ASSESSING THE NEED OF PROFESSIONAL COUNSELORS AND THEIR POTENTIAL ROLE IN BANGLADESH

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Supervisor

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Declaration

Except where full references have been given, this research report contains the independent original work which performed by myself under the supervision of Professor Shaheen Islam, PhD, Department of Educational and Counselling Psychology, University of Dhaka. This research report has not been submitted before, nor is it being submitted anywhere else at the same time for award of any degree, except for publications.

University of Dhaka

May 2017

....…………………………...

Lipy Gloria Rozario

Certification

This is to certify that the work embodied entitled **"**Assessing the Need of Professional Counselors and their Potential Role in Bangladesh**"** submitted by Lipy Gloria Rozario has been carried out entirely by the candidate, the research scholar under my supervision. This is further to certify that it is an original work and suitable in partial fulfillment for the degree of Doctor of Philosophy in Counseling Psychology, Department of Educational & Counselling Psychology, University of Dhaka. I recommend the thesis for examination.

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Abstract

ASSESSING THE NEED OF PROFESSIONAL COUNSELORS AND THEIR POTENTIAL ROLE IN BANGLADESH

The objective of this study is assessing the need of professional counselors and their potential role in Bangladesh. To achieve this objective, mixed method has been applied, predominantly qualitative study. For qualitative study, documentation, observation, interviews, focus group discussion have been used involving persons considering their age, sex, institutional affiliations, and experiences in the field. The sample size of qualitative study consists of thirty respondents, aged 25 and above and among whom 9 male, 21 are female.

For quantitative study, a survey instrument has been administered on 982 respondents, aged above 18, male 51.7%, female 48.9%, from Dhaka, Chittagong, and Rajshahi divisions in Bangladesh.

The research findings demonstrate that the number of available mental health service centers including resource persons and counselors/psychotherapist, in particular, is very limited. There is a huge gap between the existing problem and the services being provided for their mitigation. The result also shows that mental health services are mostly concentrated in Dhaka, the Capital of Bangladesh; while other districts and rural areas are badly deprived of them. Further, lack of awareness about psychological problems, stigma and knowledge about services among general population also contribute in not seeking mental health services.

As per the professionalism of the counselors, currently there are a very few professional counselors in existence. In addition, the concept about counselor’s educational background, their roles,

competency, supervision, collaboration among mental health and medical professionals is rather vague both among the professionals as well as those that are in need of these services.

It is clear from this research that Bangladesh has a long way to go in order to understand the need of professional counselors for psychological wellbeing of the people; and meeting the gap between the presently available mental health services as opposed to their adequate requirements is very essential to establish professional counseling in Bangladesh.

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Chapter 1: Introduction

In the past, basic counseling has been often practiced by family members, indigenous and spiritual healers, and medical personnel in every culture across the globe. In the course of time, using evidence-based approaches, counseling is now extensively practiced by accredited mental health professionals. For a better understanding of a professional counselor, this chapter deals with general global mental health status, mental health condition of neighboring countries, context of Bangladesh, the definitions of each term, the identity of counselors, their role, significance of this study, purpose of this study, research objectives, the history of the profession of counseling, when, where and how the profession began to be part of health systems and developed in different continents is briefly discussed.

1.1 General Mental Health Status Global

World Health Organization (WHO) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity"("WHO | Mental health: a state of well-being," 2014). Further, mental health is a "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Basing on this definition of mental health, the WHO reports that one in four suffers from mental or neurological disorders at some point of their lives. Around 450 million people currently suffer from mental health illnesses, placing mental disorders among the leading causes of ill-health and disability worldwide ("WHO | Mental disorders affect one in four people," 2013). The WHO added that mental and behavioral disorders account for about 12

percent of the global burden of diseases and by 2020 this burden would increase to 15% (Murray & Lopez, 1997).

The Global Burden of Disease Study (GBD, 2010) estimate that a substantial proportion of the world's disease burdens come from mental, neurological and substance abuse disorders. Mental disorders accounted for the largest proportion of disability-adjusted life years (56.7%), followed by neurological disorders (28.6%) and substance abuse disorders (14.7%) (Whiteford, Ferrari, Degenhardt, Feigin, & Vos, 2015).

While treatments are available for mental disorders, nearly two-thirds of people with a known mental disorder never seek help from a health professional. Stigma, discrimination and neglect prevent care and treatment from reaching people with mental disorders ("WHO | Mental disorders affect one in four people," 2013).

1.2 State of Mental Health in Neighboring Country

Neuropsychiatric disorders are estimated to contribute 11.6% of the global burden of disease and 90.2% worldwide expenditure (Presley-Cantrell et al., 2009). Some of the mental disorders and problems in India such as anxiety can be linked to concerns about the advancement of science and technology in the 21st century as in other countries in the world. Hope revolves around advancement in medicine, agriculture, and improved methods of conflict resolution; whereas anxiety revolves around the development of lethal weapons for war, pollution, climate change, and poverty (Hohenshil, Amundson, & Niles, 2015). This change has drastically affected people's personal and social lives, making them vulnerable to anxiety, depression, suicide, and marital problems. Within this context it is not difficult to acknowledge the need for

counseling services for psychological well being and sound mental health. It has been estimated that one in five needs mental health counseling in India (Masand, 2012).

Even though there is a dire need of mental health professionals to take care of the affected population, there are 0.30 psychiatrists, 0.16 psychiatrist nurses, 0.04 psychologists, 0.03 social worker for every 100,000 people (Information, Health, & Delivery, 2011). The statistics show that the significant unmet mental health need in India is a result of the acute shortage of mental health professionals. The lack of trained professional counselors makes the mental health situation even worse, as their role in primary support and prevention is not recognized in the current mental health workforce profile. Therefore, in order to cope with mental health challenges people go to the spiritual healers, mystics, priests, and indigenous practitioners (Barua, 2009).

1.3 Context of Bangladesh Parallel to Other Countries

Bangladesh is experiencing significant social and economic adjustments not dissimilar to those experienced in some other countries internationally. It has been said that counseling developed in the late 1890s and early 1900s out of a humanitarian concern to improve peoples' lives in the face of the harsh conditions associated with industrialization, (Gladding & Newsome, 2010). Many individuals and families have adversely been affected by the industrial revolutions which lead to widespread internal migration, the implementation of workhouses for the poor, factory-based labor including children and the growth in substance abuse, violence and slums.

It can be said that Bangladesh is experiencing similar transformative socio-economic change, with heavy internal migration to major cities, and consequent growth in slums and social dislocation from family and village based networks; factory based work with dormitory living;

uncontrolled use of child labor and poor regulatory management of substance abuse and domestic violence which are key contributors to unhealthy mental health. A recent survey reports that 70% women in Bangladesh keep secret of their husband's oppression which may cause psychological (Hossian, 2017).

The post traumatic stress disorders and other mental health issues displayed by soldiers returning from the First and Second World Wars (1914-1918 and 1939-1945) generated interest in the UK about counseling for effective support and to reduce the high levels of institutionalization of soldiers suffering from shellshock.

It can be said that Bangladeshis are still experiencing the impact of the Liberation War, with its dislocation, its torture cells and war crimes led to the destruction of communities (including the mass relocation of Hindus and indigenous people to India), the destruction of families and the ongoing community debate associated with those war crimes. Again, these stressors affect the need for mental health services in Bangladesh.

Like India, Bangladesh is a developing country; in some areas transitioning from an agricultural economy to a technology based economy. With the population in India exceeding 1.2 billion, the burden of mental and behavioral disorders there ranges from 9.5 to 102 per 1000 population (Gupta, Lohiya, & Kharya, 2013). An understanding of this burden has been growing rapidly. A survey on the importance of counseling conducted in 1993 revealed that only 5% of school heads believed the counseling was needed in school settings. Seven years later the same survey reported that 95% of school heads agreed that school counseling was not only necessary but was urgently required (Hohenshil, et al., 2015).

Similarly in Bangladesh, the transition to an economy based on higher levels of education is producing significant educational stress. It can be said that the education system, with its rote based teaching, is inadequate to produce the problem solving skills necessary for jobs in the future. Students and their parents in Bangladesh face intense pressure over access to good schools, completion of studies and employment. Anecdotally, this is producing a demand for educational counseling.

1.3.1 Mental Health Situation in Bangladesh

The unmet need for professional counselors in Bangladesh is not dissimilar to that in better-studied India. UN Official estimates that Bangladesh has a population of 164,247,461 (WHO, 2011). There is evidence demonstrating that between 6.5% and 31% of adults, and between 13.4% and 22% of children in Bangladesh suffer from mental health disorders (Hossain, Ahmed, Chowdhury, & Niessen, 2014). The National Institute of Mental Health in Bangladesh reports that there are currently 20.5 million people with a mental illness in Bangladesh. Among them, 1.07% (1.4 million) experience severe psychosis, 6.4% have a diagnosis of depression and 8.4% have been diagnosed with a psychoneurosis (NIMH Office Record, 2015). A recent study of WHO estimates that Bangladesh currently has 6.4 million people suffers from depression disorder. The causes of depression are poverty, unemployment, life events such as the death of a loved one or a relationship break-up, physical illness and problems caused by alcohol and drug use. Depression is a major contributor of suicide death (“Depression affects 6.4m Bangladeshis: WHO,” n.d.). It has been also found that data on mental disorders among children are scarce, with a high risk of under-reporting. Behavioral disorders are common among socially disadvantaged children, such as those living in urban slums (“State of mental health in Bangladesh | theindependentbd.com,” n.d.). The evidence suggests that psychiatric disorders

among children are also associated with malnutrition, low levels of parental education and a family history of mental illness ("Mental disorders among children associated with malnutrition | daily-sun.com," n.d.). Behavioral and emotional disorders are highly prevalent among orphans and adolescents in residential care (Giasuddin, Chowdhury, Hashimoto, Fujisawa, & Waheed, 2012). The results of this study indicate that overall the prevalence of behavioral and emotional disorders was 40.35%, of which behavioral disorders was 26.9%, emotional disorders was 10.2% and both behavioral and emotional disorders were 3.2%. Children from slum areas are significantly more likely to have serious behavioral problems, and are marginally more likely to have post-traumatic stress disorders (Mullick & Goodman, 2005).

A recent review led by the International Centre for Diarrheal Disease Research, Bangladesh (ICDDRB) found that mental disorders in Bangladesh are a serious but overlooked problem. Mental health disorders– such as depression, anxiety, addiction, schizophrenia and neurosis – have a serious impact on the health situation in Bangladesh. In order to fill the knowledge gap and to point the way towards addressing the burden associated with these conditions the ICDDRB investigators further examined the current prevalence and trends in the rates of mental health disorders in Bangladesh. The prevalence of mental disorders has been much higher in overcrowded urban communities than rural ones, and among the poor. Women are vulnerable across all settings, consistent with findings from other South Asian countries such as India and Pakistan ("State of mental health in Bangladesh | theindependentbd.com," n.d.).

Psychiatric disorders in rural areas is estimated at 16.5% (Monawar Hosain, Chatterjee, Ara, & Islam, 2007). Of these, one half suffers from a depressive disorder and one third an anxiety disorder. A significantly higher prevalence of mental disorder has been found in economically poor respondents. Depression is associated with poverty and derives from social

causes such as the tension of having girls in the family and the expenses of marrying off, inability to work and lack of education (World Health Organization, Geneva, 2010).

Schizophrenia continues to be one of the leading mental disorders in Bangladesh, with around 35% of the admitted patients at the National Institute of Mental Health (NIMH) suffering from the illness, according to the health bulletin 2014 ("Schizophrenia a major mental health concern | Dhaka Tribune," n.d.).

The bulletin of the health directorate also showed that 2,140 patients have been admitted to the National Institute of Mental Health (NIMH) in 2014 with more than 35% diagnosed with schizophrenia. The percentage had been similar in earlier years: 35.53% in 2009, 37.58% in 2010, 43.47% in 2011 and 38.1% in 2012. An Assistant Professor of Child, Adolescent and Family Psychiatry states in a media interview that among all schizophrenia patients, 25% would be fully cured through proper treatment, 25%-35% would lead normal lives by taking medicine regularly, 10%-15% would never be cured and 10%-15% would kill themselves or develop suicidal tendencies ("Schizophrenia a major mental health concern | Dhaka Tribune," 2014).

1.3.2 Help-Seeking Behavior of Mentally Challenged People

The care-seeking behavior of patients with a mental illness is central to the effective planning of mental health services. In both developed and developing countries help-seeking behavior is influenced by socio-economic, cultural and other factors. Pathway studies highlight the help-seeking behavior of patients with physical and mental illness. Research has shown that 84% of patients consulted other careers before they sought assistance from a Mental Health Professional (MHP) and the range of delay has been 8–78 weeks. 16% of patients came directly to a MHP with a mean delay of 10.5 weeks from the onset of mental illness. Among the patients

who took the indirect pathway 44% first visited individual Private Practitioners (PP), 22% first visited native or religious healers (NRH) and 12% saw rural medical practitioners (RMP). Patients seeing an NRH or an RMP had the least delay (2–2.5 weeks) and the shortest pathway to an MHP (4.5–7 weeks). The longest delay occurred amongst those seeing a PP to MHP/General Hospital (22–31 weeks). About a third of patients received a diagnosis that had poor concordance with the diagnosis made by the MHP. 70% and 40% respectively of patients with a mental illness who attended General Hospital and a PP were referred to an MHP (Giasuddin et al., 2012).

Lack of knowledge, superstitious beliefs and social stigma prevent individuals with mental health conditions from seeking care. Beliefs that mental disorders are untreatable or the result of evil influences also play a role ("Schizophrenia a major mental health concern | Dhaka Tribune," 2014).

In addition, due to the strong social stigma attached to mental health disorders in Bangladesh, the authors cautions that prevalence in both children and adults is likely to be disguised or underestimated. Related to help-seeking behavior, it has also been found that while affected by depression, individuals help-seeking behaviors started with sharing with family members, then relatives, then to look for a doctor as they perceived physical symptoms (World Health Organization, Geneva, 2010). Moreover, it has been found that the main barrier for help-seeking is determined by the major shortage of qualified mental health practitioners in Bangladesh for both adults and children, and few referrals to specialists.

1.3.3 Need for Psychosocial Counseling Service

Children from developing countries are more exposed to traumatic experiences and more likely to suffer a range of psychological problems than children from developed countries. In a recent survey 1360 children and adolescents from Bangladesh have been selected to assess symptoms of post traumatic stress disorder (PTSD), anxiety and depression. The results showed that children report high levels of exposure to traumatic events, both via direct experience of man-made direct trauma and trauma from natural disasters (Deeba & Rapee, 2015).

There is a need for expert level professional mental health support for the roughly 5 million Bangladeshi children aged 5-10 years estimated to have psychiatric disorders. Those at high risk, for instance children who had been trafficked and abandoned or living in institutions, and children of sex workers, are more likely to suffer from serious emotional and behavioral problems. Although pharmacological interventions are widely available in Bangladesh for treating psychiatric problems, psychological interventions are still rare. Apart from the psychiatric services there are very few psychologically oriented mental health services available in the country (Deeba & Rahman, 2012).

Some NGOs and dedicated researchers investigated the field of the psychosocial consequences of disaster in Bangladesh, particularly in the coastal areas and the tornado-affected areas of Tangile and Jamalpur during the last two decades (Choudhury, Quraishi, & Haque, 2006). The most remarkable survey carried out by the Social Assistance and Rehabilitation for the Physically Vulnerable (SARPV-Bangladesh) after the 1996 tornado has shown, on average, that women are more affected psychologically than men; 66% of the total sample in the disaster area have been psychologically traumatized and required emergency services. The study supports

the ideas that any disaster will have mental health consequences. Providing scientific psychological services is essential for real recovery from such a disaster.

In developing countries like Bangladesh, insufficient mental health professionals and inadequate knowledge and practice about mental health issues arising from disasters medical and paramedical staff, may lead to delays in the psychosocial management and rehabilitation of the survivors. To respond properly to a serious disaster such as a cyclone or recurrent devastating floods, the disaster mental health team should be aware of the socio-economic status, local culture, tradition, language and local livelihood patterns. Integration of the team with the network of various governmental and non-governmental organizations is essential to provide mental health services effectively.

1.3.4 Mental Health Human Resource

Even though there have been huge needs to address psychological problems of the people of Bangladesh, a limited number of professionals are providing service. A total number of professional working in mental health facilities or in private practice per 100,000 populations is 0.49 (Searo, 2006). The current study will investigate the need for professional counselors and their potential role in addressing the psychological health and mental health services in Bangladesh.

1.4 Definitions of Terms

1.4.1 The Professional Counselor's Identity

The professionalization of counseling is blurred among mental health professionals (e.g., mental health counselors, psychologists, social workers, marriage and family therapists, psychiatrists). This issue is based in large part on shared foundational knowledge, overlapping

goals and similar work environments, all of which make it difficult to clearly distinguish a mental health counselor's identity (as it is cited in Darcy & Abed-faghri, 2013). In a study of professional identity development, Gibson Colette T Dollarhide, Moss, & Gibson (2010) has found three definitional approaches to counseling by Counselors in Training (CIT):

1. as defined by the public;
2. as defined by individual CITs; and
3. as defined by experts.

Of interest is that all CITs recognized that the public had a negative perception of counseling, as represented by this CIT's comment: "[Counseling is] like a taboo subject, people don't want to talk about it or they want to keep it hidden (p. 29)." "The public has a misconception regarding this profession; they perceive a counselor as an advice-giver, somebody that is there. But nobody really knows what they do. [The public doesn't] know the difference between a counselor and a therapist or a psychiatrist or psychologist (p.29)."

The identities of counselors differ in terms of training, credentials, specialization and practice ("A-call-for-professional-unity-August-2009.pdf," n.d.). In research analysis to define the professional counselor, Mellin, Hunt, & Nichols (2011) found that participants responded in three categories, according to:

1. their tasks and the services they provided;
2. the training and credentials they obtained; and
3. their focus on wellness and development.

Since 2010, counseling has been redefined as a mental health profession, one that follows human development and psychological principles through cognitive, affective, behavioral and systematic intervention strategies to address people's wellness, personal growth, or career development as well as psychopathology (Kaplan, Tarvydas, & Gladding, 2014).

Counseling is no longer a profession only of counselors, but a function of many supporting disciplines such as social work, and psychology as a distinct profession that has an accrediting body, an ethical code, recommended curriculum, professional organizations, credentials, and licensure (Gale & Austin, 2003).

In the past, counseling and psychotherapy were considered two distinct functions. Psychotherapy was considered to take longer as a service, have greater depth and intensity, require more training, and address personality reorganization, as opposed to more reality-based problems. Psychotherapy has also been considered the treatment for individuals with severe psychopathology, while counseling applies to more common problems of living, decision-making, and personal growth (Thomas, Berven, & Chan, 2004). By the late 1980's, however, most scholars had conceded that counseling and psychotherapy are synonymous (Corsini & Wedding, 2008). It has been suggested that the effective delivery of both counseling and psychotherapy requires:

> "establishing a therapeutic working relationship with individual served; communicating with individuals in facilitative, helpful ways; obtaining information from individuals in a comprehensive and thorough manner; helping them to tell their stories and explain their problems in ways that will facilitate treatment and service planning; and facilitating follow-through on commitments

and compliance with treatment and service plans that individuals have decided to pursue" (Thomas et al., 2004, p.4).

1.4.2 Professional Counselor

For many countries, finding a right word for "counseling" is challenging. By counseling, people typically understand advice-giving and therapy. Nevertheless, neither of these terms adequately expresses the special focus of counseling. There can be a stigma attached to seeking help for personal problems. People needing support may feel counseling is another form of therapy. On the other hand those who seek assistance expecting direct advice-giving for their problems may become frustrated when they do not receive it.

In 2010, the American Counseling Association (ACA) adopted a definition that describes counseling as a professional relationship that empowers diverse individuals, families, and groups to achieve mental health, wellness, education, and career goals. The Chi Sigma Iota Counseling Academic and Professional Honor Society International (CSI) endorses the ACA definition of counseling in the following way:

> Professional counselors hold their highest graduate degree in counselor education from a nationally accredited preparation program, are credentialed by authorized state and/or national agencies, and adhere to its competency standards on matters of ethics, diversity and behavior in order to contribute to the realization of a healthy society by fostering wellness and human dignity.

Thus professional counselors are those who undergo an educational program under a governmental agency, university, or mental health group (such as a professional association) and must successfully pass an examination to demonstrate that they possess the required knowledge

and skills endorsed by the particular credential group. They receive formal training, supervision in counseling, and follow an approved code of ethics. It is to be remembered that codes of ethics differs country to country (NBCC-I, 2011) (Amundson, Niles, & Hohenshil, 2013).

1.4.3 Roles and Functions of a Counselor

A professional counselor has several roles to play in the mental health arena. In order to become a professional counselor, one has to enhance his/her professional role through education, training, and experiences that start early on in graduate training programs. Some foundational roles include individual, group and family counseling, consultancy, and research (Chronister, Chou, & Chan, 2009). A counselor's role can be differentiated from other professionals working in the mental health sphere by viewing problems occurring as developmental events that are a manifestation of the person, culture and system. Counselors consider individual's life stage, developmental history, context and broader socio-cultural issues in carrying out a need assessment and providing support. There is less emphasis on diagnosis and remediation than on focusing support on developmental growth and prevention, competencies, strengths, coping, resources, negotiating life transitions, and managing stressors (Van Hesteren & Ivey, 1990).

The primary role of a counselor is to assist clients in reaching the optimal level of their psychological functioning through resolving unhelpful patterns, identifying prevention strategies, undertaking rehabilitation, and improving their quality of life (Hershenson & Power, 1987).

1.5 Significance of the Study

This study will contribute to an improved understanding of unmet need for professional counselors in Bangladesh, and in particular the current condition of counseling services. This study will also be beneficial to policy-makers in the health sector charged with planning mental

health services and overseeing the quality and professionalism of the mental health workforce with the aim of bringing Bangladesh in line with global standards and approaches that strengthen community based, primary mental health care service delivery. Moreover, it is hoped that educational institutions will have an increased awareness of the global context for professional counseling and the contribution that accredited and licensed counselors can make in reducing unmet need for mental health services in Bangladesh. This study also makes recommendations on how to evaluate the performance of counseling services and the efficiency of counselors in their professional practice. In addition, this study will highlight the gaps in counseling service as professions. The identification of the need for training and up-skilling of counselors will help ensure standard and ethical practice. The study as a whole will contribute to implementation of quality of counseling as mental health services for the people of Bangladesh.

1.6 Purpose of the Study

The purpose of this study is to explore the extent of unmet need for professional counselors in Bangladesh. In addition, this study will help to identify the need for training and up-skilling of counselors so that they can contribute to mental health services for the people of Bangladesh.

1.7 Research Objective

General Objective: The general objective of this study is assessing the need of professional counselor and their potential roles in Bangladesh.

Specific objectives of this study are:

1. To portray the existing mental health status of the people in Bangladesh
2. To explore the extent of mental health services provided in Bangladesh
3. To ascertain the gap between services required and service provided

4. To look at the need for professional counselors further by describing the existing status of available counseling services
5. To identify the roles of professional counselors in existing service delivery system ;
6. To identifying the gaps and areas of improvement to play the role of professional counselor efficiently and mitigating the gaps

1.8 History of Professional Counseling

Ancient priests from Egypt, Mesopotamia (Iraq) and Persia (Iran) summoned prayers for natural healing in ancient time. There are differing views on when the counseling profession actually started. According to Hackney & Cormier (2009) professional counseling began in the Enlightenment era (18th century), however other scholars describe the first contemporary counselors as emerging in the late 1800s. School teachers played the role of a counselor helping primary and high school students, not only in issues relating to academic progress but also in their personal issues such as emotional difficulties and behavioral problems (Beesley, 2004).

The demand for the counseling profession increased in the late 1950s. Russian technological advancements encouraged the US Congress to pass *National Defense Education Act* (NDEA) in1958, which provided guidance programs in schools to train counselors (Bradley & Cox, 2001). Professional counseling began in the United States of America, then spread globally; for convenience one country from each continent and the Bangladeshi context are presented.

During the Depression of the 1930s, when the number of individuals and families experiencing significant socio-economic stressors in the USA, E.G. Williamson generated the first counseling theory proposing his counselor-centered theory. In this model, the counselor was

seen as an expert who identified a deficiency in the client and prescribed a procedure to remedy the problem. One decade later, Carl Rogers challenged Williamson's counselor-centered approach by developing a client-centered approach where the focus of the healing process remained on the client (Gladding & Newsome, 2003).

Almost a half-century later, more than 665,500 jobs were held by counselors in 2008 and it is projected to grow to 782,200 jobs by 2018, an 18% increase in a decade. Counseling specializations include school/vocational, rehabilitation, mental health, substance abuse, behavioral disorders, marriage and family therapy, and work in other counseling settings (Bureau of Labor statistics, 2011).

The minimum requirement to become a professional counselor is a Master's Degree which can range from 36-60 semester hours of training.

Counseling profession was influenced by guidance as it was a problem oriented as well as based in organizations rather than private practice. Counseling takes place in the education sector, including schools and higher education. The existence of school counseling dates back to the 1960s with a recommendation for the appointment of school counselors contained in a Government report (Evans, Duffey, Erford, & Gladding, 2013). Counseling spreads throughout the world quite fast.

Counseling profession developed in Nigeria through a Catholic nun who organized a workshop on career guidance for graduating students in 1959 with the goal to provide with occupational and job search information to make informed employment and career decisions; another event that helped to develop is the introduction of counseling and guidance at comprehensive high school in Aiyetoro in Ogun State in 1963; the next prominent factor that

influenced the emergence of counseling was the active role played by the Nigerian federal government when it intentionally introduced guidance and counseling services at the secondary school level via the 1977 National policy on education which has revised a number of times (Federal Ministry of Education, 2004). In Nigeria, the training of the counselors is provided by local universities, and the minimum level of training to practice counseling is: the counselor must have a bachelor of education degree in guidance and counseling (Okocha, 2013). The perception of counseling in India is different.

In India counselor is defined as confidants, advisers, teachers who help people with family problems, mental health concerns, drugs and alcohol addictions, and career decisions in different setting. Personal counseling, mental health counseling, and academic and career counseling are increasingly gaining popularity in India. But, still many clinical and counseling psychology programs in India are unaccredited. The Government has authorized the University Grant Commission (UGC) to coordinate, determine, and maintain standards of university education in India. A couple of universities are accredited by the UGC to offer a two years master’s program in applied psychology with a focus on clinical and counseling skills. Beside the master’s program, there are some diploma programs to meet the current need of counseling which fulfils all the requirements designed for the Council for Accreditation and Related Educational Programs Standards. However, the profession of clinical psychology is regulated by the Rehabilitation Council of India, but the field of counseling is not regulated by any government agency. The Association of Mental Health Counselors-India on May 4, 2010, basing it on the model of the American Counseling Association. In India personal counseling, mental health counseling, academic and career counseling are increasingly gaining the acceptance and

popularity (Jain & Sandhu, 2013). Counseling/psychotherapy profession came to Bangladesh through the emergence of psychology department.

In Bangladesh, the Department of Psychology started at Dhaka University in 1965. Later, the post graduate vocational program was initiated as a new stream in the Department of Psychology in 1996 as part of an association between London University and Dhaka University as an applied Psychology under the Faculty of Biological sciences which offers postgraduate studies and training in clinical psychology in accordance with international standards and principles and produces professional Clinical Psychologists ("Schizophrenia a major mental health concern | Dhaka Tribune," n.d.).

1.9 Development of Psychosocial Counseling

The need for counseling services in Bangladesh was recognized initially by a co-founder, past director and advisor of a Non-Government Organization (NGO). The main function of that NGO was to provide legal and social support to the disempowered, particularly women, and working children. However, the director soon recognized that the clientele needed psychosocial counseling to cope with trauma, acceptance of divorce and other psychological issues. As a result, that NGO established the psychosocial department wing in 1997 (*Unmesh*, 1, 1, 2013).

Psychosocial counseling helps clients overcome defeat and fear, further boosting them with positive change. Since 1997, that NGO has provided training on basic and advanced skills to trainee counselors by inviting international and national trainers. More than a thousand professionals and people involved in mental health and human services from the government and non-government sectors have taken part in these trainings. Most notably, the training became a one-year certified course titled "Diploma in Counseling". In 2004, the first batch of 12 certified

counselors graduated and a second batch of 18 counselors graduated in 2011 (ASOK, 2012). This NGO has been the first organization to open the door for non-psychologists to learn treatment therapies as in other countries. To date 450 people have obtained training in Transactional Analysis (TA) 101, 48 people have received the Diploma in Counseling (TA & NLP) and there are 25 trainees of Certified Transactional Analysis (CTA). As to date, this NGO has terminated their project of psycho-social counseling in 2016.

1.10 Emergence of the Department of Educational and Counseling Psychology

A British Chartered Educational Psychologist must be given credit in the establishment of educational psychology at Dhaka University. His ceaseless effort, devotion, hard work and encouragement inspired the commencement of educational psychology. As the fruit of that effort, a Masters Degree in Educational Psychology was established in 2006.

Educational psychologists are concerned with helping children and young people who are experiencing problems in educational settings with the aim of enhancing their learning. Challenges may include social or emotional problems or learning difficulties, which may include attention deficit, examination or maths phobia etc. In many cases the divorce/separation of parents and/or family quarrels affects the minds of children and students. In those cases educational psychologists help them through counseling ("The emergence of Educational and Counseling Psychology at the University of Dhaka," n.d.).

Alongside the educational psychology, counseling psychology also emanated. The emphasis in counseling involves through the professional relationship, helps the client become self aware so that he/she can choose the best way forward for her/himself. In this context, the Department of Psychology at Dhaka University introduced the Master's Degree in Counseling

Psychology in 2009 (Islam & Islam, 2010). Later, in 2011, the Department of Education and Counseling emerged as an independent department. Its programs include intensive training on applied psychological areas offering a full time one-year MS, a two-year MPhil and a three year PhD course in Educational Psychology and in Counseling Psychology. The objective of these professional courses is to provide participants with a thorough knowledge and understanding of the theories and principles of psychology. These courses develop skills in psychological assessment and intervention in the contexts both of educational and counseling psychology and working within a diverse community.

To date, 169 students graduated from the Educational and Counseling Psychology, but not all of them are providing service now. There are a number of educational psychologists and counselors providing services in that Department to avail services to those in need.

1.11 Emergence of Psychotherapy in Bangladesh

Psychiatry is a discipline which does not receive proper attention in Bangladesh's medical sector. Although there is some awareness about treating mental illnesses, there is very little awareness of the services offered through psychotherapy (Algin, Jahan, Nahar, Shahid, Shah, Fariduzzaman, 2008). A psychotherapy wing commenced at *Bangabandhu Sheikh Mujib Medical University (BSMMU)* in 1999 as patients were referred from the Out-Patients Department (OPD) and other departments of the same institute. This wing later on started its own psychotherapy training program in 2007. To date, 105 trainees have received Diplomas. Even though psychotherapy is emerging alongside pharmacological treatment, which is positive for Bangladesh, treatment targets are not being achieved due to the lack of manpower.

1.12 Jagannath University:

Department of Clinical and Counseling Psychology was established in 2011. Till date, 45 graduates came out to provide psychological service.

1.13 Harmony: A Mental Health Support Centre

Harmony, a mental health support centre is working in the mental health care field with the aim of promoting wellbeing and mental health promotion under the leadership of a leading Bangladeshi psychiatrist and psychotherapist. Harmony began in December 2012.

Harmony works with the principle of a multi-disciplinary, team-based approach with workforce consisting of psychiatrists, psychologists, psycho-social workers and communication specialists. It has three main branches: psychopharmacological treatment of psychiatric patients, psychotherapy/counseling and management of adolescent crises. Harmony offers a three-month certificate course. Admission is offered to anybody from any academic background and any profession.

Chapter 2: Methods

This chapter deals with the method that the researcher engaged in conducting this study. The purpose of this chapter is to (1) present the context and location of the study, (2) explain the research design, (3) illustrate data collection and difficulties encountered in data collection (4) provide a justification of the statistical procedures applied to analyze the data (5) state ethical considerations, and (6) Discuss the reliability and validity of the study.

2.1 Context and location for the study

This study takes place in different areas of Bangladesh and the sites are divided into three zones—Dhaka, Chittagong, and Rajshahi. The reason for this is: in these three districts departments of psychology are available in public universities. Furthermore, there are medical college hospitals where psychiatric departments are providing services. Also there are several NGOs providing training to counselors.

2.2 Research design

A research design is a procedure used to gather data, analyze data, interpret results and disseminate the findings. The descriptive and exploratory research design have been adopted due to the nature of this study as it involves narration of the people’s opinion and things happening in study context. The descriptive design is a non-experimental design as it simply involves measurement without changing its phenomenon or situation to be measured (Barker, Pistrang, & Elliott, 2002). Descriptive research, also known as statistical research, portrays data and characteristics of population or phenomenon being studied. Exploratory research provides insights into and comprehension of an issue or situation (Context & Design, n.d.).

The justification to employ descriptive and explorative research design is: it is an innovative tool for researchers. It presents an opportunity to combine both quantitative and qualitative data as a means to reconstruct the "what is" of a topic (Barker et al., 2002). Since the counseling profession is relatively a new profession in Bangladesh and the people are new to this concept, the overall picture of what counseling is, how the counselors are educated, trained and their identity and their practices need to be identified. To study this kind of phenomenon both qualitative and quantitative approaches are advantageous to understand the overall current situation. Through qualitative research the real situation can be drawn from people's view, opinion, and experience which are described in narrative way. On the other hand quantitative descriptive studies report their results using descriptive statistics.

In a research qualitative, quantitative, and mixed method (qualitative and quantitative) can be employed. Qualitative data are generated through interviews, focus group discussion, observation which is subjective and involves naturalist and interpretative approach (Rubin & Babbie, 2011). Quantitative approach is objective and data are gathered in numbers; hence statistic methods can be used to test hypothesis. It is more than simply collecting and analyzing both kinds of data; it involves both approaches so that the overall strength of both approaches help to make up the limitations of a study. The combination of both approaches provides expanded understanding of research problem (Creswell, 2009).

Participants

Purposive sampling has been applied for qualitative data collection and convenient sampling for quantitative data in this investigation. It has been done because in purposive sampling, individuals are handpicked to partake in a study since they have certain characteristics

that believed to make them good source of information (Orcher, 2017). A total of twelve participants for interviews have been selected. Among them, six practicing female counselors and two male counselors with different study background from universities, hospitals, and private organizations and four institutional heads where counseling training is being provided. The participants were identified based on purposive sampling through using colleagues and university network. This sample size was considerable since the study was exploratory where interviews are conducted. According to Barbour (2008), interviews generally consist of small sample size.

Table 2.1

Key Informant Interviewee (KII) Counselor's Details

Participant	Gender	Designation	Location of Practice
1	Male	Lecturer and practice Counseling	Drug Rehabilitation
2	Female	Psychosocial Counselors	NGO
2	Female	Practicing Psychotherapy with six months training	Private Practice
1	Female	Practicing after six months training in abroad	Private Practice
1	Male	Practicing without any training	Drug Rehabilitation
1	Female	Lecturer at the University	Private Practice

Table 2.2

KII of the Head of the Educational Institutes and NGOs

Participant	Position
1	Head of the Department of Education and Counseling Psychology
1	Head of the Psychotherapy Training from a Hospital
2	Head of two NGOs

There have been three focus groups consisting of six participants in each group, a total of eighteen members attended. In group one: there have been two female educational psychologists, two female counseling psychologists, one male psychiatrist, and one male psychosocial

counselor. All of them are professionals. In group two, there have been two female psychosocial counselors, one male trainee educational psychologists, two female trainee counseling psychologists and a clinical psychologist. In group three, there have been one female primary school teacher, one female high school teacher, one male college teacher, one male officer from a bank, one male from a private organization, and a housewife. The reason for selecting heterogeneous participants in group three is to have views of the people who might have used and/or have seen the counseling services and could give their own perspectives as well about the current counseling condition. All of the participants are Bangladeshi citizens, aged above 18 years and the interviews and focus group discussions have been conducted in Bangla.

Table 2.3

Focus Group Discussion (FGD) Sample Details

Group	Participants	Gender	Number
Group 1	Educational Psychologist	Female	2
	Psychiatrist	Male	1
	Counseling Psychologist	Female	2
	Psychosocial Counselor	Male	1
Group 2	Psychosocial Counselor	Female	2
	Trainee Educational Psychologist	Male	1
	Trainee Counseling Psychologist	Female	2
	Clinical Psychologist	Female	1
Group 3	A primary school teacher	Female	1
	A high School Teacher	Female	1
	A college teacher	Male	1
	A house Wife	Female	1
	An officer from Private Organization	Male	1
	A banker	Male	1

Moreover, a total of 982 people participated in survey for quantitative data collection among whom (51.7%) are male, (48.3%) female. The sample has been chosen through

convenient sampling. The data has been collected from the outdoor of private and public hospitals, mainly at the psychiatric departments, at private and public university premises, and hospital settings where counseling services are provided. The beneficiaries of counseling also took part in this study.

Table 2.4

Personal and Demographic Information of Survey Sample

				Division	
		Sample	Dhaka	Rajshahi	Chittagong
Character	Attributes	*(n)*	*(n)*	*(n)*	*(n)*
Total		982	397	301	284
Sex	Male	508	202	154	152
	Female	474	195	147	132
Institution	Public university	410	116	187	107
	Private university	165	28	59	78
	Medical college hospital	331	177	55	99
	Drug rehabilitation centre	38	38	0	0
	NGO	38	38	0	0
Marital status	Married	392	180	100	112
	Single	555	198	189	168
	Separated	32	18	10	4
Education	Up to SSC	93	54	23	16
	HSC	141	74	46	21
	Bachelor	195	80	46	69
	Master	387	113	153	121
	PhD	163	74	33	56
Profession	Unemployed	662	248	220	194
	Employed	238	105	49	84
	Business	80	44	30	6
Income (BDT)	<5000	353	130	62	161
	5001-10000	175	41	88	46
	10001-20000	206	90	69	47
	>20000	198	123	45	30
Age	18-28	662	236	225	201
	29-39	210	105	48	57
	40-100	112	57	25	27

Instruments

Since this study follows descriptive and explorative design, some of the tools such as interviews, focus group discussion and surveys have been administered. Thus, in this research, instruments such as interview guidelines for counseling/psychotherapy head (Appendix F), focus group discussion guidelines and counselor/psychotherapy interview (Appendix G) and survey questionnaire (Appendix I) for the general population have been developed accordingly.

Interview

Interview is one-on-one conversation that can be conducted face to face, over telephone or online. Naturally there is skeleton to follow with main key points to ensure all points to cover up. The benefit of the interview is the respondent is free of bias while providing opinion as opposed to focus group where a limited number of participants give most feedback and are influenced by other members.

Interview guidelines have been developed by the researcher for the institutes' head of the Educational Institute where the counselors are getting master degree and other institutions where short training is organized to train counselors and psychotherapists. The guideline consisted of fifteen questions and other probing questions. There are items that explore when counseling institute is developed, the entry requirement to become a counselor, their required educational background, information of the trainers, the current status of the existing counseling service, number of counselors in existence, awareness of the general populations regarding the need for professional counselor like this. Further, there is a question on how to fill up the gap between the counseling need of the people and on how to increase number of counselors.

Focus Group Discussion

A focus group is a form of qualitative research where a group of people are asked to give their perceptions, opinions, and attitude toward a product, service or packaging like this. The topic is focused and the moderator moderates the discussion. The benefit of the focus group is to have multiple respondents simultaneously to generate data. Vaughn, Schumm, & Sinagub (1996) emphasized the interactive nature of focus group interview by stating, *"The goals are to conduct on an interactive discussion that can elicit a greater, more in-depth understanding of perceptions, beliefs and experiences from multiple points of view and to document the context from which these understandings are derived"* (p.16).

In this research data has been collected from three focus groups related to how a counselor is defined, their educational background, requirements to be a professional counselors, help seeking behavior of the clients, attitude of receiving counseling, limitations of the service providers, ways to improve their limitations, and areas where counseling service needs to reach further etc.

Observation and Documentation

Data has been collected through direct observation of the researcher in the hospital settings. Furthermore some information has been taken from unpublished documents.

Survey Questionnaire

Surveys are used to obtain data from individuals about themselves, their household, or about the society. Surveys are an important instrument for collecting data and analyzing information from many people at a time. They are recognized as a key tool for conducting and

applying basic social science research (Rossi, Wright, & Anderson, 1983). Questionnaire survey assessment collects the perceptions of the people; are less expensive and easier to administer.

The survey questionnaire has been developed by the researcher borrowing ideas from Mount Holyoke's counseling service survey with their permission (see Appendix H). The questionnaire has been piloted on twenty person then some items have been simplified to understand version and finalize before administering. This questionnaire consists of some personal and demographic information such as age, gender, religion, marital status, educational background, profession, monthly income, habitat and division they come from. In addition, this survey questionnaire has seventeen items with sub-questions. The questions are divided into two major sections: first seven items are addressed to learn about the people's knowledge about and status of the psychological problems and if they have problems, who do they go for treatment. From item number eight to fifteen are about receiving counseling service, the purpose they went to the counselors for, number of sessions they received, if the service has been satisfactory to them or not. Item sixteen explores the knowledge about counseling services. There have been two open ended questions to learn about the problems for which a person received counseling, and the opinion how the gap between the need for counseling and the scarcity of counselors can be reduced.

2.3 Data Collection and Procedure

Given that this study is exploratory, the method of data collection has been by interviews, focus group discussion, observation, documentation and survey. Through interviews and focus group discussions the experiences of the participants have been explored and survey served as additional information to confirm some of the qualitative data and add supplementary data.

The researcher made a list of the prospective participants, each of them have been called over phone and those who intended to participate voluntarily have been set for face to face interview and focus group discussion. For face to face interview, the participants have been explained verbally the scope of the study, the benefit of the study and further been ensured to withdraw from the study at any time. In addition there have been written consent forms given.

Each interview lasted 20-25 minutes, and the focus group discussion lasted an hour and half for each group. To interview, the researcher has gone to each participant's office, in a quiet room to avoid interruption. During the interviews, the interviewer played a crucial role in obtaining the relevant information needed to address the research questions by probing and asking the interviewees to explain their answers or validate their statements. All the interviews have been recorded digitally with the permission of the interviewee.

For focus group discussions, eighteen professionals and non professionals are contacted to participate in three different groups. Group One comprising professionals have been conducted at the Department of Educational and Counseling Psychology of Dhaka University; Group Two and Group Three have been conducted at Carlotta Centre, a private organization in Dhaka. All of the participants who attended have been collaborative in contributing from their own perspective.

In case of administering survey, all the participants have been approached by the researcher and her two assistants. Two research assistants have been explained, and trained about the procedure of data collection and data entry.

In the beginning each individual has been explained about the research and willing and withdrawing from survey verbally. Those who have been literate have been given a written

consent form as well. Data have been gathered only from those who have given written or verbal consent. Those who have education background and are able to read and write, have filled up the survey questionnaire by themselves, whereas those who are illiterate responded to questionnaires orally and the researcher and her two assistants recorded their answers.

While collecting data from hospital setting, the researcher and her assistants have found difficulties as people have been rushing and most of the time people had been refusing to participate in the survey. At times participants withdraw from filling up as their patients been called to the doctors or had not felt like answering to some questions. Furthermore, while filling up the survey in public other people from surrounding have been curious and gathered around the respondents. This way some of the sensitive items have not been answered properly.

The data collection process had been through November 2015 to November 2016. As the data have been collected through interviews and focus group discussions, the transcription has been ensured by the researcher herself. The survey data has been processed in SPSS by the researcher and her two assistants. The interviews, focus group discussions, and survey questionnaire are done in Bangla, the mother tongue of the native Bangladeshi people.

In addition, different published and unpublished documents are collected from different official documents and newspapers for this study. Furthermore, where written documents were unavailable the researcher collected data from observation.

2.4 Data processing and analysis

Digitally recorded face to face interviews and focus group discussions have been documented, transcribed, coded and analyzed. Coding is the process of examining the raw qualitative data assigning the labels on words, phrases, sentences or paragraphs. Strauss &

Corbin (1990) identified two types of coding: Axial coding and open coding. In open coding one goes through the data and marks circling or highlighting sections of the texts. In axial coding one has a large number of codes which is necessary to be sorted out into groups. The researcher has used axial coding in her data analysis process reading carefully the texts, eliminating the overlaps, reducing the redundancies, finally collapsing the codes into categories.

For the quantitative part, Statistical Package for Social Sciences (SPSS) version 20 is rigorously used for the statistical data analysis. Coding of variable in quantitative research is very important for better interpretation of the result. The demographic information such as gender, age, social economic status (SES), family income, education background have also been coded Two open ended questionnaire in survey are coded manually.

2.5 Ethical consideration

The procedure for data collection began through the approval from the Department of Educational and Counseling Psychology (Appendix A) and Institutional Review Board (IRB) of the University of Dhaka, presenting the purpose of sampling, size of the sampling, location of study site, questionnaire, and interview guidelines and ensuring the privacy of the human subject using consent form. Formal approval has been obtained from the IRB before collecting data (Appendix B). To collect the data from hospital setting, the researcher obtained a written permission from Institutional Review Board (IRB) of two medical hospitals (Appendix C & D) and from other sites verbal permission has been obtained.

The researcher ensures the protection of the participant's identity (name, position, or other information) throughout the entire process of data collection, transcribing, analyzing, and reporting. Only title of the participants is used for quoting any of the participant's responses.

All the interviewees involved in the study have been recruited voluntary based after a verbal consent, then written informed consent (Appendix E) has been obtained. Hence, this study has been based on voluntary participation amongst the target population, but they were encouraged to take part in the study by explaining to them the benefits of the study to add to limited literature and implications for management. The responses remained anonymous during the interviews and are only identified as interviewee as their title. Ethical consideration has also been achieved by asking permission to conduct the study. Moreover, the study participants could withdraw at their own will and convenient time from the study.

2.6 Reliability and validity

To ensure that the study result is valid, the investigator has ensured that the interview questions used for Key Informant Interviewer were specific regarding the current condition of counseling. Interview questions have been piloted on two persons and then modified to easy to understand version, afterwards were determined whether the questions were valid, understandable and answerable. Same process applied for focus group discussion guidelines. The guidelines has been prepared, then three more colleagues read through and gave some observations to clarify some of the concepts. This increased the validity as well as the reliability of the study. The researcher further used inter-coder reliability where alongside the researcher one of her colleague also analyzed the data.

Furthermore, for qualitative data twelve interviewee were interviewed which is enough as after 7-8 interviews no new information arose and saturation occurred. For quantitative data a good number of participants with different background took part. This way a valid result has been generated.

Chapter 3: Results

This research is designed to explore current situation regarding the need for professional counselors and their potential roles in Bangladesh. To attain this goal, the study has been conducted in two phases. In phase 1, a qualitative study is carried out to explore current mental health conditions of the people and the services in general; the gap between required services and the services provided, the need for professional counselors and their potential roles; expectations and perceptions of clients concerning counseling services; and to identify a way forward to mitigate the gap between the need for and the delivery of counseling.

In the second phase, a cross-sectional survey has been carried out using a semi-structured questionnaire to see to what extent the findings of the qualitative study are in harmony with quantitative data, specifically from the counseling recipients' end, the presence of mental health conditions in general, the role of counselors in addressing those issues, the benefit of counseling services, and potential challenges for enhanced mental health services. The results therefore present the key findings of the qualitative and quantitative study in what follows:

Overview of presentation of study findings:

The final results of both qualitative and quantitative findings are presented in six main sections keeping specific objectives of the study in mind.

Section 1: The objective of section one is to present the selected sample of socio-demographic profiles of respondents in qualitative study and of the sample of the quantitative survey from the local government division. Gender, age, religion, marital status, educational level, profession, income and habitat are described.

Section 2: The objective of section two is to explore mental health situation of the sample, their health seeking behavior, stigma related to help seeking behavior and their awareness and attitude towards psycho-social difficulties.

Section 3: The focus of section three is on describing the available mental health services provided towards the needs of the psycho-social difficulties.

Section 4: The objective of section four is to illustrate the gap between the mental health service required and provided.

Section 5: The objective of section five is to look at the need for professional counselors further by describing the existing status of available counseling services among the survey respondents. For this purpose, the quantitative survey data related to help-seeking behavior of respondents are analyzed. Frequency of help-seeking behavior from the available counselors, the number of session(s) availed and the mode of counseling received has been reported.

Section 6: The objective of section six is to focus on the role of professional counselors in existing service delivery system. In this connection, firstly the scope and standard of service, including referral pathways among mental health professionals are delineated from qualitative data. The role of counselors is also explored by looking into the perceived benefits of the recipients from counseling services among the survey respondents. Focus is given to explore the experience of counseling services in terms of expectation, satisfaction and concern from the side of recipients among the survey respondents. It also focuses on identifying the gaps and areas of improvement to play the role of professional counselor efficiently.

Section 3.1 Selected sample characteristics of qualitative and quantitative research

A brief description of the personal and demographic profiles of the study respondents of qualitative and quantitative measurement is given in details.

For qualitative part, a total of 30 respondents volunteered in the present study. Among them 29 are from Dhaka division and 1 from Rajshahi division. The gender distribution of the sample is 9 male and 21 female; 15 respondents are of aged between 25-40 years, and rest of them are of 41-65 years old; 8 respondents from Public Institutions while 21 from Private Organizations. The marital status of the study respondents is: all are married, and their educational level is Master Degree and above. Most of the respondents (29) in qualitative part are employed while only 1 respondent is housewife.

Table 3.1.1

Personal and Demographic Information of the Respondents by Geographical Location from the Quantitative Survey (n = 982)

			Division		
		Sample	Dhaka	Rajshahi	Chittagong
Variables	Attributes	% (n)	% (n)	% (n)	% (n)
Total		100 (982)	40.4 (397)	30.7 (301)	28.9 (284)
Gender	Male	51.7 (509)	39.9 (203)	30.3 (154)	29.9 (152)
	Female	48.3 (475)	41.1 (195)	31.0 (147)	27.8 (132)
Age	18-28	67.3 (662)	35.6 (236)	34.0 (225)	30.4 (201)
	29-39	21.3 (210)	50.0 (105)	22.9 (48)	20.0 (57)
	40-100	11.4 (112)	50.9 (57)	25.0 (28)	24.1(27)
Institution	Public university	41.9 (412)	28.4 (117)	45.4 (187)	26.2 (108)
	Private university	16.8 (165)	17.0 (28)	35.8 (59)	47.3 (78)
	Medical college hospital	33.6 (331)	53.5 (177)	16.6 (55)	29.9 (99)
	Drug rehabilitation centre	3.9 (38)	100.0 (38)	0.0 (0)	0.0 (0)
	NGO	3.9 (38)	100.0 (38)	0.0 (0)	0.0 (0)
Marital status	Married	39.8 (392)	45.9 (180)	25.5 (100)	28.6 (112)
	Unmarried	56.7(558)	35.8 (200)	33.9 (189)	30.3 (169)
	Single	3.5 (34)	52.9 (18)	35.3 (12)	11.8 (4)
Education	Illiterate	4.1 (40)	60.0 (24)	22.5 (9)	17.5 (7)
	Primary to HSC	20.0 (197)	53.8 (106)	30.5 (60)	15.7 (31)
	Bachelor and above	75.9 (747)	35.9 (268)	31.1(232)	33.1 (247)
Profession	Unemployed & housewife	17.3 (170)	56.5 (96)	20.6 (35)	25.9 (39)
	Students	49.8 (490)	30.8 (151)	37.6 (184)	31.6 (155)
	Employed and business	29.2 (287)	45.6 (131)	24.4 (70)	30.0 (86)
	Others	3.8 (37)	54.1(20)	32.4 (12)	13.5 (5)
Income (BDT)	<5000	37.9 (353)	36.8 (130)	17.6 (62)	45.6 (161)
	5001-10000	18.8 (175)	23.4 (41)	50.3 (88)	26.3 (46)
	10001-20000	22.1 (206)	43.7 (90)	33.5 (69)	22.8 (47)
	>20000	21.2 (198)	62.1 (123)	22.7 (45)	15.2 (30)

The personal and demographic characteristics of the respondents of quantitative survey by their geographical locations and gender are coded into category (see Appendix J: code 001 Codebook for detailed coding of the socio-economic and demographic variables). As the figures

of Table 3.1.1 indicates, Dhaka is the location of the highest number of respondents (40.4%) followed by Rajshahi (30.7%) and Chittagong (28.9%). The gender distribution of the survey respondents is close to equal with male (51.7%) being slightly higher than female (48.3%). The gender distribution of the respondents across the three divisions is parallel to the total distribution. Most of them are from public universities (41.9%), one third from medical college hospitals (33.6%), while a few are from private universities and other organizations. Most of the respondents (67.3%) are of age group 18-28 years. Respondents from NGOs and drug rehabilitation centers of Rajshahi and Chittagong have not been covered due to the non-compliance of those institutions. More than half of the respondents are unmarried (56.7%); (75.9 %) of them have completed Bachelor's Degrees and above.

Checking professional backgrounds, consistent with university participation, almost half (49.8%) of the respondents are students, slightly more than a quarter (29.2%) has employment. While around (37.9%) of the total respondents have an income of less than 5000 taka, the other (21.1%) have a monthly income of more than 20,000 taka; another (22.1%) draw monthly earnings of 10-20,000 taka.

Table 3.1.2

Personal and Demographic Information of the Respondents by Gender (n = 982)

Variables	Attributes	Sample	Gender	
			Male	Female
		% (n)	% (n)	% (n)
Total		100 (982)	51.7 (509)	48.3 (475)
Age	18-28	67.3 (662)	54.1 (358)	45.9 (304)
	29-39	21.3 (210)	45.7 (96)	54.3 (114)
	40-100	11.4 (112)	49.1 (55)	50.9 (57)
Institution	Public university	41.9 (412)	51.7 (213)	48.3 (199)
	Private university	16.8 (165)	67.9 (112)	32.1 (53)
	Medical college hospital	33.6 (331)	40.8 (135)	59.2 (196)
	Drug rehabilitation center	3.9 (38)	100.0 (38)	0.0
	NGO	3.9 (38)	28.9 (11)	71.1 (27)
Marital status	Married	39.8 (392)	37.2 (146)	62.8 (246)
	Unmarried	56.7 (558)	62.5 (349)	37.5 (209)
	Single	3.5 (34)	41.2 (14)	58.8 (20)
Education	Illiterate	4.1 (40)	37.5 (15)	62.5 (25)
	Primary to HSC	20.0 (197)	41.1 (81)	58.9 (116)
	Bachelor and above	75.9 (747)	55.3 (413)	44.7 (334)
Profession	Unemployed and house wife	17.3 (170)	20.0 (34)	80.0 (136)
	Students	49.8 (490)	56.3 (276)	43.7 (214)
	Employed and Business	29.2 (287)	61.3 (176)	38.7 (111)
	Others	3.8 (37)	62.2 (23)	37.8 (14)
Income (BDT)	<5000	37.9 (353)	47.9 (169)	52.1 (184)
	5001-10000	18.8 (175)	48.9 (86)	51.1 (90)
	10001-20000	22.1 (206)	60.9 (126)	39.1 (81)
	>20000	21.2 (198)	51.5 (102)	48.5 (96)

It appears from the Table 3.1.2 that majority (67.3%) of the respondents were in the age range of 18-28 years. Furthermore, (54.1%) are male and (48.3%) female. The respondents of the public university were distributed almost equally by gender: male (51.7%) and female (48.3%). The marital status of the respondents corresponds (56.7%) are unmarried whereas (39.8%) are married, and (3.5%) are single (divorced, separated, widow, widower). As per educational level among the total respondents, majority (75.9%) have bachelor degree and above, among whom male (55.3%), female (44.7%).

3.2 Existing mental health status of the people in Bangladesh

Presence of psychological problems among survey respondents is explored during the study. Respondents report the sorts of psycho-social difficulties they have been facing in their lives, especially in recent times.

Table 3.2.1

Psycho-Social Problems among Survey Respondents by Gender (n = 982)

Problem faced	Sample	Gender		χ2
		Male	Female	
	% (n)	% (n)	% (n)	
Depression	69.5 (672)	53.1 (357)	46.9 (315)	3.12
Anxiety	66.8 (633)	52.4 (332)	47.6 (301)	.44
Study related	64.5 (615)	55.9 (344)	44.1 (271)	9.13**
Anger	61.7 (588)	55.8 (328)	44.2 (260)	10.62**
Personal stress	58.0 (551)	50.1 (276)	49.9 (275)	1.33
Pain of loss	54.8 (529)	49.9 (264)	50.1 (265)	1.19
Fear	54.1 (520)	47.9 (249)	52.1 (271)	5.78*
Low self esteem	46.9 (443)	52.4 (232)	47.6 (211)	0.33
Quarrel	42.1 (407)	52.1 (212)	47.9 (195)	0.05
Romantic relationship	31.8 (297)	58.9 (175)	41.1 (122)	10.60**
Phobia	28.3 (264)	49.6 (131)	50.4 (133)	0.65
Trauma	28.0(258)	50.8(131)	49.2(127)	0.09
Appearance	25.0 (235)	50.6 (119)	49.4 (116)	.04
Self harm	24.6 (234)	57.3 (134)	42.7 (100)	3.80
Suicidal ideation	19.8 (190)	47.4 (90)	52.6 (100)	1.59
Physical abuse	19.2 (184)	56.0 (103)	44.0 (81)	1.61
Child rearing	18.8 (165)	32.1 (53)	67.9 (112)	26.82
Eating too much	17.6 (169)	58.6 (99)	41.4 (70)	3.99*
Substance addiction	12.2 (118)	85.6 (101)	14.4 (17)	62.17**
Physical disability	12.1 (114)	52.6 (60)	47.4 (54)	.07
Sexual abuse	10.1 (96)	37.5 (36)	62.5 (60)	7.80**

$^{**}p < .01$, $^{*}p < .05$

Table 3.2.1 shows that among respondents depression (69.5%), anxiety (66.8%), study-related issues (64.5%), anger (61.7%), personal stress (58.0%), pain of loss (54.8%), fear

(54.1%), low self esteem (46.9%), quarrel (42.1%), romantic relationship (31.8%), phobia (28.3%), trauma (28.0%), appearance (25.0%), self harm (24.6%), suicidal ideation (19.8%), physical abuse (19.2%), childrearing (18.8%), eating too much (17.6%), substance abuse (22.2%), physical disability (12.1%), sexual abuse (10.1%). However, education and study-related issues male (55.9%) female (44.1%) and anger male (55.8%), female (44.2%) are significantly over-reported by male respondents, while fear male (47.9%) female (52.1%) is more pronounced in female respondents. Similarly, conflict in romantic relationships male (58.9%) female (41.1%), overeating male (58.6%) female (41.4%) and substance abuse male (85.6%) female (14.6%), are more prevalent among males, while sexual abuse male (37.5%) female (62.5%) is significantly higher for females.

The results of psycho-social problems by geographical locations are presented in Table 3.2.2. The incidence of suicidal ideation and attempt among the respondents in last six months is also checked which is presented in Table 3.2.3 to 3.2.4 by gender and geographical location (See Appendix J: Codebook, code number 001 and 002 for detail coding instruction).

Table 3.2.2

Psycho-Social Problems among Survey Respondents by Geographical Location (n=982)

Problem faced	Sample	Division			χ2
		Dhaka	Rajshahi	Chittagong	
	% (n)	% (n)	% (n)	% (n)	
Depression	69.5(672)	45.2 (304)	29.2 (196)	25.6 (172)	23.18*
Anxiety	66.8 (633)	47.1 (298)	26.2 (166)	26.67(169)	28.23*
Study related	64.5 (615)	39.7 (244)	29.4 (181)	30.9 (190)	2.15
Anger	61.7 (588)	45.7 (269)	25.9 (152)	28.4 (167)	16.68*
Personal stress	58.0 (551)	47.7 (263)	27.2 (150)	25.0 (138)	20.73*
Pain of loss	54.8 (529)	45.0 (238)	28.9 (153)	26.1 (138)	10.27
Fear	54.1 (520)	41.5 (216)	31.0 (161)	27.5 (143)	1.34
Low self esteem	46.9 (443)	51.0 (226)	24.6 (109)	24.4 (108)	33.15*
Quarrel	42.1 (407)	57.0 (232)	20.4 (83)	22.6 (92)	77.32*
Romantic relationship	31.8 (297)	52.5 (156)	25.9 (77)	21.5 (64)	26.26*
Phobia	28.3 (264)	50.0 (132)	23.5 (62)	26.5 (70)	13.43*
Trauma	28.0 (258)	51.9 (134)	31.4 (81)	16.7 (43)	29.43*
Appearance	25.0 (235)	45.1 (106)	34.7 (58)	30.2 (71)	4.56
Self harm	24.6 (234)	49.1 (115)	29.1 (68)	21.8 (51)	10.41*
Suicidal ideation	19.8 (190)	56.8 (108)	22.6 (43)	20.6 (39)	24.90*
Physical abuse	19.2 (184)	52.2 (96)	23.4 (43)	24.5 (45)	11.86*
Child rearing	18.8 (165)	50.3 (83)	25.5 (42)	24.2 (40)	9.47
Eating too much	17.6 (169)	39.6 (61)	33.1 (56)	27.2 (46)	.85
Substance addiction	12.2 (118)	56.8 (67)	26.3 (31)	16.9 (20)	16.32*
Physical disability	12.1 (114)	42.1 (48)	37.7 (43)	20.2 (23)	6.18
Sexual abuse	10.1 (96)	61.5 (59)	24.0 (23)	14.6 (14)	19.79*

.*$p<.01$, ** $p<.05$

Exploring psycho-social problems by respondents' geographical location reveals that almost half of reported problems come from Dhaka division. The proportion of respondents with problems is significantly higher in Dhaka division than in both Rajshahi and Chittagong divisions (Table 3.2.2).

Respondents have also been asked to report whether they had any suicidal ideation and attempted suicide (See Appendix J: Codebook, code number 003 for coding instruction). Twelve

percent of the total respondents reported that they had had suicidal thoughts in the past six months prior to responding to the survey. Fifty-four respondents (5.5% of the total) had attempted suicide. Both suicidal thoughts male (54.2%) female (45.8%) and suicidal attempts male (53.7%) female (46.3%) did not differ significantly by gender. Further analysis reveals that most of the respondents who reported to have had suicidal ideation and/or attempted suicide in last six months were single and unemployed. Majority of them have completed Master Degree.

Table 3.2.3

Experience of Suicidal Thought and Attempt in Last 6 Months by Gender (n=979)

Incidence	Sample	Gender		$\chi 2$
		Male	Female	
	% (n)	% (n)	% (n)	
Suicidal thoughts	12.1 (118)	54.2 (64)	45.8 (54)	1.24
Suicidal attempts	5.5 (54)	53.7 (29)	46.3 (25)	1.78

Table 3.2.4

Experience of Suicidal Thought and Attempt in last 6 Months by Division (n=979)

Incidence	Sample	Division			$\chi 2$
		Dhaka	Rajshahi	Chittagong	
	% (n)	% (n)	% (n)	% (n)	
Suicidal thoughts	12.1 (118)	61.0 (72)	22.0 (26)	16.9 (20)	38.18
Suicidal attempts	5.5 (54)	74.1 (40)	11.1 (6)	14.8 (8)	53.07

.*$p<.01$*

In terms of geographical location, Dhaka is again the zone from which most of the respondents report suicidal ideation and attempts (Table 3.2.4).

a) Awareness of seeking mental health service among common people

Further focus of this section of the study is to explore survey respondents' awareness of help-seeking for mental health issues in general. In order to meet this goal, respondents' nature of help-seeking for mental health problems and the area in which mental health treatment has been sought are recorded. Any family history of mental health treatment has been noted also. The results are presented in Table 3.2.5 to Table 3.2.6 by gender and geographical locations (See Appendix J: Codebook, code number 004 for coding instruction).

Table 3.2.5

General Help-Seeking Strategies for Mental Health Difficulties by Gender (n = 932)

General help seeking behavior	Sample	Gender		$\chi2$
		Male	Female	
	% (n)	% (n)	% (n)	
Don't talk about it	23.3 (229)	59.4 (136)	40.6 (93)	7.01*
Talk with family members	43.1 (423)	43.3 (183)	56.7 (240)	21.34*
Go to a psychiatrist	13.2 (130)	50.0 (65)	50.0 (65)	0.18
Go to a medical doctor	4.4 (43)	51.2 (22)	48.8 (21)	0.006
Go to a counselor psychotherapist, social worker, psychologist	19.6 (192)	52.1 (100)	47.9 (92)	0.015
Talk to friends	33.1 (325)	60.3 (196)	39.7 (129)	14.14*
Go to religious leader	5.1 (50)	74.0 (37)	26.0 (13)	10.46*
Go to Kabiraj (Traditional healer)	4.7 (46)	50.0 (23)	50.0 (23)	0.058

.**p*<.01*

Table 3.2.6

General Help Seeking Strategies for Mental Health Difficulties by Geographical Location (n=932)

General help seeking behavior	Sample	Division			$\chi 2$
		Dhaka	Rajshahi	Chittagong	
	% (n)	% (n)	% (n)	% (n)	
Don't talk about it	23.3 (229)	37.1 (85)	29.3 (67)	33.6 (77)	3.17
Talk with family members	43.1 (423)	35.7 (151)	34.8 (147)	29.6 (125)	8.87*
Go to a psychiatrist	13.2 (130)	86.9 (113)	10.8 (14)	2.3 (3)	135.47*
Go to a medical doctor	4.4 (43)	51.2 (22)	32.6 (14)	16.3 (7)	3.83
Go to a counselor psychotherapist, social worker, psychologist	19.6 (192)	80.7 (155)	13.0 (25)	6.2 (12)	162.21**
Talk to friends	33.1 (325)	34.8 (113)	31.7 (103)	33.5 (109)	7.80*
Go to religious leader	5.1 (50)	52.0 (26)	20.0 (10)	28.0 (14)	3.61
Go to Kabiraj (Traditional healer)	4.7 (46)	78.3 (36)	13.0 (6)	8.7 (4)	28.62**

.*$p<.05$,$p<.001$

Majority of the respondents say they talk with either family members (43.1%) or friends (33.1%). Approximately one quarter of the respondents say that they remain silent and do not talk about the problem they are facing, while only (20.0%) says they consult a mental health professional. In addition, around (10%) says that they usually go to traditional healers (e.g., a religious leader and Kabiraj) for their mental health issues (Table 3.2.5). However, male and female respondents differ significantly when seeking help for mental health issues. For example, males indicate they prefer to consult with friends regarding their mental health issues (60.3%), whereas females say they tend to share their issues with family members (56.7%) (See Appendix J: Codebook, code number 004 for coding instruction). Table 3.2.6 shows that Dhaka is the division where people seek more psychological/ counseling help compared to other divisions.

Table 3.2.7

History of Mental Health Treatment by Gender

Status of Mental health treatment	Attribute	Sample % (n)	Gender		χ2
			Male % (n)	Female % (n)	
Mental health treatment received	Never	72.7 (712)	52.9 (377)	47.1 (335)	2.79
	Received in last 6 months	16.9 (166)	51.8 (86)	48.2 (80)	
	Other	10.4 (57)	44.1 (45)	55.9 (57)	
Family member received mental treatment	Never	80.6 (779)	52.6 (410)	47.4 (369)	1.04
	Received in last 6 months	7.9 (76)	50.0 (38)	50.0 (38)	
	Currently receiving	11.5 (111)	47.7 (53)	52.3 (58)	

History of availing mental health treatment by gender and geographical locations are presented in Table 3.2.7 and Table 3.2.8. Although most of the respondents have experienced psycho-social problems to some extent, only 16.9% of the total respondents reported accessing mental health treatment in the last six months (Table 3.2.7). More than two-thirds of them never received any treatment for their mental health issues. A few others reported having had other treatments (10.4%). There is no gender difference in receiving mental health treatment.

In addition to respondents' own mental issues, (11.5%) of the total respondents stated that their family members are currently receiving mental health treatment, while a few (7.9%) say their family members have received such treatment in the last six months (Table 3.2.7). Again, there is no gender difference in receiving mental health treatment for family members.

While there is a gender difference in the history of respondents' mental health treatment, as well as that are received by their family members, the figures in the Table 3.2.8 show

significant differences in the proportion of respondents report receiving mental health treatment across the three geographical locations with Dhaka being the highest.

Table 3.2.8

History of Mental Health Treatment by Geographical Locations

Status of Mental health treatment	Attribute	Sample	Division			$\chi2$
			Dhaka	Rajshahi	Chittagong	
		% (n)	% (n)	% (n)	% (n)	
Mental health treatment received	Never	72.6 (710)	24.8 (176)	38.0 (270)	38.0 (270)	
	Received in last 6 months	16.9 (166)	86.7 (144)	10.2 (17)	3.0 (5)	275.84*
	Other	10.4 (102)	75.5 (77)	17.6 (18)	6.9 (7)	
Family member received mental treatment	Never	80.7 (778)	35.7 (278)	31.5 (245)	32.8 (255)	
	Received in last 6 months	7.9 (76)	47.4 (36)	32.9 (25)	19.7 (15)	51.374*
	Other	11.4 (110)	70.0 (77)	17.3 (19)	12.7 (14)	

*$p<.0001$

Perception of Mental health facilities in Bangladesh among the survey respondents is also explored and presented in Table 3.2.9.

More than sixty percent of the respondents disagrees with the statement that there are enough counseling services in Bangladesh (See Appendix J: Codebook, code number 013 for coding instruction). 70% of them agree that people hesitate to seek counseling and more than half of the total respondents believe that people are unaware of counseling services, though slightly more than (51.5%) agrees that they themselves are aware of the counseling service (Table 3.2.9).

Table 3.2.9

Male and Female Perception Regarding Mental Health Facilities in Bangladesh

Perception	Valid Cases[Total n (%)	Level of agreement	Sample	Gender		χ2
				Male	Female	
			% (n)	% (n)	% (n)	
Enough counseling centre in Bangladesh	741 (75.3%)	Completely disagree	11.1(82)	56.1 (46)	43.9 (36)	6.42
		Disagree	49.5(367)	54.2 (199)	45.8 (168)	
		Completely agree	17.0 (126)	54.0 (68)	46.0 (58)	
		Don't know	22.4 (166)	43.4 (72)	56.6 (94)	
People hesitate to seek counseling	739 (75.1%)	Completely disagree	4.2 (31)	41.9 (13)	58.1 (18)	2.60
		Disagree	14.9 (110)	49.1 (54)	50.9 (56)	
		Completely agree	70.8 (523)	53.5 (280)	46.5 (243)	
		Don't know	10.1 (75)	48.0 (36)	52.0 (39)	
People are aware of counseling services	740 (75.2%)	Completely disagree	23.0 (170)	58.2 (99)	41.8 (71)	12.49*
		Disagree	53.5 (396)	53.8 (213)	46.2 (183)	
		Completely agree	12.6 (93)	47.3 (44)	52.7 (49)	
		Don't know	10.9 (81)	35.8 (29)	64.2 (52)	
I am aware of counseling services	738 (75.0%)	Completely disagree	5.6 (41)	61.0 (25)	39.0 (16)	6.20
		Disagree	15.0 (111)	59.6 (66)	40.5 (45)	
		Completely agree	51.5 (380)	52.1 (198)	47.9 (182)	
		Don't know	27.9 (206)	46.6 (96)	43.4 (110)	

.*p<.01,*

Stigma about Mental Health

Qualitative findings related to help seeking behavior is in the same line as quantitative findings. Ten respondents agree that people are much more aware than fifteen years ago, but still there are *"Some clients who come to me incognito."* According to them, *"If the family knows I*

am going to a counselor, they will think I am crazy," or, *"If people know I came to a counselor I won't be able to get married."*

Individuals with higher socio-economic status and living in Dhaka

People of upper and middle class are aware of counseling and psychotherapy far more than ten years ago due to the media, radio and television. They come to counselors or make referrals to counselors. Comparing to the rural areas, people in Dhaka are more aware. *"Many people from other districts have come to learn about counseling but they can't find service close to their hometown,"* say college teacher from FGD.

Reluctance in receiving counseling services

There are people in the lower economic classes, especially in NGO settings, often people say, *"What would you do after listening to my suffering? Would you provide me with two meals?"* Where basic needs are not met, counseling is not valued at present, say FGD respondents working in NGO setting.

Change of attitude

People are preoccupied with *what others will think* if they go to a counselor, comment all the respondents from FGD and interviews. *"To some extent it is noticeable that people now are getting over the stigma of seeking counseling compared to ten years ago,"* says a professor of counseling psychology in FGD. Now people search for counselors. In the beginning people used to be ashamed, thinking that they were mentally ill. However, a housewife from FGD says, *"I am ashamed to share my teen age daughter cut her arms for long time."*

3.3 Explore the extent of mental health services provided in Bangladesh

Availability, initiation, number of counselors/psychotherapists and recipient of counseling services, gathered from documentation and online resources are presented in this section, followed by FGD/KII findings with regards to the need of professional counselors' service.

Table: 3.3.1

Available Mental Health Services in Different Parts of Bangladesh

Number of Service Centers	Name of Services
2	Government Hospital (Pabna and Dhaka)
50	Psychiatric Units in Public Hospitals (Bangladesh)
24	Child Development Centers (Bangladesh)
10	Private Hospital and Clinic (Dhaka)
16	Organizations Providing Counseling (Dhaka)
4	Tele Counseling Providers (Dhaka)
8	Private Universities (Dhaka)
2	Public Universities (Dhaka)

There are only two mental hospitals run by the government, and in the other fifty government hospitals there are separate psychiatric units. This indicates a negligible accessibility to mental health in a country of 16 million people. Moreover, the available services are primarily based on medical model. Only one clinical psychologist is providing psychotherapy in the National Institute of Mental Health, one clinical psychologist in another medical hospital, a social worker is providing psychotherapy in an autonomous hospital. There have been 31 posts created for clinical psychologists but the appointments are not yet given. Most of the psychiatric units lack the presence of clinical and counseling psychologists whereas in several private clinics/hospitals psychiatrists and counselors are working as a team. There are 22 Child Development Center (CDC) in the country, among which 15 centers are run by the government

and 7 are private. There are 10 private clinics providing mental health support only in Dhaka; private clinics out of Dhaka are not covered. A total of 16 Organizations are providing counseling in Dhaka with counselors who have professional knowledge and skills. There are other organizations where counseling services are being provided, but they have not been considered due to the lack of academic background and professional skills of the service providers. There are other entities providing counseling services: Four organizations provide Tele-counseling in Dhaka, eight private universities, and two public universities have counseling centers.

Considering the timeline of initiation of counseling services, it is also evident that such services are in its budding state. Documentation shows that though counseling services have been started at Counseling and Guidance Center of a Public University in 1963, actual impetus however, started with the emergence of clinical psychology in 1996. Shortly after, in 1997, a legal aid organization started its psycho-social wing to help the children and women of domestic violence and divorced women to cope with their stress. This legal Aid organization also stopped their services in December 2016. In a tertiary hospital the Psychotherapy Unit began in 1999; later the Educational and Counseling Psychology Department has been established in 2009 in a public university. Subsequently, recruitment of counselors in different, schools, colleges, universities and organizations has been made though on a small scale.

With regard *to* the qualification of counselors or psychotherapists, only two departments run two years regular postgraduate program for psychology graduates. While another medical institute offer 6 months course and an NGO provides one year diploma, for those already working in mental health field. However, this NGO quit their training program. The number of existing trained counselors /psychotherapists till date (Nov 2016) is as in Table 3.3.2.

Table 3.3.2

Number of Trainees Got Degrees in Applied Psychology until November 2016

	MS	MPhil	Training	Total
Educational & Counseling Psychology	164	5	-	169
Clinical Psychology/	146	49	-	195
Psychotherapist (6 month)	-	-	313	313
Psycho-social Counselor (1 year)	-	-	52	52

It is also apparent that the number of trained counselors/psychotherapists is very few in number as compared to the demand. It is noteworthy that all the degree holders are not in clinical practice. It is to be noted that the information on social workers is not covered.

3.4 Gap between services required and service provided

Focus Group Discussion (FGD) findings reveal further parallel data central to mental health in Bangladesh. Major themes of the content analysis are given below:

a) Services are limited only to Dhaka:

According to study respondents of key informants and FGD, mental health services are only Dhaka-based, whereas a large number of people live in villages and remote areas. *"There is huge possibility to work out of Dhaka, but no professional wants to go there. It is a pity,"* says a counselor.

"At times counselors receive phone calls from other districts such as Chittagong, Dinajpur, Khulna, and like this but we cannot find any of our colleagues to refer the callers to those districts"- emphasis is added.

One of the respondents from FDG says,

"As far as I know, there is only one counselor providing this service in Rajshahi and one in Chittagong. I am not aware of other districts having counselors. Also, it is not possible for clients to come to Dhaka once a week for several weeks to get counseling services.

Another FGD respondent shares with sadness:

What I feel bad about is that there is no counselor outside Dhaka. This is an immense problem. Psychiatrists go outside of Dhaka for one or two days to see patients; then they return. Mental health in other districts is really being neglected. At least some psychiatrists go out of the capital city for a day or two, but counselors and psychotherapists do not go out of town. We need to find a way to cover other districts."

From the documentation, it is also noticeable that the counseling/psychotherapy services are primarily Dhaka-based.

b) Non-existence in rural area:

In all FGDs, one common concern is regarding the existing imbalance between rural areas and the capital city in terms of familiarity and seeking mental health treatment. One of the FGD respondents commented,

"In rural areas, the women are still not aware of their mental health, and at times, due to social stigma and religious taboos, they do not even seek help."

c) Limited qualified service providers:

More than half of the study respondents from FGD are of the opinion that the training of counselors working in the field is not adequate. A psycho-social counselor says, "*Mostly*

counselors working in the field are not trained or only received short training. A limited number of trained professional counselors/psychotherapists are available."

d) Lack of Professional Way of Dealing with the Issues Related to Counseling

(i) Lack of clarity about qualification of counselors: Most of the KII respondents as well as respondents in FGDs stressed the fact that to be a professional counselor, a person must have basic degree *in Psychology;* preference for postgraduate degree in *Counseling Psychology* is also added. Further emphasis on skills is also given.

> *"The professional counselor must have theoretical knowledge, academic study and have a sensitive, empathetic and compassionate mind,"* says a respondent from FGD.

Whereas two responding psychotherapists believes that, "*Any masters degree holder from a Social Science background, or a medical graduate, can get psychotherapy training"…., "but it is true though that the preference is for students who have a psychology background"* adds a senior psychotherapy trainer. It is believed that "*counselors must have knowledge in abnormal psychology since it is utmost vital for a counselor to know when he/she must refer the patient to a psychiatrist or another specialized professional",* emphasizes a professor from FGD.

On the other hand, three of interviewees say that *"it is not necessary to have a background in psychology in order to be a professional counselor"*. According to them, in other countries, "*people of any discipline can be entering into counseling professionals".* However, further probe reveals ignorance of standard training protocol.

e) ***Standard of counseling service delivery system*** described by the FGD respondents highlights some important considerations necessary for maintaining quality of counselors' role.

The issue of confidentiality is loosely maintained in some settings. Most interviewees and FGD respondents state maintaining confidentiality as one of the key pillars of developing professional relationship with counselor and client, which in turn facilitates changes. However, two interview respondents are skeptical about maintaining confidentiality and setting for counseling. One declares that,

> *"Bangladesh is a collectivist society. The counselee himself/herself would share with family members what is said in the session. In cases of villages and remote areas where people live in bamboo houses, it is impossible to guarantee confidentiality and arrange a separate room."*

Such concern is also echoed by a head of the tertiary hospital where psychotherapy is provided in the stairway, *"if the proper setting is not ensured, we should not stop providing service,"* She further adds, "*something is better than nothing"* (emphasis added).

However, in private practice, confidentiality is well practiced utters a private practitioner respondents. One respondent from the FGD says that some counselors are breaching the information. He further adds, *"In training I heard a person presenting his case with names, age, and everything. We should be careful to not disclose anything. We should still work on it."*

Lack of proper setting for counseling is another urgency being portrayed,

"*Due to the lack of a proper setting, the clients do not come back,*" says a KII. *As compared to adults drop out, there is a higher dropout rate for children, due to a lack of parental commitment to bringing them",* utters an educational psychologist. *"However when the children exhibit the issue again, they return. But, it is difficult to complete the session with such irregular*

participation. It is noticeable that there is no problem child; the problems are with the parents," adds by another respondent from FGD.

Regarding setting a KII says, *"In organizations, the setting could be arranged differently; such as, the counseling room can be isolated in a place where not many people have access, the room can be sound proofed to maintain confidentiality."*

High cost counseling session is also been identified as an issue that hinders to play their role of counselors professionally. A counselor says,

"There are other issues as well, such as financial problems and the distance from their home (emphasis added). People come from all over Bangladesh to Dhaka. It is quite difficult for them to come for sessions once a week or twice a month from far away. But on a brighter note, people leaving the counseling room feel happy". A psychiatrist from FDG also mentions that because of high counseling session fee he hesitates to refer for counseling (emphasis added).

Proper referral system and cooperative work among professionals as a team is yet to be established.

Several counselors agree that some psychiatrists do refer to counselors and vice versa when there is a need. One adds, "*…this is an encouraging sign of collaboration; however, there are situations where there is a lack of team approach. We are working each from our own perspective. If we could work together, it would be much better. I really miss this collaboration,"* says another counseling psychologist from FGD. "*There should be a boundary defining who does what. Everyone must learn to make referrals*," says an interviewee.

Lack of awareness on referring to right professional is another point that arises. In order to get proper assessment and treatment, one needs to go to the properly accredited and trained

professional. However, in terms of mental health issues, "*there is huge lack of awareness regarding referring to the right professional*," says an interviewee.

One of the child psychologists expresses concern over the fact that some of her colleagues, even well-known teachers, call her and ask for help for their children's stammering, mutism, speech problem or such other matters. She adds, "*Please tell me what to do. I teach Child Development Psychology, so I know the subject. If you just give me a hint about how to solve this problem, I can manage it."* It really saddens her because they are educated and still talk like this. They are not referring their child to the right professional. Concern for referral system is also being echoed by many others.

> *"I too get upset as psychiatrists do not refer patients to us counselors in a timely manner. A suicidal adolescent who is heartbroken due to his break up, with medicine can help to a certain extent, but that adolescent person needs to share her stories and pain for healing beside medicine,"* says a psycho-social counselor in FGD.

It is evident from a psycho-social counselor's words … *"When some clients come with a pathological problem, I right away refer them to a psychiatrist or other colleagues who deal with pathological diagnosis. I don't feel qualified to work with them at all.*"….that trained counselors are aware of ethical issue of referral.

Lack of proper documentation is another prime concern being noted from observation. The documentation in counseling service is loosely maintained except in some institutions. From the researchers' observation, patient files were hand-written, if at all, and kept out in the open. It is risky as if anybody wants can access.

Section 3.5 Need for professional counselors and their potential role

(i) Need of counseling is revealed by qualitative analysis. Most of the interviewees make a general comment about counseling need like this: *"Counseling is needed for both psychosis and neurosis in different institutions beginning from the families to schools, corporate office, organizations, garments, banks and prisons."*

"Adolescents are at risk and can pass through a difficult period. Therefore, a counseling service should be mandatory in school and college settings," says a school teacher in FGD. Further, parents need to have some guidance in positive parenting and teachers in positive discipline. In a nutshell, "*people at every stage of life need counseling"* is the general theme that came up from all three focus group discussions.

A couple of the FGD respondents further emphasize on the need of conducting workshops as their role to reach to as many people as possible.

> *"In organizational settings, different workshops are much needed, such as effective communication skills, confidence building, conflict management, anger and stress management, employer-employee relationships, career-building, personal happiness etc. Beside these, there is a huge need for trauma counseling as Bangladesh is a natural and manmade disaster-prone country."*

Specified areas of counseling service that are needed have also been identified by KIIs.

A psychotherapist interviewee says,

> "*Psychotherapy or counseling is needed in hospital settings from diabetic patients to psychotic patients, their caregivers, family members, preoperational stages for the patient and family members. Pregnant mothers need to learn everything from breast*

> *feeding to childrearing. Psychotic patients' families need to learn about their family members' illnesses and know how to behave with the patients. Some other areas such as prisons and forensic departments have no counselor or psychologist yet."*

Another KII comments,

> "*I don't know whether any expert career counselor exists. Industrial and career counseling are still missing. Moreover, in industries, such as the garments industry, the employees work long hours and need to learn how to enjoy their work, further how to be assertive in communication."*

(ii) Need for para-counselors:

The issue of para-counselors comes up as a need to reach to remote areas where professional counselors can't go. Para counselors are individuals equipped with fundamental counseling knowledge and skills. Few state that *"to become a para-counselor one can have just a high school degree, after which prospective candidates can study counseling-oriented courses.*"

One respondent from Key Informant Interviewee (KII) stresses that, "*In the villages there are lots of village doctors practicing medicine, but all those cannot be called real doctors. Likewise, people can come from a different academic background to practice counseling but all of them cannot be called professional counselors, but rather para-counselors (like paramedics), since for para-counseling, academic study and field of discipline can be less intensive."*

However, the majority of the respondents from FGD and KII do not agree with the para-counselor concept due to fear of increased mal-practice.

(iii) Scope and Quality of Work as revealed from qualitative FGD and KII are analyzed to underscore the role of professional counselor. Major themes of the content analysis are given below:

a) Multi-task involvement with no clear job definition:

Four respondents of FGD report that besides **individual counseling**, now the counseling need is more focused on **family and relationship problems**. Most counselors are involved in conducting **workshops** on different psycho-social issues, particularly in university settings. *"Such programs help to bring awareness to students, staff and faculties,"* says a university counselor from FGD.

Counselors, in addition, also undertake **research and curriculum development** work. It is also being said that research is important. Two NGO workers say, *"We work on developing instruments, check the scale validity and reliability in the context of Bangladesh. Besides that, we also prepare curriculum for frontline counseling training."* Moreover, that particular NGO is working on opening a Diploma and Master's program in Clinical Counseling. They are planning to offer a curriculum combining clinical psychology and counseling psychology. In addition, they are working on developing modules for Para-counselors.

The tasks of counselors are also extended to **prepare front-line counselors and outreach programs.** Two psycho-social counselors mention that alongside providing services in NGO setting, they prepare front line counselors. In one organization, as their staff, they go to different areas to stop child marriage, provide modules to train the fieldworkers, provide workshops on trauma management.

An important aspect to note is that several NGOs are engaged in **outreach programs** to raise awareness about counseling and provide counseling.

There are concerns from service provider's side as well due to multiple roles. The issue of confidentiality again can be violated if the counselor has multiple roles and work on a team, say two psycho-social counselors in FGD. It is particularly evident in organizational setting. However a respondent from an organization says,

> *At my work place, in a Human Rights Organization, other staff members also provide counseling. They sometimes break confidentiality because they provide counseling both to children and to their parents because staff counselors are supposed to report to their directors. Afterwards when some information is shared with parents about the children, children cannot trust the professional counselors.*

b) Status of availing professional counseling service delivery

In order to look into the need of counseling services, further help-seeking behavior of the survey respondents are being explored and presented in Table 3.5.1 to 3.5.2. (See Appendix J: Codebook, code number 006 for coding instruction)

Table 3.5.1

Frequency of Help-Seeking From Counselor and Gender Variation (N = 294)

Frequency of help-seeking from counselor	Sample	Gender		$\chi2$
		Male	Female	
	% (n)	% (n)	% (n)	
One time	26.1 (62)	67.7 (42)	32.3 (20)	9.58*
More than once	35.4 (84)	42.9 (36)	57.1 (48)	3.50
More than one counselor	13.5 (32)	65.6 (21)	34.4 (11)	3.14
Currently taking	48.9 (116)	48.3 (56)	51.7 (60)	0.71

.*$p<.01$*

(i) Help-seeking behavior of survey respondents is reported in Table 3.5.1. It has been observed that less than one third (294) out of total respondents at some point in their lives have received mental health counseling. Almost 50% of them reports of receiving counseling at the time of being surveyed, while 26.1% receives counseling only once. However, 13.5% of respondents reports having received counseling from multiple counselors. Gender difference on the frequency of help-seeking behavior from counselors is found for those who had received counseling only once, with males (67.7%) outnumbering females (32.3%).

Table 3.5.2

Frequency of Help-Seeking From Counselor by Geographical Location (N=294)

Frequency of help-seeking from counselor	Sample	Division			$\chi2$
		Dhaka	Rajshahi	Chittagong	
	% (n)	% (n)	% (n)	% (n)	
One time	26.1 (62)	58.1 (36)	17.7 (11)	24.2 (15)	26.88**
More than once	35.4 (84)	89.3 (75)	7.1 (6)	3.6 (3)	8.75*
More than one counselor	13.5 (32)	78.1 (25)	12.5 (4)	9.4 (3)	0.018
Currently taking	48.9 (116)	93.1 (108)	3.4 (4)	3.4 (4)	29.71*

*$p<.0001$, **$p<.01$

Table 3.5.2 reports help-seeking behavior by geographical location and that in Dhaka 58% receives counseling once, 89% receives more than once and 93% are currently getting counseling, which is significantly higher than the other study sites.

Table 3.5.3

Mode of Counseling being Received and Gender Variation (n=291)

Mode of counseling	Sample	Gender		$\chi2$
		Male	Female	
	% (n)	% (n)	% (n)	
Individual counseling	85.0 (198)	50.0 (99)	50.0 (99)	0.22
Group counseling	8.2 (19)	57.9 (11)	42.1 (8)	0.44
Some sort of training	3.0 (7)	42.9 (3)	57.1 (4)	0.178
Workshops	6.9 (16)	56.2 (9)	43.8 (7)	0.22
Psychiatrist help	21.9 (51)	43.1 (22)	56.9 (29)	1.47

(b) Mode of counseling received by gender and geographical locations are reported in Table 3.5.3 to 3.5.4. As can be seen from the figures of Table 3.5.3, 85% of respondents receive individual counseling. Approximately 40% of the total cases consult either a psychiatrist and/or a psychotherapist. There is no gender difference on the mode of counseling received.

Table 3.5.4

Mode of Counseling by Geographical Locations (n=291)

Mode of counseling	Sample Size	Division		
		Dhaka	Rajshahi	Chittagong
	% (n)	% (n)	% (n)	% (n)
Individual counseling	85.0 (198)	83.8 (166)	9.1 (18)	7.1 (14)
Group counseling	8.2 (19)	57.9 (11)	21.1 (4)	21.1 (4)
Some sort of training	3.0 (7)	85.7 (6)	14.3 (1)	0
Workshops	6.9 (16)	81.2 (13)	6.2 (1)	12.5 (2)
Psychiatrist	21.9 (51)	90.2 (46)	5.9 (3)	3.9 (2)

*$p<.001$, **$p<.05$

Mode of counseling by geographical location shows that significantly greater percentage in Dhaka received individual (83.8%) and group counseling (57.9%) as compared to other study sites.

(c) Next, benefits from counseling

The specific area in which counseling is perceived as having worked well for the recipient among the survey respondents is identified to explore the role of counselors and is presented in Table 3.5.5 and 3.5.6, according to gender and geographical location (See Appendix J: Codebook, code number 009 for coding instruction).

In relation to the benefits of counseling, 65.0% of respondents get counseling advice from mental health counselors (Table 3.5.5). Respondents indicated that they perceived a therapeutic benefit after attending counseling in terms of learning stress management techniques (58.5%); feeling understood as a result of a perception that the counselor empathized with their situation (45.3%); and having had the opportunity to be listened to (42.7%). However, there is a gender effect on the empathetic feeling with females reporting having significantly more empathy from counseling session than males.

Table 3.5.5

Specific Areas of Benefits from Counseling by Respondents' Gender (n=826)

Areas of benefits	Sample	Gender		$\chi 2$
		Male	Female	
	% (n)	% (n)	% (n)	
Counseling Advice	65.0 (152)	51.3 (78)	48.7 (74)	0.14
Self-harm prevention	26.5 (62)	48.4 (30)	51.6 (32)	0.14
Know about sickness	29.9 (70)	54.3 (38)	45.7 (32)	0.60
Somebody understood me	45.3 (106)	40.6 (43)	59.4 (63)	7.54**
Attentive in study and work	38.0 (89)	51.7 (46)	48.3 (43)	0.09
Learn stress management	58.5 (137)	47.4 (65)	52.6 (72)	1.18
Got medical prescription	18.4 (43)	39.5 (17)	60.5 (26)	2.50
Somebody listened to me	42.7 (100)	40.0 (40)	60.0 (60)	7.60**
Reduce the symptom	28.6 (67)	47.8 (32)	52.2 (35)	0.27

**$p< .01$

Table 3.5.6

Specific Areas of Benefits from Counseling by Respondents' Geographical Locations (n=826)

Areas of benefits	Sample	Division			$\chi 2$
		Dhaka	Rajshahi	Chittagong	
	% (n)	% (n)	% (n)	% (n)	
Counseling Advice	65.0 (152)	75.7 (115)	11.8 (18)	12.5 (19)	4.96
Self-harm prevention	26.5 (62)	80.6 (50)	12.9 (8)	6.5 (4)	0.94
Know about sickness	29.9 (70)	87.1 (61)	12.9 (9)	0	10.36*
Somebody understood me	45.3 (106)	86.8 (92)	8.5 (9)	4.7 (5)	7.55**
Attentive in study and work	38.0 (89)	77.3 (68)	14.8 (13)	7.9 (7)	1.57
Learn stress management	58.5 (137)	88.3 (121)	7.3 (10)	4.4 (6)	17.60*
Got medical prescription	18.4 (43)	76.7 (33)	18.6 (8)	4.7 (2)	3.56
Somebody listened to me	42.7 (100)	88.0 (88)	9.0 (9)	3.0 (3)	10.35**
Reduce the symptom	28.6 (67)	83.6 (56)	13.4 (9)	3.0 (2)	4.65

.*$p<.001$, ** $p<.05$

d) Explore the expectation, satisfaction and concerns about counseling services among users of counseling services are presented in Table 3.5.7 to Table 3.5.9.

Table 3.5.7

Expectations from Counseling by Gender (n=584)

Expectations from counseling	Sample	Gender		$\chi 2$
		Male	Female	
	% (n)	% (n)	% (n)	
Receiving advice	37.8 (88)	54.5 (48)	45.5 (40)	1.06
My problem will be solved	68.7 (160)	53.1 (85)	46.9 (75)	1.73
Self-understanding	44.6 (104)	42.3 (44)	57.7 (60)	4.70**
My pain will be reduced	54.5 (127)	46.5 (59)	53.5 (68)	1.58
My aim and goal will be clear	45.1 (105)	47.6 (50)	52.4 (55)	0.52

.*$p<.01$, **p<.05

Table 3.5.8

Satisfaction with Counseling Rating by Gender (n=231)

Experience with counseling	Sample	Gender		$\chi 2$
		Male	Female	
	% (n)	% (n)	% (n)	
Very satisfied	39.0 (90)	43.3 (39)	56.7 (51)	3.29
Satisfied	53.7 (124)	55.6 (69)	44.4 (55)	
Dissatisfied	3.5 (8)	50.0 (4)	50.0 (4)	
Very unsatisfied	3.9 (9)	44.4 (4)	55.6 (5)	

.*$p<.01$, **p<.05

From Table 3.5.7 shows that most of the respondents come with an expectation (See Appendix J: Codebook, code number 011 for coding instruction) that their problem will be solved (68.7%). They also expect that their pain will be reduced (54.5%), their aim and goal will be clear (45.1%) and they will understand themselves clearly (44.8%). On the other hand, (44.6%) reports that they can understand themselves. However, females feel more self understanding than males (χ^2=4.70, p<.05). In Table 3.5.8 appears that 39.0% recipients are very satisfied and 53.7% of them are satisfied with their counseling sessions.

Counseling User's Concern

Respondents not only receive benefits from counseling, some also have concerns about counseling (See Appendix J: Codebook, code number 010 for coding instruction). The major concern is confidentiality (28.8%) and privacy (27.9%). There are also concerns about the number of sessions, not having an effective relationship with the counselor, no improvement and the waiting time for an appointment (Table 3.5.9). Worry with counseling is reported significantly higher by males in case of confidentiality (χ^2=4.51, p<.05) and unchanged illness (χ^2 = 7.83, *p*< .01).

Table 3.5.9

Concerns Involved with Counseling by Gender (n=305)

Concerns	Sample	Gender		χ2
		Male	Female	
	% (n)	% (n)	% (n)	
Number of session	18.8 (43)	51.2 (22)	48.8 (21)	.00
Somebody will see me	27.9 (64)	46.9 (30)	53.1 (34)	.63
Not getting along with the counselor	14.0 (32)	40.6 (13)	59.4 (19)	1.63
Waiting for appointment	12.7 (29)	48.3 (14)	51.7 (15)	.11
No improvement of illness noticed	11.4 (26)	76.9 (20)	23.1 (6)	7.83*
Anxious of confidentiality	28.8 (66)	62.1 (41)	37.9 (25)	4.51**
Others	19.7 (45)	51.1 (23)	48.9 (22)	.00

.**p<.01*, **p<.05

Satisfaction of the counseling service providers

Three of the respondents from FGD who practices counseling state that they have high success rate in counseling which makes them very satisfied. They describe some of the indicators that confirm they are successful. These are:

> *First of all the clients continue their sessions, do the homework they are given, come to the sessions on time, refer other clients to come for sessions, write in the commentary book about their improvement and the changes in their life, complete their sessions and have follow up session once in a while.*

Two others from FGD comment that their success rate is about 50% in their hospital setting and private practices. When people follow several sessions, it indicates that they are receiving some benefits. *"I feel happy when I see them growing,"* says a psycho-social counselor who practices counseling with a diploma in counseling. *Sometimes clients refer clients which indicate they are satisfied with counseling* (emphasis added).

Gaps and areas of improvements of professional counselors

Analysis of qualitative data elicited by FGD and KII identify several central themes related to gaps and areas of improvement. These themes are stated below.

Lack of supervision

The trainee counselors only in two departments are to undergo supervised training. However, no supervised training is in practice in other institutions. A professor and counseling psychologist says,

> *"We too have learned from short trainings. Some teachers and trainers at times are supervised for Transactional Analysis via email. At times due to language barrier or other technical problems, we are unable to express ourselves properly to our respective trainers. However we have our supervisor come to Dhaka to supervise our cases."*

Similar concern is expressed also with regard to trainer's qualification. A professor from FGD expresses concern over providing training, *"The paradox is that we as professors, who are providing trainings, too learned counseling through attending short training courses over several years. We don't have certification as trainer as it is found in developed countries. We don't have the scope here. So, sometime we are also consulting professionals from abroad when we need their assistance."*

Continuing Professional Development

Along with academic qualifications, to be a professional counselor one needs to have sufficient training to keep them updated. As is stressed by one professor from (KII),

> *"In order to become a counselor, beside educational knowledge and skill, one must go through the counseling process for self development, to deal with personal issues; without personal development it is quite impossible to compartmentalize all the judgments which are necessary for counseling others."*
>
> *"Also there is risk for transference and counter transference,"* adds an interviewee.

As a synopsis, being a professional counselor means having an academic background, with extensive training in counseling skills, as well as affiliation with an institution, such as a hospital, school, or an NGO, where trainees can practice their skills under supervision. Later on, they should also be willing to get continuous supervision under Continuing Professional Development, and never cease to undergo up skilling training.

"Professional counselors must, therefore, be efficient and non-judgmental in their dealings with clients, in order to reach successful outcomes," says a child counselor from FGD.

Sense of inadequacy

Sense of inadequacy on the part of the counselors is another concern. Two professionals in FGD say that they feel they are not qualified enough to handle sexual issues including homosexuality. This has been growing as a burning issue warranting quick steps.

Concern with Educational Background

Another cause for concern is drug rehabilitation/ treatment centers. In most of those centers, there are counselors who have little or no training at all. Because they had been former drug addicts, they find themselves giving counseling out of their common sense. They use the term "counseling," but do not have any idea or training in it, says a member from FGD.

Apprehension of short-trained psychotherapist

"I am not sure whether those who get 'six months' or 'three months' psychotherapy training are qualified to handle clients," says a psycho-social counselor in FGD, *"I have often seen clients who went to a [so-called] psychotherapist, or to people who followed short training courses. Those clients were severely damaged emotionally after seeing the so-called 'counselors' and 'psychotherapists.'"*

Another respondent from FGD adds, *"It is scary, people take short training and opening private practice. A body is needed to control these activities."*

Chapter 4: Discussion

To understand the need for professional counselors, this thesis asks questions related to current mental health conditions of the sample, provision of support services, the need of the people for professional counselors and their roles, and subsequently identifying the gaps and ways to mitigating those gaps so that appropriate access to the services for psychological health may be provided. In order to have a sequential analysis and understanding of the findings, this chapter is comprised of the following structure: discussion of the result, recommendations, and conclusion.

Upon completion of survey data collection as reflected in the results, the gender distribution is almost equal with male (51.7%) and female (48.3%). The age distribution of the respondents indicates that the highest percentage (67.3%) of them is from the younger age domains (18-28), unmarried (56.7%), students (49.8%), and have income <5000 (37.9%).

The discussion examines the results answering the designated research questions (see chapter one).

4.1 Existing Mental Health Status of the people of Bangladesh

The results show that reported major psycho-social problem faced by the respondents are depression (69.5%), anxiety (66.8%), study related problem (64.5%), and anger issues (61.7%). Significant difference exists, that is, male being higher than female in the study related and anger issues. It might be due to high competition to come out of financial problem which is one of the causes for depression. Anger or irritability is another symptom of depression as well. Problem with romantic issues among male (58.9%) against female (41.1%), substance addiction among male (85.6%) against female (14.4%) suggest that male significantly higher comparing to

female, whereas women are victims of sexual abuse (62.5%) that is higher than male (37.5%). The recent findings of WHO demonstrates that currently Bangladesh has 6.4 million people suffering from depression and some of the symptoms of depression are anger, irritability, suicidal thoughts (WHO, 2017). Thus, the findings are in the same line of current research.

Psycho-social problems faced by respondents from different divisions represent that all of the problems are significantly higher in Dhaka division in comparison to Rajshahi and Chittagong. The reason could be due to higher concentration of the people, and higher level of internal migration toward the capital city which may imply more personal stresses. Other research has shown that there is a higher risk of mental disorder among persons living in urban versus rural areas (Galea, Uddin, & Koenen, 2011). Another factor could be that people come to Dhaka for treatment as mental health treatment is unequally provided in other divisions (see pg. 51, Table 3.3.1). Also qualitative research confirms that counseling is Dhaka based [(see section 3.4 (a)]. Both experiences of suicidal thoughts (54.2%) and attempts (53.7%) in last six months period was considerably visible among male comparing to female, and in Dhaka division has the highest suicidal thought (61%) and attempt (74.1%) without any significant difference with other divisions. This might entail that people in Dhaka (urban) might suffer from more psychological problem due to difficult life situation and challenges. Furthermore, during the period of data collection, the survey respondents were in Dhaka, the capital city of Bangladesh for their treatment. Research shows that mental health professionals are mostly located in urban areas (Lauber & Rössler, 2007).

The findings reveal that only one third (32.8%) of the respondents seek mental health treatment and the rest of the respondents either talk to family members, friends, keep silent or go to other healers like Kabiraj (traditional healers) or to religious leaders. In terms of geographical

location where people seek mental health profession is again Dhaka, the capital city of Bangladesh, remains on the top. The result shows that 86.9% respondents seek help from psychiatrist and 80.7% from counselor/psychotherapist, psychologists and social worker. This higher percentage might be due to availability and expertise of the psycho-social help in Dhaka, capital city, comparing to other two divisions. It appears that only 16.9% of the people seek mental health treatment in the last six months and the rest never seek help among the total sample. The other research shows that stigmatization and beliefs about causes, of and attitudes towards mental illness, consequences for help-seeking prevents people from heal seeking behaviour (Lauber & Rössler, 2007). As per geographical location, again Dhaka reports the significantly higher percentage in receiving mental health treatment in last six months either personally or other family members received help.

Related to the male and female perception of mental health facilities in Bangladesh, 70.8% respondents are of the opinion that people hesitate seeking mental health counseling. Qualitative findings related to help seeking behavior is in the same line as quantitative findings. People still hesitate in seeking mental health services even there is slight positive shift comparing to ten years back. Literature also shows that nearly two thirds of people with mental health problem never seek help (WHO, 2013), further lack of knowledge, stigma, discrimination, and neglect prevents from going to mental health professionals (Dhaka Tribune, 2014). More than half respondents (53.5%) think that people are unaware of counseling services, 82.5% in Dhaka and 78.6 % in Chittagong are of the opinion that there are not enough counseling centers. Slightly more than half (51.5%) know some information regarding counseling service. Respondents in qualitative research also are in of the opinion that people with higher socio-economic status and living in Dhaka are more aware of counseling due to media such as TV,

newspaper etc., and people with lower economic classes are unwilling to receive counseling as they lack basic needs. This reluctance for seeking help might be due to lack of health budget, and lack of awareness of counseling service. The recent research shows that 30% of the patients see a general practitioner with mental health issues before they see a mental health professional (Mentla Illness, Banglapedia, 2015).

4.2 To explore the extent of mental health services provided in Bangladesh

Results show that in a country of 164,226,577 people (March 9, 2017, based on the latest United Nations estimates) there are two government hospitals, fifty psychiatric units in government hospitals. Only one clinical psychologist is in service at a mental hospital, one psycho-social counselor in a private hospital, and another clinical psychologist in another hospital. This certainly indicates the negligibility of psychological health. There are other services like tele-counseling and several private counseling/psychotherapy centers available only in Dhaka, and very few, if any, are in the other divisions (unpublished office record and observation).

As per manpower, there are only about 210 psychiatrists and a total of 729 other mental health professionals including those with only six months psychotherapy training to Master degree holder in mental health profession (Unpublished documents and office record). This limited number of professionals can never provide adequate services to huge number of populations.

4.3 To ascertain the gap between services required and service provided

From qualitative analysis, it has been revealed that services are limited to Dhaka; in rural areas in other districts, mental health professionals are almost non-existent, especially counselors. If there are any, they are not sufficiently qualified. The counseling/psychotherapy providers in public hospitals are interns from counseling and clinical psychology institutions as part of their curriculum who have not completed their study yet. Thus, after their internship period, the hospital is in short of counseling/psychotherapy manpower (from observation). This is also negligence in giving quality services to meet mental health needs of the people in public hospitals.

In terms of setting for counselors/psychotherapy in public hospitals, it is noticeable that most of the times services are provided in common rooms where more than one counselor is present, or at times in open space as stairways (from observation). As a result the assurance of confidentiality is missing. This lack of privacy might hinder in not seeking counseling service as well or reason for discontinuing sessions (from qualitative data).

From qualitative analysis, it has been observed that other factors may play roles in limited help seeking behavior such as the expensive counseling session fee in private setting. People coming from outside of Dhaka has already a financial burden for coming to the city, the distance and weekly or bi-monthly sessions are not at times possible. Since counseling is a process, several sessions are needed to have a proper outcome.

Another factor is the collaboration among health professionals, general doctors, psychiatrists, psychotherapist/counselors are still to develop. At times mental health sufferers come to counselors after trying with other professionals. The Literature shows that people seek mental health services after consulting other professionals (Giasuddin et al., 2012). It also

happens that people do not have enough understanding of mental health problems and they go to doctors for any sort of illness. Literature review demonstrates the fact that patients go to mental health professional in average 2-2.5 weeks delay (Giasuddin et al., 2012).

4.4 To look at the need for professional counselors and their role in available counseling services

From qualitative analysis, it is evident that some of the emphases such as counseling is needed for all sorts of people from school settings to organizational settings to handle day to day problems to psychotic ailing individuals. Many of the psychological problems are not in need of psychiatric medicine but a counselor/psychotherapist can help managing conflict, anger, stress, relationship issues, etc. People need to know where and who to seek professional help. Prepared manpower is limited to meet the unmet need of the huge population. It has been suggested that para-counselors will be needed to work in field level for outreach programs so that they can at least provide primary care, and then refer to the professional counselors when needed.

The qualitative result further shows that at this moment most of the hired counselors are involved in multi-tasks with no clear job description, especially in NGO settings. At times the counselors are doing out-reach programs, developing curriculum for para-counselors. These tasks somewhat hinder counselors' from their proper role of providing counseling, keeping records, etc. The organizations need to focus on appropriate job description for counselors [(See 3.5 (a)].

As to the current service delivery, the survey on the frequency of help seeking from counselors shows that more than one third (294 out of 982) respondents at some point of their lives availed counseling services. The male (67.7%) are significantly higher in receiving

counseling outnumbering female (32.3%). Higher number of male might indicate that man are to be strong and tough, and need not show their vulnerability in public. For this reason they might feel comfortable in sharing in counseling session and not in family settings. Moreover, the difference between male and female might be due to female being more open in sharing their problems with their family members (43.3%) where they already solve their problems. Frequency of counseling seeking by geographical location, again Dhaka holds the top position. Counseling recipients are significantly higher: (58.1%) received at least one time, 89.3% received more than once, and 93.1 % are currently taking. As regards to mode of counseling, 85% are taking individual counseling, Dhaka itself having 83.8% recipients. This suggests that counseling recipients are satisfied with their individual sessions. The qualitative research also generates similar result where counselors report that clients are willing to continue coming to sessions which indicates satisfaction and their improvements. It has been noticeable that individual counseling is the main mode exceeding group counseling.

Table 3.5.5 shows that there is significant difference in counseling benefits between male and female. Female are more satisfied (59.4%) as they feel understood in contrast to male (40.6%), and that someone listened to them (60%) in contrast to male (40%). This difference may suggest that those women, who received counseling, are oppressed to express their needs and rights due to domestic violence. Going to counselors might be a way for their healing. Literature shows that 72% women never share about their husband’s torture with others (Prothom Alo, March 4, 2017). The secrecy of domestic violence may cause psycho-somatic disease or other form of diseases. Again the percentage in Dhaka division is significantly higher in females than males respectively feeling understood (86.8%) and listened to by someone

(88%). On the other hand male in Dhaka division are significantly higher in learning stress management (88.3%) than the female.

There are some concerns involved with counseling sessions as well. 76.9% of male are concerned that their illness might not improve, and further 62.1% are anxious about confidentiality. Also qualitative findings shows that in some of the public hospitals counseling/psychotherapy is given in open space which may be one of the factors for attrition from counseling/psychotherapy beside their financial burden.

4.5 Gaps and areas of improvements for professional counselors

Analysis from qualitative data reveals that there are some gaps from the part of counselors which need immediate attention for improvement. These are: once the counselors are trained, they seldom get supervision due to lack of supervisors. Continuing professional development is another area missing in recently budding counseling profession for up-skilling. The counselors feel inadequate in dealing with some of the psycho-sexual issues. Some of the counselor professionals are worried of the existence of counselors with short training or claiming to be counselors even though they lack counseling related knowledge and training. In addition, there is no monitoring body for counseling professional regulation.

4.1.1 Limitation of the Study

Limitations of this study cannot be ignored. The use of convenience sampling in qualitative study introduced an element of bias in the results since most of the respondents were from counseling profession. The sample for quantitative research data was selected from three cities although most of the people are living in the rural areas and thus, limiting the breadth of the research. However, a good number of people in hospital settings came from the rural areas.

The results of this research can help and guide future research studies in this area. Perhaps some new dimensions could be explored by including people from non-counseling professions and both urban and rural areas from all the divisions of the country are considered for future research.

Problems encountered

During the process of completing this study there are several problems encountered by the researchers from the very beginning of the process of data collections which without doubt affected the dissertation's final result. These are:

(a) In order to obtain the permission from the Institutions of Review Board (IRB), limited indication have been provided for application process and of obtaining the permission. In addition, it has been a long process and a paramount time has been spent to obtain the permission from both the university and hospital settings due to limited guideline.

(b) Data are collected from public and private universities where counseling services are available and public hospitals where psychiatrist department is in existence and their nearby areas such the university campus, outdoor of the hospitals so that the representative of a variety of economic status might be included in the research. Yet, equal number of survey respondents from different socio- economic status and educational background was not possible for different reasons. Some of the variables might generate inaccurate result. Moreover, in qualitative study the focus groups and interviews have been conducted in Dhaka.

(c) In hospital settings, the participants have been too stressed out and often they disagreed to fill up the survey questions. Thus, it has been difficult to find persons willing to take part in the research with full attention.

(d) In public hospitals, most of the people have been illiterate. Thus, instead of letting them fill up the survey questions, the researcher and the research assistants have to read for them or at times explain some terminology of the survey questions.

(e) The researcher and research assistant have to take verbal consent since some of the participants did not know how to read or write. Moreover, some people were unwilling to sign any paper due to lack of trust, rather preferred to give their consent verbally.

4.1.2 Recommendations

This section is providing some recommendations that should be considered when progressing idea of establishing counseling services for improved mental health of the people in Bangladesh. It is purposely divided into two major aspects reflecting facets of mental health service delivery and training of professional counselors.

Mental Health Service Delivery

Recommendation 1: Increase mental health service centers and be mindful of equal distribution of services in all the divisional districts are the priorities to decentralized mental health services specifically counseling services out of Dhaka. Alongside the hospital settings, community clinics, schools, colleges and universities can provide psychological health support recruiting counselor graduates.

Recommendation 2: The support service coordination between NGOs and government health sectors to reach out rural areas to as many people as possible is recommended.

Recommendation 3: Referral system needs to be increased among mental health professionals (psychiatrists, clinical, counseling, educational psychologists, and social workers), doctors, and teachers.

Prevention and Promotion

Recommendation 4: For mental health awareness public media like Bangladesh Television (BTV), other private television channels, newspapers, and radio could organize more programs on the need for counseling for psychological well-being. Further, initiating campaign in every district to spread the knowledge of mental health is necessary.

Recommendation 5: In school curriculum in both primary and high school level, a chapter on mental health and counseling can be included to make students aware of mental health.

Recommendation 6: It is a dire need of establishing a monitoring body like any other professions to regulate mental health practice which will further prevent malpractice.

Training for Professional counseling

Recommendation 7: Increasing well prepared mental health man power is a vital recommendation. In order to do this, first of all, a five year plan is important for implementation. Several universities are providing master degrees in applied psychology currently. It is important to get qualified faculties and expand master degrees in other universities where psychology departments are in existence.

Recommendation 8: There are several universities which have Departments of Psychology. The general psychology graduates from different universities could be provided

with short courses in counseling/ psychotherapy skills to respond to immediate need for counseling to huge number of people in need of mental health counseling.

Recommendation 9: Counselors in organizational setting need to be focused in counseling related work for instance conducting individual and group counseling to ensure optimal level of wellbeing of the clients/patients, workshops, keeping records instead of multi task.

Recommendation 10: Experienced counselors can dedicate more time to supervise neo graduate counselors for a better service. Further, professional development skill training need to be organized frequently so that counselors can handle issues like psycho-sexual problems.

Recommendation 11: Many government and non-government organizations may not be able to afford to recruit extra counselors due to budget constraint. Thus existing service holders such as teachers, doctors and nurses could be trained in this field to provide initial help and then can refer to professional counselors.

Recommendation 12: Training Para-counselors can be continued and expanded under supervision of professional counselors. Working at grassroots level can continue for mental health awareness. Counselors could reach out to parents, students and teachers through workshops for mental health awareness.

Recommendation 13: A comprehensive training and educational package could be developed for all educational setting, as well as religious settings like Mosque, Church, and Temples to make people aware of various mental health services available, and the means by which they can access different types of services available, opening hours, and referral pathways.

Conclusion

The aims of this study have been realized. This Study has identified the existing mental health status of the people in Bangladesh describing different psychological problems they encounter in their lives, the availability of the service facilities and limited manpower to assist a population of 160 million is inadequate. Furthermore, most people are still unaware of their psychological health; even they are informed, they are still not seeking help due to lack of knowledge about the counseling service, discrimination and stigma.

It has been indentified that existent counselors are serving people in Dhaka but rural areas are still deprived of counseling service. It has also been found that counselors are involved in multi tasks, lack opportunities for skill developments and supervision for a better service. There is a tendency of malpractice from those who took short training and became psychosocial counselors. A monitoring body is in need to ensure the quality of counseling. Moreover, the collaboration among mental health professionals to work as a team is still to be established. It is clear from this research that Bangladesh has a long way to go in order to understand the need of professional counselors for psychological wellbeing of the people. Yet it is possible to mitigate all the gaps if the universities and the government collaborate to prepare professional counselors to decrease psychological burden of the people and enhance the quality of life for a better future.

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Appendix A

Psychology Ethics Committee
Department of Educational and Counselling Psychology
Faculty of Biological Sciences
4th Floor, Arts Building, University of Dhaka
www.ecpdu.net

Lipy Gloria Rozario
Ph D Researcher (131/2010-11)
Dept. of Educational and Counselling Psychology
University of Dhaka

16 April 2015

Dear Student

Application Number: DECP/P/01
Researcher Name: Lipy Gloria Rozario
Project title: ASSESSING THE NEED FOR PROFESSIONAL COUNSELLOR AND THEIR POTENTIAL ROLES IN BANGLADESH

We are writing to inform you that your application was considered by the Psychology Ethics Committee. The proposal was **approved**. Please note the conditions below.

Please save this letter, as you will be expected to include a hard copy in the appendix section of your project.

Yours sincerely

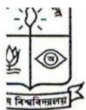
Md. Azharul Islam
Lecturer & Coordinator
Psychology Ethics Committee
Lecturer
Department of Educational
& Counselling Psychology
University of Dhaka

Professor Shaheen Islam, Ph D
Chairperson and Convenor
Psychology Ethics Committee
Dr. Shaheen Islam
Professor & Chairman
Department of Educational
& Counselling Psychology
University of Dhaka

I am advised by the Committee to remind you of the following points:

1. Please inform your supervisor immediately of any harmful outcomes during the research e.g. participant distress.
2. You must obtain approval from proper authority if study is undertaken in another institution outside the University.
3. The need to comply, throughout the conduct of the study, with good research practice standards
4. The need to refer proposed amendments to the protocol to the Ethics Committee for further review and to obtain Ethics Committee approval thereto prior to implementation (except only in cases of emergency when the welfare of the subject is paramount).
5. The desirability of including full details of the participant information sheet and consent form in an appendix to your research and of addressing specifically ethical issues in your methodological discussion.
6. Your responsibility to notify the Ethics Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Ethics Committee and/or which would raise questions about the safety and/or continued conduct of the research.

Appendix B



ডিন অফিস
জীববিজ্ঞান অনুষদ
ঢাকা বিশ্ববিদ্যালয়, ঢাকা-১০০০, বাংলাদেশ

PABX : 9661900-59/4355, 7489
Fax : 880-2-865583
E-mail : deanbio@univdhaka.edu
sahossain55@yahoo.com

নং - 07--------/ জীবঃ অনুঃ/২০১৫-২০১৬

তারিখঃ ০৮/১০/২০১৫

Professor Dr. Shaheen Islam
Chairman, Department of Educational and Counseling Psychology
University of Dhaka
Dhaka-1000.

Sub: Ethical Clearance of Research Proposal entitled "Assessing the need for professional counselors and their potential role in Bangladesh".

Dear Ms. Lipy Gloria Rozario,

I am pleased to inform you that your research proposal titled above has been elaborately discussed in the meeting of the Ethical Review Committee for Human Volunteers held on September 14, 2015.

I am happy to inform you that your proposal has been approved by the Ethical Review Committee to conduct your research project.

I wish for the success of your research project.

Professor Dr. M. Imdadul Hoque
Dean, Faculty of Biological Sciences
University of Dhaka
Dhaka-1000.

Appendix C

ঢাকা মেডিকেল কলেজ
DHAKA MEDICAL COLLEGE
Dhaka, Bangladesh

Ref: Memo No. MEU-DMC/ECC/2015/118

Date: 03/08/2015

Ethical Clearance Certificate

The Ethical Committee of Dhaka Medical College Approved the Following Research Protocol in time.

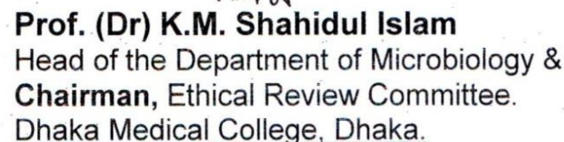
Title of the Research Work : **"Assessing the Need for Professional Counselors and their potential Role in Bangladesh".**

Principal Investigator : **Lipy Gloria Rozario**
Ph. D. – Educational and Counseling Psychology, Dhaka University

Supervisor : **Prof. Shaheen Islam,**
Chairman,
Department of Educational and Counseling Psychology, Dhaka University.

Place of Study : **Department of Psychiatry**
Dhaka Medical College Hospital, Dhaka.

Duration : **11 to 25 August, 2015 (15 days).**



Prof. (Dr) K.M. Shahidul Islam
Head of the Department of Microbiology &
Chairman, Ethical Review Committee.
Dhaka Medical College, Dhaka.

Dhaka Medical College, Dhaka-1000, Bangladesh. Tel.: 880-2-9669340, Fax : 880-2-8615919,
E-mail : dmc_principal@yahoo.com, web: http:/www.dmc.edu.com

Appendix D

Approval for data collection

Inbox x

jhunu nahar 9:58 AM (5 hours ago)

to me

Dear Gloria,

I went through the research protocol "ASSESSING THE NEED FOR PROFESSIONAL COUNSELORS AND THEIR POTENTIAL ROLE IN BANGLADESH".
Prianka Shankar Das and Sharmin Sultana Sonia may start data collection from today for the month of September.

Best wishes for you.

Prof. Dr. Jhunu Shamsun Nahar
Chairman, Department of Psychiatry
Bangabandhu Sheikh Mujib Medical university
Dhaka.

To Mr. Kabir

Jhunu S. Nahar
02/09/15

Appendix E

জনাব,

আমি, নিম্নের স্বাক্ষরকারী, বাংলাদেশে কাউন্সেলিং মনোবিজ্ঞানীর (সাইকোলজিস্ট) প্রয়োজনীয়তা এবং তাদের দায়িত্ব ও কর্তব্য বিষয়ে একটি গবেষণা পরিচালনা করতে যাচ্ছি। এ গবেষণাটি আমার পি.এইচ.ডি.ডিগ্রির অংশ হিসাবে ব্যবহার করা হবে। এ জন্য আপনার কাছ থেকে কিছু তথ্য জানতে চাই। এই তথ্য প্রদানে আপনার নাম, পরিচয় সম্পূর্ণভাবে গোপন থাকবে এবং আপনার প্রদত্ত তথ্য আমার পি.এইচ.ডি. ডিগ্রির প্রয়োজন ব্যাতিত অন্য কোনভাবেই প্রকাশ করা হবে না। তথ্য প্রদানে অসুবিধা বোধ করলে আপনি ইচ্ছা করলে যে কোন মূহূর্তে তথ্য প্রদান থেকে বিরত থাকতে পারবেন।

জরিপের প্রশ্নের উত্তরগুলি দিতে আপনার ১৫-২০ মিনিট সময় লাগবে।

আপনার মূল্যবান সময়ের জন্য আপনাকে অশেষ ধন্যবাদ।

লিপি গ্লোরিয়া রোজারিও

------------------- তারিখ ঃ

স্বাক্ষর

জনাব,

বাংলাদেশে প্রফেশনাল কাউন্সেলিং মনোবিজ্ঞানীর (সাইকোলজিস্ট) প্রয়োজনীয়তা এবং তাদের দায়িত্ব ও কর্তব্য বিষয়ে একটি গবেষণা পরিচালনা হচ্ছে। এ গবেষণাটি পি.এইচ.ডি. ডিগ্রির অংশ হিসাবে ব্যবহার করা হবে। তথ্য প্রদানে আমার নাম, পরিচয় সম্পূর্ণভাবে গোপন থাকবে এবং প্রদত্ত তথ্য পি.এইচ.ডি. ডিগ্রির প্রয়োজন এবং এ সম্পর্কিত প্রকাশনা ব্যাতিত অন্য কোনভাবেই প্রকাশ করা হবে না, এই সুবাদে আমি সেচ্ছায় কাউন্সেলিং বিষয়ক জরিপে অংশ নিচ্ছি।

জরিপে অংশগ্রহণকারীর স্বাক্ষর

তারিখ ঃ

Appendix F

Interview Guideline for Counseling/Psychotherapy Training Institute Head

প্রশ্ন ১ আপনার প্রতিষ্ঠানে কাউন্সেলিং সেবা দেন?

প্রশ্ন ২ যদি দিয়ে থাকেন তবে কতদিন যাবৎ এ প্রতিষ্ঠান কাউন্সেলিং সেবা দিয়ে যাচ্ছে?

প্রশ্ন ৩ এ প্রতিষ্ঠানে বর্তমানে কতজন কাউন্সেলর আছেন?

প্রশ্ন ৪ কারা এ সেবার প্রশিক্ষক (ট্রেইনার)?

প্রশ্ন ৫ কারা ট্রেনিং নিচ্ছেন?

প্রশ্ন ৬ তাদের ভর্তির যোগ্যতা কি?

প্রশ্ন ৭ এ প্রতিষ্ঠান থেকে প্রতি বছর কতজন করে পাশ করে বের হয়?

প্রশ্ন ৮ এখান থেকে পাশ করে কোথায় কাজ করেন?

প্রশ্ন ৯ সদ্য প্রশিক্ষণপ্রাপ্ত (নভিস) কাউন্সেলরদের কি কেউ তত্ত্ববধান করেন?

প্রশ্ন ১০ কিভাবে তাদের তত্ত্ববধান (সুপারভাইস) করেন?

প্রশ্ন ১১ সদ্য প্রশিক্ষণপ্রাপ্ত (নভিস) কাউন্সেলরগণ নিজেরা কি ব্যক্তিগত কাউন্সেলিং/থেরাপীর মধ্য দিয়ে যান? কত ঘন্টা?

প্রশ্ন ১২ এ পর্যন্ত কতজন কাউন্সেলরকে ট্রেনিং দিয়েছেন?

প্রশ্ন ১৩ কাউন্সেলরদের দক্ষতা বৃদ্ধির জন্য মাঝে মাঝে ট্রেনিং-এর ব্যাবস্থা আছে কি?

প্রশ্ন ১৪ কাউন্সেলিং ট্রেনিং ফলপ্রসু করার জন্য আপনি কি ধরনের সুপারিশ করেন?

প্রশ্ন ১৫ আপনার জানামতে অন্য কোন্ প্রতিষ্ঠান কাউন্সেলরদের দীর্ঘ মেয়াদি প্রশিক্ষণ দেয়?

Appendix G

Interview Guideline for Counselor's Interview and Focus Group Discussion

কাউন্সেলরের সাথে ইন্টারভিও/ফোকাস গ্রুপ

প্রশ্ন ১: কাদেরকে আপনি প্রফেশনাল কাউন্সেলর বলে আখ্যায়িত করবেন?

প্রশ্ন ২: তাদের কি ধরনের ট্রেনিং ও শিক্ষাগত যোগ্যতা থাকা উচিত বলে আপনি মনে করেন?

প্রশ্ন ৩: বর্তমানে বাংলাদেশে কাউন্সেলিং সেবার পরিস্থিতি কেমন? যদি মনে করেন সন্তোষজনক - তবে কেন মনে করেন? আর যদি মনে করেন সন্তোষজনক নয় - তবে কেন তা নয়?

কাউন্সেলিং সেবার গোপনীয়তা ও একান্ততা বজায় রাখা হচ্ছে কি?কাউন্সেলিং এর জন্য আলাদা কক্ষ আছে কি?
প্রশ্ন ৪: আপনি ব্যক্তিগতভাবে কোন্ কোন্ ক্ষেত্রে কাউন্সেলিং দিচ্ছেন?

প্রশ্ন ৫: যারা সেবা নিচ্ছেন তারা আপনার মতে কতটুকু উপকৃত হচ্ছেন?

যখন কেউ কাউন্সেলিং নিতে আসে তখন কি ধরনের প্রত্যাশা নিয়ে আসে?

প্রশ্ন ৬: আপনার মতানুসারে কি ধরনের (কোন্ কোন্ সমস্যার জন্য) কাউন্সেলিং দরকার?

প্রশ্ন ৭: আপনার জানামতে এ যাবৎ কোন্ কোন্ ক্ষেত্রে কাউন্সেলিং সেবা দেওয়া হচ্ছে ?

আর কোথায় এ সেবার প্রসার লাভ করা প্রয়োজন?

প্রশ্ন ৮: চাহিদার তুলনায় কাউন্সেলিং সেবার যে অপ্রতুলতা সেটা পুরন করা যায় কিভাবে?

প্রশ্ন ৯: কাউন্সেলিং সম্পর্কে জনগণ কতটুকু সচেতন বলে আপনি মনে করেন?

Appendix H

Katrina Borowiec<katrina.borowiec@mtholyoke.edu> 11/11/14

to me, iresearch-wm, Alison

Dear Sister Gloria,

Thanks for your message. Please feel free to use the Counseling Survey instrument.

Best of luck with your research!

Katrina

On Sat, Nov 8, 2014 at 5:42 AM, <rozariogloria@gmail.com> wrote:

Lipy Gloria Rozario (rozariogloria@gmail.com) sent a message using the contact form at https://www.mtholyoke.edu/contact/iresearch.

Good afternoon.

I am a PhD student in the department of Educational and counseling Psychology of Dhaka University and a part time teacher of the same department.

My research topic is "Assessing the need for professional counselors and their roles in Bangladesh". In my research I would like to use part of your survey questionnaire adapting in my language "Bangla". Would you give me permission do do it?

Thanking you in advance, I remain,

Sister Gloria

Appendix I

Survey Questionnaire

কাউন্সেলিং বিষয়ক জরিপ	ক্রমিক নম্বর

বিভাগ	১ = ঢাকা	২= রাজশাহী	৩= চট্টগ্রাম				
লিঙ্গ	১=পুরুষ	২= মহিলা					
বয়স	(১)১৮-২৮	(২) ২৯-৩৯	(৩) ৪০-৫০	(৪) ৫১-৬১	(৫) ৬২-১০০		
ধর্ম	১=ইসলাম	২= হিন্দু	৩= খ্রিস্টান	৪=বৌদ্ধ	৫=অন্যান্য		
বৈবাহিক অবস্থা	১=বিবাহিত	২=অবিবাহিত	৩=বিপত্নিক	৪=বিধবা	৫=বিবাহ বিচ্ছেদিত	৬=বিবাহিত তবে আলাদা থাকে	
শিক্ষাগত যোগ্যতা	১=অক্ষর জ্ঞান	২=প্রাথমিক	৩=মাধ্যমিক	৪=উচ্চ মাধ্যমিক	৫=স্নাতক	৬=স্নাতকোত্তর	৭=পিএইচডি
পেশা	১=বেকার	২=গৃহিনী	৩= ছাত্র	৪=চাকুরী	৫=ব্যবসা	৬=কৃষি	৭=দিন মজুর
	৮=অবসরপ্রাপ্ত	৯=অন্য কিছু হলে উল্লেখ করুন					
ব্যাক্তিগত মাসিক আয়	(০)	(১) <৫,০০০	(২)৫,০০০-১০,০০০	(৩)১০,০০০-২০,০০০	(৪) >২০,০০০		
বাসস্থান	১=শহর	২=গ্রাম					

১। জীবনে কখনো নিচের লেখা এক বা একাধিক ক্ষেত্রে সমস্যায় পড়েছেন কি?

	১=হ্যাঁ	০=না	৭৭=জানি না
ক) পড়াশুনার ব্যাপারে			
খ) রাগের /ক্রোধের কারণে			
গ) উদ্বিগ্নতা/অস্থিরতার কারণে			
ঘ) চেহারা নিয়ে			

	১=হ্যাঁ	০=না	৭৭=জানি না
ঙ) শৈশবে যৌন সংক্রান্ত অপমান/নির্যাতনের শিকার হওয়া			
চ) শৈশবে শারীরিক নির্যাতনের শিকার হওয়া			
ছ) হতাশ হওয়া			
জ) নেশা করা বা মদ্য পান করা			
ঝ) অতিমাত্রায় খাওয়া দাওয়া করা			
ঞ) পারিবারিক ঝগড়া-বিবাদ করা			
ট) ভয় পাওয়া			
ঠ) কাউকে হারাবার কষ্ট			
ড) নিয়ন্ত্রণহীন আতঙ্কে ভোগা			
ঢ) সন্তান লালন-পালন করতে গিয়ে			
ণ) শারীরিক কোন অক্ষমতার কারণে			
ত) রোমান্টিক সম্পর্ক নিয়ে			
থ) হীনমন্যতায় ভোগা			
দ) নিজের ক্ষতি করা			
ধ) নিজের মানসিক কোন চাপের কারণে			
ন) আত্মহত্যার ইচ্ছা			
প) ট্রমা বা প্রচন্ড মানসিক আঘাতের কারণে			
ফ) অন্য কোন কারণ			

২। জীবনে কখনো কি আত্মহত্যার কথা ভেবেছেন ?

ক) না, কখনোই না	০
খ) হ্যাঁ, গত ছয়মাসের মধ্যে ভেবেছি	১
গ) অন্যান্য	২

৩। জীবনে কখনো কি আত্মহত্যার চেষ্টা করেছেন?

ক) না, কখনোই না	০
খ) গত ছয়মাসের মধ্যে চেষ্টা করেছি	১
গ) অন্যান্য	২

৪। মানসিক সমস্যার কারণে আপনি কি কখনো চিকিৎসা নিয়েছেন?

ক) না, কখনো না	০
খ) হ্যাঁ, গত ছয়মাসের মধ্যে নিয়েছি	১

ঘ) অন্যান্য	২

৫। আপনি কোথায় মানসিক চিকিৎসা নিচ্ছেন?

ক) কোথাও নেইনা	০
খ) আমার এলাকায় নিই	১
গ) ঢাকায় গিয়ে নিই	২

৬। মানসিক অসুস্থতার কারণে আপনার পরিবারের কেউ কি কখনো চিকিৎসা নিয়েছে?

ক) না, কখনো না	০
খ) হ্যাঁ, গত ছয়মাসের মধ্যে নিয়েছে	১
গ) এখনো নিচ্ছে	২

৭। যখন আপনি মানসিকভাবে অসুবিধা বা সমস্যায় পড়েন তখন আপনি কাদের সহায়তা নেন?

ক) আমি কারো কাছে যাই না এবং এ ব্যাপারে আলাপ করি না	১
খ) পরিবারের অন্যান্য সদস্যদের সাথে আলাপ করি	২
গ) আমি মানসিক ডাক্তারের কাছে যাই	৩
ঘ) আমি মেডিসিনের ডাক্তারের কাছে যাই	৪
ঙ) মানসিক স্বাস্থ্যের কাউন্সেলর, সাইকোলজিস্ট, সাইকোথেরাপিস্টের, সমাজকর্মী কাছে যাই	৫
চ) বন্ধুবান্ধবের কাছে যাই	৬
ছ) ধর্মগুরু/আধ্যাত্মিক ব্যক্তির (হুজুর, পীর, ইমাম, পুরুহিত, সাধুবাবার) কাছে যাই	৭
জ) কবিরাজের কাছে যাই	৮

যদি ৭নং প্রশ্নের উত্তর ঙ হয় তবে পরবর্তী সব গুলো প্রশ্নের জবাব দিন । আর যদি ঙ না হয় তবে ১৬-১৭ নং প্রশ্নের উত্তর দিন।

৮। মানসিক চিকিৎসার জন্য কখনো কোন কাউন্সেলরের (মানসিক স্বাস্থ্যের কাউন্সেলর, সাইকোলজিস্ট, সমাজকর্মী ইত্যাদি) চিকিৎসা নিয়েছেন? (একের অধিক টিক দিতে পারবেন)

ক) হ্যাঁ, জীবনে অন্ততঃ একবার নিয়েছি	১
খ) একাধিকবার নিয়েছি	২
গ) একাধিকজনের কাছে নিয়েছি	৩
ঘ) বর্তমানে নিচ্ছি	৪

৯। আপনি কোন্ কোন্ ধরনের কাউন্সেলিং সেবার সহায়তা নিয়েছেন

ক) ব্যক্তিগত কাউন্সেলিং	১
খ) দলগত কাউন্সেলিং	২
গ) কোনো ধরনের প্রশিক্ষণ	৩
ঘ) কাউন্সেলিং সেবার কোন কর্মশালা	৪
ঙ) সাইকায়াট্রিস্টের সাহায্য	৫

চ) সাইকোথেরাপিস্টের সাহায্য	৬

১০। কয়টি ব্যক্তিগত সেশন আপনি নিয়েছেন

ক) একটিও না	০
খ) শুধুমাত্র একটা	১
গ) ২-৪ বার নিয়েছেন	২
ঘ) ৪ বারের বেশি নিয়েছেন	৩

১১। কোন্ সমস্যার জন্য আপনি কাউন্সেলিং সেশন নিয়েছেন?

১২। কাউন্সেলিং সেবা থেকে আপনি কি ধরনের সহায়তা পেয়েছেন ? (একের অধিক টিক দেওয়া যাবে)

ক) পরামর্শ বা উপদেশ পেয়েছি	১
খ) নিজেকে আঘাত করা থেকে বিরত হয়েছি	২
গ) রোগ লক্ষণ সম্বন্ধে জেনেছি	৩
ঘ) কেউ আমাকে বুঝতে পেরেছে	৪
ঙ) পড়ালেখায় এবং কাজে মনোযোগী হতে সাহায্য করেছে	৫
চ) স্ট্রেস/চাপ কমানোর কলাকৌশল শিখেছি	৬
ছ) ঔষুধের প্রেসক্রিপশন পেয়েছি	৭
জ) কেউ আমার কথা শুনেছে	৮
ঝ) রোগ লক্ষণ কমেছে	৯
ঞ) অন্যান্য	১০

১৩। কাউন্সেলিং সেবা গ্রহণ করার সময় নিচের লেখা কোন্ কোন্ বিষয় আপনার মনে উদ্বিগ্নতার সৃষ্টি করেছে

ক) সেশন সংখ্যা	১
খ) অন্যে দেখে ফেলবে	২
গ) কাউন্সেলরের সাথে বনিবনা হবে কিনা	৩
ঘ) সাক্ষাতের (এপয়েন্টমেন্টের) জন্য দীর্ঘদিন অপেক্ষা	৪
ঙ) রোগলক্ষণ/সমস্যার উন্নতি যদি না হয়	৫
চ) গোপনীয়তা রক্ষা করা হবে কিনা এ বিষয়ে উদ্বিগ্নতা	৬
জ) অন্যান্য	৭

১৪। কাউন্সেলিং-এ আপনি কি ধরনের আশা নিয়ে এসেছেন (একের অধিক টিক দিতে পারবেন)

ক) আপনি উপদেশ পাবেন	১
খ) আপনার সমস্যার সমাধান হবে	২
গ) আপনি নিজেকে বুঝতে পারবেন	৩
ঘ) আপনার কষ্ট লাঘব হবে	৪
ঙ) আপনার লক্ষ্য ও উদ্দেশ্য ঠিক করতে পারবেন	৫

১৫। কাউন্সেলিং সেবা সম্পর্কে আপনার অভিজ্ঞতা

ক) অত্যন্ত সন্তোষজনক	১
খ) সন্তোষজনক	২
গ) অসন্তোষজনক	৩
ঘ) খুবই অসন্তোষজনক	৪

১৬। নিচে লেখা বিষয়গুলো সম্পর্কে আপনার মতামত

	৩=আমি সম্পূর্ণ একমত	২=একমত নই	৭৭=জানিনা
ক) মানসিক ও আবেগিক সমস্যার জন্য পর্যাপ্ত পরিমাণ সেবাদানকারী প্রতিষ্ঠান আছে			
খ) মানসিক ও আবেগিক সমস্যায় জর্জরিত জনগণ মানসিক স্বাস্থ্য সেবা নিতে লজ্জা-বোধ করে			
গ) মানসিক ও আবেগিক সমস্যা সম্পর্কে জনগণ যথেষ্ঠ তথ্য জানে			
ঘ) কেউ মানসিক ও আবেগিক সমস্যায় পড়লে কোথায় চিকিৎসা সেবা নিবে সে সম্পর্কে আমার তথ্য জানা আছে			

১৭। কীভাবে কাউন্সেলিং সেবার উন্নতি করা যায় সে সম্পর্কে আপনার পরামর্শ বা মতামত থাকলে দিন

ডাটা সংগ্রহকারীর নাম ঃ
তারিখ ঃ

Appendix J

Codebook

Category	Code Number	SPSS variable	Full variable name	Coding instruction
		SL	Serial number	Number
Demographic and Socio-economic variables	001	Institution	Institution	1=Public University Area 2=Private University Area 3=Public Medical Hospital 4=Drug Rehab 5=NGO
		DV	Division	1=Dhaka 2=Rajshahi 3=Chittagong
		Gender	Gender	1=Male 2=Female
		Age	Age	1=18-28 2=29-39 3=40-50 4=51-61 5=62-100
		Rel	Religion	1=Islam 2=Hindu 3=Christian 4=Buddhist 5=Others
		MS	Marital Status	1=Married 2=Unmarried 3=Widower 4=Widow 5=Divorced 6=Separated
		EL	Educational Level	1=Illiterate 2=Secondary School 3=Bachelor 5=Master 6=PhD
		PF	Profession	1=Unemployed 2=Housewife 3=Student 4=Employed 5=Business 6=Farmer

Category	Code Number	SPSS variable	Full variable name	Coding instruction
				7=Day labor 8=Retired 9=Others
		IN	Income	1=<5000 2=5000-10000 3=10000-20000 4=>20000
		Habitat	Habitat	1=City 2=Village
Psychosocial issues	002	P1_ka	Study Problem	0=No 2=Yes 77=Don't know
		P1_Kha	Anger Problem	
		P1_Ga	Anxiety Problem	
		P1_gha	Appearance Problem	
		P1_umo	Sexual abuse	
		P1_cho	Physical abuse	
		P1_chho	Depression	
		P1_jo	Drug addiction	
		P1_jho	Eating too much	
		P1_nio	Quarrel	
		P1_to	Fear	
		P1_tho	Pain of loss	
		P1_do	Phobia	
		P1_dho	Childrearing	
		P1_mordhanno	Physical disability	
		P1_tto	Romantic Relationship	
		P1_ttho	Low Self Esteem	
		P1_ddo	Self-harm	
		P1_ddho	Personal Stress	
		P1_dontonno	Suicidal desire	
		P1_po	Trauma	
		P1_fo	Others	
Suicidal thought and attempt	003	P2	Suicidal thought	0=Never 1=Last 6 months 2=Others
		P3	Suicidal attempt	0=Never 1=Last 6 months 2=Others
Sta tus of me nta	004	P4	Mental treatment received	0=Never 1=Last 6 months

Category	Code Number	SPSS variable	Full variable name	Coding instruction
				2=Others
		P5	Receives treatment	0=Never 1=In my area 2=in Dhaka
		P6	Family members received treatment	0=Never 1=In the last 6 months 2=Still now
General help seeking behaviour	005	P7_ko	Don't talk about it	0=No 1=Yes
		P7_kho	Talk with family members	
		P7_go	I go to psychiatrist	
		P7_gho	Go to medical doctor	
		P7_umo	go to counsellor psychotherapist, social worker, psychologist	
		P7_cho	Talk with friends	
		P7_chho	Religious leader	
		P7_jo	Kabiraj	
Frequency of help seeking from counsellors	006	P8_ko	counsellors help received one time	0=No 1=Yes
		P8_kho	counsellors help received more than once	
		P8_go	counsellors help received more than one counsellor	
		P8_gho	counsellors help currently taking	
Mode of counselling	007	P9_ko	Individual counselling	0=No 1=Yes
		P9_kho	Group counselling	
		P9_go	Some sort of training	
		P9_gho	Workshops	
		P9_umo	Psychiatrist help	
		P9_cho	Psychotherapist help	
Number of sessions	008	P10	Number of sessions	0=None 1=Only one 2=Two to four times 3=More than four
		P11	Kind of problem received counselling	Qualitative

Category	Code Number	SPSS variable	Full variable name	Coding instruction
Benefits from counselling	009	P12_ko	Advice	0=No 1=Yes
		P12_kho	Self harm prevention	
		P12_go	Know about sickness	
		P12_gho	Somebody understood me	
		P12_umo	Attentive in study and work	
		P12_cho	Learn stress management	
		P12_jo	Somebody listened to me	
		P12_jho	Reduce the symptom	
		P12_nio	Other benefit received	
Worries with counselling	010	P13_ko	anxiety - number of session	0=No 1=Yes
		P13_kho	anxiety - somebody will see me	
		P13_go	anxiety - not getting along with the counsellor	
		P13_gho	anxiety - waiting for appointment	
		P13_umo	anxiety - no improvement of illness	
		P13_cho	anxious of confidentiality	
		P13_chho	Others	
Expectation from counselling	011	P14_ko	expectation - receiving advice	0=No 1=Yes
		P14_kho	expectation - your problem will be solved	
		P14_go	expectation - self-understanding	
		P14_gho	expectation - your pain will be reduced	
		P14_umo	expectation - your aim and goal will be clear	
Experience of counselling	012	P15	experience of your counselling	1=Very satisfied 2=Satisfied 3=Dissatisfied 4=Very unsatisfied
Perception on counselling	013	P16_ko	enough counselling center	1=Completely disagree 2=Disagree 3=Totally agree 4=don't know
		P16_kho	people are ashamed of counselling	
		P16_go	people know enough of counselling service	
		P16_gho	I know about mental health service	

Category	**Code Number**	**SPSS variable**	**Full variable name**	**Coding instruction**
		P17	How can counselling be improved	Qualitative