School of Psychological Sciences and Health

Counselling Unit

The Nature and Effectiveness of Therapies Provided in Counselling Centres at the Princess Nourah bint Abdulrahman University

By

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Declaration of Authenticity and Author's Rights

This thesis is the result of the author's original research. It has been composed by the author and has not been previously submitted for examination which has led to the award of a degree.

Signed: Date

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Abstract

Interest in counselling and guidance in Saudi Arabia has grown in recent years. Evidence about how it is delivered and by whom, as well as its effectiveness, is limited. What does psychotherapy/counselling look like in practical terms in Saudi Arabia? How have western mental health approaches and procedures fared in an Arabic/Islamic cultural milieu? What has been assimilated and what has been accommodated or adapted? In this research I aimed to explore the nature and effectiveness of the counselling services provided at Princess Nourah bint Abdulrahman University, Riyadh, Saudi Arabia. This dissertation presents two studies using complementary research methods, carried out within a pluralist, broadly critical-realistic framework.

The first study was a constructivist/descriptive qualitative counselling service research study, which aimed to map the nature of the therapists' perceptions of the counselling services, asking three broad questions: First, what kinds of services do therapists see themselves as providing to their clients? This included kinds of 'therapies', 'techniques', and 'measures'. Second, what kinds of professional experiences have therapists report, including 'years of experience', 'personal development' and 'improvement in providing counselling'? Third, what kinds of practice difficulties and challenges do therapists perceive, including 'in-session challenges' and 'external difficulties'? The study sample consisted of thirteen (out of a total of sixteen) female therapists at the counselling centre in Princess Nourah bint Abdulrahman University, Riyadh, Saudi Arabia. A semi-structured interview was developed and piloted in order to collect the study data, which was then analysed from the viewpoints of both a version of grounded theory and Braun & Clarke's thematic analysis.

The findings showed that therapists used different kinds of predominantly western forms of psychotherapy, both positivist-realist (e.g. CBT) and humanistic-phenomenological (Person-centred Therapy) as well as mostly positivist-realist therapeutic techniques (e.g. they most commonly used homework, behavioural therapy, and behavioural activation) and assessments/measures (e.g. the Beck Depression Inventory and Beck Anxiety Inventory). Furthermore, therapists generally reported that they had improved in their performance and were interested in developing their skills and providing better services, although some complained of limited opportunities to do so. Finally, therapists indicated that they faced both external difficulties (e.g. lack of privacy and conflict with co-workers) and in-session challenges with their clients (e.g. lack of client commitment to counselling and client silence) that affected their performance and work satisfaction.

The second study was a quantitative client practice-based outcome study, using what can be described as both a mental health services research design and a practice-based therapy effectiveness study of the outcomes of counselling practiced at Princess Nourah bint Abdulrahman University. It aimed to document amount of client-reported personality change in the counselling centre at the Princess Nourah bint Abdulrahman University over the course of therapy. To do this, I used a western psychotherapy outcome measure that had been developed to assess -in a non-pathologising manner- the outcome of humanist, phenomenological approaches to psychotherapy. This assessment measure, the Strathclyde Inventory (developed by Elliott, Rodgers, Freire, & Stephen, 2016), was chosen to avoid cultural sensitivities that might have been activated by more commonly-used pathology-distress measures such as the CORE-OM. Therefore, an Arabic translation of the Strathclyde Inventory was prepared, using standard practices including parallel and back translation. The result was the 20-item Arabic translation (the SI-20-A) that measures two factors based on Carl Rogers' theory of the fully functioning person, namely Congruence/Experiential Fluidity and Incongruence/Experiential Constriction, as these

concepts were considered in Islam and Arab culture. The outcome measure was administered to the clients by their therapists at the beginning, the middle, and then at the end of a course of therapy. Data from thirty eight clients was used and analysed using descriptive, inferential statistical analyses (a repeated measure ANOVA) within a critical-realist perspective; in addition, reliable and clinical significant changes were calculated to provide multiple ways of documenting reported client change or lack of it using the SI-20-A. The study results showed that there were medium to large differences between the three time points (pre-, mid- and post-tests) and that these were extremely unlikely to be due to chance ($p < .001$). Additionally, the study found that about 44% of the clients at the end of the therapy appeared to have made clinically significant and reliable changes, 50% of the clients showed no change in reported personality functioning, and one of the clients showed deterioration on this measure. However, cultural differences between Western and Saudi Arabia may have affected the study findings, a possibility that I explore in the Discussion chapter of this dissertation.

Overall, the research findings provide a multi-faceted view of counselling centre services within a Saudi university and their effectiveness, with possible benefits for these services, for the therapists, and for the university's students: The main potential benefit to the Counselling Centre is encouragement to continue to provide help and support to therapists who sometime struggle to deal with client's issues, and to consider the importance of supporting quality counselling services. The therapists involved could benefit from the knowledge that the services they provide are generally effective with many clients. And the university students could benefit from knowing what kind of services that counselling centre offers and the quality and effectiveness of these services.

Beyond Princess Nourah bint Abdulrahman University, this dissertation contributes to knowledge about the counselling and psychotherapy field in Saudi Arabia by documenting the nature of university-based counselling services provided and quantifying client

outcomes in the university counselling centre; these include the counselling services provided, therapists' their practice difficulties, and substantial amount of client pre-post change over the course of therapy. This dissertation may encourage counselling and guidance in education settings to set up a clear and fixed roles and requirements which would help therapists and counsellors to be more careful with client confidentiality and privacy, and, in addition, to provide a better work environment to carry out counselling sessions. Furthermore, it highlighted the usefulness of evaluating the performance of the counselling services. Further research is recommended in the field of counselling in higher education institutions in Saudi Arabia to replicate these findings and to provide a better understanding of counselling services at Saudi universities and their effectiveness.

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Definitions/Abbreviations

BACP	The British Association for Counselling and Psychotherapy
BDI	Beck Depression Inventory
CBT	Cognitive behavioural therapy
CORE-OM	Clinical Outcome in Routine Evaluation Outcome Measure
Hadiths	Defined as saying, deeds or agreements of the prophet Muhammad
NHS	National Health Service
PCT	Person centred therapy
PDT	Psychodynamic therapy
Qur'an	The holy book of the Muslim religion
SI	Strathclyde Inventory
UK	United Kingdom
US(A)	United States (of America)

Thesis Overview

Chapter One presents the background of the research, highlighting definitions of counselling and the nature of counselling services, and providing a summary of the three influential approaches to counselling and psychotherapy and the history of counselling in the educational institutions in the United States, United Kingdom, and Saudi Arabia. This chapter provides the Islamic and cultural perspective of counselling in Saudi Arabia.

Chapter Two provides a comprehensive review of the literature. It is divided into two sections. The first section reviews literature on the nature of the counselling services. The second section provides a review of the literature related to counselling outcomes and effectiveness.

Chapter Three provides a detailed outline of the research methodology used in the research.

Chapter Four presents the qualitative study 'The nature of the counselling based on therapists' perspectives'. The chapter clarifies the study aims and method (methodology, development of the interview questions, translation, study sample, ethical considerations, data collection and analysis, and the validity of the interview) and reports the study findings.

Chapter Five presents the quantitative study 'Client practice-based outcome study'. The study aims are outlined, the method is described (methodology, participants, measures, data collection and analysis), and the study results are presented.

Chapter Six discusses the findings of the qualitative and quantitative studies, the studies' implications, limitations, and the main contributions of this research.

Chapter 1 Introduction & Historical Review

1.1 Introduction

People seek counselling for many reasons. Sometimes they feel dissatisfied or unhappy with life. Sometimes they face specific problems which become unmanageable (Hough, 2010). Many obstacles may be faced in their home, at work, or with their friends that hinder the progress of life, as we live in a complex, busy and changing world (McLeod, 2013). In some cases, individuals need someone for support, such as a counsellor to help them, and counselling centres where they can access psychological help.

Over the last 80 years, college and university counselling centres have improved considerably in higher education (Hodges, Shelton, & King Lyn, 2017). This was a response to students' needs, as the number of university students who are under stress and emotional difficulty has increased.

Originally, university counselling was primarily interested in helping students with academic problems. Since then, it has shifted to cover career, personal and developmental problems (Hodges et al., 2017). Counselling is provided by a specialised and trained therapist/counsellor who is often influenced by one or more therapeutic perspectives. Therapists come from a variety of backgrounds and tend to use a variety of methods of therapy (King, Broster, Lloyd, & Horder, 1994).

In recent years, there has been increasing interest in providing counselling services in higher education in Saudi Arabia. Some universities have established counselling centres in order to help distressed students. Therapists/counsellors in Saudi Arabian universities provide many services to their students; they help students to adjust to the university

environment, support students with their academic problems, and assist them in understanding themselves and their abilities (Al-Bahadel, 2012). However, many people in Saudi Arabia still avoid going to see a counsellor for many reasons, including being reluctant to express their emotions and open up, the lack of services and suitable times provided by psychiatric clinics, negative perceptions of counselling, the high cost of counselling services since most of the clinics are private, lack of resources (the number of trained counsellors), and lack of information about the counsellor roles and counselling services. Until now, little has been known about what kinds of services counsellors provide to university students or about their utility and significance (Al-Owidha, 1996). Most studies on counselling have only been carried out in schools or mental health hospitals. In schools, counselling services are often provided by unspecialised and untrained staff; while in mental health hospitals, most of the work is carried out by psychiatric staff (mental health nurses, psychiatrists, social workers). Consequently, the current research was carried out to explore and evaluate a university-based counselling service by conducting two studies; first, a qualitative study on the nature of counselling services provided by therapists at Princess Nourah bint Abdulrahman University as perceived by therapists, and second, a quantitative study to evaluate the counselling services' effectiveness by calculating client change over a course of therapy.

This chapter provides definitions of counselling and counselling services, culture and counselling as well as providing an overview of the generic model of psychotherapy and the main theoretical approaches. It then documents an historical review of the development of the counselling services in the United States, United Kingdom, and Saudi Arabia.

1.2 Definitions of Guidance and Counselling

It is important to be notable that there are different services that provided to help students to deal with their problems. This section starts to define the broader service that called 'Guidance', followed by one type of service that is commonly called 'counselling', with which this current research was conducted. Guidance is a relatively more comprehensive process includes counselling as its most specialised function. Crow and Crow (1962) maintained that "*guidance is an assistance provided by competent counsellor to an individual of any age to help him [or her] direct his [or her] own life, develop his[/her] own point of view, make his[/her] own decisions, carry his[/her] own burdens*".((Kinra, 2008, p.2) Similarly, according to Jones (1934), "*to guide means to indicate, to point out, and to show the way. It means more than to assist*". There is informal guidance which is provided by parents, friends and relatives, and formal guidance which is provided by the guidance service within education setting. Guidance services are like other services and need qualified personnel to implement them satisfactorily; there are different types of guidance such as vocational guidance, educational guidance and counselling (Kinra, 2008).

Counselling is aimed at producing constructive behavioural and personality change (Carkhuff & Truax, 2008). The term ‘counselling’ has been defined similarly by various authors, for example:

> *A professional relationship between a trained counsellor and a client designed to help clients to understand and clarify their views of their life space, and to learn to reach their self-determined goals through meaningful, well-informed choices and through the resolution of problems of an emotional interpersonal nature* (Herbert & Buford, 1979, p.14).

The American Counselling Association (2004) defines counselling as

> *A professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals* (p. 366).

The British Association for Counselling and Psychotherapy give the following definitions:

> *The counselling and psychotherapy are umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance their wellbeing* (Dale, 2017, p.1).

The British Association for Counselling and Psychotherapy (BACP) also add that:

> *Counselling takes place when counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life, or loss of a sense of direction or purpose. It is always at the request of the client as on one can properly be sent for counselling* (BACP, 2004).

The Ministry of Education (1999), Saudi Arabia, define counselling as:

> *an organised and planned activity that aims at helping students to understand themselves and recognise their personal capabilities in order to give them the chance to develop their potential and to solve their problems in a way compatible with the teachings of Islam, in order to solve their problems by themselves to accomplish social, psychological, personal, vocational and educational adjustment* (Al-Ghamdi, 2015, p.27).

All of the above counselling definitions are agreed that counselling is a relationship between a counsellor (who offers help and support) and a client (who seeks help). It is

often between two people, but sometimes between a group of people and a counsellor. Counselling, thus, takes place both in individual and group settings (Hough, 2010). It is a special form of communication, a process that requires a coherent framework or structure. This structure is important as a guide for both counsellor and client (Hough, 2010).

1.3 The term 'culture'

Counselling was established in the United States and then has travelled to different countries that each have their own beliefs, values and cultural practices; therefore, it is important to consider the role of culture in how counselling has developed in other countries, such as Saudi Arabia. However, before discussing this, I first need to explore what the term 'culture' means as defined in English and Arabic dictionaries.

In the English language, the word 'culture' comes from Middle English (denoting a cultivated piece of land); the noun comes either from French *culture* or directly from Latin *cultura,* meaning 'growing, cultivation'; the verb fomr comes from obsolete French *culturer* or medieval Latin *culturare*, both based on Latin *colere,* 'tend, cultivate' . In late Middle English the sense was 'cultivation of the soil' and from this (early 16th cent.), arose 'cultivation (of the mind, faculties, or manners)'. The word is also defined as a way of life, especially the general customs and beliefs of a particular group of people at a particular time. (Oxford Dictionary)

In the Arabic, the origin of the word culture is derived from the Arabic verb educate. It has several meanings, including: acumen, intelligence, discipline, control of science, and speed of learning. It is also has defined as an overall term for the sciences, arts and literature within its general framework. It is also known as the advanced development of the human body, being educated, norms and habits, the habits, traditions, and beliefs of a country or

group of people, including behaviour, and the different patterns that people experience that are based on their experiences and beliefs, and which lead to their distinctive or individual actions, and being independent. It has been defined by Aljabry as that homogenous composite of memories, perceptions, values, and ruminations, expressions, creations and aspirations that a group of people maintain (cited in Barghathi, 2007).

The terms ‘multiculturalism’, ‘diversity’, and ‘multicultural counselling competence’ are broad terms that include various specific aspects of culture, including race, gender, social class, religious orientation, sexual orientation, and many other sociodemographic classifications in various societies (Sue & Sue, 2015, p.434).

1.4 Culture and Counselling

Sue and Sue (2015) define the term ‘cultural competence’ as providing counselling as follows:

> *(a) self-awareness (i.e., self-reflection and awareness of one's values and biases); (b) knowledge of culturally diverse groups (e.g., marginalized status, characteristics, strengths, norms, and values); and (c) specific clinical skills, including the ability to generate a wide variety of verbal and nonverbal helping responses, form a therapeutic alliance, and intervene at the individual, group, institutional, and societal levels* (p.442).

It is important in counselling and psychotherapy to understand group-specific differences. Increasing knowledge about different cultural groups and developing multicultural clinical skills can minimise the danger of stereotyping or placing inordinate weight on race or other diversity issues.

We each have our own set of beliefs, values and theoretical assumptions. In the counselling and psychotherapy field, counsellors and therapists work with different clients, so they

need to be aware of individual differences as well as considering the clients' background, culture and all aspects of their life; hence, multicultural awareness and cultural competence can reduce diagnostic errors. Multicultural counselling theory and practice was developed in North America in the 1970s to challenge the ethnocentric bias of three major theoretical areas of psychotherapy: psychodynamic, humanistic, and cognitive-behavioural (Lago, 2011). The US population consists of different ethnic populations such as African American, American Indian, Asian American and Latina American, and each of these families populations has its own beliefs, values and cultures. Consequently, all mental health organisations now promote cultural competence and the ability to work effectively with multicultural clients. As the majority of cultures in the world have a collectivistic and independent orientation (Sue & Sue, 2015), knowing the culture of these cultural groups is useful in helping counsellors understand different cultural patterns.

In addition, 14.6% of the UK population is made up of minority ethnic individuals. Counselling and psychotherapy have become more acceptable and accessible as valued therapeutic interventions; however, Western counsellors and psychotherapists, with their own theoretical cultural frames, may undervalue or even be hostile to other helping traditions. Such traditions may include informal psychological help involving family and friends, religious or spiritual leaders and prayer. A study comparing UK and African postgraduate students found that both groups sought family support, but would also recommend counselling. African students put family and friends before outsiders. To conclude, there is a growth in the number of clients coming from a range of different ethnic, cultural and faith communities in the UK. Therefore, counsellors need to be aware of multiple heritage clients (Lago, 2011).

The cultural disparity between Saudi and Western cultures is great. A counsellor's values, methods and techniques used in counselling situations should be consistent with the culture (Saleh, 1987). For instance, in the USA psychoanalytic theory has been embraced, revised, and refuted to both suit and shape the social, cultural, and economic needs of Americans; even in India, it has been revised to reflect Hindu spirituality and culture (Pratyusha, 2016).

In Saudi Arabian society, according to Islam, Allah has provided human beings with all necessary capacities and abilities, which can be affected by environmental, sociological and educational factors. People in all countries and cultures face many kinds of difficulties that can force them to seek help from other people. Counselling and guidance in Saudi Arabia reflects Islamic beliefs. Islam influences all aspects of Saudi life, and Saudis generally try to behave and act according to Islamic values (Al-Owidha, 1996). Saudis are influenced by the Islamic religion and Arabic culture, which are deeply rooted throughout the history of Saudi Arabian society. Counselling is thus viewed as a process delivered by counsellors to help clients gain an insight into facts relating to choice, plans, and adjustment in an Islamic manner based on Islamic beliefs. From an Islamic viewpoint, counselling is one of the most useful sciences and can play an important role in the emotional, social and personal development of every Muslim. Therefore, counselling that is provided in Muslim countries should be consistent with its culture (Saleh, 1987).

After a review of the literature, however, it appeared that there are many reasons that prevent Saudis from turning to counsellors or psychotherapists. The first reason is described by Al-Radhi:

> *A Saudi is used to keep his internal life separate from the cultural forces around him and reacts with his internal emotions only within the limits of his family and*

> *close acquaintances and does not react as part of a larger culture with the exception of the educated*. (Al-Owidha, 1996, p.86)

Saudis seem to be reluctant to express their emotions, especially outside the confines of family members. They tend to be an 'internalised' culture where people tend not to open up easily, and self-expression still needs to be encouraged. Most Saudis prefer to talk about their problems to a relative or a friend rather than talking to counsellors or psychotherapists.

Another reason is the lack of services and suitable times provided by the psychiatric clinics in hospitals. These clinics provide services for a small number of patients. Most of these services are based on providing prescriptions. There was an argument over providing pills to psychiatric patients more than using counselling therapies; Al-Doleam (a psychiatrist) stated that people in Saudi Arabia tend to prefer the relief of symptoms and therefore were more willing to take prescriptions, rather than go to counselling or psychotherapy which would take a long time (Al-Owidha, 1996). However, another psychiatrist, Al-Subaie (1989), argues that giving prescriptions is unwelcome in Saudi Arabia. In contrast, providing counselling and psychotherapy requires a lot of time and it is always provided by private clinics which cost a lot of money. Furthermore, Al-Yahya states that people prefer a quick solution to their problems such as pills or direct counselling (Al-Owidha, 1996).

Another reason is the persistent stereotype that seeking help is a sign of being 'crazy' and the negative perceptions of visiting a psychotherapist. Because Saudis are very conscious of how they appear to others, they will not frankly discuss personal, social, or even academic problems with a counsellor (Al-Ahmady, 1988). Some Saudis have a fear of the stigma attached to seeking help from counsellors or psychotherapists. Seeking counselling

may be associated with negative social attributions in the Arab Muslim world. It is a result of cultural sensitivity to opening up and seeking counselling services which may affect the individual and family's reputation. As reported by Al-Bahadel (2012), in order to protect their social image and avoid the associated stigma, some university students avoided seeking help or going to see a counsellor, with most students being more likely to ask for help for academic problems than for personal problems. Similar results are reported by Aldileym (2001), who states that Saudis feel embarrassed and have negative attitudes towards going to therapists or counsellors. It is a cultural and ethnic issue; some parents would not accept that their children were being seen by a counsellor due to the stigma.

In addition, the lack of resources (the number of trained counsellors) is a further reason why Saudis avoid seeking help (Al-Owidha, 1996). There is a need for specialised counsellors to meet the growing demands for counselling and psychotherapy services, especially in educational settings. As reported by many researchers (Al-Bahadel, 2012; Al-Mosawy, 1998; Al Otaibi, 2014; Al-Zahrani, 1990; Hassan, 1998), counsellors have often shown a lack of counselling skills and some are not qualified enough to provide counselling services.

1.5 The Scope of Counselling Services

The International Association of Counselling Services (2012) states that counselling services in schools and other educational settings should provide the following important functions:

- Provide counselling to students for issues that require professional intervention.
- Assist students in meeting their educational goals by playing a preventive role and teaching new skills to help them be successful in college and beyond.

- Support healthy growth and development of students by providing outreach and consultation to the campus community.
- Contribute to campus safety. (Hodges et al., 2017, p.41)

The mission of university and college counselling centres is to "assist students to define and accomplish personal, academic, and career goals by providing developmental, preventive, and remedial counselling" (CAS, 1999).

Individual counselling is still the primary service provided in university counselling centres. In order to meet the number of students in need of counselling services, university counselling centres generally offer short-term counselling. This has become the treatment of choice in educational settings. The number of student counselling sessions is typically between four and six sessions (Mair, 2016).

1.6 A Generic Model of Psychotherapy

The above two sections defined and illustrated the counselling and its services. This section provides a theoretical foundation and an explanation to understand counselling/psychotherapy process and outcome as the Generic Model provides an empirically supported representation of the this system (Kolden, 1991). The purpose of this model is to provide an overview of what is involved in the psychotherapy process and outcome. It distinguishes between psychotherapeutic process as a system of action and surrounding systems that provide its functional environment (Orlinsky, Ronnestad, & Willutzki, 2004). This system consists of interactions over times that occur between a therapist and a client; each person is a separate self, with history and roles in many other relationships in a life outside of therapy (Orlinsky et al., 2004).

Orlinsky et al. (2004) summarises the process facets of the Generic Model:

- *Organisational aspect of therapy (therapeutic contract):* This defines the norms of the roles between a client and therapist. Also, the therapeutic situation as determined by the therapist's treatment. This contract has two aspects: *contractual provisions* (including the treatment goals, methods, manner, term, fees), and *contractual implementation* (e.g., negotiation of goal consensus, repair of contractual lapses, etc.).

- *Technical aspect of therapy (therapeutic operations):* This defines the procedural tasks to which clients and therapists commit themselves when undertaking a therapeutic contract. These operations involve some form of problem presentation (by clients), expert understanding (by therapists), therapist intervention, and client cooperation.

- The *interpersonal aspect of therapy (therapeutic bond)* is the relationship between the therapist and the client, and how they engage in the course of therapy. Includes working alliance, empathic resonance and mutual affirmation (Kolden, 1991).

- The *intrapersonal aspect of therapy (self-relatedness)* involves the capacity of clients and therapists to respond to the self in therapy (Kolden, 1991). It refers to the reflective aspect of the individual's experience while engaging in activities and relationships.

- The *clinical aspect of therapy (in-session impact):* The immediate positive or negative impacts on the clients and therapists of their interactions during the therapy session.

- The *sequential aspect of process (temporal patterns):* The concept of process is linked to time as well as to function. This aspect defines the characteristics and sequence of events in session development, and the treatment stage (time), or treatment course (number of sessions).

- Counselling/ psychotherapy outcome: "*it is a clinical concept signifying some degree of improvement or deterioration in the patient's condition*" (Orlinsky et al., 2004, p.316) . It refers to immediate or long- term changes that happen as a result of a course of therapy. Many types of measure have been created for assessing psychotherapy process and these measures determined the results of this process. The evaluation methods can be applied by clients and therapists as they participated in sessions and they have their own experience (Hill & Lambert, 2004).

The generic model of psychotherapy holds that each form of therapy involves a particular configuration of these process facets (Orlinsky et al., 2004). This process occurs in a complex human environment.

In this research, two aspects of psychotherapy will be investigated – the nature of the therapies (as perceived by therapists) and the outcome of the course of therapy (as rated by clients) – by conducting qualitative and quantitative studies. The qualitative study documents the kind of therapies (interventions) that therapists use with their clients (therapeutic operations), therapists' experiences and practices, challenges and difficulties (therapeutic bond-self relatedness, and in-session positive and negative impacts) (Orlinsky et al., 2004). The quantitative study measures the effectiveness of the counselling (post-therapy outcome).

1.7 Theoretical Approaches to Counselling

There are three widely influential approaches to counselling and psychotherapy, namely psychodynamic therapy (PDT), person-centred therapy (PCT), and cognitive behavioural therapy (CBT). Each therapy has theoretical and practical implications (Bohart & Tallman, 1999) and has its own philosophies, methods, and a range of techniques. These approaches are distinct from each other in terms of their usual repertoires of interventions and their

assumptions about the nature and sources of psychopathology (Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006).

Before presenting these approaches, I will provide an explanation of how these approaches are related to Muslim and Arab cultures.

There are many published and translated books in counselling and psychotherapy approaches – that are adapted from Western countries – in Arabic language, and these approaches are still taught in many universities across Arab countries such as Lebanon, Egypt, and Saudi Arabia. However, some Arab researchers have attempted to explore how these approaches are related to Islam and Arab culture, especially the psychodynamic approach, and whether it is appropriate for application in their culture. There are a few published books that explain how psychoanalysis relates to Islam, and there are a number of different perspectives about applying this approach within a Muslim culture. Some writers have concluded that from an Islamic perspective) this approach has ideas and hypotheses that are not consistent with Islam, and some Arab psychologists have found it difficult to apply these ideas with their clients.

However, other ideas seem to be more useful such as the structure of personality, the techniques of 'free association' and the 'talking cure', as well as the importance of childhood for later development (Al-Kubaisi, 2012). Nevertheless, there is a lack of literature and studies conducted in Arab countries looking at the application and the usefulness of psychoanalysis approach.

On the other hand, there are many research studies that test and apply cognitive behavioural therapy (CBT) -- and some studies on person-centred therapy -- to Arab populations and specifically in Saudi society (see Chapter Two); this may be because these

two approaches are more consistent with Arab culture in general and with Saudi culture in particular. This perspective is consistent with findings from a study conducted by Aldileym (2001) who was interested in identifying different counselling approaches provided by school counsellors.

The Qur'an and Hadiths mention the importance of the relationship: to treat each other as brothers or sisters and to take care of each other as Allah asserted in the verse: "*The believers are but brothers, so make settlement between your brothers. And fear Allah that you may receive mercy" (Surah Al-HuJuraat, 10*:516). This supports the idea that the relationship between the counsellor and the client should be based on respecting, listening, providing empathy, and reflection, indicating that the client has the right to choose and decide – these concepts are consistent with the person-centred therapy perspective. In addition, the counselling definition that provided by the ministry of education in Saudi Arabia has features that tie into and are consistent with person-centred concepts (see section 1.2). However, from the Islamic perspective, people use Islam as a primary reference in making decisions. In addition, the Qur'an and Hadiths consider and focus on behaviour modification. Additionally, the Qur'an has explained the importance of thoughts related to people's behaviour and how these play an important role in feeling stable, compatible and safe; this concept is close to the CBT idea about rational and irrational thoughts (Al-Kubaisi, 2012).

To conclude, it seems that Islam has considered the importance of counselling in human life and has some common ideas and aspects that are close to what have been presented in some counselling and psychotherapy approaches. However, these aspects have to be within an Islamic framework. The following section presents each approach in more detail.

1.7.1 The Psychodynamic Approach

This approach was first developed by Freud, who is often considered the father of psychotherapy. Therapies derived from this approach hold the common belief that human personality and behaviour are powerfully shaped by early childhood relationships (Sommers-Flanagan & Sommers-Flanagan, 2012). This approach contains several important ideas, as follows:

1. The role of unconscious: Freud was concerned that many of client problems were the result of mental process; this means the client's problem could be hidden in an unknown region of the human mind, a view which was considered novel and challenging at the time (Hough, 2010). The goal of this therapy is to bring the client's problems from the unconscious region into consciousness (Sommers-Flanagan & Sommers-Flanagan, 2012).

2. The structure of personality: Freud believed that human personality contains three connected systems – the Id, which is the seat of biological desires, and located in unconscious region of the human mind; the Ego, which functions include memory, problem-solving abilities, and logical thought; and the Superego, which develops as a function of parental prohibition (the conscience part), and includes the ego-ideal that is a positive desire to copy adult standards (Sommers-Flanagan & Sommers-Flanagan, 2012). These three areas of personality constantly act together as a means of organising an individual's behaviour (Hough, 2010).

3. The psychosexual stages of development: Freud considered the ways in which children develop to sexual maturity and the stages through which they pass in order to achieve this (Hough, 2010).

4. The importance of past childhood experience: This was one of the most important of Freud's contributions. He focused on childhood experience and the way this experience can affect adult life. He believed that many adult problems originated from early childhood (Hough, 2010).

5. The use of ego defence mechanism: People use defence mechanisms when they experience conflict between their wishes and external reality, in order to protect themselves against extreme discomfort (Hough, 2010).

6. Transference and the nature of the therapeutic relationship: This refers to the client's feelings and emotional response to the counsellor. These feelings might be either positive or negative, and stem from childhood experience. These feelings are located within the unconscious region.

7. The significance of dreams: Freud regarded dreams as the royal road to acknowledge of unconscious activities of the mind. However, not all clients are regularly in touch with their unconscious and dream life (Hough, 2010).

8. Free association of the 'talking cure': Psychodynamic clients are encouraged to talk at their own pace and express their feelings and thoughts (Hough, 2010).

Overall, the goal of this approach is to encourage the client to talk about their feelings and emotions, before helping the client to bring their problems from the unconscious area into awareness. After Freud, this approach continued to develop in many different directions. Adler and Jung both left Freud's Inner circle to develop their own theory and approach. Alfred Adler focused on the effect of social and cultural factors on the personality development. Pine categorized the development of psychoanalytic thought as encompassing four main stages; these include: First, Freud's original drive theory; second, ego psychology functions were added as inborn and autonomous of biological drives (these include memory, thinking, intelligence and motor control); third, object relations focused on the dynamics and motivation developed within the context of earlier parent-child relationships; and fourth, self-psychology, which focuses on the need for self-cohesiveness and self-esteem as the overarching motivations that fuel human behaviour. There are many

contemporary psychodynamic movements, which include: time-limited psychodynamic psychotherapy, attachment psychotherapy and relational psychoanalysis (Sommers-Flanagan & Sommers-Flanagan, 2012). In recent years, different psychoanalytic schools of thought have converged in the effort to formulate psychoanalysis as a relational theory that sees the human mind as interactive (inherently social), with the psychoanalytic process understood as occurring between subjects rather than within the individual. Contemporary psychoanalysis seeks to provide empirical evidence to understand the how children and their environment shape each other. It seeks to bring the empirical approach to the evaluation of treatments developed from the integration of clinical experience, basic research in psychology and neuroscience and systematic analysis of the child's environment (Malberg & Mayes, 2013, p.35).

The psychodynamic approach has been the subject of considerable criticism over the years. It has historically not been well-suited or friendly toward females and individuals from divergent cultures (Sommers-Flanagan & Sommers-Flanagan, 2012, p.75). It has been criticised for the lack of empirical validity of its concepts, its lack of attention to social and cultural realities of clients and therapists, and the insular nature of its practice and training. In addition, it has been criticised for an overemphasis on subjectivity and the lack of testability in academic psychology (Pratyusha, 2016, p.18). Some of the later developments described have attempted to address these criticisms.

1.7.2 The Humanistic/Person-Centred Approach

This approach was established by Carl Rogers. He believed that everyone has sufficient innate resources to deal effectively with life (Hough, 2010); if grown in the right environment and given the right opportunities, there will be movement towards autonomy

and self-direction. Self-concept development is based on the individual's interaction with other people and the environment, and their perception of self.

In order for clients to make progress in counselling, Rogers identified three core conditions which describe a counsellor's ability and quality. The core conditions are: empathy (describing the counsellor's ability to understand the client at a deep level), unconditional positive regard (the counsellor's ability to show acceptance, warmth, and respect to the client), and congruence or genuineness (the counsellor's ability to be honest, open, sincere and authentic within the counselling relationship). Self-actualisation can only be achieved when counsellors are able to apply the core conditions and other counselling skills such as active listening, responding to clients through reflection of feelings and content, paraphrasing, responding to non-verbal communication and asking open questions (Hough, 2010). There are many aspects in this approach are relevant to a multicultural perspective (Seligman, 2006) . However, PCT may not be a good fit for some ethnic minority clients. The strong focus on the individual (in contrast to collectivism), and emphasis on authenticity and emotional expression, may conflict with some cultural values (Sommers-Flanagan & Sommers-Flanagan, 2012). Furthermore, this approach has several weaknesses:

- The approach may lead therapists to just be overly supportive of clients without challenging them (Corey, 2005).
- Difficulty in therapists allowing clients to find their own way (Corey, 2005).
- Could be an ineffective way to facilitate therapy if the therapist is non-directive and passive (Corey, 2005).
- Simplistic and unrealistically optimistic (Seligman, 2006).
- Listening and caring may not be enough (Seligman, 2006).

- Person-centred therapy does not draw on developmental, psychodynamic or behavioural therapy, thus limiting the overall understanding of clients (Seligman, 2006).
- Not appropriate for those who are not motivated to change.
- May not be useful with significant psychopathology (Seligman, 2006).
- Fails to prepare clients for the real world due to the unconditional positive regard of the therapist (Seligman, 2006).
- Lacks techniques to help clients solve problems (Seligman, 2006).

From an Islamic point of view, PCT has considered and provided some concepts that are consistent with Islamic and Arabic cultural viewpoints. Al-Shennawy (2001), an Arabic researcher, claimed that the PCT comes closest to Islamic counselling, as it focuses on the counselling relationship and encourages clients to be active and take responsibility for their lives as a whole. There are similarities between the Islamic perspective and Rogers' perspective in terms of the nature of the human being, including spirituality, self-responsibility, the fully functioning person and the core conditions. The human being is highly appreciated in both Islam and the PCT and both are interested in applying 'spirituality' to helping and supporting clients psychologically. In addition, they seek to provide a safe environment where people feel accepted and loved and tend to encourage the client to become fully functioning with a positive attitude to the direction of the self and others, taking responsibility for their own actions and choices. Furthermore, Islamic and PCT views believe in the importance of self-awareness and development through gradual movement towards change. As I mentioned earlier Islam has considered the importance of respecting, listening, providing empathy, and reflection in the counsellor – client relationship. Islam invites individuals to work perfectly, to accept others, to be

genuine in their behaviour and to do their best to understand others. PCT is based on the counsellor's attitude towards the client and to the therapy as a whole (Al-Thani, 2012).

A similar perspective was provided by Badri (2007), who compared Islamic and person-cantered principles. He argued that the principles of PCT are not new for Muslim clients because the role of the person-cantered therapy is to a high degree similar to the Prophet Muhammad's methods of dealing with others - clear communication with the other person, smiling to put the other person at ease, and attention to both verbal and nonverbal communication. In Hadiths, the Prophet Muhammad is quoted as saying, '*None of you will have faith until he likes for his (Muslim) brother what he likes for himself*". ("https://www.islamweb.net").

1.7.3 The Behavioural/Cognitive Behavioural Approach

In the 20th century, behaviour therapy evolved from the theories of human learning. Pavlov, Watson, Thorndike, Skinner, Wolpe and Bandura have contributed towards developing this approach (Hough, 2010). Cognitive behavioural therapy (CBT) combines scientific, philosophical and behavioural aspects into one comprehensive approach. This approach focuses on the way people think and behave (Branch & Willson, 2010). It aims to encourage clients to focus directly on their undesirable behaviour, and make these a target in order to make behavioural change (Hough, 2010). A basic aim is to enable clients to exercise more control over their own behaviour and the environment, as well as to help clients reduce their anxiety and distress. Counsellors need to be skilled in gathering information about the clients' anxious or emotional upset. This approach adopts several methods and techniques in order to meet the clients' needs. They use relaxation training,

systematic dispensation, planning behaviour, client self-monitoring, and other techniques (Hough, 2010).

CBT is the most popular form of therapy in the Middle East and is widely regarded as being the therapeutic intervention that is most compatible with Islam (Al-thani & Moore, 2012). Badri (2007) pointed out how closely cognitive psychology and other modern psychotherapeutic interventions recall early Islamic teaching and in effect. According to Ibn Al-Qayyim believed that any action which comes from a human being comes from his or her inner thoughts or speech. In addition, emotional, physical and cognitive habits follow a pattern that is strikingly similar to the cognitive behaviour therapy principles (Badri, 2000). Furthermore, Al-Bahadel (2004) stated that counsellors and therapists in Saudi Arabia prefer to apply CBT with their clients and encourage them to change irrational thoughts; however, the process does not focus on changing the client's belief system (Islam). The role of the counsellor is based on directivity and guidance, with homework as part of the treatment, and an Islamic CBT counsellor would ask a client to pray and do physical or mental exercises at home related to his or her problems (Al-thani & Moore, 2012).

1.7.4 Islamic Approaches to Counselling

Counsellors using this approach apply knowledge of material contained within the Holy Quran, Hadith, Sharia and the Names of Allah; this model of counselling seeks to place each client within the context of personal, social and spiritual evolution (Inayat, 2001). It is based on an Islamic understanding of the nature of human beings that incorporates spirituality into the therapeutic process. The goal of this approach is to address a variety of underlying psychological needs from a faith based perspective, to change the negative behaviours of individual for his or her own benefit and the benefit of the community; to

instil Islamic values; to enable the client to reflect on their relationship with the Creator. Islamic counselling emphasises spiritual solutions based on love and fear of Allah and the duty to fulfil our responsibilities as the servant of Allah. The prophet Mohammed stated that "*the religion is Naseehah*" (“https://www.islamweb.net”). Giving *Naseehah* to Muslims in general means giving advice. It involves guiding people, protecting them from harm, helping them when they need, providing what is beneficial for them. This type of approach (giving advice) was the most common in Muslim communities. Islamic counselling is based on an integrated framework guided by the principles of Islamic belief and practices (Rassool, 2016).

Research has shown that religious and spiritual beliefs and practices are beneficial for improving and maintaining good mental health, well-being, life satisfaction and decreased rates of suicide, substance abuse and antisocial behaviour (Rassool, 2016) and are important in a client's life (Hamjah & Mat Akhir, 2014) some studies have shown that people who are spiritual tend to have a more positive outlook and a better quality of life, and are better at coping with pain (Rassool, 2016).

Al-Shennawy (2001) suggested a method of Islamic counselling based on Islamic teaching and the Holy Quran. He views Islam as a complete system that, singlehandedly, is sufficient to help Muslims in all aspects of their lives without referring to Western approaches. Al-Malki (2002) stated that Islam guides individuals and groups to seek benefit in their lives without harming or destroying the rights of others. Islam encourages people to overcome their illnesses and disorders and enjoy their life, with the aim of living a long life.

1.8 Historical Background

This section provides a description of the historical emergence of counselling services in three different countries by providing its development and growth over years. This section begins by presenting the history of counselling services in the United States, the first place that counselling was established, before arriving in the United Kingdom. Finally, the section presents the development of counselling in Saudi Arabia wherein this research took place.

1.8.1 The History of Counselling Services in the United States

Counselling in the United States reflects historical and professional development (Munley, Duncan, McDonnell, & Sauer, 2004) over a period of eight decades (Hodges et al., 2017). It is difficult to specify when the first counselling centre was established on a college or university campus (Heppner & Neal, 1983). Historically, counselling centre roles and functions have responded to social needs and have improved over time (Stone & Archer, 1990).

In the early 1900s, several references indicated that counsellors, advisors, faculty, and deans were working with students (Heppner & Neal, 1983) and provided counselling services.

Whiteley describes five primary historical periods of counselling psychology:

- The development of the vocational guidance movement in 1909. In 1922, Viteles established the first vocational guidance clinic to provide assistance to people struggling to find a career (Hodges et al., 2017).
- The mental hygiene movement.
- Psychometrics and the study of individual differences, when personal and educational counselling was recognised.

- The evolution of counselling and psychotherapy in 1942, with Carol Rogers' classic work.
- The transition to professionalism between 1945-1955, with the growth of the perception of mental health as a social problem stimulated by Clifford Beer's book 'The Mind that Found Itself'. At this period of time, mental health services on higher education campuses were delivered by a wide range of professionals (Heppner & Neal, 1983) and many educators argued that faculty were the best professionals to provide counselling to university students (Hodges et al., 2017).

With the growth of higher education in the late 1950s and 1960s (Hedahl, 1978), concurrent development has taken a place in the counselling and psychology field (Hodges et al., 2017).

Counselling centres have expanded in over two-thirds of the institutions of higher education (Oetting, Ivey, & Weigel, 1970) and have increased in services, roles and activities. Several investigators developed instruments to assess student issues (e.g., the self-inventory of personal social relations) (Heppner & Neal, 1983) and psychological tests such as Beck's depression inventory, the Minnesota Multiphasic Personality Inventory, and other clinical assessments were becoming popular in college counselling centres (Hodges et al., 2017). Other studies examined the utilisation of counselling centres services; they found 60% of the student population utilised the counselling services.

In 1952, the American Counselling Association was established as an independent organisation to meet people's needs and to promote respect for human dignity and diversity. It focused on providing professional development and enhancing counselling programmes (American Counselling Association, 2004).

During the 1970s and 1980s, counselling continued to evolve and develop in response to social, professional, and cultural changes (Munley et al., 2004)**.** Due to the new concepts of counselling psychology and ecological management, the roles and function of counselling centres continued to develop and increase (Heppner & Neal, 1983). In general, the counselling centre functions changed from vocational counselling toward personal counselling and began to emerge as an important function (Stone & Archer, 1990).

During the 1980s, many additional counselling programmes were established in educational colleges (Munley et al., 2004). Improvements in higher education has held special relevance for university counselling centres in 1990s (Bishop, 1990). There were several studies conducted among college students and counselling centre clients that found an increase in the level of psychopathology, and each year counselling centre directors reported more personal cases and more severe client issues (Stone & Archer, 1990).

During the 1990s, counselling continued to be influenced by economic and social forces (Munley et al., 2004). The number of students looking for help, and the severity of their issues, significantly increased. These centres struggled to survive in tough economic times and limited staff relative to the number of students seeking help (Westbrook et al., 1993). In order to develop and provide an effective and helpful counselling programme (Goodyear & Shaw, 1984) to meet the needs and volume of students (Sharkin, 1997), financial support and staff resources were required. Furthermore, counsellors needed to seek further training to deal with challenging clients (Bishop, 1990) and counselling management procedures needed to be developed.

University counselling centres provided a variety of functions. They provided educational, vocational, and personal counselling, and one to-one consultations were common (Bishop,

1990) and are still the primary activity delivered to students at all counselling centres (Hodges et al., 2017). By the end of the 20th century, counselling became widely available (McLeod, 2013).

1.8.2 The History of Counselling Services in the United Kingdom

By the 1950s, counselling and the American humanistic psychologist Carol Rogers' ideas had arrived in the United Kingdom (Bondi, 2004).

In 1963, the Newsom report pointed to the importance of school counsellors to support and help underachieving students. Education, social changes (Lines, 2011), the growth of educational institutions, the increased number of inexperienced staff and the large number of school leavers were the reasons for the pressing need for counselling services in UK schools (Milner, 1974).

Guidance and counselling in higher education had a somewhat different development (Milner, 1974). In the educational context, in 1965 Keele and Reading universities offered counselling courses (Bor, Ebner-Landy, Gill, & Brace, 2002) based on similar courses offered by American universities (Milner, 1974). In the counselling services context, after the Second World War, the university health services started to provide counselling services by non-academic staff, and the first counselling services were established at the University of Keele (Milner, 1974).

In 1970, the Association for Student Counselling founded an informal association to enhance student counselling as an integral aspect of the educational process and of higher education (McMahon, 1997). At the same period of time, the National Association of Counsellors in Education was established, and by 1973 there were about 600 people who were interested in counselling in education to join these associations (Milner, 1974).

Furthermore, there were nineteen universities and colleges offering counselling services to their students, either as medical help or psychotherapy (Milner, 1974).

By 1971, the British Association for Counselling was established by a group of people who were primarily based in social services, social work and the voluntary sector (McLeod, 2013). At this time, there were 351 counsellors in schools throughout England and Wales. However, 54% of these counsellors were in only nine local education authorities (Mabey & Sorensen, 1995).

In the 1980s things had changed, with an emphasis on educational and vocational counselling and a move away from personal counselling (Mabey & Sorensen, 1995).

In the latter half of the 20th century, counselling expanded rapidly (McLeod, 2013). People in Western culture became willing to talk about their emotional and personal issues. The number of clients seeking and registering with counselling services increased considerably in higher education. Consequently, many counselling services experienced an explosion in demand; however, many services have not received any additional resources. Other counselling centres – in order to meet the demands – have made more use of unpaid staff and working in the evenings and on Saturdays (Mair, 2016).

1.8.3 The History of Counselling Services in Saudi Arabia

Saudi Arabia has become more interested in counselling and guidance over recent years. It has established counselling centres in different hospitals and schools and other education institutions, in order to satisfy people's needs. Counselling in Saudi Arabia has gone through three stages: the first stage was the creation of a national education and social activity department from 1955 to 1962 to oversee and observe various aspects of school activity; the second stage was the evolution of the education and social activity department

into the youth welfare department from 1962 to 1980; and the third stage was the establishment of the general administration of student guidance and counselling from 1981 to date.

In order to improve the counselling skills of the personnel, the general administration has established a three-phase programme. Phase one: the services were implemented by sociology and psychology teachers. Phase two: there has been a replacement of untrained staff with specialists. Phase three: the administration has established a long term programme of sending students abroad for Masters and PhDs in guidance and counselling.

Saudi Arabia is an Islamic country. Therefore, people, educational institutions, and the counselling and guidance programme are influenced, guided by and reflect the principles of Islam (Saleh, 1987). Consequently, counsellors have to use therapies and techniques that are consistent with Islam and with Saudi culture. Many of the counselling theories, techniques, practices and methods that were tailored to Saudi culture emanated from Western countries (Saleh, 1987), for example client-centred therapy, rational-emotive therapy, and cognitive behavioural therapy.

It was one of the major goals of Kingdom of Saudi Arabia to develop counselling services throughout the country, particularly career counselling in the schools (Ministry of Education, 1999). The Counselling and Guidance Administration has provided counselling training programmes for psychologists to improve their skills. In addition, universities have offered Masters and PhD degrees in counselling.

According to the General Counselling and Guidance Students Administration, the counselling programme was established to provide services in educational, counselling, vocational, health, social, and moral guidance. The administration's goal was to provide

services helping students to understand themselves, their abilities, and support them to solve their issues (Saleh, 1987). Student counselling activities were combined with social education, and these two activities serve one main purpose at all schools in Saudi Arabia. In addition, there is still no position in Saudi schools named ‘counsellor’; the service is still provided by a social worker who carries out the role of student counsellor (Saleh, 1987) and is only recently established in some universities.

In 1995 The Social Education and Student Counselling Institution at the Ministry of Education has established a plan that considers three main aspects of counselling, and it covers the following services:

- Counselling services, including educational and family counselling, whether individually or in groups, both direct or indirect (consultation).
- Psychological services, including discovering cases that require specialised services.
- Educational services, including vocational and career consultation.
- Social services, including the strengthening of links between home and school.
- Health services, such as taking care of students with additional needs and providing information on health issues.
- Research services, like surveying student attitudes regarding to certain school issues.
- The provision of in-service training for all personnel involved in student counselling.
- Contact with outside agencies and providing referral information about psychological clinics, health care settings and social centres (Al-Owidha, 1996).

The Ministry of Higher Education established a developmental project in counselling services in Saudi universities. This project was initiated in 2008, aiming to create an

effective counselling and guidance system in universities. As a result, some universities in Saudi Arabia have established counselling centres to meet students' needs. The intent has been to develop highly-trained professionals who observe and support students' psychological, physical and learning adjustments (Gerner, 1985). The oldest counselling unit was established by King Saud University, a unit that provides counselling services to the university students and staff as well as welcoming any referral clients from outside the university. It also provides supervision for students being trained in counselling (Al-Owidha, 1996). Other universities that have established counselling units include King Fahad University, Umm Al-Qura University, and Princess Nourah bint Abdulrahman University. Despite this effort, Al-Ghamdi (2015) has argued that existing counselling services do not achieve their purpose in satisfying the need of the vast majority of clients.

With regard to the studies that have been conducted in Saudi Arabia in the psychotherapy and counselling field, educational, preventative, behavioural, rational-emotive and cognitive-behavioural therapies have been the most popular approaches used by psychologists with their clients. In addition, females were more likely to work as a counsellor than males – Al-Rabiah (1996) reports that females are more interested in working as a counsellor compared with males. Moreover, Muslims females had positive attitudes toward counselling and were more likely to ask for counselling help (Khan, 2006).

1.8.4 Counselling Services at Princess Nourah bint Abdulrahman University

The Psychological and Social Counselling Unit was established recently under the students' guidance and counselling services at the university. It aims to deliver psychological and social services, helping students with their problems, modifying negative thoughts and behaviours, and in addition provides counselling training workshops

and counselling for student and counsellors (Psychological and Social Counseling Unit webpage, 2018).

There are between 10 and 12 counselling offices across the university. Each office has one or two counsellors and two to four social workers. Around 15 counsellors provide help and support to students and run counselling sessions depending on the clients' issues.

Aldileym (2011) conducted a study to explore the reality of utilising counselling services in five Saudi universities. The data were collected from 350 (213 male and 137 female) students and a 25-item questionnaire was administered. The study findings showed that the rate of counselling service utilisation was low by all students. However, female students at Princess Nourah bint Abdulrahman University utilised more of the counselling services available compared to female students at King Saud University.

1.8.5 Summery

People in all societies, at all times, have experienced emotional or psychological and behavioural issues (McLeod, 2013). Each culture has developed ways to help people to deal with their problems (Frank & Frank, 1993).

Counselling services were first developed and established in the United States before being promulgated and delivered across many countries. By reviewing the history of counselling in the United States, the United Kingdom, and Saudi Arabia, it can be seen that counselling services follow the growth and movement of educational services more generally. Counselling services were initially established in schools to meet students' academic issues. With increasing numbers of students, counselling has developed to provide more services and to support students with their personal and emotional issues. Developments in higher education have affected the way in which counselling is delivered in colleges and

universities. Nowadays, many universities in these three countries provide free counselling services to their students.

Chapter 2 Literature Review

2.1 Introduction

This chapter provides a summary of the existing relevant literature and provides a theoretical foundation and evidence for the current research. As this research contains two studies – a qualitative counselling service study, and quantitative client practice-based outcome study – the chapter is divided into two main sections. The first section presents relevant literature on the nature of the counselling services; this section includes the methods that have been used by researchers studying counselling services, followed by therapies and counselling techniques that have been used by therapists in different counselling settings. Following this, therapists' practice difficulties and challenges with organisations and clients are discussed, and finally, the kinds of problems that were presented by clients in therapy are presented. Most of the studies that were reviewed relate to counselling services, especially in Arab countries, that were conducted in schools and a small number of these studies were conducted in Saudi Arabia. In order to support this study theoretically and obtain more evidence, the researcher has reviewed relevant studies that were conducted in Western countries and the United States.

The second section of this chapter presents outcome studies that investigate the effectiveness of the counselling services at several counselling settings. It is divided into three sub-sections: therapeutic effectiveness, methods used to evaluate the counselling services, and literature concerning counselling effectiveness. However, the researcher experienced difficulty finding studies that were conducted in Arab countries, and in particular Saudi Arabia. Consequently, relevant practice-based outcome studies from Western countries and the United States were reviewed.

2.2 Counselling Services: A Narrative Review

2.2.1 Introduction

Little has been written about the nature, distribution, or effectiveness of counselling services, even in western countries (Sibbald et al., 1993). The nature of therapeutic consultation is a discrete activity requiring specific skills and expertise (Mair, 2016). According to Hoxter (1994), the counselling is known as a method of relating and responding to other people by providing them with chances to explore, to clarify and to work towards living in a more satisfactory and resourceful way.

The counselling process can be applied to individuals, couples, families, or groups and has been used in widely differing contexts and settings (Hoxter, 1994). Counselling in an educational setting is qualitatively and quantitatively different from other settings. Most Western (and, increasingly, non-Western) countries provide free access to counselling services in the education settings.

This section documents literature relating to the methods that have been used in the counselling services research field, followed by a review of the literature concerning the kind of therapies and techniques that therapists and counsellors use with their clients, and then counsellors' and therapists' practice difficulties in Western countries, Arab countries, and Saudi Arabia.

2.2.2 Research on Counselling Services: A Methodological Review

This section presents the methods that have been used in counselling services research in order to investigate the nature of services that were provided in counselling settings.

Qualitative and quantitative approaches have been used to explore the nature of counselling services in education and mental health settings. In this section I review the

kinds of therapies that were provided, and the kind of difficulties and challenges faced by therapists in their practice. I also look at the different research methods that have been use to address different types of research question. Some researchers have used mixed methods, combining the two approaches, which can often complement each other (Barker, Pistrang, & Elliott, 2016). Researchers using quantitative methods usually identify one of several variables that they intend to use in their study and continue with data collection related to those variables. This method used positivist or critical-realist quantitative approach and based on a mathematical approach, and hypotheses and theories related to the phenomena that will be studied and data can be collected via a questionnaire 'self-report' measure, observer-based measure, or projective measures.

On the other hand, phenomenology and constructivist/social constructionist qualitative approaches focus on trying to understand a phenomenon in terms of the social meanings people bring, exploring these meanings and understanding how people experienced the world. Researchers who use this approach are interested in people's stories and being part of what is being studied. In this approach, data can be gathered by conducting interviews, focus groups, or participant observation (Vossler & Moller, 2015).

After I reviewed the relevant literature, I found that the quantitative approach is most commonly used by many researchers to identify the kind of therapy used by many counsellors and therapists. Researchers such as Aldileym (2001), Al-Bahadel (2012), and Al-Ribdy (2013) administrated questionnaires in either counselling centres or mental health clinics at Saudi hospitals. Other researchers such as Buckman and Barker (2010) used more than one measure in order to obtain significant knowledge of practices, and identify therapists' preferences of therapeutic orientations. In contrast, other researchers such as Westergaard (2013) looked in more detail about counsellors'

perceptions of the kind of therapies that work better with young clients. Consequently, he used a qualitative method by conducting a semi-structured interview with counsellors.

To identify the kind difficulties faced by therapists in practice, it seemed that most of the researchers preferred to use a quantitative, positivist approach. For instance, Abdulrady, 2012; Al-ahmari, 2012; Al-Ghamdi, 2015; Al-mosawy, 1998; S. Al-Zahrani, 2012) and Al-Zahrani (2012) all applied questionnaire 'self-report' measures to collect data on counsellors' practice difficulties. Some of these questionnaires were administered to school counsellors and/or teachers and principals.

Other researchers used mixed methods in order to understand therapists' practice difficulties. For instance, Al-Gamdi's (2010) study combined two methods: a self-report measure and a semi-structured interview. These methods were administered to school principals, teachers and counsellors in order to collect more details about counsellors' difficulties. Another study conducted by Gora (1990) also used a mix of qualitative and quantitative approaches; a semi- structured interview and two questionnaires were addressed to counsellors and psychologists.

Overall, the use of quantitative or qualitative approaches depends on the research problem or questions as well as the researcher's interest. Quantitative approaches tend to be based on testing a hypothesis or theory, and apply descriptive or inferential statistics. On the other hand, qualitative approaches are based on people's stories, opinions, and experiences, collected and analyses using words and categories.

2.2.3 Use of Therapies and Techniques

2.2.3.1 Introduction

It is fundamental for university counsellors to have a wide repertoire of counselling techniques, skills and psychological assessments (Hodges et al., 2017). There are many therapies and techniques that counsellors/therapists use to help their clients deal with their problems, for instance, cognitive behavioural therapy (CBT), person-centred therapy, and psychodynamic therapy. Each therapy has its own techniques and assessments. According to Buckman and Barker (2010), there are three models for the selection of therapeutic approaches. The first model indicates that some therapists and counsellors use treatment that has been shown to be more effective for a particular psychological disorder. In the second model, some therapists and counsellors use a treatment or approach that is most suited to the client's problem, yet sometimes apply number of treatments. The third model describes inflexible therapists and counsellors who focus on and adopt one approach; for instance, a counsellor who only uses cognitive behavioural therapy (CBT) or the person centred approach with his /her clients. Usually, therapists and counsellors use more than therapy and technique in order to provide the best assistance for their clients. Gilliand et al. (1989) believe that no one technique or therapy can solve all clients' problems or situations, and different therapies emphasise fixing different aspects of human functioning; therefore each may be provide a different route toward personal development (Bohart & Tallman, 1999). Little is known about how therapists/counsellors come to adopt a preferred therapy or technique (Buckman & Barker, 2010).

2.2.3.2 Therapeutic Orientation Preferences

Therapeutic orientation preferences and selections may be influenced by a therapist's or counsellor's training experiences, philosophical views, or their personality. In some cases where multimodal approaches are required, counsellors may use techniques from a variety of theories. This section documents the kinds of therapies that were used by therapists in different psychological settings, starting with research in western mental health settings before moving on to research in Arab countries. Research carried out by King et al. (1994) examined a group of five part-time counsellors who worked at general practices in the UK. The researchers reported that counsellors provided non-directive (person-centred) therapy with their clients, and occasionally cognitive behavioural therapy was also used. However, counsellors who participated in this study showed a lack of qualifications, came from a variety of backgrounds, and tended to use different methods of therapy. Another study was conducted by Thompson (1995) to identify the kind of theories used by counselling students. A questionnaire was administered to 24 practicum students and 90 former master's level graduates at the University of Nebraska at Omaha. The results found that client-centred and behaviourism were the most frequently used therapies by the practicum students (79% reported using client-centred therapy and 75% used behaviourist therapies). Among the less than five-year graduated student population, rational emotive therapy (81%) was most commonly used. Adlerian (72%) and behaviourist (72%) therapies were more commonly used by the five- to nine-year graduated student population. However, the results may not be reflective of all counsellor populations because the questionnaire was sent to the residents of Omaha and agency counsellors only.

Furthermore, as reported by Hardy et al. (1998), counsellors use interventions and counselling techniques depending on the clients' background, capacities and personalities as well as the nature and severity of clients' presenting problems. Another study was conducted by Poznanski and McLennan (1999) to identify the kind of theoretical approaches that counsellors provided. The Counsellor Theoretical Position scale was emailed to 300 members of the Australian Psychological Society. One hundred and thirty two questionnaires were received. The results showed that 34% of participants reported their preference to provide cognitive behavioural therapy, 26% reported a psychodynamic preference, 15% reported a family systematic approach, and about 7% of the participants described themselves as eclectic. Other researchers were interested in determining the relationship between the therapist/counsellor's personality and their preference for therapeutic orientations. Such a study was conducted by Buckman and Barker (2010) to investigate the relative influence of person and training factors on preference for three common therapeutic orientations: CBT, psychodynamic therapy, and systemic therapy. The study sample consisted of 142 trainee clinical psychologists (25 men and 117 women) in the UK, and each trainee was asked to complete four measures. The results found that for CBT, preference was more influenced by trainees' personalities; in contrast, preference for psychodynamic therapy was more influenced by training factors. For systemic therapy, both factors were approximately equal. However, the study had limitations related to the self-report measure that was applied, as many participants might prefer to portray themselves as more theoretically pluralistic than they actually are in clinical situations.

Another study was conducted by Stiles et al. (2008) at the National Health service (NHS) UK primary care service in which therapists were asked to indicate the kind of

therapies that they used with their clients. The study confirmed that therapists who were working in UK primary care delivered many counselling and psychological therapies such as CBT, person-centred therapy and psychodynamic therapy. However, the researchers indicated that their study had limitations relating to the lack of therapists' qualifications and responsiveness to client problems, and lack of details in what the treatments comprised and how they were delivered. A similar study was conducted by Westergaard (2013) at a voluntary youth counselling agency in South London. The study aim was to determine counsellors' reflections on what they believed to work in their counselling practice. Semi-structured interviews were administered to five qualified counsellors (two were trained to deliver person-centred therapy, two integrative and one psychodynamic therapy) who were experienced in working with young people and were currently in practice. Counsellors were asked to express their training and theoretical orientation and identify the approaches they used with their clients. The results found that counsellors were flexible in their therapeutic approach and none of the counsellors were using specific integrative models in their work. They all applied techniques drawing from a range of theoretical orientations. In addition, they used techniques and strategies in their work when they felt it was appropriate to do so. However, the small number of this study sample did not offer a comprehensive investigation.

In Arab countries, counsellors have used many kinds of therapies in order to help meet their clients' needs. In education settings, counsellors are more likely to provide educational and preventive counselling to students, as evidenced in Al-Zahrani (1990) whose study revealed that counsellors were successful in providing educational, preventive, ethical and religious services to students. In addition, preventive therapy has

been used by the most counsellors. Similar results were reported by Aldileym (2001) in his study to explore the nature of school counselling practices and experiences in schools in Riyadh, Saudi Arabia. Two hundred and fourteen counsellors participated in his study. A 32-item questionnaire was used. The results indicated that the school counsellors used preventive therapy with the students (i.e. the counsellors tried to contact the students' parents, or tried to motivate the students to raise their academic level). Furthermore, they provided group counselling, behavioural therapy and humanistic therapies by helping students to improve their social skills or make a good connection with other people. However, there was still a lack of counselling services provided by the school counsellors, and counselling services were being provided by unspecialised workers (such as teachers or social workers), especially in Saudi schools. Moreover, giving advice was a method commonly used by most school counsellors, as opposed go more sophisticated or evidence-based approaches. Further study was conducted by Al-Ribdy (2013), and one of his study aims was to identify the level of burnout in light of counselling experience and other variables among male and female counsellors in schools in Al-Qassim, Saudi Arabia. A questionnaire was administered to 326 school counsellors: 178 males and 148 females. The study findings showed that educational counselling was the most important function that counsellors provided. The researcher added that educational counselling encourages students to understand their skills and abilities. As well, Al-Bahadel (2012) conducted his study to identify the roles and services that counsellors provided at a university counselling centre, as perceived by students. A 38-item questionnaire was administrated to 109 students at Al-Qassim University, Saudi Arabia. The students reported that they received educational,

preventive, and academic and career guidance, and that the services were more likely designed to provide direction and solutions to the students' problems.

In Arab mental health settings, psychologists provide consultation, psychotherapy and diagnosis. A study was conducted by Jamal Alail (2001) to investigate the use of psychotherapy approaches as perceived by psychiatrists. A questionnaire was administered to 63 psychiatrists at a number of Saudi mental hospitals and 11 psychiatrists at private psychological clinic. The results found that humanistic therapies, behavioural approaches, chemotherapy, and diagnosis were used the most by the therapists and psychiatrists at the hospital and the private clinic. In addition, they used cognitive therapy as well as family therapy, and there was no significant difference in psychotherapeutic methods used between the two groups. However, most of the psychiatrists at the psychological clinic preferred to use medication with clients more than refer them to a counsellor or psychologist, even though most of their clients had psychological problems and a clear need for counselling therapy. Another study was conducted by Al-Rabiah (2005) to identify the kind of services that psychologists provided at mental health hospitals in Saudi Arabia as perceived by psychiatrists. A questionnaire was administered to 64 psychiatrists: 47 males and 17 females. The findings indicated that psychologists were providing consultations, psychotherapies and carrying out diagnoses. However, the less experienced psychiatrists were less likely to identify the psychologists' roles and tasks. Sultan's (2012) study aimed to identify psychologists' tasks as perceived by psychiatrists at a mental health hospital in Misrata city, Libya. A 22-item questionnaire was administered to 47 male and female psychiatrists at the hospital. The results showed that psychologists provided consultations, psychotherapies and diagnoses. However, the study focused on

comparing the male and female responses and their awareness of the psychologists' tasks rather than identifying what the specific tasks and therapies were that psychologists provided.

2.2.3.3 Therapists' Responses, Modes and Techniques

A few studies were conducted to identify which techniques therapists and counsellors use with their clients. In general, studies have found that 30% to 40% of counsellors in practice are eclectic (Bohart & Tallman, 1999). Some researchers suggest that in order to provide effective counselling, counsellors need to be flexible in their use of counselling techniques. Researchers such as Gilliand, James and Bowman (1989) and Lazarus (1989) recommend that counsellors use a multimodal approach. Lazarus (1989) describes this approach as "systematic eclecticism", and suggests that counsellors and therapists need to be flexible, versatile and technically eclectic if they are to provide effective counselling with a wide range of client problems and personalities. He also adds that counsellors can use a variety of techniques according to what works best for the clients. In addition, Gilliand et al. (1989) believe that a specialised counsellor knows which techniques would work best with their clients' problems. However, it is not realistic to become eclectic in theory, yet it would be advisable for a counsellor to have one or two theoretical bases and to have different techniques from which to draw on.

A study by Thompson (1995) aimed to identify the kind of techniques that were used by counsellors. A questionnaire was administered to students. The results showed that client-centred techniques and attending skills were most commonly used by the counsellors. For instance, they considered empathy, genuineness, reflection of feeling, paraphrasing and unconditional positive regard in the counselling sessions.

2.2.3.4 Supervision

In general, supervision in counselling can be perceived as either training supervision or consultative supervision. Training supervision can be offered to students who are studying one of the helping professions courses such as social work, counselling, or clinical psychology. Consultative supervision is an arrangement between two qualified personnel where one offers to help the other reflect on a case (Carroll, 2001). It is a process involving two counsellors, one in the role of supervisor and the other in the role of supervisee, in order to develop the supervisee's skills, awareness and knowledge (Vallance, 2005).

In the United States, supervision takes place in and is controlled by the universities, while in the United Kingdom it existed first within private institutions and then universities and colleges of higher education became involved. "*Supervision is being as an increasingly important part of counselling training. Within the therapeutic profession it is now seen as an essential rather than an optional feature of effectiveness counselling work, being mandated in almost all training in counselling*" (Carroll, 2001, pp. 12-13).

In western countries, a number of studies have been conducted to explore the importance of supervision in counselling. A study by Vallance (2005) investigated the impact of counselling supervision as perceived by British counsellors. An open-ended questionnaire was administered to 13 counsellors and semi-structured interviews were conducted with six counsellors. The counsellors reported that the supervision was helpful; it increased self-awareness, congruence, and confidence in their work and they felt emotionally supported. However, several supervisees found the supervisor's values or beliefs could be counterproductive.

Other researchers (Bimrose & Wilden, 1994) suggest that supervision has the potential to simplify continuous self-evaluation and learning beyond the initial training phase. In addition, some studies indicate that supervision helps counsellors continue to develop, and without supervision, skills levels may decrease after training (Wiley & Ray, 1986; McMahon & Patton, 2000). In line with supervision, previous studies have reported that counsellors show interest in supervision; it provides professional support and helps counsellors to learn specific counselling techniques to deal with different clients. Furthermore, it helps to avoid burnout and decrease the stress of the work environment (McMahon & Patton, 2000).

2.2.3.5 Conclusion

Overall, I conclude that counsellors provide various kinds of therapies in both educational settings and mental health hospitals. In Western countries, most counsellors in different settings provide cognitive behavioural therapy, psychodynamic therapy and person-centred therapy. In Saudi Arabia, because counselling services have been more recently established in Saudi universities, there is a lack of studies conducted to identify the kind of therapies that therapists use with their clients. Consequently, studies conducted in schools and mental health hospitals have been reviewed for this research. In educational settings, most counsellors provide educational and preventive counselling rather than personal or psychological counselling, because counselling services in Saudi Arabian schools are still provided by a social worker or other unspecialised person. On the other hand, in mental health hospitals and as perceived by psychiatrists, consultations, psychotherapies and diagnoses are commonly carried out by psychologists. Some researchers suggest that for better impact on the outcome for counselling and psychotherapy, psychological and counselling instantiations in many

countries may recommend approaches and counselling therapies that counsellors can use with their clients, or counsellors/therapists might select the most appropriate therapies for their clients' characteristics and issues. Many therapists use and apply interventions depending on the clients' capacities, background, circumstances and personalities as well as the presentation and severity of clients' problems (Stiles et al., 2007).

2.2.4 Difficulties Faced in Practice

2.2.4.1 Introduction

An effective counsellor is one who works with clients to provide a positive outcome, and a positive change in the client's life or a reduction in adverse symptoms (Wheeler, 2000). However, in any vocational environment, people face several kinds of difficulties, and this is also the case for therapists; they may face difficulties carrying out their work or dealing with challenging clients. This section reviews literature concerning the difficulties faced by therapists in practice, challenges with organisations and clients, and illustrates what might affect their work, starting with research in Western countries before moving on to research in Arab countries and Saudi Arabia.

2.2.4.2 Organisational Challenges/External Difficulties

In general, the number of clients attending university counselling centres has increased, which has affected the average counselling budget and the number of sessions offered to students (Connell, Barkham, & Mellor-Clark, 2007). As reported by several researchers (e.g. Hodges et al., 2017), a large number of universities and colleges are struggling to meet students' needs due to limitations relating to the number of available counselling staff relative to the number of students on campus.

In Western countries, a study was conducted by Fulton (1973) to investigate school counsellors' attitudes to certain counselling issues. The study sample consisted of 16 counsellors in the UK Midlands. The results found that counsellors agreed that they should not undertake classroom teaching duties. They believed that full time training was required, and they agreed that strict confidentiality should be applied in counselling sessions.

Gora (1990) conducted a study to emphasise the impact of a counselling programme as perceived by the counsellors. The study sample consisted of 38 participants: 30 school counsellors, four school psychologists and four behaviour management counsellors in Edmonton, Canada. Semi-structured interviews and two questionnaires were administered to the participants in order to collect data. One of the study results showed that counsellors reported that the lack of sufficient counselling time, the large number of the students and lack of training in certain areas were barriers to the counsellor's effectiveness.

In Arab countries, as reported by The Arab Bureau of Education for the Gulf countries (1990), university counselling centres cannot meet all student needs because of the lack of counsellor time, the small number of specialists in counselling and weaknesses in their practical skills.

As well as this, Hassan (1998) conducted a study to explore the kinds difficulties faced by counsellors. The study sample consisted of 40 male and female school counsellors in Egypt. The findings showed that counsellors faced many difficulties and challenges in their work. The first set of problems related to therapist qualifications, lack of therapist experience, poor counselling skills, understanding their functions, the need for training

courses and workshops, and there was a lack of psychological assessments. The second set of problems related to the school administration: They did not provide an appropriate place for counselling services; therefore the therapists had no privacy during the session; there were also economic issues and a limited number of school counsellors.

Another study was carried out by Al-Mosawy (1998) to determine the counsellors' and psychologists' psychological stress in school counselling centres. A questionnaire was administered to 124 counsellors (46 counsellors and 78 psychologists) in Kuwait. The study demonstrated that counsellors and psychologists faced various kinds of difficulties, as follows: non-cooperative school administration, always being asked to carry out non-counselling tasks, lack of supportive co-workers, a limited number of counsellors, lack of psychological assessments, counselling courses and workshops, and lack of counselling skills.

In line with this, Turky (n.d.) conducted a study to determine the difficulties that school counsellors faced in their work. He administered a questionnaire to 105 male and female school counsellors in Kuwait. The results found that counsellors faced many problems, including economic issues, lack of counselling skills, lack of experience in working with clients, and lack of using psychological assessments. In addition, they faced issues related to the students; the students had difficulties expressing their problems, and there was a lack of understanding counsellors' functions and roles. Furthermore, counsellors faced difficulties related to the school administration; lack of appropriate places to provide counselling services, energy and time being taken to do other tasks, lack of psychological assessments, and finally, non-cooperative and non-supportive parents.

Abdulrady (2012 study showed similar findings. It was conducted in school in Egypt to identify counsellors' work-related psychological stress and professionalism. A questionnaire was given to 150 school counsellors. The results showed that counsellors face work difficulties related to the school administration, parents, students, and conducting counselling tasks.

In Saudi Arabia, most of the studies that have been conducted in the counselling field are based on school counsellors. Al-Zahrani (1990) found that untrained counsellors, lack of counselling skills, and non-understanding parents in terms of counsellors' roles and functions were the most common difficulties and challenges faced by counsellors.

A similar study was conducted by Al-Ghamdi (1999) in which 117 counsellors, 316 teachers, 112 principals and 451 students were examined. One of the study aims was to find the most important factor affecting counsellors' performance. The results found that counsellors complained about their time being taken up by doing educational activities, but they believed that counselling activities were more important.

A study was conducted by Al-Rebdy (2004) at a boys' intermediate school in Al-Qassim, Saudi Arabia. One of his study aims was to reveal the kinds of difficulties that counsellors face. A questionnaire was given to counsellors, principals and teachers. The results found that the limited number of counsellors at the school compared with the large number of students was a challenge for therapists. The therapists also faced difficulties related to the teachers and parents; they were non-cooperative and non-supportive, and this negatively affected the counsellors' work.

One of Al-Ghamdi's (2010) study aims was to investigate the difficulties faced by counsellors at an intermediate girl's schools in Jeddah, Saudi Arabia, as perceived by

126 principals, 237 teachers and 180 counsellors. A semi-structured interview and a questionnaire were applied. The study found that counsellors faced difficulties related to the lack of clarity in their counselling roles, excessive administrative and clerical duties, deficiencies in professional training, and non-supportive parents. However, the majority of the counsellors were insufficiently trained and unqualified to provide counselling services.

Al-Bahadel (2012) conducted a study to identify university counsellors' difficulties, as perceived by students. They found that due to unclear counselling roles, functions, and the professional code of ethics in Saudi Arabia, counsellors found themselves involved in many duties and tasks that were not related to counselling services. Because a guide of ethical practice does not exist, this made the counsellors' tasks more difficult, particularly when trying to protect clients' confidential information. Furthermore, lack of time prevented counsellors from providing more services and focusing on certain functions. In addition, the lack of professional and qualified counsellors, the large number of students, and the lack of training programmes in counselling were other challenges.

Another study was conducted by Al-Ahmari (2012), and the aim of his study was to investigate school counsellors' psychological stress and difficulties in Aseer city, Saudi Arabia. A questionnaire was administered to 62 counsellors (31 specialised in psychology and 31 held a non-relevant qualification). The study findings showed that the relationships with the students' parents, the students themselves, co-workers, and the school administration were sources of stress and difficulties. Furthermore, specialised and experienced counsellors showed less stress than the other group.

Al-Zahrani (2012) conducted his study to identify counsellors' problems in Al-Baha city, Saudi Arabia, in view of gender, qualifications, workplace and the size of the school. A questionnaire was administered to 279 counsellors (128 male and 151 female), of which 132 of them specialised in counselling. The results found that counsellors faced economic problems, problems with the school administration, students' families, the work environment and the local community.

Another study conducted by Al-Otaibi (2014) aimed to investigate the challenges and problems that school counsellors might encounter in a secondary school in Afif city, Saudi Arabia. The data were collected from 44 participants (21 head teachers and 23 school counsellors). The study findings showed that there were problems related to the Ministry of Education (insufficient finances, insufficient number of school counsellors in school, and no requirement for relevant qualifications). The second problem faced by counsellors was a non-supportive school administration. The third problem related to the teachers: lack of respect and failure to understand the counsellors' work. The fourth issue related to the counsellors themselves; they were unqualified, they showed a lack of preparation, and they felt demotivated. The final issue reported by the counsellors related to the students and their parents; parents showed a lack of understanding of counsellors' work and there was a lack of communication and cooperation from them.

Al-Ghamdi (2015) study was conducted to identify potential difficulties facing Saudi career counsellors, and investigated their perceived self-efficacy and counselling competence at private schools in Jeddah, Saudi Arabia. A self-report measure was distributed to 55 female counsellors from private schools to address the problems of efficacy. In addition, the data were collected from two focus groups of 15 counsellors and teachers at the schools. The study found that school counsellors faced various

difficulties, as follows: they showed a lack of counselling skills, they complained about unclear counselling roles and functions, unsuitable institutional settings for counselling (not enough space to provide counselling services, and the large number of students), non-cooperative teachers and administration, cultural and ethnic issues, and lack of supportive parents.

Conclusion

In general, I noticed that there were a consensus between counsellors and therapists about the practice difficulties that affected their work such as doing and being asked to do non-counselling work, the lack of counselling training courses, lack of qualified counsellors and counselling skills, and, in addition, lack of counselling roles and functions. In research in Arab countries and specifically in Saudi Arabia, counsellors described other practice difficulties such as lack of support from either school administration or students' parents, lack of privacy, and the limited number of counsellors compared to the number of students.

2.2.4.3 Therapists' Practice Difficulties and Challenges with Clients

The above section presented the kind of external difficulties that counsellors and therapists have to deal with, especially in Arab-speaking countries. In line with those challenges, counsellors and therapists have faced other challenges in dealing with clients during their counselling sessions. In general, clients do not always act proactively. Some clients are motivated to accept help and want to change, while other clients seem resistant to change, resist new ideas, may be defensive and refuse to admit or to receive any suggestions from counsellors (Bohart & Tallman, 1999). These clients

make counsellors' and therapists' work difficult. Client resistance and failure to become actively involved is one of the biggest problems therapists have to confront (Bohart & Tallman, 1999). Silence can be described as a symptom of resistance and provocation in therapy – intentionally or unintentionally – or may be linked to strong emotions and feelings. Some clients keep silent because it is the only way to cope with overwhelming emotions (Knutson & Kristiansen, 2015). Counsellors are often frustrated when they work with clients who are not opening up or expressing themselves (Gensler, 2015), and their work can be affected in a critical way and it represents a particular challenge to the therapists. Yet, therapists may see the clients' silence as defiance, resistance, or an expression of hatred, fear, frustration, or feeling of emptiness; these interpretations depend on the therapists' understanding of client communication (Knutson & Kristiansen, 2015).

Other problem is that some clients consider the counselling as a form of 'problem solving'; they expect that counsellors are going to provide them with a solution. They sit at the counselling session passively and wait for the counsellors to direct them; they do not know they are supposed to continue talk and think (Bohart & Tallman, 1999).

In Arab countries, as reported by Al-Yahya, most Arab-speaking clients prefer a quick solution for their problems and always ask for directive counselling (Al-Owidha, 1996).

In addition, counsellors and therapists face problems related to clients withdrawing, dropping out, or their lack of commitment in attending the course of therapy. One of Hassan's (1998) study findings was that clients' lack of commitment to the counselling session and lack of time to see the counsellor were difficulties and problems faced by therapists.

A further in-session challenge with clients is the client's emotions and thoughts toward receiving counselling. Some students avoid seeking help from a counsellor because they feel embarrassment or shame; in other words, they have a negative perspective towards the counselling. A number of counsellors who participated in Hassan's (1998) study stated that some students feel embarrassed to seek or ask for help from a counsellor. A similar result was reported by a university counselling centre's clients in a study conducted by Al-Bahadel (2012). These results found that some university students, in order to protect their social image and avoid the stigma attached, avoided seeking help or going to see a counsellor. This was reflected in Turky's (n.d.) study, in which counsellors who participated in his study confirmed that some students had fears to ask for a counsellor's help.

Unclear ethics and functions are another particular challenge in Saudi Arabia. This makes the counsellors' work more difficult and in some ways has affected their relationships with their clients. As reported by Al-Bahadel (2012), because a code of counselling ethics and practice does not exist in Saudi Arabia, counsellors find difficulty protecting the clients' confidential information. Consequently, clients do not trust their counsellors. This issue was also reported by one of the school counsellors in Al-Ghamdi (2015) study, who stated that "*some students did not trust us*" (p.6116).

2.2.4.4 Conclusion

It seems that most of the studies conducted on therapists' practice difficulties are located in schools, especially in Saudi Arabia, because the counselling services at Saudi universities were only recently established. Counsellors and therapists in different countries face many kinds of obstacles and challenges that affect their performance and make their work difficult. From the literature mentioned above, the difficulties that

counsellors face relate to the environment, the large number of students, the parents, administration, and the lack of clear roles and counselling skills. University counselling centres cannot meet all student needs; this is due to the large number of students, and the lack of trained and qualified counsellors. In addition, counsellors had to confront in-session challenges with their clients. They had to deal with clients dropping out, clients' silence, fears, emotions, negative perspectives towards counselling, and problems protecting clients' confidential information. Many counsellors also report an increasing need to develop their counselling skills (Hoxter, 1994). In order to improve their skills and encourage them to be more up-to-date with counselling treatments, counsellors and therapists need to attend training courses and counselling workshops.

2.3 Studies Related to Students' Presenting Problems

2.3.1 Introduction

Sometimes, people find themselves in a condition of impasse, uncertainty, and insecurity. Clients in counselling centres often do not really know why they behave in a certain way (Hough, 2010). They are confronted by circumstances to which they are unable to respond effectively (Hoxter, 1994). In general, clients attend counselling centres seek help and support. They suffer various kinds of problems, be they personal, social, emotional, academic or family issues. In Western countries, the number of students who have emotional problems has been on the increase over the past decade. Anxiety and stress problems were the most common emotional problems among university students in 1994. A more recent study has confirmed that the three highest problems stress among college counselling centres' clients were anxiety, depression and stress, as reported by clinicians (Perez-Rojas et al., 2017). Students are now presenting

more complex problems at counselling services (Storrie, Ahern, & Tuckett, 2010) and the percentage of frequent mental distress among US adults has increased from 8% to 10% in 2004 (Hyun et al., 2006). This section started by reviewing the research methods used for studying clients problems, followed by a literature review regarding problems and issues that clients present with in the counselling sessions in Western countries, followed by studies in Arab countries, and then in Saudi Arabia.

2.3.2 Methods Used for Studying Clients' Presenting Problems in Counselling Settings

In the area of clients' presenting problems, a variety of tools and methods have been used by researchers to assess depression, anxiety, and overall mental health. Many researchers in Western and Arab countries, and Saudi Arabia specifically, used positivist or critical-realist quantitative approach in order to identify the client or student problems in different educational settings.

One of the quantitative methods that has been used to collect data in this area is the questionnaire or self-report measure. Many researchers have aimed to identify the prevalence of specific disorders among university students such as depression, anxiety, irrational thoughts, or emotional disorders. For instance, Hyun et al. (2006) used a questionnaire to identify mental health problems among university students. Eisenberg et al. (2007), Garlow et al. (2008), Abdel-Fattah and Asal (2006), and Zivin, Eisenberg, Gollust, and Golberstein (2009) used questionnaires to estimate the prevalence of depression among university students, with Beck's depression inventory being commonly used. Other researchers were interested in identifying the prevalence of irrational thoughts among university students by administering irrational thought

questionnaires (Hassan & Al-Gamaly, 2003; Abo-Shaer, 2007). Overall, most of the researchers were interested in using a quantitative approach such as a questionnaire, survey, or any other reliable measure in order to determine the prevalence of any psychological problems.

2.3.3 Clients' Presenting Problems in Western Countries

This section presents studies regarding the kind of problems that clients brought up in their counselling sessions in Western countries. However, most of the studies on mental health problems at United States universities have focused on undergraduate students and only small numbers of postgraduate students were considered (Hyun et al., 2006). Many counsellors have faced challenges relating to changes in the students' presenting problems at the university (Pledge, Lapan, Heppner, Kivlighan, & Roehlke, 1998).

As reported by Kitzrow (2003) and Hunt and Eisenberg (2010), the prevalence of mental health problems has increased among university and college students and small numbers of the students were receiving appropriate treatment in these studies.

A study was conducted by Pledge et al. (1998) to present a university counselling centre's client problems. The research data were collected from 2,326 students at a large Midwestern university from 1989 to 1995. All participants completed a psychological evaluation and research assessment by using a computer. The six-year study found that the counselling centre's clients showed severe concerns including: suicidality, substance use, and history of psychiatric treatment, depression, anxiety, and very high level of distress.

Other research by Levine & Cureton (1998) confirmed that university and college students exhibited more severe psychological problems than in previous years. The

student affairs administration reported that more than half of the students had eating disorders, 42% abused drugs, 35% were alcoholics, 44% caused class disruption, and a 25% were addicted to gambling or attempted suicide. Similar results were reported by the National Survey of Counselling Centre Directors, in which approximately 16% of the counselling centre's clients showed severe psychological problems include learning disabilities, self-harm incidents, alcoholism, drugs, and sexual assault concerns.

One of the study aims conducted by Hyun et al. (2006) was to define graduate students' mental health problems at a large university in the western region of the United States. The study population was a total of 3,121 graduate students who were enrolled during the spring 2004 semester. A self-report mental health needs survey was administered. The findings indicated that almost half (45%) of the study population had experienced a stress-related problem that significantly affected their emotional wellbeing and academic performance within the previous year. In addition, about 40% of the students were feeling exhausted. However, the non-randomised sample and nonresponse bias affected the study findings.

Another disorder that had the highest prevalence among university and college students was depression, as reported by many researchers (Eisenberg et al., 2007; Garlow et al., 2008; Buchanan, 2012). In addition, The American College Health Association – National College Health Assessment 2009 confirmed that the most prevalent psychological disorder experienced by college students was depression. The student survey demonstrated that 14.9% (n = 11,777) of the college students reported a previous diagnosis of depression within their life and 32% of those students reported being diagnosed with depression within the previous school year. Furthermore, 24.5% of the students were receiving treatment (ACHA-NCHA, 2009).

In line with this, a study was conducted by Eisenberg et al. (2007) to estimate the percentages of depression, anxiety disorders, and suicidal thoughts among male and female undergraduate and postgraduate students at a Midwest public university in 2005. A nine- item depression measure was applied. A total of 2,843 students completed the questionnaire. The results showed that about 14% of undergraduate students showed positive screening for depression, and 11% of graduate students. The prevalence was less for panic disorder and anxiety, at approximately 4% of undergraduate students and 3.8% of graduate students. A very small number of students showed suicidal thoughts. However, the study focused on depression, anxiety and suicide and thus did not examine the full range of mental health problems prevalent in the university's student population.

Students who had severe symptoms of depression were more likely to experience suicidal ideation. Garlow et al.'s (2008) study was conducted at Emory University, Georgia, to examine suicidal ideation and depression among undergraduate students. Seven hundred and twenty-nine male and female students completed a nine-item depression questionnaire. The results found that around 29% of the students showed mild signs of depression, around 30% had moderate signs, and 6.6% had severe depression. However, approximately 16% of the students showed no depression.

A study conducted by Zivin, Eisenberg, Gollust, & Golberstein (2009) looked to address mental health problems among college students. The study sample consisted of 763 participants. A baseline survey was carried out in 2005 and a two-year follow up survey in 2007 to measure depression, anxiety, eating disorders, self-injury, and suicidal thoughts. The study findings showed that over one third of the study population had at

least one mental health problem at baseline or follow up, with highest prevalence for eating disorders (18-19%) and depression (13-15%).

A systematic review was conducted by Storrie et al. (2010) to identify emotional and/or mental health problems among university students. The review revealed that 51% of the students suffering mental health problems reported that they had the problems before attending college, while the remaining students reported that their psychological problems started while they were studying at the college. In addition, the most common problems were identified by students as being depression, anxiety, eating disorders, self-harm, and obsessive compulsive disorder.

2.3.4 Clients' Presenting Problems in Arab Countries

Most of the studies conducted on client problems in Arab countries measure the prevalence of specific disorders among university and college students. Hassan and Al-Gamaly's (2003) study aimed to indicate the prevalence of irrational thoughts and its relation with affective variables such as anxiety and depression among university students in Oman. Two hundred and four male and female students participated in this study and several questionnaires were administered. The study results found that the irrational thought prevalence among the study population was between 10.29% and 48.5%, and males had more irrational thoughts than females. In addition, the relationship between irrational thoughts and emotional disorders was statistically significant.

As well as this, Abo-Shaer (2007) conducted his study to investigate the prevalence of irrational thoughts and its relation with a number of variables among three Palestinian universities in Gaza. Four hundred and twelve male and female students took part in this

study. Two questionnaires were administrated to the study population. The researcher found that males had more irrational thoughts than females, and the percentage for irrational thoughts among the study population was between 9.4% and 48%.

One of Al-Aied's (2007) study aims was to indicate the prevalence of psychological disorders and its relation with other variables among Telmsan university students, Algeria. The study sample consisted of 640 male and female students and a 51-item emotional disorders questionnaire was administered. The study found that males were more depressed, angry, and stressed than females, but female students were more anxious.

A study carried out by Ali (2013) set out to determine the depression disorder percentage among university students in Egypt. Sixty depressed students were involved in the study, and the sample was divided into two groups: 30 students received the treatment (experimental group) and 30 students did not (control group). The Beck Depression Inventory was administered at the beginning of the treatment, at the end, and then at a follow up. The study showed that 16.25% of the students had depression.

A study was conducted by Brzawy (2017) to explore academic problems and their relation to a number of variables among students at the University of Chelf, Algeria. A 63-item questionnaire was administered to 212 male and female students. The findings showed that students reported several academic problems. Around 33% of the students reported problems related to their teachers (they did not have a good relationship with them, or their way of teaching), 28% had problems related to the university environment (such as inappropriate classes, non-cooperative students), 22% of the students had problems related to their study skills, and 20% had exam problems (they felt more

anxious during the exam period). In addition, they reported a need for counselling services and academic advisors in the university.

2.3.5 Clients Presenting Problems in Saudi Arabia

Most of the studies related to this area were conducted in Saudi Arabia and were interested in studying students' problems. It is widely known that Saudi Arabia has extremely high prevalence rates for anxiety and depression among school students (Al Otaibi, 2014).

Dubovsky (1983) reported on several client problems in Saudi Arabia. He reported cases of depression, suicide, alcoholism, and child abuse. Abdel-fattah & Asal (2006) conducted a study to determine the prevalence of depression in Saudi Arabia. They used Beck's Depression Inventory among 490 male and female students aged between 16 and 20. The study found the prevalence of depression among the study population was 22.4% as moderate, 7.3% as severe, and 3.7% as very severe.

Al-Gelban (2007) conducted a study in a secondary boys' school in Abha, Saudi Arabia. The depression, anxiety, and stress scales were administered to 1723 male students. The study findings showed that 59.4% of the study population had one of the three studied disorders (depression, anxiety and stress), 40.7% had at least two, and 22.6% had all three disorders. Furthermore, about 38% of students reported depression, while 45% had anxiety and 35.5% had stress.

Almustafa and Alsaatti (2007) conducted a study to determine young people's problems in the east of Saudi Arabia. The study sample consisted of 4670 young males aged between 18 and 24. The study found that 47.63% of the study population had problems related to their families, and 56.13% of the population had academic problems (these

problems related to the university and school environments, teachers, and administration). Furthermore, 60% of the study population reported social problems, and about 75% reported economic problems as they were worried about getting a job after graduation.

Al Gelban (2009) conducted another study to determine the prevalence of psychological symptoms in a Saudi secondary girls' school. The mental health questionnaire was addressed to 545 students between the ages of 14 and 19 years. The study found that 16.4% of the study population had phobic anxiety, and about 14.3% had anxiety. The prevalence of depression was 13.9%, interpersonal sensitivity amounted to 13.8%, and obsessive compulsive behaviour affected 12.3% of the study population.

Another study conducted by Al-Muhrg (2011) aimed to identify student problems in an educational setting in Riyadh, Saudi Arabia. A 71-item questionnaire was administered to 580 male school students to identify any psychological, academic, moral, social and family problems. The results showed that the students reported several psychological problems. However, there was a consensus between the study population about experiencing exam anxiety, and respondents added that they have never received any counselling services. In addition, they reported academic problems and most of the students agreed that they need an academic advisor in their school. Furthermore, the students reported several problems related to their families, and other social problems.

2.3.6 Conclusion

Overall, mental health problems have increased among school and university students. Depression has been the most common disorder in students' lives, as reported by many studies. However, most of the studies aimed to identify the prevalence of specific

disorders rather than identify what kind of problems that students or clients reported. Furthermore, students have reported many problems in different studies, such as academic, psychological, family, and social problems.

2.4 Client Practice-based Outcome: A Literature Review

2.4.1 Therapeutic Effectiveness

The effectiveness of counselling and psychotherapy refers to whether a course of therapy brings about the desired effect, and what difference therapy can make – did therapy make positive changes in the client's life (is it effective)? There are continuing arguments about which of those psychological orientations are more effective. Many policy-makers in mental health and psychological institutions adopt a positivist approach in determining which psychological therapies should be recommended or implemented for distressed clients, such as the United Kingdom's National Institute of Health and Clinical Excellence (NICE) (Cooper, 2008). They recommend using a psychological treatment that has proven value. In the United States; however, therapy can only be considered 'efficacious' if it has been shown to be more useful than no treatment (Cooper, 2008) or to some other treatment, on the assumption that some psychological therapies are more effective than others. Cognitive behavioural therapy (CBT) is commonly regarded as more efficacious and there is much evidence supporting the efficacy of this treatment for a wide variety of psychological difficulties, especially in reducing anxiety (Al-Ghamdi, 2010). It is the most studied form of psychotherapy, with hundreds of randomised outcome trials illustrating its clinical efficacy and effectiveness (Waltman & Sokol, 2017). However, fewer studies have been conducted to examine the efficacy of person-centred therapy (PCT) and psychodynamic

therapy (PDT) treatments (but see Stiles et al., 2006). By contrast, Holmes (2002) argues that CBT has been oversold, and has gained more attention by researchers to be studied as an effective therapy than other therapies or approaches. A similar view is shared by Lambert (2013), who reports that CBT has been studied most often and extensively and showed to be highly effective in reducing anxiety, however, there is evidence for other therapies as well. In other words, this has led to CBT being seen by policy-makers as more effective for treating several psychological disorders, with psychodynamic therapy and person-centred therapy being commonly seen as less effective or effective for a narrower range of disorders (Cooper, 2008).

Some researchers (e.g. Bernes, 2005) have summarised important points to make therapies effective. Therapies seek to:

- Disrupt symptoms or remove symptoms.
- Promote and enhance the capacity/strength of the clients.
- Enhance tolerance for emotional experience.

In Western countries, to prove there are no differences between these three approaches, a published study was conducted by Luborsky, McLellan, Woody, O'Brien, and Auerbach (1985) to evaluate the efficacy of three counselling treatments. Nine therapists participated in this study: three therapists applied supportive-expressive therapy, three provided cognitive behavioural therapy, and three therapists delivered drug counselling. The study findings confirmed that all three treatments were effective. As reported by Seligman (1995), many studies show that cognitive behavioural therapy, interpersonal therapy and medication have been shown to be effective treatments with specific client problems; for instance, interpersonal therapy and

medications have been shown to be effective with depressive disorder, obsessive compulsive disorder and have also worked well with panic disorder.

In line with this, Stiles et al. (2006) conducted a study at 58 NHS sites delivering counselling and psychotherapy services. Therapists were asked to indicate the types of therapies used with the clients, and therapists were provided three approaches: cognitive behavioural therapy, psychodynamic therapy, and person-centred therapy. The result showed that all three approaches appeared to be effective. Similar study findings from Barkham et al. (1996) confirmed that cognitive behavioural therapy and psychodynamic therapy showed similarly efficacious results in dealing with depressed clients; this means there was no difference between these two approaches in helping depressed clients to make progress.

In Arab countries including Saudi Arabia, many scientific studies conducted in the counselling and psychotherapy field examine the effectiveness of specific therapies with specific psychological disorders, known as the "*single-disorder*" protocols (Waltman & Sokol, 2017). Some researchers were interested in examining reality therapy in reducing depression, while others were applying cognitive behavioural therapy or rational-emotive therapy in reducing anxiety symptoms. Al-Saqhan (2005) found that rational-emotive therapy showed positive effects in decreasing anxiety and irrational thoughts in addicted patients at King Fahad Hospital, Saudi Arabia.

Another study was conducted by Al-Ghamdi (2010) to examine the effectiveness of cognitive behavioural therapy in reducing anxiety disorder in 20 clients. Participants were divided into two groups: 10 clients received CBT (experimental group) and the other 10 clients took medication (control group) at Al-Taif Mental Health Hospital,

Saudi Arabia. The study results showed that there were differences between the average of anxiety scale before and after CBT treatment.

Al-Sayed's (2010) study examined the effectiveness of reality therapy in reducing depression among students in Almansora University, Egypt. The study sample consisted of 18 students. The Beck Depression Inventory was administered. The results found that reality therapy showed positive effects in reducing depression.

In addition, Al-Hmad and Al-Momny (2014) conducted a study to identify the efficacy of reality therapy in reducing depression disorder. The study sample consisted of 19 students aged between 16 and 17. The study findings showed that reality therapy had a positive effect in reducing depression.

Further study was conducted by Naji (2016) to evaluate the effectiveness of cognitive behavioural therapy in improving self-esteem and reducing depression. Forty four depressed clients at a Khartoum psychiatric unit took part in this study. The study findings indicated that cognitive behavioural therapy had a positive impact in reducing depression and improving self-esteem among the study population.

A study was conducted by Hanour (2016) to examine the effectiveness of behavioural therapy and cognitive therapy in reducing obsessive compulsive disorder among King Abdul Aziz university students in Jeddah, Saudi Arabia. The study sample consisted of 24 students who were divided into four groups [three experimental groups of six students (the first group received behavioural therapy, the second group received cognitive therapy, and the third group received both treatments), and one control group of six students] who suffered from obsessive compulsive disorder. An obsessive compulsive scale and a diagnostic interview were administered. The results indicated

that both the behavioural therapy and cognitive therapy treatments showed positive effects in reducing obsessive compulsive disorder among the study population.

In line with this, Alshemmari (2017) conducted his study on 20 clients at Hafer Albaten mental health hospital, Saudi Arabia, to examine the effectiveness of cognitive behavioural therapy in decreasing depression levels. The study showed that cognitive behavioural therapy appeared to have an impact on reducing depression.

2.4.2 Counselling Evaluation Methods: A Methodological Review

Counselling and psychotherapy outcome mental health services research uses many data collection methods. These methods or instruments aim to assess the worth of a service. There are many outcome measures available to counsellors and therapists but for research to be valuable it needs to be easily replicated and compared with other studies (Vossler & Moller, 2015). The term 'evaluation' or its process has been identified by many researchers, as in the following descriptions.

Scriven (1972) classified evaluation into formative and summative approaches:

> *A formative evaluation is typically used for internal program purposes, and feeds back its results to influence the service as it continues to develop (or form itself). A summative evaluation provides an overall summary, typically for administrative purposes; it is often done on a larger scale with its results delayed until after the end of the evaluation period. Formative evaluations thus lend themselves to evaluating new services; while summative evaluations lend themselves to well-established ones* (Barker et al., 2016, p.200).

It also was defined by Mair (2016, p.88):

> *Evaluation is typically undertaken to demonstrate the effectiveness of services provision and has traditionally relied upon client outcome data without*

references to the kind of contextual data (e.g. presenting problems, length of therapy, types of ending etc.).

In the 1990s there was considerable focus on quantitative outcome assessments to measure the effectiveness of therapeutic strategies (Lambert, 2004) within a broadly positivist or critical-realist approach to research. Most of the early evaluation research was done in the United States in an education context. There are several methods to evaluate client changes in the therapeutic relationship. However, counsellors were less likely to use an evaluation method in order to assess their clients' changes in therapy. A study was conducted by Mellor-Clark and Barkham (2000) to demonstrate the prevalence of counsellors who use an evaluation activity. Seven hundred counsellors in primary care in the United Kingdom completed a survey on audit and evaluation activity. The results showed that approximately 62% of the counsellors were engaged in some form of monitoring or observation activity. However, the client satisfaction measures were the most common form of evaluation, being used by 46% of counsellors. Furthermore, about 30% of the counsellors designed outcome measures for themselves, while only a small number of counsellors (15%) were interested in evaluating the effectiveness of their counselling with published and validated measures.

Other researchers such as Wilson (1970) evaluated the effectiveness of counselling services by using a follow up study and counsellor opinion. He used five criteria of effectiveness: the student's ability to understand his/her personal problems, the student's motivation for change, the positive change, the benefit that the student felt from the counselling, and the counsellors' view of client improvement. Other researchers conducted a questionnaire after two years of counselling sessions using students' opinion to evaluate the effectiveness of the counselling received (Milner,

1974); this means a questionnaire or any related assessment that clients complete in order to obtain evidence of their experiences and concerns in relation to health status 'quality of life' and the results of treatment received. Client-based outcome measures have been developed to provide a variety of different functions (R Fitzpatrick, Davey, Buxton, & Jones, 1998). The third method has been used to evaluate client change based on some kind of objective measures such as a personality test (Milner, 1974); for example, the Beck Depression Inventory was commonly used by many researchers as an evaluation measure. Measuring the effectiveness of counselling treatment typically involves using valid and reliable clinical assessment pre- and post-counselling (Hodges et al., 2017). These assessments are used to compare the client level before and after the counselling sessions. For instance, the Clinical Outcome in Routine Evaluation Outcome Measure (CORE-OM), which is the most popular measure of global psychological distress in the United Kingdom, was designed for generic use across a wide range of psychological therapy professions and settings. It is a 34-item client self-report measure that assesses psychological distress; it is usually administered to clients at the first session and again at the last counselling session (John Mellor-Clark, Connell, & Cummins, 2001). Stiles et al. (2006) conducted a study on 1309 clients seen in primary and secondary care settings. The CORE-OM self-report measure was used in order to evaluate the clients' changes before and after a course of therapy. The findings showed that the average CORE-OM scores decreased from 1.74 pre-therapy to 0.8 post-therapy.

Other researchers, following a more control-oriented, positivist approach to research have asserted that to obtain a valid estimation and to be certain that therapy and no other factor is responsible for the changes, it is necessary to compare changes in therapy

(experimental group or clients who have undergone therapy) with changes in a similar group who have not received therapy (control group) (Cooper, 2008). Comparisons are made between clients who received counselling (treatment condition) and a no-treatment control group. In terms of deterioration effects estimation, Lilienfeld (2007), for example, has argued that the most valid estimates of deterioration effects can be obtained from comparisons of randomly assigned treatment and non-treatment groups.

Observation was another method used by some counsellors and therapists in order to evaluate their client's changes in therapy. As reported by Mellor-Clark and Barkham (2000), about 62% of the counsellors observed client changes and improvements during their counselling session. As well as this, a study was conducted by Aldileym (2004) to explore the nature of psychological evaluation methods used by counsellors in 162 schools in three different regions of Saudi Arabia. The results found that over 90% of counsellors stated that they used interviews, autobiographical reports, and observation as outcome evaluation methods. Moreover, 80% of counsellors believed that testing and measurement tools are important for counselling work.

2.4.3 Effectiveness of Counselling and Psychotherapy

The effectiveness of counselling and psychotherapy determines the actual difference that therapy makes (Cooper, 2008). Effectiveness research is described by Sternberg, Roediger, and Halpern (2007):

> *An effectiveness study is one that considers the outcome of psychological treatment, as it is delivered in real- world setting. Effectiveness studies can be methodologically rigorous in the sense that careful procedures are employed to identify the nature of the client's problems and to measure changes in their*

> *adjustment during the course of treatment, but they do not include random assignment to treatment conditions or placebo control groups* (p.208).

Counselling and psychotherapy have been shown to be effective in treating various kinds of psychological disorders such as anxiety, depression, marriage issues, and substance abuse (Wampold et al., 1997). However, not everything a counsellor does in the counselling session is effective or has a positive impact on client changes (Milner, 1974). While most clients improve as a result of counselling and psychotherapy, there is significant minority who do not (Cooper, 2008); in other words, some clients make positive changes by the end of the therapy while other clients get worse. This standpoint is consistent with Vossler and Moller's (2015) view of therapists' perception of their own work:

> *Many trainees or practising therapists may feel that they already have a good insight into their client's experiences, and their clients benefit from their works. However, there is evidence that counsellors and therapists are in fact not always good at judging their work or how clients experience it* (p.11).

The literature validating treatment and investigating evidence-based practice in universities is just beginning to emerge (Hodges et al., 2017). Unfortunately, there has been no study conducted in Saudi Arabia to measure or evaluate the effectiveness of counselling services in the country. For this reason, this section presents a review of literature from other countries.

On one hand, most clients seem to get better and improve with counselling and psychotherapy. A study by King et al. (1994) involved 24 male and female clients with psychological problems (19 clients were referred to a counsellor and five remained with the general practitioner and received a controlled trial). Twenty-two clients were

followed up at 12 weeks and 20 at six weeks. Clinical interviews and three self-report measures (the 28-item general health questionnaire, the Beck Depression Inventory, and the social problems questionnaire) were administered to the clients at the beginning, at 12 weeks, and then again at six months. The study findings showed that clients who remained with the general practitioner showed greater improvements in their scores than those with a counsellor. Although the study results showed that the counselling was helpful overall, two clients reported wishing they had never started the counselling.

Another study was conducted by Vonk (1996) to evaluate the effectiveness of short-term treatment at a counselling centre in Emory University, Georgia. Fifty-five clients took part; forty-four clients completed the questionnaire at the intake session and after the treatment. The other 14 clients who were in the wait/delayed treatment group were tested at intake, after waiting a minimum of 21 days for treatment, and then after delayed treatment. The study found that there was a statistically significant decrease in psychological symptoms before and after the treatment group as compared to the delayed treatment group. Furthermore, the results showed that the short-term counselling provided at the university counselling centre was effective. However, the study did not identify which treatments had been used with the clients, and the researcher considered that the unspecified short-term counselling can provide a closer approximation to real life counselling.

A similar study was conducted by Ward et al. (2000) to compare the effectiveness of general practitioner care and two general practice-based psychological therapies. The researchers used the Beck Depression Inventory and other assessments on 464 depressed and anxious clients in London and Manchester at referral and at four and 12 months later. Clients were divided into three groups: one group received cognitive

behavioural therapy, non-directive counselling was provided with second group, and the third group received usual general practitioner care. The study findings indicated that all groups improved over time. However, at four months, clients who received cognitive behaviour therapy showed more of an improvement. But at 12 months, there were no significant differences between the three treatment groups.

A ‘counselling outcomes in primary health care’ study was conducted by Mellor-Clark et al. (2001). Data were collected at nine counselling services in the United Kingdom, using the CORE system as an evaluation measure. The results showed that counselling was an effective treatment for three quarters of the clients at the nine counselling services. Furthermore, 76% of the sample made a statistically reliable change; this included 59% of the clients who made a reliable and clinically significant change, while 17% of the sample reported non-reliable change and 1.5% of the clients showed deterioration. Furthermore, the clients who were represented in that data set did not constitute a population that might be considered as the ‘worried well’; 76% of the participants scored above or at the clinical cut- off levels at the intake (first session).

A study was conducted by Baker et al. (2002) to evaluate the effectiveness of counselling in a primary care setting during three months, and followed up the clients’ progress after the counselling. Questionnaires were completed by the clients within Dorset Primary Care counselling services. The client group (who received counselling) was compared to a waiting-list group at baseline and three months. The study found that clients showed improvement and positive changes in the first three months. At six months follow up, the clients who received the counselling made further improvements.

A systematic review was conducted in 'The Effectiveness of Counselling in Primary Care' by Bower, Rowland, and Hardy (2003). Seven relevant studies were considered, comparing counselling in primary care with usual general practitioner care (GP or alternative mental health treatments) in the United Kingdom. The review indicated that counselling showed greater efficacy at reducing psychological symptoms in the short term compared with usual general practitioner care. Furthermore, over one third of clients in the counselling group showed reliable and clinically significant change compared to one fifth of those in usual care. However, these calculations were dependent on the choice of referent population, the measure of reliability used, adjustment of regression to the mean and the baseline levels of functioning, and the use of intention to treat samples.

In line with this, The British Association for Counselling and Psychotherapy confirmed the usefulness of counselling services, and reported that counsellors have perceived clients as having improved and changed in their experience of themselves or their relationships. Moreover, counselling was found to be useful.

Data were collected during a three-year period from six groups (n = 1309 clients) at 58 NHS sites delivering counselling and psychotherapy services. Three groups received cognitive behavioural therapy, person-centred therapy and psychodynamic therapy only, and three groups were treated with one of these treatments plus one additional approach (e.g. integrative, supportive, or art therapy). The CORE-OM was administered at the beginning of the counselling and then again at the end. The study findings showed that all the six groups showed improvement. However, this study was limited by not randomising the assignment to groups and by the lack of a control group (Stiles et al., 2006).

Of greater relevance to the present study, another outcome study was conducted by Connell, Barkham, and Mellor-Clark (2008) to examine the effectiveness of seven UK student counselling services. The Clinical Outcome in Routine Evaluation-Outcome Measure (CORE-OM) and the Clinical Outcomes in Routine Evaluation-Assessment (CORE-A) were used. The total sample consisted of 846 clients, however, CORE-OM pre- and post-therapy outcome data were available for 323 clients. The CORE forms were completed by students who were attending for psychological assessment at the intake session or at the first and then at the end of the counselling services. The result indicated that the rate of reliable and clinical improvement for the total sample showed that about half (50%) of the clients achieved reliable and clinical significant improvement, and 71% made reliable improvement. In addition, the highest service rate of clients achieving reliable improvement was 82% compared with 66% for the lowest. Overall, the results showed that counselling was effective for clients who completed a course of counselling or came to an agreed ending to therapy. However, the data were not available for 36% of clients who came to therapy, and pre- and post-therapy practitioner severity ratings were not available for 45% of clients.

A recent study was conducted by Choi, Buskey, and Johnson (2010) on 78 students to examine the impact and the usefulness of the counselling they received. The researchers applied pre- and post-surveys, including the Outcome Questionnaire – 45 (OQ-45) developed by Lambert et al. (1996), to assess the efficacy of clinical interventions of clients in therapy. It includes three domains related to mental health: subjective discomfort, interpersonal relations and social role performance. The results indicated that students who showed reliable and significant change reported the highest level of

improvement in academic commitment and problem solving compared with students who did not show clinical change.

On the other hand, some counselling and psychotherapy outcome studies' findings demonstrate that not all therapies are equally efficacious; this means some clients seem to get worse from therapy. Many early studies reported rates of deterioration in clients, even in those who participated in carefully controlled research protocols (Lambert, 2013). A total of 31 psychotherapy outcome studies reporting negative effects were reviewed and it was found that, whereas fewer than 5% of control clients were worse at post-treatment, 10% of clients who underwent therapy deteriorated (Levy et al., 1996). The literature on deterioration effects estimates that between 5% and 10% of clients become worse after psychotherapy (Lilienfeld, 2007). Another study showed a similar result, where around 36% of 154 male and female clients indicated that there was something harmful or problematic about their therapy (Levy et al., 1996). In contrast, results was obtained in (Hansen, Lambert, & Forman, 2002) study which showed that about a third of 2109 clients reported no benefit or feeling worse after treatment; however, about two thirds of the clients showed positive change.

2.4.4 Conclusion

Overall, in the context of therapeutic efficacy, in Western countries, much research shows that there are no differences between therapies (CBT, PCT, or PDT) in reducing psychological disorders. However, cognitive behavioural therapy (CBT) appears to be more efficacious in decreasing psychological disorders, especially depression. The reason for this is that CBT has gained more attention from researchers in examining its efficacy, especially in reducing depression, while only a small number of researchers have been interested in examining the other counselling and psychotherapy approaches

such as PCT and PDT. There is evidence showed that the Humanistic Experiential Psychotherapies have been found to be practically and statistically equivalent to CBT in effectiveness (Elliott, Greenberg, Watson, Timulak, & Freire, 2013). In addition, the person-centred approach can be applied to working with individuals, groups and families (Corey, 2005). The person-centred approach has been successful in treating problems including anxiety disorders, alcoholism, psychosomatic problems, agoraphobia, interpersonal difficulties, depression, and personality disorders (Corey, 2005).. Furthermore, most researchers were interested in examining the efficacy of a specific therapy in reducing specific disorders. As well as in Arab countries and specially in Saudi Arabia, many researchers were more interested in examine the efficacy of the CBT in reducing specific problems, while, there were few studies examining the effectiveness of other counselling approaches.

In terms of evaluation methods, in Western countries, researchers have used a wide variety of methods to evaluate the client changes. The most common method used by many researchers was a self-report outcome measure (e.g. the CORE-OM, Beck's Depression Inventory, etc.) and these are used to evaluate the client's changes at the beginning (at intake) of the counselling and then again at the end of the course of therapy. In Saudi Arabia, little is known about the evaluation methods that can be used to evaluate the counselling services; I found one study which indicated that counsellors used interviews, autobiographical reports, and observation as outcome evaluation methods.

Finally, in terms of the effectiveness of counselling and psychotherapy, most studies in this area show that counselling is effective and the clients observed in many studies seemed to get better in therapy and made improvements. However, there were some

studies which showed that a small number of clients got worse after a course of counselling. In Arab countries and Saudi Arabia, it seems that researchers were interested in doing research in the therapeutic efficacy by applied specific counselling approach in reducing specific psychological problem such as anxiety and compared client scores before and after the treatment.

This chapter reviewed literature related to the qualitative counselling services study and client practice-based outcome study. Next chapter will present the research methodology before moving to address the two research studies.

Chapter 3 Research Methodology

3.1 Research Design

After the literature was reviewed on the counselling and psychotherapy field in Saudi Arabia, it was noted that researchers used different designs to answer their research questions: some researchers used qualitative approaches, others used quantitative approaches, and some of them combined the two approaches into either a single study or in multiple studies in a sustained programme of inquiry.

In addition, it was noted that there is no single study defining how counselling centres at Saudi Arabia's universities work, and their effectiveness. Consequently, this current research was conducted. It contains two studies within an overall mixed methods design as these studies are considered to be complementary to each other in order to answer the related research questions: 'How do the counselling services at the Princes Nourah bint Abdulrahman University work?' (qualitative study) and 'Are the services provided at the counselling centre effective?' (quantitative study).

3.2 Mixed Methods

3.2.1 General research strategy in this dissertation

A combination of forms of data provides the most complete analysis of a research problem. It has been defined as "*a type of research design in which qualitative and quantitative approaches are used in types of questions, research methods, data collection and analysis procedures, and/ or inferences*" (Tashakkori & Teddlie, 2003, p.711). Another definition of mixed methods research is:

> *An approach to research in the social, behavioural, and health sciences in which the investigator gather both quantitative (closed-ended) and qualitative (open-ended)*

data, integrates the two, and then draws interpretations based on the combined strengths of both sets of data to understand research problems (Creswell, 2014, p.2).

Underlying mixed model research is the assumption that it is possible to have two worldviews, or paradigms, mixed throughout a single research project. There may be multiple research questions, each grounded in a distinct paradigm, and there might be multiple inferences relating to different worldviews (Pole, 2007, p.2).

Mixed methods research has emerged as a separate orientation during the past 20 years. There is increased use of mixed methods in different disciplines and in many countries around the word (Creswell & Plano Clark, 2011). A number of factors have contributed to the evolution of this approach, including the complexity that comes with the need for answers beyond either numbers in a quantitative sense, or words in a qualitative sense. Different typologies of mixed methods design have been proposed. Schoonenboom and Johnson (2017) summarise Creswell and Plano Clark's (2011) typology of some mixed methods designs as follows:

- Convergent parallel design: the quantitative and qualitative strands of the research are performed independently, and their results are brought together in the overall interpretation.
- Explanatory sequential design: a first phase of quantitative data collection and analysis is followed by the collection of qualitative data, which are used to explain the initial quantitative results.
- Exploratory sequential design: a first phase of qualitative data collection and analysis is followed by the collection of quantitative data to test or generalise the initial qualitative results.
- Embedded design: in a traditional qualitative or quantitative design, a strand of the other type is added to enhance the overall design.

- Transformative design: a transformative theoretical framework, e. g. feminism or critical race theory, shapes the interaction, priority, timing and mixing of the qualitative and quantitative strands.
- Multiphase design: more than two phases or both sequential and concurrent strands are combined over a period of time within a programme of study addressing an overall program objective (Schoonenboom & Johnson, 2017, p.112).

There is much debate in using mixed methods design; some writers argue that the qualitative and quantitative approaches are so different in their philosophical and methodological origins that they cannot be effectively blended (Ritchie & Lewis, 2003). Moreover, some researchers may see it as a new approach and others feel that they do not have time to learn a new approach (Creswell & Plano Clark, 2011). Others, while recognising the very different ontological and epistemological bases of the two paradigms, suggest that there can be value in combining the two approaches together (Ritchie & Lewis, 2003). On the other hand, many researchers recognise mixed methods as an accessible approach to inquiry. There are research questions that can best be answered using mixed methods and these researchers see the value of using this strategy (Creswell & Plano Clark, 2011). Each approach provides a distinctive kind of evidence, and used together they can offer a powerful resource to inform and illuminate policy and practice. Combining qualitative and quantitative approaches can provide a deeper, broader understanding of the phenomena. Another advantage is the integration component; mixed methods give readers more confidence in the results and the conclusions they draw from a study. It also helps researchers cultivate ideas for future research. Furthermore, it can be the best way to enhance confidence in findings and interpretations (McKim, 2017). Greene, Caracelli and Graham (1989) categorise the following five general purposes of using mixed methods: (1) *triangulation* seeks convergence, corroboration, correspondence

of findings from different methods that study the same phenomenon in order to increase the validity of constructs and inquiry; (2) *complementarity* seeks elaboration, illustration, enhancement, and clarification of the findings from one method with results from the other method, to increase the interpretability, meaningfulness and validity of constructs and inquiry results; (3) *development* using the findings from one method to help develop the other method; (4) *initiation* seeks to discover paradoxes and contradictions that lead to a re-framing of the research question; and (5) *expansion* seeks to extend the breadth and range of inquiry by using different methods for different inquiry components to increase the scope of inquiry by selecting the methods most appropriate for multiple inquiry components. In other words, researchers use mixed methods for several reasons when one data source may be insufficient; therefore the combination of quantitative and qualitative data provides a more complete understanding and explanation of the research problem and findings. Another reason for using mixed methods is that researchers need to generalise the findings by beginning with a qualitative phase to explore, then following up with a quantitative phase to test whether the qualitative findings are generalisable. In addition, the findings of a study may provide incomplete understanding of a research problem and it is necessary for further explanation. Other researchers use this design in order to pursue a research objective through multiple research phases. Moreover, it may be used when a situation exists whereby a theoretical perspective provides a framework for gathering both qualitative and quantitative data (Creswell & Plano Clark, 2011).

However, a mixed methods approach can present researchers with some challenges; it is not the answer to every researcher's research problem. It has sometimes been seen as problematic because of the views that qualitative and quantitative belong to separate paradigms. In contrast, combining both approaches can address the research equation

effectively (Tariq & Woodman, 2013). A further limitation of integrating both approaches is that using mixed methods requires more different skills and requires more resources and time for data collection and analysis. Mixed methods is a realistic approach wherein the researcher needs to gain experience with both qualitative and quantitative research separately and be familiar at least with the common methods of collecting quantitative data, interpreting statistical analyses and understanding the essential issues of rigour including validity, reliability and generalisability (Creswell & Plano Clark, 2011). This means it works better with a team rather than a lone researcher in order to conduct the study rigorously and within the specific time frame. It also requires innovative thinking to move between two different types of data and make meaningful links between them (Tariq & Woodman, 2013).

On the other hand, using mixed methods helps the investigators to develop a conceptual framework, and to validate quantitative findings by linking the information extracted from the qualitative phase of the study (Onwuegbuzie & Leech, 2004). Therefore, it is important to reflect on the study findings and make sure they provide an enriched understanding. Another challenge or limitation in using mixed methods is that researchers face difficulty in presenting the findings of a mixed methods study, and this may lead some researchers to present each set of data separately. However, as the number of mixed methods studies increases in the counselling and psychotherapy research literature, this should enable researchers to feel more confident in the presentation of this kind of work (Tariq & Woodman, 2013).

Qualitative and quantitative methods can be used in tandem to study the same or related phenomena in the same field of enquiry. They might also be applied to the same participants or to different participants depending on the purpose of the research (Ritchie &

Lewis, 2003). Also, they might answer different or separate questions; sometimes researchers are looking for different sets of research questions which are broadly related to the same overall topic (Mason, 2006). In the current research, I used a mixed methods design using complementary qualitative and quantitative approaches in the same broad area of investigation. This research included two separate phases/studies, answered two different questions, and was applied to different participants, but these were related to the same area of investigation (investigating a university counselling centre service). Each part of the study has its own logic of design, data generation, analysis and explanation, and these ran in parallel. This approach overall is essentially based on the idea of the co-presence of multiple methods, rather than their integration (Mason, 2006, p.5). A mixed methods design was used in the current study in order to provide a comprehensive picture of the nature of the university counselling centre and its effectiveness, and each approach was applied to different participants (therapists and clients). As we know there are often occasions where the context or consequences need to be understood at deeper level and for which qualitative investigation is needed (Ritchie & Lewis, 2003). Qualitative data provided a detailed understanding of problems as such as 'what kind of services do therapists provide at the counselling centre?' while quantitative data answered specific questions/hypotheses (Creswell, 2014), specifically, 'how much do clients at the counselling centre change?'. Both approaches followed the general process of research: identify the research problem, determine its questions, gather data, analyse data, and interpret findings (John, 2014). It can therefore be useful to apply both approaches to investigate underlying factors (the nature of the counselling services provided by therapists at the university counselling centre) that may be causing phenomena (clients change over a course of therapy) to occur.

In conclusion, the use of qualitative and quantitative approaches has increased in different disciplines and researchers are using them for different purposes and reasons. Integrating qualitative and quantitative approaches may provide deeper and broader understanding of a study phenomenon, they provide different pictures or perspectives, and each has its strengths and limitations (Creswell & Plano Clark, 2011) as identified later in this chapter. However, researchers may face various challenges in adopting a mixed methods approach.

3.2.2 Evaluation Criteria for Mixed Methods Research

The growth of mixed methods research and especially qualitative research represents one of the reasons for the growing interest in research quality criteria (Bryman, Becker, & Sempik, 2008). It is widely accepted that the quality of a study may affect its results (Liebherz, Schmidt, & Rabung, 2016). There are many commonalities in evaluation criteria between qualitative and quantitative approaches that address aspects of good research practice. These include seven criteria proposed by Elliott, Fischer and Rennie (1999): first, explicit scientific context and purpose, addressing the relationship of the study to relevant literature and stating the intended purposes or questions of the study. Second, using appropriate methods that are responsive to the research questions and purpose. Third, respect for participants; that is informed consent, confidentiality, social responsibility, and ethical research conduct. Fourth, specification of methods, including data collection, organisation and analysis procedures to be reported by the researcher. Fifth, appropriate discussion of implications of research data, and understandings are discussed in terms of their contribution to theory, content, method, and/or practical domains to be presented in appropriately tentative and contextualised terms with limitations acknowledged. Sixth, clarity of writing. Finally, seventh is contribution to knowledge. These criteria are clearly common to both quantitative and qualitative research,

and thus to mixed methods studies that combined both. However, there are in addition some evaluation criteria more specific to qualitative research while other criteria are specific to quantitative research (see two sections below: qualitative and quantitative research criteria, sections 3.3.1 and 3.4.1).

3.3 Qualitative Research

Qualitative research has become gradually more powerful within education, social science and healthcare research. It is a research strategy that usually emphasises words rather than numbers in the gathering and analysis of data (Bryman, 2008). It often involves the collection of people's experiences, views and opinions in their own words, so that researchers can attempt to understand and discover how the world is experienced by people. Because qualitative research can be linked to the therapy process, counsellors and therapists are often drawn to it (Vossler & Moller, 2015). The purpose of qualitative research is to enhance knowledge, specifically to enable the researcher to know more about the way counselling and psychotherapy operate (McLeod, 2011). It is the best method to use when researchers want to describe phenomena and look at specific details. It offers a set of flexible and sensitive methods for opening up the meanings of areas of social life. The main distinctive feature of qualitative research is that it is phenomenological, allowing the researcher to identify issues from the perspective of the study participants and understand meanings and interpretations that they give to behaviour, events or objects. In addition, it studies people in their natural settings to determine how their experience and behaviour are shaped. It is also seeks to embrace and understand the contextual influences on the research issues (McLeod, 2011). A wide variety of methods are employed when collecting data in qualitative research, such as in-depth interviews, focus group

discussions, and observation – each method has its own advantages and disadvantages (McLeod, 2003).

In recent years, around 10-20% of research studies into counselling and psychotherapy have used qualitative methods (McLeod, 2015). However, fewer qualitative studies have been published in the field of counselling and psychotherapy compared to the number of quantitative studies. Counsellors and psychotherapists are often drawn to qualitative research because its processes can be linked to therapy (Vossler & Moller, 2015) and most of qualitative researchers in the counselling and psychotherapy field aim to generate new knowledge and understanding of therapy process or outcome, or the role of therapy in society. Therefore, a qualitative approach was considered to be useful for obtaining data about university counselling centre services in Saudi Arabia. According to Agnew and Pyke (1994), "*if the purpose of the research is to describe or understand rather than predict and control, qualitative methods may be most appropriate*". A semi-structured interview was conducted to collect relevant qualitative data.

3.3.1 Evaluation Criteria for Qualitative Research

In addition to the evaluation criteria that are subject to both qualitative and quantitative approaches, there are seven criteria more specific to evaluate the quality of qualitative research in psychology, as outlined by Elliott, Fischer and Rennie (1999). These include:

1. Owning one's perspective: Researchers specify their theoretical orientations and personal anticipations, both as known in advance and as they became apparent during the research. Developing and communicating their understanding of the phenomenon under study (p.221).
2. Situating the sample: Describe the research participants and their life circumstances to aid the reader in judging the range of people and situations to which the findings might be relevant (p.221).

3. Grounding in examples: Provide examples of the data to illustrate both the analytic procedures used in the study and the understanding developed in the light of them (p.222).
4. Providing credibility checks: Researchers may use any of several methods for checking the credibility of their categories, themes or accounts (p.222).
5. Coherence: The understanding is represented in a way that achieves coherence and integration while preserving nuances in the data (p.223).
6. Accomplishing general vs. specific research tasks: Where a general understanding of a phenomenon is intended, it is based on an appropriate range of instances (informants or situations). Where understanding a specific instance or case is the goal, it has been studied and described systematically and comprehensively enough to provide the reader a basis for attaining that understanding (p.223).
7. Resonating with readers: The material is presented in such a way that readers/ reviewers understand, taking all other guidelines into account (p.224).

3.4 Quantitative Research

Quantitative research is "*explaining phenomena by collecting numerical data that are analysed using mathematically based methods (in particular statistics*)" (Muijs, 2011). The purpose of this more positivist or critical realist approach is to quantify a research problem, to measure and count issues and then generalise these findings to a broader population, such as female clients seen in Saudi universities. Quantitative data consists of information about some aspect of human experience or some personal attribute that has been transformed into numbers (McLeod, 2013). This approach measures variables to facilitate the findings of answers, uses statistical analysis to gather information in order to answer the research questions/hypotheses, and then makes an interpretation of the findings (Creswell, 2014). Researchers using this approach identify one or a few variables that they intend to use in their research work and proceed with data collection related to those

variables. It always begins with data collection based on a hypothesis or theory, and it is followed with the application of descriptive or inferential statistics. Data can be collected in this approach using several methods, such as questionnaires and observations.

This approach was considered to be useful in collecting data to evaluate university counselling services in Saudi Arabia. A self-report measure was conducted in this outcome study.

3.4.1 Evaluation Criteria for Quantitative Psychotherapy (Outcome) Research

This section provides the quality criteria that are relevant to the field of psychotherapy research. These include criteria that address general quality aspects, internal validity and external validity, as defined by Liebherz et al. (2016). I will consider criteria that are relevant to evaluating quantitative outcome studies:

1. Numbers of dropouts reported for termination and follow-up.
2. Inclusion and exclusion criteria specified.
3. Reliable and valid assessment of (at least) the primary outcome measures.
4. Numbers of excluded patients and refusals reported.
5. Problem/research question clearly stated.
6. Period of investigation (dates defining the period of recruitment and follow-up) specified.
7. Study design described.
8. Description of sample provided.
9. Treatment group and measurement times are predefined.
10. Measurement times appropriate for capturing the intervention's effect (between pre and post).
11. Results reported include data necessary for reanalyses (e.g., means and standard deviations).
12. Primary outcomes are patient relevant (e.g., quality of life and subjective impairment) how the measure relate to the culture.

13. Limitations of the study (e.g., potential sources of bias, imprecision and multiplicity of analyses) discussed.
14. Important changes of study design after the start of trial reported.
15. Presentation complete, clear, and structured.
16. Reporting of null and negative findings included.
17. Study design suitable answering the researcher's question.
18. Direction of effects identifiable for all important outcomes (eg, higher is better).
19. Outcome measures described clearly (including specification of application format, e.g., self vs. observer-rated, and psychometric properties).
20. Numbers of subjects screened reported.
21. Statistical methods used reported.
22. Power sufficient to detect a clinically important effect (between pre & post).
23. Reasons for end or stopping of trial reported (enough participant- not enough time).
24. Main results summarised with regard to the objectives of the study.
25. Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence (pp.584-585).

I did not consider the following criteria because these are not relevant to my study; these quality criteria are more relevant to group studies and healthcare research:

1. Method of allocating patients to termination and follow up.
2. Primary and secondary outcomes defined a priori.
3. Observers external and blinded to study condition (if observer-rated instruments were used).
4. Subjects blinded.
5. Intention-to-treat analyses performed.
6. Interventions (in experimental and control group, if applicable) operationalized, for example, by a manual or a detailed description allowing replication.
7. Randomized intervention assignment concealed.
8. Results reported separately for subgroups.
9. If randomization is indicated to answer the research question: Randomization described as methodologically solid. If randomization is not meaningful with regard to the research question: Comparison groups adequately selected and composite.

10. Characteristics of disorder and relevant comorbidity reported.
11. Comparability of groups being described, statistics reported.
12. Handling of loss to follow-up, if any, described.
13. Statistical tests appropriate (e.g., correction for multiple testing and adjustment for confounders).
14. Reasons for end or stopping of trial reported.
15. Unit of group assignment reported (e.g., individual, group, and community).

3.5 Methods of Data Collection

The phenomena involved in counselling and psychotherapy are complex, elusive and sensitive (McLeod, 2011, p.71). It is important to recognise that there are several ways of collecting information about these phenomena, and interviews and questionnaires are often used together in mixed methods studies (Harris & Brown, 2010). Qualitative interviewing is a flexible and familiar method of gathering people's views (McLeod, 2011), providing more in-depth insights into their attitudes, thoughts and actions, while questionnaires can provide evidence of patterns among large populations (Harris & Brown, 2010).

3.5.1 Semi-Structured Interviews

"*[A qualitative interview] is defined as an interview with the purpose of obtaining descriptions of the life world of the interviewee in order to interpret the meaning of the described phenomena*" (Kvale & Brinkmann, 2008, p.3). Interviewing has today become a key method in the human and social sciences and is a common technique used in qualitative research (McLeod, 2003). It is a one-to-one method of data collection that involves an interviewer and an interviewee. It provides deeper understanding of social phenomena than would be obtained from quantitative methods along. It is most appropriate where little is known about the study phenomena or where more description and detail are required from individual participants. The length of interview is dependent on the research

topic, researcher and participant. However, qualitative interviews typically last 20-60 minutes (Gill, Stewart, Treasure, & Chadwick, 2008). There are three fundamental types of research interviews: structured, semi-structured and unstructured. In all forms of interview, the interviewer asks questions and motivates the participant to share their individual experience, perspectives and stories.

These questions are typically asked of each interviewee in a systematic and consistent order, but interviewees are also allowed freedom to digress or elaborate (Lune & Berg, 2017, p.69). It is also a useful method to gain information about sensitive topics. The purpose of this method is to obtain detailed insight into a particular experience or set of experiences. It provides a means of uncovering information that is probably not accessible using techniques such as questionnaires and observations. In addition, it is a natural way of interaction that can take place in different situations. Moreover, it gives the interviewer the opportunity to rephrase or simplify questions that were not understood by the interviewees, and this provides more valid, useful data – in other words, semi-structured interviews can make better use of the knowledge-producing potentials of dialogues by allowing interviewers to follow up. It gives interviewers a greater chance of becoming visible as a knowledge-producing participant in the process itself (Brinkmann, 2013). Additionally, the data obtained can be recorded and reviewed several times to help produce an accurate interview report (Alshenqeeti, 2014). Finally, interviews generally take place at the participants' location and this makes it easier to access potential participants than the focus group method (Ritchie & Lewis, 2003)

However, this method has limitations; transcription is time-consuming; there is no feedback from others; and good interviews require skills to establish relationships, to use motivational probes, and to listen and react to participants. The interviewer also needs to

be flexible in changing the order of the questions/topics to follow the participant's story (Hennink, Hutter, & Bailey, 2011). Interviewees may only give what they are prepared to reveal about their perceptions, which may be idiosyncratic and subject change over time according to circumstances (Alshenqeeti, 2014). Moreover, it has been argued that interviewing involves human judgement and thus lacks reliability; this means interviews depend on the specific interaction between interviewer and interviewee, and that cannot be repeated in the same form with other people involved. In addition, the way the researcher carefully considers different analytic conjectures and takes negative cases into account makes it very likely that other analysts would reach somewhat different conclusions. Thus, it is often said from a positivist point of view that interviews cannot provide objective knowledge as they rely on subjectivity. Conversely, interviews seem uniquely capable of capturing central aspects of human conversational process, self- understanding, and ways of talking, reasoning and describing past experience and these reflect knowledge (Brinkmann, 2013). The most common objection to qualitative interviewing is that its results cannot be generalised as it is generally based on a few cases. Instead, generalisation rests to a large extent on a theoretical understanding of the subject matter.

The semi-structured interview is the most common method and was selected for this research; this type of interview involves the implementation of a set of predetermined questions and special topics that help to define the areas to be explored, also allowing the interviewer or interviewee to diverge in order to allow more detail to emerge (Gill et al., 2008). Semi-structured interviews can provide reliable, comparable qualitative data (Barker et al., 2016). They are a flexible way of gathering data that is detailed and personal (McLeod, 2003). They consist of several key questions that help to define the areas to be explored, but also allow the interviewer to diverge in order to pursue an idea or response in

more detail (Stewart, Treasure, & Chadwick, 2008). The researcher has a clearer idea and a list of questions that are to be asked in the course of the interview (see Chapter Four).

In this research the qualitative study data were collected by interviewing therapists individually in the counselling centres at Princess Nourah bint Abdulrahman University. Interviewing therapists/ counsellors has become a popular form of counselling research. Researchers in the counselling and psychotherapy field interview therapists to understand and learn more about such factors as the therapeutic process, therapeutic relationships, and therapists' development and experiences from their perspective; for example, a recent qualitative study by Donald, Carey and Rickwood (2018) was conducted to explore experiences of therapeutic change from the therapist's perspective. In another qualitative study conducted by Westergaard (2013), counsellors were asked to identify their training and theoretical orientation and explore the approaches they use in practice within a flexible interview framework. Winning (2010) also conducted a study using semi-structured interviews to explore and understand lone counsellors' experiences of working in organisations and the implications for the delivery of counselling services.

In conclusion, there has been a tendency to use semi-structured interviews in qualitative social science and psychotherapy research as a way of collecting qualitative accounts of experience. This is a flexible and familiar method for phenomenology research on people's experiences of various aspects of counselling (McLeod, 2011).

3.5.2 Psychometric Self-Report Questionnaire (Outcome Measure)

The other main research method to be used within my overall mixed methods approach was quantitative self-report using a standardised psychometric questionnaire. Quantative psychometric questionnaires are a very popular form of data collection in counselling

research, especially when gathering information from a large group or when answers are needed to a clearly defined set of questions. They always consist of two components: questions and responses. Then the responses will be summarised in percentages, frequencies, distributions, averages and other statistical approaches. In psychometric self-report measures, respondents are asked directly about their own beliefs, behaviour, attitudes, or intentions (Lavrakas, 2008).

The literature on quantitative self-report methods is enormous (Barker et al., 2016) and psychometric questionnaire research can be guided by either a positivist-realist or a phenomenological-critical realist epistemology. However, there has been some debate over the years as to the value of using self-report measures and there are undeniably drawbacks (e.g. if a client is having a good day, then even if they asked to report their experiences over the past one or two weeks, it may be that their current mood affects their responses) (Vossler & Moller, 2015, p.134). In addition, questionnaires may lead to biased reporting – they may provide a general picture, but lack depth, and may not provide adequate information on context. However, there are also benefits, particularly in terms of cost and ease of administration. In addition, research shows that clients can reveal something in their self-report measure responses which they are not comfortable raising with the therapist (Vossler & Moller, 2015, p.134). This is a good method for gathering descriptive data, covering a wide range of topics, and can be analysed using a variety of existing software. It is also a useful approach and valuable tool in helping the therapist and the clients track the therapy's progress. Vossler and Moller (2015) summarise the benefits and challenges in using quantitative methods in counselling and psychotherapy research as follows:

Benefits:

- They give an understanding of what is happening (eg, effects of treatment or changes in symptoms).
- They make it easy to compare data collection for different clients or groups.
- They can be used for large samples and offer the possibility to generalise findings with greater confidence.
- They help aggregate data and test theories.
- Because they are standardise, the allow results to be replicated to confirm findings.
- They help researchers to investigate casual relationships (p.148-149).

Challenges:

- Psychometric self-report measures rely on assumptions from positivism, based on the naïve belief that there is a single, observable world that we all experience in the same way.
- They often do not allow room for exploration of diverse individual meanings or deeper understanding of complex issues.
- They constrain participants to report on their experience in terms of categories and fixed-response questionnaires using formats designed by researchers.
- They require that the right data is collected in the first place, which cannot always be relied upon.
- Data quality may be lacking resulting in messy, confusing data.
- It can be difficult to know which statistical tests are appropriate and to understand the results.
- The focus on measurement may detract from the therapy process (p.149).

There is a wide range of valid and reliable methods for evaluating the effectiveness of counselling and psychotherapy (McLeod, 2015), such as CORE-OM (Clinical Routine Evaluation - Outcome Measure by Evans et al., 2000; Mellor-Clark, Connell, Barkham &

Cummins, 2001), the Beck Depression Inventory, and the Generalised Anxiety Disorder Assessment by Spitzer et al. (2006). A questionnaire (self-report measure) was used in the current research – looking for the outcome of university counselling services – as a suitable method to collect quantitative data, and quantify the clients' changes during a course of therapy at a university counselling centre in Saudi Arabia (see Chapter Five).

3.6 Population of this Research

This research was conducted at the Princess Nourah bint Abdulrahman University counselling centre, Saudi Arabia. It contains two different samples; the sample in the qualitative study targeted all therapists who were working at the Princess Nourah bint Abdulrahman University Counselling centre (see Chapter Four). In the quantitative study the sample targeted all clients who were attending the university counselling centre for the first time and were willing to take part in the study (see Chapter Five).

There is not a clear and agreed set of ground rules for conditions under which qualitative research can be generalised or what this process involves (Ritchie & Lewis, 2003). "Qualitative research typically tries to sample broadly enough and to interview deeply enough that all the important aspects and variations of the studied phenomenon are captured in the sample – whether the sample be 7 or 100" (Elliott & Timulak, 2005, p.151). Generalisation can be seen in this research in the qualitative study as representational generalisation, wherein what is found in the research sample can be generalised and was equally true of the parent population from which the sample is drawn. According to Ritchie and Lewis (2003), assessing representational generalisation turns on two broad issues. The first is the accuracy with which the phenomena have been captured and interpreted in the study sample; the findings in the qualitative study provided a comprehensive

understanding of how the counselling centre at the university works and what kind of services that therapists provided to their clients (the study phenomena). The second issue is the degree to which the sample is representative of the parent population sampled; 13 out of 15 therapists at the university counselling centre participated in the qualitative study and were interviewed individually. Although individual variants of circumstances, views or experiences would certainly be found within the parent population, it is at the level of categories, concepts and explanation that generalisation can take place. In addition, the data was validated and evaluated using two methods of evaluation (see Chapter Four).

The next two chapters will present the qualitative study – counselling centre activity and process – followed by the quantitative study – university counselling centre outcome. Each chapter will present the study's aims, method, analysis and results.

Chapter 4 The Nature of the Counselling Based on Therapists' Perspective: A Qualitative Study

4.1 Introduction

After reviewing the literature conducted on university counselling services in Saudi Arabia, I was unable to find any study determining or exploring these services. Most of the studies were located either in mental health hospitals or schools, not in university counselling centres. This makes a difference because in hospitals, psychotherapy courses are provided by psychiatrists, and in schools they are provided by unqualified counsellors or unspecialised staff. From the methodological aspect, most Saudi researchers applied quantitative methods in order to collect their study data. Therefore, the current study looks to collect more information and detail on counselling services, therapists' experience and their practice difficulties and challenges. Consequently, a qualitative approach was adopted and a semi-structured interview with counselling centre therapists was applied in order to collect detailed information and provide a more comprehensive picture on the university counselling centre services in Saudi Arabia.

This chapter presents a qualitative study that documents the nature of counselling services as an activity and process, taking place at the counselling centres in Princess Nourah bint Abdulrahman University. The counselling and psychotherapy services are part of the education programme in Saudi Arabia. They are designed to provide help and support to school and university students.

4.1.1 Aims

The chapter aims to answer the following five questions:

1. What type of services (therapies, techniques, and assessments) do therapists provide at the university counselling centres?
2. What kind of problems do clients present with at the counselling centre?
3. What kinds of supports and demands does the counselling centre make for therapists?
4. What are the therapists' experiences working as a therapist (years of experience, any improvement in their practice, attending courses and counselling workshops)?
5. What kind of difficulties and challenges do therapists face in their practice?

4.2 Methodology

The objective of this study is to understand and collect in-depth information about therapists' feelings, thoughts, perceptions and interpretations (Barker et al., 2016) of the nature of the counselling services provided at the university. For at least 300 years, an argument has been ongoing regarding a philosophical basis of science, called epistemology, or "the nature of knowledge" (McLeod, 2013). In the 20th century, philosophers of science attempted to analyse and understand the basic nature of scientific inquiry, that is, 'how do we know what we know?' (McLeod, 2013). Epistemology is related to ontology and methodology: ontology involves the philosophy of reality and being (Vossler & Moller, 2015); epistemology addresses how we come to know that reality (Krauss, 2005) and also the relationship between the known (participant) and the would-be knower (researcher); finally, methodology links the specific research procedures or methods to the theory behind those particular practices and the process of the research (Vossler & Moller, 2015).

There are numerous paradigms used to guide research, and authors incorporate different paradigmatic schemas to conceptualise and classify their research (Ponterotto, 2005). Guba and Lincoln (1994) defined four paradigms, namely positivism, post-positivism, constructivism/ descriptive, and critical theory. The positivist and post-positivist paradigms are referred to as scientific method and based on the rationalistic, empiricist philosophy, reflecting a deterministic philosophy in which causes determine effects or outcomes (Mackenzie & Knipe, 2006). The primary goal for these paradigms is to provide an explanation that leads to prediction and control of phenomena. Positivism and post-positivism serve as the primary foundation and anchor for quantitative research, while constructivism/ descriptive grew out of the philosophy of Husserl's phenomenology and Wilhelm Dilthey's and other German philosophers' study of interpretive understanding called hermeneutics (Mackenzie & Knipe, 2006). It approaches to research have the intention of understanding "the world of human experience" (Cohen & Manion, 1994, p.36). The constructivist/ descriptive researcher tends to rely upon the "participants' views of the situation being studied" (Creswell, 2003, p.8) and recognises the impact on the research of their own background and experiences. Constructivists hold that reality is constructed in the mind of the individual and its position espouses a hermeneutical approach, which maintains that meaning is hidden and must be brought to the surface through deep reflection, which can be stimulated by the interactive researcher-participant dialogue (Ponterotto, 2005); the constructivist researcher is most likely to rely on qualitative data collection methods and analysis or a combination of both qualitative and quantitative methods (mixed methods) (Mackenzie & Knipe, 2006). The critical-ideological paradigm is one of emancipation and transformation, one in which the researcher's proactive values are central to the task, purpose, and methods of research.

The philosophy for this current study is not the positivism/post positivism paradigm because it does not rely solely on a scientific method and it does not emphasise dualism and objectivism. That is, the researcher and the research participant and topic are assumed to exist independently of one another. It relies on constructivism/ descriptive, as this paradigm intends to understand people's experiences and views. Furthermore, constructivists/ descriptive advocate a transactional and subjectivist stance that maintains that reality is socially constructed and, therefore, the dynamic interaction between researcher and participant is central to capturing and describing the "lived experience" (Ponterotto, 2005) – and this applies to the current study. In light of the evaluation criteria for qualitative research – *owing one's perspective* and *using appropriate method* – I follow this approach by using the qualitative method of semi structured interviews, as this method is usually underpinned by constructivist principles and it is an appropriate method to collect in-depth data on participants' experiences and perspectives on the nature of the university counselling centre.

4.2.1.1 Development of the Interview Questions

Qualitative interviewing has become the most common research method across human and social sciences. The primary aim for qualitative research is to develop an understanding of how the perceived or life-world is constructed (Vossler & Moller, 2015). In order to understand the university counselling services and to collect more detailed information about the counselling services, therapists' experience, and therapists' practice difficulties, semi-structured interview questions were developed. It is a good idea to structure the interview around some type of framework. It usually starts with general questions (Barker et al., 2016). The interview schedule here was based and built on the 'Development of Psychotherapists Common Core Questionnaire'

(Orlinsky & Rønnestad, 2005) which is part of a collaborative study of psychotherapists in several countries. It contains both open-ended and closed questions. The questions are arranged into groups according to the different themes to be explored.

After the pilot interview was conducted and in order to check the understanding of what was being said and how the counselling centre operates, I added new questions under the 'kind of services' domain. These included clients' problems (what kind of problems did clients bring to the university counselling centre?), use of assessments, and evaluation of the clients' improvement. In addition, I added new items to the domain 'the organisation setting'; these included its requirements and roles.

The revised interview included four main domains with several questions and sub-questions, as follows:

- The nature of the services that therapists provide at the university counselling centre (including therapies, techniques, assessments, clients' issues, and evaluating client improvement),
- The organisational setting: the university counselling centre (including roles, supervision, any requirements),
- Therapist experience (including years of experience, changes as a therapist, and attending workshops), and finally
- Therapist practice difficulties (including external and internal difficulties, lack of confidence, doing harm, and losing control).

4.2.1.2 Translation of Interview Questions

The data were collected at the Princess Nourah bint Abdulrahman University counselling centre, Saudi Arabia. Therefore, the interview questions were translated from English to Arabic.

Translation, defined as transcribing the text of a source language into the target language (Filep, 2009), is more than just "changing the words", or as Temple and Edwards (2002) point out: "communication across languages involves more than just a literal transfer of information". As Simon (1996) writes:

> *The solutions to many of the translator's dilemmas are not to be found in dictionaries, but rather in an understanding of the way language is tied to local realities, to literary forms and to changing identities. Translators must constantly make decisions about the cultural meanings which language carries, and evaluate the degree to which the two different worlds they inhibit are 'the same'.* (Filep, 2009, p.2)

Conducting interviews and translating interview data in multilingual/multicultural settings represent complex situations, in which not only the language but also the culture has to be translated or interpreted and dealt with (Filep, 2009, p.2). However, in this case the researcher/ interviewer and the interviewees spoke the same language (Arabic) and lived in the same culture and social system (Saudi Arabia) (see Chapter One). As we have to understand language as an important part of conceptualisation, incorporating values and beliefs (Temple & Edwards, 2002) and these made the development and the translation of the interview questions easier, I understood that I had to develop questions that were situated within the therapists' culture, and to make sure these questions were all meaningful to therapists and relevant to their work, drawing on the background that I shared with them.

Based on the above issues, I therefore did not translate the interview questions and transcripts literally; I tried instead to communicate within a shared culture and understand the meaning of the data within that culture.

Piloting the Interview

Pilot studies help to get the administrative procedures roughly right and detect any gross errors in measurement or design. Pilot studies can be conducted with people closer to the target population or instead may be done with colleagues or friends (Barker et al., 2016). The purpose of the pilot study is to identify potential problem areas and deficiencies in the interview questions and protocol prior to implementation during the full study. It is also help me to become familiar with the procedures (Abu Hassan, Schattner, & Mazza, 2006) and to gains an insights that are used to improve and modify interview schedules and specific questions and add new topics/questions for discussion. It also helps refine data collection plans, analysis and the research framework (Ismail, Kinchin, & Edwards, 2018).

Before the study's interviews were conducted, a pilot interview was carried out with an Arabic-speaking therapist (who is working as a school counsellor in a high school) to test the interview questions and translation, and to make sure that each question was fully understood. In addition, to ensure that the collected data were adequate in terms of answering the general questions of the study, tentative analysis and coding of the data were carried out (see Table 4-1).

After the analysis was conducted, several questions were added in order to gain more details and information about the counselling services. Furthermore, the pilot test was useful for managing the time and practicing leading the interview.

Pilot Interview Findings

Table 4-1 Pilot Interview Analysis Categories and Meaning Units

Domain	Category	Sub-categories	Meaning Unit
1. Services	**1.1.Therapies**	1.1.1. individual 1.1.2. Group 1.1.3. Play. (Rarely)	I use the individual and group therapies with many clients/students, and sometimes I use play therapy.
	1.2.Other practices	1.2.1.SLT Exercise 1.2.2. Relaxation technique 1.2.3.IQ	I use the speech and language disorders exercises and relaxation techniques, because the most common problem that students complain about is exam anxiety. I use an Intelligence Quotient if it is necessary (for example, if the student has low academic level.
2.Clients	**2.1. Who gets the treatment?**	2.1.1Need medicine 2.2.1 Students have low academic level	Some clients need to have pharmacotherapy. Students who have low academic level.
3.Organisation Context	**3.1.Ministry of Education**	3.1.1. Provide pharmacotherapy. 3.1.2. Set up the role and policy. 3.1.3. Provide workshops and courses	Some clients need to have pharmacotherapy. In this case I should refer them to the Ministry of Education and they will do what they see necessary. We are not allowed by the Ministry of Education to use such therapies with clients at the school. We must attend workshops and courses revolving around psychological therapist requirements, IQ measures (Wechsler and Binet scale). The workshops were about mental disorders such as anxiety, depression, speech disorders and others.
	3.2. Official supervision	3.2.1.Weekly supervision. 3.2.2. Provide her with previous and future plans. 3.2.3. Help and support.	We meet weekly to discuss clients' needs and problems. In addition, I should provide her with all work that I have done, and the next week's plan. I contact the supervisor when I have some difficulties with some clients. She is always helping and supporting me with the therapy plans.
4.Therapists	4.1. **Experience**	4.1.1.Year of experience. 4.1.2. Changes/ Development. 4.1.2.1.Feeling	I have been working as a therapist for five years. I have changed a lot. I feel much better than previously. Also before working as a therapist we must attend workshops and courses revolving around

		better. 4.1.2.2.Improved in their performance. 4.1.2.3.Sources of change. 4.1.3.Attending workshops and courses 4.1.4.Practice and experience	psychological therapist requirements, IQ measures (Wechsler and Binet scale). It has had a significant impact in improving my performance, also it is a result of practice and experience). Every year there are a number of workshops and courses. During this year I have registered in three workshops. At the end of each session there was a practical work as well as an evaluation of therapist's performance.
	4.2. **Difficulties and challenges**	4.2.1.**External difficulties** 4.2.1.1.Parental interference 4.2.1.1.1. have negative perspective 4.2.1.1.2. Ask to stop the therapy sessions. 4.2.1.2.Lack of supervisor support. 4.2.1.3. School administration interference 4.2.1.4.Classes 4.2.1.5.Student absences and attendance.	Some parents have negative perspectives about counselling services. This affects the counselling sessions. For example: I may start meeting with a student for a long time, then her parents ask to stop the counselling session. This sometimes happens if the student has learning difficulties. So parents think that is not a good decision. I am not allowed to do some therapies because of lack of supervisor approval: (I have studied many kinds of psychotherapies. However, I am not authorised to use them. My work is based on guidance and counselling. It is not appropriate to use certain methods with some students. If I want to apply psychological therapies, I must get the supervisor's approval. School administration interference does not allow me to refer a student to the Ministry of Education even if she needs it. Sometimes classes are the obstacles, so I can't have a counselling session with my client. Student avoids attending the session. Also some students refuse to attend the meetings because they don't want to be seen by one of their classmates.

		4.2.2.**In-session difficulties** 4.2.2.1.Feels disappointment	I feel disappointed when clients do not attend the counselling sessions. (Some students refuse to attend the counselling sessions) or when there is no improvement in the client's case (sometimes we hold a number of counselling sessions for certain student, but there is no positive impact or improvement).

4.2.2 Participants

4.2.2.1 Therapists

Thirteen out of sixteen female therapists at counselling centres in Princess Nourah bint Abdulrahman University agreed to participate in this study. One therapist declined to take part and two others were out of the office during the study period. In light of the qualitative research evaluation criteria, some basic descriptive data was provided including that: the therapists were aged 25 and older; most of them held at least a bachelor's degree in psychology, with two of them with a master's degree in counselling and a further two having completed PhDs in counselling.

4.2.2.2 Researcher

My personal motivation for undertaking this study comes from my background, as I have both professional and personal interests in counselling and psychotherapy. I obtained my bachelor's degree in psychology, and during that period I also worked as a counsellor with orphaned children at a Social Nursing House for three months. As a researcher, I conducted a quantitative study during my master's degree in 2011 in counselling and student guidance at Al-Imam Muhammed Ibn Saud University, Riyadh,

Saudi Arabia. At this time, I was involved in a three-month psychologist training programme. As a professional, I have been working as a lecturer for three years teaching undergraduate students in the psychology department at Princess Nourah bint Abdulrahman University in Saudi Arabia.

This kind of study was a new and valuable experience for the researcher. The therapists were friendly and kind. They were able to answer any questions and share any relevant information. I expected to gain data about the kinds of services that therapists provided at the university counselling centre and to understand how the centre works, along with therapists' experiences and their practice difficulties. I did not expect the kinds of client problems that therapists reported such as obsessive compulsive disorder, anxiety, and depression; I expected academic problems to be reported. I expected that the counselling centre set up clear roles and requirements but it was not.

4.2.2.1 Supervisor

The research supervisor had been conducting therapy outcome research for more than 30 years at the time of research, using the same or similar data collection procedures. He expected the counsellors in this study to represent a range of theoretical approaches, with most being CBT therapists. He expected a range of therapeutic difficulties, similar to those reported by Orlinsky and Ronnestad (2005). He had no expectations about the organisational setting and its impact on the counsellors here, but did wonder what effect the predominant influence of Islam would have both organisationally and on the counsellors' practice here.

4.2.3 Ethical Considerations

In the initial stages and in light of the qualitative research evaluation criterion '*respect for participants*', ethical issues were considered in this study (see Appendix 1). Each therapist involved in this research was given a full information sheet and consent form (see Appendix 2), detailing what was involved in the study. The information sheet contained details regarding data protection, confidentiality and right to withdraw. The interview material was identified only by codes given to each participant to protect their identity. Therapists' identities were kept fully confidential and only general descriptions of them will be presented. In addition, the emotional impact of the interview on therapists was considered in this study; if any questions in the interview raised emotional responses such as feeling uncomfortable and distressed, therapists could request to stop the interview or to ignore a question at any time. The researcher was planning to use audio recording, but most of the therapists preferred that the interviews were not recorded. Therefore, the researcher decided to take notes. All participants were informed that the interviews recordings or notes would be transcribed with identifying information removed, and translated into English.

In practice, therapists who were willing to take part in this study were given the therapist PIS and consent form to read and sign at the beginning of the study; in addition, therapists were given the opportunity to ask any questions or express any concerns they might have about the study.

The researcher applied for and obtained two main study approvals – first, the Nourah bint Abdulrahman University approval to conduct the study at the counselling centre, and second, the University of Strathclyde Ethics Committee approval.

4.2.4 Data Collection/Procedure

Regarding the qualitative research evaluation criterion 'specification of methods', I will first talk about the data collection and organisation procedures followed by the data analysis procedures used in the study, and will then provide examples ('grounding in examples' criterion). Once the researcher had obtained the head of the university counselling centre's approval to start the interviews and got the therapists' information (e.g. names, office numbers) at the university, thirteen female therapists agreed to take part in this study. The researcher met each therapist individually to clarify that she would be asked to do two things, namely to be interviewed and to address the questionnaires to her clients (for more details about the questionnaires procedure, see Chapter Four). Once the therapists agreed to take part in the study and were willing to participate in the two studies, they were asked to read the therapist's information sheet for more details, and to sign the consent form. Then, the therapists were interviewed individually at their offices. Each interview took approximately 40-45 minutes. Fortunately, the participants were friendly and were able to share and answer all questions.

4.2.5 Analysing the Interview Data

The method I followed in analysing the interview data in general was, broadly speaking, an adaptation of grounded theory analysis developed by psychotherapy researchers and following Rennie, Phillips, & Quartaro (1988), McLeod (2011), and Elliott & Timulak (2005). This approach can be described from the viewpoints of both grounded theory and thematic analysis. First, I will describe it in terms of grounded theory, the method used to analyse the interview data) i.e. what it looks like from grounded theory's viewpoint. Then I

will present further a description in terms of the viewpoint of thematic analysis, following Clarke and Braun (2006).

4.2.5.1 Description from the Viewpoint of Grounded Theory Analysis

Descriptive/interpretive qualitative research requires flexibility during the analysis. The approach used in this part of my research was a generic approach that emphasised common methodological practices from several approaches (e.g. grounded theory, thematic analysis, empirical phenomenology, hermeneutic-interpretive research, consensual qualitative research) rather than focusing on the relatively minor differences between approaches. In this qualitative study I used a general descriptive/qualitative approach to collect and analyse the study data, as proposed by Elliott et al. (1994) and Timulak and Elliott (2005, 2019); this framework is similar to and influenced by comparable frameworks used by other researchers (e.g., Hill et al., 1997; Braun & Clark, 2006; McLeod, 2011). It is a flexible framework and, as appropriate, can be modified or added to (Elliott & Timulak, 2005, 2019, p.152).

The first step of analysis is *data preparation* (in thematic analysis this step is referred to as *becoming familiar with data*). The study data was obtained in the form of notes, and then was translated from Arabic to English. During this stage, I read the whole data set to get the whole picture, the insights and understanding of the study phenomenon, and in addition, during this initial reading an initial editing of the data took place. I recognised the repetitions, unimportant and important data that were relevant to the study phenomenon.

The second step of analysis was delineating and processing meaning units (this step is not used by either grounded theory or thematic analysis). I started to divide the data into distinctive meaning units; these were usually part of the data, even if standing out from the

context. Different sets of meaning units described different aspects of the phenomenon. Here is an example of how I classified a meaning unit:

> Informant FA07 reported that *"I use the (1) cognitive behavioural therapy to modify (2) irrational thoughts. and I always (3) use measures to determine the appropriate therapies and plan."*

I divided this meaning unit into three different units. The first one referred to the kind of therapy ("*I use cognitive behavioural therapy*"), the second to the client's problem that their therapist has to deal with ("*to modify irrational thoughts*"), and finally, the therapist mentioned that she used measurements ("*I always use measures to determine the appropriate therapies and plans*").

The next step was *finding an overall organising structure for the data* (in grounded theory, this step is referred to as *axial coding,* while in thematic analysis it is referred to as *generating initial codes*); organising the phenomenon into different processes or phases referred to as domains (in thematic analysis this referred as *a high level category)*. These domains were identified from the beginning via the interview questions (e.g. the kind of services, therapists' experience and practice difficulties). However, this domain did not specify the phenomena and in fact evolved as the analysis took place. These changes included clarifying the five domains (kind of services, clients, organisational context, therapist experience, and practice difficulties). This framework for meaningfully organising the data should be flexible and tested until it fits the data, and the researcher needs to be open to using the data to structure the organising conceptual framework (Elliott & Timulak, 2005).

The next step was the *generation of categories* (in grounded theory this step is referred to as *open coding*, while in thematic analysis is referred to as *search for themes*). This step

took place as a following step of classifying the meaning units; that is, coding or categorising the meaning units within each domains into which they have been organised. Categorising aims to discern regularities or similarities in the data and it is an interpretive process on the part of researcher in which the researcher is trying use category labels close to the original language of the informants. It also comes from the researcher's knowledge of previous theorising and findings in other studies. In this process, the meaning units are constantly compared to each other and to the emerging categories until all the data are sorted (Elliott & Timulak, 2005).

Here is an example from the study data. As mentioned above, I identified several domains, for example *the therapists' practice difficulties* domain was categorised into three categories as follows: *internal/in-session difficulties and challenges with clients, external situation difficulties,* and *no difficulties.*

The next step in creating the categories was differentiating the categories into smaller categories or subcategories (in thematic analysis this step is referred to as *reviewing themes* or *codes*). For instance; *the internal/in-session difficulties and challenges with clients* was categorised into several sub-categories, including for example *confidentiality concerns, counselling and negatively affecting client's study, client silence, lack of client commitment to therapy,* etc. (see appendix 7).

The generation of categories usually ends with a taxonomy that describes and interprets the whole phenomenon as it was contained in the gathered data (Elliott & Timulak, 2005).

The next step in the data analysis was *abstracting the main findings* from the category structure and this follows the rule of essential sufficiency (in grounded theory this step is referred to as *selective coding*, while in thematic analysis is referred to as *write up or*

reporting the findings), which means I looked for the simplest way to fully depict the study phenomena and tried to communicate them clearly to the reader (Elliott & Timulak, 2005) (see 'Findings' section).

The final step in the analysis process was validating the analysis as will be described later in the section on validity.

4.2.5.2 Further Discussion of the Interview Study Analysis from the Perspective of Thematic Analysis

In order to provide a more in-depth description of my analysis process, I will now present an account of how I analysed my data in terms of Braun and Clarke's (2006) Thematic Analyis, which they describe as *"a method for identifying, analysing and reporting patterns or themes within qualitative data"* (p.7). These themes can be used to address the research problem, organise, and describe the study data set in rich detail. It is an influential approach in the social sciences and has become widely used both in and beyond psychology and practically in applied research areas including counselling and psychotherapy (Clarke & Braun, 2018) because it offers a clear and usable framework for doing qualitative analysis (Maguire & Delahunt, 2017). It has been used in several important investigations in the field of counselling and psychotherapy research. One of the advantages of thematic analysis is that it is theoretically flexible, straightforward and accessible (McLeod, 2011) for counselling and psychotherapy researchers and has become a useful method for psychotherapy process research to explore the experiences and views of groups of clients and therapists, typically drawing on interview data (Clarke & Braun, 2018). This means it can be used within different frameworks to answer quite different research questions (Vossler & Moller, 2015). A common pitfall is to use the main interview questions as the themes (Clarke, 2013). Braun and Clarke (2006) distinguish

between two levels of themes: semantic and latent. Semantic themes '…within the explicit or surface meanings of the data and the analyst is not looking for anything beyond what a participant has said or what has been written' (p.84). In contrast, the latent level looks beyond what has been said and '…starts to identify or examine the underlying ideas, assumptions, and conceptualisations – and ideologies – that are theorised as shaping or informing the semantic content of the data' (p.84).

Iin this study I identified themes at the semantic level, using thirteen interviews lasting about 40-50 minutes. Braun and Clarke (2006) distinguish between a top-down or theoretical thematic analysis that is driven by the specific research question(s) and/or the analyst's focus, and a bottom-up or inductive one that is more driven by the data itself. In the current study I followed the top-down analysis which was driven by the research questions and sub-questions.

After completing and translating the interviews, each transcript was read intensively, several times, to *become familiar with the entire body of data* (step 1). At this stage I made some notes and noted down early impressions; the following is an example from the study's original data of how I made some notes.

> *Therapists seemed to provide several therapies in working with clients and their choice depended on the client's problems. Therapists were very clear about the importance of the supervision, attending workshops and counselling courses, the importance of years of experience in improving their performance.*

The next step/phase, called *coding*, "*is the process of systematically working through the entire data set, noting ideas, concepts and points of interest related to the research question*" (Vossler & Moller, 2015, p.189). I coded each segment of data that was relevant to the research questions and identified the similarities and differences among the

interviewees' responses and compared codes. As I worked through them I *generated new codes* and sometimes *modified existing ones* (step 2). For example, from the original data I had several codes that related to guidance and counselling at the main centre at the university and what they offer therapists. I collated this data into an initial theme called *organisational context* to identify significant broader patterns of meaning. The codes had been organised into broader themes that related to the specific research question (step 3). In step 4 of doing thematic analysis, the preliminary *themes were reviewed*, modified and developed. In addition, I considered whether the data associated with each theme accurately support it and that the themes work in the context of the entire data set. For example, from the original data analysis, the *organisational context* theme included several sub-themes such as the *counselling and guidance main centre* sub-theme and there was enough data to support it. Some of the codes here included set up the roles and policy, require reports, and provide supervision. The final refinement of the themes and the aim is to *essence what each theme is about* (Braun & Clarke, 2006, p.92). In this study analysis, for example, *what types of services did therapists provide at the university counselling centre?* is rooted in the other sub-themes (kinds of therapies, techniques, and assessments) and each sub-theme included several codes (see Appendix 7). Usually the end point of research is *reporting* the thematic analysis (step 6) (see the 'Findings' section).

4.2.6 Validity of Interview Data

There have been many attempts to construct guidelines for evaluating the credibility and the validity of qualitative research (McLeod, 2011). It has been widely recommended that researchers check the credibility of their research – one of the qualitative research evaluation criteria – by using a number of analyses, having another person review the data trail, or checking back with the informants or others like them (Barker et al., 2016).

In order to evaluate the quality of this study data, the researcher used two methods of evaluation. The first method was to check back with the respondents; that is, four months after the data were collected (therapist interviews), the researcher went back to Saudi Arabia to check with the informants about the data they provided. The second method was asking an expert qualitative analyst, my supervisor, to audit the analysis after the transcripts were translated from Arabic to English and categorised.

4.3 Findings

4.3.1 Research Phase 1 (Domain): Kind of Services

This section presents the therapists' responses regarding the kind of services they provided at the university counselling centre. It is answered three interview sub-questions, as follows: 1) What kind of therapies do you practice? 2) What kind of techniques and strategies do you use in practicing therapy? 3) What kind of assessments do you use in therapy? (See table 4.2; for a complete listing of all categories and sub-categories, see Appendix 7.)

Table 4-2 Summary of Categories and Sub-categories under Types of Counselling Services Domain

Domain	Categories	Sub-categories
Service type	Counselling therapies	Cognitive behavioural therapy
		Person centred therapy
		Reality therapy
		Logo therapy
	Techniques	Homework
		Relaxation
		Behavioural techniques and activation: 1) ABC technique. 2) Problem solving. 3) Reinforcement. 4) Exposure technique.
	Assessments	Measure the clients' problems: 1) Beck's depression inventory. 2) Anxiety scale. 3) Phobia scale. Evaluate the client's changes: 1) Observation. 2) Asking.

4.3.1.1 What Kind of Therapies are you Practicing?

Most of the counsellors indicated that they use a therapy that is suitable for the client's problems; this means most of them use more than one counselling and psychotherapy approach as appropriate with the client's needs. For instance, one said:

"....we use therapies depending on the client's situation and problem..."

When asked to be more specific and determine what kind of therapies they most commonly practice, the majority of therapists/counsellors at the university counselling centre reported using ***cognitive behavioural therapy*** (CBT) to deal with their clients. For instance,:

Informant MC03: *"... I use cognitive behavioural therapy to identify the client's irrational thoughts".*

As well as Informant MC04*: " Always I use the behavioural therapy, and sometimes I use the cognitive behaviour therapy"*

Informant CE11 stated that *" .I use and focus on the Cognitive Behavioural therapy because it is appropriate therapy for our culture and students".*

A small number of the counsellors also used ***person-centred therapy*** by encouraging their client to speak and express their feelings. For example:

Informant FM01 stated that *"I always encourages the clients to talk about their problems and feelings until she realize (has the insight) her real issues"*

Informant SS02 said that " *Sometimes I use the personal-centred therapy*".

However, a small number of therapists/counsellors used other kind of therapies with their clients, such as ***logo therapy***, and ***reality therapy***.

In conclusion, therapists used therapies that were suitable for their clients' problems, and most of them used more than one kind of therapy. The most common therapy applied by therapists at the counselling centres was cognitive behavioural therapy (CBT), with some therapists used person-centred therapy (PCT).

4.3.1.2 What Kind of Techniques and Strategies Do You Use in Therapy?

The therapists highlighted many kinds of techniques that they used during their counselling sessions. Half of therapists/counsellors gave ***homework*** to their clients. for example, informant MC04 & SS02 said that :

"I give my clients some work to do at home".

Informant MC03 stated that *" I give the client some works like reading about her issues and ask her to write about it"*

Similarly, informant FE10 reported that:

"I give some homework especially to the obsessive compulsive clients, I asked them to count how many times that a negative thought came up in their minds and to try to replace it with a positive thought".

Other techniques that were generally used by therapists/counsellors with their clients were related to ***behavioural therapy and activation***. However, they stated several techniques within the behavioural therapy, For instance, when informant SS02 administered the stress inoculation procedure, she said that:

"I use the stress inoculation procedure to decrease clients' stress and worries".

Two therapists used reinforcement techniques; according to informant MC04:

"I try to modify the client's behaviour by using the reinforcement schedule".

In addition, ***ABC technique*** was used by four of therapists to modify the client's irrational thoughts:

As reported by informant SB13: *"Uses the ABC technique by recording the client's negative thoughts and writing negative and positive thinking lists".*

Informant GH12 stated a similar response: *"I use the ABC technique and using the negative thought list".*

Furthermore, a small number of therapists applied other kinds of behaviour techniques, such as ***exposure, distraction, role playing*** and ***problem-solving techniques***.

Relaxation was another technique that some therapists used with their clients. As reported by several informants such as: MC04, FP05, CC09 & CE11:

"....use the relaxation technique".

Another informant SB13 used the same technique and she added that:

"....With the anxious and obsessive compulsive clients".

A small number of therapists used other techniques such as ***sympathy and hypnosis***.

Conclusion

Under the kind of techniques that therapists provided at the counselling centre category it can be concluded that therapists at the counselling centre provide different kinds of techniques in order to meet the clients' needs. Generally, therapists addressed homework, and typically behavioural techniques and activation, relaxation, and rarely used sympathy, and hypnosis. So, it seems that therapists preferred to give their clients some homework to do as a counselling technique.

4.3.1.3 What Kind of Assessments Do Therapists Use in Therapy?

This question is divided into two sub-questions. The first section answers the question of 'what kind of assessments do therapists use to measure the clients' issues?', and the second section answers the question of 'how do therapists evaluate clients' improvement over a course of therapy?'.

Measurements and Assessments to Measure Clients' Issues

As a result of therapist interviews, the researcher divided this sub-question into three assessment types: therapists used client problem measures, measures of resources, and personality measures. According to the resulting findings, most of counsellors at the counselling centres used and applied more than one measure and assessment, as these measures were provided by the main counselling centre.

Client Problem Measures

Most of therapists stated that measures such as ***Beck's Depression Inventory***, ***Anxiety Scales***, and ***Phobia Scales*** were provided by the main counselling centres. Therapists said that:

> *"The counselling and guidance main centre adopts some measures such as; Beck's Depression Inventory, Anxiety and Phobia Scales".*

Typically, therapists/counsellors have applied the ***Beck's Depression Inventory*** with their clients at the counselling sessions. According to Informant FM01:

> *"The counselling centre at the university adopts some measurements such as Beck's depression scale, and I use it depending on the client's problem".*

Informants SB13 and GH12 stated similar responses, saying that:

"We use measures when I need to; we have applied the Beck's Depression Inventory"

In addition, about half of therapists/counsellors at the counselling centres administered the ***anxiety scales*** however, they did not identify a specific anxiety measure; therapists reported that they:

"....use the anxiety measure..."

Some therapists use it when they need to. Informant GH12 stated that:

"I use it when I need to"

Furthermore, a small number of therapists have applied a ***scale to measure their clients' phobias***. Informants PF05, CC09 and SB13 reported that:

"We use some measures such as the phobia scale".

Measuring Resources

Therapists/counsellors used other kinds of measurements at the university counselling centre to measure the client's problems. Three therapists were using ***problem solving scales***, and informant FA07 said that:

"I use measures such as problem solving".

Informant GH12 also used the same measure, stating that:

"... I use measures when I need to, I have applied the problem solving scale".

Informant FM01 agreed with her:

"... I use it depending on the client's problems, I have used problem solving scale".

Furthermore, a small number of counsellors have applied ***self-confidence and self-esteem scales***. Three therapists have applied the ***self-confidence scales***, however, they did not identify a specific scale to measure self-confidence. Informant PF05 stated that:

"I use some measures such as self-confidence"

and informant CN08 mentioned that self-confidence was one of the clients' problem, therefore she used it with her client, stating that:

"The lack of confidence is one of the clients' problems, so I have done a questionnaire to identify this issue and other clients issues such as: exam anxiety, stress".

Also, two therapists used a ***self-esteem scale***. Informant FA07 stated that:

"I use measures such as self-esteem scale".

Informant SB13 stated a similar response: "*as I mentioned I used measure when I need to, I have used self- esteem scale."*

Personality Measures

A small number of therapists at the university counselling centre were using personality assessments, such as ***Rotter's measure, personality scales and gender identity measures***. According to informant CE11:

"I use personality scales and gender identity measures because some students think that they have some problems related to their gender, but when I used the measure with them the results showed that they are normal and did not have any problems".

Never Apply

On the other hand, there were a small number of therapists/counsellors who have ***never applied any assessment*** or measurement to their clients. Informant MC03 confirmed that the counselling and guidance unit at the university provided some measures; however she never applied any of them. She stated that:

> *"The counselling and guidance unite at the university adapted some measures such as: depression, anxiety, problem solving and obsessive compulsive disorder scale, but I did not use any measures".*

In addition, informant SS02 had similar response and she also added the reason for not using measurements during a therapy was:

> *"I did not use any measure, because the University did not offer any training course about how to apply psychological measurements".*

Evaluate Clients' Improvement

This section answers the question of how therapists evaluate the clients' improvement over a course of therapy. Therapists at the university counselling centre reported two kinds of evaluation methods. Some therapists used more than one method in order to evaluate their clients' changes.

Observed in Counselling Sessions

The majority of the therapists observed clients' changes or improvement during the counselling sessions. However, they used different kinds of observation methods. Half of therapists considered ***changes in a client's appearance*** and ***speaking*** at the counselling session as an improvement; informants CC09 and FA07 reported similar responses when they stated that:

"I can figure that out while she is speaking, or if there is any change in her appearance".

Another informant GH12 used the same method to evaluate the client change over the therapy; she confirmed that:

"I can see the changes in her appearance".

Another method that was used by therapists was ***insight***; about third of the therapists considered 'the insight'-when the client realised their issues- as change and improvement. Informants SS02, MC03, CN08 and FE10 provided similar responses in which they considered insight as a positive change in the client:

"When the clients had insight and realised the main issues during the counselling session".

Other therapists ***received messages*** from their clients telling them they 'feel better' – three therapists stated similar response, with informants GH12, SB13 and FE10 reporting that:

"Sometimes the client tells me that she feels better".

Another way of telling, as described by one therapist, is the ***client's commitment to attend counselling sessions***. Informant CE11 said that:

"I can see the client's improvement during the counselling session from her responses and commitment to attend the therapy".

Two therapists considered the ***client's commitment to completing homework*** as an improvement. Informants SB13 and CE11 reported similar responses, saying that:

"Sometimes we ask the clients to do some homework, and when they commit to do it, we consider it as an improvement in the clients".

Asking

As another evaluation method, a small number of therapists reported that they applied a ***questionnaire*** at the first session then at the end of a course of therapy; according to informants HC06 and CN08:

"I apply a questionnaire at the beginning of the counselling session, then at the end".

Furthermore, two counsellors preferred to ***ask their clients about their feelings*** toward the end of counselling sessions; informants MC04 and FP05 stated that:

"Sometimes I ask the client questions about her feelings after the counselling session".

Conclusion

Under the 'What kind of assessment do therapists use in therapy?' question there were two sub-questions: the first, indicated responses related to measurements and assessments to measure the clients' issues, and the second, was related to assessment to evaluate client improvement.

The findings of the first sub- *assessment to measure clients' issues*, indicated that, generally, therapists at the university counselling centre applied several kinds of measurements and scales (such as the Beck Depression Inventory, anxiety, phobia, problem solving, self-confidence, self-esteem and other personality scales) as these measures were provided by the main counselling centre. However, a small number of

therapists reported that they have never applied any measurements despite confirming that the counselling unit provided these measurements. So on the whole, therapists did apply measurements and assessments while a small number of therapists did not apply any measures with their clients. Furthermore, some therapists applied depression and anxiety scales while a smaller number applied phobia, self-esteem, self-confidence, problem solving and personality scales.

The findings of *"evaluating client's improvement*", showed that most of therapists used more than one method and they seemed to be interested in and concerned about evaluating their clients' improvement to provide better services. They reported various methods of evaluation – some therapists considered changes to their clients' appearance and their way of speaking as evaluation methods. Less frequently, therapists used clients' commitment to attend the therapy, do their homework, give a questionnaire, and clients telling them that they feel better as evaluation methods.

4.3.2 Research Phase/ Domain 2: Clients' Presenting Problems

This section presents therapists' responses to the kind of problems that clients presented with at the university counselling centre and answers the question: What kind of problems did the clients report? Table 4.3 shows a complete listing of all categories and sub-categories under the client problem domain.

Table 4-3 Summary of Categories under Clients' Problems

Domain	Category	Sub-category
Clients' problems	Obsessive compulsive disorder	
	Anxiety	- Generalised anxiety disorder - Exams Anxiety
	Phobia	- Social Phobia - Necrophobia - Acrophobia
	Depression	
	Interpersonal problems	- Family problems - Lack of confidence
	Academic problems	- Low academic level - Absences - The subject of study

What Kind of Problems Did the Clients Report?

According to therapists/counsellors, clients at the university counselling centre reported many kinds of problems. The majority of therapists stated that there are clients with ***obsessive compulsive disorder***. For example,

Informants SS02 and FA07 said that *"There are some clients with obsessive compulsive disorder".*

Moreover, about half of therapists stated that ***anxiety*** was another problem reported by the clients at the university counselling centre. The resulting findings showed that there are several kinds of anxiety reported at the counselling centres. Some therapists stated that there are clients with anxiety, with informants FP05, MC04 and FA07 saying:

"There are clients with anxiety".

Another type of reported anxiety is more specific and develops in students when they have exams, which makes them seek counselling help. Three therapists reported that there were clients with exam anxiety, and informant SB13 said that

"The most common issue that I have faced at the exam period in the university is anxiety".

Furthermore, a variety of ***phobias*** were presented by the clients at the university counselling centre. Nine therapists indicated that they had clients who presented with one type of this disorder. Six therapists had to deal with clients who had social phobia, with informant CC09 stating that:

"Some clients have fears of presenting in front of a group of people, they do not want to be criticised by other students".

And informant CE11stated that:

"My client had a phobia of communicating with other students or teachers at the university".

A small number of therapists reported clients with ***phobia and fear of death disorders***, and one individual therapist reported a case of acrophobia; she stated that:

> *"There are clients with acrophobia; they could not attend classes in the third floor". (informant MC03)*

In addition to the clients' anxiety problems, eight therapists agreed that ***depression*** was one of the common presenting problems at the counselling centre. For example, informants MC04 and CE11 reported that:

> *"There are some clients with depression",*

and informants FA07 and FE10 added that:

> *"It [depression] is the most common problem that I deal with".*

Another problem identified by the majority of therapists related to ***clients' interpersonal relationships***. And some therapists found that family issues were a problem for clients, such as informant GH12 stating that:

> *"Some clients had family issues with their parent or husband".*

As a variant category, therapists reported the ***lack client confidence*** as another interpersonal issue. Such as informants FA07 and HC06 stated that:

> *"Clients have problems related to the lack of confidence",*

And informant SS02 therapist added:

> *"It [lack of confidence] is the most common problem, [in] clients' relationships with their friends or teachers".*

A small number of therapists reported other problems that clients brought up at the counselling sessions, such as ***academic issues***. Four therapists identified several kinds of academic problems, such as clients who scored poorly at the academic level, absences, and the client's course of study. Informant FM01 stated that:

> *"Students who have low academic achievement are always referred to me by the students' deanship to solve the problem".*

Another informant MC04 stated that:

> *"The client's absences – they did not attend their lectures".*

Finally, a small number of therapists reported other kind of client problems such as ***pharmacotherapy needs*** and ***drug addiction***.

Conclusion

From the above findings, it seems that clients at the counselling centre report many different problems. The therapists identified that they have to deal with many problems such as obsessive compulsive disorder, different kinds of anxiety, phobias, depression, and interpersonal problems. There were seven categories within the domain *clients' problems*. The first of these categories occurred in nine of 13 therapists, who reported obsessive compulsive disorder as one of their clients' problems. The second, which was reported by eight of 13 therapists, was anxiety. In addition, therapists reported other kinds of problems

that clients presented with at the counselling centre; in general, counsellors at the counselling centre saw clients with depression and different types of phobias; less common were family problems, academic issues and interpersonal problems. So, some therapists were working with clients who presented family issues while other therapists did not, and similarly with academic issues and interpersonal problems.

4.3.3 Research Phase/Domain 3: University Counselling Centre Roles and Requirements

This section presents the therapists' responses regarding the roles and requirements that counselling centre adapted whether there was any supervision, and whether the counselling centre offered help and support. See Table 4.4 for a complete listing of all categories and meaning units.

Table 4-4 Summary of Category under Counselling Centre Roles and Requirements

Domain	**Category**
Counselling Centre Roles and Requirements	Set up the Role and Policy
	Supervision
	Receive Help and Support
	Therapists meetings

4.3.3.1 Set up of Role and Policy

There was consensus among therapists/counsellors that ***the counselling and guidance main centre sets up the roles and policies*** at the centre, and provides report forms, measurements, and client information forms. They stated that:

> *"The main counselling centre at the university provides us with the measurements, such as Beck Depression Inventory and anxiety scales, report forms and client information forms".*

However, informants reported that there were always changes to the roles and requirements, which related to changes of the head of the counselling centre.

Furthermore, therapists were ***required to send weekly, monthly, or final reports*** to the main counselling centre. They reported that:

> *"We have to send to the main counselling and guidance centre weekly or monthly reports".*

Furthermore, therapists were required to ***send reports to their supervisors***. Some of therapists were required to provide weekly report. Informant CN08 stated that:

> *"We are required to send a weekly report to our supervisor about the client's issues; this includes how many clients I have met, and the kind of therapy I have used."*

Similarly, with the monthly reports, typically, therapists were required to send ***monthly reports and this depended on their supervisors and the Head of the University Counselling Centre***. Informant FE10 stated that:

"We need to send to the counselling main centre and my supervisor (who is social worker) a monthly report."

It is interesting to note that therapists reported different responses related to the kind of reports that were required to send. Some of them stated that they send weekly reports and other therapists stated that they send monthly reports; this seemed to depend on their supervisors and the Head of the University Counselling Centre.

In addition, nearly half of therapists stated that they had to send ***a statistics report***, including client numbers and problem types, to their supervisors and the Main Counselling Centre. Informant MF01 and six other therapists confirmed that:

"We are required to send statistics reports showing how many clients that I have met and the clients' problems: academic, economic, behavioural and ethical issues".

4.3.3.2 Supervision

The findings show that a number of therapists reported that they had supervisors at their counselling unit to follow up their work and performance. Informants MF01 and MC03 said:

"We have supervisors in our counselling unit to follow up our work, and we need to send them weekly or monthly reports".

Another informant FE10 added that:

"My supervisor is a social worker who I need to send detailed forms about my clients".

4.3.3.3 Receive Help and Support

The majority of therapists/counsellors agreed that when they faced any difficulties, they either ***contacted the counselling main centre or other therapists and social workers*** to ask for help and support on certain client issues. Some informants such as MF01 and SS02 stated that:

> *"I contact the counselling and guidance main centre, when I have some difficulties with clients".*

Several therapists added that:

> *"Sometimes I ask other therapists for help and suggestions".* (Informant MC03)

4.3.3.4 Therapist Meetings

Half of therapists at the university counselling centre indicated that they ***used to have therapist meetings***, but that these had stopped when the head of the Counselling and Social Unit was changed; at these meetings, therapists could bring up any difficulties or discuss any clients' issues and asking for help or suggestions. Informant FA07 stated that:

> *"We used to have therapists' and social workers' meetings to discuss and provide suggestions about client's problems without mentioning any personal information".*

Three therapists' responses revealed that:

> *"We have meetings with our supervisors, therapists and social workers"* (informant CC09)

Conclusion

Overall, under the organisational context domain there are two questions and other sub-questions. The results show that the main counselling and guidance centre at the university is responsible for setting up the roles and policies at the counselling centres around the university. As reported by all therapists (n=13), the main centre provides client forms and reports to each unit. The responses to the setting up the roles and policies question are divided into two sub-categories: first, required reports; the result shows that generally, they were required to report each client case to the main centre and to their supervisors. The second, is offering help and support, the finding shows that typically, therapists seemed happy to ask for help and support if they faced any difficulties, by contacting the Main Counselling Unit or asking other therapists.

The second question under this domain is related to therapist meetings, the findings show that six out of 13 therapists agreed that they have meetings with other therapists and social workers to discuss client issues.

4.3.4 Research Phase / Domain 4: Therapists' Experience

Under this domain four questions, as follows: How long have you been working as a therapist?, How much have you changed overall as a therapist?, what are the sources of changes?, What if any, courses, seminars or workshops have you attended? (see Table 4.5).

Table 4-5 Summary of Categories and Sub-categories under Therapists' Experience Domain

Domain	Category	Sub-category
Therapist Experience	Years of experience	
	Changes	- Improved in their performance - Feeling Better
	Source of changes	- Years of experience and practice - Reading - Attending workshops
	Workshops	- Internal workshops: -Yes -No - External workshops: -Yes -No

4.3.4.1 How Long Have You Been Working as a Therapist?

There were differences among the therapists/counsellors in terms of years of experience. The therapists had between two and 16 years of experience. About a third of them had been working as a therapist at the university counselling centre for four years.

4.3.4.2 How Much Have You Changed Overall as a Therapist?

The majority of therapists at the university counselling centre indicated that they had ***improved in their performance***,

> Informant FM01 stated that *"My performance improved a lot – now I can deal with the client's case, and things have become clearer".*

Another therapist said that:

> *"I have changed in the way of using counselling therapies".* Informant SS02

Informant MC04 added that:

> *The beginning was difficult, but with practice and working with clients my performance has improved".*

The ***therapists feeling better*** sub-category indicates that three therapists reported that they feel much better in their performance. Informant FB05 stated that:

> *"I feel much better, I have learned a lot"*

And another therapist said that:

> *"My work was below the average. Actually, when I got this job I did not do psychologist work. But now I feel better and I can recognize the therapies and the issue".* (Informant HC06)

4.3.4.3 What are the Sources of Changes

Responses to this question are divided into three sub-categories. First sub-category was described by seven therapists this improvement is ***a result of the years of experience, practice, and working with different clients***. One therapist stated that:

> *"It is very useful to work with many clients, I improved in my performance as a result of experience and practice"* (Informant CN08)

The second, reading sub-category the result shows that, five therapists tried to improve their knowledge in counselling and psychotherapy ***by reading.*** Informant MC04 stated that:

> *"We try to improve our performance by reading".*

And one therapist added:

> *"I read a lot on counselling and psychology in order to update my knowledge, especially when I have a new client. I always read about her problem".* (Informant FM01)

Another sub-category as described by one therapist was ***attending some courses and workshops*** in order to improve her skills.

4.3.4.4 What, If Any, Courses, Seminars or Workshops Have You Attended?

Therapists' responses to this question are divided into three sub-categories interested in attending internal workshops, and interested in attending external workshops, and there were two kinds of responses under these sub-categories therapists who are interested in attending and those who are not. The third sub-question indicated the therapist perceived need for additional training.

Internal Workshops

There were two opposite responses about the courses that were offered by the university. Half of therapists at the university counselling centre stated that they have ***attended workshops and courses in counselling and psychology organised by the main counselling and guidance centre at the university***. Some therapists stated that:

> *"We were required to attend a three-month course in psychological disorders and counselling skills. This course was organised by the main counselling centre at the university". (*Informants FB05 and FA07).

Other therapists reported that:

*"We have attended many workshops that were organised by the main counselling centre". (*Informants CN08 and FE10)

One therapist added that:

"I have attended many workshops that were organised by the Main Counselling Centre, such as counselling techniques, counselling skills, family therapy, and diagnosis and psychotherapies". (Informant CE11)

Another therapist added that:

"Also, I have attended workshops in cognitive behavioural therapy and student problems". (Informant GH12)

On the other hand, six out of 13 therapists ***did not attend any courses or workshops that were organised by the main counselling centre at the university***, because as they said:

"The university did not offer any courses in the counselling and psychology field". (Informants FM01 and SS02).

It is interesting to note these therapists reported two different responses about the university offering courses and workshops in counselling and psychotherapy. I speculate that this might be due to the period of obtaining and starting their job at the university, and especially at the counselling centre. For example, three of the six therapists who reported that the university did not offer any courses had been working at the university for more than nine years. Another two of them stated that they did not have time to attend either external or internal workshops.

External Workshops

Most of therapists ***showed interest in attending external workshops and courses*** (outside of the university) in counselling and psychotherapy in order to continue to develop their practice and knowledge. They reported different kinds of courses; for instance, informant SS02 stated that:

> *"I attended workshops in phobias and anxiety disorders".*

Informant HC06 said:

> *"I attended workshops in self-development and obsessive compulsive disorder".*

However, five out of 13 therapists stated that ***a lack of time prevents them from attending any external workshops***, as they said:

> *"We do not have time to attend courses or workshops".* (Informant MC03 and MC04).

Therapist Perceived Need for Additional Training

The majority of therapists ***suggested that the university must provide more courses in order to meet their needs in improving their performance and counselling skills***; for instance, they would like to have ***courses in psychotherapy and associated theories***. Some therapists stated that:

> *"We would like the university to provide courses and workshops in psychological theories in order to improve our skills".* (Informants CE11, SS02 and MC03)

In addition, a small number of therapists said that:

> *"We would like courses in cognitive behavioural therapy (CBT)".* (Informants FA07 and FE10).

Two therapists identified that they need to learn ***how to use counselling measures***, as one therapist said that:

> *"I would like to learn how to apply psychological measures"* (Informant FA07)

While another therapist stated that,

> *"I would like to have a course in how to use the Minnesota Multiphasic Personality Inventory".* (Informant SB13)

Conclusion

In conclusion, under the 'therapist experience' domain there are four questions, the answer of each question being divided into several sub-categories. For the first question, 'years of experience' the findings show that there were differences among therapists in their years of experience. The results of the second question, 'therapist improvement', show that therapists typically indicated that they have improved in their performance and counselling skills, with several feeling much better in providing counselling.

Therapists also referred to several sources of change in the findings of the third sub-category; typical was years of experience or practice and working with many different client cases. Five out of thirteen therapists tried to improve their knowledge by reading, and one therapist by attending courses in counselling and psychology.

Typically, therapists were interested in attending courses and workshops at the university. They agreed that the main counselling centre had organised many courses in the counselling and psychology field. In contradiction to this, however, six out of thirteen therapists disagreed with them and indicated that the counselling centre had never organised any courses.

Furthermore, generally, therapists were also interested in attending other workshops outside of the university. They reported several kinds of courses that they had attended. However, some therapists indicated that they did not have time to attend workshops outside of the university.

In contrast, generally, therapists showed interest in attending courses in counselling and psychotherapies that would be organised by the main counselling centre. They wished that the main counselling centre would show interest and offer courses for them in order to improve their performance.

4.3.5 Research Phase /Domain 5: Therapist Practice Difficulties and Challenges

This domain was answered two questions related to: the external situational difficulties that therapists face, and in-session challenges and difficulties with clients (see Table 4.6 for a summary of these categories).

Table4-6: Summary of Categories and Sub-categories under Therapist Practice Difficulties

Domain	**Category**	**Sub-category**
Practice difficulties	External situational difficulties	- Lack of privacy - Conflict with co-workers and administration - Lack of support/resources
	In-session Difficulties	- Lack of client commitment to therapy sessions - Client silence - Emotions and thoughts - Clients' fear - Have difficulties in using therapies and counselling techniques

4.3.5.1 What Kinds of Difficulties or Obstacles Have You Encountered in Your Practice as a Therapist?

There were differences in the difficulties faced by therapists, both externally in the context of the counselling centre and during counselling sessions.

External Situational Difficulties

Concerning the difficulties and obstacles faced by therapists and hindering them from doing their work, the main complaint identified by therapists in general was ***the lack of privacy and private locations***. Some of them complained about not having privacy during the counselling sessions, and said:

> *"There is no privacy, and it is an inappropriate place for counselling".* (Informant MC03).

Some of them ***shared their offices*** with other therapists and social workers. One therapist stated:

> *"We are three working at the same office – two therapists and one social worker. When one of us needs to meet a client, the others have to leave the office. And before making any appointment with any client I need to make sure that the office will be available".* (Informant SS02).

Another therapist said:

> *"I used to work with ten therapists at the same office"* . (Informant CN08)

This sometimes caused conflict between employees at the counselling centre. Other therapists identified that ***co-workers and students would open the office door at any time***.

One therapist stated:

> *"There are some co-workers do not respect my work; they open the door during the session".* (Informant FM01)

The second difficulty identified by two therapists was ***the conflict with co-workers and administration***. One therapist stated that:

> *"Sometimes the other co-workers taunt me about how I care about my work; they said you don't need to do this kind of work".* (Informant MC03).

Another therapist complained about her supervisor, saying that:

> *"My supervisor was not treating us kindly".* (Informant FP05)

A variant difficulty identified was ***inappropriate tasks***, meaning that their supervisors asked them to do other tasks that were not related to the therapist's role. One therapist said that:

> *"Sometimes we should do other tasks (that are not a psychological task) like some activities*". (Informant HC06).

Finally, rarely, therapists described ***the lack of support and counselling resources*** as other difficulties that they faced at the university counselling centre. One therapist said:

> "*The university does not provide enough measures".* (Informant AF07).

And another therapist stated:

> *"The university does not provide workshops or professional courses for us".* (Informant CC09).

Overall, it seemed that therapists at the counselling centre faced several difficulties that affect their work. There was consensus among therapists that they needed to have privacy while they have a counselling session with a client. In addition, they had conflicts with co-workers and management, they were asked to do other, non-counselling tasks, and the lack of support and resources all impacted on their work.

In-session Difficulties/Challenges with Clients

Therapists faced other difficulties related to their clients during the counselling sessions, and these affected their work. Typically, therapists described ***the lack of client commitment to therapy sessions*** as the most common difficulty. They provided several explanations; one therapist stated that this appeared to be a case of a client's class timetable which prevented her from attending the session. She said:

> *"Some clients did not commit to attend the counselling sessions because of their class timetable".* (Informant MC03).

Another therapist agreed with this as some clients came to only one counselling session and did not show up again, but she gave another reason for this situation. She described it as "*getting an excuse*", and she commented that:

"Some clients did not commit to attending the counselling sessions, or some of clients visit the therapists to get an excuse to avoid attending their classes." (Informant SS02).

It is important to note that some clients came to the counsellors looking for and seeking help, while other students visited the counsellors for a personal need but not a counselling need.

Further difficulty faced by therapists during their counselling sessions was ***client silence***. Five out of 13 therapists considered this as a difficulty, and found it challenging to work with clients who remained silent and avoided talking during the counselling session. One therapist stated:

"*Client's silence, I would end the session if the client keeps not talking".* (Informant FE10*).*

Another therapist described client silence or resistance as a result of a referring case; for instance when a student has an argument with a university staff member or a fight with other students, they were always referred to a counsellor even if she was not willing to see one. She said:

"Client's silence is one of the difficulties". (Informant SS02).

She added*:*

"This always happens when the client has been referred to me by the main counselling centre" . (Informant SS02)

Moreover, a small number of therapists agreed that ***clients' emotions and thoughts*** were one of the difficulties that they faced during counselling sessions. Clients showed different emotions and thoughts during the sessions, and each therapist mentioned different kinds of emotional problems. One therapist said:

> *"The client's stress was one of difficulties that I needed to deal with". (*Informant MC04).

Another therapist stated that:

> *"Some clients show emotional attachments to me, they did not understand the relationship between the therapist and the client. In this case I would refer them to another therapist".* (Informant FE10).

One therapist mentioned that,

> *"Some clients have negative perspectives about attending a therapy; other clients believed that the counsellor will solve their problems at the first session".* (Informant HC06).

In addition to the clients' emotional problems, one therapist stated that:

> *"It is difficult to deal with stubborn clients; they are not open for any new idea or suggestion".* (Informant FP05).

A further problem mentioned by the therapists was ***clients' fear.*** The therapists mentioned two types of client fears: the first one was ***related to confidentiality and privacy***, and the second was about their ***academic status***. Three therapists described some clients as feeling insecure about what was happening between them and their therapists during the

counselling session in terms of whether their therapists would maintain confidentiality or whether their parents would be involved at any stage. Two therapists stated that:

> *"Some clients have a fear or worry to tell their parents about their problems or about attending a therapy".(* Informant FM01 and MC03).

Another fear was described as being when the client worries about their academic status; one therapist added:

> *"Some clients think that attending a course of therapy will negatively affect their studies".* (Informant FM01).

Finally, three counsellors indicated that sometimes they had ***difficulties in using therapies and counselling techniques with their clients during the counselling sessions;*** this could be explained as a lack of appropriate counselling environment. One therapist stated:

> *"I have difficulty applying the relaxation technique with my clients".* (Informant CC09).

It can be concluded that therapists at the counselling centre faced many kinds of difficulties during counselling sessions and these obstacles related to their clients, such as the lack of client commitment the therapy, client silence, clients' fears, clients' emotions and thoughts, and finally the therapists' lack of successful use of therapies and counselling techniques.

4.3.5.2 Have You Experienced a Lack of Confidence in Your Practice?

A small number of therapists described that sometimes they ***had fear and doubts of not being helpful or providing enough support for their clients*** – 'a lack of confidence'. One therapist stated that:

> *"If I face a difficulty in dealing with a client, I prefer to refer her to another therapist or sometimes ask for help and support from other therapists".* (Informant FM01).

However, generally, therapists stated that they ***had never felt a lack of confidence*** in therapies that they provided to their clients. A small number of therapists indicated that they had never experienced a lack of confidence.

4.3.5.3 Have You Felt Afraid That You Were Doing More Harm Than Good as a Therapist?

The majority of therapists at the counselling centre stated that they ***had never done things that may cause more harm than good to their clients***. However, one therapist mentioned that,

> *"Sometimes the length of the counselling session may cause harm".* (Informant MC04).

4.3.5.4 Have you ever felt you Lost Control of a Therapeutic Situation?

The majority of therapists indicated that they ***felt they were able to control everything*** that clients brought it up to the counselling sessions. However, three therapists had different feelings. One therapist revealed that:

"Sometimes when I feel I am going to lose control, I prefer to turn to the health and safety unit at the university and ask for help and assistance." (Informant FM01).

Conclusion

Under the 'therapists' practice difficulties and challenges' domain therapists responded to two questions that related to: the 'external situational difficulties' and the 'in-session challenges'.

The result under the "*external challenges"* question showed that most therapists reported the lack of privacy and inappropriate place to carry out therapy were the commonest difficulties. Next came conflict with co-workers and doing inappropriate tasks, while the findings under the "*in-session challenges*" question showed that seven out of 13 therapists reported lack of client commitment to the counselling session as one challenge that they had to deal with. Several therapists indicated that clients' silence was another difficulty. Clients' fears was another challenge reported by three out of 13 therapists.

4.4 Summary

This qualitative study aimed to describe the nature of the counselling services provided by therapists at the Princess Nourah bint Abdulrahman University counselling centres. Thirteen out of sixteen female therapists agreed to participate in this study. Once the interviews were conducted, transcribed and translated to English, qualitative analyses were performed, following Elliott and Timulak's (2005) version of grounded theory and Braun and Clarke's (2006) thematic analysis.

From the findings, three core categories and several subcategories were identified to enable illustration of the nature of counselling as an activity and process. The study found that

therapists used therapies that were most suitable for the clients' problems and some of them used more than one approach. According to Buckman and Barker (2010), therapists used a therapy or approach that was most appropriate for the client's problem, and sometimes they applied a number of therapies. The therapists in this study used and applied several kinds of counselling techniques, such as homework and relaxation. Furthermore, they used assessments to measure the clients' problems and evaluate any improvement.

According to the participants, the university counselling centre set up the roles, polices, and therapist meetings. In addition, the centre offered and provided help and support to them, and required monthly and yearly reports.

In terms of the years of experience, the participating therapists had been working in their roles in the counselling centres for several years. Some of them showed interest in attending courses and workshops in counselling and psychotherapies. However, others found that the lack of time prevents them from attending counselling workshops. In addition, some therapists expressed their need for counselling training courses in order to improve their skills.

The therapists in this study faced many kinds of difficulties. The main complaints identified by all therapists were the lack of privacy and inappropriate locations for sessions; some therapists shared their offices with social workers and other therapists. Another difficulty was the lack of client commitment to therapy sessions; for example, some clients attended only the first session and then did not show up again. Some therapists also found client silence to be a difficult situation to deal with.

Overall, this chapter presented the kinds of therapies and techniques that therapists provided at the counselling centres, their experiences of being and working as a therapist, and the difficulties faced in practice. In general, therapists seemed satisfied with their work as a counsellor in the university and reported really liking what they were doing. However, they thought it would be helpful if the University Counselling Centre provided a better physical environment, more counselling workshops and professional courses, counselling measurement and training courses. They also wanted the Counselling Centre to offer support, encouragement, supervision and to set up clear roles and polices.

Chapter 5 University Counselling Centre Outcome: A Quantitative Study

5.1 Introduction

Since 1998, a number of counselling services in higher education have attempted to demonstrate the effectiveness of their work using the practice-based evidence paradigm (PBE; Mair, 2016), a quantitative approach rooted in the practice setting (e.g. university counselling settings, UK primary care settings). The concept of practice-based outcome research has been highly influential in recent years (McLeod, 2013). It aims to gather data by implementing routine data collection procedures using measurement and evaluation procedures within community settings. This means collecting data from as many clients as possible in order to measure the effectiveness of the counselling provided in that setting**.** Counselling services are increasingly required to measure clients' outcomes using a questionnaire-based 'repeated measures' design (Vossler & Moller, 2015)**.** Data can be gathered before and after treatment, during the therapy, or session-by-session, and usually there is no control over client or service provision. Data from different sites can be combined to build evidence about the effectiveness of counselling and psychotherapy. This data is necessary to enhance and develop the practice of counsellors and to determine the value of their work (Vossler & Moller, 2015)**.**

Many research questions in counselling seek to determine whether the counsellor is offering an effective service or if counselling is really assisting people with their life (Heppner, Wampold, & Kivlighan, 2008). Quantitative methods and outcome measures can help therapists to evaluate client outcomes and service performance (Vossler & Moller, 2015)**.**

This chapter answers the second general question of this research: is the therapy provided at the counselling centre in Princess Nourah bint Abdulrahman University effective? This outcome study aims to evaluate client change and therapy effectiveness by conducting a self-report questionnaire-based 'repeated measures' design at the university's counselling services, to find reliable evidence that the services that therapists provide at the counselling centre yield substantial benefits that make changes to clients' lives, and if so, to quantify these changes (Vossler & Moller, 2015). A one group pre-post tests design has been adopted in this study. This design has statistical power to client change over time; it measures the outcome variables at different points in time on the same group (Lawal, 2014). Statistically, each client's post-test scores are compared to their post-test scores using a paired-samples t-test (Vossler & Moller, 2015).

5.1.1 Aims

This study aims to answer the following research sub-questions:

1. Are there any differences between the female clients' scores at the beginning of counselling, mid- counselling, and then at the end of counselling?
2. How much change did the clients show?
3. What is the proportion of clients who showed reliable change, clinically significant change, improvement, or deterioration?
4. Are any of the clients doing better or worse than would be expected in relation to their pre-therapy status?

5.2 Method

5.2.1 Methodology

The growth of science has been associated with debates around the role of measurement and mathematics. There is a growing interest among counsellors and psychologists regarding the relevance of philosophical insights and ideas for their work. Consequently, there have been many attempts to make sense of the process of science and to launch a framework of rules of scientific method (McLeod, 2013).

The 'critical realist' paradigm has elements of both positivism and constructivism (Krauss, 2005). The critical realist paradigm views reality as multiple and mediated by power relations, with interaction between the researcher and the researched ideally being transformational and empowering (Vossler & Moller, 2015). This concept agrees that our knowledge of reality is a result of social conditioning, and this cannot be understood independently of the social actors involved in the knowledge derivation process (Krauss, 2005).

In recent years, the fields of counselling and psychotherapy have been looking for useful specific methods and generally moving in the direction of a useful paradigm for therapy research (McLeod, 2013). Jerome Bruner, Dan Fishman and Bent Flyvbjerg have been influential within this movement. Bruner, for example, argues that any attempt to carry out useful research needs to remain open to different ways of interpretation (McLeod, 2013). According to Bruner, there are two ways of knowing: the paradigmatic and narrative modes. The paradigmatic mode 'attempts to fulfil the ideal of [a] formal, mathematical system of description and explanation', while the narrative mode deals with 'intention and action'.

Different modes of research allow us to understand different phenomena and for different reasons. The methods chosen depend more on what the researcher is trying to do rather than on what is practical in the situation (Krauss, 2005). The methods used by the researcher must match the particular phenomenon of interest, and by focusing on the phenomenon under examination rather than the methodology, researchers can select appropriate methodologies for their enquiries (Falconer & Mackay, 1999). The idea is to select a way of understanding that works in terms of making a difference to people's lives (McLeod, 2013).

The epistemological standpoint taken in this study is best described as critical-realist and based on the epistemological relativism. This understands the counselling process as a social practice and emphasizes the relational interaction between therapist/counsellor and client. Therapists work with clients to help them bring about effective change and make differences to their lives. The critical realist paradigm provides resources to understand the nature of the person and the nature of society and is concerned with social change (Hepburn, 2003). This study aimed to evaluate client change (that is, the differences between a client's score at the start of treatment, mid-treatment, and at the end), and to quantify the magnitude of this change (Vossler & Moller, 2015) over the course of counselling within a particular social context. This study is based on the assumption that people have the ability to make changes in their life and that these changes can occur within counselling.

This assumption of changes may be tested based on the study data, as I used a self-report measure designed to evaluate the clients' changes (for better or worse) over the course of therapy and to predict outcomes of the counselling. This measure reflected the clients' own experiences of personal development and their movement toward becoming more fully

functioning persons, as this occurred under natural conditions when facilitative interpersonal conditions were present. It did so by answering statements based on person-centred perspective. This measure allowed the researcher to determine whether the client's pre- post change was reliable and clinically significant.

> *"Evaluation research in clinical services is case tracking. This sets out to evaluate the outcome of individual clients in contrast to the groupings of clients. The basic procedure is to compare each client's progress throughout the therapy against the trajectory that would be expected; given that client's initial clinical status"* (Barker et al., 2016, p.213).

5.2.2 Participants

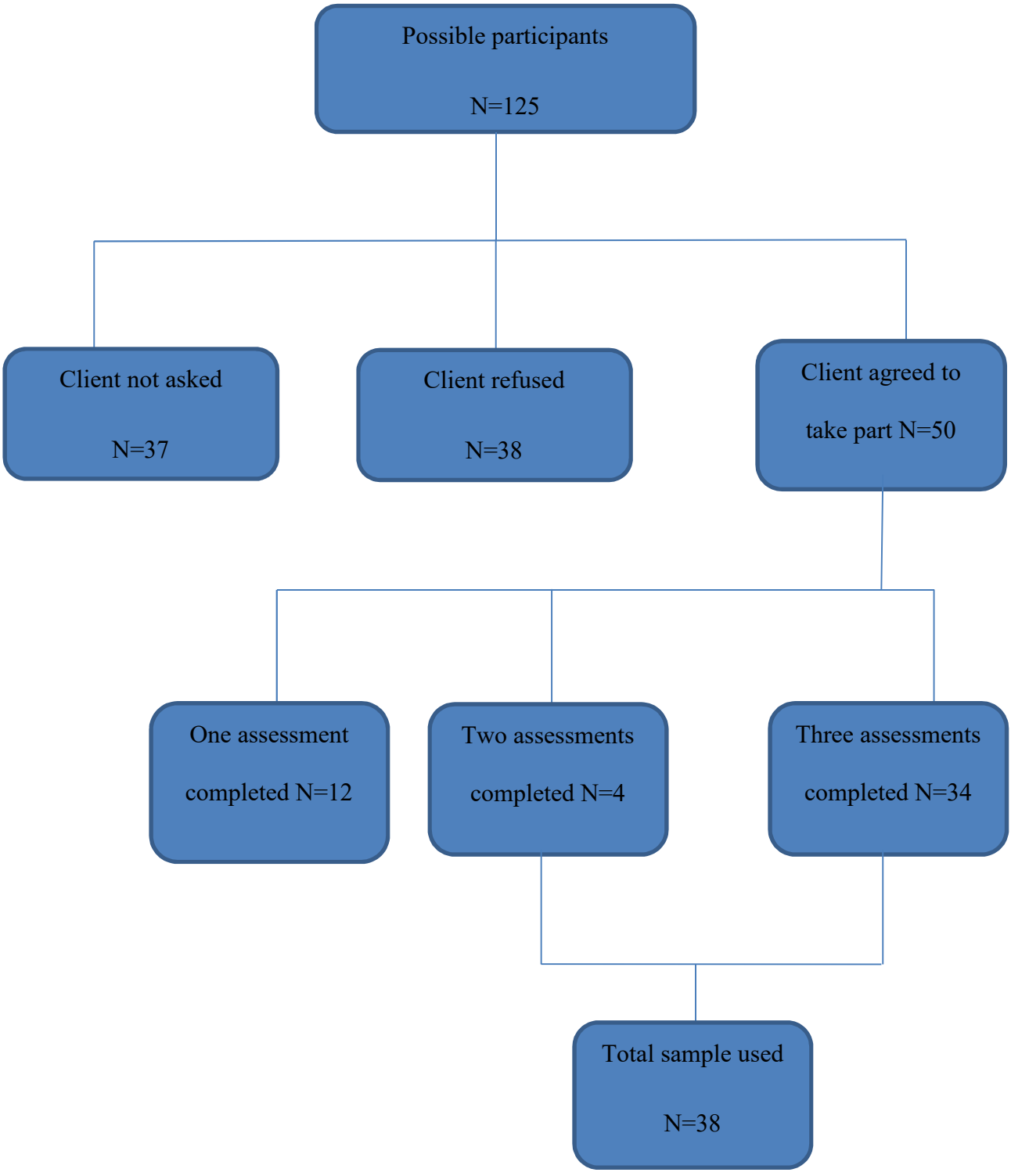
This study took place at the counselling centre in Princess Nourah bint Abdulrahman University, Riyadh, Saudi Arabia. Eleven therapists and fifty clients at the centre participated in this study.

5.2.2.1 Clients

Thirty-seven clients were not asked by their therapists to fill in the questionnaires; according to some therapists, they stated that they did not have the chance to ask their clients to fill in the questionnaire, or they did not have time. In addition, 38 clients refused to take part. In the end, 50 clients in the counselling centres at Princess Nourah bint Abdulrahman University agreed to take part in this study. However, only 34 of the clients completed all three assessments: at the first session, at mid-therapy, and then at the end of counselling. Four clients completed two assessments: at the first session and at the mid-session. Twelve clients completed only one assessment and were not used in any of the analyses; it was thus very common for students to attend one counselling session and then

terminate the services (compare to Hodges et al., 2017). The consort diagram (see figure 5.1) below provides further details regarding the number of participants.

Figure 5-1 Consort diagram for client outcome study



In light of the quality criteria for evaluating outcome research in psychotherapy (see chapter 3), the consort diagram presents the number of available, excluded, and refused clients. In addition, the inclusion and exclusion criteria for client participation are specified below.

Inclusion Criteria for Clients' Participation

- The study included clients who have just engaged university counselling centres for counselling or psychotherapy, did so for the first time, and consented to take part in the study.

Exclusion Criteria for Clients' Participation

- Clients who started therapy before the starting date of the study or were returning after previous counselling were excluded. In addition, students who contacted the counselling centre only for literature, referrals etc were also excluded.

In addition, I did not use data from the 12 clients who visited therapists only once or twice and did not complete any later assessments beyond pre-test.

5.2.2.2 Ethical Considerations

Over the last fifty years, research ethics have become an essential aspect of research, especially for studies that involve people (Vossler & Moller, 2015). Ethical approval was obtained from the University of Strathclyde Ethics Committee in January 2016 (see Appendix 1). In order to protect the clients' confidential data and privacy, the client information sheet, consent form (see Appendix 3) and questionnaires (see Appendix 5 & 6)

were given to the clients by their therapists, and I did not contact with the clients directly. Furthermore, I asked therapists to store the consent forms in their confidential client files, and make sure that any personal information on the questionnaires was deleted. Furthermore, numerical codes were given to each participant and their participation in the research was anonymous.

Emotional impact was also considered. There was a risk that participants might become upset by some of the questions; therefore, they had the chance to stop answering questions or withdraw from the study at any point with no consequences. If the respondents needed any support or had any issues with the study, they could discuss it with their therapists.

5.2.2.3 Therapists

Eleven female therapists agreed to take part in this study. All of the therapists were over 25 years old. The majority held bachelor's degrees in psychology, two therapists had master's degrees in counselling, and two were doing PhDs in counselling. They used various kinds of therapies, such as cognitive behavioural therapy (CBT), person-centred therapy. In general, the therapists reported providing short-term counselling, ranging between four and six sessions. The qualitative interview study reported in the previous chapter provides extensive detail about the nature of this group of therapists' theoretical orientation, techniques used, experience, organisational context and difficulties both with clients and organisationally.

5.2.2.4 Researcher

Based on the therapists' interview data concerning the nature of the therapy (see Chapter Three), I assumed and expected that the course of counselling provided by therapists at the university counselling centres would be effective and that at least some clients would show

positive changes by the end of the therapy. I was surprised and did not expect the number of clients who asked for help from a counsellor and were willing to attend the therapy; this means that people in Saudi Arabia have begun to change their negative views about getting help from a person outside the family and not a friend.

5.2.2.5 Supervisor

The supervisor expected outcome results to be comparable to those for the English-language version of Strathclyde Inventory in the University of Strathclyde Research Clinic (i.e., a large pre-post effect size of around 1.0 sd).

5.2.3 Measures

A demographic questionnaire was developed in order to identify the characteristics of the study population. In addition, the 20-item version of the Strathclyde Inventory (SI-20) was used – a self-report instrument (see Appendix 6) that has previously been validated and is commonly used in the counselling unit at the University of Strathclyde. It was used to measure client changes before and after the counselling. Following the quality criteria for the outcome study (see chapter 3), both questionnaires are described clearly in the next two sections.

5.2.3.1 Demographic Questionnaire

A demographic questionnaire was created in order to identify the participants' characteristics. The questionnaire contains questions pertaining to the subject of the study, year of the study, age, marital status, father's occupation, type of issues, if the client has had any previous counselling, and if any of their family members have also sought therapy (see Appendix 5).

5.2.3.2 Strathclyde Inventory Development

The Strathclyde Inventory is a self-report outcome measure developed by Freire (2007). The first version of the Strathclyde Inventory consisted of 51 items. These items were developed to measure Carl Rogers' concept of the fully-functioning person; this was the pilot version and covered six dimensions of therapeutic change described by Rogers: "internal locus of evaluation, existential living, openness of experience, acceptance of others, psychological adjustment and self-liking" (Rogers, 1961). Thirty items were positively framed (i.e., measured client congruence) and 21 items were negatively framed (i.e., measured client incongruence). Then, this version of the Strathclyde Inventory (SI-51) was revised and the number of items was reduced to 31 (19 items were positive and 12 items were negative). The SI has demonstrated excellent item reliability (Stephen, 2016) with a Cronbach's alpha of .94; construct validity was assessed through comparisons with several other outcome measures (Freire, 2007) and there was good convergence with these measures (Stephen, 2016).

This version of SI-31 item was then adopted and developed by Elliott, Rogers and Stephen (see Elliott (2017), for scoring and interpretation instructions). For the next step, Elliott and Rodgers used data collected from a clinical population to examine the instrument's internal consistency, dimensions and reliability and to produce a 16-item version (Stephen, 2016).

The more recent 20-item version adopted in this study was developed by Elliott, Rodgers, Freire and Stephen (2016). It measures two factors, namely Congruence/Experiential Fluidity and Incongruence/Experiential Constriction. The positively worded congruence subscale items were 1, 4, 5, 8, 10, 11, 13, 14, 16, 18, 19, and 20. It was rated using a five-point Likert scale ranging from 0 to 4, as follows: never (0), only occasionally (1), sometimes (2), often (3), and all or most of the time (4). The negatively worded

incongruence subscale items were 2, 3, 6, 7, 9, 12, 15, and 17, rated from 4 to 0 as follows: never (4), only occasionally (3), sometimes (2), often (1), and all or most of the time (0). To score the Strathclyde Inventory, all scores were added up and divided by the number of non-missing items. This gives the mean or average congruence score. Another way to score it is to separately calculate the mean of the positively worded congruence subscale items and the mean of the negatively worded incongruence subscale items (Elliott, 2017).

The cut-off score was established using the optimal method, Jacobson criterion c, and data collected by Folk-Skinner, Elliott, and Wheeler (2010). The clinical cut-off score of 2.45 was included in this study. On the SI, higher scores are better. This means if a client scores 2.45 or below, they are in the clinical range (Elliott, 2017). The SI-20 takes approximately 3-5 minutes to be completed.

This instrument has been tested and refined by a series of researchers using data collected from a variety of client (clinical population) and non-client population samples (Stephen, 2016).

A more recent French study was conducted (Zech et al., 2018) to investigate the SI-22 item French version (SI-22-F) validity and sensitivity to change among clinical and non-clinical samples. The SI-22-F showed a good inter-item consistency with Cronbach alpha of .88 and adequate temporal consistency. Also, the results showed that the scale is well designed to assess the process of personality development.

Strathclyde Inventory Translation Procedure

Many research tools have been translated into different languages, and data may even be available on scale reliability and validity, as well as norms in a range of language communities (McLeod, 2015, p.106). There are several tools in the psychology field that

have been translated into the Arabic language and have been used in many studies in Arab countries, such as the Beck Depression Inventory and the Taylor Mainfest Anxiety Scale, and have shown good reliability. Translation is a complex endeavour because the ways in which the meaning of emotional and psychological terms may be subtly different in different languages (McLeod, 2015). As mentioned above, the Strathclyde Inventory was developed to measure Carl Rogers' concept of the fully-functioning person (person-centred therapy). This theory (see Chapter One) has been translated into Arabic and many writers have included it in many counselling and psychology books (e.g. Al-Katib, 2007; Qasem, 2012; Zahran, 1998) and it is still taught in all Saudi universities (e.g. King Saud University, Princess Nourah bint Abdulrahman University, and Al-Imam Muhammed bin Saud University). This shows that person-centred therapy is widely considered to be an appropriate therapy to be taught and used with clients in Saudi Arabia, and is regarded as culturally consistent with Arabic and specifically with Islamic society.

The translation procedure was one of the most challenging tasks to be performed in this dissertation. The study data were to be collected from the counselling centre at Princess Nourah bint Abdulrahman University, Saudi Arabia. For this reason, the researcher translated the SI-20 into Arabic. Choosing the most appropriate wording for the translation of the instrument was particularly challenging. The SI-20 was given to a translation company to translate it from English into Arabic, and then a comparison between the researcher's translation and the company's translation was undertaken. To ensure that the respondents would understand the questions (Brace, 2013), each item was discussed with my supervisor to make sure that all item meanings were understood correctly. Further review and back translation (from Arabic back to English) were undertaken by two professors in Psychology in Saudi Arabia. Following this, the Arabic version was given to

a specialist in the Arabic language (who has a PhD qualification in Arabic Language) to check the language and grammar used in the questionnaire. Arabic items were presented in the same order as those in the English version. Finally, Arabic speakers were asked to fill out the questionnaire as a pilot test, to ensure that all of the respondents understood the questions in the same way (Wilson, 2013) and that the items were clear and unambiguous (Brace, 2013).

Item Selection

Descriptive analysis was conducted using SPSS Statistics 22 for the Arabic version of the SI-20 to measure the instrument's reliability, as the averaging process assumes that the items are parallel (Barker et al., 2016). Based on the reliability analysis (see table 5.1) the results found that items 7 ('I have looked to others for approval or disapproval'), 9 ('I have found myself "on guard" when relating with others'), 15 ('I have hidden some elements of myself behind a "mask"'), and 16 ('I have felt true to myself') showed low values (.206, -.001, 280, and 265, respectively) of correlation with the total score for the scale, and if I removed these items, the Cronbach's alpha (the internal consistency of the scale) would be improved. In other words, items 7, 9, 15 and 16 did not hang together with the rest of the scale, and there was insufficient consistency across the whole scale (Barker et al., 2016) so these items would be considered inconsistent items. In addition, the results showed that item 10 demonstrated low correlation with the total score for the scale; however, if I deleted this item, the Cronbach's alpha value would decrease (.844). Consequently, item 10 was kept and items 7, 9, 15 and 16 were removed from the SI Arabic version.

In addition, I conducted another analysis to confirm the results and provide further about these four items in order to make sure it was appropriate to remove them. Consequently, Rasch analysis (Bond & Fox, 2007) was also conducted. The results of the Rasch analysis

suggested removing item 9 (‘I have found myself "on guard" when relating with others’) because this item fell into the more difficult end of the variable and was harder to endorse across clients, which limited its value as an item. On the other hand, item 1 (‘I have been able to be spontaneous’) was located at the easiest level of ability of the respondents; this means item 1 has the highest probability of being endorsed, and was affirmed by many clients. Furthermore, items 7, 15 and 16 were located in the middle of the continuum and within a group of eight items (3, 13, 7, 17, 4, 16, 20, and 15); this means these items appeared to measure similar portions of the trait and therefore, from the measurement perspective, were redundant and were therefore removed – see the ‘item selection’ section below. Based on this, I concluded that both analyses the reliability and Rasch analyses showed similar findings supporting removing the four items from the scale.

Table 5-1 Item Analyses for the Strathclyde Inventory

SI-20 Item	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
1. I have been able to be spontaneous	.356	.436	.841
2. I have condemned myself for my attitudes or behaviour (R)	.562	.445	.832
3. I have tried to be what others think I should be (R)	.482	.443	.836
4. I have trusted my own reactions to situations	.648	.688	.829
5. I have experienced very satisfying personal relationships	.476	.466	.837
6. I have felt afraid of my emotional reactions (R)	.407	.386	.839
7. I have looked to others for approval or disapproval (R)	.206	.360	.848
8. I have expressed myself in my own unique way	.593	.574	.831
9. I have found myself “on guard” when relating with others (R)	-.001	.390	.855
10. I have made choices based on my own internal sense of what is right	.265	.495	.844
11. I have listened sensitively to myself	.560	.631	.833
12. I have felt myself doing things that were out of my control (R)	.503	.563	.835
13. I have lived fully in each new moment	.399	.373	.840
14. I have been aware of my feelings	.480	.378	.836
15. I have hidden some elements of myself behind a “mask” (R)	.280	.290	.845
16. I have felt true to myself	.265	.242	.845
17. I have felt myself doing things that are out of character for me (R)	.478	.469	.836
18. I have accepted my feelings	.475	.458	.836
19. I have been able to resolve conflicts within myself	.503	.526	.835
20. I have felt it is all right to be the kind of person I am	.575	.592	.831

Note. Cronbach's Alpha item reliability for the Arabic translation of the SI-20 was .845 (N=110 assessments)

Reliability of the SI-16 – Arabic version (SI-16-A)

Reliability is the ability of an instrument to measure the attributes of a variable or construct consistently (Geri & Haber, 2014). Reliability refers to the degree of reproducibility of the measurement; if a researcher were to measure in different ways, the same results will be found each time (Barker, Pistrang, & Elliott, 2016). The minimum acceptable value is 0.70, with 0.80 considered a good value for reliability, and 0.90 considered to be overkill or triviality (Barker, Pistrang, & Elliott, 2016). Cronbach's alpha was calculated in this study to determine the internal consistency of the questionnaire (referred to as the SI – 16 – A). The SI-16-A version showed good reliability with a Cronbach's coefficient of .86. This means the items in the SI Arabic version were correlated to each other and showed a good degree of internal consistency.

Validity of the SI Arabic version

Validity is calculated to determine "whether the measure measures what it is supposed to measure" (Barker et al., 2016). Validity may be assessed in several different ways, which correspond to different types of validity used in academic research. The most commonly used measures of validity are content validity, face validity, criterion validity and construct validity (Barker et al., 2016).

Construct validity is examined by quantitatively assessing the relationships of a construct to a set of other variables. The Rasch framework offers procedures for constructing and revising social science measurement instruments and documenting measurement properties of instruments (e.g., reliability, construct validity) (Boone, Yale, & Staver, 2014). Consequently, a Rasch analysis was run to evaluate the validity and quality of the SI-20 Arabic version. I used the full 20- item Arabic version to calculate the instrument validity;

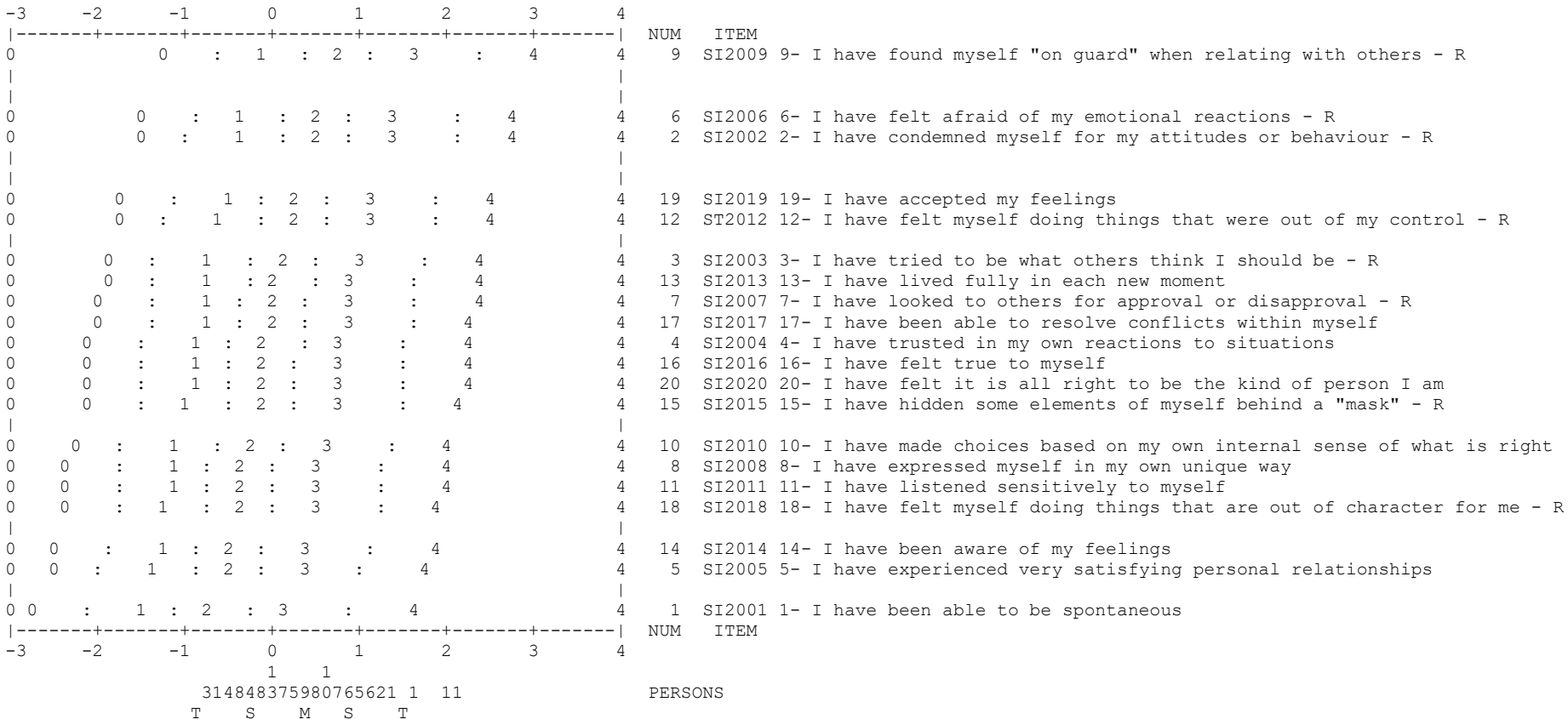
to confirm and provide more evidence that there were four items that were not consistent with the whole scale; those items were removed (see item selection section).

There are number of Rasch techniques that can be taken to evaluate the quality of a measuring instrument. The technique that the researcher used here to understand the SI-20 Arabic version is item ordering and location. The item's location may be interpreted as its relative difficulty for respondents to endorse; this means items located to the right of the continuum midpoint of 0 logit are more difficult to endorse than those located to the left (Hendriks, Fyfe, Styles, Skinner & Merriman, 2012), which are considered "items at the easy end of continuum" (Boone et al., 2014). More intense items are likely to be asserted only by a client possessing higher total scores on a set of items, whereas easier items are likely to be asserted by many clients, including those with lower total scores (Hendriks et al., 2012).

To analyse the SI-20-A version's performance and quality of measurement, and to compare clients' performance (Boone et al., 2014), Rasch analysis was conducted. The Rasch model for test items assumes a single underlying variable or dimensions, and identification of items that do not contribute to useful measurement can be accomplished by reviewing item ordering (Boone et al., 2014). Examining the order and location of items provides further evidence of scale validity (Hendriks, Fyfe, Styles, Skinner, & Merriman, 2012) High item reliability indicates enough items spread along the continuum in which some items are more difficult and some items are easier to be endorsed accordingly. The result showed that each SI-20-A item was located in a position that indicates the level of difficulty or ease of each item with regard to the variable. Each item along the measured dimension showed the probability of the respondent with a specific ability level (Boone et al., 2014). According to the item-person map (see Figure 5.2) items 1, 5, and 14 were

located on the easiest level of ability of the respondent; this means clients were able to be at this level of congruence (to be spontaneous, satisfied with their relationships and aware of their feelings). Next, clients were able to more easily change in this level of congruence (items 18, 11, 8, and 10 – to not feel that they are doing things out of character, able to listen to their self sensitively, express their feelings, and make choices based on their own internal sense of what is right). Then they were at the moderate level of change to be at the next higher level of congruence (items 15, 20, 16, 4, 17, 7, 13, and 3). After that, clients encountered a number of difficulties changing at the levels of congruence (items 12 and 19 – to feel that they control their actions or behaviour and to accept their feelings). Following this, clients were at the level of change difficulty (items 2 and 6 – to not condemn themselves for their attitudes or behaviour and to not be afraid of their reactions). At the highest level of difficulty (congruence), the reverse-scored item 9 (‘I have not found myself "on guard" when relating with others’) was located; this means this item had a lower probability of being endorsed, and this item was only denied by clients who possessed higher total scores on the whole set of items.

Figure 5-2 Item-person Map



Furthermore, it was essential that the questionnaire be able to detect important changes including sensitivity to change or responsiveness over time within individuals, which might reflect therapeutic effects. It is conceivable for an instrument to be both reliable and valid in other ways but not responsive, and this dimension of a health status measure is increasingly essential to evaluate (Ray Fitzpatrick, Davey, Buxton, & Jones, 1998). Some authors consider this change 'responsiveness' as an aspect of validity (Hadorn, Hays, Uebersax, & Theresa Hauber, 1992). Guyatt et al., (1989) defined responsiveness as the ability of an instrument to detect clinically important changes. In this study, the clients' change over the course of therapy is evaluated in a variety of ways, including effect size, reliable change, and clinically significant change (see 'Findings' section).

5.2.4 Data Collection Procedure

The researcher collected the study data from the counselling centre at Princess Nourah bint Abdulrahman University, Saudi Arabia. Once the head of the university counselling centre had approved the study, a list of counselling centre therapists' names and office numbers had been obtained, the researcher met with each therapist to explain the procedure of administering the questionnaires to their clients. Each therapist was provided with a 6- to 10-page information packet (including cover letter, client PIS, client consent form, three copies of the Strathclyde Inventory, and a brief demographic questionnaire) and a copy of name coding and the number of the assessment (for therapist use only) to identify their clients.

Eleven female therapists agreed to take part in this procedure. The researcher participated in this study by teaching and explaining the questionnaire procedure to the therapists and by providing the information packets to each therapist as mentioned above. Therapists

were asked to administer the questionnaires to their clients at the beginning of the therapy, at the mid-point, and at the end, then collect and store these questionnaire packets before handing them over to the researcher. In addition, therapists were asked to add their clients' code numbers to all questionnaires and make sure that no personal information such as names were included on the forms. During this period, I visited and contacted the therapists several times to make sure that they administered the questionnaires to their clients.

Clients who agreed to participate in the study were asked by their therapists to read and sign the PIS and consent forms, and to complete the questionnaires (demographic questionnaire and SI), then return these to their therapists at the first session of counselling to be stored in their confidential client files until being handed over to the researcher. The therapists were asked to keep and store the consent forms in their clients' confidential files, and make sure there was not any personal information in the client's questionnaires before handing these to the researcher.

Therapists collected the PIS, consent form, demographic questionnaire, and the first Strathclyde Inventory in a sealed envelope from the clients at the beginning of counselling, and the SI was administered mid-treatment (session 3-4) and at the end of the therapy. The SI takes approximately five minutes. Each client was given a code in order to protect their identity (each packet had a code), and the outcome measures were subsequently collected from the therapists.

During this period, supervisor Professor Elliott offered support, recommendations, and assistance to the researcher in terms of obtaining ethical approval, translating the SI, support during the data collection period, and helping with analysis.

5.2.5 Data Analysis

Quantitative data analysis can be either descriptive or inferential. Descriptive statistics are used to summarise findings of the data in the study, while inferential statistics provide an evaluation of the real values of the measured variables of the study population (Vossler & Moller, 2015).

Initially, descriptive analyses were conducted to provide a summary of the study data set. Descriptive statistics were used to describe the group's responses in the form of means, standard deviations, frequencies, and percentages. Statistical analysis and statistical significance are essential for evaluation of the therapy; they notify the researcher that the degree of change was not due to chance (Lambert, 2004). However, this analysis does not provide evidence of clinical significance. Consequently, reliable change and clinically significant change were calculated in this study using the procedures identified by Jacobson and colleagues in order to determine how much change occurred during the course of therapy, and how many clients returned to normal function (Jacobson & Truax, 1991). The clinically significant change method involves "calculating the number of clients moving from a dysfunctional to a normative range" (Lambert, 2004). Furthermore, linear regression analysis and residual gain analyses were used to model the relationship between the predictor variable and the response variable. These were conducted to evaluate the amount of change in the post-test and the number of clients who did better or worse than would be expected at the end of therapy.

5.3 Findings

5.3.1 Demographic Questionnaire

This section presents a detailed description of the demographic information provided by the clients. Two clients either forgot or declined to complete the entire demographic questionnaire.

5.3.1.1 Academic Subject

In the questionnaire, academic subjects were divided into three subject groups: sciences, social sciences and humanities, and business. Table **5-2** below shows that 47.3% of the clients studied social sciences and humanities, 21.05% studied sciences, and 13.15% studied in the business school. 18.4% of the clients did not complete this section of the demographic questionnaire.

Table 5-2 Frequency Distribution of Academic Subject of Study Clients

Subject	Frequency	Percentage
Social sciences and humanities	18	47.3%
Sciences	8	21.05%
Business	5	13.15%
Not completed	7	18.4%
Total	38	100%

Note. n=38

5.3.1.2 Year in School

This section was divided into four groups: first year, second year, third year, and fourth year of school. Table **5-3** below states that 31.5% of the clients were studying in the first year of school. Approximately 34.21% of the clients were studying in the second year,

18.4% were in the third year, and 7.8% of the clients were in the last year. It was found that 7.8% of the clients did not complete this section of the demographic questionnaire.

Table 5-3 Frequency Distribution of Year in School

Year in School	Frequency	Percentage
First year	12	31.5%
Second year	13	34.2 %
Third year	7	18.4%
Fourth year	3	7.8%
Not completed	3	7.8%
Total	38	100%

(n=38)

5.3.2 Client Ages

In the questionnaire, age was divided into three age groups: 18-21 years, 21-24 years, and 25 years and older. **Table 5-4** shows that the largest group of clients (44.7%) fell within the range 18-21 years, followed by those who belonged to the age group 21-24 (42.1%); a small percentage of the sample, 7.8%, were 25 and older. It was also found that 5.2% of the clients either declined or forgot to complete this question.

Table 5-4 Frequency Distribution of Client Age

Age Range	Frequency	Percentage
18-21 years	17	44.7%
21- 24 years	16	42.1%
25 and older	3	7.8%
Not completed	2	5.2%
Total	38	100%

(n=38)

5.3.3 Marital Status

Responses fell in three: married, single, divorced. Table **5-5** below shows that the largest percentage of clients (73.6%) were single, followed by the married group at 15.7%, and the smallest percentage of clients were divorced (5.2%). Also, it was found that none of the sample was widowed or chose 'would rather not say'. In addition, 5.2% of the clients did not complete this section.

Table 5-5 Frequency Distribution of Client Marital Status

Marital Status	Frequency	Percentage
Married	6	15.7%
Single	28	73.6%
Divorced	2	5.2%
Widowed	0	0%
Would rather not say	0	0%
Not completed	2	5.2%
Total	38	100%

(n=38)

5.3.4 Client Presenting Problems

The clients were asked to define their problems, which were divided into five categories: academic, social, family, personal, and other problems. Table **5-6** below shows that the largest group of the clients (63.1%) had personal issues, whereas 15.7% of the sample indicated that they had family issues. It was also found that only 5.2% of the clients indicated that they had academic issues, and the same number of clients had social problems. Furthermore, 7.8% of the clients did not define their issues.

From the qualitative study findings the majority of therapists reported different kinds of client problems that they dealt with; the results showed that clients presented psychological issues such as: obsessive compulsive disorder, anxiety, phobia and depression. These findings were consistent with clients' descriptions of their problem as the table below shows; about 63% of the participants described their problem as a psychological problem. Furthermore, about five therapists reported family issues as this also reported by the clients. Finally, a small number of therapists stated academic and social issues.

Table 5-6 Frequency Distribution of the Clients' Problems

Kind of Issues	Frequency	Percentage
Academic	2	5.2%
Social	2	5.2%
Family	6	15.7%
Psychological	24	63.1%
Others	1	2.6%
Not completed	3	7.8%
Total	38	100%

(n=38)

5.3.5 Previous Counselling

In the questionnaire, clients were asked to indicate whether they had visited a counsellor previously. they had previous counselling.

Table **5-7** below shows that more than half of the respondents (65.7%) had not been seen by a counsellor before, whereas 21% had visited a counsellor. However, 13.1% of the sample did not say whether they had previous counselling.

Table 5-7 Frequency Distribution of the Previous Counselling

Previous Counselling	Frequency	Percentage
Yes	8	21%
No	25	65.7%
Not completed	5	13.1%
Total	38	100%

(n=38)

5.3.6 Family Members' Therapy

According to the clients' responses to the question of 'are any of their family members going to therapy?', table 5.8 below indicates that the majority of the clients' family members (81.5%) were not going to a counsellor. 7.8% of the clients' family members were going to see a counsellor, and a small number (10.5%) of clients did not complete this

Table 5-8 Frequency Distribution of the Clients' Family Members Use of Therapy

Family Members	Frequency	Percentage
Yes	3	7.8%
No	31	81.5%
Not completed	4	10.5%
Total	38	100%

(n=38)

5.3.7 Client Therapy Outcome

5.3.8 Descriptive Statistics on Individual Items Pre-therapy

Table **5-9** below shows descriptive data on individual items' means and standard deviations pre-therapy. It indicates that the pre-therapy mean was 2.22 (SD = .79). Item one 'I have been able to be spontaneous' showed the most strongly endorsed difficulty (M = 2.95, SD = 1.25). However, the negatively scored item 2 'I have condemned myself for my attitudes or behaviour' showed the least strongly endorsed item (M = 1.58, SD = 1.38). In addition, the means for items 12 and 13 were identical (M = 1.92).

Table 5-9 Descriptive Statistics on Individual Items at Pre-therapy

Items	M	SD
1. I have been able to be spontaneous	2.95	1.251
2. I have condemned myself for my attitudes or behaviour (R)	1.58	1.388
3. I have tried to be what others think I should be (R)	2.29	1.354
4. I have trusted my own reactions to situations	1.97	1.284
5. I have experienced very satisfying personal relationships	2.82	1.182
6. I have felt afraid of my emotional reactions (R)	1.74	1.349
8. I have expressed myself in my own unique way	2.45	1.350
10 .I have made choices based on my own internal sense of what is right	2.50	1.202
11 .I have listened sensitively to myself	2.39	1.326
12 .I have felt myself doing things that were out of my control (R)	1.92	1.383
13. I have lived fully in each new moment	1.92	1.194
14. I have been aware of my feelings	2.61	1.326
17. I have felt myself doing things that are out of character for me (R)	2.05	1.335
18. I have accepted my feelings	2.63	1.344
19. I have been able to resolve conflicts within myself	1.79	1.455
20. I have felt it is all right to be the kind of person I am	2.05	1.451
Pre –test 16 items	**2.22**	**.79**

Note. N= 38. (R) = Reverse scored item

5.3.9 Research Question 1: Statistical Differences between Client Pre- vs Post-scores

The data analysis was conducted to answer the study question 'Are there any differences between the clients' scores at the beginning of counselling, mid-counselling, and at the end of counselling?'. Thirty-four clients completed three assessments of the Strathclyde Inventory Arabic version, and four clients completed two assessments. One hundred and ten completed assessments were returned.

Descriptive Analysis

The descriptive statistics are associated with clients' pre-, mid-, and post-tests. Clients' pre-therapy SI-16 scores (see Table 5-10) ranged from 1.00 to 3.63 (M = 2.22, SD = 79), while their mid-therapy SI scores ranged from 1.38 to 3.75 (M = 2.43, SD = 58), and the clients' post-therapy SI scores ranged from 1.38 to 3.81 (M = 2.77, SD = 54).

Table 5-10 Descriptive Statistics for Three SI Assessments (Pre, Mid, and Post-test)

SI	N	M	SD
Pre test	38	2.22	.79
Mid test	38	2.43	.58
Post test	34	2.77	.54
Total	110	2.46	.68

Inferential Statistical Analyses: Repeated Measures ANOVA

To determine the differences between the means of the three groups, a repeated measure ANOVA was performed. Prior to conducting the repeated measures ANOVA, the assumption of normality was evaluated and determined to be satisfied. However, the Mauchly's test indicated that the assumption of sphericity had been violated (χ^2 (2) = 11.97, p <.05); therefore the degrees of freedom value was corrected using the Greenhouse-Geisser (Table 5-11) estimate of sphericity (Ɛ = .76). The result of the one-way repeated measures ANOVA showed that the clients' scores were significantly affected by the counselling sessions F (d.f.: 1.52, 3.50) =14.77, p < .000. In other words, there is a difference between the three time points (pre-, mid- and post-tests) and it was statistically significant at p < .000.

Table 5-11 Tests of Within-Subjects Effects

Source		Type III Sum of Squares	Df	Mean Square	F	Sig.
SI	Sphericity Assumed	5.33	2	2.66	14.77	.000
	Greenhouse-Geisser	5.33	1.52	3.50	14.77	.000
(SI)	Sphericity Assumed	11.92	66	.18		
	Greenhouse-Geisser	11.92	50.31	.23		

To know exactly which of the three assessments were significantly different from one another, Bonferroni post hoc tests were conducted. Table **5-12** shows that clients' change differed significantly from pre- test (M = 2.22, SD = .81) compared to post-test (M = 2.77, SD = 54; p = .000). However, the change between the clients' scores at the pre- and mid-test (M = 2.43, SD = .61) was not significantly different (p = .060). Nevertheless, there was a significant difference (p = .001) in the clients' scores between the mid- and post-test.

Table 5-12 Pre, Mid and Post-test Comparisons

SI	**Mean Differences**	**Statistical Significant**
Pre-mid test	-.21	.060
Mid-post test	-.34	.001
Pre-post test	-.55	.000

(N=34)

5.3.10 Research Question 2: Client Change

To investigate client change over the course of therapy, effect size, reliable change, regression and residual gain analyses were conducted.

How much Change Did the Clients Show?

"*An effect size allows the size of the differences between the means of two samples to be quantified in a single value; it is basically an index of how significant the difference is*" (Vossler & Moller, 2015, p.140).

To indicate the degree of change that has been produced by any intervention (McLeod, 2013), the effect size was calculated. The effect size is "the difference between the pre- and the post-therapy mean scores, divided by the pooled standard deviation for pre- and post-test" (Barker et al., 2016). Cohen (1992) suggests that 0.2 can be considered a small effect size, 0.5 a medium effect size, and 0.8 a large effect size. The calculation of the effect size in this study for pre- and post-tests was large (0.79). For the pre- and mid-tests, the effect size was small (0.29), and for the mid- and post-tests it was medium (0.60). In other words, clients made small changes between the pre- and mid- test, however there was a large amount of change between the pre- and post-test, and medium amount of change between the mid- and post-test. The clients completed the mid- test at the third or fourth session with the total amount of six or eight sessions.

What Is the Proportion of Clients Who Showed Reliable Change, Clinically Significant Change, Improvement, and Deterioration?

The most popular statistical method for estimating meaningful change requires that two criteria be met in order for change to be considered meaningful: (1) treated clients must make statistically reliable improvements as a result of the treatment (Lambert, 2013), and

(2) treated clients must move from the clinical population to the non-clinical population. Using pre- and post-test data, reliable change (RC) and clinically significant change were calculated using the procedures identified by Jacobson and colleagues (Jacobson & Truax, 1991). Reliable change (Jacobson & Truax, 1991) is change in a client's score between two time points which is large enough not to be due to measurement error introduced as a consequence of using a particular measure twice. It shows how much change has occurred during the course of therapy (Jacobson & Truax, 1991). "*The differences between a client's score at the start of treatment and at the end and in quantifying the magnitude of this change*" (Vossler & Moller, 2015) is a calculation of a difference score (post-test minus pre-test) divided by the standard error of measurement (calculation based on the reliability of the measure) (Lambert, 2013). The client needs to have shifted by a certain number of points on the measurement scale (McLeod, 2013) for change to be considered as reliable. For the Strathclyde Inventory (SI-20), the test/retest reliability has been estimated at .79, while the general pre-therapy standard deviation has been estimated at 0.47 (Stephen, 2016); this yields a reliable change index value of 0.59 ($p < .05$) this value was calculated on large sample size, while my sample size is quite small and this will produce less reliable estimates of the effect size. Consequently, I used the normative value of (0.59). This means the client's score between the pre- and post-test must move at least than six-tenths of a point to be considered as a reliable change. The result showed 16 clients (47%) made reliable changes at the end of the counselling (see Table **5-14**). In other words, approximately half of the study population improved by at least .6 points (>.6).

Clinically significant change or recovery is a move from below to above an established clinical cut-off point. "The cut-off point is the point when the subject has to cross at the

time of the post-test in order to be classified changed to clinically significant degree" (Jacobson & Truax, 1991). The cut-off points for clinical and non-clinical scores can be established by administering a scale, in its development phase, to group of people known to represent clinical and non-clinical populations (McLeod, 2013). If a client returned to normal function at the end of therapy, this means he/she made a clinically significant change. In this study, to measure the clinically significant change over a course of counselling, the Strathclyde Inventory cut-off point of 2.45 was used; this point was calculated using the procedures identified by Jacobson's criterion c. The means and the standard deviations from data collected by Folk-Skinner et al. (2010) for counselling students were used to represent the non-clinical population, resulting in a non-clinical population mean of 2.88 and a SD of 0.506. The clinical population data was derived from Strathclyde Research Clinic pre-therapy data (Elliott, 2017; Stephen, 2016) with mean of 1.87 and a SD of 0.64. For this change to be clinically significant, the client's score must move from below the cut-off point (clinical population) of 2.45 to above it (non-clinical population). In other words, any client who started the therapy in the clinical population needs to move to the non-clinical population for the change to be considered clinically significant.

Based on this analysis, 20 (59%) clients were within the clinical range, with the lowest score of 1 at the beginning of the counselling (see table 5.13); this means they were below the cut-off point (dysfunctional population) at the start of therapy (see Table 5.15). However, 14 (41%) clients were not within the clinical range when they started the course of therapy; in other words, they were above the cut-off point (functional, or nonclinical population), and the lowest score for these clients was 2.5 (see 5.15). In light of the quality

criteria for the outcome study, Table 5.15 shows the individual results and positive and negative findings were reported.

At the end of the counselling course, seven (20%) clients remained in the clinical range. However, 13 clients moved from the clinical range to the non-clinical range; this means they made clinical significant change. The frequencies of clinical and non-clinical population are presented in

Table 5-13.

Table 5-13 **The Frequency of Clinical and Non-clinical Population at Pre & Post-test**

SI- 16 Arabic	**Clinical Range**	**Non-clinical Range**	**Correlation Pre with Post**
Pre-test	20 (59%)	14 (41%)	.44
Post-test	7 (20%)	27 (79%)	

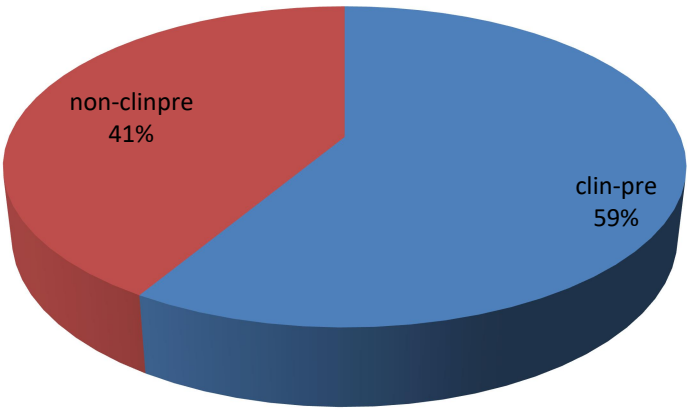


Figure 5-3 Client Proportions in the Clinical and Non-clinical Ranges at Pre-test

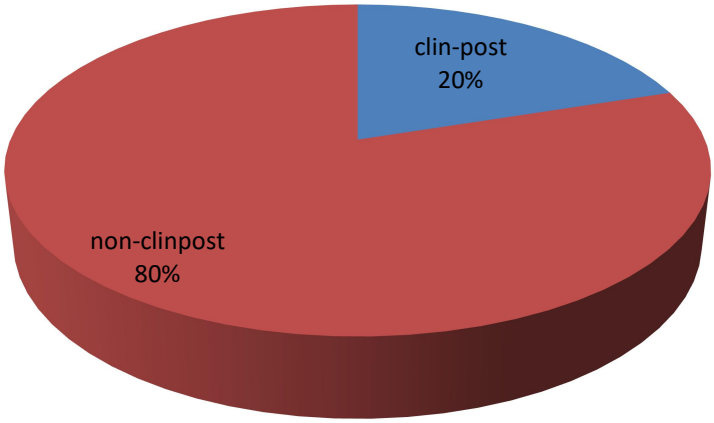


Figure 5-4 Client Proportions in the Clinical and Non-clinical Ranges at Post - test

Table 5-14 indicates that, at the end of the therapy, 15 clients (44 %) showed reliable and clinically significant change. In other words, 15 clients crossed over the cut-off point of 2.45 with a reliable change of .59. Generally speaking, it can be said that approximately half of the clients had a positive outcome, while 50 % (17 clients) showed no benefit or no change. However, one client showed reliable change but not clinically significant change; in other words, this client has improved but not recovered, she was still in the clinical range at the end of therapy. In addition, only one client (3 %) showed deterioration at the end counselling course; many earlier studies have documented rates of deterioration in adult clients at about 5 % to 10% (Lambert, 2013).

Table 5-14 Reliable and Clinical Significant

Site/ N	**Reliable but not clinical-sig change**	**Reliable & Clinical-sig change**	**No change**	**Deteriorated**	**Caseness change**
(SI-16)	N = 1	N= 15	N=17	N= 1	*N= 17*
%	(3%)	(44%)	(50%)	(3%)	

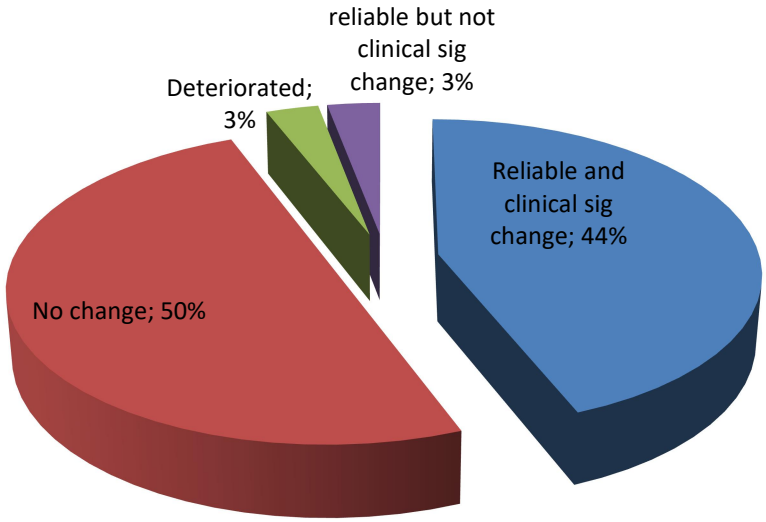


Figure 5-5 Reliable and Clinically Significant Change Profiles

Table 5.15 Pre and Post Scores Differences and Residual

Client ID	Pre	Post	Difference	Residual gain	Reliable Change
CE602	1.19	2.75	1.56	0.56	Y
K102	1.56	3.25	1.69	1.34	Y
K101	1.38	2.69	1.31	0.33	Y
D204	1.56	2.06	0.5	-1.03	N
CE603	1	2.56	1.56	0.30	Y
K104	1.81	3.06	1.25	0.81	Y
HH05	3.19	3.31	0.12	0.48	N
CE601	1.81	2.75	0.94	0.19	Y
K105	1.69	2.75	1.06	0.26	Y
K106	1.19	2.75	1.56	0.56	Y
HH01	2.88	2.81	-0.07	-.32	N
HH03	3.5	3.81	0.31	1.30	N
A305	2.94	3.38	0.44	0.77	N
A306	1.81	2.69	0.88	0.07	Y
PC01	3	2.63	-0.37	-.76	N
PC02	1.88	1.88	0	-1.59	N
PC03	2.69	2.31	-0.38	-1.21	N
PC04	3.5	3.25	-0.25	0.18	N
G205	1.63	2.88	1.25	0.56	Y
SC02	3.63	3.19	-0.44	-.01	N
CB602	3.38	3	-0.38	-.24	N
CB601	2.5	2.94	0.44	0.16	N
CB603	3	3	0	-.01	N
CB604	3.38	3.25	-0.13	0.25	N
CB605	1.63	2.5	0.87	-.19	Y
HH04	1.69	1.38	-0.31	-2.48	N
G201	1.13	2.06	0.93	-.77	Y
PC010	1.5	3	1.5	0.88	Y
K108	2.13	2.94	0.81	0.38	Y

PC012	**2.31**	**3.75**	**1.44**	**1.90**	**Y**
K107	**1.56**	**3**	**1.44**	**0.84**	**Y**
A303-1	**2.5**	**1.56**	**-0.94**	**-2.60**	**D**
K103	**3.19**	**3.06**	**-0.13**	**-.014**	**N**
T1101	**1.81**	**2.19**	**0.38**	**-.92**	**N**

Note. n = 34. Correlation pre with difference = -0.75, Correlation post with difference = 0.24. Y=Yes, N=No, D= Deteriorated

Did any of the Clients Do Better or Worse than Expected?

Regression and residual gain analysis: Scatter Plot. Figure **5-6** indicates that a good linear relationship exists between the pre- and post-tests. Consequently, linear regression analysis was conducted to predict the amount of change in the post-test. The adjusted R^2 of the model is 0.17 with the $R^2 = 0.198$. This means that linear regression explains 19.8% of the variance in the data. The T-value was calculated to investigate the differences between the pre- and post- t = 2.81. The clients above the line were doing better than would be expected. However, the clients below the line were doing less than would be expected. The results were that approximately 55% of the respondents did better than would be expected. However, 44% did less well than would be expected. Furthermore, there are small numbers of outlier clients who were substantially above and below the line. Outliers are usually defined as those being more than two standard deviations away from the mean (Barker et al., 2016). The scatter plot shows that two clients were worse than would be expected. The first client started the first counselling session with 2.50 'non-clinical range' (this means that she was above the SI cut-off point of 2.45) and ended with a clinical population score of 1.56. According to the demographic questionnaire, this client was a second-year undergraduate student, her age was between 21 and 24, and she described her problem as a personal problem; she did not have any previous history of attending counselling or

psychotherapy. She is the only client who showed deterioration at the end of the therapy. The second client started the therapy with clinical range score of 1.69 and she remained within the clinical range at the end of therapy, with a lower score of 1.38. According to the demographic questionnaire, this client was aged between 18 and 21, a first-year undergraduate student, and she did not have any previous history of attending counselling or psychotherapy.

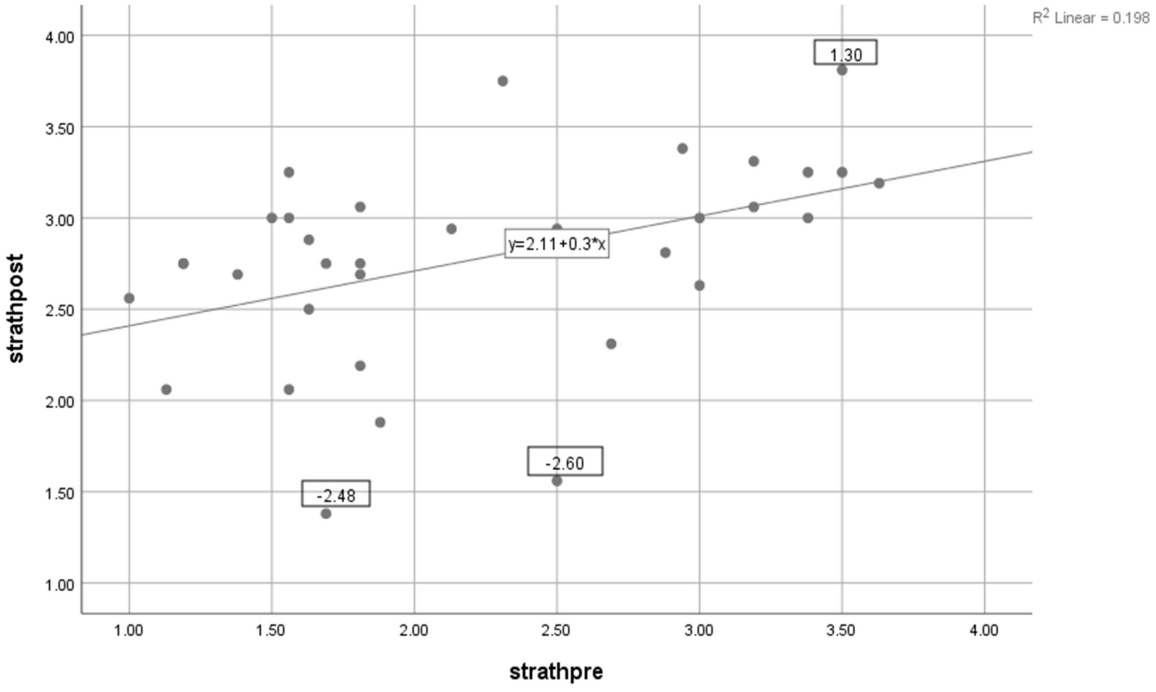


Figure 5-6 Scatter Plots for the Pre and Post-test Relationship

5.4 Summary

The main aim of this study was to explore the effectiveness of counselling or psychotherapy in Princess Nourah bint Abdulrahman's counselling centres by applying the Strathclyde Inventory (SI-20) Arabic version (an outcome measure).

This study consisted of two phases; in phase 1, statistical analysis examined the differences between the clients' scores at the beginning of counselling, mid-counselling, and then at the end of counselling. In phase 2, to determine the client change over a course of therapy, reliable change analysis was conducted.

The study data were collected from clients who were attending the Princess Nourah bint Abdulrahman counselling centre for the first time. Around 50 clients agreed to take part in the study, however only 34 clients successfully completed the three assessments. To answer research questions for phase one, the differences between the means of the three groups were assessed using a repeated measures ANOVA, and showed that there was a difference between the three time points (pre-, mid-, and post-tests), which was statistically significant ($p = .000$).

In phase two, to indicate the degree of changes produced by the clients at the university counselling centre (McLeod, 2013), the effect size was calculated. The results showed that the change between the pre- and post-test was large. The other approach to report on the counselling's effectiveness was to calculate the proportion of individual cases that meet two criteria before client change is considered meaningful: (1) treated clients showed clinically significant change (they moved from the dysfunctional range to functional range) as a result of treatment, and (2) this move needed to be by a certain number of points (reliable change) (McLeod, 2013). The results showed that 44% of the clients at the end of

the therapy made clinically significant and reliable changes. However, one respondent showed clinically significant change which was not reliable. Another client showed deterioration at the end of the counselling. Stulz and Lutz (2007) found that different clients have different trajectories of change, which has implications both for understanding how therapy works and for treatment. Moreover, many early studies indicated rates of deterioration in clients (Lambert, 2013).

Chapter 6 Discussion

6.1 Introduction

This chapter begins with sections that present the two studies' main findings and discuss them separately as related to previous literature, evaluating each study in terms of the existing literature and standards of good research practice. I will first present a discussion about the qualitative study's main findings, its implications and limitations, followed by a discussion of the main findings of the quantitative study, and its implications and limitations. Then, I will present the complementarity between the qualitative Counselling Services Study and the quantitative Client Practice-based Outcome Study. At the end of this chapter, I will provide some suggestions for further research and my personal reflections.

6.2 Discussion of the Qualitative Study Main Findings

This section provides an interpretation and dissection of the main findings of the qualitative study, as perceived by therapists at the university counselling centre. It is divided into four main sections, as follows: 1) the kinds of therapies and techniques, 2) university counselling centre's clients, 3) therapists' experience, and 4) therapists' practice difficulties and challenges.

6.2.1 Kinds of Therapies and Techniques

This section discusses the research question 'What kind of services did therapists provide at the counselling centre?'. It is divided into four sub-topics: the use of therapies, common therapy, common techniques, and finally, measurements and assessments.

6.2.1.1 Use of a Range of Therapies Depending on Clients' Problems

From the results, it is clear that therapists provide different therapies and techniques with their clients and they use more than one therapy depending on their suitability for the client's problems. This approach to selection of therapies is consistent with a model that was identified by Buckman and Barker (2010), which demonstrated that some therapists use the treatment that is most suited to the client's problem. A similar view was also shared by Gilliand et al. (1989) who believed that one treatment cannot solve all clients' problems, and that counsellors need to be flexible in applying counselling therapies or techniques (Lazarus, 1989). A similar pattern of results was obtained with counsellors at a voluntary youth counselling agency in London, who reported that they were flexible in providing therapies and that none of them were using one specific approach (Westergaard, 2013). However, some researchers found that it is not realistic for therapists to become eclectic in theory, and that it would be more beneficial to draw from one or two theoretical bases. I speculate that the reason behind this approach to therapy selection might be due to therapists having no involvement in any psychotherapy training courses or placement programmes while undertaking their bachelors degree or after graduation. It is important to highlight the fact that no universities in Saudi Arabia offer any courses or degrees in specific therapies or psychological treatments; they offer undergraduate and postgraduate courses in general psychology, and no training or placement programme is required to get the degree or to work as a counsellor. Thus, the therapists in this study were applying therapies and techniques based on their learning of general psychological principles.

6.2.1.1.1 Cognitive-Behavioural Therapy was most Common; but Person-Centred Therapy was also used

With regards to the most common approach that has been used by the therapists, the results showed that the majority of therapists use cognitive behavioural therapy. This result ties in well with previous studies (e.g. Poznanski & McLennan, 1999; Stiles et al., 2007; Buckman & Barker, 2010; Westergaard, 2013) that indicated that cognitive behavioural therapy (CBT) was commonly used by counsellors across a range of different counselling settings. It is notable that the majority of the counsellors who reported using cognitive behavioural therapy also reported that they had to deal with obsessive compulsive clients; this may explain therapists' selection of CBT on the basis that they found this treatment the most suitable therapy to deal with anxious clients. This implies that therapists believed that using CBT was associated with reducing the symptoms of obsessive compulsive disorder. Over 40 years of published studies indicate that CBT is an effective treatment for obsessive compulsive disorder (e.g. Stein, 2002; Abramowitz, Taylor, & McKay, 2009; Foa, 2010; Hanour, 2016). However, as described earlier in Chapter Two, cognitive behavioural therapy has attracted more attention from researchers for study and this did prove that the other therapies were less effective in treating psychological disorders.

From the results, person-centred therapy was another treatment highlighted by some therapists; this approach also is supported by results in the existing literature (Elliott et al., 2013; King et al., 1994; Stiles et al., 2007; Thompson, 1995; Westergaard, 2013) at different counselling settings at the University. While counsellors in education settings in Saudi Arabia provided educational and preventive counselling to students (Al-Zahrani, 1990; Aldileym, 2001; & Al-Ribdy 2013), this can be explained by the fact that there is a strong and direct relationship between the kind of counselling services in Saudi schools

and the counsellor's background and qualifications, which are always provided by either a social worker or unspecialised counsellor (Saleh, 1987).

However, when comparing this study's results to those of previous studies conducted in Saudi Arabia, it is important to note that most of the studies were conducted in school counselling or mental health settings, and there has been no study conducted in a university counselling centre setting. With regard to this study's results it must be pointed out that previous studies reported findings about different kinds of interventions: school counsellors provided educational consultations and preventive therapy with their students, while in the mental health settings they provided consultation, diagnosis, and psychotherapy. However, the previous studies did not specify what kind of psychotherapies psychologists used with their clients.

6.2.1.2 CBT Homework was the most Common Technique

There is a strong link between the above findings of CBT being the most common therapy used by therapists and findings about the question; "*what kinds of techniques did therapists use in their practice?*" This indicated that CBT homework was the most common technique, administrated by half of the therapists. One therapist reported that she used this treatment tool with obsessive compulsive clients, stating that "*I asked them to count how many times a negative thought brought up in their minds and try to replace it with a positive thought*". In addition, therapists identified other tools of treatment such as stress inoculation, use of the ABC model, role playing and relaxation. It is notable that therapists were also eclectic in using techniques, and a similar concept was recommended by Lazarus (1989), who stated that counselling would be more effective if counsellors used a wide range of counselling techniques and tailored them for each specific client problem.

In contrast, these study findings differ from Thompson (1995) who reported that person-centred techniques were more commonly used in counselling students. The reasons behind this maybe depend on the background and training of the person who provide the training courses in institutions, and students during the training try to adapt their personalities to fit with the theoretical orientation their educators embrace.

6.2.1.3 Symptom-specific Measures such as the Beck instruments were most commonly used

Most of therapists at the university counselling centre highlighted that the main counselling centre at the university provided measures such as the Beck Depression Inventory, anxiety and phobia scales. In fact, the majority of therapists applied these measures as well as others such as problem solving scales, self-confidence and self-esteem scales. The reasons for using these assessments and scales, as explained by therapists, were to gain more information to reach a specific diagnosis of the client's condition and to develop a treatment plan. As identified by Moon (2012), the purpose of using these assessments is to identify, analyse, evaluate and address the client's problems and circumstances in a counselling relationship. Moreover, client assessment and diagnosis are integral parts of the counselling process (Hohenshil, Findley, Hanna, & Schauer, 1996). Nevertheless, three therapists stated that they have never applied any of these measurements during their practices.

However, these findings are different from previous study findings such as Al-Mosawy's (1998) study, in which counsellors and psychologists reported that there was a lcak of psychological assessment. A similar finding was reported by school counsellors in Turky's

(n.d.) study, which indicated that there was a lack of using and providing psychological assessments.

From the results, the Beck Depression Inventory was commonly used and administered by therapists and/or researchers at the counselling centre; this result is consistent with many previous studies (Abdel-Fattah & Asal, 2006; Al-Sayed, 1997; Ali, 2013; Ward et al., 2000) which administered the Beck Depression Inventory in their research. It is important to note that from the previous literature in Arab and Western countries, this instrument was commonly used in order to determine the prevalence of depression among university students; in other words, this instrument has been used as a tool for evaluation purposes as well as for diagnosis.

6.2.2 University Counselling Centre Clients

This section presents and discusses the main findings of two questions: 'What kind of evaluation methods did therapists use?' and 'What kind of problems did the clients report?' These questions relate to the clients who attended the university counselling centre, as perceived by therapists. It is divided into two sub-topics: evaluating client changes, and clients' presenting problems.

6.2.2.1 Observation was the most common Evaluation Methods to Evaluate the Client's Change

With regards to the assessment and evaluation methods that have been used by therapists at the counselling centre, the results showed that observing the clients during therapy sessions was the most common evaluation methods, used by nearly half of the therapists at the university counselling centre. Therapists considered changes in the client's appearance and their way of speaking as an improvement. Similar responses have been reported in

previous literature (Mellor-Clark & Barkham, 2000; Aldileym, 2004b), which have shown that observation was used by counsellors in order to evaluate client changes. However, in line with the idea of an evaluation method, it can be concluded from the previous outcome studies (e.g. King et al., 1994; Vonk, 1996; Ward et al., 2000) that an available and validated self-report outcome measure was most commonly used by researchers as an evaluation method. This view is consistent with three therapists' responses who indicated that they used a questionnaire in order to evaluate their clients' improvement. It is important to highlight that counsellors need to quantify their clients' improvement by using a validated outcome measure at each session; this could simply mean that some understanding of quantitative methods can be a huge benefit to counsellors, clients, and services (Vossler & Moller, 2015). Thus, the findings of this section which indicated that only a small number of therapists (n=3) used this method, which could be due either to the lack of availability of the measures and assessments at the counselling centre or the lack of knowledge and experience of using these kind of methods.

6.2.2.2 Obsessive Compulsive Disorder was most Common Problem that Clients presented

The prevalence of psychological problems has increased among university and college students (Kitzrow, 2003; Hunt & Eisenberg, 2010). The majority of therapists agreed that obsessive compulsive disorder was one of the clients' problems at the university counselling centre. However, this result differs from what has been found in previous studies (Al Gelban, 2009; Al Otaibi, 2014) located in Saudi Arabia, which indicated that depression was the most common problem among school students. It can be argued that these differences might be due to the majority of the studies conducted in this area being

focused on determining the prevalence of specific disorders among the student population. Moreover, most of the studies were administered to school student populations.

Further results show that more than half of therapists have mentioned other problems brought up by clients at counselling sessions such as anxiety, phobias and depression. This result is consistent with those found in previous studies located in Western countries, Arab countries and Saudi Arabia (e.g.; Hassan & Al-Gamaly, 2003; Eisenberg et al., 2007; Garlow et al., 2008; Buchanan, 2012) which indicated that students have reported many kinds of problems such as anxiety and depression, and these psychological problems were the most common among the student population. These findings might be consistent with those found in the quantitative study (Chapter Four) when 63% of the clients considered their problems to be personal in nature (based on the demographic questionnaire analysis); from the researcher's standpoint, this can be considered as a psychological problem.

6.2.3 Therapists' Experience

This section presents and discusses the main findings about the therapists' experience. It is divided into four sub-sections, as follows: years of experience and improvement, sources of change, courses and workshops, and finally, supervision.

6.2.3.1 Rang of Years of Experience and Improvement in Performance

Years of experience varied widely among therapists, between two and 16 years. On one hand, the majority of therapists demonstrated that they had improved in their performance, describing it as though they feel more effective and can deal with a range of different client circumstances. A similar conclusion was reached by Wheeler (2000) who stated that experienced therapists seemed to produce better results with some client groups than others. On the other hand, they indicated that there is still room for improvement.

6.2.3.2 Reading and Attending Counselling Courses as Sources of Change and Improvement

In line with the previous section, there were also some important differences in the sources of change and improvement among the study participants. The study results show that five therapists tried to improve their performance and knowledge in counselling by reading, and eight therapists have attended courses and workshops in counselling and psychotherapy outside the university.

However, it is notable that therapists reported still seeking more resources in order to improve their performance and counselling skills, and that they saw this as something that could be achieved by attending more training courses in counselling and psychotherapy. This view is consistent with other counsellors' views, who believed that training full time was required (Fulton, 1973). It is also important to highlight the fact that therapists were interested in improving their performance with clients.

These findings are directly in line with other findings wherein therapists complained about the lack of resources that would help them to improve their performance and provide better services to clients, such as the provision of counselling and psychotherapy courses and workshops. Moreover, providing more resources for psychological measurement and assessment to therapists at the university counselling centre would also be beneficial. These results are consistent with those found in previous studies (e.g**.** Al-Mosawy, 1998; Al-Zahrani, 1990; Gora, 1990; Hassan, 1998) which have demonstrated that counsellors complained about the lack of psychological assessments, training courses and workshops that should be provided by the educational ministry. However, most of the studies that have been conducted in this area of Saudi Arabia were located in schools, in which

counselling services are provided by unspecialised counsellors. The majority of therapists at the university counselling centre held at least bachelor's degrees in psychology.

6.2.3.3 Contradictory Responses toward Courses and Workshops that Offered by the University Counselling Unit

The study findings indicated that about half of the therapists stated that the university has offered some courses in counselling – with at least one mandatory course – and that they had attended these courses. However, six therapists disagreed and stated that the university has never offered any courses in counselling.

In line with this, therapists in this study, as discussed in the above section, showed interest in attending counselling and psychotherapy courses and workshops. The majority of the observed therapists reported that they would benefit greatly from attending counselling courses and they wished that the university counselling centre would consider this need by providing more courses. The therapists believed that these courses would help them to improve their skills and knowledge; this result is consistent with the Stein and Lambert (1995) study which showed that more highly trained therapists can produce better results for certain clients. From one aspect, these needs may be considered as a lack of counselling courses provided by the main counselling centre at the university, and also depend on therapists' motivation to attend courses outside of the university. From another aspect, these needs may be explained as a lack of counsellors' qualifications, lack of the provision of sufficient training courses, lack of their skills, and lack of providing psychological measures. The same problems were identified by many school counsellors in previous literature from Western countries, Arab countries and Saudi Arabia (Al-Bahadel, 2012; Al-Ghamdi, 2010a; Al-Mosawy, 1998; Al Otaibi, 2014; Gora, 1990; Hassan, 1998).

6.2.3.4 Consensus Responses in Receiving Supervision

There were indications by all therapists that they have received help and support from the main counselling centre, other therapists, or social workers whenever required. In addition, they stated that they have regular meetings either with their supervisors or with the Head of the main counselling centre at the university. Additionally, therapists were required to send reports to the main centre and their supervisors regarding their clients' cases. Furthermore, they believed that supervision was important and helped them if they felt they were struggling with any of their cases. A similar conclusion has been reported by other researchers who have suggested that supervision could help counsellors to develop and improve their working relationship with clients (e.g. Bimrose & Wilden, 1994; McMahon & Patton, 2000).

6.2.4 Therapists' Practice Difficulties

As described earlier, therapists faced and had to confront challenges and work difficulties which affected their performance in negative way. In this section, therapists' external difficulties will be presented and discussed, followed by challenges encountered with clients.

6.2.4.1 External Practice Difficulties

This section highlights and discusses therapists' external difficulties and challenges. It is important to note that there were several studies in this area conducted in Arab countries and Saudi Arabia; however, most of these studies were located in schools not universities.

6.2.4.1.1 Lack of Privacy

Therapists identified several challenges; all therapists highlighted that lack of privacy and having an appropriate place to provide counselling were the most pressing challenges.

Previous literature (e.g. Al-Zahrani, 2012; Hassan, 1998; Turky, n.d.) focusing on Arab countries and especially in Saudi Arabia drew more attention to counsellors' 'external' difficulties, and counsellors' responses in those studies were consistent with the therapists' responses in this study; they complained about not having an appropriate work environment to provide their counselling services. However, in Saudi Arabia, all of the studies on counsellors' practice difficulties were conducted in schools and no studies were conducted at a university counselling centre to determine those counsellors' practice difficulties.

6.2.4.1.2 Non-supportive Staff

A further challenge identified by some therapists was that they are surrounded by uncooperative and unsupportive co-workers (e.g. other therapists, social works, supervisors, or other workers from the main counselling unit) and this made their work more difficult. A similar pattern of results was obtained in previous studies (Al-Bahadel, 2012; Al-Ghamdi, 2010a, 2015; Al-Zahrani, 1990; Al Otaibi, 2014) in which counsellors complained that they did not receive any support from the school administration or teachers as the latter did not understand and respect the counsellors' work. Similarly, in this study, what therapists meant by the terms 'non-cooperation' and 'non-supportive stuff' was the fact that they had to share an office with other co-workers, were not being respected by others, and were not provided with needed counselling assessment materials and courses. I speculate that this might be due to the counsellors' roles and functions being still unknown and unclear to the majority of staff. This led to the therapists facing further challenges, such as being asked to carry out tasks unrelated to counselling and becoming involved with other activities. This view is consistent with the school counsellors' experienced reported in previous studies where their time was taken up carrying out non-

counselling tasks such as educational activities (Abdulrady, 2012; Al-Ghamdi, 1999; Turky, n.d.).

6.2.4.2 In-Session Practice Difficulties

This section highlights and discusses the internal practice difficulties and challenges that therapists face at the university counselling centre with their clients. It is important to note that there has been no previous study conducted on counsellors' in-session difficulties in the Saudi Arabian context.

6.2.4.2.1 Lack of Client Commitment

In line with practice challenges and difficulties, therapists at the counselling centre indicated that they also faced in-session challenges. Approximately half of the therapists described high levels of drop out, clients withdrawing from treatment, and their lack of commitment to the therapy as being the most common challenges, and they provided different explanations for these challenges. This view is shared by Hassan (1998) who demonstrated that one of the most frequent difficulties faced by counsellors was the lack of commitment of clients to the counselling sessions, and this seemed to be dependent on their free time. A similar conclusion was reported by Hodges et al. (2017) – it was very common for students to attend one counselling session and then terminate the service. Therapists seemed disappointed when clients did not show up again especially when they started the therapy plan. Some therapists tried to contact their clients and asked them to attend the next session or if they are going to attend the next session. In addition, some therapists indicated that we knew that referred clients were not happy and they will not return to the session, except if they were required to attend the session by the Students Affairs at the University.

6.2.4.2.2 Silence

From the results, five therapists identified another challenge: client silence. One therapist described this silence as a type of resistance, especially with referred clients. This standpoint is shared by (Bohart & Tallman, 1999) who described the silence "*as resistance which can inadvertently establish an adversarial role between the client and the therapist*". Knutson and Kristiansen (2015) held a similar perspective that silence can be identified as a symptom of resistance. However, from the therapists' explanations of silence and based on their responses, it can be speculated that this might be due to a number students being forced to see a therapist at the main counselling centre even if they do not want to. It is also important to note that the different explanations that were provided by therapists seemed to be dependent on the therapists' understanding of the client's motivation, way of communicating, and feelings (Coltart, 1991).

6.2.4.2.3 Emotions and Feelings

The study findings indicate that six therapists reported challenges related to the clients' emotions and feelings toward the counselling. Different indications were provided by therapists; some clients showed stress, and others adopted a negative perspective toward the counselling. These different explanations tie in with previous studies (e.g. Al-Mosawy, 1998; Al-Bahadel, 2012; Turky, n.d.) who also report clients' negative perspectives toward the counselling services. Therapists reported that some clients, when they come to the counselling session, are always conscious and try to make sure that they have not been seen by other students, especially their friends. This finding is consistent with previous studies (e.g. Al-Bahadel, 2012; Aldileym, 2001) that described this view toward counselling as a cultural issue.

Other feelings presented by clients, as perceived by therapists, included that clients worried about the security of their confidential information. This standpoint of "feeling insecure" might be due to unclear ethics and counsellors roles and functions in Saudi Arabia. This appears to affect both the therapists and the clients; therapists in terms of not knowing their roles and how best to protect their clients' confidential information, and clients in not feeling secure and trusting towards their counsellors. It also may affect the counselling outcome; perhaps some of the clients who showed no benefit change or deterioration in the outcome study faced some of these challenges.

6.2.5 Study Implications/strengths and Suggestions

Due to the limited amount of research on the nature of university counselling centres in Saudi Arabia, the study findings have provided valuable information based on the view of university counselling centre therapists. These findings have important implications and contributions to the knowledge of counselling services in Saudi Arabia, and specifically to the Princess Nourah bint Abdulrahman University, as related to the therapists' interests and needs. Moreover, these findings point to ways to enhance and develop the counselling services at the university. In addition, it was mentioned in Chapter One that many Saudis avoid going to see a counsellor, and it can be speculated that this might be due to lack of information about the counselling roles, counselling services and how the counselling works. Hence, this study's findings have provided useful information about what services students can access and how the centre works, which may encourage and motivate them to take the first step and visit a counsellor when they feel the need.

In light of the qualitative research evaluation criteria of *'owing one's perspective, coherence* and *accomplishing general vs. specific research tasks*, this current study

provides an overview and better understanding of how the counselling centre at the university works and proceeds by gathering specific data on the common counselling therapies, techniques, measures, and assessments that therapists at the university counselling centre have been using with their clients. The results from these sections revealed the therapists' need for training courses and workshops in counselling and psychotherapy which they believed would help them to develop and improve in their performance, thus leading to better outcomes in clients. It suggests that the university should give more attention to this area and provide counselling courses in order to enhance the counsellors' performance and skills. In addition, based on the therapists' responses, therapists need to be provided with psychological measures and training on how to use these measures properly.

Furthermore, the results highlight therapists' challenges and difficulties in practice. This leads to the realisation that the main counselling centre should consider these difficulties and provide a better environment to deliver effective counselling services.

In light of the qualitative research evaluation criteria (*grounding in examples criterion*) I provided in the analysis and findings sections some examples from the informants/ participants, as these examples allow appraisal of the fit between the data and the researcher's understanding of them; they also allow readers to conceptualise possible alternative meanings and understandings (Elliott et al., 1999, p.222). To evaluate the validity of the interview data (*providing credibility checks evaluation criterion*) I used two methods for checking the credibility of data categories; first, I checked these understandings with the original informants/therapists; and second, I asked an additional analyst, my supervisor, to audit all my analyses and codings.

As indicated by the previous literature about unclear counselling roles and functions, and by the lack of a professional code of ethics in Saudi Arabia, these perceptions suggest that an ethical framework and code of practice for therapists is needed in order to provide clarity about counsellors' roles and functions.

6.2.6 Study Limitations

This was my first experience of doing qualitative research, interviews, data collection and analysis. As most of the therapists did not allow for the interview to be audio recorded, I had to take notes (*respect of participant criterion*); consequently, one limitation is the possibility that I may have missed some important information provided by the therapists during the interviews. In spite of this, I tried to take detailed notes of their responses and asked them if they could repeat some points to make sure that I got enough and correct information, or to add further information. As well as this, I carried out follow-up interviews with some of the therapists (based on their availability) to double check their responses *(providing credibility checks criterion*).

In terms of the data analysis process and to overcome any difficulty in this area, I attended several workshops in qualitative research analysis, and checked the analysis with my supervisor.

In light of the qualitative research evaluation criteria (*situating the sample criterion*), I did not provide a demographic questionnaire or ask specific questions that are related to the sample characteristic; however, most of them talked about their qualifications and their experience in the counselling field even though I did not ask, and this was useful information to be included in the participant section for the study (Chapter Four).

6.3 Discussion of the Quantitative Study's Main Findings

This section summarises and discusses the main findings, contributions and limitations in the outcome study and compares these findings with previous literature. This present study was designed to assess the effectiveness of the counselling services at Princess Nourah bint Abdulrahman University by calculating the clients' scores and changes over a course of therapy to determine whether or not there are differences between the client scores at three time points (beginning of the counselling, in the middle, and at the end), and to determine how many clients showed reliable change, clinically significant change, and deterioration.

6.3.1 Differences in the Client Scores

The result of the one-way repeated measures ANOVA showed that the clients' scores were significantly affected by the counselling sessions (F (1.52, 50.30) =14.70, $p < .05$). This means there were differences between the three time points from the beginning of therapy to the middle and then at the end of therapy. This finding is consistent with a previous outcome study conducted by Stiles et al. (2006) which demonstrated that there were differences in the client scores between the pre-therapy and the post-therapy. However, the change between client scores at the pre- and mid-test ($M = 2.43$, $SD = .61$) was not statistically significant ($p = .060$); thus, it can be speculated that this might be due to the way the questionnaire was administered to the clients, or dependent on the total number of counselling sessions. In addition, it could simply mean that 3 to 4 (as the second questionnaires were administrated at the 3rd or the 4th session) sessions were not enough to produce the clients change and more session were needed. While there was a significant difference between the pre-test and the post-test, this is considered to be an important

finding. It is notable that the large changes were occurred between the first and the last session (pre-post).

6.3.2 Client Change

Initially, the results indicated that 14 clients (41%) were not within the clinical range, while 20 clients (59%) were within the clinical range when they started their counselling sessions. At the end of the counselling course, 13 clients moved from the clinical range to the non-clinical range; however, seven clients remained within the clinical range. The present finding seems to be consistent with a previous study (Mellor-Clark et al., 2001) which indicated that about 24% of the study sample were not within the clinical range at the intake session, and 76% of the sample were within the clinical population. From the results, it is clear that not all clients who were seeking help started their course of therapy in the clinical population range, and dividing the clients into clinical and non-clinical populations seemed to be dependent on the outcome measure that was used in the study and its cut-off point. However, the CORE-OM self-report questionnaire was used in Mellor-Clark et al. (2001) study, while in this study the Strathclyde Inventory was used. Both of these instruments are appropriate within a repeated measure design and can be used for the same purpose; however each of them contains different domains.

From the reliable and clinical significant change analysis, the results indicated that 47% of the clients made reliable change, and about 44% of the clients showed reliable and clinically significant change at the end of the counselling. However, 50% of the study population showed no change or benefit, although only one client showed deterioration at the end of their counselling course. I can speculate that this percentage maybe presents the clients with difficult to change or some of these clients were forced to see therapists. The

findings are directly in line with previous findings (e.g. Mellor-Clark et al., 2001; Connell et al., 2008) which indicated that about half of the clients in both studies made reliable and clinically significant changes at the end of counselling. Additionally, there were some clients who showed no change and 1.5% of clients showed deterioration. However, there were also some important differences between my study and their studies based on the counselling settings, the kind of therapies that clients received the methods, data collection procedure, and population. It is important to highlight that in each effectiveness study there were some clients who showed reliable change and/or clinically significant change, while other clients show no change or deterioration. It is interesting to note that each client has a different personality and they may respond to therapy differently. It is also may depend on the client's motivations to change and/or approaches that were used by therapists which may provide a different path toward personal development and emphasise different aspects of the clients (Bohart & Tallman, 1999).

Further results from the regression and residual gain analysis found that 55% of the clients did better than expected. However, 44% did worse than would be expected. This analysis was conducted to evaluate the amount of change in the post-test.

Finally, it can be concluded that the counselling provided at the university counselling centre was effective or had a positive impact on some clients (44%) who made reliable and significant change. While 50% of the clients showed no change, this could be due to the fact that many of them started the course of therapy within the non-clinical population.

6.3.3 Study Implications

Most of the studies conducted in Saudi Arabia were carried out to examine the effectiveness of a specific therapy to reduce a specific disorder. There has been no study

conducted to evaluate client changes over a course of therapy in a general university mental health counselling settings. The findings of this outcome study have a number of important implications and contributions for the field of counselling in Saudi Arabia. It demonstrated the utility and the significance of the Princess Nourah bint Abdulrahman counselling centre services. In addition, these study findings provide valuable information to therapists, and the main counselling centre at the university. Therapists could benefit from the knowledge that the services being provided were generally effective with many clients. However, at the same time therapists may want to improve their performance. The Main Counselling Centre benefit is to continue to provide help and support to therapists and consider the importance of the quality of the counselling services that are provided.

In light of the quality criteria for evaluating the outcome study in the psychotherapy field, the study's questions, design, methods, methodology were described and stated clearly, and appropriate statistical tests were performed. In addition, the main findings were summarised with regard to the objectives of the study in Chapter Five. In addition, I considered and applied the quantitative outcome study criteria "see chapter 3" throughout the outcome study "chapter 5".

6.3.4 Study Limitations

There are a number of limitations to this study: the method, the distribution of the questionnaire, small sample size, and lack of time for data collection. The main limitation was the lack of outcome measures in the Arabic language, which meant that the twenty-item version of the Strathclyde Inventory needed to be translated from English to Arabic. It was difficult to find an outcome study that conducted in Saudi Arabia. However, some researchers in Saudi Arabia used the Beck Depression Inventory (BDI) to determine the prevalence of depression but not as an outcome measure, as in Western countries the BDI

was commonly used by many researchers as an evaluation measure. This implies that it might be better to use an instrument that has been used with the Arab population before such as the BDI.

It is important to note that the translation procedure was challenging; however, to avoid translation errors, multiple reviews and checks were carried out. Another limitation related to the study was that items had to be removed from the SI-20 based on psychometric analyses using study data; the reliability and validity were calculated for the tool and four items were removed because these items showed low values of correlation with the total scores of the scale, and these items did not contribute to useful measurement; however, this also reduced the comparability of the English and Arabic-language versions of the SI. These items (‘I have looked to others for approval or disapproval’), (‘I have found myself "on guard" when relating with others’), (‘I have hidden some elements of myself behind a “mask”’), and (‘I have felt true to myself’) can be explained in light of the culture difference between western and Saudi Arabia. Parents in Saudi Arabia are portrayed in the culture as resources of learning values and as always being able to provide council in almost any situation. Thus, we always look for their approval and disapproval, ask them to help us in making decisions, and they always encourage their children to be careful with everything and return to them if they face any problem.

Another limitation of this study is the questionnaire administration procedure –- that is, whether therapists followed the procedure that was explained to them or not. To avoid this limitation, each therapist was provided with information about addressing the questionnaire to the clients, including confidential information protection. Furthermore, I tried to keep in touch with the therapists to make sure that they followed the procedure and to remind them about the questionnaire.

Another limitation is the small sample size. This might have been due to several factors, including therapists' lack of motivation or forgetting to ask their clients, as well with therapists' lack of availability. Two therapists agreed to take part in this study, but then they were on holiday during the data collection period without giving any notice to the researcher. However, the results did suggest that student counselling was effective for many of the clients who started the counselling within the clinical range of distress.

The lack of time for data collection (*period of investigation quality criterion*) was another limitation which also limited the sample size. I faced a delay from the Saudi Arabian Cultural Bureau in the UK to travel back to Saudi Arabia to start the data collection. In addition, I was allowed to stay there for only three months. So to collect more data, I left the questionnaires with the therapists after I explained the procedure and got their contact information to check with them. Then, I went back four months later to collect the questionnaires. It is very likely that my not being there to remind and motivate the therapists meant that less data was collected.

6.4 Culture and counselling in Saudi Arabia

As discussed earlier in this dissertation, Saudi Arabia became more interested in counselling and psychotherapy as many counselling centres in Saudi's universities have established in order to meet the students' needs.

I also considered the culture differences by providing more details in Saudis perspective toward counselling. In addition, Arab researchers have attempted to explore how counselling approaches such as (CBT, PCT, and psychodynamic therapy) are related and appropriate to be applied in Arab, Muslim, or Saudi culture. The literature indicated that there are some useful concepts in each approach which are consistent with Islamic and

Arab values and culture. And the present research findings confirmed the use of these different approaches and techniques by the university's therapists.

6.5 Complementarity between the Qualitative Counselling Services Study and Client Practice-based Outcome Study

There were two main phases of this research: first, to understand and explore the nature of the Princess Nourah bint Abdulrahman University counselling centre services as perceived by therapists as there is little known about how counselling centres work and what kind of services provide, and second, to look at client outcomes as a result of the counselling they have received and examine its effectiveness.

Each of the two studies aimed to provide evidence of how the university's counselling centre works, and whether the services that are provided to clients at the centre work. Together, these studies provide important insights into the counselling services field in Saudi Arabia. Therapists at the counselling centre provided an overview about the counselling services. They determined the kind of therapies and techniques used with their clients, they demonstrated their need for training programmes and counselling workshops in order to improve their counselling skills, and they identified the difficulties and challenges faced in their practice and within the university. In the second study, clients' outcomes over the course of their therapy showed that there were differences between the three time points (pre-test, mid-test and post-test). Further results showed that half of the clients had a reliable positive outcome on the SI-16-A, although 42% showed no benefit.

It can be seen that there might be a relationship between the clients who showed no change/ benefit, or even deterioration, and therapists' responses in the interview study in that some clients were being forced to see a therapist by the main counselling centre staff,

even if they did not want to. Another explanation for these results might be due to the unsuitable environment in which the counselling took place, as therapists reported that they did not have privacy during their counselling sessions. These difficulties might explain the results of clients who showed no benefit or who even deteriorated by the end of therapy, as they could have disrupted the counselling sessions and made clients uncomfortable.

6.6 Research Contributions

Judging from the limited literature and small number of research studies conducted in Saudi Arabia, little is known about the nature of its university counselling centres and their effectiveness. Most of the existing counselling research studies were conducted either in mental health hospitals or school counselling centres. The findings of this research thus contribute to counselling and psychotherapy research, and to counsellors and psychologists wishing to understand how a university counselling centre in Saudi Arabia works, what services it offers, what therapies, techniques, measures and evaluation methods that counsellors adapted and used, and whether client seen in this centre make any changes by the end of therapy.

The present findings demonstrate that therapists provided different kinds of therapies and techniques which were more suitable for the client's problem such as (CBT, PCT). In addition, therapists indicated that they have improved in their performance and they felt much better in providing counselling as these a result of work experiences and reading. Furthermore, they faced difficulties while providing counselling sessions as well as environment challenges. The counselling services outcome showed that about 44% of the clients made reliable and clinically significant change but that about 50% of clients showed no change at the end of the counselling sessions.

In practice, the two studies may provide benefit to the therapists at the university counselling centre. The therapists may benefit from learning about the counselling approaches provided by other therapists, their practice difficulties and challenges, the importance of the supervision provided by the main centre and the effectiveness of the counselling services that they provided. Therapists may also get the benefit of the outcome study findings as these results are necessary to enhance and develop their practice and to determine the value of their work.

In addition, both studies may provide benefit to the Princess Nourah bint Abdulrahman University counselling centre as this research provides an overview of how the counselling centre works as perceived by therapists and its outcome as reported by clients.

6.7 Researcher's Accountability

My background in counselling and guidance and my lack of experience in working and training as a counsellor (when I was undergraduate student I had only 3 months placement program in the last semester) may explain why I chose to do this kind of research, and why I selected the research methods (interview and self -report measure) that I did. I was really interested and became more interested to know how counselling in Saudi Arabia works, what it provides and offers, and whether the counselling provided is effective.

The research findings have influenced by many factors; they could have been influenced by my background and interest in counselling and psychotherapy, and more particularly by questions I selected for the interview schedule, by the instrument that I used, by the way I asked the questions and how therapists administered the questionnaire. Beyond this, an important influence was how therapists/counsellors interpreted the questions I asked in the interviews, and how clients understood the questionnaire instructions and items. These

factors may also explain the unexpected findings in both studies: For example, I did not expect that the counselling centre offered supervision, support and courses, as reported by some therapists. I also did not expect the kinds of client problems that therapists reported such as obsessive compulsive disorder, anxiety, and depression; instead, I expected academic problems to be most common. I expected to find that the counselling centre set up clear roles and requirements, but this turned out to not be the case. Furthermore, I did not expect that about half of the clients would show no benefit or change by the end of the therapy. I was also surprised by the number of clients who agreed to take part in this study; I expected only small numbers due to client concerns about privacy and confidentiality.

6.8 Suggestions for Future Research

As there is no existing study that documents and determines the counselling services, specifically looking in depth at therapists' experience and practice difficulties and calculating the clients' outcome over a course of therapy, this research finding contributes to the counselling field in Saudi Arabia. It provides rich information that explains the university counselling centre service, how it works, and what its outcomes look like.

The findings point to future research that may be conducted among counselling centres at different universities with a larger sample. Such study could investigate the relationship between the services that therapists provide and their outcomes. These could include therapist effects; the impact of therapists' interventions on the clients' changes over a course of therapy. Further research is also necessary to investigate therapists' in-session practice difficulties by looking in depth to determine the nature of these challenges.

Further outcome research is recommended using different outcome measures or administering the SI-20-A on a larger sample and testing its validity and reliability, as

there has been no study conducted to calculate client change over a course of therapy – especially at a university counselling centre in Saudi Arabia. In addition, researchers in the counselling and psychotherapy field should develop an outcome measure and test its validity and reliability so that it can be used in a counselling centre as an evaluation measure. This may help therapists/counsellors and counselling organisations to more effectively evaluate the quality of their work.

6.9 Personal Reflections

As a researcher, I became more interested in this topic after noticing the lack of studies conducted in counselling services and practice-based outcomes in Saudi Arabia.

This was my first experience contacting and interviewing participants. When I was developing my qualitative research questions I did not expect to collect all of the data that I did. It was not easy to ask people to give details regarding their work and at the same time provide help to administer the questionnaires to their clients. Therefore, what I found surprising and unexpected was that most of the therapists at the counselling service were very kind and willing to offer any information that I needed. This was particularly helpful when it came to conducting the follow up interviews. In light of the research findings I did not expect the level of supervision offered by the university counselling centre and the positive impact this had on the therapists' performance. On the other hand, I expected that the counselling would have adapted clear, fixed roles and polices, and that staff would have been more careful with client confidentiality and privacy, a key area of dissatisfaction for therapists, who were unhappy when the counselling centre asked for client personal information that therapists did not think clients had given permission for them to share.

In terms of methodological learning, this was my first experience analysing research data. This research added new knowledge to my personal learning as I now understand and have become more aware of how to analyse qualitative and quantitative data. I gained new knowledge about carrying out a version of grounded theory and thematic analysis and conducting the analysis of client change: calculating the reliable and significant change.

As an academic lecturer, I hope to be able to use this experience to conduct more research within the field of counselling, exploring the therapists' work and its relationship with the outcome. I would like to translate the CORE Outcome Measure (Barkham, Gilbert, Connell, Marshall, & Twigg, 2005) into Arabic, test its validity and reliability in the Arabic population, and then suggest it for use in counselling centres as an evaluation method. I would also potentially use the SI-20-A with a larger sample. As a future counsellor, now I have attained the Counselling Skills Certificate Course (COSCA) I would love to be involved in a training programme in counselling and psychotherapy to eventually work as a counsellor.

References

Abdel-Fattah, M., & Asal, A. (2006). Prevalence, symptomatology, and risk factors for depression among high school students in Saudi Arabia. *Europe's Journal of Psychology*, *2*(3).

Abdulrady, N. (2012). *psychological stress and its relationship with efficiency among school counsellors*. Al-Azhar University.

Abo-Shaer, A. (2007). *The irrational thought and its realtion with some variables among Palestinian universities students*. Isalmic university.

Abramowitz, J. S., Taylor, S., & McKay, D. (2009). *Obsessive-compulsive disorder*. *The Lancet* (Vol. 374). Elsevier Ltd. https://doi.org/10.1016/S0140-6736(09)60240-3

Abu Hassan, Z., Schattner, P., & Mazza, D. (2006). Doing a pilot study: Why is it essential? *Malays Fam Physician*, *1*(2–3), 70–73.

Al- Rabiah, F. (1996). King Saud University's students perspective toward the profession of clinical psychologist. *Scientific Journal of the Faculty of Art, Minia University*, *20*, 65–95.

Al-Ahmady, M. (1988). *The importance of various guidance and counseling functions at King Abdul Aziz University, Saudi Arabia, as perceived by administrators, faculty, and students*. Ohio University.

Al-Ahmari, S. (2012). The professional psychological pressures among schools' counsellors in Aseer, Saudi Arabia. *Educational Journal, Alazhar University*, *147*(1), 187–223.

Al-Aied. (2007). The importance of mental health for university students. *Damascus University Journal*, *23*(273–298).

Al-Bahadel, D. (2004). *The feasibility of introducing counseling for women and family therapy into society within Saudi Arabia*. University of East Anglia, Norwich, UK.

Al-Bahadel, D. (2012). The role and functions of the students ' counseling centre as perceived by students at Al-Qassim University in Saudi Arabia. *Damascus University Journal*, *28*(3), 31–74.

Al-Gelban, K. (2007). Depression, anxiety and stress among Saudi adolescent school boys. *The Journal of the Royal Society for the Promotion of Health*, *127*(1), 33–37.

Al-Ghamdi, H. (2010). Effectiveness of cognitive behavioral therapy in the reduction of generalized anxiety disorder. *Educational and Psychological Science Journal, Umm-AlQura University*, *2*(1).

Al-Ghamdi, N. (2010a). *An inverstigation into perceptions of actual and ideal role of*

school counsellors in SAudi Arabia girls' school. Durham Univresity.

Al-Ghamdi, N. (2010b). *An Investigation into Perceptions of the Actual and Ideal Role of School Counsellors in Saudi Arabia Girls' Schools*. Durham University.

Al-Ghamdi, N. (2015). The problems faced in career counseling in Saudi Arabia : an exploratory study in private girls schools, *27*(6), 6113–6117.

Al-Ghamdi, S. (1999). *Perceptions of the role of the secondary school counsellor in Saudi Arabia*. University of Hull.

Al-Hmad, & Al-Momny. (2014). The role of counseling and reality therapy in reducing adolescents' feeling of psychological depression. *Almanarah Journal for Research*, *20*(1).

Al-Katib, S. (2007). *Counselling in school: its foundations, theories and applications* (2ed ed.). Al-Ain: University Book House.

Al-Kubaisi, A. W. (2012). *Guidance and educational guidance: studies and research*. Debono Center for Teaching Thinking.

Al-Malki, M. (2002). *Attitudes of Qatari citizens towards marriage and family counseling*. , University of Abertay, Dundee, UK.

Al-Mosawy, H. (1998). Psychological stress among counselling servcies employees. *Educational Journal, Kuwait University*, *12*(47).

Al-Muhrg, M. (2011). Student problems and the availability of the counselling services at the education settings. *Humanities and Social Sciences Journal*, *18*.

Al-Owidha, S. (1996). *Counselling and psychotherapy perceptions of Saudi Arabian Students in Britain*. University of Manchester.

Al-Rabiah, F. (2005). The role of clinical Psychologist as perceived by psychiatrist. *Unpublished Article*.

Al-Rebdy, S. (2004). *The role of the school counsellor as perceived by counsellors, principals and teachers in Saudi Arabia.* University of Manchester.

Al-Ribdy, S. (2013). Level of burnout among counsellors at Qassim educational region in light of some variables. *Humanities and Administrative Science Journal*, *3*, 239–309.

Al-Saqhan, N. (2005). *Evaluation of rational and emotive therapy efficiency in decreasing anexiety and irrational thoughts degree concering addicts slept in King Fahad Hospital in Qassim*. Naif Arab University for Security Sciences.

Al-Sayed, M. (1997). *Effectiveness of the realistic therapy in reducing depression among the university students and its impact on self esteem*. Almansora University, Egypt.

Al-Shennawy, M. (2001). *Studies in Islamic guidance to counseling therapy*. Cairo:

Ghareeb House of Printing Publishing and Distribution.

Al-Subaie, A. (1989). Psychiatry in Saudi Arabia: cultural perspectives. *Transcultural Psychiatric Research Review*, *29*, 245–262.

Al-Thani, A. (2012). *An Islamic modification of the Person-Centered Counseling Approach*. Doha: QScience.com.

Al-thani, A., & Moore, J. (2012). Nondirective counseling in Islamic culture in the Middle East explored through the work of one Muslim person-centered counselor in the State of Qatar. *Person-Centered & Experiential Psychotherapies*, *11*(3), 190–204. https://doi.org/10.1080/14779757.2012.686888

Al-Yahya, F. (n.d.). *Saudi Arabia: Acknowledging problems in a transitional culture*. *unpublished article*. Riyadh, Saudi Arabia.

Al-Zahrani, A. (1990). The Guidance and counselling programme: An exploratory study in Taif District. Paper given in the annual conference of the Saudi Education and Psychology Association.

Al-Zahrani, S. (2012). *Counsellor's problems in Albaha area in the Kingdom of Saudi Arabia*. Yarmouk University.

Al Gelban, K. (2009). Prevalence of psychological symptoms in Saudi secondary school girls in Abha, Saudi Arabia. *Annals of Saudi Medicine*, *29*(4), 275.

Al Otaibi, T. (2014). Challenging Existing Views of the Role of School Counsellors in the Kingdom of Saudi Arabia. In *8th Annual Keele Counselling Conference* (pp. 1–23).

Aldileym, F. (2001). Common practices in school counselling and their relationships with the academic major, educational stage and professional experience of counsellors. *King Saud University Journal*, *13*(2), 439–478.

Aldileym, F. (2004). The reality of psychological evaluation in school counselling. *Saudi Educational and Psychological Association*.

Aldileym, F. (2011). The reality of utilizing counseling services in the Saudi universities. *Saudi Higher Education*, *6*.

Ali, M. (2013). *Effectiveness of the counselling in reducing depression among the university students*. Ain Shams University, Egypt.

Almustafa, A., & Alsaatti, A. (2007). Youths' problems in the Eastern region of Saudi Arabia and ways of confronting them. *Journal of Security Research*, *15*(7), 10–53.

Alshemmari, M. (2017). *The effectiveness of cognitive behavioural therapy program in reducing clinical depression for the patients in the Mental Health Hospital in Hafr Albaten*. Naif Arab University for Security Sciences.

Alshenqeeti, H. (2014). Interviewing as a data collection method : A critical review, *3*(1),

39–45. https://doi.org/10.5430/elr.v3n1p39

American College Health Association-National College Health Assessment [ACHA-NCHA]. (2009). *Journal of American College Health*, *57*(5), 477–488.

American Counelling Association. (2004). Available at https://www.counseling.org/.

Arab Bureau of Education for the Gulf Countries. (1990). Educational counselling in the universities of the Gulf countries. Riyadh, Saudi Arabia.

Badri, B. (2000). *Contemplation: An islamic psycho-spiritual study*. *nternational Institute of Islamic Thought*.

Badri, B. (2007). Can the psychotherapy of muslim patients be of real help to them within being islamimized?

Baker, R., Baker, E., Allen, H., Golden, S., Thomas, P., Hollingbery, T., … Gibson, S. (2002). A naturalistic longitudinal evaluation of counselling in primary care. *Counselling Psychology Quarterly*, *15*(4), 359–373. https://doi.org/10.1080/0951507021000050195

Barghathi, M. (2007). *Arab culture and globalization: A sociological study of the opinions of arab intellectuals*. Arab Institution for Research & Publication.

Barker, C., Pistrang, N., & Elliott, R. (2016). *Research methods in clinical psychology: An introduction for students and practicioners* (Third). West Sussex: Wiley & Sons.

Barkham, M., Gilbert, N., Connell, J., Marshall, C., & Twigg, E. (2005). Suitability and utility of the CORE–OM and CORE–A for assessing severity of presenting problems in psychological therapy services based in primary and secondary care settings. *The British Journal of Psychiatry*, *186*(3), 239–246.

Barkham, M., Rees, A., Shapiro, D. A., Hardy, G. E., & Reynolds, S. (1996). Dose-effect relations in time-limited psychotherapy for depression. *Journal of Consulting and Clinical Psychology*, *64*(5), 927–935. https://doi.org/10.1037/0022-006X.64.5.927

Bernes, K. (2005). The elements of effective counselling. *The National Consultation on Career Development*. https://doi.org/10.1080/00094056.1969.10727155

Bimrose, J., & Wilden, S. (1994). Supervision in careers guidance: empowerment or control? *British Journal of Guidance and Counselling, 22*, 373–383.

Bishop, J. (1990). The University Counseling Center: An Agenda for the 1990s. *Journal of Counseling & Development*. https://doi.org/10.1002/j.1556-6676.1990.tb02519.x

Bohart, A. C., & Tallman, K. (1999). When the active client is difficult. In *How clients make therapy work: The process of active self-healing.* (pp. 167–200). Washington: American Psychological Association. https://doi.org/http://dx.doi.org/10.1037/10323-007

Bond, T. G., & Fox, C. M. (2007). *Applying the rasch model: fundamental measurement in the human sciences* (2nd ed.). New Jersy: Elbaum.

Bondi, L. (2004). '"A double-edged sword"'? The professionalisation of counselling in the United Kingdom. *Health & Place*, *10*(4), 319–328.

Boone, W. J., Yale, M. S., & Staver, J. R. (2014). *Rasch analysis in the human sciences*. *Rasch Analysis in the Human Sciences*. https://doi.org/10.1007/978-94-007-6857-4

Bor, R., Ebner-Landy, J., Gill, S., & Brace, C. (2002). *Counselling in school*. London: SAGE.

Bower, P., Rowland, N., & Hardy, R. (2003). The clinical effectiveness of counselling in primary care: a systematic review and meta-analysis. *Psychological Medicine*, *33*(2), 203–215. https://doi.org/10.1017/S0033291702006979

Brace, I. (2013). *Questionnaire design: How to plan, structure and write survey material for effective market research (market research in practice)* (3rd ed.). London: Kogan Page.

Branch, R., & Willson, R. (2010). *Cognitive behavioral therapy for dummies* (2nd ed.). West Sussex: Wiley & Sons.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Brinkmann, S. (2013). *Qualitative interviewing*. New York: Oxford University Press.

Bryman, A. (2008). *Social research methods.* Oxford: Oxford University Press.

Bryman, A., Becker, S., & Sempik, J. (2008). Quality criteria for quantitative , qualitative and mixed methods research : A view from social policy. *International Journal of Social Research Methodology*, *11*(4), 261–276. https://doi.org/10.1080/13645570701401644

Brzawy, N. (2017). Academic problems among the students of the University of Chelf and their relation with some variables. *Humanities and Social Academic Research Journal*, *12*, 60–71.

Buchanan, J. L. (2012). Prevention of Depression in the College Student Population: A Review of the Literature. *Archives of Psychiatric Nursing*, *26*(1), 21–42. https://doi.org/10.1016/j.apnu.2011.03.003

Buckman, J. R., & Barker, C. (2010). Therapeutic orientation preferences in trainee clinical psychologists: Personality or training? *Psychotherapy Research*, *20*(3), 247–258. https://doi.org/10.1080/10503300903352693

Carkhuff, R., & Truax, C. (2008). *Toward effective counselling and psychotherapy: training and practice*. New Brunswick: Aldin transaction.

Carroll, M. (2001). *Counselling supervision*. SAGE.

Choi, K.-H., Buskey, W., & Johnson, B. (2010). Evaluation of counseling outcomes at a university counseling center: The impact of clinically significant change on problem resolution and academic functioning. *Journal of Counselling Psychology*, *57*(3), 297–303.

Clarke, V., & Braun, V. (2018). Using thematic analysis in counselling and psychotherapy research : A critical reflection. *Counselling and Psychotherapy Research*, *18*(2), 107–110. https://doi.org/10.1002/capr.12165

Cohen, J. (1992). A power primer. *Psychological Bulletin*, *112*, 155–159.

Cohen, L., & Manion, L. (1994). *Research methods in education* (4th ed.). London: Routledge.

Coltart, N. (1991). The silent patient. *Psychoanalytic Dialogues*, *1*(4), 439–453. https://doi.org/10.1080/10481889109538914

Connell, J., Barkham, M., & Mellor-Clark, J. (2007). CORE-OM mental health norms of students attending university counselling services benchmarked against an age-matched primary care sample. *British Journal of Guidance and Counselling*, *35*(1), 41–57. https://doi.org/10.1080/03069880601106781

Connell, J., Barkham, M., & Mellor-Clark, J. (2008). The effectiveness of UK student counselling services: an analysis using the CORE System. *British Journal of Guidance and Counselling*, *36*(1), 1–18. https://doi.org/10.1080/03069880701715655

Cooper, M. (2008).ó *Essential research findings in counselling and psychotherapy*. London: SAGE.

Corey, C. (2005). *Theory and practice of counseling & psychotherapy* (7th ed.). Belmont, CA: Thomson Learning.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2ed ed.). Thousand Oaks: SAGE.

Creswell, J. W. (2014). *A concise introduction to mixed methods research*. Thousand Oaks: SAGE.

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2ed editio). SAGE.

Dale, H. (2017). *Choosing a counsellor or psychotherapist*.

Donald, I. N., Carey, T. A., & Rickwood, D. J. (2018). Therapeutic change in young people—A qualitative investigation of client and therapist perspectives. *Wiley*, *18*(4), 402–411.

Dubovsky, S. (1983). Psychiatry in Saudi Arabia. *NCBI*, *140*(11), 1455–1459.

Education, C. for the A. of S. in H., & (CAS). (1999). *The role of counseling programs: CAS standards contextual statement*. Washington, DC.

Eisenberg, D., Gollust, S. E., Golberstein, E., & Hefner, J. L. (2007). Prevalence and Correlates of Depression, Anxiety, and Suicidality Among University Students. *American Journal of Orthopsychiatry*, *77*(4), 534–542. https://doi.org/10.1037/0002-9432.77.4.534

Elliott, R. (2017). *Scoring and interpreting the Stathclyde Inventory*.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related ® elds. *British Journal of Clinical Psychology*, *38*, 215–229.

Elliott, R., Greenberg, L. S., Watson, J., Timulak, L., & Freire, E. (2013). Research on humanistic- experiential psychotherapies. In *Bergin & Garfield's Handbook of psychotherapy and behavior change* (pp. 495–538). Retrieved from https://strathprints.strath.ac.uk/37895/5/Elliott_et_al_HEP_Review_2013_post_print.pdf

Elliott, R., & Timulak, L. (2005). Descriptive and interpretive approaches to qualitative research. In *A handbook of research methods for clinical and health psychology* (pp. 147–160). Oxford University Press.

Falconer, D., & Mackay, D. (1999). Ontological problems of pluralist research methodology (p. 216). AMCIS.

Filep, B. (2009). Interview and translation strategies : coping with multilingual settings and data. *Copernicus Publications*, *4*, 59–70.

Fitzpatrick, R., Davey, C., Buxton, M. J., & Jones, D. R. (1998). *Evaluating patient-based outcome measures for use in clinical trials*. *Health Technology Assessment* (Vol. 2). https://doi.org/9812244

Fitzpatrick, R., Davey, C., Buxton, M. J., & Jones, D. R. (1998). *Evaluating patient-based outcome measures for use in clinical trials*. *Health Technology Assessment* (Vol. 2). https://doi.org/9812244

Foa, E. B. (2010). Cognitive behavioral therapy of obsessive-compulsive disorder. *Dialogues Clin Neurosci*, *12*(2), 199–207.

Folk-Skinner, J., Elliott, R., & Wheeler, S. (2010). A baptism of fire: a qualitative investigation of a trainee counsellors' experienvce at the start of training. *Counselling and Psychotherapy Research*, *10*(2), 83–92.

Frank, J., & Frank, J. (1993). *Persuasion and healing: A comparative study of psychotherapy* (third). Baltimore: JHU Press.

Freire, E. S. (2007). *The Strathclyde Inventory:A psychotherapy outcome measure based*

on the person-centred theory of change. University of Strathclyde.

Fulton, J. F. (1973). Attitudes of school counsellors to some counselling issues. *British Journal of Guidance & Counselling*, *1*(2), 80–90. Retrieved from 10.1080/03069887308259354

Garlow, S. J., Rosenberg, J., Moore, J. D., Haas, A. P., Koestner, B., Hendin, H., & Nemeroff, C. B. (2008). Depression, depression and suicidal ideation in college students: Results from the American Foundation for Suicide Prevention College Screening Project at Emory University. *Depression and Anxiety*, *25*(6), 482–488. https://doi.org/10.1002/da.20321

Gensler, D. (2015). Silence in adolescent psychotherapy. *Journal of Infant, Child, and Adolescent Psychotherapy*, *14*(2), 188–195. https://doi.org/10.1080/15289168.2015.1032635

Gerner, M. (1985). The school psychologist in Saudi Arabia. *School Psychology International*, *6*, 88–94.

Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups. *BRITISH DENTAL JOURNAL*, *204*(6), 291–295. Retrieved from http://dx.doi.org/10.1038/bdj.2008.192

Gilliand, B., James, R., & Bowman, J. (1989). *Theories and strategies in counselling and psychotherapy* (2ndh ed.). New Jersy: Englewood Cliffs.

Goodyear, R., & Shaw, M. (1984). Primary prevention on campus and in the community. *The Personnel and Guidance Journal*, *62*(9), 507–562.

Gora, R. (1990). *An evaluation study of school counsellors' perceptions of their effectiveness*.

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis*, *11*, 255–274.

Guyatt, G., Nogradi, S., Halcrow, S., Singer, J., Sullivan, M. J., & Fallen, E. L. (1989). Development and testing of a new measure of health status for clinical trials in heart failure. *Journal of General Internal Medicine*, *4*(2), 101–107.

Hadorn, D., Hays, R. D., Uebersax, J., & Theresa Hauber. (1992). Improving task comprehension in the measurement of health state preferences. A trial of informational cartoon figures and a paired-comparison task. *Journal of Clinical Epidemiology*, *45*(3), 233–243.

Hamjah, S. H., & Mat Akhir, N. S. (2014). Islamic approach in counseling. *Springer Science+Business Media New*, *53*, 279–289. https://doi.org/10.1007/s10943-013-9703-4

Hanour, K. (2016). The effectiveness of behavioral therapy and cognitive therapy to alleviate obsessive- compulsive disorder among university students. *Educational Journal*, (46), 219–299.

Hansen, N., Lambert, M., & Forman, E. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice*, *9*, 329–343.

Hardy, G., Stiles, W., Barkham, M., & Startup, M. (1998). Therapist responsiveness to client interpersonal styles during time-limited treatments for depression. *Journal of Consulting and Clinical Psychology*, *66*, 304–312.

Harris, L. R., & Brown, G. T. L. (2010). Mixing interview and questionnaire methods : Practical problems in aligning data. *Practical Assessment, Research & Evaluation A Peer-Reviewed Electronic Journal*, *15*(1).

Hassan, A., & Al-Gamaly, F. (2003). Irrational Beliefs among Sultan Qaboos University students and its relation with some affective variables. *Educational Science Journal, Qatar University*, *4*.

Hassan, H. (1998). Difficulties related to school counselling services. The 14Tth Psychology Conference in Egypt.

Hedahl, B. . (1978). The professionalization of change agents: Growth and development of counselling centers as institutions. In *A handbook and guide for the college and university counselling centre* (pp. 24–39). Westport, Ct: Greenwood.

Hendriks, J., Fyfe, S., Styles, I., Skinner, S., & Merriman, G. (2012). Scale construction utilising the Rasch unidimensional measurement model: a measurement of adolescent attitudes towards abortion. *Australasian Medical Journal*, *5*(5), 251–261.

Hennink, M., Hutter, I., & Bailey, A. (2011). *Qualitative research methods*. London: SAGE.

Hepburn, A. (2003). *An introduction to critical social psychology*. London: SAGE.

Heppner, P., & Neal, G. (1983). Holding up the mirror: research on the roles and functions of counselling centers in higher education. *SAGE*, *11*(1), 81–98.

Heppner, P., Wampold, B., & Kivlighan, D. (2008). *Research design in counseling* (third). Thomson.

Herbert, B., & Buford, S. (1979). *Theories of counseling* (third). McGraw-Hill.

Hill, C., & Lambert, M. (2004). Methodological issues in studing psychotherapy processes and outcome. In *Bergin and garfield's handbook of psychotherapy and behavior change* (5th ed.). New York: Wiley.

Hodges, S., Shelton, K., & King Lyn, M. (2017). *The college and university counselling*

manual: Integrating essential services. Springer.

Hohenshil, T. H., Findley, W., Hanna, G., & Schauer, A. (1996). Role of assessment and diagnosis in counseling. *Journal of Counseling & Development*, *75*, 64–67. https://doi.org/10.1002/j.1556-6676.1996.tb02316.x

Holmes, J. (2002). All you need is cognitive behaviour therapy? *British Medical Journal*, *324*, 288–290.

Hough, M. (2010). *Counselling skills and theory* (3rd ed.). Hodder Education.

Hoxter, H. Z. (1994). The nature of counselling. *Higher Education in Europe*, *19*(3), 7–9. https://doi.org/10.1080/0379772940190302

https://www.islamweb.net. (n.d.). Retrieved from https://www.islamweb.net/ar/

Hunt, J., & Eisenberg, D. (2010). Mental health problems and help-seeking behavior among college students. *Journal of Adolescent Health*, *46*(1), 3–10. https://doi.org/10.1016/j.jadohealth.2009.08.008

Hyun, J., Quinn, B., Madon, T., & Lustig, S. (2006). Graduate student mental health : Needs assessment and utilization of counseling services. *Journal of College Student Development*, *47*(3), 247–266.

Inayat, Q. (2001). The relationship between integrative and Islamic counselling. *Counselling Psychology Quarterly*, *14*(4), 381–386.

Ismail, N., Kinchin, G., & Edwards, J.-A. (2018). Pilot study, does it really matter? learning lessons from conducting a pilot study for a qualitative PhD thesis. *International Journal of Social Science Research*, *6*(1).

Jacobson, N., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*, 12–19.

Jamal Alail, M. (2001). A comparative study on the difference in resistance during the psychological treatment between a sample of the beneficiaries from the psychological and treatment and guidance in Kingdom of Saudi Arabia. *AskZad*, *21*.

King, M., Broster, G., Lloyd, M., & Horder, J. (1994). Controlled trials in the evaluation of counselling in general practice. *British Journal of General Practice*, *44*(382), 229–232.

Kinra, A. (2008). *Guidance and counselling*. Dorling Kindersley.

Kitzrow, M. A. (2003). The mental health needs of today's college students: Challenges and recommendations. *NASPA Journal*, *41*(1), 167–181. https://doi.org/10.2202/1949-6605.1310

Knutson, H. V., & Kristiansen, A. (2015). Varieties of silence: Understanding different

forms and functions of silence in a psychotherapeutic setting. *Contemporary Psychoanalysis*, *51*(1), 1–30. https://doi.org/10.1080/00107530.2015.954218

Kolden, G. G. (1991). The generic model of psychotherapy: an empirical investigation of patterns of process and outcome relationships. *Psychotherapy Research*, *1*(1), 62–73. https://doi.org/10.1080/10503309112331334071

Krauss, S. (2005). *Research paradigms and meaning making : A primer*. *The Qualitative Report* (Vol. 10). https://doi.org/10.1176/appi.ajp.162.10.1985

Kvale, S., & Brinkmann, S. (2008). *Interviews: learning the craft of qualitative research interviewing* (2ed ed.). Thousand Oaks: SAGE.

Lago, C. (2011). *The handbook of transcultural counselling and psychotherapy*. London: McGraw-Hill Education.

Lambert, M. (2004). *Bergin and Garfield's handbook of psychotherapy and behavior change*. John Wiley & Sons, Inc.

Lambert, M. (2013). *Bergin and Garfield's handbook of psychotherapy and behavior change*. John Wiley & Sons, Inc.

Lavrakas, P. J. (2008). Self-reported measure. *SAGE*.

Lawal, B. (2014). *Repeated measures design. in: Applied statistical methods in agriculture, health and life sciences.* Switzerland: Springer.

Lazarus, A. (1989). *The practice of multimodal therapy*. New York: Holt, Rinehart, & Winston.

Levine, A., & Cureton, J. (1998). *When hope and fear collide: A portrait of today's college student*. Wiley.

Levy, J. A., Glass, C. R., Arnkoff, D. B., Gershefski, J. J., & Elkin, I. (1996). Clients' perceptions of treatment for depression: II. problematic or hindering aspects. *Psychotherapy Research*, *6*(4), 249–262. https://doi.org/10.1080/10503309612331331778

Liebherz, S., Schmidt, N., & Rabung, S. (2016). How to assess the quality of psychotherapy outcome studies : A systematic review of quality assessment criteria. *Psychotherapy Research*, *26*(5), 573–589. https://doi.org/10.1080/10503307.2015.1044763

Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Association for Psychologicak Science*, *2*(1), 53–71.

Lines, D. (2011). *Brief counselling in school* (third). SAGE.

Luborsky, L., McLellan, A., Woody, G., O'Brien, C., & Auerbach, A. (1985). Therapist success and its determinants. *NCBI*, *42*(6), 602–611.

Lune, H., & Berg, B. (2017). *Qualitative research methods for the social sciences* (9th ed.). Pearson Education Limited.

Mabey, J., & Sorensen, B. (1995). *Counselling for young people*. Buckingham: Open University Press.

Mackenzie, N., & Knipe, S. (2006). Research dilemmas: Paradigms , methods and methodology Research paradigms. *Issues In Educational Research*, *16*(2), 193–205. Retrieved from http://www.iier.org.au/iier16/mackenzie.html

Maguire, M., & Delahunt, B. (2017). Doing a thematic analysis : A practical , step-by-step guide for learning and teaching scholars ., *8*(3), 3351–33514.

Mair, D. (2016). *Short- term counselling in higher education: context, theory and practice*. New York: Routledge.

Malberg, N., & Mayes, L. (2013). The contemporary psychodynamic developmental perspective. *Child and Adolescent Psychiatric Clinics of North America*, *22*(1), 33–49.

Mason, J. (2006). *Six strategies for mixing methods and linking data in social science research*. Manchester.

Mckim, C. A. (2017). The value of mixed methods research : A mixed methods study. *Journal of Mixed Methods Research*, *11*(2), 202–222. https://doi.org/10.1177/1558689815607096

McLeod, J. (2003). *Doing counselling research*. London: SAGE.

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. London: SAGE.

McLeod, J. (2013). *An introduction to research in counselling and psychotherapy*. London: SAGE.

McLeod, J. (2015). *Doing research in counselling and psychotherapy* (3rd ed.). London: SAGE.

McMahon, M., & Patton, W. (2000). Conversations on clinical supervision: Benefits perceived by school counsellors. *British Journal of Guidance & Counselling*, *28*(3), 339–351. https://doi.org/10.1080/713652301

McMhahon, G. (1997). *Handbbook of counselling*. (S. Palmer, Ed.) (2nd ed.). Routledge.

Mellor-Clark, J., & Barkham, M. (2000). *The handbook of counselling and psychotherapy*. London: SAGE.

Mellor-Clark, J., Connell, J., & Cummins, P. (2001). Counselling outcomes in primary health care: A CORE system data profile. *European Journal of Psychotherapy & Counselling*, *4*(1), 65–86. https://doi.org/10.1080/1364253011004011

Milner, P. (1974). *Counselling in education*. J.M.Dent & Sons Ltd.

Ministry of Education. Definition bulletin about guidance and counselling in the Kingdom of Saudi Arabia. Riyadh (1999).

Moon, T. R. (2012). The role of assessment in counseling. In *Theory Into Practice* (pp. 1–12). https://doi.org/10.1207/s15430421tip4403_7

Muijs, D. (2011). *Doing quantitative research in education with SPSS* (2nd ed.). Los Angeles: SAGE.

Munley, P. H., Duncan, L. E., Mcdonnell, K. A., & Sauer, E. M. (2004). Counselling psychology in the United States of America. *Counselling Psychology Quarterly*, *17*(3), 247–271. https://doi.org/10.1080/09515070412331317602

Naji, M. (2016). the effectiveness of cognitive behavioral program on improving self-esteem and relieving depression among patients of depression. *Journal of Educational Sciences*, *17*(3), 1858–7224.

Oetting, E., Ivey, A., & Weigel, R. (1970). *The college and university counselling center*. *Student personal series* (Vol. 11). Washington, DC.

Onwuegbuzie, A. J., & Leech, N. L. (2004). Enhancing the interpretation of significant findings : The role of mixed methods research. *The Qualitative Report*, *9*(4), 770–792.

Orlinsky, D., & Rønnestad, M. H. (2005). *How Psychotherapists Develop: A Study of Therapeutic Work and Professional Growth*. Washington, DC: American Psychological Association. https://doi.org/10.1037/11157-000

Orlinsky, D., Ronnestad, M., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: continuity and change. In *Bergin and Garfield's handbook of psychotherapy and behavior change* (Fifth, pp. 307–390). New York: John Wiley & Sons, Inc.

Perez-Rojas, A., Bartholomew, T., Lockard, A., Janis, R., Carney, D., Xiao, H., … Hayes, J. (2017). Presenting concerns in counselling centres: The view from clinicians on the ground. *American Psychological Association*, *14*(4), 416–427.

Pledge, D. S., Lapan, R. T., Heppner, P. P., Kivlighan, D., & Roehlke, H. J. (1998). Stability and severity of presenting problems at a university counseling center: A 6-year analysis. *Professional Psychology: Research and Practice*, *29*(4), 386–389. https://doi.org/10.1037/0735-7028.29.4.386

Pole, K. (2007). Mixed methods designs : A review of strategies for blending quantitative and qualitative methodologies. *Mid-Western Educational Researcher*, *20*(4).

Ponterotto, J. G. (2005). Qualitative research in counseling Psychology : A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, *52*(2), 126–136. https://doi.org/10.1037/0022-0167.52.2.126

Poznanski, J. J., & McLennan, J. (1999). Measuring counsellor theoretical orientation. *Counselling Psychology Quarterly*, *12*(4), 327–334. https://doi.org/10.1080/09515079908254103

Pratyusha, U.-N. (2016). *Psychoanalytic theory and cultural competence in psychotherapy*. American Psychological Association.

Psychological and Social Counseling Unit. (2018). http://www.pnu.edu.sa/arr/Deanships/StudentAffairs/AgencyGuidance/Pages/units/pscUnit.aspx.

Qasem, A. (2012). *Counselling and psychotherapy theories*. Amman: Dar Alfker.

Rassool, G. H. (2016). *Islamic counselling: An introduction to theory and practice.* New York: Routledge/Taylor & Francis Group.

Rennie, D. L., Phillips, J. R., & Quartaro, G. K. (1988). Grounded theory: A promising approach to conceptualization in psychology? *Canadian Psychology, 29*, 139–150.

Ritchie, J., & Lewis, J. (2003). *Qualitative research practice aguide for social science students and sesearchers*. London: SAGE.

Rogers, C. (1961). *On becoming a person*. Oxford: Houghton Mifflin.

Saleh, M. A. (1987). Counseling and guidance in the Kingdom of Saudi Arabia. *International Journal of the Advancement of Counselling*, *286*(10), 277–286.

Schoonenboom, J., & Johnson, R. B. (2017). How to construct a mixed methods research design. *Springer*, *69*(2), 197–131.

Seligman, L. (2006). *Theories of counseling and psychotherapy: Systems, strategies, and skills* (2nd ed.). New Jersy: Pearson Education, Ltd.

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychological Association*, *50*(12), 965–974. https://doi.org/10.1037/0003-066X.50.12.965

Sharkin, B. (1997). Increasing severity of presenting problems in college counselling centers: A closer look. *Journal of Counselling & Development*, *75*, 275–281.

Sibbald, B., Addington-Hall, J., Brenneman, D., & Freeling, P. (1993). Counsellors in English and Welsh general practices: their nature and distribution. *BMJ*, *33*(6), 29–33. https://doi.org/10.2307/29718062

Sommers-Flanagan, J., & Sommers-Flanagan, R. (2012). *Counselling and psychotherapy theories in context and practice*. New Jersy: Wiley & Sons.

Stein, D. J. (2002). *Obsessive-compulsive disorder*. *Lancet* (Vol. 360). https://doi.org/10.1016/S0140-6736(02)09620-4

Stein, D., & Lambert, M. (1995). Graduate training in psychotherapy: are therapy outcomes enhanced? *Journal of Consulting and Clinical Psychology*, *63*(2), 182–196.

Stephen, S. (2016). The strathclyde inventory: Next step in the development of person-centered outcome measure. New York.

Sternberg, R. J., Roediger, H. L., & Halpern, D. F. (2007). *Critical thinking in psychology*. New York: Eds.

Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: Interviews and focus groups. *British Dental Journal*, *204*(6), 291–295.

Stiles, W. B., Barkham, M., Mellor-Clark, J., & Connell, J. (2007). Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies in UK primary-care routine practice: Replication in a larger sample. *Psychological Medicine*, *38*(5), 677–688. https://doi.org/10.1017/S0033291707001511

Stiles, W. B., Barkham, M., Twigg, E., Mellor-Clark, J., & Cooper, M. (2006). Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies as practised in UK National Health Service settings. *Psychological Medicine*, *36*(4), 555–566. https://doi.org/10.1017/S0033291706007136

Stone, G., & Archer, J. (1990). College and university counseling centers in the 1990s: challenges and limits. *The Counselling and Psychologist*, *18*(4), 539–607.

Storrie, K., Ahern, K., & Tuckett, A. (2010). A systematic review: Students with mental health problems-A growing problem. *International Journal of Nursing Practice*, *16*(1), 1–6. https://doi.org/10.1111/j.1440-172X.2009.01813.x

Stulz, N., & Lutz, W. (2007). Multidimensional patterns of change in outpatient psychotherapy: The phase model revisited. *Journal of Clinical Psychology*, *63*(9), 817–833.

Sue, D. W., & Sue, D. (2015). *Counseling the culturally diverse : Theory and Practice*. John Wiley & Sons, Inc.

Sultan, A. (2012). Clinical psychologists' tasks as perceived by psychiatrists at mental health hospital in Misrata city. *Al-Asmaria Univerity Journal*, *25*.

Tariq, S., & Woodman, J. (2013). Using mixed methods in health research. *Journal of the Royal Society of Medicine*, *4*(6).

Temple, B., & Edwards, R. (2002). Interpreters/translators and cross language research: reflexivity and border crossing. *International Journal of Qualitative Methods*, *1*(2).

Thompson, P. J. (1995). *A comparative study of counseling theories & techniques used by practicum students and former graduates*. University of Nebraska at Omaha.

Turky, M. (n.d.). Difficulties face school counselling services in Kuwait.

Vallance, K. (2005). Exploring counsellor perceptions of the impact of counselling supervision on clients. *Counselling and Psychotherapy Research*, *5*(2), 107–110. https://doi.org/10.1080/03069880412331303330

Vonk, E., & Thyer, B. (1996). Evaluating the effectivness of short-term treatment at a University counselling center. *Journal of Clinical Psychology*, *55*(9), 121–127.

Vossler, A., & Moller, N. (2015). *The counseling and psychotherapy research handbook*. London: SAGE.

Waltman, S. H., & Sokol, L. (2017). *The Generic Model of Cognitive Behavioral Therapy*. *The Science of Cognitive Behavioral Therapy*. Elsevier Inc. https://doi.org/10.1016/B978-0-12-803457-6.00001-5

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empiricially, "all must have prizes." *Psychological Bulletin*, *122*(3), 203–215. https://doi.org/10.1037/0033-2909.122.3.203

Ward, E., King, M., Lloyd, M., Bower, P., Sibbald, B., Farrelly, S., … Addington-hall, J. (2000). Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression. I: Clinical effectiveness. *British Medical Journal*, *321*(December), 1383–1388.

Westbrook, F. D., Kandell, J. J., Kirkland, S. E., Phillips, P. E., Regan, A. M., Medvene, A., & Oslin, Y. D. (1993). University campus consultation: opportunities and limitations. *Journal of Counseling & Development*, *71*(6), 684–688.

Westergaard, J. (2013). Counselling young people: Counsellors' perspectives on "what works" - An exploratory study. *Counselling and Psychotherapy Research*, *13*(2), 98–105. https://doi.org/10.1080/14733145.2012.730541

Wheeler, S. (2000). What makes a good counsellor? An analysis of ways in which counsellor trainers construe good and bad counselling trainees. *Counselling Psychology Quarterly*, *13*(1), 65–83. https://doi.org/10.1080/09515070050011079

Wiley, M., & Ray, P. (1986). Counseling supervision by developmental level. *Journal of Counseling Psychology*, *33*, 439–445.

Wilson, C. (2013). *Credible checklists and quality questionnaires: a user- centered design method*. San Francisco: Morgsn Kaufmann.

Wilson, J. R. (1970). Report of the first year of a counselling services in a college of education. *The Counsellor*, *4*.

Winning, F. J. (2010). Counselling in organisations: What is the experience of the lone counsellor? *Wiley2*, *10*(4), 249–257.

Zahran, H. (1998). *Counselling and guidance*. Cairo: Alam Al Kotob.

Zech, E., Brison, C., Elliott, R., Rodgers, B., Jeffrey, H. D., Zech, E., … Elliott, R. (2018). Measuring Rogers ' conception of personality development: validation of the Strathclyde Inventory-French version measuring Rogers ' conception of personality development. *Person-Centered & Experiential Psychotherapies*, 1–25. https://doi.org/10.1080/14779757.2018.1473788

Zivin, K., Eisenberg, D., Gollust, S., & Golberstein, E. (2009). Persistence of mental health problems and needs in a college student population. *Journal of Affective Disorders*, *117*(3), 180–185.

Appendix 1 Ethics Application Form

Please answer all questions

1. Title of the investigation
The Nature and Effectiveness of Therapies Provided in counselling centres at the Princess Nourah bint Abdulrahman University.
Please state the title on the PIS and Consent Form, if different:

2. Chief Investigator (must be at least a Grade 7 member of staff or equivalent)
Name: prof. Robert Elliott ☒Professor ☐ Reader ☐ Senior Lecturer

☐ Lecturer

☐ Senior Teaching Fellow

☐ Teaching Fellow

Department: School of Psychological Sciences and Health

Telephone: +44 (0)141.548.3703

E-mail: Robert.Elliott@strath.ac.uk

3. Other Strathclyde investigator(s)

Name: Afnan Alhimaidi

Status (e.g. lecturer, post-/undergraduate): PhD student

Department: School of Psychological Sciences and Health

Telephone:

E-mail: **afnan.alhimaidi@strath.ac.uk**

4. Non-Strathclyde collaborating investigator(s) (where applicable)

Name: Lucia Berdondini

Status (e.g. lecturer, post-/undergraduate): Associate Lecturer

Department/Institution: University of East London

If student(s), name of supervisor:

Telephone:

E-mail: luciaberdondini@gmail.com

Please provide details for all investigators involved in the study:

5. Overseas Supervisor(s) (where applicable)

Name(s): Rana Alhotan

Status: Lecturer

Department/Institution: Department of Psychology/ Princess Nourah bint Abdulrahman University**.**

Telephone:

Email: rfalhotan@pnu.edu.sa

I can confirm that the local supervisor has obtained a copy of the Code of Practice: Yes ☒ No ☐

Please provide details for all supervisors involved in the study:

6. Location of the investigation

At what place(s) will the investigation be conducted

The study will take a place in Counselling centres at Princess Nourah bint Abdulrahman University, Riyadh, Saudi Arabia.

If this is not on University of Strathclyde premises, how have you satisfied yourself that adequate Health and Safety arrangements are in place to prevent injury or harm?

The study will be conducted at the Princess Nourah bint Abdulrahman University, where Health and Safety arrangements are in place and regularly revised and updated.

7. Duration of the investigation

Duration(years/months) : 2 years

Start date (expected): 1 / 2 / 2016 Completion date (expected): 1 / 2 / 2018

8. Sponsor

Please note that this is not the funder; refer to Section C and Annexes 1 and 3 of the Code of Practice for a definition and the key responsibilities of the sponsor.

Will the sponsor be the University of Strathclyde: Yes ☒ No ☐

If not, please specify who is the sponsor:

9. Funding body or proposed funding body (if applicable)

Name of funding body: Princess Nourah bint Abdulrahman University- Saudi Arabia

Status of proposal – if seeking funding (please click appropriate box):

☐ In preparation

☐ Submitted

☒ Accepted

Date of submission of proposal: 1 / 2 / 2015 Date of start of funding: 1 / 2 / 2018

10. Ethical issues

Describe the main ethical issues and how you propose to address them:

1)Issues common to both groups of participants:

a) Privacy:

-The Researcher must maintain confidentiality of participants; identity and response. Some participants may avoid answering some questions if they feel it will reveal their identity. To avoid this issue, the researcher must clarify to the participants that she will use the information for the research purpose only. The researcher will also inform the therapists that they or their client can leave blank any questions they feel would be compromise their confidentiality

b) Data protection:

-It will only apply to therapist consent form and recording interview. They will be stored in a security locked cabinet at the university and will be accessible only by the researcher and her supervisors. I will remove any identifying information when transcribing the interviews. Obtaining and storing client consent forms will be the therapist's responsibility; they will be asked to keep them in a secure place at their offices. The client questionnaires will be kept in a locked room at the university.

e) All participants will be told if they want to have access to the final result of the research they can contact me at any point and ask for a copy of papers and other kinds of dissemination.

2)Issues related to clients:

a) Anonymity and Data Protection:

- I will not contact the clients directly. The questionnaire will be sent/ given to therapists to use with their clients in order to protect their privacy.
- I will give PIS and consent forms to the therapists to give to their clients to sign; the therapists will then store the consent forms in their confidential client files. I will work closely with the therapists to help them do this.

b) Emotional Impact of Questionnaires on participants:

- Some participants might become upset about some questions; they have a chance to stop answering questionnaires. The PIS will make clear that in case they need to, clients can stop filling out the questionnaire or withdraw from the study at any point with no consequences.

-In the PIS I will provide my email in case participants want to contact me to ask questions, or to receive support related to the questionnaires.

-The PIS states that they can discuss any issue about the research with their therapists.

3) Issues related to counsellors:

a) Confidentiality:

-Because therapists will be interviewed by me, interview material will be identified only by codes give each one to protect their identity.

b) General information about the therapists:

-Dissemination for data (in PhD thesis or publication): therapists' identity will be kept

fully confidential and description of councilors will be generalized.
c) Emotional Impact of the interview on therapists:
-Some questions in the interview may raise emotional responses such as feeling uncomfortable and distressed; to address this, therapists will be encouraged ask to stop the interview or to ignore a question at any time.
d)The interview will be audio recorded:
- The record will be kept secure by me in a securely locked cabinet at the university, which only I and my supervisors can access.
-Participants may ask for a copy of their own recording and in this case I will duplicate the recording of the interview and give a copy to them.
-Participants will be informed that their interviews will be transcribed with identifying information removed, and translated into English.

11. Objectives of investigation (including the academic rationale and justification for the investigation) Please use plain English.

People face many obstacles in their home, work, or with their friends that hinder the progress of life. In some cases, they need someone who can support them. They need a counselor to help them, and counseling centres where they can access psychological help. Saudi Arabia has become more interested in counseling and guidance. It has established counseling centers in different hospitals and schools and other education institutions, in order to satisfy people's needs. The counseling in Saudi Arabia has gone through three stages: The first stage was the creation of a national education and social activity department from 1955 to 1962 to oversee and observe various aspects of school activity. The second stage was that the education and social activity department then evolved into the youth welfare department from 1962 to 1980. The third stage was the establishment of the general administration of student guidance and counseling from 1981 until now. There are different types of counseling therapies that psychologists use; many of those therapies are derived from Western culture, for example: client –centered therapy, rational-emotive

therapy, and cognitive behavioral therapy.

With regard to the studies that have been done in Saudi Arabia in the psychotherapy and counseling area, rational-emotive and cognitive-behavioral therapies have been the most popular therapies that psychologists used with their clients. "Most psychologists in Saudi Arabia use Oetting's counseling classification (traditional model, consultation model, psychotherapy model, vocational guidance model, academic model, training model, student service model, research model." (Adlaim, 2011)

Some Universities in Saudi Arabia have established counseling centres such as: King Faisal University in Dammam, King Abd-alazez University in Jaddah, Princess Nourah bint Abdulrahman University in Riyadh, and Al- Imam muhammed Ibn Saud University in Riyadh. There is to date no study on the effects of therapy provided in Saudi Arabia. Many of studies that I have found and read have done on counselling were interested in one type of Psychological therapy. Alternatively, studies have been conducted on academic, vocational and psychological guidance, but not on the therapies that are practiced in the counseling centres, such as Adlaim's study (2011), which reported the rate of utilization of counselling services by male and female students in five Saudi universities.

In my study I will explore the nature and effectiveness of therapies provided in counseling centers, and whether they improve after the therapy sessions. In addition, my study will document the kind of therapies that therapists practice, therapists' qualifications, and the obstacles that they face in their practice. Aldlaim (2011) developed a questionnaire consisting of 25 items, which were divided into three dimensions (academic, vocational and psychological). I will use a questionnaire in this study. The sample for my study will be up to 120 clients and 11 therapists (psychologists) at Princess Nourah bint Abdulrahman University. The Aldlaim study revealed that no significant differences were found between male and female students in their utilization of counseling services and that the rate of service utilization by all students was low. My study will contribute new and different information around this topic and will contribute to the development and the advancement of research and knowledge in the field of counselling in Saudi Arabia.

References:
Adlaim, F. (2011). *The reality of utilizing counseling services in the Saudi universities.* Unpublished counselling study, King saud Bin Abdulaziz University, Riyadh, Saudi Arabia.

12. Participants

Please detail the nature of the participants:
There are 19 counselling offices at the University; however, some of these only house social workers; I will approach the 11 psychologist counselors at the University. The participants will therefore be:

1) a group of therapists working in these offices
2) clients attending therapy in these offices

Summarise the number and age (range) of each group of participants:

Therapists

Number: 11 Age (range) 25 and older

Clients:

Number: up to 120 Age (range) 19 and older

Please detail any inclusion/exclusion criteria and any further screening procedures to be used:
Inclusion:
-The study will include clients who have just engaged counseling centers for first; to measure their improvement at the start of their counselling, mid (session 4) and at the last sessions.
-The study will include psychologists who are working in the counseling offices at Princess Nourah bint Abdulrahman University.
Exclusion:
-The study will exclude clients who have visited therapists only one time or twice.
-The study will exclude any clients who have visited therapists before the date of the study or are returning after previous counselling.

13. Nature of the participants

Please note that investigations governed by the Code of Practice that involve any of the types of participants listed in B1(b) must be submitted to the University Ethics Committee (UEC) rather than DEC/SEC for approval.

Do any of the participants fall into a category listed in Section B1(b) (participant considerations) applicable in this investigation?: Yes ☒ **No** ☐

If yes, please detail which category (and submit this application to the UEC):

Considering the size and the anonymity of the sample of clients it is possible some participants may be psychologically or medically vulnerable.

14. Method of recruitment

Describe the method of recruitment (see section B4 of the Code of Practice), providing information on any payments, expenses or other incentives.

Data will be collected from two groups of voluntary participants (therapists and clients) in the counseling offices at Princess Nourah bint Abdulrahman University.

The first group is therapists: I will contact face to face the head of the counselling center at the university to get permission to email [see Appendix 5b] the PIS and therapist consent form to therapists.

Then, therapists who are willing to participate in this research will be asked to sign the form and forward it either to my email or through internal mail.

The second group is clients: I will ask intake worker (a social worker) to give information packets (including cover letter [see Appendix5a], Client PIS, Client Consent Form, the Strathclyde Inventory, and a brief demographic questionnaire [see Appendix 7]) to all new clients at their intake interview, to take away with them and to look over on their own.

15. Participant consent

Please state the groups from whom consent/assent will be sought (please refer to the Guidance Document). The PIS and Consent Form(s) to be used should be attached

to this application form.

The sample of the study will be two groups: therapists and clients.

1-Therapist PIS and consent form [see Appendix 2b] will be read and signed at the beginning of the study; therapists will be given the opportunity to ask questions or express any concerns they might have the study.

2-Client PIS and consent form [see Appendix 2a] will be given to clients by the intake worker at the intake session. Clients will be informed about the process of filling out the instrument, they will be asked to complete the questionnaire initially after signing the consent form. Clients will be given the researcher's contact email in case they have questions about the study.

16. Methodology

Investigations governed by the Code of Practice which involve any of the types of projects listed in B1(a) must be submitted to the University Ethics Committee rather than DEC/SEC for approval.

Are any of the categories mentioned in the Code of Practice Section B1(a) (project considerations) applicable in this investigation? ☒ Yes ☐ No

If 'yes' please detail: a situation where highly personal, intimate or other private or confidential information of a personal nature is sought .

Describe the research methodology and procedure, providing a timeline of activities where possible. Please use plain English.

This study is interested in two main things: First, female Saudi therapist's training, background and practice difficulties; and second, client change over the course of counselling (that is, the differences between a client's score at the start of treatment, mid and at the end- and in quantifying the magnitude of this change; Vossler & Moller, 2015). It will be mixed methods study. It is designed to combine qualitative and quantitative methods.

Qualitative data will be collected from interviewing therapists. The results will be analyzed thematically (TA) it is a philosophically neutral method for identifying themes/ patterns across data (Vossler & Moller, 2015)

Quantitative data will be analyzed by using statistical methods for analyzing client change (using t- tests, effect size, and reliable change calculations I will provide to each counselor a list of codes to identify the clients, for example (C101, C102….) in order to

protect their clients' identity.
Timeline:

Ethical approval: January 2016

Identifying participants & data collection: March 2016 – December 2016

Data Analysis: January – June 2017

Write up as a chapter of the dissertation: June 2017 – November 2017

PhD Dissertation Submission**:** February 2018

References:
Vossler, A & Moller, N. (2015). *The Counseling And Psychotherapy Research Handbook.*

What specific techniques will be employed and what exactly is asked of the participants? Please identify any non-validated scale or measure and include any scale and measures charts as an Appendix to this application. Please include questionnaires, interview schedules or any other non-standardised method of data collection as appendices to this application.

This study consists of two phases:
Phase one: Therapist Interview Study
This phase will focus on qualitative semi-structured interview data [see Appendix 4] to provide information about the kind of therapies that counselors practice, their practice difficulties and other relevant experiences. The interviews will be recorded; this will take approximately 45 minutes each, and each therapist will be given a code instead of their name.

Phase two: Client Outcome Study
This phase will focus on quantitative data. I will use a client outcome measure, the Strathclyde Inventory- 16 (Freire, Rodgers & Elliott, 2012)[see Appendix 3]. The questionnaire will be translated into Arabic and the translation. Therapists will be asked to collect the Strathclyde Inventory -after the client seal it in an envelope- from their clients at the beginning of counselling, and to also administer it at mid-treatment (session 4) and at the end of the therapy. This will take approximately about 5 minutes. Each client will be given a code in order protect their identity, (each of the packet will has a code). Subsequently, I will collect the outcome measures from the therapists. These data will be analyzed by descriptive and inferential statistics which will be used to summarize results (Vossler & Moller, 2015).

References:
Vossler, A & Moller, N. (2015). *The Counseling And Psychotherapy Research*

Handbook.

Where an independent reviewer is not used, then the UEC, DEC or SEC reserves the right to scrutinise the methodology. Has this methodology been subject to independent scrutiny? Yes ☐ No ☒

If yes, please provide the name and contact details of the independent reviewer:

17. Previous experience of the investigator(s) with the procedures involved. Experience **should demonstrate an ability to carry out the proposed research in accordance with the written methodology.**

Strathclyde investigator: Afnan Alhimaidi
I have been working as an academic for three years at Princess Nourah bint Abdulrahman University in Saudi Arabia. I have done quantitative research during my master degree in 2011 in counselling and student guidance at Al- Imam Muhammed Ibn Saud University, Riyadh. Saudi Arabia I involved in a psychologist training program for three months during my master degree.

Supervisor (Robert Elliott):

The Principal Investigator and Supervisor has been doing quantitative and qualitative research on counseling for 40 years, and has published 150 articles or book chapters, many of them on counseling research methods.

18. Data collection, storage and security

How and where are data handled? Please specify whether it will be fully anonymous

(i.e. the identity unknown even to the researchers) or pseudo-anonymised (i.e. the raw data is anonymised and given a code name, with the key for code names being stored in a separate location from the raw data) - if neither please justify.

The data for the Therapists will be pseudo- anonymised by removing all identifying information such as names and places at point of transcription; each of therapist will be given a code in order to assure confidentiality, and I will keep the consent forms and therapist's interview audio recording in a secure locked cabinet at the university. Recordings will be erased after analysis is completed.

Data from clients will be fully anonymized, from the point of view of the researcher: Collecting, storing and securing client consent forms and questionnaire data will be therapist's responsibility; that is, they will be asked to store these in their confidential client files, until handing the questionnaires over to me (I will only collect client questionnaires from them). I will work closely with the therapists to help them do this. Client questionnaires will be kept in a locked room at the university.

Explain how and where it will be stored, who has access to it, how long it will be stored and whether it will be securely destroyed after use:

Therapist data will be stored in secure locked cabinet at the university. All on-line data will be password protected.
Therapist data: the consent form and the recorded interviews will be given a code and kept in a secure locked cabinet at the university. They will accessible only to the researcher and her supervisors. All recorded interviews will be erased after analysis.
Clients' data: Consent forms will be therapist's responsibility. They will be asked to store them in their confidential client files in their offices before handling them to the investigator. Therapists will be asked to add their clients' code numbers to all questionnaires and make sure that no personal information such as names are included on the forms. I will work closely with the therapists to help them do this. Once collected, the fully anonymised questionnaires will be stored and kept in a secure locked room at the university, where only my supervisors and I will have the access to the data.
All data will be destroyed 5 years after the research project completed.

Will anyone other than the named investigators have access to the data? Yes ☐

No ☒

If 'yes' please explain:

19. Potential risks or hazards

Describe the potential risks and hazards associated with the investigation:

Risk or hazard to participants:

- It might some of the clients become upset about some questions in the questionnaire. If so, they can stop answering and discuss this with their therapist.

-It might some of the therapists become uncomfortable or embarrassed about answering some questions during the interview. If this happens, they can stop the interview or ignore the question. If they wish, they will be able to be discussed their discomfort with the researcher, who may also encourage them to discuss any concerns further the Intake Worker, who is also their supervisor.

-Based on the risk assessment, the most likely hazard is therapists accidentally revealing their client's identity to the researcher, by failing to properly anonymise the outcome measure (for example by not removing the client's name from the form). To address this, the researcher will train and support the therapists to remove identifying client information, and will immediately inform therapists of problems with this. As an additional safeguard, the researcher will ask therapist to check again the questionnaires to make sure that they have removed all personal information in the questionnaires before they handing these to me.

-Some participants may be concerned that their responses on the questionnaire or the interview will identify them or will not properly be secured. Therefore, procedures for anoymising and securing the data will be explained to participants in the PIS, including

the fact that each participant will be given a code; and names or other identifying information will be removed.

- If during the therapist interview I become aware of any current ethical issue or risk to another person or to the therapist I may have to take action. In this case, I would discuss this with the therapist, report it to my supervisors, and possibly the head of the counselling service at the university.

Has a specific Risk Assessment been completed for the research in accordance with the University's Risk Management Framework (Risk Management Framework)?

Yes ☒ **No** ☐

If yes, please attach risk form (S20) to your ethics application. If 'no', please explain why not:

20. What method will you use to communicate the outcomes and any additional relevant details of the study to the participants?

Participants can ask and request a copy of the study results, which will be sent to them when available. They will be informed that the study results will take a period of time (at least one year) before being reported.

21. How will the outcomes of the study be disseminated (e.g. will you seek to publish the results and, if relevant, how will you protect the identities of your participants in said dissemination)?

I am planning to contact the Saudi Association for Education & Psychology. King Saud University, Riyadh, to publish my study in one of their journals. Participant identities will be fully anonymised in any publications of conference presentations. In addition, it may be published an international counselling or psychotherapy journal.

Checklist	**Enclosed**	**N/A**
Participant Information Sheet(s): 2a & 2b	☒	☐
Consent Form(s): 2a & 2b	☒	☐
Sample questionnaire(s): Strathclyde Inventory: 3	☒	☐
Sample interview format(s): 4	☒	☐
Sample advertisement(s): 5a & 5b	☒	☐
Any other documents (please specify below)	☒	☐
S20 Risk Assessment Form: 6	☒	☐
Demographic questionnaire: 7	☐	☐
	☐	☐
	☐	☐

Appendix 2 Therapist Information Sheet and Consent Form

This document has been translated to Arabic and printed on University letterhead.

Name of department: School of Psychological Sciences & Health

Title of the study: The N*ature and Effectiveness of Therapies Provided in counselling centres At Princess Nourah bint Abdulrahman University.*

Introduction

I am Afnan Ahmed Alhimaidi, a Ph.D. student in The School of Psychological Sciences & Health at the University of Strathclyde (UK).

Contact details:

Email: Afnan.alhimaidi@strath.ca.uk

Or aaalhimaidi@pnu.edu.sa

What is the purpose of this investigation?

I will explore the nature and effectiveness of therapies provided in counselling centres at Princess Nourah bint Abdulrahman University, that is, the kind of therapies that therapists practice, therapists' qualifications, and the obstacles that they face in their practice. My study will contribute new and different information about the nature and effectiveness of these therapies and will contribute to the development and the advancement of the field of counselling in Saudi Arabia.

Do you have to take part?

Your participation in this study is voluntary (either your participation to be interviewed or to give and collect the questionnaires from the participants). You will be interviewed by the researcher and the interview will be recorded. You have the right to refuse to record the interview, in which case the researcher would take notes on the interview. You have the right to ask for a copy of your interview recording or notes. You will be given a code instead of your name. The data that you have provided at the interview will be pseudo anonymised. The researcher will remove any identifying information when transcribing the interviews and she will keep your consent form and interview audio recording in a secure locked cabinet at the university. Recordings will be erased after analysis is completed. You have the right to omit or refuse to answer or respond to any question. You may decide to stop being a part of the research study at any time without explanation or penalty. You can ask that any data you have supplied to that point be withdrawn/ destroyed.

* If you have any questions as a result of reading this information sheet or at any point in the study, please contact the researcher.

What will you do in the study?

Therapists will be interviewed individually by the researcher and the interview will be recorded. The topic of this interview will be the kinds of therapy that therapists practice, therapists' qualifications, and the difficulties that they face in their practice. The study will take place at counselling centres at Princess Nourah bint Abdulrahman University, Riyadh, Saudi Arabia in 2016.

You will also be asked to store and keep participant consent forms in your confidential client files and to secure them in your office. In addition, you will be asked to collect the Strathclyde Inventory and a demographic form from participants at the beginning of counselling, and to also administer the Strathclyde Inventory at mid-treatment (session 4) and at the end of the therapy. If there is any personal information on the participant questionnaires you will be asked to delete it before handing them to the researcher.

Why have you been invited to take part?

All therapists who are currently working in counselling centres at Princess Nourah bint Abdulrahman University are being asked to take part.

What are the potential risks to you in taking part?

- You may worry that your responses on the interview will identify you or will not be properly secured. In order to deal with this, the researcher will protect the confidentiality of the information. Your data will be pseudo- anonymised by removing all identifying information such as names and places at point of transcription; you will be given a code in order to assure confidentiality, and I will keep your consent form and interview audio recording in a secure locked cabinet at the university. Recordings will be erased after analysis is completed.

-If during the interview I become aware of any current ethical issue or risk to another person or to yourself I may have to take action. In this case, I would discuss this with you, report it to my supervisors, and possibly the head of the counseling service at the university.

What happens to the information in the project?

The data I will collect do not contain any personal information about you. The data will be used only for research purposes.

-I will keep consent forms and interview audio recordings in a secure locked cabinet at the university. Each record will be given a code to protect your identity.

-The interviews will be transcribed and translated into English but kept anonymously for my supervisors.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

What happens next?

-Your participation in this study is voluntary. You will be asked to read and sign a consent form to be involved in this study. You may decide to stop being a part of the research study at any time without explanation. You have the right to ask that any data you have supplied to that point be withdrawn/ destroyed.

I would like to inform you that I am planning to contact the Saudi Association for Education & Psychology. King Saud University, Riyadh, to publish this study in one of their journals. Your identity will be fully anonymised in any publications of conference presentations. In addition, it may be published an international counselling or psychotherapy journal.

If you are interested hearing about the results of this study, please let me know and I will send you a report when it becomes available**.**

Researcher contact details:
Afnan Ahmed Alhimaidi.

Email: Afnan.alhimaidi@strath.ca.uk

Or aaalhimaidi@pnu.edu.sa

University Of Strathclyde contact details:

Counselling unit, Room GH678, Graham Hills Building, 40 George Street, Glasgow G1 1QE, Scotland, United Kingdom

Telephone **+44 (0) 141 548 3414**

Chief Investigator details:

This study is supervised by:

Robert Elliott, Ph.D.
Professor of Counselling
University of Strathclyde (Scotland)
Counselling Unit, School of Psychological Sciences and Health, University of Strathclyde, Room 507, Graham Hills Building, 40 George Street, Glasgow, G1 1QE
+44 (0)141.548.3703 (work)
+44 (0)7772.432.341 (M)
e-mail: Robert.Elliott@strath.ac.uk

This investigation was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee
Research & Knowledge Exchange Services
University of Strathclyde
Graham Hills Building
50 George Street
Glasgow
G1 1QE

Telephone: 0141 548 3707
Email: ethics@strath.ac.uk

Therapist Consent Form

Name of department: School of Psychological Sciences & Health

Title of the study: *The Nature and Effectiveness of Therapies Provided in counselling centres At Princess Nourah bint Abdulrahman University.*

- I confirm that I have read and understood the information sheet for the above project and that the researcher has answered any queries to my satisfaction.
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences. If I exercise my right to withdraw and I don't want my data to be used, any data which have been collected from me will be destroyed.
- I understand that any information recorded in the investigation will remain confidential and no information that identifies me will be made publicly available.
- I agree to collect the Strathclyde Inventory from the participants at the beginning of counselling, and to also administer it to them at mid-treatment (session 4) and at the end of the therapy.
- I understand that I need to keep participants consent forms in confidential client files.
- I understand that I need to remove any personal information from the participant's questionnaires before giving them to the researcher.

- I consent to being a participant in the project.
- I consent to being audio recorded as part of the project. (If you say no, I will take detailed notes on your interview instead.)

(PRINT NAME)	
Signature of Participant:	Date:

IF YOU HAVE AGREED TO TAKE PART IN THIS STUDY PLEASE FORWARD IT EITHER TO MY EMAIL OR THROUGH INTERNAL MAIL. IF YOU HAVE NOT AGREED TO TAKE PART IN THIS STUDY, PLEASE STOP HERE.

Appendix 3 Client Information Sheet and Consent Form

This document has been translated to Arabic and printed on University letterhead].

Name of department: School of Psychological Sciences & Health

Title of the study: *The Nature and Effectiveness of Therapies Provided in counselling centres at the Princess Nourah bint Abdulrahman University*

Introduction:

I am Afnan Ahmed Alhimaidi, a PhD student in the School of Psychological Sciences & Health at University of Strathclyde (UK)

Contact details:

Email: Afnan.alhimaidi@strath.ca.uk

Or aaalhimaidi@pnu.edu.sa

What is the purpose of this investigation?

I will explore the nature and effectiveness of therapies provided in the counselling services at Princess Nourah bint Abdulrahman University, that is, whether and how much clients improve over the course of therapy. (I will also interviewing therapists in this service.) My study will contribute new and different information about the nature and effectiveness of these therapies and will contribute to the development and the advancement of the field of counselling in Saudi Arabia.

Do you have to take part?

Your participation in this study is completely voluntary; in other words, you can say no and this will not affect any of the services that you receive from the counselling center; for example, you can still take advantage of the services that the counselling centre provides. Your intake worker (social worker) has given you an information packet (including cover

letter, this form, a Consent Form, and two questionnaires: an outcome questionnaire called the Strathclyde Inventory, and a brief demographic form.

If you are interested to participate in this study you can take the packet away with you and to look over on your own. If you agree to take part, please sign the Consent Form, complete the two questionnaires attached and return them to the envelope and seal it (please do this with all questionnaires that you will be given) , then give the packet (with your consent) to your therapist at the first session. You will later be asked by your therapist to complete the outcome questionnaire at session 4 and again at or after your last session (again in a sealed envelope). You can decide to stop being a part of the research study at any time without explanation or penalty. You have the right to ask that any data you have supplied to that point be withdrawn and destroyed. You have the right to omit or refuse to answer or respond to any question. You have the right to have your questions about the study answered. You will not be asked to provide any personal identity information (such as your name). You will be given a code instead of your name on the questionnaires. If you have any questions as a result of reading this information sheet, you should ask the researcher or your therapist before the study begins.

Your therapist will be involved in this study, but she will not see and discuss any information that you provided in the questionnaires.

What will you do in the project?

Clients will be asked to complete a demographic form and an outcome questionnaire before starting therapy and an outcome questionnaire that they will later be given by their therapists. The study will take a place at counselling centres at Princess Nourah bint Abdulrahman University, Riyadh, Saudi Arabia in 2016**.**

Why have you been invited to take part?

Participants will be up to120 clients in counselling offices at Princess Nourah bint Abdulrahman University.

The study will include clients who just engaged counselling centres for the first time.

What are the potential risks to you in taking part?

- You may become upset about some questions in the questionnaire. So, you can stop answering and discuss this with your therapist.

- Researcher will protect the confidentiality of the information. You may worry that your responses on the questionnaire will identify you or will not be properly secured. To address this, you will be given a code in order to protect your identity. The researcher will work with your therapist to make sure that they remove your identifying information. As an additional safeguard, the researcher will ask therapist to check again the questionnaires to make sure that they have removed all personal information in the questionnaires before they handing these to me.

What happens to the information in the project?

The data I will collect do not contain any personal information about you. The data will be used only for research purpose.

Therapists will be asked to store and kept client consent forms in their confidential client files. You will be asked to complete a questionnaire by your therapist; I will not contact with you directly. There are no personal information required (e. g client name). Your data will be fully anonymized, from the point of view of the researcher**.**

What happens next?

Your participation in this study is voluntary. You will be asked to read and sign a consent form to be involved in this study. You may decide to stop being a part of the research study at any time without explanation. You have the right to ask that any data you have supplied to that point be withdrawn/ destroyed.

I would like to inform you that I am planning to contact the Saudi Association for Education & Psychology. King Saud University, Riyadh, to publish this study in one of their journals. Your identity will be fully anonymised in any publications of conference presentations. In addition, it may be published an international counselling or psychotherapy journal.

If you are interested hearing about the results of this, please let me know and I will send you a report when it becomes available.

Researcher contact details:

Afnan Ahmed Alhimaidi.

Email: Afnan.alhimaidi@strath.ca.uk

Or aaalhimaidi@pnu.edu.sa

University Of Strathclyde contact details:

Counselling unit, Room GH678, Graham Hills Building, 40 George Street, Glasgow G1 1QE, Scotland, United Kingdom

Telephone **+44 (0) 141 548 3414**

Chief Investigator details:

This study is supervised by:

Robert Elliott, Ph.D.

Professor of Counselling

University of Strathclyde (UK)

Counselling Unit, School of Psychological Sciences and Health, University of Strathclyde,

Room 507, Graham Hills Building, 40 George Street, Glasgow, G1 1QE

+44 (0)141.548.3703 (work)

+44 (0)7772.432.341 (M)

e-mail: Robert.Elliott@strath.ac.uk

This investigation was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee
Research & Knowledge Exchange Services
University of Strathclyde
Graham Hills Building
50 George Street
Glasgow
G1 1QE

Telephone: 0141 548 3707
Email: ethics@strath.ac.uk

Client Consent Form

Name of department: School of Psychological Sciences & Health

Title of the study: *The Nature and Effectiveness of Therapies Provided in counselling centres at the Princess Nourah bint Abdulrahman University.*

- I confirm that I have read and understood the information sheet for the above project and the researcher has answered any queries to my satisfaction.
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, without having to give a reason and without any consequences.
- I understand that I can withdraw my data from the study at any time.
- I understand that any information collected in the investigation will remain confidential and no information that identifies me will be made publicly available.
- I understand I am being asked to complete two questionnaires now, and the outcome questionnaire at session 4 and at the last session.
- I consent to being a participant in the project.

(PRINT NAME)	
Signature of Participant:	Date:

IF YOU HAVE AGREED TO TAKE PART IN THIS STUDY PLEASE COMPLETE THE ATTACHED TWO QUESTIONNAIRES. IF YOU HAVE NOT AGREED TO TAKE PART IN THIS STUDY, PLEASE STOP HERE.

Appendix 4 Interviews Questions

A. Kind of therapies:

1. What kind of therapies are you practicing?

2. What kind of techniques and strategies do you use in practicing therapy?

3. What kind of assessment s do you use in therapy?

4. What kind of problems did clients present at the counselling centre?

B. Originations settings:

1. What kinds of supports and demands dose the counselling centre make for therapists?

C. Experience and development:

1) How long have you been working as a therapist?

2) How much have you changed overall as a therapist?

3) What if any courses, seminars or workshops have you attended? What effects on your practice have experiences had?

4) Do you have formal supervision?

D. Therapists Practice Difficulties and Challenges:

1. What kinds of difficulties or obstacles have you encountered in your practice as a therapist here at the University?

2. Have you experienced any of the following difficulties in your practice, if yes how did you deal with these difficulties? (Please explain any that apply):

a) a. Have you experienced a lack of confidence in your practice?

b) b. Have you felt afraid that you were doing more harm than good as a therapist?

c) c. Have you felt you lost control of the therapeutic situation?

Appendix 5 Demographic Questionnaire

Code number:_____

Subject/major: _____

Year in school:

- First year.
- Second year.
- Third year.
- Fourth year.

Age:

- 18-21
- 21-24
- 25 and older.

Your current marital status:

- Married.
- Single.
- Divorced.
- Widowed.
- Would rather not say.

Father's occupation: _____

Why I've come for counselling (indicate all that apply):

- Academic issues
- Social problems
- Family issues
- Personal issues
- Other issues:_____

Any previous counselling or psychotherapy:

_____

Are any of your other family members going to therapy?: Yes / No

If yes, for how long? _____

Appendix 6 Strathclyde Inventory – 20

Client ID _____ Male ☐ Female ☐ Age _____ Date ___/___/___ Session_____

Please read each statement below and think how often you sense it has been true for you DURING THE **LAST Week**. Then mark the box that is closest to this. There are no right or wrong answers – it is only important what is true for you individually.

OVER THE LAST MONTH	Never	Only Occasio-nally	Some-times	Often	All or Most of the time
1. I have been able to be spontaneous	☐0	☐1	☐2	☐3	☐4
2. I have condemned myself for my attitudes or behaviour	☐4	☐3	☐2	☐1	☐0
3. I have tried to be what others think I should be	☐4	☐3	☐2	☐1	☐0
4. I have trusted my own reactions to situations	☐0	☐1	☐2	☐3	☐4
5. I have experienced very satisfying personal relationships	☐0	☐1	☐2	☐3	☐4
6. I have felt afraid of my emotional reactions	☐4	☐3	☐2	☐1	☐0
7. I have looked to others for approval or disapproval	☐4	☐3	☐2	☐1	☐0
8. I have expressed myself in my own unique way	☐0	☐1	☐2	☐3	☐4
9. I have found myself "on guard" when relating with others	☐4	☐3	☐2	☐1	☐0
10. I have made choices based on my own internal sense of what is right	☐0	☐1	☐2	☐3	☐4
11. I have listened sensitively to myself	☐0	☐1	☐2	☐3	☐4
12. I have felt myself doing things that were out of my control	☐4	☐3	☐2	☐1	☐0
13. I have lived fully in each new moment	☐0	☐1	☐2	☐3	☐4
14. I have been aware of my feelings	☐0	☐1	☐2	☐3	☐4
15. I have hidden some elements of myself behind a "mask"	☐4	☐3	☐2	☐1	☐0
16. I have felt true to myself	☐0	☐1	☐2	☐3	☐4
17. I have felt myself doing things that are out of character for me	☐4	☐3	☐2	☐1	☐0

OVER THE LAST MONTH	Never	Only Occasio-nally	Some-times	Often	All or Most of the time
18. I have accepted my feelings	☐0	☐1	☐2	☐3	☐4
19. I have been able to resolve conflicts within myself	☐0	☐1	☐2	☐3	☐4
20. I have felt it is all right to be the kind of person I am	☐0	☐1	☐2	☐3	☐4

Appendix 7 Interview Analysis

Domain 1: Kind of Services

Category	Sub-category	ID Numbers	Meaning units	NO.
A.Therapies	A.1.Person centered therapy	FM01	A.1.1. I always encourage the client to talk about their problems and feeling until she realize (Insight) her real issues. The client provides the solution and this is the appropriate technique with younger people.	4
		SS02	A.1.2. use therapies depending on the client's situation. Sometimes I use the personal-centered therapy.	
		MC03	A.1.3. Sometimes I use the personal-centered therapy; I encourage the client to keep talking.	
		CN08	A.1.4. Sometimes I use the personal-centered therapy.	
	A.2. Cognitive Behavioral therapy	SS02	A.2.1. it depends on the situation and client problems, I used CBT.	
		MC03	A.2.2. I use the behavioral therapy to modify the clients' behavior. Also, I use the cognitive therapy.	
		MC04	A.2.3.Always I use the behavioral therapy, and sometimes I use the cognitive behavior therapy.	

		FP05	A.2.4. It is depends on the client's problem and situation, I use cognitive behavior therapy.	12
		HC06	A.2.5. I use cognitive behavior therapy).	
		FA07	A.2.6. I use the cognitive behavioral therapy to modify irrational thoughts. I always use measures to determine the appropriate therapies and plan.	
		CN08	A.2.7. I use the behavioral therapy because most of the students are normal. I have met one client who is going to a psychiatrist. But before I start a counseling session with her, I asked her to bring a report about her situation.	
		CC09	A.2.8. I use therapies depending on the client’s situation. I use the cognitive behavioral.	
		FE10	A.2.9. Often I use the cognitive behavior therapy to modify client's thought.	
		CE11	A.2.10.I use and focus on the Cognitive Behavioral therapy because it is appropriate therapy for our culture and students.	

		GH12	A.2.11.My work is often based on the Cognitive Behavioral therapy. Also, I use Rational emotional therapy with clients	
		SB13	A.2.12. It depends on the client's issue, I always use the cognitive behavioral therapy. I always start with a general conversation until the client accepts me and trust. Some students attend only one or two sessions. The number of the counseling sessions based on the client needs, issues and feeling comfortable. Also, I explain to her that I will provide a preventive treatment to solve your future problems. In some cases I set more sessions depend on the client issues. Some clients need to see a Psychiatrist that would help her.	
	A.4. Logo therapy	CC09	A.4.1. I often use the logo therapy.	1
	A.5. Reality therapy.	CC09	A.5.1. Also, I use the reality therapy.	2
		GH12	A.5.2. Reality therapy.	
B. Techniques	B.1.Homework	SS02	B.1.1 I give the client some works to do it at home.	
		MC03)	B.1.2. I give the client some works like reading about her issues and ask her to write about it.	

			MC04	B.1.3. I give the client some works to do it.	7
			FP05	B.1.4. Also, I give the client some homework.	
			HC06	B.1.5. Also, I give the client some homework.	
			FE10	B.1.6. Also I give some homework especially to the obsessive compulsive clients, I asked them to count how many times that a negative thought came up in their minds and to try to replace it with a positive thought	
			CE11	B.1.7. It depends on the clients' situation; I use the homework as a technique.	
	B.2. Behavioral techniques and .activation	B.2.1. Stress inoculation .procedure	SS02	B2.1.1 Stress inoculation procedure. I Use stress inoculation procedure to decrease clients stress and worries.	

		B.2.2.Reinforcement	FA07	B2.2.1. B.5.3.(I USE SELF- ESTEEM ' the client's considers herself as ineffective and useless person' AND RENIFORCEMENT.	
			MC04	B.2.2.2. I try to modify the client's behavior by using the reinforcement schedule. I encourage them to do some exercise like walking or doing her favorite hobbies to decrease stress	
		B.2.3.ABC technique	CC09	B.2.3.1. Record the client's thought	
			GH12	B.2.3.2. Uses the ABC technique by recording the client's negative thoughts, and writing negative and positive thinking lists"	
			SB13	B.2.3.3. I use the ABC technique with clients who fail the tests, by comparing between negative and positive reaction. I encourage clients to write about their problems.	
			FP05	B.2.3.4.I use the ABC model to modify the client's irrational though	
		B.2.4.Exposure Technique	HC06	B.2.4.1. I use Exposure Technique and the Assertiveness Skills to increase the confidence level.	2
			GH12	B.2.4.2.I use exposure and responses prevention technique.	

		B.2.5.Distraction technique	HC06	B.2.5.1.I use Distraction Technique to modify the negative thoughts.	1
		B.2.6.Role playing	SB13	.B.2.6.1. Role playing.	1
		B.2.7.problems solving.	HC06	B.2.7.1.problems solving technique by determining the level of feeling. Then, discuss the idea.	2
			FM01	B.2.7.2.'De-Briefing' I always encourages the client to talk about their problems and feeling.	
	B.3. relaxation.		MC04	B.3.1. I use also the relaxation technique with the clients.	5
			FP05	B.3.2. I use the relaxation.	
			CC09	B.3.3. I use the relaxation.	
			CE11	B.3.4. Also, I use the relaxation.	
			SB13	B.3.5. I train the client how to do the relaxation. And I always use it with the anxiety and obsessive compulsive disorder.	
	B.5. the sympathy		CE11	B.4.1. In some cases I use the sympathy).	1

B.6. Hypnosis	CE11	B.5.1. Suggestion as a kind of the hypnosis.	2
	GH12	B.5.1. I use the hypnosis technique with some clients if they have)negative thought and I replace it with positive thought and feeling	

Interviews Cross Analysis

Domain 1: Kind of Services

Category	Sub-category		ID Numbers	Meaning units
A. Measuring the client's problems. Assessments	A.1.Problems	A.1.1.Depression(8)	FM01	A.1.1.1.The counseling and guidance center adopt some measurements such as; Beck Depression Inventory; I use them depend on the client's problems.
			PF05	A.1.1.2. Depression. I use some measures like; anxiety, phobia, self- confidence and Beck Depression Inventory.
			FA07	A.1.1.3. Depression. Yes I use measures such as; anxiety, depression, self-esteem and problems solving.)
			CN08	A.1.1.4. I use measures. I use the Beck Depression Inventory.
			FE10	A.1.1.5. Depression measure. I use the Beck Depression Inventory and anxiety measures.

			CE11	A.1.6. I use the Beck Depression Inventory.
			GH12	A.1.7. I use measures when I need. I have applied the Beck Depression Inventory.
			Sb13	A.1.8. I use measures when I need like: Beck Depression Inventory , self- confidence, self- esteem measures.
		A.1.2.Anxiety (7)	FM01	A.1.2.1. The counseling and guidance center adopt some measurements such as: anxiety sacle . I use them depend on the client's issues.
			PF05	A.1.2.2. I use some measures like; anxiety scale.
			FA07	A.1.2.3. Yes I use measures such as; anxiety scale.
			CN08	A.1.2.4. I use the anxiety scale. I have done a questionnaire about the student's issues, their issues were; stress, exam anxiety and lack of self- confidence.
			CC09	A.1.2.5. Yes I use measures such as; anxiety scale.

			FE10	A.1.2.6. I use the anxiety scale.
			GH12	A.1.2.7. I use measures when I need. I have applied the anxiety scale.
		A.1.3.Obsessive compulsive (1)	FM01	A.1.3.1. The counseling and guidance center adopt some measurements such as; obsessive compulsive scale. I use them depend on the client's issues.
		A.1.4.Phobia (3)	PF05	A.1.4.1. I use some measures like: phobia scale.
			CC09	A.1.4.2. Yes I use measures such as: Phobia scale.
			SB13	A.1.4.3. I use measures when I need, such as: self-confidence scales.
	A.2.Resources	A.1.2.Self-confidence (2)	PF05	A.1.2.1. I use some measures, such as: self- confidence scales.
			CN08	A.1.2.2. I have done a questionnaire about the student's issues, their issues were; stress, exam anxiety and lack of self- confidence.

		A.2.2. self -esteem. (2)	FA07	A.2.1. Yes I use measures such as: a self-esteem scale.
			SB13	A.2.2.2. I use measures when I need such as: self-esteem scales
		A.2.3.Problem solving. (3)	FM01	A.2.3.1. The counseling and guidance center adopt some measures such as: problems solving scales. I use them depending on the client's issues.
			GH12	A.2.3.2. I use measures when I need to. I have applied problems solving scales.
			FA07	A.2.3.3.Yes I use measures such as; problems solving scales.
	A.3.Personality.	A.3.1. Rotter's measure. (1)	CC09	A.3.1.1.Rotter measure. Yes I use measures such as; Rotter measure.
		A.3.2. Personal scales and Gender identity (1)	CE11	A.3.2.1. I use personality scales and gender identity measures because some students think that they have some problems related to their gender, but when I used the measure with them the results showed that they are

				normal and did not have any problems.
	B.Never apply (3)		SS02	B.1. have never applied any measure. (Because the University did not offer any training course about how to apply psychological measurements.
			MC03	B.2. The counselling and guidance centre adopt some measurements such as; Beck Depression Inventory, anxiety, problems solving, and obsessive compulsive scales. But I did not use them.
			MC04	B.3. I have never applied any measures. (One time, I was planning to use a measure with a client in the second session bout she did not show up).

Category	Description		ID Numbers	Meaning units
B. Evaluate the clients' improvement	B.1. Observed in Counselling sessions	B.1.1.The Insight. (4)	SS02	B.1.1The clients had the insight.
			MC03	B.1.2 When the clients had insight and realised the main issues during the counselling session.
			CN08	B.1.3. The insight.
			FE10	B.1.4. The insight.
		B.1.2.Changes in appearance and speaking (5)	MC04	B.1.2.1.I can figure out that while her talking or behave.
			FA07	B.1.2.2.Changes in clients' appearance and speaking. I can figure that out while she is speaking, or if there is any change in her appearance.
			CN08	B.1.2.3. Changes In her behavior .I can see the changes in her appearance.
			CC09	B.1.2.4. I can figure out that while she is talking

				and if there are any changes in her appearance
			GH12	B.1.2.5. I can see the changes in her appearance and her relationships with her friends.
		B.1.3 Telling (4)	CE11	B.1.3.1. I can see the client's improvement during the counselling sessions from her responses and the commitment to attend the therapy.
			GH12	B.1.3.2.Telling me that she feels better.
			SB13	B.1.3.3. I got messages from clients to thank and telling me that she feels better.
			FE10	B.1.3.4. Sometimes the client tells me that she feels better.
		B.1.4.doing homework (2)	SB13	B.1.4.1. Sometimes I ask the clients to do some homework, and when they commit to do it, I consider it as an improvement in the clients. I use it with clients have negative thought or anxiety.
			CE11	B.1.4.2.Homework; for example: making a decision, and the way of thinking. Furthermore, I

				encourage the clients to involve in the university activities
		B.1.5.Observation (1)	FE10	B.1.5.1. I observe the client's behaviour and the way of speaking.
		B.1.6. Improvement in the academic level (2)	FE10	B.1.6.1. The clients with the academic issues show improvement in their academic levels.
			GH12	B.1.6.2. Improvement in her academic level.
	B.2. Questions asked of clients	B.2.1.Asking questions. (2)	MC04	B.2.1.1. Sometimes I ask the client questions about her feeling after the counseling session.
			FP05	B.2.1.2. I ask the client some questions if she feels better. Also, at the end of each session I put new plane and aims for the next session.
		B.2.2.	HC06	B.2.2.1. I apply a questionnaire at the first session, then at the last session, by asking the

		Questionnaires. (3)		.clients to determine their feeling level from 1to10
			CN08	B.2.2.2. I apply a questionnaire at the beginning of the counseling session, then at the end.
			GH12	B.2.2.3. I administrate a measure (depression or anxiety) at the first and the last counselling sessions.

Interviews Cross Analysis

Domain: Kind of Services

Category	Sub-category		ID Numbers	Meaning units	No
A. Client's Issues	A.1.Anxiety	A.1.1.Generalized Anxiety disorder. (5)	FM01	A.1.1.1.Students with anxiety.	5
			SS02	A.1.1.2. There is some problems such as anxiety.	
			FA07	A.1.1.3.Anxiety.	
			MC04	A.1.1.4.Anxiety and stress.	
			FP05	A.1.1.5.Students with anxiety.	
		A.1.2. Exams Anxiety. (3)	MC03	A.1.2.1. There is some problems such as exam anxiety.	3
			HC06	A.1.2.2.Future anxiety, and exams anxiety.	
			SB13	A.1.2.3. The most common issue that I have faced at	

				the exam period in the university is anxiety.	
		A.1.3.Obsessive compulsive.	SS02	A.1.3.1. obsessive compulsive disorder	9
			MC03	A.1.3.2.Obsessive compulsive disorder and adapted irrational thinking	
			HC06	A1.3.4.Obsessive compulsive disorder.	
			FA07	A.1.3.5.obsessive compulsive disorder	
			CC09	A.1.3.6. obsessive compulsive disorder.	
			FE10	A.1.3.7. Some clients have the obsessive compulsive.	

				CE11	A.1.3.8. And obsessive compulsive disorder.	
				GH12	A.1.3.9. Obsessive compulsive.	
				SB13	A.1.3.10 .Many client with Obsessive compulsive disorder.	
		A.1.4.Phobia.	A.1.4.1. Acrophobia	MC03	A.1.4.1.1. There are clients with acrophobia; they could not attend classes in the third floor.	1
			A.1.4.2. Phobia And Necrophobia	MC04	A.1.4.2.1.Phobia.	2
				FP05	A.1.4.2.2. Necrophobia.	
			A.1.4.3. Social phobia	HC06	A.1.4.3.1.Social phobia.	
				FA07	A.1.4.3.2. Social phobia.	6

				CC09	A.1.4.3.3. Social phobia, Some clients have fears of presenting in front of a group of people, they do not want to be criticized by other students.	
				CE11	A.1.4.3.4. My client had a phobia of communicating with other students or teachers at the university.	
				GH12	A.1.4.3.5. They have social phobia.	
				SB13	A.1.4.3.6. They have a fear related to places and people.	
	A.2.Depression.			FM01	A.2.1.Students with depression.	8
				MC03	A.2.2.There is some students with depression.	
				MC04	A.2.3.There is some clients with depression.	
				HC06	A.2.4. Depression.	
				FA07	A.2.5. The most clients I have met have a Bipolar disorder, and most of them have got medical treatment. They come to me to get reinforcement.	

			FE10	A.2.6. It is the most common problem that I deal with is the depression.	
			CE11	A.2.7. There is some students with depression.	
			GH12	A.2.8. Depression.	
	A.3. Academic Issues.	A.3.1. low academic level and cheating	FM01	A.3.1.1.Students who have low academic achievement are always referred to me by the students' deanship to solve the problem. (Some students were referred to me from The Deanship of students' affairs or their department).	1
		A.3.2.Absences	MC04	A.3.2.1. The client's absences; they did not attend their lectures	1
		A.3.3.Study's Subject/ subject of study	CN08	A.3.3.1. The most problems the students have is academic issues; they did not want to study nursling, they want other major.	2
			CE11	A.3.3.2. Some students have problems with their major, they want to study another major.	

	A.4. pharmacotherapy needs.		FM01	A.4.1.Some clients need to have pharmacotherapy. In this case I should refer them to the counseling and guidance main center. Then, they will do what they see it's necessary.	2
			CN08	A.4.2. There are students have schizophrenia.	
	A.5.Interpersonal Issues.	A.5.1.difficulties.	SS02	A.5.1.1.The most issues are in the student's relationship with their friends or teachers.	4
			FP05	A.5.1.2. Clients have lack of confidence and families issues.	
			HC06	A.5.1.3. Clients have problems related to lack of confidence.	
			AF07	A.5.1.4.lack of confidence.	
		A.5.2.Family issues	FP05	A.6.2.1. Family problems.	
			CN08	A.5.2.2.Also, some students have family issues.	

			CC09	A.5.2.3. Family issues.	5
			FE10	A.5.2.4. Family issues are the social workers task; they sometimes need to contact the clients' parents.	
			CE11	A.5.2.5.They didn’t respect her opinion, sometimes the students fight with each other' in this case always they are referred by the security or the student deanship.	
			GH12	A.5.2.6. Some clients have problems with their parents or husbands.	
		A.5.3.POST-TRAUMATIC STRESS DISORDER.	GH12	A.5.3.1. When they lose one of the family members, or have family issues.	1

	A.6.Drugs addicted.	MC04	A.6.1. I have helped one drugs addicted client, she took one year.	1

Interviews Cross Analysis

.Domain 2: Organisation context

Category	Sub-category	ID Numbers	Meaning units	Number of informants
A.1.Counselling and guidance main centre	A.1.1.Set up the role and policy	MF01 SS02 MC03 MC04 FP05 HC06 AF07 CN08 CC09 FE10 CE11	A.1.1.1.provide measures clients' information forms, and report forms.	13

			GH12 SB13		
	A.1.2. Requires Report	A.1.2.1. Daily or Weekly report	MF01	A.1.2.1.1 We need to send to our supervisor and to the counseling and guidance main center weekly	5
			MC03	A.1.2.1.2. We need to send daily or weekly report	
			CN08	A.1.2.1.3. We are required to send a weekly report to our supervisor about the clients issues, how many clients I have met, and the kind of therapy I have use.	
			CC09	A.1.2.1.4. I have to send a Summary report to counselling and guidance main centre, and send more details to my supervisor.	
			SB13	A.1.2.1.5. In some Psychological or mental cases I have to send a detailed report to the main center. Also, I send a weekly report (include the techniques, measures and what I have done at the counseling session) to the counseling center.	
		A.1.2.2. monthly	MF01	A.1.2.2.1We have to send to the counselling and guidance main	

		report.		center monthly report.	
			SS02	A.1.2.2.2. we also send monthly report.	
					6
			MC04	A.1.2.2.3. I have to send a report about the clients to the counselling main centre.	
			FP05	A.1.2.2.4.We have to send to the counselling and guidance main center monthly report about the number of clients that I have met and the kind of issues.	
			HC06	A.1.2.2.5.Also, there is monthly report.	
			FE10	A.1.2.2.6. We need to send to the counselling main centre and my supervisor (who is social worker) monthly report.	
			CE11	A.1.2.2.7. In the past, we used to send a short report about each client without any personal information (we used a cod for each client) to the counseling and guidance main center. But now we have to send a report with all information 'the techniques and therapies' include	

				the personal information like; names.	
		A.1.2.3. Statistic report	MF01	A.1.2.3.1. We are required to send statistics reports showing how many clients that I have met and the clients' problems: academic, economic, behavioural and ethical issues.	7
			MC03	A.1.2.3.2. We have to send to the counseling and guidance main center weekly statistical report shows that; how many clients that I have met and the kind of issues academic, economic, behavioral and ethical issue	
			HC06	A.1.2.3.3. We have to send to the counselling and guidance main center statistic report about the number of clients and their issues.)	
			FA07	A.1.2.3.4. We have to send to the counselling and guidance main **(.**center statistic report about the number of clients and their issues	
			CN08	A.1.2.3.5. We have to send to the counseling and guidance main center monthly statistical report shows that; how many clients I have met.	
			CC09	A.1.2.3..6. We have to send to the counselling and guidance main	

				center statistic report about the number of clients and their issues.	
			GH12	A.1.2.3.7. I have to send a statistic report to the counselling and main center every month.	
		A.1.2.4.Final report	FP05	A.1.2.4.1.In the end of each semester we have to send a final report to the main centre about all clients without the personal information.	3
			FA07	A.1.2.4.2. When I finish sessions with a client, I send a report about her to counselling and guidance main centre.	
			GH12	A.1.2.4.3. In some Psychological or mental cases I have to send a detailed report to the main center.	
	A.1.3. Offers Help and support (10)		MF01	A.1.3.1.I contact the counselling and guidance main center when I have some difficulties with some clients (clients with depression to discuss their issues. There were therapists meeting twice a month to discuss clients' issues and provide some suggestions.	
			SS02	A.1.3.2.Sometimes I read about the client Issue. But, when I have difficulties with the client issue I ask therapists for helping and	10

			suggestions. In some cases I have to contact the counselling and guidance main center.	
		MC03	A.1.3.3. If I have difficulties with the client issue I ask therapists for helping and suggestions.	
		FP05	A.1.3.4. I contact the counselling and guidance main center when I have some difficulties with some clients.	
		HC06	A.1.3.5. I contact the counselling and guidance main center when I have clients with psychosis.	
		FA07	A.1.3.6. If I have difficulties with a client, I refer her to the main centre or sometimes she needs pharmacotherapy. Sometimes I ask psychologist friend from outside the university about her suggestion and opinion in some cases.	
		CN08	A.1.3.7. If I have difficulties with the client issue I ask my supervisor for helping and suggestions.	
		FE10	A.1.3.8. Sometimes I discuss some clients' issues with a social worker especially with family issues.	

		CE11	A.1.3. 9. If I have difficulties with the client issue I ask therapists for helping and suggestions. Some cases need to be discussed with a team of a social worker, counselor, and doctor (To translate reports, give her time off, make sure of any medication that the client take.	
		SB13	A.1.3.10.If I have difficulties with the client issue I ask therapists for helping and suggestions.	
B. Therapist meeting.		FP05	B.1. We used to have therapists meeting every week at the main center to discuss clients' issues and provide some suggestions.	6
		HC06	B.2. We have meeting at the main center every two month. Also, all psychologists at my center meet with the head of the student affairs who evaluates our work.)	
		FA07	B.3. We used to have weekly meeting with other therapists. But now we meet every two weeks.	
		CN08	B.4. We used to have weekly therapists and social workers meeting to discuss and provide suggestions about the clients'	

			problems without mentioning any personal information.	
		CC09	B.5 We have meetings with our supervisors, therapists and social workers.	
		CE11	B.6. We have therapists meeting to discuss and provide suggestions about the clients' issues without any personal information.	
C. Supervision		FP05	C.1. We were supervised by counsellor who refers the clients to us. We have supervisors in our counselling unit to follow up our work, and we need to send them weekly or monthly reports	4
		MF01	C.2. We have a supervisor in our counseling center to follow up my work.	
		CN08	C.3. We have a supervisor in our counselling centre at the nursery school to evaluate my work.	
		CC09	C.4. My supervisor is a social worker who I need to send detailed forms about my clients	

Interviews Cross Analysis

Domain 3: [Therapist Experience

Category	Sub-category	ID Numbers	Meaning units	Number of informants
A.Year of experience	A.1. Two Years	MC04	A.1.1. Two years.	1
	A.2.Four Years	SS02	A.2.1. I have been working as a therapist for four years.	4
		MC03	A.2.2. I have been working as a therapist for four years.	
		CN08	A.2.3. I used to work at a school for one year. Then, I have volunteered at a hospital for five months as a clinical psychologist. Now, I am	

			working as a therapist at the university for four years.	
		SB13	A.2.4. I have been working as a therapist for 4 years.	
	A.3.Four and half years	FM01	A.3.1. I have been working as a therapist for four and half years.	1
	A.4.Five years	FP05	A.4.1. I have been working as a therapist for Five years. I have volunteered for 5 months at a counselling Centre.	2
		FA07	A.4.2. I have worked at Alyamamh hospital. Also, I have volunteered at Alamal complex for mental health. Then I got this job. I have been working for 5 years at the university.	
	A.5. 8 years	CC09	A.5.1. I have been working for 8 years at the university.)	1
	A.6. 9 years	FE10	A.6.1. I have been working as a therapist for 9	1

			years.	
	A.7. 12 years.	HC06	A.7.1. I have been working as a therapist for 12years.	2
		GH12	A.7.2. I have been working as a therapist for 12 years. And I have worked in a psychological clinic for one year.	
	A.8. 16 years	CE11	A.8.1. I have been working as a therapist for sixteen years	1
B. Changes.	B.1. Feel better	FM01	B.1.1.Now I am more flexible on a personal level. Before I had shock toward the clients' problems. I was very emotive.	3
		FP05	B.1.2. I feel much better, I have learned a lot.	
		HC06	B.1.3. My work was below the average. Actually, when I got this job I did not do psychologist work. But now I feel better and I can recognize the therapies and the issues.	

	B.2.improved performance	FM01	B.2.1.I have improved a lot. Now I can deal with the situation 90% as a therapist and client (professional relationship). Things became more clearly. I can identify the main objective.	11
		SS02	B.2.2. I have changed in the way of using counselling therapies	
		MC03	B.2.3.I improved my performance.	
		MC04	B.2.4. The beginning was difficult, but with practice and working with clients my performance has improved.	
		FA07	B.2.5. My performance has improved.	
		CN08	B.2.6.it is very useful to have many clients.	

		CC09	B.2.7.yes, I can say I have improved 40% in my performance.	
		FE10	B.2.8.My performance has improved. At the beginning, my work was based on what I have learned at the bachelor.	
		CE11	B.2.9.I have improved a lot. I got a master degree, and now I am doing a PhD, and still I need to improve my skills.	
		GH12	B.2.10.I have improved 70%. I have done a student group meeting and discussion. To talk about social and psychological issues, also, provide courses and workshops in self-confidence and improvement. We provide preventive and developmental approaches.	
		SB13	B.2.11.I am confidence that I have improved a lot, And my performance is excellent. Also, I can see my improvement when the client improved	

C. sources of changes	C.1. Practice, experience,	SS02	C.1.1. practice, experience	7
		MC03	C.1.2. practice, experience.	
		Fp05	C.1.3. practice and experience	
		HC06	C.1.4. practice and experience	
		CN08	C.1.5. practice, experience, I have done an induction program about the psychologist's task contact number, student's issues, and what they .know about the mental health.	
		CE11	C.1.6. studying and experience.	
		GH12	C.1.7. Experience	
	C.2.Reading.	**FM01	C.2.1. I read a lot on counselling and psychology in order to update my knowledge, especially when I have a new client. I always read about her problem.	5
		MC03	C.2.2. And reading.	

		MC04	C.2.3.I try to improve my performance by reading	
		GH12	C.2.4. : Reading,	
		SB13	C.2.5.Reading.	
	C3. Training program	GH12	C.3.1.Attending courses and workshops.	1
E.Attending internal workshops and courses.	E.1.Yes.	MC04	E.1.1. I have attended workshops in psychologist skills, how to decrease stress, self- confidence	7
		FP05	E.1.2. We were required to attend a three-month course in psychological disorders and counselling skills. This course was organised by the main counselling centre at the university.	
		FA07	E.1.3. I have attended workshops in psychological disorder for three months.	
		CN08	E.1.4. The university has offered a course for two weeks. Also, I am working as a secretary for the National Committee for Mental Health Promotion	

			at the university.	
		FE10	E.1.5. I have attended workshops like the interview technique, and the counselling and guidance technique and methods.	
		CE11	E.1.6. yes. I have attended many workshops that were organised by the Main Counselling Centre, such as counselling techniques, counselling skills, family therapy, and diagnosis and psychotherapies. We still need more courses.	
		GH12	E.1.7. I have attended many workshops that have organised by the university, such as; Cognitive behavioural therapy, counselling skills, students problems, students counselling and guidance.	
	E.2.No	FM01	D.2.1. The university did not provide workshops and courses related to psychology. I wish they do. Because I need that. I have attended workshop in communication skills, work pressures	6

		SS02	D.2.2. no, Because the university did not offer any workshops or courses in psychology. I hope the university offer courses to improve our performance	
		MC03	D.2.3. No, Because the university did not offer any workshops or courses in psychology	
		HC06	E.2.4.N0.	
		CC09	E.2.5.No.	
		SB13	E.2.6. The most of the workshops that the university provides are on the leadership.	
F .Attending External workshop	F.1.Yes	FM01	F.1.1. I have attended some workshop outside the university. But now I do not have the time	8
		SS02	F.1.2. I have attended workshops in phobia and anxiety outside the university	
		HC06	F.1.3. I attended workshops in self-development and obsessive compulsive disorder.	

		FA07	F.1.4. I have attended courses outside the university.	
		CN08	F.1.5.Yes. I have attended.	
		CC09	F.1.6. I have attended many of workshops, courses, and conferences.	
		CE11	F.1.7. yes. I have attended many courses.	
		GH12	F.1.8. yes. I have attended many courses like; hypnosis, Neuro-linguistic programming, and Emotional freedom technique.	
	E.2.NO	MC03	F.2.1.I don't have time	5
		MC04	F.2.2. I don't have time to attend workshops	
		FP05	F.2.3. I did not attend any workshop outside the university.	
		FE10	F.2.4.No	

		SB13	F.2.5. : No. I don't have time	
D. Needs Assessment	D.1.CBT Course	SS02	D.1.1.I would like training courses in the CBT.	4
		FA07	D.1.2.I would like courses in CBT.	
		FE10	D.1.3.Courses in the CBT.	
		CC09	D.1.4.In CBT.	
	D.2. Psychotherapy and other theories.	SS02	D.2.1. The university did not offer any workshops or courses in psychology. I hope the university offer courses to improve our performance	6
		FM01	D.2.2. The university does not provide workshops and courses revolve to psychology. I wish they do. Because I need that. I have attended workshop in communication skills, work pressures	
		MC03	D.2.3. (Because the university did not offer any workshops or courses in psychology	

		CE11	D.2.4.I would like the university provides more courses and workshops in psychology therapies and theory with more explanation and detailed for each of theory.	
		GH12	D.2.5. Also, I would like the university provides courses in the new psychological theory, Gender identity disorder.	
		CC09	D.2.6.I would like to have in depth view about The DSM4, 'Acceptance and commitment therapy.	
	D.3.Counselling skills	CC09	D.3.1.Interview techniques.	3
		FE10	D3.2.Courses in the interview techniques	
		SB13	D.3.3.I would like to improve my skills in counseling. The most of the workshops that the university provides are on the leadership.	

	D.4.Assessment skills	FA07	D.4.1.Psychological measures.	3
		HC06	D.4.2.I would like to have a course in how to use Minnesota Multiphasic Personality Inventory.	
		SB13	D.4.3.The counselor tasks.	
	D.5.The health specialist license	GH12	D.5.1.I would like to get health specialist license for psychologist.	1

Interviews Cross Analysis

Domain 4: Therapist difficulties

Category	Sub-category	ID Numbers	Meaning units	Number of informants
A.External Situational Obstacles	A.1. Lack of privacy and private locations	FM01	A.1.1.It is Uninitialized place. We don't have much privacy during the sessions. There are some co-workers do not respect my work; they open the door during the session.	13
		SS02	A.1.2. We are three working at the same office – two therapists and one social worker. When one of us needs to meet a client, the others have to leave the office. And before making any appointment with any client I need to make sure that the office will be available.	

		MC03	A.1.3. There is no privacy, and it is an inappropriate place for counselling.	
		MC04	A.1.4. We don't have privacy.	
		FP05	A.1.5. I used to have difficulties with the place. It was Uninitialized. But, now I don’t have any difficulties.	
		FA07	A.1.6. It is inappropriate place. I don’t have the relaxation seat.	
		CN08	A.1.7. I used to work with ten therapists at the same office; I was working at the counseling main center the place was inappropriate. We were ten therapists at the same place but now at the nursery school it more comfortable and quiet.	
		CC09	A.1.8. The place is inappropriate and there is no privacy during the session. Also, I can't do a group therapy because there is no place to do it.	
		FE10	A.1.9. there is no privacy and I don’t have appropriate	

			place.	
		CE11	A.1.10. I have changed my office a lot some of the offices were good and comfortable. But this office is inappropriate there is no ventilation.	
		GH12	A.1.11. inappropriate place, No relaxation seat. I have been asking for relaxation sofa but no responses).	
		SB13	A.1.12. inappropriate place. (No measures, workshops and .No relaxation seat	
	A.2. Conflicts with co-workers & management.	MC04	A.2.1. Sometimes the other co-workers taunt me about how I care about my work; they said you don't need to do this kind of work.	2
		FP05	A.2.2. My supervisor was not treating us kindly	
	A.3. Inappropriate Tasks	HC06	A.3.1. Sometimes we should do other task (that are not psychological task) like do some activities.	2

		GH12	A.3.2. I have been asked by the counselling and guidance centre to send client's files and a detailed report with the personal information.	
	A.4. Lack of Support/resources.	AF07	A.4.1. I have to use specific measures. And the university don't provide enough measures.	2
		CC09	A.5.2. The university don't provide workshops or professional courses for us.	
B.in session difficulties and challenges (with clients)	B.1. Clients fear that: B.1.1. Confidentiality concerns.	FM01	B.1.1.1. Some clients have a fear that maybe the therapist will tell their parents.	3
		MC03	B.1.1.2. Some clients have a fear or worry to tell their parents about their problems or about attending a therapy.	
		SS02	B.1.1.3.Sometime I have difficulties dealing with clients. So, I need more times to explain to her about privacy and confidence.	

	B.1.2. Counselling will negatively Affect their studies.	FM01	B.1.2.1. Also, they think if they attend the counseling sessions will affect their studies. So, in this case I need more times to get her confidence. I always mention confidence and confidential client information.	1
	B.2. Client silence	SS02	B.2.1 Client's silence is one of the difficulties. This always happens when the client has been referred to me by the main counselling center	5
		MC04	B.2.2. Clients silence.	
		FA07	B.2.3. silent clients	
		FE10	B.2.4. Client's silence, I would end the session if the client keeps not talking. Or sometimes they didn't talk about the main problem They talk about different things.	
		GH12	B.2.5. Some clients keep silent for a while or talking about different thing and after three or four sessions start talking about their real problems.	

	B.3. Lack of client commitment to therapy/Nonattendance of sessions	SS02	B.3.1 Some clients did not commit to attending the counselling sessions, or some of clients visit the therapists to get an excuse to avoid attending their classes.	7
		MC03	B.3.2. .Some clients are not committed to attend the counselling sessions because of their class timetable.	
		MC04	B.3.3. Some clients are not committed to attend the counselling sessions.	
		FA07	B.3.4. (Some clients are not committed to attend the counselling sessions.	
		CN08	B.3.5. Some clients are not committed to attend the counselling sessions, so sometimes I call them or send an email. In some situation I contact the client's parents.	
		CC09	B.3.6. .Some clients are not committed to attend the counselling sessions.	
		FE10	B.3.7. Some clients are not committed to attend the	

			counselling sessions	
	B.4. Relapse.	MC04	B.4.1 I am worry that the client recrudescence after the counselling session, specially addicted clients.	1
	B.5. Clients emotion And thought.	MC04	B.5.1. The client's stress was one of difficulties that I needed to deal with.	4
		FE10	B.5.2. Emotional attachment. Some clients show emotional attachments to me, they did not understand the relationship between the therapist and the client. In this case I would refer them to another therapist.	
		HC06	B.5.3. Some clients have negative perspectives about attending a therapy; other clients believed that the counsellor will solve their problems at the first session.	
		FP05	B.5.4 It is difficult to deal with stubborn clients; they are not open for any new idea or suggestion..	
	B.6. Using therapies and techniques	HC06	B.6.1. I have difficulties in using some therapies and techniques.	3

		CC09	B.8.2. I have difficulty applying the relaxation technique with my clients because I don't have an appropriate place.	
		FA07	B.6.3.I have disabilities clients and sometimes I don't know how to deal with them. I don't have enough experiences to do.	
C	B.7therapist doubts & fears: of not . :(being to help (lack of confidence B.7.1.. Feeling: maybe, sometimes I cannot provide support.	FM01	C.1.1. Sometimes If I face a difficulty in dealing with a client, I prefer to refer her to another therapist or sometimes ask for help and support from other therapists.	4
		SS02	C.1.2. I do not understand the client issues, but during ١C. her talking I can figure her issues out.	
		MC03	C.1.3. sometimes I have difficulties in changing clients' idea or thinking	
		MC04	C.1.4.Sometimes I do a therapy plan for a client, But then I feel that it will not working, so I change it.	

	B.7.2.No	FP05	C.2.1.No	5
		HC06	C.2.2.No.	
		FA07	C.2.3.N0	
		CN08	C.2.4.No.	
		SB13	C.2.5.NO	
	B.8. of doing more harm. B.8.1.NO	FM01	E.1.1.No	8
		SS02	E.1.2.No	
		MC03	E.1.3.No	
		MC04	E.1.4. Sometimes the length of the counselling session may cause harm.	

		FP05	E.1.4.No	
		HC06	E.1.5.No	
		FA07	E.1.6.NO	
		CN08	E.1.7.No	
		SB13	E.1.8.No	
	B.9. <u>of losing control</u> <u>of the therapeutic situation</u> B.9.1.Not really	FM01	F.1.1. I have Faced collapse, convulsion and screamed clients. In convulsion case I contact the health unit at the University and I try to keep the client safe until they arrive. But in the other cases I can control that.	
		MC04	F.1.2. There are some aggressive clients. Some clients leave the session.	
		HC06	F.1.3. (sometimes I feel boring if the reason for the client visit is only talking not asking for help)	
	B.9.2.No	SS02	F.2.1.No	6

		MC03	F.2.2. I can deal with emotive clients and keep her calm.	
		FP05	F.2.3.No.	
		FA07	F.2.4.NO.	
		CN08	F.2.5.No.	
		SB13	F.2.6.NO	
C. No difficulties		CE11	I don’t have any difficulties during the counselling session. I always encourage the client to talk without any interrupting. I can deal with client's anger and emotion. In addition, 90% of the client committed the counselling sessions.)	2
		SB13	. No I don’t have. (I have faced emotional clients (Crying) but I can help her to relax).	