Marriage counselling in general practice: an assessment of the work of marriage guidance counsellors in a general medical practice

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Abstract

This study describes, discusses and assesses the impact of a marriage guidance counselling service in a general medical practice. It considers the role of the counsellor in the primary health care team, the appropriateness of providing a counselling service in this setting and the nature and effect of the counselling as experienced by individual clients. The material derives from records provided by the counsellors, from medical casenotes and from interviews with 83 clients counselled at the practice, with their counsellors and with their G.Ps.

The counselling service did appear to be a valued and valuable addition to the range of practice services. It was viewed by clients, counsellors and G.Ps. as contributing to the quality of patient care, as increasing access to counselling for potential clients and as improving the status and job satisfaction of counsellors. Over half of the clients interviewed had found the counselling of substantial and lasting help and only one-fifth reported no help at all. However, there were significant discrepancies between the assessments of clients, those of their counsellors and those of their G.Ps., emphasising the dangers of equating client satisfaction with professional judgements. There was also no evidence from medical casenotes to substantiate the claims that counselling in this setting reduces demand for medical services. In addition, if this was to become a general policy development, there were argued to be some unresolved issues in areas such as the desirability of moving towards access to counselling through medical referral; the motivation of clients for whom counselling was 'prescribed'; and the pressures on unpaid, part-time counsellors and on their voluntary marriage guidance organisation, in terms of the most appropriate use of their limited resources and the difficulties of working alongside a statutory, highly professionalised service, provided largely 'free' at the point of demand.

MARRIAGE COUNSELLING IN GENERAL PRACTICE - AN ASSESSMENT OF THE WORK OF MARRIAGE GUIDANCE COUNSELLORS IN A GENERAL MEDICAL PRACTICE

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Chapter 1

Introduction

Marriage guidance counselling has a history in Britain of around 45 years. It is situated firmly in the voluntary sector of social services, although depending substantially on central and local government grants. Most centres of population now have a marriage guidance service. The development and operation of the marriage guidance 'movement' are discussed in some detail in chapter 2.

Marriage guidance counsellors have traditionally worked from specific marriage guidance centres, but in recent years there has been a move towards closer co-operation with other social services. One of the links most frequently advocated is with general medical practices. The counsellor is seen here as a member of the primary health care team and the link acknowledges a belief in the relationship between 'health' and 'happiness' (particularly marital happiness) and in the psychosomatic nature of many of the symptoms presented to the general practitioner.

There are still relatively few counsellors attached to general medical practices. The National Marriage Guidance Council, in a survey in March 1978, found 50 schemes in operation involving their constituent councils, although the amount of contact and co-operation varied considerably.(1)

The nature of these attachments and the range of advantages and disadvantages that may result for the counsellors, the general practice and the clients are discussed in chapter 3, using the

findings of the few studies that have been carried out. This is, however, still a relatively unexplored field of social research. It holds out considerable promise as an area for investigation, relevant to the nature of medicine and of health care provision and the role of counselling in that provision. Counselling in this setting also offers the opportunity to assess its impact on clients more systematically than is otherwise possible, as they are patients of the practice and thus can be more easily 'followed-up'.

What follows is therefore essentially an exploratory study, looking in detail at the provision of a counselling service in one particular medical practice and at the meaning of that service, in general and in particular terms, to the participants. It begins by briefly considering marital breakdown and marriage guidance counselling (chapter 2). It then endeavours to explore three working assumptions:

1. that research in the field of marital counselling, in spite of the considerable difficulties it poses, can yield results which are meaningful and are relevant to policy formulation, and is thus an important undertaking (chapters 4 and 5);

2. that the attachment of marriage guidance counsellors to general medical practices is an appropriate and valuable development, improving the scope, quantity and quality of the counselling service and improving primary health care (chapters 3,6 and 7);

3. that counselling in a general medical practice is of help to clients and that the extent and nature of this help and the

consequent impact on the GP's workload can be fruitfully explored by examining assessments by clients, as well as by their counsellors and general practitioners (chapters 8, 9 and 10).

Chapter 11 attempts to summarise the material in the preceding chapters and to draw some conclusions.

Chapter 2

Marital breakdown and marriage guidance counselling

This chapter contains a brief discussion of the rising divorce rate, the consequences in terms of financial, social and psychological costs and the evidence of public concern. It then considers the National Marriage Guidance Council, with its constituent local councils, as a voluntary organisation which is specifically concerned to help and support people with marital problems. The structure of the organisation, the counsellors who are selected, trained and work within it, the model of counselling which appears to be employed and the clients who seek help are described.

Marital breakdown and its consequences

On the basis of current figures, it has been estimated that one out of every three marriages in England and Wales can be expected to end in divorce.(1) By 1979, more than one in five of all marriages for both men and women were remarriages of those previously divorced.(2)

A large proportion of divorcees, especially in the younger age-groups, remarry. The Finer Report estimated that in the decade 1962-71 more than 62% of divorced persons entered a subsequent marriage.(3) Leete and Anthony, in a sample survey of 1,000 couples divorced in 1973 found that about half married within five years, mostly shortly after divorce. Only in under one quarter of the couples did neither hushand nor wife remarry.(4) Thus it seems that the breakdown of one marriage does not necessarily indicate a dis-illusionment with marriage as an institution. However, if we can expect a significant proportion of the population to experience divorce and remarriage during their lifetimes(5), this obviously

represents a divergence from the traditional Christian idea of marriage as a monogamous relationship creating a permanent bond broken only by death.

The rising number of divorces in recent years has attracted considerable attention. In 1961, nearly 32,000 petitions for divorce were filed in England and Wales. By 1970 this figure had risen to over 71,500. Then came the enormous leap following the enactment of the 1969 Divorce Reform Act to 111,000 in 1971.[6] Although some of this leap could be accounted for by a backlog of spouses who suddenly found they had grounds for divorce, it seems likely that the rising figures through the 1970s (up to a 1979 figure of around 164,000[7]) are an indication that a substantially higher level of divorce than ever before is here for the foreseeable future.

Increases in the number of divorces do not necessarily, of course, indicate a corresponding increase in the percentage of marriages that break down. For example, the population has increased and the proportion of the population, especially of women, who marry has increased.[8] These factors mean that a rise in the numbers of divorces could be expected. A more meaningful way to look at the trend is to consider the divorce rate. In 1961, 21 of every 10,000 married couples were granted a divorce. By 1979, the rate was 112 per 10,000.[9] However, even these statistics must be treated with caution as an indicator of greater marital disharmony. It is perhaps to be expected that more marriages break down, given that they tend to last longer nowadays, due to earlier ages of marriage and fewer premature deaths.[10] The Finer Report argued that it was to be expected that as high a percentage of people marrying as at

present would lead to a relatively high rate of divorce:

> "Indeed, given what is known about such factors as the distribution of homosexuality and chronic ill-health, psychological as well as physical, among the population at large, it is obvious that the present popularity of marriage must be drawing into the institution large numbers who lack any evident vocation for it. From this point of view a very high marriage rate will lead to a disproportionately high rate of breakdown." (11)

Legal reforms have also undoubtedly influenced the rate of divorce. Liberalisation of the divorce laws and the introduction and extension of legal aid has meant that more marriages that have broken down can be legally ended.(12)

The recorded incidence of marital breakdown may well be an underestimate. As well as those couples who still remain together despite a de facto breakdown, there is an increasing proportion who live together without a formal marriage ceremony.(13) Divorce statistics would reveal nothing about the ending of these relationships.

Separation and divorce often impose heavy financial costs on the individuals involved and on the State. For example, there is the cost of supplementary benefits to divorced and separated parents (mostly women) and their children; the cost of legal aid for divorce proceedings; and the cost to local authorities of taking children into care. Dominian estimates the cost of supplementary benefit to be of the order of £400 millions a year. To this he adds the cost of children in care, absence from work, prescriptions for stress due to marital breakdown, medical care and admission to

hospital for psychiatric or physical reasons associated with marital stress, making, he estimates, a total annual cost of between half a billion and one billion pounds on the public purse.(14)

For the individuals involved, where there was previously one household to maintain, there are now two, and this is likely, especially where children are involved, to lead to a lower standard of living for both partners. The number of one-parent families has increased substantially in recent years largely due to increased numbers of divorced lone mothers. In 1976, according to Leete's estimates, there were 750,000 one-parent families, constituting about 11% of all families and containing more than one and a quarter million dependent children.(15) Divorced and separated women with dependent children are particularly likely to have a low level of income. The Finer Report found that, in 1971, a half of fatherless families other than widows' families (that is, those headed by divorced, separated and single women) had supplementary benefit as their main source of income. (16)

It is difficult to generalise about the social and psychological 'costs' of marriage breakdown, either on the spouses involved or their children. The quality of family relationships may have been so poor that separation improves the environment of all concerned. However, there seems no doubt that difficulties can arise from the very situation of being in a one-parent family, or in a family where one or both partners have been married before, in a society still predominantly (however, unrealistically) based on the assumption of life-long, monogamous marriages, particularly with the added stigma that can still arise from divorce.(17)

The rise in the number and rate of divorces has attracted considerable attention, but is obviously only a very crude measure of the quality of marital relationships in contemporary society. It is perhaps more widely used than is justified because of the far greater difficulty involved in assessing the degree of satisfaction afforded both partners by marriages which are still legally in existence. It could be hypothesised that a rising divorce rate indicated an improvement in the quality of marriage: people are less prepared than previously to remain in unsatisfactory relationships, and women, with their legal and, to a limited extent, financial emancipation, are more able to extricate themselves from an intolerable marriage. Certainly, many writers have linked higher divorce rates to higher expectations of marriage:

> "Thus for some commentators divorce is not a sign of failure but a symbol of the pursuit of greater realisation of wholeness and perfection." (18)

Whatever trends the rising divorce rate may actually reflect, it has led to widespread concern. One of the expressions of that concern was the setting up, in 1975, by the Home Office in consultation with the Department of Health and Social Security, of a Working Party to consider marital disharmony and the provision of helping services. The Working Party reported in 1979, in a consultative document entitled 'Marriage Matters.'(19)

In their introduction the members stated:

> "We have come to the view, which we think is shared by many informed people in the educational and caring

> services, that the part which marital disharmony plays in the creation of social problems is a frequently neglected cause of personal and social distress." (20)

They later say:

> "The State should accept a responsibility - shared with caring individuals and independent initiatives - for relieving private misery and exercising social concern by the provision of services through statutory and other public agencies to help with marital problems." (21)

Thus marital problems - considered by many to be the most personal and private of problems - are defined as a rightful concern of state social policy.

In the process of deciding whether or not to end a marriage, or how to cope with disharmony within it, it is not unexpected that in our 'personal service society',(22) there are a wide range of occupations and organisations, both in and outside the state sector, who would claim to have some expertise in providing help and support to the individuals involved. However, when discussing any kind of social service, care must be taken not to exaggerate the 'experts'' contribution. It is highly probable that family and friends still provide the majority of 'marital counselling', although the 'experts' may argue that this is only at a very basic level and possibly very dangerous if the problems involved are complex.(23)

Apart from friends and relatives, there are a whole range of paid professional people who, in the course of their work, are likely to encounter and be asked for help by people with marital problems.

These include doctors, social workers, health visitors, clergymen, probation officers and solicitors. Marriage counselling is not the central task for any of these professions and the individuals within them are likely to claim very varied degrees of interest and expertise in this field. Only the probation service has a specific responsibility in this field (although some other social workers could perhaps be included). However, there is some evidence (see later) to suggest, for example, that a large proportion of those whose marriages actually break up do at some point consult their general practitioner with associated problems; and probably most people seeking a legal separation or a divorce consult a solicitor.(24)

There are also some voluntary organisations (i.e. outside the state sector, although frequently funded at least partially from public funds) who are approached by people with marital problems. Citizens' Advice Bureaux and the Samaritans are two such organisations mentioned in 'Marriage Matters' who, although not specialising in marital work, do find that a significant proportion of their clients have problems in this area. The Institute of Marital Studies is a more specialised voluntary agency which does provide a therapeutic service, but whose main role is as a training and research institution.(25)

There is also a group of voluntary organisations: the National Marriage Guidance Council; the Catholic Marriage Advisory Council; and the Jewish Marriage Education Council. These are specialised agencies whose main function is service provision. All of them have part-time, voluntary 'counsellors' and all concern themselves with education and preparation for marriage, as well as what is

referred to as the 'remedial' side. It is with the 'remedial' work of one of these organisations - the National Marriage Guidance Council - that this study is particularly concerned.

Marriage guidance councils and their counsellors

The National Marriage Guidance Council (NMGC) is a specialist agency in that it focuses specifically on the marriage relationship as its central concern. However, it also claims to be generic in that it is concerned with all the different aspects of that relationship: sexual, emotional, legal, psychological and social.

NMGC is responsible for the selection and training of counsellors and provides continuing tutorial support for all practising counsellors. The actual counselling service is provided by local marriage guidance councils (MGCs), which are constituent members of the national body, but are autonomous and responsible for the sponsoring of counsellors and for their own finances. The service is not entirely free for clients; they are usually expected to make some donation for each interview.

The organisation dates from just before the last war, when the first council was set up by a group of professional people who were concerned about the growing number of divorces, which then numbered about 7,000 a year [26] and about what they saw as the increasing problem of family breakdown. It was also felt, as it still is by many people to-day, that 'broken homes' and unhappy marriages were the root causes of many social problems such as juvenile delinquency, poor educational attainment by children and family violence.

In 1948, following the recommendations of the Denning Committee,[27] the Home Office gave the first grant to NMGC. The post-war years have witnessed a rapid expansion in the organisation. After an initially slow start, by 1957 there were about 700 counsellors who saw about 10,000 cases in a year.[28] In 1980 there were about 1,600 counsellors, seeing 34,000 new cases.[29] Geographical coverage is now extensive: In 1978, there were 145 constituent MGCs staffing over 500 centres in England, Wales and Northern Ireland. (Scotland has its own, separate organisation)[30]

Marriage guidance counsellors work on a part-time basis (they are expected to give a minimum of about seven hours a week, including three hours contact with clients, for 40 weeks a year[31]) and are largely unpaid. There have recently been some moves towards paying counsellors, especially those who counsel for more than a few hours a week,[32] but this usually only involves minimal remuneration and the development is by no means universally welcomed.[34] As well as considerations of cost, there is a feeling among some people that a voluntary workforce has a kind of moral superiority and is "the mark of a healthy community".[34]

Relying on volunteers (for counselling and for administrative work) certainly enables the councils to run on very small budgets. In 1976, the total cost throughout the country was about £750,000. In the same year, as well as the educational side of their work, counsellors carried out about 160,000 hour-long interviews. About two-thirds of the finance is from public funds: a Home Office grant to NMGC and local authority grants to individual MGCs. The remaining one third comes from voluntary donations, sales of publications, payments by clients and course fees.[35]

As one would expect, most counsellors are female (nearly four to every one male counsellor); most are middle-class; most are aged between thirty and fifty; most are married; and most have had an above average education.[36] Many have been or are social workers, teachers or (in the case of men) members of the clergy.[37]

Prospective counsellors are initially sponsored by a local council and then have to attend a selection conference run by NMGC. A surprisingly stable proportion of about half the candidates each year are accepted.[38] These embark on an in-service training, which extends over two years and usually consists of six residential courses, each lasting two days, which are run and financed by the national organisation. Counsellors usually start to see clients after the first training course.

The importance attached to confidentiality and to the one-to-one relationship meant that until very recently it was not possible to learn how to counsel by direct observation - 'sitting next to Nelly'. However, in the last year, following the recommendations of a review of counsellor training, a system of 'learning by observation' has been introduced for newly selected counsellors. By mid-1982 it was estimated that about three-quarters of new counsellors sat in with experienced counsellors as part of their training.[39] There is still no direct supervision of the work of new counsellors.

There are other, more long-established, ways in which NMGC maintains some control or supervision of counselling practice. Counsellors are expected to attend regular case-discussions and also to participate in an individual tutorial system using experienced

counsellors, who examine the trainee's case notes and discuss his or her work in some detail. This training at the local level (although it is still under the control of NMGC) continues right through the counsellor's career. NMGC also runs post-basic training courses in a variety of specialised areas. These procedures enable NMGC to ensure at least some broad consistency in the nature of the service offered, both with regard to the maintenance of certain 'standards' and with regard to adherence on the part of the counsellors to a certain model of counselling. Indeed, the Working Party on Marriage Guidance commented on the strength of NMGC and the possible effect of this on local MGCs. They warned of the danger that "the strong leadership and control exercised by the national headquarters" may "undermine experiment and initiative by local councils".(40)

A concern which has been voiced relating to the voluntary nature of counselling is how far the service can continue to expand and operate at an optimal level while still relying so extensively on unpaid part-time staff. Thus the Working Party commented:

> "The system of training would be more economical if it were used to support counsellors working more hours each. The counselling is of a good standard, but there is too high a proportion of counsellors in basic training; the whole system would benefit immeasurably by retention of those experienced counsellors whose sole reason for leaving is to go into an agency where they are paid."(41)

In fact, Heisler, in a study relating to 1970-71, found a remarkably low rate of voluntary withdrawal (about 6% per annum). Most of those withdrawing were experienced counsellors (72% had been counselling for over three years), but less than one in five left to go into paid employment.(42) This implies that a little

over 1% of the counselling work-force each year is lost by the organisation to the labour market. However, it tells us nothing, of course, about how many more recruits would be forthcoming (and how many lost) if counselling was remunerated employment and offered opportunities for full-time work.

One could comment that although the unit costs of training may be lower if counsellors worked more hours per week and the 'wastage rate' was reduced to an even lower level, this is likely to be far outweighed by the extra costs incurred if this were achieved by paying counsellors. There does remain, however, the argument that counsellors improve with practice and thus that the quality of their work would increase if they counselled more frequently and over a longer period of time. On the other hand, there may be advantages in retaining the present pattern of employment. For example, the part-time nature of the work may enable counsellors to demonstrate a sensitivity and freshness in their approach to clients, which may be difficult to maintain in a full-time capacity. Volunteers, whose livelihood does not depend on their continuing to counsel, may be easier to 'cool out' of the system should they prove unsatisfactory. The present pattern also enables MGCs to draw on a pool of people who are already in remunerated employment, often in related fields.

A Model of Counselling

In order to properly study the provision of marriage guidance counselling, it is necessary to have some idea of what is understood by this enterprise. There is an enormous and sometimes very

sophisticated literature on counselling, much of it written by American authors. No attempt is made here to do justice to the variety of 'theory and practice in counselling' (to paraphrase one of the well-known recent texts[43]). The aim is rather to consider the 'model' (or 'models') of counselling mentioned above, which seems to influence the training offered by NMGC to trainee counsellors. Concentration is therefore on the literature produced by that organisation, in the form of various information leaflets and books published, and also on other books on marriage and counselling recommended by NMGC.

It is constantly emphasised in marriage guidance literature that counselling is not a standardised service and no two counsellors will operate in the same way.[44] Indeed some writers have stressed that the counselling offered by one counsellor will vary according to the perceived (and often changing) requirements of each case and client.[45] However, this does not mean that there is no view of the ideal in counselling, nor of the ideal counsellor. To quote Nicholas Tyndall, the present chief officer of NMGC:

> "The counsellor's approach to (marital) problems is fundamentally client-centred. His task is not to diagnose nor to prescribe remedies, but rather to share with clients the troubles, doubts and tensions of their marriages. This is essentially a listening process." (46)

He argues that the ideal counsellor has:

> "...some combination of the crucial factors of genuineness, non-possessive warmth and accurate empathy. Basically conflict-free people are sought who can display 'creative' openness to other people and their problems....(counselling) requires counsellors to possess a high degree of personal insight, to know how to respond with sensitivity and to be able to tolerate stress, anxiety and inadequacy." (47)

Timms and Blampied, in their interviews with marriage guidance counsellors and clients found that although both had difficulty in describing the experience of counselling and the nature of the councillor's expertise, counselling could however be seen as "rule-following behaviour".[48] 'Good' counsellors are good listeners, demonstrate an understanding of the nature of the problems, develop warm (although limited and 'formal') relationships with their clients and can help them towards making decisions about or coping better with a given situation.

The idea of counselling as a'listening process', mentioned by both Tyndall and Timms and Blampied, implies a rather passive role for counsellors. This represents an interesting shift, as some of the earlier literature on marriage counselling in this country, notably David Mace's book, 'Marriage Counselling', published in 1948, draws far more clearly on a 'treatment' model of counselling, and also posits a far more active role for the counsellor. He talks about marital disharmony as a 'disease' to be 'diagnosed' and 'treated'.[49] The very name 'marriage guidance' implies the giving of positive advice, and as such it may not convey very accurately the nature of the help many of to-day's counsellors are prepared to give. For example, Herbert and Jarvis, writing in 1970, argue:

> "....it is not a function of the counsellor to solve the clients' problems for him. He is not an oracle dispensing wisdom, and it is not his business to advise or exhort or persuade." (50)

This is a warning which is repeated many times in the marriage counselling literature.[51] Timms and Blampied found that it was a message which was transmitted to both counsellors and clients

(though frequently not to referral agents) and that the concept of 'advice' was used to define counselling in a negative sense (i.e. "whatever else (counselling) is, it is not advice giving"[52]). However, Timms and Blampied also point out that even if straightforward and overt 'advice' is not considered to be a proper element in counselling, counsellors do suggest ways of behaving and clients do discern some guidance and influence; through what the authors describe as 'round-about advice', 'persuasive opinion' or 'selective attention'.[53] The issue then is whether such influence is qualitatively different to or only more subtle than, more obvious forms of direction and prescription.

It is over fifteen years since Halmos argued that the ideal of non-directiveness in counselling cannot be realised and indeed is incompatible with the moral values inherent in counselling:

> ".... in the singling out of specific symptoms, response-systems and behavioural elements for attention, interpretation and discussion, the counsellor's moral influence is made quite specific and detailed". (54)

Although some individual marriage guidance counsellors, especially those with other casework or psychotherapeutic training and experience, may argue that they have moved beyond this particular element in the 'faith of the counsellors'[55], some of the references quoted above, and an examination of the recommended booklist for counsellors in training[56] suggests that the 'fiction of non-directiveness' still has a powerful appeal (although, it is only fair to point out that the book list also includes Halmos' book!)

If marriage counselling is not advice-giving, what, then, is

it? According to 'Marriage Matters' counselling involves:

> "... the counsellor (offering) the client a relationship in which he may discover himself and find resources within himself - and within his marriage - by which to help himself and find his own way; in short, to enlarge his area of freedom and to move within it." (57)

The development of the 'relationship' between counsellor and client is seen as a central element in counselling - Times and Blampied describe counselling as akin to "... going for a walk with a relationship".[58] Guiver argues:

> "The nature of a relationship that a counsellor makes with a client is quite vital, since it is the tool - the only tool - that she (or he) has to work with." (59)

A good counselling relationship sometimes seems to be seen as more than a 'tool', as an end in itself - a definition of 'successful' counselling - just as it has been argued that social workers tend to judge the success of their casework by the quality of their relationship with the client.[60] It is seen as feeding back into the client's marital and other relationships; indeed it is viewed as reflecting a marriage, with a good counselling relationship providing the same opportunities as a good marriage. According to Dominian:

> "Effective counselling provides a fresh opportunity through which clients can discover their own value, their potential and their capacity to give themselves .... A successful marriage, of course, achieves precisely this mutual acknowledgement and acceptance, which in turn promotes personal growth." (61)

This kind of counselling seems to be seen as appropriate for

people who are having problems with their marital and other relationships and suffering consequent emotional stress and distress, but who would not be defined as psychiatrically ill - in other words, people who are reacting normally to a stressful situation.(62) However, this does not mean that the responsibility for this situation is attributed to something external to the individual. The concept of 'immaturity' is often used (or implied) in the explanation of marital difficulties. To refer to Dominian again, in a book highly recommended to trainee marriage guidance counsellors:

> "Marital breakdown is intimately associated with the presence of one or both partners who have only partially or incompletely negotiated the various phases (of emotional growth) and the spouse is chosen as a means to complete growth which should have been completed prior to marriage, or to supply vital personal needs missing during the period of development." (63)

In spite of the contemporary emphasis on the non-directive nature of counselling, NMGC still has quite clear principles on which its work is based. In the 'Notes for Prospective Counsellors', it is written that:

> "The National Marriage Guidance Council is concerned primarily with marriage and family relationships, and believes that the well-being of society is dependent on the stability of marriage." (64)

The contrast between clearly-stated principles and non-directive techniques may well produce certain tensions. Thus, for example, the stated belief in the importance of the stability of marriage must mean that one aim of NMGC is to enhance this stability. One valid indicator of success, especially given the relative ease with which unhappy marriages can now be legally ended, would thus be a drop in

the overall divorce rate. However, counsellors are anxious to stress that their 'success' in individual cases cannot be measured in terms of whether the couple become divorced or stay married. They point out, quite reasonably, that the separation could be very amicable or the staying together cause enormous misery. Counselling is argued to have a role in easing separation as well as in aiding reconciliation.(65)

The crucial issue is whether, in their practice, counsellors can distinguish between their belief in marriage as a valuable social institution, and the question of whether a particular marriage is of value to the partners. A study by Nicky Hart of divorced people suggests that at least certain counsellors still view part of their task as being to preserve particular marriages. She reports that those of her sample who went to marriage guidance councils found that the counsellors tried to dissuade them from their chosen course of ending their marriage, or at least communicated their disapproval of it.(66)

However, some councils have actually started 'divorce counselling',(67) offering help and support to people during and after their divorce. Again, this represents a shift from earlier policy. In 1948, Mace wrote:

> "... the action taken by those whose marriage had failed lay outside the specific province of marriage guidance. Our task was the positive one of building sound unions, and if possible of mending broken ones. If we failed in this, the issue passed out of our province." (68)

This view still seems to accord with the public image of NMGC. Murch's study of a sample of divorce petitioners(69) suggests that,

in the eyes of most divorcees, marriage guidance agencies are too identified with the preservation of marriage to be suitable for work with couples who have definitely decided to separate.

In many ways marriage counselling is very akin to a certain kind of social work ideal. The clients do not overwhelmingly come from 'deprived' backgrounds, they are voluntary, motivated to seek help and, one would assume, anxious to be helped. Because of the voluntary nature of their attendance, those clients who persist, with whom the counsellor has therefore most contact, are likely to be sympathetic towards and responsive to the sort of techniques that counselling relies on. Counsellors have no statutory responsibilities. They have a clearly defined area of work, in which they claim expertise. They work with a considerable amount of autonomy, with no direct supervision of their practice, and the control that is exercised is principally through 'peer review', by colleagues who are themselves counsellors, and not by any outside bureaucracy.(70) In addition they have virtually no concern with material problems. Heisler and Whitehouse, in their study of marriage guidance clients, found that counsellors only mentioned 'social factors' as a problem for their clients in 3% of cases.(71) Even if these factors are present, they are evidently not generally considered to be the counsellor's responsibility. Moreover, even though they are admitted to exacerbate some marital difficulties, they are felt to be essentially peripheral to the core of marital disharmony, sometimes used as an excuse to mask the deeper dimensions of the problem. For example, Domonian argues:

> "When the needs (to feel wanted, appreciated and reassured) are primarily emotional and severe, material inadequacies

> provide a suitable vehicle to express the underlying frustration. When genuine material deprivation is present, this often blurs the real issue, which remains and explains the failure to improve relations even after conditions have improved." (72)

The paradox is that this marriage counselling, which in these ways could be said to be the epitome of a certain model of 'professional' social work practice, is carried out not by highly-trained and highly-paid professionals, but by voluntary, part-time people, with comparatively limited training.

The clients of marriage guidance counsellors

It has already been noted, earlier in this chapter, that there has been a substantial increase in the divorce rate. It was also seen that there has been a substantial expansion in marriage guidance counselling, although this has been at a steadier rate. However, it cannot necessarily be assumed that the two are directly connected because very little is known about the relationship between the population who seek and obtain divorces and the clients of counselling agencies. Is the latter group a subsection of the former group, or are they completely different groups? If they are different groups, is that because the counselling leads to reconciliation? Or is it because the people who seek counselling are sufficiently motivated to 'save' their marriages so that divorce is not seen as a viable alternative?

David Mace, the secretary of NMGC in its early years, wrote that:

> "... the (marriage guidance) centre ... is the constructive alternative to the divorce court. If the divorce court

> is the mortuary for dead marriages, the guidance centre is the hospital for sick ones." (73)

Developing this analogy further, the questions that cannot at present be answered is whether sick marriages which receive counselling and improve their state of health would otherwise eventually have died,or whether they would have spontaneously recovered anyway; and also whether those marriages certified as dead in the divorce courts suffered from diseases which were fatal from the start, or whether early treatment could have prevented their demise.

What is clear is that far fewer people currently seek the help of recognised counselling agencies than become divorced. For example, in Britain in 1975, there were about 130,000 divorces granted, whereas the combined number of counselling cases for NMGC, The Scottish Marriage Guidance Council and the Catholic Marriage Advisory Council were about 43,000.(74) The Working Party on Marriage Guidance estimated that in the late 1970s, when over 150,000 divorces a year were being granted, around 100,000 people a year approached the specific marital agencies and probation officers, by no means all of whom go through the divorce courts.(75) In other words, the situation certainly had not been reached where the divorcing population were one subsection of those seeking counselling.

Some countries have attempted to achieve this by compulsory reconciliation procedures, usually operated through the courts. Thus all divorcees must have utilised, at least nominally, a marriage counselling service. Such procedures have not been introduced in Britain, partly because in operation they often seem to be unsuccessful.(76) On the other hand, the liberalisation of divorce has

been accompanied by at least token encouragement of reconciliation. The 1969 Divorce Reform Act empowered the court to adjourn divorce proceedings if it considers there is a reasonable possibility of reconciliation, and it also required the solicitor acting for the petitioner to certify whether he has discussed the possibility of reconciliation with his client.(77) These clauses seem based on the assumption, or at least on the hope, that some divorcing couples are not 'past the point of no return', and that their marriages could be (and it is desirable that they should be) 'saved'.

Solicitors are of course unlikely to see themselves as marriage counsellors and indeed it would often be financially unwise for them to be too successful at dissuading potential clients from pursuing divorce proceedings. A recent, small-scale study by Murch of a sample of 102 divorce petitioners found that most solicitors dutifully enquired about the possibility of reconciliation, but seemed to regard it very much as a formality. Only one person out of the 102 had actually consulted a marriage guidance counsellor after being told about this service by their solicitor. Of course, as Murch points out, this sample could be considered the 'failures'. There may be others who found their way to counsellors through solicitors and were in fact reconciled, so were outside the scope of this study.(78)

What then is known about the people who do consult marriage guidance counsellors? As far as NMGC clients are concerned, there have been two large-scale studies: one by Wallis and Booker relating to the early 1950s,(79) and a more recent survey by Heisler and Whitehouse of all clients having their first interview in April 1975.(80)

Statistics in the annual reports of the NMGC provide some up-to-date information. There is also a study by Fogarty of a sample of clients of the Catholic Marriage Advisory Council seen in 1973.[81] These all tell us something about the demographic characteristics of the clients (as recorded by counsellors) and also include counsellor assessments of the problems of the clients and the effectiveness of counselling help.

For the purpose of this research, the Heisler and Whitehouse study is the most relevant. One finding which was perhaps unexpected was that the social class distribution of clients was broadly similar to that of the general population.[82] NMGC thus do not appear to be providing a service markedly weighted towards the articulate middle-class. What is not examined is how far the counsellors assessed the 'outcome' of the case differentially with social class.

As far as age is concerned, perhaps less unexpectedly, it was found that NMGC clients were very similar to the divorcing population, with 64% of male and 71% of female clients aged between 20 and 40.[83] The number of years for which they were married also showed a similar pattern to that of divorcees - 22.5% of MGC clients had been married for less than five years and over half for ten years or less.[84] This suggests that NMGC is dealing with the group most 'at risk' of marriage breakdown, although if Dominian's contention that most marital problems have their origins in the very early years of marriage is correct, the counsellors may be seeing many people whose difficulties are already entrenched.[85]

Most frequently, it was the wife who made contact with the counsellor.[86] Heisler and Whitehouse found that the proportion

of cases in which the husband made first contact had fallen since the Wallis and Booker survey.[87] However, the proportion of joint first interviews had increased and they do suggest that these are the cases with the greatest chance of a favourable outcome.[88] It is also the wife who has the most contact with the counsellor. The 1981 Annual Report of the NMGC shows that women were involved in more than three quarters of all interviews in 1978 and men in just over half.[89]

The clients usually came on their own initiative rather than through any formal referral channels: 70% were reported by Heisler and Whitehouse as 'self-referrals', although the category could cover a wide variety of routes to the counsellor.[90] About three quarters of the cases involved a couple who were still living together and only 1% involved a single person with no partner.[91] The most frequent problems presented (at least as they were perceived by the counsellors) were in the very general category of 'personal traits of either partner' (55% of cases), and the more specific categories of sexual difficulties (31%) and infidelity (22%).[92]

Most counselling was found to be short-term: by the end of July 1975 (some four months after the first interview), only one fifth of cases were reported as still continuing. Half had been closed after mutual discussion and nearly 30% of clients had just stopped coming, without discussion with the counsellor.[93]

Although this is not reported in the study findings, Heisler later stated that half of all cases lasted for only one or two interviews.[94] She has also looked at some of the one-interview

cases in the survey. She found that these were more likely to involve clients from lower socio-occupational classes (thus rather modifying the earlier view of the counselling service as having no marked social class bias); clients who came on their own; and clients who were likely to stop coming without discussion with the counsellor (i.e. relatively few were 'planned' to last only one interview).[95]

It is difficult to progress beyond this kind of data about clients. It can be surmised that they are all (or virtually all) involved in what seems to them and/or their partner to be serious marital conflict. Timms and Blampied argue that people usually come to define their marriage as problematic with reluctance, and found that their sample of clients mostly described a long and very painful process of deterioration in their marital relationships before they sought the help of counselling agencies.[96] An approach to a marriage guidance council could be seen as an indication that they feel that their marriage has not irretrievably broken down and that there is a desire to improve the marital relationship. However, there could be alternative reasons for consulting a counsellor. The clients could be those whose marriages have irretrievably broken down, but whose system of morality or religious beliefs inhibit them from seeking a divorce. Or they could be individuals who do not in fact hope for, nor desire a reconciliation, but who want to be able to demonstrate when they seek a divorce that they have 'tried everything'. Obviously the original motivations of the clients have important implications for how one assesses the purpose and the effectiveness of counselling.

Summary and conclusions

The substantial increase in the divorce rate over the years since the 1969 Divorce Reform Act does not, as has been shown, necessarily reflect a corresponding increase in the rate of marital breakdown nor a disillusionment with the institution of marriage as such. Nonetheless, it does represent changing patterns of marriage and family life and has aroused much public concern. It imposes considerable, although not always quantifiable,financial, social and psychological costs on the individuals involved and often on the larger community.

The National Marriage Guidance Council is one of the best-known of the organisations who concern themselves with the quality of marital relationships, with constituent councils in most population centres. At present the organisation relies on part-time and largely unpaid counsellors, who undergo a fairly brief, although continuing training. There is some debate over how far this pattern should continue and whether further expansion will be possible without major changes.

The organisation seems to adhere to a very individualised model of counselling, although it was argued that it is still possible to discern some view of the ideal in counselling or the ideal counsellor. A 'non-directive' approach still seems to be favoured, particularly with regard to the avoidance of 'advice'; marriage 'guidance' counselling appears here to be somewhat misleading. The organisation is nonetheless firmly based on a belief in the importance and desirability of marriage as an institution, even if it does not

claim to seek to perpetuate particular marriages.

In spite of the expansion of NMGC and other counselling agencies, far fewer people currently seek help from these agencies than become divorced. In fact it is not known how far the two groups overlap, although studies suggest that very few divorcees have approached such agencies. There is some information on the characteristics of marriage counselling clients. Their social class composition is not very different from that of the general population, and their ages and duration of marriage very similar to that of the divorcing population. It is the wife who most frequently makes the first approach and she generally comes on her own initiative. Counselling is usually a short-term experience and in about half of all cases only lasts for one or two interviews. In nearly one-third of cases, the clients also stop coming on their own initiative, without discussion with the counsellor. The lack of follow-up data on the clients or research interviews with them limits any further descriptions.

Follow-up data could be easier to obtain if the clients were also patients of a general medical practice to which their counsellor was attached. The next chapter discusses the implications of such attachments for the counsellors, the clients and the counselling.

Chapter 3

Marriage Guidance Counselling in General Medical Practice

This chapter describes the trend towards the attachment of some marriage guidance counsellors to general medical practices. It uses studies of social work and of counselling in general practice to give some idea of the scope for marital and other counselling in that setting and to indicate some of the advantages and disadvantages.

Counselling attachments

Marriage Guidance Councils have traditionally carried out their counselling work from their own premises. This was a conscious decision made early on in the development of the organisation. It was argued that the marriage guidance centre should provide a 'neutral ground', free from any association with any existing organisations, such as the Church or the Courts, and away from the marital home, offering complete privacy and with no interruptions.(1)

This is still the usual pattern, but in recent years there has been an increasing number of experiments with counsellors working from premises associated with other services. By far the majority of these experiments have involved medical premises - either health centres of group practices. An NMGC survey in March 1978 found 50 schemes involving their constituent councils in operation.(2) The actual amount of contact and co-operation between the counsellors and the general practitioners in these schemes can vary enormously, from virtually nil - they just happen to be working in close proximity - to some arrangements which are like full 'attachments'. In the

latter situation, although the counsellors still (in theory at least) retain complete autonomy in their work, they see only clients who are patients of the practice, these clients are usually referred by practice doctors, and there is regular contact and consultation between counsellors and doctors.

In many ways, this has been viewed as a 'natural' and beneficial development. There is increasing awareness of the complex interaction between health - physical and mental - and happiness or emotional well-being. A much-quoted study by Crombie estimated that of the problems brought to the G.P. for primary assessment:

> "... the emotional component is as important as, or more important than the organic in 27% and appreciable in a further 21% of diagnostic situations." (3)

Murch's study of divorce petitioners suggest that general practitioners are the group of professionals most frequently consulted by those with marital problems. (4) Chester, in a study of a sample of women petitioning for divorce, found that 85% of them reported ill-health, which they ascribed to their marriage breakdown. (5) 75% of these women had sought medical help. He suggests that:

> "... a high proportion of those theoretically available for reconciliation seek medical help at a time before they have made a commitment to divorce. ... Even short of effective reconciliation, there is much that can be done to support people in these vulnerable circumstances and to mitigate the consequences of marriage breakdown for those concerned." (6)

It may be that some people approach their G.P. specifically to discuss marital problems, without having any identifiable medical symptoms. The G.P. is a professional with whom most people are likely

to have contact, who is held generally in high respect, whose services are wide-ranging, confidential and hold no stigma for those consulting him, and who is readily available without charge. It is thus small wonder that he or she is used as a kind of 'clearing house' for the whole gamut of physical, psychological, emotional and social problems by some patients. Halmos has suggested that, in some senses, the doctor has, in our secularised society, taken over the general conselling role which was previously the domain of the clergy.(7) However, Halmos also suggests that doctors are ill-equipped to assume this role:

> "... doctors are untrained and, therefore, unqualified to render assistance through intimate personal consultation about moral or social problems. ... an intensive study of physical medicine is not always favourable to the fostering of proficiency in the appraisal of human relationships." (8)

Since Halmos's book was published, there have been some changes. More psychology is included in the undergraduate training of doctors, and general practitioner training includes among its aims:

> "(The) understanding of the way in which inter-personal relationships within the family can cause health problems or alter their presentation, course and management..."

and the development of:

> "a capacity for empathy and for forming a specific and effective relationship with patients ..." (9)

However, the majority of currently practising G.Ps. will, even to-day, have had little or no training in counselling in inter-

personal relationships, and very few would claim expertise in this field. In addition, they may have neither the time nor the inclination to extend their sphere of work in this way. General practitioners, thus, are obviously a major potential source of referrals for marriage counsellors. They are already the largest single outside source of referrals.(10)

The attachment of marriage guidance counsellors can also be seen as an expression of the expanding concept of 'team care' in general practice. 'Team care' and an appreciation of the value of co-operation between health and welfare services in the community are not new ideas. The 1946 National Health Service Act included a duty on local authorities to provide and maintain health centres for the use not only of G.Ps. community nursing staff and dentists, but also of social and welfare services.(11) This duty has never been enacted to any substantial extent, but the post-war period has seen a gradual though accelerating trend away from the single-handed G.P. towards group practices and, in more recent years, towards the employment and attachment of nursing and ancilliary staff by and to these practices.(12)

Attachments and other forms of co-operation between social workers and G.Ps. have also become more common, although these seem to have posed more problems. On the one hand, social workers seem less willing than nursing staff to see themselves as members of a team with the G.P. as the leader. On the other hand, there appears to be continuing ignorance and suspicion among many G.Ps. as to the work and role of the social worker.(13)

Social work is the statutory service which perhaps has most in common with that offered by marriage guidance counsellors, and the inclusion of social workers in general practice teams represents a significant widening of the definition of the scope of primary health care. Thus it is relevant to look at some of the studies of social work in general practices that have been carried out.

Gilchrist et al [14] found in 1976 that just over half of the social services departments in Great Britain had organised links with G.Ps., and that most schemes were of fairly recent origin (over 70% had started since 1973). However, the nature of the schemes varied enormously. Approaching half consisted of 'liaison only', which meant merely that there was 'communication' between social worker and G.P. and the former accepted referrals from the latter. Consequently, the average number of hours that the social workers spent working in general practice was very low (mean 4.59, median 2). The survey found only 6 schemes out of 219 where the social worker worked full-time in general practice. The experimental schemes that have been studied have on the whole involved more ambitious programmes of co-operation.[15]

There have also been some studies of the attachment of 'general purpose' counsellors to general practice, who are not specifically trained by nor working for NMGC and its constituent Councils.[16] However, the first report specifically on the work of marriage guidance counsellors in general practice was from the practice with which this research is concerned. Marsh and Barr, in 1975, described the first 12 months of the attachment, during which time 160 counselling appointments were made, involving individuals in twenty-one marriages.[17]

Waydenfeld and Waydenfeld attempted a more systematic study of the outcomes of 'surgery counselling',[18] The work of nine marriage guidance counsellors in nine North London practices with 88 clients referred during a six-month period in 1977 was evaluated by means of questionnaires filled in by the counsellors, the G.Ps. and the clients. Cohen and Halpern have published a much more discursive account of their attachment, where about 30 patients have been seen by the marriage guidance counsellor over three years.[19] A recent report by Reading Marriage Guidance Council discusses the attachment of four of their counsellors to a group practice and a health centre and their work with 121 'cases' over 15 months.[20] Finally, as already mentioned, Heisler carried out a survey of marriage counsellors working in medical settings in 1978, and found 50 schemes in operation.[21]

There are two ways in which these studies are particularly relevant for the present research. Firstly, they can give some idea of the potential scope for marital counselling (and more general forms of counselling) in a general medical practice. The expansion and increasing acceptance of co-operation between social workers and other forms of counsellors and G.Ps. may reflect and encourage a broadening of medical perspectives which could 'open the door' for marriage guidance counsellors. On the other hand, insofar as the groups are seen as alternatives, with overlapping expertise, it may be that, for example, the addition of a social worker to a primary health care team could pre-empt that of a marriage guidance counsellor. Wyld, in his discussion of 'Counselling in General Practice", argues that:

"....'counsellors' in general practice must themselves automatically become generalists." (22)

- and talks about the G.P. choosing between the several alternatives available. Secondly, the studies can indicate some of the advantages and disadvantages of 'counselling' in this setting.

The scope for counselling in general practice

By looking at the number and proportion of clients referred in these attachments who were reported as having personal relationship, particularly marital, problems, it is possible to gain some idea of the likely demand for a marriage guidance counsellor. Table 1 summarises some of the relevant information from the studies.

Table 1. Numbers and proportion of referred clients specified to have relationship and marital problems

	Year(s) of study	General relationship problems		Marital problems		Need casework help	
		No.	%	No.	%	No.	%
Collins	1961 - 2					87	40
Forman and Fairbairn	1963 - 6	148	36.2	46	11.2		
Goldberg and Neil	1965 - 9	856	30	c.425	c.15		
Rushton and Briscoe	1977	71	42	22	13		
*Meacher	1974 - 5	44	67	23	35		
*Waydenfeld and Waydenfeld	1977	35	40	41	47		

* Unlike the figures for the other studies the 'marital problems' category is not a subset of 'relationshipproblems', although there is highly likely to be some overlap.

Forman and Fairbairn estimate that the provision of a casework service

was the major contribution of the medical social worker in their study. The medical social worker herself estimated that over one-third of all the cases referred to her involved some personal relationship difficulties, including, in about a tenth of cases, marital difficulties. The authors conclude that in a group practice of six doctors and 14,400 patients there was sufficient need to occupy at least one full-time social worker. (23)

Goldberg and Neill report that during the four-year attachment, about 40% of referrals involved the social worker in casework help. A third involved, as a main problem, difficulties in family relationships, of which almost half were marital difficulties. Again they conclude that this particular practice (of a radically different nature to that described by Forman and Fairbairn) of four/five G.Ps. and about 9,000 patients could keep a full-time social worker occupied. (24)

In Collins' account of her attachment to general practice, the details are presented in a rather different form and thus not easily comparable. However, a similar proportion of about 40% of cases which came to her attention over the year were assessed as needing casework help. Some of these patients were asked, by means of a postal questionnaire, to comment on the almoner's work. Nearly 90% said that she had been of some help and the most frequently mentioned types of help were 'someone to turn to when necessary' (45%) and 'obtained help for you' (45%), indicating that the almoner's role was both a practical and a counselling one. (25)

Rushton and Briscoe report on the nature of the problems of the clients referred to the General Practice Research Unit social

workers attached to a health centre. The social workers gave marital problems/family break-up as the reason for referral in 13% of cases; emotional problems/mental illness in client or family in 24%; and social relationships in 5%. Thus in over 40% of cases, the referral problems were ones requiring casework help, including 13% which could be seen as more specifically appropriate to marital counselling. When asked about the whole range of problems they identified in each case, the social workers gave these areas even more importance. Out of 168 referrals, 53 were estimated to have marital/family break-up problems, 96 emotional problems and 94 problems in social relationships. Overall difficulties in relationships were noted in over three-quarters of cases.(26)

It is thus clear that in these attachments the social workers were expected and prepared to tackle problems relevant to counselling skills, including marital counselling. Indeed, Rushton and Briscoe argue that as it has been found that G.Ps. tend to avoid the exploration of emotional factors, these skills comprise a major area of social work expertise in a primary health care setting.(27) Of course, one important difference between social workers and marriage guidance counsellors is the former's combination of practical knowledge and casework skills. In cases where the two forms of help are necessary in combination, it may be that the social worker has a significant advantage. Interestingly, the social workers in Rushton and Briscoe's study only noted this combination in 10% of their cases.(28)

Turning to studies involving the attachment of counsellors rather than social workers, Anderson and Hasler imply that a broad-based counselling approach, such as they report on, is more useful in

general practice than the more circumscribed role of marriage guidance counsellors and can enable more referrals to be made. In this attachment, the referrals usually involved relationship difficulties of some kind, although no specific figures are given.(29) This was also true of the clients of the counsellors in Meacher's study: 67% had 'relationship difficulties' and 35% 'marital difficulties'.(30)

Of course, it may be that, as Wyld suggests, marriage guidance counsellors in general practice do tend to become 'generalists' and to operate within a less circumscribed role than their title suggests. Marsh and Barr's article talks specifically about help being given to marriages.(31) On the other hand, Cohen and Halpern obviously have a very broad view of the marriage guidance counsellor's role, arguing that in the role of 'practice counsellor' she:

> "should be able to deal with those personal and family crises which are not specifically psychiatric in all age-groups." (32)

They also see the counsellor as having a role which is distinct from that of the social worker, pointing out that the latter are usually local authority employees, faced with the conflicts which this produces and with the possibly unfavourable reaction of patients to being associated with a statutory authority; and furthermore with increasing constraints on finance and staffing which may mean insufficient time for remedial and preventive casework.

Waydenfeld and Waydenfeld suggest a similarly broad role for marriage guidance counsellors. Only in the case of 41 of 88 patients was 'marital problem' given as the reason for referral and

'anxiety' and 'relationship problem' were given in about the same number.[33] One of the G.Ps. involved in the Reading project talks about the counselling being:

> "... primarily in the area of marital breakdown, but significant work has been done in the area of behaviour problems in children as the result of the marital breakdown. The counselling has also covered support concerning the care of dependent relatives. Bereavements too have been supported." (34)

Two-thirds (43) of the counsellors responding to Heisler's survey similarly worked with a broad range of problems other than marital ones: bereavement counselling, single people with relationship difficulties and parent/child conflict were the most frequently mentioned.[35]

Thus, there is some evidence to suggest that counsellors who are part of marriage guidance organisations do tend to adopt a fairly broad definition of their role in general practice. This does, of course, reflect the already-noted [36] trend in the marriage guidance movement. However, it seems probable that these counsellors would be more likely to see clients without specifically marital problems where they were working in a general practice setting and most of their clients were referred by G.Ps. than in the more usual setting of a marriage guidance centre dealing mostly with self-referrals. Whether this is a desirable trend is quite another matter: in terms of the best use of limited available resources, or in terms of the extent to which the counsellor trained in marriage guidance counselling is equipped to cope with a broader range of clients and problems. However, even given a fairly specific brief to help people with marital problems, the studies quoted do indicate

that there is a demand, expressed in terms of referral to the attached worker, for a counselling service.

Advantages and disadvantages of counselling in a general practice

These studies also comment, often in some detail, on the advantages and disadvantages of practising social work or counselling in this setting. As, perhaps, one would expect, especially given the pre-dominance of participants in the schemes among the authors, this method of working is generally favoured, although Collins does express quite marked reservations.

The attachment of a counsellor could offer many benefits to the G.P. This additional source of expertise could both increase the quality of care he offers his patients and decrease his workload. The G.P. is enabled to share the burden of responsibility of patients whom he is likely to find particularly demanding. It is reasonable to hypothesise that patients who are being counselled may consult their doctor less frequently[37] and that their consultations may be confined to more narrowly-defined 'medical' problems. The counselling needs of patients are likely to be especially time-consuming, and the G.P. can refer to someone who has appointments which last an hour rather than a few minutes. The pressures from patients to prescribe psychotropic drugs may decrease.[38] Counselling, representing as it does an attempt to tackle the root causes of problems, offers the prospect of a more long-term improvement in the patient than does treating the symptoms.

The counsellors themselves could potentially derive some considerable benefits. For example, job satisfaction seems to be

increased by working as one of a 'team', whose members can give each other support.(39) Close physical proximity makes subsequent feedback and consultation easier and this may be particuarly important in the case of individuals with medical and social or emotional elements in their illness. Medical back-up can be readily available and, if permission is granted, the counsellors can have access to details of the medical and family history of clients.(40 They are working in a less professionally isolated setting and in one where there is more likely to be a long-term relationship with the clients, thus enabling feedback after counselling has ceased and maybe more likelihood of a client returning subsequently.(41) Working from medical premises may enhance the status of the counsellor and make it easier to liaise with outside agencies.(42) Access to potential clients is improved, both in terms of numbers and in terms of the range of people and problems. Having a counsellor on the premises may well encourage a G.P. to make more referrals than he would have done to an outside agency. He knows the counsellor and can make a referral to a specific person rather than to a marriage guidance council. A definite referral and a recommendation from a trusted G.P. may be accepted and followed up by individuals who would never consider approaching the local marriage guidance council independently. This may include groups who would not see marriage guidance counsellors as appropriate sources of help for themselves or their problems, such as the single, widowed and divorced, as well as those with more clearly 'marital' problems.(43)

Working with a counsellor may also make the G.P. more sensitive to underlying marital and other relationship difficulties, so encouraging early referrals.(44) A common complaint of counsellors is that

they do not see many of their clients until a lot of damage is already done and conflicts have built up over years. Chester's study [45] suggests that many women consult their doctor at a relatively early stage in marital breakdown.

The G.P. can also act as a 'filter', sifting out those of his patients whom he considers could benefit from counselling and preparing them, so that fewer clients are likely to arrive with unrealistic expectations.[46] There also seem to be fewer unkept first appointments in general practice.[47] This 'filtering' and preparation could be seen as an advantage to clients as well. It may be easier for them to seek help of this kind once a trusted G.P. has explained something of what it involves and has made a definite recommendation and referral. Clients may be more confident that different aspects of their 'treatment' are fully co-ordinated if there is co-operation between the doctor and the counsellor. Counselling takes place in surroundings which are familiar to them and which house a wide range of services, thus not carrying any stigma associated with the label 'marriage guidance'. The likelihood is that they will also be nearer to home than the nearest marriage guidance centre. They may well benefit from and appreciate the greater amount of time that the counsellor can give them compared to the G.P.

Finally, given the already-mentioned estimates of the scale of costs involved in marital conflict and breakdown[48] and the publicly-expressed concern about the stability of family life, as exemplified by the publication of 'Marriage Matters',[49] it could be argued that the whole community may benefit, in economic

and social terms, from successful counselling attachments. More specifically, besides the reduced rate of medical consultation and drug prescription that it has been argued results from counselling in general practice, if counselling, as at present, remains a largely voluntary and unpaid activity, it could be seen as a cheap alternative to care from a highly-paid G.P. From this perspective, even if consulting a marriage guidance counsellor is no more efficacious than consulting a G.P., it could be argued to be a desirable substitute.

However, there is by no means universal or unreserved support for counselling in this setting. Some of the differences from the traditional setting which are seen as advantages in one sense could equally be viewed as disadvantages in another. For example, access to medical records and case discussions between G.P. and counsellor could be seen as breaches of confidentiality. The very proximity of the practice premises to the client's home and the familiarity of the surroundings could make for less anonymity.(50) Clients are more likely to meet people they know - both other patients and members of the practice staff. After counselling has finished, it may be less easy for them to put the experience behind them. Again, a G.P. referral may 'filter out' unsuitable clients, but Collins argues that the pressure of work in general practice may militate against good and comprehensive referrals.(51) This method of working may produce some clients who only attend because their doctor has 'prescribed' this particular kind of treatment and who thus are less motivated and even resentful.(52) If, as seems likely, counselling depends for its effectiveness on the willing and

active participation of clients, the less voluntary nature of their approach may pose problems. They may feel rejected by the G.P. whom they originally chose as an appropriate source of help.[53] They may have consulted the doctor in the hope of obtaining some practical help or medical treatment or relief of physical symptoms. The ethical issue then arises of how far G.P. and counsellor are justified in using the 'presenting problems' as a way into exploring deeper difficulties which they feel underly these.[54]

Some G.Ps. may feel that it is their responsibility to counsel those of their patients who approach them for help, rather than 'passing the buck', especially to a part-time volunteer about whose status and training they may have doubts. Others may find problems arise from an increased workload, as they become more sensitive to the underlying causes of patients' ill-health and become less willing to treat only the symptoms. Several studies have stressed the importance of the full co-operation and enthusiasm of all parties concerned to the successful operation of attachments. For example, the G.Ps. must want to work in 'multi-professional teams' and be interested in the 'social malaise' of their patients.[55] This suggests that there may be some difficulty in generalising from arrangements which operate successfully in a few experimental settings.

Being a voluntary worker, normally expected to give only a few hours a week of her time, can pose problems for the counsellor, in a team otherwise staffed by remunerated,often full-time professionals. A substantial commitment seems to be demanded of counsellors in general practice, (including counselling hours, the writing of casenotes, formal and informal contact with the G.Ps. and other practice staff[56]) and their paid colleagues may forget that this

is the counsellors' own time. If she does only attend for a few hours a week, it may be difficult to build up and sustain the relationahips with the other staff which are necessary for successful co-operation. The practice commitment may mean less contact with marriage guidance colleagues.[57] This is a problem insofar as the support and supervision of counsellors and their work is through a system of case discussions and tutorials with other counsellors and tutors. 'Professional isolation' is a problem which has also been mentioned in the context of social worker attachments to general practice.[58]

There are associated financial problems. Not only is the counsellor likely to feel the lack of her own remuneration more keenly, but, in a 'free' NHS setting, it may be more difficult to ask for the client contributions which are an essential part of the organisation's revenue.[59] Clients who go to a marriage guidance centre are likely to be aware of the voluntary nature of the organisation, and are normally expected to contribute something towards the cost of each counselling session. The situation is somewhat different in general practice. Clients are referred to the counsellor in the same way as they may be referred to the practice nursing staff, the social worker or a hospital consultant, all of whom provide services involving no direct consumer contributions.

There is also the question of how far G.Ps. should contribute towards the costs of providing a counselling service for their patients, especially if this enables the quality of care to be enhanced and their own workload reduced. The Working Party on

Marriage Guidance points out that at present there would be a difficulty in paying for counselling out of NHS funds, as counsellors do not fall into the categories of auxiliary staff for whom G.Ps. can claim 75% reimbursement.(60)

More fundamental problems can be posed. For example, the opposite side of the coin of 'co-operation' could be seen as 'collusion'. One aspect of the growing popularity of 'team care' which has perhaps not attracted the attention it deserves, is that it makes it more difficult for individuals to escape and seek help from alternative agencies. Their reputation and the interpretation of their problems follow them from expert to expert. If G.P. attachments were to become the normal pattern of working for marriage guidance counsellors, another separate 'door' on which to 'knock' would disappear.

Another possible danger in this type of arrangement is that marriage counselling becomes too identified with a particular model of marital problems. Early writers on the National Marriage Guidance Council, like Mace, although they freely used medical terms to describe counselling, were anxious to avoid its identification with one perspective. To them the essence of NMGC was that it provided a generic approach to the marriage relationship(61). If the 'normal' route to marriage guidance counselling became referral through a doctor, it would become necessary for those with marital problems to define themselves as in need of medical attention. Even given that many already do so, this would seem both unwarranted and undesirable. This problem may be alleviated if the nature of the primary health care team were extended to include, for example,

social work services and thus became less associated with the medical model. However, it may still be felt undesirable for a voluntary organisation to be drawn into such close co-operation with the statutory services.

In a different way, the model of work of marriage guidance counsellors in general practice may be widened. It appears from the literature that some doctors will refer a broader range of people and problems than is traditionally felt to lie within the scope of marriage guidance counselling: single people, adolescents, those with clinical depression or problems of addition, and so on.[62] Marriage guidance councils increasingly emphasise that they are open to anyone who feels they could be of help, but the question remains of whether the training and expertise of the counsellor enables her to cope with a wide range of emotional and psychological problems, or with those whose problems may not be linked to a marital-type relationship. Even if she could help in these areas, given that there are plenty of marital problems around and given that the organisation was founded and is financed on the basis of its marital work, should the limited resources available be spread thinly over a wider field?

There are other problems surrounding the allocation of limited resources. Counsellors in some 'attachment' schemes, maybe initiated through the enthusiasm of one G.P., have found that referrals have been slow or completely lacking.[63] If they reserve appointment times which are not then utilised, they thus waste time which could have been spent counselling clients from the centre's waiting-list. Paradoxically, difficulties can also arise

if an 'attachment' scheme is particularly successful in terms of the number of people referred and the number of times they are seen. The local Marriage Guidance Council can find that a high proportion of its total counselling resources, in terms of counselling hours and of money for administrative and travelling expenses, is being used by the scheme. Thus a small section of the total population covered by the Council is receiving a disproportionate slice of the service.

This could become a general problem. Even if the advantages of close co-operation between doctors and marriage guidance counsellors were felt to greatly outweigh any disadvantages, for 'attachment' to be the normal pattern of counselling would involve a considerable expansion of the marriage guidance service. In England and Wales there are currently around 1,600 counsellors [64] compared with just under 9,000 general medical practices [65] with about 22,300 doctors working in them[66] in England alone. Thus, given the relative shortfall of counsellors, there is the danger that the more counsellors who do restrict their work to the patients of particular practices, the poorer served, in terms of counsellors available, will be the rest of the population.

The extent and permanence of this particular problem depends on the ability of marriage guidance councils to expand, and to recruit (and retain) sufficient counsellors to make up the relative shortfall. The Working Party on Marriage Guidance commented:

> "The main questions raised by the evidence are how long the council can both continue to work on an exclusively voluntary basis and make its service more available and comprehensive." (67)

The Working Party felt that the major problem lay not so much in recruitment of counsellors but in their retention. They point out that a third or more of all practising marriage counsellors may still be in their period of basic training.(68) This could lead not only to difficulties in sustaining any rapid expansion in the numbers of counsellors, but also to a shortage of experienced counsellors with confidence in their professional standing. It is likely to be this group who most easily forge successful co-operative links with other professional groups, such as G.Ps.

These arguments led the Working Party to favour the introduction and extension of payment schemes for counsellors (although they are careful to stress that the issue is one on which the marriage guidance councils must themselves decide). Payment may also encourage and enable counsellors to work more hours a week; several studies have mentioned this as necessary to the success of general practice attachment schemes.(69)

Of course, as was pointed out in chapter 2, any significant payment of counsellors will increase the overall cost of the service, particularly if it is accompanied by an increase in the number of counsellors and the number of hours worked by each one. This may well prove to be difficult to finance from voluntary sources, thus could have implications for public expenditure. However, given that counsellors are unlikely to be as highly remunerated as G.Ps. insofar as one service is an alternative to another, the overall cost may actually decline. The studies which claim to find that counselling leads to a decrease in G.P. consultations (as well as prescriptions for expensive drugs) imply this model.(70)

However, the paradox so evident over recent years of increasing health care expenditure on an increasingly healthy population must suggest some caution in relying on this model. Insofar as counselling becomes a complement to, rather than a substitute for medical care, the overall effect may be to enhance the quality of patient/client care, but not necessarily to reduce expenditure. Doctors who at present hold a narrow definition of their role, and tend to treat physical and psychosomatic symptoms rather than search for the underlying causes, may become sensitised to signs of emotional stress and relationship problems. It then may become less easy to deal with patients in five minutes or less by means of a prescription. If doctors act as 'filtering' agents for counsellors' potential clients, this could be extremely time-consuming, especially if he finds himself carrying out a kind of 'reception' or 'intake' interview, such as is found in some marriage guidance councils. He could, given close co-operation with and education about counselling, even begin to carry out more counselling of his patients himself.

Given this alternative model, it may be that the implications in terms of quality and cost of expanding counselling attachments to general practice may be rather different. While some existing studies suggest that quality can be enhanced while costs are reduced, or at least not increased (a very attractive combination), it may be that increased quality of care does, in fact, cost more. A counselling service in general practice then becomes less of a cheap alternative and more of an 'added luxury' to primary health care.

Summary and conclusions

Studies of the attachment of social workers, of 'general purpose' counsellors and of marriage guidance counsellors to general medical practices seem to show that there is ample scope for a counselling service within the ambit of the primary health care team. In experimental and publicised schemes at least, G.Ps. were willing and able to refer significant numbers of their patients considered to need help with their personal relationships, including marital relationships. This does not of course necessarily mean that NMGC counsellors are the ideal people to provide that help.

The studies also discuss what are considered to be the advantages and disadvantages of providing a counselling service in this setting. It has been argued that it results in a decrease in the G.Ps' workload; an improvement in the status and job satisfaction of counsellors; increased and earlier access to clients; more co-ordinated, less stigmatised and improved quality of care for patients/clients; and economic and social benefits to the community at large.

There is less emphasis in the studies and reviews of attachments of the disadvantages and difficulties associated with these innovations. Some concern is expressed over issues of confidentiality, and anonymity, and collusion in team care settings and over the pressure which may be exerted on unwilling potential clients to attend. It is recognised that apparently successful 'experiments' may not repeat that success when generalised to involve less enthusiastic and motivated participants. In the case specifically

of marriage guidance counsellors, there could be problems associated with the operation of a voluntary service dependent partly on client donations and utilising part-time, unpaid staff, in the context of a National Health Service, providing services which are largely free at the point of consumption and employing highly professionalised and often full-time staff. General practice attachments, in which the counsellors may well be referred clients with general rather than specifically marital relationship problems and these clients are those who have defined themselves as needing medical attention, raise questions about the allocation of the limited resources of the marriage guidance organisation. The attachment of only one counsellor to each general practice would require a considerable expansion of the number of counsellors. Even if this were possible, the question has not been addressed as to how far this should be the only route of access to counsellors. Apart from the issue of the desirability of such a close association between medical and counselling services, the question of the implications of this association for the costs and quality of primary health care need to be carefully considered.

One advantage of counselling attachments to general practice lies in the realm of research rather than direct service provision. Counselling clients who are also practice patients are likely to be more accessible to a researcher and thus to offer more opportunities for client assessments and outcome studies. In the next chapter, the potential and difficulties associated with these areas of research are explored.

Chapter 4

Research into the impact of a marriage guidance counselling service

This chapter considers some of the methodological difficulties posed by research into the outcomes of counselling and research using clients' attitudes and assessments. Some areas in which compromise seems to have been inevitable in these fields of research are discussed. However, it is noted that compromise has often been in the context of the positivist tradition, and a 'humanist' alternative is considered.

Research in social policy, including the provision of social services,should aim to meet two, sometimes conflicting, criteria. Firstly, it should be 'academically respectable' - that is, it should use the best possible methods to achieve accurate and meaningful results. Secondly, however, it has some responsibility to contribute to an understanding of the social services and to consider the options open for future development - thus it should in some way be 'relevant' and of use to those administering and working in these services. In 'Marriage Matters' it is argued that this latter aim has frequently not been achieved in this area of research:

> "Certainly very many practitioners find it difficult to fit even relevant findings into their work and discover that much published material does not speak to their preoccupations and dilemmas." (1)

This study is related to two areas of social research which perhaps pose some of the most difficult theoretical and methodological

problems: research into the impact or outcomes of counselling and consumer opinion research.

Research into counselling outcomes

There has been a reluctance, especially in this country, among counsellors and counselling agencies, to embark on research designed to measure the 'results' of their work.[2] The research which has been done, such as the huge number of studies carried out in the U.S., [3], has frequently been criticised for its inadequate design and faulty execution.

One of the areas of difficulty lies in the lack of any clear-cut aims or criteria of effectiveness in counselling. Those which do emerge tend to be at a very generalised, abstract level and very difficult to measure; for example:

> "Effective counselling provides a fresh opportunity through which clients can discover their own value, their potential and their capacity to give themselves." (4)

This reluctance - even inability - to specify any but the most general aims is of course closely linked with the image of counselling which sees the counsellor as an essentially passive and non-directive figure. It is not for the counsellor to decide aims for the client; his role is to enable the client to decide for himself what his problems are and how best to tackle them.

Another source of resistance to the specification of aims and criteria is very clearly expressed in the related field of social

work in an article by Goldberg and Fruin, describing an attempt to:

> "... encourage social workers to take a more evaluative attitude to their work." (5)

They argue that:

> "Problems of measurement or the search for objective evidence in support of the assumptions on which social work intervention is based do not occupy a central place in the social work curriculum in Britain. Putting people into categories and qauntifying phenomena which, in part, consist of subjective experiences, is at variance with the social workers' belief in the uniqueness of each individual experience and the need to individualise problems in order to help people in their difficulties." (6)

This is a difficulty also noted by Timms and Blampied, in their study of marriage counselling. They point out that both counsellors and clients intend that the experience of counselling be individualised, thus:

> "... any <u>general</u> analysis has to work continuously against the grain of the interview material, almost against the intentions of the respondents..." (7)

This 'individualisation' emphasises the difficulties of talking about counselling as one particular kind of activity. Several writers have pointed out that counsellors may work in very different ways.(8)

However, Halmos, in his book 'The Faith of the Counsellors',(9) maintains that there are common elements in counselling, which

together comprise this 'faith'. His work is still one of the best expositions of the obstacles, inherent in the nature of counselling, to developing measurable criteria of success. He argues that notions of success associated with 'curing' are inappropriate to counselling, because there is no original integrity to which the individual can return. No-one, therefore, can expect:

> "...complete restitution to some mythical state of unspoilt mental health." (10)

Thus, in some sense, counselling is always 'broken off in the middle'. The process of counselling never finishes: it is potentially interminable with no foreseeable end. It follows from this, Halmos argues, that the counselling process is seen as its own justification because of the moral sustenance it gives to counsellor and client, as an end in itself and therefore that it does not need to be vindicated by its achievements. This gives to counsellors:

> "... the assurance derived from an unanalysable moral imperative." (11)

- and means that they can maintain their faith in counselling in the absence of, and without feeling the need for, any clear-cut evidence of their success. He quotes from a book by J.H.Wallis, one of the writers on marriage guidance counselling already referred to:

> "Whether or not we as counsellor ... 'do anything' is beside the point. Sometimes a spontaneous action becomes a kind of symbol, a recognition of the other person's need for help and our own willingness to try to give it." (12)

It may be possible to break down the very abstract aims that counsellors are prepared to express into more specific and (at least potentially) more measureable categories: for example 'increased ability to compromise' or 'increased communication'. However, the ideal would then be to carry out a longitudinal study, somehow measuring the 'ratings' of clients before and after counselling. Apart from the problems of isolating the effects of counselling in any measured changes, the question then arises of whether such a study would be acceptable to counsellor and client, or whether it would be felt to interfere with the counselling process, particularly if an outside researcher was involved.

To the outsider, surveying the field of marital counselling, some fairly concrete indicators, involving measurable criteria, do spring to mind. For example, there is the possibility of using as one indicator of success the number of clients who are still married to or still living with their spouses after a certain time. The objections counsellors have to this measure have already been discussed. (13) A more acceptable criterion, although one which it would be difficult to employ for anything but a very long-term study, would be whether ex-clients who did become divorced and subsequently re-married, made a better choice of spouse or themselves were better at being a spouse the second time around than similar divorcees who had not been counselled!

In the context of marriage counselling in a general practice, some other possible 'concrete' outcomes emerge: whether patients attend surgery less frequently, go to work more regularly, and need fewer tranquilisers and anti-depressants. There is, however,

a need for caution when employing these criteria. For example, even if the incidence of prescription of psychotropic drugs does fall, this may indicate not an 'improvement' in the patient's emotional state, but that he or she has found an alternative way of coping with or expressing the frustrations of an unsatisfactory relationship. This may be the counselling itself, which, rather than resolving anything, merely provides an alternative 'prop', or it may be some other means, such as the use of physical violence.

Consumer opinion research

One possible way of avoiding the difficulties of a longitudinal study which encroaches on the counselling itself, and yet probing more deeply than these concrete measures allow, is to gather assessments of the impact of counselling, particularly from counsellors and clients, and, where the counselling is in the setting of general medical practice, from the doctors in that practice.

If we accept that those providing the service have some 'expertise' in the field, by virtue of their selection, training and experience, then their assessments must carry some weight. However, assessments solely based on the opinions of the providers are rightly regarded with some scepticism. It can be assumed that most marriage guidance counsellors, particularly as they receive virtually no payment for their work, believe that they are providing a valuable service, which does help at least a significant proportion of their clients. Insofar as they have a vested interest in the scope and status of marriage counselling, it could also be argued that there is an inducement to be optimistic about the effect of their work. In

related fields, such as social work, some research studies have suggested that the providers of the service are over-optimistic about its effects on the clients.(14) Others, on the contrary, have found the practitioners to be somewhat pessimistic compared with their clients, perhaps because of the afore-mentioned belief in the never-ending nature of counselling or casework.(15)

It is therefore desirable to have also an assessment by the clients in order to gain a more balanced picture. In the evaluation of any social service, the satisfaction of the recipients is one (although not the only) important factor. If the clients are asked how far and in what ways they feel the counselling helped them and/or their marriage, this would enable one kind of assessment of the impact of counselling to be made, even if it falls far short of demonstrating in any 'objective' sense whether or not the clients have undergone the aimed-for "emotional development" and "personality growth". (16)

It is important to emphasise that assessment based on client satisfaction does not enable a judgement to be made about the overall quality of the service offered. Satisfied clients have not necessarily received a satisfactory service by other criteria. Marsh and Kaim-Caudle discuss this in relation to patient satisfaction in general practice:

> "A dissatisfied patient of one doctor may have received better care than the satisfied patient of the same or another doctor." (17)

Rees, in his study of social work clients, also found that:

> "... positive or negative outcomes did not always correspond to clients' feelings of satisfaction or dissatisfaction." (18)

It was quite possible for clients to be satisfied even though the social worker appeared to have done nothing for them - even, in one case Rees quotes, when the client had simply been forgotten!

There are other difficulties in using client assessments as a basis for evaluating social services. For example, Shaw points out that it may be difficult for researchers (especially, one presumes, research-practitioners), attuned to the concepts and language of the providers of services, to carry out an evaluation in terms that the consumer can understand and respond to in a meaningful way. (19) Consumer responses may in addition be favourably biased and reflect a reluctance to criticise a likeable and well-meaning service provider. As Fahs Beck argues, in a review of American counselling studies:

> "... improvement may (be) ... reported for some reason other than real gains, such as a wish to please the counsellor, ... or a need ... to feel that his substantial investment in treatment was worthwhile." (20)

In the British context, the client is unlikely to have the same financial stake in success as his American counterpart, but he may have invested considerable time and emotional energy in counselling.

There are also problems in ensuring that the research is actually testing the whole spectrum of consumer opinion, rather than

a section of that opinion which is willing and able to be tested. To take an obvious example in interviewing counselling clients, the research is not reaching that section of consumers who do not agree or are not able to be interviewed, nor the population of potential consumers who were deterred by some aspect of the provision from ever actually contacting the counselling service in the first place.

The wider the spectrum of opinion tested, the more another dilemma is likely to become apparent: what Shaw calls the problem of 'conflicting preferences'. [21] Clients or consumers are unlikely all to voice the same preferences. The only way in which this dilemma can be resolved is if these different reactions and preferences can be fitted into some classificatory schemes; if they are associated with certain characteristics of the client, his problems, the agency and so on, and can be predicted from these characteristics.

These and many other methodological difficulties make it clear that neither the evaluation of counselling nor the testing of client opinion are straightforward matters. They present specific difficulties as well as the more general difficulties which seem to be inherent in much social policy research. Thus research in this area, if it is to be done at all, can be viewed as a series of compromises between what appear often to be contradictory aims.

There are several areas in which the issue of compromise seems to have been particularly relevant to researchers in this field:

Confidentiality versus the acquisition of knowledge

Firstly there is the compromise between confidentiality and the acquisition and spreading of knowledge, which is the primary purpose of research. The issue of confidentiality is one of the first to present itself to any researcher in the field of counselling. One of the fundamental assumptions of the counselling interview - and one on which the whole-hearted participation of clients may well depend - is that all that transpires within it is confidential. The concern of counsellors is thus understandable and something which must be shared by the researcher. It is, of course, one of the factors which have made follow-up studies of clients so difficult.

Problems arising from this issue arise at a number of points during a research project. Firstly, there is the problem of how to reach former (or current) clients. There may be some resistance among counsellors to the idea of approaching former clients at all, on the grounds that they should be able to put that episode of their life completely behind them, and should not be asked to talk about matters which may reopen old wounds. Any follow-up is thus argued to be unethical and to breach confidentiality.

Besides this general objection, there is the problem that other family or household members, especially spouses, may not have known that the client had consulted a marriage guidance counsellor. It would in this case be particularly unethical to make a direct approach to clients which was specifically concerned with their counselling experiences. Some studies [22] have avoided this problem by asking counsellors to select clients whose domestic

circumstances made a specific approach possible. However, this is immediately likely to exclude an important part of the client population. Alternatively, it would be possible to sample from the existing client population, during or at the end of counselling, with counsellors asking the clients directly for their participation.[23] This would be likely to identify the research project closely with the counsellor and the counselling agency, which may be felt to be a disadvantage.[24] It would also mean the likely loss of these clients who unexpectedly terminated their counselling - another potentially interesting group.

Research into counselling provided in a general practice setting does have some advantages in these respects. Clients are likely to have some continuing contact with the practice as patients. The widespread and non-stigmatising role of patient offers an opportunity to approach them without labelling them as marriage guidance clients. On a practical level, practice records are more likely than marriage guidance agencies to have an up-to-date address or at least to reveal that the client has left the practice and probably the area.

Problems arising from the issue of confidentiality are also evident in decisions as to how to conduct an interview with a client. Timms and Blampied found it necessary to reassure counsellors whose participation they were seeking that they would not probe into the details of clients' marital problems.[25] On the one hand, the researcher wants to respect the interviewee's right to privacy and to select what information he wishes to impart. On the other hand, the interviewer wants to obtain as full a picture as possible

of the counselling and the client's attitudes to it. Thus the question arises of how far, having gained the goodwill and co-operation of the interviewee, he should probe into areas which he senses are not being fully articulated, try to extract information and opinions relating to subjects which the client would not freely discuss. This is not only an ethical question, as creating feelings of antagonism, embarrassment and so on in the client may distort the interview material.

Confidentiality is also an important issue when it comes to the recording and publishing of research findings. If people are to express themselves freely, they need assurance that the findings of the research are recorded and published in such a way as to ensure their continued anonymity. The use of taped interviews enables the fullest and most accurate record to be made, but, on the other hand, tapes constitute a lasting and very personally identifiable record, even though researchers may stress that they will be destroyed after transcription.

As far as the publishing of findings is concerned, the fuller and more meaningful the picture that is presented, the greater the possibility of identification. Anonymity is particularly difficult in a small research study. Disguising names will not be enough in many instances to prevent the counsellors and other involved parties from recognising clients. The counsellors are also understandably curious about what has happened to their clients, some of whom they will have come to know very well. If the research involves interviewing service providers as well as clients about individual cases, the counsellors will already know who has agreed to be interviewed.

There may well in these circumstances be some pressure on the researcher, trusting the counsellors and anxious to be helpful, to satisfy their curiosity.

Independence versus involvement

The second set of compromises which seem to be particuarly relevant to this research study are those concerning independence as against involvement. This dilemma has several facets, but basically is composed of, on the one hand, the desirability of researchers having a degree of 'distance' from the subject of their research and, on the other hand, the desirability of researchers having an understanding of, involvement in and even commitment to that subject.

One facet of the dilemma is the question of whether researchers into the counselling should be counsellors themselves, or at least practitioners in a related area. To be a practitioner has considerable advantages. Counsellors have more familiarity with the subject matter and thus they are, it could be argued, less at risk of totally misunderstanding the nature and aims of the counselling. They are likely to more easily win the trust and co-operation of the counsellors whose clients are being studied, who may think of them as less threatening, knowing that they are likely to be committed to the same basic principles. They may be also more trusted by clients, having the status of members of a 'caring profession' in whom they have already placed their trust. The findings of practitioner-researchers may also hold more credibility in the eyes of other counsellors and thus be more influential. The

practitioner-researcher model has recently attracted support from the authors of 'Marriage Matters', who argue the advantages of people studying and researching into their own work.(26)

However, of course, there are disadvantages in this model. A commitment to the subject of study may blind the involved researcher to the possibility that some fundamental assumptions could be challenged. He or she has an inbuilt predisposition towards the improvement and expansion of that particular sphere of social policy, not towards its replacement and often not towards its radical change. He or she may well be more trusted by some clients, but others, particularly those with substantial criticism, may be more inhibited. The research findings of practitioner-researchers may achieve less credibility in the eyes of those outside the profession, who may have considerable policy influence. All this applies most strongly, of course, to those whose research involves their own clients and their own experimental schemes.

Another facet of the dilemma, especially for those outside the profession or service being considered, is that of maintaining this distance,with its advantages, yet gaining the maximum co-operation of practitioners and clients. Without this co-operation, research cannot be done at all, yet gaining it can be very time-consuming (a practical, but important point) and risks lessening the distance. The outside researcher can end up losing his advantages, yet not being enough of an 'insider' to share the advantages accruing to that position. The likelihood of co-operation, from service providers at least, is enhanced for the outside researcher if he is invited by them to conduct the research. However, in accepting this

invitation, there are already the beginnings of a moral obligation to produce something constructive and useful to those individuals. Subsequent discussions and growing acquaintance with them, and with their hopes and fears, all serve to increase this sense of moral obligation. Not only could this mean that a totally or very highly critical set of findings would be very difficult to publish, but, more subtly, it becomes less and less likely that the researcher will produce that kind of study. In talking to counsellors, for example, who are likely to be intelligent, articulate, kind and open people, it is difficult to completely avoid a certain incorporation into their perspective.

Service providers are also likely to be asked to give a significant amount of time to the research project and this further increases the moral obligation to produce something which is useful to them. Here, the interests and concerns of academic researchers and of practitioners are likely to diverge. Those concerned with the provision of a service want research which will give them clear guidelines for the future development of that service and which will give them a convincing weapon to use in the competition for scarce resources. Thus they want results which are not only favourable, but also definite, clear-cut and unambiguous. The researcher, concerned to preserve his academic respectability, may find it difficult to provide these. His interests may lie in the very complexities and ambiguities that make 'progress' in social policy and decisions among competing services so difficult to define and make. He will be concerned not to over-simplify his conclusions, to surround them with 'ifs' and 'buts' and 'maybe's'.

His academic status can also derive just as easily (perhaps more so) from critiques of policy and provision as from more favourable comments.

As far as clients are concerned, to achieve maximum co-operation it is necesssary, as much as with service providers, for the researcher to be presented as someone in whom they can put their trust, as someone to whom they can feel free to express their opinions. One of the problems with this is that different types of clients are likely to react differently to particular interviewer characteristics. Age, sex, accent, appearance and marital status, as well as the approach and the background of the interviewer, are all likely to be important, but it is difficult to specify in what ways they will influence the responses of particular clients.

In order to avoid, as far as possible, any 'contamination' of interview material, it could be argued that the aim of the interviewer should be to behave in such a way as to leave no impression of himself behind with those interviewed. This implies a very passive and almost business-like approach, which is likely to be difficult to maintain in sensitive areas of research, such as counselling. Some clients are likely to be lonely; most have gone through (or are still going through) very painful experiences. A friendly, encouraging, sympathetic approach is likely to thus be attractive to interviewer and client. However, the interview may well raise echoes of the counselling and an approach which is similar to that of the counsellor may mean that it is difficult to avoid the interview becoming, for the client, another counselling session. Added to this is the fact that clients, in the same way as counsellors,

are giving up their time and effort to the interviewer. Has, then, the latter any obligations in return, in terms of providing company, a sympathetic listener and so on?

Research design

A third area in which studies in this field have been concerned with compromises with the 'ideal' is that of research design. Some of the research reviews already referred to in this chapter [27] have in fact argued that a much better research design would have been possible in many studies, but all emphasise the complexity involved.

Many of the reviewers, together with most of the studies which they review, lie firmly in the positivist tradition. Positivism has a long-standing dominance as a method of approach to research in the social sciences and still holds considerable appeal. Taken from the natural sciences, it holds out the promise of objectivity, neutrality, replicability and certainty in its results. It stresses the expertise of the researcher and his distance from his subject-matter and thus enhances his status. It promises 'knowledge' as something distinct from values. In areas of research related to policy issues, a positivist methodology appears to be the one which can offer the clearest contribution to decision-making.

The positivist tradition as an appropriate model for the natural sciences has not been unchallenged.[28] However criticism of its adoption as a model for social research have been at two levels. Firstly, the inability of the social sciences to ever achieve the positivist ideal and secondly, the inappropriateness of this model

for research concerning reflective human beings, who attach meaning to their actions and behaviour.

For a social researcher who aspires to the positivist tradition of 'scientific research', the methodological ideal would be to have access to a large sample of the population in which he or she is interested; to be sure that the sample is representative of that population; to obtain a high, representative response rate; to be sure that respondents were willing to give and had the capacity for truthful, comprehensive and meaningful responses; to have detached and able interviewers of integrity; to be able to ask clear and unambiguous questions which do not predispose towards certain answers; and to be able to hold all factors constant, bar those which are being investigated. Social research projects, especially in this field, can never wholly achieve that ideal.

One issue concerns the size of the project. Many studies of counselling outcomes and client assessments have involved relatively small numbers, especially of service providers.[29] In the context of research in Britain into the provision of counselling in a general practice, a small-scale project does have certain advantages. There is a paucity of existing research and this is an innovatory form of service provision. A small-scale project enables all the interviewing to be carried out by one individual and makes it more feasible to utilise a relatively unstructured format which can enable the respondents to express themselves fully. On the other hand, there is no check on interviewer bias, such as may be possible if more than one interviewer was involved.

In small projects, there is also particular difficulty in separating out the effects of counselling from that of particular counsellors. The problem is less with a large sample, because individual differences are more likely to 'even themselves out'. It is also a problem which will be of lesser importance the more uniform the selection, training and consequent operation of counsellors. However, in the case of NMGC-trained marriage guidance counsellors, there is emphasis on the individual nature of counselling and the need for each counsellor to develop his or her own style.(30) In addition, except, very recently, in the first stages of training, no counsellor normally directly observes the work of a fellow counsellor. This means that assessments of the impact of a particular counsellor cannot be easily generalised to say anything about the impact of counselling in general. This may have added importance given the findings of some studies of psychotherapy which suggest that 'average' results (which may be very similar to those of control groups) in fact conceal wide variations in outcomes - i.e. some treatment and some therapists do good, some do no good and some actually do harm.(31)

A small-scale exploratory project can provide suggestions for the most fruitful directions of future research, and can increase understanding of the ways in which counselling makes an impact, positive and negative, on a group of particular people. However, a small and specific study means that it is very difficult to argue any 'firm' or generalisable conclusions - about marriage counselling in general practice, let alone about marriage counselling as a whole.

It may well be actually misleading to draw any conclusions for

policy from a study such as this. One major problem when attempting to judge the 'success' of any innovation in social policy is that those involved in experimental schemes are likely to be those who are proud of the work they do, who are keen to improve the standard of the service, and who are enthusiastic about the particular reforms proposed. Thus any attempt to generalise from an apparently positive result may well lead to disappointment. It does, however, seem likely that if the results are largely negative, the reforms would be unlikely to succeed with staff who are less proud of their work and less committed to reform.

Another area of compromise in research design in the positivist tradition is likely to be the response rate. Most studies, as well as being concerned with a population too large to cover completely, are dealing with a population who are not all accessible to the researcher. Thus it is often impossible to extract a manageable number of respondents from the total who are in all ways representative of the whole client population (even in those dimensions which are obvious and measurable). Samples are likely not to include those who have moved away, some of those approached may fail to respond and others may refuse to participate. In a variety of ways, both in terms of personal characteristics and in terms of experience of the service being investigated, those excluded in these ways are likely to be different from those included.

There are ways of maximising the response rate. For example, moral pressure can be exerted on clients to participate by using a direct approach from someone to whom they feel beholden or whose authority they respect (although this may well reduce the

representativeness of the sample and distort the integrity of client responses to the research interview). The well-tried procedure of requiring clients to opt out of participation rather than to opt in can be used.[32] Follow-up reminders to initial invitations are another virtually universal mechanism. Potential participants can even be offered more positive inducements, such as financial reward. However, none of these are likely to produce a 100% response rate and the usual rate for research studies in this area is far lower.[33]

Positivist research design also has to cope with the problem of controlling for extraneous factors which may influence the results of a research project. In this area, researchers are dealing with human beings in the 'real world' in all its infinite variety. It is impossible to hold all factors constant except those which are being investigated. Thus, for example, if it is found that a given counselling situation appears to be 'successful' relative to others, it is very difficult to tell whether this is due to the counselling itself, or due to any of the other, innumerable factors which could influence the outcome. There could be differences between individual counsellors, or individual clients, or between such external factors as housing, a change of job or income.

One frequently-used method of separating out the influence of external factors from that of the actual service being provided - of trying to assess whether the experimental group would have done as well without any service at all - is to use a control group,

matched as closely as possible with the experimental group, except that they do not receive the service. Exact matching is an ideal to which the researcher can only aspire, but, in the context of marriage counselling, this would mean having a control group with similar characteristics, including similar marital problems, but not receiving counselling. This has been done in some of the American studies that Fahs Beck reports on,[34] by randomly assigning some applicants to a waiting list and giving the others immediate counselling. This procedure raises quite serious ethical questions, but can perhaps be justified if applicants to the agency normally have to wait an appreciable time before their first appointment. In England, people seeking help from marriage guidance counselling agencies usually obtain an appointment at fairly short notice and it would be difficult to justify asking them to wait three to six months while the research study was carried out.

Another device Fahs Beck suggests is to treat those clients who only attend for one interview as the control group, on the basis that they have received virtually no service. This would be feasible, provided enough one-interview cases could be traced, but again this may be more appropriate for the American pattern of counselling - which is a highly-paid, professional task, more akin to psychotherapy - than for the British marriage guidance service, with its emphasis on short-term help. In the British context, one interview could be as helpful, given a particular type of problem, as ten.

There are more fundamental problems associated with the concept of a 'control group', which rests on the assumption that this group is a 'no-treatment' group. Much of the research which has argued

the lack of effect of psychotherapy and counselling has based this argument on the finding that the average rates of improvement of individuals receiving 'treatment' are very similar to the average improvement rates (apparently the result of 'spontaneous remission') of 'non-treatment' control groups.(35) However, one of the subsequent critiques of these findings has been the argument that on examination the control groups will often be found to have been 'contaminated', in the sense that they have received substantial help from professionals and from lay people.(36) This debate is an instructive example, not only of the difficulties of control groups, but also of the difficulties in delineating 'counselling' or 'psychotherapy' as a specific and limited expertise, rather than a human attribute which is shared by many non-specialists.

In spite of all these difficulties, many studies, particularly in the United States, have persisted in attempts to emulate the positivist model of natural science and they have been criticised by many reviewers in terms of their failure to achieve that model. This, as Maguire points out, is particularly anomalous in the case of practitioner-researchers who, while adhering to the theory of the uniqueness of the individual in their counselling philosophy, persist in concentrating on trends and averages, and generalisable conclusions in their research. She supports Bergin's argument for:

> ".... recasting the scientist-practitioner model in new terms of innovating practice and naturalistic inquiry rather than an integration of traditional practice and physics-style research ..." (37)

This highlights the fundamental issue of whether the positivist

model is appropriate in social science research. Hughes, for example, argues for the 'humanist alternative', on the grounds that:

> ".... in studying social realities, we are not dealing with a reality made up of 'brute fact', a reality of external 'thing-like' forces and objects, but one that is constituted by people related to each other through practices identified and given meaning by the language used to describe them, invoke them and carry them out."(38)

Much of the basic 'data'of social science research (the inner mental states of individuals, the nature of social groups) is not directly observable, but has to be formulated from various manifestations, such as individual behaviour, reported attitudes and beliefs and so on. The humanist approach challenges the positivist assumptions that observational categories are independent of theoretical ones, that these manifestations can be assigned any fixed and 'objective' meanings in terms of the social realities they reflect, and that the interpretation of the social researcher of these realities is necessarily the superior one.

Of course, critiques of positivism, as Hughes points out, have their own difficulties. An acceptance of the idea that forms of knowledge are grounded in social practice makes any search for 'social laws' very problematic, means that it is difficult to distinguish 'knowledge' from beliefs, opinions and values and seems to condemn social research to:

> "... an awesome relativity in which no one can claim better knowledge than any other." (39)

Hughes' interpretation of the role of social research using a

humanist approach is as:

> "... efforts to formulate what our societies, our culture, can mean, are capable of, may develop, exploring... 'our fundamental options in life' ... a moral enterprise". (40)

Of what might this approach consist? Denzin describes a humanist approach which he calls 'naturalistic behaviorism':

> "... the studied commitment to actively enter the worlds of native people and to render those worlds understandable from the standpoint of a theory that is grounded in the behaviors, languages, definitions, attitudes and feelings of those studied... The naturalist is thus obliged to enter people's minds, if only through retrospective accounts of past actions." (41)

The naturalist is somewhat eclectic when it comes to the choice of research methods:

> "He will admit into his analyses any and all data that are ethically allowable". (42)

However, a rejection of positivism does not mean abandoning all the traditional canons of science:

> "The naturalist is committed to sophisticated rigor. Which is to say he is committed to making his data and explanatory schemes as public and replicable as possible." (43)

Denzin also argues as does Wiseman in the same volume, (44) against the prior construction of theoretical frameworks within which specific hypotheses are formulated and subsequently tested and for a grounding of theory:

> "... in the behaviors of those studied. The naturalist resists schemes and models which oversimplify the complexities of everyday life." (45)

This leads on to a further area of compromise in social research.

Clarity versus complexity

Part of the appeal of positivism may be related to a further compromise between apparently contradictory aims in social research. The positivist scientific model holds out the promise (in theory at least) of producing clear, accurate and unambiguous results. On the other hand, the social researcher frequently finds that, to keep faith with his material, he should convey the variety of meanings and the complexity of responses and findings. The issue, then, is the compromise between clarity and complexity.

One point at which this dilemma must be tackled is in the decision as to how to collect the research material. For example, if client interviews are to be part of that material, the researcher must decide where his interviewing method will lie along the continuum from highly structured to unstructured. The more that interviews are structured, the easier recording is likely to be, the more straightforward and clear (although not necessarily accurate and meaningful) the findings will be to analyse and compare and the less evident opportunity there is for the researcher's own biases and misinterpretations to distort the material. On the other hand the more unstructured the interview, the more opportunity it gives clients to convey the complexity of their attitudes and feelings and to avoid the 'straightjacket' of predetermined categories of

response.

Semi-structured interviews are often chosen, which appear to ensure that, on the one hand, material is collected from each respondent which covers the same ground and thus offers the possibility of aggregation and analysis, and, on the other, clients can talk relatively freely. However, this 'middle-road' in fact risks having all the disadvantages and none of the advantages of either end of the structured-unstructured continuum. A large amount of material is likely to be collected and it will probably be difficult to fit into systematic categories. At the same time, the fact that those interviewed are guided in their responses to some extent, restricts the potential richness of semantic analysis that can be carried out.

The issue of clarity as against complexity is also crucial at the point of describing and analysing the material collected. The task is one of categorising, classifying and discerning patterns (a necessary process both in academic terms and in terms of deriving any lessons for practice and policy) but coping with the reality of data which often appears random and unique. This is, on a small scale, one facet of the paradox of human individuality and societal patterns. Timms and Blampied, as noted above, found this is a paradox particularly pertinent to counselling research.[46]

As they imply, this characteristic places a considerable responsibility on the researcher, who has to decide how to edit and 'make sense' of the responses of his subjects. Even if interviews are fully tape-recorded this editing process has to occur at the point of analysing the material if the result is to be more than a

series of full transcriptions. The researcher chooses which material to include and which to exclude, and where to lay the emphasis. Particuarly in studies of a qualitative nature, it would be quite possible to use the same material to support several, quite different interpretations. The temptation is always to choose those responses which 'make sense' rather than 'nonsense' in the researcher's terms.

Complexity must also be acknowledged when concepts such as 'helpfulness' or 'satisfaction' are being used. In client opinion studies, even if the maximum co-operation is forthcoming from clients, the question arises of how adequate global and unilear concepts such as these are, as a meaningful measure of the complex of feelings and attitudes that they may well have. It does not easily allow, for example, for clients satisfied with some and not other aspects of the service provided. 'Satisfaction' thus needs breaking down into its component parts.

Hughes discusses the use of scaling procedures in the measurement of attitudes in some detail. He makes the important point that:

> "The open-textured quality of ordinary language which the investigator tries to remedy, in part at least, by the provision of forced-choice answers ...., place a question mark against the assumption that the researcher and the respondent share 'the same community of... meaning.....' If this assumption of meaning equivalence cannot be upheld then it is no longer clear in what sense it can be said that the attitude measure is a measure at all" (47)

There are other problems with concepts such as 'satisfaction' and 'helpfulness'. For example,they only make sense in a particular

context and are not easily comparable between individuals and over-time. One individual's satisfaction may be another's dissatisfaction, or the same individual's dissatisfaction at a different time, depending on the type and level of expectations and a whole host of other factors.

If these problems of conceptualisation can be overcome or at least recognised and minimised, there are still others which relate particularly to the issue of providing policy guidelines and information useful to practitioners. For example, how satisfied is satisfactory? How helpful is helpful enough? Given that no service is ever likely to meet the needs and wishes of all the relevant population totally, which proportion of clients have to be how dis-satisfied before change is deemed necessary? If there is a significant degree of dissatisfaction, this could imply change in a variety of ways: an improvement in the quantity or quality of the service; a change in its nature; an abandoning of the service; better education of clients so that they are better able to take advantage of the service; or a better filtering of prospective clients so that only those who are appropriate reach the service. Lastly, there is the issue of the validity of client as against service-provider, especially 'professional' opinions. If these opinions differ substantially, as some studies have found,[48] this may be in itself an interesting academic finding, but is difficult to translate into policy implications, unless one has a notion of a hierarchy of validity of those opinions.

Summary and conclusions

Research into counselling outcomes and research into consumer opinions both face difficulties in achieving methodological respectability and acceptability and in providing guidelines for practitioners and policy-makers. The individualisation of counselling and the reluctance to specify any but the most general aims pose problems for the measurement of outcomes. Indirect indicators, such as reductions in the use of medical services, may not in fact reflect improvements resulting from counselling. Using the assessments of the service recipients pose problems of method, interpretation and the relationship between client satisfaction and quality of service.

Thus compromise between conflicting aims seems to have been a prominent theme in research in these areas:between the need for confidentiality and the desire to acquire knowledge; between the desirability of 'distance' between the researcher and the subject of his research and the advantages of close involvement and strong commitment; between the 'ideal' and the 'possible' in research design; and between the desire for clear and unambiguous research results and the need to be faithful to the complexity of human reality. Many of these compromises, especially in the area of research design, have been expressed in the terms of a positivist ideal in social science. However, it is argued that it may well be that positivism is an inappropriate model and that a humanist approach, despite its problems of relativism, may offer a more meaningful interpretation of social phenomena.

It is clear from the above prolonged, although still not exhaustive discussion, that research into marriage counselling outcomes poses many methodological problems, to most of which there are no complete answers. This makes salient the question of whether research in this area should be attempted at all. Perhaps the resistance of some professionals to evaluations of their work and to following up clients is justified.

Samuel Butler once said:

> "life is the art of drawing sufficient conclusions from insufficient premises" (49)

The crucial factor that should determine whether or not research is carried out in a particular area is not how easy it will be to devise a study of methodological perfection or which will offer clear policy guidelines, but how important it seems to the researcher that the field should be studied. Marriage, like it or not, is a very important area of social life, and its stability is seen as essential to the maintenance of society by many people.(50) Given the apparent importance of marriage, the provision of marital counselling services assumes a consequent importance.

On this basis it could be argued that however difficult it is and however imperfectly a study can be carried out, a systematic assessment of the impact of marriage counselling should be attempted. The researcher's task is to practice Samuel Butler's 'art' to the best of his or her ability. The rest of this study describes such an attempt, beginning, in the next chapter, with a discussion of research methods.

Chapter 5

The Medical Centre Study - Research Methods

In this chapter the research methods used in the present study are discussed, in the light of some of the issues raised in chapter 4. The setting-up of the study; the selection of clients to interview, the approach to them and their representativeness; the interviewing and the subsequent analysis, are all described.

Outline of Research Methods

The approach employed was primarily a humanist one, emphasising the importance of the meanings attached by participants to the provision of a counselling service and their individual experiences of the impact of that service. This approach seemed to be particularly appropriate taking into consideration both the subject matter of the study and its exploratory nature.

The study also utilises the eclectic approach to research methods advocated by Denzin.[1] In addition, the attachment of primary importance to the meanings attributed to social action by participants does not diminish the value of attempting to be as systematic and rigorous as possible in the sampling of the population, the method of approach and the analysis of the data collected. As Hughes argues, the 'moral enterprise' model of the humanist approach:

> "... does not imply an end to rational thought, the careful assembly of evidence, the dedicated exploration of ideas in the spirit of science, but it may guard us against trying to

resolve such issues by a slavish recourse to routine method." (2)

The study fell into two parts:

(i) a description and analysis of the provision of a counselling service in a general medical practice,

(ii) an exploration of the impact of this service on particular clients.

Data for the first part of the study were obtained by talking to those involved as 'service-providers' (i.e. the counsellors and G.Ps.) and as 'service-recipients' (i.e. the clients) and also by analysing information provided by the counsellors on the characteristics of all the clients they had seen between the beginning of 1975 and the end of 1978.

Data for the second part of the study was obtained primarily through interviews with former clients, their counsellors and G.Ps., but also through a limited examination of some medical records. The main study interviews were preceded by a pilot study. The client interviews formed the major part of the fieldwork - in terms of numbers, duration and depth. Thus the study was first and foremost one of client opinion, with material about individual clients from counsellors and G.Ps. (and in some cases from medical records) being seen on the whole as a counterpoint to the client interview material.

The clients were approached by means of a short postal questionnaire and a letter signed by their G.P. and sent out by the practice secretary.

a copy of this letter and questionnaire can be found in Appendix I. The clients were asked to indicate which of a list of practice services they had utilised during the past few years, and about which of these they would be prepared to be interviewed by the researcher. Marriage guidance counselling was included in the list. It was stressed in the letter that the practice was always concerned about the satisfaction of patients with the services offered, and that a response to the questionnaire would help the practice to provide a better service in the future. The independence of the researcher from the practice was also stressed, as was the confidentiality of the interviews. A stamped envelope, addressed to the researcher at her university, was enclosed for the return of the questionnaire. The letters and postal questionnaires for the pilot study were sent out to all the clients in the sample together, but those for the main study were sent out in groups of between 20-30 at approximately fortnightly intervals, to enable the researcher to contact respondents and arrange an interview as soon as possible after they replied. Reminders were sent out after a few weeks. The three counsellors and the five G.Ps. involved were also interviewed. They were approached through a telephone call, followed by a personal letter from the researcher. (see Appendix IV).

The interviews with clients, and with the counsellors and G.Ps., were all carried out by the same researcher, using a semi-structured interview schedule which acted mostly as a guide to areas to be covered and as a memory refresher (a copy of the schedule can be found in Appendix II). The respondents were encouraged to talk freely, without adhering to any particular pattern. The researcher took notes during the interview and subsequently wrote these up in fuller form as soon as possible (usually immediately) after the interview

and always within 24 hours.

The pilot study was carried out to test the interview schedules and the response rate from clients. The sample for this consisted of all the 27 cases since January 1975 (which included 37 clients) of the counsellor who had initiated the practice attachment (see Table 1). These were chosen because it was not certain how much time this counsellor would be able to give to the study in the months ahead, given her substantial family commitments.

Table 1 The pilot study client sample

	No. of clients	No. of cases
All clients of counsellor A from January 1975:		
total sample	37	27
moved	14	10
'active' sample	23	17
no response	2	-(1)
refused	4	2(2)
not contacted	1	1
interviewed	16	14

(1) cases where no response from any of clients involved

(2) cases where client(s) refused and no client interviewed.

It was found that 14 of the 37 clients had subsequently moved away from the area and had left the practice. This is a very considerable number and may be an indication of greater mobility on the part of those with marital or other relationship problems. Thus an 'active' sample of 23 clients remained. A response was received from 21 of these (15 women and 6 men). Seventeen of these agreed to be interviewed (3 men and 14 women) and all but one of these were

eventually seen. The one omitted failed to turn up to two appointments and was discovered to be currently seeing a counsellor at the practice, as well as a psychiatrist, so it was decided not to pursue her further.

The interview schedules for the counsellors and the G.Ps. were also piloted, by interviewing one G.P. and the above-mentioned counsellor. A discussion of four of the clients interviewed was included.

The main study included all those clients who had first seen one of the counsellors between June 1976 and December 1978. This produced a population of 204 clients. (see Table II)

Table II The main study client sample

	No. of clients	No. of cases
All clients of counsellors B and C from June 1976 to December 1978:		
Total sample	204	145
moved	41	29
still being counselled	16	9
not practice patients	6	-
already approached	8	6
counsellor requested no approach	7	5
'active' sample	126	96
no response	27	13 (1)
refused	30	21 (2)
not contacted	2	2
interviewed	67	60

(1) cases where no responses from any of clients involved

(2) cases where client(s) refused and no client interviewed.

However, of these,78 had to be excluded for a variety of reasons: 41 had moved from the practice; 16 were still being counselled; 6 were not patients at the practice; 8 had already been approached during the pilot study; and the counsellors requested that 7 clients should not be approached.

Of the 126 who remained and were subsequently contacted, 67 agreed and were subsequently interviewed, 30 refused to be interviewed and 27 did not respond. One was in hospital and one could not be contacted.

Interviews were also conducted with the two remaining counsellors and with all the five G.Ps. of the practice.

This, then, is a brief outline of the methods used in the research. Particular aspects of these methods will now be examined in more detail.

Initiation of the study

The general practice involved in the study was a particularly research-orientated one, and was already known to the researcher through a previous study carried out by a colleague and one of the G.Ps. She became involved when this same G.P., aware of her interest in the concept of 'team care' in general practice, approached her with the suggestion that she may like to 'evaluate' the counselling service which was then the newest addition to that team care.

Two salient points are thus already evident which were discussed in chapter 4. Firstly, the practice was by no means a typical one -

indeed, it seems to have been the very first to initiate a marriage guidance counselling 'attachment' scheme and certainly the first to report on it.[3] Secondly, the researcher, although not a practitioner, nor with any previous involvement in the marriage guidance movement, had been invited to conduct the study, by at least one of the service-providers (and subsequently found the others willing to co-operate as fully as they were able). She was thus faced immediately with the 'independence versus involvement' dilemma.

The small scale of the study

It is also already evident that the proposed study was on a small-scale, involving one general practice, three counsellors and five doctors (plus a few locum and trainee doctors) and a total client population of 204 in the main and 37 in the pilot study.

The small size was in part an intended and desired feature of the project. Given the paucity of existing research and the relatively innovatory nature of the counsellors' work, a small-scale, exploratory study seemed appropriate. The numbers were such that it was possible for one researcher to carry out the study. It was hoped that it would provide, firstly, guidelines for future research on a larger and more generalisable scale and, secondly, an increase in our understanding of the ways in which counselling made (or did not make) an impact, positive and/or negative, on a group of clients. Small numbers also facilitate the conveying of the complexities and ambiguities which, it was argued in chapter 4,[4] are an inherent feature of the social world and thus of social research.

Similar arguments can be used to justify the absence of a client (or service-provider) control group in this study. The central concern was not to determine in any 'objective' positivist sense (if this is ever possible) whether individual clients would have fared any better or any worse without counselling, but to look in some depth at the perceptions of clients, counsellors and G.Ps. regarding the helpfulness or otherwise of counselling. Thus, the issue of the influence of 'extraneous' factors on the individual's life as compared with the influence of counselling was tackled at the same level: clients were asked how important the counselling had been in comparison with the contribution of anyone or anything else to their attempts to cope with their problems.

Obtaining the client interview sample

As the number of service-providers involved in the study was small, they were all interviewed, except for one G.P. who had left the practice. However, one counsellor (the one who had initiated the attachment) was unable to give much time to the study, because of heavy domestic responsibilities. It was thus decided that her clients (37 in all) should constitute the population for the pilot study.

The client population with which the research was concerned comprised, most broadly, all the patients of the Medical Centre who had been seen by one or more of the counsellors since January 1975. For the main study interviews it was decided to exclude clients who had commenced counselling prior to June 1976. This was because it was considered unreasonable to expect the clients of

more than three years previously to recall the experience of counselling and its impact with any clarity. In fact, the pilot study, which included clients who last saw the counsellor up to 3½ years prior to their interviews, did not support this assumption.

This client population (including the 37 clients of the pilot study) totalled 241 individuals up to the end of 1978. It was not possible to approach all these for an interview. On the one hand, given that the interviews were expected to be fairly lengthy and were all to be conducted by one person, who could only devote herself part-time to the study, 241 interviews were considered impracticable. On the other hand, as has already been noted, characteristics of some of the potential respondents ruled them out. Some had moved away from the practice and from the area. Others would not be registered with the practice, but would be included in the sample because their partners were patients. In these cases the method of approach outlined below would not enable them to be contacted. A few individuals were recorded two or even three times, because they had seen more than one of the counsellors. In a very few cases, the counsellors asked that the clients should not be approached - either because of the very sensitive nature of the problem, or because counselling was continuing. In these ways 92 of the 241 individuals were excluded, leaving an 'active' sample of 149. (see Table III)

Table III The total client sample

	clients		cases	
	No.	%	No.	%
Total sample	241	100	172	100
moved	55	23	39	23
still being counselled	16	7	9	5
not practice patients	6	2	-	-
already approached	8	3	6	3
counsellor requested no approach	7	3	5	3
'active' sample	149	62	113	66
'active' sample	149	100	113	100
no response	29	19	13	12 (1)
refused	34	23	23	20 (2)
not contacted	3	2	3	3
interviewed	83	56	74	65

(1) cases where no response from any of clients involved

(2) cases where client(s) refused and no client interviewed

Already, of course, the representativeness of the sample was in doubt. To take the most obvious example, the 55 people who had moved away from the area may well have characteristics which are different from those who have stayed. One can hypothesise that they are more likely to be young, single, not originating from the area and/or more mobile in their employment. They may be those who are moving to make a 'fresh start' in an existing relationship, or a 'clean break' from that relationship.

However, left with a population of 149, the question then arose as to whether any systematic sampling would be necessary to

to reduce these numbers to more manageable proportions. The answer depended on the response rate. As it turned out (see discussion below) this was of the order to make systematic sampling unnecessary. This avoided the problems of deciding how to sample, but increased the doubts about the representativeness of the sample.

The method of approach to the clients

In any research study which depends on the active, voluntary participation of individuals, the method of approach is obviously crucial. The aim is to produce the maximum number of respondents willing and able to co-operate. It is reasonable to suggest that this may be most likely to be achieved if the approach is one that assures confidentiality, minimises the 'costs' to the respondent and maximises the 'benefits' to the respondent. A high response rate may also be achieved, as discussed in chapter 4,[5] by exerting moral pressure on clients to participate through a direct approach from someone to whom they feel beholden or whom they respect.

The method of approach to the clients has been described above. It ensured that there was no breach of confidentiality, in that the researcher did not know the identity of clients unless they replied to the questionnaire. The possible embarrassment of clients especially in cases where the spouse or other household members were not aware that they had seen the counsellor was also avoided by this general approach, which asked about a whole range of practice services. There were also positive advantages in that information was obtained about the clients' use of other services and, in the interviews, about their degree of satisfaction with these.

It minimised the 'costs' to respondents, both in the financial sense (a stamped envelope was included) and in other ways. For example, the postal questionnaire was brief and simple and the maximum choice was given as to the timing and place of interview. The letter stressed the 'benefits' to the practice (and thus to patient care) of patient assessments of the services provided. Replying to the researcher's university rather than back to the practice emphasised her independence, although some link with the practice was retained. This was designed to reassure clients that their continuing care from the practice would not be prejudiced by their discussions with the researcher, yet to emphasise that their G.P. knew about and supported the research.

The method of approach did mean that the costs to potential respondents of <u>not</u> participating were also quite low. They were required to opt in rather than opt out of an interview, and the structure of the questionnaire, together with the fact that it was to be returned to someone outside the practice, was such that it was quite easy to deny having ever seen the counsellor. However, some moral pressure was exerted: the initial letter was signed by the G.P., who may well be a figure of some authority and power in the individual's life; and reminders were sent out to initial non-respondents.

The approach used was only chosen after considerable discussion and was considered to be both ethical and the best way of preserving confidentiality. However, the fact cannot be ignored that it does involve some measure of deviousness on the part of the researcher. This was only brought home to her when there was a risk of this being

uncovered. For example, it so happened that one interviewed client was also employed in research at the practice, and it was therefore felt necessary to warn the rest of the practice staff not to mention the 'marriage counselling research' to her. This must raise the issue of whether this concern would have been felt if the researcher had had no reservations about the ethics of the approach.

However, overall, the approach seemed to work well. When interviewed, the clients were quite willing to focus on the counselling they had experienced, while the researcher was also able to obtain some useful information on the use of other practice services and their levels of satisfaction with these. A very small number had agreed to be interviewed without mentioning that they had seen the marriage guidance counsellor but this was found not to be a deliberate omission, but due either to uncertainty over her title or a feeling that they had not seen sufficient of her to be able to comment on the service. It was found to be quite easy to then steer the interview round to the counselling. Only in one case did a respondent consistently maintain that she had not seen the counsellor.

The client response rate

The original outline of the research project envisaged a response rate of only around 30%, given the delicate nature of the subject matter. As can be seen from the above description of the pilot study, the response rate from those who were approached (the 'active' sample) exceeded all expectations. Sixteen of the twenty-three clients agreed and were subsequently interviewed.

The response in the main study was not as high, (67 interviewed out of 126 approached) although it was still more than had originally been anticipated. Taking both the pilot and the main study together, of those approached, 83 people (56%) were interviewed, 34 (23%) refused, 29 (19%) did not respond and 3 (2%) could not be contacted. (see Table III)

The 'active' sample of 149 clients were involved in 113 cases (i.e. some cases involved two partners). As in some cases one partner agreed to be interviewed while the other did not, this meant that the proportion of cases contacted was higher than the proportion of clients: 74 out of 113 (65%) (see Tables I to IV for the detailed figures).

Table IV Clients interviewed and cases contacted as a proportion of total client and case population in sample

	Proportion of total sample		Proportion of 'active' sample	
	Clients %	Cases %	Clients %	Cases %
Pilot study (16 clients in 14 cases)	43	52	70	82
Main study (67 clients in 60 cases)	33	41	53	63
Total (83 clients in 74 cases)	35	43	56	65

This response rate produced the maximum number of interviews with which the researcher could cope, in terms of the time available for the fieldwork. However, the question has already been raised

of the representativeness of the resulting sample.

Two aspects of this representativeness can be considered. Firstly, how similar were those interviewed and those not interviewed in terms of their 'input' characteristics - for example, their demographic and socio-economic characteristics, the number of interviews and their perceived problems? Secondly, how similar were the two groups in terms of their 'output' characteristics - for example their level of satisfaction with the service, the ways in which they felt they had been helped/not helped and their subsequent history?

Neither of these aspects can be fully elucidated but we can investigate both to some degree.

In some ways, the 'input' characteristics of those interviewed were very similar to those of the total client population. For example, the types of problems that the counsellors recorded showed very similar profiles, with 'personal traits' recorded in around two-thirds of cases and 'sexual difficulties' in over one-third.(see Table V) The marital status of interviewed clients also broadly reflected that all the clients, with around three quarters of the total married and living together, around one-tenth married and living apart, a similar proportion single and the remaining few cohabiting. (see Table VI)

Table V Types of problems (counsellor-recorded) of clients interviewed compared with total client population in sample

	clients interviewed		total client sample	
	No.	%	No.	%
management of money	7	9	22	11
sexual difficulties	27	36	77	40
infidelity	9	12	27	14
personal traits	51	69	125	65
social factors	2	3	12	6
interference from relatives/ difficulties with child	8	11	23	12
desertion	5	7	9	5
other	8	11	15	8
unspecified	-	-	2	1

(total is more than 100% because more than one problem mentioned for some clients)

Table VI Marital status of clients interviewed compared with total client population in sample

	clients interviewed		total client sample	
	No.	%	No.	%
married, living together	62	75	188	78
married, living apart	10	12	18	7
cohabiting	4	5	10	4
engaged	-	-	3	1
single	7	9	21	9
divorced, living together	-	-	1	<1
Total	83	100	241	100

However, there were some significant differences. The most obvious is sex. Over three-quarters of those interviewed were female, whereas women comprised a smaller majority (about 64%) of all the clients. (see Table VII) This overrepresentation is likely to be a result of a variety of factors, including the methodology of the study itself and the clients' inclinations and opportunities. The sampling method, as already explained, excluded those spouses who were not practice patients (6 in number) and these were all male. Women are also more likely to be at home during the day and therefore more able and willing to give the time necessary for an interview (although the researcher did make it clear that she would see people in the evening and at weekends). When responding to the postal questionnaire, the clients were aware that the interviewer would be a woman and this may have had some effect. In addition, women were more likely to have been the primary referral and to have had the largest number of interviews. Perhaps, therefore, they were more likely to feel that they could contribute to an assessment of the counselling service.

Table VII Sex of clients interviewed compared with total client population in sample

	clients interviewed		total client population	
	number	%	number	%
men	20	24	87	36
women	63	76	154	64
total	83	100	241	100

There was also some variation in terms of age. (see Table VIII)

No one under 20 years old was interviewed, (whereas these comprised 5% of clients) and the under-30s were under-represented as a whole. This is partly accounted for by the greater geographical mobility of these younger age-groups. Correspondingly, the older age-groups were overrepresented among those interviewed.

Table VIII Age of clients interviewed compared with total client population in sample

	clients interviewed		Total client population	
	number	%	number	%
< 20	-	-	13	5
20 - 29	18	22	71	29
30 - 39	35	42	87	36
40 - 49	16	19	41	17
50 - 59	9	11	18	7
60 or over	5	6	7	3
not known	-	-	4	2
Total	83	100	241	100

Social class seemed to be another dimension along which those interviewed were not strictly representative of clients as a whole. (see Table IX) It is impossible to analyse this with any degree of precision as the social class categorisation of the counsellors (based on the occupation of the head of the household) was found not to be very accurate, but could only be checked in those cases where clients were interviewed. They had, following the pattern of the data published in the Heisler and Whitehouse [6] study, recorded the class rather than a specific occupation and failed to differentiate between class III (non-manual) and Class III (manual). This division

may well have been a significant one in the context of the response rate and of the outcomes of counselling. However, in general terms, it seems that clients of a higher social class were more likely to be interviewed. For example, of 233 clients (the remaining 8 of the 241 clients recorded by the counsellors were 'double-counts'),46% of those categorised as social class I or II were interviewed, compared with 37% of social class III clients and 23% categorised as social class IV or V. This was partly due to the greater numbers of lower social class clients being excluded from the survey because, for example, they had moved from the practice. However, the response rates among the active sample of 149 showed a consistent relationship to social class as well. About two-thirds from social classes I and II were interviewed compared with 56% from social class III and under a half from social classes IV and V. One minor, but interesting point is that of the six women dependent on social security in the sample, five were interviewed. The other one was still a continuing case.

Table IX Clients interviewed, by social class (RG70), as a proportion of total and of 'active' client population in sample

		total sample		'active' sample	
		number	%	number	%
I and II	interviewed	33	46	33	65
	not interviewed	39	54	18	35
	total	72	100	51	100
III	interviewed	28	37	28	56
	not interviewed	48	63	22	44
	total	76	100	50	100
IV and V	interviewed	16	23	16	46
	not interviewed	53	77	19	54
	total	69	100	35	100
other	interviewed	6	67	6	86
	not interviewed	3	33	1	14
	total	9	100	7	100
not known	interviewed	-	-	-	-
	not interviewed	15	100	6	100
	total	15	100	6	100

Finally, there were some differences between clients who were and who were not interviewed as regards the number of counselling interviews they had. (see Table X) However, the only marked difference was, as one may expect, some under-representation of those who only had one interview.

Table X Number of counselling interviews of clients interviewed compared with total client population in sample

	clients interviewed		total client population	
	number	%	number	%
1	6	7	45	19
2	13	16	32	13
3 - 5	28	34	67	28
6 - 10	12	14	39	16
11 - 20	15	18	39	16
< 20	9	11	19	8
total	83	100	241	100

If we turn to output characteristics, any conclusions have to be based even more on speculation. If we look at case-history, as recorded by the counsellors, the clients interviewed are very similar to those not interviewed. (see Table XI) Among both groups, over four-fifths of cases ended after discussion between client and counsellor, and virtually all the remainder finished when the client stopped coming without any discussion.

Table XI Case - history of cases in which clients interviewed compared with total case population in sample

	cases in which clients interviewed		total case population	
	number	%	number	%
closed after discussion	64	86	140	81
referred	1	1	3	2
client stopped coming	9	12	26	15
other	-	-	2	1
not known	-	-	1	1
total	74	100	172	100

It would be reasonable to suggest that the respondents may not have been representative in terms of their levels of satisfaction with the counselling service. It may be that those with a high level would want to express that satisfaction as a way of saying 'thank-you' to the counsellor. Those who were dissatisfied may be reluctant to criticise, especially as they may be continuing to use other practice services. The efforts of the researcher to emphasise her independence and the confidentiality of interviews may not have been completely successful. Alternatively, those who felt strongly either way may be more likely to agree to be interviewed than those with mixed feelings or without a clear opinion. It is difficult to assess the validity of these hypotheses, but among those interviewed there were those who were very satisfied, those who were very dissatisfied and those who felt ambivalent. Thus all groups were represented, but the balance between them may have been untypical.

Another way in which the 'output' characteristics of those interviewed may have differed from those not interviewed, is in terms of what happened after counselling ceased. The likely characteristics of those who had moved away have already been mentioned. Even among those still with the practice, those whose relationship had subsequently broken down and/or who had formed a new relationship in which they were concerned not to 'rock the boat', may have been less willing to be interviewed. Again, all that can be said is that a wide range of subsequent histories was represented, but maybe in an unrepresentative balance.

To sum up, there are no apparent dimensions of difference

between those interviewed and those who either refused or did not respond which are of such a magnitude as to render the material collected so distorted as to lose all validity and meaning. However, there are some evident differences (and may be others which were not recognised) which make it necessary to preserve a certain caution in generalising from that material to talk about the clients as a whole. This of course only serves to reinforce the essentially exploratory nature of this study.

The interviewing methods

Interviews were conducted with 83 clients,with three counsellors and with five G.Ps.The client interviews lasted, on average, about one hour, although they varied from half an hour to some interviews of well over two hours, depending on the individual's willingness to talk in detail about the counselling, and the amount of time they were prepared and able to give. The counsellor and the G.P. interviews also took varying amounts of time, reflecting in this case not so much a variation in the time they were prepared to give up, or in the detail of their responses, but more the differences in the number of clients or patients whom they had counselled or referred, and who had been interviewed. That part of the interview which was concerned with counselling in general practice lasted about one to one and a half hours. In discussion about individuals, the counsellors on the whole had more to say and certainly had more detailed case-histories from which to work. With some notable exceptions, the G.Ps. could only comment relatively briefly and sometimes not at all on their referred patients.

Clients were given the option of being interviewed in their own homes or at the practice premises. Most chose the former. For those who came to the practice the interviews were conducted in an office which was neither used for counselling nor for surgeries. With the exception of the counsellor who no longer worked at the practice, all the counsellor and G.P. interviews were conducted at the practice.

All interview schedules were piloted as described above. No changes were made to those for the G.Ps. and the counsellors. It was found that the questions did cover all the information required. There were some minor modifications made to the client schedule, mainly involving some extra questions which the researcher had, in practice, included in her later pilot interviews. Thus the pilot and the main study interviews are to a large extent comparable. Where this is not so, the differences will be noted in the discussion of the study's findings. Both versions of the client schedule were circulated to the practice G.Ps. and representatives of the local and national marriage guidance organisation for comment and approval.

As mentioned above, the interviews were all carried out by the same person, using semi-structured schedules. The aim was to gather material from each respondent which covered the same ground, and which could thus be compared, but at the same time to encourage the maximum freedom of expression. A completely unstructured interview would have made any collecting together and comparison of material very difficult and it was decided that the researcher should impose to a certain extent, her views on the relevant areas of discussion. On the other hand, it was not felt that an assessment such as this of

the impact of counselling could be fruitfully undertaken by means of a tightly-structured interview schedule, which could predispose to 'yes' and 'no' responses. Clients could find it easier to talk about very personal and maybe painful subjects and experiences in the context of a relatively open interview. For clients, counsellors and G.Ps., the freedom of expression enabled them to convey the complexity of health and personal problems and of assessing what impact, if any, counselling had had. Moser and Kalton argue that:

> "... where the survey subject is highly complex or emotional, it may be that the greater flexibility of the informal approach succeeds better than set questions in getting to the heart of the respondent's opinion." (7)

As they point out, interviews can have varying degrees of informality. The interviews in this research show some similarity to those described as 'focused' by Merton and Kendall.[8] They describe four characteristics of a focused interview:

(1) the persons interviewed are known to have been involved in a particular concrete situation;

(2) the hypothetically significant elements, patterns and total structure of the situation have been previously analysed by the investigator;

(3) on the basis of this analysis, the investigator has fashioned an interview guide, setting forth the major areas of enquiry;

(4) the interview itself is focused on the subjective experiences of the persons exposed to the pre-analysed situation.

Merton and Kendall draw many of their examples from studies where the investigator was able directly to observe the 'concrete situation', for example, to view a film or television programme which respondents had seen. In this research, the counselling sessions were not directly observed in this way, thus it was impossible to carry out 'content analysis' in the way Merton and Kendall describe. However, in the use of an interview guide, the focus on subjective experiences and attitudes, and the emphasis on giving the subjects the opportunity to express themselves about matters of central significance to them, rather than those presumed to be important by the interviewer, the interviews of clients, counsellors and G.Ps. in this study were modelled on Merton and Kendall's pattern.

Choosing the 'middle-road' of a focused or semi-structured interview, while being an attempt to avoid the disadvantages of either extreme, risks, in fact, falling victim to the disadvantages of both and the advantages of neither. A substantial amount of material was collected of a nature and range which made systematic comparison and the categorisation of responses a difficult, although not impossible task. The manual recording (by writing notes) of the interviews was far more difficult than would have been the case if less open-ended questions and a more tightly-structured schedule had been used. This inevitably raises questions about the interviewer's selection of 'important' and 'relevant' information to record. Encouraging respondents to talk freely, by means of a sympathetic approach, assurances of confidentiality and appropriate 'prompts', raised for some clients echoes of counselling and so it was on occasion difficult to prevent the interview becoming another 'counselling' session.

On the other hand, the fact that those interviewed were guided in their responses to some extent, combined with the decision not to tape-record the interviews (on the grounds that this would risk inhibiting the responses) did restrict the potential richness of the analysis which could be carried out.

However, given the aims of the interviewing - to look at the impact of counselling on individual clients and their relationships, and at the same time to make some assessment of the provision of a counselling service in a primary health care setting - the use of 'guided free responses' seemed to be the best method. The fact that all the interviews were carried out by one individual - the researcher herself - meant that familiarity with the possible pitfalls was acquired during the first few pilot interviews, and that at least any bias of which she was unaware was likely to be a consistent one.

The analysis of interview data

The analysis of the data from interviews, especially from the 83 client interviews, proved immensely complex and time-consuming. The starting-point was the set of notes written up soon (usually immediately) after the interview, in which the interview material was organised as far as possible into an order consistent with the interview schedule. Some of the material was coded and transferred onto Copeland-Chatterton punch cards: one relating to each client interviewed. Details of this material and its coding are given in Appendix III. It consisted of some demographic data, such as age, sex, marital status; some data relating the client to the practice and the counselling (G.P., counsellor seen, number of interviews,

whether spouse seen and so on); and some data which reduced to their simplest elements the responses to more complex issues arising during the interview. For example, the responses to questions about the helpfulness of counselling were categorised as 'yes'; qualified yes/yes and no; no. Most of the data was from the client interviews, but some (counsellor's and G.P's.opinion on helpfulness of counselling; G.P's.reason for referral) derived from that part of the G.P. and counsellor interviews which related to individual clients.

The use of punch-cards facilitated some simple cross-checking and cross-tabulation of the interview material. However, as Moser and Kalton point out, one of the chief advantages of 'informal' interviews is that they enable a more complete picture of a person's attitude to be obtained than would be possible through a formal interview:

> "If this gain is not to be sacrificed, the analysis must regain a fair amount of detail and not merely be compressed into a series of statistical tables". (9)

Thus the bulk of the analysis comprised the painstaking, but ultimately rewarding task of drawing out the responses of each client (and, where appropriate, each G.P. and counsellor) to each issue or topic, and exploring their diversity as well as their similarities. This was done by listing all individual responses considered relevant to particular areas - a kind of loose and extended coding - and an analysis of all the material so collected. In many cases, the record of the interview was sufficiently detailed to enable what the researcher considered to be a valid reconstruction of the actual response. Thus the 'quotes' which are found in chapters 6,8, 9 and 10 are, strictly

speaking, the researcher's interpretation of the responses of interviewees. In a rather different sense, of course, this is not dissimilar to the process that occurs when edited 'highlights' of tape-recorded interviews are reproduced. In both cases, the justification is in terms of the greater immediacy and 'liveliness' of data presented in this manner.

Wiseman, in a detailed discussion of her own research procedures, points out that especially in qualitative research one of the major analytic decisions which have to be made concern the 'social system model' - the pattern of organisation of the social world being presented.(10) There are several possible models and, as in many studies, no one model has complete pre-eminence in the presentation of the findings of this research. However, the major section of the analysis, in chapters 8, 9 and 10, gives dominance to what Wiseman calls the 'time-order or career model', on the assumption that everything has a 'natural history' - a beginning, middle and end - even if one 'end' can constitute another 'beginning'.

Summary and conclusions

This chapter has discussed the methods used to collect the material which forms the substance of the remaining part of the thesis. The aims were to describe and analyse the counselling service being provided at a particular general medical practice and to explore the impact of this service on clients, using primarily the perceptions of clients themselves, but also those of their counsellors and G.Ps. The sources of material were firstly records

on the clients, some specially compiled by their counsellors and (in the case of clients registered with one doctor) medical case-notes, and secondly, semi-structured interviews with clients, counsellors and G.Ps.

The study gained the full co-operation of all three counsellors and the five G.Ps. currently at the practice. The response rate from clients was higher than expected and 83 out of 149 approached were interviewed. However, there were also some clients in the original population who could not be approached, the majority because they had moved away. The interviewed clients were different in some measurable ways from those who were not interviewed: more of them were female, older age-groups were over-represented, as were those of a higher social-class and those who had only one counselling interview. There may have been other, less easily measurable differences associated with satisfaction with counselling or subsequent personal relationships. However, within the interviewed client population, a wide range of all these characteristics was represented, enabling a rich variety of material and responses to be collected. It was this variety which was essential to the value of a study such as this one, focusing on increasing the understanding of the clients' individual experiences.

Following the logic of this focus, the interviews were conducted in such a way as to allow the maximum freedom of expression on the part of respondents, only ensuring that all covered the same broad subject areas. Although some responses, with a considerable factual element, could be analysed and compared in a fairly straightforward manner, the bulk of the material necessitated a painstaking,

but ultimately rewarding process of listing all the responses considered relevant to particular areas and exploring themes, similarities and diversities.

Many social researchers find themselves sounding apologetic, even defensive, about the methods they use and the material they present. This study would not claim to have completely escaped that trap, originating essentially from the still-powerful aura of the positivist model. However, it can be claimed with some justification that social research has more to gain from the infinite variety, the complexity and the capacity for reflection of its subject-matter than it loses from those same characteristics. It is hoped that the subsequent report capitalises on these advantages.

Chapter 6

Counselling at The Medical Centre

This chapter describes the counselling service provided at the Medical Centre and discusses the attitudes of those involved towards that service. The material derives from the interviews conducted with the clients, with the three counsellors who had worked at the practice and the five G.Ps. who were the practice principals in 1978-79.

The mechanics of the counselling service

One of the earliest examples of a counsellor working with the patients of a general practice was at this Medical Centre. It comprises a group practice of five general practitioners, serving most of the inhabitants of a medium-sized suburb of Teesside, in North East England, as well as some families living in the surrounding areas. The practice is by no means typical. It is a teaching practice, and also has a very enthusiastic attitude to the concept of the 'team' in general practice. Thus, home nurses, health visitors, practice nurses, midwives, a community psychiatric nurse and a social worker all work at and from the practice premises, which are large and well-equipped. On the administration side, there are a number of receptionists, a secretary and a practice manager.

The counselling attachment scheme arose very much through the efforts of a particular individual counsellor and one of the general practitioners. The counsellor had long felt that a medical or

health centre setting might be appropriate for counselling, initially for reasons of geographical convenience - she felt that more 'outposts' were necessary in order to facilitate access to a counsellor. The high costs and inconvenience of travelling to the main marriage guidance centre, she argued, discouraged many potential clients. The general practitioner, on the other hand, was perhaps the most committed of his group to the 'team' concept in primary health care, and was receptive to suggestions for further extensions to that team.

After preliminary discussions between these two, a series of meetings and discussions was arranged with the other doctors, nurses and the receptionists. The impression is (although this might be mistaken) that these meetings were more to inform the other practice partners and staff about the work of the marriage guidance counsellor and to decide how the counsellor was to work from the practice, rather than to decide whether she should come at all. Four of the five G.Ps. who were then practising are still there. Their reaction to having a counsellor on the premises was varied. Two, as well as the G.P. who initiated the proposal, were in favour of the idea. One of these knew nothing about marriage guidance counselling and had never suggested it to any of his patients: the other had already referred patients to the local Marriage Guidance Council. The fourth G.P. said that he "didn't take too kindly to the idea" at the time, feeling that marriage guidance counselling was "an invasion of the confidentiality of marriage". He subsequently changed his mind, but has never referred as many patients as his colleagues.

The counsellor eventually began to counsel from the practice in

November 1972. Referrals of clients came from the start. The overwhelming majority have always been from the G.Ps., but a few were passed on by the health visitors, a few referred themselves and, particularly when the service became established, some former clients returned on their own initiative. Some G.Ps. were quicker to refer than others - it was a year before the final partner referred one of his patients. There are still considerable variations between the number of referrals from different G.Ps.

The volume of work by 1975 justified the addition of a second counsellor. This counsellor was approached personally by the first counsellor, who introduced her to the practice G.Ps. and staff. Soon after this, the first counsellor began to run down her case-load, due to increasing domestic commitments. She finished counselling at the practice in 1976, and was replaced in September of that year by a third counsellor, again approached and introduced by the first one. The departure of one of the main driving forces behind the setting-up of this 'attachment' did not seem to hinder its development although both subsequent counsellors commented that they took a while to settle in. In the later 1970's the counsellors were devoting a considerable number of hours a week to clients at the practice, and a waiting list periodically emerged.

At the time of the study, two marriage guidance counsellors were attached to the practice, although one was counselling for substantially more hours a week than the other. A room on the premises was allocated for their exclusive use at particular times of the week, equipped with easy chairs and a low 'coffee-table', instead of the upright chairs, and the desk standing between doctor

and patient, more typical of medical consulting-rooms. This room was used for counselling both during the day, when the practice was busy with patients, and doctors and nurses were holding surgeries, and in the evenings, after everyone had gone home except the cleaners.

In most cases, although clients were referred by their G.P., they were left to make their own appointments. Normally, the G.Ps. did not refer to a particular counsellor, although sometimes they would mention the name of the counsellor who saw most of the clients. An appointments book was left at the desk, with the times at which the counsellor doing the most hours was available. The receptionists arranged most of these first appointments. If there was no time immediately available, the client would be put on a waiting list and told that he or she would be contacted as soon as possible. The other counsellor would then pick these up as she had time and telephone them (or write if necessary) to arrange an appointment. This is contrary to the usual marriage guidance practice of the secretary making all appointments, and it is unusual for a counsellor to contact a potential client.

Clients who came during the day would either wait in the general waiting-room, or (more often) in the corridor outside the counselling room. If it was necessary for one of the receptionists to call them through, she would just say: 'You can go through now', rather than: 'Next for the marriage guidance counsellor'! Clients whose appointments were in the evening would just wait outside the room until the counsellor was ready. Any subsequent appointments after the first were usually made by the client and the counsellor at the end of the interview. The counsellor would then record the time

and date in the appointments book.

These then are the mechanics of the counselling service. It was generally considered, by all three counsellors and all five G.Ps. interviewed, to be flourishing and successful. The counsellors all enjoyed working in the practice and the G.Ps. all valued this addition to the services offered by the practice.

The G.Ps.' and counsellors' views on counselling in general practice

Both counsellors and G.Ps. were asked about the role which they saw counsellors as fulfilling in a general medical practice. The counsellors felt that they could help individuals with a fairly wide range of relationship problems, not just those defined as marital. The G.Ps. were more divided: three of the five preferring to restrict their referrals to those which involved specifically marital problems. This division will be further discussed in looking at the referral patterns of the G.Ps.

The nature of the counsellors' contribution was most frequently expressed in terms of the time which they could give to their clients. Several respondents pointed out that, on the whole,psychiatrists and social workers, as well as G.Ps., found themselves unable to devote a whole hour to one or two individuals. The G.Ps. tended to tie this up with a saving, or a more appropriate use of their time; although one did say that he found himself doing more counselling of patients nowadays. The influence of the counsellors had made him less happy about just sending someone away with a prescription. The counsellors all referred to this influence: two to the educative

role they played in the training of health visitors and G.Ps., and the third to the 'humanising' effect which she felt they had had on the way the G.Ps. viewed their patients.

Besides the G.Ps. themselves, there are a number of other professionals whose work might be expected to overlap with that of the counsellors. The practice had an attached social worker and (from the beginning of 1979) an attached community psychiatric nurse. It also, of course, had access to psychiatric specialists at the local hospitals.

In this particular practice, there seems to have been very little overlap or mutual suspicion between the social worker and the counsellors. The impression from all respondents (although the notable omission is the social worker herself, who was not interviewed[1]) was that referrals to the social worker were primarily those involving material or practical problems, or those with a large social element. It was generally agreed that, along with her statutory duties, these problems kept her more than fully occupied.

The boundary between counselling and psychiatric referral seemed less clear-cut. Several respondents mentioned the low psychiatric referral rate of the practice and there did seem to be an emphasis on maintaining responsibility for patients who were mentally ill as far as possible. Only one of the G.Ps. had clearly used the counsellors to support him in this task, and referred to counselling as 'psychotherapy'.

However, he was the G.P. who referred the greatest number of

patients, and the counsellors clearly felt that they had been involved in the care of some 'mentally ill' patients. They expressed the boundary of their capabilities very much in terms of a notion of the 'level' of disturbance and of 'treatment' required. Beyond a certain level or 'depth' they felt no longer able to cope. In fact, however, they felt this was less of a problem in a general practice setting than in a marriage guidance centre. They could more easily consult or refer back to the G.P., and also found it easier to liaise with the local psychiatric services.

The community psychiatric nurse was a recent addition to the practice team, and it appeared that this was likely to have some influence on the counsellors' work. The G.P. who had previously seen the counsellors as his main support in the care of psychiatrically-ill patients, talked about being more selective since being provided with the services of the nurse. He, as others had perhaps always done, was beginning to draw the line between referral of patients with clearly defined psychiatric symptoms and those with emotional disturbances more specifically associated with relationship problems.

The counsellors were asked to talk about the advantages and disadvantages of working in a general practice setting. The former were felt to outweigh the latter. They found the accommodation good and they felt the contact with the G.Ps. was relevant to their work (in the sense of the link between "physical symptoms and emotional upsets") and valuable (in giving access to a wider range of clients and often, they felt, at an earlier stage of their problems). They appreciated the greater feedback about clients: from the clients themselves and from the G.Ps., which they felt increased their 'job

satisfaction'. They also, particularly the counsellor who had the heaviest caseload, found their professional status in the eyes of others enhanced, and thus liaison with outside agencies easier.

In other words, they talked of the advantages in very similar terms to those used by the studies discussed in Chapter 3. However, there was also mention of some areas of potential or actual difficulty: of the effort and time involved in developing good relationships and contacts with the rest of the practice team; of the consequences of medical referral; of issues of confidentiality; of the dangers of professional isolation; and of issues of finance.

One of the primary concerns of the first counsellor was to make contact and develop good relationships with the G.Ps. and staff at the practice. If this innovation was to be accepted and patients referred, there was the need for herself and her work to become known, understood and respected. Other studies, as mentioned in chapter 3,[2] suggest that this is particularly important for the acceptance of a voluntary worker, counselling only a few hours a week and having had a limited training, by doctors and nurses, working for a salary, usually full-time and with years of training behind them.

After the initial round of discussions with all members of the 'team', the counsellor made a conscious effort to maintain contact. She had coffee on one day a week with the doctors, some of the nurses, the social worker and any visitors to the practice. She also met with other staff, including the receptionists, practice nurses and health visitors over lunch once a week. She always let the practice secretary know that she had arrived. Whenever new locum or trainee

doctors or nurses arrived, or new receptionists, she would arrange to talk with them. It fact, she later participated in the programme for trainee health visitors.

Her successors, particularly the second counsellor, who carried most of the caseload, maintained these efforts at continuing contact and both stressed the importance of this. Perhaps this is only to be expected in a movement founded on a belief in the primary importance of relationships. One counsellor actually argued that good relationships with the practice staff are as important as good relationships with clients. This counsellor attended both the morning and afternoon coffee-breaks weekly and was a member of the practice house committee. The other counsellor, who carried a considerably smaller caseload, did not maintain such regular contact, but usually joined in a coffee-break once a fortnight.

Both these counsellors emphasised that they used these and other informal contacts for very general and social conversation, rather than for discussion of particular cases or clients. More specific discussions were usually held in private, with the client's G.P. Contact over individual clients seemed to vary considerably between different G.Ps. Some would leave notes, some would telephone and others would pass on no details at all. In some cases, the G.P. would want to talk with the counsellor during and after the period of counselling. In others, there was no involvement, or the counsellor was expected to contact the G.P. only on the (very rare) occasions when she was worried about the physical or psychological health of a client and the way counselling was going. One G.P. pointed out that the operation of a 'personal doctor' system at the

practice, whereby patients normally saw the doctor with whom they were registered each time they consulted, facilitated feedback from the patients themselves: The G.Ps. generally felt that they utilised this method of feedback if they were continuing to see the patient. However the impression that most of the G.Ps., on most occasions, had no contact with the counsellor over their referred patients was substantially reinforced by the lack of knowledge they mostly displayed about the impact of counselling on individual cases.[3] This seemed to reflect a mixture of forgetfulness and lack of time on the one hand, and respect for the expertise and responsibility of the counsellors on the other. It was usually left up to the counsellor to approach the G.P. about a case if she felt the need for discussion.

From the counsellors' point of view, the amount and type of contact seems to have been satisfactory. One of them, as well as one of the G.Ps., mentioned that she preferred to start with a 'clean sheet', rather than with someone else's definitions of the client's problems. They all emphasised the ease of contact with the doctors over a particular case, and the doctors' willingness to give up time for discussion with the counsellors if this was requested. This kind of ad hoc support and accessibility was obviously very important, particularly to the counsellor who carried the biggest caseload. Some of the G.Ps. also mentioned the advantages of having both the counsellor and the doctor 'on the spot' if and when problems do arise. Of course, this was not always the case: the counsellors were not there every day and there were occasions when no G.P. was available, but the researcher did come across a couple of instances where a patient was directed straight from the doctor's surgery into the counsellor's room.

More generalised, formal methods of contact were not considered by the counsellors to be necessary, although one did remark that perhaps it is not wise to always rely on the efficacy of informal contacts. However, she was the same counsellor who argued a cogent analogy with other types of treatment 'prescribed' by the doctor: reporting or referring back is only necessary if the 'medicine' doesn't work. She thus did not automatically keep the G.P. informed about every case he referred; unlike her colleague who did leave brief notes on the doctors' shelves to inform the G.P. that she was seeing particular individuals.

When asked specifically about the interviewed clients, the counsellors reported that they had had some contact with the G.Ps. in the case of 43 out of 75 clients.(see Table I) However, this contact varied enormously, from a brief 'thank-you' to the G.P. for a particular referral, to full discussions and co-operation in treatment. The most frequently mentioned type of contact (13 times) was where the G.P. would fill in some of the relevant aspects of the client's background - family, medical and so on - either before or, more usually, during the period of counselling. Less frequently (mentioned 3 times) information passed the other way: the counsellor would contact the G.P. to tell him about something which had emerged during counselling and which worried her.

Table I Counsellors' reported contact with G.Ps. over individual clients (n = 75)

Yes	43
No	29
Not known	3
Total	75

Presumably, some exchange of information also occurred in the discussions and reporting back to the G.P. on how counselling was going which were mentioned 12 times. This type of contact occurred predominantly (9 out of the 12 times) with one G.P. The counsellors particularly commented on the interest he showed in the patients he referred and his active encouragement of discussions with the counsellors.

The type of contact which could most clearly be described as constituting 'team-work' - co-operation with the G.P. or support from him in the care of the individual was only mentioned 7 times. In 4 of these cases, an individual had been referred with overt psychiatric symptoms, and the counsellor felt in need of some medical support. It seems that, on the whole, 'team-work' in this context was interpreted as having available counsellors who worked fairly independently, rather than being involved in any more active forms of co-operation with the G.Ps.

This means that the advantages mentioned by several previous studies as accruing to counselling in general practice, of co-operation and co-ordination in the care of individuals and the availability of medical back-up for the counsellor, were in this scheme[4] largely of a passive nature. The counsellors did have access to the medical records (but the G.Ps. did not have access to the counsellors' case-notes - an interesting difference) and did feel they could approach the client's doctor if they felt it was desirable. However, actual contact to discuss individual cases was relatively infrequent, often very brief when it did occur and not formalised.

Two of the three counsellors expressed some reservations about the effects on their clients of having been referred by their G.P., sometimes in a fairly directive manner, as is clear from the later discussion in chapter 8.(5) It has already been noted in chapter 2(6) that the majority of clients coming to a marriage guidance centre are 'self-referred', thus, in some ways at least, they could be said to be more truly'volunteers' for counselling. The counsellors felt that in some cases this was a significant difference: that those who came after strong pressure from the G.P. tended not to "last the course", or that the first session was taken up with the clients' feelings of resentment, especially when counselling had been offered to them as an alternative to the 'medical' forms of treatment they had originally sought. The possible link between clients' initial reluctance to see the counsellor and the extent to which they eventually found counselling helpful is discussed below.(7)

The 'other side of the coin' of co-ordination and co-operation, issues of collusion and breaches of confidentiality,did not seem to be seen as particular problems in this scheme. The two counsellors who discussed this issue with the researcher both said that they would only pass on specific information after the client had given permission. As already mentioned, they all kept their own, separate case-notes, which were not available to the rest of the staff. However, the counsellors did have access to the medical records and both they and the G.Ps. seem to have been quite happy about the exchange of general information about clients within the practice team (see later in this chapter for the views of the clients themselves). Each was confident of the others' discretion. One counsellor did, nonetheless,refuse the request of one G.P. to observe counselling from behind a one-way

mirror!

However, the counsellors did seem more sensitive to another difficulty which it has been argued can arise in the context of counselling attachments to general practice: that of isolation from the peer-group and tutorial support and supervision of the marriage guidance council organisation.(8) As one of the counsellors interviewed put it, this is the 'only way to exercise quality control'.

This isolation could be more pronounced in a general practice setting like this one, where in some ways the work of the counsellors was rather different from that in a marriage guidance centre: for example, the range of clients wider; the number of unkept appointments fewer; the contacting of clients and arranging of appointments by the counsellor more frequent; subsequent contact with clients more likely; and as already mentioned, the support available 'on the spot' and access to other information on the clients substantial. All three counsellors were very aware of this danger, especially as they enjoyed 'surgery counselling' so much and found that it overcame some of the frustrations (and, in a different way, isolation) of centre counselling.

The local marriage guidance council seemed to regard the Medical Centre experiment very much as the first counsellor's 'baby'.It had resulted very much from her own enthusiasm and initiative and,being an experienced counsellor, she was allowed to develop the service as she thought necessary. However, she was expected, particularly at first, to report back fully and frequently to the Council. She continued to attend fortnightly counsellors' meetings and to see her tutor, as

did her two successors. Her contacts were also strengthened through administrative responsibilities with the Council - as a member of the Executive Committee and later as the Executive Officer.

The second counsellor became very heavily involved in practice counselling and by 1979 was counselling for about 12 hours each week at the surgery. Thus for her the risk of isolation from her counselling organisation and colleagues could have been considerable. Indeed she admitted that she could function at the practice in a completely insular way. However, again, there were other ways in which the link with the marriage guidance council was maintained. She continued to counsel a few clients outside the surgery setting (although these were mainly clients with some connection with the practice), and attended case discussions and tutorials. She was also involved with the Executive - as a member of a sub-committee - and now and again would go to NMGC headquarters for conferences and training courses.

The third counsellor, while also being involved administratively and in case discussions and tutorials, remained far more directly involved with actual counselling in the marriage guidance centre, only doing about half of her counselling at the Medical Centre. She counselled for substantially fewer hours than the second counsellor, and tended to take the 'overspill' of those referred patients who could not be fitted in to one of her colleague's appointment times. To carry on with counselling at the marriage guidance centre was her choice, to avoid the danger as she put it, of 'drifting off away' from the local marriage guidance council. She felt very much that although the counselling itself was very similar wherever it was carried out, the total experience was very different. The practice

counsellors had a steady stream of clients and very few unkept appointments. They were thus cushioned against many of the frustrations of 'normal' marriage guidance counselling, and it would be easy for them to feel part of the practice rather than part of the marriage guidance movement.

Maintaining contact with the practice, maintaining contact with marriage guidance and carrying out a substantial amount of counselling, which involved the writing of detailed case-notes as well as the actual hour of contact: all this involved the Medical Centre counsellors, especially one of them, in a very heavy commitment of time. To take the counselling alone, one counsellor had regular appointment times (which were usually filled) for 8 hours every Tuesday and 3 hours every Wednesday evening. She estimated that writing casenotes took her another 3 hours. On top of that, she had fortnightly case-discussions with other counsellors and triannual tutorials, as well as counselling conferences and further training courses. She also had to find the time for dicussion with the G.Ps. and other practice staff, as well as with outside agencies. In addition to this, she chose to take an active part in the administration of the practice. She obviously enjoyed this level of commitment, far above the minimum of three hours a week counselling expected of marriage guidance counsellors, but she also expressed some sense of grievance that the paid workers at the practice sometimes failed to recognise that she was giving of her own, unpaid time.

This brings in the issue of finance. Three aspects of this issue were mentioned by those involved in this scheme: firstly, the question of payment of the counsellors, secondly, the question of client contributions and thirdly, the question of the financial

arrangements between the practice and the local marriage guidance council.

To take the last first, one problem that did emerge for the local marriage guidance council out of the apparent 'success' of the scheme, in terms of the number of people referred and the number of times they were seen, was that within a relatively short time a high proportion of their counselling resources, in terms of counselling hours, were being used by the practice. This meant that a small section of the population within the council's area were receiving a disproportionate slice of the counselling cake. However, it also meant that the G.Ps. were making considerable use of counsellors to help them in the care of their patients, and perhaps to decrease their workloads, at virtually no cost to themselves, but, in terms of travelling and administrative expenses,at some cost to the marriage guidance council, who, like most voluntary organisations, suffered from a chronic shortage of money. On the other hand, the fact that a similar counselling service was provided 'free' for the G.Ps. at the local marriage guidance centre complicated the issue, although it could be argued that the traditional form of service had not been found to be as valuable by the G.Ps. as having counsellors 'on the spot'. Also, the counsellors were being provided with free accommodation of a high standard and were also gaining access to a considerable number and range of people whom the counsellors felt they could help, but who would not necessarily have approached the marriage guidance organisation. In these ways, it was possible to argue that the doctors were doing marriage guidance a favour. After some discussion, it had been eventually agreed that the practice should make an annual donation to the Council.

The question of payment of the individual counsellors is one that has been increasingly discussed in recent years, and some Councils have introduced limited payment systems [9] (although not this particular one). In this G.P. attachment, the time commitment was particularly relevant. Many counsellors (including most male counsellors) are also working in paid jobs. One of the counsellors interviewed periodically worked as a teacher. However, the counsellor most involved in the practice scarcely had any time left to take up remunerated employment. She felt very strongly that the current position was unsatisfactory and, in her words, 'embarrassing'. According to her, counselling in general practice was valuable; to do it properly a substantial time-commitment was necessary; and people would only be prepared to give that amount of time if they were paid. In fact, she looked forward to the time when counselling services become part of the range of health and personal social services provided by government.

Two of the G.Ps. interviewed supported the idea that the counsellors should be paid for their work, one arguing that not only would this give counsellors 'professional respectability' in the eyes of the general public and of other professional groups, but also remove the 'middle-class do-gooder' image, which he believed deterred some potential clients from the lower socio-economic groups. However, two G.Ps.declared themselves supporters of the independent, voluntary (i.e. unpaid) nature of the service. One expressed the fear that there would be pressure on counsellors as paid public employees to carry out certain statutory duties, to take on more clients, and thus to lose one of their most valuable attributes: time. There was no mention of the possibility that one major

attraction of marriage guidance counsellors, in an era of economic constraints, may well be their cheapness.

Marriage guidance counsellors are cheap from the point of view of service providers and the public purse, but, given the largely 'free' nature of the National Health Service they can be relatively expensive from the immediate point of view of the consumer.

The G.Ps. interviewed did not mention payment to patients they referred, who were thus quite likely to assume the counselling service was part of the range of 'free' practice services. Asking for contributions in this context could be more difficult. However, these particular counsellors, after some initial awkwardness, did start to broach the topic with clients and, by the time of the survey, counselling at that practice was bringing in a substantial revenue to the local marriage guidance council.

The clients' views on counselling in general practice

The client interviews also included some questions about counselling in a general practice. They were asked about the appropriateness of counselling in this setting; the advantages and disadvantages; how they felt about coming to the surgery to see the counsellor; and how satisfactory they had found the administration of the service.

Only one client, who had found counselling unhelpful and who was the only client who felt that going to see the counsellor had made things worse[10] was actually opposed to the idea of the provision

of a counselling service at the practice (see Table II). She felt that such a service should be outside your own area. A further three clients saw no particular reason why the counselling service should be at the practice rather than provided separately. Another eight, though generally in favour of the idea, expressed some reservations. For all but one of these clients, these reservations again concerned the service being close to home. (see Table III) They were worried about neighbourhood gossip, about seeing people they knew in the surgery who would then know they were seeing a counsellor. Only one client mentioned the issue of confidentiality, which has been an important area of concern in the minds of counsellors and doctors when considering co-operation,[11] and even this client said that it was not something which had personally worried him. Of course, it may well be that those clients most concerned about confidentiality would not have consented to be interviewed by the researcher!

Table II Client views on desirability of providing counselling service in general medical practice (n = 83)

Yes	70
No	1
Yes, with reservations	8
No advantages	3
No response	1
Total	83

Table III Client views on disadvantages of counselling service in general medical practice (n = 9)

Lack of anonymity in practice	3
Lack of anonymity in home area	5
Worries about confidentiality	1
Total	9

Thus, 78 clients out of 82 who were asked this question declared themselves to be in favour of a counselling service being provided at the practice, of whom 70 expressed no reservations. This included some clients who had personally found the counselling of very limited or no help. Unless this reflects people's unwillingness to support the withdrawal of any service currently provided, it does seem to suggest that these individuals did not interpret counselling's failure to help them as indicating a generally useless service. Most in fact were able to specify the advantages they felt accrued to counselling in this setting, although one dissatisfied client, it must be admitted, could only come up with:

"Well, I suppose it might help some people".

Table IV Client views on advantages of counselling service in general medical practice (n = 78)

Conveniently near home	27
Services all under one roof	22
Pleasant/familiar surroundings	26
No stigma/anonymous	19
Counsellor always there	1
G.P./counsellor link	56
Increases awareness of counselling service	1

(Total number is more than 78 because more than one response given by some clients)

The advantages mentioned (see Table IV)can be divided broadly into physical and psychological. Twenty-seven clients felt that the proximity of the surgery to where they lived made the counselling service 'handy' or 'convenient'. Twenty-two talked about the advantages of the services being 'all under one roof', including several who added that making an appointment 'on the spot' gave no time to get 'cold feet'.

Twenty-six clients mentioned the pleasant or familiar surroundings of the surgery as being an advantage and making them feel more comfortable, and five spontaneously said that they would never have gone to a marriage guidance centre. These responses were very much on the border-line between the physical and psychological and were perhaps linked with the issue of stigma. The relative lack of stigma associated with seeing the counsellor at the surgery rather than at a marriage guidance centre was specifically mentioned by nineteen clients. They pointed out that there was no need to go in through a door labelled 'marriage guidance'; that the variety of services provided at the practice gave some 'cover' and that they just told friends that they 'had an appointment at the surgery'. "Stigma' is, of course, a complex phenomenon, composed as it is of a mixture of the individual's own attitudes and those which he attributes to others. Several clients implied that, regardless of the attitudes of other people, they themselves felt that to see a counsellor in the context of a general medical practice was less 'shameful'. For example one male client said:

> "I wouldn't have gone to a marriage guidance centre - it's a special place. At the surgery, counselling is part of the medical treatment.'

(however, this must be balanced against the feelings of seven clients, discussed above, that counselling at their local surgery enhanced the risk of stigma). Only one client at this point in the interview talked about the advantage that the counsellor was 'always there' - that access was made easier. However, this advantage was also implied by the thirteen clients who, as discussed below,[12] talked about 'the door' being 'left open' for them at the end of counselling, as well as the client who felt that awareness of the counselling service was increased in this setting.

The advantages so far mentioned all pertain to the counselling, which is seen as benefiting from being situated at the practice. However, some clients did mention ways in which the counselling benefited the practice. For example, two women said that the service brought a 'human element' or a 'personal side' to the practice, and one that 'it saves the doctors' time'.

In all, fifty-six of the eight-three clients interviewed mentioned an advantage in the link between the G.P. and the counsellor. They argued that the G.P. was often the first person to see those with marital or other emotional and relationship problems. Several mentioned the link between physical and emotional symptoms and problems. It was felt by some that people would be more likely to go if they were referred by their G.P., especially if the referral was to a named counsellor, working on the same premises. This extra pressure on 'patients' to become 'clients' could of course be seen as a disadvantage in the case of those who subsequently found the counselling of no help.

These advantages were all concerned with the greater likelihood

of individuals gaining access to the counsellor if she worked in a general practice, as was the comment of one client that this setting increases the public's awareness of the service. Others mentioned were about the benefit to the total care and treatment of the individual if counselling was provided in this setting. Twenty-one clients talked about the value of co-operation between the counsellor and the G.P.: of cross-referrals, mutual consultations and the exchange of information and opinions. Counselling was seen by them as a 'natural' part of the range of services provided in primary health care and the counsellor as a 'natural' member of the general practice team. Some clients emphasised the special expertise of the counselling and the fact that she had more time, which enabled her to provide a service which complemented that of the G.P.

The response of one client illustrates well some of the advantages that clients perceived of a counselling service in general practice:

> "I would not have known where the marriage guidance council was and anyway, I would never have gone. My problems were very much tied up with my health, so the liaison with the doctor was very important, the counsellor wasn't so isolated. The doctors know you, so they can help the counsellor and it seems to me that it's the normal and natural place for counselling. It saves the doctor's time too - they haven't enough time."

The clients were also asked more specifically whether they liked seeing the counsellor at the surgery or would have preferred somewhere else, for example, at their home. (see Table V) The counsellors were adhering very much to the traditional pattern of

marriage guidance counselling of not making home visits. Only two of the clients interviewed had been seen at home: one was severely disabled and the other, who had recently been deserted by her husband and was very reluctant to venture out at all, was counselled at home and in the practice.

Table V Client views on seeing counsellor at the surgery (n = 83)

Happy to see counsellor at surgery	10
Prefer surgery to home	47
Prefer home to surgery	9
Prefer somewhere out of area	1
No preference	14
Only saw counsellor at home	1
No response	1
Total	83

On the whole, the clients seemed quite happy to attend the surgery. Only ten expressed a preference for somewhere else - nine for a home visit and one for a centre outside her home area - and even some of these qualified this by saying that it would be less efficient of the counsellors time. Two clients had baby-sitting problems, but the major reasons for feeling that the surgery was not the ideal setting was that there was the risk of seeing people you knew, and the feeling that the counselling would be more effective in the clients' home, where 'it all happens', where people are more relaxed, more 'themselves' and where the counsellor would be able to see the home situation.

On the other hand, there were forty-seven clients who specifically

said that they would not have liked a home visit. Paradoxically, many of the reasons given implied that they would be less able to relax in their own homes. There was always the risk of interruption, there was less privacy, with spouses and children around, and many clients felt the need to get away from the home environment to 'neutral ground'. Some felt that the setting of their own home would be too informal, would require less effort from them, or would mean that they would be distracted by concern about 'being the hostess' or making sure everything was clean and tidy. A couple of clients made the point that the invasion of their privacy was less complete if they could keep the counselling separate and 'leave it behind' in the surgery.

The marked, although not universal, preference for seeing the counsellor at the surgery expressed by the majority of the clients may, of course, be partly a product of their own experience. However it does reinforce the widespread view within marriage guidance counselling, that home visits are not on the whole desirable.[13]

Table VI Whether clients had any problems with appointments (n = 83)

No problems	74
Rather booked up	7
Double-booked	1
No response	1
Total	83

There appeared to be few problems in arranging to see the counsellor. (see Table VI) In most cases, either the G.P. or

the client made the first appointment through the receptionist and subsequent appointments were arranged at the end of each session with the counsellor herself. There appeared to be very little delay in obtaining a first appointment: the maximum wait reported by clients was three weeks and for most it was far shorter. However, there is no doubt that at times the pressure of work for the counsellors built up considerably and several clients did comment that they seemed very booked up. Long delays in obtaining interviews were probably avoided by two factors. Firstly, as has been noted,(14) one counsellor was prepared to work a much larger number of hours than is usual. Secondly, close contact with the counsellors on the part of the G.Ps., who referred the vast majority of clients, may well have led to an adjustment in their referral rates according to the counsellors' workload. In fact, two of the G.Ps. did comment that they restricted their number of referrals at times, and four of the five felt that the service could well be expanded in terms of hours per week.

The clients were also asked how they felt about the receptionists knowing they were seeing the counsellor. (see Table VII) Receptionists have often been found to be the least popular 'gatekeepers' to primary care services,(15) although Maluccio, in his study of clients of a family service agency, found that an approach through the receptionist produced a very high positive response rate to a request for an interview, which he attributed to the clients' liking for and trust in her.(16)

Table VII Client views on receptionists knowing they were seeing counsellor (n = 83)

No problems	49
Some misgivings	13
No contact	17
No response	4
Total	83

Thirteen clients did express some misgivings, four of whom knew one or several of the receptionists socially. Seventeen had no contact with the receptionist - they either came for counselling at a time when none were on duty, or else they went straight through to the counselling room, without 'checking-in' at the desk. Some of these clients had deliberately arranged their counselling to avoid contact. However, the majority said that they were not at all worried that the receptionists knew who they were going to see. Two of these specifically mentioned how helpful and 'businesslike' they had been, which avoided any possible embarrassment.

Summary and conclusions

This study had the advantage of focusing on a general medical practice with one of the longest experiences of having an attached counselling service. It was thus particularly interesting to consider how this apparently successful innovation operated and the attitudes towards it of both service-providers and service-recipients.

The reaction of all groups to the counselling service was

overwhelmingly positive. In fact, the general desirability of having such a service was expressed in far more positive terms than was its impact on individual clients (see later). The service was seen as specifically one of marital counselling by three of the five G.Ps., although the counsellors saw their potential as wider. A counselling attachment was felt to have benefits for the G.Ps., in terms of reducing their workload and increasing their understanding; for the counsellors, in terms of access to clients, job satisfaction and professional status; and for the clients, in terms of more co-ordinated, more comprehensive and (in the case of counselling) less stigmatising and often more convenient treatment and help. The service appeared to operate well,in administrative terms, and doctors and counsellors and clients appeared quite happy about the extent and nature of contact and co-operation between the service-providers in this 'team-care'. However, when this aspect was fully explored, it was found to operate in a relatively passive fashion. There were opportunities to discuss individual cases, but these were utilised relatively infrequently (except with respect to one G.P.)

The G.Ps. expressed no criticisms of the counselling service, allhough one had initially had some resistance to the idea. They did, however, differ as to whether counsellors should become a fully-paid profession working as part of the statutory services or should remain independent and voluntary.

The clients expressed very few reservations, but those few were virtually all related to the lack of anonymity associated with

having a counselling service in their home area and at their local practice. The counsellors did however perceive a range of potential or actual difficulties. They found it necessary to give a considerable amount of time to the development and maintenance of good contact and relationships with the doctors and other practice staff; they expressed some reservations about the motivation of clients referred to them in a fairly directive manner; they were very sensitive to the issue of confidentiality, although seemed happy with the 'modus operandi' at the practice; and they were conscious of the dangers of becoming isolated from their marriage guidance colleagues and from the tutorial guidance and support of the marriage guidance organisation. Lastly, they mentioned issues of finance: the question of payment of the counsellors, the question of obtaining client contributions and the question of how far the practice should remunerate the local marriage guidance council for the service provided. Much of the counsellors' discussion related to the juxta-position of a voluntary service using unpaid workers and a statutory service, 'free' at the point of demand, and employing paid staff.

However, these reservations were evidently outweighed for the counsellors by the advantages they felt accrued to the general practice setting. Thus all three groups of respondents were in accord in their support. The next step is to look at how far these general expressions of approval and opinions on the value and scope of the counselling service were reflected in its contact with actual clients. The next chapter will consider some of the characteristics of those receiving counselling and of the counselling they received.

Chapter 7

The Clients

In this chapter, some characteristics of the clients counselled at the Medical Centre, derived from counsellor records, are described and compared with those of marriage guidance clients generally and of the clients counselled in other attachment schemes.

This chapter is concerned with an analysis of data on all the clients who were patients of the Medical Centre, seen by the counsellors between the beginning of 1975 and the end of 1978. This data was provided by the counsellors from their case-records. It was possible to check the accuracy of the information by comparing it with information given by those clients who were interviewed. There was found to be a high degree of concurrence, except regarding the recording of socio-occupational class. This information must accordingly be treated with particular caution.

In this chapter, an attempt is made to answer questions such as: "What sort of people, with what sort of problems, were referred to the counsellors?" "Who referred them?" "How many counselling sessions did they attend?" How did their counselling end?" At certain points in the analysis it will be possible to compare the answers with those obtained from national or other local data. For example, the National Marriage Guidance Council collects annual returns from all local marriage guidance councils, including some information on clients and client interviews.[1] Another source is a far more detailed national study, already referred to in chapter 3,

which was made of all marriage guidance clients who first came in April,1975.[2] Lastly, the results have been published of two studies of 'surgery counselling' (referred to in chapter 4): one of counselling in nine practices in North London, which includes information on 99 clients first seen between April and September, 1977,[3] and another of counselling in a surgery and a health centre in Reading involving 121 cases over the 15 months between October 1979 and December 1980.[4] Obviously, any comparisons must be treated with care, given the different numbers and time-span involved.

Table I Division of work between the counsellors

	Cases	clients	interviews
Counsellor A	27	37	309
Counsellor B	126	187	1278
Counsellor C	39	53	342
Total	192	277	1929

In the period January 1975 to the end of December 1978, the three counsellors at the Medical Centre recorded information about 192 cases involving 277 clients. In a very small number of cases, the clients had seen more than one counsellor, (occasionally, all three). The information on these thus appears more than once and will be treated as two or three separate cases. 126 of the 192 recorded cases were dealt with by one of the three counsellors and she conducted two-thirds of the 1929 interviews (see Table I). It is important to remember, therefore, that her particular pattern of work (which may reflect her individual ideas on counselling

rather than any influences from the medical setting) will have a dominating effect on the overall results. Where there are significant differences between the cases or clients seen by each counsellor, these will be noted.

Source of referral

It is of course no surprise to find that the pattern of referrals at the Medical Centre is very different from the national pattern. Nationally, in April 1975, 12% of cases were referred by the medical profession.(5) A few people came through other agencies - solicitors, for example - but the majority (70%) referred themselves. Of course, we do not know how many of these were given the idea, or encouraged to approach a marriage guidance counsellor by their doctor. However, what little evidence there is suggests that a relatively small proportion of G.Ps. have any real knowledge of, or contact with marriage guidance counsellors and that few recommend counselling to patients who come to them with health problems arising from marital stress.(6)

Table II Source of referral of cases

	Cases	
	Number	%
Dr. A	87	
Dr. B	31	
Dr. C	21	
Dr. D	19	
Dr. E	5	
Dr. F	4	
Other G.P.	6	
Total G.P.	173	90
self	12	6
Other	5	3
Not stated	2	1
Total	192	100

At the Medical Centre, on the other hand, 90% of the cases were referred directly by the G.Ps.(see Table II). Only in 6% of cases did clients approach the counsellors on their own initiative, and the small number remaining were referred by a health visitor, a relative, a hospital consultant, a hospital social worker and a neighbour. One might hypothesise that as the service has become more well-known and established, more patients would refer themselves and other members of the practice team would become more ready to refer. As far as new referrals are concerned, this does not seem to have occurred; indeed, if anything, the predominance of G.P. referrals has increased. A similar predominance of medical referrals was noted also in the Reading study, where all but 24 of the 121 referrals were from G.Ps. and 18 of the remainder were

referred by local psychiatrists.[7] However, one of the features of counselling in this setting seems to be that clients are more likely to return to the counsellor if a subsequent 'crisis' occurs. Many of these 're-referrals' at the Medical Centre seem to be initiated by the clients directly with the counsellor.

Table II shows a marked variation in the number of referrals between the G.Ps. Some of this was due to the fact that they had not all been in the practice over the whole period. However, both the G.P. who referred most and the G.P. who referred least worked in the practice over the whole four years. The former referred 87 of the total of 173 G.P.-referred cases (almost exactly half), whereas the latter only referred 4. There could be a number of reasons for these variations: a lack of knowledge about the counsellor or counselling; scepticism about the value of counselling or actual opposition; a belief that the G.P. should have the responsibility for counselling his own patients; a lack of 'suitable' patients to refer; a failure to recognise 'underlying' relationship problems; and so on. The doctor who referred most patients did seem to demonstrate the greatest eclecticism in his referrals; he referred 17 of the 21 single people among the clients, including three children in their early teens. These variations will be further explored in a discussion of the interviews with the G.Ps.[8]

Category of first interview

Table III First interview by sex

	Cases	
	Number	%
With man	41	21
With woman	124	65
Joint	27	14
Total	192	100

The April 1975 survey of marriage guidance clients found that in a quarter of cases the husband came first, in nearly a fifth of cases the two partners came together and in 56% of cases it was the wife who initiated contact.(9) The same order is found in the Medical Centre figures, but with rather more women coming first (65%) and rather fewer men (21%) and couples (14%) (see Table III). This is most likely to be a reflection of the higher G.P. consultation rate of women, especially during child-bearing years, when one would expect most use of marriage counselling services. The North London survey found an even greater predominance of women (74%), although it is not clear from their results whether this refers to first interviews or total interviews.(10) The lower proportion of joint first interviews at the Medical Centre reflects at least partly the higher proportion of single people among those referred (see below.)

State of relationship at first interview

Table IV State of relationship at first interview

	Cases	
	Number	%
married, living together	137	71
married, living apart	20	10
cohabiting	11	6
engaged	2	1
single, divorced, widowed	21	11
divorced, living together	1	1
Total	192	100

Both in the 1975 national survey and at the Medical Centre, in approaching three-quarters of cases the clients were married and living together when they first saw the counsellor (see Table IV).[11] However, in the remaining cases, the pattern is rather different. The national survey found that most were married, but living apart (21%). At the Medical Centre, only 11% came into this category, and the same proportion were single, either never having been married, or having been divorced or widowed. 6% were cohabiting, compared with the national figure of 2%.

The North London survey categorised the cases slightly differently, but found an even more pronounced shift from the traditional clientele of marriage guidance counsellors, with only just over half the cases involving clients who were married and living together, a tenth cohabiting and around a quarter who were single.[12]

However, this does not seem to be an inevitable feature of counselling in general practice. The Reading study does not appear to involve any unmarried individuals at all.[13] In addition, it must be pointed out that the disparity between the Medical Centre figures and those obtained nationally is almost entirely accounted for by the eclectic nature of the referrals of one G.P., as mentioned above. His colleagues, whether intentionally or not, tended to refer the 'traditional' types of clients in terms of marital status.

Number of years married or cohabiting

In order to make the figures more comparable, in the light of the greater proportion of clients at the Medical Centre who were single, information on duration of the marital relationship was analysed rather differently from the method used in the April 1975 national survey. Thus those who were neither married nor cohabiting were initially excluded from both samples.

Table V Years married/cohabiting (n = 169)

	cases	
	Number	%
< 1	9	5
1 - 5	33	20
6 - 10	50	30
11 - 15	23	14
16 - 20	14	8
21 - 30	18	11
30 +	10	6
not known	12	7
Total	169	100

Both the national and the Medical Centre surveys shows that in something over half of the relevant cases, the clients were seen within the first ten years of marriage (see Table V).[14] Within these ten years, there are quite substantial differences between the two, but these are not consistent. A higher proportion of clients were seen in the first year of marriage, and in the fifth to tenth years at the Medical Centre, but a lower proportion with one to five years of married life behind them. This could be important, as early referral could be seen as one of the potential advantages of G.P. attachment, given the frequently-expressed counsellor belief that the earlier help is given, the more hopeful the 'prognosis'. Recent research by Dominian [15] suggests that many marital tensions and conflicts begin in the very early stages of marriage. Certainly, the fact that the majority of divorces occur within 10 years of marriage indicates that the critical period during which it is determined whether or not a marriage should be legally ended often occurs at a fairly early stage of the relationship.

The above discussion should however be qualified in two important respects. Firstly, in nearly a fifth of the relevant Medical Centre cases, the clients had been married for over 20 years. Counselling was obviously seen as relevant for those with long-established relationships, and problems arising from these relationships were evidently coming to the attention of the G.Ps. Secondly, the discussion has assumed that the problems presented for counselling by this group were associated with their marital relationships. This assumption will be investigated when the client interviews are analysed.

Previous marriages of clients and spouses

Table VI Previous marriages of clients and spouses

	Men		Women		Total		
	Number	%	Number	%	Number	%	
Yes	17	10	34	18	51	14	(1)
No	155	88	148	80	303	84	
Not known	4	2	2	1	6	2	
Sub total	176	100	184	100	360	100	
Not applicable	(2) 16		8		24		
Total	192		192		192		

(1) includes previous marriages of divorced and widowed clients

(2) i.e. single person of other sex seen, or client under marriageable age.

About 14% of the clients seen by the Medical Centre counsellors and of their spouses (where relevant) had been involved in a marriage which had now ended, through death or divorce (see Table VI). Some were still single, others had re-married. Almost twice as many women as men (18% as compared with 10%) had previous marriages. This is partly, but not completely accounted for by the prevalence of women among the divorced and widowed referrals.

In an era when nearly a third of all marriages involve a remarriage for one or both partners,[16] these figures probably do not reflect a sample of people very different from the national average.

Number of children

Table VII Number of children of clients under 18

	Cases	
	Number	%
0	59	31
1	43	22
2	55	29
3	24	13
> 3	8	5
Not applicable	3	2
Total	192	100

Leaving aside the three cases where the clients were themselves children, in nearly a third of cases, the Medical Centre clients had no dependent children (see Table VII). About a half had one or two dependent children. Thus the counsellors were involved with very few large families - in 82% of the cases, there were 2 or fewer children.

The major difference compared to the results of the 1975 survey was in the proportion of cases where no children were involved - 16% compared with 31% at the Medical Centre.[17] This is likely to be partly a product of other differences already noted - the larger proportion of single clients and of clients seen during their first year of marriage. The North London survey looked at the number of children under 16 and found, as one would expect, a similar tendency, although substantially more pronounced, for counsellors to be working with more clients with no dependent

children.

Age-groups of clients

If we look at the data in the form in which it was collected in the 1975 national survey,[19] that is at the ages of clients and their spouses, we find that apart from a larger proportion of young people, the age distribution among the Medical Centre cases was very similar to the national pattern, with the majority of counselling involving the 20-50 age-group.

Table VIII Age-groups of clients

	Men		Women		Total	
	number	%	number	%	number	%
< 20	3	3	13	7	16	6
20 - 29	29	28	54	31	83	30
30 - 39	40	39	58	33	98	35
40 - 49	20	19	30	17	50	18
50 - 59	7	7	11	6	18	6
60 - 69	2	2	4	2	6	2
70+	-	-	1	1	1	<1
Not known	2	2	3	2	5	2
Total	103	100	174	100	277	100

However, a more meaningful analysis in terms of describing the counsellors' pattern of work is of the ages of those 277 people who actually saw the Medical Centre counsellors and it is this data which is contained in Table VIII. There emerges again the pre-dominance of the 20-50 age-group - 81% of the women and 86% of the men were between these ages. The women tended to be

slightly younger than the men and 7% of them were aged under 20. Three children were also among the clients: two girls (aged 12 and 14) and a boy (aged 14). Overall, just under a third of clients were in their 20s and just over a third in their thirties. The North London survey looked at age-groups by case rather than by client.[20] They found a very similar age-distribution, with over 80% aged 20-50, and nearly 5% under 20. No over-60s were among those counselled in this survey. The Reading study reports an even heavier predominance of this age-group among presenting clients - over 90% between 20 and 50 and none under age 20.[21] By far the largest single age-group were those in their 30s, who constituted over half of the total number of clients.

These patterns are not the same as the pattern of G.P. consultations.[22] For example, there is a very marked under-representation of elderly people, although another population group with a high consultation rate - women of child-bearing age - are well-represented. The over-60s were under-represented relative even to their numbers in the population as a whole.[23] Thus it seems either that the G.Ps. are deciding that they, or the health and relationship problems they present, are not on the whole amenable to counselling, or that elderly people are unwilling to accept referral. It is difficult to assess the extent of specifically marital relationship problems among the elderly. However, divorce is a phenomenon particularly of the early years of marriage and divorce rates are lower for older age-groups.[24] Also, a significant proportion have lost their spouses through death.[25]

Problem areas

The Medical Centre counsellors were asked to specify which of

a list of 'problem areas' applied to each of their cases. The list was the same as was used in the national survey and included: management of money; sexual difficulties; infidelity; personal traits; social factors; interference from relatives/difficulties with child; and desertion (see Table IX).

Table IX Problem areas specified by counsellor by case

	Counsellor A		Counsellor B		Counsellor C		Total	
	No.	%	No.	%	No.	%	No.	%
Money management	7	26	4	3	11	28	22	11
Sexual difficulties	15	56	40	32	22	56	77	40
Infidelity	4	15	15	12	8	21	27	14
Personal traits	17	63	75	60	33	85	125	65
Social factors	6	22	3	2	3	8	12	6
Interference from relatives/difficulties with child	7	26	9	7	7	18	23	12
Desertion	3	11	2	2	4	10	9	5
Other	5	19	7	6	3	8	15	8
Not specified	2	7	-	-	-	-	2	1

(total is more than 100% because more than one problem area mentioned in some cases)

Some of the problems involved in the collection of information of this kind were evident in the Medical Centre results. For example, 'personal traits' is a rather vague and potentially all-embracing category, and so it is hardly surprising that it was mentioned in nearly two-thirds of cases. Different counsellors seemed to interpret its range of meaning in different ways. Thus one mentioned this 'problem area' in 33 out of her 39 cases, while another recorded it in only 75 out of 126 cases.

Counsellor differences were evident in other ways - the same two counsellors recorded 'sexual difficulties' in, respectively, 22 out of 27 and 40 out of 126 cases. It is difficult to tell whether this reflects differences in referrals to the counsellors (accidental or intentional) or differences in their interpretation of the nature of their clients' problems. There were also significant differences between counsellors as to the number of problems they reported in each case (see Table X). The counsellor who had seen clients in 126 cases only reported one 'problem area' in 100 of them, two in 24 and three in two. The other two recorded up to five and six problems per case, and were much more likely to record two or three.

Table X Number of problems reported per case by counsellor

	Counsellor A		Counsellor B		Counsellor C		Total	
	No.	%	No.	%	No.	%	No.	%
1	7	26	100	79	10	26	117	61
2	6	22	24	19	17	44	47	24
3	6	22	2	2	5	13	13	7
> 3	6	22	-	-	7	18	13	7
unspecified	2	7	-	-			2	1
Total	27	100	126	100	39	100	192	100

Bearing in mind these difficulties in interpreting the data, the two most important 'problem areas', both at the Medical Centre and in the national survey,[26] were those of 'personal traits' and 'sexual difficulties' (recorded at the Medical Centre in respectively 65% and 40% of cases). Also worth mentioning is the relative lack of importance ascribed to problems which are

likely to have significant 'practical' or 'material' element, such as 'social factors' (only mentioned in 6% of the Medical Centre cases, and this being almost entirely attributable to one counsellor) and 'management of money' (11%). This could reflect several factors: the type of patients whom the G.Ps. are most likely to refer, or who are most likely to accept referral; a generally high level of affluence among the Medical Centre patients; a failure of counsellors to recognise material problems; or a feeling among counsellors that these are not the 'real' causes of marital or other relationship difficulties, or that they are not areas particularly amenable to or appropriate for counselling techniques, thus not relevant to the 'case'. The attachment of a social worker to the Medical Centre was probably of some significance here: the G.Ps., when interviewed, said that they tended to refer to her those patients with problems requiring practical help.

It is also interesting to note, in the context of 'surgery counselling', how seldom the Medical Centre counsellors mentioned illness as a 'problem area'. Admittedly there was not a separate specific category with that heading, due to the origins of the categorisation, but illness could have been mentioned under the 'other' category, and indeed it was by two of the three counsellors, but very seldom. Presumably, depression presented by clients could have been categorised as a 'personal trait', but there was a marked lack of reference to more clearly defined medical problems.

Number of interviews

Information was collected in order to try and answer two

types of questions: with whom were interviews conducted and how many times were clients seen?

Table XI Number of interviews by category

	number	%
Men	487	25
Women	1023	53
Children under 16	26	1
Men and Women	388	20
Parents and children	5	1
Total	1929	100

Out of a total of 1929 interviews in the four year period, 1023 (53%) were with women on their own, 487 (25%) with men on their own and 388 (20%) were joint interviews with a man and a women (see Table XI). The remaining few were with children under 16, either on their own, or with their mothers.

Table XII Sex of clients seen in each case involving a marital relationship

	number	%
woman only	76	44
man only	20	12
both	75	44
Total	171	100

Of the 171 cases where the clients had a marital-type relationship, both partners were seen in 76 (44%) of them, only the woman in 75 (44%) and only the man in 20 (12%) see Table XII). Thus not only,

as was shown earlier, was it more likely that women will be referred more than men, but also it was women who received the majority of counselling. The counsellors did vary somewhat in the proportion

Table XIII Number of interviews with men and women by counsellor

	Counsellor A		Counsellor B		Counsellor C		Total	
	No.	%	No.	%	No.	%	No.	%
with men	120	33	588	38	177	43	885	38
with women	249	67	958	62	230	57	1437	62
Total	369	100	1546	100	407	100	2322	100

of their time spent with men and women - they all had more contact (as measured by number of interviews) with women, but the proportion ranged from 57% to 67% (see Table XIII). The differences were largely due to the distorting influences of a small number of clients who had a very large number of interviews.

Table XIV Number of interviews per case by category (excluding child cases and third party interviews)

	With men only		With women only		Joint	
	No.	%	No.	%	No.	%
0(1)	105	56	37	20	123	66
1	16	8	35	19	21	11
2	19	10	28	15	5	3
3 - 5	26	14	42	21	17	9
6 - 10	9	5	23	13	10	6
11 - 20	11	6	14	7	9	5
21 - 30	2	2	5	3	4	2
31+	1	1	5	3	-	-
Total	189	100	189	100	189	100

(1) i.e. where case involved no interviews in that category.

The Medical Centre counsellors during this period still predominantly interviewed clients separately - as is apparent from Table XI, only a fifth of all interviews were joint, and in two-thirds of cases there were no joint interviews at all (see Table XIV). This is difficult to compare with national data, as there has been a marked trend towards joint interviews in recent years. The April 1975 survey found very much the same pattern,[27] but in the latest figures show that over 30% of all interviews in 1980 were conducted with both partners present[28] and some of these involved two counsellors as well - a form of counselling which had not occurred at the Medical Centre. Of course, when, as at the Medical Centre a higher than usual proportion of single people are being referred, one would expect, all other things being equal, to have fewer joint interviews. Thus a comparison of the Medical Centre where 66% of all cases involved no joint interviews and the April 1975 survey, where the figure was 68%, does suggest that the counsellors were conducting joint interviews in relatively more of the cases where there are two partners. This may be important given the belief that the chances of a 'change' in the situation or 'the client's adaptation to it' are increased if there are joint interviews.[29]

Table XV Number of interviews per case by counsellor

	Counsellor A		Counsellor B		Counsellor C		Total	
	No.	%	No.	%	No.	%	No.	%
1	2	7	20	16	10	26	32	17
2	2	7	16	13	5	13	23	12
3 - 5	8	30	27	21	11	28	46	24
6 - 10	8	30	23	18	2	5	33	17
11 - 20	3	11	25	20	7	18	35	18
21 - 30	2	7	7	6	1	3	10	5
31+	2	7	8	6	3	8	13	7
Total cases	27	100	126	100	39	100	192	100
total interviews	309		1278		342		1929	
average number of interviews per case	11.4		10.1		8.8		10.0	
median number of interviews per case	6		5		4		5	

All of the Medical Centre Cases were recorded as 'completed' at the time that information was gathered, although, as will be discussed later, one of the features of counselling in general practice seems to be an increased likelihood of clients returning for further counselling at a later date. If we look at the number of times that clients were seen, the average was 10 per case (see Table XV). These figures are particularly difficult to compare with any national data, but do seem to indicate that the average duration of counselling is longer in this general practice than nationally. For example, the latest NMGC Annual Report[30] giving figures for all interviews and all cases (continuing and completed) started during 1980, gives an average of 5.3 interviews per case.

This tendency was found to be even more pronounced in the North London survey, where the average number of counselling sessions per case was 15.4.[31] However, in the setting of the surgery and the health centre in the Reading study,[32] the average number of interviews per completed case was 8.8 and 6.6 respectively: still higher than, but closer to the national figures. These disparities, like others, only serve to suggest the variety of patterns of work of marriage guidance counsellors within what appear to be similar settings.

The Medical Centre figures are distorted by a number of very prolonged cases. Taking the median rather than the average gives a rather different picture of the general pattern of the counsellors' work. Thus, the overall median number of interviews was 5, and the figures for the individual counsellors were 5,4 and 6 (see Table XV). The figures for individual cases were spread widely around the median. 30% of cases involved more than 10 interviews. Examples of very prolonged cases were 86 interviews with one couple and 81 with another (seen by different counsellors). One young girl saw two of the counsellors over a period of more than four years. These cases may reflect a role for the counsellors in the continuing support' of patients who otherwise may make heavy, but not strictly 'medical' demands on the doctors. If so, the question then arises of whether this is an appropriate counselling task. Even if these were not patients who would otherwise be frequently consulting the doctor, there is the question of whether long-term counselling was providing benefits to them, or whether the counsellor and the client found it difficult to terminate a relationship which may have outlived its usefulness. The interviews with clients, counsellors and G.Ps. are one way of attempting to clarify this situation.

At the other extreme, 29% of cases involved only one or two interviews. Here, there were significant counsellor differences, the figures ranging from 14%, to 29%, to 39%. The question arises of whether these figures represent people who found counselling to be of no help to them, or whether one or two sessions of counselling was sufficient to provide them with all the help they needed. Again, this question can only really be tackled by talking to the people involved, but some hint may be forthcoming from the histories of these particular cases. (see below)

Case-history

Table XVI Case-history by counsellor (at 30.6.79)

	Counsellor A		Counsellor B		Counsellor C		Total	
	No.	%	No.	%	No.	%	No.	%
Closed after discussion	21	78	109	87	26	67	156	81
Referred to other agency	3	11	1	1	-	-	4	2
Client stopped coming, no discussion	2	7	16	13	11	28	29	15
Other	1	4	-	-	1	3	2	1
Not known	-	-	-	-	1	3	1	1
Total	27	100	126	100	39	100	192	100

The question asked here relates to how the counselling ended. At the time the data were first analysed, all 192 of the Medical Centre cases were recorded as closed, although a few have since been re-opened. Of these the great majority (81%) were recorded

as 'closed after discussion', most of the rest (15%) were ended when the 'client stopped coming', and the few remaining cases were 'referred to another agency' (2%) or moved away (1%) (see Table XVI). These figures are not easy to compare with those from the April 1975 survey,[33] as this included some 'continuing' cases (21%). Given that these were cases in which clients had shown some commitment to counselling by continuing to attend interviews, one can hypothesise that these would be more likely to end after discussion between client and counsellor. Thus, if they are left aside, there is likely to be an underestimate of the proportion of cases in that category and a corresponding over-estimate of the proportion of completed cases which ended after a unilateral decision on the part of the client.

However, bearing this in mind, if we look at the 'completed' cases recorded in the national survey, we find that only just over half (54%) terminated after discussion, and over a third (35%) ended when the client stopped coming. Even if <u>all</u> the 'continuing' cases are put into the former category, this still only increases it to 64%, and decreases the proportion of the latter category to 28%. In the case of two of the three counsellors (including the one who undertook the majority of the counselling) this is still well out of line with their reports.

This would seem to imply that many of the Medical Centre clients, for some reason, feel more 'committed' to counselling in the sense that they do not just fail to turn up for another session. Maybe they have the thought in their minds that they are likely to have continuing contact with the practice and are wary of upsetting their

doctors, or the practice staff. Or maybe they regard counselling in this setting as a 'course of treatment' prescribed for them by their G.P. and thus they will see it through until the course is deemed to have finished, whether or not they feel it is doing them any good.

The North London survey also found a tendency, though not as marked, for clients to talk with the counsellors about when counselling should end.[34] Of the 85 cases in which they had this information, just over three-quarters were terminated by 'mutual agreement', and just over one-fifth by clients acting on their own initiative without discussion.

However, as regards the Medical Centre figures, care must be taken not to read too much into these differences. The small numbers make it difficult to break down the figures further, but there do seem to be substantial differences between the counsellors. Also, the exact meaning of 'closed after discussion' is debatable. Does this include <u>all</u> cases where the counsellor knew that the client was not coming back, even if it was only through a telephone message, or only those cases where the counsellor and client had discussed fully when counselling should end and had reached a mutual decision? How the counselling ended is another area which will be more fully explored in the interviews.

Table XVII Case-history in 1 and 2 interview cases

	No.	%
Closed after discussion	31	56
Referred to other agency	2	4
Client stopped coming, no discussion	20	36
Other	1	2
Not known	1	2
Total	55	100

As far as those cases with only one or two interviews are concerned, a substantially higher proportion than overall are recorded as ending when 'the client stopped coming' (see Table XVII). This applied to 20 of the 55 cases (36% as opposed to 15% overall). However, over half (31) of these short-term cases were 'closed after discussion', and it is reasonable to hypothesise that, in at least some of these, counsellor and client felt that even this brief spell of counselling had been of some use. Again, it was hoped that the interviews would clarify this point.

Socio-occupational class

It has already been noted that checking the counsellor-recorded information on clients with those clients who were interviewed revealed the estimate of socio-occupational class to be the only item with a substantial margin of error. It must therefore be regarded with some caution.

Table XVIII Social class (RG70) by case (counsellor-recorded if client not interviewed)

	No.	%
I	15	8
II	42	22
III	58	30
IV	45	23
V	11	6
unemployed, no job stated	2	1
women on social security	6	3
armed forces	1	< 1
not known	12	6
Total	192	100

Table XVIII shows the socio-occupational class of cases (rather than clients - the proportions are virtually identical), recorded by the researcher in the cases of those clients interviewed and by the counsellors in all other cases. Telescoping the figures somewhat, apart from the 10% or so who were not classified into any of the five categories, around one third of cases fell into classes I and II, one third into class III and one third into classes IV and V. A very broad comparison with recent national census figures (see Table XIX) shows some over-representation of classes I and II, but the greatest under-representation being of class III rather than IV and V. However, the differences are not of major dimensions and lead one to question the assumption, as did the April 1975 survey,[35] that marriage guidance is providing a counselling service predominantly for the middle-classes.

Table XIX Percentage of economically active and retired persons, males and females, in each social class, Great Britain

Social class (RG 70)	%	
I	4	22
II	18	
III N	21	49
III M	28	
IV	21	29
V	8	
	100	

Source: 1. Reid Social Class Differences in Britain (1977) table 3.1. Derived from table 30, Census 1971, Economic Activity (10% sample) 1975, part 4.

Of course, leaving aside the issue of accuracy, there is also the question of how far, in the context of this study, it is meaningful to compare the clients with 'national figures'. The potential client population in this instance was not the national or even the local population, but the patients registered with the practice (and, in some cases, their immediate family). In fact, even this is not strictly accurate, given the differences between the G.Ps. of the practice in their referral rates. It would thus be more meaningful to compare the socio-occupational class of the clients with that of the practice population. Failing that, given that the Medical Centre serves most of the population of the village in which it is sited, and about two-thirds of the patients live in that village,[36] figures relating to that population would be second-best.

Table XX Households of patients by social class, 1972. (n = 1,482)

Social class	%
I and II	26
III	55
IV and V	19
Total	100

Source: Marsh and Kaim-Caudle (1976) pp 46-47

The study by Marsh and Kaim-Caudle [37] gives some data relating to 1972 for the households of patients of one of the G.Ps., with whom just over one fifth of the patients were registered. There is no reason to suppose that these patients differed markedly in any way from the rest of the practice population. They did differ somewhat in social class distribution from the norm, with a rather higher proportion of households in social classes I and II and in III, and a correspondingly lower proportion in IV and V (see Table XX). The figures, as they relate to households, are only roughly comparable to the figures relating to cases. However, they suggest even more strongly than a national comparison that it is social class III who are most under-represented among clients; indeed there appear to be proportionately more referrals in social classes IV and V as well as I and II than one would expect. It is possible to speculate that these may be rather different kinds of referrals and may involve rather different work for the counsellors. Once again, it was hoped that interviews would clarify this to some extent.

Summary and conclusions

In this chapter, some of the characteristics of the clients counselled at the Medical Centre and of their counselling have been examined, using mainly counsellor-provided information. These have been compared, where possible, with information on the characteristics of marriage guidance clients and their counselling as a whole, as well as those described in relation to other general practice attachments.

The main differences that emerged between the features of clients and counselling at the Medical Centre and the national picture were in the source of referral, with the G.Ps. playing an overwhelmingly important role at the practice compared with a predominance of self-referrals nationally; in the larger proportion of single people and of women seen at the practice; in the higher average number of interviews (although the average did not reflect the experience of most clients,containing within it some very prolonged and some very brief cases); and in the apparently larger proportion of cases which ended after discussion between counsellor and client rather than because the client just stopped coming. However, not all these seemed to be inevitable differences associated with general practice attachments. Other published accounts show the variations between those attachments which have been the subject of detailed research. It seems likely that these variations would be far greater if these details were available for the whole range of marriage guidance counselling attachments to general practice.

This analysis gives some idea of the type of clients receiving

counselling at the Medical Centre and of their experience of that counselling. However, the interpretation of some of the information is not clear. Interviewing clients as well as their counsellors and G.Ps., offers an opportunity both to expand the amount of material available to the researcher and also to explore its meaning and interpretation from the viewpoint of service - recipients and service-providers. The following three chapters discuss the results of this enterprise.

Chapter 8

The Route to the Counsellor - From Patient to Client

Chapters 8 to 10 all discuss the experience of counselling at the Medical Centre of individual clients. The discussion is based on material from the interviews with 83 clients, involved in 74 cases, and (in the case of 74 clients) with their counsellors and their G.Ps. For most purposes, the material obtained in the pilot study is comparable with that obtained in the main study, and will be presented in an undifferentiated manner. Where this is not so, the differences will be discussed. The study's methodology and the representativeness of the client sample have been described and discussed in chapter 5. Chapter 5 also contains details of some of the demographic characteristics of the clients interviewed.

This chapter looks at how patients of the G.Ps. became clients of the counsellors. It considers why they approached their doctor and why they were referred (or why they referred themselves); their reactions to that referral and the ideas they had about counselling; the time at which they were referred in relation to how long they had had their problems; and the contact between the spouses of the referred clients and the counsellors.

The clients and the practice

The 83 clients interviewed comprised 63 women and twenty men. The largest group (35) were in their 30's, and in total two-thirds were under 40. The majority (62) were married and living with their spouses when they first saw the counsellor, although one quarter were

either separated (10), cohabiting (4) or single (7). Thirty-three clients were in socio-occupational classes 1 and 11, 28 in class III and 16 in IV and V. Five clients were women outside the labour market, dependent on social security, and one had a husband in the armed forces.

Of the 83 clients, 51 had been counselled by one of the counsellors, 16 by the second and 13 by the third, one by two of the counsellors and two by all three. They had had varying amount of contact with their counsellors, ranging from seven clients who only had one interview, to 9 who had more than 20 (the highest recorded number being 66). The largest group, about a third, had between 3 and 5 interviews. Most had only been for one series of counselling sessions, but besides the few who had seen more than one counsellor, there were some who had returned to the same counsellor on subsequent occasions.

Over 40% (34) of the clients were registered with the general practitioner who referred most heavily of the five in the practice, and only 8% (7) were registered with the G.P. who referred least. Most of the clients had been referred by the G.P. with whom they were officially registered and this reflects the operation of a 'personal doctor' system at this general practice, in which patients are encouraged to consult the same doctor on every occasion.

Table I Length of time registered with practice of clients interviewed (n = 83)

Number of years	Number of clients
5 or less	17
6 - 10	18
11 - 15	12
16 - 20	7
21 - 30	7
31 - 40	15
> 40	5
not recorded	2
Total	83

Many of the clients had been registered with the practice over a substantial period of time (see Table I). Over half (46) had been registered for more than ten years and almost a quarter for more than thirty years. Twenty had been with the practice all, or virtually all their lives and a further three during their childhood, but with a subsequent break. It must be remembered, however, that this group of clients is likely to be more geographically stable than the average, as clients who had moved from the practice since counselling were excluded from the sample.

Table II Use of practice services of clients interviewed

(i) Number of services used n = 83

	men	women	total
0	10	9	19
1	8	29	37
2	2	11	13
3	-	7	7
>3	-	7	7
total	20	63	83

(ii) Type of service used n = 64

	men	women	total
Practice nurse	6	33	39
Home nurse	4	27	31
Social worker	2	3	5
Family Planning nurse	-	17	17
Midwife	-	10	10
Health visitor	-	12	12

(Total is more than 64 because some clients used more than one service)

(iii) Satisfaction with services used n = 64

	PN	HN	SW	FPNS	MW	HV
very satisfied/satisfied	39	27	4	12	7	10
quite satisfied	-	1	-	-	2	1
not very satisfied	-	3	1	5	1	1
total	39	31	5	17	10	12

(Total is more than 64 because some clients used more than one service)

clients satisfied with all services	53
clients critical of some services	7
clients critical of all services	4
total	64

The clients were asked to record on the postal questionnaire initially sent to them which of a list of practice services (apart from the doctors) they had used 'during the last few years' and this information was checked and amplified during the interview (see Table II). Excluding marriage guidance counselling, 19 of the 83 had not used any other practice service and a further 50 had only used one or two (although the amount of contact was not recorded). Thus only 14 of the interviewed clients (all of them women) had made use of three or more different services. The two most frequently mentioned were the practice nurse (39 times) and the home nurse(31 times). Only 5 of the clients had seen the practice social worker.

There was generally a high level of satisfaction reported by the clients with these services. That provided by the practice nurse was particularly praised, with all respondents expressing satisfaction, but, overall, only 11 of the 64 clients with any experience expressed any criticisms of the services they had received.

Table III Satisfaction with practice of clients interviewed (n = 83)

very satisfied	26
satisfied	25
quite satisfied	13
not very satisfied	15
not recorded	4
total	83

Seventy-nine of the clients were also asked about their overall level of satisfaction with the practice (this question was not asked of four of the pilot study clients) (see Table III). Twenty-six said

that they were very satisfied, expressing no reservations and a further 25 that they were satisfied, with only minor criticisms. Of the remainder, 13 were 'quite satisfied', although there were some major aspects of the practice with which they were not entirely happy: for example, several mentioned the difficulty of obtaining a home visit from their G.P. The other 15 were 'not very satisfied', of whom several declared their intention of changing to another practice.

Thus, in terms of this brief and rather impressionistic analysis, this study involves a patient population expressing a fairly high level of satisfaction with their general practice and the services provided within it. Only just over one in eight expressed specific criticisms of services they had received, and nearly two-thirds of those asked said they were 'very satisfied' or 'satisfied' with the practice as a whole. However, there are at least two comments worth making here. Firstly, studies of general practice have tended to find a very high level of patient satisfaction. For example, Marsh and Kaim-Caudle, looking at the patients of one doctor in this same practice in 1973, found an astonishing proportion of respondents (95%) expressed overall satisfaction, although significant minorities did have some specific criticisms.(1) Thus, we may be dealing here with a population with a less than average degree of satisfaction. Secondly, however, the meaning of these responses are by no means clear and unambiguous. It may be that the different context of the interviews and different phrasing of the questions in the Marsh and Kaim-Caudle study may mean the findings are not directly comparable with those of the present study. In addition, in chapter 9 of this study, when looking at client responses to questions about the helpfulness of counselling, the adequacy of a unilinear concept of satisfaction-dissatisfaction,

with a number of points along a scale on which client responses are rated, is questioned. Thus, these responses should only be viewed as a very general indication of the clients' attitudes towards the general practice in which they are patients.

Table IV Initial referral agent of clients interviewed (n = 83)

Dr. A	33
Dr. B	8
Dr. C	10
Dr. D	10
Dr. E	1
Other G.P.	5
Total G.P.	67
other	7
spouse referred first	9
total	83

One of the major differences between the clients interviewed in this study and the traditional clientele of marriage guidance counsellors was that the great majority (67 out of 83) were referred by one or other of the G.Ps. at the Medical Centre (see Table IV). Of the remainder 7 were 'primary' clients (i.e. those who had made the first contact with the counsellor). Four had referred themselves, including three who had seen a notice in the surgery, and the other three had been referred by a daughter (who had contacted the G.P.), a hospital social worker and a neighbour. The other 9 consisted of 'secondary' clients (those who had seen the counsellor after their partners had made the first contact), three of whom were currently seeing their G.P. regularly.

Thus for all but a very few of these clients, there were strong links between their status as patients of the practice and their contact with a counsellor. Most had initially defined their problems as medical, by approaching their G.P., although, of course, for some of these the free, accessible and non-stigmatising nature of the professional help offered by a doctor may have been equally as important as his specific medical expertise. The 'medicalisation' of a range of problems associated with what one of the G.Ps. in this practice called 'dis-ease' is a much-discussed phenomenon[2] and one which is backed up by the fact that 'dis-ease' can produce very real symptoms of 'disease'.

Reasons for consultation

The 67 clients referred by a G.P. were asked why they had consulted him or her in the first place. The G.Ps. were also asked the same question in relation to the 61 G.P.-referred clients about whom they were interviewed. The responses of each group were categorised along the same four broad dimensions: physical health problems; depression, tension, irritability and other psychological problems; sexual difficulties; and other marital difficulties. Many of the clients of the G.Ps. mentioned more than one reason for the consultation.

Table V Clients' reasons for G.P. consultation (n = 67)

Physical health problems	19
Depression/tension/irritability	51
sexual difficulties	9
Other marital difficulties	19
(Total is more than 67 because some clients mentioned more than one reason)	

The client responses (see Table V) suggested that the overwhelming majority had had the kind of health problem in which physical and psychological symptoms and causes were inextricably mixed. Altogether, 51 of the 67 said they had come complaining of feeling depressed, tense, anxious, or irritable. Associated with these feelings were loss of weight, difficulty in sleeping, and other physical symptoms. Three clients came with quite dramatic physical symptoms: one with blackouts and two with severe chest pains, for which no physiological cause could be found. Even those clients with the clearest physical illness mentioned psychological symptoms as well. For example, one man had high blood pressure and had collapsed at home. When seeing his G.P., he had subsequently confided his irritability, depression and sexual impotence. Another woman's eczema was exacerbated by her husband's repeated suicide attempts. Two women, with long histories of severe, progressive diseases regularly consulted their G.P. for depression.

Nineteen clients in all came to the doctor prepared to talk about their marital problems (all but seven of the 67 clients were married or cohabiting). An attempt was made by the interviewer to

separate this group from those who only revealed marital difficulties after probing from the doctor, although the distinction was not always clear. The aim was to pinpoint those who had originally seen marital issues as relevant to the medical consultation.

Of the nineteen, most presented their marital difficulties as part and parcel of a more clearly 'medical' problem : physical, psychological or sexual. The largest group (eleven) presented marital problems associated with depression, tension or irritability. Only four - all women in their twenties or early thirties - had specifically consulted their G.P. about their marital difficulties, with no attempt to 'medicalise' the problems. A further two had come for treatment of physical injuries inflicted by their husband.

Sexual difficulties were only mentioned by nine clients, but five of these came specifically and solely to talk about these. Obviously, these people saw medical expertise as extending to sexual matters - they were seeking a solution to these difficulties, rather than treatment of associated symptoms of depression and so on.

Table VI G.P.-reported reasons for consultation by client (n = 61)

Physical health problems	19
Depression/tension/irritability	51
Sexual difficulties	7
Other marital difficulties	43

(Total is more than 61 because more than one reason was mentioned in some cases)

As far as the G.Ps. were concerned, the most frequently mentioned reasons for consultation again fell into the second category: they reported that fifty-one individuals in all came complaining of psychological symptoms. Most of these were of a relatively unspecific nature, but they include a group of six who demonstrated more specific psychiatric symptoms: hydrophobia, agoraphobia, severe agitated depression and so on, and a further three who had made suicide attempts. In six and five cases respectively, depression and anxiety were associated with difficulties in family (other than marital) relationships and relationships at work. Two women sought help with their grief following a sudden bereavement.

Marital problems were also mentioned frequently - sexual difficulties in the case of seven clients, but other marriage difficulties in the case of forty-three clients. In most cases these marital difficulties were also associated with psychological symptoms.

Another significant group of clients (19) were reported to have consulted with a physical health problem. These fell into two groups. Firstly, there were those individuals, usually well-known to the doctor, who had some long-standing chronic condition, for example, high blood pressure, angina, arthritis and Crohn's disease. Some were suffering from a depression which was associated with or exacerbating their physical ill-health. Many of the illnesses mentioned were those often argued to have psychosomatic elements. Secondly, there was a group who came complaining of a variety of symptoms or minor illnesses, sometimes presenting frequently with different physical and psychological ailments, many of which were found to have no obvious physiological cause, and others which their G.P. considered did not in themselves

merit a surgery visit. The implication in many cases was that the individual had, consciously or unconsciously, used a 'respectable', clearly medical reason to gain access to the doctor in the hope of then obtaining a rather different kind of help.

The inextricable mixture of physical and psychological symptoms and causes is thus evident in both G.P. and client responses to the question of why the doctor was consulted in the first place. These two sets of responses are not directly comparable. It was hoped that they might be, given that the questions were worded in the same way, but it was found that the two groups did not respond in the same way. Clients tended to talk about the specific consultation or series of consultations during which counselling was suggested, and could remember fairly precisely the initial reason for coming to see the doctor. On the other hand the G.Ps' recollection was often, not surprisingly, far less precise. In some cases they could only remember the occasion by looking at the medical notes, which were often not very comprehensive, nor precise. Their responses, therefore, tended to be far more related to the general medical history of that period and about what had emerged in the course of consultations, rather than the specific initial reason for the consultation. As a result, for example, they mentioned 'marriage difficulties' (other than sexual) in the case of 43 clients, whereas only 19 clients had themselves given this as a reason for coming to see their G.P. (and this included two who were not included in the G.P. interview sample). Another difference was in the range of problems specified: the G.Ps. tended to talk about a greater range of 'problems per person'. However, this was largely accounted for by the more frequent mention of marriage difficulties.

In spite of these differences, both sets of responses show the dominance of psychological symptoms among the group. In the client interviews, over three-quarters of the responses mentioned depression, tension, irritability or inability to cope. The corresponding proportion in the G.P. interviews was 84%.

An obvious consequent question relates to how far the G.Ps. thus saw counselling as a way of relieving or 'treating' these psychological symptoms, whatever their origins or causes, or whether these were those of their patients in whom they considered these symptoms to be related to problems in a marital relationship. Seven of the clients in this group were not married nor cohabiting but two of these had recently been widowed and four were divorced and becoming involved in new, marital-type relationships. Thus, on the basis of these demographic characteristics, only one, male client obviously did not fit easily into the traditional 'marriage guidance' category. As far as the rest are concerned, it is necessary to look at why they were referred.

Reasons for referral

The G.Ps. were asked in general terms to describe the criteria by which they decided that it would be appropriate to refer a patient for counselling. The five G.Ps. fell into two groups, in the sense that three specified that they would only refer people with marital problems; indeed they emphasised that for a variety of reasons, such as the counsellors' training and the most effective use of their limited time, they were unhappy about referrals of a general nature. The other two, in contrast, preferred a wider definition of appropriate

referrals. One doctor referred to:

> "People with complex interpersonal and social problems - not just marital, all problems with relationships."

- although he did restrict his referrals to adults and tended not to refer those with more specific psychiatric problems, especially as the practice by that time had the services of a community psychiatric nurse.

The remaining G.P. drew no such boundaries. He would (and did) refer:

> "Anyone with any kind of psychological problem... people who don't just have problems, but are neurotic about them... (in)-sufficiently mature to weather a crisis ... persistent psychological/relationship problems."

Table VII G.Ps' reasons for referral to counsellor (n=61)

Primarily marital problems		45
Primarily other problems		16
- work	4	
- family relationships	4	
- depression/agoraphobia	4	
- physical illness	3	
- bereavement	2	
- elucidation	2	
- unwanted pregnancy	1	
Total		61

(Sub-total is more than 16 because more than one reason mentioned in some cases)

When the G.Ps. were asked why they had referred particular patients to the counsellor (see Table VII), this divide was again evident, particularly marking off the last G.P. from the rest. In the case of 45 of the 61 patients, they said that the primary reason for referral was for discussion of marital problems. The counsellor was thus, in this sense, in the majority of cases, fulfilling a traditional role. Indeed, the 16 patients who were referred primarily to discuss problems which were not marital were, with one exception, all referred by one of the five G.Ps. The one exception was a women with what was described as 'extended post-natal depression'. She had subsequently moved to another practice and her medical notes had been sent on. The doctor's recollection of the referral was hazy and it may well have been that he suspected an underlying marital problem.

Thus only one of the G.Ps., in the case of this client sample, was not using the counsellors solely for marital counselling but rather as a more general purpose counsellor. This G.P. referred most heavily and had already stated his support for an eclectic role for the counsellors. He was the G.P. who tended to refer single people and adolescents, and to use the counsellors, as he described it, for 'a mild form of psychotherapy'. Thus 15 of the 33 clients he had referred - almost half - were not referred primarily for marital difficulties. They were having difficulties at work, or with relationships generally; or they suffered from long-term, neurotic psychiatric symptoms; or they were finding it difficult to cope with a specific crisis, such as bereavement. Some were referred as the G.P. put it, for 'elucidation and assessment'. He had felt that counselling, with its relaxed atmosphere and hour-long appointments, might be able to shed some light on the causes of psychosomatic or psychological

symptoms.

The above represents an unusually specific statement of the reason for referral. In the great majority of cases, the G.Ps. found it difficult to go beyond very simple statements about 'discussion' of problems or to specify the nature of the help which they anticipated that the counsellor may have been able to provide.

Table VIII Client-reported reasons for referral, or self-referral, to counsellor (n = 83)

Someone to talk to	40
Someone to clarify problems	25
Someone with time	7
Someone with expertise	8
Alternative to medication	4
Someone to advise	3
An outsider	2
Someone to ease tension	2
Need to see both partners	9
G.P. was vague/non committal	11

(Total is more than 83 because more than one reason mentioned in some cases)

It is thus interesting to look at the responses of the clients to a similar question about why they were referred. All the clients, except four who were self-referred, were asked why the people who suggested they see the counsellor thought she might help them. The self-referred clients were asked why they thought the counsellor might help (see Table VIII). All of the small group of self-referred clients had approached the counsellor in what seemed like a spirit of desperation, wanting positive advice and guidance about problems they had

defined as marital. All of the nine secondary referrals said that it was suggested to them that their spouse's problems may have more chance of being resolved if both partners talked with the counsellor. On the other hand many of the referred 'primary' clients found it difficult to answer this question with any precision, and this often seemed to reflect the vagueness with which the G.Ps. themselves explained the reasons for referral. The kind of help that it was suggested might result was usually couched in very general terms, such as "someone to talk to" (mentioned by 40 clients), or someone to clarify their problems (25 clients). The G.Ps.,according to the clients, sometimes talked about the counsellors having more time, or being 'experts', or as providing an alternative to anti-depressants. However, in the majority of cases, they did not seem to attempt any explanation of the nature of counselling at all, or, if they did, their patients were not in a fit state to absorb the information. This is important, as it has been argued[3] that one advantage of marriage guidance counsellors working in general practice is that the doctors can act as 'filters', to exclude those prospective clients who may be unsuitable for counselling and to prepare others so that they know what to expect.

It certainly seems, judging from the memories of these clients, that the G.Ps. were not undertaking the latter function. Indeed, eleven clients did comment that their G.P. had been rather vague or non-committal, and, of the 67 primary G.P. referrals, nineteen said that they had not been told that it was a marriage guidance counsellor to whom they'd been referred. Some were puzzled by this vague referral, and some expressed shock and horror when they discovered it was to a marriage guidance counsellor. For example,

one woman, referred with her husband, said:

> "I'd just spent two weeks in hospital and felt worse after I'd come out .... just cried all the time .... I think the doctor thought there was some other reason for my tears, so he suggested we should see Mrs. .... We were both baffled, we didn't know who she was or why we were supposed to see her.... The receptionists said she was a 'counsellor'. I was frightened ... When we found out she was a marriage guidance counsellor, we were horrified and shocked. Our marriage is idyllic".

The counsellors did mention during their interviews (see earlier) that they sometimes had to spend the first counselling session 'working through' the clients' reactions to finding out who the counsellor was.

There were some exceptions, particularly among those referred by one of the doctors, who did seem to perform more of a filtering function than his colleagues. For example:

> "He said that she was a marriage guidance counsellor. He said that she couldn't promise a 'solution', but she'd speak to me and help me to see the situation more clearly - it would be someone to reflect the situation".

Several reasons could be behind this apparent widespread lack of explanation of who the counsellor was, or what she may be able to do (and this applied equally to the handful of clients referred by other people). It may be, as has been suggested above, that some clients were in an emotional frame of mind which made it difficult for them to absorb an explanation which was given. They may simply have forgotten what the doctor said. However, a significant number did specifically recall how vague the doctor had been. It may have been that the G.Ps. were unable to specify what exactly 'counselling' was. Or they may have felt it was better for those they referred

to start off with no preconceptions. Or they may have been worried that some potential clients would have been deterred from going by an unfavourable image of marriage guidance counsellors. In some ways they could have been accused of 'passing the buck' - leaving the counsellors to deal with some rather confused and perhaps hostile people!

This impression of some lack of explanation on the part of the G.Ps. to the patients they referred, was reinforced by the G.Ps' responses to a general question about how they suggested to patients that they might see one of the counsellors. They tended to talk about having counsellors on the premises (two did not always specify that they were marriage guidance counsellors) who "may help", who had the "time and expertise" for "talking problems over".

Reactions to referral

How did the patients react to this often vague referral and mention of a 'counsellor'. All of the G.Ps. found that there were some initially negative reactions, although their estimates ranged from "the majority" to "a few". All managed to persuade some patients who had initial reservations eventually to go. However, they reported very varied "refusal rates". One G.P. was only prepared to say that "the majority" to whom he suggested counselling did see one of the practice counsellors; two estimated that around 25% refused; and the remaining two talked about a very small proportion who did not eventually go.

Of course, these were all guesses on the part of the G.Ps. and

thus their accuracy may well be questionable. However, if there are real differences, it is interesting to speculate on the reasons for this. They could lie in the approach of the doctor to suggesting counselling; or in the type of patient to whom he chooses to suggest counselling; or even in the nature of the patients on a particular G.P.'s list in a group practice, particularly as it may well be that patients gravitate towards the doctor whose 'style' they prefer. Of the two doctors who reported the lowest 'refusal rates', one had expressed a long-standing interest in counselling and had seen it as part of his job to counsel his patients. Thus his patients may have been more familiar with and attracted to a counselling approach. The other was the G.P. who demonstrated most enthusiasm for the counselling service - in terms of the number and eclecticism of his referrals - and expressed the most awareness of his own lack of expertise in counselling. His low 'refusal rate' may therefore have been related to his high motivation to refer. He did talk about being 'quite directive' on occasion to the patients he felt should see the counsellor.

Those patients who constituted the 'refusal rate' were of course by definition outside the sample of interviewed clients. However, it was likely that the sample did include some who demonstrated at least initial reluctance.

Table IX Client reactions to referral to counsellor (n = 79)

Positive	31
Negative	26
Ambivalent/neutral	22
total	79

The referred clients were thus asked how they reacted to the suggestion of going to see the counsellor (see Table IX). The responses were categorised into those who reacted positively, those who reacted negatively and those who had ambivalent feelings or none at all. However, the division between these was not an easy one to maintain.

There were thirty-one clients who expressed positive feelings. They seem to divide into two groups, although there is some overlap. On the one hand, there were those who spoke of their relief and of how pleased they were to have the chance to talk to someone, especially someone who was an outsider,not involved. Some expressed their trust in their G.P.'s referral:

> "I was quite happy to go - I believe in doing what the doctor recommends".

On the other hand there was a significant group whose positive feelings were linked with a sense of desperation. One woman expresses this in an extreme manner:

> "I was dying to go - for us both to go. I was clutching at every straw by then".

Others were less dramatic, but conveyed the same impression. One man said:

> "Anything that could possibly help was worth a try".

This impression of desperation was quite widespread among the clients interviewed. It has been suggested[4] that general practitioners may see individuals at an earlier stage of their marital or other

relationship problems than other professionals, but some of these individuals were obviously already, as one put it, at their "wits' end". In all, twenty of the seventy-nine referred clients spontaneously said they were 'desperate', 'would try anything' or 'see anyone'. In some, as the examples above show, this desperation produced positive reactions. In others, ambivalent or negative reactions were expressed - in these cases, the clients were so desperate that they went in spite of their doubts or pessimism about the outcome:

> "I wanted to try anything and everything. I wasn't very optimistic, but I thought I'd give it a go".

It has already been mentioned that some clients' positive reactions were linked by them to referral from a trusted G.P. However, G.P. encouragement or pressure was also linked to some negative reactions. Clients only went because their doctors wanted them to, although they themselves were not very keen on the idea. All of the five G.Ps., when interviewed, did give the impression that they engaged in some fairly active persuasion of initially reluctant clients; by asking them whether they had gone and repeating the suggestion over a number of consultations; by 'prescribing' counselling quite firmly; or occasionally, by actually making the appointment or taking the patient to meet the counsellor.

This is linked to the issue of whether clients resent being 'passed on' or 'fobbed off' by their G.Ps. when it was he whom they had approached for help.[5] Only four or five of the 67 G.P.-referred clients suggested in their responses that they may have felt something of this. The most forceful was a client who had become hysterical

during a surgery consultation:

> "Dr. .... brought Mrs. .... in to talk to me, calm me down. I was very annoyed when I found out she was a marriage guidance counsellor. I felt annoyed that he'd pushed me on to someone else".

Others only implied that they felt this way:

> "Dr.... suggested I went to have a chat with the social worker (in fact it was the counsellor, J.K.). Actually, I wasn't very bothered about going, as I felt better after seeing Dr. . I can talk to him and I was a bit frightened of seeing someone else".

> "I didn't mind (being referred). I felt I'd already spent a lot of Dr. 's time".

In all, twenty-six of the referred clients expressed negative reactions to the idea of seeing a counsellor. The most common of these, mentioned by sixteen clients, was a lack of optimism regarding what counselling could do; they did not see the point of going, or were dubious about the efficacy of counselling. Eight talked about feelings of embarrassment or apprehensiveness, and the same number said that they did not feel their problems were that bad. Only two said they did not like the idea of seeing a marriage guidance counsellor, but it has already been mentioned that at least nineteen clients were not told that the person to whom they had been referred was a marriage guidance counsellor.

Only a few clients expressed actual anger at the suggestion, or at the pressure being put upon them. For example, one woman (a secondary referral) said:

"I didn't want to go. I was annoyed because I felt I was being forced into it. I didn't see the point of going. I went in a very antagonistic frame of mind."

A less aggressive and more typical negative reaction came from another secondary referral, a male client:

"I hadn't any objection to going, but I didn't see what good talking would do. I wasn't hopeful."

Twenty-two clients either expressed mixed feelings or had no strong feelings either way. One example of mixed feelings came from a male client:

"I was clutching at straws by that time and would see anyone. I was curious, but rather pessimistic."

Some of the clients whose reactions could be described as 'neutral' attributed this to their mental or emotional state at that time. Again, a male client expresses this well:

"When the doctor suggested it initially, I was so far down that I didn't care either way, I just did what was suggested. Nothing mattered."

We return here, of course, to the issue of the G.P. referral, and several of the clients who did not feel particularly strongly either way about seeing a counsellor, specified that they had agreed because that was what their doctor had suggested. More generally, this must apply to all those clients who expressed negative, mixed or neutral feelings. They saw the counsellor only because of some pressure from a third person - usually their G.P., sometimes a spouse

and in a few instances someone else. Of the clients interviewed, one would expect this group of forty-eight (especially the forty primary referrals among them) to be the least likely to have contacted a marriage guidance counsellor working at a counselling centre. Their reactions to the service are thus particularly interesting. The links between initial reaction to the idea of seeing a counsellor and eventual reaction to the counselling will be examined later.

Table X Length of time referred clients took to decide to see counsellor (n = 79)

Straight away	69
after a while	9
not recorded	1
total	79

On the whole, even those clients who were not very optimistic about the outcome, went to see the counsellor as soon as possible (see Table X). Only nine clients delayed going. Three said that their G.P. had suggested it several times before they were persuaded. Six thought it over themselves for a few weeks before they decided to go, some cancelling appointments they had made initially. Their eventual decision resulted from a variety of factors: having plucked up sufficient courage; not wanting to disappoint the doctor; or an unbearable build-up of problems.

Timing of referral

It has already been noted that in spite of the assertion that counsellors in general practice are likely to see people at an early

stage of their problems,[6] some of the clients were clearly already in a state of some desperation.

Table XI Whether clients wished they had seen counsellor earlier (n = 83)

Yes	35
No	45
Don't know	1
Not recorded	2
total	83

All but two of the eighty-three clients interviewed (one woman denied ever having seen the counsellor and the question was omitted in error from one interview) were thus asked if they wished they had seen a counsellor earlier (see Table XI). A small majority (45) said 'no'. They either felt that the time at which counselling had been suggested to them was the most appropriate, or (in the case of those who felt they derived no benefit from counselling) that the counselling would have been of no more help at an earlier stage. However, there were two clients who felt that although they had derived no benefit from counselling, it could have helped them earlier in the history of their health and marital problems. This feeling that counselling came too late, rather than being intrinsically irrelevant or useless to them, was also conveyed by ten clients who had found counselling only of limited help, but who wished they had seen the counsellor earlier.

Duration of problems

Table XII Duration of clients' problems (n = 83)

< 3 months		5
3 months - 1 year		20
2 - 5 years		19
6 - 10 years		14
>10 years		24
not recorded		1
	Total	83
All/almost all married life	28	

On the other hand, when asked the presumably related question of how long they had had their problems before they saw the counsellor, many of the clients talked about fairly long periods of time (see Table XII). Nearly half (38) mentioned periods of six years or more, and 24 went back more than ten years. Twenty-eight of the married clients talked about a period covering virtually the whole of their married lives. This would seem to substantiate recent claims[7] that many marital problems became apparent in the very early years of married life, although it is important to remember that these clients were looking in retrospect at a situation which had subsequently warranted marriage guidance counselling. This counselling is likely to have encouraged them to search for early signs of stress and to reinterpret situations they may not have seen as particularly problematic at the time.

Several clients pointed to particular events as initiating or precipitating problems, both in relationships with others and in their

own mental health. Pregnancy, or the birth of a child were the most frequently mentioned. Others included early retirement, children becoming adult, an episode of ill-health, and a spouse suddenly leaving home. Three women had husbands who had suddenly suffered a dramatic decline in their mental state.

It was quite clear that to some of these people these events had at least partially 'caused' their problems. Sometimes, especially in the case of the three last-mentioned women, all of whom had husbands who had been diagnosed as severely mentally ill, this argument was convincing. However, many counsellors would argue[8] that extraneous factors do not 'cause' relationship or other mental or emotional problems, although they may exacerbate those that already exist. Some of the clients also demonstrated their belief in this pattern. For example, one man said that really his problems had begun very early in married life but had become far worse when his health began to deteriorate and he was forced to take early retirement. He was one of several clients who distinguished both long-standing, chronic problems and a more recent, acute crisis. Interestingly, however, his wife pointed to his early retirement as the origin of their problems.

Preconceptions of counselling

The clients were asked if they could remember what they expected counselling to be like before their first meeting with the counsellor, and whether, in fact, their preconceptions were subsequently confirmed. This did not seem to be an easy question to tackle - many clients found it difficult to remember what they had expected now that the memory had been superseded by actual experience, and thirty-seven of

them said they had no preconceptions at all. For some, of course, this was likely to reflect reality - they just had no idea of what to expect given the above-mentioned vagueness of their G.P. when he suggested counselling.

Table XIII Client preconceptions of counselling (n = 83)

Active, directive counsellor	22
Questioning, listening counsellor	20
'Do-gooder', 'Busybody'	3
No preconceptions	37
Not recorded	1
total	83

Of those who could remember some preconceptions, the largest group (twenty-two clients) said that they expected to be given advice and told what to do about their problems, or talked about 'treatment' by an expert (see Table XIII). This is perhaps not surprising given that they had usually initially approached their doctor, a professional who is expected to be fairly positive and directive in his dealings with patients. These preconceptions may also reasonably be expected to result from the title of marriage guidance counsellor. An unfavourable aspect of the image of this occupation was reflected in the preconceptions of three clients who expected a 'do-gooder' or an 'interfering busybody'.

The remaining twenty clients (one of the eighty-three denied having seen the counsellor) reported in retrospect what could be seen as a more accurate picture of how marriage guidance counsellors see their work. They expected someone who would ask them questions,

explore their past, listen to them and help them to understand. Several of these drew on previous experience of what they saw as similar situations: two had already been to a marriage guidance counsellor, one referred to the approach she had found in an encounter group, two already had some knowledge of counselling from their work, and five mentioned that they had seen television programmes about counselling.

As one would anticipate from reading the counselling literature and talking to counsellors, those who expected a very 'active' and directive counsellor were, all except one, surprised by the reality. Their reactions to this varied. Ten clients felt advice and guidance from an 'expert' was what they needed and so felt disappointed by what they saw as lack of direction on the part of the counsellor. On the other hand, five clients expressed their relief that the counsellor was not going to tell them what they should do. For the remaining six, counselling was not as they had expected, but they were prepared to give this version a try.

Of the twenty clients who had expected a less directive counsellor, fourteen said that their expectations had been fulfilled. Only six found the counselling different from what they had anticipated. One admitted that although she had been told that the counsellor would listen and encourage her to talk, she was secretly hoping for some 'magic wand'. Another was similarly disappointed that all this talking did not produce for her an explanation of her marital problems. However, for the other four, the surprise lay not in the techniques of counselling, which were much as they expected, but more in their ability to participate. They found they could relax and talk freely

without embarrassment, and they attributed this to the personality and the expertise of the counsellor.

Contact of spouses with the counsellor

All of those clients who had been the first to have contact with the counsellor had travelled the route from patient to client. All were registered with the practice and all had had recent contact with their G.P., even those who were not directly referred by him. However, there was another group of clients: those who have been called 'secondary referrals', who may not necessarily have been to see their G.P. recently, nor even be registered with that practice. Only nine of the 83 clients interviewed were secondary referrals. In addition, six were single at the time of counselling, with no steady partner. The remaining sixty-eight clients were asked whether it had been suggested to their spouses that they might see the counsellor and, if so, by whom and with what result (see Table XIV).

Table XIV Contact of spouses with counsellor - primary client referrals (n = 74)

Joint first interview	10
Subsequent contact with spouse	15
No contact with spouse	43
N/A (single)	6
total	74

Ten of these clients had been accompanied by their spouses to the first interview - either it had been suggested when they were referred to the counsellor that they should go together, or they had

arrived at that decision themselves. In the case of fifteen clients, although they had originally gone to see the counsellor on their own, their spouse had subsequently had some contact. However, the largest group (forty-three) comprised those whose spouses had had no contact with the counsellor. Thus of the sixty-eight cases where the clients had a marital-type relationship, both partners were only seen in 37% of them. This is an even lower figure than the 44% found among the total married client population at the Medical Centre and, given that counsellors believe that work involving both spouses generally proves more fruitful,[9] deserves some attention. Why did so many spouses not travel the route to becoming clients?

The married clients who were primary referrals, and whose spouses had had no contact with the counsellor, were asked why this was so.

In six cases, the spouse was not available at the time. Four had left home, one was in hospital and one was abroad. In thirteen cases, according to the clients, contact with the spouse was never suggested by the counsellor, and in another four the clients failed to pass on the counsellor's suggestion to their spouse. In the case of these last four, some wish to keep the counsellor to themselves was apparent, for example, by defining their problem as only concerning themselves, not their marriage. This was also evident in the words of some of those who said that contact was never suggested, yet whose problems were clearly marital. In these cases it would be surprising if the counsellor had not suggested seeing the spouse. It may be that the client had forgotten or had never heard the suggestion in the first place. A good example is that of a man who saw one of the counsellors eight times. He talked about the

help counselling had been to him with great enthusiasm and said:

> "I regard Mrs. . as one of my best friends - I trust her... I never told my wife I was going ... Mrs. . never suggested she should see my wife ... I didn't want her to come".

On the other hand, the counsellor, feeling that a good relationship with the client was producing fruitful counselling (as well as being personally rewarding to her), may have been reluctant to risk that relationship by suggesting the introduction of a third person. The above client's counsellor, when she was interviewed about him, expressed equally great enthusiasm about him and the effect counselling had had, and talked about the rapport which had developed. It may have been that both she and the client consciously or unconsciously felt that the wife would intrude on that rapport.

Another male client, who had seen a different counsellor, and who had only with great reluctance and after a considerable time, suggested counselling to his wife, talked about his fear that she would 'put a wedge' between him and the counsellor. Clients seemed anxious to preserve their exclusive relationship with the counsellor and also fearful of the introduction of another version of the marital story, which may have put them in a less favourable light.

In the remaining twenty of these forty-three cases it was suggested to the spouse that he or she should see the counsellor as well, but the spouse either refused (seven cases) or agreed, but never actually made and kept an appointment. The reasons given by the clients for these refusals fell mainly into two groups. Some spouses saw no point in going as they saw the problem as belonging

to the client and not to them. Others were reluctant to talk about their feelings or what they considered to be private aspects of their lives, or thought counselling was a 'waste of time'. We can derive some indication of how enthusiastically the clients suggested counselling to these spouses by looking at the responses to the question: "Would you have liked your husband/wife to come?" Of the twenty, ten replied in the affirmative, seven replied in the negative or said they were 'not bothered', and two said that they had wanted their spouse to come at the time, but looking back now they did not think it would have made any difference. (One client was not asked the question, in error).

How did these excluded spouses feel about their husband or wife seeing the counsellor? In all, in seven cases, the client never told his or her spouse that they were seeing the counsellor, either because of this desire to exclude them for some reason, or because they were afraid of their reaction. Of the spouses who did know, six raised active and continuing objections - they did not like the idea of their spouses discussing their private lives with a third person. Only about the same number, however, showed any positive enthusiasm for the idea.

If we return to the group of sixty-eight clients with a marital-type relationship and who were primary referrals, we can separate out thirty-nine clients to whom it was suggested that their spouse should come to see the counsellor. The clients to whom this applied were asked by whom and how this suggestion was passed on to their husbands and wives. In the majority of cases, the counsellor suggested that they themselves should ask their spouse. In two cases, the spouses were asked by their G.P. whom they were consulting regularly.

However, in seven cases (involving two of the three counsellors) the counsellor approached the spouse directly, either by telephone or by letter. This would seem to be unusual in the context of marriage guidance counselling[10] and reflects the more active role in initiating contact with clients that at least two out of three counsellors felt able to pursue in the setting of a general medical practice. In terms of persuading spouses to attend, the evidence suggests it had some success. Only one of the seven clients approached directly refused to come, and six of the fifteen cases in this sample where spouses did subsequently see the counsellor, were those where a direct approach was made.

Previous contact with marriage guidance counsellors

Table XV Clients' previous experience of marriage guidance counselling (n = 83)

Yes		8
helpful	1	
not helpful	7	
No		75
had thought about going	10	
never thought about going	65	
Total		83

Very few of the clients had had any previous contact with marriage guidance counsellors - seven women and one man out of the eighty-three had been to a marriage guidance centre, and only one of these had found the counselling they received helpful (see Table XV).

The remaining clients were also asked whether they had ever thought of going. Ten replied that they had, but either they had been put off by their spouse's refusal to participate, or had changed their minds when it actually came to telephoning for an appointment.

Thus, sixty-five of the eighty-three clients interviewed had never either gone to a marriage guidance counsellor or thought about going. Of course, some of them may have done so at some time during their present crisis, if there had been no counsellor at the practice. However, this does suggest that there is some validity in the assertion that marriage guidance counsellors in a general practice are reaching people whom they would never otherwise see.(11)

Appropriateness of referral

Table XVI Counsellor's opinion on appropriateness of referral (n = 68)

Yes	54
Yes in terms of content, no in terms of person	9
Not sure	4
No	1
Total	68

Of course, reaching a formerly inaccessible clientele is only of value if the clients are people for whom counselling is appropriate and useful. One way of approaching this question and at the same time of gauging the counsellors' satisfaction with this particular 'route' to counselling, was to ask them whether they thought the referrals were appropriate. Their responses reflect their general

satisfaction with the way in which their skills were being utilised by the practice (see Table XVI). Leaving aside the 7 clients who reached the counsellors through self-referral (who were all felt to have referred themselves appropriately), the clients and their problems were felt to be suitable for counselling in the case of 54 out of the 68 clients about which the counsellors were interviewed. Reservations were thus expressed in only about one fifth of cases. Thus, occasional comments such as: "Dr. - does make me feel a bit like a dustbin sometimes", and: "Mrs. - was only referred because she was a nuisance", were passed in a semi-serious manner and appeared not to reflect a major bone of contention.

The reservations that the counsellors did express were almost exclusively related to the type of person rather than the type of problem. Thus it is evident that the counsellors defined their sphere of expertise very widely - more so than some of the doctors (see above). In nine cases, the counsellors felt that the referral was appropriate in terms of content, but not in terms of the individual involved, in four cases the counsellor was not sure, and only in one case - where the woman had come on the suggestion of a neighbour - did the counsellor say firmly that the referral was not appropriate. So what caused the counsellors to have reservations? What kind of individual was not suitable for counselling? It was found that the answers from the counsellors tended to be very much in terms of the client's ability or inability to 'use' counselling - in other words, personal rather than situational characteristics. These responses bring us on to another area: that of the helpfulness of counselling. This will be discussed in chapter 9.

Summary and conclusions

The nature of this research meant that all those interviewed about their counselling experience had been both patients of the practice and clients of a counsellor. More than half had been registered with the practice for over ten years and, overall, a fairly high level of satisfaction was expressed with the level of service they had received. These findings, however, were rather impressionistic and must be viewed in the context of the very high levels of patient satisfaction generally reported in studies of general practice.

Very few of those interviewed had previous experience of marriage guidance counselling. The route from the status of patient to that of client had usually been through referral by a G.P.whom the individual had consulted. It was found that most of these medical consultations had concerned a mixture of physical and psychological symptoms and characteristics. Relatively few patients had come specifically to discuss marital or other relationship problems. However, for most, these clearly emerged over the course of their consultations, as these were, for the G.Ps. the rationale for referral to the counsellor in the overwhelming majority of cases. In fact, except with respect to one G.P. (who did, however, refer more than his colleagues), the referrals were to discuss primarily marital relationship problems. Only in a few cases did the counsellors feel that these referrals were inappropriate and these were related to the nature of the individual rather than of the content of the problem.

The G.Ps. found it very difficult to be specific about the nature of the help that counselling could offer, and this impression was

reinforced by the recollections of many clients of a very vague and general explanation of whom they would see and why. Only just over one-third reported reacting positively to the idea, almost as many reacted negatively and the rest were ambivalent or had no strong feelings either way. However, these reactions were linked to a wide range of preconceptions about what referral would involve, including a significant group who reported no preconceptions at all.

Many of the clients interviewed gave the impression of having reached a point of some desperation in coping with their problems. They certainly often appeared to have had those problems for an appreciable length of time. On the other hand, a small majority felt that the timing of their referral was about right; that counselling would have been no more helpful - or no less unhelpful - at an earlier stage.

Most of the clients interviewed were primary referrals and most were married. It is thus perhaps surprising that of those cases in which the clients had marital-type relationships, for a variety of reasons, both partners were only seen in 37%. This did not seem to reflect the preferences of the counsellors, but rather those of either the clients or their spouses.

It has been argued that general practice attachments can offer counsellors the opportunity to counsel more effectively: for example through access to a broader range of clients at an earlier stage of their problems. The evidence from this research is not entirely clear. It suggests that many clients are being counselled who may not otherwise have approached the marriage guidance service: who had no previous experience of it and whose reaction to the idea was

not entirely favourable, but who still accepted referral. However, the problems were still primarily those of marital relationships, at least as perceived at the point of referral, especially if the referrals of one of the five G.Ps. are excluded. These problems were also reported as quite long-standing and as frequently inducing a feeling of desperation in the individual. Thirty-five of the eighty-three clients interviewed said that they wished they had gone earlier (of course it is important to remember that the counselling attachment had only been operating for a few years). Also, given the widespread opinion that marital counselling is generally more fruitful if both partners are involved, the high proportion of cases in which this was not so deserves some attention.

In order to clarify this evidence, it would seem useful to investigate how helpful counselling was perceived to be. This is the task of the next chapter.

Chapter 9

The Extent and Nature of Help Given by the Counsellors

In this chapter is explored the area at the very core of the interviews. Client responses to questions about the extent and nature of the help given by counselling and the sources of their satisfaction/dissatisfaction are examined. It is discussed how far these perceptions accord with those of the counsellors and G.Ps. Other potential or actual sources of help are examined and the question is raised as to how far it is possible to delineate the characteristics of individuals, or of their counselling, which will predispose towards an outcome rated highly by clients.

The client responses

The client responses to the question of whether counselling had helped them could be grouped into three broad categories: the unqualified 'yes's', the qualified 'yes's', and the 'no's' (see Table I). Forty-six of the 83 clients interviewed (55%) fell into the first category. They felt that counselling had helped them and that at least some of the effects of that help had lasted. 20 clients (24%) said that counselling had been of some help, but qualified this in some way. Either they felt that in some important areas counselling had not helped, or that the beneficial effects had only been short-term. Two clients who had found counselling helpful on one occasion, but not on another were also included in this category. Finally, there were 17 clients (20%) who felt they had obtained little or no benefit from counselling.

Table I Client responses to question: "Did counselling help you at all?" (n = 83)

	No.	%
yes	46	55
qualified yes/yes and no	20	24
no	17	20
total	83	100

As had already been discussed in the context of the study's methodology, it cannot be assumed that the numbers of clients who were satisfied or dissatisfied with the outcome of counselling in the interview sample accurately reflect the overall distribution of client attitudes. There may well be an over-representation of satisfied clients, or of clients with strong feelings either way. However, the sample does include clients with a wide range of feelings of satisfaction and of dissatisfaction.

The responses also revealed the inadequacies of a unilinear concept of client satisfaction - dissatisfaction, such as, for example, is implied in the usage of scales with a number of points on which client responses can be rated. The relatively unstructured discussion revealed that most clients have a mixture of feelings and very few were entirely satisfied or dissatisfied with every aspect of their counselling experience. As we shall see, some of those whose initial reaction to the question 'Did you find counselling helpful' was an unqualified 'yes' went on to specify certain ways in which they had found counselling disappointing as well as rewarding, and equally, some clients whose initial response was 'no' went on to stress some positive aspects. In a few cases the initial response seemed to be

actually misleading. For example, one woman who had described the counselling as 'very helpful' appeared to become less and less enthusiastic about it as she talked further and produced very little to substantiate her initial global response. The research methods used thus served to illustrate very well the complexities of a concept such as 'client satisfaction'.

Sources of dissatisfaction

The discussion will consider first the principal sources of dissatisfaction with counselling as a helping service, as expressed by those who had not found counselling a help, or who had mixed feelings. This involves responses from 37 clients: 20 who had expressed mixed feelings and 17 who had found counselling of no help. The categorisation of responses of such a rich variety inevitably involves the researcher in a somewhat arbitrary exercise of judgement, but they do seem to fall into several different groups (see Table II).

Table II Reasons why counselling did not help - client responses (n = 36)

	No. of responses
No impact on problems	19
Inadequacies of counselling	18
Personal characteristics of counsellor	4
Characteristics of client	8
Spouse refused to participate	2
Too late	2
One can only help oneself	4
No help necessary	3
Benefits wore off	10

(Total number is more than 36 because some clients gave more than one response)

Firstly, there are those respondents who judged the failure of counselling by its lack of impact on their problems. Counselling failed to solve, lessen or clarify their problems. This was the most frequent single reason for dissatisfaction, being mentioned by 19 clients. These clients did seem to fall into two sub-groups, although the division between them is not sufficiently clear to state categorically how many are in each. On the one hand there were clients who seemed resigned to the insolubility of their problems: no-one and nothing could change the situation. For example, one client had a husband suffering from a severe, long-standing and recurring mental illness; another client had had no sexual relationship with his wife for over twenty years; and a third had suffered from Crohn's disease for twenty years and, after a stormy marriage and eventual divorce ten years previously, had regularly been treated for depression and had gone through several disastrous relationships. These clients, with what seemed to them intractable problems, tended not to have expected much of counselling, and the subsequent experience only served to confirm those low expectations.

On the other hand there were some clients who seemed to have been far more disappointed in the lack of impact of counselling on their situation. They had begun with some degree of optimism. Several said that they had already thought of all the suggestions the counsellor made, or that they seemed to be going over the same ground over and over again and getting no further forward. One client expressed his disappointment that the counsellor had failed to discover the reason for his depression. Another had gone hoping for some advice on how to cope with her loneliness in a new area and her husband's lack of understanding, and was disappointed by the

counsellor's reluctance to give an opinion. Two clients, already determined on divorce, had been disappointed by the counsellors' lack of help with practical problems to do with the custody of children, financial matters and so on.

Some of these 'disappointments' could be argued to derive from a lack of understanding of the nature of counselling and thus they overlap with the comments of a group of 18 clients who attributed their dissatisfaction to the inadequacies or inappropriateness of counselling, (or, more accurately, counselling as practiced by these particular counsellors), as a means of tackling their problems.

Counselling has been called 'the talking cure'[1] and, as we shall see later, one of the chief sources of satisfaction with counselling was the opportunity it gave clients to talk. However, four clients also mentioned this as a source of dissatisfaction, with comments such as: "She just talked". "Talking didn't do any good". "Talking often made me feel worse". The non-directive nature of counselling and the passive role of the counsellor also seemed to some clients to be unhelpful - they were looking for 'expert advice' or an 'outsider's opinion'. One client expressed it as 'giving all the time and getting nothing back'. One woman argued that she and her husband were 'too far apart' to be able to communicate with each other during counselling as the counsellor expected. Another felt that when an individual is very upset, their need is for someone to take them in hand, like a child, and to be more forceful and directive. The same woman found the counsellor to be too sympathetic, too much on her side; she felt she needed someone to put her husband's point of view. In contrast, another client complained that his counsellor

was not sympathetic enough:

> "I needed an expert in handling grief. All my moral props had been swept away and I felt lost. What I needed initially was comfort, but she 'stood off' too much. She just tried to lead me to see the way I was at fault ... She wasn't supportive, she put too much stress on my shortcomings".

Some of the criticisms falling into this group related more to the specific nature of marriage guidance counselling. For example, some clients were annoyed by what they saw as an irrelevant emphasis on their marital relationships and an unwillingness or inability on the part of the counsellor to discuss more general problems. One attributed this to the focus of training of marriage guidance counsellors and their lack of expertise in other relationship and psychological problems.

The level of competence of the counsellor was another factor which for some clients was a source of great satisfaction and respect (see later), while for others it was a source of dissatisfaction: they perceived her competence as inadequate or inappropriate. There were comments such as: "She was obviously not psychiatrically trained" and "I was worried about a lay person doing such a responsible and dangerous job". Two clients pointed to their own knowledge of counselling techniques as a difficulty, one remarking: "I could run mental rings round her". All these clients were well-educated and all but one were in social classes I or II, suggesting that perhaps in this group there may be some resistance to attributing expertise to anyone who is not a fully-trained and highly-paid professional.

Comments about the nature of the counselling overlap with comments

which related dissatisfaction with counselling to the personal characteristics of the counsellors. Only two clients (both women) out of the 83 interviewed indicated a personal dislike of their counsellor. In fact it is worth mentioning at this point how many of the clients (including, and perhaps especially, those who found the counselling of little use) stressed their personal liking for their counsellor, how good a listener she was, how kind and understanding, how sympathetic and how easy to talk to. This may of course be the product of a particular individual's personality, or it may reflect counsellors' training. Counselling texts stress the importance of establishing a good relationship with clients:

> "... The nature of the relationship that a counsellor makes with a client is quite vital, since it is the tool - the only tool - that she (or he) has to work with". (2)

In fact, some argue that providing a relationship in which the client can feel himself to be a person of worth is an important part of the therapy of counselling. As Halmos puts it:

> "The counsellors ..... profess ... that they consider their warm personal attachment to the help-seeker as a vital instrument of helping". (3)

As well as the two women who disliked their counsellor, a third client, a man, although stressing what a 'nice' person she was, found it difficult to relate to her, finding her too "suburban middle-class, safe in her happy marriage". Another man, embarrassed at having to discuss his sexual problem, found his counsellor "too well-spoken for me to feel comfortable" and was puzzled by the whole process of counselling.

Embarrassment and reluctance to talk about intimate and personal matters were mentioned by several clients as an obstacle to the helpfulness of counselling. These comprised one aspect of a group of eight comments which related dissatisfaction with the process and outcome of counselling to characteristics of the client, him or herself. Some of the clients' comments were:

> "I found talking about my mother indecent, disloyal; I wasn't very happy about rattling skeletons".
>
> "It was difficult to get across how I felt, I didn't like revealing my private life".
>
> "I didn't like talking about sex, and 'doing it to order' turned me right off".

Other clients blamed their dissatisfaction on their unrealistic expectations: for example, that counselling could effect a 'miracle cure', or that the counsellor would make a spouse come along and talk about the marital break-down.

Two clients pointed to the lack of participation by their spouses as a factor in the lack of help counselling could give them, and another two said counselling had come too late, revealing a view of counselling as a problem-solving rather than a problem-coping mechanism. Four argued that, ultimately, one can only help oneself, and three that, really, no help was necessary and the referral had puzzled them.

Finally, there were a group of ten clients whose dissatisfaction or mixed feelings stemmed, at least partly, from the immediate or short-term nature of the benefits counselling had provided. One woman said:

"I enjoyed going, I felt less depressed and it helped me to understand our problems better, but there's a difference between talking about things in the counselling room and when you come home to the same problems.... no real benefits have lasted till now."

Others talked about 'gradually slipping back', benefits 'wearing off' and 'no lasting effect'. It seems that at least some of these felt a need for periodic 'booster' counselling sessions. Of course, the option was open to them to return to the counsellor and this will be discussed later.

Sources of satisfaction

Looking at the sources of satisfaction of those clients who found counselling of some or of considerable help, responses from 66 clients are involved, (20 with mixed feelings, 46 who answered 'yes'). The categorisation of these responses posed even more difficulties than that of the negative responses of 36 clients (see Table III). However, it is an exercise which must be attempted if any sense is to be made of such a substantial amount of material, and the researcher has done her best to faithfully convey the flavour and the meaning of what was said to her.

Table III Reasons why counselling helped - client responses (n = 66)

	No. of responses
Someone to talk to	47
Personal characteristics of counsellor	34
Increased understanding	40
Improved communication	15
Support over a difficult time	12
Improved sexual relationship	12
Improved general marital relationship	28
Improved general relationships	12
Help to decide about marriage	9
Helped me as an individual	25
Helped spouse	10
Could cope better	17
Practical help and advice	17
Better health	45

(Total number is more than 66 because some clients gave more than one response)

The most frequent response to the question: "How did you find the counselling helpful", and in many cases the initial response, was 'someone to talk to'. Forty-seven clients referred to this: nearly three-quarters. Many expressed their 'relief' at having someone to whom they could talk and said how they had been 'bottling things up'. One man said how, having agreed to see the counsellor, he and his wife were committed to talking; they could not avoid discussing the problems as they had done at home.

However, for most people, friends and relatives as well as a variety of other professional workers can all be 'someone to talk to'. How far and with what result the clients had talked to

others about their problems will be discussed later. However, at this point in the interview, several factors were mentioned which gave the counsellors an advantage over these groups. Some referred to advantages derived from the nature of their counsellors' job: 'ex-officio' advantages, so to speak. Five clients mentioned the relief it was to find someone with plenty of time and several others implied this when, in response to another question, they gave 'lack of time' as a reason why they did not find their G.P. or psychiatrist as helpful (see later). Twenty-one talked of the advantages of the counsellor being an 'outsider' or a 'third party', impartial and without bias or close involvement in the situation. Outsiders are strangers, come fresh to the situation, can act as 'referees' and do not take sides. Some clients saw these characteristics as useful in making the counsellor an effective 'sounding board', against whom they could bounce off their feelings and opinions, or in front of whom they could more easily talk with their spouses. Others gave the 'outsider' a more active role, in attributing greater validity to her opinions and suggestions. Four clients referred to the knowledge that what they said would be treated in complete confidence, even from their spouse, as opposed to the fear that friends, neighbours and even relatives would gossip. Two specifically mentioned their counsellor's professional skills:

> "... like a friend, but with knowledge"

and

> "... someone who's qualified and trained to understand".

Other clients talked about more personal characteristics of the counsellors which made them rewarding people with whom to talk. The line between these characteristics and those deriving from the nature of counselling is of course not always clear, as it would be possible to argue that the training of counsellors encourages the development of certain personal qualities.

Thirteen clients described how easy their counsellor was to talk to and how relaxed she was, and six described her as a good listener. Two welcomed her sympathetic attitude and one the fact that she was 'not too sympathetic'! Ten referred in very positive terms to their personal liking for the counsellor and how much they had enjoyed seeing her. For example, one man said:

"I now regard her as one of my best friends".

- and another client, a woman:

"she was a very nice person - in fact 'superb' is the best way to describe her".

There were comments from nine clients on the understanding - of themselves and their problems - that the counsellors had shown. Two clients spoke of the relief of finding someone who actually seemed to believe them (both of these had husbands who were behaving in a rather bizarre fashion). Four talked about their counsellor's sincerity, and the impression she gave of 'caring', with remarks like:

"... she had your interests at heart"

and

"... everything you said was important".

In all, 34 of the 66 clients who found counselling of some help referred specifically to some aspect of the counsellors' personal characteristics when describing the nature of that help. No doubt many others would have done so if they had been prompted by the interviewer. Many implied the importance of the personal relationship by talking about the help they received from the counsellor rather than from counselling. Perhaps more significant are the findings that, firstly, no-one who had found counselling helpful referred in negative terms to their counsellor's personal characteristics, and, secondly, many of those who had not found counselling helpful nevertheless (as discussed earlier) emphasised what a nice person they had found the counsellor to be. Only two expressed an active dislike.

It is important, of course, to remember that people may find it easier to express their positive than their negative feelings about an individual, especially to a third person who might not have completely successfully dissociated herself from that individual. However, the lack of prompting during all but a very few interviews meant that the responses were spontaneous - there was no need for the clients to express any views one way or the other.

The evidence does suggest that the development of some personal liking for the counsellor is an important element in 'successful' counselling as perceived by clients. Indeed one client specifically said how important it was to like the counsellor - that it was only

as she grew to like her counsellor that she found counselling helpful. Unprompted, over half the 'satisfied' clients interviewed mentioned this aspect, and none mentioned a personal dislike. For many of this group, the impression was that this personal relationship was of considerable importance, even while many also welcomed its boundaries - expressed in time (the limited number of sessions) and in space (its limitation to the counselling room and the counsellors' lack of involvement in other aspects of the clients' lives). A note of desperation sometimes crept in:

"No-one else understood"

"The only person I could talk to"

"The only person who believed me"

However, given that half of those clients interviewed who had not found counselling helpful also referred to their liking for the counsellor, it seems that this is not a <u>sufficient</u> feature for client satisfaction. Either the dissatisfied clients had higher, or different expectations, or the satisfied clients derived something more from counselling than a pleasant encounter with someone they liked and who they felt cared about them.

The clients were also asked during their interviews about another, rather different personal characteristic of the counsellors: their sex. At the time of the interviews, there had only been female counsellors working at the practice. All the doctors were male, and there had been only male doctors at the practice since the counselling began, with the exception of one female trainee G.P., who subsequently returned for a few months as a locum. There were, however, a number

of female nursing and health visiting staff and a female social worker.

Table IV Client views on preferred sex of counsellor (n = 83)

Female	43
Male	7
No preference	31
No response	2
total	83

The clients were asked whether they would have preferred to see a male counsellor (see Table IV). 43 of the 83 clients expressed a preference for a woman counsellor rather than a man, including 9 of the 20 male clients. Of course, as some of them pointed out, their response was undoubtedly influenced by the fact that a female counsellor was all they had known. Apart from this, the reasons given were couched in very similar terms, although there were some differences between the sexes. Both male and female clients talked about women being easier to talk to, especially about very personal matters, and more sympathetic. However, many of the women stressed the greater understanding of their problems that another woman was likely to have - one client talked about women 'being all sisters under the skin". Most of the men, on the other hand, directly or indirectly stressed their ability to be more frank and open in talking to a women, because there was no need for any 'bravado'. They seemed to think that it would be more difficult to admit to problems and failures, especially sexual ones, to another man. As

one client put it:

> "I find it much easier to talk to a woman about intimate things. With men, there's always the competitive element, which makes for a defence mechanism."

Both men and women said that they found it less embarrassing to talk about sexual matters with a woman. It is perhaps worth noting at this point that several of these clients (all women) said that they would have liked to see a woman G.P. at the practice, especially for 'women's problems', while one man said very definitely that while he preferred a female counsellor, he would not like a female doctor!

Only 7 clients said that they would have rather seen a man. This included 2 men, but they both said that their preference was 'marginal'. As one would expect, these tended (except two) to be individuals who had not found counselling very helpful. The women felt that a man could have put their spouse's point of view, or that they had always related better to men.

That left 31 who said that they had no preference for a male or female counsellor (there was no response from 2 clients). Several emphasised that the sex of the counsellor was unimportant; it was the type of person that mattered. This brings us back again to the significance of a personal liking for the counsellor.

One woman who had found counselling of little help and whose husband had refused to see the counsellor, argued that her discussions with the counsellor had actually made communication with her husband more difficult, as he resented her sharing their 'private life' with

an outsider. However, quite a few clients spoke of how counselling had helped them to communicate more easily with other people. Thirteen said that communication specifically with their spouse had improved; they found it easier to express their feelings and to talk to them, either in general, or about particular issues which had previously been difficult: sexual difficulties or the illness of one of the partners, for example. Two more clients talked of better communication with family members generally and with people at work.

Another benefit of counselling mentioned by many of the clients was an increase in their understanding: of themselves, of other people and of their problems. Forty clients in all referred to some enhanced understanding. Sixteen of these considered that counselling had helped them to understand themselves, develop more 'insight' into their own behaviour and feelings, 'sort out' their minds. Eleven talked about increased understanding of other people, usually their spouse, his or her behaviour and point of view. Finally, twenty-three clients referred to an increased understanding of their problems, or the situation they were in. Obviously there is likely to be considerable overlap between understanding yourself and other people and understanding the problems you face. The clients' problems were, after all, often constituted by or composed of people. One client expressed this as follows:

> "She helped me to sort my own problems out ... I went with a marriage problem, which I saw as something 'external', and found that I had to look at myself ... The counsellor helped me to understand myself and my wife ... and this solved my problems".

Thus counselling provided someone to talk to, a rewarding personal

relationship, improved communication with other people and increased understanding. All these could be persuasively argued to be 'good things' in themselves and indeed some clients found it difficult to go further. For example, 'talking' in itself provided substantial relief to many, particularly those who had previously 'bottled up' all their feelings. One client talked of 'letting off steam... an escape valve ... a shoulder to cry on'. However, it is worth asking whether all this talking, communication and understanding produced any more tangible benefits.

Twelve clients talked about 'support over a particularly difficult period' or over some kind of 'crisis'. Two had recently been widowed and another four were having to adjust to the ending of their marital relationship through separation and divorce. Three clients were facing crises in their continuing relationships with other family members: a violent husband, a wayward teenage daughter and a husband suffering from acute mental illness. The remaining three were suffering exacerbations of illnesses of their own: two with severe clinical depression and one with arthritis. Talking to the counsellor, they said, helped them to come to terms with and get through this 'crisis' period.

Related to this were the seventeen clients who said that counselling had increased their capacity to cope or to accept a situation which had previously seemed to be intolerable. For example:

> "She helped me to cope with the situation. I'd felt out in the cold over my husband's mental breakdowns - no-one had advised me how to cope, how to behave towards him"

"I found myself more able to accept my husband as he is".

"I look at things differently now, can accept situations more".

There is, of course, nothing intrinsically desirable about accepting the 'status quo' or learning to cope with an unsatisfactory or unpleasant situation, although these clients did seem to feel it was for the best.

More specifically, three clients mentioned that counselling had helped them to make up their mind to continue in their marriage, to stay with their spouse. In all, nine clients talked about help in making a decision about their marriage. Four had decided to leave their spouses and start divorce proceedings, and the remaining two to attempt a reconciliation.

Many clients involved in unsatisfactory marital relationships did not mention the possibility of separation and divorce, but did indicate that counselling had helped their relationship with their spouse. Twenty-eight clients in all talked about some improvement in their marital relationship, although the responses in this group varied enormously from:

"Counselling saved my marriage"

to;

"It did improve our relationship, so that the divorce was amicable and we've stayed friends".

and:

> "We got on better for a while, but eventually he started drinking again and I left him".

Twelve clients referred more specifically to improvements in their sexual relationship. In some cases this was part of a more general improvement - sexual problems had only been part of, or a symptom of wider marital problems. Others saw this as the fundamental problem in a marriage which was otherwise satisfactory. As with their general marital relationships, the extent and duration of the help they reported varied enormously.

Twelve clients referred to help with other relationships, for example, with other family members, at work and with new friends.

Twenty-five clients talked of how counselling had helped them as an individual. Some linked this with improvements in their existing relationships:

> "I've changed, I'm much more patient now, I let things go. That's helped my relationship with my wife and how I get on with people at work".

Others felt that changes in them had made it easier to make good new relationships:

> "The counsellor taught me how to make better relationships, to help other people and to appreciate the help they gave me. I hope that if I remarry I'll be able to manage it better because of what I've learnt from her".

However, for others, this individual help that they received was clearly distinct from and not necessarily linked to any improvement in their relationships:

> "Counselling gradually built my confidence up, but it didn't improve our relationship. Things are only better now because he's got a new job and is away much of the time".

> "She suggested I developed some outside interests, so I took an A-level sociology course, I took a job and I run a jazz band - and that's been very important. But my husband and I don't get on any better".

Looking more closely at the ways in which clients felt counselling had helped them as an individual, several are mentioned quite frequently. For example, eight clients talked about building up their self-confidence and four about lessening their guilt or the feeling that they were always wrong. Eleven clients referred to improvements in their behaviour, making them 'better' people. The changes were in the direction of greater tolerance, flexibility and the open expression of feelings. Overall, the impression is that these clients felt that counselling had made them more 'competent' as well as more likeable people. The counsellor is seen to have performed an educative function; the concepts of 'learning' and 'teaching' were frequently used.

Some clients felt that the counsellor had performed this 'educative' function with regard to their spouses. Counselling had in some way helped and changed their partners, which in turn had had beneficial repercussions on the relationship (none of the ten clients in this group spoke of changes in their spouses as individuals which had not improved the relationship; maybe this response would not have followed from a question 'How did counselling help you?') Some

examples were:

> "It made my husband realise that he had to share his feelings, not keep them to himself, to let me get through to him".
>
> "She told my husband a few home truths, which mellowed him a bit".
>
> "She helped my wife a lot, she was much better, which made for less tension between us".

We have already seen that one of the sources of dissatisfaction with the results of counselling was the reluctance or inability of the counsellors to give advice or practical help. However, seventeen of those who found counselling of some help, talked about the advice and practical help they had received. This apparent contradiction could be the result of several factors. For example, it could be that the counsellors varied in their attitude towards giving more directive and concrete help according to their interpretation of what was necessary for that client in that situation. This would not be incompatible with a counselling philosophy which stresses the individuality of clients and the flexibility necessary in counsellors. On the other hand, it could be that, as some writers have recently suggested, we need to look more closely at the concept of 'advice'[4] and recognise that it can involve a variety of types of behaviour, not all of which deserve the low esteem in which 'advice' is generally held by counsellors.

Certainly, in some instances, the counsellors did seem to have behaved in a fairly directive and active manner. For example, one woman who was suffering serious physical violence at the hands of her husband, told of the way in which the counsellor had contacted a

solicitor, the local social services department and a battered wives' hostel on her behalf. She talked of 'positive, practical help'. Another who had seen two counsellors, explained why she preferred the second:

> "She gave her opinion, gave advice, she wasn't passive like the other one".

It is interesting to note here, however, as an indication that counsellors may be flexible in their approach, that another client who had seen both these counsellors, found the first counsellor to be the more directive and the one who gave advice. She too preferred the second counsellor, but because she listened rather than gave 'guidance'.

Others talked about the counsellor 'making suggestions', 'pointing out where I'd gone wrong', and giving 'helpful advice'. Lastly, a very practical benefit which one woman immediately mentioned and which obviously had meant a great deal to her. She said that going to see the counsellor with her husband, one evening a week, meant that they had to find a baby-sitter. This being done, they started to spend the evening out together after the counselling session. For the first time in years, this woman was enjoying a weekly night out of the house, with her husband.

On the other hand, some satisfied clients emphasised how pleased they had been that their counsellor had not given them advice, but had enabled them to work things out for themselves. The difficulties of putting a 'non-directive' approach into practice have been widely discussed but these clients certainly felt they had made their own

decisions:

> "She didn't give you any advice, but made you come to your own conclusions".
>
> "She didn't try to give me advice, but helped me to work things out for myself, which was much better".

One of the major assumptions on which the co-operation of marriage guidance counsellors and general medical practitioners is based is that an individual's health and the state of his close personal relationships are closely linked, and that action to improve the latter will have favourable effects on the former (we are not here concerned with the possibility that the causal relationship may often be the reverse, although one could argue that with some plausibility). Thus, an important area in which to explore client attitudes is the area of health. If we use a very broad concept of health improvements to include statements like 'it made me feel better' and 'it was a relief', forty-five of the sixty-six clients spontaneously mentioned this type of help.

All of these talked about an improvement in their mental health: they felt less depressed, less tense, more relaxed and at ease, or less worried about their health. They ranged from individuals who were reacting quite normally to particularly stressful or unhappy situations, to several who were suffering from severe clinical depression. Obviously, the statement 'I felt less depressed' meant something very different in the case of each group.

Thirty-four clients said that they were now less depressed or tense than they had been when they had seen the counsellor and all

but two considered that counselling had definitely contributed to this long-term improvement. This improvement was not always immediate - in fact two clients said that they felt more depressed in the short-term and another two implied similar reactions when they spoke of counselling as a'painful process', bringing to the surface things they had been trying to forget and giving them 'a few bad days'.

On the other hand, the remaining eleven clients felt better immediately after counselling - usually as a result of being able to talk to someone - but the effects tended to wear off after a few days. Counselling seemed to ease the symptoms, but not to help them tackle the root causes of their depression.

Several clients mentioned medication for depression or anxiety: two said that counselling had provided a better alternative to 'tablets'; three that counselling had helped them to stop taking medication, as well as one who had been helped to stop drinking excessively; and two that although they felt less depressed, they had continued on medication - these were both women with a long history of depression and psychiatric treatment.

Some clients mentioned other tangible benefits which had resulted from this lessening of depression or anxiety. Six had started to sleep better, three stopped losing weight, two felt less run-down and two found that the chest pains which had originally brought them to the doctor had disappeared. Several also linked improvements in the state of their mental health to improvements in their relationships with others.

The concept of 'satisfaction-dissatisfaction'.

At the beginning of this chapter, it was discussed how the interviews had revealed the inadequacies of a unilinear concept of client satisfaction-dissatisfaction. There were a significant proportion of clients with mixed feelings, some of whom started off by responding with a clear 'yes' or 'no', but then went on to describe a lot of feelings in the opposite direction. Even clients who expressed strong feelings one way or the other sometimes added qualifications to these expressions.

This was particularly marked in the case of those who said that they had not found counselling at all helpful. It has already been noted that several stressed how nice a person they had found the counsellor to be. In all, 12 of the 17 dissatisfied clients expressed some positive feelings, and only one actually regretted seeing the counsellor and said that it made matters worse. Ten of these had enjoyed talking or found it a relief to talk to the counsellor. Four referred to some increase in their understanding of themselves, their problems or other people. Two spoke of short-term improvements in their relationships with other people and two of short-term improvements in their mental state. Two pointed out that they had gone back several times as evidence that they could not have found it totally unhelpful - although there is the question of how far they were influenced by the 'prescribing' of a 'course of counselling' by their G.P.

There were also some negative feelings and disappointments expressed by 19 of the 46 clients who had found counselling of significant and lasting help. The most frequent was that they had 'slipped back'

in some respects or to some degree. Some benefits had lasted, but some had faded once contact with the counsellor had ceased. This was actually mentioned by 13 of the 46 satisfied clients and some others gave that impression during the interview.

Some satisfied clients talked about other ways in which counselling had not been helpful. Five clients who had remained married since counselling said that counselling had not helped their relationship with their spouses, including one who said that counselling had actually led to a deterioration:

> "Counselling brought home and highlighted things about my marriage that I hadn't noticed before. It did make for a lot of tension and deterioration in the marriage, and my husband blamed the counselling... However, in the end, you've got to be honest with yourself, so maybe it was for the good".

Only in one other case (already mentioned on page 231) did the client actually feel counselling had made her marital relationship worse, and that client had not found counselling helpful on that occasion. Indeed, it is perhaps surprising at first that clients can define marriage guidance counselling as helpful and at the same time say that it did not improve their continuing marital relationship. These individuals tended to express their satisfaction in terms of help to them as individuals or help to cope with or accept their situation with all its limitations.

Five 'satisfied' clients said that counselling had not helped them to feel less depressed, two of these saying that they were still 'up and down' and on medication. The remaining three felt much less depressed than they had been but all linked this with some change in their medical condition. Two had been diagnosed as having some

physiological basis to their depression, and the third had been treated for a physical sexual problem and had subsequently been able to enjoy her marital sexual relationship. Finally, one woman said that counselling had not helped her to make up her mind about her marriage.

To sum up, 46 of the 82 clients had found counselling of significant and lasting help, and a further 20 had at least derived some benefits. The most frequent benefits mentioned were having someone like the counsellor to talk to; improvements in mental health; increased understanding of people and problems; improved relationships with other people, and help in becoming a more competent, likeable person.

The remaining 16 clients had not found counselling helpful, and the reasons most frequently mentioned by these and the 20 clients with mixed feelings were the lack of impact on their personal problems, the inadequacies of counselling and the short-term nature of any improvements.

Recommending counselling

Lastly, in relation to the helpfulness of counselling, the clients were asked whether they would recommend their friends or relatives to see a counsellor if they had problems and, if so, what kinds of problems they thought would be appropriate.

Table V Whether clients would recommend counselling to their friends or relatives (n = 83)

Yes - no occasion to	42
Yes - has done so	26
No - too embarrassed	6
No - not helpful	6
No response	3
	83

Table V shows that twelve clients altogether replied in the negative and they fell into two equal groups. Six said they would be too embarrassed to admit that they themselves had seen a counsellor, and all but one of these had found counselling of some help. The other six felt that they could not, in all sincerity, say that the counselling had been of any help to them.

Of the remaining clients who answered this question, 26 had recommended counselling to friends and relatives (although only some of these had actually taken up the suggestion). This represents nearly a third of the total sample of clients - a much higher proportion than that found, for example, by Timms and Blampied,[6]. Altogether 85% of the 80 clients interviewed who were asked this question said that they had recommended counselling or that they would do so if the occasion arose. One can hypothesise why these clients appeared to show little reticence about their counselling experiences. It may be that those who were prepared to be interviewed by the researcher were likely to be those most prepared to talk to others about their counselling (although this does not explain the disparity with Timms and Blampied's findings). It may also be that, as has been suggested

in another context, the stigma associated with marriage guidance counselling is lessened in a general practice setting.[7] A significant minority of these clients had problems which were not directly defined as related to marital 'failure', and even those who did often had accompanying, 'respectable', medical problems.

It is interesting to note that both of the two clients who had expressed a personal dislike of their counsellor, at this point said that they would recommend counselling, but not that particular counsellor. For them, the failure of counselling to help could be attributed to that individual rather than the technique or service as such.

Table VI Client views on appropriate problems for counselling (n = 83)

Marital problems	40
General relationship problems	5
Anything needing talking over	16
Family problems	8
Personal rather than marital problems	6
No response	8
total	83

As far as the type of problem thought appropriate is concerned, over half of the 75 clients who responded to this question referred to various marital problems. For them the counsellor was specifically a 'marriage' counsellor. Indeed one man, who had discussed with the counsellor both problems relating to his work and to his marriage, said that he had not found her so helpful with the former.

Another client, a woman, had felt the need to talk to someone after her husband died, but had thought that she no longer 'qualified' to see the counsellor, as she was no longer married.

However, 35 clients drew wider boundaries. They talked about problems with the family and with all kinds of relationships. Some mentioned problems within the individual: depression, lack of self-knowledge, 'nervous problems' and so on. Sixteen clients talked in a very broad way about counselling being able to help with 'anything needing talking over'. Some of these inferred that the counsellor could act as a substitute for family and friends, where it was impossible to discuss the problem with them, or for the G.P., who had insufficient time. For example, one woman said:

> "I think counselling could help with almost any problem needing discussion, where there was no-one else to discuss with. That could avoid a lot of stress on the family."

Another said:

> "The counsellor's got the advantage of impartiality and time. Any problem which isn't just physical would be appropriate. The G.Ps. haven't got sufficient time, and it's not such a friendly relationship as it used to be."

Table VII Client views on appropriate people for counselling help (n = 83)

Must want to be helped	8
Those who cannot reflect on own situation	2
Younger couples, early in marriage	4
Those who will talk/listen/be flexible/help themselves	3
Those from similar social class background to counsellor	1
No response	66

(total number more than 83 because two responses from one client)

The clients were also asked what kinds of people they thought would be appropriate for counselling help (see Table VII). Most found this very difficult to specify, and only 18 responses were collected. Nearly half of these 18 talked about the need for individuals to want to be helped, in order for counselling to benefit them and a further three specified people who were prepared to talk, to follow suggestions and be flexible, or to help themselves. This group had obviously absorbed the principle that the active participation of the client is essential to effective counselling.[8] Four, referring to marriage counselling, felt that the service was more appropriate for young couples in the early years of marriage. Two talked about individuals who were unable by themselves to stand back from their own situation and reflect. Only one client, a professional in a related field, mentioned the oft-quoted criticism of marriage guidance counsellors:

> "The social class I and II background of counsellors and their persistent 'do-gooder' image makes it very difficult for them to understand and help people from other backgrounds."

This study in fact found little evidence to substantiate that claim.[9]

Having looked in some detail at client views on the helpfulness of their counselling, it is pertinent to consider the responses of the counsellors and the G.Ps. to similar questions about the clients. As has been pointed out previously, these responses are not nearly as detailed as those of the clients. This is hardly surprising, given that each counsellor and G.P. were being asked about a number (sometimes a large number) of cases rather than only one, and also that they were discussing the experience of another individual rather than their own.

The Counsellor Responses

The counsellors were asked, as were the G.Ps., how helpful they thought the counselling had been to particular individuals. Their responses related to 75 clients: all the interviewed clients who had been counselled by the two current counsellors, but omitting eight of the clients interviewed during the pilot study who had seen the first counsellor. The responses were initially grouped into similar broad categories as those of the clients to the equivalent question: the unqualified 'yes's', the qualified 'yes's' and the 'no's' (see Table VIII). An extra category had to be added,as was necessary also in relation to the G.Ps' responses (see later) of 'don't know's. This included a far smaller number of clients than fell into this category in the G.Ps' responses (7 compared to 39) and had a rather different meaning. Only in one case was a counsellor unable to recollect the client and the counselling sessions. In the case of the other 6 clients in this category, the counsellor quite clearly remembered

the clients and the counselling but were unable to assess how helpful it had been, either because of lack of feedback from clients, or because of their own 'confusion' about what was happening.

Table VIII Counsellor's opinion on helpfulness of counselling to clients (n = 75)

	No.	%
yes	34	45
qualified yes/yes and no	20	27
no	14	19
don't know	7	9
total	75	100

In the case of approaching half of the 75 clients, the counsellors felt that counselling had been of significant and lasting help. In the case of one-fifth they felt there had been some help, but expressed some reservations. In another one-fifth, they felt counselling had been of no help. This left about one-tenth in which the counsellor was unable to express an opinion.

As far as was possible, the reasons which the counsellors gave for the helpfulness or lack of helpfulness of counselling, were categorised similarly to those of the clients. However, as can be seen (Table IX), it was necessary to add some further categories and there were some client categories into which no counsellors' responses fell.

Table IX Reasons why counselling helped - counsellor responses (n = 60)

Someone to talk to	9
Characteristics of client	10
Increased understanding	24
Improved communication	6
Support over a difficult time	12
Improved sexual relationship	7
Improved general marital relationship	12
Improved general relationships	7
Helped to decide about marriage	2
Helped client as an individual	24
Helped spouse	-
Could cope better	2
Practical help and advice	2
Better health	2
Client satisfied *	5
G.P. reported benefit *	2

* categories with no equivalent in client responses

(Total number is more than 60 because more than one reason given in some cases)

It can be argued, with some persuasiveness, that the counsellors' responses tell us as much about their 'model' of counselling, as about the particular clients. They were concentrated very heavily in certain categories, which could be argued to illustrate what they saw to be the aims of and the obstacles to 'good' counselling.

In talking about the helpfulness of counselling, (see Table IX) the counsellors' emphasis was primarily on the individual client. 'Increased understanding' on the part of the client, either of him

or herself, or of other people, and help to the client as an individual were both mentioned 24 times - twice as frequently as any other single category of response. The importance of the individual is stressed in a rather different way in the 10 responses which refer to the contribution of the client to the helpfulness of counselling. This category is the counterpart of the client responses which referred to the characteristics of the counsellor. As some clients felt that the personality of their counsellor had been a significant element in their satisfaction with counselling, so the counsellors stressed the significance of the clients' personality in some cases: their ability to 'use' counselling in a fruitful manner, or to establish a rapport with the counsellor.

This is not to say that the counsellors were not interested in relationships. In fact, they mentioned an improvement in relationships in the cases of 19 clients altogether. If that broad category is broken down into the more specific categories used for the client responses, the counsellors mentioned an improvement in the marital relationship in the case of 12 clients, more specifically in sexual relationships for 7 clients, and improved relationships generally - with friends and other relatives for example - for 7 clients.

The other category mentioned quite frequently (12 times) was that of 'support over a difficult time'. The counsellors recognised that some of their clients were at a crisis point - in their marital relationships (including bereavement), or their health - and felt that they had been able to offer some support. It is interesting that in the case of nine of these clients, 'support' seems to have been an alternative to 'real' counselling. The

counsellors were talking about people who they felt either had no need of counselling or were unable to make use of it. For example, one of the counsellors talked about the support she had given to two women with young children and recurrent marital problems:

> "It (counselling) did give her support while she was coming, support over a crisis stage. She may have gained some understanding, but only very limited. There was no real progress... Growing-up was what she needed to do, but she had so many other problems that she had no time to cope with that."

> "She did feel supported by counselling, but growth was very limited. The relationship was helped while counselling was going on but it's probably very up and down in the long-term. She had no general support from her family for example - and so she used me as a 'mum'-type figure. She really needs that kind of on-going support."

Table X Reasons why counselling did not help - counsellor responses (n = 40)

No impact on problems	6
Inadequacies of counselling	1
Personal characteristics of counsellor	2
Characteristics of client	23
Spouse refused to participate/opposed counselling	2
Too late	-
One can only help oneself	-
No help necessary	-
Benefits wore off/would wear off	2
No counselling necessary*	4
Client failed to return*	6

* categories with no equivalent in client responses

(Total number is more than 40 because more than one reason given in some cases)

Turning to the reasons given by the counsellors for the lack of helpfulness of counselling (see Table X), one can see most clearly the emphasis placed on the individual and his or her ability to make use of counselling. In the case of 23 out of the 40 clients to whom this analysis applies, the counsellors referred to client characteristics. These were mentioned nearly four times as frequently as any other category. Clients were described as:

> "Not counselling material, would only moan, wouldn't do anything or shift her position."
>
> "Probably not able to change"
>
> "Very difficult to counsel - severe, practical, cold, couldn't put down barriers, so there was no relationship with him. There was a lot of work to be done, but he was not prepared to do it."
>
> "Stubborn, spoilt, couldn't listen and obsessed by herself. Not counselling material"
>
> "Didn't increase in self-understanding."
>
> "She always denied the problems, never 'let me in'. She didn't really resolve anything or look at herself."
>
> "She wasn't prepared to give the necessary time to get out of counselling as much as she could have."

It is possible to get a clearer picture of what the counsellors saw as 'good' counselling and ideal counselling material from these negative comments than from their more positive comments on the helpfulness of counselling. A 'good' client is one who is able to form a warm relationship with the counsellor, who can lower defensive barriers and is prepared to 'work hard' at the problem and give the necessary time to counselling. She or he must be prepared to talk and to listen, to look critically at her or himself and to change. 'Good' counselling produces growth, more self-understanding and

increased maturity - again, there is the emphasis on the individual. On occasions, the counsellors inferred that changes in the individual could actually worsen current, especially current marital relationships. For example, talking about one client a counsellor said:

> "I felt she'd benefited, because she could look at the situation in different ways. But then she stopped coming - I think because she recognised the danger to her marital relationship."

The same counsellor inferred a similar paradox when talking about another client, who had initially attended with her husband:

> "The second interview was just with Mrs. - and was very positive. She realised that her sexual frigidity towards her husband was just one expression of her lack of feeling for him generally... Then... Mrs.- didn't contact me again. I was disappointed She may have realised what was happening and what she would discover, and she had the strength to say 'no'."

In all, the counsellors mentioned 6 clients who had failed to return. In these cases, the counsellors were obviously left with a sense of frustration. There was the feeling that the start had been promising, that there was plenty of work to be done. For example:

> "She only came once. It was a good first session - we liked each other, had a good rapport, she could share things, was motivated. I suggested that her husband should come too, but they never turned up. I don't know why - maybe I should have continued to just see her for a while. I was disappointed."

Some of the above examples serve to illustrate how, just as in the case of the client responses, a unilinear concept of satisfaction-

dissatisfaction would have been inadequate to describe the range and mix of feelings, so in the case of the counsellor responses, a unilinear concept of helpfulness - lack of helpfulness would have failed to do justice to the complexities they expressed. Counselling could be of benefit in some way, but may actually be detrimental in others (supporting the thesis suggested earlier that counselling can do harm).[10] The counsellor can give help in certain ways - for example, in the form of short-term support - which she does not consider to be counselling at all, and even to people who are not 'counselling material'. Practical help is another example of non-counselling help which the counsellors seemed happy to offer under certain circumstances: for example, for a woman who needed accommodation and referral to a solicitor to arrange a separation for her and her children from her violent husband; and for another woman who wanted advice on how to set about finding a part-time job and arranging day-care for her youngest child. However, this practical role was accompanied (and perhaps made acceptable) by a more traditional counselling role. In the former case, the client was given 'the confidence to leave' through counselling. In the latter, counselling helped the client to develop more understanding of her mentally-ill husband and to decide to stay with him.

The G.P. responses

The G.Ps. were asked during their interviews about the outcome of counselling and their criteria of 'success' both in general terms and in relation to particular individuals. They found the questions on the whole very difficult to answer in any detailed or specific way. One G.P. expressed most clearly the impression that was conveyed by

all of them:

> "I haven't ever really defined any criteria of success. I tend to use the counsellors' definition of how they think counselling is going, along with rather haphazard feedback from patients. There are a large number of cases where we don't know whether counselling is doing any good ... All-in-all, I get the impression of overall benefit, but I haven't looked at it systematically. There aren't any startling results, but I wouldn't expect them in the field of personal relationships - the work involved is slow and long-term"

All the G.Ps. talked about reductions in the consultation and medication rates of many of those who were counselled and two referred to changes in the individuals: increased maturity and 'balance', more contented and less selfish. Thus, they all felt that the counselling service was a 'good thing', adding to the quality of care provided by the practice and in some instances decreasing the demands on them, but were unable to go beyond rather vague and general assertions.

Table XI G.P's. opinion on helpfulness of counselling to their patients (n = 74)

	No.	%
Yes	14	19
Thinks yes	19	26
Qualified yes/yes and No	8	11
No	13	18
Don't know	20	27
total	74	100

This impression was strengthened when it came to questions about

the helpfulness of counselling to particular individuals who were their patients, or whom they had referred (see Table XI). The most striking aspect of the responses was the large number of individuals about whom the G.P. was unable to give an 'informed' reply. In the case of over half (39) of the 74 clients, the G.Ps. either said that they did not know whether counselling had helped, as they had not seen the individuals since or had had no feedback when they had seen them (20 clients), or that they thought counselling had helped as the individuals seemed to be better, in terms of consulting less frequently, needing less medication and being in better health, but they did not know whether this could directly be attributed to counselling as, again, there had been no feedback. This strengthens the impression given by the counsellors that in many cases any contact with the G.P. was very brief and involved no detailed discussion.(11)

The G.Ps. could say more about the remaining 35 clients as there had been more 'follow-up' of their experiences of counselling. In some cases the individual had 'reported back' to their G.P; in others, the G.P. had himself asked how they were getting on; in others there had been some discussion between the G.P. and the counsellor. They felt that counselling had been of substantial help to 14 of these clients, that it had not helped 13 and that for the remaining eight clients, there had been some benefits, or counselling had probably contributed something to their consequent improvement in health and well-being.

Table XII G.P.s' criteria of benefit of counselling (n = 41)

Lower consultation rate	24
Better health/less depressed	24
Less medication	21
Specific problem solved/lessened	9
Individual or 3rd party reports benefit	7
No longer discusses relationship/emotional problem with G.P.	6
Received a lot of counselling	2
Has come to terms with problem	1

(Total number is more than 41 because more than one criterion mentioned in some cases)

In spite of the difficulties of drawing any meaningful conclusions from these responses, it is worth looking at the group of 41 clients whom the G.Ps. considered may have derived some benefit from counselling (i.e. excluding the 'don't knows' and the 'nos'), to discover the criteria they used to define this benefit. (see Table XII). As in the client interviews the aim was that the responses should not be guided - the G.Ps. should not be offered any 'check-list'.

Thus it is no surprise to find that medical criteria of benefit predominate. Less or no medication, a lower consultation rate and a better state of health (including a lessening of depression) were all mentioned in relation to over 20 clients, and at least one of these was mentioned in the case of 30 of the 41 clients. Because of the reasons suggested above, it would be unwise to read too much into this predominance. However, it does suggest, firstly, that these G.Ps. have what one could describe as a 'medical model' of counselling. They see it as having the potential to improve health and they judge

its usefulness in these terms.

The second implication derives from the criteria of fewer consultations. This could either, as suggested above,[12] result from an improvement in health and thus less need for medical attention, or it could result from the individual taking up less of the G.P's. time with matters which are not strictly appropriate to a medical consultation. This implication is also obvious in the case of five clients where, although the overall consultation rate may not have fallen, the individuals no longer discussed their relationship or emotional problems with the G.P. This criterion was particularly used by one G.P., but of course it is necessary to be cautious in interpreting it as meaning the counselling had been of benefit to the individual, as opposed to of benefit to the G.P. in terms of a lower or more appropriate work-load. It may have been that these patients had 'given up', assuming that they could not expect any further help from that source. This interpretation is certainly the more plausible in the case of one other client about whom this same G.P. commented that she no longer discussed her marital problems but he did not think counselling had helped her. Of the five clients in this group whom the G.P. felt did derive some benefit, all had concurred in their interviews that counselling had been of some help, although only two had found that help to be substantial and/or lasting.

In the case of ten clients, the G.Ps. referred to the impact of counselling on a specific problem - the problem had been 'solved or lessened' for nine clients and another had 'come to terms' with her problem.

The G.Ps. only mentioned positive feedback from five of their patients, together with two 'third parties': a wife and a psychiatrist.

Finally, two G.Ps. used as a criterion of benefit in the case of two clients the fact that they had seen a lot of the counsellor. Whether 'helpfulness' or 'benefit' is, in fact, related to the number of counselling sessions will be considered later.(13)

Table XIII G.P.s' criteria of lack of benefit of counselling (n = 26)

No change/increase in consultation rates	9
Has not come to terms with/coped with problems	8
No improvement in health	7
Other factors may have produced improvement	7
Patient did not like counselling	6
No change/increase in medication rates	5
(Total number is more than 26 because more than one criterion mentioned in some cases)	

Turning to the criteria which the G.Ps. used to suggest that counselling had not been of benefit (see Table XIII), one can see that medical or health-related criteria are again important, although they do not predominate in the same way. They relate to a group of 26 clients (i.e. excluding the 'yes's' and 'thinks yes's' and some of the 'dont know's'). No change, or an increase in consultation or medication rates were mentioned in the case of 9 and 5 clients respectively, and no improvement or a deterioration in health in 7. At least one of these was mentioned in the case of twelve of the 26 clients.

The G.Ps. referred to negative feedback from the clients in 6 cases. They perceived that eight were still unable to cope with or come to terms with their problems. On the other hand they had seen a marked improvement in the case of seven clients, but felt that this was due to factors other than the effect of counselling: a remission in a chronic illness, the improved health of a spouse, a new job and so on. This strengthens the impression that it was not the usual practice for the G.Ps. to 'follow up' their referrals to the counsellor, even to the extent of asking the individual how they had found counselling when they next saw them.

Whether counselling helped - a comparison of the responses of clients, counsellors and G.Ps.

This section involves looking at the responses of all three parties interviewed (clients, counsellors and G.Ps) to questions about the helpfulness of counselling. The aim is to consider similarities and differences between these three, especially with regard to their assessments of how far counselling had been helpful in individual cases.

Looking first at the overall pattern of responses (see Tables I, VIII and XI), 56% of clients said that counselling had been of significant and lasting benefit compared with a rather lower figure of 45% for both counsellors and G.Ps. (in the case of the G.P. responses, those where the G.P. thought that counselling had helped although there had been no specific feedback are included in this figure). However, the existence of a number of 'don't know' responses does rather distort this comparison, especially with regard to the G.Ps. If these are omitted, as in Table XIV, the proportion of 'yes' responses rises to 50% for the counsellors and to 61% for the G.Ps. Thus,

clients, counsellors and G.Ps. all thought that counselling had been of significant help to at least half of the clients about whom they felt able to express an opinion.

Table XIV Helpfulness of counselling - comparison of overall responses of clients, counsellors and G.Ps. omitting 'don't knows'

	Clients (n = 83)		Counsellors (n = 68)		G.Ps. (n = 54	
	No.	%	No.	%	No.	%
yes/thinks yes	46	56	34	50	33	61
qualified yes/ yes and no	20	24	20	29	8	15
no	17	20	14	21	13	24
total	83	100	68	100	54	100

Turning to the responses which expressed mixed feelings about the benefits of counselling (again omitting the 'dont knows' from the total), counsellors were somewhat more likely than clients to offer this qualified response (29% compared with 24% although the number of responses is the same) and far more likely than the G.Ps. (15%) In fact, if, as may be justified, the 6 out of the 7 counsellor 'dont know' responses are included in this category of 'mixed feeling', reflecting as they do a 'confusion' about what was happening in the counselling rather than simply not being able to remember, the proportion rises to 35%.

There may be a number of reasons for this tendency on the part of the counsellors to be cautious in assessing the helpfulness of counselling. They were, of course, aware that the clients had also been interviewed and may have been apprehensive lest their enthusiasm

be refuted by the clients' responses. The responses may also reflect the idea that counselling is a process in which the aims are never fully achieved, but rather have the status of 'ideals'.[14] In some cases, the reservations were associated with the fact that they felt that 'counselling' had never actually taken place. They had, they thought, helped the client, but in ways which did not involve counselling, either because the client was not 'suitable' or because he or she had no need of counselling help.

The greatest similarity between clients, counsellors and G.Ps. was found in the category of negative responses. In the case of 20%, 21% and 24% of the clients respectively they felt that counselling had not been of help.

Thus the overall pattern of responses, while displaying some differences, are not markedly discordant between the three groups. All three groups of respondents felt that, in the case of between 76% and 80% of the clients involved in the study (excluding from the G.P. and counsellor responses those about whom they did not feel able to comment) at least some benefit had been derived from counselling.

However, turning from the overall pattern to a comparison of the responses of the three groups with respect to individual clients and their counselling experience, a greater degree of disparity does emerge. Of course, this kind of comparison is only possible for the 74 clients about whom the G.Ps. and counsellors had been interviewed.

Table XV Helpfulness of counselling - comparison of responses of clients, counsellors and G.Ps. relating to particular clients (n = 74)

Agreement		16
Yes	13	
Qualified yes/yes and no	1	
No	2	
No disagreement		14
Yes	9	
Qualified yes/yes and no	1	
No	4	
Marked disagreement		17
Some disagreement		27

Only in the case of sixteen out of the 74 clients was there unequivocal agreement between client, counsellor and G.P. (see Table XV): these are almost all (with three exceptions) clients about whom there was agreement that counselling was of substantial benefit. In the case of two clients there was unanimous agreement that counselling did not help, and in the case of the remaining client, all three parties had mixed feelings.

There was no disagreement over a further 14 clients: one of the three parties (in one case, two) did not feel able to comment, and the others (or other!) agreed in their responses.

Thus in the case of 44 of the 74 clients (nearly 60%) there was some disparity in the responses of the three groups. In the responses relating to 17 clients, the disparity was marked, in the

sense of at least one respondent replying that counselling had been of substantial benefit and at least one that it had been of no benefit. In the case of the remaining 27, there was some disparity, but not as marked: the responses only ranged between 'mixed feelings' and the positive or the negative end of the spectrum.

Table XVI Helpfulness of counselling - comparison of responses of clients and counsellors relating to particular clients (n = 74)

Agreement		35
Yes	22	
Qualified yes/yes and no	7	
No	6	
No disagreement		7
Yes	3	
Qualified yes/yes and no	1	
No	3	
Marked disagreement		8
Some disagreement		24

Table XVII Helpfulness of counselling - comparison of responses of clients and G.Ps. relating to particular clients (n = 74)

Agreement		27
Yes	19	
Qualified yes/yes and no	3	
No	5	
No disagreement		20
Yes	13	
Qualified yes/yes and no	4	
No	3	
Marked disagreement		9
Some disagreement		18

Table XVIII Helpfulness of counselling - comparison of responses of counsellors and G.Ps. relating to particular clients (n = 74)

Agreement		24
Yes	19	
Qualified yes/yes and no	2	
No	3	
No disagreement		26
Yes	8	
Qualified yes/yes and no	6	
No	5	
Marked disagreement		7
Some disagreement		17

These disparities are not accounted for by any one 'odd man out', but seem to be widely distributed, with differences between clients and counsellors (see Table XVI), clients and G.Ps. (see Table XVII) and counsellors and G.Ps. (see Table XVIII). Thus, for example, the responses of clients and counsellors agree or do not disagree in 42 cases, of clients and G.Ps. in 47 cases and of counsellors and G.Ps. in 50 cases. The higher level of the last two figures are due to the large number of 'don't know' responses by the G.Ps. Marked disparities between clients and counsellors occur in 8 cases, between clients and G.Ps. in 9 cases and between counsellors and G.Ps. in 7 cases.

Neither do these disparities show any persistent bias in any particular direction as has been demonstrated in the discussion of the broad similarities of the overall pattern, except for some tendency for the counsellor to express mixed feelings more often and the G.Ps. less often than the clients.

One obvious conclusion to be drawn from these comparisons is that client satisfaction with a particular service is by no means to be equated with 'professional' opinions as to the benefits derived by particular clients. It is also noteworthy that members of different professions may demonstrate marked disparities in their opinions, although in this study, that must be a rather tentative conclusion, due to the large number of individuals in whose case the G.P. had not followed up their counselling experience, so could not express an opinion, or, at best, could only hazard an 'informed guess'.

The analysis also suggests that studies which offer only a

comparison of the overall pattern of responses may be misleading. Apparent harmony may significantly break down when individual cases are isolated. However, this result should not be over-dramatised. Disparities were only marked in the case of 17 (23%) of the 74 clients. In the case of 44 (59%) of the 74 clients, all three parties felt that counselling had been of some, though possibly limited benefit.

The policy implications of these disparities are rather confusing. One becomes entangled in questions about whose opinion should rank highest: the client, who, after all, provides the overt rationale for the existence of the service; the counsellor, who is the supposed 'expert' in this sphere; or the G.P., under whose auspices the service is being provided? One clear implication is that counsellor and G.P. need to be aware that their perception of 'benefit' or lack of it, is not always the same as that of the individuals with whom they work. This leads to questions about the type of client or type of problem where there is most likely to be some disparity. It would surely help the 'professionals' to carry out their work more effectively if they could be made aware of the types of situation in which there may be unrecognised differences in the perceptions of needs and the extent to which they were being met.

In fact, this study did not enable the delineation of any such 'types'. For example, marked disparities between clients and counsellors did not seem to be associated with people of any particular age, sex or social class. They did not just involve clients who had been counselled once or twice: although this did apply to five of the eight. They were all the clients of one counsellor, but she was

the counsellor who had counselled 54 of the 74 clients. They had come with marital and more general problems, although it is perhaps, worth noting that only two of the eight had problems which one would traditionally associate with 'marriage guidance'. The problems of the other six were not primarily those of marital breakdown, although the marriage relationship may have been seen as an important area for discussion by the counsellor. Marked disparities between clients and G.Ps. were associated with a similar variety of personal characteristics, problems and counselling experiences.

It may be that there is no obvious way to distinguish cases in which communication between individual clients, their counsellors and their G.Ps. is likely to fail in this way. It may even be, of course, that failure to communicate is not the problem; that these disparities arise from very real differences of opinion over the effects of (successful) counselling, for example, the counselling idea that, at least during the initial stages of being helped, an individual may feel a lot worse.[15] There was some evidence in this study that where clients did provide direct feedback to the G.Ps., they were prepared to convey their dissatisfaction as well as their satisfaction. Some more formalised system of feedback to the referring G.P. and of communication between the G.P. and counsellor with regard to individual clients may promote more awareness of widely diverging perceptions of the efficacy of counselling.

It is also possible in this study to go further in examining the perceptions of helpfulness of clients and counsellors by comparing their reasons for saying that counselling was or was not of benefit. It was found, as has been discussed above, to be feasible to categorise

the responses of both these groups in a similar fashion. If these categories are listed according to the number of responses from each group, it is found that a rather different pattern emerges.

The interpretation of these differences must be carried out with some caution. The large disparity in the number of responses from clients compared with counsellors reflects the greater time devoted to this topic in the client interviews. Thus it is quite possible, for example, that given more time to discuss each client the counsellors would have produced a rather different pattern of responses. However, it is worth reiterating at this point that no 'check-list' was used for either type of interview and thus the responses of both groups were relatively 'free'.

Table XIX Reasons why counselling did help - comparison of overall ranked responses of clients and counsellors

Client responses (n = 66)		Counsellor responses (n = 60)	
1. Someone to talk to	47	1. (Increased understanding	24
		(Helped client as an individual	24
2. Better health	45		
		3. (Support over a difficult time	12
3. Increased understanding	40	(Improved general marital relationship	12
4. Personal characteristics of counsellor	34	5. Characteristics of client	10
5. Improved general marital relationship	28	6. Someone to talk to	9
6. Heled me as an individual	25	7. (Improved general relationships	7
		(Improved sexual relationship	7
7. (Could cope better	17		
(Practical help and advice	17	9. Improved communication	6
9. Improved communication	15	10. Client satisfied	5
10. (Support over a difficult time	12	11. (Helped to decide about marriage	2
(Improved general relationships	12	(Could cope better	2
(Improved sexual relationship	12	(Practical help and advice	2
		(Better health	2
13. Helped spouse	10	(G.P. reported benefit	2
14. Helped to decide about marriage	9		

(Total numbers are more than 66 and 60 respectively, because more than one response given in some cases).

There are some striking differences in the responses related to the benefits of counselling (see Table XIX). For example, the two categories mentioned most frequently by clients ('someone to talk to' and 'better health') rank respectively sixth and equal bottom on the list of counsellor responses. This is perhaps not surprising as, judging from the literature,[16] the provision of a sympathetic, listening ear and 'making people feel better' are not seen to be the fundamental aims of counselling. Another interesting difference is that while the clients mentioned help to their marriage and to themselves as individuals about the same number of times, the counsellor mentioned help to individuals twice as frequently as help to the marital relationship. This reinforces the impression already discussed that the counsellors' main focus, in spite of the marital bias of their training, was on help to the individual.

Table XX Reasons why counselling did not help - comparison of overall ranked responses of clients and counsellors

Client responses (n = 36)		Counsellor responses (n = 40)	
1. No impact on problems	19	1. Characteristics of client	23
2. Inadequacies of counselling	18	2. (No impact on problems	6
		(Client failed to return	6
3. Benefits wore off	10		
		4. No counselling necessary	4
4. Characteristics of client	8		
		5. (Personal characteristics of counsellor	2
5. (Personal characteristics of counsellor	4	(Spouse opposed counselling	2
(One can only help oneself	4	(Benefits would wear off	2
7. No help necessary	3	8. Inadequacies of counselling	1
8. (Spouse refused to participate	2		
(Too late	2		

(Total numbers are more than 36 and 40 respectively, because more than one response given in some cases)

Turning to the reasons given as to why counselling was not of help, the same caveats apply to the interpretation of the findings (see Table XX). However, here, there is a very striking difference between the pattern of client and counsellor responses. Clients were most likely to attribute the failure of counselling to help to its failure to make any impact, or any lasting impact, on their problems - counselling at least as practised by that counsellor, was not seen to be an efficacious method of tackling those problems. The counsellors, on the other hand,only saw counselling as inappropriate or inadequate in the case of 5 clients - one with a severe and overt psychiatric disorder and four who, in the counsellor's opinion, had no need of counselling. They overwhelmingly attributed the lack of benefit to the failure of the client to make proper use of counselling, because of personal characteristics, circumstances and so on.

The overall impression is that many clients appreciated a kind of help from the counsellors that would be seen by the latter as something less than 'real' counselling. Not surprisingly, where counselling was not felt to be helpful, clients tended to point to the inadequacies of counselling (only occasionally to the inadequacies of the counsellor) whereas the counsellor, having faith in the potential efficacy of their work in the tackling of a very wide range of problems, concentrated on the inadequacies, or inappropriate expectations of the clients. Where counselling was found helpful, clients often pointed to more simple forms of help, requiring less professional expertise,than did the counsellors. Where there was not seen to be any benefit, it was perhaps because clients tended to expect too much, for example, in terms of problem-

solving - of counselling, and because counsellors tended to expect too much of clients.

Other sources of help

There are a wide range of trained and untrained people to whom those with marital or other relationship problems could turn for help. The clients were asked if they had talked to anyone else about their marital problems and if so, whom had they found most helpful.

Table XXI Other people to whom clients had talked (n = 83)

G.P.	67
Psychiatrist	10
Friends and relatives	39
Solicitor	6
Hospital specialist	4
Other	11
No-one	8
(Total number is more than 83 because more than one source mentioned in some cases)	

As one would expect, given the fact that most of these clients were referred to the counsellor by their G.P., the majority mentioned the G.P. as someone to whom they had talked (see Table XXI). The sixteen who did not included many of the secondary referrals and some of those who had referred themselves, as well as a few who had found that they completely 'dried-up' when they actually entered

the consulting room . Ten clients mentioned a psychiatrist, whom either they or their spouse were counsulting, four a hospital specialist and one a private doctor. The other professionals most frequently mentioned were solicitors (by six clients); three referred to nurses, three to clergymen, one to the 'school truant officer', and one to a probation officer. One had found a sympathetic ear in her work organiser and one belonged to a diabetic society.

Nearly half of the clients (thirty-nine) had said something about their problems to friends and relatives. Finally, there was a rather sad group of eight people who said that they had never talked to anyone else at all. This included six men. Men, perhaps surprisingly, were not under-represented generally in the group of clients who had talked to 'friends and relatives' (eight out of thirty-nine), although six of these eight men specified close friends rather than members of their family.

Table XXII Source of most help for clients (n = 83)

G.P.	11
Psychiatrist	3
Friends and relatives	13
Solicitor	3
Hospital specialist	1
Other	3
No-one	9
Marriage guidance counsellor	61

(Total number is more than 83 because more than one source mentioned in some cases)

If we look now at whom the clients found to be most helpful, a very striking picture emerges (see Table XXII). Forty-nine of the eighty-three clients specified the counsellor as being the source of most help, and a further twelve said that they had found her equally as helpful as a variety of other people to whom they had talked. This included fifteen people who had earlier said that counselling had only been of limited help to them and even one who said that counselling had not helped her at all (she explained this discrepancy by talking about her liking for the counsellor). Thus, even some of those for whom counselling had been a disappointment, or had just confirmed their initial pessimism, had found the counsellor more helpful than anyone else.

One of the next largest groups was of nine clients who had found no-one to be of any help. Other formal and informal sources were mentioned by relatively few people. For some insight into why the counsellor was perceived of most help by so many of those interviewed, it is useful to look at the limitations on the potential helpfulness of others.

Although, as we shall see later, many of the clients had a high regard for their G.P., only one client specified her G.P. as the source of most help in her relationship problems. She described him as the 'old type of family doctor' with whom you can discuss anything. Ten others said that the G.P. had been equally as helpful as other people, but in different ways. With a few exceptions, even for those people the G.P's. help was not in terms of 'someone to talk to', which was the most frequently mentioned type of help given by counselling. Instead he helped with medication, with patience and understanding, and with appropriate referrals.

For most of the clients, discussion of their relationship problems with their G.P. had been relatively brief and superficial. Some specifically distinguished between the kind of 'talking' they had done with their G.P. - for example, one woman described it as 'a few grumbles' - and the deeper discussion with the counsellor. The most frequently mentioned reason for this was the G.P's. lack of time, sometimes inferred by his patients from a crowded waiting room, a concentration on physical symptoms, or even a habit of looking at his watch. Some talked about their G.P's lack of communicativeness: they did not find him easy to talk to, he did not appear to listen or to be interested in their problems. These comments were sometimes presented as complaints, but more often as statements of fact - these clients did not see it as the G.P's job to act as a counsellor, so it was no wonder that he could not help them in this particular way. Several commented on the G.P's lack of training or expertise in this field.

Of the ten clients who reported having talked about their problems to a psychiatrist, none had found him of most help and only three had found him equally as helpful as other people (a hospital nursing sister in one case, the counsellor in the other two). Again, lack of time was the most frequently mentioned reason - short consultations meant that there was no time to do any more than 'skate round the problem' as one client put it.

Five of the clients said that they had found friends and relatives of most help and a further eight that they had been equally as helpful as other 'formal' sources of help. All except one were

women. On the whole, they consisted either of clients whose problems were not defined by them as marital and who said that they received substantial support from their husbands, or a few who were helped by friends and relatives through the ending of a marital relationship, through death or divorce. Those who were trying to decide whether or not to end their marriages, or who were involved in difficult continuing relationships tended not to find friends and relatives helpful. The chief reasons sprang from their involvement in the situation. They were too biased - in favour of or against the client - and gave unwelcome or conflicting advice. They were too emotionally involved, and, especially close family members, they were likely to be part of the problem themselves. Several clients said that, in the hope that their conflicts would eventually be resolved, they did not wish to spoil their image of being one of a happily married couple, or confirm the unfavourable image their friends and relatives already had of their spouse.

It has recently been suggested [17] that it is only when informal networks of support fail, that more formal sources of help are approached, such as counsellors. The clients were not asked whether they had tried to talk to their friends and relatives before, or after going to the doctor, but it appears that for most of them, the informal network had failed. Either they had not talked to their friends or relatives at all about their problem, or they tried, but found the kind of help they were offered to be unsatisfactory. One would have to do a very different kind of study to determine whether those with similar problems, but who never reach the doctor's surgery, or the counselling room, do receive more satisfactory support from

those around them. One point worth noting here is that when asked how counselling had helped them, fifteen clients said that counselling had helped them to talk more easily to their husbands, their families and their friends.[18] It may be that use of this 'formal friendship' had helped them to be able in future to better utilise their own friendships.

To sum up, the greatest advantages which the counsellor has over other formal sources of help seem to reside in the amount of time she has and, to a lesser extent, in her expertise and experience. Being an outsider gave her her most striking advantage over family and friends. More generally, the amount of help that most others can give may be limited by the nature of their contact - present and continuing - with the individual or couple. To a certain extent, one has to live with one's family and friends and even with one's doctor, especially a G.P.It is likely that one will have to interact with them in the future - about different subjects and on different levels. Some people may find it embarrassing to consult a G.P. about their minor (or major) ailments, to whom the month before they were talking about their sexual difficulties. Some, as mentioned above, may not want to be known for ever as 'the couple who nearly split up' or their one-time violent husbands to be shunned for ever by their relatives. More insidiously, they may not want to risk upsetting, by not responding to their suggestions, those who have some power over the quality of their lives - either material or emotional. Contact with a marriage guidance counsellor, as well as promising confidentiality, is limited in time and in the boundaries of its subject matter. When it is finished it can be truly left behind.

Of course, while the impression from many of the clients was that they did perceive these advantages, it could be argued that the attachment of counsellors to medical surgeries and health centres means counselling is less completely and less easily left behind. Counsellors risk becoming associated with other areas of the clients' lives and with other professionals who have a continuing contact. Some of the advantages and disadvantages of this association have already been noted.(19)

An ideal client?

Not all clients expressed the same level of satisfaction as regards the helpfulness of counselling. It is thus worth considering whether there are any factors either concerning the personal characteristics of individuals, or their attitudes to counselling, which could enable a prediction to be made regarding the likelihood of particular kinds of people finding the counselling service of help. This could aid doctors and other referral agents in their 'filtering' or 'gate-keeper' role, and perhaps also help counsellors themselves to determine how best to concentrate their limited resources.

The kind of data collected in this study obviously limits the nature of the analyses which it is possible to carry out. For example, there was no attempt to construct any kind of 'personality profile' or carry out any psychological tests. Thus client reactions to counselling can only be compared with fairly straightforward and 'concrete' characteristics. It is not possible, for example, to test the implication in the counsellor responses to questions about the helpfulness of counselling that certain kinds of people respond

best to counselling: those who can lower defensive barriers; form warm relationships; communicate well; and exhibit self-criticism and flexibility.[20]

On the other hand, it is unlikely that referral agents such as the G.Ps. or even the counsellors themselves, would have the time or facilities to carry out psychological testing on potential clients (even if they had faith in the validity of such testing). They are more likely to have more ready access to characteristics such as age, sex, social class, marital status and at least the presenting nature of the individual's problem.

Another caveat is related to the disparity of views on the helpfulness of counselling between clients, G.Ps. and counsellors. This means that the client characteristics associated with client satisfaction or dissatisfaction are not necessarily those associated with benefits perceived by the professionals.

Table XXIII Sex by whether counselling helped (n = 83)

	Total	Counselling helpful	Mixed feelings about counselling	Counselling not helpful
female	63	36	13	14
male	20	10	7	3
total	83	46	20	17

Table XXIV Age by whether counselling helped (n = 83)

	Total	Counselling helpful	Mixed feelings about counselling	Counselling not helpful
20s	18	10	5	3
30s	35	19	7	9
40s	16	11	3	2
50s	9	3	4	2
60 or over	5	3	1	1
total	83	46	20	17

Table XXV Socio-occupational class (RG 70) by whether counselling helped (n = 83)

	Total	Counselling helpful	Mixed feelings about counselling	Counselling not helpful
I and II	34	19	6	9
III	28	14	8	6
IV and V	16	9	5	2
Other	5	4	1	-
total	83	46	20	17

Table XXVI Years married/cohabiting by whether counselling helped (n = 66*)

	Total	Counselling helpful	Mixed feelings about counselling	Counselling not helpful
< 1	2	1	-	1
1 - 5	12	7	3	2
6 - 10	22	13	5	4
11 - 20	12	7	1	4
> 20	18	10	7	1
total	66	38	16	12

* i.e. excluding 16 clients whom G.Ps. reported that they referred for reasons other than marital problems, and one client who was referred by a neighbour for discussion of general family problems.

Looking at some of the demographic characteristics of clients, Tables XXIII - XXVI consider the relationship between the client-reported helpfulness of counselling and the client's sex, age, socio-occupational class and (where relevant) number of years married or cohabiting. Unfortunately, they offer no simple guidelines. They do however question some established assumptions. For example, it does not seem that clients of a higher socio-occupational class find counselling more helpful (Table XXV). Nor does it appear that more help is given to those at a fairly early stage in their marital relationships (Table XXVI). Indeed, the most satisfied clients appeared to be those who had been married for over 20 years: only one of this group of 19 reported no help at all. Of course, it may be that those from lower socio-occupational classes and whose relationships stretch over many years are reporting help which the counsellors

would not see as 'real' counselling, but as, for example, 'support'. However, the fact remains that clients of all classes and with relationships of varying duration, as well as of all ages and both sexes, appeared to follow not very dissimilar patterns in their responses to questions about the overall helpfulness of counselling.

Table XXVII Reactions to the idea of counselling by whether counselling helped (n = 83)

	Total	Counselling helpful	Mixed feelings about counselling	Counselling not helpful
Positive	35	21	9	5
Ambivalent/neutral	22	13	5	4
Negative	25	12	6	7
No responses	1	-	-	1
Total	83	46	20	17

One question which is particularly relevant to counselling in this setting of general medical practice is how far the individual's initial reaction to the idea of seeing a counsellor was associated with how helpful he or she eventually found counselling to be. Was it worthwhile for the referring G.P. to persuade an initially reluctant patient to see the counsellor? Looking at the 82 clients (excluding the one who denied ever having seen the counsellor, but including the nine secondary referrals, the four self-referrals, and the three clients referred by other people as well as the 66 referred by their G.P.), there does appear to be some, although not a very strong relationship (see Table XXVII). Among the 35 clients whose initial reaction was a positive one (and the four self-referrals are assumed to fall into this category), well over half reported that counselling had been of lasting and substantial help

and only one in seven reported no help at all. This compares with figures of just under half and about two in seven among those 25 clients whose initial reaction was negative. This does seem to indicate a lower 'success rate' in terms of client satisfaction among those who needed some persuasion. However, nearly half did find counselling eventually to be of substantial and lasting help and approaching three-quarters reported deriving some benefit.

Table XXVIII Reasons for referral* by whether counselling helped (n = 83)

	Total	Counselling helpful	Mixed feelings about counselling	Counselling not helpful
Marital problems	66	38	16	12
Other problems	17	8	4	5
Total	83	46	20	17

* as reported by G.P. in case of 61 clients about whom interviewed; otherwise as reported by clients.

It has been noted elsewhere [21] that most of the interviewed clients had problems which were primarily defined as marital and thus fell within the traditional sphere of activity of marriage guidance counselling. However, there was a minority, overwhelmingly referred by one G.P., who saw the counsellor to discuss more general emotional and psychological problems. Thus another pertinent issue is how far these less typical clients found counselling to be helpful. Any comparison of the two groups must be speculative, as they are of such different sizes. However, again, there is some indication of possible differences (see Table XXVIII). For

example, while less than one in five of those with marital problems reported no benefit the figure was not far short of one in three for those with other problems. Once more, however, a substantial majority of these clients did feel that counselling had been of some help.

Table XXIX Client preconceptions of counselling by whether counselling helped (n = 83)

	Total	Counselling helpful	Mixed feelings about counselling	Counselling not helpful
Active, directive counsellor	22	10	8	4
Questioning, listening counsellor	20	10	4	6
'Do-gooder', 'busybody'.	3	2	1	-
No preconceptions	37	24	7	6
No response	1	-	-	1
Total	83	46	20	17

It has already been seen[22] how, for many of the interviewed clients, referral by their G.P. did not involve a particularly clear explanation of what to expect from counselling. Thus, it was suggested, one of the advantages claimed for counselling in general practice - that the 'filtering' process would result in fewer clients with inappropriate expectations - was not particularly evident in this study. However, the question then arises of how far this is important; how far client preconceptions relate to the perceived helpfulness of counselling. Table XXIX suggests that there is little apparent relationship. Clients who approach counselling with what could be seen as more realistic

preconceptions are not more likely to report benefits. In fact, the figures seem to suggest that the most promising clients are those who came with no preconceptions at all! As pointed out in the discussion in Chapter 8,[23] these preconceptions can lead to feelings of optimism or pessimism among potential clients. Thus it is worth noting that, of the four clients expecting an active directive counsellor and finding counselling unhelpful, three had hoped for some active direction. On the other hand, of the six who had perhaps more accurately, expected the counsellor to question and listen and who had not found counselling helpful, five had been pessimistic in the first place. Overall, however, these findings suggest that the failure in many cases of the G.P. to explain very specifically the nature of counselling may not be of particular relevance to the helpfulness of counselling.

Table XXX Contact with spouse by whether counselling helped (n = 77*)

	Total	Counselling helpful	Mixed feelings about counselling	Counselling not helpful
Contact	34	19	14	1
No contact	43	22	5	16
Total	77	41	19	17

* i.e. excluding six clients with no steady partner at the time of counselling

It has been suggested by Heisler and Whitehouse[24] that contact with both spouses increases the chance of a successful outcome in marriage guidance counselling. Table XXX shows the clients

assessments of the helpfulness of counselling according to whether there was or was not contact between the counsellor and the spouse. It would seem to support the hypothesis: only one of the 34 clients whose spouse also saw the counsellor reported no help at all, compared with 16 of the 43 whose spouse had no contact. This could be the result of several factors. For example, in cases where both spouses are prepared to attend it could well be that there is a higher level of motivation and the relationship is felt by both to be of some value. It could also be, as Heisler and Whitehouse imply, that counselling is more efficacious when both partners are involved. This study does not however, support their hypothesis that joint interviews are the significant element. Numbers are too small for any firm conclusions, but all of the five clients whose spouse had contact with the counsellor, but with no joint interviews, found counselling of significant and lasting help.

Table XXXI Number of interviews by whether counselling helped (n = 83)

	Total	Counselling helpful	Mixed feelings about counselling	Counselling not helpful
1	6	2	1	3
2	13	6	1	6
3 - 10	40	23	10	7
> 10	24	15	8	1
Total	83	46	20	17

Lastly, moving away from the characteristics of the clients

to those of their counselling, Table XXXI suggests that there is some evidence to support the concern marriage guidance counsellors express over cases of very short duration.[25] While about half of those clients with only one or two interviews found counselling of no benefit, this applied to just over one in six of those with between three and ten interviews and to only one of the 24 clients who had more than ten interviews. However, the exact nature of this relationship is uncertain. It may well be that there are only a few interviews because counselling is found to be unhelpful, rather than counselling being unable to help in a few interviews. Perhaps more importantly in the context of this study, the fact that this relationship does exist implies that the likelihood of clients referred by their doctors only persisting with counsellors because it is 'prescribed' for them is not great.

Summary and conclusions

This chapter has been concerned with the extent and nature of the help given by the counsellors to their clients at the medical centre. The most detailed material relates to the perceptions of clients, but the G.Ps.and the counsellors were also asked about the helpfulness of counselling.

It was found that just over half (46) of the 83 clients interviewed perceived the counselling to have been of significant and lasting help. One-quarter (20) reported some help, but expressed reservations about the extent or lasting effects of that help. The remaining one-fifth (17) reported very little or no help.

Although these categories are useful for delineating broad reactions to the experience of counselling, it was found that they tended to understate the complexity of the mixture of feelings the clients had. When they were asked to elaborate further, very few clients were found to be entirely satisfied or dissatisfied with their counselling experience. Most expressed some reservations, most described some positive aspects. In some cases, the initial response was misleading.

The principal sources of client dissatisfaction with the helpfulness of counselling were that it failed to have any impact on their problems; or that it was an inadequate or inappropriate type of help; or that any benefits there were tended to wear off over time. The principal sources of satisfaction with the helpfulness of counselling were that it offered a chance to talk to someone, and that someone was impartial, an outsider, with professional expertise and personal qualities which were admired; it made the clients feel better; it increased their understanding of their problem; it improved their marital and other relationships; and it helped them as individuals.

Asking the clients whether they would recommend counselling to people they knew was another way of assessing how far they perceived it to be at least a potentially helpful service. Only twelve clients said that they would not do so and in the case of only half of these was this because of their own negative experiences. The remaining six said they would not like to admit having seen a counsellor. This confirmed the impression given by the overwhelmingly positive response reported in chapter 6 to a question

about whether a counselling service should be provided in a general practice. One striking finding was that more than four-fifths of the clients said they would recommend counselling, and nearly one-third reported that they actually had done so. This is a much higher proportion than found in some other studies and may reflect the lesser degree of stigma once the service is associated with health care.

About half the clients specified marital problems as those most appropriate for the counselling, but a significant minority did mention a wider range of problems. They found it very difficult to respond to a question about the appropriate type of person, but of those few who did, the most important criterion appeared to be motivation - people must want to be helped.

The responses of counsellors and G.Ps. to questions about the helpfulness of counselling were less detailed and, particularly those of the G.Ps., characterised by a number of 'don't know's'. Nonetheless, leaving those aside, the overall patterns were quite similar. The counsellors were somewhat more and the G.Ps. somewhat less likely to express a mixture of feelings. However, this apparently high level of agreement breaks down when responses relating to individual clients are considered. In the case of 44 of the 74 clients for whom some comparison was possible there was some disparity and in the case of 17 this disparity was marked, in the sense of at least one response at the negative and one at the positive end of the spectrum. The disparities showed no marked bias, they were not accounted for by the responses of any one of the three groups, nor was there evidence that they were associated

with clients or counselling of a particular type. Disparities emerge also in a comparison of the reasons why counsellors and clients describe counselling as helpful or not helpful. The benefits most frequently mentioned by clients were 'someone to talk to' and 'better health', whereas the counsellors emphasised 'increased understanding' and 'helped client as an individual'. In responses relating to lack of helpfulness the clients most frequently referred to the inadequacies of counselling, the counsellors to the inadequacies or inappropriate expectations of clients.

Disparities such as these may reflect a lack of communication between clients, their counsellors and their G.Ps., different expectations and different perceptions of needs, of benefits and of the experience of counselling. They do warn of the dangers of relying on the assessments of any one group to judge the quality or success of a service and of equating professional judgements with client satisfaction (or indeed with other professional judgements). They raise complex issues associated with notions of a hierarchy of validity of opinions and assessments, especially if the aim is to draw implications for policy developments.

This chapter also considered other sources of help for the clients. Not surprisingly, given the context of the research, most of the clients had talked to their G.P. about their problems. The only other group mentioned with any frequency (39 times) was 'friends and relatives'. When asked whom they had found to be of most help, clients specified their counsellor far more often than anyone else, including some clients who had earlier said that counselling had been only of limited help to them. It did appear that for most of the

clients interviewed, very few alternative sources of help had been found. The counsellors seemed to have advantages over those informal and other formal sources that did exist.

Lastly, in this chapter, the question was tackled of how far it was possible to delineate particular characteristics of the clients or of their counselling which predisposed towards an outcome which they reported as helpful. No clear picture emerged. Clients were somewhat more likely to have found counselling helpful if they had initially reacted positively to the idea and if they had been referred with marital rather than more general relationship problems. They were much more likely to report that counselling was helpful if there had also been contact with a spouse and if they had had more than one or two interviews. The interpretation of these latter findings are, however, very uncertain.

The study was a retrospective one and thus it was likely that the accounts of those interviewed of what had happened in the past were coloured by subsequent events. The next chapter considers different aspects of the clients' experiences since counselling had ended.

Chapter 10

After Counselling

This chapter looks at how counselling ended and at what happened to clients after their counselling: to their problems, to their circumstances and to their use of medical services.

All those interviewed were former clients, who had come to the end of their counselling, although this did not rule out the possibility of their becoming clients again; indeed, one woman was waiting for a new appointment. It was thus possible to explore what happened since they stopped seeing the counsellor, as well as how the termination of counselling had occurred.

One aspect of this has already been discussed: it was seen[1] that ten of the clients found any help they had derived from counselling had been limited to the immediate or short-term. Over a longer period, they had 'slipped back' and the benefits had 'worn off', until they found themselves back in the same situation as before.

In addition, the interviewed clients were asked how counselling had ended; whether they still had the same problems as when they had gone to see the counsellor; and whether any changes in their circumstances had or could affect those problems.

Finally, the researcher had some counsellor-recorded information on how counselling ended, and also access to the medical records

of some of the interviewed clients, which could, it was hoped, reveal something about the impact of counselling on subsequent health and the use of medical services.

The termination of counselling

Information was recorded by the counsellors on the number of interviews with each client and how counselling had ended. In addition, the clients in the main study (67) were asked why they had stopped seeing the counsellor and whether they had ever thought of going back.

It has already been noted[2] that, compared with the total client sample, there was some underrepresentation, among those interviewed, of clients who only had one or two counselling interviews. These accounted in total for nearly one-quarter of the 83 interviewed. One-third had between three and five interviews, 14% between six and ten and the remaining 29% over ten. These clients are thus a group of whom about three-quarters have shown some degree of 'staying power'.

In an overwhelming majority of cases (86%) the counsellors recorded that counselling had ended after discussion with the clients.[3] It was thus their perception that at least some kind of preparation for termination had occurred; it was not completely unplanned.

Table I Client reasons for termination of counselling (n = 66)

Not getting anywhere/no help	14
No further need/problems solved	15
Felt better/situation improved	14
Could not go any further	14
Spouse's influence	6
Becoming too dependent	5
Too busy/failed to make another appointment	11
Counsellor suggested time to stop	8

(Total number is more than 66 because more than one reason given in some cases)

When the 66 clients in the main study (omitting the one who denied having seen the counsellor) were asked why they had stopped seeing the counsellor, a variety of reasons were given. The most numerically important fell into three broad groups (see Table I). Firstly, 14 clients said that counselling was not helping them, that they were not 'getting anywhere', including one who said that there was no relevant problem in the first place. Secondly there were the clients who stopped going because of an improvement in their situation. Fifteen said that there was no more need to go, their problems had been totally or substantially solved. Fourteen said that they felt better, or the situation was better. Thirdly, there were 14 clients who felt that the counsellor had done as much as she could and could go no further - these responses usually carried with them the implication that there was still some way to go, but that it was now up to the clients themselves. These three groups overlap to some extent, so only refer to 37 separate clients.

Six clients talked about a spouse's influence. Four stopped going because the spouse had refused to go, one because her husband expressed his opposition and one because the marital relationship had deteriorated to such an extent that she accepted that her aim of reconciliation was no longer feasible.

Five clients referred to their fear of becoming too dependent on the counsellor and their wish to stand on their own feet. For eleven clients, counselling ended more as an act of omission than as a positive decision. Nine simply failed to turn up for, or to make another appointment, and two talked about being 'too busy'. One could reasonably have hypothesised that these clients had a fairly low level of commitment to counselling. However, they included individuals who had expressed great appreciation of counselling and who had attended over a substantial period of time.

This raises again the issue of the extent to which the termination of counselling is planned rather than being something which just 'happens'. There has been some attention in the recent counselling and casework literature to the importance of the end-phase of contact with clients, as opposed to a traditional emphasis on the importance of the first interview. Social workers talk about 'contracts' with their clients[4] which enable the casework to be planned on the basis of a mutually-agreed number of interviews. Maluccio, in his recent study of client attitudes,[5] devotes considerable attention to the process of 'becoming disengaged', as do Timms and Blampied in their study of marriage guidance clients.[6]

Table II Client-reported decision to stop counselling (n = 66)

Counsellor's decision	8
Client's decision	46
Mutual agreement	12
Total	66

There were only twenty of the sixty-six clients who specified that the counsellor had participated in the decision to end counselling (see Table II). Eight of these said that the counsellor had suggested it was time to stop; twelve said it had been a mutual decision. The other forty-six clients conveyed the impression that the decision had been largely their own. In the case of many of these forty-six clients, it was clear that as far as they perceived it, the end of counselling 'just happened' and was not something which was planned by the counsellor. This includes the eleven clients who either failed to make another appointment, or were 'too busy' to carry on. (It is worth noting that only one client actually admitted to failing to turn up for an appointment. The others either did not make another appointment, or rang the counsellor to let her know they were not coming). It also includes most of the clients who stopped because they were not finding counselling helpful.

There was no evidence of 'contracts' being made at the beginning of counselling, involving specifying a certain number of interviews. However, in a few cases, the clients' responses did suggest a planned termination. This usually took the form of interviews at less and less frequent intervals, until eventually either the counsellor or the client suggested that they should cease altogether.

In other cases, the client said that they gradually realised that the interviews were becoming repetitive or more of a social occasion, and that was the point at which they felt it was time to stop. This suggests that the counsellor may have been rather reluctant to make the decision herself. These client responses give a rather different interpretation to the phrase 'closed after discussion'.

There certainly was a very strong impression from client responses that the counsellors did not see counselling as something which was ever completely finished, although it may have for the moment reached the limits of its usefulness. This was indicated by the large number of clients who referred, in a variety of ways, to the issue of returning to see the counsellor (see Table III). Only seven of the main study clients (plus three in the pilot study) had actually contacted a counsellor again, either talking with her over the telephone or seeing her in person. However, of those who had not returned, fifteen said that they had thought about it and thirteen of those remaining quite spontaneously mentioned that 'the door' had been left open for them to return if they wished, or that they would return if it was necessary.

Table III Whether clients had ever thought of returning to counsellor (n = 67)

No	44
yes	15
had returned/contacted her	7
Total	67

Thus 35 of the 67 clients interviewed in the main study either

knew they could go back if necessary, had thought of doing so, or had actually returned. The counsellors were obviously making it clear that they were offering a continuing service. However, there was a group of 15 clients who had thought about returning, but had not done so. What were the obstacles? Most of the clients said that things had never become sufficiently serious. Maluccio's suggestion that return could be seen as a 'failure' on the part of the worker, or as a sign of deterioration in the client's functioning[7] could be relevant in explaining their hesitancy. A few clients expressed more specific reasons: for example, the reluctance of one woman to 'go through all that again' and the fear that things would 'slip back' after counselling finished, as they had before. Another woman felt that, as her marriage had ended, the service was no longer appropriate. However, this was not a widespread feeling. Quite a few clients talked about consulting the counsellor about general family matters, not just the marital relationship. This substantiates the assertion, discussed in chapter 9,[8] that many clients saw the counsellor's expertise as extending beyond marital problems narrowly defined.

The clients' problems

Some of the clients' responses to questions about the helpfulness of counselling have already suggested that there may not be a straight-forward relationship between that helpfulness and problem-solving. Other questions helped to clarify this issue, as well as to explore what the clients perceived to have happened to their lives and relationships since the counselling.

Table IV Whether clients still had the same problems (n = 83)

Yes	24
Yes, but cope better	17
No	42
Total	83

All the clients were asked whether they still had the same problems as before they saw the counsellor (see Table IV). Twenty-four of the eighty-three stated quite unequivocally that they had. Another seventeen said that the problems were still there, but that they could now cope with them better. The remaining 42 said that they no longer had the same problems.

For most of the 42, there appeared to have been a definite improvement in their lives and relationship. The exceptions were a woman whose husband had died since she saw the counsellor; two men who said that their former marital and family problems had been replaced by another set, which in some ways were worse; and a woman who said that the problems were only less acute because her husband's new job meant that he was away from home more often.

Of the remaining 38, three clients had been reconciled with their spouses and a further ten talked about general improvements in their marital or family relationships. Three referred more specifically to the resolution of sexual problems. Fourteen had subsequently been or were in the process of being divorced - a change which they had been seeking, or with which they had now come to terms. Seven of these talked about a new relationship, as did another three who had had no stable partner at the time of counselling. Two women,

recently bereaved at the time of counselling, felt that they had successfully come to terms with the loss of their husbands.

Five of the clients talked about improvements in their mental health, and two referred to either themselves or their spouse drinking less. Three mentioned improvements in the work situation of themselves or their spouse.

Table V Whether clients still had the same problems by client-reported helpfulness of counselling (n = 83)

Still the same problems:		
Counselling helpful		6
Mixed feelings about counselling		11
Counselling not helpful		7
	Total	24
Same problems, but cope better:		
Counselling helpful		14
Mixed feelings about counselling		1
Counselling not helpful		2
	Total	17
No longer the same problems:		
Counselling helpful		26
Mixed feelings about counselling		8
Counselling not helpful		8
	Total	42

There seemed to be some relationship between how helpful clients had found counselling and whether their problems had remained the same, although this relationship needs to be looked at with care (see Table V). More than three-fifths (26) of the 42 clients who reported that they no longer had the same problems had found counselling

a substantial and lasting help, while three quarters (18) of the 24 who felt their problems were the same as before reported no or only limited help from counselling.

However, the clearest link seemed to be among the 17 clients who replied that they still had the same problems but could now cope with them better. All but three had found counselling to be of substantial and lasting help. Also, some clients reported a lot of help from counselling but felt their problems were still the same as before. Even some of those who reacted positively to counselling and felt their problems had lessened or disappeared sometimes mentioned what could be regarded as extraneous factors as the reason - such as the elderly widow who talked about 'time' as being 'the great healer' in helping her to come to terms with bereavement, the woman who referred to changes in the behaviour of a spouse who had not seen the counsellor, and the two clients who referred to physical treatment for their depression. This suggests that, for some clients at least, 'help' can be distinguished from 'problem solving'. Counselling could be experienced as very helpful and yet not have much apparent impact on the problems with which they came.

Other clients appear to link 'helpfulness' with 'problem-solving' far more. The six clients who said they still had the same problems and had not found counselling helpful, together with most of the eleven with continuing problems and mixed feelings about counselling, all referred to the inability of counselling to do anything concrete about the situation in which they found themselves: be it marital breakdown, chronic illness or whatever. For example, one woman said:

"The counsellor couldn't help. Nothing helped at first ... It wasn't going to mend the marriage."

Another, male, client said:

"Talking to the counsellor made me feel better for a while, but it didn't change the situation at all."

There were also examples, as one would expect, of the reverse side of the coin - clients who attributed the helpfulness of counselling to the fact that it 'solved' or substantially diminished their problems. The most obvious are the cases of the three clients who talked of how counselling had resolved their sexual problems.

The importance to some clients of extraneous factors in determining the resolution or otherwise of their problems has already been mentioned. This is a complex issue. Quite a few clients mentioned factors outside counselling - for example, the establishment of a new relationship. The question then arises (and is virtually unanswerable) of how far this can be regarded as something quite separate from counselling, which would have occurred had the person never become a client. Alternatively, did counselling enable this new relationship to be formed and successfully maintained? Different versions emerged from the clients: some clearly linked the two:

"Mrs. . taught me how to make better relationships, especially with my brother and my new woman friend."

Others, even some who had found counselling helpful, saw their new relationship as quite fortuitous and unconnected with counselling.

One must also consider the question (although, once more, this will be virtually unanswerable) of how far changes in the circumstances of the clients influence their perception of the helpfulness of counselling. For example, an improvement in the situation of a former client may encourage a more positive interpretation of the experience of counselling and of many other forms of help given at the time, than if the situation had deteriorated. Again, it is possible that counselling and the changing situation are linked or separate.

Changes in circumstances

This is related to the question of how far the problems of these clients are 'caused' by and therefore susceptible to improvement by changes in circumstances. Alternatively, how far these problems are the result of inadequacies within the individual him or herself, and thus inappropriately blamed on external factors, such as straitened economic circumstances, or the unlikeable and unreasonable behaviour of other people, or an unsuitable job.

Counsellors tend to lean towards the latter type of explanation and, even where the client's circumstances are indisputably difficult, concentrate on the feelings, attitudes and responses of the clients, rather than ways in which the circumstances could be altered.(9)

This is hardly surprising. Counsellors, especially as members of a voluntary organisation with no statutory powers and no brief to distribute material resources, can do very little about the economic plight of clients, their physical surroundings or the

behaviour of people with whom they have no contact. Their whole training is oriented towards 'the personal' as Halmos puts it,[10] towards relationships and towards the contribution which people make to their own happiness and unhappiness.

In fact, Timms and Blampied[11] have suggested that counsellors often know very little about what is happening to their clients outside the counselling room.

Table VI Changes in clients' circumstances which had affected problems (n = 83)

No	32
Yes, for better	36
Yes, for worse	12
Yes, for better and worse	1
No response	2
Total	83

The clients interviewed were asked to specify any changes in their circumstances which they felt had had an impact on their problem since they saw the counsellor, and whether any such changes could help them. Thirty-two of the 81 clients asked (the questions were inadvertantly omitted in two interviews) reported no changes in their circumstances, or no changes which had affected their problems (see Table VI). Of the remaining 49, nearly three-quarters (36) said that circumstances had improved, a quarter (12) that they had deteriorated, and one woman said that in some ways things had got better and in some ways worse.

The circumstances specified varied enormously, but a few areas seemed to be particularly important to clients in their bearing on their problems: their relationships with others (mentioned 26 times); their housing and the area in which they lived (mentioned 12 times); and their job (mentioned 21 times).

Table VII Whether any (further) changes in circumstances would help problems (n = 83)

No, external circumstances irrelevant		20
No, circumstances improved and problems resolved		21
Yes:	Housing, area	9
	Work	9
	Health	7
	Income	5
Changes associated with relationships		12
G.P. or nurse to visit sometimes		1
No response		6

(Total number is more than 83 because more than one change mentioned in some cases)

When clients were asked whether any changes in circumstances could help their problems, it emerged that about three-quarters of them did feel that circumstances were important (see Table VII). Only 20 of the 77 clients (there was no response from 6 clients) replied that external circumstances were irrelevant as the problem lay inside themselves. Almost the same number (21) expressed no wish for any further changes, but this was because their circumstances and the associated problems had already improved.

That left 35 clients who did think further changes could help

them. Work and housing were the most frequently mentioned (both on nine occasions), with health (on seven occasions) and income (on five occasions) being the other main areas of improvement seen as relevant.

The absence, in responses to this question, of any direct references to relationships with others may have been the result of an emphasis on the part of the interviewer on 'concrete' circumstances. However, there were some responses which were obviously associated with unsatisfactory relationships. Five clients talked about as yet unfinalised divorces, or incomplete separations; one about leaving her spouse; and four about difficult or restricting relationships with parents and children. One client wanted to make a 'fresh start'; two referred to changes in the behaviour of other people; and one to finding someone to live with. Lastly, one elderly woman expressed the wish that her G.P. or a practice nurse would visit her sometimes.

Although it is dangerous to draw any firm conclusions from analyses of these responses, it is worth noting that only one of the twenty clients who talked about their problems as being inside themselves had found counselling of no help: a highly-educated man who had criticised the type of counselling he had been offered, inferring that a different type might have helped him. On the other hand, over a quarter of the 57 clients who saw external circumstances as relevant said that counselling had not helped them. This difference could be the result of the different nature of the clients' problems, differences in their perception of what were similar problems, or a reinterpretation of the nature of their problems on

the part of those who had been favourably impressed by counselling.

Table VIII Whether counselling brought any new problems to light (n = 83)

Yes	32
No	50
No response	1
Total	83

It has been argued that one of the benefits (or maybe dangers) of counselling is that it encourages clients to take a fresh look at their situation and at their relationships and perhaps discover previously unrecognised sources of their difficulties.[12] Thirty-two of the eighty-three clients agreed that counselling had brought to light or clarified problems of which they had previously been unaware (see Table VIII) In some cases these were quite specific. For example, one woman talked about the realisation that her husband did not love her. Two clients became aware that a sexual problem was in fact a symptom of more general marital difficulties. In other cases, the clients talked about a clarification of their problems, the contribution that they themselves were making to them and the point of view of their spouses. Here the recognition of hitherto unsuspected problems shaded into increased understanding of those which were already apparent to the individual. On the whole, these were described as painful processes, but, in the long-term, necessary and constructive.

The impact of counselling on medical consultation and prescription rates

Waydenfeld and Waydenfeld, in their prospective study,[13] suggested that the attachment of marriage guidance counsellors to general medical practices generally led to a reduction in the consultation and prescription rates of the patients referred. Lightening of the G.P's.workload has been one of the advantages that have been argued to accrue to these kinds of attachments. It has already been noted that all the G.Ps. at the Medical Centre felt that the counselling service had, in many cases, reduced the number of medical contacts and of drug prescriptions, and that many of the clients referred to an improvement in their health as being one of the benefits of counselling.[14]

It was decided to explore the possibility of looking at the consultation and prescription rates of counselled patients in this retrospective study. Permission was obtained from the G.P. who had referred the largest number of the clients interviewed to examine the medical records of those individuals registered with him. This gave a total of 34. One set of notes was unobtainable, and so 33 were examined.

Prospective studies involve the disadvantage that the behaviour of those participating may change as a result of being under study. Thus, for example, G.Ps. may think more carefully about initiating repeat consultations or prescribing drugs, particularly if they would like to be able to demonstrate the value of counselling attachments. Of course, this can be argued to be a desirable development and may last after the study ends, but it makes it rather difficult to

argue that the counselling had some direct impact on the patient.

Retrospective studies involve looking at data gathered and recorded before the research begins. These, while avoiding the 'Hawthorne' - type effect described above, also have their disadvantages, some of which are well illustrated here. For example, the data which is used will not have been gathered with an eye to the needs of the specific research project, and maybe without any systematic analysis in mind at all. Thus, the medical records were found to be frequently very difficult to read and, the researcher suspected, incomplete (this was confirmed as likely by the G.P. concerned!). They only contained details of medical consultations (omitting, for example, visits to the nurse) and it was sometimes difficult to distinguish an actual consultation from a repeat prescription.

Finally, a problem affecting both prospective and retrospective studies, of this kind, is the familiar one of isolating the impact of counselling from the impact of all the other factors impinging on the individual's life at that time. Many of those referred to the counsellor were at a particularly difficult point in their lives, and were translating their difficulties into a demand for medical attention. All kinds of factors, including even time itself, may, have produced a lessening of that 'crisis feeling', or a move away from seeking help from a medical source, of which counselling is only one.

The above discussion obviously leads to the conclusion that the findings of this study must be treated with caution. However,

they are interesting, if only for the rather different picture they paint from that of the Waydenfelds' study, or even that of the interviewees in this study.

The 33 sets of medical notes examined comprised those of 25 women and 8 men. All but 3 had been patients of this particular practice for over ten years and many for much longer. The records ranged from one brown card to a number of bulging folders tied together. Three types of information were extracted: a brief summary of recorded illnesses; the number of consultations recorded in each year since 1970; and the prescription of mood-altering drugs and hypnotics.

Table IX Psychological symptoms and medical case-history (n = 33)

Psychological symptoms associated with specific incident/spouse's illness	9
Longstanding/chronic psychological symptoms associated with social problems	12
Longstanding/chronic psychological symptoms associated with diagnosed psychiatric illness	5
Longstanding/chronic psychological symptoms associated with diagnosed physical illness	7
Total	33

One of the most striking features of the data was that, in every single case, depression, tension or anxiety (and often a mixture of all three) were mentioned at some point (see Table IX). It is difficult to know how far this differs from the population as a whole. There do not appear to be any studies which examine the incidence of psychiatric symptoms over the life-time of individuals. Brook & Cooper conclude that between 10 and 20% of NHS registered patients

present with psychiatric symptoms in any given year.[15] Marsh, writing about his own patients at the Medical Centre, reported 'psychiatric disease' as the second most common reason for consultation, accounting for 14% of the total.[16]

However, it may be rather simplistic to look at this group of individuals as belonging to one, indivisible category. Also, it could with some justification be argued that it is hardly surprising that people referred to a counsellor to discuss their marital or other relationship problems exhibit some symptoms of emotional stress.

This group of 33 clients do in fact fall initially into broad categories (see Table IX): those whose psychiatric symptoms appeared to be associated solely with a specific problem or crisis: marital breakdown or the illness of a spouse, for example, and those with more longstanding symptoms, sometimes recorded over decades. This last group, comprising 24 (nearly ¾) of the total, can be further subdivided into three, although the boundaries are less distinct and the classification of some individuals relies on the researcher's lay judgement. Firstly, there was a relatively small group of 5 clients, whose symptoms were associated with a diagnosed and defined psychiatric illness: 'hydrophobia', 'agoraphobia', 'hypermania' and so on. These had all been referred to a psychiatrist and some had received in-patient treatment. A second group, of 7 clients, had psychiatric symptoms alongside a chronic and serious physical illness: multiple sclerosis, Crohn's Disease and so on. Their symptoms post-dated and appeared to be a reaction to their illness (although several were illnesses themselves considered to have

psychosomatic elements).

The largest group, of twelve clients, had long-standing and chronic symptoms, which did not appear to be part of any clear psychiatric condition (in fact, in several cases, a psychiatrist had given the opinion that the individual was not psychiatrically ill). Instead, their depression, anxiety and so on seemed to stem from what could be called 'social problems'. There was reference to family conflict, to problems at work, to 'personal inadequacy' and 'immaturity', to domestic violence and to a succession of difficult relationships.

In all but two of the cases, drug therapy had been used at some point to try to alleviate these symptoms. Tranquillisers, hypnotics and anti-depressants were all mentioned, ranging from single prescriptions of Valium or Mogadon, to a huge variety of major mood-altering drugs, prescribed at regular intervals over a period of many years. Twenty-eight of the 33 patients were being prescribed one or several of these drugs at the time of referral to the counsellor.

Table X Average recorded consultation rates 1970-79[1] (n = 33)

< 1	2
1 - 1.9	6
2 - 2.9	7
3 - 3.9	9
4 - 4.9	3
5 - 5.9	3
6 or more	3
Total	33

(1) Except where record only begins more recently (3 cases)

Average consultation rates were recorded over the previous ten years (see Table X). These were inevitably only a rough guide given the likely inaccuracies mentioned above. Where it was unclear whether given entries were consultations or repeat prescriptions, it was decided to take half as consultations.

On average, these individuals did not appear to be particularly heavy consulters. Nearly half were recorded as consulting on average less than 3 times a year and nearly ¾ less than 4 times a year. Only three saw the doctor on average 6 or more times a year. This is particularly low when one considers that 20 of the 33 were women of child-bearing age, although there was only a very small number of another group with a high average consultation rate: elderly people.

If we take a year halfway through this period (1975), the General Household Survey (GHS) found the average number of G.P. (NHS) consultations per year for women aged between 15 and 44 to be 4.2.[17]

Among the 20 patients in this category, the average was 4.3 and the median 3.

Table XI Average recorded number of consultations in year in which first saw counsellor (n = 33)

Females		Age-groups		
		15 - 44 (n = 20)	45 - 64 (n = 4)	75+ (n=1)
Survey	: median	4.25	4.5	2
	average	6.2	5	2
1978 GHS	: average	4.6	3.7	5.7
Males				
		15 - 44 (n = 6)	45 - 64 (n = 2)	
Survey	: median	4	7	
	average	4.3	7	
1978 GHS	: average	2.4	3.7	

However, looking at the consultation rates in the actual year of referral, and comparing them with the equivalent sex and age groups in the 1978 GHS[18] (the year in which the largest number of referrals from this group was made), there is some evidence that around the time of referral, these individuals were making somewhat heavier demands on the G.P's. time (see Table XI). Of course, the comparison is not an entirely perfect one. The GHS relies on respondents' recall at interview, not on medical records. Also, the figures will include respondents with a 'nil return', whereas most of these individuals had inevitably seen their G.P. at least once, in order to be referred. Marsh and Kaim-Caudle, in their

analysis of a G.P's. workload, demonstrate the effect this can have on average consultation rates.[19]

Taking again, as an example, the largest group, women aged 15-44, the average number of consultations in the year of referral among the 20 patients in this group was 6.2, compared with a GHS figure of 4.6. However, half of the women did fall below the GHS figure, the average being pushed up by a few patients with very high rates. For the six men in this age-group, the average was 4.3 compared with the GHS figure of 2.4 Two of this group consulted less than the GHS average. This pattern was broadly repeated among the few patients in the other age/sex groups, with the notable exception of one, very fit, elderly lady of over 80!

Thus, with a few exceptions, these individuals did not appear, on average, to be particularly heavy users of the G.P's. time. However, another important question is whether there is any evidence that referral to a counsellor lowered the consultation rate, and/or had any impact on the prescription rate.

Of course, in the absence of a perfectly matched control group, these kinds of questions are impossible to answer with any certainty, in the positivist sense. What the consultation rate would have been in the absence of counselling is as difficult to estimate as what mortality rates would be in the absence of doctors. Perhaps the most meaningful data are in fact those provided by the G.Ps' overall impression (developed without the 'benefit' of any quantitative analyses) that, in a significant number of cases, the counsellor did lighten their potential workload.

Table XII Relationship between counselling and medical consultation and prescription rates (n = 33)

	No.	%
No apparent impact, or increase in consultation/prescription rates	20	61
Referred when consultation rate high, no apparent impact	4	12
Some fall in consultation and prescription rates	3	9
Some fall in consultation rates, no apparent impact on prescription rates	2	6
Substantial fall in consultation and prescription rates	2	6
Substantial fall in consultation rates, no apparent impact on prescription rates	1	3
Some short-term fall in consultation and prescription rates, but no apparent long-term impact	1	3
Total	33	100

All that can be said in looking at the data provided by the medical casenotes is that there is, in most instances, no evidence to support the thesis put forward by the Waydenfelds and others,[20] that consultation rates and prescription rates fall following referral to a counsellor (see Table XII). In nearly ¾ of cases (24) there was no apparent impact on either consultation or prescription rates, and in some of these, the rates had actually risen since referral. In one other case there had been an immediate fall, but no apparent impact in the longer term (this of course may have been true of more than one individual case, but disguised because of the grouping of consultations and prescriptions by year). As far as medical consultations were concerned, the individuals in this group

were either relatively frequent consulters, who continued to come quite often; or people who hardly ever consulted and had rarely consulted since; or people who had not previously seen the G.P. very often but who, since the incident which prompted referral to the counsellor, had become more regular consulters. Similar groupings applied relating to prescription rates.

This left just under ¼ of the patients (8) for whom there did appear to be some reduction in consultation and of prescription rates. This was more commonly a reduction in the former; prescription rates only showed a fall in the case of 5 patients. In only two of the 33 cases was there a substantial fall in both the consultation and prescription rates. There seemed to be no link between client satisfaction with counselling and any impact on consultations or prescriptions.

The conclusion is therefore that the case for arguing for the attachment of counsellors to a general medical practice on the grounds that the workload of the G.Ps. and the amount of prescribing of psychotropic drugs will be thereby reduced is not yet proven. This is perhaps one of the most important areas for further research. Moreover, that research needs to be particularly sensitively carried out. The problem that so many factors extraneous to counselling will affect the use of medical services and the state of the individual's emotional life has already been mentioned. The meaning of any changes in consultation rates (or lack of change) needs also to be examined carefully, including the question of how many are G.P.-initiated, 'repeat' consultations. There were some remarks made in the G.P. interviews which are relevant here. For example,

one G.P. talked about becoming more sensitive to his patients' emotional needs since the counsellor attachment. Coping with these rather than with presenting symptoms may well promote a higher consultation rate, at least in the short and medium-term. However, one could argue in this case that the counsellors' presence had made a significant addition to the quality of patient care. Conversely, it has already been suggested that a lower consultation rate may reflect the patient's dissatisfaction with having been referred to the counsellor and a turning to someone else for help with his or her personal problems. Another G.P. remarked in several cases that although the consultation rate had not fallen, his impression was that he was now dealing with what he felt were 'medical' matters more relevant to his expertise. All this suggests that the quality of the data needs to be high and thus that, in spite of its disadvantages, a prospective study may be preferable. However, the time-period should ideally be years rather than months. There certainly needs to be a distinction between the period during which counselling is being provided and after termination. Also, given the objectives of counselling to help people to understand and come to terms with themselves and their relationships with others (and the claims of many clients in this study that these had been lasting benefits of counselling), it would be desirable to assess whether referral to an attached counsellor has any long-term impact on the nature rather than just the amount of medical attention and treatment accorded to the individual.

Summary and conclusions

All the clients interviewed in this study had (for the present

at least) come to the end of their counselling. Thus it was possible to explore what had happened to them in the subsequent period.

It seemed from the counsellors' records that, in the case of the great majority of clients, the termination of counselling was not completely unplanned - the client had not just stopped coming. On the other hand, the clients' responses showed that they perceived the decision as primarily theirs, rather than coming from the counsellor or from a process of mutual agreement. They certainly were not on the whole aware of any plan of 'disengagement' being operated by the counsellors. The main reasons they gave for the decision were either that the counselling was not helping them, or that their situation had improved, or that the counsellor had done as much as she could. However, many of these clients recognised that there was the possibility of re-contacting the counsellor and a sizeable group either had done so or had thought of so doing.

About half of the clients reported that they no longer had the same problems as when they saw the counsellor. However, this could by no means always be associated with the helpfulness of counselling. The group who most clearly saw the counselling as helpful consisted of those clients who reported that they still had the same problems as before, but could now cope with them better. 'Help' therefore does not seem to be necessarily linked with 'problem-solving', for some clients at least.

On the other hand, 32 of the 83 clients said that counselling had brought new problems, or previously unrecognised sources of their difficulties, to light. Again, this was not necessarily associated with finding counselling unhelpful; indeed, the processes

were mainly described as painful, but constructive.

Changes in circumstances, actual or potential, were seen by many clients as being of significance to their problems. Altogether, 49 of the 83 said that there had been some changes in their circumstances, for better or for worse, since counselling had ended, which had affected their problems. Changes in relationships with others, in jobs and in their housing situation were most frequently mentioned. Only about one-quarter of the clients demonstrated, in their responses to a question about whether any changes could help them, their belief that external circumstances were irrelevant as the problem lay inside themselves. This group could be argued as consisting of those people who most clearly expressed the ethos of counselling - certainly only one had found the counselling of no help.

The final area of subsequent experience which was considered was the clients' use of medical services at the practice. The consultation and prescription rates of the 34 clients registered with one doctor at the practice were compared before and after counselling. This data had obvious limitations which made it necessary to be careful about its interpretation. However, all of the clients were recorded as having consulted with symptoms such as depression, tension and anxiety, and in the case of nearly three-quarters these were longstanding, associated with social problems or psychiatric or physical illness. All but two had received associated drug therapy at some point, and all but five were being prescribed such drugs at the time of referral to the counsellor. With a few notable exceptions, these individuals did not however seem to be particularly heavy users of the doctors' time, as judged by their recorded consultation rates.

Both the evidence from previous studies and from the impressions given by the G.Ps. and clients interviewed in this study suggested that counselling lessened subsequent demands on medical services. However, the medical records failed to support this. In the case of 24 of the 33 clients there was no apparent impact on consultation or prescription rates. Neither did there seem to be a link between the reported helpfulness of counselling and the subsequent use of medical services.

It was suggested that further research into this area needs to be carried out, using better quality data, before any conclusion can be drawn about the impact of a counselling service on the amount and nature of the health care needs and demands of clients.

Chapter 11

Summary and Conclusions

This chapter will look back over Chapters 1-10, in an attempt to summarise the findings and discussions and to draw some conclusions, in the light of the issues raised.

In the Introduction (Chapter 1) three, very broad, 'working assumptions' were outlined and it is perhaps worthwhile to repeat them at this stage, as a way of structuring the subsequent summary of the material:

Research into marriage counselling

> "That research in the field of marriage counselling, in spite of the considerable difficulties it poses, can yield results which are meaningful and are relevant to policy formulation and is thus an important undertaking.

Chapter 2 discussed the high and rising divorce rate and the public concern which has been aroused regarding the consequent financial and other costs of this trend, as well as the way in which this concern about marital relationships has been exemplified by the growth of the marriage guidance counselling movement. Thus, it can be argued, that most private of relationships and the efforts made in our society to improve its quality and durability through social policies in the statutory and voluntary sectors, are a proper and important subject for social research.

Chapter 4 looked at some of the difficulties posed by marital counselling as a subject for social, particularly social policy research. More specifically, this chapter discussed research into counselling outcomes and the use of client or 'consumer' opinion studies and some of the dilemmas posed by these. It was concluded that any study will fall far short of the methodological ideal in the traditional positivistic - scientific sense; indeed, it was questioned whether this is the most appropriate model towards which to aim. The case was put forward for an alternative 'humanist' approach. However, this does not rule out systematic, rigorous and enlightening studies, which can be of some value to policy-makers and practitioners, as well as in the academic sense. The present study, of a small-scale and exploratory nature, was thus embarked upon with these aims in mind.

Chapter 5 discussed the research methods used by the study, which involved the use of records on clients (some compiled by the counsellors and some medical casenotes), and of 'focused' interviews conducted with former clients, counsellors and G.Ps. In all, 83 clients were interviewed and the response rate (56%) from those approached was higher than originally anticipated. The interviewed clients did differ in some ways from the total client population, and it is quite possible that they also differed in respect of other, less easily measurable dimensions. However, a wide range was represented in terms of age, sex, social class, marital status, reported satisfaction with counselling, types of problems, number of counselling interviews and so on. In analysing the material, stress was laid on conveying the complexity and meaning of the interviewees' responses more than on any sophisticated

(and in this context probably of dubious validity) statistical techniques.

Attachments of marriage guidance counsellors

> That the attachment of marriage guidance counsellors to general medical practices is an appropriate and valuable development, improving the quality of the counselling service and of primary health care.

Chapter 2 contained a brief account of marriage guidance counselling, counsellors and their clients. In chapter 3, the trend (although at present on a relatively small and experimental scale) of 'attaching' marriage guidance counsellors to general medical practices was discussed, drawing largely on the existing literature, on co-operation between social workers as well as counsellors and G.Ps. This literature enabled an assessment of the potential scope for marriage guidance counsellors in this setting and also an indication of some of the advantages and disadvantages which may emerge.

On the whole, the literature is highly favourable, particularly, as one would expect, accounts which relate to particular experiments, staffed by enthusiastic participants who are, by definition, not typical of their professions as a whole. There does seem to be plenty of scope for marital and more general relationship counselling, in that G.Ps. frequently find themselves approached by patients with these problems and often feel that they themselves are ill-equipped to cope with them. The attachment of a counsellor is argued to bring benefits to the G.P., to the counsellor, to the client and to the community as a whole. In fact, the promise is

often implicit of an increase in the quantity and quality of patient care without an increase, perhaps even with a decrease, in the cost of that care. The advantages are usually presented as far outweighing the possible disadvantages of this setting, which relate most often (although not exclusively) to difficulties which could be overcome by a change in the attitudes of G.Ps. or by reform of the marriage counselling organisation.

In chapters 6 and 7, an attempt was made to assess how far the assertions of the literature were borne out by an examination of the attachment scheme at the Medical Centre (itself, of course, not a 'typical' practice). In chapter 6, the 'mechanics' of the scheme were described and material from the G.P., counsellor and client interviews was used to consider the role of the counsellor in general practice. This made it possible to assess the advantages and disadvantages of providing counselling in this setting, as an addition to the range of primary health care services.

All the G.Ps. and the counsellors described the scheme in positive terms. It was found that three of the five G.Ps. defined the role of the counsellors as concerned specifically with marital relationship problems, while the other two, including the G.P. who made the largest number of referrals, drew wider boundaries. These wider boundaries were also accepted by the counsellors themselves.

The counsellors talked of the advantages of working in a general practice setting in very similar terms to those found in other studies, but they also mentioned some actual or potential

difficulties. These principally concerned the amount of time it was necessary to devote to the counselling attachment which, given the voluntary nature of their work, was considerable; the nature of the medical referral and possible effects on the attitudes of clients; isolation from the marriage guidance organisation; and issues of finance: concerning both the remuneration of individual counsellors and the financing of their marriage guidance council.

Client reactions to the provision of a counselling service at the Medical Centre were overwhelmingly positive - far more so than their reactions to the counselling they themselves had received. Only one of the 83 expressed total opposition. They felt that this setting had both physical and psychological advantages over a marriage guidance centre and over two-thirds mentioned the advantages of a link between the G.P. and the counsellor. They also expressed the view that, on the whole, the scheme worked well in administrative terms.

Chapter 7 contained an analysis of the counsellor-provided records on 277 clients they had seen at the practice over a four-year period. Source of referral, demographic characteristics, counsellor-perceived problem areas, number and type of interviews and how counselling ended were all examined and compared, where possible, with national data on marriage guidance clients and with data from other studies of the work of marriage guidance counsellors in general practice. This enabled some conclusions to be drawn about how far there were differences between the clients and the counselling in general practice and in the more traditional setting.

In some ways, the practice counsellors were still carrying out the traditional kind of marriage guidance counselling. The typical client was a married woman in her 20s or 30s, living with her husband, whose perceived problems lay in the fields of personal traits or sexual difficulties. However, there were some significant differences. The first was that the great majority of Medical Centre clients were recommended, even told (with varying degrees of directiveness) by their G.P. to make an appointment with a counsellor - in some cases, the appointment was made for them. In a sense, therefore, counselling was 'prescribed', and a less voluntary undertaking than is usual for clients at a centre, most of whom are self-referred. This could produce a variety of effects.

One rather obvious, but important effect is that a far higher proportion of Medical Centre patients received counselling than the proportion of the population as a whole. In the four years 1975-78 inclusive, nearly 2% of the patient population saw a counsellor at the practice. During the same four years 118,500 new cases came to marriage guidance councils in England and Wales.(1) On the generous assumption that these involved 200,000 clients, this represents about 0.4% of the population. On a more local level, the demands of the practice on counselling time could pose problems for the local marriage guidance council. A high proportion of their limited counselling resources, in terms of time and money, was being devoted to a small proportion of the population in their area.

The 'prescribing' of counselling may also result in a proportion

of passive or even unwilling clients, who only attend because their doctor has told them to. Given that counselling depends on the active and willing participation of clients, this could make the counsellor's task a very difficult one. There was some evidence that clients who only attended because of persuasion by their G.P. were less likely to find counselling helpful, although this by no means always applied. On the other hand, this method of referral could increase the likelihood of 'success' in counselling. If the G.P. is aware of the nature of counselling, he can act as a 'filter', selecting clients who are likely to benefit and ensuring that they do not have inappropriate expectations. Moreover, the 'prescribing' of counselling could mean that individuals are reached who could benefit from counselling, but who would never have the courage to take the initiative themselves, or who would not think it appropriate for their situation. This is likely to include the significant minority of single referrals (11%) in this study who are very unlikely to approach a marriage guidance council. The client interviews suggested that it also included many of those who were married and defined as having marital problems.

There is another issue which needs careful consideration. When clients approach independent marriage guidance councils on a voluntary, self-referred basis, it can be assumed that generally they will feel free to stop seeing the counsellor if they do not want to undergo the exploration of feelings and the 'digging deep' that counselling involves. Certainly the counsellor is independent of any other helping profession with which the client may be involved and unlike, for example, her social work counterpart has no statutory

powers nor does she control access to material resources. However, the situation in a general practice attachment is rather different. The clients are not so 'voluntary'. They have come seeking medical help and may well feel constrained by the need to maintain a good relationship with their G.P., with whom they are likely to have continuing contact. In this context counsellors are less able to reject the counselling process. The criticisms of Wootton and others that social workers refuse to accept the 'presenting problems' of clients and their use of casework techniques on those who may be in no position to insist on maintaining their definition of the situation are of relevance here.(2)

The majority of the counselling at the Medical Centre was with women. Women were more likely to be referred in the first place than men, and had more contact in terms of total number of interviews. This predominance of women was more marked than is the case nationally and may be considered an undesirable result of counsellors working in a setting where women are disproportionately represented among service recipients. Counselling involved mainly the 20-50 age-group with a marked under-representation of the very young and older age-groups - the latter particularly given their relatively high medical consultation rates. About 80% of the clients were married or cohabiting and living with their spouses when they were referred, but a significant minority (11%) were single, either never having been married, or being widowed or divorced. This is a much higher proportion than was found in the national survey of marriage guidance clients in the mid-1970s, but is almost entirely accounted for by the referrals of one of the G.Ps. His colleagues overwhelmingly referred married individuals

or couples. Around half of the married clients had been married for less than ten years. The problems of the clients (as interpreted by the counsellors) fell mainly in the areas of 'personal traits' and 'sexual difficulties': a similar pattern to the national one.

There was an enormous variation in the duration of counselling. Nearly a third of cases involved only one or two interviews, and a similar proportion involved more than ten interviews, with some very prolonged cases. These pushed the average number of interviews up to a level significantly higher than the figure found in marriage guidance counselling nationally. In these prolonged cases, the counsellors seemed to be providing a source of long-term support to clients. This may well relieve the G.Ps. of some of the workload produced by frequent surgery attenders. It is another matter whether it is an appropriate use of counselling time.

Another difference associated with counselling in this setting appeared to be in the way counselling ended. At the Medical Centre, the great majority of cases were reported by the counsellors as 'closed after discussion' between themselves and the clients, and only in a small minority did the client just stop coming without any discussion. Although the figures are not strictly comparable, the 1975 national survey found over one-third of cases falling into the latter category. This, together with the impression of the counsellors that there were fewer unkept first appointments in a general practice attachment, was an important source of greater 'job satisfaction' for them.

The 'filtering' of clients through G.P. referral, together with a smaller number of unkept appointments, a larger average number of interviews and an increased likelihood that counselling would end after discussion between counsellor and client compared with the national picture: all these suggested that the Medical Centre attachment was providing a valuable and valued service. However, it is necessary to be cautious about any such conclusions. For example, the perseverance of clients could be attributable to the 'prescription' of counselling, analogous to persevering with a course of treatment which is unpleasant and in which one has little faith, but which an 'expert' has deemed to be good for one. It is important to remember that these clients are likely to be continuing patients of the practice and thus wary of upsetting their doctors or any of the other practice staff. Just as it is sensible to complete a course of antibiotics before returning to complain that they do no good, so it may be thought sensible to 'complete the course' of counselling before going back to the doctor with the symptoms unrelieved. Completing the course cannot therefore be equated with client satisfaction or with the helpfulness of counselling. To test this further the third of the working assumptions described in the Introduction needs to be examined.

The helpfulness of counselling

> That counselling in a general medical practice setting is of help to clients and that the extent and nature of this help and the consequent impact on the G.Ps. workload can be fruitfully explored by examining the assessments by clients, as well as by their counsellors and G.Ps.

Chapters 8, 9 and 10 were concerned with the individual

experience of counselling at the Medical Centre of 83 clients, using material from interviews with clients, counsellors and G.Ps. The discussion followed a broadly sequential pattern: looking first at how the patients became counselling clients and their experience of and reactions to this transition. Next, the extent and nature of help given to clients through counselling, as assessed by clients, counsellors and G.Ps., was considered and the question of whether it was possible to distinguish particular client characteristics which made it more likely that they would find counselling helpful. Lastly, how counselling ended and what had occurred since was discussed, including the question of whether counselling appeared to have had any impact on subsequent medical consultation and prescription rates.

Most of these clients were referred by their G.P. The majority had initially consulted the G.P. with problems which involved a mixture of physical and psychological symptoms and characteristics. Only a few had come specifically to discuss sexual or other marital difficulties, although for others these did emerge during their discussions with the G.P. Most were referred to the counsellor for discussion of marital problems, and the exceptions virtually all derived from the referrals of one G.P. The other G.Ps. were thus using the counselling service in a traditional way, in the sense of restricting the range of problems referred to those associated specifically with marital relationships.

They also did not appear to be performing a particularly active 'filtering' function in their referrals, in the sense of preparing their patients and explaining to them what they could

expect from counselling, or even exactly to whom they were being referred. Thus clients reported a wide range of pre-conceptions about counselling and an appreciable number could remember none at all.

When clients were asked about their reactions to referral, the responses suggested that the counsellors at the Medical Centre were seeing some individuals who would never have reached a marriage guidance centre. About one-third reported negative reactions and almost the same number were ambivalent or had no strong feelings either way. It is likely that these individuals only went because it was suggested, even 'prescribed', by their G.Ps. This impression is strengthened by the fact that even some of those who reacted positively had never been or thought of going to a marriage guidance counsellor.

As well as extending the range of clients, the hope has been expressed that general practice attachments will increase access to people at an early stage of their problems. It may be that some of those clients who said they had never thought of marriage guidance would later have reached the stage of trying it as a 'last resort'. However, some of them reported that they had reached a stage of some desperation, and many talked about having had their problems for a considerable time before seeing the counsellor.

Given that, as has already been mentioned, most clients were referred, or referred themselves, to discuss problems associated with their marital relationships, it is perhaps surprising that in the cases of 43 of the 68 'primary referrals' with a marital relationship there had been no contact between their spouse and the counsellor. On the

whole it seemed that this was the result of either the spouse's reluctance to see the counsellor, or the client's reluctance to share the counsellor with their spouse, rather than the preference of the counsellors themselves. The counsellors mostly left the decision to the clients and their spouses, although in the few cases where they did approach spouses directly (a practice which does not seem to be in the tradition of marriage guidance counselling), they appeared to have considerable success in persuading them to attend.

When asked about the helpfulness of counselling, over half of the interviewed clients reported that they had found it to be of substantial and lasting help. About one-quarter reported some degree of help, but this had been limited in nature. The remaining one-fifth had not found the counselling experience a helpful one. Overall, this pattern of responses is quite similar to that of the counsellors and the G.Ps. when they were asked similar questions with reference to their clients and patients. There were some differences, mainly relating to the large number of 'don't know' responses from the G.Ps., reflecting a tendency not to follow up their referrals very actively. There was also a tendency on the part of the counsellors to be rather more cautious about the helpfulness of counselling.

However, this apparent concord breaks down when responses are analysed with respect to individual clients. In the case of about three-fifths of the 74 clients interviewed about whom the G.Ps. and counsellors had also been interviewed, there was some disagreement between the three parties, and in approaching one-quarter

the disparity in responses was marked. Disparities occurred between the assessments of clients and counsellors, clients and G.Ps. and counsellors and G.Ps. They showed no consistent bias, nor did they seem to be associated with particular client characteristics, problems or counselling experiences. However, they do emphasise the dangers of equating professional perceptions of the benefits or otherwise of a service with client satisfaction or dissatisfaction, or, indeed, with the perceptions of another profession.

Different patterns of responses also emerged in a comparison of counsellor and client responses to questions about their reasons for assessing counselling as helpful or not helpful. Lack of helpfulness tended to be attributed by clients to the inadequacies of counselling, but by counsellors to the inadequacies of clients, or their inappropriate expectations. The benefits most frequently mentioned by clients tended to be of a relatively simple nature (for example 'someone to talk to') and not to reflect the fundamental professional aims of counselling. The most popular counsellor responses, on the other hand, referred to increased understanding and improved individual functioning.

The clients were asked about other sources of help with their problems. Most mentioned having talked to their G.P. (not surprisingly, given the context of the research), but only a few had had contact with other professionals. Almost half reported talking to 'informal' sources of help: friends and relatives. A notable finding was that forty-nine (about three-fifths) of the clients said that the counsellor had been more helpful than anyone else and

a further 12 ranked her equally with others. Other formal and informal sources of help were mentioned by very few people. The counsellor was seen to have the advantage over other professionals of having more time and, to some extent, more expertise, and over friends and relatives of having less involvement. The limitations (in time and range) of the counsellors' involvement in the lives of their clients seemed to make the clients more able to be open and to confide freely some very personal problems.

Given the different levels of satisfaction with counselling expressed by different clients, the question arises whether these are related in any systematic way to characteristics of the client or of their counselling experience. This study suggests that there is no easy way of delineating the 'ideal client'. Clients with positive and negative reactions to referral; with marital and other problems; with appropriate and inappropriate expectations of counselling, as well as with none at all; of all classes, ages and both sexes; and with marital relationships of varying durations, all showed a wide range of responses. There was some relationship between a positive reaction to referral to the counsellor and the client reporting that he or she had found counselling of substantial help. The counsellors also seemed to have somewhat more success when dealing with marital rather than more general problems. However, the only striking relationships were found between high degrees of client-reported helpfulness and, firstly, contact with both spouses and, secondly, a large number of interviews. It is difficult to assess the meaning of these relationships, as cause and effect cannot easily be disentangled. Contact with husband and wife may reflect a high degree of motivation on the part of both

spouses, which is likely to predispose towards successful counselling. Similarly, a large number of interviews is likely to result from clients finding counselling helpful and thus wishing to maintain contact with the counsellor. In other words, these characteristics may be as much a product of helpful counselling as helpful counselling is a product of the characteristics.

As far as the ending of counselling was concerned, the impression from the counsellors' recording of 'case-history' was that this had occurred after discussion with the clients in most cases. The proportion of cases where clients just stopped coming was considerably lower than had been found in the national survey. However, the assumption that this implied some degree of planning was not supported by the responses of clients to questions about why the counselling ended. It did seem that counselling in a general practice setting reduced the likelihood of clients simply failing to turn up for their next appointment, which has important implications for the efficient use of the counsellors time. However, forty-seven of the 66 clients who were asked conveyed the impression that the decision had largely been their own and many of these saw the end of counselling as something that 'just happened'. There was no evidence of 'contracts' being made between counsellor and client, nor, in most cases, of any planned termination. In fact, the large number of clients who referred to the issue of returning to see their counsellor at some time, suggested that the counsellors conveyed the impression that counselling was something which never finally ended.

Clients were also asked about what had happened to their problems and their circumstances since they saw the counsellor.

Almost exactly half said they had no longer the same problems and for all but a few of these, this had resulted in an improvement in their lives. Over one-quarter said they still had the same problems, and the remaining one-fifth that although the problems were still there, they could now cope with them better. It was interesting to find that for some clients at least counselling was not associated with problem-solving. Although there was some relationship between clients finding counselling helpful and reporting their problems no longer the same, the clearest link was between a positive response and clients reporting that the problems were still there, but they could cope with them better.

Questions about changes in circumstances in areas such as housing, health, work and the behaviour of others revealed that clients often felt these were of relevance to their problems. Well over half of those asked mentioned changes in their circumstances since they saw the counsellor which had had an impact on their problems and about three-quarters said that such changes either had or could be important. Thus only a minority (20) appeared to concur with, or have absorbed the dominant counselling view that problems, particularly relationship problems, emerge from difficulties within the individual, rather than from outside factors. All but one of this minority had found counselling of some help, as opposed to less than three-quarters of the other clients.

Investigation of another aspect of what had happened to the clients since counselling was through the examination of the medial records of those registered with the doctor who had referred most patients. The aim was to see whether these records substantiated

the claims of previous surveys reported in the literature and repeated by the G.Ps. and many of the clients interviewed in the present study, that counselling led to an improvement in health and a decrease in the demand for medical services.

The records of 33 clients were examined. The most striking feature was that, in every single case, depression, tension or anxiety, or a mixture of these was mentioned. The clients, however, fell into several broad categories. Some had psychiatric symptoms associated with a specific crisis; others had symptoms of a more chronic and longstanding nature: sometimes associated with a specific psychiatric or a physical illness and sometimes with 'social' and 'relationship' problems. All but two had received drug therapy at some time.

The clients were not particularly heavy consulters: only three saw the doctor on average more than six times a year between 1970 and 1979. However, there is some evidence that at the time of their referral these individuals were making heavier demands than previously on the doctors' time.

As far as the impact of counselling on these consultation rates and also on prescription rates is concerned, no evidence was found to support the hypothesis that counselling results in a marked decline of either. In nearly three-quarters of cases, there was no apparent impact (in some, rates had actually risen), and in only two of the 33 cases was there a substantial fall in both consultations and prescriptions. Of course, there is no means of knowing what the rates would have been in the absence of

counselling, but there was nothing in this retrospective examination of the medical records akin to the significant decreases reported, for example, in the Waydenfelds' prospective study.[3]

Conclusions

It is appropriate here to emphasise once again that this study makes no claims to general validity and applicability. The style, the subject-matter and the locale of the research mean that those who search for definite answers and clear lessons for policy will be disappointed. However, what has been achieved is a testing-out of some of the assumptions which have emerged from the existing sparse, but growing literature, and a detailed analysis of the workings of one social policy experiment. Research in this field has been shown to be feasible, achieving the co-operation of counsellors, of G.Ps. and, most importantly, of a substantial number of clients.

As is the case with many social policy developments, the provision of a counselling service within a general medical practice can be argued to have several aims. The most obvious and the one which is likely to be the primary response of the supporters of the development, is the enhancement of the quality of patient care in primary health services. However, it could also be seen as a way of obtaining more clients for marriage guidance counsellors, more status for their work and more job satisfaction. From the G.Ps.' point of view, one aim of the service could be to lessen their workload, enabling them to increase the size of their patient population and/or to concentrate on health problems which fall

more within their sphere of competence. Finally, from the point of view of the public purse, the aim of the counselling service could be to lower the costs of the health service: either by substituting cheaper marriage guidance counsellors for more expensive medical practitioners or, more postively, by effectively tackling some of the emotional problems which underly psychiatric and psychosomatic illness.

Some of the findings of this study can be considered in the light of these aims. The quality of patient care is a concept which is inherently difficult to measure. This study concentrated on one of the imperfect measures: the perceptions of service-providers and service-recipients relating to the counselling and its efficacy. It was found that in general terms there was overwhelming approval of the counselling service from all groups, as adding to the quantity and quality of patient care. 'Team care' was a concept which was implicit or explicit in many replies, although it seemed that in practice it was not a particularly active process in terms of communication and active collaboration. Indeed, one of the surprises of the research, particularly given the enthusiasm of the G.Ps. for the counselling service, and for the research project, was the large number of cases in which they did not know whether counselling had been helpful as they had not followed up their referral.

In relation to individual clients, it was also felt that counselling had been of some help in all but a minority of cases. For example, only one in five of the clients interviewed had derived no help, although many of the rest had some reservations.

Even if one assumes that all those who refused to be interviewed or failed to respond to the request for an interview were dissatisfied (an assumption which was not borne out by the remarks on some of the negative replies to the postal questionnaire), approaching one-half of the clients had found counselling of some help and nearly one-third had found that help to be substantial and lasting. Unfortunately, there does not seem any easy way to distinguish the kind of person for whom, or the kind of situation in which counselling is likely to be most helpful. In fact, substantial and interesting discrepancies emerged between the assessments of clients, G.Ps. and counsellors. This may have been because they were using rather different criteria. A clue to this lies in the rather different ways in which counsellors and clients expressed the helpfulness and unhelpfulness of counselling. 'Quality of care' is thus likely to have a variety of meanings to different groups. The most optimistic interpretation of the findings of the interviews is that only in the case of six clients out of 74 did none of the three respondents feel that counselling had been of any help. The most pessimistic interpretation, however, is that in only 22 of the 74 was there no dissension from the view that counselling had been of substantial and lasting help.

Turning to the second aim of a counselling attachment to general practice, access to clients for counsellors was increased. The counsellors were seeing a higher proportion of the Medical Centre patients than marriage guidance counsellors overall see of the general population. Most of the clients interviewed had never thought of approaching a marriage guidance counsellor and many said they would not have gone to the usual type of marriage guidance

centre. However, contrary to reports from some other attachments, there was less evidence of a major change in the range of clients. With one exception, the G.Ps. used the service in the traditional way: to refer married patients with problems defined as marital in content. The two counsellors, however, were prepared to define their role more broadly. This broader role had obviously emerged in the experiences of some clients, of whom nearly half considered that the counsellor could help with more than specifically marital problems.

'Status' is another concept which is difficult to define and measure. The part-time and voluntary nature of marriage guidance counselling means that it is likely to be viewed with some suspicion, or lack of esteem, by professionals working in related fields. Incorporation into the primary health care team could enhance the respectability of counsellors by association, not just in the eyes of other members of that team, but also of outsiders. For example, one of the counsellors interviewed commented on the increased confidence she felt when contacting a hospital doctor when she could mention the Medical Centre as her base.

However, another element in status is surely autonomy. It could be suggested that attachment to a team in which the doctors are so evidently the dominant group: in terms of professional status and remuneration, as well as (except in the case of health centres) in terms of their ownership of the practice, could lessen the autonomy of marriage guidance counsellors. This study certainly found that the G.Ps. in effect controlled initial access to the counsellors. The vast majority of the clients were referred by their G.P., although

there was evidence that some clients returned subsequently to the counsellor without a medical referral. However, after initial referral, it did seem that the counsellors still enjoyed a high degree of autonomy in their work. None of the G.Ps. could be said to supervise the counselling, nor to require of the counsellors that they 'reported back' in any formal or detailed way. Contact over individual clients was most frequently initiated by the counsellors. Given the generally high regard in which the service appeared to be held by the G.Ps., this lack of supervision seemed to indicate a high degree of confidence in the expertise of the counsellors. However, a more cynical interpretation could argue that the counsellors were allowed autonomy because counselling was not considered to pose any dangers to the individuals referred: the idea might well be 'It will not do any harm and, one never knows, it may even do some good'.

The third aim of a counselling attachment concerns the effects on the workloads of the G.Ps. Here, there appears to be contrary and unclear evidence. The opinions of the G.Ps. in this study, as reflected in their interview responses, and the findings from previous studies suggest a decrease in the medical workload. There was however no evidence to substantiate this in the medical records of individual clients, which were examined. However, this is clearly an issue which deserves further attention and which ties in with the final aim of a counselling service: the lowering of the costs to the public purse of health services. It is necessary to ask to what extent marriage guidance counsellors can substitute for G.Ps. and other medical and even para-medical personnel. The cost of these counsellors is very low at present, but it is doubtful

how far the volume of their contribution could be increased with introducing more general remuneration for their work. Nonetheless, it is likely that they will remain far less expensive than doctors.

Not only does the quantity of the G.P.'s workload need to be considered here, but also its content. It may be, as was suggested by one of the G.Ps. in this study that although his workload does not decrease, it becomes more appropriate given the G.P.'s areas of competence. Doctors may have more time to spend on the medical rather than social or emotional aspects of their patients' problems. It may also be, as was suggested by another of the G.Ps., that as doctors become more sensitised to counselling issues, they actually spend more time listening to patients and less time prescribing drugs. The financial implications of this will depend on the relative cost of the doctor's time and the pharmaceutical products. Non-financial implications, notably the effect on the quality of patient care, must also be included in the balance sheet. Social policy makers may need to ask themselves what price they are prepared to pay for a given increase in quality of care rather than how far counselling services will decrease the cost of primary health care, while maintaining or even improving the quality.

The experience of the National Health Service as a whole since its inception in 1948 may have some relevance here. The initial expectations that 'free' access to health care for the whole population, would lead to a declining pool of ill-health and thus eventually to a reduction in real expenditure on health services, were disappointed. There certainly has been an improvement in the population's health, some of which may be attributed to the National Health Service. However, doctors and other health service

workers have turned their attention to other areas of medicine and medical progress itself had produced new needs. It has become apparent that the issue is not one of when the amount of ill-health will decline, but one of how much the nation, or its policy makers, are prepared to spend on increasing the potentially limitless range and quality of health services. Marriage guidance counselling represents one small area in which this issue may take concrete form.

References and footnotes

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Chapter 2

1. J.Haskey 'The proportion of marriages ending in divorce' in Office of Population Censuses and Surveys Population Trends 27 (1982), pp 4-7

2. Haskey (1982), pp 4-7

3. Sir Morris Finer (chairman) Report of the Committee on One-Parent Families Volume 1 (1974), p.52, table 3.26

The Report points out that this figure probably underestimates the proportion who remarry, because of the distorting effect of the large number of divorces at the end of this decade, following the 1969 Divorce Reform Act.

4. R.Leete and S.Anthony 'Divorce and remarriage: a record linkage study' in Office of Population Censuses and Surveys Population Trends 16 (1979), pp 5-11

5. Finer (1974), p.50, table 3.23

6. Office of Population Censuses and Surveys Population Trends 24 (1981b),p.40, table 15.

The number of petitions filed is a more accurate indicator of the trend in divorces than the number of decrees made absolute, as the latter figure also reflects the rate of dispatch of court business.

7. Office of Population Censuses and Surveys (1981b),p.40, table 15

8. While the proportion of men who ever marry has remained fairly constant, the proportion of women has steadily risen. In Victorian times, almost one-third of women aged 20-44 remained single (Finer (1974), p.23). In 1931, 83% of women in the age-group 45-49 were or had been married. By 1974, this had risen to 93%. The figure for men remained at about 90% (J.Dominian Marriage in Britain 1945-1980 (1980))

9. Office of Population Censuses and Surveys (1981b),p.40, table 15.

10. Dominian (1980), pp 13-14.

However, as Dominian points out, the overwhelming incidence of marital breakdown occurs in the early years of marriage. There is, though, a second, if lower peak of divorce rates about 20 years after marriage.

11. Finer (1974), p.25, para. 3.9

12. There is a discussion of some of these factors in The Law Commission Reform of the Grounds of Divorce : the Field of Choice (1966).

13. A. Brown and K.Kiernan 'Cohabitation in Great Britain : Evidence from the General Household Survey' in Office of Population Censuses and Surveys Population Trends 25 (1981), pp 4-10

14. Dominian (1980), p.17

15. R.Leete, 'One-Parent Families : Numbers and Characteristics' in Office of Population Censuses and Surveys Population Trends 13 (1978), pp 4-9

16. Finer (1974), p.244, table 5.1

17. This 'stigma' is well illustrated in D.Marsden Mothers Alone (1973) and in N.Hart When Marriage Ends (1976). See also Working Party on Marriage Guidance Marriage Matters (1979), pp 16-17, for a brief discussion of some of the non-financial costs, especially in relation to children.

18. Dominian (1980), p.9

19. Working Party on Marriage Guidance (1979)

20. Working Party on Marriage Guidance (1979), Introduction, para 10.

21. Working Party on Marriage Guidance (1979), p.17

22. P.Halmos The Personal Service Society (1970)

23. See, for example, W.Herbert and F.Jarvis Marriage Counselling in the Community (1970), ch.5

24. Recent legal reforms mean that this is no longer required in undefended divorce suits (the great majority of the total), but it seems likely that where property and/or the care of children are involved, most people will continue to consult a solicitor.

25. Working Party on Marriage Guidance (1979), pp 39-43, pp 54-55 and p.139

26. O.McGregor Divorce in England (1957), p.36, table 1

50. Herbert and Jarvis (1970), p.23

51. For example, see National Marriage Guidance Council Help with Marriage (no date); Venables (1971), p.4; J.Dominian Marital Breakdown (1968), p.142

52. Timms and Blampied (1980), p.155

53. Timms and Blampied (1980), pp 155-157

54. P.Halmos The Faith of the Counsellors (1965), p.105

55. P.Ewart and J.Kutz 'An Examination of Advice - Giving as a Therapeutic Intervention' Smith College Studies in Social Work (1976), pp 3-19. This is an example of changing attitudes to advice as a casework technique.

56. National Marriage Guidance Council Counsellor Training Reading List (1979)

57. Working Party on Marriage Guidance (1979), pp 5-6

58. Timms and Blampied (1980), p.172

59. Guiver (1973), p.15

60. Perhaps the best-known example, although it has subsequently attracted some methodological criticisms, is H.Meyer et al Girls at Vocational High (1958).

61. Dominian (1968), p.143

62. Herbert and Jarvis (1970), p.12; Venables (1971), p.6.

63. Dominian (1968), p.40. See also Herbert and Jarvis (1970), p.9 and Venables (1971), p.9

64. National Marriage Guidance Council Notes for Prospective Counsellors (1975).

65. Working Party on Marriage Guidance (1979), pp 5-6

66. Hart (1976), p.122

67. Editorial in the Annual Report of the London Marriage Guidance Council 1975/76

68. Mace (1948), p.89

69. M.Murch Evidence to the Home Office Marriage Guidance Working Party (no date)

70. There are the executive committees of the local marriage guidance councils, who have the formal responsibility for the counselling service, but these do not seem to have much influence over the 'professional practice' aspects of the work.

71. J.Heisler and A.Whitehouse The NMGC Client 1975 (no date), Table A. It should however be noted that M.Fogarty's study of a sample of the clients of the Catholic Marriage Advisory Council in 1973 (The Catholic Marriage Advisory Council and its Clients (1976))found that the counsellors assessed 'material problems' as being important in 16% of cases - a rather higher proportion.

72. Dominian (1968), p.56

73. Mace (1948), p.17

74. D.Hooper 'Yesterday's Counsellors for Tomorrow's Problems?' Marriage Guidance (1976), p.150

75. Working Party on Marriage Guidance (1979), p.24

76. See the discussion in Finer (1974), pp 181-186

77. The Divorce Reform Act (1969), section 3.

78. Murch (no date) pp 4-9

79. Wallis and Booker (1958)

80. Heisler and Whitehouse (no date).

81. Fogarty (1976)

82. Heisler and Whitehouse (no date),fig. 1.

83. Heisler and Whitehouse (no date),table II.7

84. Heisler and Whitehouse (no date),fig. 7

85. J.Dominian as reported in J.Ilman 'Courting Makes a Comeback' The Sunday Times (1978)

86. Heisler and Whitehouse (no date), fig.4

87. Heisler and Whitehouse (no date), fig.4

88. Heisler and Whitehouse (no date), table B

89. Annual Report of the National Marriage Guidance Council 1981, p.14

90. Heisler and Whitehouse (no date), table II.1

91. Heisler and Whitehouse (no date), table II.3

92. Heisler and Whitehouse (no date), table II.12

93. Heisler and Whitehouse (no date), table II.14

94. J.Heisler 'Client - Counsellor Interaction' Marriage Guidance (1977), p.234

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96. Timms and Blampied (1980), ch.4

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10. Heisler and Whitehouse (no date), table II.1

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12. J.Anderson et al 'Attachment of Community Nurses to General Medical Practices : A Follow-up Study' British Medical Journal (1970), pp 103-105

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(iii) E.Goldberg and J.Neill Social Work in General Practice (1972)

(iv) B.Bowen et al 'Adventure Into Health' Update (1978), pp 1512-1515; A. Rushton and M.Briscoe 'Social Work as an Aspect of Primary Health Care : the Social Workers' View' British Journal of Social Work (1981), pp 61-76; R.Corney and M.Briscoe 'Social Workers and Their Clients : a Comparison Between Primary Health Care and Local Authority Settings' Journal of the Royal College of General Practitioners (1977), pp 295-301

16. (i) M.Meacher A Pilot Counselling Scheme With General Practitioners (1977)

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38. Waydenfeld and Waydenfeld (1978)

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10. Halmos (1965), p.151

11. Halmos (1965), p.150

12. Halmos (1965), p.150

13. See chapter 2, p.21

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18. S.Rees Social Work Face to Face (1978), p.61

19. I.Shaw 'Consumer Opinion and Social Policy : A Research Review' Journal of Social Policy (1976), pp 22-23

20. Fahs Beck (1975), p.161

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25. Timms and Blampied (1980), p.21

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28. J.Hughes The Philosphy of Social Research (1980), p.61

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30. Tyndall (1973), p.4

31. C.Truax and R.Carkhuff Towards Effective Counseling and Psychotherapy (1967), pp 5-6

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33. Timms and Blampied (1980); Heisler (1977); Waydenfeld and Waydenfeld (1978)

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39. Hughes (1980), p.124

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50. For example, see The Law Commission Reform of the Grounds of Divorce : The Field of Choice (1966)

Abrams, in an attempt to develop 'subjective social indicators', asked people to name what they considered the three most important

domains determining their level of satisfaction with life. Marriage was mentioned most frequently, with the related domain of 'family life' a close second. Perhaps more surprisingly, when he asked his respondents which area of their lives gave them most satisfaction, marriage again came top of the list. M.Abrams 'Subjective Social Indicators' in Central Statistical Office Social Trends (1973)

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2. Hughes (1980), p. 130
3. Marsh and Barr (1975)
4. P.80
5. P.74
6. Heisler and Whitehouse (no date)
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10. J.Wiseman (1979), p.115

Chapter 6

1. In retrospect, the social worker should have been formally interviewed as the professional whose work might be expected to be closest to that of the counsellors. However, only part of her caseload derived from practice referrals and these did seem to be of a very different nature to those of the counsellors.
2. For example, Heisler (1979)
3. Chapter 9, p.257
4. Chapter 3, p. 43 and p 44
5. P. 195
6. P. 27

7. Chapter 9, pp. 285-286

8. Heisler (1979)

9. Chapter 2, p.12

10. Chapter 9 p.231

11. Cohen and Halpern (1978), p.482

12. Chapter 10 p.300

13. N.Tyndall Marriage Guidance Counselling (no date), p.3

14. P. 131

15. Marsh and Kaim-Caudle (1976), pp 120-122

16. A.Maluccio Learning From Clients (1979), Appendix A.

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7. Reading and District Marriage Guidance Council (1981), p.10

8. See chapter 8,pp.188-191

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10. Waydenfeld and Waydenfeld (1978), p.10

11. Heisler and Whitehouse (no date), table II.3

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13. Reading and District Marriage Guidance Council (1981)

14. Heisler and Whitehouse (no date), table II.5

15. As reported by Ilman (1978)

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18. Waydenfeld and Waydenfeld (1978), p.10

19. Heisler and Whitehouse (no date), table II.7

20. Waydenfeld and Waydenfeld (1978), p.9

21. Reading and District Marriage Guidance Council (1981), p.12

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26. Heisler and Whitehouse (no date), table II.12

27. Heisler and Whitehouse (no date), table II.13

28. Annual Report of the National Marriage Guidance Council 1981,p.14

29. Heisler and Whitehouse (no date), pp 12-13

30. Annual Report of the National Marriage Guidance Council 1981,p.14

31. Waydenfeld and Waydenfeld (1978), p.28

32. Reading and District Marriage Guidance Council (1981), p.8

33. Heisler and Whitehouse (no date), table II.14

34. Waydenfeld and Waydenfeld (1978), p.23

35. Heisler and Whitehouse (no date), p.5

36. Marsh and Kaim-Caudle (1976), p.46

37. Marsh and Kaim-Caudle (1976), p.46

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1. Marsh and Kaim-Caudle (1976), p.119

2. Crombie (1963); Office of Health Economics The Health Care Dilemma (1975)

3. Waydenfeld and Waydenfeld (1978); Marsh and Barr (1975)

4. Marsh and Barr (1975); Chester (1973)

5. Woodhouse (1977)

6. See reference 4

7. Dominian, as reported by Ilman (1978)

8. See chapter 2, pp 22-23

9. Heisler and Whitehouse (no date), pp 12-13

10. Guiver (1973), p.32

11. Heisler (1979)

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1. Venables (1971),p.60

2. Guiver (1973), p.15

3. Halmos (1965), p.74

4. Ewalt and Kutz (1976)

5. For example, by Halmos (1965)

6. Timms and Blampied (1980)

7. Chapter 3, p.44

8. Venables (1971), pp 131-132

9. P.284

10. Chapter 4, p.73

11. Chapter 6, pp. 125-126

12. Chapter 3, p.42

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14. Herbert and Jarvis (1970)

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16. Herbert and Jarvis (1970), p.46; Tyndall (no date), p.4.

17. Timms and Blampied (1980)

18. P.232

19. Chapter 3, pp.48-49

20. P. 253-254

21. Chapter 8, p.190

22. Chapter 8, pp.191-194

23. Pp. 203-206

24. Heisler and Whitehouse (no date), pp 12-13

25. Heisler (1977)

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1. Chapter 9, pp. 223-224

2. Chapter 5, p.105 and Table X

3. Chapter 5, p.106 and Table XI

4. J.Hutten Short-Term Contracts in Social Work (1977)

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6. Timms and Blampied (1980)

7. Maluccio (1979), pp 96-97

8. P. 246

9. Herbert and Jarvis (1970), chapter 8

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17. Office of Population Censuses and Surveys General Household Survey 1975 (1978), table 7.16

18. Office of Population Censuses and Surveys General Household Survey 1978 (1980), table 7.10

19. Marsh and Kaim-Caudle (1976), p.89, table 11

20. Waydenfeld and Waydenfeld (1978)

Chapter 11

1. Annual Report of the National Marriage Guidance Council 1976, ----1977, ----1978, ----1979

2. Wootton (1959)

3. Waydenfeld and Waydenfeld (1978)

Appendix I

Letter and reminder, with postal questionnaire, to counselling clients.

MEDICAL CENTRE

M.B., B.S., M.R.C.G.P.
M.B., F.R.C.G.P., D.C.H., D.OBST.R.C.O.G.
M.B., Ch.B., M.R.C.G.P.
M.B., M.R.C.P.
M.B., B.S., M.R.C.G.P., D.OBST.R.C.O.G.

Telephone: [illegible] (2 lines)
Appointments: [illegible]

Dear

The staff in this surgery feel that it is very important to know how satisfied their patients are with the health and related services which are offered by the practice. We are writing to you, as one of our patients, to ask about the services you have received during the last few years. We also hope that you will agree to be interviewed about your experiences of these services.

These interviews will be completely confidential and, so that you can express your opinions freely, we have asked Mrs. Jane Keithley, a lecturer in social administration at Durham University and a qualified nurse, to conduct them. She is completely independent of the practice and will only report her findings to us in general terms, without referring to any patients by name.

We hope you will fill in and return the enclosed questionnaire even if you have not received any of these services, and even if you are not prepared to be interviewed.

If you are willing to be interviewed, would you please indicate, in the space provided, the times at which you would be available, and whether you would prefer to see Mrs. Keithley at your home or at the practice premises.

We enclose a stamped envelope, addressed to Mrs. Keithley, for your reply.

Thank you for your co-operation.

Yours sincerely,

MEDICAL CENTRE

, M.D., D.O., M.R.C.G.P.
M.B., F.R.C.G.P., D.C.H., D.Obst.R.C.O.G.
', M.B., ChM., M.R.C.G.P.
M.B., M.R.C.P.
M.B., B.S., M.R.C.G.P., D.Obst.R.C.O.G.

Telephone: [illegible] (2 lines)
Appointments: [illegible]

Dear

We wrote to you about three weeks ago, to ask about the services you have received from the staff of this practice and whether you would agree to be interviewed about your experience of these services. The interviews will be carried out by Mrs. Jane Keithley, a lecturer in social administration at Durham University and a qualified nurse, who is completely independent of the practice. She would only report her findings in general terms, without referring to any patients by name.

We would like to obtain the views of as wide a selection of our patients as possible and so we are writing to you once more to ask you to fill in and return the questionnaire, of which we enclose a copy. This could be of great value to us in improving the services we offer to all our patients. Please return the questionnaire even if you have not received any of these services and even if you are not prepared to be interviewed.

Thank you for your cooperation.

Yours sincerely,

MEDICAL CENTRE SURVEY

Name: Mr./Mrs./Miss .....

Address: .....

.....

.....

1. Have you personally received services from the following staff at the Medical Centre during the last few years? (Please tick where appropriate).

	Yes	No
Health Visitor	___	___
District Nurse or Practice Nurse	___	___
Social Worker	___	___
Marriage Guidance Counsellor	___	___
Midwife	___	___
Family Planning Nursing Sister	___	___

2. If you have received services from any of these staff would you be prepared to be interviewed about them? (Please tick where appropriate).

	Yes	No
Health Visitor	___	___
District Nurse or Practice Nurse	___	___
Social Worker	___	___
Marriage Guidance Counsellor	___	___
Midwife	___	___
Family Planning Nursing Sister	___	___

3. If you are willing to be interviewed could you give an indication of the times at which you would be available? (Please tick where appropriate).

	Morning	Afternoon	Evening
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

3. cont.d

Would you prefer to be interviewed:

On the practice premises? ☐

At your own home? ☐

Is there a telephone number at which you could be contacted to arrange an interview?

Telephone number: .....

Please return the completed questionnaire in the stamped, addressed envelope provided.

Appendix II

Client interview schedule

CLIENT INTERVIEW SCHEDULE

Section 1 Introduction

Check identity of person

Remind them of questionnaire they filled in

Introduce myself and state purpose of visit:

> We are looking at various services which are provided by the Medical Centre, and are particularly interested to find out what the patients think of these services.

Stress complete confidentiality of all that is said, and independence from practice.

Section 2

Check occupation, marital status and age

Check length of time registered at practice and with whom registered

Check services received:

> You say here that you have been to see .....
> Is that right? I would like to ask you a few questions about when you saw .....
>
> (i) reason for service?
> (ii) when service received?
> (iii) number of times service received?
> (iv) satisfaction with service? Anything unsatisfactory?

(Repeat as necessary for other services received)

Introduction to interview about marriage counselling:

> I notice that you also put here that you have been for marriage counselling. Is that right? You probably know that this is a service which has only fairly recently been provided at the surgery, so that not many people have yet received it, so I would like to ask you about this particular service in a bit more detail.
>
> Let me just repeat that everything you say will be treated as completely confidential. Also, let me assure you that neither your doctor nor your counsellor have given me any confidential information about you.

Section 3

(1) Did anyone suggest that you might like to go to see the counsellor?

(2) (If yes to (1)). Who suggested it?

(3) (If yes: G.P./H.V./other practice staff to (1)). For what reason had you gone to see him/her in the first place?

(4) (If yes to (1)). Why do you think they thought that the counsellor may help you?

(5) (If yes to (1)). What did you think at first of the idea of seeing a counsellor?

(6) (If no to (1)). What made you think of going to see the counsellor?

(7) What did your husband/wife/partner think of the idea of you seeing a counsellor when it was first suggested?

(8) Had you ever been to a marriage guidance counsellor before?

(9) (If no to (8)). Had you ever thought of doing so?

(10) (If yes to (1)). Did you go and see the counsellor as soon as you could or did you wait a while?

(11) (If waited a while). How long was it before you decided that you would see the counsellor? What made you decide to go eventually?

(12) Before you saw the counsellor, what did you expect counselling to be like? How did you think the counsellor would try to help you?

(13) When you actually met the counsellor and started counselling, was it as you expected?

(14) (If no to (13)). In what ways was it different?

(15) Did you feel that counselling helped you in any way?

(16) (If no to (15)). Why did you find it unhelpful? Did you regret having gone to the counsellor?

(17) (If yes to (15)). How did counselling help you?

(18) Do you wish that you had gone earlier to the counsellor?

(19) (If first referral). Was it suggested to your husband/wife/partner that they should see the counsellor?

(20) (If yes to (19)). Who suggested it?

(21) (If yes to (19)). Did they agree?

(22) (If yes to (21)). Did they actually go to see the counsellor?

(23) (If no to (21)). Why did they refuse?

(24) (If no to (19) or (21)). Would you have liked them to see the counsellor?

(25) For how long had you your problems before you saw the counsellor?

(26) Have you talked to anyone else about these problems?

(27) (If yes to (26)). Did you find ..... more helpful/as helpful/less helpful than the counsellor?

(28) Do you feel that you still have the same problems now as you did before you saw the counsellor?

(29) Did counselling bring to light any new problems that you had not previously been aware of?

(30) Why did you stop seeing the counsellor?

(31) Have you ever thought of going back to see the counsellor again?

(32) Have there been any recent changes in your circumstances or those of your husband/wife/partner which you think may have affected your problems.

(33) Do you think that any of the above changes in circumstances could have helped you with your problems? Could they have helped you more/as much/less than the counsellor?

Now, I'd like to finish with a few more general questions.

(34) Would you rather have seen a male counsellor?

(35) Can you give any reasons for your preference?

(36) Do you think a counselling service like the one at the Medical Centre should be provided in a general practice?

(37) (If no to (32)). Can you tell me what you think are the disadvantages?

(38) (If yes to (32)). Can you tell me what you think are the advantages?

(39) Did you like seeing the counsellor at the surgery, or would you have preferred to see her somewhere else?

(40) (If would have preferred somewhere else). Where? Why?

(41) Did you find it easy to arrange an appointment with the counsellor?

(42) How did you feel about the doctors' receptionists knowing that you were seeing the counsellor?

(43) Would you recommend your friends to see a counsellor if they had problems?

(44) (If no to (39)). Why not?

(45) (If yes to (39)). What would you consider to be the sorts of people/problems that could be helped by the counsellor.

(46) Have you any other comments about the counselling service?

(47) Overall, how satisfied are you with the practice?

Appendix III

Coding of interview data.

AGE

1	:	20 - 29
2	:	30 - 39
3	:	40 - 49
4	:	50 - 59
5	:	60 +

SEX

6	:	Male
7	:	Female

MARITAL STATUS

8	:	married, together
9	:	married, separated
10	:	cohabiting
11	:	divorced, widowed, single (specify on card)

YEARS MARRIED/COHABITING

12	:	< 1
13	:	1 - 5
14	:	6 - 10
15	:	11 - 20
16	:	>20
no punch	:	not applicable

NO. OF INTERVIEWS

17	:	1
18	:	2
19	:	3 - 10
20	:	>10

INITIAL REFERRAL AGENT

21	:	Dr. A
22	:	Dr. B
23	:	Dr. C
24	:	Dr. D
25	:	Dr. F
26	:	other G.P.
27	:	other (specify on card)
no punch	:	not applicable (spouse referred first)

REASONS FOR CONSULTATION

28	:	physical health problem
29	:	depression/tension/irritability
30	:	marital difficulties (other than sexual)
31	:	sexual difficulties
no punch	:	not applicable

WHY REFERRED (GP-REPORTED)

32	:	marital problems
33	:	other problems (specify on card)
no punch	:	not applicable/not known

REACTIONS

34	:	positive
35	:	negative
36	:	mixed/neutral/openminded
no punch	:	not applicable

PREVIOUS EXPERIENCE

37	:	yes
38	:	no

PRECONCEPTIONS

39	:	none
40	:	advice and guidance/positive assistance/'treatment'
41	:	questioning, listening
42	:	'do-gooder', 'busybody'

WHETHER HELP GIVEN

43	:	yes
44	:	qualified yes, yes and no
45	:	no

WISH HAD GONE EARLIER

46	:	yes
47	:	no
no punch	:	not recorded/not known

DURATION OF PROBLEMS

48	:	< 3 months
49	:	3 months - 1 year
50	:	2 - 5 years
51	:	6 - 10 years
52	:	> 10 years
no punch	:	not recorded

(where more immediate 'crisis' mentioned as well, specify time-period on card)

CONTACT OF SPOUSES

53	:	joint first interview
54	:	subsequent or prior contact with spouse
55	:	no contact with spouse
no punch	:	not applicable

OTHER SOURCES OF HELP

56	:	G.P.
57	:	psychiatrist
58	:	friends and relatives
59	:	other (specify on card)
no punch	:	no-one

SOURCE OF MOST HELP

60	:	G.P.
61	:	psychiatrist
62	:	friends and relatives
63	:	marriage guidance counsellor
64	:	other (specify on card)
65	:	all equally in different ways
no punch	:	not applicable/no-one

STILL THE SAME PROBLEMS

66	:	yes
67	:	yes, but cope better
68	:	no

CHANGED CIRCUMSTANCES

69	:	yes, for better
70	:	yes, for worse
71	:	no

RECOMMEND COUNSELLING TO FRIENDS

72	:	would recommend/has recommended
73	:	would not recommend
no punch	:	not recorded

APPROPRIATE PROBLEMS FOR COUNSELLOR

74	:	marital problems
75	:	wider range of problems
no punch	:	not applicable

ATTITUDE TO PRACTICE

76	:	very satisfied
77	:	satisfied
78	:	quite satisfied
79	:	not very satisfied
no punch	:	not recorded/not known

SOCIO-OCCUPATIONAL CLASS

80	:	1
81	:	2
82	:	3 NM
83	:	3 M
84	:	4
85	:	5
no punch	:	not known/not classifiable (specify on card)

COUNSELLOR'S OPINION ON HELP

86	:	yes
87	:	qualified yes/yes and no
88	:	no
no punch	:	not known/not recorded

G.P's OPINION ON HELP

89	:	yes/thinks yes
90	:	qualified yes/yes and no
91	:	no
92	:	not sure
no punch	:	not known

COUNSELLOR

93	:	Counsellor A
94	:	Counsellor B
95	:	Counsellor C

Appendix IV

Pre-interview letters to G.Ps.

and to counsellors.

PRE-INTERVIEW LETTER TO G.P.s.

Dear Doctor - ,

Thank you for agreeing to see me on (date). The patients whose counselling I would like to discuss with you are:

(list of patients)

The areas that I would like to cover regarding these particular people are:

(1) reason for initial consultation with you

(2) how you thought the counsellor could help

(3) your assessment of the impact of the counselling.

In addition, I would like to discuss with you the following general areas:

(1) initial and subsequent reaction to the idea of counsellors as part of the medical care team.

(2) the amount and type of contact you have with the counsellors - in general and regarding specific cases.

(3) the role which you see the counsellors as fulfilling (including its relationship to your own role).

(4) the criteria by which patients are selected as suitable for referral.

(5) the ways in which you suggest counselling to patients, and their reactions. Do you have many patients who refuse to go ?

(6) what do you expect counselling to do for your patients ? What criteria do you use to judge whether counselling has been helpful or unhelpful ?

(7) have you found there to be any problems about the counselling service ? How would you like to see it develop in the future ?

I look forward to seeing you.

Yours sincerely,

Jane Keithley

PRE-INTERVIEW LETTER TO COUNSELLORS

Dear ,

Thank you for agreeing to see me on (date). The clients that I would like to discuss with you are:

(list of clients)

The areas that I would like to cover regarding those particular people are:

(1) how appropriate was the referral?

(2) how far do you feel that counselling helped that particular individual and his/her relationships.

(3) how much contact did you have before, during and after the counselling, with the G.P. and other relevant practice staff about the client?

In addition, I would like to discuss with you the following general areas:

(1) how you initially became involved in working in general practice.

(2) the pros and cons of working in this setting.

(3) the amount of contact you have with the doctors and other staff in the Medical Centre.

(4) maintenance of contact with Marriage Guidance Council.

(5) the role of the counsellor in general practice.

(6) the appropriate criteria for referral to you and how far the doctors have referred appropriately.

(7) the confidentiality aspect of working in a health team setting.

I look forward to seeing you.

Yours sincerely,

Jane Keithley

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