

**The Specialty of Counselling Psychology: A Study Conducted
at Three Western Cape Universities**

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Abstract

A lot has been written and debated on psychology as a profession in South Africa. However, there is only a small amount written about the specific professional category of counselling psychology. Much of the debate centres on the overlap in practice patterns and types of problems seen by clinical and counselling psychologists, to the extent that it has been suggested that counselling psychology be integrated into the field of clinical psychology. This paper aims to inform this debate by examining the areas of professional interest and career aspirations of psychology Honours students. The perceptions of the specialty from the perspective of clinical and counselling Masters student's and Masters course convenors also informs the debate. Data was collected using survey research and semi-structured interviews. The three Western Cape universities provided the setting for the research and the findings are therefore specific to the Western Cape. Findings indicate that a predominant boundary exists between the specialties but that it is threatened by other factors such as status and training programmes.

Keywords: counselling psychology, clinical psychology, boundaries, status, combined-integrated training programmes

The Specialty of Counselling Psychology: A Study Conducted at Three Western Cape Universities

“I’m not sure...” is an answer often received when asking someone to explain the difference between a counselling and a clinical psychologist. The reason for this ambiguity between the specialties and its meaning for professional psychology is an area that has been open to deliberation for many years now.

Counselling psychology has had a long history of validating itself as a distinct entity from clinical psychology (Leong & Leach, 2007). The role of counselling psychology as a subfield of psychology is a contentious issue evoking much debate (Cassin, Singer, Dobson, & Altmaier, 2007; Cobb et al., 2004; Leach, Akhurst, & Basson, 2003; Neimeyer, Rice, & Keilin, 2009). Counselling psychology in South Africa is representative of the many difficulties that U.S. counselling psychology confronts (Leach et al., 2003). Both countries face three predominant problems influencing perceptions of this specialty.

The first major concern is the blurring of the professional boundaries between clinical and counselling psychology (Leach et al., 2003, Pillay & Peterson, 1996, Watson & Fouche, 2007). The blurring of the professional boundaries refers primarily to the overlap in practice patterns and types of problems seen by clinical and counselling psychologists. The second major concern is how the combined-integrated training (C-I training) of clinical and counselling Masters (MA) students affects the relevance of counselling psychology as a separate entity from clinical psychology at a post-graduate level of training. The third major concern is the general lack of understanding by the public and other interdisciplinary professionals regarding the differences between the two specialties (Watson & Fouche, 2007).

The interrelatedness of clinical and counselling psychology is highlighted in the literature as well as in this paper in that it is impossible to examine counselling psychology without discussing clinical psychology. Conversely, clinical psychology can be examined without reference to counselling psychology. The role of counselling and not clinical psychology is questioned partly because counselling psychology cannot stand alone. Therefore, the relationship between the specialties plays an important part in the debate regarding the current state of counselling psychology as a specialty. The examination of this issue will take place within the theoretical framework of “boundary work”.

Boundary Work

The sociologist Gieryn originally coined the term boundary-work. He defined boundary-work as the assigning of particular characteristics to an institution with the intention of constructing a social boundary that differentiates certain intellectual activities as being outside that boundary. When Gieryn refers to institutions, he is alluding to its practitioners, methods, knowledge, values and work organisation (Gieryn, 1983, 1999).

Psychology is a diverse field where the lack of integration is often perceived as a fundamental problem. Pluralism, however can be constructive and only becomes a problem when the boundaries between the specialties are no longer explored or contested. Instead, an attitude of common ignorance and apathy prevails (Derksen, 2005). Currently in South Africa there seems to be little discussion regarding the boundaries that exist between clinical and counselling psychology. This is particularly noticeable in the literature where only a small amount of research exists on this topic. An attitude of common ignorance and apathy is displayed in the knowledge of the public and professionals towards the distinction of the two subfields (Leach, Akhurst, & Basson, 2003; Watson & Fouche, 2007). Common ignorance and apathy is warned against in situations where pluralism exists (Derksen, 2005).

To position clinical and counselling psychology in the realm of boundary work, a definition of the two specialties is required to enable an understanding of the theoretical distinctions that exist between the specialties.

Defining the Specialties

A definition of the two specialties can be drawn from the scope of practice as reported in the government gazette (April 2010).

Clinical psychologists deal with:

- assessing, diagnosing, and intervening in patients dealing with life challenges, particularly those with developmental and forms of psychological distress and/or psychopathology; assessing cognitive, personality, emotional, and neuropsychological functions in psychological distress and/or psychopathology; identifying psychopathology in psychiatric disorders, and psychological conditions; identifying, and diagnosing psychiatric disorders and psychological conditions; applying evidenced based

psychological interventions to people with psychological, and psychiatric conditions; referring patients to appropriate professionals for further assessment or intervention;

- advising on the development of policies, based on various aspects of psychological theory and research; designing, managing, and evaluating programmes dealing with psychological, and psychiatric problems;
- training, and supervising other registered clinical psychologists in clinical psychology.

Counselling psychologists deal with:

- assessing, diagnosing, and intervening with patients dealing with life challenges, and developmental problems to optimize psychological wellbeing; assessing cognitive, personality, emotional and neuropsychological functions in relation to life challenges and developmental problems; assessing developmental processes (e.g. career choice), and adjustment;
- identifying psychopathology, and its impact on developmental processes, and adjustment; identifying, and diagnosing disorders of adjustments; applying psychological interventions to patients with developmental challenges, and adjustment problems: performing therapeutic counselling interventions; referring patients to appropriate professionals for further assessment or intervention;
- advising on the development of policies, based on various aspects of psychological theory and research; designing, managing and evaluating programmes dealing with developmental, and adjustment problems (downloaded from: http://www.hpcsa.co.za/downloads/psycho_education/form-103.pdf.)

The above two definitions indicate one notable difference between the two specialties in that clinical psychologists are able to work with people who are psychopathological while counselling psychologists work with people facing life challenges and developmental problems. The problem with this boundary is that it is a “one-way” boundary. In other words, counselling psychologists are not allowed to work with psychopathology but clinical psychologists are allowed to work with life challenges and developmental problems. This results in the boundary limiting counselling psychology while giving clinical psychology free reign.

Counselling Psychology: Boundaries and Perceptions

According to the literature, the greatest distinction between the two subfields occurs at their point of origin. Clinical psychology developed in response to the mental health movement stressing the importance of the diagnosis and treatment of psychopathology. Due to the emphasis on assessment, diagnosis and treatment, clinical psychology is based on the medical model. Counselling psychology has its roots in the vocational guidance movement and in the past placed emphasis on the vocational abilities and career interests of comparatively well-functioning individuals (Cassin et al., 2007; Cobb et al., 2004; Leong & Leach, 2007; Morgan & Cohen, 2008; Neimeyer et al., 2009).

Clinical psychology has maintained strong ties to the medical model whereas counselling psychology's attachment to vocational guidance is no longer evident. It has been argued that counselling psychology's waning commitment to its vocational and guidance roots may indicate a further erosion of its distinctiveness in relation to one of its historical characteristics (Neimeyer et al., 2009). Notwithstanding their initial divergence, the populations served, problems addressed, and training areas seem to be converging. The professional interests and career aspirations of clinical and counselling students may highlight additional boundaries (Cassin et al., 2007).

Professional interests and career aspirations

An online survey of post-graduate students carried out in the USA, revealed some important differences between the two fields. The most significant difference was in the area of career aspirations, where a bigger proportion of clinical students expressed an interest in clinical/hospital careers, whereas counselling students showed a greater interest in university counselling centres, non-profit organisations and other careers (Cassin et al., 2007).

The findings of this study were consistent with an analysis, also conducted in the USA, of internship placements that found students in clinical psychology predominantly being placed in medical centres and hospital settings, as compared to counselling psychology students who were principally placed in university counselling centres. What is of interest is that the placement of counselling psychology students in medical settings is a growing trend with these settings now being rated as the third most frequent internship for counselling psychologists (Neimeyer et al., 2009). This indicates a further convergence of the specialties from an internship perspective. It is unclear whether this trend extends to South Africa, as little research exists on internship placements of clinical and counselling psychologists.

The specialties of clinical and counselling psychology showed slight differences in theoretical orientations, populations served and therapy formats. Both clinical (68.9%) and counselling (57.6%) post-graduate students in the USA and Canada rated cognitive-behavioural therapy (CBT) as their number one therapy format (Cassins, Akhurst, & Basson, 2007). According to Goodyear et al. (2008), the move toward CBT was predicted by studies in America that showed that CBT would increase more than any other systems this decade. The emergence of the evidence-based movement accounts for the rise in popularity of CBT as many of the empirically based treatments are within the general class of CBT (Goodyear et al., 2008). Some

differences between the specialties emerged such as clinical psychology programmes allying more closely with biological, behavioural and cognitive-behavioural models of change. A reason for this finding could be that all three of these approaches are empirically supported treatments for several of the psychological disorders that clinical psychologists treat. Counselling psychology programmes on the other hand showed greater support for the interpersonal and humanistic/existential approaches, which are argued to be more suitable for the issues faced by higher functioning clients who are often seen by counselling psychologists (Cassin et al., 2007).

The populations served by both specialties also showed slight differences according to the literature from the USA. Although both specialties expressed a preference for working with adults (Cassin et al., 2007; Cobb et al., 2004), it was found that the percentage of graduate students in counselling psychology who favoured providing their services to adult populations (83%) was higher than conveyed by clinical psychology students (74%). Students in clinical psychology expressed a greater preference to serve children (38%) compared with the percentage for counselling psychology students (27%). In the South African context, Pillay and Petersen (1996) established that counselling and clinical psychologists saw far more adult clients than children.

In terms of therapy formats, the archival descriptions of the Commission for the Recognition of Practice Areas and Proficiencies in Professional Psychology (CRSPPP) specify that counselling psychologists serve clientele in all formats (i.e., individuals, families, couples, groups, and organisations). Clinical psychologists serve clientele in all formats with the exception of organisations (Cobb et al., 2004). This however is not the case in South Africa (J. Louw, personal communication, October 27, 2010). Another important distinction that occurs between the specialties revolves around the issue of status.

Professional status

Historical bias remains evident with regard to issues of power and status in the psychology profession (Leach, Akhurst, & Basson, 2003). Clinical psychology has historically and is currently afforded a much higher status than counselling psychology. This status disparity is often referred to as the “step-child” status of counselling psychology (Leong & Leach, 2007). The early medicalisation of the psychology profession could have had a harmful effect on the progress of counselling psychology in South Africa. The traditional diagnostic and prescriptive treatment approaches followed by the medical profession, psychiatry, and clinical psychology

may have viewed the basic theory of counselling psychology described by human nature and its developmental, humanistic, and preventative foundations as less relevant. The argument could follow that the status of clinical psychology is so elevated that counselling psychology has been sidelined. Combined-integrated training programmes are an additional factor affecting the current state of counselling psychology.

Combined-Integrated Training Programmes

C-I training has recently received increased attention from American psychologists. Despite this being a contentious issue in South Africa little to no research exists on the meaning and effects of combined-integrated training for psychology from a South African perspective. C-I training programmes are defined as follows according to the American literature:

Combined-Integrated Doctoral Training Programs in Psychology produce general practice care, and health service psychologists who are competent to function in a variety of professional and academic settings and roles; these programs achieve this goal by intentionally combining and/or integrating education and training across two or more of the recognized practice areas. (Shealy, Cobb, Crowley, Nelson, & Peterson, 2004, p. 902).

In the USA, combined programmes have existed since the 1970's (Morgan & Cohen, 2008). One of the predominant reasons given in the American literature for combining programmes is the lack of differentiation in the accreditation guidelines for clinical and counselling psychology programmes. In the USA clinical, counselling, school, and "combined" programmes must act in response to an identical set of criteria to meet American Psychological Association (APA) accreditation standards (Cobb et al., 2004). This situation is mirrored in the accreditation guidelines of clinical and counselling psychology in South Africa (see Appendix A).

In the American literature those in favour of the C-I model expound on the major overlap among professional areas in psychology (Cobb et al., 2004). Other motivational reasons for C-I training programmes are as follows: (a) psychologists with training across the practice areas are employed in progressively more similar settings and accordingly are required to have comparable competencies; (b) psychologists are perceived as the same by most people outside the field; (c) competence within and across the practice areas of psychology should be taught in a way that is complementary and synergistic (Shealy et al., 2004). A further reason in favour of C-

I training models discussed in the South African literature is that combined programmes lead to good interdisciplinary work (Leach et al., 2003).

On the other hand, Watson and Fouche (2007) argue that the training of counselling and clinical psychologists is too entangled, resulting in a loss of identity for counselling psychologists. The elevated status of clinical psychology could be a reason for clinical psychology not experiencing the same loss of identity as experienced by counselling psychologists.

That C-I training programmes result in a loss of identity for counselling psychology requires an examination of the current status of C-I training programmes in South Africa. The term C-I training programmes is used to refer to a university MA programme that trains clinical and counselling MA students as one group with little to no variation between the two programmes. Leach et al. last reported on this information in 2003. They found that three of the South African universities trained MA students using a C-I training model. For the purpose of the current research each of the 17 South African universities were phoned to ascertain the current status of their MA psychology training programmes. The information received from the universities showed that currently nine of the MA training programmes take the form of combined-integrated programmes. The number of universities offering a MA degree in counselling psychology (either on its own or as part of a C-I training programme) have also increased from six in 2003 to eleven in 2010. Although the number of universities offering a MA degree in counselling psychology has almost doubled in seven years, most of these form part of C-I training programmes. The number of C-I training programmes has tripled in the last seven years. The combining of the programmes has implications for the profession of psychology as a whole.

Implications

Some authors have contended that the distinctions between clinical and counselling psychology are no longer consequential to the public or the profession, and that the two specialties can be integrated into a single training programme (Cassin et al., 2007; Cobb et al., 2004). Considering the overlap across these specialties, particularly with regard to the occupational roles and functions, there is little wonder why both professionals and students have trouble articulating the distinction between the subfields of psychology (Morgan & Cohen, 2008).

These reasons have prompted this study, which aims to discover more about the status of counselling psychology in the Western Cape from the perspective of psychology post-graduate students and training institutions. This perspective will inform the debate regarding the blurring of professional boundaries firstly from the professional interests and career aspirations of psychology post-graduate students, secondly from the training of clinical and counselling MA students, and thirdly the understanding psychology post-graduate students have of the professional category counselling psychology.

Method

The three Western Cape universities, the University of the Western Cape (UWC), the University of Cape Town (UCT), and Stellenbosch University provided the setting for the present research project. The research project consisted of two parts. Honours students in psychology at the three universities were surveyed in one phase of the current study, assessing their career aspirations and professional interests as a way to find out from possible future clinical and counselling psychologists how they perceive the differences between clinical and counselling psychology.

In the second phase, semi-structured interviews were conducted with a small sample of clinical and counselling MA students and with the three course convenors for the MA training programmes. These interviews intended to ascertain perceptions of the specialty of counselling psychology at this level of study as well as to learn more about C-I training programmes in the Western Cape. The research project utilised a cross-sectional design (Rosenthal & Rosnow, 2008).

Participants

Participants were recruited from the three universities in the Western Cape. Stellenbosch University and UWC offer C-I training for their clinical and counselling MA programmes. UCT offers an MA degree in clinical psychology only.

Survey participants

Honours students in psychology were recruited from the three Western Cape Universities for the survey phase of the study. Recruitment took place via the students' academic programme. There are 120 Honours students in psychology in the Western Cape for 2010. Seventy-three of the 120 Honours students completed the survey. This is a response rate of 60.83%.

Interview participants

Eight clinical and counselling MA students were recruited from the three Western Cape Universities. Of the eight students, six were completing degrees in clinical psychology and two (both located at one university) were completing degrees in counselling psychology.

The course convenors from each of the MA training programmes at the three universities were recruited to participate in a semi-structured interview. The course convenor from one of the universities was unable to participate in the interview due to time constraints. The previous course convenor, whose tenure was completed at the end of 2009, agreed to participate in the interview in the current course convenors' place.

Measures

The survey questionnaire

The 26-item questionnaire used for the present study was based on a questionnaire administered to psychology graduate students in the USA and Canada (Cassin et al., 2007). A copy of the questionnaire was received upon request from the first author of the journal article, Dr. Stephanie Cassin. The paper examined the specialties of counselling and clinical psychology but also considered the differences in gender and degree type (PhD and PsyD). The study centred on the perspectives of psychology graduate students and their professional interests and career aspirations (Dr. S. Cassin, personal communication, April 16, 2010).

Although the current questionnaire retains items from the Cassin et al. (2007) questionnaire, other items were revised or added to ensure the appropriateness of the questionnaire with regard to the current study. Exclusions included questions pertaining to children and/or family responsibilities and questions about training programmes and training models.

Items in the survey questionnaire specific to this study requested information regarding educational characteristics; areas of interest for future work; university involvement in career planning; career aspirations; and demographic details (see Appendix B).

The semi-structured interviews

The semi-structured interview for the clinical and counselling MA students requested information regarding the respondents' perceptions of counselling psychology and its relationship to clinical psychology; information they had received regarding the specialties; areas of interest for future work and professional interests (see Appendix C).

The questions included in the semi-structured interviews with the psychology MA course convenors differed slightly according to the type of training programme they convened. Therefore questions for course convenors of C-I training programmes (see Appendix D) differed to the questionnaire for the course convenor at UCT (see Appendix D).

The researcher conducted all 11 interviews and the interviews were recorded for accuracy of information. The interviews took half an hour to complete.

Procedure

Survey questionnaire

Participants for the survey questionnaire were recruited via the psychology Honours course convenor at each of the three universities. A request to conduct a pen-and-paper survey was made telephonically and by e-mail. The request was granted by all three universities. As per the request of the researcher, the survey was administered at the end of the lecture that had the highest attendance level for the semester. This measure ensured a maximum response rate.

Approximately three days before conducting the survey, the course convenor sent a pre-notice letter to each of the students on the researcher's behalf. The information provided in the pre-notice letter included the details of the person conducting the research, the purpose of the research project, and the time and place the survey would be conducted.

The surveys were conducted in person by the researcher. Before commencing with the survey, students received a verbal overview of the research project as well as information regarding confidentiality and anonymity and that the completion of questions was optional.

Respondents were invited to ask the researcher questions before, during or after the survey. The most frequently asked question occurred during the survey when respondents wanted to know the meaning of the word "geriatric". For conducting future surveys, this word was altered to read "geriatric/elderly".

Semi-structured interviews

The clinical and counselling MA students from the three universities received a letter via e-mail containing the same information as the pre-notice letter sent to the Honours students. The e-mail requested their participation in the research project. The students who responded were contacted and a time and place for the interview was confirmed. Most of the interviews took place in an office at the respondent's place of training. Before the interviews commenced, respondents received a consent form to complete. The consent form informed the respondents of

the confidential nature of the interview and their right to withdraw from the interview at any time (see Appendix E). Respondents received a verbal request to record the interview using a digital voice recorder. All respondents consented.

The MA course convenors proved extremely difficult to access. Permission to conduct the interview was gained through e-mails, telephone calls and interactions with the course convenors' secretaries. The semi-structured interviews were conducted in the course convenors office at their place of work. The course convenors received the same consent form as the MA students and all gave consent for the recording of the interview.

The data for both phases of the research project was collected from the 1st of August 2010 to the 15th of October 2010.

Ethical Considerations

Ethical approval for the research was obtained from the Ethics Committee of the UCT Department of Psychology. Both Stellenbosch University and UWC required proof of the UCT ethics approval. Over and above this, a separate ethics application needed to be submitted to the UWC ethics department. Ethics approval from UWC was granted.

Further ethical considerations complicated the research project. As part of the ethics stipulations, two of the universities requested that they remain unidentifiable in the findings of the research project. Without using the names of the specific universities, certain information in the findings could implicate particular universities. It was therefore decided that findings be presented in a general format and the only comparisons would be between students interested in pursuing a career in clinical psychology versus those interested in a career in counselling psychology.

Results

Data Analysis

The results from the survey questionnaire were analysed using tabular analysis. The tables contain detailed descriptive statistics, which most often take the form of percentages. This allows for ease of comparison. Recruitment took place with the entire population of Honours students in psychology attending Western Cape universities thus making the use of inferential statistics unnecessary. Inference of the data did not extend to populations outside of the Western Cape.

The results from the open-ended question asked in the survey questionnaire, and from the semi-structured interviews were analysed using basic thematic analysis.

Results from the open-ended question were divided into two basic themes: (a) students who stated that they did not know the difference between the specialties, and (b) those who claimed to know the difference between clinical and counselling psychology. The responses of those who claimed to know the difference between the specialties were further analysed and the predominant themes selected and reported on.

The recordings of the semi-structured interviews were transcribed and analysed. Analysis took place by selecting salient themes that emerged from the interviews with the clinical and counselling MA students and the MA course convenors.

The analysis of the data is divided into two parts: the analysis of the survey data followed by the analysis of the semi-structured interviews.

Analysis of Survey Data

Sample demographic characteristics

The demographic characteristics of the Honours students in psychology who participated in the survey are displayed in Table 1.

Age and Gender

As reported the mean age of the respondents in the survey was 24.93 years (SD=6.282). However, there is a large difference between the youngest respondents (21 years old) and the oldest respondent (53 years old). The data showed that 78.87% of the respondents were 25 years old or younger. This data is representative of the lack of “mature” students engaged in post-graduate study in psychology.

As a reflection of the gender disparity in professional psychology, 91.67% of the respondents were female.

TABLE 1 Demographic information for the Sample of Psychology Honours Students

	Psychology Students (n=72)	
	M	SD
Age (in years)	24.93	6.282
Gender	n	%
Female	66	91.67
Male	6	8.33
Ethnicity		
Black	4	5.56
Coloured	17	23.61
Asian/Indian	5	6.94
White	41	56.94
Missing data	3	4.17
Marital Status		
Single	64	88.89
Cohabiting	1	1.39
Married	7	9.72
Separated	0	0
Divorced	0	0
Widowed	0	0

Ethnicity

A current debate in the profession of psychology centres on the issue of ethnic representativeness. Part of the debate focuses on the over-representation of white people in the profession and the influence this has on the relevance of psychology in the South African context. The survey data confirms this situation with 56.94% of respondents classifying themselves as white with the minority of students (5.56%) classifying themselves as black. Two of the respondents who did not complete this item wrote on the survey that they would not classify themselves and preferred to be viewed as humans. This is partially indicative of the sensitive nature of the issue.

Marital status

The majority of the students classified themselves as single (88.89%).

Specialty area

In terms of the specialty areas, the survey data shows that 63.89% of the respondents expressed a principal interest in clinical psychology while only 12.50% of the respondents conveyed counselling psychology as their area of principal interest. These findings are in agreement with the literature, which also found a higher percentage of respondents expressing a greater interest in, clinical as opposed to counselling psychology (Cassin et al., 2007; Pillay & Petersen, 1996).

The remaining respondents (23.61%) in the current study expressed an interest in something other than clinical or counselling psychology. These respondents indicated categories such as research psychology, neuropsychology, and educational psychology as their area of predominant interest. It is interesting to note that there are more respondents interested in other specialties in psychology than those expressing an interest in counselling psychology.

With regard to the respondents and their career planning and interests, the data suggested an interesting and relevant finding. This finding centres on information provided to the respondents about the specialties of clinical and counselling psychology by their university departments.

University departments and career planning

The information university students receive from their training programme influences the future paths they choose (Morgan & Cohen, 2008). A lack of information results in a lack of understanding.

As part of the survey, respondents were asked where they received the most information regarding the differences between clinical and counselling psychology (see Table 2). Less than 10% of the respondents indicated that they had received information regarding the specialties from their university departments. The majority of the respondents reported that either they had received no information (34.43%) or that the information they had was from their own reading (34.43%). A later question asked respondents to indicate whether they felt they would be making an informed decision if forced into making a choice between a MA in clinical versus a MA in counselling psychology. Almost half of the respondents (47.54%) indicated that they did not think they would be making an informed decision.

If universities do not provide adequate information regarding the specialty of counselling psychology and the differences that exist between clinical and counselling psychology this could

perpetuate the ambiguity regarding counselling psychology and its role as a specialty in the profession of psychology.

TABLE 2: University Departments and Career Planning

	Psychology Students (n=61)	
	n	%
Information received about clinical and counselling psychology		
University department	6	9.84
Own reading	21	34.43
Professional Board	1	1.64
Registered psychologists	7	11.48
Current MA students	5	8.2
No information received	21	34.43

Note: Missing data comprises 11 students who did not complete this item.

Counselling psychology and Clinical psychology: A comparison

The remainder of the survey analysis compares the specialties of clinical and counselling psychology from the perspective of post-graduate students in the Western Cape. Since this section of the survey is a direct comparison between respondents interested in clinical and counselling psychology, the respondents who indicated that they had no interest in pursuing a degree or career in either of these specialties (23.61%) were not required to complete this section of the survey. They are thus excluded from this portion of the analysis.

For the sake of convenience, respondents who expressed a predominant interest in clinical psychology are referred to as the “clinical respondents” and those students interested in counselling psychology are referred to as “counselling respondents”.

Areas of professional Interest

The literature that examines counselling and clinical psychology from the perspective of psychology students found slight differences between the areas of professional interest of those students interested in counselling versus clinical psychology (Cassin et al., 2007; Cobb et al., 2004). Due to these findings, areas of professional interest are considered potential boundary

markers between the specialties. The areas of professional interest are divided into the following topics: theoretical orientations, clinical populations, and therapy formats (See Table 3).

Theoretical orientation

The top four theoretical orientations indicated by counselling and clinical respondents are psychodynamic, cognitive behavioural, behavioural, and humanistic. These findings indicate no difference between the specialties except in the order of rating and even here little difference is indicated with the top two choices being the same for each specialty. As predicted by the literature, cognitive behavioural therapy was rated as one of the top two choices for both specialties (Cassin et al., 2007; Goodyear et al. 2008; Neimeyer et al., 2009).

TABLE 3: Areas of Professional Interest

	Speciality, n (%)	
	Clinical (n=46)	Counselling (n=9)
Theoretical orientation		
Behavioural	23 (16.91)	4 (2.94)
Biological	13 (9.56)	0 (0.00)
Cognitive Behavioural	25 (18.38)	6 (4.41)
Eclectic	15 (11.03)	2 (1.47)
Humanistic	18 (13.24)	5 (3.68)
Psychodynamic	26 (19.12)	5 (3.68)
Systems Theory	7 (5.15)	2 (1.47)
Other	8 (5.88)	1 (0.74)
Missing Data	1 (0.74)	0 (0.00)
Clinical Population		
Child	15 (32.61)	3 (33.33)
Adolescent	7 (15.22)	1 (11.11)
Adult	17 (36.96)	2 (22.22)
Geriatric	1 (2.17)	0 (0)
Missing Data	6 (13.04)	3 (33.33)
Therapy Format		
Individual	37 (80.43)	3 (33.33)
Couple/Marital	2 (4.35)	1 (11.11)
Family	1 (2.17)	0 (0)
Group	3 (6.52)	2 (22.22)
Missing Data	3 (6.52)	3 (33.33)

Note: Theoretical orientations do not sum to 100 because respondents could select a maximum of three choices.

Missing data indicates data excluded due to incorrect completion

Clinical population and therapy format

In the survey questionnaire respondents were asked to rate the choices for clinical population and therapy format from 1 (area of greatest interest) to 4 (area of least interest). For the purpose of analysis only the proportion of first choices for each sub-category as indicated by the respondents is reported. For example, the proportion of clinical respondents who chose children as their first choice for clinical population is 32.61%; the proportion of clinical respondents who chose adolescents as their first choice of clinical population is 15.22%; etcetera.

The findings of the analysis for clinical populations indicate that clinical respondents are most interested in working with adults (36.96%) in comparison to counselling respondents who

are most interested in working with children (33.33%). These findings do not correspond with the literature, which reported a predominant interest for both specialties in working with the adult population, followed by adolescents and then children (Cassin, et al., 2007; Pillay & Petersen, 1996). Both specialties indicated that the clinical population they were least likely to work with were the elderly.

Analysis of the category “therapy formats” showed that both clinical (80.43%) and counselling (33.33%) respondents preferred to work with clients on an individual basis. This finding corresponds to findings in the literature (Cassin et al., 2007; Neimeyer et al. 2009; Pillay & Petersen, 1996). The therapy format that both clinical (2.17%) and counselling (0,00%) respondents considered themselves least likely to work with as a first choice is “family”. None of the counselling respondents indicated that they wanted to work with families, which is a strange finding as they indicated their preferred clinical population to be children. It would therefore seem pertinent to rate working with families as a priority.

The data reported by the counselling respondents needs to be analysed with caution. Due to the incorrect completion of the questions three items had to be excluded from the analysis. This meant that only six counselling respondents completed the questions pertaining to clinical populations and therapy formats.

Career aspirations

The items in this section of the questionnaire examined the reasons why respondents expressed a particular interest in either clinical or counselling psychology. Respondents were also asked to indicate what job they would prefer upon graduating (See Table 4).

Interest in specialty

The top three reasons indicated by clinical respondents for their interest in clinical psychology in particular were doing therapy/assessments with clients; job security and working with people in communities with a low socio-economic status. Counselling respondents reported that their top three reasons for their particular interest in counselling psychology were doing therapy/assessments with clients; working with people in communities; and working in a team setting. Although there is a slight difference in the third choice of each specialty, the top two choices for both specialties are the same. A possible reason that counselling respondents rated job security so low is because they have fewer options of places to work, as a hospital setting is not an option for them.

The option “other” rated fairly well for both clinical and counselling respondents. Examples indicated under this option included for clinical: the desire to work with mentally ill patients (a reason given by five of the respondents). The counselling respondents gave examples such as using sports as a way to develop communities.

TABLE 4: Career Aspirations

	Speciality, n (%)	
	Clinical (n=46)	Counselling (n=9)
Predominant reason for interest in speciality		
High income	13 (10.65)	0 (0.00)
Prestige	8 (65.55)	1 (3.50)
Work in team setting	14 (30.32)	7 (25.00)
Therapy / assessments	37 (30.32)	8 (28.57)
Job security	19 (15.57)	1 (3.57)
Health / retirement benefits	3 (2.45)	0 (0.00)
Community work	19 (15.57)	8 (28.57)
Other	9 (7.37)	3 (10.71)
Work setting upon graduating		
Hospital setting	25 (54.35)	1 (11.11)
NGO / Community	13 (28.26)	4 (44.44)
Private Practice	10 (21.74)	2 (22.22)
Administration	1 (2.17)	0 (0)
Academia	0 (0)	0 (0)
Research	3 (6.52)	0 (0)
Corporate / business setting	0 (0)	1 (11.11)
Other	2 (4.35)	1 (11.11)
Missing Data	2 (4.35)	0 (0)

Note: Predominant reasons for interest in speciality do not sum to 100 because respondents could

select a maximum of three choices

Missing data indicates data excluded due to incorrect completion

Preferred work setting

The following three work settings ranked in the top three for both clinical and counselling respondents: hospital setting, NGO/community setting and private practice. The difference occurred in the order in which they were ranked and in particular to the work setting rated as the first option for each of the specialties. Over half of the clinical respondents selected a hospital

setting as their first choice of place to work. Just under half of the counselling respondents selected a NGO/community setting as their first work option. This finding is in agreement with the literature and is indicative of the existing boundary marker namely; work setting that exists between the specialties (Cassin et al., 2007; Neimeyer et al., 2009).

That private practice rated in the top three choices of both specialties is also congruent with the literature that indicated that over half of South African clinical and counselling psychologists surveyed worked in private practice (Pillay & Petersen, 1996). A separate question in the current survey asked students whether they planned to establish their own private practice during the course of their career. An overwhelming majority (93.22%) responded “yes” versus 6.78% who said “no”. No clear boundaries delineate the specialties in private practice indicating that this is where much of the ambiguity regarding the boundaries between the two specialties occurs.

Perceived differences between the specialties

The survey contained one open-ended question, which asked the respondents to state their opinion as to the difference that exists between a counselling psychologist and a clinical psychologist. An indication of clear distinctions separating the specialties would specify the presence of boundary markers. A quarter of the respondents (14 respondents) described clinical psychologists as being able to work in a hospital setting with patients displaying severe psychopathologies and counselling psychologists as competent to work with high functioning individuals struggling with problems of life. A further 13 respondents also indicated that clinical psychologists could work with patients with severe psychopathologies but were unsure of the role of counselling psychologists. Five of the respondents said that they did not know the difference between a clinical and a counselling psychologist and eight of the respondents left this item blank. Other answers were given by 16 of the respondents. These answers included: (a) clinical psychology bordering on psychiatry; (b) clinical psychologists having a higher status than counselling psychologists; (c) counselling psychologists work in community settings developing interventions; (d) clinical psychologists work in private practice versus counselling psychologists who work in community settings; (e) clinical psychologists receive more formal and extensive training. Responses “c” and “d” indicate that the respondent is unsure of the differences that exist between the specialties, while the remainder of the respondents indicate other perceived boundary markers between the specialties.

This open-ended question highlights a clear boundary marker that exists between the specialties namely that clinical psychologists work with severe pathologies in a hospital setting as compared to counselling psychologists who deal with problems of living.

Analysis of Semi-Structured Interviews

Clinical and counselling MA students

Three definite themes emerged from the interviews conducted with the MA clinical and counselling students. The first theme identified the main difference between clinical and counselling psychology as perceived by these respondents. The second theme centred on the status difference between the specialties. Third, the respondents indicated whether they felt informed by their university departments about the differences between clinical and counselling psychology.

The main difference that exists between clinical and counselling psychology as perceived by the majority of the MA students (all except one who did not know) is that clinical psychologists are able to work with severe pathologies in a hospital setting. Counselling psychologists on the other hand can only work with high functioning people struggling with everyday life problems. This concurs with the South African scope of work as reported in the Government Gazette (April, 2010), and the literature as well as being identified by the Honours respondents as the most distinct boundary marker between the specialties.

All of the respondents acknowledged an existing difference in the status between the specialties with clinical psychology being more highly regarded than counselling psychology. Some interesting reasons were given for the perceived status difference. One of the respondents commented that the status problem originates in the name “counselling” as this is linked to “counsellor” which is seen as less than a psychologist. More generic reasons given for the perceived difference in status related to clinical psychologists completing their internship in a psychiatric facility, many respondents viewed this to be more challenging than counselling internships. Another reason was the extended learning period for clinical psychologists in the form of community service.

None of the MA respondents felt that they had adequate knowledge about the specialties of clinical and counselling psychology. They all said that they had not received any information from their universities regarding the two specialties. Since they did seem to know something about the specialties a probing question was asked to determine where they received their

information. The students gave a variety of answers such as practical experience and observing staff members, through their own reading, from the Health Professions Council of South Africa (HPCSA) website and by asking professionals like lecturers and qualified psychologists.

Clinical and counselling course convenors

A prominent reason for wanting to interview the MA clinical and counselling course convenors in particular was to find out more about the training programmes offered for MA clinical and counselling students in the Western Cape with a particular area of interest being the application of the C-I training programmes. Three salient themes emerged from the interviews with the clinical and counselling course convenors.

In the first theme, the course convenors identified clinical psychologists as being able to work in a hospital setting with severe pathologies. Counselling psychologists on the other hand work with problems of living. One of the course convenors also suggested that counselling psychologists work more in community settings. A separate course convenor raised the issue of private practice as he/she felt that this area resulted in the most ambiguity surrounding the boundary issue in professional psychology.

A second theme that emerged centred on the status issue that exists between the specialties. The course convenors all agreed that clinical psychologists are perceived as having a higher status in comparison to counselling psychologists. Not all of the course convenors felt that this perception was warranted as counselling MA students study the same course content as clinical MA students. One of the course convenors felt that the reason for the elevated status of clinical psychology was due to its psychiatric parameters. The psychiatric parameters refer to clinical psychologists working in psychiatric hospitals alongside psychiatrists as well as the strong ties clinical psychology has with the medical model. This was also a reason expressed in the literature for the elevated status of clinical psychology to the detriment of counselling psychology (Leach et al., 2003). Status was also cited by course convenors as one of the reasons for introducing C-I training programmes.

This leads into the third theme discussed by all of the course convenors, namely training using C-I training programmes. Key decision makers in clinical and counselling MA training programmes believed that teaching clinical and counselling psychologists the same curriculum at the same time would diminish the status issue that exists between the two specialties. Since the students for both specialties would be learning the same information they would not perceive

each other as more or less qualified. Another reason for running C-I training programmes was the perceived necessity for all students to have the same knowledge. This is considered important in the South African context where both specialties should be moving in a community direction where they will be faced with a large spectrum of pathologies and problems of everyday functioning. One of the course convenors discussed the advantages of a generic label for psychologists and only once expertise had been gained in a specific area could psychologists become accredited as a specialist in something. According to this course convenor, the Professional Board of Psychology had discussed a generic label but the idea was later discarded. A lot of agreement is evident between the Honours students, MA students and the course convenors particularly in the area of work setting for clinical and counselling psychologists and in the area of perceived status between the two specialties.

Discussion

The results of this study provide two kinds of important information about counselling psychology and its relationship with clinical psychology. The first part of the information concerns the differences or boundaries that exist between the specialties. The second type of information is concerned with the effect of training programmes on the relevance of counselling psychology. The findings of these two areas will be discussed in relation to their effect on the relevance of counselling psychology in the Western Cape.

Counselling Psychology and Clinical Psychology: Boundaries

This study explored potential boundary markers that exist between the specialties through the survey data, with a specific focus on the areas of professional interest and career aspirations of psychology Honours students, as well as with the open-ended question and semi-structured interviews.

The most distinctive boundary marker identified in the literature as well as from the findings in this study was the ability of clinical psychologists to work with psychopathologies in a hospital setting. Conversely counselling psychologists work with people struggling with problems of everyday living. This boundary marker will be referred to as “work setting”. This distinction between the specialties emerges throughout this paper. The literature discussed identifies work setting as a prominent boundary marker. It is the only distinction identified in the scope of practice for the two subfields. Both the MA respondents and the course convenors indicate psychopathology and problems of living as the only distinction between the specialties.

The psychology Honours respondents expressed this as a prominent boundary marker in their answers to the open-ended questions and through their choice of work setting: clinical respondents indicated a hospital setting as their first choice of place to work in comparison to counselling respondents whose first choice was an NGO/community setting.

Private practice, however threatens this distinct boundary marker. As specified in the literature over half of practicing psychologists work in private practice (Pillay & Petersen, 1996). The vast majority of psychology Honours respondents said that they would establish their own private practice at some point in their career. As pointed out by one of the course convenors, private practice is the main culprit for the blurring of the professional boundaries between clinical and counselling psychology. The reason for the lack of distinction is that the majority of patients seen in private practice present with problems of everyday living or mild psychopathologies. Therefore, both clinical and counselling psychologists in private practice are essentially dealing with the same type of patient. Considering that the public deals predominantly with psychologists in private practice could be a reason for their lack of understanding concerning the two specialties.

That a clear and defining boundary exists between clinical and counselling psychology is a significant finding. However, another threatening factor as discussed earlier in this paper is that this boundary is a “one-way” boundary limiting the scope of practice for counselling psychologists only. Linked to this is the lack of a defining boundary unique to counselling psychology. A further threat to this defining boundary that exists between the specialties is the issue of status.

Professional status

The literature discusses the elevated status of clinical psychology in relation to counselling psychology (Leach, Akhurst, & Basson, 2003). The findings from the data highlight this perception particularly from the perspective of the clinical and counselling MA respondents and the course convenors. Every one of these participants acknowledged the perception that clinical psychology has a superior status level in comparison with counselling psychology. The open-ended question of the survey also revealed that some Honours students perceive the status difference between the specialties to be a distinction between clinical and counselling psychology. The reasons for the status disparity between the specialties were explored in the semi-structured interviews.

The findings from this data confirmed the findings of Leach et al. (2003) in that the early medicalisation of psychology has had a harmful effect on the development of counselling psychology particularly regarding status. Most of the reasons for the status discrepancy as discussed in the interviews related to clinical psychology having a closer relationship with the medical profession. This involved factors like, clinical psychologists working in hospitals within psychiatric parameters and being referred to as the “doctors of the profession” all of which point to the medicalisation of the field being a major role-player in the status disparity. Even the naming of the two specialties, as alluded to by one of the MA students has repercussions for the specialties. The label “clinical” has a medical connotation versus “counselling” which is related to the term counsellor. In South Africa a short course through an organisation like “Life Line” allows just about anybody to become a counsellor.

Status threatens the most distinct boundary marker that exists between clinical and counselling psychology and is a prominent threat to the relevance of counselling psychology. Status threatens the boundary marker by elevating the ability of clinical psychologists to work in hospital settings with psychopathology to such a degree that it sidelines the specialty of counselling psychology rendering it seemingly irrelevant in a comparison of the two specialties. The findings from the data also suggest that status was one of the reasons for the implementations of C-I training at Western Cape universities. This form of training (Watson & Fouche, 2007) negatively affects the identity of counselling psychologists.

Training institutions and counselling psychology

If universities do not inform students about the specialties that constitute their profession, where are they going to learn about the distinctions that exist between clinical and counselling psychology (Morgan & Cohen, 2008)? Universities not only have a social responsibility to society as a whole but their departments also have responsibilities to the professions for which they train (Ngonyama ka Sigogo et al., 2004).

An overwhelming theme that emerged in the findings of the data was that university students from the three universities at both the Honours and the Masters level felt that they had received little to no information from their university department regarding the specialty of counselling psychology and its distinction from clinical psychology. The significance of this is that university departments are sending out future professionals who are lacking knowledge about their profession and the specialties that exist within the profession. This is an important

factor in perpetuating the lack of knowledge regarding counselling psychology. If professionals enter the working arena “not knowing”, how can lay people or professionals from other areas be expected to know the difference between a clinical and a counselling psychologist?

Regardless of whether a university department offers a MA degree in counselling or even educational psychology, universities have a responsibility to the profession of psychology to inform their students at some point in their training about the specialties that exist within the profession. The importance of this is that professionals entering the work place are aware of the distinctions that exist between the specialties as well as how the specialties function together. If this is not done the result is a stagnation of the boundaries resulting in the relevance of one or all of the specialties being questioned as can be seen in the current situation facing the profession of psychology. In psychology the situation is further exacerbated by the implementation of C-I training programmes.

MA training programmes

C-I training programmes are a contentious subject regarding the training of clinical and counselling psychologists. This is also an extremely under-researched area in South Africa, which makes it hard to comment on in relation to the literature.

As mentioned previously one of the reasons given for utilising C-I training is to alleviate the status issue that exists between the specialties. The effectiveness of this strategy is difficult to gauge. Currently in the Western Cape Universities, only 3 out of the 28 clinical and counselling MA students are specialising in counselling psychology. It is very unlikely given this situation that training programmes will be experiencing problems with status issues between their students with so few “voices” representing counselling psychology. Another dimension to this aspect is that status could be the driving force behind so few students specialising in counselling psychology.

Another reason given for the use of C-I training programmes is that students need training in all areas of the profession regardless of their specialty. Counselling psychologists will therefore be able to recognise pathologies and refer correctly and clinical psychologists will be able to help people experiencing life problems. Theoretically, this seems like a sound argument. However, from a boundary work perspective this form of training results in a stagnation of the boundaries as the boundaries between the specialties slowly become enmeshed with one another (Watson & Fouche, 2007). The practical result is two specialties that are too

similar to one another or one specialty being sidelined in favour of the other. The latter scenario appears to be the one facing clinical and counselling psychology in the Western Cape at present.

An informal canvassing of universities that offer C-I training revealed that a recent Board inspection resulted in some of these universities being asked to separate the training of clinical and counselling psychology students. The effects this will have on the profession of psychology in general and the specialties in particular will be interesting to monitor.

A point made in the literature but not commented on in the findings of the data is that the accreditation guidelines and the lack of distinction between training programmes for clinical and counselling psychology played a significant role in the development of C-I training programmes in the USA (Cobb et al., 2004; Shealy et al., 2004). This despite the fact that the accreditation guidelines (Appendix B) in South Africa regarding clinical and counselling psychology indicate the same overlap as those experienced in the context of the USA.

Limitations and implications for future research

At least two features of this study suggest some caution in interpreting the findings. First, the small sample of respondents interested in counselling psychology could affect the nature of the data. Second, psychology Honours students are in the infancy of their career decision making lives. What they have indicated in this survey data could easily change within a year. This directs the discussion towards the need for further research.

Due to the transient nature of student's career aspirations at the Honours level research is needed regarding the current professional status of clinical and counselling psychologists in South Africa. The last time this topic was researched was in 1996 by Pillay and Peterson. This paper is regularly cited in journal articles discussing topics such as the specialties of clinical and counselling psychology, community psychology and the relevance of psychology in the South African context. Research on the topic of professional status would be of value to many different role-players within the profession of psychology.

Another area for future research as highlighted in this study is the controversial area of C-I training. In psychology, the fact that science informs practice and practice informs science is a valued and often referred to attribute of the profession. However, in the professions institutions for training a practice is being utilised that has no scientific backing from a South African perspective. This is a worrying fact that should be addressed.

Conclusion

The predominant boundary of work setting that exists between clinical and counselling psychology is threatened by factors that elevate the profession of clinical psychology. This is exacerbated by a loss of identity for counselling psychologists occurring because of C-I training programmes.

A further concern is the small amount of interest shown in counselling psychology by post-graduate psychology students at the Western Cape universities. There are only three students pursuing a MA degree in counselling psychology while a small minority of Honours respondents expressed an interest in counselling psychology.

The current state of counselling psychology, from a professional and training perspective, requires the attention of researchers and professionals as a matter importance to the profession of psychology.

