or written. Chapter 6 employs elements of both the semantic and the latent approach to identifying themes which allows for a substantial examination of the data. Elements of the semantic approach have been used to describe what GPs have said about psychologists in light of the recent Medicare changes. Following this, the thematic analysis in Chapter 6 operates at a latent level allowing for a deeper analysis of the data in terms of how it orients to existing issues in the public perception of psychology, thus providing some insight into why GPs have offered a particular view of psychologists.

3.7 Summary

This chapter has provided information regarding the development of the empirical studies presented in this thesis. The investigation and issues related to the public perception of psychologists can be approached in many ways and presents a diverse
range of options with regard to methodology and analysis. In essence, a range of separate questions were generated which provided some parameters around the analysis of the public perception of psychologists. The questions generated reflect the social representations perspective that shared public perceptions of social objects are multi-faceted and can be investigated across a range of sites. The sites include: the opinions of individuals (Chapter 4); publicly accessible websites (Chapter 5A); submissions to government (Chapter 5B); and special interest groups (Chapter 6). It is to the empirical studies that this thesis now turns.
CHAPTER 4: THE PUBLIC PERCEPTION OF CLINICAL PSYCHOLOGISTS: A DISCURSIVE ANALYSIS

The following Chapter 4 has been published in its entirety and in its current form in the Australian Psychologist, 2007, 42, 2-14. A PDF copy of this article is available on request.

Title
Public perception of clinical psychologists: A discursive analysis

Author
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Abstract

The public image of psychology has recently been a topic of debate amongst psychologists particularly with regard to training in clinical psychology (Dyck & O’Donovan, 2003; Helmes & Wilmoth, 2004). Inherent in this debate is the question of the status of psychology in Australia in comparison to other mental health professionals. Outside Australia several attempts have been made to measure the public perception of clinical psychologists; however, there is a paucity of contemporary Australian literature dedicated to investigating this phenomenon. In this study a discursive approach was employed to critique a technique previously used to measure the public perception of clinical psychologists. The findings were twofold: first, that the nomothetic, aggregational approach is flawed when deconstructed with discursive analytic methodology; and second, that the public’s perception of clinical psychologists is formed using information about other mental health professionals (namely psychiatrists) which is at best invalid, and at worst detrimental to the profession of clinical psychology. A number of recommendations are made to assist the profession of psychology in demarcating itself from other mental health professions.
Introduction

The professional practice of psychology has experienced significant growth in recent times and is quickly becoming ubiquitous. Recent debate amongst psychologists about the state of training in professional psychology has alluded to the importance of the public perception of clinical psychologists, particularly with regard to the status of psychologists in comparison with other mental health professionals (Dyck & O’Donovan, 2003; Helmes & Wilmoth, 2004; Hopson & Cunningham, 1995; Pryor & Knowles, 2001). However, despite the proliferation of professional psychology throughout the public domain, clinical psychologists run the risk of being confused with other mental health professionals including psychiatrists, social workers and counsellors (Fall et al., 2000; Von Sydow & Reimer, 1998). The extant literature cites a number of reasons for the importance of clarifying the different roles of mental health professionals which can be broadly arranged into two categories.

The first category addresses general issues around the ethical responsibility of each profession to accurately inform the public as to the nature of their role. (Von Sydow & Reimer, 1998). The second category revolves around the professional, marketing, and financial issues for the mental health professions and refers to the shrinking funds for mental health services, the struggle for ownership of prescribing rights and rights to specific forms of therapy, and the general blurring of boundaries between professions (Fall et al., 2000; Wollersheim & Walsh). As Wollersheim and Walsh (2000) succinctly point out: “To reach consumers effectively, it is essential to understand their existing attitudes toward the commodity being marketed” (emphasis mine; p. 171).
With specific regard to the profession of psychology, issues of professional identity have recently been catapulted into the spotlight following the Consensus Conference on Combined and Integrated Doctoral Training in Psychology held at James Madison University in Harrisonburg (U.S.A.). The objectives and outcomes of this conference were manifold but can be summarised as an attempt to streamline the professional training of psychologists. The rationale for this is outlined by Shealy, Cobb, Crowley, Nelson and Peterson (2004) who suggest that health care providers in psychology currently fall into three main areas summarised as the clinical, counselling and school specialties. However, they note the poor correlation between any one individual psychologists' ‘specialist’ training, and the place of employment and tasks ultimately performed by that psychologist. Moreover, they observe that the academic community, policy makers and the public are currently unable to reliably perceive substantive differences between these three specialties of professional psychology: “in fact, all three of these areas rightly note that their practitioners work with most of the same clinical populations, presenting problems, and procedures” (2004, p. 899). This clearly highlights the inadequate professional identity of psychologists as noted by the profession itself. As Fall et al (2000) note: “If the professions themselves are uncertain about identity issues, think of the confusion the public must face when trying to choose among the various disciplines” (p. 123).
Measurement of the public perception of clinical psychologists

There are two major approaches which have been used by psychology to measure public opinion. First is the work of Webb and Speer (1986) who attempted to improve the original questionnaire methodology employed by Guest (1948). To this end they used the prototype strategy which was constructed in four phases and can be summarised as follows. The first step was generation of the adjectives using descriptive paragraphs deemed to be typical of psychologists, psychiatrists, physicians, counsellors, teachers and scientists from 98 undergraduates which were grouped according to frequency of appearance resulting in a list of 40 descriptive features.

In the second step, 20 students sorted the list of 40 descriptive features into groups according to similarity of meaning. The groups underwent cluster analysis which ultimately resulted in 11 final adjective clusters which are listed in Table 1 with the summary constructs used by Webb and Speer (1986).
Table 1

Adjective Clusters and Summary Constructs From Webb and Speer (1986)

<table>
<thead>
<tr>
<th>Adjective cluster</th>
<th>Summary construct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cold, uninterested, introverted, odd</td>
<td>Alienated</td>
</tr>
<tr>
<td>Bossy, hostile, greedy, egotistical</td>
<td>Arrogant</td>
</tr>
<tr>
<td>Dedicated, persistent, well trained</td>
<td>Dedicated</td>
</tr>
<tr>
<td>Helpful, caring, friendly, a good listener</td>
<td>Helpful</td>
</tr>
<tr>
<td>Curious, probing, a researcher</td>
<td>Inquisitive</td>
</tr>
<tr>
<td>Patient, calm, self-controlled</td>
<td>Patient</td>
</tr>
<tr>
<td>Deals with mental problems, studies behaviour, Studies the mind</td>
<td>Psychological</td>
</tr>
<tr>
<td>Rich, nicely dressed, professional looking</td>
<td>Rich</td>
</tr>
<tr>
<td>Enjoys learning, intelligent, studious, knowledgeable, school-related, wise</td>
<td>Scholarly</td>
</tr>
<tr>
<td>Necessary, underpaid</td>
<td>Unappreciated</td>
</tr>
<tr>
<td>Understanding, understands people, well adjusted, gives advice</td>
<td>Understanding</td>
</tr>
</tbody>
</table>

The third phase involved another sample of subjects consisting of 128 undergraduates rating each of the six professions on how typically they were described by each of the 11 adjective clusters. Finally, a fourth group of undergraduates (N=50)
made favourability ratings on each of the 11 adjective clusters and their accompanying summary constructs.

The development of a secondary tool

Despite Webb’s (1989) recommendation to use the prototype strategy as a whole, other studies have judged the four-phase approach to be too complex and time consuming. The result has been a “secondary” tool which relies on the validity of phases one and two of Webb and Speer (1986) and simply replicates phase three of their study (Warner & Bradley, 1991; Wollersheim & Walsh, 1993). This approach constitutes the second method used by psychology to measure the public perception of clinical psychologists. In essence, the approach used by Warner and Bradley (1991) and Wollersheim and Walsh (1993) assumes that the words used to describe clinical psychologists and the clusters that they fall into will replicate the findings of Webb and Speer (1986). The secondary tool then replicates phase three of Webb and Speer (1986) by asking subjects to rate the goodness of fit of clinical psychologists to each of these word clusters. While Wollersheim and Walsh (1993) asked subjects to rank the clusters according to “desirability” in an attempt to address the issue of favourability, Warner and Bradley (1991) did not. Instead, favourability was assumed to be a function of the perceived valence of the adjective cluster.

Criticisms of the secondary tool

It can be seen therefore that Webb and Speer’s (1986) original intention of casting a broader net and obtaining a spontaneous list of features to describe mental...
health professionals has ostensibly been reduced to just another questionnaire which asks the subject “on a scale of 1 to 10, how well do you think the word ‘arrogant’ or the word ‘dedicated’ describes a psychologist?”.

In addition, a second criticism of the secondary tool is the assumption of favourability based on the perceived valence of the adjective cluster. While it seems that most people might rate the clusters summarised by the constructs helpful and alienated as positive and negatively respectively, we will see that this is not always the case.

*Rationale for the study*

It can be seen that whilst being different constructs, the profession's own perception of its identity, and the public perception of the profession's identity are subtly but inextricably intertwined. In conjunction with the ethical, clinical, financial and professional (marketing) factors previously outlined, it is suggested that gaining a clear and valid understanding of the public perception of clinical psychologists is a necessary and worthwhile undertaking for the profession itself.

Therefore, the first objective of this study is to challenge the validity of the adjective clusters and the summary constructs as generated by Webb and Speer (1986). It is hypothesised that a number of participants will interpret some of the seemingly negative clusters as positive, and some of the seemingly positive clusters as negative. The second hypothesis is that a number of participants will have a different interpretation for words inside a cluster which are designed to be representative of a single construct. The final hypothesis is that the imprecise public perception of clinical psychologists is actively detrimental to the profession because people form an opinion
about clinical psychologists based on other mental health professionals. Consequently, it is proposed that a number of individuals will be interviewed to obtain their views on clinical psychologists. These individuals will also have completed the secondary tool used by Warner and Bradley (1991) and Wollersheim and Walsh (1993). This will result in two distinct ‘measures’ of the public perception of clinical psychologists which can be analysed using a discursive approach (Potter & Wetherell, 1987).

**Method**

The secondary tool employed by Warner and Bradley (1991) and Wollersheim and Walsh (1993) was replicated and administered to 124 undergraduate students from Murdoch University in Western Australia. The exact format of the questionnaire can be seen in Appendix A (note the use of the whole clusters as illustrated in Table 1 rather than the summary constructs). The questionnaire listed the 11 adjective clusters as used by Warner and Bradley (1991) and Wollersheim and Walsh (1993) and asked participants “on a scale of 1-10 where 1 = not at all, and 10 = completely, totally, absolutely, how well do you think each of these 11 adjective clusters describes a clinical psychologist?”. This resulted in each adjective cluster obtaining a score between one and ten with regard to goodness of fit for clinical psychologists. In addition, participants were requested to “please indicate whether you consider each of these 11 clusters to be representative of negative, positive or neutral characteristics”.

Of the 124 questionnaires administered, 100 questionnaires were suitable for analysis and the initial results can be seen below in Table 2.
Table 2
Mean score for each adjective cluster and the frequency of being ranked as either a negative, positive or neutral characteristic.

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Mean Score out of 10</th>
<th>% Negative</th>
<th>% Positive</th>
<th>% Neutral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alienated</td>
<td>3.05</td>
<td>89</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Arrogant</td>
<td>2.41</td>
<td>88</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Dedicated</td>
<td>7.53</td>
<td>3</td>
<td>96</td>
<td>1</td>
</tr>
<tr>
<td>Helpful</td>
<td>7.49</td>
<td>1</td>
<td>98</td>
<td>1</td>
</tr>
<tr>
<td>Inquisitive</td>
<td>6.92</td>
<td>4</td>
<td>74</td>
<td>22</td>
</tr>
<tr>
<td>Patient</td>
<td>7.70</td>
<td>1</td>
<td>92</td>
<td>7</td>
</tr>
<tr>
<td>Psychological</td>
<td>8.28</td>
<td>0</td>
<td>78</td>
<td>22</td>
</tr>
<tr>
<td>Rich*</td>
<td>5.99</td>
<td>8</td>
<td>37</td>
<td>49</td>
</tr>
<tr>
<td>Scholarly</td>
<td>6.82</td>
<td>1</td>
<td>90</td>
<td>9</td>
</tr>
<tr>
<td>Unappreciated*</td>
<td>4.77</td>
<td>22</td>
<td>11</td>
<td>56</td>
</tr>
<tr>
<td>Understanding*</td>
<td>7.27</td>
<td>2</td>
<td>92</td>
<td>4</td>
</tr>
</tbody>
</table>

* denotes clusters whose total frequency of being ranked was less than 100% due to one of the clusters not being ascribed a label

This illustrates for example, that the adjective cluster of cold, uninterested, introverted and odd (represented by the summary construct alienated) achieved an average “goodness of fit” rating of 3.05 out of 10. Similarly, it can be seen that 89% of the time this cluster was seen as a negative characteristic, 7% of the time it was seen as a positive characteristic, and 4% of the time it was seen as a neutral characteristic. The 100 suitable questionnaires were then analysed to gain an initial measure of the strength and valence of the attitudes towards clinical psychologists. See Appendix B for a full description of this procedure.
Because one of the objectives of this study was to test the validity of the secondary tool by comparing the data from the questionnaire and the data obtained from interview, it was considered best to interview participants who expressed firm opinions in the questionnaire. Therefore, participants who expressed strong and definitely weighted opinions about clinical psychologists (either positive or negative) were considered more appropriate for this study. Consequently, participants with positivity scores in the highest 25% (very positive view of clinical psychologists) and participants with neutrality scores in the lowest 25% (very firm opinions) were chosen as being representative of the participants with the strongest and most positive attitude towards clinical psychologists. A number of participants fulfilled both these criteria (N= 15) and the interview participants (with a strong and positive attitude towards clinical psychologists) were drawn specifically from this group. To gain interview data from participants with strong negative views about clinical psychologists, participants with positivity scores in the lowest 25% (very negative view of clinical psychologists) and neutrality scores in the lowest 25% (very firm opinions) were selected. A number of participants fulfilled both these criteria (N= 3) and the interview participants (with a strong and negative attitude towards clinical psychologists) were drawn specifically from this group.

*Interview format*

The interview followed the same format for each participant which allowed for responses to specific questions as well as elaboration on those responses. There were eight stages to the interview format as outlined in Table 3.
Table 3

Interview Format Outlining the Questions Asked and Points Raised at Each Stage of the Interview.

<table>
<thead>
<tr>
<th>Stage of Interview</th>
<th>Questions asked/points raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>interview objectives outlined and consent form signed</td>
</tr>
<tr>
<td>Stage 2</td>
<td>overall results outlined and participant asked to elaborate</td>
</tr>
<tr>
<td>Stage 3</td>
<td>specific responses outlined and participant asked to elaborate</td>
</tr>
<tr>
<td>Stage 4</td>
<td>participant outlines existing knowledge of clinical psychologists and is asked to distinguish between a clinical psychologist, psychiatrist and counsellor</td>
</tr>
<tr>
<td>Stage 5</td>
<td>participant outlines where existing knowledge comes from</td>
</tr>
<tr>
<td>Stage 6</td>
<td>participants describe contact with clinical psychologists (their own or a close family member’s direct experience considered as relevant)</td>
</tr>
<tr>
<td>Stage 7</td>
<td>opportunity for participants to add any further relevant information</td>
</tr>
<tr>
<td>Stage 8</td>
<td>interview concludes, tape turned off, participants thanked and debriefed as to the nature and objectives of the study</td>
</tr>
</tbody>
</table>

A discursive approach (Potter & Wetherell, 1987) was used to emphasise the individual nature of the data and investigate the underlying meaning of the individual’s response. All participants have been de-identified, and any individuals or institutions referred to in the transcript have had their names removed to prevent identification.
Analysis and discussion

Interpretation of the clusters as a whole

The following extracts highlight instances during interview when the participants identified whole clusters which would generally be considered negative as being positive, and whole clusters generally considered to be positive as negative. In Extract 1, L1 is responding to why she was less positive about the cluster of “helpful”, “caring”, “friendly” and “a good listener” which she rated a six out of ten.

Extract 1

Int:
L1: 1 ummm (.) well I think that (.) when you when you're
2 going in to seek help you (.) you know (.) as a
3 psychologist you don’t want you want to help them but
4 you can't be their best friend that doesn't you know
5 like you (.) being someone's best friend and relating to
6 them in that way (.) is not the best thing for them

In contrast to the suggestion of Wollersheim and Walsh (1993), L1 in the above extract has de-emphasised the importance of the cluster summarised by the construct helpful. The suggestion is that if the psychologist is helpful, caring, friendly, and a good listener, this can be counter-productive to the ultimate role of the psychologist. This sentiment is expressed clearly in lines 5 and 6 when L1 says that being someone’s friend is not the best thing for them. The demarcation between helping people which is seen as positive (line 3) and being friendly which is seen as negative (lines 5 and 6)
reflects an individual interpretation of the cluster and is an attempt to make sense of what is clearly an ambiguous cluster for this participant.

Just as the previous participant expressed the notion that being friendly can be counter-productive, other participants reframed clusters typically seen as negative as being somewhat positive. In the following extract, H reframes the cluster of cold, uninterested, introverted and odd as a positive characteristic.

Extract 2

Int: 1 yeah I just wondered if you could tell me a bit about that
H:  2 ummm the reason why I thought introverted it’s because
    3 ummm I guess they’re in touch (. ) ahhh let me have a
    4 think (. ) the approach would be that they’re really
    5 getting into something they’re not ummm (. ) I guess
    6 they’re very (. ) not studious but I’m trying to find the
    7 right words (. ) ummm well I think you need to be
    8 introverted to a certain point because you really need
    9 to be in touch with yourself and be able to get into
   10 people ahhh beyond the social façade (. ) which is
   11 probably what clinical psychologists need to do (. ) ummm
   12 (. ) I think they just like in terms of introversion as
   13 well like obviously you know like they’re knowledgeable
   14 they need to be able to study and really get into the
   15 book side of things and case studies and whatever ummm
   16 so I guess why I think It’s positive is you really need
   17 to have that foundation ummm and also very inquisitive I
In lines 8 to 11, H reframes the concept of introversion from a negative characteristic to a positive characteristic by alluding to the ability to get beyond the social façade and “get into people”. Again, in lines 12 to 15, the concept of introversion is positioned immediately prior to a string of references designed to carry academic weight. Introversion is akin to being knowledgeable. Moreover, it suggests the ability to study and “get into the book side of things”. Finally, the presence of introversion shows an ability to “get into” case studies. Rather than suggesting shyness or social awkwardness, the concept of introversion is presented as a desirable and somewhat academic quality. However, if an aptitude for introversion is seen as being useful for a psychologist, the following extract in the same interview suggests the ability to be cold, uninterested and odd is a mandatory prerequisite.

Extract 3

Int:  1 and just in that cluster again there was a couple of
2 other adjectives like cold and uninterested and
3 odd
H:  4 mmhmm
Int:  5 they were in the same cluster as introverted and you
6 rated that cluster as positive so I wondered if you
7 could just sort of fill me in a bit on what on you know
your thinking of (.) why cold and uninterested and odd
might be positive characteristics as well

H: that was in the same cluster

Int: yeah

H: ummm well uninterested [.] uninterested could be
looking at like so obviously clinical psychologists
can't be too emotional

Int: sure

H: they've got to have this façade like
they're there you're telling them stuff and I think if
they showed too much emotion it can't be a positive
thing cos you're reacting to what people are saying and
it might deter them from going on or continuing or you
know so I think you need to have that kind of where the
person just gives and you can just absorb without
showing too much (. ) cold (. ) I mean obviously that can
be interpreted as cold but it's not really it's just you
know just kind of a you know a blank page you know cos
you don't want to give any clues away to how you're
seeing and judging this person kind of thing so

Int: sure and odd?

H: [laughs] I dunno it just happened to be in
that cluster

Int: [laughs]

In lines 13 and 14 H equates interest in the client with being too emotional and
thus justifies the psychologist being “uninterested” in the client. In addition, the
statement is preceded with the descriptor “obviously” to indicate that this is general knowledge and therefore indisputable. In lines 23 to 27 the characteristic cold is identified as having multiple interpretations. An “obvious” interpretation is that cold is cold; however, it is also acknowledged that for a psychologist, being cold can suggest a degree of objectivity or neutrality. Finally, the adjective odd is dealt with according to its proximity to the other descriptors. H laughs as if to dismiss the notion that odd can be justified as a positive characteristic, but then goes on to provide some insight as to why odd should be open to individual interpretation.

Extract 4

H: 1 but it's an interesting interpretation odd odd what does odd mean I mean just it's very subjective odd you know
Int: 3 sure
H: 4 what someone might think is odd to someone isn't odd to someone else and people might perceive them as being odd because they're introverted and you know all that I mean just cos odd is different to what society wants people want society wants extroversion da da da and cos you're opposite to that maybe I thought that's why odd was in there cos people perceive them as odd

In these extracts H has provided a number of reasonable and valid explanations as to why being cold, uninterested, introverted and odd should be seen as positive
characteristics. Finally, H is asked to summarise these explanations in an alternative definition of the adjective cluster.

Extract 5

Int: 1 yeah could you summarise you
2 obviously think they're positive characteristics
H: 3 yeah
Int: 4 and ummm you've explained very well why you think they
5 are positive characteristics
H: 6 yeah
Int: 7 about the ahhh distance and the (. ) ummm yeah the
8 distance that they help put between people and I just
9 wondered if you could give me another word or you know
10 an indication as to why that's ummm another word really
11 as to why that's positive
H: 12 [inaudible] but I'd say objective I think it'd be
13 objective

Thus the explanatory work which justifies the transition of cold, uninterested, introverted and odd from seemingly negative characteristics to patently positive characteristics is complete. When one sees the descriptors cold, uninterested, introverted or odd, one can consider the object of these descriptions to be academic, knowledgeable, and most importantly, objective. A psychologist is not cold, he is objective; a psychologist is not uninterested, she is objective; neither are these same psychologists introverted or odd, they are of course, objective.
**Interpretation of different words in the same cluster**

The following extracts highlight instances during interview when participants judged some adjectives of the cluster as having one meaning, and other adjectives in the cluster to have another meaning. The rationale for this is to challenge the validity of the clusters as a whole based on the question “is the distillation of people’s spontaneous descriptive prose into clusters of single words valid?” The following extract from L2 whose scores were relatively negative towards clinical psychologists suggests it is not.

**Extract 6**

Int: 1 so is what you're suggesting that the clusters can be a bit
2 contradictory some times
L2: 3 the words are contradictory
Int: 4 can you give me an example
L2: 5 (. ) ok enjoys learning, intelligent, studious, knowledgeable, school related and wise umm (. ) a lot of
6 people enjoy learning umm someone that’s stayed at
7 school as long as they should or have to got to get a
8 degree must have enjoyed learning
Int: 10 mmmmm
L2: 11 intelligent (. ) yes but lots of people are intelligent
Int: 12 mmm
L2: 13 umm studious (. ) that has some negative connotations I
14 suppose (. ) ummm you know that sort of geek thing
Despite the question posed by the interviewer in lines 1 and 2 suggesting the contradictory nature of the clusters as a whole, in line 3, L2 orients the interviewer to the notion that the individual words inside each of the clusters are contradictory. The example provided is the cluster summarised by the construct scholarly which contains the descriptors enjoys learning, intelligent, studious, knowledgeable, school-related and wise. L2 concedes a degree of similarity between the adjectives enjoys learning, intelligent, studious and knowledgeable (with various caveats along the way such as “lots of people are intelligent”), but does not agree that the adjective wise belongs in the cluster. This is stated unequivocally in lines 21 to 23 with the notion that “wise tends not to fit in with the other words…you can be all of the previous things and not necessarily wise”.

Confusing the role of psychologists and psychiatrists

As Helmes and Wilmouth note: “anecdotal evidence suggests that ignorance of the skills of psychologists among other healthcare professions and the public is a matter
that warrants immediate efforts by organised psychology in Australia” (2004, p.42).

While Webb (1989) observes the tendency of the public to place clinical psychologists and psychiatrists in the same category, she makes no comment on this phenomenon. Despite this, the seeming interchangeability between these two professions would seem to be a fundamental point to consider when discussing the public perception of clinical psychologists. An immediate question that arises is whether or not the public are making judgments of clinical psychologists based on what they know about psychiatrists. The following extract suggests very strongly that this does occur whilst simultaneously highlighting some of the negative implications for the profession. J has rated both the clusters of cold, uninterested, introverted and odd and bossy, hostile, greedy and egotistical as seven out of ten.

**Extract 7**

Int: 1 I just wonder if you can elaborate a little bit on both of those clusters
2 J: 3 ummm that reflected my experience with umm clinical psychologists umm well when I was fourteen I was
4 admitted into AAA hospital and there I was placed with
5 umm firstly I was put with two normal psychologists and
6 umm they wanted to do a family therapy and all this sort of stuff and my mum spat it and she wouldn't do family
7 therapy so they put me onto a clinical psychologist and
8 umm basically I I was in there for four weeks and the
9 four weeks that I was under the clinical psychologist
all I got was sort of like I just got told what to do
what to eat what to wear when to get up when I could sit
don't even able to open my mouth even if I did it didn't make a difference cos no
one listened to me anyway it was like don't listen to
her it's not her talking it's the eating disorder it is
I lost my self I lost my personal value I didn't have a
personal value anymore to the clinical psychologist I
only had the value of the disease (.) and umm then when
I was fifteeen I went into BBB Hospital and here

Int: mmhmm

J: and I was put under a clinical psychologist called
doctor X (.) and umm (.) he was terrible
absolutely terrible like I was in there for twenty four
hours and in that twenty four hours umm I was accused of
being bulimic in the first twenty four hours because I'd
eaten what they'd given to me and I hadn't gained weight
over the twenty four hour period they accused me of
being bulimic and then they took away things like I had
a room and I was paying like my parents paid something
like four thousand dollars for me to stay there to do
the clinic that they had there (.) and umm I didn't see
him in the first day I just got a message from the nurse
saying that he was not impressed with me and that he was
punishing me by taking away the television in my room
(.) and the bathroom in my room he was locking and I
wasn't allowed to use the bathroom and if I wanted to
use the bathroom I had to call a nurse to watch me go to
the bathroom I was fifteen years old and I found this ridiculous and umm so that was in the first twenty four hours and in the second twenty four hours I was there for two days I still didn't see him even though I'm paying him sort of three hundred dollars a day to come and see me and analyse me I didn't see him again he just looked at my chart apparently in the morning and a nurse came in and said to me look he's still not happy about aaah you're not allowed any visitors anymore and your telephone's been taken away you're not allowed to you can't make a phone call if you want to talk to your parents you've got to go to the nurses desk and ring your parents from there and you're only allowed to talk to them for two minutes (. ) excuse my language but you know like what are you doing do you know what I mean like I may I may have something wrong with me but that doesn't mean you can just treat me like you are and umm (. ) so I pretty much spat the dummy said look I'm leaving I'm discharging myself and they said look you're only sixteen years old you can't do that I was fifteen at the time and they said you're only sixteen years old you can't do that we're gonna put you in the psych ward and I said I beg your pardon and so they took me

Int: sorry to interrupt you but do you mean they were going to umm have you sectioned (. ) involuntarily admitted

J: mmmmm into the psych ward and I said no you're not and I like I picked up the phone and I rang my parents and my parents came down and they had an interview with doctor
Int: ok (.). is doctor X a clinical psychologist

J: I believe so yes

This is a poignant and distressing account of J’s interaction with the medical system for treatment of an “eating disorder”. However the eating disorder diagnosis was eventually retracted and J was re-diagnosed with a metabolic disorder with the primary symptom of difficulty achieving weight gain. J’s impression of clinical psychologists as measured by the questionnaire can be seen in her scores of seven out of ten for the clusters **cold**, **uninterested**, **introverted** and **odd** and **bossy**, **hostile**, **greedy** and **egotistical**. In addition, these negative sentiments are powerfully reinforced in her
interview statements. Moreover, in lines 76 to 79, J draws a clear link between her interactions with Dr X and her “main attitude of clinical psychologists being rude and sort of just not caring at all”. However, in this instance, J has based her opinion of clinical psychologists on the actions of a mental health professional who is actually a psychiatrist. The interviewer was aware of this during the interview process and queries J’s understanding of the clinician’s professional status in line 84. However, J confirms the notion that as far as she is concerned, Dr X is a clinical psychologist.

This distinction between a “normal psychologist” and a “clinical psychologist” is made in the early part of this extract in lines 6 to 9 during J’s initial admission to AAA hospital. On the basis of her later categorisation of Dr X as a clinical psychologist, it is possible that her reference to a “normal psychologist” refers to a clinical psychologist and her reference to a clinical psychologist refers to a psychiatrist. Whatever the details of categorisation are in the first admission referred to by J, the second admission to hospital forms the basis for her attitude towards clinical psychologists and can be considered as firm evidence that individuals can (and do) form opinions of clinical psychologists (sometimes extraordinarily negative), on the basis of their experience with psychiatrists.

**Conclusion**

A number of conclusions can be drawn from the work outlined in this paper regarding the public perception of clinical psychologists, the validity of the questionnaire developed by Webb and Speer (1986), and the demarcation of clinical
psychologists from other mental health professionals. With regard to the validity of the questionnaire, two main objections arise.

First, it seems clear from the data that individuals can interpret seemingly positive adjective clusters as negative and seemingly negative clusters as positive. The first example cited in this paper is the decreased significance of being helpful, and the suggestion that it may be counter-productive to the ultimate role of the psychologist as offered by L1. The second example is the reframing of cold, uninterested, introverted and odd as positive characteristics by H. As well as being present in the interview data, this phenomenon is also clearly outlined in Table 2 which shows a number of generally negative characteristics being judged as positive. It can be seen therefore, that a fundamental flaw in the secondary tool as employed by Warner and Bradley (1991) is the assumption of favourability based on the perceived valence of the adjective cluster. This provides some direction for the profession of psychology which needs to be cognisant of the need to include favourability ratings in any studies which claim to provide a measure of public perception.

Second, the data show that individual words inside the clusters possess incongruent characteristics which make it difficult for the participant to judge the clusters as a whole (as the questionnaire developed by Webb & Speer actually requires them to do). An example is the incongruence between the adjective wise and the remaining words inside the cluster summarised by the construct scholarly. L2 makes this distinction clearly in the comment “you can be all of the previous things and not necessarily wise” (extract 6 lines 22 to 23). Other examples include the distinction between being patient and self-controlled but not calm, and being cold, uninterested and
introverted, but not odd. This suggests strongly that the distillation of people’s
spontaneous descriptive prose into a cluster of single words is not a valid method for
capturing the true public perception of psychologists. Rather than collecting,
aggregating and then analysing the data, it seems likely that a more valid method is to
collect the data and then analyse it. If necessary the individual results can be aggregated
after analysis to give a broader and more comprehensive picture of the public perception
of clinical psychologists. This aggregation of the data after it has been analysed ensures
that genuine and significant differences in public perception of the profession between
individuals are taken for what they are; naturally occurring and meaningful variations on
the norm rather than statistical noise or error.

Limitations

There are three potential criticisms of the approach taken in this present work
including the type of population used, the specific methodological limitations of
conducting interviews and the limitations of qualitative research in general.

First, the use of an undergraduate university population in this study can be
partly explained with reference to the populations employed by Webb and Speer (1986)
who developed the original questionnaire and also employed an undergraduate
university population. Consequently, any attempt to challenge the validity of their
approach would gain in legitimacy by using the same population.

Second, Potter and Wetherell (1987) note at least two methodological limitations
of conducting interviews and analysing the data. The first revolves around the tendency
to analyse the words (or the transcript of the words) rather than the intended meaning of
the words. The second limitation is similar and refers to the potential subjective bias regarding the recording and interpretation of the data. These are valid concerns and while discourse analysis and conversation analysis are similar, interested readers are directed to the writings of Levinson (1983) who notes a number of theoretical distinctions between the two which suggest that the above criticisms could be significantly ameliorated using a strict conversation analysis methodology.

Finally there is significant debate about the merit of qualitative approaches in general and what they can offer to the discipline of psychology. Traditional research in psychology has employed a “positivist” approach and focused on the importance of obtaining an “average” from a large pool of subjects. Therefore, criticism of qualitative research centres around concerns of researcher bias and lack of objectivity in general, and the ability to generalise from the study sample to the population in specific. In addition issues of representativeness (the subjects studied are seen as atypical), and the capacity of qualitative approaches to replicate their findings is often questioned. With a small sample (N=10) and a patently qualitative approach, this paper is subject to a number of these criticisms including representativeness, reproducibility and generalisability. However, a number of authors outline some of the advantages of qualitative research. For example Sacks (1992) offers a theory based on the notion that any particular culture will show order at all points. This suggests that a macro approach based on an aggregationist model is not the only way, and a micro approach focusing on the detail in individual cases and in individual environments will reveal important properties of the culture as whole. Consequently, the data obtained from 10 participants (or one participant) can be seen to illuminate important properties of the whole and can
serve as a valid indicator of performance and functioning in the system at large. Some of the advantages of this micro, qualitative approach include: a rich level of detail not often obtained in quantitative research; the ability to illuminate the individual nature of data and the inherent explanatory work and underlying meaning of the individual’s response which makes it an ideal tool to gain insight into the individual’s perception of a particular group, concept or construct; and the ability to account for the specific situation of the research. Interested readers are directed to Kidder and Fine (1997) who provide a useful account of some of the history and advantages of qualitative research. Moreover, for an introduction to the ongoing and robust debate about quantitative versus qualitative research interested readers are directed to Burman (1997) and Wagner (1995). Finally, with regard to exploring the validity of analysing single-subject conversation, interested readers are directed to the writings of Sacks (1972, 1992), and Silverman (1998).

Nevertheless, despite the advantages of qualitative research outlined above, further qualitative studies of the public perception of clinical psychologists would be useful to strengthen and support the findings presented in this paper.

**Future research and suggestions**

The reasons for different interpretations of, or incongruence between, clusters is worthy of discussion. Potter and Wetherell (1987) note the traditional understanding of the development of public perception whereby an individual forms an opinion (for example “caring”) based on the object (for example a clinical psychologist). This is in contrast to the theory espoused by social representations which has an additional
dimension referred to as a representation. In social representations theory, the individual observes the object, constructs a representation of the object and then forms an opinion based on the representation rather than the object itself (Potter & Edwards, 1999). Because social representations are mental entities which take into account existing beliefs and value systems, they can be used to explain attitudes and actions towards an object of representation and allow for a more complex and holistic understanding of the object. It seems possible that members of the public form a perception of clinical psychologists based on their subjectively constructed, individual representation of what a psychologist is, or how they see a clinical psychologist should be. This provides some direction for future research which may benefit from using a social representations model when investigating public perception of the profession.

Other possible areas of interest include the effect of direct experience of a clinical psychologist (defined throughout this paper as either the individual’s own, or a close family member’s direct experience with a clinical psychologist in a therapeutic situation), and the public's knowledge of the training required to be a psychologist and the clinical tasks performed. It may be noteworthy that all of the three participants who displayed a negative attitude towards clinical psychologists had direct experience of them. This is in contrast to only three out of the seven participants who displayed a positive attitude towards clinical psychologists. Further research could focus on this finding and investigate the significance (if any) of direct experience of a clinical psychologist on the ultimate opinion of clinical psychologists.

Finally, with regard to the implications of inadequate demarcation from other mental health professionals for the profession of clinical psychology it can be seen that
confusion among members of the public can (and indeed does) lead to judgments about clinical psychology being made on the basis of information about other mental health professionals. To aid in delineating clearly between the role of the psychiatrist and the psychologist it is recommended that the profession embark on a public awareness campaign to clearly describe the role of psychologists as well as outlining a number of the strengths which are unique to the profession.

These strengths include a commitment to using clinical interventions which have been heavily researched in gold standard studies and found to be effective (cognitive behavioural therapy for depression, for example). Unlike many other professions which simply refer to relevant clinical research, psychology has a strong history of evaluating, appraising and critiquing the extant literature. While not exclusive to psychology, this formidable academic skill means psychologists are well placed to critique and analyse the methodology of complex studies from various disciplines and not just psychological research literature. Furthermore, psychologists are the sole users of a number of psychometrically sound assessment tools which can add meaningful data to the clinical picture. The majority of other mental health professionals (including psychiatrists) are not licensed to administer or interpret these tools which provides psychology with a meaningful, valuable and unique string to its bow. Additionally, the practice of hypothesis testing in clinical assessment and intervention though not unique to psychologists, has a long history in psychology (Bernstein & Kerr, 1993; Kendall & Norton-Ford, 1982). Finally, the recent developments at the Consensus Conference on Combined and Integrated Doctoral Training in Psychology which are designed to provide a link between psychology training and tasks performed, can be seen as a
further way in which the profession can clearly and distinctly outline its role to members and use that clarification as a platform to deliver the message to the public. For the sake of the profession it seems imperative that professional psychology in Australia undertakes a campaign of clarification and demarcation to ensure the role of clinical psychologists is well articulated and clearly understood by members of the public and other healthcare professionals.
Appendix A

Name: ____________________
Student number: ________________
Phone number: _________________________
Email address: ________________________

Questionnaire

On a scale of 1 to 10 where 1 = not at all and 10 = completely, totally, absolutely how well do you think each of these 11 adjective clusters describes a clinical psychologist. In addition, please indicate whether you consider each of these 11 clusters to be representative of positive, negative or neutral characteristics.

1. cold, uninterested, introverted, odd _____
2. bossy, hostile, greedy, egotistical _____
3. dedicated, persistent, well trained _____
4. helpful, caring, friendly, a good listener _____
5. curious, probing, a researcher _____
6. patient, calm, self-controlled _____
7. deals with mental problems, studies behaviour, studies the mind _____
8. rich, nicely dressed, professional looking ______
9. enjoys learning, intelligent, studious, knowledgeable, school-related, wise _____
10. necessary, underpaid _____
11. understanding, understands people, well adjusted, gives advice ______
Appendix B

Procedure for obtaining a measure of positivity, negativity, neutrality, and strength of attitude towards clinical psychologists from the questionnaire data.

The scores out of ten for each of the 11 adjective clusters which were ascribed a positive label were added together. Similarly, the scores out of 10 for each of the 11 adjective clusters which were ascribed a negative label were added together. A measure of positivity towards clinical psychologists was then obtained by subtracting the total negative score from the total positive score. High scores on the positive scale indicated a positive attitude towards clinical psychologists and low scores indicated a negative attitude towards clinical psychologists.

Following this, the scores out of 10 for each of the 11 adjective clusters which were ascribed a neutral label were added together. As both the positive and negative dimensions indicated a degree of feeling of some sort (by definition, either a positive or negative feeling) a measure of neutrality was obtained by adding the positive and negative scores together and subtracting this total from the neutral score. For example, if the positive and negative scores were low and the neutral score was raised, a high measure of neutrality would be indicated by a high score. In contrast, if the positive and negative scores were raised and the neutral score was low, a low (or negative) score would indicate a low measure of neutrality.

Consequently, each participant achieved an overall positivity score and an overall neutrality score. The positivity scores ranged from 8 to 85 (M = 43.4). The neutrality scores ranged from -10 to 95. (M = 45.63). These scores were then ranked in ascending order. Positivity scores in the lowest 25% (N=26) were considered to represent
participants with the least positive attitude towards clinical psychologists. Conversely, positivity scores in the highest 25% (N=26) were considered to represent participants with the most positive attitudes towards clinical psychologists. A similar process was carried out with the neutrality scores. Consequently, neutrality scores in the highest 25% (N=24) were considered to represent participants with the most neutral attitude towards clinical psychologists and neutrality scores in the lowest 25% (N=26) were considered to represent participants with the least neutral attitude towards clinical psychologists.

The following Chapter 5 has recently been submitted to Computers in Human Behavior.

The active management of psychology’s public image: The role of a professional association.

Shaun Dempsey & Ngaire Donaghue

Running head: Managing psychology’s public image
Abstract

Rising community concern about mental illness in recent years has led to an increase in social attention to mental health care services. The kind of role that psychologists can take in responding to these concerns depends to a large extent on public understandings of what psychology is and the kinds of expertise psychologists have to offer. The present study investigates the way in which a professional psychology organisation (the Australian Psychological Society) uses its website to present information to the public about psychology. We analyse the way in which material on the APS website manages public perceptions of psychology including; the types of problems that psychologists commonly work with; the difference between psychologists and psychiatrists, and the effectiveness of psychological interventions. Findings are discussed in terms of the ways in which professional psychological organisations can represent the interests of their members and contribute to greater public understanding of the range of mental health and well-being services that can be provided by psychologists.
The active management of psychology’s public image through use of the internet: The role of a professional association.

Public attention to issues of mental health and psychological well-being has increased dramatically in recent years. The economic costs alone of mental health disorders provide compelling reasons for governments and other social institutions to seek effective interventions (Kessler et al., 2008; Moulding et al., 2007; National Academy of Sciences, 2009; Perkins et al., 2007, van Gool, 2007); mental health disorders are estimated to cost in the order of £77 billion a year in the United Kingdom (National Health Service, n.d.) and $34 billion per year in Australia in treatment and lost productivity (The Brain Dynamics Centre, n.d.) In addition to these economic costs to societies, the costs to individuals are often also very high with mental health disorders resulting in a range of negative outcomes including personal distress, family dysfunction, difficulties with employment, self harm, and suicide. In this context, efforts to increase public awareness and uptake of mental health services have proliferated as evidenced by the presence of various non-government organisations such as Beyond Blue in Australia (www.beyondblue.org.au) and the Depression Alliance in the United Kingdom (www.depressionalliance.org), which have taken an active role in providing community outreach.

The kind of role that psychology can play in responding to rising concerns about mental health depends to a large extent on public perceptions of psychology. People are more likely to seek out psychological services if they have a clear and positive understanding of the kind of help psychologists can provide (Hinnefeld, 1996; Webb,
1989), and public funding for psychological services is more likely to receive public support to the extent that there is widespread understanding of the effectiveness and value of psychological treatments (Dobson, 2002). The public image of psychologists is complex and shifting, and there are many sources of information about psychology that can influence the image of psychology in the public eye. Psychologist characters in film and television, reports about psychologists in the media, personal experiences and exposure to information about psychology on the internet can all contribute to people’s understandings of what psychology is and what it can offer them.

The internet, and subsequently corporate websites, are relatively new phenomena, and as such research on this topic is scant. However, Topalian (2003) has observed that corporate websites have become an increasingly important means for disseminating corporate information and allowing customers to communicate with the organization. There are a number of different audiences likely to access the Australian Psychological Society (APS) website including: consumers of psychology (both individuals and groups), referring agents (such as GPs), competitors of psychologists (such as psychiatrists or other providers of mental health services), the APS, and the government of the day.

The information provided by the APS to its various audiences comes in the form of pamphlets, brochures, books, newsletters, journals, tip sheets, position papers and statements, radio interviews, conferences and its website. The internet is a particularly interesting site of information exchange because the interactive nature of its use means that visitors to the APS website are presented with a range of choices regarding the links they access and the information that they obtain.
One of the roles of the APS website is to direct people to the information that they require. On one level, this audience segmentation and direction is overt; for example, the APS requires a member login and password to access particular pages on the website. On another level, this audience separation is more subtly managed; for example, the APS structures its website to have certain links or headings which subtly guide the reader towards, or away from, particular sets of information. Two headings which seem designed to direct traffic in a particular direction include “practitioner resources” and “community information”. The “practitioner resources” heading seems to be particularly relevant for practising psychologists and designed to guide them towards information about psychologist registration, practice management, Medicare rebates and wages for psychologists. In contrast to this, the “community information” heading seems to be particularly relevant for non-psychologists and guides potential clients or referrers to information about how to find a psychologist, the difference between psychologists and psychiatrists, and the current fees and rebates for psychological services.

Into this mix, also, are the efforts made by psychology’s professional bodies to promote psychology. The APS on its website describes its mission as ‘to represent, promote and advance psychology and psychologists within the context of improving community well-being and scientific knowledge’, and has as one of its goals ‘to enhance the profile of APS psychologists and psychology and increase public access to and utilisation of psychological services’ (APS website). This paper investigates how the APS uses the internet to go about navigating the complex array of existing community attitudes and knowledge about psychology to promote a positive and professional image of psychology and encourage people with mental health concerns to seek help from
psychologists. We present as a case study an analysis of the website of the Australian Psychological Society, the peak professional body for psychologists in Australia. The website is the ‘public face’ of the society, and our analysis identifies the ways in which the APS presents information and orients to existing perceptions of psychology in order to create a public image for psychology that ‘enhances the profile of …psychologists’ (APS website).

The representational context

As a consumer-led medium, informational websites such as the APS’s provide information to consumers who have self-selected to receive that information. This means that a typical visitor to the APS site already has some interest in psychology and some general expectation about what psychology is and what it can offer; visiting the website is a means of seeking further information for an already formed interest. Therefore, before discussing the specific information presented on the APS website, we need to consider the representational context which may inform the prior beliefs, expectations and concerns that consumers bring with them to the APS website, and within which the APS must attempt to manage the public perception of psychologists.

As Wollersheim and Walsh note in their study of the professional positioning of clinical psychologists, ‘to reach consumers effectively, it is essential to understand their existing attitudes toward the commodity being marketed’ (1993, p. 171).

Several studies have investigated the public perception of psychologists in Australia (Hartwig & Delin, 2003; Hopson & Cunningham, 1995; Sharpley, 1986; Wollersheim, & Walsh, 1993) and the United States (Benjamin, 1986a; Thumin, & Zebelman, 1967; Webb, & Speer, 1986). The broad conclusions of these studies are that
the public perception of psychologists is unclear, and that there is particular confusion in
the public eye between psychologists and psychiatrists. Several issues emerge as
requiring particular attention in the promotion of a positive image of psychology to the
community; differentiation between psychologists and other mental health service
providers (particularly psychiatrists), the tension between orienting psychological
services as promoting mental health versus treating mental illness, and the efficacy of
psychological treatments. These issues are discussed in turn below.

*The distinctive competence of psychologists*

The confusion in the public eye between psychologists and psychiatrists has long
been established, with the consistent finding that people don’t distinguish between the
two professions to any significant degree (Amrine, 1965, Dempsey, 2007, Guest, 1948,
Speer, 1986). In a study of public perceptions of mental health professionals, Sharpley
(1986) found that psychologists and psychiatrists were categorized together into a
distinct sub-group, which was contrasted with social workers and counsellors. The well-
established public confusion between psychology and psychiatry creates a clear need for
these professions to work to establish their distinctive competence (Andrews, 1999;
Selznick, 1957) in order to successfully market their services to potential clients.
Psychologists are part of an increasing group of mental health providers competing for
limited public and private resources (Wollersheim & Walsh, 1993), providing a
compelling reason for the development of clarity and distinction around professional
boundaries, job descriptions and services provided.
The task of responding to public confusion about the differences between psychologists and psychiatrists is complicated, however, by the possibility that a simple distinction between the two professions may not always work in psychology’s favour. Although there are many differences in the typical approach of psychologists and psychiatrists (Golomb et al, 2000; Twining, 2005), there is also a good deal of overlap (Webb, 1980) and in many ways the simplest and clearest way to distinguish between the two is by reference to the fact that psychiatry is a specialisation within medicine whereas psychology is not. Given the high prestige generally associated with medical training, promoters of psychology face the somewhat delicate task of articulating the distinctiveness of psychology in a way that does not invite the inference that psychology is inferior to, or of a lesser clinical standard than psychiatry. This distinction is likely to be particularly salient for consumers as it aligns with the ability to prescribe pharmaceutical treatments such as antidepressants or anti-anxiety medications, and thus defines a difference in (possible) treatment approaches that is highly visible and meaningful to potential consumers.

In addition to the confusion that exists in public understanding of the roles of psychologists and psychiatrists in treating mental illness, a parallel confusion between the roles of psychologists and counsellors may be seen in relation to the treatment of ‘everyday problems’. A distinction in public perception between counsellors, who are seen as approachable and accessible, and psychologists, who are seen as more clinically skilled but less available, has been noted by Sharpley (1986, see also, Fall, Levitov, Jennings & Ebert, 2000; Warner & Bradley, 1991; Webb & Speer, 1986). Sharpely found that psychologists were seen as “private practice and fee-demanding professionals
who study human behaviour and thoughts” (p. 57) compared to counsellors who were seen as “non fee-demanding professionals who are more practical and help the average person solve emotional problems” (p. 57). Further highlighting the distinction between counsellors and psychologists, Webb and Speer (1986) found that psychologists were perceived as dealing with abnormal clinical issues, while counsellors were perceived as dealing with the normal, ‘everyday’ issues. Finally, counsellors have also been seen as more helpful and caring than psychologists (Warner & Bradley, 1991). This distinction in the perceived accessibility of counsellors and their ability to manage low level clinical issues, and the perception of psychologists as more specialised experts in the area of mental health creates an important issue to be attended to by promoters of psychology.

*The effectiveness of psychological interventions*

Psychologists are the primary (though not the only) providers of psychological interventions and as such the credibility and thus the public perception of psychologists is partly based on the perceived efficacy of psychological interventions. The natural tension between therapeutic eclecticism and the philosophy of evidence based practice produces some ambiguity and disagreement about the effectiveness of psychological interventions in general, and the effectiveness of psychological interventions under specific circumstances (Chambless, & Ollendick, 2001; Dawes, 1994; Eysenck, 1952; Grencavage, & Norcross, 1990; Luborsky, Crits-Christoph, Melon, & Auerbach, 1988; Mintz, Drake, & Crits-Cristoph, 1996; Seligman, 1995). Competing accounts exist regarding the efficacy of psychological treatments; psychological interventions have been argued by some to be generally ineffective (Epstein, 2006; Eysenck, 1952; Smail,
2001; Smail, 2006); by others to be generally effective as a result of non-specific factors (Lambert & Ogles, 2004; Luborsky, Singer & Luborsky, 1975; Wampold, 2001); and by still others to be generally effective as a result of specific factors (Barlow, Craske, Cerny, & Klosko, 1989; Beck, et al 1979; EmmelKamp, 1994; Michelson et at., 1990 ). Furthermore, the profession of psychology has developed a broad repertoire of distinct, and sometime contradictory, approaches to therapeutic treatment resulting in an extensive range of therapies that are in use at present. Although the existence of a wide and varied range of treatments provides flexibility for practitioners and clients in seeking effective responses to psychological distress, at the same time, this eclecticism may make it more difficult for the profession to claim expertise as providers of specialist therapeutic interventions. Promoters of psychology need to manage the inherent tensions between representing a number of possible clinical interventions which cater for the varying needs of clients and the different preferences of clinicians, while also ensuring that each of these possible interventions is seen as efficacious and complementary (or at least not detrimental) to other treatments. Hence articulating clear and credible claims about the efficacy of psychological interventions is a matter that needs to be attended to in promoting the public image of psychologists.

**Rationale for the paper**

Various organisations including professional associations, government agencies, non-government organisations (NGOs) and universities have engaged in the marketing of psychology by employing a range of media sources including, television, radio, print media and the internet to provide information about psychologists to the public. The
Australian Psychological Society (APS) is the largest professional body for psychologists in Australia, representing the views of more than 17,000 members, and is a significant provider of information to the general public about psychology. One of the primary methods the APS employs for representing its members and disseminating information about the profession is through its website. According to the APS, their website is designed to “represent, promote and advance psychology within the context of improving community wellbeing and scientific knowledge.” (APS, n.d). Hence, the APS website is a useful site to commence an analysis of the public image of psychologists.

As the recognised professional body for psychologists in Australia, the APS has an explicitly stated interest in the representation, promotion and advancement of psychology. This paper will analyse the text and structure of sections of the APS website to examine the ways in which the APS guides visitors to its site and presents information by attending to the varied interests of its members, as well as managing potential threats to the public perception of psychologists, in its portrayal of psychology to the public.

Method

Description of the APS website

The APS website can be located on the World Wide Web at the address http://www.psychology.org.au/. The home page has a number of links and logos as well as up to date information which is reviewed regularly including recent media releases, upcoming conference details, and special deals for members of the APS. The site has a range of links, some of which are available to the public, and a selection of other links
that require the member to log in with a username and password. As we are interested in
the APS’s use of its website to engage with the public, the material used in this analysis
comes from pages contained within the ‘Community Information’ section of the
website. The analysis provided here is based on material viewed on the website on 21
March 2009.

Analytic approach

We analysed the material on the website using a thematic analysis (Braun &
Clarke, 2006). As the ways in which arguments were formulated and the context in
which information was presented were important to the analysis (rather than simply
classifying the content), the flexibility of a thematic analysis, its ability to provide a
comprehensive and systematic description of the data, and the opportunity it provides to
focus on and illuminate specific aspects of the data make it an appropriate choice for
analysing this material. In approaching the website material, we were particularly
interested in examining how the APS oriented to managing consumer perceptions of
issues that have previously been identified as important and problematic for the public
perception of psychology (as discussed in the introduction). Our analysis focuses first on
identifying references to these issues in the website materials, and then on examining
how the active management of these issues by the APS orients to existing perceptions
and confusions about psychology and psychologists, and the ways in which the APS
goes about portraying psychology so as to maximise its own (multiple) interests.

Analysis and Discussion

Presenting psychologists as general counsellors and mental health specialists
As we have discussed earlier in this paper, one of the issues confronting the APS in its attempts to portray psychology to the general public is how to balance the desire to show the relevance of psychology to a wide range of ‘everyday’ problems while simultaneously maintaining the credibility of psychology in treating serious mental illness. In this section, we examine how this issue is managed on the APS website.

On entering the APS website and following the “About psychologists” link, the following text is encountered:

Psychologists are experts in human behaviour. Most psychologists help mentally healthy people to find ways of functioning better. For example, they train people to handle stress and family problems. Psychological therapies are also widely used by groups and organisations.

It is clear that at this ‘early’ point in the website (accessed directly from the home page) that psychologists are presented as having expertise that can assist with a wide range of common concerns, thus establishing a very broad potential consumer base and scope of practice for psychologists. The use of the phrase “mentally healthy people” clearly orients to and explicitly rejects the notion that consulting a psychologist might indicate that a person was mentally ill. The selective reference to the seemingly ubiquitous and somewhat low grade issues of “stress” and “family problems” can be read as another effort to locate psychology firmly within the sphere of ordinary people. Of course, the introductory section of the website is not designed to furnish the reader with a comprehensive list of the services provided by psychologists; however, the material that is chosen here forms a major part of the ‘first impression’ of psychologists created by the website. Psychologists do many other things in addition to training people...
to handle stress and family problems. It seems clear that the APS has made a strategic choice in favour of presenting psychologists as experts in the concerns of everyday life.

This emphasis on psychology as a means of improving human functioning, rather than treating mental illness, is further reinforced when the reader accesses the “Consulting an APS Psychologist” link:

Everyday problems, such as work stress, relationship troubles and coping with illness, can seriously affect your life. Addressing these concerns is vital to enjoying life and good relationships.

APS psychologists can help with these situations. They equip people with the skills needed to function better and to prevent problems. Click on the links below for more information on the common reasons why people visit psychologists.

In this extract the APS continues to emphasise the mundane, ordinary, everyday problems that people might experience at various times throughout the course of their life. The use of the word “everyday” at the beginning of the paragraph informs the reader that the core business of APS psychologists is dealing with the run of the mill issues that might be experienced by ordinary people. This is further highlighted with the reference to “enjoying life and good relationships” which normalises the use of psychological services, emphasising that psychologists help people to achieve their goals and do things better.

In contrast, other sections of the website emphasise the role of psychologists as experts in dealing with complex mental health disorders. For example, the “Consulting an APS Psychologist” page presents a number of links, which take the reader to
different pages each of which describe a serious mental health disorder including major depression, schizophrenia, bipolar disorder and suicidal ideation. These links are labelled with a diagnostic category (such as ‘schizophrenia’), rather than, say, by describing symptoms or experiences that characterise these disorders. This suggests that these pages are designed for people who already have an idea of what they are looking for, and works to separate the discussion of serious mental illness from a more general discussion of “everyday problems”. In contrast to the “everyday problems” of the earlier pages, the information reached by following these links emphasises the serious nature of these disorders, and the role that psychologists can play in treating them. For example, following the link titled “Depression”, the reader is informed that:

Clinical depression is a mental, emotional and physical state that is intense, long-lasting and seriously affects daily life. It is a pervasive despair, not just a mood that someone can snap out of readily.

The role of psychological treatments such as Cognitive Behavioural Therapy (CBT) and Interpersonal Therapy (IPT) are described as being “typically far more effective than general supportive counselling”. Similarly, in the link titled “Schizophrenia”, the reader is informed that

Schizophrenia is a mental illness that seriously affects the way a person acts, thinks and feels, and may be characterised by hallucinations, delusions and disorganisation.

The role of psychologists in providing CBT, psycho-education and case management is discussed with emphasis on the need for therapy ‘to be provided by psychologists with extensive post-graduate training in the therapeutic management of mental health disorders’. The reader is left in no doubt that this is the domain of highly
specialised clinicians with advanced training. Here we see that rather than appealing to the broad base of society by positioning psychology as primarily treating everyday problems such as work stress or relationship problems, this section of the website emphasises the clinical proficiency of psychologists and the serious nature of the disorders with which they deal.

In the extracts from the website discussed in this section we can see that the APS attends first to the presentation of psychologists as having expertise in ‘human behaviour’ that is widely applicable to a range of ‘everyday’ problems experienced by ‘mentally healthy’ people. Having established this position, attention is then directed to also securing psychology’s role in the treatment of mental illness and serious psychological disorders. It is notable that although no firm boundary is explicitly drawn between the everyday and the clinical, the structure of the website works to separate “everyday matters” from discussions of “mental illnesses” by the use of separate pages linked by labels corresponding to diagnostic categories. In this discussion concerning mental illness, no special mention is made of the role of clinical psychologists. The only suggestion that there might be some kind of qualitative difference between everyday and clinical issues comes in a section of the website which discusses the differences between psychology and psychiatry, which we discuss in the next section.

The Difference between Psychologists and Psychiatrists

The well-documented confusion in the public mind about the differences between psychologists and psychiatrists is recognised and responded to on the APS website on a dedicated section of the “About Psychologists” page. It states that,
Psychologists and psychiatrists both work in the area of mental health, and often work together. However, there are some significant differences between the two professions in the following areas:

The above extract acknowledges that the two professions have some common elements and similarities including working in the area of mental health. Moreover, in addition to these similarities, this phrase also implies a collegial relationship between the two professions who “often work together”. Notions of teamwork and interdisciplinary harmony are thus evoked as the reader is informed of the common scope of practice and shared responsibilities of the two professions. However, this impression is quickly qualified by the statement that follows which introduces the idea of “significant differences between the two professions”. The APS can be seen here to be attending early on in its discussion of this issue to the need to establish distinctive competence for psychologists. One of the differences as outlined by the APS website is the type of clientele catered to by each profession. The first extract outlines the role of psychologists:

Psychologists help mentally healthy people find ways of functioning better. Some psychologists specialise in treating people with a mental illness. Read about the common reasons why people see psychologists.

This is followed by a description of the role of psychiatrists which says:

Psychiatrists mainly treat people with a mental illness, such as schizophrenia.

In this extract the APS uses the distinction between clientele as a point of difference between psychologists and psychiatrists, with psychologists portrayed as
being able to deal with both the everyday and the specialist problems, whereas psychiatrists are seen to deal only with mental illness. However, compared to the previous section where psychologists were clearly identified as having a role in the treatment of mental illness such as schizophrenia, this skill is now de-emphasised and the construct of mental illness is used as a point of difference between the professions. It is noteworthy that psychologists “help” people, whereas psychiatrists “treat” people.

The profession of psychology has a broad and eclectic base which employs a wide range of different philosophies, interventions, and approaches. Therefore, for reasons of marketing and distinctive competence (Andrews, 1971; Selznick, 1957), it becomes important for the profession to have a clear perception of itself and its boundaries compared to other similar professions. Additionally, the number of mentally healthy people who need to find ways of functioning better is likely to be higher than the number of people who need to be treated for a mental illness. Thus having expertise in ‘helping’ as well as ‘treating’ is important in ensuring a wide referral base for the profession of psychology. The notion that there might be some different expertise required for these two types of practice is alluded to in the statement that ‘some psychologists specialise in treating people with mental illness’, however, the distinction is not strongly marked, and no reference to the additional training required to register as a clinical psychologist is made here. Furthermore, in providing clear differentiation between the professions of psychology and psychiatry, it is important that the discipline of psychology is not seen as inferior to, or less effective that psychiatry in the treatment of mental illness. The APS attends carefully to this issue in its discussion of the education and qualifications of psychologists and psychiatrists:
Psychologists study human behaviour in their undergraduate and postgraduate degrees before undertaking supervised experience and gaining registration. They do not have a medical degree, however many study for a similar number of years to specialise in various aspects of psychology. For example, clinical psychologists study for at least six years to attain their qualifications.

Psychiatrists have a medical degree, which involves six years of studying general medicine, followed by further study to specialise in psychiatry.

It can be seen in this extract that a number of strategies of positive representation of the self and suppression of positive information of the other have been employed (Oktar, 2001). For psychologists, the emphasis is placed on positive information including that they do a number of things such as: studying human behaviour; gaining undergraduate degrees; gaining postgraduate degrees; undertaking supervised experience; and then gaining registration (a total of five achievements). In contrast, the strategy of de-emphasising positive information is employed with regard to psychiatrists who seem to do fewer things (a total of three achievements). Moreover, with regard to registration, the reader is not similarly informed that medical practitioners also gain registration on completion of their studies. The notion of being registered as a psychologist (or any other type of health professional) is partly designed to instil public confidence and ensure competence. It seems likely that neglecting to provide the parallel information that medical practitioners also gain registration upon completion of their studies, may have the subtle effect of de-emphasising a positive aspect of the medical profession by omitting basic information.
The particularity of the way in which the training of psychologists and psychiatrists is presented can be seen by contrasting the APS’s presentation with information provided by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) about the training of psychiatrists; the RANZCP website states that psychiatrists train for a minimum of 13 years and that five of those years consist of specialist training in a full range of psychiatric problems (Royal Australian and New Zealand College of Psychiatrists, n.d.). In its statements about the education and qualifications of both psychologists and psychiatrists, and in particular the claim that psychologists “study for a similar number of years to specialise in various aspects of psychology”, the APS can be seen as having chosen a selective comparison that minimises the potential inference that psychologists are less qualified than psychiatrists.

We have shown in the extracts above how the APS have paid considerable attention to demarcating the education, qualifications and services provided by psychologists from those of psychiatrists. However, it is worth noting that this same energy has not been expended in demarcating the profession of psychology from any other profession such as counsellors or social workers. The literature has clearly established that the confusion between psychologists and psychiatrists has been a considerable problem over the years (Guest, 1948; Grossack, 1954; Thumin and Zebelman, 1967). However, additional literature has also established that there is extensive public confusion over the role of psychologists and other mental health workers (Warner & Bradley, 1991; Hopson & Cunningham, 1995; Von Sydow & Reimer, 1998; Fall et al, 2000). In light of this confusion between psychologists and many other mental health professionals (not just psychiatrists), it is interesting that the
APS has focused its efforts on describing and distinguishing their role only as compared to psychiatrists. For example, there is no information on the APS website devoted to explaining the differences between psychologists and counsellors, or psychologists and social workers. Similarly, there is no information on the APS website devoted to outlining the education and qualifications of psychologists compared to counsellors or social workers. In fact, in stark contrast to the profession of psychiatry which features a number of times on the APS website, there is no mention of any other mental health professions.

*The effectiveness of psychological interventions*

In addition to establishing the expertise of psychologists as mental health professionals, the APS website also devotes considerable space to advocating for the effectiveness of psychological treatments. On the “Consulting an APS Psychologist page” there is a small section of text that reads:

> Research shows psychological treatments are effective in managing many common mental health disorders

This is followed by a link labelled “Find out more about the effectiveness of psychological treatments”. The same link is also contained on the “About Psychologists” page, following a statement that “psychologists cannot prescribe medication”. The effectiveness of psychological treatments page begins by repeating the previous sentence (above), and then continuing:

> Some treatments are at least as successful as medication in treating the most prevalent conditions, such as depression and anxiety
The claim that psychological treatments are as successful as medication is upgraded a little further down the page, where it is claimed that psychological treatments are sometimes *more* effective than medication:

A review of current research shows that a range of well-defined psychological treatments: are effective at treating the most common mental health conditions; are effective in treating most anxiety and depression disorders; are the treatment of choice for most childhood problems; tend to be more effective than medication over the long term, because people receiving medication only are more likely to relapse after they stop taking it; and are viable treatments, in terms of both their effectiveness and costs.

The subtext of this information suggests the presence of a range of unambiguous and precise psychological interventions which can be employed in the treatment of common mental health conditions. Although different forms of treatment are not named here, treatments are always referred to in the plural, and frequent reference is made to a “range” of treatments. More specific information about different types of treatments is provided on the pages reached via the next series of links. For example, when following the “Depression” link under the “Consulting an APS Psychologist” page, the reader is given the following information:

Two of the most well-researched treatments are called Cognitive Behaviour Therapy and Interpersonal Therapy. These approaches are structured, specialised and typically far more effective than general supportive counselling. Cognitive Behaviour Therapy is particularly effective in helping to reduce and control thoughts associated with
depression and to develop long-term coping skills to minimise future episodes.

Again, we can see in this extract that although the existence of a wide range of treatments is alluded to, only two are explicitly named. The APS can be seen as attempting to manage the trade-off between directly reflecting the diverse range of treatments available to clients (and offered by its members) and maintaining a clear sense that psychology has some kind of unified position on “what works” by not delving too deeply into the specifics of different approaches to treatment. The APS also avoids taking a potentially contentious position with respect to its membership by selecting as examples treatments that are particularly “well-researched” rather than making any direct claims about the relative effectiveness of different psychological treatments.

General discussion

In the foregoing analysis we have examined how, in its presentation of information to the general public via its website, the APS uses the internet to attend carefully to a number of issues that have previously been identified as problematic in public perceptions of psychology. Three issues in particular were actively managed by the APS across the website: the expertise of psychologists in assisting people to manage “everyday” versus “clinical” problems; the differences between psychologists and psychiatrists; and the effectiveness of psychological treatments.

With regard to the perception of psychologists as either mental health experts dealing with issues such as major depression and schizophrenia, or friendly counsellors who help individuals with less serious problems, it can be seen that the APS switches between these presentations depending on the context. For example, in order to widen
the referral base for psychology and highlight the accessibility of psychologists, the APS are able to underline the role of psychologists in helping “mentally healthy people”. However, when wishing to emphasise the expert nature of clinical services provided by psychologists in order to promote psychologists as providers of Medicare funded mental health care, the APS highlight the role of psychologists in dealing with severe mental health disorders such as major depression and schizophrenia. This presentation of psychologists as being capable of dual roles, without undermining claims to expertise in either one of these roles, requires active management by the APS, and is achieved in subtle ways by the language employed and the information presented.

Concerning the well-documented public confusion between psychologists and psychiatrists, two points can be made. First it can be seen that the APS makes a concerted effort to provide information to the public to allow them to differentiate between psychologists and psychiatrists, but does not show this same concern for the differentiation between psychologists and other professions. Second, with regard to the training of psychologists and psychiatrists, the APS website emphasises positive information about the training of psychologists while de-emphasising positive information about the training of psychiatrists.

Attempts to positively manage the perception of psychologists in relation to psychiatrists can be understood as being driven by the importance of distinctive competence (Andrews, 1971; Selznick, 1957) and economic factors such as the allocation of scarce mental health resources in an increasingly competitive market (Boonekamp, 1994). For example, as we have argued elsewhere (Authors, in press), General Practitioners’ understanding of the distinctive role of psychologists has
important consequences for the degree to which referrals are made to psychologists, which in turn has professional and financial implications for psychologists.

Finally, with regard to the effectiveness of psychological treatments it can be seen that the APS actively argues for the effectiveness of non-medication based treatments in general, and then argues for the existence of a range of specific psychotherapeutic interventions including CBT. These arguments are mostly made using quite non-specific language to describe the treatments; typically, the existence of a range of “well-defined” psychological treatments is noted, and then an example (usually CBT) is given. This strategy allows the APS to strongly argue for the general effectiveness of psychotherapy, which is well established in the literature (Burns & Nolen-Hoeksema, 1992; Horvath & Symonds, 1991; Liechsenring & Rabung, 2008; Martin, Garske & Davis, 2000; Seligman, 1995; Wampold, 2001; ), while avoiding the more contentious and professionally divisive debates about the evidence for specific effects in various forms of psychotherapy (Wampold, 2001). Arguing for the effectiveness of psychotherapeutic interventions is in effect arguing for the validity of psychologists in general as psychologist predominately use psychotherapeutic interventions in their dealings with clients.

The use of the internet by professional psychological organisations as a means of managing the public image of psychology has received little attention in the literature, but it is of course to be expected that the expertise that psychology has in persuasion and impression formation would be employed by the profession itself to promote its own cause. Professional psychology organisations can be understood as being driven by a number of factors including: a desire to increase the number of individuals self-referring
to the profession; a desire to increase the number of groups (such as GPs) referring to
the profession; a desire for the government of the day to have psychologists at the
forefront of their mind as providers of specialist mental health services in the public
system; and a desire to encourage prospective students to enter into psychology as a
profession. These interests are diverse and contain inherent tensions which need to be
managed. These include the tension that needs to be managed between ensuring that
psychologists are seen as having expertise that can be of use to many people
experiencing a range of common, “everyday” problems, while at the same time ensuring
that the role of psychologists in responding to clinically significant mental illness is not
undermined. We have seen how the APS manages this issue in the design of the
“Community Information” section of its website through the use of headings and links
that guide people toward, or away from, certain kinds of information.

Limitations and further research

This paper has outlined some of the methods and rationale for the APS in
managing the tensions associated with the public image of psychology. However it must
be acknowledged that this represents a particular approach taken by one professional
association for psychology in Australia, and that other promoters of psychology and
other professional associations may adopt different strategies. Future research focusing
on the methods and messages used by other psychological bodies in Australia and other
countries will provide a more complete insight into the role of professional associations
in managing the public image of psychology on an international scale, and will enable
greater analysis of the ways in which the presentation of psychology is tailored to the
specific agendas and priorities of the different contexts in which information is presented.

Conclusion

The management of the public perception of psychology is a matter of importance for individual psychologists and for the profession of psychology more generally. In this paper, we have examined some of the ways in which a professional psychology association (the APS) has responded to the task of promoting psychology and psychologists, and of negotiating some of the pre-existing public perceptions of the profession while simultaneously managing the varied interests and practices of its members. By initiating an investigation specifically into the style and content of the messages that psychology presents to the public regarding its professional image, we hope that a wider discussion and debate will be opened about how to best communicate to the public the kinds of help that psychology can provide in negotiating the myriad challenges of contemporary life.
CHAPTER 5B: THE ACTIVE MANAGEMENT OF PSYCHOLOGY’S PUBLIC IMAGE: THE ROLE OF THE APS SUBMISSIONS TO GOVERNMENT AS A MEANS OF MANAGING THE IMAGE OF PSYCHOLOGY

5B.1 Overview

In Chapter 5A I argued that the APS actively presents information to the general public via its website, and attends carefully to a number of issues that have previously been identified as problematic in public perceptions of psychology. Three issues in particular were identified across the website: the expertise of psychologists in assisting people to manage “everyday” versus “clinical” problems; the differences between psychologists and psychiatrists; and the effectiveness of psychological treatments. This analysis showed how the APS presented their message to a diverse audience using the internet as the medium. This current chapter provides a contrasting example of the APS tailoring their message to a very specific audience, using a different medium; namely a series of written submissions made by the APS to government. Between 2003 and 2005 the APS drafted a number of submissions (Appendices C, D, E and F) which were sent to the government to advocate on behalf of psychologists and psychology for the inclusion of psychological interventions on the Medicare rebate. These major changes to the systems governing the provision of mental health care in Australia were introduced in November 2006 by the federal government. The APS had an important role to play in this process in a variety of ways and this chapter focuses on the written submissions to government. It is argued these submissions to government have the same broad goal as the
information posted on the APS website; that is to argue for the profession of psychology as a capable, and in some ways preferable, provider of mental health services. However, in this instance, the message is directed specifically towards the funding body (the Federal Government) rather than the various other stakeholders in psychological health care identified in Chapter 2. This chapter will discuss some of the differences in the way in which the APS makes the case for the value of psychological services in these submissions to government, as compared to the content which currently exists on the APS website. The purpose of this analysis is to highlight the role of the APS in actively managing information according to the context and the type of audience receiving the message.

This analysis of this chapter is based on four documents submitted by the APS to government between 2003 and 2005. Appendix C is the first submission which was written in 2003 and is titled Submission to the Senate Select Committee on Medicare September 2003. Appendix D is the second submission which was written in 2005 and is titled Preliminary Submission to the Senate Select Committee on Mental Health April 2005. Appendix E is the third submission which was written in 2005 and which is titled Submission to the Senate Select Committee on Mental Health May 2005. Appendix F is the fourth submission which is undated and carries the title Meeting Australia’s mental health needs: Increasing community access and decreasing health workforce shortages. A supplementary submission to that sent to the Prime Minister, Chair of the Council of Australian Governments. I obtained these submissions directly from the APS office in September 2007.
5B.2 Thematic differences

5B.2.1 Cost effectiveness versus clinical effectiveness

A striking difference in the arguments made in the APS Medicare submissions compared to the APS website is the emphasis on financial detail and cost effectiveness compared to clinical effectiveness. For example, Appendix F Meeting Australia’s mental health needs: Increasing community access and decreasing health workforce shortages. A supplementary submission to that sent to the Prime Minister, Chair of the Council of Australian Governments, consists of four recommendations with accompanying costings. The first recommendation is for increased access to psychological treatments for mental health problems in primary care settings. This is followed by a discussion of the budgetary impact of the proposed change:

“This is predicated on the notion that not all of the proposed 5000 clinical and mental health specialist psychologists will access a program of MBS items. On the basis that some 2500 specialist psychologists were to see 30 clients per year for an average of 6 sessions per client, this would mean some 450,000 sessions per year.” (p. 6)

The number of sessions per year is then multiplied by the fee for each session (calculated at $107.70 which is the cost for a session greater than 40 minutes under the Better Outcomes in Mental Health Care Initiative), coming to a grand total of $48.46 million dollars.
Another recommendation in the same document is for increased access to psychologists through general practices. This recommendation also has an accompanying discussion of its budgetary implications:

“This is predicated on the notion that BOMHC ATAPS [Better Outcomes in Mental Health Care Access to Allied Psychological Services] involved the expenditure of $11.2m during 2004/2005 and that this was to be expanded during 2005/2006 by another $8.4 million. This results in an expenditure of $19.6 million for the current year. A tripling of that expenditure would mean an additional $39.2 million” (p. 10).

This information is interesting mostly for the level of fiscal detail which has been attended to by the APS. Clearly, this is a comprehensive and meticulous proposal which has been prepared after some significant fiscal research, taking into account a vast range of pecuniary considerations.

The emphasis placed by the APS on the economic viability of psychological interventions is shown across multiple references to cost effectiveness in the APS submissions to government. Two examples out of the many available are discussed below.
For example, in the submission to the senate select committee on mental health (May, 2005) (Appendix E), the APS argues for a link between evidence based psychological interventions and cost efficiency.

“Cognitive –behavioural therapy (CBT) interventions have been shown to be the evidence-based ‘best practice’ for depression, anxiety, panic disorder and alcohol/drug use. For example, CBT is a more effective (and cost-efficient) treatment for major Depressive Disorder than anti-depressant medication (Selective Serotonin Reuptake Inhibitors [SSRIs]) in most cases, especially for youth.” (p. 15)

Overall, the proposal suggests that treatments which are evidence based will be clinically effective in the shortest time possible and as such will also be the most cost effective intervention. While the line between clinical efficiency and economic efficiency is not clearly delineated by the APS in this extract, the point is nevertheless made that “psychological services are therefore developed according to the most effective and cost efficient practice” (p. 15).

A second example can be seen in the submission to the senate select committee on Medicare September 2003 (Appendix C) which concludes with five recommendations listed verbatim (and with emphasis intact) as follows:
“Evidence-based practice should be at the core of a good health service. Applied to mental health or many physical health disorders, this means that psychological interventions should be just as well supported by Medicare as conventional medical and psychiatric services. If, as is suggested above, the psychological treatments are more effective, it would be much better for health program initiatives to favour or direct patients to psychological services.

The principle of universal access suggests that discrimination between services is unsupportable and that evidence-based services that are shown to be cost effective should receive the same backing as other established services.

There are potential cost savings to be generated here. It was noted above that psychiatric consultation and resultant pharmacological scripts account for close to $1 billion dollars per year. Specialist medical services overall may cost between $4 billion and $5 billion per year for consultations alone without adding in the pharmacological costs. If it can be shown that psychological interventions are more efficient, then funds should be redirected accordingly.

Inequity of treatment session limits. If, as is suggested only 12 sessions are felt necessary for treating some high prevalence mental health conditions, then why are psychiatry patients offered 50 sessions (or 220)? To place a similar defensible restriction on psychiatry costs would mean that in place of one psychiatry patient with depression or anxiety with a conventional 50-session
package, **four** other patients could be seen for a CBT or similar treatment package. That is not a 10 or 20 per cent improvement (which would not be a bad achievement) but 400 per cent: **four times the number of services for the same cost.** The possible savings in pharmaceuticals has not even been taken into account.

Issues of accountability and constraint need to be imposed on specialist services. The same detail demanded of GPs should be set for specialist services as well. These issues have often been acknowledged but shelved by government departments as too hard. It would a “fairer Medicare” if accountability for this expenditure of billions of dollars was confronted.” (p. 8).

Four of the five recommendations explicitly refer to the cost effectiveness or economic accountability of psychological interventions. For example the second recommendation argues against the “discrimination” that exists between psychiatric and psychological services and suggests that cost effective, evidence based interventions should receive equal funding as “other established services” (meaning psychiatric services). Similarly, the third recommendation argues for a redirection of funding from psychiatric to psychological services based on notions of economic efficiency.

These explicit references to economic viability and cost effectiveness in the APS submissions can be contrasted with numerous references on the APS website to clinical effectiveness.
For example under the link titled “Consulting an APS Psychologist” the claim is made that “Research shows psychological treatments are effective in managing many common mental health disorders”. This is followed by a link to a new page titled “Effectiveness of Psychological Treatments” which contains the following information:

Research shows psychological treatments are effective in managing many common mental health disorders. Some treatments are at least as successful as medication in treating the most prevalent conditions, such as depression and anxiety.

Around one in five Australians develop common disorders and they have limited access to psychological treatments. These approaches are based on changing behaviour without medication. In comparison, the use of medication, such as anti-depressants, is growing rapidly, with prescriptions doubling between 1994 and 2000. Research into medication has also generally received far more funding than studies of psychological approaches.

The most prevalent adult mental health conditions are depression, anxiety, and substance abuse, which affect around 18 per cent of adults. A similar percentage of children and adolescents develop anxiety, depression and disruptive behaviour.
A review of current research shows that a range of well-defined psychological treatments: are effective at treating the most common mental health conditions; are effective in treating most anxiety and depression disorders; are the treatment of choice for most childhood problems; tend to be more effective than medication over the long term, because people receiving medication only are more likely to relapse after they stop taking it; and are viable treatments, in terms of both their effectiveness and costs.

It can be seen therefore that the APS website information which touches on effectiveness is focused predominately on the clinical effectiveness of psychological treatments rather than the cost effectiveness. The initial claim of psychological treatments being effective in managing many common mental health disorders refers exclusively to the clinical effectiveness of psychological interventions, not the cost efficiency. Moreover, of the five points outlined in extract immediately above, the first four are directed at emphasising the role of psychological interventions with clinical disorders such as anxiety, depression and childhood disorders. There is no reference to cost effectiveness in these four bullet points however there is a small concession to the role of cost effectiveness in the last bullet point which jointly addresses the clinical effectiveness of psychological interventions and their cost efficiency. This is in contrast to the APS submissions to government (as illustrated in Appendix C) which highlight the importance of cost effectiveness, and only make reference to clinical effectiveness by mentioning the notion of evidence based practice.
5B.2.2 Medical and mental health issues versus everyday issues

A second point of difference between the APS submissions and the APS website is the emphasis placed on addressing only diagnosable mental illnesses in the submissions compared to the emphasis placed on both specialist mental health issues and everyday issues in the APS website.

For example the first sentence in the introduction of the APS submission to the senate select committee on mental health May 2005 (Appendix E), begins with a reference to mental health as the leading cause of disability burden in Australia. The mental health issues of particular concern are then identified as “affective disorders (depression, dysthymia, mania, hypomania and bipolar disorder), anxiety disorders (panic disorder, agoraphobia, social phobia, obsessive compulsive disorder, generalised anxiety disorder and post-traumatic stress disorder), eating and substance-use disorders.” (p. 4). This is a clear example of the APS placing serious mental health issues firmly on the agenda with regard to their amenability to psychological intervention.

Further examples can be seen again later in the same document whereby the APS outlines the role of cognitive behavioural therapy for a number of disorders including major depressive disorder, schizophrenia, anxiety, panic disorder, alcohol use, and drug use. In addition to these stand alone psychological disorders, the APS also highlights the role of psychological interventions for disorders which occur in the presence of a pre-existing medical condition by reporting that “there is also considerable evidence of the
beneficial impact of psychological interventions on recovery, treatment adherence and quality of life as well as significant treatment cost reductions for a number of other chronic conditions (cancer, diabetes, and respiratory illness)” (p. 13). In addition to these chronic medical diseases, the APS also comments favourably on the utility of psychological intervention for other medical diseases including the association between heart disease and depression.

A final point of interest that is relevant to this section is the format of referencing used by the APS in their submissions to government. The APS produces its publications according to American Psychological Association (APA) style which employs the author-date format. This style of referencing is used by the APS and all psychology departments in Australia without exception and is the standard format for all forms of writing in psychology from undergraduate assignments to articles in premier psychology journals. APS publications which employ this system include the journals, Australian Journal of Psychology, Australian Psychologist, and Clinical Psychologist, and other publications such as the InPsych Bulletin and a series of regular position papers. However, in the submissions to government on Medicare, the APS chose to employ an alternative style of referencing using numbered references known as the Vancouver system which is widely used in the medical literature. This appears to be an extraordinary departure from convention for the APS whose professional writing in journals, position papers and their website has always previously employed the author-date system.
While the APS has written this submission for government, it is possible that the style of referencing (which is used predominately in the medical literature) has been employed by the APS because they are competing with established medical services that are based with Medicare such as GPs and psychiatrists. If this is indeed the case there are at least two possible reasons for this. The first is that the APS are aiming to “mirror” their target audience with the objective of building rapport and putting the other party at ease. A second possible reason for using the Vancouver system might be that the APS are aware they are writing for the medical community and are simply attempting to make it easier for their target audience to interpret the message. Issues of style and format can be contentious for some academic communities and the deliberate use of a style which expedites the consumption of a particular message might be well received by the reader in some quarters. Nonetheless, the relinquishing of their own, widely adopted style in favour of that of the medical establishment can be read as a move that subtly shows the APS’s recognition of its own relatively low power positions in the negotiations that it is attempting to make.

5B.2.3 The cost and competence of psychiatrists versus the role of psychiatrists

Another point of difference between the APS submissions and the APS website is the emphasis placed on raising questions about the competence and cost of psychiatrists in the submissions compared to the emphasis placed on simply describing the role of psychiatrists on the APS website.
For example in the submission to the senate select committee on Medicare the APS outlines in detail the funding arrangements in place for individuals who seek consultation or therapy with a psychiatrist starting with the statement that “Currently, members of the public with depression or anxiety seeking the specialist services of a psychologist receive nothing from Medicare while the same person referred to a psychiatrist receives a rebate of $141.90 per session” (p. 7, emphasis in original). The point is elaborated on in the same paragraph with the information that this rebate of $141.90 is available for up to 50 sessions per year with a psychiatrist, and is followed with additional rebates of $70 for a further 170 sessions per year. The conclusion is drawn that the full amount of the Medicare rebate can total up to $18,995 which “stands in stark contrast to zero dollars for patients or clients of psychologists.” (p. 7, emphasis in original).

The APS uses two examples here to emphasise the difference between the provision of a psychiatric rebate and the lack of a psychological rebate. The first example is the single session rebate for a psychiatrist of $141.90 compared to no rebate for psychologists. The use of bold print for the word “nothing” is also employed to further highlight to point. This economic line of argument is then reinforced by totalling the number of rebatable sessions available for an individual over the course of a year resulting in the figure of $18,995. Similar to the single session instance, this example is also accompanied with the use of bold print for the word “zero” to further highlight the discrepancy between psychiatric rebates and psychological rebates.
This noting of the discrepancy between psychiatric and psychological rebates is followed by a pointed discussion of the high degree of similarity in the treatment provided by psychologists and psychiatrists, and a parenthetical note that psychologists are in fact better trained than psychiatrists in the provision of these treatments:

“Given the now overwhelming scientific evidence that for many of the mental health disorders common in the community, the most effective and more longstanding treatments are psychological in nature, and assuming a psychiatrist attempts these treatments, one can assert that for the same service the patient gets nothing rebated by the government to see a Psychologist (who, for CBT and other psychological services, is the better trained professional) but $141.90 to see a psychiatrist.” (p. 7, emphasis in original).

This paragraph has a number of features worthy of closer inspection. First is the use of the phrase “overwhelming scientific evidence” which has overtones that are similar to those Smail’s (1978) observation of the word “scientific” which he argues is designed to instil a sense of empiricism and civilisation in the reader. So not only is the evidence “scientific”, but it is also “overwhelming” which conveys to the reader a sense of the vastness and irrefutability of the data. Moreover, the notion of effectiveness is discussed again with the statement that psychological treatments are the “most effective” for “many of the mental health disorders common in the community”. The focus then broadens from only addressing issues of cost, to also discussing the competence of psychiatrists to conduct appropriate treatments. This issue is raised with the statement
that psychiatrists might also “attempt” these psychological interventions. The use of the word “attempt” raises issues of competence, in contrast to other phrases which may have been used such as “conducts”, “performs” or “completes” psychological interventions.

This emphasis on the cost and competence of psychiatrists in the APS submissions can be contrasted with the content on the APS website which focuses predominately on describing the role of psychiatrists. For example the link which takes the reader to the page titled “psychologists and psychiatrists” offers some similarities and differences between psychologists and psychiatrists as follows:

Psychologists and psychiatrists both work in the area of mental health, and often work together. However, there are some significant differences between the two professions in the following areas:

The differences which are subsequently outlined have been discussed previously in Chapter 5A. However for the purposes of the current chapter, it is noted that the similarities and differences outlined by the APS are not focused on the cost of either of the professions. Instead, the APS simply outlines the role of psychologists and the role of psychiatrists describing some of the inherent differences including education, qualifications and scope of practice.
5B.3 Discussion

This chapter has provided an analysis of the APS submissions to government advocating on behalf of the profession for the inclusion of psychological interventions on the Medicare rebate. The aim of this analysis was to provide an example of how the APS tailors its message when communicating to a specific audience; namely the federal government. Across the submissions to government, three issues were identified as points of difference between the APS website and the submissions: an emphasis on cost effectiveness as compared to clinical effectiveness; and emphasis on specialised mental health issues as compared to more everyday issues; and an emphasis on the cost and competence of psychiatrists as compared to describing the role of psychiatrists.

These thematic differences in content between the APS website and the APS submissions to government can be accounted for by the different audiences for whom the content has been prepared. Chapter 2 outlines the different stakeholders who have a vested interest in the psychological health care market including: the consumers; the competitors; the government; the APS; and the referring agents. In contrast to the content on the APS website which appears to have been written from a perspective which takes into account all five of the above mentioned stakeholders, the APS submissions to government were written *by* the APS *for* the government of the day. This narrowing in scope of the reading audience has implications for the content which can be specifically regulated for one particular audience rather than a range of readers. It seems likely from the content in the APS submissions to government that the APS have identified the cost of psychological interventions, the specialised nature of psychologists
as mental health providers, and the cost of psychiatrists as factors which are salient to government when considering the issue of psychologists as the preferred providers of Medicare funded psychological health care. The importance of these factors in the submissions to government by the APS has been achieved by the subtle use of language and emphasis. For example, the cost of psychological interventions is highlighted by the use of bold text; the specialised nature of psychologists as mental health providers is emphasised by linking psychologists with evidence based interventions such as CBT; and the cost of psychiatrists is clearly outlined with a series of detailed financial calculations. These emphases provide a further example of the APS actively managing the public image of psychologists to achieve a particular aim. In this instance it is argued that the aim is to lobby government (as a funding body) for the appropriateness of psychologists as the preferred provider of specialised mental health care interventions.

However, despite the active management of the perception of psychology in which the APS engages, it can also be seen that they possess little power, relative to the government for whom they are writing, and the medical establishment with which they are competing. Hence, the APS are seeking to change the status quo and persuade its more powerful audience of the need to include psychological services on Medicare along with psychiatrists and GPs.

5B.4 Conclusion

Chapter 5 has provided two examples of the APS actively managing the public image of psychologists. In Chapter 5A, it was argued that the APS manage the content on their
website to promote psychology and psychologists, and to negotiate some of the pre-existing public perceptions of the profession while managing the varied interests and practices of its members. In Chapter 5B it has been argued that the APS have constructed a series of submissions to government arguing for the allocation of psychologists as the primary providers of Medicare funded mental health interventions. While there have been subtle differences in presentation between the APS website and the APS submissions to government, likely due to the type of audience which has been targeted by the APS, the overall point has been made that the APS actively manage the public image of psychologists across two different domains.
CHAPTER 6: GENERAL PRACTITIONERS’ PERCEPTIONS OF PSYCHOLOGISTS: A RESPONSE TO THE MEDICARE CHANGES IN AUSTRALIA

The following Chapter 6 has been published in its entirety and in its current form in the Australian Psychologist 2009, 44, 279-290. A copy of the acceptance letter and a PDF copy of this article are available on request.

Title: General Practitioners’ perceptions of psychologists: A response to the Medicare changes in Australia.

Shaun Dempsey & Ngaire Donaghue
Abstract

General practitioners (GPs) have historically been at the centre of primary health care delivery in Australia, including delivery of mental health care services. However, recent changes by the Australian federal government have led to the creation of a number of mental health care items provided by psychologists which are now available on the Medicare Benefits Schedule. The aim of the present study is to examine GPs’ perceptions of psychologists and the ways in which GPs have responded to these policy changes in making referrals for mental health patients. Nine GPs were interviewed regarding the provision of mental health care services. Analysis of the interviews revealed a number of themes including the benefits of the new Medicare policy in increasing accessibility of psychologists, GPs’ frustrations with the bureaucracy surrounding the use of this policy, GPs’ knowledge about the specific skills and training of psychologists, and the importance of GPs’ matching patients and clinicians. Recommendations are made to facilitate the professional and clinical relationship between GPs and psychologists.
Provision of accessible and effective mental health services has become an increasing priority in Australia over the last decade. This increasing attention may be attributable to the growing recognition that the effects of mental health problems are pervasive and economically significant. The proportion of adults with a diagnosed chronic mental health disorder or behavioural problem in Australia has increased over time from 5.9% in 1995, to 9.6% in 2001 and then 11.0% in 2004 (ABS, 2006). In addition to the enormous personal and social costs of mental illness, the economic effects are substantial. For example, depression alone accounts for a minimum of six million work days lost each year in Australia and a further 12 million days of decreased productivity. In 1999 the cost of lost productivity in Australia as a result of mental illness was estimated at $34 billion per annum (The Brain Dynamics Centre, n.d.).

Acute and severe psychiatric services have generally been provided by public inpatient and outpatient mental health services. However, the majority of mental health services for patients in the community with a range of less severe disorders have traditionally been provided by GPs (Andrews, 1994; Harrison & Britt, 2004; Australian Government, 2002). Harrison and Britt (2004) report that the most common mental health symptoms presented to GPs were “mood disorders, stress related disorders, behavioural syndromes and disorders due to psychoactive substances” (p. 781). A study of mental health treatment services in France, the United Kingdom and the Netherlands found that GPs were the primary medical carers for psychological stress as well as providing in excess of 80% of the prescriptions for psychotropic medications (Norton, David, & Boulenger, 2007). GPs are particularly likely to provide the bulk of mental
health services for people living in rural and remote areas, due to the scarcity of psychologists and other mental health specialists in these areas (Caldwell, et al., 2004).

It is likely that GPs’ substantial role in delivery of mental health services is partly due to funding structures which have allowed patients to obtain a significant rebate for health care provided by a GP compared to other health service providers. However, both the Australian government (n.d.), and GPs themselves (Royal Australian College of General Practitioners, n.d.) have explicitly supported GPs as being providers of mental health services. In addition several authors have highlighted the important role of GPs in providing professional help in the first instance for generalised mental health problems (Andrews, Henderson & Hall, 2001; Britt et al., 2004; Charles, Britt, Fahridin & Miller, 2007). With specific regard to depression, Hickie, Pirkis, Blashki, Groom and Davenport (2004) note that “Australians rank their GP as the professional they would most likely turn to if they were experiencing depression” (p. 15).

Psychologists have long argued for a larger role in the provision of publicly funded mental health services (Australian Psychological Society, n.d.), reasoning that as specially trained providers of mental health care, psychologists are best positioned to provide the level of care that will effectively reduce the burden of mental illness in the community. Various levels of government in Australia have recently responded to reports from parliamentary inquiries and independent reviews acknowledging the need for an increased level of participation by psychologists in mental health care service provision. The history and context surrounding the development of these policies is covered clearly in other documents (Moulding et al., 2007; Perkins et al., 2007, van Gool, 2007). In conjunction with this, a range of individual government departments
have highlighted the need for coordination of inter-agency services to provide a more seamless and integrated mental health care system (Council of Australian Governments, 2006). This paper examines responses of GPs to a federal government scheme designed to increase access to psychologists for patients with mental health problems.

Policy changes to increase access to psychological services

In recognition that the majority of people utilised their GP as the primary practitioner for help with mental health issues and that the specialised services of psychologists are under-utilised, the Australian Government has developed policies to better integrate the mental health care services provided by GPs with more specialised mental health professionals.

The Better Outcomes in Mental Health Care (BOIMHC) scheme, introduced in July 2001, was the first of these policies. BOIMHC had two main objectives. First it provided 6 hours of ‘level one’ training to GPs to enable them to identify mental health problems and refer patients to more specialised mental health care professionals, such as psychologists. Second, it provided 20 hours of ‘level two’ training to GPs which was designed to allow them to deliver Medicare funded items referred to as focused psychological strategies. A significant component of the BOIMHC program is the Access to Allied Psychological Services scheme (ATAPS) which has been comprehensively described and discussed in a series of interim reports (Pirkis, Blashki, Headey, Morley & Kohn, 2003; Pirkis, Morley, Kohn, Blashki & Burgess, 2005). The findings of these reports have been very well summarised in a more recent document (Kohn et al., 2007). While both the Department of Health and Ageing (Australian
Government, 2002) and the Australian Psychological Society (n.d.) note the positive effects of the BOIMHC scheme with regard to improving access to psychological services, the APS has argued that the program did not go far enough. Specifically they suggest that it restricted the use of allied psychological services to only those 20% of GPs who had completed the program, thus failing to adequately increase access to psychological services (Australian Psychological Society, n.d.).

In order to address the limitations of the BOIMHC, a second mental health access policy was developed: the “Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS” scheme. This scheme, introduced in November 2006, was developed in conjunction with General Practitioners and led to the creation of a number of mental health care items which are now available on the Medicare Benefits Schedule\(^1\). The items have been designed to assist GPs to engage in the early detection, assessment and intervention of patients with mental health problems, and generate referrals to psychologists and other allied mental health service providers. Under the scheme, as part of a GP Mental Health Care Plan, patients can receive rebates of up $131 per session with a clinical psychologist and $96 per session with a general psychologist for up to 12 sessions.

There are two major ways the system is naturally used. The first is GP driven whereby the patient presents spontaneously to the GP who then makes an assessment and subsequent decision to refer for psychological assistance. The second pathway is more patient driven with the patient deciding to seek psychological treatment (perhaps in consultation with a psychologist) and visiting a GP with the express purpose of arranging a GP mental health care plan. According to the Australian Psychological

\(^1\) Throughout the paper, we refer to this policy as ‘the Medicare changes’
Society (APS) this scheme has had unprecedented success in increasing access to psychological services, with psychologists participating in the survey reporting that “approximately 73% of their clients would not have been able to access psychological services without a Medicare rebate, demonstrating the huge, previously unmet need of the Australian population for access to affordable psychological treatment” (Australian Psychological Society, 2008).

The introduction of the Medicare changes raises a number of interesting questions. The primary objective of the Medicare changes was to improve access to psychological services and the first question asks whether or not this has been achieved. A second related question concerns the effectiveness of the changes and the bureaucracy linked with the Medicare changes. The third question is focused on the factors that GPs take into consideration when making referrals to psychologists, and how this has changed with the introduction of the Medicare rebates for psychological services. Sigel and Leiper (2004) found that GPs in the UK made referral decisions based on their perceptions and views of psychological disorders as well as their professional interactions with psychologists. The final question investigates the extent to which GPs are aware of psychology as a profession and the skills and qualifications which psychologists possess to enable them to take on a large share of mental health care provision. To this end, nine GPs were interviewed to ascertain their views on a range of subjects related to psychologists and the provision of psychological care, in the new climate created by the Medicare changes.
Method

Participants

Participants were all GPs currently practising in a regional city in Queensland. There are 36 GP practices in this regional centre and participants were recruited by contacting general practice clinics and requesting the practice manager to distribute an information flyer to all GPs. Upon expression of interest from GPs, the interviewer then made a mutually convenient time, date and place to conduct the interview. All interviews were conducted at the GP’s place of work apart from one interview which was conducted at a GP’s home at her request. The length of interviews ranged from 12 minutes to 27 minutes. The total combined time of interviews was 2 hours 49 minutes, with the average time for each interview being just over 18 minutes.

Interview format

The interview followed the same format for each participant allowing for responses to specific questions as well as elaboration on those responses. The following topics were covered in each interview: a brief outline of the participant’s experience as a GP; whether they had any special interest or additional training in mental health; factors considered in referring a patient to a psychologist; expectations of services received from a psychologist compared to a psychiatrist or counsellor; the participant’s sources of knowledge about psychologists; understandings of the type and amount of training undertaken by psychologists; the nature of the participant’s contact with psychologists; perceptions of their patients’ views of psychologists; any reservations about referring
patients to psychologists; and whether their referral pattern had changed since the
introduction of the Medicare changes.

All interviews were audio-recorded and then transcribed orthographically. All
participants have been de-identified, and any individuals or institutions referred to in the
transcript have had their names removed to preserve anonymity.

*Analytic approach*

A thematic analysis (Braun & Clarke, 2006) was used to explore the issues that emerged across the interviews with the GPs. A thematic analysis “is a method for
identifying, analysing and reporting patterns (themes) within data. It minimally
organizes and describes your data set in (rich) detail” (Braun & Clarke, 2006, p. 79).
These authors also note that a theme “captures something important about the data in
relation to the research question” (p. 82). The inherent flexibility of a thematic analysis,
its ability to provide a comprehensive and systematic description of the data, and the
opportunity it provides to focus on and illuminate specific aspects of the data make it an
appropriate choice for the methodology in this study.

The analysis began with a close reading of all interview transcripts, followed by a
second reading in which recurring themes were identified. Extracts that best exemplified
the themes were excerpted and analysed. Once the major themes had been identified, the
interview transcripts were read again in their entirety in order to identify any counter-
instances and to ensure that the analysis provided a fair representation of the data.
Analysis and discussion

Several themes recurred prominently across the interviews, and are discussed in turn below.

Accessibility

One of the major themes evident in the data concerned the extent to which the Medicare changes had made psychological services more accessible to the general public. There was a mixed response from GPs with regard to the impact of the Medicare changes on affordability and accessibility. For example in Extract 1, P was very positive about the Medicare changes:

Extract 1

P: and I have to say that the Medicare changes have been fantastic around access... because it’s made it financially accessible to people who otherwise just couldn’t really do it or could do it for a couple of sessions maybe (.) but would really struggle to do it

Similarly, K was generally positive about the effect of the Medicare changes citing improvements in access and cost to support the point:

Extract 2

K: I mean one of the reservations up to now has always been the cost issue and availability so (.) ummm (.) you know there was the public system where people didn’t have to pay anything but they often had to wait a considerable period (.) which could have been a problem (.) and then if they wanted to go privately they’ve got concern about expense (.) with the introduction of the mental health
items that has certainly improved .) and ummm so that reservation about just access and cost has improved considerably

However, some GPs were more circumspect as can be seen in the interview with D, who acknowledges an increased referral rate based on improved affordability, while also conceding that the gap between Medicare rebate and the up front fee of some psychologists is more than some patients are able to afford.

Extract 3
D: I’m probably referring more of those who said that they couldn't otherwise afford to go using the mental health (. ) plan …. I did a mental health care plan for someone and she still couldn’t afford the difference so she’s on the program through the division where they pay a ten dollar co-contribution

The assumption that private psychological care was now affordable for patients was also questioned by B, who in addition to pointing to the substantial gap between the cost of a psychological consultation and the Medicare rebate also noted the negative effects of decreasing the availability of services through the public mental health system.

Extract 4
B: patients are generally disappointed cos they expect it’s gonna cost them nothing and it still costs them quite a bit with most psychologists …. it’s a little bit more affordable for some people but it actually hasn’t solved the affordability problem and the other thing that’s happened is it’s pretty much impossible to get much done in the public system now cos they just all flick it and say you can get it through Medicare (. ) so they see them once and then say go back and see your GP and get a mental health care plan.
Thus although most GPs considered that the Medicare changes had improved the accessibility of psychological services, some were still keen to point out that financial barriers to access still exist for many patients, and that the new policies have not solved access issues entirely.

**Bureaucracy**

A second theme which was evident in the interviews relates to the processes involved in using the new mental health care plans to allow patients to access psychological treatment through the new scheme. The overwhelming trend pattern across the interviews was for GPs to express frustration related to the process of completing the GP mental health care plans, as evidenced by the following extracts:

**Extract 5**

K: there’s always the initial frustration of the …paperwork and bureaucracy involved in making a referral (.) there’s no way you can do a decent job a of GP mental health care plan in fifteen minutes (.) I tend to get people to come back for half hour appointments so I can do a reasonable job of it.

K refers explicitly to the “frustration” the “paperwork” and the “bureaucracy” involved in completing the mental health care plans. The impossibility of completing a mental health care plan in the typical GP session of 15 minutes is also outlined as is K’s solution which is to book a second longer appointment for patients who require this service. This reference to the bureaucracy surrounding the mental health care plans, and the strategy of booking double appointments is also supported by A in extract 6.

**Extract 6**

A: this bureaucratic process really just gets in front of it (.) I’ve made that point I think probably in spades (.) the problem is that now it’s almost a disincentive to
the GP in the sense that to do a mental health care plan properly (.) and to administer the tool properly and so forth is the work of thirty minutes

In addition to referring to the time required to complete a mental health care plan, A makes the point that rather than making it easier for patients to access psychological services, the new mental health care plans can actually act as a “disincentive” for GPs. Implicit in this comment is the notion that prior to the introduction of the mental health care plans it was easier and thus more common to refer to psychologists. Hence it can be seen that according to A, the bureaucracy involved in completing the mental health care plans may have nullified some of the intended positive effects such as increased accessibility. This is further highlighted when A comments:

Extract 7

A: well certainly the bureaucracy (.) the so called Medicare changes have not made it easier – and there is still a vast pool of treatable psychopathology sitting out there in the community unaddressed because the system makes it so hard.

The theme of mental health care plans being unwieldy and time consuming is continued with M who states:

Extract 8

M: the other thing that I have...on a frequent basis recently since they've started is the mental health care plans…with psychologists referring people (.) just telling people just go and see your doctor and get one of these knocked out so they book a standard consult and the paperwork is not something that can be done in a standard consult for a new patient (.) ummm and but they come with the expectation it will all be done (.) I’d say the vast majority of the people don’t fit
the criteria …. (.) so they don’t actually fit so but then it turns into the GPs all lying (.) I turn into the bastard because I say you don’t fit this qualification.

In this extract M also supports the notion that a mental health care plan can not be completed within the time constraints of a standard GP appointment. Moreover, in this extract we also see the beginnings of some of the relationship dynamics and subsequent tensions between GPs and psychologists with regard to the writing of mental health care plans and the provision of psychological services.

Essentially, GPs rely on psychologists to provide high quality, effective psychological interventions for their patients. Psychologists, on the other hand rely on GPs for a percentage of their referrals and patients who desire Medicare funded intervention from a psychologist can only access this benefit with a referral from a GP. However, GPs are clearly stating they do not have adequate time to thoroughly generate and process these referrals. Compared to the usual medical process of writing a referral letter to a specialist, the current bureaucracy surrounding the mental health care plans is seen as cumbersome. Consider the following extract from A who outlined the limitations of the Medicare changes.

Extract 9
A: the current Medicare system (.) is atrocious… and the reason why it’s atrocious is that I have to prepare a mental health care plan (.) which presupposes some form of mental illness (.) and presupposes that first of all that I know and can adequately administer you know an assessment tool (.) which I can’t (.) I was never trained to you know the ones that you know (.) and then that somehow or another I’m going to administer the same tool six weeks or six sessions down
the line and somehow or another sit in judgement over my colleague as to whether they've (.) you know (.) I mean the system's ludicrous (.) if I want your heart cut out I write a letter to the cardiothoracic surgeon that's all I need to do (.) if I need some assistance with some CBT which is a technique I'm not trained in (.) I ought to be able to send somebody off to a colleague for a reasonable Medicare rebate with as little fuss as possible

The tensions that are generated between GPs and psychologists are seen again in this final extract from B who provides one further piece of evidence that mental health care plans can not be completed in a standard GP consult.

Extract 10

B: some psychologists will just tell the patient to come here and (.) and get a mental health care plan so they can access the rebates…which doesn't really work when you've got 10 minutes to do it.

It seems clear therefore, that GPs feel they do not have adequate time to attend to the mental health care plans which are necessary for the client to receive a Medicare rebate. The frustration felt by GPs at trying to complete a mental health plan in a standard 15 minute consultation was clearly expressed across the interviews. This frustration can perhaps be seen as somewhat self-inflicted, as the recommended fee of $153 for a mental health plan is intended to provide for a long consultation (30 minutes), and perhaps some of the dissatisfaction around the bureaucratic processes would be reduced if this time allocation were recognised. However, although the time burden was a major concern for most GPs, others issues, including the lack of training and expertise needed
to assess the mental health problems of patients, and the expectations of patients that GPs would simply ‘rubber stamp’ their requests for a mental health plan were also a significant source of concern.

**Issues in making a referral**

A third theme which was evident in the data was the concern and consideration taken by GPs when referring their patients for psychological care. GPs were generally very conscious of matching their patients’ needs with a psychologist who could provide an appropriate psychological intervention. Moreover, GPs showed a marked preference for referring their patients to a psychologist with whom they (the GPs) were familiar.

**Matching**

Throughout the course of data collection there were a number of issues which spontaneously arose when asking GPs about their referral process. One of these was the issue of matching clients to psychologists where possible. The GPs who participated in this study seemed routinely aware of the subtle nuances involved in psychotherapy and commented on the importance of matching their patients with an appropriate psychologist. Some of the issues which were seen to be important in achieving a suitable match between patient and psychologist were factors which are routinely used to organise, and assist with the smooth running of society such as gender, age spirituality and sexuality. However, other factors were more specific to the realm of health care including the type of disorder exhibited by the patient, and the financial considerations.
inherent in receiving psychological care. The importance of gender when matching clients to a psychologist is outlined in the following extract.

Extract 11

P: I worry about my younger female patients that I’m referring (.) I would feel (.) …a lot of them would have had abuse histories…and (.) ummm (.) so I try and choose (.) a psychologist that the patient will feel overtly very safe with (.) right from the beginning…and I think gender for a lot of my patients is a very big (.) I mean I have patients who who won’t even see male doctors

In this extract, P has outlined the importance of gender with regard to referring young female patients to male psychologists. In addition to this P has also made a direct association between the gender match between patient and psychologist and the subsequent ability of the psychologist to provide an overtly safe environment for the client.

The issue of matching client/psychologist personality is complex and important and clients can be easily deterred from seeking psychological assistance following a negative experience with a mental health provider. However, personality is one area of matching for which it is difficult to control as acknowledged in the following extract provided by K.

Extract 12

K: yeah (.) and ummm and whether it’s the right person for the patient (.) and to some extent that’s never going to be possible to answer entirely cos you can never entirely predict whether any given person is going to hit it off with any
known psychologist or. there’s always that to some extent or. personality aah or. which you can’t predict.

**Known versus unknown psychologists**

A second issue which spontaneously arose when asking GPs about their referral process was the notion that GPs tend to refer to psychologists they know, rather than psychologists per se. This is illustrated clearly in the following extract from B.

Extract 13

B: well my main reservation would be not knowing the individual and what they're like and. there’s not really good opportunities to find out ummm or none that I'm aware of or. to find out what individuals are like ummm so or. that would be my main res or. ... as a group referring to psychologists I don’t have a problem but or. they do vary a lot and without knowing what each individual’s interested in or what they’re like or. yeah it’d be or. I’d be a bit reserved with someone I knew nothing about

In this extract, B emphasises the importance of knowing the psychologist to whom referrals are made. In the following extract, A takes responsibility for referring patients to a psychologist who is considered trustworthy and raises the stakes from knowing the psychologist to trusting the psychologist. In this context, the concept of trust in a professional relationship between GP and psychologist, could reasonably encompass overall clinical competence and reputation, and specific clinical competence to deal with particular disorders or issues. When asked if he had any reservations about referring patients to a psychologist, A replies:
Extract 14

A: Provided it's a psychologist that I trust (.) and it's up to me to make sure that
the referrals are appropriate (.) no

A makes clear in this statement that referring patients to an unknown psychologist,
just because they are a qualified member of the profession of psychology, is not
adequate. Rather, the importance of knowing and trusting the individual is highlighted.
This is further emphasised by P who makes an explicit distinction between knowledge
of the individual compared to knowledge of the profession of psychology.

Extract 15

P: I would have a particular person in mind (.) someone if it’s maybe a man with
PTSD or something like that I have (.) there are particular psychologists I use
but that's more from personal knowledge of them rather than (.)
Int: knowledge of the profession per se
P: yes exactly

Finally, K offers a similar view based on matching the patient’s needs to
the psychologists expertise when he says:
Extract 16

K: one of the reservations is you just don’t know as much as you’d like about that psychologist or counsellor (.). what their strengths and weaknesses might be (.). whether they’re going to be right for the particular patient that’s sitting in front of you (.).

It can be seen across these extracts that GPs don't necessarily refer their patients simply to qualified psychologists. Rather, they refer their patients to qualified psychologists they know and trust and who have the skills for that particular patient. However, this orients us to the point raised by B in extract 13 who lamented the lack of opportunities to get to know individual psychologists. It seems clear that GPs take the notion of the therapeutic relationship seriously, and prefer to refer their patients to a psychologist who is likely to be appropriate for their patient with regard to age, gender and clinical need.

Professional identity

The previous section shows that GPs have a clear preference for making referrals to psychologists with whom they have an existing relationship. However, if there are indeed limited opportunities for GPs to get to know individual psychologists, are GPs comfortable in referring to psychologists on the basis of their professional identity? In the following extract, A suggests not.

Extract 17

A: that’s where it comes from (.). look (.). this is a very difficult art and (.). as I’ve mentioned before not everybody can turn the trick (.). the ones who have seen
people who really do it (.) they’re not a problem they understand (.) it is my view that there are lots of people sticking their hand up saying I can listen to your problems (.) that really don’t have either the training or if they’ve got the training don’t have the expertise to really be effective (.) ummm that’s clouded by the fact there are a lot of people out there with so many problems and so few resources that (.) you know nobody’s really gonna be terribly successful (.) but there’s also a lot of people out there charging people money for being a very sympathetic ear (.) and no more (.) that really makes it difficult for the good clinical psychologists (.) you know there really needs to be a much more effective regulating mechanism (.) you know just so you get some idea (.) I understand the size of what I’ve said (.) on the one hand if there was a banner saying I am a clinical psychologist and I could depend upon that in the same way as I could depend on somebody having had say a surgical degree to be able to conduct the business of clinical psychology then I’d be I’d be very grateful for that

Int:  mhmmm

A:  not everybody who has a fellowship of the college of surgeons is a good surgeon

Int:  mhmmm

A:  lots of people who have a F R A C S will never ever get to see a patient of mine if I can help it

Int:  mhmmm

A:  but at least I have a banner there that says we’ve whittled down the ummm list and you can pick from here and you’ve got a reasonable chance within this group of finding what you want (.) that really doesn’t clearly exist (.) at least from my perception in clinical psychology (.) I referred also to this great well of
psychopathology that's sitting out there people who are emotionally uncomfortable and are seeking you know more emotional comfort if you took away all the willing ears and just left the clinical psychologists that problem of access would become even worse

Int: mhmmm

A: ummm and so what I'm suggesting is that there needs to be a clear sort of a label yes I have been trained in among you know in clinical psychology and in the techniques of clinical psychology and I appreciate there are labels and so forth they're just they're not visible you see

Int: I mean it sounds like you've had experience with people who are clinical psychologists or at least call themselves clinical psychologists who don't deliver the sort of service that you're after

A: I'm afraid there's too many of them

Int: yep

A: yeah I'm afraid there's too many of them and I suspect that that's because there isn't across australia you know any university can offer a degree just about that it calls clinical psychology there isn't a body like for example the australian medical council that goes around accrediting medical schools and says listen this isn't just up to specs sorry you're going to have to do this again otherwise you won't be able to use this label for your graduates that sort of raising of the standards of education so that if you've got a qualification then across australia everybody knows you've reached a certain standard I think that's important

Int: and that's not in place for clinical psychologists

A: well it's not my perception that it is

178
In this extract, A clearly expresses the perception that there is not a governing body responsible for accrediting psychology courses in universities in Australia; an inaccurate perception as this role is carried out by the Australian Psychology Accreditation Council (APAC) on behalf of the State and Territory Registration Boards. There are also some other problematic messages contained in this extract. First, when A states that there needs to be a “clear sort of a label”, the subtext to that message would seem to be that currently the label of “clinical psychologist” does not have as much validity or currency as might be expected. According to A, a GP runs a “reasonable” chance of finding a “dependable” surgeon following a referral to someone who has a surgical degree. In contrast to this, the business of referring a patient to a clinical psychologist is not considered dependable. A points out the importance of marketing, branding and labelling for the profession of psychology and makes an unfavourable comparison to the profession of chiropractic which has successfully educated the public as to its scope of practice.
During the course of interviews GPs were asked to outline their understanding of the type and amount of training undertaken by psychologists as well as the various sources from which they had gained their knowledge of psychologists. This question yielded a range of results however GPs were rarely in possession of the full facts with regard to this issue. Some responses were vague:

**Extract 18**

Int: and (.) what is your understanding of (.) ummm (.) the training that psychologists undertake

C: (.) right well I assume it’s a fairly intensive training and analysing problems and different therapies to deal with that as opposed to just your medicinal ones (.) mmmm

However, most responses did include the notion that psychologists completed a university degree and some further training consisting of either placements or further postgraduate study. For example K states that:

**Extract 19**

K: the average psychologist has probably been through (.) at least sort of three maybe four years of university training (.) and then I’m not sure about post university placement whether there’s like a supervised period

And B supports this notion of a university degree with further training and supervision with the following statement:
Extract 20

B: well obviously you need a university degree first (.) and then I understand you need your clinical ummm (.) to get your clinical psychology you’ve got to do some more training and supervision and get assessed but I don’t know details

Sources of knowledge

During the course of interviews GPs were also asked to outline the sources of their knowledge about psychologists. Many of the GPs interviewed identified a range of secondary sources such as information from their medical degree, patient comments, working in the same locality as a psychologist, or even letters from psychologists about their patients as their major source of information. For example M openly conceded his lack of contact with psychologists and suggests that written correspondence with psychologists has been his primary source of information about the profession.

Extract 21

Int: from where have you got your existing knowledge of psychologists

M: aaah look I actually don’t know any of them ummm (.) I haven’t met any of them ummm (.) vaguely ummm (.) a lot of the time again it’s self referral so people rock up and say I’ve booked an appointment with whatever whoever I just need a referral ummm and (.) basically correspondence is the main way I’ve sort of done it

B also outlines written correspondence as a major source of information about the profession; however in this instance verbal correspondence is also identified as a primary source.
Extract 22

Int: whereabouts have you got your existing knowledge about psychologists from

B: hmmm(.) well from(.) talking to psychologists(.) or from patients back and forth(.) letters that they’ve sent(.) basically that I guess

However, later in the interview, B reinforces the importance of written correspondence as a source of information about psychologists, and adds that patient comments relating to their experience with a psychologist can also provide useful information about the profession.

Extract 23

B: patients will come in telling me someone was particularly good and they were very happy with them(.) umm(.) and the other(.) if I got a good letter back giving me good information(.) that’s helpful to me when I’m seeing the patient as well

Int: so does the(.) your patient feedback shape your perception of psychologists

B: well fairly largely because that’s the main access I have to any information(.) or letters if they do send a letter

This lack of direct experience of psychologists as a source of information about the profession is reinforced with S and K who suggest their primary source of the profession as information received during their medical degree. For example S states:

Extract 24

Int: from where have you got your existing knowledge of psychologists
S: ummm just through my medical degree

And K supports this with the statement:

Extract 25
Int: from where have you got your existing knowledge about psychologists
K: aaaaah (.) ok (. ) got to think about that (. ) I mean obviously there was some (. )
     introduction to it through the undergraduate medical degree

However, for those GPs who work in a clinic which has a resident psychologist, the response can be very different. For example, P works in a GP clinic with a number of psychologists. In contrast to the previous extracts in which GPs identified a range of secondary sources as their primary supply of information about the profession of psychology, P identified working directly with psychologists, and the immediacy and frequency of communication and interaction as a major influence on her perception of the profession.

Extract 26
P: and I can understand that that's fine and that's probably all you've got time for
   and it's probably adequate (.) but the difference between that and being able to
   ( .) have a cup of tea with the clinical psychologist you know the psychologist
   who saw your patient the previous day and you've seen that patient the next
day ( .) and to be able to say well tell me what happened what do you think
   how's it going ( .) is completely different.
Int: so that's the major factor that it's ummm ( . ) the proximity and the
    immediacy
P: It’s the immediacy and the frequency...of the feedback you know so I can say to... I really need to speak to you just really quickly about so and so...what do you think (.) how do you think he’s going and she'll say blah blah and I'll say that’s great I'll follow that up at the next appointment or so it’s that... kind of team approach that I work very happily in

And later in the same interview P further emphasises the role of proximity by commenting on the experience of working with psychologists off site compared to those on site. The construct of confidentiality is seen as a crucial factor which outlines the difference between working in close proximity with psychologists, and having a less direct working relationship with them.

Extract 27

P: interestingly the psychologists that work off site are far more (.) seem to be a lot more (.) leery of conversations (.) it’s almost like they are more worried about patient (.) inappropriately worried about patient confidentiality...whereas the ones I work with (.) we are able I think to have very effective conversations without impairing patient confi you know I don’t need the content of what they’re talking about but just the broad strokes and I find that very helpful whereas the telephone conversations can be a bit (.) ummm (.) more circumspect (.)

There is a clear sense that the ability of a GP to work effectively with a psychologist is influenced by factors such as proximity and medium of communication. This is illustrated by P’s comments when she acknowledges the role of proximity in allowing for immediate and frequent communication that produces more “effective
conversations” than are available when working with psychologists who are not physically co-located, and where the conversations can be more circumspect.

**Discussion and conclusions**

The Medicare changes were designed to increase the availability of psychological services for patients with mental health care needs. On the one hand, the APS have declared the changes a resounding success, although, having lobbied cogently and vehemently for these changes for some years prior to their introduction, it could be argued the APS has a vested interest in the success of the new changes. On the other hand, GPs working at the interface of policy change and clinical service provision are somewhat more equivocal. While some GPs are openly optimistic about the changes, others are ambivalent or even negative. It should be noted however, that even the GPs who are negative about the current Medicare changes are not negative about increasing community access to psychological services per se. Rather, they have criticisms about how the changes have been set up and administered. Moreover, a large portion of these criticisms are related to the bureaucracy of the GP mental health care plans which are time consuming to complete. The major issue appears to be GP workloads and the increased burden of paperwork which has arisen with the new Medicare changes.

With regard to the second two questions related to referrals to psychologists and professional identity, the data suggest that GPs want to know more about the psychologists to whom they are referring. It seems clear that GPs prefer to deal diligently with the notion of matching their patients with an appropriate provider of psychological services. It also seems clear that GPs have a limited understanding of the
type and amount of training undertaken by psychologists. This raised two important issues for GP’s of knowing and trusting the psychologists to whom they are referring. It could be argued that to know a psychologist is a relatively straightforward process which begins with being aware of their credentials and qualifications. In contrast to this, the notion of trusting a psychologist is a more complex construct which demands that, in addition to knowing the amount and type of training undertaken, one must also be aware of the details of the person: their ability to empathise with a patient; their reliability with correspondence; their proven clinical efficacy over a significant period of time. These constructs of knowing and trusting are inextricably linked with issues of proximity and the subsequent immediacy and frequency of communication.

Limitations

The purpose of this research was to address a set of questions about the recent Medicare changes related to accessibility, bureaucracy, referrals to psychologists, and GP perceptions of psychologists. We have provided some preliminary answers to these questions on the basis of interviews with GPs who are working within the new mental healthcare frameworks provided by the Australian Federal government. However, there are a number of limitations to the present study. The number of participants in this study was relatively small and it would be useful to follow up the experiences of GPs with the Medicare changes using survey research with a larger sample of respondents. However, one of the benefits of the qualitative approach employed in this study is that respondents were easily able to express their ambivalence about the consequences of the Medicare changes when referring patients out for mental health care, and their opinions of the
professional identity of psychologists. Furthermore, all participants in this study were drawn from a single mid-size regional city in Queensland. Although GPs are likely to encounter many of the same issues wherever they practice, there may also be systematic differences between metropolitan, regional and rural practitioners which we were unable to address in this study. Future work which addresses the particular issues facing practitioners in different regions and with a range of practice profiles would be valuable.

**Recommendations**

In response to the issues outlined above, a number of recommendations are made. First, to facilitate the process of GPs getting to know who psychologists are and what they do, it is recommended that an appropriate body gain access to the training arena of new medical graduates to provide detailed information to medical students. This information could encompass issues such as recognising mental health disorders, appropriate referral criteria, and the best way to make and maintain professional relationships with psychologists. Moreover, once these medical students have graduated, it would be appropriate for more specialised information to be provided to new graduates who are working as GPs and are enrolled in the two year GP registrar program. The Mental Health Professionals’ Association (MHPA) is comprised of four prominent mental health bodies in Australia including the Royal Australian College of Psychiatrists (RANZCP), the Australian Psychological Society (APS), the Royal Australian College of General Practitioners (RACGP) and the Australian College of Mental Health Nurses (ACMHN). These four bodies oversee the clinical and operational standards for each of their professions. A possible model to commence the training of
new medical graduates and established GPs could see the RANZCP, the APS, and the ACMHN providing information to the RACGP who then formally educate their GP members.

A second means of assisting GPs in knowing and trusting psychologists is the co-location of GPs and psychologists. It is anticipated that co-location will enhance communication, increase trust between the professions and lead directly to improved outcomes for those patients presenting to GPs for mental health disorders. This is not a new recommendation; the APS have previously lobbied for more formal links between GPs and psychologists in the form of co-locating (Australian Psychological Society, 2005). Indeed, the APS has taken this argument further suggesting the need for the restructuring of the Divisions of General Practice into Divisions of Primary Care which would then accommodate GPs, psychologists, nurses, physiotherapists, podiatrists and a range of other allied health care providers.

However, while co-location of psychologists with GPs has been associated with better health outcomes (Moulding, et al, 2007; Perkins, et al, 2007) there are potential disadvantages which also need to be considered. For example while psychologists who are embedded in general practice may have more opportunity to engage in informal liaisons with GPs, this also leads to an increased risk of psychologists losing contact with mental health services. Secondly, the issue of GPs actually having rooms available becomes an issue, and finally the notion of co-location means that the referral base for psychologists is somewhat limited with GPs being reluctant to refer outside their general practice. Nevertheless, whichever path is ultimately taken, it seems that the proximity
which allows for immediate and frequent face to face contact between GPs and psychologists is a crucial factor in improving communication.

Finally, to reduce the bureaucratic load on GPs with regard to the GP mental health care plans, and facilitate the smooth referral of potential mental health clients to psychologists, it is recommended that a significantly abridged referral process be introduced for GPs allowing them to quickly and easily request an initial assessment by a psychologist. If this initial assessment reveals the presence of a diagnosable mental health disorder, the psychologist could then direct the client back to the referring GP with initial clinical findings and the advice that a 30 minute session is required for the construction of a mental health care plan. The benefits of this approach are that the GP may circumvent the writing of a mental health care plan for those clients for whom it is not appropriate, and secondly that psychologists can provide valuable clinical advice for GPs which may then be used in writing the mental health care plan. With this model the psychologist is compelled to direct clients back to the GP for the mental health care plan and the GP remains at the hub of primary health care provision. However in addition, the GP also receives useful clinical advice which can be used in formulating the mental health care plan. Furthermore, most psychologists are familiar with the various outcome measures such as the Kessler Psychological Distress Scale (K10) and the Depression, Anxiety and Stress Scale (DASS) which are required by Medicare at assessment and review. Hence they could administer and interpret these tools at assessment, review and discharge (which is part of their expertise) thereby further reducing the workload of GPs. It is anticipated that this increased role of psychologists would enhance the processes of assessment and mental health care formulation for clients seeking publicly
funded psychological care on Medicare. Moreover, it would lead to a reduction of the bureaucratic load on GPs while still respecting their role as the principal provider of primary health care services.
CHAPTER 7: CONCLUSION

7.1 Overview

The current dissertation has had as its focus the public image of psychologists which was explored using four qualitative empirical studies each investigating a different aspect of the issue. This aim of this final chapter is to draw together the findings of these four empirical studies, discuss their implications for the public perception of psychology and recommend directions for future research in the area of public perception of psychologists.

7.2 Introduction

Chapter 4 discussed some of the methodological options to use when investigating the public image of psychologists and presented initial data about how a selection of members of the public perceived psychologists. Chapter 5 presented a range of extracts describing how the major professional association for psychology in Australia (the APS) was actively involved in the construction and management of the public image of psychologists. The third study provided a contrasting example of the APS tailoring their message to a very specific audience by using a medium other than the internet; namely a series of written submissions to government to advocate on behalf of psychologists for the inclusion of psychological interventions on the Medicare rebate. Finally, chapter 6 explored GPs’ perceptions of psychologists with regard to training and expertise and a range of recommendations were made in light of the findings.
The profession of psychology has become more prominent and has arguably increased in importance and relevance over the last century. As a relatively young profession, psychology is continuing to define its roles and boundaries and at this point in time our Western culture is particularly invested in the notion of psychological well being (World Health Organisation, 2001). Awareness of the impacts of mental illness, such as family dysfunction, economic losses, suicide and personal distress, has prompted governments to elevate the importance of the psychological well being of its citizens to heights not previously attained (National Health Service, n.d.). This has created enormous opportunity for the profession of psychology which potentially has a much larger role and degree of social relevance than ever before. However, to take full strategic advantage of this, psychologists need to be able to clearly articulate their role and understand how they are perceived by the general public.

Previous research to ascertain the public image of psychologists has been conducted (Webb & Speer, 1986; Warner & Bradley, 1991; Wollersheim & Walsh, 1993). This research resulted in a range of important initial data regarding the public perception of psychologists. For example, Webb and Speer (1986) pointed to the confusion that exists in the public eye between psychologists and psychiatrists, also noting that psychologists and psychiatrists were preferred over counsellors when dealing with more severe issues. Warner and Bradley (1991) also identified a lack of understanding of the role of psychologists, and rated psychiatrists as the preferred clinician when dealing with severe disorders or cases requiring medication. Wollersheim and Walsh (1993) reported that their participants lacked understanding of, and confidence in psychologists. Moreover,
they found that participants “generally preferred treatment by psychiatrists or counselors, even though psychologists were rated more favorably than psychiatrists on personal qualities” (p. 171).

While one of the themes in these findings is the confusion about, and lack of confidence in psychologists, another important theme arising from these studies is that participants were forthcoming with their views on psychologists, even though it was clear that they lacked knowledge about the role of psychologists. This expression of firm views about psychologists despite a lack of understanding regarding their exact role is one of the limitations in these studies. Rather than responding to the interviewers’ queries on the basis of a personal interaction with a psychologist, or direct clinical experience with a psychologist, these participants were expressing an opinion of psychologists based on their own representation of psychologists. Rather than considering this as a source of error or bias in people’s reports, this thesis argues that social representations of psychology and psychologists constitute a large part of the knowledge that people draw on when forming and expressing their “personal” opinions about psychology. Accordingly, this thesis has employed a methodological approach based on social representations theory to investigate the public perception of psychologists and psychology from a number of angles. The use of social representations theory in this thesis has allowed for an analysis of the construct of public perception in a way which adds to previous quantitative studies by facilitating a deeper and more multifaceted investigation. Specifically, an example of the benefits of employing a qualitative social representations type of approach can be seen in Chapter 5. Previous studies have often
noted the confusion among members of the public about the differences between 
psychologists and psychiatrists (Grossack, 1954; Guest, 1948; Nunnally & Kinross, 
1958; Sharpley, 1986; Thumin & Zebelman, 1967; Von Sydow & Reimer, 1998; Webb 
& Speer, 1986). This confusion was also found among participants in the study reported 
in Chapter 4 of this thesis. As a social representations perspective draws attention to the 
fluid, dynamic and interrelated aspects of public opinion, rather than simply noting the 
public confusion about psychologists and psychiatrists and then moving on, in Chapter 5 
the intersections between this issue and other important aspects of the public perception 
of psychologists are examined. That is, rather than asking why psychology as a 
profession (as represented by the APS) is not doing a better job of clearing up public 
confusion about the role of psychologists compared to psychiatrists, Chapter 5 examines 
how the need to promote the distinctive competence of psychologists is managed at the 
same time as parallel (and sometimes competing) concerns such as the wide range of 
services offered by psychologists (from the management of mental illness to the 
promotion of well being and the effectiveness of psychological treatments). This level of 
examination provides some insight into the why and how of the public perception of 
psychologists rather than simply the what which has been the major concern of previous 
studies.

7.3 General discussion

To add to the already existing quantitative data pool, the empirical study in Chapter 4 
contrasted the results obtained by the previous methodology (Webb & Speer, 1986; 
Warner & Bradley, 1991; Wollersheim & Walsh, 1993) with what participants were 
actually saying. Compared to the aggregational approach employed in previous
quantitative methodology, the qualitative approach of asking participants directly what they thought about psychologists provided an additional and informative dimension to the data pool. Participants who had rated psychologists in a particular way using the quantitative tool employed by previous authors (Webb & Speer, 1986; Warner & Bradley, 1991; Wollersheim & Walsh, 1993), often subsequently spoke about psychologists in an entirely different way when asked directly to provide their opinion. For example, one of the participants reframed the concept of introversion from a negative characteristic to a positive characteristic by alluding to the ability of the psychologists to get beyond the surface issues. Similarly, the same participant in Chapter 4 equated the notion of a psychologist being interested in the client with being too emotional thus providing a justification for the psychologist being “uninterested” in the client. This finding has been taken into consideration during the data collection phase in Chapter 6 whereby GPs were directly asked to provide their perceptions of psychologists with regard to training and expertise in light of the recent Medicare changes.

A second finding in Chapter 4 was that participants displayed a lack of knowledge about psychologists in general, and the difference between psychologists and psychiatrists in particular. Specifically, it was shown that an individual can express a perception about psychologists based on what they know about someone who is not a psychologist (in this case a psychiatrist). The literature is clear about the confusion between psychologists and psychiatrists (Amrine, 1965, Guest, 1948, Grossack, 1954, Nunnally & Kinross, 1958, Thumin & Zebelman, 1967, Webb & Speer, 1986), and Chapter 4 in
this dissertation has provided a supporting qualitative perspective on this matter. Extract 7 in Chapter 4 provides a clear example of a participant who formed her perception of psychologists on the basis of information she had received about psychiatrists.

In light of the uncertainty in the public eye surrounding the role of psychologists and psychiatrists, it is pertinent to ask whether the profession itself sees this as a problem, and if so, how it is managing this confusion. Consequently, the issue of confusion between psychologists and psychiatrists was one of the prominent concerns of Chapter 5 which provided a range of extracts describing how the APS were actively involved in creating and managing the public image of psychology and psychologists. The APS is the major professional body for psychologists in Australia representing the views of over 17,000 members. Chapter 5 is based on extracts from the APS website, and a series of submissions to government that highlight a range of ways the APS actively manages the public image of psychology and psychologists. It is suggested that the ways in which psychology’s public image is actively managed has become more important as a result of the increasing social relevance of psychologists. Moreover, the parameters around the role of psychology are considered crucial because it is proposed that the public will develop an image of psychologists in relation to the tasks that psychologists perform, and the clientele with which psychologists engage. Hence, the issue of the flexibility and stability of psychology is thrown sharply into focus. It has been suggested that health care providers “are increasingly aware of the changing relationship with the environment and especially of the need to be more responsive to consumers” (Boonekamp, 1994, p. 11). The present research investigation suggests that the
profession of psychology may benefit from establishing and maintaining a flexible approach in the face of the highly dynamic health care market in which it operates. The advantage of this flexible approach is in ensuring a broad referral base, and a professional stance capable of taking advantage of future potential professional opportunities. However, it should be noted that a potential disadvantage of this approach is in the dilution and attenuation of the public image of psychology. If one is to be “all things to all people”, then one’s public image is likely to be fuzzy and poorly articulated. The trade off of having a broad referral base, which it is argued is crucial to maintaining viability in a competitive health care market, may be the eventual degradation of the public image of the profession, which can be seen to be ultimately damaging to market viability. Hence, flexibility must be balanced with clarity of role at any one time.

Chapter 5A discussed a number of ways that the APS are engaged in the active management of the public image of psychology and psychologists and suggested that there are good economic and professional reasons for the APS having a vested interest in the promotion of a positive image of psychologists. For example the notion of distinctive competence (Andrews, 1971; Selznick, 1957) outlines the importance of a particular profession identifying its specific capabilities to ensure market viability in the face of competitors who may have similar qualities. Hence, the identification of psychologists as providers of non-medication based interventions sets them apart from psychiatrists who are identified on the APS website as providers of primarily medication based interventions. Further motivation for the APS positively promoting the profession
of psychology is provided by economic factors in the current health care market which see an increasing amount of competition for public mental health care funding. It stands to reason that if psychologists are perceived as accessible and well trained practitioners who employ effective interventions, they will be viewed by government as potential providers of specialist mental health care, and will receive at least a fair share of self referrals and referrals from GPs. With specific regard to the government’s perception of psychologists, Chapter 5B investigated the subtle ways in which the APS managed the image of psychologists, and advocated for the profession through a series of written submissions arguing for the inclusion of psychological interventions on Medicare. With specific regard to GPs’ perceptions of psychologists and taking contemporary marketing and financial considerations into account, Chapter 6 built on the background provided by the previous two empirical studies and directly asked GPs about their perception of psychologists with specific regard to training and expertise. The collection of data from GPs was undertaken in light of their role as the primary referrer of individuals with mental health disorders to psychologists.

Some GPs were openly optimistic about the Medicare changes which increased patient access to psychological services while others were ambivalent or even negative. However, the negativity which did arise was predominately directed at the implementation of the GP mental health care plans which were considered bureaucratic and time consuming to complete. The data in this study suggested that GPs liked to match their patients with an appropriate psychologist (in terms of gender, expertise and personality) and therefore wanted to know more about the psychologists to whom they
were referring. The data also suggested that GPs had a limited understanding of the type and amount of training undertaken by psychologists and a number of recommendations were put forward to remedy this including co-location and increased training for GP registrars. In response to the GPs’ concerns about the bureaucracy of the mental health care plans it was further recommended that a significantly abridged referral process be implemented where GPs make an initial referral to a psychologist who then administers the Medicare mandated outcomes tools (K10 and DASS), and makes some recommendations for the GP to incorporate into the mental health care plan. This simultaneously reduces the bureaucratic load on GPs and makes better use of psychologists’ expertise in mental health.

This thesis argues that the extant literature devoted to the role of psychologists and the public understanding of psychologists is scant relative to the importance of the topic. There may be at least two reasons for this. First, psychology is a relatively young profession attaining some prominence in the early to mid decades of the 20th Century as outlined in Chapter 2. This lack of experience and exposure in the professional arena, compared to other professions such as medicine and teaching, necessarily means that the role description of psychology will be less well developed, and thus the tendency to engage in self reflection and professional contemplation will be similarly underdeveloped. Second, much like the disciplines of law and ethics are in a perpetual state of “catch up” with the sometimes precocious developments of science (Mnyusiwalla, Daar, & Singer, 2003), psychology is currently attempting to keep up with the burgeoning social relevance it has experienced in recent decades. While it can
be seen that the discipline of psychology is sometimes driving the increase in social relevance as evidenced in Chapter 5 where the APS make a case for the increased accessibility of psychologists and psychological interventions, the profession needs to simultaneously attend to an improvement in the literature surrounding the role and relevance of psychology.

This recent higher profile of psychologists in the community and increasing social relevance has implications for the public perception of psychologists. For example, as outlined in Chapter 4, individuals can and do make judgements about psychologists based on information about other healthcare professionals including psychiatrists highlighting the need for clear and concise information about psychologists. As a result of this, Chapter 5 investigated two particular sources of information about psychologists; the APS website and a range of submissions to government designed to argue for the inclusion of psychological services on Medicare. Chapter 5A provided one example of the APS managing the image of psychologists via their website particularly with regard to issues of psychological efficacy, the confusion between psychologists and psychiatrists and the role of psychologists as either mental health specialists or everyday counsellors. Chapter 5B provided a contrasting example of the APS managing the image of psychologists in their series of submissions to government designed to argue for the inclusion of psychological services on Medicare. This lobbying by the APS made a significant contribution to the recent Medicare changes which form the background for the questions asked in Chapter 6. As a result of these changes, psychologists have been thrust into the foreground as national providers of specialised mental health services.
with over two million claims for psychological services having been made from November 2006 to May 2008 (Carey, Rickwood & Baker, 2009). This represents an enormous opportunity for psychologists who can seize upon this recent increase in social relevance to advance the profile of the profession. However, this also represents a threat to the profession of psychology with the potential for misinformation about psychologists to cause long lasting damage to the profession.

7.4 Limitations and future research

The empirical studies in the current research investigation represent an alternative approach to the quantitative methods which have been previously employed when examining the construct of the public image of psychologists. The issue of methodology was the focus of the first empirical study in this dissertation where it was recommended that a qualitative approach be employed as an adjunct to the aggregational approach previously used. An obvious criticism which may be levelled at the methodology of the empirical chapters in this dissertation is the limited number of participants who were interviewed during the data collection phase. While it is acknowledged that greater numbers of participants would likely yield a more fully representative sample, it is also argued that the data body used in these studies is representative of some aspect of the public image of psychologists. Sack’s notion of “order at all points” as discussed in the conclusion of Chapter 4 suggests that focusing on the micro detail in individual cases can reveal important properties of the construct as a whole. Therefore, the data from one participant must be taken seriously as providing a piece of the puzzle which ultimately comes together in a representative amalgam. It is not suggested that the findings in this
dissertation are incontestable; rather they are presented here to provide an alternative to the purely quantitative approach which has previously been employed, and to give important insight into some of the questions which have been posed, as well as informing future direction for ongoing research.

With general regard to the public perception of psychology, it is recommended that while future research should expand on this study and provide further data related to the profession of psychology, the issue of gaining an understanding of the public perception of the science of psychology should also be addressed. Indeed academics in the field of psychology with their twin interests in science and research should be well placed to undertake this initial research. With specific regard to the generally poor level of understanding about the role of psychologists, future research could expand the range of participants from undergraduate students to members of the general public. Moreover, when seeking perceptions specifically about psychologists it may be beneficial to distinguish between populations who have personal experience with seeing a psychologist, and those who do not, to identify possible trends in perceptions of psychologists as a function of having experienced psychotherapeutic assessment or intervention. Finally, the issue of the perception of general psychologists versus clinical psychologists within the profession has come to light as a result of the recent Medicare changes which cater for clinical psychologists at a higher rate than general psychologists. This has generated a considerable degree of tension specifically with regard to value for money (Carey, Rickwood & Baker, 2009) and would be highly worthy of further research to ascertain if there is any difference in public perception
between these two categories. With specific regard to the role of professional associations as active managers of the public image of psychology, future research could focus on information provided by the APS in venues other than the APS website or the submissions to government which have formed the data set for the analyses in Chapter 5 of this thesis. Examples include media releases, extracts from APS publications including the InPsych Bulletin, state newsletters, position statements and review papers. In addition, it may be beneficial to analyse data sets from other professional associations such as the British Psychological Society and the American Psychological Society. This would provide further information about the ways in which professional associations write for different audiences. For example, state newsletters would primarily be written for the audience of psychologists, whereas position statements may be intended for distribution through the media to be ultimately received by psychologists, GPs, the education department or government (just to name a few).

With specific regard to General Practitioners’ understanding of the role of psychologists, it is recommended that further data be collected from GPs regarding their ongoing perceptions of the impact of the Medicare changes. The processes surrounding these changes are relatively new and it would be prudent to engage in follow up interviews with GPs in 12-24 months to allow time for all parties to adjust to the new changes, and for existing bureaucratic problems to be acknowledged and solved. In addition to this it is also recommended that a three way dialogue be set up allowing collection of data from individuals who have been referred to psychologists by GPs. For example, qualitative interviews could take place simultaneously with both the referring
GP and the patient who has been referred to gain a broader view of the perception of psychologists from both of these sources. This approach is likely to yield a range of consistencies and discrepancies in the perception of psychologists which would be worthy of more detailed examination. A final comment surrounds the direction of research in psychology to date which has traditionally focused on “doing the work” by paying attention predominately to clinical and theoretical issues. However, it is suggested in this current research investigation that while maintaining the focus of this research direction is important, it would also be of significant benefit to the discipline to highlight the professional issues surrounding psychology including the public image of psychologists, and devote specific resources to creating research opportunities to investigate these issues. The recent burgeoning social relevance of psychologists combined with a dynamic and fluid health care market make this additional research domain in psychology a priority.

### 7.5 Concluding comments

The current applied psychology thesis investigated a number of questions around the public image of psychologists using a qualitative approach employing aspects of social representations theory (Abric, 1993; Moscovici, 1988) and thematic analysis (Braun & Clarke, 2006). Core themes identified include the lack of clarity between the roles of psychologists and psychiatrists as expressed by clients, the various ways that the public image of psychologists can be actively constructed, and the confusion around the role and skills of psychologists leading to the need for further education of stakeholders. Furthermore, the effectiveness of psychological interventions was identified as an
important issue with regard to the validity of the profession, and thus the perception of psychologists as generated by stakeholders in the general public.

The current research investigation has recommended further research into the public image of psychologists particularly in light of the recent increasing social relevance of psychology. The contemporary health care market is a dynamic and competitive environment and the profession of psychology needs to find a balance between flexibility – which maximises the applicability and appeal of psychology to a wide range of potential consumers – and stability, ensuring that stakeholders have a clear understanding of the role and skills of psychologists. It seems likely that the social relevance of psychologists will continue to increase in the future and this will require an attendant emphasis on research designed to investigate the intricacies of these phenomena. The use of a multifaceted approach, such as that employed in this thesis, which allows for flexible, dynamic and intersecting contributions to the public perception of psychology will provide an opportunity to consider how these systems of attitudes and opinions combine to form perceptions of psychology at a particular moment in time.
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APPENDIX A: Transcribed data for Chapter 4
Participant 1: “A1”

Int: Alright A thanks for coming in today. Umm (. ) you participated in the first phase of my study which was aah filling out the questionnaire in (. ) during lecture time (. ) and the results from that ummm (. ) I'll just feed them back to you (. ) umm they indicated you had a fairly positive perception of clinical psychologists

and I just wondered if you could sort of elaborate on the results you gave in the questionnaire

A1: Ok (. ) Umm I'll start of with the, I remember I put ahh the only question I ahh question I put a (. ) zero for was first one about I think emotional content cos umm or empathy with the client and I (. ) I can see that having advantages and disadvantages so at the end of the day I thought they balanced each other out [laughs] in terms of being good to be able to empathise with someone but you don't want to empathise too much cos you might kind of get into a co-dependent situation (. ) the the client might latch on emotionally to the therapist so it's good to be able to [coughs] have skills in dealing with that and I think that's probably (. ) umm I'd probably rate that as probably one of the higher skills that's I think is needed by a good clinical psychologist is how to deal with all the transference and counter-transference and how to umm (. ) yeah deal with all that stuff

OK umm and I think the other questions were were largely a function of education and training which I think's important umm just to have a broad base of understanding of what's been done in the past and umm just the whole history of psychology I guess and diagnosis and all that sort of (. ) those sorts of issues are pretty fundamental

Int: OK lovely and I was gonna mention umm your first point about the emotional content I guess it it (. ) says um that er the characteristic is umm being cold, uninterested, introverted and odd and yeah I notice you rated that as a er neutral characteristic rather than say a positive or a negative characteristic

A1: well It's the way it's used you know I think that's probably and that’s [coughs] ummm yeah it can (. ) emotions can be used for [laughs] good things or not good things it depends on the intention I think of the (. ) clinician. Umm so

Int: OK so intent's very important rather than umm the actual (. ) is it the way
that you use it or the intent of how you're using it. I think
the intent I mean what's umm (. . .) yeah er why you're doing what
you're doing umm sure there may be there may be generation
of emotional content but if that hasn't got a clear intention
about why you're doing it I think the potential for some sort
of manipulation ummm could, could occur and that could
be quite damaging.

Int: OK sure (. . .) I wonder if you could that that's very clear I
wonder if you could give me an indication of when it would be
appropriate to display some of these characteristics
being cold, uninterested, introverted or odd when when the intent
would warrant umm the use of those particular characteristics
A1: well if someone's umm I dunno, I did a tutorial presentation
on EMDR with Vietnam Vets and say (. . .) you know you got a
vietnam vet talking about [coughs] some you know he's reliving
some traumatic memories all about people getting cut and
bodies everywhere I mean it'd be pretty in that situation
it'd be pretty good to have a fairly neutral emotional
interaction with their description because otherwise the
therapist (. . .) or clinician can would be biased if they got
emotionally involved with that I mean on the one hand though (. . .)
in that situation you still want to be able to have sort of some
sort of empathy with them but you don't want to kind of umm
[coughs] get caught up in their stuff so in that situation (. .)
having a a neutral emotional position would be I think an asset

Int: OK sure, I understand. Umm (. . .) I guess that just takes us onto
the next area I want want to chat briefly about and that is
umm (. . .) tell me what you know about clinical
psychologists.

A1: Ummm (. . .) oh just mainly what I've read [laughs] in first
semester I mean (. . .) umm (. . .) I've got a friend who's umm (. . .) I
don't think she's not (. . .) I know she's got her masters but
I'm not sure if she's actually done her registrar period (. .)
but she's sort of told me a bit about it, just the amount of
study that needs to be done and er it sounds pretty ummm full on
[laughs] not sure if I want to do it myself [laughing still]
but yeah it sounds like there's a lot of hard work goes
into it so I guess at the end of the day you think when people
finish that ummm you think you'd like to think they know what
they're on about which I think is a pretty natural assumption
given the amount of time one invests in it.

Int: OK so you're saying there's a direct
correlation between the amount of years that someone spends
studying a particular area and (. . .) is it their competence in
that area or there sort of general status in society?

A1: Ohh probably more related to their [coughs] competence I mean
I would correlate you know the years of study of any
profession with you know what they do at the end like you know
medicine or engineers or whatever umm

Int: OK

A1: yeah so I don't really [sighs] I probably [coughs]
associate the status to a secondary characteristic rather
than the primary
Int: So that tells me that inside the field of clinical psychology because of that level of education you consider them to be relatively competent.

A1: Ok. What can you tell me about where what they actually do inside that category of clinical psychology and perhaps how they relate to other other disciplines (.) maybe like psychiatrists (.) counsellors ummm (.) so I guess what I'm saying is intra (.)

Int: clin psych you've given me a good idea as to (.) the notion that level of education equals competence.

A1: but inter discipline how do you see clinical psychologists fitting into that picture?

A1: Ummm (.) well I guess I could see them working with in a relationship with psychiatrists because from my understanding ummm correct me if I'm wrong but a clinical psychologist can't administer drugs? Is that right?

Int: that's correct.

A1: Yeah. So obviously then someone that they thought was (.) you know had schizophrenia for example they could obviously refer them to a psychiatrist who could then (.) give them drugs or if they needed or people with other conditions that they felt needed some sort of drugs so obviously obviously on that level I can see them working in (.) umm a relationship or in tandem with a psychiatrist. Ummm or another umm ohh I dunno say a neuropsychologist someone who say had [coughs] some sort of brain damage or something and they needed to ummm I dunno get some ummm medical diagnosis

Int: Yep

A1: of how their brain's working I could see them working in that field (.) or ummm (.) I know Murdoch offers a minor in forensic psychology which ummm (.) I can see them working with police you know I mean not I guess a forensic psychologist is more would work more in detail than say a normal clinical psychologist obviously but I mean again there's some (.) interface there ummm and people in education and so forth and so yeah

Int: Yeah

A1: I see a fairly you know [coughs] while on one level it's a quite a specialised field I can see it having a quite w-w-w wide interface with different areas of the community.

Int: Yeah sure. (.) Ummm (.) and you've given me you've outlined there a couple of diff specific differences perhaps between psychologists a clin psych and a psychiatrist and that is that one gives medications 'a psychiatrist'

A1: Mmmhmm

Int: and the other one doesn't. I wonder if you could (.) ummm perhaps give me any differences that you're aware of between (.) any more differences you're aware of between clinical psychologists and psychiatrists or even clinical psychologists and counsellors.
A1: Well with psychiatrists I mean my I've got a friend of mine who's a medical doctor and she's actually spending this six months doing her pre (.) ahh registration to start to start her training to be a psychiatrist which from all she's told me takes quite a few years

Int: sure

A1: so she's been working at Graylands doing some horrible shifts doing electro (.) shock therapy [laughs] so ummm which it's I'm glad it's her not me I don't think I'd have the stomach for that but I've I think psychiatrists obviously are doctors and then they do additional training mainly in mental disorders and knowledge of drugs that's my general understanding of psychiatrists. Ummm (.). counsellors ummm (.). well (.). ahhh (.). how can I put it ummmm (.). I think psychologists I think probably have a greater (.). knowledge of ummm (.). say the history of psychology and (.). the way that science is put together and the various perspectives in psychology and human behaviour perhaps than than counsellors, counsellors probably have a more down to earth, practical (.). ummm [coughs] I don't know if practical's the right word but from more of their own experience than say a psychologist (.). ummm I guess which has pros and cons a con being that they might be terribly biased in their opinions about things whereas I hope to think a psychologist would be a bit more open minded and given the scientific training (.). would be able to be more critical about diagnosing things (.). and testing things and being more rigorous in that sense.

Int: ok

A1: whereas a counsellor may be a little bit more subjective and probably wouldn't have the breadth of knowledge of say a psychologist would (.). ummm (.). yeah (.). ummm though I can see (.). you know [coughs] from what I've been told at the information night one of the speakers ummm who was talking about psychology and work said (.). ummm in the psychology undergraduate course there's not much counselling (.). practical counselling done so (.). ahh whereas a counsellor probably (.). may have better inter may have better counselling skills cos maybe that's you know they spend more time working on that.

Int: Ok how would you define counselling skills and do you see that psychologists (.). use counselling skills and if so to what degree compared to a counsellor?

A1: Ummm well I guess it depends where the psychologist wants to work ummm (.). cos I know like Curtin Uni for example does a Masters in counselling psychology which which this university doesn't so (.). I like to expect that a psychologist who wanted to go more into counselling would probably do a masters in that field so they would (.). again I haven't looked into it a great deal myself but I'd like to assume they would pick up on their counselling skills ummm in a much more specialised way and probably at the end of the day would just be as you know as good as a counsellor and probably have more knowledge given their theoretical background (.). Ummm that's I guess one answer but (.). ummm (.). [exhales deeply] I'm just trying to think of something specific I I guess (.). you know (.). ummm [laughs] what
am I trying to say here (.) I guess just off the top of my head
I

\text{Int:} \hspace{1cm} \text{l sure}

\text{A1:} \hspace{1cm} I imagine I have this image of a counsellor being probably a bit more ummm (.) probably a bit better able at creating empathy and emotional rapport than a clinical psychologist probably a bit bit more distant

\text{Int:} \hspace{1cm} \text{Ok}

\text{A1:} \hspace{1cm} yeah that's probably what I'm get getting at and and for some people that may be a problem

\text{Int:} \hspace{1cm} \text{can you see it being an advantage at times as well?}

\text{A1:} \hspace{1cm} Oh definitely yeah because [coughs] problem with as I said when I started if you have too much of an emotional rapport it can be get (.) incredibly ummm subjective and ummm (. ) all sorts of problems with transference so it's a bit of a tricky one and and I imagine a psychologist particularly one who's done say counselling a masters in counselling would be much more aware of (. ) the intricacies of that issue maybe than just a counsellor who hasn't done any any more training.

\text{Int:} \hspace{1cm} \text{Sure (. ) ummm there's a there's a couple of times you've mentioned issues of transference and counter-transference and I'm quite interested in (.) if you could give me a ahhh an idea of your understanding of those concepts.}

\text{A1:} \hspace{1cm} well ummm (. ) well given generally well my understanding is say someone goes to see a clinical psychologist for an issue say on failures or whatever ummm (. ) given that the clinician is in a position of power or authority (. ) ummm the client may start relating to them as if they relate to a power figure in their life like their dad or their you know something like that or else (. ) ummmm (. ) [coughs] the clinician may have mannerisms or behaviours that reminds them of someone that they hate (. ) again I'll use their dad as an example so

\text{Int:} \hspace{1cm} \text{ls sure}

\text{A1:} \hspace{1cm} right from the start (.) by the clinician just being who they are they may the the client may be inadvertently projecting stuff onto them that maybe they don't even know themselves they're doing that's interfering with the way that the the therapy's proceeding (.) so [coughs] (. ) ummm so I guess those are probably is an example of how I see transference where (. ) ummmm (. ) other behaviours from other relationships are brought into the room

\text{Int:} \hspace{1cm} \text{and counter-transference?}

\text{A1:} \hspace{1cm} Well ummmm from the therapist back to the (. ) clinician (. ) back to the client? Umm (. ) well again I mean the the [laughs] client may remind the therapist of someone they really dislike from a past relationship or a past experience or (. ) again people have a habit of reminding people of other people and ahhh you know that can I guess work for the positive or negative or maybe in a male female situation you know there may be some sort of sexual attraction or sexual dynamic going on

\text{Int:} \hspace{1cm} \text{sure}

\text{A1:} \hspace{1cm} which could be a real problem

\text{Int:} \hspace{1cm} \text{ok mate (.) thank you very much for that the last thing I just wanted to ummm to bring up or to ask you (.) really

\text{A1:} \hspace{1cm} \text{l Mmmhmmm}
Int: is have you had any direct experience of (. ) a clinical psychologist (. ) either yourself or immediate family
A1: I've been to see I have had a few sessions with a psychologist but she wasn't (. ) a clinical psychologist she just had the degree of basic ummm (. ) she just had a BA in psych so I actually haven't (. ) ummm no I don't think I've actually seen a fully registered clinical psychologist no
Int: Ok ok (. ) I just wa sorry I've realised that ummm we've only lightly tou touched on the notion of where you've got your information about clinical psychologists from (. ) you did mention something I can't remember where
A1: ummm mainly through well I have done a (. ) a couple of years ago (. ) I finished a psychotherapy course and there were a couple of
Int: I see
A1: (. ) I'm pretty sure there was a couple of (. ) at least one woman was definitely a clin psych (. ) ummm (. ) that comes to mind (. ) and I dunno I guess through talking to other people (. ) you sort of pick up what (. ) how the story works and also being here at the information evening it was pretty clear what how the whole thing works
Int: here at the university you mean
A1: yeah (. ) ummm so it's just through my own experiences and reading really
Int: sure
A1: yeah
Int: Ok ummm unless there's anything else you want to talk about with regard to your perception of clinical psychologists then I'm happy to uhh to call that finished
A1: Ummm (. ) yeah just probably just one more thing
Int: sure
A1: (. ) I (. ) I know the one of the I think it was Sandy Williams mentioned it's about a hundred and sixty bucks an hour and to be to be quite honest about it (. ) probably one of the (. ) I mean [coughs] I was looking you know looking at it (. ) unless you can get a rebate on your health insurance I think the cost is certainly pretty prohibitive (. ) to be honest (. ) umm umm
Int: Ok so you see that as a positive factor with regards to clin psych's or negative
A1: well probably negative in the sense in the initial analysis of it because (. ) on the other side of the equation you get what you pay for so if you're gonna fork out that sort of money you're gonna get a good service (. ) but (. ) I dunno that's something that ummm [coughs] (. ) ahhh you know I can I can all you know due to that cost due to that cost they're only gonna attract a certain clientele that can afford that so I guess that's all [laughs] I really want to say on that one [still laughing]. They're sort of pitching themselves to a particular market
Int: and and that (. ) I agree and do you see any problems with that?
A1: (. ) aahhh (. )
Int: and I guess more importantly how does that make you feel about the profession

237
A1: well (.) [exhales deeply] I guess I've got mixed feelings about it (.) cos (.) I mean it depends how you look at it I mean if you look at it purely as a business thing that's fine but (.) I dunno (.)

Int: do you see psychologists as business people?
A1: (.) to a degree yeah I definitely do I think you've got to be business minded I think I mean everyone runs a business ummm and helping people is a business and It's you know [laughs] big business so I don't have a problem with that attitude I guess probably ahhh (.) I guess it just gets back to what the clinician's intentions are (.) what they want to do and all (.) that sort of stuff but (.) ummm but I guess from just looking at you know you look at probably people that (.) ummm ahh hang on (.) I guess what I feel frustrated about is that (.) ummm (.) due to the cost you won't be able to people that probably need help probably won't get it

Int: ok and just to finish that off how does that make you feel about the profession?
A1: (.) probably frustrated

Int: ok
A1: yeah (.) frustrated I would say
Int: sure thanks for that
A1: yeah
Int: is there anything else you want to add before we finish?
A1: No that's about it
Int: Alright (.) thanks A.
A1: No worries

Participant 2: “A2”

Int: Hello ummm I just wanted to go through some of the things that you put on the questionnaire that you filled out in class last week.
A2: Mmmhmm
Int: Ummm (.) it seemed to me that your overall impression of clinical psychologists was very positive
A2: Yeah [laughs]
Int: would that be fair to say?
A2: Mmmhmm
Int: Ok (.) there were a couple of things that stood out ummm one was ahhh (.) that you felt that they were very dedicated and persistent and well trained (.) ummm (.) and very helpful and caring and good listeners and so on (.) there's a few other things as well (.) I wonder if you can just elaborate on your general perception of clinical psychologists particularly (.) in light of the fact it was a fairly positive perception (.) and I'm just wondering where that comes from.
A2: (.) ummm (.) dunno [laughs] (.) ummm (.) cos my friend is a psychologist
Int: I see
A2: yeah (.) she seems very nice and caring [laughs] [inaudible]
Int: Ok (.) your friend works as a psychologist?
A2: yeah (.)
Int: Ok (.) here in Perth?
A2: No she works at Sydney
Int: I see (.) right. Is she a clinical psychologist or a different type of psychologist?
A2: She's finished her Bachelor of psychology (.) I think she's doing Masters now (.) I thinks she's doing clinical
Int: Yep ok (.) that's great what what do you know about what she does
A2: (.). Hmmmm (.). not a lot [laughs] (.). yeah (.)
Int: has she told you (.). ummm you know about certain aspects of her job or her course?
A2: (.). Hmmmm no
Int: Ok
A2: cos she lives in Sydney so it's really hard to
Int: Have you got your perceptions of clinical psychologist from anywhere else perhaps other sources, other people or other areas.
A2: (.). Hmmmm (.). [laughs] Maybe from TV
Int: Ok great. What have you seen on the TV?
A2: (.). ummm (.). it's Chinese videos I just recently watched
Int: Ok tell me a bit about them
A2: Ummm (.). ummm (.). just (.). se:::em helpful to a person that needs (.). yeah [laughs] in need [laughs] ummmm ryeah
Int: iok that's interesting can you tell me how the person was in need?
A2: Ummm (.). it was ummm (.). not so (.). ummm (.). happy with his family members
Int: sure
A2: and he became very (.). didn't talk much to his family and
Int: I see
A2: a psychologist help him (.). to work things out
Int: Ok great. Did you get a an idea of how the psychologist went about helping him work out those difficulties with his family [inaudible]
A2: (.). Ummm (.). ummm (.). sort of (.). he just like made him draw a lot because he it was his way of expressing
Int: I see
A2: he couldn't say it but he could (.). draw yep [laughs]
Int: sure (.). ok ummm (.). what other ways did the psychologist use to to help this man work out his problems?
A2: Ummm (.). he found he the (.). what do you call them the client's friend [laughs] to help him
Int: the which?
A2: the client's (.). friend
Int: I see yes
A2: yeah (.)
Int: so the psychologist helped this young helped this person by working with his already existing supports (.). his already existing social supports
A2: Yeah
Int: Ok (.). Ummm (.). ok (.). ummm you’ve also said ummm that you think that clinical psychologists are very patient, calm self controlled (.).

A2: [laughs] I think they should be

Int: ok

A2: L cos if you’re not patient then (.). you won’t sit there long enough to listen to their client what they have to

Int: MMMmmmm

A2: say (.). and you won’t be able to help them (.). because you won’t listen

Int: so do you think that clinical psychologists are patient or do you think they should be

A2: (.). I haven’t (.). hmmm (.). seen or met a (.). clinical psychologist (.). I think they should be

Int: Ok (.). that’s fine (.). that’s clear (.). ummm (.). I guess you’ve also said that ummm (.). you don’t think that clinical psychologists are bossy and hostile

A2: [laughs]

Int: and greedy and egotistical

A2: Mmmhm ummm (.). I dunno [laughs] ummm (.). can’t mmm bossy [laughs] ummm (.). [laughs]

Int: Ok no no that’s fine (.). I guess something that’s ummm of interest to me A is (.). exactly how much you might know about clinical psychologists ummm you know say compared to other professions like a psychiatrist or a counsellor could you perhaps tell me the difference between a psychologist and a psychiatrist?

A2: [laughs] (.). ummm I don’t think yeah I really met one (.). I don’t think I could (.). tell you

Int: Ok (.). do you know how many years training a psychiatrist has?

A2: (.). mmmm no?

Int: Ok (.). and a psychologist?

A2: a psychologist as in just so (.).

Int: a clinical psychologist

A2: Umm is it seven?

Int: ahh (.). it’s six yeah

A2: oh six oh [laughs] I thought it was seven. well in this country

Int: anyway [laughs]

A2: oh

Int: Yeah yeah (.). ok (.). ummm you also said to me that you’ve got some of your ideas about clinical psychologists from (.). are they movies in China?

A2: [laughs] Mmmhm movies from Hong Kong

Int: from Hong Kong

A2: yeah

Int: Ok (.). ummm (.). is there anywhere else that you’ve got your ideas about clinical psychologists from?

A2: (.). Hmm (.). ummm (.). ummm (.). don’t think so

Int: Ok (.). and I suppose finally umm have you had any direct experience yourself or immediate family of clinical psychologists?

A2: (.). no
Participant 3: “H”

Int: Ok H thanks for coming in (. ) ummm I just wanted to chat with you about the results of the questionnaires
H: Mmmhmm
Int: that you filled out for me the other day ummm it seems that overall you had a very positive impression of clinical psychologists
H: Yep
Int: and I just wondered if you could elaborate on that a bit for me
H: ahh why I had such a positive Mmmhmm
Int: yeah
H: ummm oh I guess it's I know a few ummm I have a few friends that are psychologists and a couple that are clinical psychologists and they're really great people (. ) ummm that's probably why and I sort of know what they do and what they're like ummm I guess you know that's probably why (. ) ummm I have a high opinion of them cos I know them and I think they've got great qualities.
Int: lovely tell me a bit about those qualities
H: ummm I think ummm oh well they are (. ) they are kind of quite let me think umm (. ) they are objective I think in their approach to things but they also have a side to them which is also ummm they have like a humane side ummm (. ) I think they're very understanding people but I think the good thing about it is ok they're empathetic and everything but they can actually remove themselves from a situation and give their advice from an objective point of view so they have like the sort of the human (. ) ahhh personable side but they also have that objective side
Int: I see
H: so I think that's a really good balance
Int: ok
H: and inter interpersonally I deal with them on a social level I know I sort of know their ummm what they're like as people and they're really great but also I know that from a professional point of view from other people I know they're quite successful in what they do
Int: ok that's great tell me a little bit about that about what you know about clinical psychologists professionally with regards to other people
H: ok
Int: how they're successful
H: ok ummm well so about how I perceive it
Int: yeah I guess you you mentioned then that you know ummm that some people who have been to see clinical psychologists in a professional
H: yeah
Int: capacity
H: yeah
Int: yeah and you said that ummm that you've known that the clin psychs have been quite successful
H: yep
Int: I just wondered if you could tell me a bit about that
H: Ummm I guess ummm well I guess it's just like what I meant was I knew more by reputation as opposed to knowing people that go to
Int: I see
H: acquaintance might say you know they're quite successful in what they're doing and they've progressed really well ummm as opposed to having known people who've actually gone to them I guess
Int: I don't mean patients
H: friends of friends I don't have patients I don't have people directly umm I guess it's just also having met them and also heard what I've heard about them ummm that's sort of given me the sort of good perception of them ahhh successful only because I know they've done really well in their career umm as opposed to having known people who've actually gone to them I guess
Int: I see
H: that's probably what I said like I umm where you know acquaintance might say you know they're quite successful in what they're doing and they've progressed really well ummm as opposed to having known people who've actually gone to them I guess
Int: I don't mean patients
H: friends of friends yeah friends of friends I don't have patients I don't have people directly umm I guess it's just also having met them and also heard what I've heard about them ummm that's sort of given me the sort of good perception of them ahhh successful only because I know they've done really well in their career umm as opposed to having known people who've actually gone to them I guess
Int: I see
H: someone who's gone to them and been really happy with ahh the treatment you know or whatever
Int: I see so you're making a distinction between umm professionally and career successful as opposed to clinically successful
H: yeah yeah I guess that's what I'm yeah I think it's just to clear that up yep
Int: ok great ummm so just pursuing that line of professionally successful ummm tell me a little bit about you you obviously have ahh a fairly clear perception that clin psych's are professionally successful
H: Mmmhmm
Int: just tell me a little bit about where you get that from is this from you friends or is it from other sources or anecdotally
H: in regards to the people that I know or just in general as r
Int: no about clinical psy about clinical psychologists in general
H: yeah
Int: and the fact that they're (. .) they're professionally successful and that they have good careers is what I'm hearing you saying?
H: yeah I understand that these particular people that I know are successful in their careers
Int: I see
H: yeah not [inaudible] I mean
Int: purely direct it's personal experience yep personal experience yeah
H: that's where I'm coming from yeah yep
Int: ok great (. .) you (.) there was one other point H with regards to you know how I asked you to rate the characteristics with regards to negativity or positivity umm there was the first adjective cluster was umm I'll read it out
H: mmmhmm
Int: it was cold, uninterested, introverted and odd
H: mmmhmm
Int: and you actually rated that as a positive characteristic
H: oh ok
Int: yeah I just wondered if you could tell me bit about that
H: ummm the reason why I thought introverted it's because ummm I guess they're in touch (. .) ahh let me have a think (. .) the approach would be that they're really getting into something they're not umm (. .) I guess they're very (. .) not studious but I'm trying to find the right words (. .) umm well I think you need to be introverted to a certain point because you really need to be in touch with yourself and be able to get into people ahh beyond the social façade (. .) which is probably what clinical psychologists need to do (. .) umm (. .) I think they just like in terms of introversion as well like obviously you know like they're knowledgeable they need to be able to study and really get into the book side of things and case studies and whatever umm so I guess why I think It's positive is you really need to have that foundation umm and also very inquisitive I think they'd have a very to me also odd well that sort of [inaudible] means inquisitive as well
Int: sure ok
H: [inaudible] and people's motives
Int: and so so what you're saying is the ability to be introspective (. .) individually it's useful because it means you're then able to look inside other people as it were
H: yeah yeah
Int: is that what you're saying
H: yeah sort of as well yeah yep
Int: and just in that cluster again there was a couple of other adjectives like cold and uninterested and odd
H: mmmhmm
Int: they were in the same cluster as introverted and you rated that cluster as positive so I wondered if you could just sort of fill me in a bit on what on you know your thinking of (.). why cold and uninterested and odd might be positive characteristics as well

H: that was in the same cluster?

Int: yeah

H: ummm well uninterested [inaudible] uninterested could be looking at like so obviously clinical psychologists can't be too emotional they've got to have this façade like

Int: lsure

H: they're there you're telling them stuff and I think if they showed too much emotion it can't be a positive thing cos you're reacting to what people saying and it might deter them from going on or continuing or you know so I think you need to have that kind of where the person just gives and you can just absorb without showing too much (.). cold (.). I mean obviously that can be interpreted as cold but it's not really it's just you know just kind of a you know a blank page you know cos you don't want to give any clues away to how you're seeing and judging this person kind of thing so

Int: sure and odd?

H: [laughs] I dunno it just happened to be in rthat cluster

Int: lsure [laughs]

H: but it's an interesting interpretation odd odd what does odd mean I mean just it's very subjective odd you know what

Int: lsure

someone might think is odd to someone isn't odd to someone else and people might perceive them as being odd because they're introverted and you know all that I mean just cos odd is different to what society wants people want society wants extroversion da da da and cos you're opposite to that maybe I thought that's why odd was in there cos people perceive them as odd

Int: sure that's great (.). I just wondered if (.). just sort of finishing on that particular cluster I just wondered if you could give me another word for cold, uninterested and odd oh sorry cold, uninterested and introverted

H: another word to put rthem into together

Int: lyeah could you summarise you obviously think they're positive characteristics

H: yeah

Int: and ummm you've explained very well why you think they are positive rcharacteristics

H: lyeah

Int: about the ahhh distance and the (.). ummm yeah the distance that they help put between people and I just wondered if you could give me another word or you know an indication as to why that's ummm another word really as to why that's positive

H: [inaudible] but I'd say objective I think it'd be objective

Int: good yeah that's good alright ummmm (.). I guess (.). the other thing I was interested in H was (.). you filled me in a little bit about ummm (.). how you know (.). or where you've got your information about clinical psychologists

H: mmmhhmm
Int: ummm (.) I wonder if you can just outline the differences for example between a clinical psychologist and say a psychiatrist or a clinical psychologist and a counsellor

H: ummm well psychiatrist is ummm obviously you do a medical degree and then you specialise in psychiatry (.) which is I dunno a year a year or two after your medical degree

Int: ok

H: ummm (.) ummm and I mean and that's more like to do with I dunno physiological things and regards to the brain (.) ummm (.) and more like I guess they're both I mean one deals more with mental conditions and problems with the ummm ones more to do with clinical psychology's more to do with ahhhh behaviour as a result of perhaps (.) the way you process things or ummm (.)

Int: so the psychiatrist is dealing with mental problems

H: yeah

Int: and the psychologist is dealing with normal behaviour?

H: yeah not normal I mean you've got people with mental problems as

well but

Int: mmhmm

H: maybe ones that more impact on the behaviour of someone (.) I guess they both impact on behaviour (.) but I guess clinical psychology has a greater spectrum you have like people with like little issues and people with massive you know big issues and psychiatry only deals with the really top end

Int: mmhmm

H: of the major you know major issues and mental illnesses

Int: I see so it's a matter of severity

H: yahhh:

Int: is what you're saying that the psychiatrists tend to deal with the you know the top ten percent of the most severe cases and the psychologists perhaps deal with (.) a broader spectrum you know including the other ninety percent?

H: mmhmm

Int: great (.) ummm what are your thoughts on differences (.) and similarities between say a clinical psychologist and a counsellor for example

H: (.) ok ummm well a clinical psychologist umm again you could make a distinction where (.) counsellors probably ummm I dunno I've always thought of counsellors as maybe (.) listening and giving you some advice or direction but not giving you specific (.) well I guess you think (.) how do I explain this (.) I think a clinical psychologist deals more with mental illnesses like serious things as well

Int: mmhmm

H: I mean you know I said to you they have a bigger spectrum and ummm (.) whilst maybe counselling is more to do with normal people that have some issues with their life personal interpersonal (.) like not with mental problems or mental diseases or ah mental conditions (.) they have like more just like more problems with their interpersonal skills or problems at home ummm so I think ummm (.) a counsellor would like be someone you could go to and they would give you advice and maybe just go a couple of times you know maybe a clinical psychologist is sort of like more serious you go on a regular basis and is
ummm (.) probably a bit more prescriptive in what they tell you (.).

Int: mmm ok that's great (..) ummm apart from your friends who are clinical psychologists ummm and I'm guessing that's where you got some of you information about what clinical psychologists do and what they're rlike

H: hmhmhm

Int: from ummm (..) where else have you got your information about what clinical psychologists are like from

H: probably the media really talking about things yeah

Int: tell me a bit about that (..) which part of the media (..) papers radio TV magazines all of the above (..) and how is it (..) how are they presented in the media

H: ummm (..) well [inaudible] a lot of things come up you know there might be a clinical psychologist talking about something in the news or they say that you know research was done by psychologists and they found this rand ahh

Int: hmhmhm

H: so I think it goes (..) it's like (..) they're like a legitimate source of information so when there is like an article that mentions the study (..) that makes it more legit so ummm it [inaudible] across a lot of mediums even like fashion magazines [laughs] have like you know studies ummm so and I think most of the time they're perceived in a positive way because they're quite a legitimate group of people like they're serious like you know (.).

Int: what gives them that legitimacy do you think

H: ummm well ummm their qualifications you know ummm you know they're people who've gone to uni they've studied they've years you know years of experience ummm yeah it's like it's I mean gosh if you're a psychologist you know you've obviously done lots of years of studying and you've spent a lot of time studying human behaviour I mean they are quite a legitimate pers you know they're a professional they're a specialist in a particular field and like any specialist in a particular field they're obviously they have credibility

Int: ok sorry I interrupted you there when you were talking about the media you mentioned magazines and so on

H: hmhmhm yeah

Int: if you can just perhaps pick up from from where you left off ummm (..) we::ll lets think umm I I dunno it's just that the way they're always perceived as like there was findings of this and this and they'll say you know it was done by psychologists or there might be some psychologist talking about something so obviously they're opinion is valued (..) ummm uh uh you know it's just like a back up to something they'll say uh they'll present an information and back it up with you know by research by psychologists so it just gives it that again

Int: ok

H: going back to legitimacy and credibility (..) ummm (..) umm I've never seen it I've never believed taken a sort of it being a negative thing aah they're like say it's negative negative view (..) what they say but ummm yeah its just basically yeah that's sort of it
Int: ok that's fine so you specified that ahh your friends and the media [coughs] is there anywhere else you might have got your information about what clinical psychologists do and what they're like

H: ummm let me think oh obviously in regards to you know purely you know how common knowledge is that you know people have you know issues umm problems with themselves like mentally they [inaudible] like you know to a clinical psychologist to sort themselves out like It's like a solution to you know up there to people's problems

Int: so that's common knowledge yeah common knowledge society that kind of thing it's sort of there you know we have they're support system available to people for people who have problems yeah

Int: ok and I guess finally have you had any direct experience of clinical psychologists yourself (.) as a patient or (.)

H: yeah or your immediate family even having direct experience with a clin psych yeah in a a treatment role

Int: yeah ok

H: yeah mmmmm

Int: ummm I don't want to aah intrude ummm but I do want to (.). I would like to know ummm how that level of experience has impacted on you on your current views

H: yeah

Int: ummm because obviously it's a confound in the sense that if you've had direct experience then um that will influence your views. So I wonder if you can just tell me as much as you're comfortable with umm and (.). no more about about your direct experience with clinical psychologists

H: yeah umm actually aah it was it was a family member who had a eating disorder

Int: mmhmm

H: and we aah I was actually quite young I was probably about only 12 at the time I didn't quite understand the whole what was going on and like we had a you know the whole family we went and with the person that was umm had the eating disorder went to see the psychologist in a hospital situation

Int: mmhmm

H: went a few times but to be honest with you I totally forgot about that til you mentioned it it's so bizarre it didn't make much of an impression on me to be honest it was a long time yeah it was a while back umm and it I actually didn't get a good impression thinking about it now I just remember that they didn't do a lot like it was really bizarre actually this is terrible I've got this really positive view and now I've gone back to this experience I had a long time ago I thought well this is like a waste of time (.). honestly this is awful to say this but maybe that's because it was a group experience and I think I was quite young I didn't really appreciate what was going on (.).
Int: just tell me a little bit more about perhaps the not so good impression that you remember you said just now it was a waste of time to a certain extent
H: yeah [laughs]
Int: just elaborate on that a little bit for me
H: ohh cos I remember getting asked I have really it's like a bit blurry but I remember getting asked questions which I really thought weren't relevant for me like but obviously they at the time I was too young to appreciate what they were trying to do but obviously they were trying to get information from the family as to why the person might be the way they were in terms of their problem

Int: Mmmhmm
H: and I just think why are they and they felt quite intrusive like I I kind of wanted to help the person that wasn't well but I felt why are they asking me these questions like its that person that's ill you know why do I have

H: (inaudible) Int: (inaudible)
Int: could you give me an example of one of those questions
H: oh oh I've kinda ohh ohh I can't really remember
Int: that's fine
H: sorry I just a little bit ummm it's a while back I can't remember
Int: it sounds like it was quite a while ago
H: yeah yeah and I think [inaudible] situation and I think it's cos I didn't want to be there either so I felt really uncomfortable so maybe I closed off so I wasn't really you participating as well as I should

Int: yeah
H: maybe asking me about my eating habits or something like that ummm I thought what's that got to do with it
Int: sure
H: so I dunno (.) yeah
Int: ok (. ) ok is there anything else you wanted to mention about your perception of clinical psychologists positive negative anything that we've touched on or anything we haven't touched on before we finish up
H: ummmm ( . ) aah ( . ) no I probably think of something later [inaudible] oh look just in general I guess I just have a maybe I've got such a positive point of view because of my personal experience of psychologists because I know them as people and I think they're really good and what they do is really great and umm obviously I'm interested in it cos I'm studying it so maybe I dunno if that's gonna sway my perceptions of it so that's the only thing I probably think you know ummm yep
Int: sure ok alright (. ) well if you've if you've nothing else to add then we'll finish up there
H: Mmmhmm
Participant 4: “S1”

Int: Ok S thanks for coming in
S1: that's alright
Int: (. ) ummm (. ) I just wanted to umm go over a couple of umm the responses that you gave
S1: \( ^{\text{Mmmhmm if I can remember them [laughs]}} \)
Int: ok I'll give you a reminder
S1: ok [laughs]
Int: ummm (. ) overall it seems that you had a very positive perception of clinical psychologists
S1: \( ^{\text{Mmmhmm}} \)
Int: ummm there was a couple of things in particular but I just wondered if you could elaborate in the first instance on (. ) you know on your perception of clinical psychologists whether you think that it is positive or whether it is positive
S1: \( ^{\text{Mmmhmm}} \)
Int: and if so why it is
S1: (. ) ummm well basically I've come to psychology ummm [inaudible] if I had a view I wouldn't go into psychology [laughs] in the first place but ummm (. ) I haven't come into contact with many clinical psychologists but of the psychologists I have come into contact with everything's been positive so far (. ) they've been really willing to help very ummm (. ) caring you know [inaudible] things like that so (. ) ummm the stereotype I think I try not to pay attention to most of the time (. ) ummm and create my own opinion of things
Int: lovely ok there's two things there I just wanted to pick up on the first one is you said that most of the psychologists that you've come in contact with (. ) just tell me a bit about them who they are what they're like
S1: \( ^{\text{Ok we had a ( . ) guidance counsellor I think was a psychologist at our school and ummm I ( ) had a few meetings with him in terms of psychology as well as some things that happened in my life so ummm he was all he was sort of person who really inspired me to do psychology (. ) ummm and then people who I've come in contact with who I've discussed about psychology I haven't actually had like sessions with them but yeah they've always been really friendly and willing to listen and things so yeah}} \)
Int: is that people on campus or
S1: no people in prior to coming to university who umm I've encountered you know you mention that you want to do psychology people say ohh I know somebody who does psychology so yeah if you get in contact with people and start talking
Int: so is that friend of friend type information
S1: \( ^{\text{Yeah that sort of thing}} \)
Int: rather than direct experience
S1: \( ^{\text{Yep ( . ) and also like talking to them like you meet up at different places ummm I went on a contiki tour and spoke to one person who was studying psychology she was in third year}} \)
Int: \( ^{\text{Yep}} \)

249
S1: and we talked about things (.) ummm (.) just even different places ummm I worked last year and I don't think (.) I've just come across people along the way in sort of informal conversation

Int: yep ok lovely ummm and the second point I just wanted to pick up on there was what is the stereotype of clinical psychologists

S1: I think ummm (.) basically from movies and things like that there's certainly an opinion that quite a few I think the image is that you go to a psychologist you lie on a couch and umm they fall asleep while you just blabber along [laughs] and umm I think that's something that (.) is negative because it's not really umm (.) trying to solve the persons (.) well you're not trying to solve people's problems but yeah not really giving psychologists a good (.) image anyway umm certainly not the whole (.) scientist (.) umm separate from the individual stereotype rather than the actual one on one talking to and helping people through things

Int: so are you saying that you see psychologists as (.) more caring and less

S1: mmhmm there's ahh both aspects (.) umm it depends on what the psychologist you're talking about is doing like in a counselling level and that sort of clinical psychology where there's a lot of interaction and then there's also the research side of things (.) ummm and the experimental side of things as well

Int: ok lovely umm you've mentioned umm just in your questionnaire

S1: umm you you've given very high umm points to (.) two umm of the adjective clusters the first one is I'll read it out for you

It's curious, probing, and a researcher you've given that nine out of ten

S1: mmhmm

Int: and the second one that's in the same mo mold is deals with mental problems, studies behaviour, and studies the mind

S1: mmhmm

Int: you've given that a nine as well (.) that's telling me a little bit but I just wonder if you can elaborate on both of those clusters

S1: ok (.) umm (.) I think that I mean to to get any sort of (.) I dunno things about people you have to be sort of probing and continuing people along where they're going anyway (.) ummm (.) and as far as research goes I mean how is the area going to improve unless the people in it are prepared to further it so I think most clinical psychologists are looking for ways to I mean its a lot of the things in psychology are fairly new anyway so yeah ummm most psychologists are prepared to assist in research and really interested in the new aspects of psychology and furthering their knowledge

Int: ok what sort of research do you see psychologists as being involved in sorry clinical psychologists
S1: mmhmm ummm human behaviour, thought processes, ummm (. ) mmm emotions ummm (. ) lots of things memory even ummm (. ) 

Int: that's fine and and do you see those areas as specific to clinical psychologists or (. ) 

S1: yes and no aah I think its sort of the areas overlap quite a bit but umm yeah especially in clinical psychology but in general psychology as well 

Int: ok great (. ) ummm (. ) you've also (. ) given ten out of ten to another cluster ummm rS 

S1: mmhmm 

Int: which is umm I'll read it out again it's dedicated, persistent and well trained 

S1: mmhmm 

Int: so I'm guessing that you think clinical psychologists are very dedicated very persistent and very well trained 

S1: mmhmm 

Int: ok 

S1: I think that ummm (. ) I was sort of like comparing it to sort of like a counselling level ummm clinical psychologists have to go through a whole process to get there and you'd hope that they'd be certainly committed to that training process rather than just wanting to actually do the end section of that 

Int: sure 

S1: ummm [laughs] 

Int: can you tell me a bit about the process as you see it 

S1: ummm well (. ) ahh basically studying psychology as an undergraduate student then furthering doing post grad studies I think it's a couple of years or yeah masters or whatever and then um to actually become a member of the psychology association there's quite a process in [inaudible] sorry that's my mobile [laughs] 

Int: ok 

S1: it's only a message it's ok 

Int: ok 

S1: to actually get there (. ) I went to a doctor the other day and he said by the time you get there you'll be wanting to have kids so [laughs] it'd be pointless anyway and I was like ok [still laughing] 

Int: so how do you think it takes to get 

S1: aahhh 

Int: total years of training to become a clinical psychologist 

S1: umm at least S::ix but I think more like eight 

Int: ok 

S1: mmhmm 

Int: ok (. ) ummm (. ) and you've mentioned a couple of times there different (. ) well the counsellors at least I just wonder if you can (. ) distinguish for me between a number of different types of professions lets say clinical psychologists and psychiatrists 

S1: mmhmm 

Int: or clinical psychologists and counsellors
S1: ok (.) ummm from my knowledge [laughs] which may not be as good as some other peoples [still laughing] (.) psychiatrists have a background in medicine a::nd umm are sort of more concerned with the actual (.) brain I think rather than behaviour (.) I'm not really sure but (.) umm and counsellors I've heard quite a bit about I don't know whether it's ummm (.) what people are saying but ummm (.) it':::s not very hard to become a counsellor in Australia in particular like ummm (.) basically without much training people can put a sign on their door saying they're a counsellor and umm whereas like a psychologist a clinical psychologist you have to go through (.). a long path to get there

Int: ok (.) how much counselling do you see clinical psychologist doing

S1: (.) ummm I guess it's an important part of what they do but umm I know that there's a lot beyond that as well and umm I mean from my guidance counsellor in high school (.) every time he saw someone there was a lot of behind the scenes work that would go on after and before hand

Int: writing up reports on (.). different people and things that they've said and umm but even like informal encounters he'd go and do research on (.) to assist me even and umm just I don't know a lot of his time was spent not in counselling but doing preparation and work afterwards as well

S1: (.) ok sure ok (.) ummm (.) ok (.) the next thing I just want to ask about umm S is umm (.) where you've got your information about clinical psychologists from

S1: ummm that's a hard question (.) I suppose (.) just bits and pieces here there and everywhere umm (.) reading when I decided or was interested in psychology I read a lot of sort of umm I suppose career style books in psychology and umm got a image in my mind of what a clinical psychologist was at that time I wasn't looking in particular at clinical psychology but umm you just get a background information about it

Int: sure

S1: ummm (.) I suppose even the stereotype and general knowledge in the community I've picked up things but it's the a mixture of different areas

Int: ok have you picked up any ideas or perceptions from other sources perhaps the media for example

S1: (.) ummm (.) probably not that I can name any specific [inaudible] but

Int: mmhmm

S1: umm I would say so I mean I know from studying English in year twelve like the techniques used by the media to give a certain image like positioning people in front of bookcases and things like that which probably (.) furthers images in people's minds(.)

Int: ok (.) ummm (.) I the last thing I just wanted to umm ask and its because I sort on need to know umm (.) where people are getting their (.) information from I guess

S1: (.) information? mmhmm

Int: and where how people are forming their perceptions so I'm asking everyone umm have you had any direct experience umm or direct involvement with a clinical psychologist
S1: no not directly only school psychologist
Int: ok ok and no immediate family that have had umm direct involvement with a clin psych
S1: possibly but it hasn't been umm (.). said out aloud [laughs]
Int: ok and consequently hasn't shaped your perceptions
S1: no
Int: ok that's fine (.). is there anything else that you wanted to say about your perception of clin psychs
S1: mmhhmm
Int: umm (.). anything that we've mentioned that we haven't mentioned anything else that you wanted to add
S1: ummm (.). not really but I think that a lot of people do have the wrong image well not necessarily the wrong image but a misconceived image of what a clinical psychologist is and their role in society and I think that there probably should be more sort of information out there about what they actually do
Int: you mentioned that prior but what you said was that with regards to you know the movie scene where the psychologist
S1: mmhhmm
Int: is falling asleep on the couch
S1: yep
Int: umm (.). what do you think the public perception of clinical psychologists is
S1: probably just that I mean that's where most people I think have their image of them from (.). what they see on television
Int: yep
S1: umm and in movies
Int: yep
S1: and I don't think that's really very accurate in most cases [laughs]
Int: ok ok anything else you want to say before we finish up
S1: no oh besides the fact that most people have an image of an American sort of clinical psychologist or therapist rather than an Australian sort of just from movies
Int: mmhhmm that's interesting
S1: ummm I think a lot more people in America sort of have contact with (.). therapists and psychologists than we do in Australia and umm there may be a more clear view or a more stereotypical view in America
Int: mmhhmm
S1: having not been there myself but umm certainly the movies we see are generally American movies (.). [laughs]
Int: ok anything else
S1: nope can't think of anything
Int: alright thanks very much S
S1: that's alright

Participant 5: “J”
Int: ok thanks for coming in (.) as you know I just wanted to have a chat with you about some of your responses to the questionnaire that you filled out for me with regards to your perception of clin psychs [coughs] ummm so perhaps we'll just start with aahh it seems to me that compared to the other one hundred and twenty four people [coughs] that I administered the questionnaire to (. ) you were actually towards the more negative end of the scale with regards to your perception of clinical psychologists r( . ) umm I wondered if you could just
J: mmhmm
Int: elaborate on that for a start and tell me if that's valid
J: umm yeah it is valid I don't have the most positive view of clinical psychologists at all
Int: ok
J: umm (. ) I think it's probably mainly for the reason that when I was thirteen I was diagnosed myself with anorexia nervosa and I suffered with it for about seven and a half years
Int: right
J: and in my time I saw many clinical psychologists and not one of them helped me and not one of them treated me as an individual and my case actually turned out to be that I had a metabolic problem (. ) but no one would listen to me and for seven and a half years I got treated like an eating disorder patient and not a single clinical psychologist would even understand if I sat down and said look it's not that I don't eat it's not that I don't want to eat it's not that I have a problem with food blah blah but none of them seemed to listen they just put you into a category and shove you in the same camp
Int: ok great so (. ) your perceptions are directly related to your own experience
J: ummm not just my own experience but from coming from umm I don't know if [inaudible] first year students but I'm doing a second year unit abnormal psych and umm my lecturer Mark Rapley has given me an entirely different perspective of clinical psychologists as well from where he's come from umm ahh England umm one of the mental institutions in England I think and ahh he actually he did about four or five lectures on where he came from and how people in there have been in there for forty or fifty years and they didn't even have any problems with them and if it was this day and age and they'd actually been (. ) mentally analysed again then they would have been set free a long time ago and I dunno it's just really changed my perspective on clinical psychologists in a big way
Int: ok great can umm you just fill me in a little bit more umm on exactly how that perception's been changed say by Mark's lectures
J: umm during Mark's lectures it's just been (. ) I just seem to find that most clinical psychologists categorise people without treating them as and individual they'll just sort of grab someone and if they have like two or three (. ) symptoms of one disorder in the DSM-IV or whatever they'll go ok fine that's what's wrong with them and they just categorise them as a
stereotype treat them all the same give them all medication
don't listen to what they have to say or whether or not they're
enjoying like do you know what I mean

Int: sure

J: like they don't help them in an individual way the just put them
all in the same category

Int: ok great so with regards to your own personal experience and
also what you're learning through your course through lectures
like Mark's

J: mmhmm

Int: what what do you think is the cause of of the approach of
clinical psychologists where as you see it they don't treat
people as individuals they treat them as sort of a mass level

J: yeah I don't I can't really I can't really umm analyse that
because I don't know what every single clinical psychologist
thinks I mean I know that not all of them are the same ummm but
I'd say the majority of them do and it's probably cos they're
careless in what they do they just want to get the job done
done therefore [inaudible] takes drugs like society wants a quick fix
for whatever's wrong with them and so if someone's got
depression it's like ohh you just take this drug and go home do
you know what I mean and it's the same with someone who's been
diagnosed with an eating disorder they just go ohh we'll just
give them this treatment cos this is the treatment everyone has

Int: mmhmm

J: and it it just feel it's just a quick fix like they don't want
to have to deal with it so they just make it easier on
themselves by putting them all in the same category

Int: sure

J: not having to take on more from each individual

Int: yeah ok so you've said two things there careless and quick fix

J: mmhmm

Int: does that sum it up with regards to why you think clin psychs
treat people in not so an efficient way

J: pretty much yeah

Int: ok umm I also noticed here umm I'll just read one of the
clusters out for you umm you've said that you think that on a
scale of nought to ten clinical psychologists fit into this
category seven out of ten umm ok so that's quite high and that's
the category of being cold, uninterested, introverted and odd
and along the same lines the next one is ummm bossy, hostile,
greedy and egotistical and again you've given that a seven out
of ten as well

J: mmhmm

Int: I just wonder if you can elaborate a little bit on both of those
clusters

J: ummm that reflected my experience with umm clinical
psychologists umm well when I was fourteen I was admitted into
ABC hospital and there I was placed with umm firstly I was put
with two normal psychologists and umm they wanted to do a family
therapy and all this sort of stuff and my mum spat it and she
wouldn't do family therapy so they put me onto a clinical
psychologist and umm basically I I was in there for four weeks
and the four weeks that I was under the clinical psychologist
all I got was sort of like I just got told what to do what to eat what to wear when I could sit down I just found it like I wasn't even able to open my mouth even if I did it didn't make a difference cos no one listened to me anyway it was like don't listen to her it's not her talking it's the eating disorder it it I lost my self I lost my personal value I didn't have a personal value anymore to the clinical psychologist I only had the value of the disease (.) and umm then when I was fifteen I went into Maryville Hospital (here

Int: mmhmmm

J: and I was put under a clinical psychologist called doctor X (.) and umm (.) he was terrible absolutely terrible like I was in there for twenty four hours and in that twenty four hours umm I was accused of being bulimic in the first twenty four hours because I'd eaten what they'd given to me and I hadn't gained weight over the twenty four hour period they accused me of being bulimic and then they took away things like I had a room and I was paying like my parents paid something like four thousand dollars for me to stay there to do the clinic that they had there (.) and umm I didn't see him in the first day I just got a message from the nurse saying that he was not impressed with me and that he was punishing me by taking away the television in my room (.) and the bathroom in my room he was locking and I wasn't allowed to use the bathroom and if I wanted to use the bathroom I had to call a nurse to watch me go to the bathroom I was fifteen years old and I found this ridiculous and umm so that was in the first twenty four hours and in the second twenty four hours I was there for two days I still didn't see him even though I'm paying him sort of three hundred dollars a day to come and see me and analyse me I didn't see him again he just looked at my chart apparently in the morning and a nurse came in and said to me look he's still not happy about aaah you're not allowed any visitors anymore and your telephone's been taken away you're not allowed to you can't make a phone call if you want to talk to your parents you've got to go to the nurses desk and ring your parents from there and you're only allowed to talk to them for two minutes (.) excuse my language but you know like what are you doing do you know what I mean like I may I may have something wrong with me but that doesn't mean you can just treat me like you are and umm (.) so I pretty much spat the dummy said look I'm leaving I'm discharging myself and they said look you're only sixteen years old you can't do that I was fifteen at the time and they said you're only sixteen years old you can't do that we're gonna put you in the psych ward and I said I beg your pardon and so they took me

Int: sorry to interrupt you but do you mean they were going to umm have you sectioned (.) involuntarily admitted

J: mmhmmm into the psych ward and I said no you're not and I like I picked up the phone and I rang my parents and my parents came down and they had an interview with doctor X doctor X told my parents that (.) he's been seeing me every day for half an hour and talking to me and saying that my attitude towards the program was terrible blah blah doctor X told my parents that (.) he's been seeing me every day for half an hour and talking to me and saying that my attitude towards the program was
terrible blah blah doctor X told my parents that (. ) he's been seeing me every day for half an hour and talking to me and saying that my attitude towards the program was terrible blah blah blah of course my parents believed him and he's going ohh if your daughter's saying she hasn't seen me it's the eating disorder talking and I hadn't even seen the bloke hadn't seen the bloke since the day I got I got admitted and I saw him for five minutes then and that was when my main attitude of clinical psychologists being rude and sort of just not caring at all as to how you feel and what you say (. ) and that's why I I accept that like you know a big percentage of them probably wouldn't be like that but the ones that I have been in contact with (. ) have been and considering the amount of money that I've paid them (. ) it wasn't worth it

Int: ok (. ) is doctor Dickerson a clinical psychologist
J: I believe so yes
Int: ok (. ) ok (. ) umm (. ) there's one of the positive attributes that you've labelled and I'll just read it out again
J: mmhmm
Int: ummm curious, probing and a researcher and you put eight out of ten umm I'm just wondering if you can tell me a bit about that as well
J: ok (. ) I get that umm not so much through my first [inaudible] experience with psychologist umm but it's also when I was sixteen seventeen umm I went and saw a sports psychologist (. ) and he put me through to a clinical psychologist cos umm when I first came down with anorexia nervosa I was in the Australian institute of sport for swimming and umm I when I went to see him he sort of took blood tests off me all sorts of stuff and he disappeared for about six months and I didn't hear from him and then umm about six months later he sort of rang up mum and dad and asked them to come in for an interview and they went in and he'd been researching what was wrong with me for the past sort of (. ) five and a half months and he dedicated so much time to it he tracked down what was wrong with me how it affects blah blah blah and umm (. ) when my mum and dad said to him why did you spend so much time on it he sort of just said well I was just curious why would someone sit there and talk to me and say you know like I don't have a problem with food I'm happy to eat blah blah blah but still have all these problems and so that's where my attitude mainly came from that and it also came from umm I know a lot of students here who are doing their masters degree in psychology and they seem to be curious and that's that's what I think that the young generation of psychologists clinical psychologists is a big improvement to the older generation (. ) and that's why I gave it such a high mark

Int: sure ok so you made a distinction between the people that you've been in contact with
J: I I find personally that the older generation is a lot (. ) a lot more sort of we're right we know what we're talking about we're fantastic you just shut up do you know what I mean like they're they're more big headed and egocentric about what they do and they don't care about you whereas the younger generation seem to take more interest in the person

Int: what do you think that's about
J: I think it might be different in the training but I think it also might have something to do with the money that they're earning at that sort of level and also if they've got so many patients waiting coming to see them they probably lose their care factor whereas if you're a sort of new psychologist and you're just beginning to get your name out there you're probably gonna take a whole lot more care in what you do so that you get a good (.) umm what's the word I'm looking for (.) reputation and therefore I mean maybe they'll change as they get older but it just seems that also the education's a whole lot better as well they seem to be a whole lot more open minded now about that people are individuals rather than just (.) \[inaudible\] them all in the same place

Int: sure ok (.) ummm (.) interestingly I think J you've aah there's I'll just read out one more cluster which the

J: mmhmm

Int: last one I just want to bring up with you umm (.) with umm the cluster that entails being patient, calm and self controlled umm you've given that a seven out of ten and you've labelled that a positive attribute ummm I just wonder if you can tell me a little bit about that cluster and that score

J: well I gave that a seven out of ten ummm because I think that those three aspects in a clinical psychologist are definitely very very positive things like if you've got a clinical psychologist who is patient who does care blah blah blah you're probably gonna get a whole lot better treatment out of him than someone who doesn't who isn't patient with you who just sort of wants to go you said three words to me I know exactly what's wrong with you off we go and that's why I said it was positive (.) the reason I gave it a seven (.) umm basically because ummm I think it's a very umm the main important aspects of a clinical psychologist and I gave it a seven because the last three or four clinical psychologist that I have seen have those qualities umm but again that was reflecting on my like (.) my latest (.) contact with clinical psychologists not my first

Int: ok so your perception seems to have changed over the years would that be fair to say

J: umm it's probably changed since I started studying it myself actually umm (.) and it's also changed umm since I first since I was thirteen fourteen fifteen when I saw umm was taken to clinical psychologists in hospital with them and did programs and things like that umm they were all the older generation I'd say they were like in their forties fifties and sixties and it was my my like aah (.) I hated all of them (.) I didn't at first like every time I went there I told them the same story I told them exactly what I felt every time it always ended up the same I always ended up being thrown into camp or hospital and just treated like everybody else and umm and then when I was finally sort of old enough to sort of say look I'm not doing this anymore I'm gonna go gonna go my own way \[inaudible\] it was like (.) cos I got to the point where I was I don't want to spend any more time in hospital and I don't care if I die out of hospital it's better than living inside hospital (.) and so I was out for about six months and I dropped about fourteen kilos I think and
I went into umm I went over to Queensland and I saw a specialist in Queensland and that was when things started to get better (.)

Int: ok (.)
J: does that sort of answer your question
Int: well I guess yeah you've made a distinction between umm (.). then and now is what I'm sort of hearing
J: mmhmm
Int: and I'd just be interested to know how your perception has changed I guess cos early days it sounds like an extremely negative experience and yet these days you're at least willing to say that on a scale of nought to ten you've given seven to the fact that you think clinical psychologists are patient, calm and self controlled
J: mmhmm well I make I make the differentiation because umm I don't' know I think it was mainly because when I was (.). I mean you may say (.). you could probably think well she was young and she had an immature view but I don't think that was it at all I think it was umm when I actually started to choose my path like to choose my own clinical psychologists to choose the people that I deal with like I mean I saw at least twenty clinical psychologists before I chose the one that I wanted to stay with and I think it was I mean my views changed because there may be a lot of crummy ones out there but if you go to enough you'll find a good one

Int: ok that makes sense wh what do you think the ratio is so how many you you've had a personal experience of how many you've had to go through to get one that you're happy with
J: wwww
Int: would that be representative
J: ummm yeah it would be representative to an extent but I think that if you go with the younger generation of clinical psychologists I think you're probably on a better bet than the older ones

Int: ok
J: I mean that may sound really sort of aah racist on an age level but it's true like it's what I've found it's what I've honestly found

Int: mmhmm sure ok (.). I'm just gonna move off the specific points and just down to umm the next section (.). I've been asking people umm what they know about clinical psychologists you've given me a good indication of that I just wonder if you can outline perhaps the difference for me as far as you're concerned between say a clinical psychologist and a psychiatrist or a clinical psychologist and a counsellor
J: ummm (.). I can definitely differentiate between a clinical psychologist and a counsellor umm cos I still see a psychologist now ummm (.). through a lot of the shit I had to go through when I was younger umm but basically I mean the psychologist that I see I just talk to her and she she just wants to listen and she just wants to help me through whatever I have to go through and she agrees with like she doesn't agree with everything I say but she points me in the right direction without saying you know you have to do this like I find that a psychologist to me (.). or a counsellor (.). I've never seen a counsellor but I just assume that they'd be sort of on the same ratio (.). umm (.).
Int: sorry a counsellor and a psychologist
J: yeah in the way that they help people I would assume that they'd be sort of on the same level umm but I would say that they don't tell you what to do like order you to do things they ask you to do things and they tell you they sort of indicate what the benefits are of some things and what the downfalls are of some choices and entirely really the decision is up to you (.) but they just make it slightly easier for you (.) by pointing out what's right and what's wrong
Int: that's a counsellor
J: and that's what I'd find in a psych that's what I see in a psychologist and a counsellor umm but the psychologist that I see she does that for me helps me with all the decisions that I make whereas I find that umm the differentiation in a clinical psychologist is they don't talk to you they don't ask you they don't point you in the right direction they tell you where you're gonna go they tell you what's gonna happen and how you're gonna end up
Int: sure
J: and that's where my differentiation comes in
Int: sure ok and perhaps between a clini psych and a psychiatrist
J: umm (.) I don't really think there'd be much difference to be honest with you (.) I really don't (.) once you've been put into a mental institution I really don't think there'd be much difference
Int: in the way that they interact with you or with regards to their duties
J: both (.) I think that aah maybe a psychiatrist would probably have less interaction with the person ummm they probably just come in and give drugs or something like that but I mean like I say I don't know cos I've never been in an actual mental institution with a psychiatrist and a clinical psychologist (.) I can't really differentiate what I don't know but that's my assumption anyway
Int: sure ok (.) ummm (.) and the last point J really is umm just one we've already touched on so I'll just raise it with you anyway but you've been really clear and that is have you had direct experience of a clinical psychologist
J: [laughs] yeah [still laughing]
Int: you've been really clear about that (.) umm so I think we'll consider that one covered ummm (.) now I've also been saying to people if there's anything else you want to say about your general perception of clinical psychologists please feel free umm it's an open forum
J: ummm (.) there's not really much else I had to say but just want to make it clear that I don't think that all clinical psychologists are bad but I just think that the majority of them aren't out there to help you they're out there to help themselves
Int: ok (.) thanks very much J

Participant 6: "C"
Int: ok C thanks for coming in
C: you're welcome
C: umm as you know I just wanted to have a chat with you about the questionnaires that you filled out for me last week umm with regards to your perception of clinical psychologists umm and I notice that your broad perception seemed to be quite positive
C: yeah
Int: and I just wondered if could elaborate a little bit for me on your positive perception (. ) why that might be
C: because I have clinical good clinical psychologist in my school when I was actually in school (. ) it's kind of like I had one in Malaysia as well and he was very good at giving advice one on one (. ) but we all admitted he couldn't give advice to a group
Int: ok what was the difference do you think (. ) why was that difference there
C: umm I dunno I think he was just more personable one on one and he was just more interesting when he tried to counsel a group (. ) lets just say it got a bit boring
Int: in what capacity was he trying to counsel a group
C: ummm he (. ) because when you become the school psychologist in Malaysia you generally have to give motivational talks to the whole school and most of us just struggled to stay awake
Int: ok (. ) but you felt that on a one to one level he was quite good and so is that the only place where your perception of clinical psychologists comes from or have you got other areas as well
C: mmm as well as the one I had over she was pretty good as well so for me ummm (. ) I'd like to think that umm to me clinical psychologists have to be happy people and basically I don't want to be like (. ) the sad depressed the typical stereotype on TV is like cartoon ones but I don't think they're really like that
Int: ok just (. ) that's interesting fill me in a little bit about a bit more about your your perception of the stereotype
C: I think the stereotype of psychologists is horrendous because they're either portrayed as balding in glasses (. ) umm really eccentric which I think is just way off the mark
Int: ok ok (. ) umm so just a couple of the points that you've made here you've said that you find clinical psychologists to be (. ) I'll read out the adjective cluster dedicated, persistent and well trained and you've given that a nine out of ten
C: yep
Int: umm can you elaborate a little bit for me on that particular cluster
C: aah ok (. ) because the clinical psychologist that I have met are very dedicated to their job (. ) they were very dedicated even though they did not get much support from I mean at that time the students were [inaudible] which I thought was very admirable
Int: very (in a clarifying voice)
C: admirable (. ) umm what were the other adjectives
Int: aah persistent and well trained
C: yeah I actually met a lot of clinical psychologists and they all strike me as being really well trained (. ) they knew how to deal with whatever problems the students came up with
Int: aah the comments about persistence
C: persistence aah there was one case where (. ) someone one of the students was having a problem and it's like (. ) the guy just wouldn't let her go like he wanted he really really wanted to know what was wrong with her he was really concerned which I thought was really good
Int: ok (. ) ok umm another one of the other clusters I'll just read it out for you C is understanding, understands people, well adjusted and gives advice (. ) I wonder if you can just elaborate a little bit on that for me
C: understanding (. ) yeah one important lesson I learnt from (. ) ok because in Malaysia I was a peer counsellor which is why I know the clinical psychologist really well because he trained me (. ) umm the most important lesson he taught me and he practised was that you have to listen and you have to understand and sometimes you don't have to give advice
Int: ok
C: so that's aah [inaudible]
Int: but this particular cluster here you've given a nine out of ten and that includes giving advice I just wonder if you can elaborate a little bit more on that (. ) on your giving advice versus not giving advice
C: umm (. ) I I do give advice but there are cases where sometimes they just want to let their feelings out they just want to outpour instead of listening to practical advice
Int: ok
C: you just have to know when to tell the difference
Int: ok (. ) umm (. ) talking about telling the difference I'll just move onto the next point which is (. ) I've been asking people if they could perhaps differentiate for me between say a clinical psychologist and a psychiatrist (. ) or a clinical psychologist and a counsellor
C: that's a good one umm I've been told that psychiatrists have a medicine degree and they would be (. ) they're allowed to give medicine as well as couns aah do the whole psychology thing (. ) but umm I have heard of cases I don't know whether these are real but psychiatrists are portrayed as everyone they think that all the psychological problems are biology based (. ) yeah not like mind based so I don't know if that's a true thing or not but I've heard (. ) and counsellor (. )
Int: sorry just going back to that point C and (. ) does that mean that conversely you think that clinical psychologists don't think that some problems are biologically based
C: no I do believe that psychologists are very open and accept the biological basis as well as the umm (. ) ones based on the mind which I appreciate I think what somebody told me is that psychiatrists are not as open minded on that issue yeh
Int: alright
C: and you were going to say about the counsellor
Int: I think the counsellor basically listens and gives advice or I mean they don't tell you how the mind works I don't think not as deeply as a psychologist
C: ok (. ) you see (. ) what sort of a role do you see psychologists as having with regards to counselling
C: I think a psychologist could be just as good as a counsellor. I think the psychologist would be better trained because they would realise some are biologically based as well as some which is emotionally based as well.

Int: ok so you see that psychologists have a role as a counsellor but there's something in addition to that isn't that right?

C: yes

Int: ok (. ) ummm you've given me a little bit of umm information about this next point C but umm I just was wondering where you've got your information about clinical psychologists from

C: well (. ) one of my cousins is umm (. ) she did study psychology but she's not a practising psychologist (. ) as well as umm one of my (. ) friends dad is a psychiatrist (. ) so as well as since I'm studying psychology I'm learning more about it as I go along (. ) which yeah it's hard basically to pick things up as well and I've had an interest in psychology ever since I was young

Int: ok so it's a personal interest you know some people that are studying psychology

C: [laughs] yeah

Int: have you ever had any direct experience of a clinical psychologist yourself

C: [laughs] oh I have seen a clinical psychologist before

Int: ok (. ) I don't mean to pry (. ) ummm but I wonder if you could tell me as much as you're comfortable with about that

C: umm basically I was having (. ) a slight bout of depression brought from a (. ) a guy I was young at that time and

Int: sure

C: my exams were coming ummm I had a month til the exams and I couldn't study so I just thought I'd try and he was pretty helpful actually (. ) so

Int: ok do you think that experience has shaped your perception?

C: yes

Int: do you think if he hadn't been helpful then you would have a different perception?

C: yes it's possible

Int: alright umm (. ) just to finish off with umm is there anything else you want to tell me about your perception of clinical psychologists anything in general perhaps something [inaudible]

C: (. ) I guess not actually I just imagine clinical psychologist to be a person who tries his best and is not half bald or in glasses or psychotic. [laughs then something inaudible]

Int: [laughs] what was that last bit

C: I think they're really screwed up the interpretation they've been putting on TV

Int: yeah sure (. ) alright well if that's all you want to say we'll finish it off thanks C

Participant 7: “L1”
Int:  ok thanks for coming (. ) ummm as you know I just wanted to have
a chat with you about the questionnaire you filled out for me
the other day ummm (. ) it seems (. ) that you (. ) overall you a
fairly positive perception of clinical psychologists
L1:  yeah
Int:  and I just wondered if you could perhaps elaborate on that a
little bit
L1:  umm well I mean I think that in any profession you're gonna have
( . ) umm people who either abuse a position or ( . ) you know ( . )
aren't qualified or whatever and I think that happens generally
across the whole broad spectrum and in general most clinical
psychologists are going into their work you know to ( . ) help
people out with any problems they might have ( . ) ummm you know I
think the whole stereotype of cos I know the whole stereotype is
as soon as you meet someone and you go ohh I'm a psychologist
( . ) or I'm studying psychology they go ohh ok you stay away from
me you're gonna examine my head ( . ) umm you know but in general
you know it's sort of when you're in the workplace you stay away
from me you're gonna examine my head ( . ) umm you know but in
general its you know it's sort of when you're in the workplace
you're in the workplace and then outside of that ( . ) you know
you might pick up on extra things but ( . ) it's not necessarily
( . ) you know but anyway
Int:  so ( . ) just tell me a little bit about the stereotype as you see
it
L1:  well ( . ) see I don't have much of a one but umm ( . ) you know I
notice that when I tell a lot of people they go oh you know what
are you doing here I'm studying you know I'm studying psychology
and they go oooh ok you know and they get that look on their
face like you know take a step back [laughs] take a step back
away or whatever
Int:  ok
L1:  and I think just a lot of the perception is is that umm (. ) you
know psychologists believe that you know maybe they're above (. )
ummm people or they feel the need to analyse over analyse
everything but umm (. ) you know I don't actually know any
psychologists or anything like that but then I mean I would
imagine you know it's just sort of ( . ) it's a profession and you
know you go in to help people and when people ask for your help
you give it as much as you can but ( . ) you know there's only so
much you can study and so much you can learn
Int:  sure (. ) sure ok (. )umm I'll just go through a couple of
individual responses that you've given if that's ( . ) alright
L1:  sure
Int:  and I'll just read out the clusters that are relevant (. ) the
cluster here which is umm (. ) patient, calm and self controlled
and you've given that a ten out of ten so you obviously think
that psychologists are very patient, calm and self controlled I
wonder if you can just elaborate on that a bit for me
L1:  well (. ) see I think a lot of people when they come in you know
to ( . ) sort out their problems and everything like that it's
often because they don't quite have all the coping mechanisms
to deal with them or something like that ( . ) you know if you've
got ( . ) someone and you're going in to seek their help and you
know they are overly emotional or (.) you know quick to jump on things and everything like that you know then that's (.) that's going to tell you that well maybe this is somebody that I can't you know trust or you know is not quite in a position to help me out so I think that you know (.) if nothing else just for the image you have to (.) you have to be able to control your own know like any of your own stereotypes or anything like that you have to be controlled and patient you know listen through and try to help them and do whatever you can when you're you know in that position so you have to (.) you know show that and you know (.) embrace all of those qualities

Int: and you obviously think that clinical psychologists do that
L1: yeah I mean especially if they are doing their job well [laughs]
Int: what if they're not
L1: umm (.) I dunno I think everybody goes through rough patches and (.) I think that (.) especially when you're in the position of of having people come to you every day where you know (.) a lot of people coming and going well I want a quick fix to this problem or (.) a lot of the times you're seeing you know worser side of society you're seeing all these families that are constantly you know divorcing or you know kids who have gone through (.) unspeakable atrocities and things like that so (.) you know it would have to be very hard not to let that affect you and (.) umm (.) you know sort of make you think well bloody hell everyone's (.) you know nuts out there you know people are just not good people you know so
Int: ok ok (.) so just getting back to that (.) you've made it really clear that some clinical psychologists should be patient, calm and self controlled
L1: yeah and I would think that most are you know you probably
Int: tell me a bit about that (.) on what do you base that
L1: ummm I don't know just general (.) like (.) I dunno a general belief that you know ninety percent ninety five percent in every profession you know whether it be police officers or (.) umm psychologists or whatever a businessman (.) ninety five percent of people do their job well and they (.) do it to the best of their ability (.) ummm (.) you know and it's often the five percent that perhaps don't do their jobs to the best of their ability or take advantage of their position they're the five percent that gets onto the TV and into the media and so that's the (.) perception that (.) that the public sees I mean often you know (.) if you're gonna hear about (.) you know a psychologist or something and the thing is it's either because they've done something really great or (.) you know the opposite (.) they've done something really bad
Int: sure
L1: so you know people sort of go it's a lot easier to believe the worst in people than it is to believe the best
Int: ok (.) umm (.) one of the aah interesting things that you've given L is another cluster I'll just read them out for you it's helpful, caring, friendly, and a good listener and as opposed to some of your other scores which were in the nines or the tens you've given that one a six (.) I just wonder if you can
elaborate on that and perhaps your reasons for not being quite so positive about that particular cluster

L1: ummm (.) well I think that (.) when you when you're going in to seek help you (.) you know (.) as a psychologist you don't want you want to help them but you can't be their best friend that doesn't you know like you (.) being someone's best friend and relating to them in that way (.) is not the best thing for them yes you want to help them and yes umm you're going to do everything you can but you have to be objective about it and you can't (.) you know go you're my best friend and you know because in that situation when you're talking to a friend and helping through a friend you're going to tell them you know everything's going to be ok it's not your fault you know we'll help you get through this blah blah blah whereas (.) when you're a psychologist you go ok well lets look go into this issues I'm gonna do everything I can to help you but you've got to be honest with me and you know and the psychologist has to be objective about what they're listening to because they have to understand that you're only hearing one (.) person's (.) side of the story and you know you're never quite (.) you can never know the whole picture

Int: sure so just picking up on that does being helpful and caring and being a good listener (.) does that mean that you can't be objective as well

L1: no I think that you do you have to be a good listener and you have to ummm (.) you know be all that but as far as I think it's more the friendship aspect of it that you have to be really careful of that you don't get too attached because (.) then you can't help but have your emotions cloud your judgments and as a psychologist I think you have to you know

Int: -keep that in perspective all the time

L1: umm and just one of the final umm sort of clusters that I wanted to pick up on and I'll just read it out for you again it's (.) rich, nicely dressed, professional looking and you've given that a nine out of ten so you obviously think most psychologists are rich and nicely dressed and professional looking would that fair to say

L1: umm well I know clinical psychologists seem to get paid very well umm you know it's sort of up to them whether or not they're rich how well they they manage their money but umm (.) I think that if you're gonna have somebody come into you and expect them to tell you all their problems and everything like that you do have to be professional looking and and ummm (.) you know it's the same way that if you're going to go and hand over you know six hundred dollars for this person to help you with a problem and you know if you've got one person in a you know suit well dressed and very professional looking and you've got somebody else in a pair of you know (.) I dunno (.) cargo shorts with a [laughs because interviewer is wearing cargo type shorts and points to them ☺ ] not like not like that but you know like if you've got someone with scraggy hair or you know or not shaven or whatever it's gonna that's gonna make a difference

Int: sure
L1: on what you consider you know to be that level of professionalism
Int: so again (.) you obviously think it's desirable that clinical psychologists are rich, and nicely dressed and professional looking
L1: yeah and I mean it's supposed to be sort of (.) umm (.) you know I think that a lot of the times the way that you dress and the way that you present yourself (.) it that emits a certain level of confidence and you I if I went and saw somebody and everything like that I would want them you know to be a confident person who you know because I would relate to that and go ok well this person knows what they're talking about you know so (.) I'm gonna go with them [laughs] as opposed to someone who just sort of doesn't really worry about their appearance or you know (.)
Int: sure but just (.) it's clear that you think that's desirable
L1: yeah
Int: but but you've actually said that you think that clinical psychologists are rich and nicely dressed and professional looking and I just wondered what that might have been based on
L1: umm I guess just the fact that that would be a desirable quality so I would imagine that if it's desirable for me it would be desirable for most other people [laughs] in clinical psychologists so
Int: sure
L1: you know I mean I (.) when I was filling this out this was sort of like if I were to go into a clinical psychology you know that would be you know what I would expect of myself but if also I was going to see somebody else that would be what I would expect of them
Int: so it's a personal expectation
L1: yeah
Int: rather than something you believe that actually happens or do you believe it happens
L1: ummm you know I believe that most of the time yeah it does happen like (.) the beliefs are common among the general populous
Int: sure (.) that's fine (.) umm I'm just gonna move down to the sort of the next theme and I've been asking people (.) what do you know about clinical psychologists (.) and perhaps (.) specifically if you could perhaps outline for me as far as you're concerned what the difference between a clinical psychologist and say a psychiatrist is or a clinical psychologist and perhaps a counsellor
L1: ummm (.) geez I dunno ummm [laughs] I haven't actually I mean like I say I've never (.) done any work with clinical psychologists or anything like that umm (.) I'm actually doing psychology with criminology so I want to be going into the police force ummm (.) so aside from what I've seen on television which you know probably isn't too (.) umm accurate but ummm (.) you know I mean I would imagine the difference between a (.) psychologist and a counsellor to be the level of (.) umm (.) I'm lost for words umm like the level of degrees (.) degrees as far as you know like how much schooling and education they've had
aah a counsellor I think is sort of more towards the social work and umm not as many degrees or as required

Int: as opposed to perhaps a psychologist
L1: who has to go through you know the four years and then the two years afterwards from the masters or whatever umm I think counselling is is just it's sort of like a one or you can probably do it in one or two years and it's a different sort of set up

Int: ok do you see that psychologists have got any role in counselling
L1: umm yeah I mean you know the I mean the whole basis of it is you're going out there to help people with their problems and and everything like that I think that probably umm as a psychologist you're working much more in depth and long term umm with specific patients than you would be as a counsellor where it's more ummm you know you're having to deal with a much larger base of clientele and you're probably not getting to work with them as in depth or for as long at a time as as

Int: so it's to do with how long you might be with a particular client or certain clients for
L1: yeah exactly

Int: ok umm and perhaps the difference between a clinical psychologist and a psychiatrist
L1: absolutely no idea could not tell you [laughs]

Int: do you see them as being the same
L1: umm yeah well actually I don't know if I see them the same I just don't know I I if somebody asked me what was the difference I just couldn't tell them

Int: so in that sense then what's your perception of psychiatrists exactly the same as what your perception of
L1: I would imagine yeah it's pretty on par

Int: ok
L1: so

Int: ok ummm I guess the other thing I just wanted to pick up on is where have you got your information about clinical psychologists from
L1: ummm Frasier on TV ummm [laughs] I know some people who've gone and had counselling and everything like that umm

Int: just to pick up on that is Frasier a psychologist
L1: he's a psychiatrist isn't he [laughs] there you go ummm [laughs] I don't where I've picked up my information from actually I guess it's just from you know people who've said they've gone to see a psychologist or ummm you know from what I've seen on TV and what I've heard on you know talk radio shows

Int: what have you heard on the radio and what have you seen on TV
L1: well actually I lived in Seattle for a while so [laughs] ummm we had the whole like talk radio psychiatry talk radio psychology thing and ummm you know the big yeah I mean Frasier's been huge it's so sad that I'm getting my information from here [laughs] I don't know I guess it's just the general perception
and the stereotypes and umm (.) you know (.) what I would expect if I (.)
Int: so it's a combination of stereotypes plus personal expectation
L1: yeah exactly I mean if I was gonna go and (.) you know pay someone five hundred dollars an hour to help me solve my problems that's what I would expect of them [laughs]
Int: sure
L1: so
Int: ok (.) ummm (.) and the last theme that I've been asking everyone (.) umm L is aahh have you had any direct experience aah of a clinical psychologist
L1: ummm (.) are you a clinical psychologist because that would probably be the extent of [laughs] it right now
Int: that's fine
L1: yeah no umm (.) not really (.) I like moved when I was a kid I just moved from school to school to school to school (quickly) so I went and saw a lot of counsellors you know the sort of (.) same sort of speel you know like how can I help you adjust to your new environment and all this [laughs] and it's just like I don't know let me go out of here and talk to people [laughs] that was sort of it umm there wasn't really umm yeah never really (.) whatever
Int: ok
L1: [laughs]
Int: that's the end of my themes is there anything else you wanted to add you know about your general perception of clin psychs anything umm anything else that you wanted to say or perhaps sum up
L1: it's not based on fact or anything I've read [laughs] umm yeah that's about it [laughs] (.) I've learned I mean I've learned a lot more about the role of psychologists this year but not really (trails off)
Int: sure ok well if that's all you want to say then we'll finish up
L1: ok

Participant 8: “L2”

Int: alright L thanks for coming in umm as I said I just want to umm (.) ask you to elaborate on umm some of the answers that you gave in the questionnaire
L2: L sure
Int: you filled out for me regarding clinical psychologists (.) one of the things that came through overall was that umm compared to a lot of the rest of the scores your scores came out relatively negative with regards to clinical psychologists and I just wondered if you could fill me in on whether that's accurate and if so (.) umm what some of the reasons for that might be
L2: ummm (. ) well I guess the groups of words (. ) umm like each one taken on their own would convey something different and it was an overall impression ummm (. ) I'm struggling a little bit now

Int: that's alright so do you want to give me an example perhaps of umm one of the clusters that's a bit (. ) so is what you're suggesting that the clusters can be a bit contradictory some times

L2: the words are contradictory

Int: lovely give me an example

L2: (. ) ok enjoys learning, intelligent, studious, knowledgeable, school related and wise umm (. ) a lot of people enjoy learning umm someone that's stayed at school as long as they should or have to got to get a degree must have enjoyed learning

Int: mmm

L2: intelligent (. ) yes but lots of people are intelligent

Int: mmm

L2: umm studious (. ) that has some negative connotations I suppose (. ) ummm you know that sort of geek thing

Int: sure

L2: ummm (. ) knowledgeable well should be knowledgeable or you wouldn't be in that sort of a position (. ) school related (. ) that's going back to the studious and geeky sort of thing

Int: mmm

L2: and wise (. ) wise to me tends not to fit in with the other words (. ) wise is (. ) you can be all of the previous things and not necessarily wise

Int: how would you sort of make that difference between wise and those other words how would you define wise as compared to those other words

L2: I suppose wise would be wisdom comes perhaps (. ) with age with experience (. ) with interacting with people in a broader sense and I suppose (. ) umm (. ) someone that's spent a lot of time at university is not necessarily wise hasn't necessarily had those sort of (. ) umm (. ) encounters I mean you live a life the same as everyone else (. ) but the university is (. ) a unique [inaudible] environment in a sense for wisdom ummm (. ) and I'm sort of being extreme here I'm not saying that someone that comes out of the university system can not be wise (. ) but to me they tend not to fit in with the other words

Int: so you're saying that people can be wise independent of whether they're university educated or not

L2: yes and you can be intelligent and knowledgeable and not necessarily wise (. ) umm (. ) wisdom (. ) in my own personal experience its' a very rare commodity (. ) what I consider to be genuine wisdom

Int: sure

L2: what I consider to be genuine wisdom someone I would turn to for advice

Int: sure

L2: umm (. ) my personal situation is such that I actually went through the exercise a couple of years ago umm (. ) I was planning a separation (. ) umm and I (. ) I set out the people who I would look to for support and the people I would look to for support and take their advice in situations I suppose (. )
without giving them a tag (. ) I consider them to be wise ( . ) and they were a very small group

Int: mmhmm
L2: umm its just ( . ) the way I look at things ( . )

Int: that's completely valid ( . ) that's fine L ( . ) are there any other word clusters in there that you would consider to be contradictory

L2: ( . ) patient, calm, self controlled you could be patient and self controlled without being calm

Int: mmhmm
L2: umm self controlled it's a discipline thing ( . ) whereas patient and calm is is to me more personality type thing ( . ) it's a deeper more genuine thing

Int: is what you're saying that personality is more internal and ingrained and self control which is a more external learned type behaviour

L2: can be applied yes ( . ) you know I can see why they’re clustered together there relative they're related

Int: mmhmm
L2: but to me they are ( . ) they convey different things

Int: mmhmm sure
L2: and that sort of ( . ) that was what influenced things

Int: how did you rate that one for example
L2: I've given that a six

Int: and positive yep
L: positive ( . ) umm positive because ( . ) if you're not patient and calm but you're self controlled and therefore appear to be when appropriate well that's a positive thing

Int: mmhmm ( . ) sure
L2: so that's how I come up with that one

Int: sure ( . ) and by giving it six out of ten you felt that six times out of ten that particular cluster even though it was contradictory was applicable to clinical psychologists

L2: yes ( . ) well a clinical psychologist should be all of those things ( . ) should be self controlled if they're not patient and calm I mean they should appear to be

Int: uhuh but you it's not that you consider that you should be patient, self controlled, and calm according to the questionnaire you considered that six times out of ten they were patient, self controlled, and calm
L2: umm ( . ) I didn't actually rate it as six times out of ten it was sort of like

Int: no no you're right it was on a scale of one to ten
L2: where one equals not at all and ten equals completely, positively, absolutely

L2: tens a very high score

Int: that's right
L2: and the way I rated it eight is still a very high score

Int: mmhmm
L2: ( . ) seven is still a pretty good score

Int: mmhmm
L2: and it came in at just one under seven

Int: sure
L2: which is how I got there
Int: sure (. ) I mean (. ) you understood the task which is that that Likert scale from one to ten

L2: yes

Int: did you then find yourself tempted to or even (. ) that you did perhaps rate psychologists according to how they should be rather than how you felt they were

L2: (. ) ummm (. ) clinical psychologists are just people

Int: mmhmm

L2: when it comes down to it

Int: mmhmm

L2: ummm (. ) and much as we (. ) we she says [laughs] all of first semester ummm (. ) ideally you do the best you can

Int: mmhmm

L2: especially when you're at work (. ) if you're dealing with someone's life (. ) but the reality is you won't always get it right (. ) ummm the person you are can't help but be present (. ) and influence what you do (. ) how you respond (. ) that sort of thing

Int: mmm

L2: ummm (. ) I guess it's (. ) I guess somewhere in here is my judgment on people (. ) people living up to the ideals they set for themselves (. )

Int: is there an element of what clinical psychologists should be in they way you've scored that questionnaire then

L2: there's an element of what everyone should be (. ) and falls short of umm (. ) we all [coughs] ideally we aim high for ourselves (. ) ummm (. ) possibly we should aim higher than we actually achieve because there's no point setting the bar lower than what you think is (. ) your very best

Int: mmm

L2: so that being the judgment the reality is [laughs] on occasions you're not going to reach the goals you set yourself or the standards you set yourself so I guess we're getting some of my negative philosophy coming through here (. ) ummm (. )

Int: ok

L2: did I actually answer the question

Int: well ummm (. ) [coughs] I guess I'd like to sort of ask you to elaborate on (. ) when you were filling out the questionnaire (. ) clearly you understood the task which was (. ) one to ten

L2: mmhmm

Int: and a goodness of fit for clinical psychologists (. ) I wondered if there was an element of (. ) your scoring that was related to how clinical psychologists should be rather than how you actually perceived they were (. ) did that influence your scoring at all

L2: (. ) run that question by me again

Int: lets say [coughs] lets say ummm (. ) that on a scale of one to ten (. ) one of the clusters there is patient, self controlled and calm

L2: yeah

Int: ummm and if you thought that clinical psychologists were actually very patient, very self controlled and very calm cos (. ) forgetting that you might consider that cluster to be somewhat contradictory

L2: mmhmm
you would then rate that a nine or a ten out of ten (.) umm but
is it possible that (.) umm it's also possible that people might
ummm apply a particular score (.) they might ummm they might think
that clinical psychologists [coughs] aren't very patient, self
controlled or calm (.) umm but they think they should be (.) and
on the basis of the fact of that what they think clinical
psychologists should be they would then rate that a nine or ten
out of ten (.) they might only think they're a four or a five
(.) they're not very patient they're not very self controlled or
calm but they think they should be so I'm gonna give that a nine
or a ten (.) did that influence your scoring at all

L2: (.) no I don't think so
Int: ok that's fine
L2: that seems to be less of an issue for me
Int: so your scores were related to your perceptions of clinical
psychologists rather than how you perceived clinical
psychologists should be
L2: (.) it's very difficult to draw the line between the two (.)
Int: ok tell me a bit about that
L2: (.) and also for me there's also the issue of (.) as a clinical
psychologist working (.) and not working (.) umm and that
actually wasn't explored here and it wasn't stated whether it
should be one or the other umm
Int: can you just clarify that for me (.) what do you mean by that
L2: well (.) you're a clinical psychologist but you have a life
outside
Int: mmhmm
L2: ummm (.) you know (.) umm just because you can counsel someone
who's having a crisis doesn't mean you can deal with one of your
own effectively
Int: sure
L2: ummm (.)
Int: so the questionnaire didn't allow for a split between personal
and professional life
L2: yes (.) and I have (.) I have no problem with the in fact I
would be very surprised if a [coughs] clinical psychologists
actually rate any better at dealing with their own personal
lives than anyone else (.) although idealistically they should
have a better understanding ummm excuse me [coughs]
Int: do you want me to get some water
L2: umm no I'm right just a bit of a dry throat
Int: sure
L2: [takes out cough lolly] I'm organised [laughs] (.) ummm [coughs]
sorry (.) yep what was I saying yep just because [coughs] you
know how people and relationships work and motivation and all
sorts of things (.) there's no guarantee that you can see it in
yourself or your own family umm (.) your own situation and deal
with it effectively
Int: sure
L2: [inaudible] patient, calm, self controlled all that sort of
thing might go out the window once you're at the office
Int: and that was a factor when you were trying to score this
questionnaire (.) the inability of it to cater for the
difference between personal and professional lives
L2: yes I think so (.). ummm I didn't give it a lot of thought but it did pass through my mind
Int: and what do you think now (have you given it some thought since
L2: [coughs] mmm sorry (.). not until I looked at the questionnaire again
Int: ok
L2: I really umm (.). until I'd seen it or was prompted by the words again I had a lot of trouble remembering specifics
Int: mmm
L2: but it is something that I've thought about (.). ummm (.). personal problems no personal situations are personal (.). umm and you can look at them (.). your own situation and see them from one view (.). [laughs] and if you're in a good mood or a bad mood or a particularly different mood you can look at them from the other side
Int: mmmhmm
L2: and they can appear completely different
Int: mmmmmm
L2: and to try and judge (.). which is accurate which is appropriate (.). just because you can see both sides clearly (.). doesn't mean that you know (.). what's appropriate and what's not
Int: sure
L2: and umm (.). but very often someone else's situation can seem crystal clear (.). you can see your friend [coughs] (.). [inaudible] a friend who's linked up with a person that's a total loser that's totally wrong for them it's crystal clear to you (.). and everyone else around you except (.). except your friend (.). [coughs] and I know that I've been in that sort of a situation where everyone else can see that it was wrong for me but I couldn't (.). and (.). and I'm not overly confident that I would (.). if I was in the same situation again see it any clearer
Int: sure (.). so you're suggesting that (.). a lot of these qualities might be present in someone's professional life but not their personal life
L2: yes
Int: ok good
L2: and I guess that (.). that's umm part of the way the score was downgraded a little (.). because umm (.). it was a way of sort of incorporating a lot of different issues
Int: sure sure
L2: the questionnaire was umm (.). once you (.). [coughs] I sort of found myself getting down (.). moderately well but seemed like the bottom end of the questionnaire I had more difficulty with and I don't quite know why actually I should have another look at that [laughs] (.). [long look at questionnaire] mmm understanding, understands people, well adjusted gives advice (.). [coughs] yes well you give advice and you might be understanding (.). you might understand people but it doesn't mean you're well adjusted at all [laughs] and who's to say who's well adjusted (.). yeah [inaudible] as it progressed [coughs] I sort of became more diverted with the words and phrases (.).
Int: did you find the format of the questionnaire helpful or unhelpful when it came to trying to express your perceptions of clinical psychologists
L2: (.). well it was interesting in that it got me thinking (.). some (.). some of the issues I hadn't really (.). umm. given a lot of thought to (.). [coughs] (.). [inaudible] particularly to clinical psychologists

Int: are you sure I can't get you some water

L2: actually that might be a good idea

Int: yeah [break for approximately 90 seconds while interviewer is getting a glass of water]

Int: you've sort of said that some of the clusters were contradictory (.). would there have been a better way for you to have expressed your perception of clinical psychologists

L2: no I don't think so umm (.). perceptions of anyone is a complex issue umm (.). and I think (.). I think out there in the wider community there's a (.). there's a general perception that psychologists (.). a bit like policeman really (.). there to be rubbed off (.). when you need one you expect one to be available and sympathetic and all those sorts of things (.). which is unreasonable (.). umm (.). if in times crisis you turn to a professional for help (.). you should offer them respect most of the time (.). but not [inaudible] life's not like that and I guess (.). I guess it's all just seeing (.). going through questionnaires seeing those words written down (.). made me think of that

Int: mmm

L2: excuse me [reaching for a tissue]

Int: sure (.). I wonder if I could just come to umm (.). some of the specific responses L and

L2: mmhmm

Int: just get you to elaborate on them and talk about them a bit (.). umm one example is cluster (.). two (.). which is bossy, hostile, greedy and egotistical (.). you rated that an eight out of ten (.). so that would seem to be a fairly good fit with clinical psychologists (.)

L2: (.). just the fact that you've got a (.). university degree (.). tends to (.). tends to go with arrogance umm (.).

Int: right

L2: you think you know that (.). how things work (.). how things can help (.). you have to be arrogant to think that you can help someone to think that someone would take your advice (.). umm (.). yeah (.). umm bossy that's not a very good word at all (.). but (.). umm (.).

Int: and hostile and egotistical

L2: (.). that was a bit harsh wasn't it [laughs] no that was very harsh (.). ummm (.).

Int: do you think that's a incongruent cluster or did you were you having problems with that cluster being contradictory as well

L2: (.). well it's (.). some of it's very negative (.). to me bossy's very negative

Int: sure

L2: but arrogance is only a little bit negative (.). is arrogance there

Int: no no its not

L2: it's not ok ok that's what I've come up with (.). umm (.). but it doesn't mean it's inappropriate (.). bossy would be inappropriate

Int: uhhuh
L2: (.) umm (.) but (.) mmm (.) struggling a little bit (.) I think it you know (.) thinking about it eight is very harsh but nonetheless I think there are elements conveyed in that cluster (.) that are part of (.) that I would perceive as being part of a psychologist

Int: ok lovely and what are those elements L
L2: being confident
Int: mmhmm
L2: being prepared to tell people (.) how to deal with things
Int: mmhmm
L2: yeah (.) spending years of your life (.) probing people and thinking that you know how to fix things
Int: and do you see those qualities that you've just umm outlined as positive or negative
L2: well they're both
Int: a bit of both
L2: yeah
Int: sure
L2: I mean I think what clinical psychologists do is potentially very valuable
Int: uuhuh
L2: I think people need those (.) those skills (.) to be able to (inaudible ) when they need them (.) but nonetheless on the part of the individual sitting in the chair giving the advice it is (.) a different thing to do (.) it takes a certain sort of confidence and (.) and belief in yourself (.) to tell people what they should do and how they should live their lives (.) how they can fix things (.) and not all those qualities are (.) one hundred percent admirable
Int: mmhmm
L2: when look at the other side
Int: mmhmm
L2: and I guess that's what I saw in that cluster
Int: sure
L2: it it's a bit hard (.) to try and (.) crystallise all of those thoughts (.) put them into words and then pass them on (.) umm you know and I only had (.) a relatively short time to try to (.) try to convey to you the thoughts that went through my head (.) and not all these thoughts went through my head
Int: mmm
L2: I'm trying to give you an elaborate (.) a fairly full version of the snippets that appeared to me at the time
Int: sure sure (.) ok (.) I'll just move on perhaps to one of the other clusters umm in contrast to that cluster of bossy and egotistical to which you scored eight out of ten (.) umm (.) next door to that is a cluster which you rated as positive which is umm I'll read them out it's dedicated, persistent, and well trained (.) and you've given that an eight out of ten as well so I just wonder if you can tell me a bit about how being dedicated, persistent and well trained which is positive (.) you've rated that positively (.) sits next door to being bossy, and hostile and greedy and egotistical which you've said is eight out of ten as well (.) do they sit together
L2: (.) they are in some ways (.) the flip side of the coin
Int: uuhuh
L2: well well trained that's pretty clear really that was fairly simple (.). if you've spent years at school you've done the training so you are well trained (.). what were the other two words

Int: dedicated and persistent

L2: (.). you have to be dedicated and persistent to get the training (.). dedicated and persistent as applied to a work environment (.). umm (.). [coughs] (.). I imagine people that come and tell you (.). as a psychologist the things that matter most to them (.).

Int: why is that

L2: [(inaudible)] (.). umm one of my favourite sayings for a while is umm (.). we all misrepresent ourselves to (.). the world our partners (.). to ourselves on occasions (.). and I suppose (.). umm (.). that practising psychology (.). that's a barrier (.). that people don't normally (.). these are assumptions assumptions that I [(inaudible)]

Int: sure sure

L2: umm reveal (.). what's most personal (.). what's deepest what's hidden sometimes to themselves even

Int: mmm

L2: as a clinical psychologist you would have to be dedicated and persistent

Int: mmm

L2: because you will need to know those things

Int: mmm

L2: ummm

Int: ok

L2: so that's why I've rated that fairly highly

Int: sure (.). sure

L2: but coming back to the previous one (.). if you weren't convinced that there was a reason (.). that you could help then you wouldn't be dedicated and persistent (.). so that's why I said it's sort of like the flip side of the coin

Int: and being convinced you can help has a touch of arrogance to it is that what you're saying

L2: yes

Int: yep

L2: yes that's the way I see it

Int: sure (.). I'll just move on in the framework that I've been following and the next thing I've been asking people is ummm (.). can you tell me what you know about clinical psychologists and perhaps a good way to do that is to outline to me (.). what you consider to be the difference between say clinical psychologists and psychiatrists or (.). clinical psychologists and counsellors

L2: I'm not a hundred percent clear on the difference (.). but umm

Int: just in your own words umm in your own perceptions

L2: (.). umm well a counsellor anyone can call themselves a counsellor (.). that's my perception

Int: mmmmm

L2: so anyone that (.). umm perceives they can help someone else or wants to delve into other people's lives (.). [coughs] they can simply call themselves a counsellor

Int: mmmmm

L2: (.). umm a lot of religious groups (.). would I suppose claim to be counsellors
Int: mmhmm (.). what about a psychiatrist say
L2: psychiatrists
Int: mmhmm
L2: (.). I suppose the perception is (.). there’s an extra layer of (.). education (.). umm [coughs] (.). so a psychologist fits between those two I suppose (.). ummm but I think (.). a counsellor would be the most accessible to (.). the general public
Int: mmhmm
L2: and a lot of people turn to counsellors
Int: mmhmm
L2: but umm and (.). psychiatrists (.). I think a lot of people would tend (.). to avoid as umm (.). as those that are mentally (.). only those that are mentally really seriously ill would need a psychiatrist
Int: what do you see as the differences in training between a psychiatrist and a psychologist maybe length of time at university (.). quality of degree that sort of thing
L2: (.). umm (.). yes a longer time spent at university or institutions of higher education
Int: mmhmm mmhmm for (.).
L2: psychiatry (.). and I don’t even know if that’s accurate
Int: mmhmm
L2: but that’s sort of the way I see it
Int: mmhmm
L2: but I see psychologists as (.). the most (.). the most valuable (.). but readily accessible to the public
Int: mm (.). so most valuable out of psychiatrists, counsellors and psychologists
L2: (.). umm probably on a percentage basis
Int: mmhmm sure
L2: (.). umm (.). for me personally (.). umm I had access to a psychologist through centrelink and (.). my personal situation was such that I was umm (.). diagnosed as depressed by a doctor on more than one occasion (.). well on one occasion which was a real shock and umm and then I realised because of my personal circumstances I was like going there again and I thought I’m not going back to the doctor cos he’ll just prescribe me some stuff (.). which I didn’t take last time and I’m not going to take this time (.). I umm realised that through centrelink I could access a psychologist
Int: mmhmm
L2: which I did so (.). and that was my way of dealing with what I was going through rather than go to a GP and get some drugs
Int: mmhmm
L2: umm and that’s what I mean when I say they’re accessible
Int: mmhmm that’s direct personal experience
L2: yes (.). but I wouldn’t have gone to a counsellor in my local church or anything like that umm (.). with the same (.). with the same situation (.). and that’s (.). I have a fairly alternative religion so that’s part of the reason but nonetheless I do value training in a professional and that’s what I was looking for
Int: mm mm sure
L2: so that was sort of my personal experience
Int: sure (.) that's actually getting onto the next phase L which is where have you got your info about clinical psychologists from (..) and I guess you've outlined partly from personal experience and I just wonder if you can elaborate on that aspect of it and perhaps any other areas that you've got your information about clinical psychologists from

L2: umm (..) people (..) people have a very low opinion of psychologists

Int: uuhh

L2: particularly psychology students

Int: mmm

L2: close to the end of the first semester for me but I'm sort of learning to duck when people say oh what are you doing at uni and say psychology and they go ooooh (..) umm (..) they think they think you're doing psych to find out about your innermost self as if you don't know already (..) and umm (..) so there's sort of like there's that cringe factor out there (..) umm

Int: but where have you got your perceptions of clinical psychologists from

L2: umm (..) my own personal experience (..) umm (.,) I don't think I've actually encountered very many or any psychologists socially (..) umm I'm just trying to think but if I have (..) none of them have stayed in my memory so (..) umm (..) ohh actually that's not true (..) no no that was a social worker [laughs] (.,) my (.,) aah my father broke his back a long long time ago and umm I had ahh siblings but there was also a bunch of foster kids living there (.,) and umm (.,) I can remember my mother having come back from the hospital having spoken to the young (.,) yeah it must have been a social worker (.,) she probably wasn't a psychologist (.,) and aah (.,) she'd sort of had a look at the young view of the family situation and her response to my mother was oh dear I've no idea what you're going to do this is a new situation for me which was one hundred percent useless and umm (.,) you know in her ignorance she should have kept it quiet not actually passed it on in that situation

Int: sure

L2: umm (.,) and as I say she probably wasn't a psychologist (.,) but

Int: mmm

L2: and I was a child back then

Int: mmmmm

L2: and I probably associated that with that group of professionals

Int: mmm

L2: umm (.,) less than perfect (.,) human just like everyone else

Int: mmm (.,) I'm still trying to get an idea about where you've got your perceptions about clinical psychologists (.,) is it purely if it's purely through personal experience then that's fine (.,) umm so it is I just wondered if there were other factors as well if not (.,) so it is

L2: (.,) I guess (.,) to say it's purely from personal experience is sort of limiting it and I think it's probably inaccurate but I'm struggling to think of (.,) examples

Int: that's fine

L2: that have contributed to my view umm (.,) a lot of things you take on board and you don't really know where they're from

Int: just sort of absorbed them somehow
L2: yes umm books you read (.) books articles (.) umm a variety of sources (.) although some personal experience included in there

Int: sure (.) ok umm the final area (.) again you've touched on that really L I'll just put it out there in case you want to add anything it's have you had any direct experience of a clinical psychologist and you've sort of outlined that you have and (.) given me a brief outline of the nature of that (.) umm (.) do you think that's affected your perception of clin psychs one way or the other

L2: umm (.) yes it's affected my opinion (.) and but umm I have to say that she was (.) helpful and (.) positive and umm (.) achieved what I needed just going to talk to her on quite a few occasions and she was just (.) available whenever I needed her she was helpful (.) ummm actually there was another occasion (.) yes that was years ago (.) umm this was when I was still (.) when I still perceived there was umm a future for the marriage (.) umm (.) the husband and I went to a psychologist (.) umm (.) and we were living (.) up north I'm not sure if it was Roebourne or Broome at the time so it was a case of seeing a psychologist once (.) we both went umm and I do remember that as being helpful (.) but looking back on it now (.) the fact that it was a (.) umm an isolated one hour session or whatever it was was inadequate and (.) the staff should have been aware that that was the potential

Int: in a negative or positive way

L2: bit of both

Int: mmm

L2: umm (.) the information we got was helpful it was interesting to know (.) but (.) really (.) umm was like opening a Pandora's box but the psychologist should have been aware that that was the potential

Int: sure

L2: and didn't do anything didn't prepare me in any way umm and that was probably (.) from my situation (.) should have done

Int: mmm sure

L2: so I guess that was negative in that aspect of it

Int: mmm

L2: so that's two personal experiences

Int: mmm

L2: one glowing and positive and one mixed

Int: mmm sure (.) we're getting towards the end of time (.) I just (.) is there anything else that you wanted to add (.) that I haven't covered or perhaps that you wanted to add just regarding your perception of clinical psychologists before we finish up

L2: (.).umm I think I've talked up a storm as usual (.). laughs

Int: alright thank you very much it's been very helpful

Participant 9: “L3”

Int: alright L thanks very much for coming in

L3: that's ok
Int: as you know I just wanted to chat with you about your responses to the questionnaire that you filled out in lecture for me a couple of weeks ago (.). umm and what I might do is just outline what the general picture of your questionnaire was and then perhaps we can talk about a couple of specifics

L3: mmhmm

Int: umm (.). it seems that according to umm some of the ratings you gave there was a fairly negative picture of clinical psychologists overall (.). umm and I just wondered if that was valid for you and if it is (.). what where that might come from (.). what it's about (.). if you could just elaborate on that a for me that would be great

L3: [laughs] oh it was negative was it [still laughing]

Int: [laughs] well it's not a problem umm I'm really interested in your perceptions and if what the questionnaire umm presents doesn't match your perceptions then that's ok if it does that's great you tell me about that

L3: [laughs] oh it was negative was it [still laughing]

Int: [laughs] well it's not a problem umm I'm really interested in your perceptions and if what the questionnaire umm presents doesn't match your perceptions then that's ok if it does that's great you tell me about that

L3: mmhmm

Int: (.). and if it doesn't tell me about that as well

L3: (.). umm I think I probably base it on just one experience (.). so I mean that's just not really valid I suppose because (.). it was just one experience where I actually did go and see a clinical psychologist

Int: I see

L3: and I found he was very detached from my problem (.). and sort of a bit (.). sterile and a bit umm (.). unemotional kind of thing

Int: sure

L3: so it sort of just made me think ohh what are they supposed to do then (.). I found it just that they were he was very umm (.). matter of fact about things where I felt that I needed not just theories and (.). and problem solving

Int: mmhmm

L3: I needed him to perhaps come closer I know he's not allowed to like touch you or anything [laughs] but I needed some kind of emotional connection as well

Int: I see

L3: so that's probably what I based the whole thing on

Int: sure so you would say that the way your questionnaire looks is incongruent with how you feel about clin psychs

L3: umm well I don't know cos I've not met every single clinical psychologist

Int: no (.). but your perception of clin psychs which is what this tool is meant to measure

L3: I guess you know my perception is (.). I guess I'm quite pictorial in my brain

Int: mmhmm

L3: so my perception I guess is umm you know someone who wears grey [laughs] and and doesn't quite (.). umm (.). just trying to think (.). someone who's yeah grey who who (.). umm who relies perhaps too much on theories rather than (.). than a lot of things that the person might be going through including like their spiritual (.). thing something that might be a spiritual thing or (.). or (.). or umm (.). could be a health thing or you know it's more that the p:: that the clinical psychologist is more focused on (.). just (.). psychology and nothing else
Int: sure
L3: does that make any sense
Int: yep yep yep that's great
L3: [laughs]
Int: (.). does the format I wonder (.). the format of the questionnaire
give you an opportunity to fully express (.). umm your perception
of clinical psychologists
L3: (.). ummm (.). I guess what you could have done as well is (.). put
a little bit at the bottom where (.). where people could perhaps
not be so confined to these (.). certain ideas and they could put
their own ideas in as well
Int: just like a descriptive paragraph or something like that you
mean
L3: yeah (.).
Int: ok (.). why do you think that L
L3: (.). well because umm (.). with these with these statements about
clinical psychologists they're very definite
Int: mmhmm
L3: whereas umm (.). I don't think people are that definite with
their opinions
Int: sure
L3: so if you give people a chance to actually write what they
really think or feel about their perceptions of a clinical
psychologist then (.). yeah it gives them a little bit of freedom
I guess to (.).
Int: sure
L3: to put their own thought in as well
Int: sure
L3: yeah
Int: yep (.). I might just move onto a couple of the umm specific
clusters umm L and perhaps just talk about those for a minute
umm (.). for example umm (.). one of the clusters the first one in
fact I'll read it out says cold, uninterested, introverted and
odd and you've rated that you've given that nine out of ten so
I'm guessing that you think that that cluster describes clinical
psychologists very well
L3: well (.). the guy that I saw yeah[laughs]
Int: uhh this is about your perceptions so
L3: yeah
Int: so it would describe your perception of clinical psychologists
very well
L3: yeah yeah
Int: ok (.). umm there's another cluster in there and I'll read
it out again it's umm patient, calm, and self controlled and
you've given that a nine out of ten as well
L3: mmhmm
Int: and rated it as a positive characteristic
L3: yeah
Int: and I just wonder if those two clusters (.). do they sit together
very easily or are they quite incongruent (.).
L3: I think out of all of them there's (.). like out of everything
you can pull the negative or the positive (.). so I think because
he was like that
Int: mmhmm
L3: I can see how that could be a positive thing as well if (.).

282
Int: tell me a bit about that
L3: umm (.) can I look at the words [laughs]
Int: course you can course you can
L3: umm (.) yeah it's kind of contradictory isn't it but umm (.) I think there's a difference between someone being cold and someone being patient (.) so (.). so patient would be positive and cold would be negative
Int: ok so you don't you don't see them as (.). mutually exclusive
L3: (.). I don't see them as what sorry
Int: mutually exclusive (.). doesn't have to be either or (.). you can be both of those things
L3: you can be both of those things I would think that you know they're the same and yeah there's a difference you know between calm and interested as well (.). someone's calm (.). they might be calm but they might be interested also (.). and (.). yeah I mean introverted is quite (.). can be quite negative I think if umm (.). you know it means they're more sort of in in themselves and in their own head rather than self controlled where it means that (.). that they're umm (.). that they're keeping a little bit of self control in the situation so I would still agree with what I've written (.). does that answer your question
Int: sure yeah it does basically what you're saying is that those two clusters umm sit together fairly comfortably (.). there's no conflict or contradiction
L3: initially when you look at it it looks like a bit of a contradiction but (.). I think no because certain things I see you know the patient, calm and self controlled I see that as quite a positive thing whereas
Int: sure
L3: you know the cold, uninterested, introverted and odd (.). perhaps not odd I quite like odd (.). but
Int: you quite like odd
L3: mmm
Int: you think that's a positive characteristic
L3: yeah I do (.). I probably wouldn't have put odd in a negative (.). section but (.). yeah
Int: ok so that cluster's got a certain element of contradiction in it
L3: well yeah because the words are put together I think (.). like (.). those three words are longer than odd [laughs] so you probably (.). wouldn't think of odd as relevant as the other three words perhaps does that make any sense
Int: yeah sure
L3: yeah so umm
Int: so it's actually the size of [laughs]
L3: the word
Int: is that right that influences whether you agree with the statement or not to a certain extent
L3: well well I guess when you analyse it (.). umm (.). you read the first three words which are cold, uninterested, and introverted and they're longer words and there's little odd at the end (.). so I guess I would have focused on those three bigger words and put a nine in the
negative next to it but I probably wouldn't have put odd in a negative section

Int: sure
L3: mmm

Int: no I see what you're saying [participant passes sheet back to interviewer] sorry we'll have to do this swapping backwards and forwards

L3: yeah sure

Int: if that's ok there's also umm another cluster here and again and I'll just read it out umm it's a rich, nicely dressed, professional looking umm you've given that ten umm so I'm guessing you think that fits the bill for psychologists umm but by the same token you've rated that as negative and I just wonder if you can tell me a little bit about that being a negative cluster

L3: that's a bit extreme of me isn't it [laughs] umm well I mean I they would be rich and nicely dressed and professional I would imagine umm mmm I think when I was actually answering this I didn't know whether it was positive or negative so I think I put negative because sometimes that can be if someone if perhaps a clinical a a person who's going to see a clinical psychologist is not rich, nicely dressed and professional looking then it's kind of like a hierarchy thing

Int: mmm
L3: perhaps but umm

Int: a certain level of intimidation perhaps
L3: perhaps

Int: mmm
L3: yeah (.I guess you don't know yeah I probably just put negative because I thought well maybe that's not such a positive thing yeah

Int: you were aware there was a neutral option as well
L3: ohh no no I'm sorry I wasn't aware of that

Int: ok
L3: yeah I would have put neutral for that probably

Int: ok
L3: yep [laughs]

Int: umm I guess I'm just gonna work my way down sort of the framework of questions that I've been asking everyone

L3: mmm
Int: umm and I'm interested in what you know about clinical psychologists umm perhaps a good way to to elaborate on that is if you could perhaps outline for me the difference between a clinical psychologist and say a psychiatrist or a clinical psychologist and a counsellor umm

L3: umm I think a psychiatrist deals more with umm like the medical side of psychiatric illness so they're dealing more with illness in of the brain rather than umm behaviour oil problems and they deal also with like medication and umm

Int: and what about level of training
L3: umm much more I think they have to be a doctor and a psychologist I think that's they have to I think it's
ten ten or twelve years of actual study for a psychiatrist and a psy (.) a clinical psychologist is that
L3: umm (.) they are they (.) do four years at university including their honours and and then two years of (.) umm practising with practising clinical psychology with umm with someone watching over them and they more (.) they deal more with (.) with behavioural problems within certain (.) things like umm work institutions or family or relationships
Int: mmmhhm
L3: so they mainly deal with umm (.) with helping people work out why they’re behaving in certain ways and trying to help them (.) with that
Int: sure
L3: learnt new ways and what was the other one
Int: well a (.) counsellor or a social worker or
L3: oh a counsellor
Int: just (.) the difference between say a clin psych and a counsellor
L3: well a counsellor (.) doesn't have to go to a university (.) and (.) they more help (.) help people with immediate problems I would imagine issues or problems that they have (.) and helping them find the next step into something (.) they're not like analysing (.) I wouldn't say like they wouldn't be analysing
Int: who does the analysing
L3: the psy clinical psychologist I would imagine
Int: ok
L3: I’m not (.) the psychiatrist as well
Int: ok
L3: yeah the counsellor would not be doing that they would just be (.) helping the person deal with an issue (.) a particular issue (.) and they would probably refer that person onto a psychologist if they felt that that person (.) was having problems (.) in certain areas
Int: what would what would justify a referral onto a clin psych
L3: umm (.) perhaps if they were having severe (.) marital problems (.) or severe (.) sexual problems or (.)
Int: what about if they were having mild marital problems or mild sexual problems
L3: mmm I don’t know (.) I don’t know who would deal with that
Int: sure (.)
L3: yeah
Int: umm do you see (.) what sort of role do you see psychologists have as providing counselling (.) any role or no role or (.) what type of role if there is a role there for psychologists to engage in counselling
L3: (.) yes I think that they would engage in it
Int: mmmhhm
L3: sorry what was the question again
Int: do you see that psychologists actually have any role in providing counselling (.) and if so (.) what degree of counselling might they provide (.) what level what type umm as opposed to a counsellor for example
L3: I think that they would need to cos you can't just offer them (.).
    advice and then not sort of (.). get to the real issues about (.).
    yeah that's difficult
Int: that's ok
L3: yeah
Int: do you see some overlap there so from what I'm hearing you're
    saying that psychologists should engage in counselling
L3: yeah
Int: as well
L3: yeah cos you can't just give people (.).
    theories and things without actually helping them integrate it into their
    lives or (.).
Int: would it be different to the type of counselling that a
    counsellor might offer (.). would it be the same or (.).
L3: I think it would be different cos you'd be drawing from lots of
    information as well (.).
    so you could show people umm (.). the
different theories perhaps and show them how that could affect
    them (.).
    so you'd be drawing from a lot more information and you
    could integrate that into the counselling
Int: mmhmm
L3: so the person could understand (.).
    not just what they could do but also (.). well it's a kind of education as well for the
    person
Int: (.). sure (.). umm I guess following on from that I'm
    interested in where you might have got your information about
    clinical psychologists from (.).
    you've given me an indication that you've had direct experience of a clin psych umm (.).
    but I wonder if (.).
    I wonder a) if that's impacted on your perception of clin psychs and b) where else you might have got your
    information about clin psychs from
L3: (.). I think just umm (.). from around university kind of
    picking up information about what clinical psychologists do (.).
    umm (.).
    I probably yeah base my perception on not just one
    [laughs] one experience umm (.).
    and umm (.).
    where else would I have got (.).
    that's about it really
Int: mmhmm
L3: I've never (.).
    I I got the information from what a psychiatrist
    does from a doctor
Int: mmhmm
L3: so
Int: mmhmmmm
L3: (.).
    then he yeah and he also told me that clinical psychologists
    were different so
Int: mmhmm
L3: yeah
Int: ok (.). and I guess the other side of that question is you've
    told me a little about your experience of clinical psychologists
    your own personal experience (.).
    umm (.).
    has that impacted on your own perception do you think
L3: mmmm
Int: tell me a bit about that
L3: (.). umm (.).
    yeah because he was so (.). clinical [laughs]
    umm (.)
    I was just really put off by I just thought it wasn't very (.).
    umm wholesome experience
Int: sure
L3: and (.) yeah and umm he wanted me to come back and see him again and I didn't because I just I didn't I felt uncomfortable with
Int: mmm
L3: (.) with the experience ryeah
Int: ¼mmm sure
L3: yeah
Int: ok (.) that's sort of the framework aah that we've followed (.). is there anything else at all that you might want to add about clin psychs or indeed (.) umm you know the utility of the questionnaire with regards to expressing those perceptions
L3: (.) umm (.). I know they get paid well [laughs] and that's about it really
Int: alright L that's fine (.) if you've nothing else to add we'll leave it there.

Participant 10: “S2”

Int: ok S thanks for coming in
S2: ½no worries
Int: ¼umm as you know I'm just gonna ask you a couple of questions about umm the responses that you gave in the questionnaire about your perceptions of clinical psychologists and (.). overall it seems that you had a quite a positive impression of clinical psychologists (.). and I wonder if that was sort of genuine (.). if that was valid umm about how you actually feel and if so (.). if you can just tell me a bit about that
S2: umm when I was thirteen in my first year of high school I had a few social problems lets say (.). and umm my mother being the paranoid schizophrenic that she actually is took me to a clinical psychologist (.). and umm she was a very nice lady who didn't do much for me but you know I figured it out on my own but she was genuinely trying to help me she was you know just trying to do the best she could you know she wasn't trying to you know she wasn't there for the money or anything like that (.). cos you know the first question I asked her was how much are you being paid for this and we sorted that out quite a way (.). but umm yeah so my impression of clinical psychologists was formed from those two meetings and generally came off as very positive so that's why I felt you know I've given the impressions that I have in that survey
Int: ok so is it a valid (.). you would agree with what the questionnaire is um produced that is that you do have a fairly positive impression
S2: yes because I've had first hand experience with one
Int: sure (.). ok have you had any other um experience of clin psychs or are your perceptions formed from any other sort of er from any other input
S2: umm I've rung help lines a few times but it wasn't for me it was for friends who were having problems umm was having troubles coping with their problems and I've rung umm what was it aah kids help line or life line um I've had friends who were having eating disorders umm suicidal feelings (.). I had a friend who committed suicide I had to ring them for me (.). umm generally the ones who had trained counsellors I thought were very helpful (.). and I'm not sure if trained counsellors are clinical psychologists (.). probably not (.). but they just trained counsellors added to my perception of the clinical psychologists as being very educated helpful people (.). who had then helped me and my problems (.). but umm one time I rang some other help line it wasn't a trained counsellor it was just some lady on the other end (.). and she was actually did not help me at all she was quite negative

Int: mmm
S2: towards any experiences that I was going through
Int: sure
S2: so the positive umm experiences I had between counsellors helped reinforce my stereotype of the good helpful clinician
Int: so it was just tell me a bit about that (.). because presumably they're different jobs (.). different umm (.). yeah different professions as such (.). just tell me a little bit about how the positivity of one experience can reinforce another profession
S2: well my thoughts about it was that (.). in my stereotypical mind clinical psychologist is someone who's there you know the whole sit down tell me about your childhood sort of thing (.). which I'm sure you must get a lot of but (.). and as a result someone who's there to sit there and listen to your problems and help you deal with [inaudible] so I've associated that with the people on the help lines the trained counsellors (.). who I feel are probably like doing pretty much the exact same job just with less training (.). the exact same job so the fact that they are also good at their job helped reinforce the fact what I thought about (.). clinical psychologists
Int: ok
S2: the fact that they were so good er just positive reinforcement
Int: yep ok (.). straight from the behaviourist
S2: yeah probably [laughs]
Int: lecture there [laughs] good on you (.). umm (.). ok (.). some of the stuff that's come through is very positive umm S I'll just I'll just outline it if that's ok there's one cluster there that says (.). umm rich, nicely dressed, professional looking you rated that as a positive cluster and you've given that ten out of ten umm I just wondered if you could elaborate on that a bit more for me
S2: the therapist that my mum sent to was one that she actually went to herself when her father died umm it was in Fremantle lovely little umm (.). terrace umm it was very very well to do sort of well established she was when you went into her house it was lovely furnished you know very rich paintings on the wall she was dressed business suit like you know there wasn't anything like you know shabby office papers everywhere scattered hair everything like that you know so and the receptionist was
dressed lovely you know there was up to date magazines the whole office sort of gave me the impression of psychology being a well to do field and this office in particular (. ) held some very well educated people who were very good at their job and what they did (. ) so that's where the ten came from

_Int:_ did you see umm (. ) did the plushness of the surrounds and umm yeah (. ) the er flavour of the place as being well off (. ) did that have any negative connotations at all for you or were they purely positive

_S2:_ ohh I was only thirteen at the time so I don't think it really impact I'm looking back now thinking how I would have done it (. ) but umm I don't think it would have had any negative impacts I was looking at it er you know at that point when I went to see I did not want to go and see her I was there because a) I was getting the day off school and b) my mum pretty much insisted (. ) so I was just like you know being very negative about the experience at the time

_Int:_ mmhmm

_S2:_ right now looking back on it thinking she probably didn't actually help me cos I sorted it out on my own (. ) to the best of my knowledge (. ) maybe she did do something (. ) you never know (. ) but umm so the negative any negative experience I did have then it wouldn't have been due to the plushness of the place it would have been due to to the fact that I didn't want to be there

_Int:_ mmhmm and you said something interesting there as well which was that (. ) umm you sorted these problems out (. ) very much yourself and yet you've still got a positive umm perception of clin psychs as a result of your experience so how does that fit

_S2:_ umm well the problem itself was that I was having problems fitting in (. ) cos I'd come from a very very small Montessori school (. ) have you heard of them Montessori

_Int:_ I have

_S2:_ brilliant school I might add (. ) anyway I'd come from a Montessori school straight into the catholic high school where there's a hundred and fifty kids in a class and I graduated you know three months previously from a class of eleven including myself

_Int:_ mmmm

_S2:_ so you can see what a huge transition that was (. )

_Int:_ mmm

_S2:_ where I knew everyone from the ages of four and up (. ) in a Montessori school to a school where I knew absolutely no-one

_Int:_ mmm

_S2:_ and there were groups that had come up from the primary school (. ) and everyone seemed to know each other so I had a few social problems fitting in and I didn't want to go to school so mum insisted oh you know she's taken it out of proportion so she wants to go and see this therapist and you know she's doing whatever she can that's cool (. ) and umm (. ) so we went to two sessions with that lady and she was trying to build up my self esteem and what not (. ) and she gave me a list of things to do and to stick it on my mirror telling me what a great person I am and so on (. ) but umm yeah half an hour later I threw that list away cos I thought I don't need a therapist (. ) anyway which I
didn't but umm yeah it was the fact that I threw the list away and I sorted the problems out on my own I thought you know get your act together do what you want to do don't give a stuff about everyone else but the fact that I had such a (.) positive image of the therapist was the fact that she was doing her best to help me and I appreciated that even though I didn't want to be there

Int: even though apparently it didn't work
S2: I didn't think it didn't think it helped me I don't (.) I think I sorted it out on my own it took like you know like several years actually to get to feel like I was socially in tune with everyone (.) but I'm pretty sure it was due to the fact that you know I was (.) at first hand I'm pretty shy well I was then I'm not now(.) I just needed some time to sort myself out and I don't think she really helped me out but that doesn't affect my image of her as a helpful person

Int: ok so (.) why do you think she was a helpful person cos clearly she didn't help you out
S2: because she was doing her best to help me (.) that was her priority to help me sort out the problem

Int: I see so it was the effort rather than the effect
S2: it was the effort rather than the effect
Int: I see
S2: yep
Int: ok
S2: which is why you know it gave me that positive image of her
Int: ok (.) ok did you think that she was (.) well trained well educated
S2: umm yes I did from the (.) language she was using and the way her office was obviously she'd spent a fair bit of time training in education to be there to be able to do that in those surroundings

Int: so why was it do you think that a sort of well educated well to do well trained (.) quite caring therapist by the sound of it (.) was actually a failure when it came to outcomes
S2: I think it was more to do with me than her (.) I said my mother had actually gone to her (.)

Int: mmm
S2: and she really helped my mum out (.) she really did a lot for my mum which is why my mum took her took me to her but I think it was the fact that (.) I just needed personally to sort my head out it had nothing really to do with you know clinical depression or anything a therapist could really help me with I just needed time

Int: mmmm
S2: not a therapist (.) so the the due to the fact that she was so helpful towards my mum and my mum worshipped the ground she walked on (.) I think I gather the impression she was a lovely lady but you know she just couldn't help me with that particular problem (.) if my dad had died and I had gone to see her perhaps things would have been different

Int: sure

290
S2: and she would have really helped me but that's just the situation yeah
Int: sure (. ) ok that's clear (. ) umm (. ) do you have any negative perceptions of clinical psychologists
S2: (. ) not really maybe (. ) maybe the fact that you know you hear in umm papers you know this psychologist has said what not and these people need to be rehabilitated and not locked up (. ) maybe you sort of get the image in the media that clinical psychologists are just into their books you know not (. ) using enough common sense (. ) like sometimes a spade's a spade at the end (. ) ok so I've got a few ramblings of that in my head yeah maybe they're not using enough common sense
Int: perhaps you could tell me about some of those ramblings
S2: umm not ramblings that's not the word vibes that's the word I want to use vibes
Int: sure
S2: umm like you read in the paper like these heroin addicts need to do this and this and this is why criminals do this and this and this is why they shot this so and so (. ) and you're thinking sometimes a spade's just a spade you just do something cos you've made a choice and you're responsible for that choice it's not due to the fact that you know (. ) you're mother smacked you when you were three and a half cos you yelled at your sister (. ) sometimes a spade is just a spade so I think sometimes people will fall (. ) clinical psychologists will fall back on their books and their psychology to explain something which is just quite easily be explained by common sense
Int: and do you see that as a (. ) failing of clinical psychology and if so how does that affect your perception
S2: I see it as a failing of individuals that are clinical psychologists I don't see it as a failing of the profession overall (. ) ok cos some people are stupid and most people are bright (. ) ok so I see it as failing that some people
Int: generous of you I think
S2: [laughs] yeah (. ) well I see it as an individual thing ok which will affect my (. ) it may give somewhat negative connotations to professions slight ones (. )
Int: mmm
S2: alright which just reinforces my view if I'm going to become a clinical psychologist which I'm not sure of yet (. ) and I will try and use more common sense and I am aware of the failings of others which I think is a failing so as a result I'm going to try do in the opposite use more common sense
Int: sure (. ) just working our way down umm I've been asking people (. ) tell me what you know about clinical psychologists about their level of training (. ) what sort of tasks they perform umm and perhaps what the differences are between say a clinical psychologist and a psychiatrist might be (. ) or a clinical psychologist and a counsellor
S2: umm lets see (. ) clinical psychologist you need seven years of university training to the best of my knowledge (. ) could be wrong don't really know (. ) umm basically a clinical psychologist is what's otherwise known as a therapist (. ) ok once again you know this is not totally accurate I'm sure but
umm (.) as a therapist they're the whole sit down on the couch and tell me about your childhood stereotype (.) ok umm (.) as far as I know clinical psychologists are not into research (.) ok they're just into regular counselling the difference between a clinical psychologist and a psychiatrist (.) a psychiatrist is actually a trained medical doctor who can prescribe medicines (.) umm a clinical psychologist isn't able to prescribe any medications whatever all they can do is recommend that they go and see a psychiatrist (.) umm again psychiatrist medical training (.) psychologist psychological training umm (.) counsellor (.) you can do a course [laughs] at TAFE umm I don't think to be a counsellor you very rarely go through university you can go through TAFE and take a specialised course but it's not the same level of education and training (.) ok a counsellor performs similar duties to a clinical psychologist but they're not the same and there's not as much level of education and training involved

Int: mmhmm and what might some of those duties be
S2: of which
Int: well you said that the umm some of the duties of the counsellor or clinical psychologist overlap
S2: mmhmm
Int: I just wonder if you can perhaps outline a couple of those
S2: ummm alright lets see (.) a clinical psychologist will sit down and discuss your problems with you (.) and as a counsellor (.) umm counsellors clinical psychologists there to help you try and sort through your problems get back to whatever it is you want to be (.) normal (.) umm in apostrophes (.) umm I think the difference is in difference in between counselling and clinical psychologist is a counsellor is there to mostly listen to your problems and give advice but it's not from as clearly trained background (.) umm a clinical psychologist would be able to recognise a disorder a psychological disorder quicker than a psych aah quicker sorry than a counsellor would be able to
Int: ok so that's the difference (.) what might some of the similarities be you said there was some overlap with regards to tasks
S2: it's the tasks like I said before that they can sit down and listen to their problems
Int: I see
S2: help them through it
Int: so that listening sort of aspect is it
S2: the whole listening helping people to work through any problems that they might have come to in the first place (.)
Int: sure
S2: any advice that they can give like maybe you could handle this situation in this way
Int: sure
S2: and so on
Int: sure ok (.) following on from that I've been asking people (.) where they've got their information about clinical psychologists from
S2: (.) ok well obviously first hand experience
S2: aah first hand experience just (.) aah things you've picked up
in the media (.) you know sort of

S2: well like I said before the whole common sense vibe thing that's
picked up from ramblings in the media you know so and so said
this and then obviously they go that's so ridiculous (.)
ludicrous in fact (.) but umm what else let me see (.) books you
might read I can't name any for you right now but yeah

S2: just once again vibes you pick up small impressions that overall
add to the whole

S2: know what I'm saying so (.) what was the question [laughs]

S2: where you've got your perceptions I mean

S2: you've got a good perception of you've got a clear perception in
your own head of clinical psychologists

S2: well ninety percent like I would say would be first hand
experience from my own experience with clinical psychologist and
the counsellors on these help lines and the fact that my mum
went to one and felt so in talking about it to me when I she
told me I had to go to one

S2: and umm like I said about ten percent twenty percent might have
come from media influences (.) of stereotypes

S2: uhm media news reports where psychologists and clinical
psychologists have been quoted (.) uhm (.) newspaper clippings

S2: again where people have been quoted

S2: (.) uhm television shows (.) look at Frasier clinical
psychologist you know someone who sits there who's there to help
people out umm all the media has huge influence on people even
though they don't realise it that's why advertising is such a
lucrative business (.) you know media has played a huge part in
everyone's impressions

S2: [laughs] there you go [still laughing]

S2: (.) no I think that's pretty much good

S2: that's pretty much all I have to say

Int: thanks very much S
APPENDIX B: Transcribed data for Chapter 6
Participant 1: “P”

Int: alright so I'm just going to ask you some questions about (.).
thoughts about psychologists essentially (.). the first thing I'd
like to ask "P" is what what factors would lead you to refer
someone to a psychologist.

P: when you say psychologist (.). do you mean clinical psychologist
or educational psychologist or forensic psychologist ok

Int: well um either one of those

P: any one of those

Int: yeah

P: ok well um (.). if I was working with a child maybe for
investigation of a behavioural disorder I was worried that they
may have a specific learning disorder or learning disability
then I would refer them to an educational
psychologist

Int: mmhm

P: to get a full

Int: mmhm

P: and the whole work

Int: mmhm

P: if I was looking after someone with (.). a specific (.). mental
illness or (.). issue I would refer them to a clinical
psychologist (.). so someone with severe anxiety or (.).
depression or (.). PTSD or (.). depending on what their particular
problem is (.). I would think about particular psychologists that
I would like to refer to for those particular problems so if
it's a young person

Int: mmhm

P: I would have a particular person in mind (.). someone if it's
maybe a man with PTSD or something like that I have (.). there
are particular psychologists I use but that's more from personal
knowledge of them rather than (.).

Int: knowledge of the profession per

P: yes exactly so individual psychologists cos I know what
they like to work with yeah

Int: just extending that question a bit (.). is there any situation
under which you would just refer to a general psychologist
rather than a specialist title psychologist

P: ummm (.). I suppose if (.). ummm (.). I was just looking for a
fairly brief intervention so some sort of solution focused you
know quite straight forward (.). aah maybe specifically looking
for a bit of CBT or something I may not think that hard
about

Int: mmhm

P: it would be sort along the way of (.). along the lines of who
would be available

Int: mmhm (.). have you ever referred to a general psychologist

P: ummm (.). I do (.). yeah (.). yep

Int: ok (.). and presumably it's under those circumstances when that
you've just described that (.). so when it's a brief intervention
or just some simple CBT that you'd refer to a general
psychologist rather than a specialist title psychologist
P: yes (.) yes (.) yes
Int: so just extending that question a little bit further what type of service (.) would you expect from a psychologist (.) compared to your expectations of (.) a psychiatrist or a counselor
P: (.). ummm (.). from a psychologist (.). I (.). would expect them to assess the patient (.) and (.) discuss with the patient (.) the most appropriate form of therapy for that condition and that patient
Int: mmmh
P: and then (.). maybe feed back to me at some point in this process quite early on about what they think (.). the main issues are and what they think the intervention (.). would be that's required (.). ummm (.). I wouldn't really expect a psychologist to (.). be very involved in medication issues (.). ummm (.). and I wouldn't this is more like what I wouldn't I wouldn't refer like (.). if (.). someone was having a fairly (.). common or garden relationship issue for example
Int: mmmh
P: I wouldn't necessarily refer them to a psychologist I might suggest that they go to relationships Australia (.). or you know a sort of counseling (.) service
Int: mmmh
P: I've got off the point what was the original question you said (.). what would I expect them rather than a psychiatrist
Int: well we can put that in a couple of different ways
P: in a different way
Int: essentially we can ask ummm (.). under (.). what type of service would you expect (.). from a psychologist (.) or a
counsellor
P: yeah
Int: and then perhaps I can ask what type of service might you expect from a psychiatrist (.) or a
counsellor
P: ok
Int: for the same issue
P: for the same issue (.). ok you see for I would refer to a psychiatrist for a one off assessment say if I'm really uncertain about the diagnosis (.). for example I'm worried that there's a psychosis or I'm worried this could be early onset schizophrenia or
type of schizophrenia or
Int: mmmh
P: or (.). there's something that doesn't fit with what I think it is you know (.). or would I refer (.). yeah I would refer to the CATT team if someone was at risk
Int: mmmh
P: so those are the kind of psychiatric interventions (.). counselors (.). I (.). tend almost never to refer (.) to
Int: mmmh
P: I would al (.). maybe because I think probably in general practice we can do quite a lot of counseling you know in inverted commas (.). I would tend to refer to psychologists most exclusively (.). I can't think (.). I might have advised someone to go to relationships Australia for example (.). but I don't know that I would have referred
Int: (.) so the reason that you don't refer to counselors is because you feel that you can provide that service in your practice
P: I suppose
Int: (.) so the reason that you don't refer to counselors is because you feel that you can provide that service in your practice
P: I suppose
Int: (.) in inverted commas (.) cos I'm never quite sure what they are and what their qualifications are I'm always a bit worried that they may have done a (.) couple of weekends (.) you know (.) somewhere (.) and (.) may not be accredited whereas if I refer to a psychologist I fee very confident that if they say they're a psychologist (.) I know they've had a certain training that they're accredited with their organisation that they're you know they have CPD and all that and (.) I'm a little bit uncertain of the very broad umbrella (.) that (.). counseling (.) services does that make sense
Int: it does make sense
P: yeah
Int: and (.) ummm (.) it it leads nicely into the question about (.) what sort of training do you think psychologists have had
P: well I think psychologists have been to university and done a degree and had supervised (.) placements and (.) have worked very hard to have their qualifications
Int: (laughs) nice of you to say so
P: well I do (laughs)
Int: but the level of training (.) like the number of years training and the type the actual type of training (.) are you (.). familiar with
P: Int: well it's only with clinical psychologists I'm aware it's years and years and they have to do a masters and they have to do all these supervised placements (.) indeed some of them (.) ummm (.) at least two of them I know are doing their doctorates (.) ummm and it's a lot of work (.) and I think their training is very rigorous and their supervision is rigorous and I think that's really good
Int: and for general psychologists do you know what the level of training is for them
P: ummm (.) I'm less certain about that (.) but it's at least a university degree I know that and supervised placements for sure
Int: excellent (.) thank you (.) ummm (.) I guess it would be useful to (.) to get a bit of an idea about from where you have got your existing knowledge of psychologists (.) so you carry a certain amount of knowledge about psychologists who they are what they do the services they provide the training they've received and it would be good if you could give me (.) an indication about where you got that knowledge from
P: (.). ummm I suppose from colleagues really
Int: general practitioner colleagues
P: psychologist colleague guesses
Int: oh ok
P: largely
Int: yep
P: yeah
Int: (.) so they they verbally say to you (.) this is who I am this is what I do this is the training that I've received
yeah and in general practice we do a lot of continuing professional development and (.) and over the years I would have done you know extra stuff in mental health

yeap any other sources at all

aahhh (.) are you allowed to say your husband

you can say whatever you like absolutely yeah yeah

(laughs) yeah yeah I mean obviously from psychiatrists over the years and colleagues

yeah cos your husband is a psychiatrist isn't he

aahhh (.) I suppose from reading and

I've been a doctor now for nearly twenty years so it would be yeah

I don't know if I could unpick you know everything I (.) all the places I would have got it from but there've been a variety of largely colleagues of one variety or another either doctors or or psychologists yes

mmmm ok thank you (.) ummm this is quite an open ended question "P" but I would like to just ask you to describe (.). any significant contact or contacts that you might have had with a psychologist so particularly negative or

psychiatrist or psychologist

psychologist

psychologist

yeah

particularly (.)

cos I know you've had a lot of contact with psychiatrists (laughs)

(laughs) yes (laughs)

I guess any ummm any significant contact it might be significantly positive significantly negative or just significant in some way

in recently or or

in Australia (.). cos I know that you are overseas trained in Australia ummm ok significant contacts (.). well we have three psychologists psychologists who work out of our practice

so I have an enormous amount to do with them around patient care really on a daily basis

and that has been a very significant positive encounter (.). and we've also had a we had a psychology masters student placed with us oh gosh it must have been a year or more

trying to think (.). and she was supervised so so it was so (.). I think that largely my contact with psychologists has been positive I I like (.). I I think they work very effectively in
general practice and I think they're a very good part of that primary care approach to mental health

Int: the psychologists that you work with are the three of them clinical psychologists

P: two of them are
Int: two of them are (.) is there any difference in the sort of interactions or service that you receive from the clinical psychologists compared to (.) is it just a general registered psychologist

P: yes she is (.) but she has a special (.) aaah skills in ummm substance abuse

Int: yep

P: so in fact we use her I mean she has other interests as well but she's fantastic for substance abuse patients so the interactions would be very similar

Int: yep ok

P: they're around patients really

Int: and what is it about those I mean you've said they are (.) that you work closely with them and they are positive interactions (.) can I ask you to tell me why they're to describe why they're positive

P: why they're positive ummm it's positive cos it's immediate feedback I think if you were to talk about negative experiences not negative but sort of neutral is that for example ummm (.) the (.) community mental health ran a series or or I think are still running a series of three (.) six sessions of CBT workshops for patients

Int: mmmh mmmh I know them

P: have you been involved

Int: no no I know the people that run them

P: yeah (.) which I think is fantastic a wonderful service but there's very little (.) we get one letter

Int: mmm

P: and and I can understand that that's fine and that's probably all you've got time for and it's probably adequate (.) but the difference between that and being able to (.) have a cup of tea with the clinical psychologist you know the psychologist who saw your patient the previous day and you've seen that patient the next day (.) and to be able to say well tell me what happened what do you think how's it going (.) is completely different.

Int: so that's the major factor that it's ummm (.) the proximity and the immediacy

P: it's the immediacy and the frequency

Int: yep

P: of the feedback you know so I can say to I can say to Deb I really need to speak to you just really quickly about so and so

Int: mmm

P: what do you think (.) how do you think he's going and she'll say blah blah and I'll say that's great I'll follow that up at the next appointment or so it's that it's that kind of team approach that I work very happily in

Int: mmm
P: and for the psychologists who I refer to who I don't work with (. ) I like the fact they're always happy to take a phone call (. ) they'll always phone me back (. ) they're very responsive so that's really nice as well so I often will have a phone call from a psychologist about a patient.

Int: mmhh

P: and that's very useful (. ) interestingly the psychologists that work off site are far more (. ) seem to be a lot more (. ) leery of conversations (. ) it's almost like they are more worried about patient (. ) inappropriately worried about patient confidentiality.

Int: mmhh mmhh

P: whereas the ones I work with (. ) we are able I think to have very effective conversations without impairing patient confidentiality you know I don't need the content of what they're talking about but just the broad strokes and I find that very helpful whereas the telephone conversations can be a bit (. ) ummm (. ) more circumspect (. ) do you know what I mean?

Int: I do yeah

P: not quite so easy perhaps do you have any thoughts about why you think that is?

P: oh I think I know the psychologists I work with really well

Int: yep (. ) and the ones that are off site (. ) it's just a (. ) different degree of understanding and trust and communication and

A: oh I don't know I mean quite a few of them I'd say not I think they are happy to talk but but you get more (. ) there's more distance I think between it

Int: mmhh

P: I don't know if it makes a difference in the end it just (. )

Int: mmhh

P: you know I don't know if it makes a difference for the patient

Int: mmhh (. ) mmhh (. ) thank you for that one ummm (. ) what (. ) I'd like to ask now what what do you think your patient's perceptions are of of psychologists

P: ummm (. ) well they'd be very broad (. ) I think some would have found the experience of seeing a psychologist very very helpful (. ) even life saving (. ) and others would not have found it very helpful

Int: yeah right

P: yeah

Int: so it sounds like you've got a couple of examples I wonder if you could you give a couple of examples

P: oh specific examples

Int: of both of those situations a life saving interaction with a psychologist and ahhh ahhh a not very helpful interaction

P: ummm (. ) oh (. ) lots of examples but ummm one that comes to mind is I was involved in the terminal care the palliative care of a fairly young man (. ) ummm (. ) and then (. ) I can't remember if I was there when he died or (. ) anyway I was very involved in his care

Int: mmhh

P: and the wife had not been a patient of mine but I kind of kept vaguely vaguely in touch with her and about (. ) six or seven
months after (. he died (. maybe not even (. she phoned me in a complete state and said I must come and see you I must come and see you and she came to see me and she'd been trying and trying and she was just not getting anywhere she was completely (.) ummm stuck (. and aaah just she was grief stricken

Int: mmmhh
P: it was terrible (. and I said look I am going to get you to see someone she wasn't that sure and I said just just try give it a try (. and I phoned ummm a a colleague (. not one of the ones I work with but someone else who I feel is very good with grief (. working with grief and I said please can you see her and she said absolutely I'll see her and ummm (. I saw the woman the widow after one session she she made a point of coming to me and she said (. I can't believe it I feel like a new person (. I cannot believe that just one session could have made such a difference

Int: mmmhh
P: and she went for a second one subsequently (. just because that had been arranged (. and she hasn't been back yet

Int: mmmhh
P: she knows she can come back

Int: mmmhh
P: and I think that was a very powerful thing for her having felt (. and she was uncertain about (. the value of it

Int: mmmhh
P: it just was a complete turnaround for her so (. so that was really good

Int: ok that's an example of a very positive aaah perception that a client had of psychologists
P: yes

Int: do some of your patients have (. negative perceptions of psychologists that you're aware of
P: (. ummm (. I don't know if it's negative more than they're not sure if it's been helpful

Int: mmmhh
P: which is different isn't it

Int: mmmhh
P: and also (. there are personality differences aren't there like you send one person to a psychologist (. and they don't quite click or hit it off

Int: mmmhh
P: and I always say before I refer them look you're not getting married (. if it doesn't work (. you don't think you know this is going to be helpful we can try someone else

Int: mmmhh
P: and I've done that a couple of times and then it's worked and the second referral will have been more (. helpful helpful to the patient but I think those are very (. nebulous reasons why people would or wouldn't get on with you know

Int: mmmhh (. do you think that personality stuff is more important when they're trying to connect with psychologists than it might be if they're trying to connect with some other service provider you know like an accountant or

P: (laughs) g accountant

Int: mmmhh (. even a GP even a GP for example
P: no I think it's as important for a GP
Int: yep
P: oh yeah (.) I think you've got to trust the person you're
confiding in daily you've got to feel comfortable with them
Int: I do yeah
P: for whatever reason whatever makes it comfortable for you
Int: yep
P: ummm I think particular psychologists I think people feel very
vulnerable (.) and are far less likely to disclose (.) or to be
accepting of (.) you know they need stuff that's coming out if
they don't trust or like the person
Int: mmmh (.) so you would see GP's and psychologists similar in that
P: oh absolutely
Int: other professions as well
P: ummm (.) you mean other caring professions or (.) (inaudible)
other professions (.) I guess you've got to trust your lawyer
don't you (laughs) I don't you but I don't you wouldn't have to
Int: mmmh
P: I think people probably need to have some sense of liking their
doctor or liking their psychologist or feeling that they are
people that (.) you know you have a connection with (.) I could
be wrong (.) lots of people don't like their surgeons
Int: yep
P: but are happy for them to cut them open you know to be
(inaudible) but they wouldn't like them like them so maybe
that's different
Int: (.). yeah (.) umm (.). I guess getting towards the end now really
I (.). would like to just ask do you have any reservations
about referring patients to psychologists
P: reservations (.). what what do you mean like
Int: I guess are there any circumstances under which (.). ummm (.). you
(.) feel (.) that (.). that someone may have a have a issue which
fits inside a psychologists remit but for some reason you have
some reservations about referring either that person something
about their specific situation or something about their specific
condition
P: (.). ummm (.). I'm very careful about (.). referring younger women
to a male psychologist
Int: mmmh
P: I can't think of an instance where I've done that (.). and in (.).
Int: and that's because
A: ohh (.). I guess because a lot of the younger women I see either
request not (.). they would request a female rather than a male
and I wouldn't talk them into you know
Int: mmmh
P: I wouldn't talk them into it (.). I worry that lots of the female
patients in that situation that I have are extremely vulnerable
ummm (.). and (.). I mean this is a big prejudice of mine coming
out isn't it (laughs) I would worry (.). really worry (.). about
an unhealthy situation arising (.). cos some of those women would
be very dependant (.). even though I know that psychologists
would be trained to deal with it I would just I would just kind
of kind of avoid going down that route isn't that funny (.). I
would happily refer male patients to male psychologists but a number of times my male patients have come back and said I'd rather see a woman

Int: yep
P: which is very interesting and I I think I explored that a little bit with them but those would have been some of my less successful referrals to men not always and some have been extremely successful but ummm so would there be any so I worry about my younger female patients that I'm referring I would feel

Int: can you tell me sort of I guess explicitly what you're worried about
P: a lot of them would have had abuse histories
Int: yep
P: and so I try and choose a psychologist that the patient will feel overtly very safe with right from the beginning and gender is one of

Int: and gender is one of the
P: I think gender for a lot of my patients is a very big I mean I have patients who who won't even see male doctors they that it's that big an issue for them and ummm I think we're very lucky to have that choice here you know that they yeah

Int: so that's great so that's one of the main reservations that you have about referring a particular person to a psychologist is that the gender match mightn't fit or the vulnerability match mightn't fit
P: yes and some psychologists are a wee bit more spiritual or you know I don't know how you would classify new agey you know whatever you would do so I would carefully think about my patient and when that would be something that they would find helpful or confronting or unhelpful you know so I would try and match ummm more you know traditional or less or yeah I try and match my patients quite carefully (laughs) with their psychologist

Int: excellent
P: but I don't know if that's a consi(inaudible) I don't know if those are reservations it's just more trying to think about what will fit best for that particular patient

Int: that's fine so if I'm hearing you correctly what you've said is that ummm you do try and match quite carefully based on gender stuff and also based on lets be be frank spirituality stuff

Int: yeah any other factors on which you sort of judge or try and match up patients to psychologists
P: aaaah I think about sexuality

Int: yep tell me a bit about that
P: ummm I like I've referred a couple of younger gay women who may be struggling that may be one of their issues I've said would you like to see a psychologist who is also gay

Int: yep
P: and they said yes
Int: yep
P: and that’s been quite a (. ) successful (. ) match those couple of times
Int: excellent
P: ummm (. ) I try and match younger patients with someone that I know enjoys and has (. ) you know (. ) enjoys working with younger people (. ) so I try and do that cos there’s some psychologists who don’t really like working with (. ) younger people (. ) and I (. ) for the eating disordered people I try and use specific psychologists who I know have a special interest in that so you just trying to match up the spirituality (. ) age (. ) sexuality
P: sexuality and illness really
Int: clinical expertise and the illness
P: yes the illness of that particular patient like ummm (. ) one of our psychologists does hypnotherapy which I think is fantastic for post trauma you know for PTSD and bad anxiety and so on so I would use her for that almost exclusively (. ) you know speak start with her first to see (inaudible)
Int: mmmmh (. ) ok well look that’s that’s the end of the questions I wanted to ask
P: oh good did I get the right answers (laughs)
Int: you gave all the right answers P
P: (laughs)
Int: you there anything else that you wanted to (. ) I guess just offer spontaneously about your perception of (. ) specifically as a GP who makes referrals to psychologists about your perceptions of psychologists general clinical (. ) anything (. ) anything that you’d like to offer spontaneously.
P: spontaneously (. ) ummm (. ) I suppose I feel most confident with clinical psychologists
Int: yep
P: I wish there were more educational psychologists (laughs)
Int: yep
P: ummm (. ) I feel that psychologists are an absolutely key part of primary care (. ) I just don’t see how we can possibly deal with everything that we deal with in terms of mental health issue without having really good access to psychology
Int: mmmh
P: and I have to say that the Medicare changes have been fantastic around access you’re aware of the Medicare changes
Int: oh yeah yeah
P: yeah
Int: I’m just wondering if you could sort of elaborate a bit
P: oh because it’s made it financially accessible to people that who otherwise just couldn’t really do it or could do it for a couple of sessions maybe (. ) but would would really struggle to (. ) to do it
Int: mmmh
P: and I think that’s really (. ) that’s been marvelous really
Int: (. ) ok (. ) thanks very much I appreciate your time
P: that’s my pleasure (laughs)
Participant 2: “C”

Int: the first thing “C” is just (.) I want (.) I wonder if you can just tell me a bit about yourself as a GP and whether you’ve got any special interest in mental health
C: I wouldn’t say special interest in mental health but obviously we see a lot of patients with mental health issues (.) yeah
Int: ok
C: I’ve been practising for twenty years so
Int: ok so you’ve been practising for twenty years
C: mhm
Int: do you have any additional training in mental health
C: no
Int: ok (.) so what (.) what factors would lead you to refer someone to a psychologist
C: well basically obviously if they’re presenting with a problem that (.) ummm (.) like depression anxiety whatever (.) obviously there’s numerous issues through childhood whatever (.) ummm (.) so if it’s something that obviously we can look at medications to help (.) but if there’s underlying problems that they need some counselling or some help with working through it I would refer to a psychologist (.) mhm
Int: so the main ones you see are anxiety depression and childhood issues
C: oh there’s myriad of them I was just giving a few examples yeah yeah
Int: ok (.) ummm (.) if you did make a referral to a psychologist what (.) what sort of service do you expect from (.)
C: I’m particular in who I refer particular patients to see usually I’ve had some I mean we obviously don’t see all the psychologists but we get feedback from patients that really influences
Int: mhm
C: ummm (.) so we sort of have a set I don’t know I suppose after being ten or twenty years we do have a set sort of idea that a particular patient might have a rapport with a particular psychologist that you’re aware of trying to match them is ummm pretty important ummm (.) and some people obviously initially specify gender depending on what their problem is anyway so obviously that will limit you in what way you’re going (.) ummm (.) so there would be the main concerns (.) yeah (.) obviously there’s lots of other issues then financially whether people what avenues they can look for a psychologist depending on what they can afford (.) so that can be quite limiting (.) mhm
Int: so (.) the patients ummm (.) make a choice about psychologists based on gender to a certain extent
C: oh a lot of them do yeah
Int: and what factors do you take into consideration when you’re trying to match a psychologist with a patient
C: (. ) often age (. ) ummm (. ) yeah I mean your average sixteen year old is probably not going to relate very well to a sixty year old psychologist cos they' ll initially they' ll automatically have that perception of this person as an old fuddy and we're not going to get anywhere (. ) so things just subtle little things like that can make a difference ummm (. ) yeah and depending again a lot of the feedback I get I mean unfortunately there's some people out there who have unresolved issues themselves and that tends to reflect back in what we hear in the feedback we get from them mmmm

Int: yeah (. ) when you refer someone to a psychologist what do you expect (. ) what sort of service do you expect will happen

C: well just basically somebody who's going to give them the help in analysing their problems and trying to sort through the issues that they need to resolve ummm (. ) obviously I don't really like people who kinda of try and make decisions and tell the patients what to do cos that's not really what we're at usually it it's just more support and helping them with strategies to deal with their problems (. ) ummm (. ) which most are yeah fine (. ) yeah

Int: and I guess (. ) I'd also be interested to know what type of service you might expect if you made a referral to a psychiatrist compared to a psychologist

C: hmmm (. ) I don't actually do many referrals to psychiatrists largely because our access to them is very limited here ummm so I really have to be struggling with my patient to refer to a psychiatrist (. ) we do get a lot of patients here that are being referred from the psychiatric unit at Kirwan cos they're basically low on numbers and they're referring them to us and we're sort of working together on that but when I have somebody who's never actually seen a psychiatrist (. ) only if they've got a slightly more complicated mental illness like schizophrenia or uncontrolled bi-polar disorder (. ) it's really I feel getting out of the realm of just totally just a GP ummm and obviously we will get those patients with straight forward just a straight forward depression that we're just not making the progress with

Int: mhmhm

C: so really yeah I mean if I get to a six month stage and we're not making any headway (. ) I'll look at referring to a psychiatrist (. ) ummm

Int: is that after you've referred to a psychologist or sometimes it might just tbe

C: t end to varies on the patient mmmm

Int: (. ) so (. ) can I also ask where from where have you got your existing knowledge of psychologists

C: (. ) what do you mean (. ) do you mean my actual psychologists that are available or actual what they're trained to do

Int: yeah well what they're trained to do like what service they provide

C: well probably from my existing well probably obviously from training in college we (. ) did a little bit of a touch on psychology so (. ) yeah (. ) just built from there (. ) yeah
Int: and (. ) what is your understanding of (. ) ummm (. ) the training that psychologists undertake
C: (. ) right well I assume it's a fairly intensive training and analysing problems and different therapies to deal with that as opposed to just your medicinal ones (. ) mmmm
Int: (. ) ummm (. ) (. ) would you be able to just describe any significant contacts you've had with psychologists whether they're significantly negative or positive (. ) or (. ) significant in some way
C: oh (. ) gosh (. ) off the top of my head (. ) you mean a patient experience that's been related back to me
Int: mmmm or or
C: (.) can't think of anything that stands out as a particular yeah (. )
Int: or even a a ummm (. ) an interaction that you've had with a psychologist that you might have deemed (. ) particularly sig (. ) yeah aaah negative or positive
C: (. ) yeah (. ) gosh I mean I haven't fortunately had any personal reason to go there (. ) yeah I mean I can't think of any particular example as such I mean (. ) probably the only issues I have had (. ) I did have a very interesting comment from a psychiatrist once with a patient just basically adamant that they not see a psychologist cos he felt a lot of things are sometimes best left hidden and not dragged up from the past if people have sort of got to say fifty five or sixty and haven't really resolved some childhood issues (. ) his comment to me was sometimes they're best left lying there and not (. ) yeah his (. ) basically his warning was to be a little bit wary (. ) sometimes you will have (. ) probably yeah I mean that probably sounds a bit fuddy duddy but say like a younger inexperienced psychologist who has to find a reason which may not necessarily (. ) yeah and the power of suggestion I'm very wary of that obviously all these you know this new increasing reporting of childhood abuse I think yeah you've got to be very wary that ideas aren't set that then develop in your patient's mind if you think your patient is prone to that
Int: mmm
C: it's not something with the psychologist I choose that I've had an issue with but I have heard some horror stories yeah
Int: you've heard some horror stories
C: well just of (. ) sometimes we get some very young just out of college psychologists you know all very idealistic and eager beaver and yeah perhaps over analyse situations and and make suggestions which then become very stuck in the patient's mind and whether they actually yeah sometimes the reality as opposed to the power of suggestion and trying to differentiate that (. ) ummm (. ) yeah it's like basically saying to somebody look you're depressed because (. ) you may have been abused as a child that sort of power of suggestion
Int: mmm
C: and then they sort of they had absolutely no awareness of anything like that happening but because you know we're all influenced by the media and the reports suddenly you have somebody coming in you know that you've seen for twenty years
saying you know I think I was abused as a child and then it becomes I was abused as a child

Int: mmmm
C: (. .) yeah (. .) yeah (. .) I'm a little bit wary of that because often it may not be the reality of the situation

Int: that sounds like
C: So that's probably my only really negative thing there but yeah it's got to be something you've got to be careful with

Int: sure thanks for that (. .) I'm yeah
C: ummm (. .) have have you had experience of that happening or have you heard of your colleagues other GP's
C: yeah just more other GP's I haven't had a personal

Int: yep
C: patient that's had an issue (. .) mmmm

Int: (. .) ummm (. .) this is we've covered this to a certain extent but (. .) but ummm (. .) I do just need to ask (. .) do you have any (. .) reservations about referring patients to a psychologist
C: well only yeah (. .) if I've got a patient (. .) I'll usually wait with a little bit of progress if I've got a patient who presents who's extremely distressed and depressed at the time (. .) ummm (. .) I usually often and if there are issues that they feel they want to talk about with a psychologist I sometimes encourage them just to wait a little while till they're feeling a little bit better

Int: mmmm
C: (. .) ummm (. .) so they can actually cope with the issues that might come up with all the the ummm yeah the psychology (. .) sometimes they're just a bit fragile and if they're confronted with too much they can't cope with that so (. .) yeah but I don't really have any (. .) you know unless somebody's been seeing a psychologist weekly for the last twenty years and you know sometimes you'll have people with that sort of dependency

Int: mmmm
C: you know trying to access through the public system so obviously things like that if I don't feel are actually genuinely needing to see one (. .) mmmm

Int: ok and just finally (. .) how (. .) you know the Medicare changes came in
C: mmmm
Int: in November 05 (. .)
C: you mean the mental health care plans
Int: November 06 (. .) yeah how how's your referral pattern changed since the Medicare rebates came in
C: yeah there's certainly people who qualify for that mental health care plan but unfortunately you know I mean you're probably aware a lot of it's not just psychologists but a lot of allied health professionals have (. .) basically misconstrued what the mental health care plan and the other care plans are about and there has been a bit of a tendency to (. .) put pressure on GP's to do the plans and (. .) ummm (. .) actually I read a report in one of the GP things the other day cos now there's a new dental health plan where people are coming in you know with a Medicare
number written down saying I just want you to do the thing for that number (.) yeah without actually really understanding what it's all about and who really qualifies for it (.) so yeah it's something worth being a little bit careful about (.) mmmm I think there's been something nine hundred fines handed out to GP's over the mental health care plan being done inappropriately so (.) mmmm

Int: oh really
C: we're very wary yeah the HIC do watch over our shoulders so (.) you know if you come in with somebody who's got depression for two months and they've taken themselves to a psychologist and they've been told they can get a mental health care plan cos then it will be free which is basically what is being said they may not necessarily qualify for it you know it's just like a marriage separation it's just that initial thing whether that goes into that category of mental health illness there's a lot of question mark about that (.) and we're being watched very carefully (.) yeah

Int: ok so that certainly influences the way
C: so yes (.) and unfortunately what's been happening there's that sort of thing about the pressure being put on GP's cos they're coming back saying I've been told I can get these visits for free so if you don't consider they qualify for them (.) then they just you know (.) quite can get a lot of anger generated at you because (.) they've been told one thing so yeah we just we're probably a little bit (.) I'm disappointed in how some of the psychologists have handled it

Int: right
C: mmmm

Int: and so are you (.) your sense is that psychologists have told these clients that they're eligible for free mental health care plans when they really haven't actually read through who qualifies for a mental health care plan and they need to have read all the documents which is about a five page document but I think a lot of them are just seeing the item number and yeah (laughs)

Int: and have you had that experience yourself with a client or a patient coming to see you and saying I'm eligible for the mental health care plan
C: oh all the time mmmm

Int: and are they always eligible for the mental health care plan in your experience
C: no (laughs) they're not yeah yeah

Int: and do you feed that back to the psychologist
C: oh yeah definitely mmmm well I mean I've had some psychologists ring me directly and say why aren't you doing this and then you just let them know why not mmmm

Int: ok (.) so do you have any general thoughts on whether it's a good thing or a bad thing for those Medicare rebates and the mental health (.)
C: oh look it's certainly been good for some people but it's like any new government thing that comes in (.) it's also been a little bit abused by the public system out at Kirwan as a way to turf their patients out of there and reduce their numbers (.)
because they're obviously overloaded and not coping so like I had a few people that I had referred there and again that's a thing I rarely do so if I'm referring a patient there I want them seen ummm and they've just been sending them back saying we suggest you do a mental health care plan and send them out to a psychologist and yeah (. ) so it's a little bit of sort of a yeah probably will work for some patients but yeah it's something I could have done myself I don't need them to actually tell me that that's (laughs) what I could have done
Int: mmmm
C: yes so it's been used so all those plans that come in by the government yeah unfortunately they get used as (. ) yeah (. ) ways of channelling patients to take the pressure off certain areas so (. ) yeah ( .) and of course then there's been a shortage of psychologists actually to look after the patients that qualify there as well cos obviously even the ones that do charge there's a reduced fee and yeah not all of them are happy to do it on that basis
Int: mmmm (.) just to finish up "C"
C: yeah
Int: I mean do you have any sort of final spontaneous thoughts about your perception of psychologists how you see them
C: no I mean I definitely find them quite helpful I'm more than happy to to work with them
Int: mmmm
C: heal lots of patients (. )
Int: mmmm thanks very much

Participant 3 : “A”

Int: “A” ummm (. ) what I'd like to do to do to start is to just ask you to tell me a bit about yourself as a GP and whether you've got any special interest in mental health at all
A: ummm (. ) well I'm a GP of thirty years standing I operate this place northside medical (. ) my interests in general practice are very broad I wouldn't say I had a particular interest in mental health care but of course (. ) over half my patients at the very least need some sort of mental health care so you know I can't be disinterested in it
Int: I see (. ) over half
A: oh yeah I think there's a like there's a psychological component (. ) to most suffering
Int: ummm do you have any special training in mental health or any particular special understanding as a GP
A: no only my fellowship of the college and what was necessary for that (. )
Int: ( .) so what factors would lead you to refer one of your patients to a psychologist
A: right (. ) well I suppose there's a long list but the top of them is three (. ) if once I have taken a depressed patient and restored them to some degree of euthymia (. ) ummm at that stage having the patient feeling better I encourage them to go and find out why it happened to them in the first place (. ) clearly depression is multifactorial sort of illness but a substantial number of the people I see fare well in the long term with cognitive some CBT and aah although I like to present them to a psychologist capable of thinking in paragraphs rather than you know half sentences

Int: mmmm
A: so I do that ummm (. ) where possible (. ) although I don't frequently have couples come in to see me (. ) I send people who are having relationship difficulties

Int: mmmm
A: to psychologists ummm (. ) and (. ) you know then there are the more specialised needs you know children who aren't doing well et cetera et cetera (. ) so I aah have a for example I have a routine where if I'm (. ) I look after the boarders at Townsville Grammar School (. ) I have a routine that if there's any (. ) ummm (. ) distress at all in that group being away from their parents that they go over and see P and talk to P W about it yeah who does a very good job (. ) so there you go I mean I suppose I should say my mother's a clinical psychologist you know I've been aah well

Int: that's good to know (. ) cos it obviously gives you special information to a certain extent
A: mmmm

Int: ok so essentially just paraphrasing (. ) ummm the mood stuff the relationship stuff and the ummm adolescent boy stuff or you know special needs children (. ) sometimes the school system (. ) yeah it's interesting (. ) I like to send kids who've been assessed by a department of education process (. ) through an alternative assessment process often if it's not serving them (. ) and there's a specific reason for that which is probably beyond the scope of this and that is that (. ) the way the department is organised if a child can achieve a label (. ) certain funding is made available to deal with it whereas very frequently the last thing these kids need is a label they need understanding and techniques but (. )

Int: aspergers would be a typical one that attracts funding
A: oh yeah you know lets cram this kid into this diagnosis you know yeah but you know I mean that's you know a relatively small part of the (inaudible)

Int: after you've referred someone to a psychologist (. ) whether it's adult child whatever the problem is (. ) what sort of service do you expect from a psychologist (. ) what do you think they'll do
A: ok (. ) look I don't want you to take any of this to heart I am very particular about whomever I send patients to aah this doesn't just apply to psychologists first of all (. ) ummm (. ) they have to do some good they I like a record of having been effective in the treatment of my patients be it surgeons psychologists paediatricians (. ) you know (. ) ummm (. ) so you know they have to be effective (. ) ummm that's a tough call for psychologists often (. ) for reasons which I could go into (. )
ummm what do I expect of them (..) frankly (..) I think the nature of the process is I expect less in terms of formal communication from them than I would expect from most of my specialist (..) I'm quite happy for a patient to go away confide in the psychologist (..) ummm (..) freely and without any fear that any of the aaah confidence is going to come back to me even though I'm their GP and they'll come back to see me you know (..) the nature of that interchange is often that it involves people right where they can hurt most (..) so a formal reporting process to me is unnecessary ummm (..) on the other hand obviously if a psychologist discovers something about which I should know (..)

Int: risk issues and so on
A: yeah exactly you know suicidality and or you know or if they believe the patient needs some pharmacological assistance or whatever well obviously I'd like that communicated to me in a timely way

Int: ok (..) you mentioned before that it's at least if I was hearing you correctly that it's difficult for psychologists to show effective outcomes (..)
A: aaah and that's because the system's stacked up against them you know (..) I mean it costs a lot of money one of the things I am (..) I frequently say to people look this person will charge you a hundred and fifty dollars for the hour you've seen them and it will seem to you at the time that you've just had a nice chat (..) ummm (..) a string of four or five such interviews can radically change your life (..) you would think nothing of paying seven hundred and fifty dollars to replace the tyres on your car (..) you know (..) but seven hundred and fifty dollars to rearrange your life and make it completely more effective and happy (..) but that is a lesson (..) and that's not easy (..) access to ummm appropriate reimbursements for psychological care for patients is very very difficult to achieve unless they're umm employer which some employers do come to the party (..) the current Medicare system (..) is atrocious

Int: right
A: and the reason why it's atrocious is that I have to prepare a mental health care plan (..) which presupposes some form of mental illness (..) and presupposes that first of all that I know and can adequately administer you know an assessment tool (..) which I can't (..) I was never trained to you know the ones that you know (..) and then that somehow or another I'm going to administer the same tool six weeks or six sessions down the line and somehow or another sit in judgement over my colleague as to whether they've (..) you know (..) I mean the system's ludicrous (..) if I want your heart cut out I write a letter to the cardiothoracic surgeon that's all I need to do (..) if I need some assistance with some CBT which is a technique I'm not trained in (..) I ought to be able to send somebody off to a colleague for a reasonable Medicare rebate with as little fuss as possible you know and it really does obstruct the system and so the you know a lot of my psychological (..) psychologist colleagues are now wrapped up in this business of trying to get GP's to do mental health care plans

Int: mhm
A: so the patient can get cheap treatment (.) but the GP's sitting there looking at this screeds and screeds of stuff in the medical benefits schedule (.) that make it very (.) to comply with that (.) makes it very difficult (.) to comply honestly with applying an assessment tool to a patient (.) you know and (.) an angry teenager (.) you know these kids aren't going to sit there and meekly do assessment tools or if they do they do because they've been very effectively dealt with by a professional who's been trained to do it (.) not in a (.) you know not in this rat race

Int: mmmm
A: yeah
Int: so (.) ummm I mean that's something I was gonna ask at the end but it's come up so I'll ask it now explicitly I mean how has if at all has your referral pattern changed since the Medicare aah changes came in
A: (.) I don't think I refer any more or less people (.) than I did (.) because I always used to try to get them to go (.) I am not sure (.) that the process because it is so beauracratised and remember that the very people you're trying to arrange this for (.) are at the very least emotionally ummm (.)

Int: I mean that's something I was gonna ask at the end but it's come up so I'll ask it now explicitly I mean how has if at all has your referral pattern changed since the Medicare aah changes came in
A: (.) I don't think I refer any more or less people (.) than I did (.) because I always used to try to get them to go (.) I am not sure (.) that the process because it is so beauracratised and remember that the very people you're trying to arrange this for (.) are at the very least emotionally ummm (.)

Int: so to summarise that it sounds like your referral rate to psychologists hasn't increased because of the changes (.) it hasn't decreased (.) but it's pretty much stayed the same and that's because of the large amount of beauracracy around ummm (.)
A: well certainly the bureaucracy (.) the so called Medicare changes have not made it easier

Int: yep
A: ummm (.) and there is still a vast pool of treatable psychopathology sitting out there in the community unadressed because the system makes it so hard

Int: ok umm (.) I'd just like to get a bit of an idea (.) if there's any differences about your referrals to psychologists compared to say psychiatrists or do you make referrals to counsellors (.) and if so
A: I don't refer to counsellors in general

Int: ok

A: look yeah I this is a generalisation and all generalisations are inherently unfair to some of the people who are being essentially having been the beneficiary of good psychological advice myself ummm I'm I'm aware that it's a very subtle art you know to be able to listen carefully to be able to keep your personality out of the process something I'm utterly incapable of okay doke but to be able to ask the right incisive question at the right time and plant it like an oak seed and wait for it to bear fruit you know twelve months down the line you know that's a skill not every not every not every clinical psychologist has got it by the way

Int: sure

A: but in counsellors I find it but rarely you know so I've just made a point of that with respect to psychiatrists for the very odd patient and I don't see many of them that requires essentially analysis as opposed to CBT really needs to get back in there and rearrange their personality as opposed to understand how to deal with things in their life they don't deal well with aah you know well I'm you know I refer those to psychiatrists but gee they are rare umm what I refer to psychiatrists are I you know are essentially pharmacological problems or problems where I am having difficulty getting a good diagnostic formulation that's what those guys do for me

Int: excellent ok ummm I ask this of everyone but you have alluded to the fact that you've been a recipient of good psychological care

A: mmm

Int: so thank you for that transparency I guess I'd like to ask from where have you got your existing knowledge of psychologists

A: oh well from mum

Int: yes

A: aaaaah I spent the first almost half of my clinical career in Longreach where I had no access whatsoever I then came to Townsville where there were people available it took me some time to start availing myself of them I would have to say the bulk of it really came from my own experience of consulting a good clinical psychologist and just and I there was a certain wow factor in that

Int: yep

A: mmm

Int: that's good ummm what's your understanding of the type and amount of training undertaken by psychologists

A: well they do a university degree aah which involves at least a masters degree in clinical psychology so ummm it's four or five years of university training with a substantial practical and supervised ummm you know aah part to it as I understand it the course varies from university to university I have the my mother for example did a four year course with honours this is many years ago now at the university of Newcastle my daughter who's enrolled in clinical psychology
at the university of Melbourne but is intermitting for a year between grade twelve and starting aaah will be doing a five year course

Int: ok
A: you know and yeah at the end of that she'll have covered the field of (..) the basics of psychology (..) some psychological research (..) and the clinical psychology component and I've had a look at the course because it's my daughter doing it and I can see she's gonna be busy each of those five years

Int: and at the end her qualification will be as a (.).
A: master of clinical (..) master of psychology in brackets clinical
Int: ok and she'll be eligible for the specialist title clinical psychologist
A: mmmm
Int: ummm (..) again this has already come up but I ask this of everyone (..) I wonder if you can describe any significant contacts either personally or clinically that you've had with a psychologist
A: (..) aaah personally with JC (..) ummm (..) over (..) I'm fond of saying to patients I've got a solicitor I've got an accountant and I've got a clinical psychologist and I chose each of them with equal care ummm (..) because I think it's (..) and I don't go and see my lawyer every day and I don't go and see but there's times I need to see my lawyer and there's times I need to see my psychologist (..) I was very very very effective in (..) I think I went in to see J understanding that anything I was going to about the world I was going to have to do to myself (..) you know I wasn't going to be able to change everybody else (..) but by gee she was effective and kind in pointing out some of my inadequacies to me (laughs) (..) ummm look I think the other one that shines like a beacon in this town is PW (..) you know P is a very effective woman in terms of helping kids to deal with difficult things you know and and they you know I think a lot of the you know (..) you know you send a patient with a hernia to a surgeon and he comes back with a small scar and no hernia (..) but that doesn't happen in clinical psychology (..) what you take is somebody who wasn't coping and somehow or another (..) they're not turning up in your surgery anymore (..) and it's very difficult to see the thing that isn't there (..) you know

Int: mmmm
A: but (..) particularly with this subset of Townsville grammar patients I mean P makes just about every space a winner (..) now I don't ask her how she did it (..) because referring to the confidentiality thing (..) I think it's important for those kids predominately they're girls being sent to boarding school trying to get through all of that teenage girl stuff in an environment which tries to be ok but doesn't suit them all (..) and they stop having (..) they go to P and somehow they stop turning up well I reckon that's (..) that's brilliant (..) that's exactly what you want you know (.)

Int: ok excellent
A: yeah
Int: we're getting close to the end just so you know (..) I'm conscious of your time (..) ummm (..) look it's a bit of a turn
around question (.) what do you think your patients perceptions of psychologists are do they give you any indication
A: right (.) ummm first of all they don't distinguish between counsellors and psychologists and some of them don't distinguish between counsellors psychologists or psychiatrists ok (.)
Int: how do you know that
A: ummm (.). I went and saw a counsellor doctor and (.)
Int: aha
A: or when you're sending them (.). well I've seen when your sending them off to see a psychologist (.). I've seen lots of counsellors doctor (.). you know that's the
Int: okay
A: that's where it comes from (.). look (.). this is a very difficult art and (.). as I've mentioned before not everybody can turn the trick (.). the ones who have seen people who really do it (.). they're not a problem they understand (.). it is my view that there are lots of people sticking their hand up saying I can listen to your problems (.). that really don't have either the training or if they've got the training don't have the expertise to really be effective (.). ummm that's clouded by the fact there are a lot of people out there with so many problems and so few resources that (.). you know nobody's really gonna be terribly successful (.). but there's also a lot of people out there charging people money for being a very sympathetic ear (.). and no more (.). that really makes it difficult for the good clinical psychologists (.). you know there really needs to be a much more effective regulating mechanism (.). you know just so you get some idea (.). I understand the size of what I've said (.). on the one hand if there was a banner saying I am a clinical psychologist and I could depend upon that in the same way as I could depend on somebody having had say a surgical degree to be able to conduct the business of clinical psychology then I'd be I'd be very grateful for that
Int: mmmm
A: not everybody who has a fellowship of the college of surgeons is a good surgeon
Int: mmmm
A: lots of people who have a F R A C S will never ever get to see a patient of mine if I can help it
Int: mmmm
A: but at least I have a banner there that says we've whittled down the ummm list and you can pick from here and you've got a reasonable chance within this group of finding what you want (.). that really doesn't clearly exist (.). at least from my perception in clinical psychology (.). I referred also to this great well of psychopathology that's sitting out there people who are emotionally uncomfortable (.). and and and are seeking you know more emotional comfort (.). if you took away all the willing ears and just left the clinical psychologists (.). that problem of access would become even worse (.).
A: ummm and so (.) what I'm suggesting (.) is that there needs to be a clear sort of a label (.) yes I have been trained in among you know in clinical psychology and in the techniques of clinical psychology (.) ummm (.) you know ummm (.) and (.) I appreciate there are labels and so forth (.) they're just (.) they're not visible you see

Int: I mean it sounds like you've had experience with people who are clinical psychologists or at least call themselves clinical psychologists who don't deliver the sort of service that you're after

A: I'm afraid there's too many of them

Int: yep

A: yeah (.) I'm afraid there's too many of them (.) and I suspect that that's because there isn't (.) across australia (.) you know any university can offer a degree just about that it calls clinical psychology (.) there isn't a body like for example the australian medical council that goes around accrediting medical schools and says listen this isn't just up to specs (.) sorry you're going to have to do this again otherwise you won't be able to use this label for your graduates (.) ten years ago this very nearly happened at the university of queensland (.) they went very very close to losing A M C accreditation god knows what would have happened if they actually did (.) that sort of raising of the standards of education so that if you've got a qualification then across australia everybody knows you've reached a certain standard I think that's important

Int: and that's not in place for clinical psychologists

A: well it's not my perception that it is

Int: excellent

A: yeah it's not perception that it is (.) if it is it needs to be you know (.) you know trumpeted more eh (.)

Int: aha

A: but also (.) the guys who don't have the label (.) need to be ummm more readily identifiable (.) now look there is a whole raft of complementary medicine people working in townsville some of them are very good (.) ummm (.) the ummm however the fact that they are not doctors is immediately obvious (.) so a patient entering into those arrangements enters into it with a very clear understanding that what they're doing is they're consulting a complementary medicine practitioner (.) of whatever reason and they their expectations of the process are appropriate and so forth (.) many people who go to see a counsellor (.) have really no idea what type of level of service or whatever that they're getting or that they can expect and remember you know they're vulnerable at the time

Int: mhm
A: so (.) you know (.) a labelling system or you know (.) a labelling system which allows patients to understand (.) what it is that they're actually buying (.) I think is important (.) I'd have to say too that (.) the psychological profession as a profession I don't think has been particularly good (.) compare it to chiropractic (.) everybody knows what a chiropractor does (.) you know it's much harder it seems to me for clinical psychologists to let people know what it is that they do (.) or more importantly what it is that they don't do (.) yeah

Int: yep sure ok (.) thank you last question and again you've touched on it but I'll ask it explicitly (.) do you have any reservations about referring patients to a psychologist and if so what might they be

A: ummm (.) right (.) provided it's a psychologist that I trust (.) and it's up to me to make sure that the referrals are appropriate (.) no

Int: mhmm ok (.) so essentially you don't make referrals to psychologists that have reservations about because any psychologist that you refer to is a psychologist that you trust and you know what the service is gonna be

A: aah I've recently had the problem because "J" is retiring (.) you know (.) I by the way there's nothing specific about psychology in this I you know I refer all my patients to very few surgeons or very few you know I have a very small group because I understand what they're going to do yeah so this is and psychology is exactly the same as cardiology or you know general surgery in this regard (.) ummm (.) but when J retired I had a considerable problem (.) having already had P with adolescent psychology that was easy and child psychology that was easy you know until I hit upon SD

Int: yep ummm (.) the change to somebody else (.) and clinical psychology is like this (.) too clinical psychologists do have the power to do their patient enormous harm if they don't do it well a lot of other people either do good or leave them alone (.) so you've always got your heart in your mouth when your patient's going off to see a new psychologist because you don't know unless you've seen the results of twenty people that they've that person's seen before that they're not going to do something that actually leaves your patient worse off (.) and if you're in the game you will know that if you've had somebody who's been off to see a colleague who hasn't done the job properly (.) that patient is much harder to look after than the person who just comes fresh

Int: excellent (.) A that's they're the questions I wanted to ask I don't know if there's anything else spontaneous that you want to add

A: no

Int: but I really appreciate your time thanks very much

A: ok
Participant 4: “M”

Int: what I'd like to do first is just ask you to tell me a little bit about yourself as a GP

M: yep

Int: whether you've got any special interest in mental health or any special training in mental health

M: yep (. ) ummm (. ) as a GP I was previously full time army (. ) got out and have been working privately since (. ) aaah (. ) 2005 (. ) ummm most of what I do at the moment is ummm well fifty percent is ummm occupational med (. ) and the rest is a fair bit of kids stuff and a smattering of just normal general practice stuff (. ) ummm yeah and I haven't actually done any formal mental training (. ) mental health training

Int: mmm ok thanks (. ) so what factors would lead you to refer one of your patients to a psychologist

M: ummm (. ) a lot of ummm (. ) a lot of referrals I do are ummm (. ) patient driven ummm (. ) I think there's a bit of misunderstanding about the system to a lot of degree and a lot of people think they need a doctors referral to see a psychologist when in fact a lot of the time they can self refer (. ) a lot of the time for aaah (. ) most of my referrals would be for ummm psychological support for workplace issues ummm (. ) in particular injury rehab or stalled recovery from injury ummm or ummm early childhood behavioural problems is probably my most common (. ) that's generally through child and youth mental health services ummm (. ) beyond that ummm you know occasionally sort of general anxiety and mood disorders and stuff like that

Int: so for any of those three categories or for all three if you like

M: yep

Int: ummm what sort of service would you expect from a psychologist if you made a referral for one or all of those categories

M: ummm (. ) as far as definitive treatment goes ummm (. ) yeah it's sort of hard to generalise cos it’s such an amorphous group of people but ummm certainly for the kids stuff ummm I see it as more a diagnostic role to exclude specific behavioural ahhhh disorders ummm so basically then you can go down the school based programs or disciplinary programs and stuff like that ummm while being relatively comfortable that you're not sort of overlooking an organic illness (. ) ummm and also just sort of education about you know emotion control and expressing anger and feelings and frustration in acceptable ways (. ) ummm for the work injuries and rehab and and or sort of work place stress or or bullying or whatever (. ) I suppose there's two of them there's the sort of workplace stress and bullying thing ummm first basically ummm a lot of people are poorly developed in
their conflict personal conflict resolution skills aah or lack confidence or the knowledge of how to raise concerns or whatever with various various people (. ) so I guess a bit of ummm (. ) aaaaah (. ) you know ego building to some degree so that generally that's an ok thing to do as well as sort of practical tips on you know how to raise ummm issues and be comfortable with their legitimacy in doing so (. ) ummm in terms of ummm you know stalled physical rehab which is I suppose as in at the moment if employee market conditions being relatively good especially mining wise (. ) I don't tend to find a lot of people who don't want to get better ummm but occasionally you get people who are excessively concerned about being broken forever and how they're never going to be able to do anything and it's aah largely I'm hoping for but don't always get ummm a reassurance that ummm you know basically a second person to say the same (. ) you know try and maintain an upbeat sort of positive outlook on their rehab ummm perspective so ummm they're pretty much the ummm sort of main ones and the other one mood disorders mood disorders are sort of the CBT thing and aah putting aaaaah life events in perspective ummm and sort of dealing with individual (. ) learning to deal with individual problems as opposed to seeing individual problems as a (. ) as a symptom of how you know how their whole life is turning to crap (. ) so ummm (. ) yeah basically just reminding them that we're there feeling good or bad (. ) bad things are gonna happen and you just have to deal with it (. ) the fact that your toast dropped on the floor does not mean that the world is caving in so ummm yeah (. ) that's basically the main ones I guess

Int: ok (. ) I guess just following in from that what type of service would you expect for those sort of (. ) what type of service would you expect from a psychologist ummm (. ) sorry how would the type of service you expect from a psychologist as you've just outlined differ from the type of service you might expect from a psychiatrist or a counselor

M: yep ummm (. ) counselors mmmm (. ) aaaaah look (. ) I suppose to some degree I see counselors as being more useful in the practicalities of things ummm I see counselors being people who can arrange services or give guidance about where to turn for ummm various aid aaaaah and you know giving guidance or recommendations about aah you know workplace things (. ) or you know career guidance or whatever ummm whereas psychologists in a sense I see more on looking at the way a person's actually thinking and helping them to interpret things aaaaah and expressing their concerns differently so I see psychologists working more on the persons behaviour and the way that they're perceiving and thinking about what they're doing whereas the counselors I see being more a practical (. ) a practical role (. ) as far as psychiatrists go (. ) generally I refer people to psychiatrists for (. ) refractory conditions or or (. ) complex organic issues that will probably or will require medication or or other so yeah if it's a medication issue it's psychiatry if it's so yeah (. ) I don't think I ever will probably refer schizophrenia or or to psychology do novo if the psychiatrist thinks it's a good idea that's fine but generally they'll go off to them or refractory depression ummm (. ) psychology would be
part of it but aaah that would be (. ) psychiatry would probably be first before the psychologist

Int: ok thanks (. ) ummm from where have you got your existing knowledge of psychologists

M: aaah look I actually don't know any of them ummm (. ) I haven't met any of them ummm (. ) vaguely ummm (. ) a lot of the time again it's self referral so people rock up and say I've booked an appointment with whatever whoever I just need a referral ummm and (. ) basically correspondence is the main way I've sort of done it ummm and I guess locality is the other thing ummm SS is just up the road (pronounced shoyer rather than shower)

Int: MS do you mean

M: that's the one SS is a physio at the moment MS is yeah so (. ) he's probably the most commonly used one for people that I see ummm (. ) again with a (. ) as often as not they've already seen him or already plan on seeing him (. ) so yeah I don't actually know any of them in particular so I don't have a particularly good feel for what they do (. ) or like in terms of their special interests or or whatever so ummm (. ) I've had a few ummm a few that I've ummm (. ) not a few but a couple that I've learned pretty quickly (. ) ummm haven't had (. ) well haven't when I say they haven't they don't have the skills that I expected them to they haven't had the skills compatible with my expectations ummm (. ) in the sense that (. ) ok there was one particular disastrous one that it was a work one that I basically wanted him to (. ) pat him on the head and say “you'll be right champ” and he basically wrote back a letter saying I recommend this person have several weeks off work aaah which (. ) just made things immeasurably worse so (. ) ummm (. ) he got over that but yeah again that's a matter of knowing what people are good at what ummm which at the moment I don't really have a handle on so

Int: ok (. ) ummm (. ) what's your understanding of the type and the amount of training undertaken by psychologists

M: ummm I think it's a bit variable in terms of aaaah sort of the amount depending on where you're which uni you go to but it's usually I think a three or four year degree and then to work privately is usually a masters program I think (inaudible) which I guess would be aaah (. ) you know up to three years but usually sort of one two ummm (. ) aaaah (. ) and then I assume probably similar to general practice if you've got special interests in whatever you do your sort of training in your special fields of interest (. ) on an ongoing (. ) basis (. )

Int: so that's interesting so your sense is to work in private practice you have a masters

M: to be a clinical psychologist I believe (. ) my impression was that you have a masters

Int: ummm (. ) look M (. ) you just touched on something earlier on that I just want to go back to and I (. ) one of my general questions is to describe any significant contacts you've had with a psychologist and you sort of told me about one

M: which was interesting I wonder if there's (. ) you want to extend on that story or give another story about a particularly positive or negative interaction you might have had with a psychologist
M: yeah (. ) ummm oh look I've had ahaah (. ) I had (. ) the one's that spring to mind I guess ahaah MS actually referred someone to me which I thought was a very good thing (. ) ummm it was a guy a policemen involved in the palm island riots who had not seen anyone for anything (. ) this was a couple of weeks ago ummm and obviously the riots were some time ago ahaah and was essentially sent to see a psychologist ummm by workmates and he sent him to see me because he hadn't seen anyone ahaah so I think that was a positive (. ) ahaah and certainly I've had one (. ) I had one young fella I saw today with ummm a significant gambling addiction that came back and was much happier that it had ummm ahaah you know (. ) quite a few sessions of psychology and that basically stopped that and was much happier with life ummm so they're the good ones the ummm (. ) I suppose a few recurrent but they're not that (. ) the first one's not that recurrent the other one's very recurrent (. ) ummm (. ) one of the things I struggle with just as in general medicine (. ) bu ummm (. ) is the concept of stress leave ummm (. ) and taking time off work ummm (. ) my personal feeling is if (. ) if time off work is utilised to look for other jobs or you know plan on how you're gonna resolve conflict or whatever (. ) that can be useful ummm beyond that (. ) just disappearing from work for an extended period without notice is probably not going to improve the way you're (. ) ummm treated at work (. ) so if you feel like you're being persecuted just disappearing for a month with no notice is probably not gonna make people like you any better ummm so (. ) I've had a couple of people referred from psychologists saying can you do a work cover thing so for this person to have a few weeks off and I basically say no ummm (. ) or you know I'll say have a couple of days but during these couple of days I want you to go to centrelink (. ) you know have a meeting with the people there (. ) look for other job options ummm and have a think and get back to me ummm and decide whether or not you want to work at the place ahaah if you don't you know that's fine (. ) but if you're (. ) you're gonna have it you know (. ) you need time so ummm so ahaah I guess one of the (. ) as a general thing as soon as other people tell me what to do for other people (. ) immediately gets me off side (. ) I think you know if you're referring people to me for my opinion (. ) that's great but referring people to give them a certificate for a few weeks off work (. ) ummm (. ) you know (. ) if you've already made the decision for what I'm going to do then that's a bit annoying ummm (. ) but again that doesn't happen very often it's been I think one maybe two cases so that's not often (. ) the other thing that I have ummm (. ) sort of on a frequent basis recently since they've started is the mental health care plans (. ) ummm with psychologists referring people (. ) just telling people just go and see your doctor and get one of these knocked out so they book a standard consult and the paperwork is not something that can be done in a standard consult for a new patient (. ) ummm and but they come with the expectation it will all be done (. ) I'd say the vast majority of the people don't fit the criteria because it's for (. ) ummm relationship counseling or for (. ) ahaah work stress or whatever and under the guidelines it has to be a diagnosable mental illness so ummm (. ) you know ummm arguments with the missus is
not a DSM IV criteria so they don't actually fit so but then it turns into the GP's all lying (.). I turn into the bastard because I say you don't fit this qualification ummm (.). so or I say yeah that's fine but we're gonna book you back in for a long consult next week ummm (.). and don't do it in a standard consult so ummm (.). I think (.). I think there's a few ummm psychologists that are (.). aaaah and I've had this from child and youth mental health services as well (.). ummm I had one just the other day for a ummm (.). I sent a ten year old newly diagnosed insulin dependant diabetic off ummm (.). it was fine but it's obviously a very stressful sort of diagnosis and I said you know can you have a look and they said you'd be better to get this done under a um GP mental health care plan (.). and I'm thinking (.). I can send him privately but you obviously don't understand the system so (.). ummm I think there's a bit of misunderstanding about who actually qualifies for these and a lack of appreciation of the fact that it's not something that you can just book into a standard consult and just get done especially for new patients so ummm (.). I think referring people back to GP's to discuss is fine but telling them to go back to your GP and come back with a referral (.). ummm (.). is a bit inappropriate at times (.). but they're the main ones but beyond that ummm (.). I think that’s about it (.).

Int: a bit of a turn around question
M: yep

Int: what do you think your patients' perceptions of psychologists are

M: oh ummm some (.). I think the thing with psychology with psychologists is very similar to (.). doctors in the sense that it's very personality specific (.). aah and I've had a few people that have had (.). have seen a psychologist in the past and wanted to go and see another one again (.). ummm and reading not too far into it it's been purely a personality clash (.). ummm or the person obviously went to a psychologist cos they were in a bad state of mind at the time and whoever they talked to was gonna piss them off so (.). they had a very negative first impression of their encounter with a psychologist and they've sworn off them forever and a day (.). ummm (.). however (.). you know there are people that are happy to go and see them (.). the (.). and you do get some people with you know depression or anxiety disorders that don't want medication but want to go and see someone that can usually spend a bit more time than general practitioners and you know obviously that's what they do as a full time sort of occupation so they obviously do it better (.). ummm (.). and they (.). and a lot of patients actually see that as an adjunctive treatment so it's a pretty wide spectrum of people who actively seek it out to people who actively resist it (.).

Int: ok (.). do you have any reservations about referring any of your patients to psychologists

M: ummm (.). aside from the fact that (.). administratively it's a hassle because I know that as soon as I write a referral (.). the next (.). they're gonna be sent back saying can you do a GP mental health care plan (.). which at the best of times is a pain in the arse (.). ummm again a lot of the time it's not actually appropriate to do in the first place (.). and usually I'll do it
in the first place (. ) you know if it's legitimately warranted
I'll do it as part of the referral (. ) so yeah beyond that I
don't have any real problems with it (. ) but it's just a
administrative hassle more than anything else so
Int: ok
M: and the other thing they don't generally realize is that the
rebates if they've got private health insurance the rebates are
roughly (. ) you know equitable with on their health insurance as
they are on the GP mental health care plan and they can't get
both (. ) but anyway so yeah (. ) yeah beyond that not really so
Int: ok and last question (. ) ummm has your referral pattern changed
at all since the GP mental health care plans came in
M: ummm (. ) not substantially I don't think (. ) ummm (. ) I think
ummm (. ) probably (. ) maybe a little bit more but probably not a
lot and I think probably the fact that I think I'm doing more of
them is probably (. ) I'm just noticing the paperwork more (. )
ummm so I don't think I'm sending more people off but it's (. ) I
notice when I do (. ) which is yeah (. ) so I don't think it's
really changed too much
Int: ok excellent (. ) they're all the questions I wanted to ask is
there anything else that you wanted to add spontaneously about
your perception of psychologists (. ) either positive negative or
anything like that
M: no not especially ummm (. ) ummm we have actually this evening at
the after hours a information session about ummm (. ) ummm (. )
referral pathways for after hours mental health care (. ) and we
have a (. ) again I don't know them but we've got aaaaah a
psychology ummm group that is happy to be sort of called in
after hours to do acute care stuff at the after hours clinic so
(. ) so ummm so yeah (. ) I think they're part of the (. ) sort of
health care infrastructure and they've (. ) they have a place
ummm it's not a place for everybody and even in some people for
whom it would happen once they're not receptive to it and in the
end if they're not receptive to it it's gonna be a waste of time
(. ) ummm (. ) aaaaah
Int: ok that's great thanks very much
M: cool

Participant 5: “B”

Int: the first thing I'd like to ask is can you tell me a bit about
yourself as a GP whether you've got any special interest in
mental health or any special training in mental health
B: aaahh well no special training ummm I guess in previous years I'd
ummm be (. ) well I suppose going right back as a student I did
the lifeline counselling telephone counsellors course (. ) I did
that and telephone counselling for a while (. ) ummm and then
I've been to a number of like short counselling courses for GP's
(. ) but that's it
Int: ok (. ) do you do counselling in your own practice here
B: well it depends what you call counselling but its I mean in its broadest term it would be totally unavoidable (.) it's what you're here for in a way (.). ummm but (.). yeah like (.). I have lots of people come in to me with lots of problems (.). and I flick them when I can but (.). sometimes you can't do that very easily anyway or it's not appropriate to do it (.).

Int: what factors would lead you to refer someone to a psychologist

B: ummm if I think they need some ongoing psychotherapy of some kind (.). ummm and the other factor for me is just time pressure here it's hard to do it (.).

Int: what sort of things would you consider to be psychotherapy

B: ummm pretty broad (.). talking in a broad term of psychotherapy as well so ummm (.). well there's a lot of relationship problems (.). depression anxiety kind of things (.). ummm sometimes smoking cessation or that sort of thing (.). ummm (.). sometimes work stress type things that are not resolving themselves very well (.). ummm a whole gamut of things like that I guess (.).

Int: and once you've made a referral of a patient of yours to a psychologist what sort of service do you expect from them what do you think will happen

B: (.). ummm (.). well I assume they'll see the person make an assessment and arrange some suitable sessions (.). and obviously ummm (.). because you don't need a referral to see a psychologist normally (.). it works a bit different from a lot other referrals and ummm referring to a lot of people you expect to get a letter back saying what's going on (.). you don't necessarily (.). you get that from some psychologists but not from most ummm (.). the new mental health care plans of course and all that's changed things a bit ummm (.). they're a pain in the arse to do basically (.). umm and some psychologists will just tell the patient to come here and (.). and get a mental health care plan so they can access the rebates (coughs) which doesn't really work when you've got 10 minutes to do it so ummm that's a bit of a nuisance (.). umm I find I do get a little bit back from psychologists if you're doing but that not really a lot (.). so in terms of service well (.). that's ok so long as the right things happening with the patient but probably there should be more communication I think cos usually I'm still seeing a patient along the way and asking how they're going as well (.).

Int: so you expect them to make an assessment provide some sort of service in sessions and communicate with you

B: aaaah I don't expect them to communicate necessarily cos it doesn't always happen but I would prefer that they did

Int: what sort of ummm service might you expect from a psychiatrist or a counsellor if you refer some of your patients to either of those services

B: ummm well a psychiatrist works within in a system of referring to other specialists (.). just first thing is I hardly ever do it because in townsville you can't get to see a psychiatrist (.). but when you can ummm (.). you can be expecting to get a letter back saying what was going on and (.). ummm yeah keep in regular contact that's the main difference (.). the other (.). the main reason I would choose a psychiatrist rather than a psychologist would be ummm well it sometimes if I knew the person and they I thought they were particularly good at something but otherwise
if umm if there was some complicated medication issues (.) umm I would refer to psychiatrists more if they were accessible but they generally aren't in townsville (.) so it's a bit of a lost cause here (.) counsellors (.) ummm (.) well it would depend on the counsellor ummm (.) I guess I would tend to have more faith in knowing a psychologist has got appropriate training counsellors could be just about anybody and you're not sure what training they've had ummm (.) but sometimes if they're working for like an organisation like centre care or something like that (.) the payment's an issue with means testing that might be a reason to be doing it that way but (.) I would think the majority of people I'd be (.) getting people to see would be psychologists who are doing the counselling these days anyway

Int: just picking up from something that you've said there (.) would you refer some of your patients to psychiatrists more frequently (.) some of these patients that you ummm might currently refer to psychologists (.) would you refer some of those to psychiatrists if they were more accessible

B: mmm yeah I would

Int: whereabouts have you got your existing knowledge about psychologists from

B: hmmm (.) well from (.) talking to psychologists (.) or from patients back and forth (.) letters that they've sent (.) basically that I guess

Int: ok and what's your understanding of the type and amount of training that psychologists undertake

B: well obviously you need a university degree first (.) and then I understand you need your clinical ummm (.) to get your clinical psychology you've got to do some more training and supervision and get assessed but I don't know details

Int: ummm it's a bit of an open ended question this one (.) I'd like you to just (.) if you can just think about a situation you might have had with a psychologist (.) an interaction that's been particularly negative or particularly positive (.) ummm and perhaps just describe that

B: ummm (.) I'm trying to think negative first (.) umm the only (.) I can't think of anything outstanding but the main negatives would be patients coming back saying that they weren't happy with the person (.) and that could be for a variety of reasons not necessarily to do with the psychologist but sometimes it might be (.) ummm (.) ummm (.) I can't think of specific really bad things though (.) good (.) ummm again (.) ummm patients will come in telling me someone was particularly good and they were very happy with them (.) umm (.) and the other (.) if I got a good letter back giving me good information (.) that's helpful to me when I'm seeing the patient as well

Int: so does the (.) your patient feedback shape your perception of psychologists

B: well fairly largely because that's the main access I have to any information (.) or letters if they do send a letter

Int: just on that note what do you think your patients' perceptions of psychologists are

B: ummm I think that would vary a lot from patient to patient ummm (.) I think it's changed a lot over the years I think ummm people are far more accepting of seeing someone now than they
would have been ten or twenty years ago. I actually think Beyond Blue has made a big difference to that. I see a lot more men quite happy to come and talk about problems whereas and happy to see someone as well whereas they would not have been so happy in the past so that's the first thing. I forget the question what's the question

Int: well what do you think your patients' perception of psychologists is

B: in general yeah as I say it varies some would say I'm not a nut case I don't need to see a psychologist but some say how's talking going to help me ummm not gonna sort of solve the problem but I find the majority actually quite accepting of seeing someone and think that it would be helpful to talk to someone at least beyond that I'm not really sure what people think

Int: do you have any reservations about referring your patients to psychologists and if so tell me a bit about them. what are they based on

B: well my main reservation would be not knowing the individual and what they're like and there's note really good opportunities to find out ummm or none that I'm aware of to find out what individuals are like so that would be my main reservation I don't as a group referring to psychologists I don't have a problem but they do vary a lot and without knowing what each individual's interested in or what they're like yeah it'd be (.) I'd be a bit reserved with someone I knew nothing about

Int: so it sounds like you have a sense that there's a pot of psychologists a group of psychologists and there's a certain amount of variance in their expertise and efficacy and stuff

B: definitely

Int: can you tell me a little bit about that as far as your experience goes

B: ummm well I'm sure you've met some mad psychologists too so (laughs)

Int: (laughs)

B: ummm well like psychiatry a lot well a fair percentage go into it because of their own problems ummm and they might still be effective but ummm yeah so some of them are a bit strange themselves and well you're in a closed room with a patient you're not quite sure what's going on in there so that's and and some are obviously excellent so you know people vary a lot depending on their training and their experience and their expertise and everything else and their personality and a lot of things I certainly have patients who are psychologists who are pretty mad

Int: do you think the training makes is a significant factor in whether a psychologist is gonna be able to treat your patients effectively

B: I would hope so there wouldn't be a lot of point in training otherwise would there but yeah I think ummm well the type the quality of the training and the extent of the training definitely makes a difference
Int: ummm (.) and it's the last question B (.) how has your referral pattern changed since the GP mental health care plans came in if at all

B: well yeah I've done quite a few of them ummm (.) and I mean patients are generally disappointed cos they expect it's gonna cost them nothing and it still costs them quite a bit with most psychologists (.) aaaah (.) if they have sussed someone out themselves who is cheaper and they want to go there because they're cheaper (.) I'm probably more inclined to do that than choosing myself ummm otherwise how it's changed (.) well I've done more ref (.) I've done more referrals that I've written myself obviously cos a lot of other times people would just take themselves or I wouldn't do a written referral they'd just go anyway ummm (.) whether I'm referring more people for psychology (.) probably a bit more in that it's a little bit more affordable for some people but it actually hasn't solved the affordability problem and the other thing that's happened is it's pretty much impossible to get much done in the public system now cos they just all flick it and say you can get it through Medicare (.) so they see them once and then say go back and see your GP and get a mental health care plan (.) and really it's a wasted (.) they probably spend most of their time wasting their time doing that rather than actually seeing people for ongoing care

Int: right ok (.) just to finish off with I mean (.) that's the list of the questions that I wanted to ask do you have anything else that you'd like to sort of add spontaneously about your perception of psychologists with your experience as a GP

B: mmmm no not really

Int: ok thanks very much

B: ok

Participant 6: “S”

Int: ummm S I just wanted to start by asking you to tell me a bit about yourself as a GP

S: mhmmm

Int: and whether you've got any special interest in mental health or any special training in mental health

S: ok ummm I'm a basic GP registrar so I've just started my two year program the RACGP so I've been a GP for nine weeks (laughs) (.) before that I was a resident for four years and in my intern year I did a term in psychiatry at townsville hospital ummm (.) that was three months long and that's been my only experience of mental health so far ummm (.) the last two years I've been doing emergency work overseas (.) so I haven't experienced much mental health in that capacity (.) but I'm finding I'm getting a lot of patients with mental health issues coming in here as a GP so that's an area I want to find out more about yeah

Int: ok so what factors would lead you to refer one of your patients to a psychologist
S: ummm I’m finding that I’m getting a lot of people (.).
particularly a lot of women young women and more middle aged
women who are coming in who I think (.). are depressed but not at
a level where they’d necessarily need to be referred to the
crisis team or have an admission ummm and I think that they’re
suitable for (.), for going under a mental health care plan so
you know (.), depression that I think I can manage with the help
of a psychologist (.), and I refer people on to a psychologist
when I feel like cognitive behaviour therapy for managing sort
of different aspects of their lives ummm might help manage their
depression (.). so (.).

Int: so how do you think cognitive behaviour therapy sort of fits
into that picture
S: ummm it’s actually something I’d like to know more about
(laughs) and I’ve been wanting to ask a psychologist myself ummm
(.), I guess when (.), when someone comes in for their initial
visit and I kind of work out that I think they have a mental
health problem and I get them to come back for a longer visit
and go into more detail about what’s been going on in their life
if I identify any (.), any kind of behaviours that (.), ummm that
might be helped by (.), my perception of cognitive behavioural
therapy is identifying problem behaviours and then a
psychologist ummm educating people with regard to strategies to
try and overcome the problem behaviours ummm by (.), getting
people to talk about them and identify them in their own lives
and think about triggers for them and then (.), ummm you know
strategies if they encounter a trigger having a bit of a
strategy to put in place to avoid (.), you know their problem
behaviours (.). yeah (.), I guess (.), I might be completely wrong
(laughs) ummm that’s just from uni quite a few years ago

Int: ok thanks for that (.). that’s great (.). after you’ve referred
one of your patients to a psychologist what type of intervention
would you expect (.). what type of service would you expect ummm
(.). yeah (.).

S: ummm I suppose because the main ones most of the ones I’ve
referred have been for depression ummm one of the goals on their
mental health care plan is that they’re aiming to you know feel
better about their life and themselves and to ummm overcome the
symptoms of depression so develop more motivation ummm to become
(.), you know overcome that apathy where they’re feeling a lack
of pleasure in their lives so (.), sometimes I feel that that
might be because of different factors in their lives like being
involved in some bad relationships or they’re in an unhappy
marriage or if they’re having problems at work (.). I see those
areas as areas that a psychologist can help them with and (.). by
improving those areas that can help them work towards their goal
of overcoming the depression

Int: mmmm
S: yeah
Int: ok (.). and do you make referrals to psychiatrists or counsellors
for your typical clientele
S: no I haven’t encountered anyone yet that I (.). well I’ve only
been here nine weeks and I haven’t seen anyone who I felt needed
to see a psychiatrist oh except for one lady who came in saying
that she was suicidal (.). and she actually was subsequently
diagnosed borderline personality and on the day when she was telling me she was suicidal (. ) I was a bit dubious (. ) but she was referred to ummm the crisis team at the hospital and they took care of her but umm apart from her I haven't referred anyone to a psychiatrist (. ) everyone else has been managed by me and three psychology referrals yeah

Int: from where have you got your existing knowledge of psychologists
S: ummm just through my medical degree and I'll be honest and say that (. ) I really think that I would love to know more (. ) I feel like I don't know exactly what they do but ummm it's more through talking to other GP's who say you know I'd refer this sort of a person to see a psychologist (. ) that's the main thing but not through any detailed knowledge of what they actually do (. ) ummm yeah (. ) so I do feel it's an area that I need to know more about (. ) in particular being new to townsville umm I'm trying to feel my way with regard to what psychologists are better for what sort of problems you know I saw a young girl the other day with anorexia and I've seen you know young men or I might see older women and I (. ) it's something I see as trying to find the right personality fit like you can send ten patients to the one psychologist I find and five of them will think that they're good and the other five won't feel that they're identifying with that psychologist and (. ) and so I want to try and get to know who's in townsville and what fits are best for what types of patients

Int: mmmmm
S: yeah

Int: and how have you been feeling your way through that (. ) receiving assistance from GP colleagues
S: yeah by talking to my bosses here (. ) the principals in the practice and saying I've got this sort of a patient who you know which psychologist would be (. ) be a good one to refer to and I'm actually finding they don't have any hard and fast rules and they don't seem to ummm always have a definite idea either (laughs) they say oh there's a big long list just try whoever or you know that sort of thing so (. ) one of my referrals I sent (. ) a nurse here saw a umm psychologist when she was going through a marriage break up and she thought she was fantastic so I've sent a few people to see her (. ) yeah

Int: at the end of the interview I might just ask you her name if that's alright
S: yeah

Int: the psychologists name
S: yep yep

Int: ummm (. ) what's your understanding of the type and the amount of training undertaken by psychologists
S: ummm I think what I know is they do a four year psychology degree but then if they want to become an actual clinical practising psychologist they have to do a masters of two years then they can go into private practice on their own (. ) if they do the four year degree I think they can get jobs (. ) possibly hospital jobs or jobs in as teachers or in (. ) you know in the corporate world but not as a (. ) not seeing patients on their own is that right (laughs) I don't even know if that's right
Int: and where did you get your info about the training that psychologists do as you've just described
S: oh just when I was at uni and I had a friend who was doing psychology (.) she (.) what (.) she actually did her four year degree and then she went into the police force (.) so she didn't go on and do her masters (.) that was eight years ago ummm (.) that I had that friend doing that study so that's how old my knowledge is of that (.) I haven't known anyone since going through psychology training
Int: can you describe any significant contacts that you've had with a psychologist in a clinical setting you know either a particularly negative experience or a particularly positive experience
S: oh actually I don't think I've had any actually really other than ummm (.) cos I've only been here nine weeks I've sent a few people to (.) I've probably sent six people to see psychologists and of them some have only had one visit (.) some are still waiting for appointments so I'm still waiting to get feedback on how everyone's going (.) yeah (.)
Int: ok and that sort of leads nicely into my next question about (.). what do you think your patients perception of psychologists is
S: ummm I think they see it as someone who's going to help them work on the problems in their life (.) to try and work out how to feel better ummm and more positive about things and if there are issues that are troubling them how to (.) how to learn to deal with those (.) and what I say to them is that nothing is kind of a quick fix you're not going to feel better overnight by going to see someone who's going to magically fix you (.) it's more about seeing someone who can help to teach you how to improve your life
Int: do you think that they think they're gonna get a quick fix
S: I think some do (.) and I try and explain that (.) and same with my treatment if I'm starting someone on an antidepressant I explain that nothing in the management of depression is a quick fix and they often take a while to become unwell and so it takes a while to make them better through medication or through psychology or through both
Int: do you have any ummm reservations about referring patients to a psychologist
S: ummm I suppose just being new to townsville and not knowing the people that I'm referring to and not knowing (.) not having met them and knowing (.) ummm (.) I suppose having had other patients who've been happy with them (.) I sort of feel like I'm feeling my way in the dark sometimes just hoping that that patient will have a connection with that psychologist ummm it's the same with GP's you know I see patients who I feel I have a good connection with and then some days I'll see patients where I think ooh (.) I don't think that patient really connected with me at all so and I know that would happen with psychologists (.) so I'm just hoping when I'm referring someone who's feeling unwell and in a bit of a crisis situation that I'm referring to someone who's gonna (.) they will feel like they're gonna gain from the therapeutic relationship rather than come back to me and say I didn't like that person at all (.) I don't think they're doing anything for me
Int: have you had that experience
S: one person did yeah (.) yep (.) mmm
Int: and do you think that was purely around client therapist personality fit
S: it sounds like it yeah (.) yep mmmm
Int: and the last question I always ask although it might be different for you seeing as you said you were new to townsville but (.) so maybe I can reframe the question rather than asking how has your referral pattern changed since the GP mental health care plans came in maybe I'll ask (.) how is the aaah (.) how are the GP mental health changes influencing your referral practice
S: I suppose ummm (.) because I know that that's there I would tend to take (.) I would tend to use it a lot because it's (.) I feel like it's something else something additional you can offer a patient (.) when someone comes in here and they're you know they're miserable and they feel like their life's falling apart and I feel quite powerless to help them in the long run (.) like I can talk to them and identify a few of their issues and decide whether or not I think they would benefit from medication but I feel like having the mental health care plan where I can say to people look why don't we try this (.) why don't we try referring you to a psychologist it's like an additional (.) helping factor that (.) that also gives me a bit of (.) makes me feel a bit better that there's another avenue I can try to help them cos I think a lot of (.) well I know myself and probably a lot of GP's probably feel a bit powerless sometimes cos they're quite umm complex problems with mental health and (.)and the fact that there are no quick fixes and it takes a long time to get people better (.) it's good to know that you've got a back up and kind of ummm (.) just that really clear cut system for knowing that you can refer people and you can say to them look it's under Medicare and you'll get a rebate and people are usually pretty enthusiastic about that so (.) it's like ummm (.) it's like having (.) knowing there's someone else in the therapeutic relationship with the patient (laughs) and it takes the pressure off and makes you feel better about helping the patient (.) whereas if I'd come in before the mental health care plans I would have been thinking oh should I refer them or not are they (.) is it gonna benefit them to spend the money or (.) ummm you know is it really going to help them and it would be harder to sell to the patient I think when you're saying to them it's going to cost you this much and that sort of thing ummm (.) yeah (.) so I think it's a good thing I'm happy it's there and I think as a basic registrar it's helped me a lot to know that that framework's in place yeah
Int: ok (.) S they're all the sort of specific questions I wanted to ask so I'll just throw it open to you at the end for you if you'd like to spontaneously add anything else at all about your thoughts around your perception of psychologists in a clinical setting
S: ummm (.) I suppose ummm I know that they have (.) psychologists are like GP's and doctors they have lots of different interest areas (.) so my perception is that not every psychologist is ummm (.) well not wants to see but is interested in the whole range of mental health issues that they might have specialist
areas ummm (.) and you they can help more with some problems
than with others and I don't know if any of this is correct but
I suppose I feel like they (.) psychology can help more with
depression anxiety anger management (.) relationship issues (.)
probably than psychosis and that end of the mental health
spectrum if I had a patient suffering from psychosis I would
definitely send them to a psychiatrist probably (.) and leave it
to a psychiatrist to decide if psychology was warranted in that
case cos yeah (.) it's like physio (phone rings) I sort of
vaguely know what they do but I don't really (laughs) and
sometimes you send a patient hoping this will help but you don't
know for sure if it's going to (.) just excuse me for a sec
(answers phone...conversation not transcribed) sorry ummm yeah so
(.) I guess probably if there are education sessions for new
GP's and I think our training (.) our consortium our training
consortium tropical medical training is planning to try and do
this get a psychologist in to talk to the basic registrars about
exactly what psychologists do and (.) umm when it's appropriate
to refer and when not and how to know who to refer to (.) ummm
they know (.) my trainers know that that's an issue for us and
they are trying to get a workshop together cos we have training
every two weeks out at the university (.) ummm (.) I think they
have had a bit of trouble trying to get someone to come but I'm
not sure who's working on it (laughs) but ummm (.) yeah (.)
we're all kind of eagerly awaiting a bit more training in that
area (.) cos we do see a lot of ummm mental health patients (.)
yeah (.)

Int: great alright well thank you very much
S: that's ok
Int: that's the stuff I wanted to ask (.) I'll turn this off

Participant 7: “N”

Int: ok N the first thing I'd like to ask is just to tell me a little
bit about yourself as a GP whether you've got any special
interest in mental health or any special training in mental
health
N: ok (.) I'm a GP registrar so I've been doing the program since
the beginning of the year it's my first GP term ummm (.) I've
done a psych term as a resident (.) I haven't had much exposure
to the GP side of mental health yet (.)
Int: ok (.) ummm so (.) so far in your own practice what are the
factors that would lead you to make a referral of one of your
patients to a psychologist
N: ummm I suppose because of my limited exposure (.) to as you say
to the GP side of mental health ummm (.) the number one that I
have seen is a lot to do with cognitive behavioural therapy
Int: mmm
N: so patients (.) I can see would benefit from those thought
process changes (.) ummm (.) a lot of patients who are
undergoing situational crisis (.) ummm (.) that probably would
benefit from a lot more time just discussing their issues rather than the fifteen minutes that GP's have (.) I think that's a big plus of the psychologist referrals ummm and that new GP mental health care plan allows you to do that a lot more than what you probably would have otherwise because of the government subsidy associated with it so (.) yeah

Int: what might be some of the situational crises that you refer a patient for

N: ummm examples of patients that sort of (.) the (.) cos I'm (.) well I suppose I attract younger patients umm (.) so the ones that are going through relationship breakups (.) ummm stresses with work (.) umm (.) and the patients I have referred you've seen a turn around (.) I've seen a turn around in two or three reviews by a psychologist so they've been quite beneficial (.) the other side that I've referred is ummm (.) young children with parents (.) ummm (.) we've got a specific child psychologists here who deals with behavioural issues and things like that for children (.) mhhhm (.) she's been quite beneficial (.)

Int: ok (.) great (.) when you make a referral of one of you patients to a psychologist what sort of service do you expect with regards to assessment and intervention

N: ummm (.) I suppose (.) I expect the psychologist to delve a little bit more into the initial problem you always know there is a (.) a lot of the time (.) there's probably a deeper issue going on (.) ummm with these people that they haven't actually dealt with in the past (.) sort of I expect during that time period to find other issues going on (.) mmmm (.) what else do I expect (.) I expect the psychologist to ummm (.) develop techniques with the patients (.) to allow them to sort of deal with their own problems (.) which (.) I expect the patients to give that feedback to me (.) so they've been doing such and such to prevent their anxiety (.) you know they've been doing such and such to ummm help with their depression (.) so I expect sort of ummm (.) I suppose in a way homework for the patients or management plans for the patients (.) ummm (.) yeah (.) don't know what else (.) I also I suppose make a point to patients to is (.) a lot of patients say I've tried counsellors in the past or tried talking in the past (.) there's no use it's no use I just want medication (.) and I use (.) especially a lot of the psychologists here to develop that relationship with the patient so that they have a bit more trust in the psychologists (.) cos I think a lot of people (.) don't (.) a lot of people feel that they don't get their worth from it (.) mmm (.)

Int: how do you know that (.) how what (.) what (.) you've obviously got some information around the fact that you have a feeling that people don't trust psychologists in some instances (.) how's that (.) how have you got that info

N: just particular patients especially the ones that have been having issues throughout their whole teenage years and sort now of into their twenties thirties and are still having issues with ummm adjustment disorders or whatever they're usually the ones who have gone through the whole process of being (.) having (.) being referred to psychologists that they either don't get along with or maybe they don't have that connection with and they just
dismiss them (.) they say no counselling doesn’t work (.) and I think it takes a long time to get that person to try it again or (.) or get a new take on that person to actually go to a psychologist (.) yeah (.)

Int: ok (.) ummm how would the referrals differ that you make to a psychologist compared to say (.) do you make referrals to a counsellor or a psychiatrist

N: psychologists (.) I suppose the simple answer is psychologists are a lot easier to refer to (.) here (.) because psychiatrists are basically non existent or you have to pay a lot of money for them (.) so even if a lot of the time you know they have some kind of mental illness (.) if it’s an acute mental illness I refer to the hospital (.) or see if you can work through it with a psychologist first (.) counsellors I don’t think (.) I haven’t had much to do with counsellors so I don’t really know the distinct difference (.) but I think that psychologists have a bit more of an understanding of the thought processes involved in you know (.) their crises or their thinking methods or ummm have a bit more to do with changing those thought processes rather than just being a listener

Int: ok ummm (.) I’ll just pick up on that point N (.) what is your understanding of the type and amount of training undertaken by psychologists

N: I know it’s changed recently (.) I know that they used to have to just do a degree majoring in psychology ummm (.) but recently it’s changed you have to do a PhD in order to be able to be a clinical psychologist isn’t it (.) ummm (.) is that what you come out of with after a PhD (.) you have to do a masters in psychology so it’s probably a minimum of five years at least (.) yeah (.) my dad’s a psychologist so

Int: ok

N: he (.) if he goes out of his (.) well he was a psychologist but he still does continue practising APS because if he gets out he’ll have to do a PhD to get back in or something like that (.) so (.) there’s quite a lot of (.) study involved

Int: ok

N: yeah (.) is that right

Int: I’ll fill you in at the end if that suits

N: oh alright

Int: ummm (.) but aaah (.) so your understanding is that it used to be a four year course

N: yeah

Int: and then you could practise as a psychologist

N: yeah

Int: ummm but now (.) you have to do your PhD

N: yeah (.) yeah

Int: ok (.) ummm (.) and I (.) it’s along similar lines I’d like to ask from where have you got your existing knowledge of psychologists

N: I suppose word of mouth (.) we don’t (.) you know being straight from sort of hospitals (.) we don’t really have much to do with psychologists in hospital apart from when you’re doing your mental health rotation (.) ummm (.) yeah there’s not really much exposure from the doctor’s point of view (.)
Int:  ok (.) have you had any significant contact with psychologists in your clinical work either significantly positive or significantly negative

N:  (. .) once (.) but I’ve only been doing it for a couple of months (. .) ummm (. .) I just had to speak to a psychologist one of the psychologists here to get her opinion of a patient ummm and I find it better one on one chatting with those those psychologists ummm (. .) I haven’t yet had any feedback from any of the patients that I’ve referred except from the patients themselves (. .) so I’m wondering whether that loop is a bit limited in terms of feedback from patients (. .) I don’t know what the routine is whether you feedback after one review or three reviews or (. .) that loop seems to be a bit hazy

Int:  so your experience of talking with the psychologist about the patient was that a good thing or

N:  mmmm

Int:  it was

N:  very very good thing (. .) yeah (. .) it gave me a little bit of direction what to do (. .) yeah

Int:  ok (. .) does that psychologist work here in your clinic

N:  mmmm yeah

Int:  ummm a bit of a turn around question (. .) what do you think your patients perceptions of psychologists are

N:  (. .) ummm (. .) I think a lot of people have a TV stereotype of psychologists sitting on a couch chatting and just talking and just people you know (. .) aha (. .) aha (. .) just having someone to talk to (. .) I think (. .) I think a lot of people just want the easy option a lot of the time and ummm (. .) don’t realise that it may take a number of sessions with a psychologist it may take long term work and I always try and emphasise that to patients before they go and see a psychologist that you know sometimes things can’t be solved just in a week (. .) does need to go on for a bit longer (. .) I think there’s a general (. .) I think there’s a general positive opinion of psychologists

Int:  why do you say that

N:  but maybe not just psychologists (. .) maybe psychologists counsellors I don’t know if that’s (. .) people generally just think psychologists are the same as counsellors ummm (. .) cos people can sometimes be their opening line I just want a referral to a psychologist (. .) could be just (. .) rather than me making a suggestion

Int:  ok (. .) do you have any reservations about referring patients to a psychologist

N:  ummm (. .) not yet (. .) I may (laughs) ummm

Int:  why is that

N:  (. .) ummm (. .) just from that earlier point of you know if they lose that trust a lot of the time (. .) the whole idea of talking through a problem may be totally shut off to them if that trust is gone (. .) ummm (. .) but I haven’t come across that yet so (. .) no

Int:  but you think that that’s a possibility that there might be (. .) a time when referring to a psychologist is (. .) ummm you have some reservations about that because you think that (. .) you have a sense that the (. .) match won’t fit is that what you mean
N: yeah (.). yeah (.). it's a similar thing to doctor patient relationship it's the same sort of thing (.). if the personality doesn't match or the person doesn't feel that they're getting a response or (.). they'll go elsewhere or just totally shut off from the idea of (.). psychologists help or (.). therapy

Int: and the last question if I can

N: mmmm

Int: is ummm (.). how if at all has your referral pattern to psychologists changed since the GP mental health care plans came in

N: well I wasn't here before all that (.). but I know it does make it easier and I know in the division (.). I think the division in townsville itself has a further rebate for people who have a sort of have health care cards and are struggling (.). I've had one particular patient who only had to pay ten dollars per session cos all else has been covered and that's been really really successful with her ummm (.). I (.). it just gives assistance (.). like I continue to review her and we still have that sort of relationship but it just gives assistance to her treatment that I probably couldn't provide cos I don't have that experience

Int: mmmm

N: yeah

Int: ok (.). is there anything else that you wanted to add at all about your perception of psychologists before we finish up

N: no I think that's it (laughs)

Int: ok thanks very much

Participant 8: “D”

Int: ok D the first thing is just I wanted to ask you to tell me a little bit about yourself as a GP and whether you've got any special interests or special training in mental health

D: ummm (.). yeah no I'm a GP I have umm special training in women's health and family planning (.). but not in mental health

Int: any special interest

D: in mental health or (.). I think as part of womens health yes but ummm (.). nothing sort of beyond that (.). I haven't done I mean I go to occasional presentations and things on mental health but I haven't done any of the umm GP run (.). division run programs on mental health

Int: what are the sort of factors that would lead you to refer one of your patients to a psychologist

D: ummm (.). I generally (.). I probably if somebody if I've diagnosed anybody with anxiety or panic or depression I'll always throw counseling in as a treatment option (.). umm and I will almost always refer to a psychologist (.). use a psychologist as somebody to refer to rather than someone else so it's kind of part of the treatment spectrum I guess
Int: mmmm (.) and when you do refer one of your patients to a psychologist what sort of service do you expect from them with regards to assessment and intervention

D: ummm (.) I guess what I'm looking for are (.) coping strategies for the patient investigating or discussing with the patient what sort of things might be impacting on the way they're feeling from you know the past or the present (.) ummm stressors in their life or ummm determining how they are coping with things and giving them better ways of dealing with things maybe using I mean sometimes hypnosis and that sort of stuff (.) possibly but that's not like specifically anything that I direct umm (.) yeah any of the treatments they have (.) mainly cognitive behavioural therapy mainly mmm

Int: ok ummm (.) how does the reasons that you refer someone to a psychologist how do they (.) how does it differ if you make a referral to a psychiatrist or say a counselor (.) what are the differences about your referral umm reasons for referring to a psychologist compared to a psychiatrist or a counselor

D: psychiatrists are so hard to get in to that the only reason I would refer to a psychiatrist is if I have a medication dilemma (.) ummm if I think they need things other than medications then that's when I'll use a psychologist cos I can't get them in to see a psychiatrist (.) umm a counselor I guess I don't know the training background of a counselor so I tend to (.) I know a bit more about the training background of a psychologist (.) and the level of education that they've had and that sort of thing and I'm more comfortable referring them to a psychologist than I am to a counselor who kind of could have any background in counseling

Int: so what is your understanding of the training that psychologists do

D: ummm (.) well I mean (.) umm obviously it's a university based course umm (.) from what I understand in most instances it's they beyond just the basic university course to get anywhere in psychology (.) ummm (.) so (.) yeah it's a standardized kind of course I mean obviously different universities do different things (.) ummm but (.) ummm I guess because it's mainly umm tertiary institution based education that I'm trusting the course

Int: do you have any sense of how long the training is for psychologists or what level of academia they might eventually reach (.) they have to reach to become a psychologist

D: ummm (.) yeah (.) as I said a psychology degree as part of like a science degree is not going to get the psychologist to where they need to be is my understanding and they often need to (.) you know have a masters or possibly a PhD or something like that (.) ummm beyond just the basic degree ummm (.)

Int: ok from whereabouts have you got your existing knowledge of psychologists

D: ummm (laughs) it may not even be right I don't know that's just (.) I guess what I'm (.) yeah I don't know I don't even think I've got any friends who are psychologists (inaudible) pick their brains much I don't know (laughs)

Int: I guess my thoughts are I mean you've got a sense of what a psychologist is (.) ummm and (.) I'm genuinely curious as to
ummm you know the sources that you've used to develop that sense of what a psychologist is

D: I don't know I mean I went to university I guess so (. ) and I went to colleges and I had acquaintances who would have been psychologists so I guess I'm a bit familiar about that (. ) their course but just from being in the education (. ) you know I know that an engineering course is four years and they can do this that and the other it's sort of just from picking up what people around me were doing I guess

Int: mmm (. ) I mean have you had any significant umm contacts with psychologists in your clinical work you know significantly positive or significantly negative

D: ummm (. ) I suppose (. ) ummm (. ) in terms of referring patients I have (. ) I guess one of the concerns I that have with a psychologist is that I'll write a letter to them and I often get absolutely nothing back not even that the patient presented (. ) but sometimes I'll do (. ) sometimes there's probably a couple of psychologists who'll keep me in the loop or say I think this person's deteriorating you know I think they need something else or (. ) they don't seem to be coping with whatever medication I've put them on even (. ) and that's good I think I like to have some feedback to know that (. ) so I don't I mean I know they don't generally divulge a lot of information (. ) some of them divulge more than others but it would just be at least nice to hear that the person's actually made contact and that something is happening (laughs) rather than having to get feedback from the patient

Int: so it sounds like there's a dual experience there on the one hand you've had a good experience when you've got feedback from psychologists and on the other hand it's been a negative experience when you

D: In that I've heard yeah nothing (. ) it's like well we're not allowed to talk about it kind of thing which I think is a bit (. ) you know even physios write back to me and if I bother to write a referral to an allied health professional I get a letter back from them ummm but psychologists seem to be a lot more silent than the average person that I might refer to

Int: sure what's that about do you reckon from your perspective

D: I don't know (. ) whether it's a confidentiality thing which I think is a bit strange given the patient's obviously divulged things to me to make them refer them to the psychologist (. ) whether it's a time based thing whether that's not part of the routine at the end of the consultation to write the letter dictate the letter or (. ) I don't know (laughs) I guess I haven't sorted that out (laughs)

Int: yep ok (. ) sure (. ) I mean that's an interesting story (. ) do you have any other thoughts about significant contacts with psychologists with a you know as I say significantly positive or negative (. )

D: aaaah (. ) I mean I (. ) there's one that that (. ) I suppose I've had a few patients to and she'll even suggest other programs she'll get the patients plugged into you know things in other cities or other states or something where they might have other family support and (. ) I think that's good (. ) you know if the psychologist is suggesting look I think they should be an
inpatient in here and this is how the system works (.). I'm mostly gonna say yep I think that sounds like a good idea (.). I'll go ahead with that I'm happy to help (.). I contribute and make that happen umm (.). yeah (.). there's never been a (.). I've never had a phone call from one of them and thought (.). you know (.). I don't like what you've said or I don't like you or (laughs) I don't like your attitude or anything like that I haven't had that kind of negative experience it's more just the lack of feedback that

Int: sure
D: that is the concern
Int: a bit of a turnaround question (.). what do you think your patients think about psychologists
D: (.). ummm (.). most (.). I think a lot of people are (.). are quite positive about the idea of going to see a psychologist ummm (.). I think there's a cost issue involved with some of them (.). and there are now programs established that we can get around that or assist them to some degree (.). ummm (.). but I (.). and there are some people who (.). probably mostly the males who are kind of you know just give me medication and that's the way I want to deal with it (.). I don't want to go and talk to somebody about it but that's not always the case it's probably a stereotype but you know (.). ummm (.). so no I (.). and I suppose when people have come back to see me I've (.). I don't get a (.). ooh that was a terrible experience (.). just for your information I wouldn't recommend that you refer anybody back to that person (.). anything like that (.). I get that feedback from specialists you know he was a pig or he didn't do this or he didn't explain anything or she didn't blah blah blah but I don't tend to get that kind of feedback from psychologists

Int: ok (.). and do you have any reservations about referring your patients to psychologists
D: no not at all (.). if if (.). if I would rather that they have you know I think medications are good but I think they’re good on (.). they probably actually work better or the whole outcome is better if they're getting help from a psychologist as well as you know help from a medication (.). I think we're all too much into the just take the tablet and you'll be ok

Int: yep
D: umm and they need to (.). if they get those coping skills this time around then maybe there won't be a next time around
Int: yep (.). ok (.). and the last question how (.). if at all has your referral pattern changed since the GP mental health care plans came in
D: ummm (.). well I've never used a umm the DASS (.). tick and flick thing (.). I've never used a (.). you know my referrals were always you know this person is depressed and they are off their food and you know I give the whole you know kind of symptomatology and a bit of background if there's background about their work or their spouse or something like that and that will be my referral (.). and I won't have done a DASS so in the mental health care plan I'm now supposed to do some sort of objective assessment of where they are so I use a tool that I've not used before ummm (.). I probably do (.). the tick and flick of the referral form that we have has stuff about their their
affect and their insight and stuff that I probably wouldn't have gone to in that detail in my referral letter so I guess the information is probably more detailed (. ) ummm (. ) yeah so that would be the changes

Int: excellent so you're not necessarily referring (. ) are you referring more or less patients to psychologists

D: ummm (. ) I think it's (. ) I don't know (. ) it's probably (. ) I'm probably referring more of those who said that they couldn't otherwise afford to go using the mental health (. ) plan (. ) ummm (. ) so yeah I mean I've got one woman who wanted to see a psychologist just came down from cairns got the mental health care plan done I'd forgotten the DASS bit (. ) sent it up to her and I haven't heard anything from her so I haven't finished the plan and I haven't (. ) she obviously hasn't seen anybody or she's decided ooh I'll just go and see someone anyway (. ) so (. ) I don't know it's not for everybody (. ) I did a mental health care plan for someone and she still couldn't afford the difference so she's on the program through the division where they pay a ten dollar co-contribution cos she's not a pensioner but one of her things is she goes out on spending sprees (laughs) the husband's taken the credit card and you know there's some other issues happening so (. ) she kind of was a special case that got into the program ummm (. ) so I think those kind of programs are good and I guess I (. ) I don't know (. ) I don't put everybody on a mental health care plan if I think somebody's quite happy to see a psychologist and they have private health cover and then I don't necessarily need Medicare to pay for every psychological consultation so

Int: ok that's the end of my questions (. ) is there anything else you wanted to add spontaneously about your own perception of psychologists clinically or professionally

D: umm no I think that covers everything

Int: thanks no I think that covers everything

D: thank you
Int: what are the sort of factors would lead you to refer one of your patients to a psychologist

K: I guess there's probably two main factors. One is a perceived clinical need and two is aah practical availability. To be honest you can argue there's a clinical need for quite a lot of people that I see. I guess there's a third factor of course is whether the patient is at all interested and willing. That's a big factor. But a large proportion of general practice consultations have some psychological underlay or overlay. And then there's a significant number that actually have diagnosable psychiatric problems. I guess the commonest ones are your depressions and anxieties. And I fully believe that probably psychotherapy should be the first line for a lot of them. Umm but it's then a matter of whether the patient's willing to engage in that and whether their psychologist is available within a reasonable time frame.

Int: Once you've made a referral to a psychologist what sort of service do you expect from them

K: Well I guess you hope you hope that they're available within a few days or a couple of weeks rather than a couple of months. Which is usually the case in Townsville. Usually there is a reasonable availability. Although that depends on financial situation as well. For the patient the Medicare items help with that. I guess that's another subject but in terms of the actual umm service. I mean I'm really often I am hoping that the psychologist will make more of an assessment as to try and pin down the diagnosis because as a GP with an average fifteen minute consult you often get a sense of you know this is a depressive disorder of this is an anxiety disorder but you can't always quite pin it down to the fine details of whether it's social anxiety or generalized anxiety disorder. Aah there just isn't always time so I often hope the psychologist can help with that and then I hope that the psychologist can choose an appropriate form of therapy. I mean obviously there are a hundred and one different approaches to psychotherapy and counseling. A lot of the time I guess I'm looking for some CBT. But I tend to feel that probably the psychologist is the better person to decide the right therapy for the right person. And then I hope to get some correspondence back sooner or later to let me know if the patient's attending and what the diagnosis there might be and their treatment approach does that answer the question?

Int: it does that's great thanks and just comparatively umm if you made a referral to a psychiatrist or a counselor compared to the service you might get or expect from a psychologist

K: I can answer that fairly clearly with a psychiatrist. Counsellor's a bit more. I have to confess I'm not always entirely clear. Umm necessarily as to how much difference there's going to be from a counselor to a psychologist. You know I've got we can talk about that as far as a psychiatrist goes ummm I tend to want people
to see a psychiatrist if I think they're at the more severe end (.) of the spectrum and definitely needing (.) likely to need medication input (.) ummm so (.) severe depressives (.) I guess people that have significant suicidal ideation it would be nice if they can see a psychiatrist (.) where that's possible (.) not always possible (.) ummm (.) and then certainly the umm more (.) complex or less common psychiatric problems so (.) somebody that I think's got psychosis (.) somebody that I think's got anorexia nervosa (.) (inaudible) ummm (.) somebody who's ummm really not coping with their life cos they're (.) to a severe extent you know (.) I guess all mental illness causes some impact on your ability to live aah normally (.) but where it's severely dysfunctional (.) ummm (.) as far as a counselor goes (.) again as I said I'm a bit vague about it (.) ummm (.) my (.) again partly it comes down to availability sometimes (.) I guess (.) I tend to feel that counselors are probably more useful for (.) perhaps the milder end of the spectrum where you know someone's had an acute stress disorder or a grief reaction or something and just needs to talk things through over a couple of sessions (.) whereas with something a little bit more complex like (.) moderate depression needing some cognitive behavioural approach maybe or (.) ummm (.) you know sort of (.) I guess major issues from previous life (.) child sexual abuse that sort of thing (.) I guess my preference would be to see somebody with a (.) what I presume is a bit more extensive training (.) (laughs)

Int: which leads nicely into (.) my next question
K: yes

Int: around what's your understanding of the type and amount of training undertaken by psychologists
K: ok aaaaah again I'm a little fuzzy (.) but I guess I'm thinking that the average psychologist has probably been through (.) at least sort of three maybe four years of university training (.) and then I'm not sure about post university placement whether there's like a supervised period (.) I'd be interested to know that (.) and you've then got your clinical psychologists that are supposed to have done (.) more like five or (.) years and then sort of specific clinical placements so (.) a more extensive training as I understand it (.) ummm (.) whereas counselors can be rather variable I understand from anything from having done a sort of three month (.) diploma on top of their nursing degree or something to maybe a couple of years (.) that's something I would like more information about (laughs) but that's where I'm at at the moment (.)

Int: that's great
K: mmmmm

Int: ummm (.) when we're finished we can just chat about
K: yeah (.) I'd be interested to know

Int: ummm (.) and I guess along similar lines (.) from where have you got your existing knowledge about psychologists
K: aaaaah (.) ok (.) got to think about that (.) I mean obviously there was some (.) introduction to it through the undergraduate medical degree (.) ummm (.) you know we actually did a semester of medical psychology in my training degree so we were introduced to the various streams of psychology (.)
psychotherapy (. ) the various theories of psychological
development all that

Int: who provided that training
K: that was the university of Melbourne
Int: what (. ) were the lecturers psychologists
K: yeah yeah some of them were (. ) clinical psychologists or
psychologists ummm (. ) I think there might have been a couple of
psychiatrists but I think it was mainly psychologists (. ) quite
a long time ago (. ) ummm (. ) and then (. ) through your ummm I
guess through your clinical training when you get to the
clinical years of your medical student training you have (. )
have to be honest I probably had very little direct contact with
psychologists but there was always you know in this situation or
that situation the new training doctor would say you know it
would be good to get a psychologist for this or that (. ) ummm
(.) and then doing the mental health training (. ) so three
months at mental health here in Townsville it was a you know the
multi-disciplinary teams (. ) I would sometimes be discussing
patients with A J or ummm (. ) the other lady that was there at
the time (. ) I can't remember her name (. ) worked in the acute
mental health unit (. ) referring and discussing patients with
them (. ) so that gave me some sense and then umm (. ) just in
recent times there's been some direct communication regarding
patients with
P M (. ) umm (. ) I suppose it's probably reasonable to mention
that (. ) I have had the odd session with counselors myself
Int:
K: as well which has been helpful over the years so that usually
gives some insight into how it works (. ) it wasn't actually a
psychologist though I actually saw a doctor (. ) originally an
obstetrician who moved into counseling at some point down in
Melbourne (. ) doctor R Mc (. ) whose solutions oriented
counseling approach and aaah I saw one of the chaplains at uni a
few times (. ) he was good too (. ) yep
Int: ok thank you (. ) we may have already just touched on that K but
um (. ) either in a personal or in a clinical sense I'll just
ask if you can describe any significant contacts you've had with
a psychologist (. ) significantly positive or significantly
negative
K: well I think I was fortunate in that my (. ) I think probably my
first encounter with one was umm R Mc (. ) and ummm (. ) my
experiences with him were extremely positive (. ) to the point
where I'm not sure if I would be sitting here today if I hadn't
had a few visits with him over the course of my training (. ) he
was extremely helpful
Int: was R a psychologist
K: yeah (. ) so R Mc (. ) as I said he was trained as a medical
doctor he actually worked as an obstetrician and then somehow or
other (. ) decided at some point in his career that he wanted to
go into talk therapy umm (. ) he trained under Erickson at one
stage or something like that (. ) but then he sort of came up
with his own style (. ) he's written a couple of books about what
he calls solutions oriented counseling (. ) so umm yeah I found
him very very useful (. ) and the chaplain at the uni was quite
good as well more of a sort of talking (. ) I suppose counseling
talking (. ) aaa I've never actually seen a trained psychologist (. ) ummm but my experiences working with them at acute mental health were good (. ) I found A J very good to deal with and talk to ummm same with the other lady that was there as well (. ) but I can't remember her name (. ) and again just in the last couple of months discussing patients with P M I think's been valuable (. ) so ummm yeah (. ) do I have any negative experiences to counteract I mean all those have been reasonably positive (. ) I don't think so (. ) ummm I probably should mention one (laughs) (. ) I did have a couple of patients that ummm (. ) in the last year or so (. ) one who didn't want to go back to a psychologist I sent them to because of her ummm (. ) swearing (. ) during the consultation (laughs) which was interesting (. ) unexpected (. ) I wasn't expecting to hear that (. ) and aah (. ) one other patient who aah (. ) whether it was real or perceived but she felt the psychologist was making inappropriate (. ) irrelevant remarks about her weight (. ) and needing to lose weight when she didn't think that was what she was there for ummm (. ) it wasn't the primary issue so that relationship broke down (. ) with some acrimony (laughs) ummm (. ) so yeah there's always (. ) there's always gonna be the odd one where it doesn't work out (. )

Int: again K you have just preceded but I'm gonna ask what do you think your client's perceptions of psychologists are generally
K: ummm (. ) there's a wide range of perceptions ummm (. ) there's a gender difference as well (. ) I mean men generally seem to be pretty hard to convince that seeing a psychologist is a good idea (. ) it's just a (. ) automatic stigma it seems that you're being labeled as nuts if you have to go and see a psychologist (. ) which men don't like at all (. ) aaah whereas (. ) most female patients are much more willing to acknowledge that talking through stuff with somebody (. ) would be potentially helpful (. ) ummm (. ) yeah so I mean I guess it's not a terribly sophisticated (. ) (laughs) it's pretty true to say most of the female patients I see that have stress or psychological issues (. ) have a relatively positive feeling about the idea of seeing a psychologist (. ) and most men don't (laughs) which umm yeah (. ) that would be about it really

Int: ok (. ) do you have any reservations as a GP about referring any of your patients to see a psychologist
K: (. ) well I have reservations now about those two particular psychologists that I had that experience with (. ) even though I'm aware that it may have just been a one off misunderstanding or (. ) a bad aah you know just because one consultation doesn't work out doesn't mean they would be a problem with other patients ummm (. ) happens to every therapist that they have the odd consultation that doesn't go well (. ) ummm and beyond that ummm (. ) sorry the question again (. ) do I have any reservations

Int: yes
K: about sending people (. ) ummm (. ) I mean one of the reservations up to now has always been the cost issue and availability so (. ) ummm (. ) you know there was the public system where people didn't have to pay anything but they often had to wait a considerable period (. ) which could have been a problem (. ) and then if they wanted to go privately they've got concern about
expense (.) with the introduction of the mental health items that has certainly improved (.) and ummm so that reservation about just access and cost has improved considerably (.) aaah (.) and so has having a psychologist move in once a week aaah (.) has improved things as well ummm (.) any other reservations (.) there is just a bit of a concern that there are a you know we've got a list from the division of (.) something like (.) five pages of ummm (.) psychologists and counselors here (.) one of the reservations is you just don't know as much as you'd like about that psychologist or counselor (.) what their strengths and weaknesses might be (.) whether they're going to be right for the particular patient that's sitting in front of you (.) now interestingly that issue has just been improved recently as well because the division has appointed a mental health liaison officer L B and ummm (.) my dealings with her so far have been excellent (.) so she (.) she is often able to kind of (.) reasonably match the patient (.) the situation to the right person (.) in the brief (.) she's only been on for a month or two so you know it's still early days (.) but so far it's been very helpful to have that available

Int: mmmm ok
K: (.) to ring her up and say who should this person see (.) she usually gets back to me in a minute with a reasonable option (.) so yeah those are the reservations but a lot of them are actually improving (.)

Int: ok
K: in the last year or so
Int: and the last question is around the Medicare changes (.) how has your referral pattern changed if at all since the GP mental health care plans came in
K: there's no doubt that they've increased (.) I certainly perceive that I've been sending more people to psychologists cos of (.) of the improving in access and cost issues for the patient (.) ummm (.) there's always the initial frustration of the ummm (.) paperwork and bureaucracy involved in making a referral (.) there's no way you can do a decent job a of GP mental health care plan in fifteen minutes (.) I imagine there are probably GP's out there who just scribble away (laughs) and whip it off in ten minutes or something (.) I tend to get people to come back for half hour appointments so I can do a reasonable job of it (.) mind you that may be improving a bit for us as well (.) cos we've just (.) I don't know if you're aware but we've got a mental health nurse recently come on staff here as well (.) P H

Int: P yes I know P
K: and apparently he's gonna be able to do a fair few of the mental health plans for us and then just (.) he'll do it up and then send it back to us and we'll speed through it and sign off on it so that will probably help (.) ummm (.) I keep forgetting the original question what was it again (laughs)

Int: how has your referral pattern changed
K: yeah it's basically increased ummm (.) and ummm (.) a lot of the people that I wanted to send (.) would liked to have send to psychologists but (.) because of those access blocks cost or availability I wasn't able to do so (.) I am now able to do so (.) and that's good (.) I still think ummm (.) it's going to be
a gradual process to improve that further over time (.) ummm (.) cos it takes a while for psychologists and psychiatric nurses and GP's to learn to work together (.) even with the umm (.) you know even with the (inaudible) you know Medicare incentives and all that it's still gonna take a bit of time (.) but aaah I think it's definitely been a step forward and I'm glad that I am able to get more access to psychologist input (.) certainly helps us as GP's cos we don't always have the time that we'd ideally like to try and sort through mental health issues (.) ummm (.) yeah (.)

Int: ok (.) that's the questions that I wanted to ask (.) is there anything else you just wanted to add spontaneously about your perception of psychologists before we finish

K: I think probably the most ummm (.) I think probably the one (.) biggest aaah (.) concern has been just not quite knowing (.) what your (.) what your patient's being sent to (laughs) in the sense of how much training does this person have and what is their area of interest (.) ummm (.) what yeah (.) and ummm and whether it's the right person for the patient (.) and to some extent that's never going to be possible to answer entirely cos you can never entirely predict whether any given person is going to hit it off with any given psychologist (.) there's always that to some extent (.) personality aaah (.) which you can't predict but (.) that's that has always been an ongoing concern just how you as a GP get to know (.) and also particularly in Townsville they change all the time like there's a lot of ummm (.) ummm (.) coming and going of psychologists in Townsville umm (.) change (.) seems to change from year to year (.) it's the same with all the health services in Townsville you know there's quite a high turnover (.) ummm as people move in and move out over time (.) umm but yeah it looks as though this ummm (.) I'm hoping this umm (.) division liaison officer thing continues (.) so far it's looking very good in helping to address that problem (.) that's probably about it (.)

Int: thanks very much
APPENDIX C : APS submission to Government

Submission to the Senate Select Committee on Medicare September 2003
APPENDIX D: APS submission to Government

Preliminary submission to the Senate Select Committee on mental health April 2005
APPENDIX E: APS submission to Government

Submission to the Senate Select Committee on mental health May 2005
APPENDIX F: APS submission to Government

Meeting Australia’s mental health needs: Increasing community access and decreasing health workforce shortages. A supplementary submission to that sent to the Prime Minister, Chair of the Council of Australian Governments (no date).
APPENDIX G: Consent form for questionnaire Chapter 4
Project Title: Public perception of clinical psychologists: Discourse analysis Vs cluster analysis.

I am a Masters of Applied Psychology student at Murdoch University investigating the public perception of clinical psychologists. The purpose of this study is to obtain a contemporary measure of public perception of clinical psychologists as well as challenging the validity of an approach which has been used in the past.

You can help in this study by consenting to complete this questionnaire. It is anticipated that it will take no more than 5 minutes to complete the questionnaire. Participants can decide to withdraw their consent at any time. All information given during the questionnaire is confidential and no names or other information that might identify you will be used in any publication arising from the research. Following completion of the questionnaire I may contact you to take part in a videotaped discussion about your perceptions of clinical psychologists. Feedback on the study will be willingly provided at your request.

If you are willing to participate in this study, could you please complete the details below. If you have any questions about this project please feel free to contact either myself, Shaun Dempsey on 0403 169 950 or my supervisor, Dr Mark Rapley, on 9360 2861.

My supervisor and I are happy to discuss with you any concerns you may have on how this study has been conducted, or alternatively you can contact Murdoch University's Human Research Ethics Committee on 9360 6677.

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I (the participant) have read the information above. Any questions I have asked have been answered to my satisfaction. I agree to take part in this activity, however, I know that I may change my mind and stop at any time. I understand that all information provided is treated as confidential and will not be released by the investigator unless required to do so by law.

I agree that research data gathered for this study may be published provided my name or other information which might identify me is not used. I am happy to be contacted by phone or email to participate in the second phase of this study.

Participant: ___________________

Signature: ___________________

Date: ___________________

Investigator:  Shaun Dempsey

Date: ___________________
APPENDIX H: Consent form for interview Chapter 4
Project Title: Public perception of clinical psychologists: Discourse analysis Vs cluster analysis.

I am a Masters of Applied Psychology student at Murdoch University investigating the public perception of clinical psychologists. The purpose of this study is to obtain a contemporary measure of public perception of clinical psychologists as well as challenging the validity of an approach which has been used in the past.

You have already helped in this study by completing the questionnaire. The next and final phase of gathering data is an informal discussion with you regarding your perception of clinical psychologists. Participants can decide to withdraw their consent at any time. To aid analysis of the data it will be necessary for me to videotape our discussion, however, all information given during the discussion is confidential and no names or other information that might identify you will be used in any publication arising from the research. Feedback on the study will be willingly provided at your request.

If you are willing to participate in this discussion and consent to it being videotaped, could you please complete the details below. If you have any questions about this project please feel free to contact either myself, Shaun Dempsey on 0403 169 950 or my supervisor, Dr Mark Rapley, on 9360 2861.

My supervisor and I are happy to discuss with you any concerns you may have on how this study has been conducted, or alternatively you can contact Murdoch University's Human Research Ethics Committee on 9360 6677.

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I (the participant) have read the information above. Any questions I have asked have been answered to my satisfaction. I agree to take part in this activity, however, I know that I may change my mind and stop at any time. I understand that all information provided is treated as confidential and will not be released by the investigator unless required to do so by law. I agree that research data gathered for this study may be published provided my name or other information which might identify me is not used.

Name:_________________________

Signature:______________________

Student number:_______________

Date:__________________________

Investigator: Shaun Dempsey
APPENDIX I: Information flyer for interview Chapter 6
What do you really think of psychologists???

This is your chance to reveal all

I am a clinical psychologist working with Queensland Health, and a PhD candidate at Murdoch University investigating the creation of the public image of psychologists. The purpose of this study is to investigate the views that General Medical Practitioners have of psychologists. To this end, a series of questions will be posed addressing issues around factors which influence referral to a psychologist, and existing knowledge of the qualifications and role of psychologists.

You can help in this study by consenting to participate in an interview. It is anticipated that the time to participate in the interview will be no more than 10 minutes. Questions contained in the interview address issues such as your reasons for referring a patient to a psychologist rather than a counsellor or other mental health clinician, any reservations you may have about referring to a psychologist, and your impression of the quality of service received from psychologists in your clinical experience. I would value your opinion highly and invite you to feel free to contribute your full and frank views.

I understand that time is a precious commodity for you and I would be happy to meet at a time and place that is most convenient for you.

No names or other information that might identify you will be used in any publication arising from the research. Feedback on the study will be provided to participants upon request.

Shaun_dempsey@health.qld.gov.au

0421 034 185
APPENDIX J: Consent form for interview Chapter 6
Project Title: The creation of the public image of psychologists.

I am a PhD student at Murdoch University investigating the creation of the public image of psychologists under the Supervision of Dr Ngaire Donaghue. The purpose of this study is to investigate the views that General Medical Practitioners and Guidance Officers may have of psychologists. To this end, a series of questions will be posed addressing issues around factors which influence referral to a psychologist, and existing knowledge of the qualifications and role of psychologists.

You can help in this study by consenting to participate in an interview. It is anticipated that the time to participate in the interview will be no more than 15 minutes. Questions contained in the interview address issues such as your reasons for referring a patient to a psychologist rather than a counsellor or other mental health clinician, any reservations you may have about referring to a psychologist, and your impression of the quality of service received from psychologists in your clinical experience. Participants can decide to withdraw their consent at any time. All information given during the survey is confidential and no names or other information that might identify you will be used in any publication arising from the research. Feedback on the study will be provided to participants upon request.

If you are willing to participate in this study, could you please complete the details below. If you have any questions about this project please feel free to contact either myself, Shaun Dempsey, on 0421 034 185, or my supervisor, Dr Ngaire Donaghue, on 9360 6450. My supervisor and I are happy to discuss with you any concerns you may have on how this study has been conducted. If you wish to talk to an independent person about your concerns you can contact Murdoch University's Human Research Ethics Committee on 9360 6677 or email ethics@murdoch.edu.au.

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I (the participant) have read the information above. Any questions I have asked have been answered to my satisfaction. I agree to take part in this activity, however, I know that I may change my mind and stop at any time.

I understand that all information provided is treated as confidential and will not be released by the investigator unless required to do so by law.

I agree for this interview to be taped for purposes of transcription.

I agree that research data gathered for this study may be published provided my name or other information which might identify me is not used.

Participant:
Date:

Investigator: Dr Ngaire Donaghue
Date:

Investigator's Name: Shaun Dempsey