Evaluation of psychological services provided by educational institutions and hospitals

A thesis submitted to the Department of Educational and Counselling Psychology of the University of Dhaka for the degree of Master of Philosophy (MPhil) in Counselling Psychology

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Declaration

I declare that the work on **Evaluation of psychological services provided by educational institutions and hospitals** is my own work, both in conception and execution and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. I also declare that no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Certificate of supervisor

This is to certify that I have read the dissertation entitled **"Evaluation of psychological services provided by educational institutions and hospitals"** submitted by **Sayeda Amina Efat** for the degree of Master of Philosophy in Counselling Psychology and this is a record of authentic/original research carried out by her under my supervision and guidance.

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Abstract

The objective of the study was to evaluate the psychological services of educational institutions and hospitals by comparing client's feedback on counsellors' behaviour and counselling sessions. Two hundred clients (120 from universities and 80 from hospitals) were purposively selected from six hospitals and five educational institutions. They were asked to complete the Client's Evaluation of Counselor Behavior Short Form (CECB-S) and the Session Evaluation Questionnaire (SEQ) as measures of the service quality they had taken from their respective organizations. Data were analyzed using independent sample t-test and two-way Analysis of Variances (ANOVA).

Results indicated that mean client evaluation (CE) score by the clients of educational institutions was significantly higher than the clients of hospital setting (t=10.112, p<.001) but the mean session evaluation (SE) scores did not vary between the two service settings (t=-1.077, p>.05). The SE scores also did not differ significantly between the clients of public and private universities (t=-.049, p>.001) or between government and private hospitals (t=.569, p>.001). The interaction between age and gender (p >0.05) or gender and number of sessions (p >0.05) was not statistically significant for both CE and SE. However, CE score increased with number of sessions (p<.000).

Clients taking services from universities evaluated their counsellors' behaviours favourably than clients taking services from hospitals, but their rating on individual sessions did not vary. Further studies should explore possible reasons for these differences by addressing counsellors' personal qualities, experiences, skills, and therapeutic mode.

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List of Abbreviations

CE	Client evaluation
SE	Session evaluation
CECB-S	Client evaluation of counselor behavior short form
SEQ	Session evaluation questionnaire
SES	Socio economic status
NS	Number of sessions

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Chapter 1

Introduction

1. Introduction

Applied psychologists, as mental health service providers, are trained in many psychotherapeutic approaches to support and influence individuals' ability to function in different environments and coping up with mental health issues. Moreover, demands for psychologists in hospitals and educational institutions settings have dramatically increased and mental health has become one of the most important disciplines in health care system (Savickas,2000). Therefore, evaluation of psychological service in various setting like educational institutions and hospitals is a situational priority in the field of mental health research.

1.1 Psychological service and psychotherapy:

Psychological services are defined as acts of psychological assessment, diagnosis, and intervention provided to a client. Psychotherapy is an effective psychological intervention for a multitude of psychological, behavioural, and somatic problems, symptoms, and disorders and thus rightfully considered as a main approach in mental and somatic health care management (Prince et al., 2007; Goldfried, 2013). A qualified professional (e.g., a counselling, clinical, educational psychologist, and psychiatrist) administers treatment with the goal of removing or changing current symptoms, minimizing or reversing dysfunctional patterns of behaviour, and encouraging healthy personality growth and development. The therapist assists the patient in regaining control of their emotions and life by offering them various coping strategies and skills. Psychotherapy sessions can take a number of forms, depending on what sort of treatment and assistance that client requires and the condition they are dealing with. Several forms of psychotherapy are discussed below-

1.1.1 Individual psychotherapy:

Individual psychotherapy is a verbal interaction in which qualified professionals use psychological procedures to alleviate distress and promote adaptive living in people who would like their help (Weiner,.2016). Individual therapy sessions provide client with the chance discuss concerns or situations with a skilled practitioner maintaining confidentiality. It is a treatment that works for a wide range of emotional issues and mental illnesses. Individual psychotherapy offers different forms. In spite of the theory behind each type, individual psychotherapy strives to help any individual overcome different issues and problems by identifying and exploring their concerns and problems and developing strategies.

1.1.2 Family therapy:

The central aim of family therapy is to facilitate the resolution of presenting problems and to promote healthy family development by focusing primarily on the relationships between the person with the problem and significant members of his or her family and social network. (Carr.,2012). Family therapy is intended to address particular difficulties affecting the family's psychological wellbeing, such as major life transitions or mental health issues. When a family experiences a stressful event that may damage family connections, such as financial struggle, divorce, or the death of a loved one, they might benefit from family counselling. Furthermore, it can be useful in treating mental health issues that affect the entire family, such as depression, substance abuse, chronic illness, and food issues, as well as everyday concerns in children and adolescents, such as communication problems, interpersonal conflict, or behavioural problems.

1.1.3 Couples therapy:

Couples therapy is psychotherapy for married or unmarried couples who are in a relationship (Couples Therapy: Definition & Techniques, 2021). Couples counselling may

help with a variety of relationship concerns, such as recurring disagreements, feelings of separation, family issues, an affair, the birth of a child, sex issues, or challenges caused by external stressors, etc. The goal of couple's therapy is to help couples address difficulties and improve their communication skills. Although the couple's therapist may meet one or both of the couple alone at some point throughout the therapy term, both people will normally be present in each therapy session.

1.1.4 Group therapy:

Group therapy is a type of psychotherapy in which a group of clients gathers to address a similar issue. Group counselling sessions are led and supervised by a certified mental health counsellor or psychologist. A group therapy session is not a free-for all discussion; rather, the leader establishes ground rules for the group to follow in facilitating discussion, connection, and growth among the individuals gathered. Groups can be as small as three or four people, although group therapy sessions are usually attended by eight to twelve people (although it is possible to have more participants). The group usually meets once or twice a week, for an hour or two. (Malhotra et al., 2021)

1.2 Evaluation approaches of psychological service:

The term "evaluation research" is used for the various approaches, depending on the processes being evaluated (Milne 1987): 'effort evaluation' focus at the relation between characteristics and activities of a program or service (e.g. psychologist/client ratio, physical setting) and funds spent on it (e.g. personnel and equipment), 'process evaluation' is typically restricted to a clear summary of the services rendered over time (number of clients, type and variety of services offered); 'performance evaluation' sets the correlation between service cost and the purpose of the service to be accomplished; The 'client satisfaction evaluation' explores the acceptance of mental health service by clients. The assessment of outcomes is the centre of the evaluative research; the analysis focuses here on the outcome of a

measurement. This method is selected when evaluating the efficacy of treatments or services. The outcome evaluation most specifically applies to the primary goal of the care "to improve the patient" (Schwartz et al.1973).

1.3 Psychological service in hospital settings:

If someone is in a mental health crisis, staying in a hospital may be the best approach to keep them safe and give them with the amount of care they require. This might be because they need to be hospitalized for a short length of time for further assessment, or they require more acute care that can be provided elsewhere, or there is a risk to their safety if they do not stay in hospital. For example, if they are seriously self-harming or at danger of acting on suicide ideas, or if there is a chance, they may harm someone else.

Bangladesh has one mental health institute, the National Institute of Mental Health (NIMH), (Choudhury, 2006) which is a 200-bed specialized mental hospital. In addition to the NIMH, the country has a 500-bed mental hospital (Pabna Mental Hospital, 162 kilometres west of Dhaka), 31 community-based psychiatric inpatient units, 15 forensic inpatient units, 3900 beds in residential facilities (e.g., homes for the destitute, inpatient detoxification centres, and homes for people with mental disability), and 50 outpatient mental health facilities. Dhaka Medical College established a mental health service in 1974. The Institute of Postgraduate Medicine and Research (now Bangabandhu Sheikh Mujib Medical University, BSMMU) and other medical colleges, as well as the Institute of Mental Health and Research, were then given access to this service. This service provided both outpatient and inpatient services. Currently, all 13 government medical schools and hospitals, as well as some non-government medical college hospitals, offer outpatient and inpatient psychiatric services (Karim et al,. 2006).

The majority of these mental health institutions are concentrated in urban regions, notably in major cities (World Health Organization, 2007). Despite the fact that 70% of the

Bangladeshi population lives in rural regions and the nation covers an area of 147,570 km2, the density of psychiatric beds in or around the capital Dhaka is five times that of the rest of the country. (Nuri et al., 2018). When all psychiatric beds in community psychiatric units and mental hospitals are counted, Bangladesh has just one psychiatric bed for every 100,000 people (World Health Organization, 2007), which is much lower than the European median of 72/100,000 persons (World Health Organization, 2017). In Bangladesh, just 0.49% of healthcare workers are educated to provide mental health treatments, and there are even fewer psychiatrists (0.16 per 100,000 population) (World Health Organization,.2020). The majority of these professional's work in the country's urban areas, particularly in Dhaka, the capital city. Psychiatrists, nurses, psychologists, social workers, occupational therapists, and general mental health professionals are examples of mental healthcare practitioners in Bangladesh (Islam & Biswas, 2015). Around 62% of psychosocial professionals, including clinical or counselling psychologists, social workers, nurses, and occupational therapists, work for government-run mental health facilities, 26% work for non-governmental organizations (NGOs) or in private practice, and 12% work in both the public and private sectors. Human resource allocation between urban and rural regions is extremely disproportionate, with a large concentration in urban areas (Islam & Biswas,.2014a, 2014b). Furthermore, there is a significant stigma and misconception about mental illness in Bangladeshi society. As a result, access to mental health care is inequitable and inadequate (Ahmed et al., 2015).

1.4 Psychological services in educational institutions:

An increasing amount of attention is being directed to the transition to higher education as experienced by traditional-age and adult students. It is a movement that incorporates a great deal of stress and challenge. Although some students are able to experience this transition as a challenge to personal growth, other students are overwhelmed by the changes and experience emotional maladjustment and depression. Complex

psychological histories often underpin these problems, further complicating treatment. These difficulties are often present as inefficiencies in coping with familial separation, time and stress management, basic study techniques, goal setting, relationship formation, handling emotions, and self-esteem crystallization. Personal, academic, social, and professional success depend on the student's ability to manage these aspects of their lives. The services that institutions provide to address students' personal and psychological problems depend heavily on the institution's philosophy, available resources, and campus need. Colleges and universities of all types should develop and implement confidential services that span multiple policy arenas in order to sufficiently address these problems. Creating partnerships with various facets of the institution, such as the college counselling and mental health centre, student health services, women's centre, learning centre, spiritual and religious organizations, and other associations, expands the scope of programs offered and students affected. Comprehensive initiatives that incorporate the domains of psychotherapy, treatment, prevention, outreach, academics and learning, and career, enable institutions of higher education to sufficiently ensure that services are meeting the diverse personal and psychological needs of students. Individual, group, couples, and children and family counselling opportunities address issues related to family, relationship, and personal dynamics. Psychological, neuropsychological, alcohol and drug, and career assessments provide information necessary to better serve the student. Colleges and universities also disperse self-help and educational materials as well as employ standardized programs and interactive computer systems. Islam et al., (2020) recent study investigated the prevalence of depression and anxiety among Bangladeshi university students during the COVID-19 pandemic. A total of 476 university students living in Bangladesh participated in this cross-sectional web-based survey. Result shows that 392 (82.4%) students were found to have mild to severe depressive symptoms, and 389 (87.7%) students were found to have mild to severe

anxiety symptoms. Educational institutions may outsource counselling services or develop a referral system to direct students to services offered in the community.

A petition was filed with the High Court on November 24, 2019, demanding the appointment of clinical or counselling psychologists in all educational institutions around Bangladesh. According to the petition, the refusal to hire a clinical psychologist and counsellor in all educational institutions violates Articles 17 (ka, kha), 18 (1, 2), and 32 of the constitution. It said that it is the responsibility of the state to implement effective measures to assure citizens' access to education and health care. Respondents to the petitions include the chairman of the University Grants Commission (UGC), the secretaries of education, public administration, health and family planning, primary and mass education, and the director of education. However, drug abuse, suicide attempts, sexual harassment, moral degradation, reckless behaviour, and inattention to academics are common and dangerously growing among students. That is why, according to the petition, psychologists and counsellors are required at all educational institutions (Dhaka Tribune, 2020).

1.5 Mental Health conditions in Bangladesh

The coronavirus disease 2019 (COVID-19) pandemic has caused a havoc in the general scenario of mental health in Bangladesh. According to Banna, et al (2020), currently, the prevalence of depression (57.9%), stress (59.7%), and anxiety (33.7%) symptoms in the adult population are significantly greater than pre-pandemic rates. Another study by Khan et al, (2020) discovered that 28.5 percent, 33.3 percent, and 46.92 percent of home-quarantined pupils reported stress, anxiety, and depressive symptoms, respectively. The burden of mental health disorders in Bangladesh is yet to be measured precisely as done in the developed countries. Approximately Among 7000 graduates from medical schools around Bangladesh each year only a few of the choose to specialize in psychiatry. Psychiatrists, psychiatric nurses, Counseling and clinical psychologists provide mental health treatments, with little to

no multidisciplinary collaboration. Access to psychiatrists and other mental health experts is challenging for rural areas. Mental health treatments are frequently limited to a divisional tertiary level, with psychiatrists working at public medical college hospitals in cities. With only 260 psychiatrists servicing a population of 162 million, a large portion of the population unable to access mental health service. The few mental community care institutions that exist around the country are severely strained in terms of both people and financial resources. The National Institute of Mental Health (NIMH) in Dhaka is now the country's sole national-level mental health institute. Bangladesh's poor understanding of mental health adds to a lack of adequate care programs, ignoring the population's mental health requirements. Unfortunately, there are few non-governmental organizations (NGOs) dedicated to promoting mental health. A systemic review reported the prevalence of mental disorders is to vary from 6.5 to 31.0% among adults and 3.4 to 22.9% among children in the country (Hossain et al,.2014).

Bangladesh is a densely populated country having population density of 1063 per square kilometer and total population is about 160 million. Health sector is advancing dramatically with its existing manpower empowering the primary health care (PHC). However, the referral system between the care levels is very poor in Bangladesh. Hence, to provide the better mental health coverage and services integration of mental health support with PHC is somewhat obligatory. There are options of general physicians training in assessing, planning and prescribing the common mental health problems but they are insufficient in frequency and quantity due to different factors such as fund problem. Human, logistic and financial resources for mental health in terms of psychiatrists, psychologists, psychiatric nurses, social workers, occupational therapists, hospital bed, community services allocation and budget for mental health are extremely poor (Karim et al,.2006). As the burden of mental disorders in Bangladesh is high and the benefits of integrating mental health in primary care are enormous in terms of reducing disease burden, treatment gap and cost

burden for individuals and families, promoting respect for human rights and overall good health outcomes. Adequate training during undergraduate education, refreshers training and continued medical education in mental health for primary care physicians is crucial for identifying individuals with mental health disorders in primary care. Considering the scarcity of human resources for health and that a majority of the people access informal providers in Bangladesh, training the traditional healers under the formal umbrella subject to required rules and regulations may be explored. Utilizing the informal sector may not only reduce load on the existing human resource crisis but facilitate in reducing stigma associated with mental health disorders. Feasible collaboration and communication with the secondary and tertiary level specialist services using modern technology cannot be underestimated. The primary care focused mental health care and general practice focusing on screening, detection, treatment, referral and follow up of the depression and other mental disorder can play as the most effective way of covering the majority of the mental health patients at community level. Tele psychiatric approach such as video conferencing, teleconferencing consulting methods can be used to support the primary care services. Furthermore, extensive research can pave pathways to what works and what does not.

1.6 Literature review

Nuri et al (2019) study explored experience and perception of patients and their attendants of mental health care services at the National Institute of Mental Health (NIMH) which is the only national level mental health institute in Bangladesh. A facility-based cross-sectional study was conducted using a mixed-method design at the NIMH. A total of 40 respondents (patients, or their attendants if the patient was minor or unable to respond due to lack of mental stability) visiting the outpatient department (OPD) of NIMH were selected by purposive sampling. For each of the ten ICD 10 categories (10th revision of International Classification of Diseases by the World Health Organization [WHO]) for mental disorders,

four patients were chosen. Finally, 13 patients and 27 attendants (on behalf of 17 minor patients and 10 adult patients unable to respond) participated in the interview. The respondents rated 34 short statements clustered around four dimensions of care (accessibility, interpersonal communications, condition of the waiting and consultation rooms, and general quality of OPD services) and they interpreted those scores as follows: 7.6–10 very satisfied/very good quality, 5.1–7.5 satisfied/good quality, 2.6–5.0 dissatisfied/poor quality and 1.0–2.5 completely dissatisfied/very poor quality. For accessibility and interpersonal communications, the patients perceived care as very good (average scores on a Likert scale of 1–10 were 8.3 and 7.6, respectively). Patients receiving services from the NIMH OPD had a positive perception of the quality of care in general. But, at an individual level, some respondents expressed dissatisfaction.

Choi, Buskey & Johnson (2010), study investigated how receiving personal counselling at a university counselling centre helps students deal with their personal problems and facilitates academic functioning. To that end, this study used both clinical and academic outcome measures that are relevant to the practice of counselling provided at a counselling centre and its unique function in an institution of higher education. In addition, this study used the clinical significance methodology (Jacobson & Truax, 1991) that takes into account clients' differences in making clinically reliable and significant change. Pre-intake and post-termination surveys, including the Outcome Questionnaire (Lambert et al.1994), were completed by 78 clients, and the responses were analysed using clinical significance methodology. The results revealed that those who made clinically reliable and significant change (i.e., the recovered group) reported the highest level of improvement in academic commitment to their educational goals and problem resolution, compared with those who did not make clinically significant change.

Mohr, Gelso, & Hill (2005) investigated client and counsellor trainee attachment as predictors of session evaluation and countertransference behaviour in 93 first counselling sessions. Results indicated that client attachment predicted aspects of session evaluation, whereas counsellor attachment and the interaction of client and counsellor attachment predicted aspects of countertransference. Specifically, client fearful attachment was negatively associated with client ratings of session smoothness and depth and with counsellor ratings of session smoothness. Counsellor dismissing attachment was positively associated with supervisor ratings of hostile countertransference.

Lent et al. (2006) study showed that two versions of a counselor self-efficacy (CSE) measure were administered to 110 counselors: a general version, assessing perceived capability to perform basic helping skills and manage the session process with clients generally; and a client-specific version, tapping capability to perform the same behaviors with a specific, current client. Client-specific CSE was found to (a) relate moderately to strongly with general CSE over the course of four counseling sessions, (b) increase significantly over sessions, and (c) account for unique variance in counselors' evaluations of the quality of their sessions. Although it was not a useful direct predictor of clients' session ratings, higher client-specific CSE was associated with greater congruence between counselors' and clients' perceptions of session quality. Implications for further research and training are considered.

Mohr, Gelso & Hill (2005) conducted a study with the objective to explore, do evaluations of psychotherapy sessions predict treatment outcome? Clients (n = 40) and their therapists rated each session (n = 16 per client) of their brief therapy on the Session Evaluation Questionnaire (SEQ), which yields indices of session Depth (power, value) and Smoothness (comfort, safety). External raters rated tape-recordings of half of the sessions. SEQ ratings by one of two principal therapists were strongly correlated with client

improvement on self-report measures; those of the other therapist were not. Clients' SEQ ratings did not show the expected correlations with improvement. External raters' ratings of session Smoothness were significantly correlated with client improvement on some measures.

Heppner & Heesacker (1983) examined (a) the relationship between perceived counselor expertness, attractiveness, and trustworthiness and client satisfaction; (b) the relationships between specific client expectations on perceived counselor characteristics and client satisfaction; and (c) the effects of actual counselor experience level on perceived counselor characteristics and client satisfaction. The 55 counselors who participated in the study were either beginning or advancing practicum students, doctoral-level interns, or PhD counselors; clients were 72 students who sought help at a university counseling center. Clients completed an Expectations About Counseling (EAC) questionnaire before entering counseling, as well as the Counseling Evaluation Inventory (CEI) and Counselor Rating Form (CRF) after several weeks of counseling. CRF and CEI were correlated, but EAC scores were not strongly related to the CEI or CRF scores. Actual counselor experience level did not differentially affect CEI or CRF scores. Findings are discussed in terms of several variables (e.g., legitimate power, source variables, and client satisfaction) that may differentially affect the influence process over time.

Greenfield (1983) studied for evaluating university counseling services, client satisfaction assessment has been hampered by inadequate instrumentation. Systematic use of a short form of the Client Satisfaction Questionnaire (CSQ) in one such center over the past 5 years is described, together with strategies to ensure maximal accuracy and utilization of results. Several method factors were investigated. Optional respondent identification was not found to reduce response rate or increase reported satisfaction compared to anonymity, while a sub study obtaining very high response suggested bias from nonresponse to the routine survey (response rate = 40%) was not great. The CSQ was found to have excellent

psychometric properties and many advantages for use in student service settings. Relationships between satisfaction and a number of other variables such as demographics, pre-counseling expectancies, problem type and severity, counselor differences, and duration of counseling are reported.

Berger et al. (2005) study explored the impact of gender on attitudes toward psychological help seeking. In this study 155 adult male volunteers completed the Gender Role Conflict Scale–I, Male Role Norms Inventory—Revised, Bermond–Vorst Alexithymia Questionnaire, and Attitudes Toward Seeking Professional Psychological Help Scale. Data were analyzed using regression analysis. Results indicated that men who score higher on measures of gender role conflict and traditional masculinity ideology tend to have more negative attitudes toward psychological help seeking.

Moors & Zech, (2017) examined the effects of psychotherapists' behaviors during a first simulated therapy session on clients' satisfaction, including their intention to pursue or drop out from therapy. The importance of psychotherapists' warmth on clients' satisfaction was examined to check previous findings stressing this determining factor. Examining the role of warm behaviors is however insufficient according to the interpersonal perspective. They therefore tested the role of the psychotherapist's agentic behaviors since only a few studies provide contradictory results about the role of this interpersonal dimension on clients' satisfaction and how it is influenced by matching up client and therapist's profiles. To test their hypotheses and control for alternative therapy-related explanatory variables, they used different videos as experimental conditions manipulating the therapist's behaviors. Seventy-five participants had to imagine themselves as potential clients arriving for a first therapy session. They successively watched a role-playing therapist behaving according to five randomized interpersonal profiles. Results confirmed that warmth was a major dimension predicting client satisfaction. They revealed that agency was also a determinant of client

satisfaction and that its effects depended on the client's own interpersonal agentic profile. Dominant clients were found to be more satisfied with the dominant psychotherapist than the submissive one while submissive clients preferred only the warm psychotherapist. These findings are discussed and suggest that therapists may need to be flexible and adapt their behaviors according to their client's interpersonal profile to increase their client satisfaction and decrease drop outs.

1.7 Rationale of the study

In Bangladesh, psychological services have been provided for the last 20 years. In a few settings, their work provisions include taking clients' feedback, and most of the time, their feedback regarding the service is informal. Even though formal feedback was collected, it was only used for the organization's own understanding of their service. This study aimed to evaluate the psychological services provided by educational institutions and hospitals in an organized, structured, and formal way. The clients evaluated their counsellors' behaviour and the quality of the sessions. A client's perception and attitude towards their counsellors is of the utmost importance for effective service delivery. The present study will help us to identify the need for training and scaling of the counsellors so that they can contribute to the mental health service for the people of Bangladesh. In addition, following the outbreak of the COVID-19 pandemic in Bangladesh, all the educational institutions, have been shuttered until December 19, 2020. However, such measures have the potential to generate and intensify mental stress in people, particularly students. Shafiq and Nipa et al (2020) conducted an online survey of 1000 students from various public and private institutions in the country to investigate the variables that contribute to students' mental stress. According to the survey results, students at private institutions (80.6%) are more psychologically burdened than students at public universities (77%). As a result, it is critical to implement a time-sensitive strategy and plan for managing student mental health. In such a post-pandemic

situation, this study helps us to explore a systematic evaluation of the current mental health services offered by educational institutions and hospitals, which can also enlighten us about the upcoming steps to ensure the well-being of students as well as citizens of our country. Furthermore, a comparative analysis of various types of institutions aids us in understanding the present state of mental health services. Another significant aspect is that there have been several studies on the prevalence of mental health issues, but very few studies on the evaluation of mental health services by using systematic assessment tool, have been undertaken on a national level. Finally, this study will assist us in filling the vacuum while also paving the way for a significant quantity of research on a national basis on the evaluation of mental health services given by various types of institutions and organizations.

1.8 Objectives of the study

1.8.1 General objective

The purpose of this study was to evaluate the psychological services provided by educational institutions (university) and hospitals.

1.8.2 Specific objectives

Between group comparison

1. To see whether the client's evaluation of counsellor behaviour varies according to the psychological services provided by educational institutions and hospitals.

2. To see whether the clients' session evaluation varies according to the psychological services provided by educational institutions and hospitals.

Within group comparison

3.To see whether client's session evaluation and client's evaluation of counsellor behaviour varies according to the psychological services provided by the type of educational institutions (public and private educational institutions).

4.To see whether clients' session evaluation and client's evaluation of counsellor behaviour varies according to the psychological services provided by type of hospitals (government. hospital and private hospital).

Impact of demographic variable

5.To see whether the client’s evaluation of counsellor behaviour vary according to age, gender and number of the session.

6.To see whether the client’s session evaluation vary according to age, gender and number of the session.

Chapter 02

Method

2. Method

2.1 Participants

Participants of this research are the clients who have received psychological services from educational institutes and hospitals of Dhaka city. Samples were collected from six hospitals (four government hospitals and two private hospitals) and five educational institutions (two public universities and three private universities).

The sample consists of 200 clients who received at least three therapy sessions (120 from educational institutions and 80 from hospitals setting) were included in this research. Both in-person clients and online clients were included in this study. Age range of the participants were 18 to 60 years. Participants average age was 34 years (SD 23.45 years).

Duration of data collection: From 26.07.2019 to 19.09.2021

2.2 Sampling technique

Non-probability (purposive sampling) was used for this study.

Inclusion criteria of the participants were-

1. Clients either from educational institutions or hospitals
2. Age 18 to 60 years
3. Received at least three individual or group sessions
4. Educated with access to internet facilities
5. Absence of psychotic illness

Exclusion criteria of the participants were-

1. clients who do not have insights
2. clients who received psychological services from private practitioners or other type of organization

Table 2.1: Institution, Gender and age distribution of sample

Variables	Participant Number		Percentage	Total
Educational institutions (University)	Public	80	40%	120 (60%)
	Private	40	20%	
Hospital	Govt.	48	24%	80 (40%)
	Private	32	16%	
Gender	Male	98	49%	200
	Female	102	51%	
Age Range	18-20	9	4.5%	200
	21-30	53	26.5%	
	31-40	67	33.5%	
	41-50	52	26%	
	51-60	13	6.5%	
	61- above	6	3%	

2.3 Measuring instruments

The following instruments were used in the present study.

- Personal information form
- Bangla Client's Evaluation of Counselor Behavior short form
- Bangla Session Evaluation Questionnaire

2.3.1 Personal information form

This form includes age, sex, socio-economic status, educational background, name of the institution providing psychological service, and the number of sessions, etc.

2.3.2 Bangla Client's Evaluation of Counsellor Behaviour short form

Counsellor Performance Evaluation: The Client's Evaluation of Counsellor Behaviour Short Form (CECB-S) developed by Amanda Christine Messina (2005). CECB-S is a 33-question survey established on the aspects of empathy, genuineness, and unconditional

positive regard. The items are graded on a 7-point Likert scale (1 = strongly disagree; 7 = strongly agree). The CECB-S was designed by performing an element analysis on the sixty-one questions included in the original CECB instrument. Items that failed to load on one of the three factors of empathy, genuineness, and unconditional positive regard (.5 factor loading level) were omitted. Following the factor analysis, 33 items remained and comprise the CECB-S instrument. Items on the CECB-S instrument analysing empathy contain (e.g. "accepting of me as someone," "was disapproving of me," and "enjoyed being with me"). Items analysing genuineness contain (e.g. "was open and honest with me," and "appeared to be genuine"). Items analysing unconditional positive regard include ("accepting of me as an individual," and "understanding of me."). The Bangla translated version of Counsellor Behaviour Short Form CECB-S developed by the researcher.

2.3.3 Bangla Session Evaluation Questionnaire

The development of a Session Evaluation questionnaire (Form 5) (Stiles, 1980; Stiles & Snow, 1984b) was developed to assess the counselling sessions by the clients. This questionnaire consists of 21 items, where clients can rate the session. Calculating the SEQ (Form 5) Indexes of session depth, session smoothness, post-session positivity, and post-session arousal are scored as the mean ratings of the suitable items, as indicated in the mentioned formulas. In the form, item order is mixed within each segment (session evaluation and post-session mood), and item directionality is approximately balanced. Each item is scored from 1 to 7, reversed as appropriate, with higher scores denoting greater depth, smoothness, positivity, or arousal. The mean is considered an index, instead of the sum of the item scores, in order that the scores lie on the identical 7-point scale as the individual items, making interpretation simpler. In particular, indicating the adjective on the right-hand side of the form as the name of each item:

Depth = [(8-worthless) + deep + (8-empty) + powerful + (8-ordinary)] / 5.

Smoothness = [easy + (8-tense) + pleasant + smooth + (8-uncomfortable)] / 5.

Positivity = [(8-sad) + pleased + definite + (8-afraid) + (8-unfriendly)] / 5.

Arousal = [(8-still) + excited + fast + (8-peaceful) + aroused] / 5.

It is to be mentioned that only 20 of the 21 SEQ items are utilized in these directories. The remaining one is the first session evaluation item, "bad-good," which is inclined to be used differently by clients than by therapists (Stiles, 1980; Stiles & Snow, 1984b). For therapists, bad-to-good has loaded on the depth factor, except for clients, it has often been divided between depth and smoothness. Due to its innate interest as a worldwide evaluation item (see Stiles et al., 1994). The bangle translated version of the session evaluation form was developed by the researcher. Demographic information questioners were used to collect the client's demographic variables such as age, sex, and socioeconomic status.

2.3.4 Reliability and Validity

The outcomes bolstered the theory that the CECB-S gives a precise record of the guide's conduct in the meeting. To decide the legitimacy of the scale, it was suggested that as guides gain involvement with treatment, they ought not exclusively to have the option to introduce themselves to their customers with more certainty yet that their strategies and advising conduct would improve after some time (Borman and Ramrez, 1975; Larson et al., 1992; Meer, 2001;). At the point when the experience level of the advocates was analysed, uncovered that the greater part of the positive inquiries (ones that indicated ideal parts of advising) demonstrated an expansion in scores provided the guidance of the accomplished instructors. The two inquiries that demonstrated kindness toward the unpracticed guides ("Uncomfortable to be with" and "Was opposing me") were questions that indicated negative parts of directing conduct and were progressively adept to be shown by unpracticed advisors. There were a few inquiries in the study that were not fundamentally unique when the experience was thought about. Three of the five converse inquiries ("Not confided in enough

to share individual things about myself", "Didn't have a clue what they were doing," and "impatient with me" had no huge distinction between the experience levels. One opportunity for this is customers see a specialist as somebody in a place of intensity, and who ought to consistently be trusted, wouldn't be there doing treatment if they didn't have a clue what they were doing, and ought to consistently be patent, paying little mind to how the advisor was carrying on while with the customer (La Crosse and Barak 1976; Corrigan and Schmidt, 1983). These three specific Counsellor Performance Evaluation 60 inquiries may take advantage of that "hero impact" and customers were hesitant to rate them in an awful light on these inquiries, regardless of how the specialist may have been carrying on. The other three inquiries that didn't come up altogether extraordinary when the experience was inspected were "Urged me to set objectives," "Offered me guidance regarding what to do," and "Proposed ways could think, feel or carry on unexpectedly." One clarification might be that the last two inquiries appear to infer a similar idea, so it is sensible that customers completing the overview would give them little appraisals. These inquiries may tap a lot into the direction of the advisor, because various directions have alternate points of view after offering guidance or alternatives in treatment. The centre where this study was controlled has a wide assortment of directions, and one purpose behind not having a noteworthy contrast might be that the inquiries were lost between the directions. Likewise, the three of these inquiries are presumably more successfully replied in a Yes/No, or True/False configuration. It's hard to measure on a Likert scale how much guidance was given, how much objectives were urged to be set, and how frequently recommendations were made. A chance to expand the legitimacy of the study is to have a Likert and a Boolean organization for questions that can be estimated in inclinations and basic Yes/No answers. At the point when a dependability check was done on the overview, it was discovered that the coefficient alpha incentive for the study was .8848.

Evaluation of psychological services provided by educational institutions and hospitals

2.3.5 Cronbach's Alpha:

Both the CECB-S and the SEQ questionnaires have a seven-point Likert scale, so Cronbach's alpha method was used to measure the reliability of the questionnaires. For CECB-S and SEQ, Cronbach's alpha was found to be 0.930 and 0.739, respectively, which indicates that both questionnaires are reliable for use in Bangladesh.

2.4 Ethical consideration

The research proposal was approved by the Research Ethics Committee of the Department of Educational and Counselling Psychology, University of Dhaka (Approval number #105). Consent was taken from each participant appropriately through online regarding their participation. They were informed that their information will be kept confidential and only be used for research purpose. It was ensuring that the participants understand the concept of the research and they have no obligation to participate and can withdraw at any point during the working period without any negative consequences.

2.5 Procedure

In order to collect data, the questionnaires CECB-S and SEQ were translated by three translators who were experts in the field of psychology. The translated versions were compared by a panel of experts consisting of four members, where one was a professor of psychology, another was an editor of an English newspaper, and the other two were the supervisor and researcher of the present study. The Bangla versions of the questionnaires were prepared with their consent. This Bangla translated version was again back translated into English by a student in the English department and an editor of an English newspaper. Again, their back translated versions were evaluated by the same expert panel. After discussion, an agreement was reached on the final version of the Bangla questionnaires.

Because the data was collected using an online platform, the consent in the Google form was first prepared, followed by the online questionnaires. Approximately 15

counsellors who were working at educational institutes and hospital settings were contacted to reach the participants/clients. The purpose of the study was explained to them. The participants were approached by their counsellors.

The majority of clients received their sessions in person, but when the COVID-19 pandemic began, some clients received their sessions through online. They were asked to send the questionnaire to their client through email or social media. In all cases, the questionnaires were filled in by the participants and sent directly to the researcher. The researcher also communicates with the participant via an online platform. There were no set time limits for the responses to be made. On average, it takes around 15 to 20 minutes to fill in the questions. After completion of the questionnaire, participants were thanked through the Google forms.

2.6 Statistical Analysis

The respondents were given a Google form. There were three types of forms, including personal information form, Bangla Client's Evaluation of Counsellor Behaviour short form and Bangla translated Session Evaluation Questionnaire. In the case of the personal information form, the respondents could fill in the form by giving a tick (√). In the case of the Bangla Client's Evaluation of Counsellor Behaviour short form, respondents give their responses on a 7-point Likert scale (1 = strongly disagree; 7 = strongly agree) and on the Bangla translated Session Evaluation Questionnaire scale, respondents also gave their responses on each item being scored from 1 to 7. It does all the required scoring and computes total scale scores as well as total test scores. After scoring was completed, all data were exported to an SPSS data file for further analysis. For between and within group comparisons, several independent sample t-tests were conducted. Also, a two-way ANOVA was conducted to explore the impact of several variables on the CE and SE score.

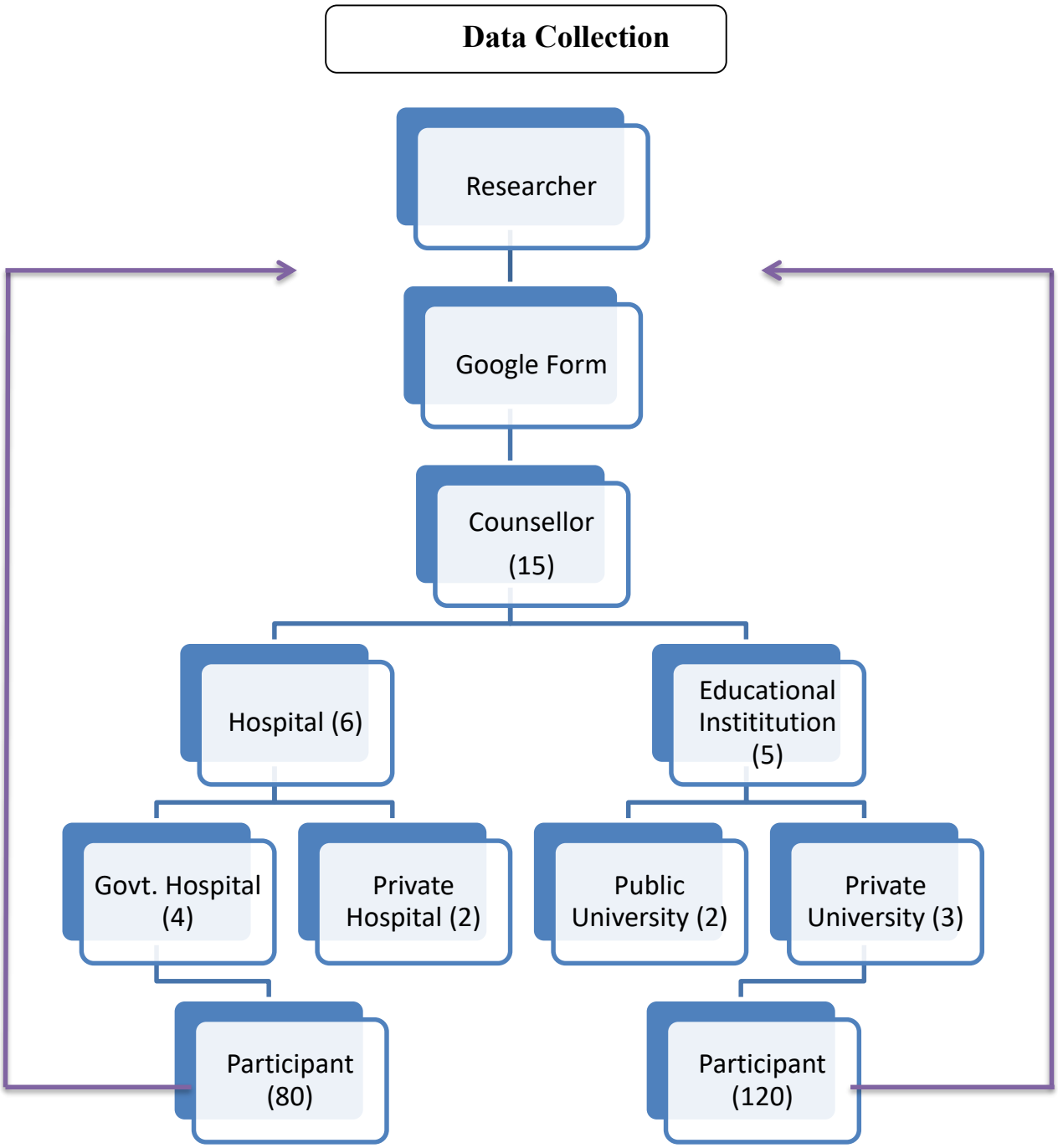

Figure 2.1: Data Collection process

Chapter 03

Results

3. Results

The result segment is divided into three parts, which are given below:

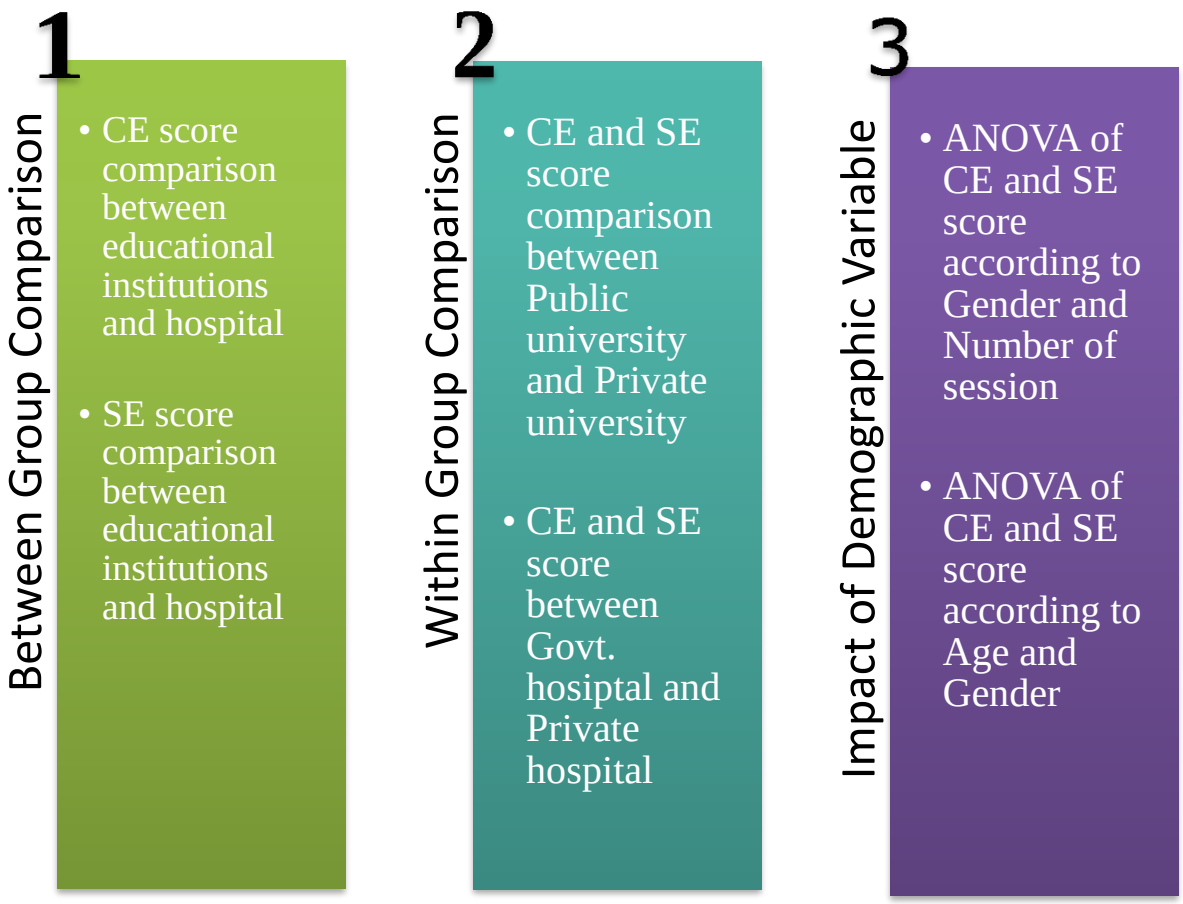

Figure 3.1: Three parts of result section

3.1 Between group comparison

In the first phase, Client Evaluation of Counselor Behavior short form (CE) and Session Evaluation Questionnaire (SE) score between hospitals and educational institutions were calculated.

Table 3.1: Mean difference of CE scores between educational institution and hospital participants

	Institute	N	Mean	SD	t
CE total	Educational Institutions	120	1.73	16.03	10.112*
	Hospital	80	1.44	22.07	

*p<.001 CE = Client Evaluation

An independent-sample t-test was used to assess the client's evaluation of counselor behavior in educational institutions (university) or hospital settings. The t-test was statistically significant (t=10.112, p<.001), the mean CE score for the educational institutions setting (M=1.73, SD=16.03) was significantly higher (mean difference 29.01, 95% CI [23.69, 34.32]) than the hospital settings (M=1.44, SD=22.07).

Table 3.2: *Mean difference of SE scores between educational institutions and hospitals participants*

	Institute	N	Mean	SD	t
SE total	Educational Institutions	120	87.58	9.23	-1.077
	Hospitals	80	88.88	6.86	

Note. SE= Session Evaluation

Again, an independent-sample t-test was used to assess the session evaluation by participants in educational institutions (university) and hospital setting. The t-test was not statistically significant. It means that there is no difference between the mean SE scores of educational institutions and hospitals.

3.2 Within group comparison

First of all, a comparison of SE and CE scores was calculated between public and private educational institutions (universities) in the within-group comparison. Then, a comparison between private hospitals and government hospitals on both SE and CE scores was calculated.

Table 3.3: Mean difference of CE and SE scores between public and private educational institutions

	Educational Institutions (university)	N	Mean	SD	t
CE total	Public	80	1.74	15.13	1.59
	Private	40	1.69	17.65	
SE total	Public	80	87.69	10.54	-.049
	Private	40	87.78	5.98	

Note: CE=Client Evaluation, SE= Session Evaluation

An independent-sample t-test was used to assess client's evaluation (CE) and session evaluation (SE) between public and private educational institutions (university).

In case of CE, t-test was not statistically significant. It means that there is no difference between the mean CE scores of public and private educational institutions.

In addition, the t-test was not statistically significant in the case of SE. It means that there is no difference between the mean SE scores of public and private educational institutions.

Table 3.4: *Mean difference of CE and SE scores between govt. hospitals and private hospitals participants*

	Hospital	N	Mean	SD	t
CE total	Govt.	48	1.43	25.31	-.178
	Private	32	1.45	17.05	
SE total	Govt.	48	89.02	7.50	.569
	Private	32	88.13	5.90	

Note: CE=Client Evaluation, SE= Session Evaluation

An independent-sample t-test was used to assess client's evaluation (CE) and session evaluation (SE) between govt. hospital and private hospital setting.

In case of CE, t-test was not statistically significant. It means that there is no difference between the mean CE scores of public and private hospitals.

In addition, the t-test was not statistically significant in the case of SE. It means that there is no difference between the mean SE scores of public and private hospitals.

3.3 Impact of demographic variable

Finally, in the third part, a two-way between-groups analysis of variance was conducted to explore the impact of several variables on the CE and SE score.

Table 3.5: ANOVA of CE scores between Gender and Number of sessions

Dependent Variable: CE total

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Gender	261.992	1	261.992	.615	.434	.003
NS	27861.611	4	6965.403	16.355	.000	.257
Gender*NS	2529.802	4	632.451	1.485	.208	.030

R Squared = .265 (Adjusted R Squared = .230), NS=Number of sessions

Table 3.6: Descriptive statistics of CE score according to Gender and Number of sessions

Variables	Male		Female		Total	
Number of sessions	M	SD	M	SD	M	SD
3-5	1.4537	26.28250	1.4832	31.14752	1.4690	28.75672
6-10	1.5989	14.78429	1.6675	15.75451	1.6263	15.29589
11-15	1.7364	15.90769	1.6690	10.66257	1.6922	12.86589
16-20	1.7577	15.89630	1.7000	7.86653	1.7242	12.02158
21-more	1.6770	10.72184	1.8285	17.29569	1.7367	15.39210

Note. CE=Client evaluation

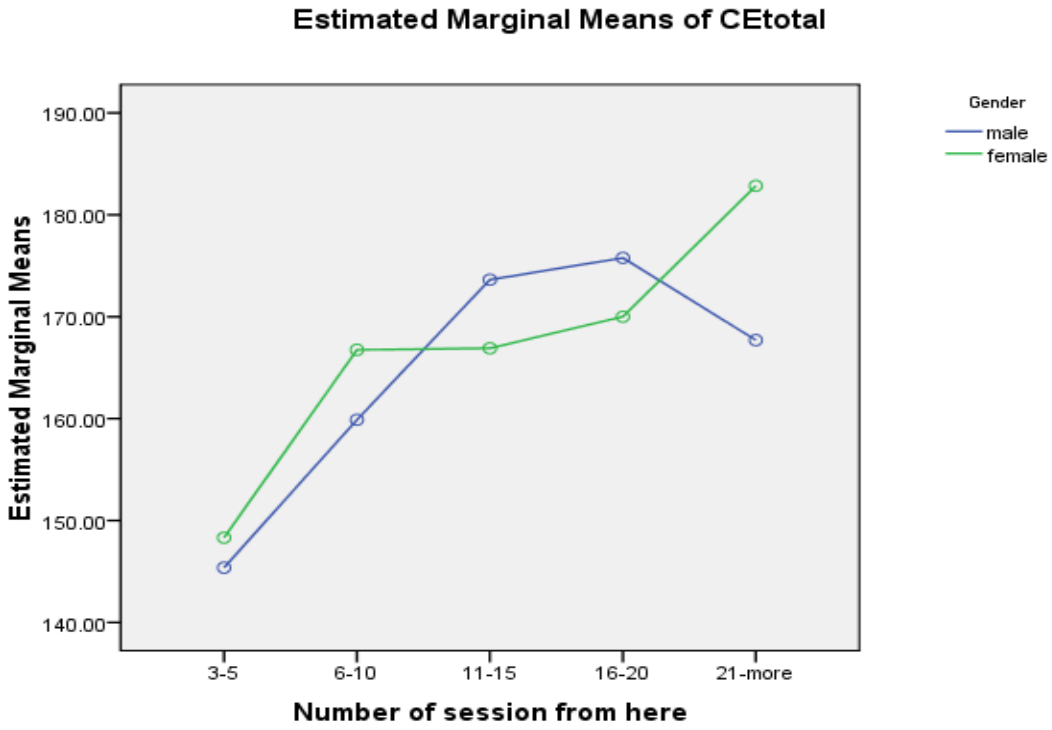

Figure 3.2: ANOVA analysis of Gender and Number of sessions on CE

A two-way between-groups analysis of variance was calculated. There were two-gender level (male, female) and number of sessions had five level. The interaction between gender and number of sessions was not statistically significant. There was not statistically significant main effect for gender. The main effect for number of sessions, F (4, 189) = 16.355, p = .000, did reach highly statistical significance.

Table 3.7: *ANOVA of SE scores between Gender and Number of sessions*

Dependent Variable: SE total

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Gender	443.284	1	443.284	6.537	.011	.033
NS	56.507	4	14.127	.208	.934	.004
Gender*NS	563.396	4	140.849	2.077	.085	.042

R Squared = .075 (Adjusted R Squared = .031), NS=Number of sessions

Table 3.8: *Descriptive statistics of SE score according to Gender and Number of sessions*

Variables	Male		Female		Total	
Number of sessions	M	SD	M	SD	M	SD
3-5	88.400	7.126	88.474	7.544	88.438	7.295
6-10	83.611	9.331	92.083	18.691	87.000	14.192
11-15	87.818	8.219	90.952	4.092	89.875	5.906
16-20	88.307	5.406	87.000	7.499	87.548	6.632
21-more	85.100	2.404	90.923	10.144	87.393	7.097

Note. SE=Session Evaluation

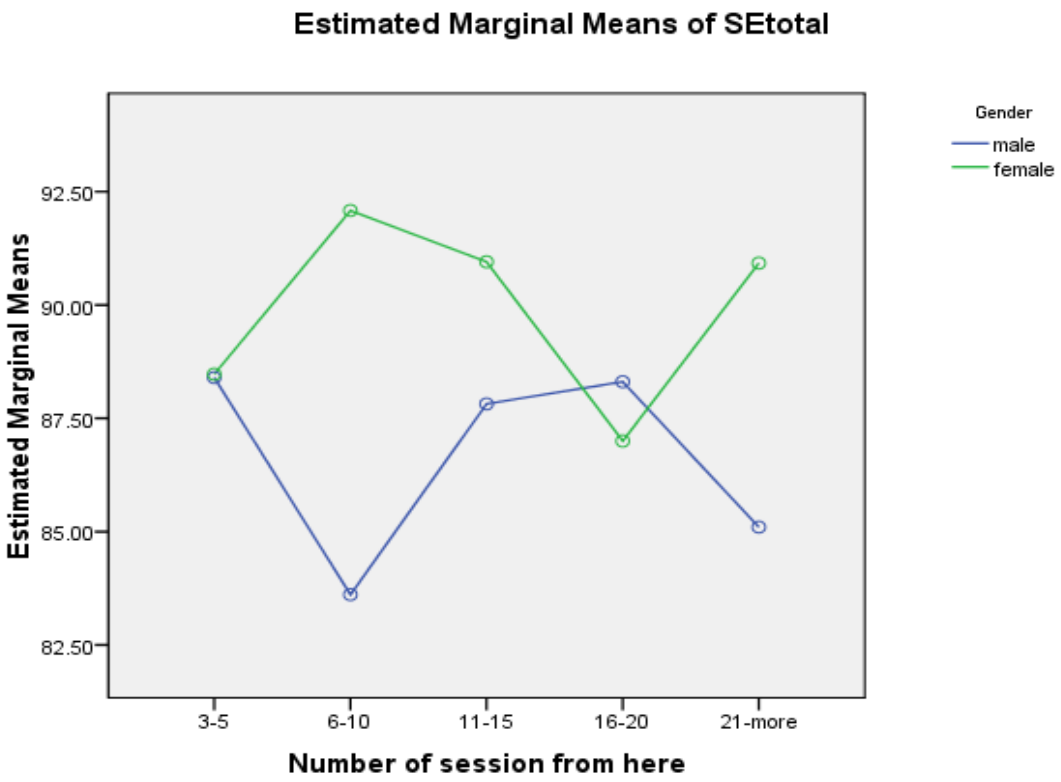

Figure 3.3: ANOVA analysis of Gender and Number of sessions on SE

A two-way between-groups analysis of variance was calculated. There were two-gender level (male, female) and number of sessions had five level. The interaction between gender and number of sessions was not statistically significant. There was a statistically significant main effect for gender, F (1, 189) = 6.357, p= .011; the main effect for number of sessions, did not reach statistical significance.

Table 3.9: *ANOVA of CE scores between Age and Gender*

Dependent Variable: CE total

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Age	16910.696	5	3382.139	7.060	.000	.157
Gender	209.545	1	209.545	.437	.509	.002
Age*Gender	1504.144	4	376.036	.785	.536	.016

R Squared = .173 (Adjusted R Squared = .129), *Note:* CE=Client Evaluation

Table 3.10: *Descriptive statistics for CE score according to Age and Gender*

Variables	Male		Female		Total	
Age	M	SD	M	SD	M	SD
18-20	130.500	10.944	127.200	9.788	128.850	7.341
21-30	166.500	4.136	178.800	4.377	172.650	3.011
31-40	158.250	3.869	159.400	3.700	158.825	2.677
41-50	160.731	4.292	159.615	4.292	160.173	3.035
51-60	156.250	7.738	161.600	9.788	158.925	6.239
61 above	-------	--------	156.000	8.935	156.000	8.935

Note: CE=Client Evaluation

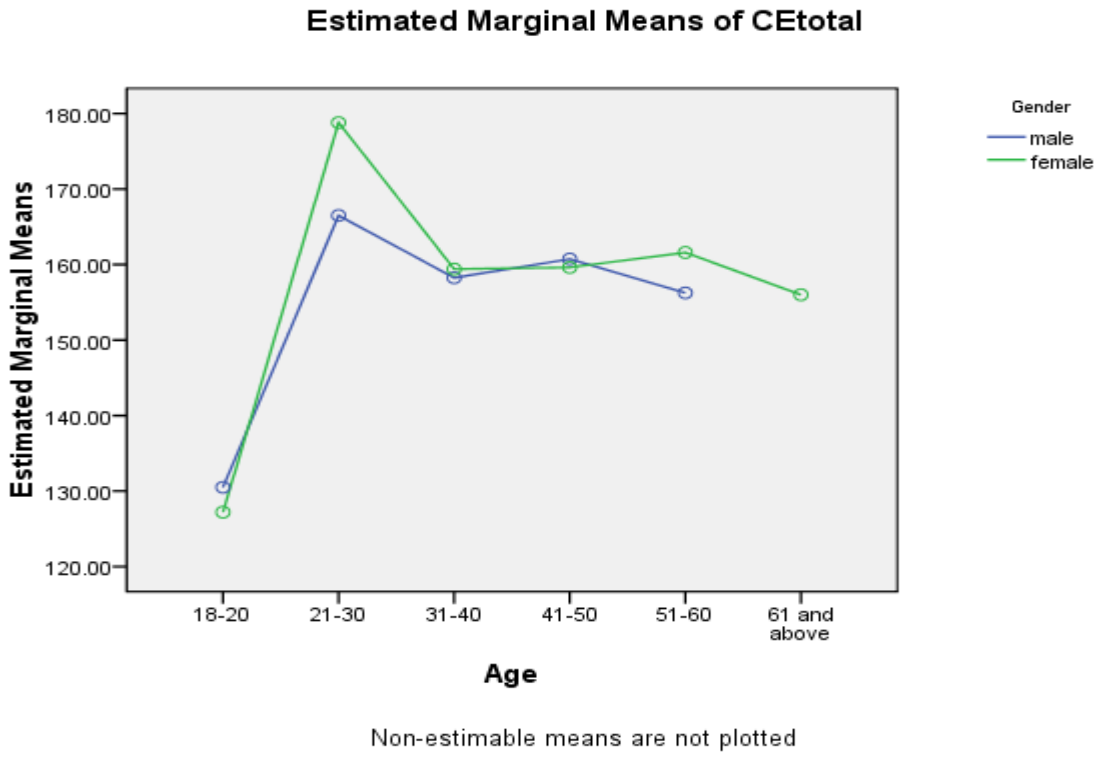

Figure 3.4: ANOVA analysis of Gender and Age on CE

A two-way between-groups analysis of variance was calculated. There were six-age level and Gender had two level (male and female). The interaction between age and gender was not statistically significant. There was a statistically highly significant main effect for age level, F (5, 189) = 7.060, p= .000; the main effect for gender, did not reach statistical significance.

Table 3.11: ANOVA of SE scores between Age and Gender

Dependent Variable: SE total

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Age	702.072	5	140.414	2.071	.071	.052
Gender	244.016	1	244.016	3.598	.059	.019
Age*Gender	22.382	4	5.596	.083	.988	.002

R Squared = .081 (Adjusted R Squared = .032), *Note:* SE= Session Evaluation

Table 3.12: *Descriptive statistics for SE score according to Age and Gender*

Variables	Male		Female		Total	
Age	M	SD	M	SD	M	SD
18-20	82.250	4.117	86.400	3.683	84.325	2.762
21-30	88.071	1.556	89.920	1.647	88.996	1.133
31-40	86.500	1.456	89.886	1.392	88.193	1.007
41-50	84.577	1.615	87.615	1.615	86.096	1.142
51-60	91.500	2.911	94.600	3.683	93.050	2.347
61 above	----------	---------	91.333	3.362	91.333	3.362

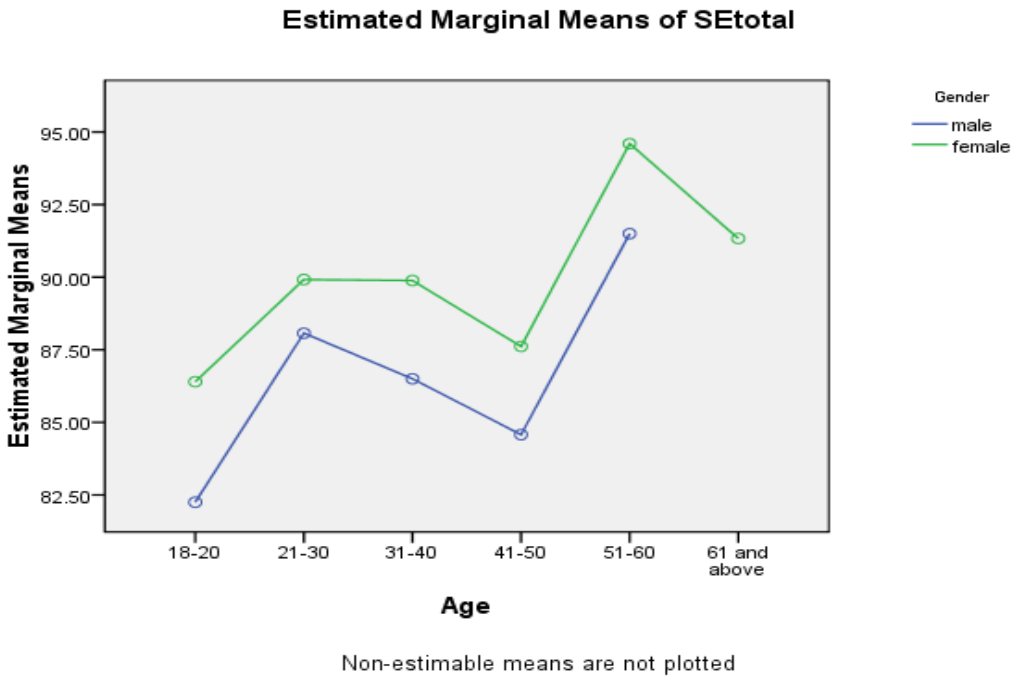

Figure 3.5: ANOVA analysis of Gender and Age on SE

A two-way between-groups analysis of variance was calculated. There were six-age level and Gender had two level (male and female). The interaction between age and gender was not statistically significant. There was a statistically not significant main effect for age level. In addition, the main effect for gender did not reach statistical significance.

Chapter 04

Discussion

4. Discussion

The research was undertaken to evaluate the psychological services provided by educational institutions (five universities) and hospitals (six hospitals). Result showed that there was a significant difference between hospitals and educational institutions' mean Client Evaluation (CE) scores, where the mean CE score for the educational institution was higher than the hospital setting (see table no: 3.1). However, the mean Session Evaluation (SE) scores for the educational institutions was not significantly different from the mean SE score of the hospital setting (see table no: 3.2). Similarly, Nuri., et al (2019) study explored experience and perception of patients and their attendants of mental health care services at the National Institute of Mental Health (NIMH), which concluded that patients receiving services from the NIMH OPD had a positive perception of the quality of care in general. But, at an individual level, some respondents expressed dissatisfaction. So, these findings have little similarity with the present study. Client perception in general about the sessions has no significant difference (hospital vs educational institutions) but at individual level, perception about counsellor behaviour has significant difference between educational institutions and hospitals. It might be due to the difference between seating arrangement, privacy, open space service, external noise and other interferences that are very common in hospital setting. Also, brief duration of session, client pressure etc. plays a role in providing services at hospital settings.

In government hospital settings, sometimes counsellors might be bound to provide five or more sessions in a single day. Therefore, considering the physical condition and pressure of clients, it is not possible to provide proper counselling even with the best intention to serve the clients (Rozario,2019). Furthermore, as SE was a rating questionnaire there could be a possibility that the clients might have respondent in general way that is

avoiding the two extreme and responding on the middle part. On the other hand, in CE items were arranged in questions. Therefore, clients answered the questions more carefully.

Secondly, in within group comparison of educational institutions (universities) results indicates that mean CE score comparison for the public and private educational institutions was not statistically significant (see table no: 3.3). Also, mean SE score comparison between public educational institutions and private educational institutions was not statistically significant (see table no: 3.3). So, there was no significant difference between public and private educational institutions counselling service. It might be due to the fact that both private and public educational institutions mental health services are still at primary level to define any vast difference. In addition, very few public and private educational institutions have such counselling facilities for students.

In within group comparison of hospitals, result indicates that mean CE score between Govt. Hospital and Private hospital setting was not statistically significant (see table no: 3.4). Also, mean SE score comparison between Govt. Hospital and Private Hospital setting was not statistically significant (see table no: 3.4). So, findings indicated that there was no significant difference of counselling service in private and public hospital. Again, it might be because counselling services are still at primary level or not available at every hospital in our country to detect any major difference.

Finally, in the final part, neither the interaction between gender and number of sessions nor the interaction between age and gender has a significant impact on CE or SE score (see table no: 3.5, 3.7, 3.9 & 3.11). Because some research has suggested that other variables such as first impression (Brown, 1970 & Laungani 2010), counselor attending behavior (James 1996), client-counselor attachment (Mohr, 2005), and client-counselor ethnic similarity (Fraga,2003) have a greater impact on counselling session or counselor behavior evaluation.

However, in case of CE score the main effect for number of sessions did reach statistical significance (see table no: 3.5). It shows that as the number of session increases, so does the total mean CE score (see table no: 3.6). As a result, those who had taken 6 to 10 sessions or more rated the counselor more positively than those who had only taken 2 or 4 sessions. Similarly, research has indicated that clients who terminate therapy prematurely often reported poorer outcomes than individuals who stay in therapy until treatment goals are reached (Archer, et al. 2000; Klein, et al. 2003 & Moras, 1986). Secondly, it indicates that gender had a statistically significant main effect on SE score (see table no: 3.7). It shows that the mean SE score of females was greater than that of males (see table no: 3.8) which means females rate overall session more positively than males. Similarly, other research indicated that women were more positive than men on attitudes toward seeking psychological help (Addis et al, 2003; Berger et al. 2005; Doherty et al. 2010; McCarthy et al. 2004).

In addition, in case of the CE score there was a statistically highly significant main effect for age levels (Table no: 3.9). It shows that the total mean score was significantly higher at the 21 to 30 age group level (see table no: 3.10), which indicates that participants in early adulthood (age range: 21–30) have evaluated counsellors more positively than other age ranges. It might be due to the fact that this particular age range represents a genuine developmental phase in the life cycle. Developing a strong personal identity, mature friendships and mature intimate relationships, reorienting familial ties, constructing a core of ideological principles, choosing a long-term vocation, finding one's bearings, and looking ahead to the future are among its fundamental developmental issues. Therefore, this might be the fact that due to this particular age range complexity they evaluated the role of counsellor (counsellor Behaviour) more positively in their life.

Further studies should explore possible reasons for these differences by addressing counselors' personal qualities, experiences, skills, and therapeutic mode. For example, there are a variety of counselling approaches practiced by counselors like: Cognitive Behavior Therapy (CBT), Transactional Analysis (TA), Neuro-Linguistic Programming (NLP), Eye Movement Desensitization and Reprocessing (EMDR) etc (Rozario,2019). There is a high probability that various counselling approaches might have an impact on counselor behavior or the overall session. As a result, taking into account of the potential variables likely to influence counselling outcomes may provide useful information in future evaluation studies. In the future, more systematic and standard investigations using the Client Evaluation of Counselor Behavior short form (CECB-S) or Session Evaluation Questionnaire (SEQ) need to administer at a national level considering the research gap regarding the quality of the counseling services offered in our country.

4.1 Limitation and Recommendation:

The sample for the present study was selected only from Dhaka City, so it is difficult to generalize for the total population. Moreover, rather than these two types of institutions, many other organizations and private practitioners are rendering psychological services; this also should be taken into consideration in future research. However, some organizations also refused to give access of such survey. Also, it will be better if it can include more demographic variables like client-counsellor cultural similarity, counsellor skills, qualities, experiences and counsellor first impression or non-verbal behaviour, or some counsellor demographic variable to explore the impact on client perception. Others could be included to have a clear picture. If further opportunities are available, then scale adaptation can also be done. The finding of two questionnaires will help the counsellor and advisors to improve their service. Better service can be ensured depending on the findings of the study. First of all, mental health services in hospitals specially counselling service needs to be improved both in case of setting or environment and also including diverse counselling practitioner and supervision facilities. These client evaluation of counsellor behaviour short form (CECB-S) and session evaluation questionnaire (SEQ) can be easily used by the psychological service providers of any organization (hospital and educational institutions, private clinic, NGOs, etc.) to have a structure understanding of the client's perceptions about the service they are offering.

Chapter 05

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Chapter 06
Appendices

6. Appendices

6.1 Appendix-A Descriptive statistic

Frequency and percentage of the categorical variables

		Frequency	Percent
Institute	University	120	60
	Hospital	80	40
Socio-economic status	Lower class	20	10
	Middle class	92	46
	Higher middle class	77	38.5
	Higher class	11	5.5
Number of sessions	3-5	74	37
	6-10	30	15
	11-15	32	16
	16-20	31	15.5
	21-more	33	16.5
Age	18-20	9	4.5
	21-30	53	26.5
	31-40	67	33.5
	41-50	52	26
	51-60	13	6.5
	61 and above	6	3
Gender	Male	98	49
	Female	102	51

6.2 Appendix-B Explanatory statement

প্রিয় অংশগ্রহণকারী,

আমি সৈয়দা আমিনা ইফাত, ঢাকা বিশ্ববিদ্যালয় এডুকেশনাল এন্ড কাউন্সেলিং সাইকোলজি বিভাগের এম.ফিল গবেষক। আমার গবেষণার বিষয়বস্তু ঃ Evaluation of psychological services provided by educational institutions and hospitals. উপাত্ত সংগ্রহ করার ক্ষেত্রে আপনার সহযোগিতা কামনা করছি।

এই ফর্মের সাথে ২ টি প্রশ্নমালা সংযুক্ত রয়েছে। প্রশ্নমালার অন্তর্ভূক্ত উক্তি গুলো ভালোভাবে বুঝে আপনার জন্য প্রযোজ্য উত্তরটিতে টিক চিহ্ন দিন। এখানে কোন ভূল বা সঠিক উত্তর নেই। খেয়াল রাখবেন যেন কোন প্রশ্ন বাদ পড়ে না যায়। প্রশ্ন পূরণ করতে সর্বোচ্চ ১০ মিনিট সময় লাগবে।

বর্তমান গবেষণাটি এডুকেশনাল এন্ড কাউন্সেলিং সাইকোলজি বিভাগের ইথিক্স কমিটি দ্বারা অনুমোদিত। গবেষণাটি অধ্যাপক ড. মেহজাবীন হকের তত্ত্বাবধানে করা হচ্ছে। সংগৃহিত তথ্য শুধুমাত্র গবেষণার কাজে ব্যবহার হবে। আপনি চাইলে যে কোন সময় এই গবেষণা থেকে নিজেকে প্রত্যাহার করে নিতে পারবেন। সেক্ষেত্রে আপনার সকল তথ্য ডাটাবেজ থেকে মুছে দেয়া হবে।

সম্মতিপত্রঃ

সকল তথ্য ও গবেষণার বিষয়বস্তু ভালোভাবে পড়ে এই গবেষণায় অংশগ্রহণ করার সদয় সম্মতি দিচ্ছি।

হ্যাঁ ☐ না ☐

Evaluation of psychological services provided by educational institutions and hospitals

6.3 Appendix-C Demographic information

১। বয়সঃ-	২। লিঙ্গ (টিকচিহ্নদিন) পুরুষ□নারী□
৩। আর্থ-সামাজিকঅবস্থাঃ নিম্নবিত্ত□ মধ্যবিত্ত□ উচ্চমধ্যবিত্ত□ উচ্চবিত্ত□	৪। বৈবাহিকঅবস্থাঃ বিবাহিত (স্বামী/স্ত্রী একসাথে থাকি)□ বিবাহিত (স্বামী/স্ত্রী একসাথে থাকিনা) □ বিবাহিত (স্বামী/স্ত্রী বেঁচে নেই) □ অবিবাহিত□ বিধবা□বিপত্নীক□
৫। পেশাঃ সরকারিচাকুরী□ বেসরকারিচাকুরী□ ব্যবসা□ অন্যান্য: গৃহীনি□ বেকার□ অবসরপ্রাপ্ত□ কৃষি□	৬। শিক্ষাগত যোগ্যতাঃ এসএসসি/সমমানপর্যন্ত□ এইচএসসি/সমমানপর্যন্ত□ স্নাতক/সমমানপর্যন্ত□ স্নাতকোত্তর/সমমানপর্যন্ত□
৭। এখান থেকে কয়টি সেশনগ্রহনকরেছেন? ৩-৫ টি□ ৬-১০ টি□ ১১-১৫ টি□ ১৬-২০ টি□ ২১-উর্ধ্বে□	৮। কোথা থেকে মনোসেবাগ্রহণকরেছেন?

6.4 Appendix-D Client Evaluation of Counselor Behavior Short Form(CECB-S)

কাউন্সিলর এর কর্মদক্ষতা মূল্যায়ন
কাউন্সিলরের আচরণে ক্লায়েন্টের মূল্যায়ন এর সংক্ষিপ্ত ফরম (CECB-S) ২০০৫

আইডি ---------- তারিখ ----------

আমার কাউন্সিলর হল ঃ		অসম্মত						সম্মত
১.	নিয়মিত ভাবে সাক্ষাত পাওয়া যায়	১	২	৩	৪	৫	৬	৭
২.	তার সাথে থাকতে আমার অস্বস্তি লাগে	১	২	৩	৪	৫	৬	৭
৩.	ব্যক্তিগত বিষয় শেয়ার করার মত যথেষ্ট বিশ্বস্ত নয়	১	২	৩	৪	৫	৬	৭
৪.	একজন ব্যক্তি হিসেবে আমাকে গ্রহণ করেন	১	২	৩	৪	৫	৬	৭
৫.	জ্ঞানসম্পন্ন	১	২	৩	৪	৫	৬	৭
৬.	তারা জানেই না তারা কি করেছিলেন	১	২	৩	৪	৫	৬	৭
৭.	আমাকে বুঝতে পারেন	১	২	৩	৪	৫	৬	৭
৮.	আমার ব্যাপারে ধৈর্য্যহীন থাকেন	১	২	৩	৪	৫	৬	৭
৯.	আমার সঙ্গ উপভোগ করছেন	১	২	৩	৪	৫	৬	৭
১০.	আমার লক্ষ্য পূরণে সহায়তা করছেন	১	২	৩	৪	৫	৬	৭
১১.	সমস্যার সমাধান খুজে বের করার তাগিদ দিয়েছেন	১	২	৩	৪	৫	৬	৭
১২.	লক্ষ্য নির্দ্ধারণ করতে আমাকে অনুপ্রাণিত করেছেন	১	২	৩	৪	৫	৬	৭
১৩.	আমি যখন একটা বলেছি আর করেছি আরেকটি তখনই চ্যালেঞ্জ করেছেন	১	২	৩	৪	৫	৬	৭
১৪.	আমার আচরণ ব্যাখ্যা করার জন্য এর অন্তর্নিহিত কারণ খুজেছেন	১	২	৩	৪	৫	৬	৭
১৫.	সেসন কোনদিকে যাবে সে ব্যাপারে দিক নির্দেশনা দিয়েছেন	১	২	৩	৪	৫	৬	৭
১৬.	শুরু থেকেই কাউন্সিলিং প্রক্রিয়া সম্পর্কে ব্যাখ্যা দিয়েছেন	১	২	৩	৪	৫	৬	৭
১৭.	তাকে অকৃত্রিম মনে হয়েছে	১	২	৩	৪	৫	৬	৭
১৮.	আমার সমস্যাগুলো নতুন অথবা ভিন্নভাবে দেখার পরামর্শ দিয়েছেন	১	২	৩	৪	৫	৬	৭
১৯.	মনোযোগ দিয়ে আমার কথা শুনেছেন	১	২	৩	৪	৫	৬	৭
২০.	কাউন্সিলিং এ আমার লক্ষ্যগুলো অর্জনে সাহায্য করেছেন	১	২	৩	৪	৫	৬	৭
২১.	কি করতে হবে সে সম্পর্কে আমাকে উপদেশ দিয়েছেন	১	২	৩	৪	৫	৬	৭
২২.	আমার সাথে পেশাদারী আচরণ করেছেন	১	২	৩	৪	৫	৬	৭
২৩.	আমার সাথে খোলাখুলি এবং সততার সাথে কথা বলেছেন	১	২	৩	৪	৫	৬	৭
২৪.	কাউন্সিলিং এ আমার লক্ষ্য কি সেটা জিজ্ঞেস করেছিলেন	১	২	৩	৪	৫	৬	৭
২৫.	কাঙ্খিত পরিবর্তন আনতে পারায় আমার প্রশংসা করেছিলেন	১	২	৩	৪	৫	৬	৭
২৬.	সব পরিস্থিতিতে মানিয়ে চলতে পারে এমন মনে হয়েছে	১	২	৩	৪	৫	৬	৭
২৭.	আমার পরিবর্তনের চেষ্টাকে সমর্থন দিয়েছেন	১	২	৩	৪	৫	৬	৭
২৮.	তাকে উচ্চশিক্ষিত/প্রশিক্ষিত মনে হয়েছে	১	২	৩	৪	৫	৬	৭
২৯.	আমাকে পরামর্শ দিয়েছেন কিভাবে আমি ভিন্নভাবে চিন্তা, অনুভব এবং আচারন করতে পারি	১	২	৩	৪	৫	৬	৭
৩০.	কাজ দিয়েছেন সম্পূর্ণ করার জন্য	১	২	৩	৪	৫	৬	৭
৩১.	আমাকে সমর্থন করতে পারতেন না	১	২	৩	৪	৫	৬	৭
৩২.	আমার সমস্যার সমাধান করতে বিভিন্ন কৌশল ব্যবহার করে আমাকে সাহায্য করেছেন	১	২	৩	৪	৫	৬	৭
৩৩ .	আমি অন্যদেরকে আমার কাউন্সিলরের কাছে সুপারিশ করব	১	২	৩	৪	৫	৬	৭

6.5 Appendix-E Session Evaluation Questionnaire(SEQ)

সেসন মূল্যায়ন প্রশ্নাবলী (ফরম- ৫)

আইডি# ---------- তারিখঃ ----------

এই সেশন সম্পর্কে আপনার অনুভূতি অনুগ্রহ করে সঠিক নম্বরে গোল দাগ দিন।

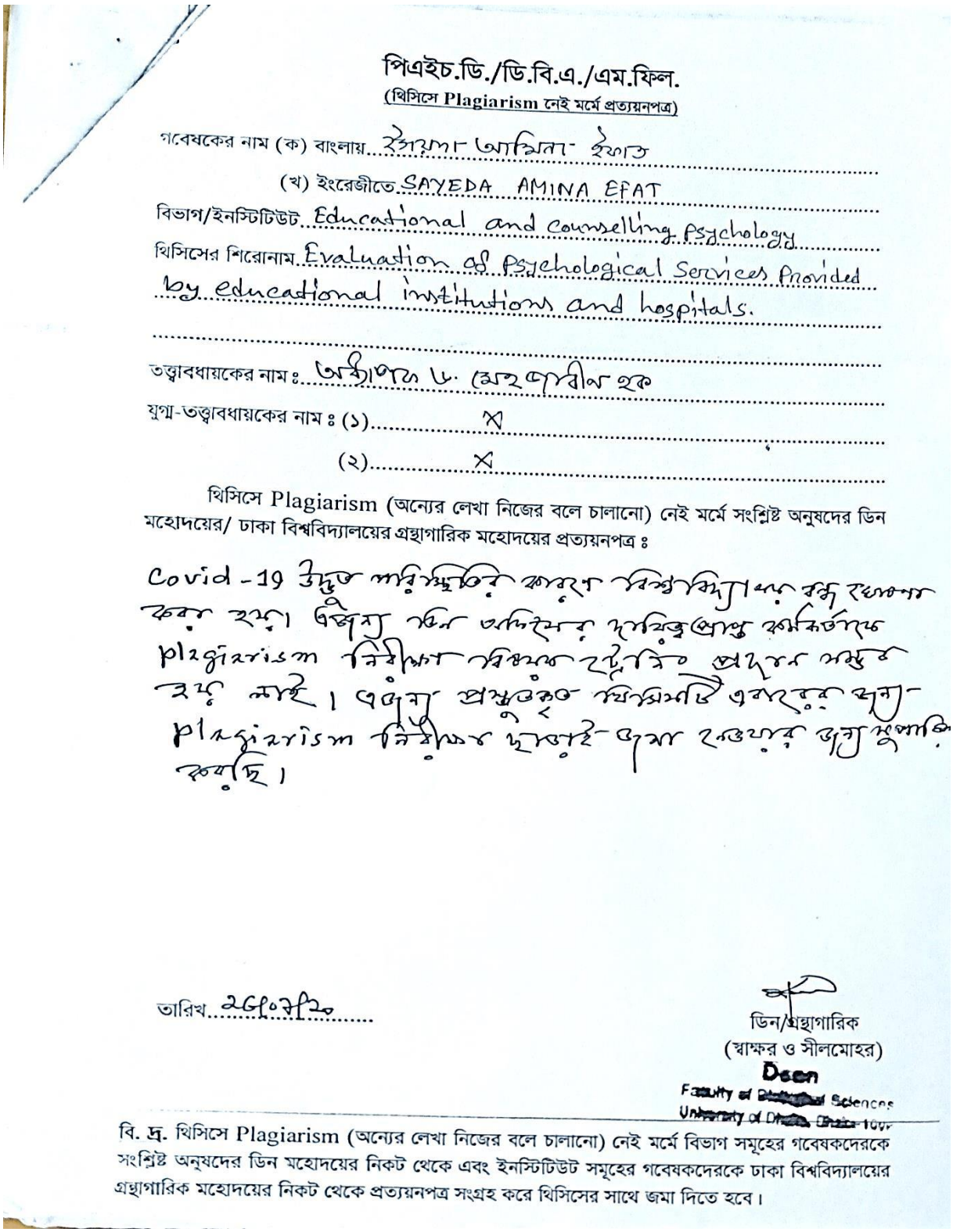
এই সেসনটি ছিলঃ

খারাপ	১	২	৩	৪	৫	৬	৭	ভালো
কঠিন	১	২	৩	৪	৫	৬	৭	সহজ
মূল্যবান	১	২	৩	৪	৫	৬	৭	মূল্যহীন
ভাসাভাসা	১	২	৩	৪	৫	৬	৭	গভীর
আরামদায়ক	১	২	৩	৪	৫	৬	৭	কিছুটা উদ্বিগ্ন
অপ্রীতিকর	১	২	৩	৪	৫	৬	৭	প্রীতিকর
পূর্ণ	১	২	৩	৪	৫	৬	৭	খালি
দুর্বল	১	২	৩	৪	৫	৬	৭	শক্তিশালী
বিশেষ	১	২	৩	৪	৫	৬	৭	সাধারণ
অমসৃণ	১	২	৩	৪	৫	৬	৭	মসৃণ
সস্থিকর	১	২	৩	৪	৫	৬	৭	অসস্থিকর

এই মুহূর্তে আমার অনুভূতিঃ

সুখী	১	২	৩	৪	৫	৬	৭	দু:খিত
রাগান্বিত	১	২	৩	৪	৫	৬	৭	আনন্দিত
পরিবর্তনশীল	১	২	৩	৪	৫	৬	৭	স্থির
অনিশ্চিত	১	২	৩	৪	৫	৬	৭	নিশ্চিত
শান্ত	১	২	৩	৪	৫	৬	৭	উত্তেজিত
সুনিশ্চিত	১	২	৩	৪	৫	৬	৭	ভীত
বন্ধুভাবাপন্ন	১	২	৩	৪	৫	৬	৭	বন্ধুভাবাপন্ন নয়
ধীর	১	২	৩	৪	৫	৬	৭	দ্রুত
উদ্যমী	১	২	৩	৪	৫	৬	৭	প্রশান্তিময়
শান্ত	১	২	৩	৪	৫	৬	৭	উত্তেজিত

6.6 Appendix F: Ethical Clearance



পিএইচ.ডি./ডি.বি.এ./এম.ফিল.

(থিসিসে Plagiarism নেই মর্মে প্রত্যয়নপত্র)

গবেষকের নাম (ক) বাংলায় সৈয়দা আমিনা ইফাত

(খ) ইংরেজীতে SAYEDA AMINA EFAT

বিভাগ/ইনস্টিটিউট Educational and Counselling Psychology

থিসিসের শিরোনাম Evaluation of Psychological Services Provided by Educational Institutions and Hospitals.

তত্ত্বাবধায়কের নাম ঃ অধ্যাপক ড. মোহাম্মদ শহীদুল হক

যুগ্ম-তত্ত্বাবধায়কের নাম ঃ (১) ×

(২) ×

থিসিসে Plagiarism (অন্যের লেখা নিজের বলে চালানো) নেই মর্মে সংশ্লিষ্ট অনুষদের ডিন মহোদয়ের/ ঢাকা বিশ্ববিদ্যালয়ের গ্রন্থাগারিক মহোদয়ের প্রত্যয়নপত্র ঃ

Covid-19 উদ্ভূত পরিস্থিতির কারণে বিশ্ববিদ্যালয় বন্ধ থাকায় কাজ করা হয়। উল্লেখ্য যে, অভিসন্দর্ভ মূল্যায়নের জন্য চূড়ান্তভাবে plagiarism নিরীক্ষার সফটওয়্যার ব্যবহার করার সুযোগ নাই। তাই প্রস্তুতকৃত থিসিসটি একাডেমিক কাজে plagiarism নিরীক্ষার মাধ্যমে- তুলনা হওয়ার জন্য সুপারিশ করছি।

তারিখ 26/07/20

ডিন/গ্রন্থাগারিক

(স্বাক্ষর ও সীলমোহর)

Dean

Faculty of Biological Sciences

University of Dhaka, Dhaka-1000

বি. দ্র. থিসিসে Plagiarism (অন্যের লেখা নিজের বলে চালানো) নেই মর্মে বিভাগ সমূহের গবেষকদেরকে সংশ্লিষ্ট অনুষদের ডিন মহোদয়ের নিকট থেকে এবং ইনস্টিটিউট সমূহের গবেষকদেরকে ঢাকা বিশ্ববিদ্যালয়ের গ্রন্থাগারিক মহোদয়ের নিকট থেকে প্রত্যয়নপত্র সংগ্রহ করে থিসিসের সাথে জমা দিতে হবে।