Counselling Knowledge and Skills in Papua New Guinea: Identifying the Gaps

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Jane L Fowler[1] · Mark P Lynch[2] · Jennifer Larsen[2]

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Abstract
This paper reports on the counselling knowledge and skills held and utilised by Papua New Guinean counsellors. Twenty-five counsellors from government and non-government sectors, representing all four regions of PNG, participated in individual in-depth interviews and video-recorded simulated counselling sessions. Counselling knowledge was assessed via content analysis of interview data that explored counselling concepts associated with the purpose and practice of counselling. Skills were assessed via the Counselling Skills and Competencies Tool. Results indicated that participants had low levels of counselling knowledge and skills. The paper outlines three key areas that should be the focus of counselling training for PNG counsellors: (1) fundamental knowledge and skills, (2) theories and frameworks for guiding the counselling process, and (3) the PNG cultural context.

Keywords Counselling skills · Counselling knowledge · Papua New Guinea · Skills and competencies; Counselling skills and competencies tool

Introduction

Papua New Guinea (PNG) is a nation of nations, made up of more than 840 individual tribes, each with its own language, cultural norms, and customs. PNG is consistently recognised in humanitarian studies as one of the most dangerous places on the planet to live, especially for women (García-Moreno et al. 2015; Human Rights Watch 2017). Gender-based violence, domestic violence, and intimate partner violence is among the highest in the world, with more than 50% of women experiencing forced sex in their lifetime (Biersack et al. 2016; Fulu et al. 2013).

✉ Jane L Fowler
j.fowler@griffith.edu.au

[1] School of Human Services and Social Work and Menzies Health Institute, Griffith University, 68 University Drive, Meadowbrook, QLD 4131, Australia

[2] School of Human Services and Social Work, Griffith University, Meadowbrook, QLD, Australia

The influence of the outside world – which was largely unfelt until the middle of last century – can be seen everywhere. HIV/AIDS is at epidemic proportions (Kelly-Hanku et al. 2018), trauma from sorcery-related violence is commonplace (Forsyth 2014), and drug and alcohol abuse, gambling, and child abuse are rife (Dinnen 2017; Nickson et al. 2019; Pickles 2019). These individual and social problems, combined with illiteracy, poverty, and geographic inaccessibility, create a dire picture of a country in desperate need of psychosocial interventions (Adu Krow et al. 2013; Grundy et al. 2019). Indeed, there has never been a greater need for access to skilled and knowledgeable counselling practitioners (Australia's Department of Foreign Affairs and Trade (DFAT) 2017). The core counselling knowledge and skills held and utilised by Papua New Guinean nationals currently working as counsellors in their country is investigated.

Despite the plethora of individual and social problems, recognition of the need for counselling in PNG is a relatively new phenomenon and access to skilled counsellors is sorely lacking (Grundy et al. 2019; Human Rights Watch 2017; United Nations International Emergency Children's Fund 2014). Traditionally, each tribe has had its own system or custom for dealing with issues needing correction, advice, healing, grieving, or behaviour change. Often these would include some sort of justice, exchange, and/or ritual, which would hold meaning and provide psychological and relational reconciliation for individuals and their community (Rumsey 2008).

Auxier et al. (2005) described this form of counselling as "a corrective process administered by elder family members, village leaders, clergy, and teachers who counsel those who stray from cultural or religious norms" (p. 142). The primacy of the ancient tribal systems began to weaken in the mid 1950s with the influx of Christian missionaries. Denominations of all kinds claimed divine authority and began to teach what was acceptable behaviour and how to attain it (Eves 2010). Pastors and ministers became equally, or more, powerful than village Elders in providing solutions for suffering. As parishioners shared their struggles with clergy who listened and offered spiritual and Bible-based counsel, the church became PNG's first counselling provider (Benton 2008).

As influence from the West continued, other bodies began to provide counselling in PNG: non-government organisations, community-based organisations, government agencies, private companies, and well-intentioned individuals wanting to ease the burden of care. In 2017, DFAT identified 85 counselling service providers across 14 nations in the Pacific region, of which 22 (or 26%) were based in PNG. In total, 43 of those 85 organisations responded to an online survey and/or interview question asking whether they provided 'basic' and/or 'skilled' counselling. Basic counselling was defined as the provision of a set of primary and essential counselling skills, including empathy and unconditional positive regard (respect without judgement); supportive listening and questioning skills; the ability to establish trust, explore issues and needs; and encouragement to make decisions (DFAT 2017). Skilled or professional counselling was distinguished from basic counselling through the higher skill level of the counsellor who would be able to reflect; make skilled observations; use effective questioning; facilitate coping mechanisms; summarise goals and priorities; conduct risk assessments; support the development of an action plan; and provide further guidance (DFAT 2017). Skilled counsellors may also be able to apply specific therapeutic interventions such as cognitive behaviour strategies, trauma-focused interventions, or a combination of various therapeutic approaches (DFAT 2017). Of the 43 organisations that responded, 52% reported providing basic counselling and 48% reported providing skilled counselling.

There are several other key findings in DFAT's (2017) report that are particularly relevant for the current study. First, among the organisations/individuals that provide counselling, quality varies considerably. Although some have strong basic skills, many counsellors lack understanding and application of the basic principles of counselling, for example not to judge or influence but to strengthen and listen. Second, a strong motivation to help often leads to inappropriate counselling interventions being undertaken. For example, rather than listening and supporting clients to develop their own plan of action, there is a tendency among counsellors to want to advise or instruct the survivor. This is not surprising given that, traditionally, counselling in the Pacific Region is seen as a process in which people with authority advise or direct others on what they should do (Auxier et al. 2005). Third, there is a lack of understanding about ethical principles of counselling, such as protection of clients' rights, avoiding harm being done, and providing encouragement to the client to make responsible decisions. Fourth, only a minority of counsellors use therapeutic approaches (e.g., trauma-focused, cognitive-behavioural, or solution-focused therapy) in their practice. Yet, counselling theories such as these provide a necessary framework for linking understanding, interpretation and, ultimately, appropriate action (Ivey et al. 2018).

In interpreting the findings of DFAT's (2017) study, several factors should be considered given the context of the current study. For example, DFAT's report was on counselling 'across the Pacific region' which includes, but is not specifically about, PNG. Indeed, the PNG data included in the analysis is not identifiable (to other than the authors of that report) and therefore not able to be interpreted separately from the collective Pacific region data set. Further, PNG was represented in the report by data provided by eight counselling organisations/providers only, which is a very limited data source. Moreover, it is not clear from the report whether individual counsellors reported on their own knowledge, skills, and practice (other than in Vanuatu and Fiji where focus groups were held) or whether directors or managers of organisations/providers reported generally about their counselling staff. Thus, is it unclear whether actual 'PNG counsellors' have had the opportunity to reflect and report on their own levels of counselling knowledge and skills. A separate but related factor, recognised by DFAT, is whether the online questionnaire used in their research may have limited participants' responses to the questions posed, for example to expand on the experience and practice of counselling staff and/or be specific about the type of 'basic' or 'skilled' counselling an individual or organisation might provide. Nevertheless, DFAT's (2017) report provides the closest possible picture of counselling in PNG available to date.

The need to enhance the quality of counselling in Pacific regions has not gone unrecognised. Indeed, DFAT's (2017) report provided a list of recommendations including developing agreed national practice standards, establishing registration and accreditation processes, supporting the formation of counsellor associations, improving the quality of training for counsellors, and ensuring that core counselling competencies are understood and practiced. PNG have taken some steps toward regulation with the recent establishment of the PNG Counsellors' Association, which will develop practice standards and establish registration processes. However, it is the final recommendation listed above – 'ensuring core competencies are understood and practiced' – that is key to enhancing the quality of counselling in PNG. As such, it is the purpose of this study to assess actual core counselling knowledge and skills, held by current frontline counsellors in PNG. Such an assessment will provide a baseline measure from which to measure subsequent improvement and may in fact inform other higher-level recommendations, for example, those related to registration and accreditation, agreed standards, and training

development. Moreover, until current knowledge and skills levels are assessed it will not be possible to develop appropriate plans of action to fill the gap between current and ideal core counselling competencies. Given that there has never been a greater need in PNG for skilled and knowledgeable counselling practitioners (DFAT 2017), we argue that this assessment should be viewed as a major priority for counselling in PNG. Thus, the purpose of the current study is to investigate the core counselling knowledge and skills held and applied by PNG nationals currently working as counsellors in their country.

Method

Design

The study employed a mixed-method design utilising both qualitative and quantitative data collection and analyses. Qualitative data were collected via semi-structured interviews that explored participants' knowledge and understanding of the purpose and practice of counselling. Quantitative data were recorded by scoring each participant's application of counselling skills and competencies using the Counselling Skills and Competencies Tool (CSCT) (under review). All data collection occurred prior to participants engaging in a Graduate Certificate in Counselling, with interviews conducted in PNG at a pre-course workshop and video sessions recorded in Australia. Content analyses of interview data and participant scores on the CSCT are presented in the results section.

Participants

Twenty-five Papua New Guinean counsellors, who had been selected to undertake a Graduate Certificate in Counselling but had not yet commenced the course, volunteered to participate in the study. Data from all 25 participants, who were the full complement of students enrolled in the course, were collected and analysed for both the quantitative and qualitative aspects of the study. Table 1 presents demographic information including gender, age, academic qualifications, religion, employer, and position held in the organisation in which they were employed.

In addition to any formal qualifications, participants reported limited training in the field of counselling. Specifically, 9 participants reported no training, 10 reported 'some short workshops' run by agencies such as ChildFund, UNICEF, various churches, or the Education Department, and 3 reported having undertaken a 3-month course on basic counselling skills taught by the PNG Counsellors' Association. Two people reported that their counselling training was 'on the job'; one of whom had worked for three years without pay at the nation's only psychiatric hospital in order to be granted the title of Master of Clinical Psychology.

Regardless of qualifications or training, the 25 participants were deemed to be 'PNG counsellors' for the purpose of this study on the basis that they met two counselling-related criteria: (1) had five years' work experience in a counselling, case management, or social work related area and (2) were directly involved in the provision of counselling services and/or teaching counselling or a related subject (e.g., psychology or social work) in PNG. These two criteria (among others that were not counselling-related) were those that had been met to gain selection into the Graduate Certificate in Counselling.

Table 1 Participant demographics for gender, age, academic qualification, religion, employer, and position held in organisation

Demographic	N	
Gender		
Female	20	(Age range 27–66; M = 42.2)
Male	5	(Age range 32–57; M = 43.6)
Qualification		
Bachelor	25	(7 counselling related: 6 psychology, 1 social work)
Masters	5	(1 counselling related: ministry)
Religion		
Christian	23	
Other	2	
Employer		
Government-funded	17	
Non-government/faith-based	5	
Mining	2	
Private counsellor	1	
Position		
Telephone counsellor	2	
Welfare officer	4	
Human resources manager	2	
Community development officer	1	
Counselling trainer/educator	4	
Policy development officer	2	
Nurse/medical officer	2	
Police officer	2	
Psychologist	1	
Child counsellor	1	
HIV counsellor	2	
Social worker	1	
Child protection officer	1	
Location		
Highlands	6	
Islands	5	
Momase	7	
Southern	7	

Data Collection and Analysis

Two forms of data collection were used in this study: 25 individual semi-structured interviews to assess counselling knowledge and 24 video-recorded simulated counselling sessions (one participant's session was not recorded due to video failure) to assess counselling skills. As part of a broader interview, participants were asked a range of questions that explored their counselling knowledge. As explained by Geldard et al. (2016), "understanding what counselling is, the nature of the counselling relationship …[is] an essential foundation as you begin, and continue, your journey towards becoming an effective counsellor" (p.1). Indeed, it was this foundational knowledge that was of interest in this study. Some sample interview questions were 'What is the purpose of counselling?', 'What is your role as a counsellor?', 'How do you approach working with a client?', and 'Which theoretical frameworks or approaches do you find useful?' Interviews ranged in length from 13 to 38 min, with an average length of 28 min, and were transcribed verbatim.

Two analysts, experienced in qualitative data analysis, were employed to analyse the content of the interviews. Transcripts were coded twice: first, for manifest evidence of knowledge about the purpose and practice of counselling, and second, for latent or underlying meaning of purpose and practice. Babbie (2001) distinguished between the two levels of coding and encouraged the use of both methods. He argued that although the manifest or visible, surface content had the advantage of ease and reliability, the latent or underlying meaning of the content provides depth and validity to the research.

At the first level of coding, transcripts were trawled for the presence of words and concepts associated with the purpose and practice of counselling, using the Psychotherapy and Counselling Federation of Australia's (2013) comprehensive definition of counselling: *Professional counselling is a* ***safe*** *and* ***confidential collaboration*** *between qualified counsellors and clients to* ***promote mental health*** *and* ***wellbeing***, ***enhance self-understanding***, *and* ***resolve identified concerns***. *Clients are* ***active participants*** *in the counselling* ***process at every stage***. *Counsellors are* ***fully present*** *with their clients, using* ***empathy*** *and* ***deep listening*** *to establish* ***positive working relationships***. *Counselling is effective when clients feel safe,* ***understood***, ***respected***, *and* ***accepted without judgement***. *Counselling is a profession with a strong* ***evidence base***. *Counsellors use* ***empirically supported interventions*** *and* ***specialised interpersonal skills*** *to* ***facilitate change*** *and* ***empower clients***. For example, a transcript reference to 'I know about cognitive-behaviour therapy' was recorded as an ***empirically supported intervention*** and 'solving problems' as ***resolve identified concerns.***

At the second level of coding, transcripts were trawled for supporting or contradictory evidence of a deeper level of understanding of the word or concept to which they referred. For example, if 'I know about cognitive-behaviour therapy' was followed by 'and I use it to change their thought patterns' it would be recorded as supporting evidence. On the other hand, if 'solving problems' was followed by 'telling them that what they are doing is not right and not to do it again' it was recorded as contradictory evidence.

The two analysts worked independently to code the data. They were given identical instructions for coding, namely that the first level of analysis was to search for exact and/or similar words or concepts to those identified in and highlighted in PACFA's (2013) definition and that the second level of analysis was to search for evidence of latent or deeper understanding of the meaning of those words or concepts. Recording of data at the first level of analysis was how many transcripts included reference to the relevant word or concept, not how many times it was mentioned in each transcript, bearing in mind Babbie's (2001) warning that numerous mentions of the word 'confidential', for example, does not indicate a higher degree of 'confidentiality'. At the second level, recording of data was whether supporting evidence (i.e., demonstrating understanding) or contradictory evidence (i.e., demonstrating misunderstanding) of each word or concept was present.

Of the 25 transcripts that were coded, 9 (i.e., over one-third of the total) were coded by both analysts. To begin, 4 of the 25 transcripts were independently coded and the inter-rater reliability was calculated before discussing, comparing, and contrasting (Weber 1990). Inter-rater reliability was calculated, using Miles and Huberman's (1994) method of percentage agreement, at 98% for the first level and 92% at the second level. Although both rates were considered high, the two analysts engaged in deep discussion to explore the differences that occurred at the second level of coding. An additional five transcripts were independently coded for inter-rater reliabilities of 98% and 94%, respectively. Due to the high inter-rater reliability in the coding of the nine initial transcripts, indicating consistency in the data being selected and coded, the remaining 16 transcripts were coded by only one analyst.

The second method of data collection was video-recorded simulated counselling sessions. Each participant was the counsellor, using the same role-play situation with an actor as client. Participants were asked to 'conduct a 30-minute counselling session', which provided the opportunity to observe skills and competencies as they are actually applied in a (as close to possible) real counselling situation. The recorded sessions ranged in length from 10.12 to 26.83 min, with an average length of 18.23 min.

The Counselling Skills and Competencies Tool (CSCT) (under review) was used to rate participants' skills and competencies. The CSCT is a 23-item scale that was developed via a thorough and comprehensive process of item selection, scale construction and scoring, and tests for content validity, inter-rater reliability, and test-retest reliability. The process of item selection, to ensure content validity, commenced with a review of well-known textbooks, commonly and internationally used in counselling education (viz., Corey 2015; Geldard et al. 2016; Ivey et al. 2018). From this review, a list of counselling skills and competencies that would be expected of beginning and developing counsellors was compiled. Next, three experienced practicing counsellors were invited to provide feedback on the list and to identify omissions, and three beginning counsellors were asked what they considered to be the most significant inclusions and omission in their training. These conversations confirmed the list that had been compiled. Ratings on 7-point scales of comprehensiveness and adequacy of the items as representing the domain of counselling skills and competencies by three experienced counsellors, who had not been employed in scale development, were 6 or 7 on 7-point scales.

Each item on the CSCT is rated on a 6-point scale from 0 'harmful', 1 'below expectations', 2 'slightly below expectations', 3 'slightly above expectations', 4 'above expectations' to 5 'well above expectations'. The individual item scores render six sub-scale scores for Attending (4 items; eye contact, vocal quality, body language, verbal tracking), Reflecting (3 items; reflection of content, reflection of feeling, summarising), Questioning (5 items; open, closed, clarifying, specifying, elaborating questions), Therapeutic Alliance (2 items; relationship, rapport), Core Counselling Conditions (4 items; congruence, unconditional positive regard, empathy, respect), and Facilitating the Session (5 items; open the session, hear the story, prioritise primary concerns, work on change, close the session). For each scale, a participant can score a maximum of 5 with a total score for the CSCT out of 30. Table 2 shows a sample item for each of the six sub-scales of the CSCT.

Table 2 Counselling skills and competencies tool: sub-scales with sample items

Scale	Sample item	
	Skill/ Competency	Definition
Attending	Vocal quality	Tone of voice and speech rate communicates warmth and ease
Reflecting	Reflection of content	Paraphrase or reflect back, using own words, what has been said
Questioning	Clarifying questions	Seek to understand what has been said such as 'Are you saying that…?'
Therapeutic Alliance	Relationship	Counsellor is attentive and actively engaging and bonding with client
Core Counselling Conditions	Congruence	Counsellor demonstrates genuine, authentic, and true self with client
Facilitating the Session	Open the session	Counsellor introduces the session and establishes guidelines and emotional safety

Inter-rater reliability, using a panel of four raters, resulted in intraclass correlation coefficients for the Attending, Reflecting, Questioning, Therapeutic Alliance, Core Counselling Conditions, and Facilitating the Session dimensions of, respectively, .841, .822, .776, .759, .751, and .551 for the average across raters, and .628, .664, .736, .412, .575, and .627 for a single rater. The F value in all cases was statistically significant ($p < .01$). Test-retest reliability, using two raters as the measure of consistency over an interval of 4 weeks, yielded coefficients ranging from .73 to .90.

Results

Counselling Knowledge

Table 3 provides a summary of the content analysis of 25 interviews transcripts for evidence of understanding of the purpose and practice of counselling. Twenty-one key words or concepts, from PACFA's (2013) comprehensive definition of counselling, are listed in the table. Alongside each word/concept is the number of transcripts in which that word/concept was mentioned, followed by the number of transcripts that provided supporting evidence to show understanding of the word/concept (and a sample comment), and the number that provided contradictory evidence that demonstrated a lack of understanding (and a sample comment).

Level 1 analysis shows that 15 of the words/concepts were mentioned by participants: three by 12 or more participants, twelve by between 1 and 6 participants, and six were not mentioned at all. Level 2 analysis shows that there was limited evidence of understanding of the words/concepts, with 7 of the 15 mentioned having supporting evidence and 8 of them being supported by only 1–3 comments. For example, although all participants mentioned 'deep listening' (or in fact 'listening' was accepted by the analysts) only three participants showed further understanding such as, 'I listen and paraphrase; I ask questions to check content'. The second and third most mentioned concepts, 'resolve concerns' and 'confidential', respectively, showed a similar result. For example, 'problem-solving' (an acceptable term for 'resolve concerns') was mentioned by 18 of 25 (72%) participants but only two participants provided a deeper understanding of what this involved, 'I don't give advice – I allow the client to come up with options themselves'.

Indeed, there was a higher amount of contradictory evidence for the two most mentioned concepts, i.e., 10 instances each for 'deep listening' and 'resolve concerns'. For example, one participant, who counsels survivors of domestic and sexual violence, said active listening was key and then followed it up with 'the first question [I ask] is did they do that to you?, then what did you do to make that happen to you?' Similarly, participants provided examples of how they engage in problem solving such as, 'providing advice about what the client should do', usually by 'making suggestions' or directly telling them what to do. One respondent offered, 'I encourage them, tell them that what they are doing is not right and not to do it again. And then I refer them out'.

Table 3 also shows no evidence to suggest that counsellors applied a theoretical approach or framework to their counselling. Only six counsellors referred to a particular counselling theory by name; one each mentioned Narrative, Solution-Focused, Cognitive Behavioural Therapy, and Developmental Psychology, and two participants referred to Person-Centred counselling. However, there was not a single case where the naming of a theory was followed up by an accurate description of how it was (or could be) applied. For example, comments included 'I

Table 3 Content analysis of interview transcripts ($N = 25$) for understanding of knowledge about the purpose and practice of counselling

	Level 1 analysis	Level 2 analysis			
		Supporting evidence		Contradictory evidence	
Word/concept	N	n	Sample comment	n	Sample comment
Deep listening	25	3	I listen and paraphrase; I ask questions to check content.	10	The first question [I ask] is 'did they do that to you?' , then 'what did you do to make that happen to you?
Resolve concerns	18	2	I don't give advice – I allow the client to come up with options themselves.	10	I tell them that what they are doing is not right and not to do it again.
Confidential	12	3	Not to say anything to others in the village.	0	*No evidence.*
Respected	6	3	Clients and counsellors need to respect each other.	0	*No evidence.*
Empirically supported interventions	6	0	*No evidence.*	4	It's Person-Centred… I talk about Genesis, the fall of man, the creation of man which created power imbalances.
Positive working relationships	5	1	Making them feel comfortable is most important to build rapport with each person and allow them to feel heard	0	*No evidence.*
Accepted without judgement	4	1	Acceptance of every person is important. We are all unique.	1	God will judge them on what they do.
Specialised interpersonal skills	3	1	I ask open-ended questions.	0	*No evidence.*
Collaboration	3	0	*No evidence.*	0	*No evidence.*
Well-being	3	0	*No evidence.*	0	*No evidence.*
Process/stages	2	0	*No evidence.*	2	Explain the company policy, and that if they continue to drink alcohol and beat their wife they will no longer be employed.
Understood	2	0	*No evidence.*	0	*No evidence.*
Facilitate change	2	0	*No evidence.*	0	*No evidence.*
Empower clients	1	1	Okay, you are good at this and how about you doing this? So, like they have the control over…	0	*No evidence.*
Mental health	1	0	*No evidence.*	0	*No evidence.*
Safe	0	0	*No evidence.*	0	*No evidence.*
Self-understanding	0	0	*No evidence.*	0	*No evidence.*
Active participants	0	0	*No evidence.*	0	*No evidence.*
Presentness	0	0	*No evidence.*	0	*No evidence.*
Empathy	0	0	*No evidence.*	0	*No evidence.*
Evidence base	0	0	*No evidence.*	0	*No evidence.*

know about CBT but I don't use it. I respond to the client as they're talking' and 'I know that Narrative therapy is just letting them tell their story'. The two counsellors who mentioned Person-Centred counselling both linked this approach to their faith, for example, 'It's Person-Centred… I talk about Genesis, the fall of man, the creation of man which created power imbalances'. Similarly, there was no evidence that participants understood that there were stages or phases of a counselling session, with one participant explaining that her process was to 'explain the company policy, and that if they continue to drink alcohol and beat their wife they will no longer be employed'. It should be noted that these two concepts – theoretical approaches/frameworks and counselling process/stages – were directly asked about in the interviews.

Two predominant themes emerged from the interviews that were not included in the definition that we used as our framework for analysis: 'helping' and 'solving problems'. The vast majority of participants (21 of 25) (84%) mentioned 'helping' in their responses. Although 'helping' is inarguably a key factor in counselling, arguably it is covered in the list of concepts that were used in the content analysis. This view is supported by the data that showed where helping was mentioned, it was generally explained in terms of 'listening' and 'providing advice', both of which were concepts that were used for analysis. The second theme was the importance of God and prayer, mentioned by 18 of the 25 participants (72%). For example, participants described their role as 'to share God' and to get their clients to re-engage with church and God so that 'better behaviour' and/or healing would result. These views are exemplified in the following comments, 'I tell them to submit to God, that he will heal and help you. They have to develop a relationship with God', 'I explain that connecting with church and God will help them very much with their problems', and 'I tell them if they get their husband to come to church, he will learn he must stop hitting them'. Six counsellors reported opening and closing their sessions with prayer, for example, 'We have to start with prayer' and 'I close the session with prayer and give them a bible verse to study'.

Counselling Skills and Competencies

CSCT Ratings

The CSCT was used to rate each participant's counselling skills and competencies. Table 4 shows the mean scores for the six scales (out of 5) and total (out of 30). Results show that one scale only (attending) reached the standard of 'slightly above expectations', two scales (therapeutic alliance and core counselling conditions) measured approximately halfway between 'slightly below' and 'slightly above expectations', and three scales (reflecting,

Table 4 Counselling skills and competencies tool scale and total mean scores ($N = 24$)

Scale	Range		Mean	SD	Median
Attending	1.75	4.00	3.08	.62	3.00
Reflecting	1.00	3.17	2.01	.74	2.00
Questioning	1.00	3.20	2.27	.73	2.45
Therapeutic Alliance	1.00	4.00	2.60	.76	2.63
Core Counselling Conditions	1.25	3.75	2.63	.63	2.63
Facilitating the Session	1.00	3.40	2.03	.82	2.05
Total	7.50	20.12	14.63	3.75	14.77

questioning, and facilitating the session) only just reached the standard of 'slightly below expectations'. The average total score for the CSCT was 14.63, which is less than half the total amount of points that can be scored. These scores indicated a low level of skill and competency. Further, despite being asked to conduct a 30-min session, the average length was 18.23 min with the shortest session lasting only 10.12 min which is additional evidence that participants lacked the skills and competencies to structure and facilitate a comprehensive counselling session.

Video Observations

Qualitative observational data provides support and further explanation of the CSCT results. Although all participants opened the session with some form of greeting, there was not a single 'opening' that discussed confidentiality, set a comfortable scene, outlined the process of the session, and so on. Mainly, counsellors were eager to discover the presenting problem and find a solution, thus rushing to a premature close. As a result, there was inadequate attention given to exploring the presenting issue/s or concern/s, prioritising issues, moving toward change, or bringing closure to the session, i.e., the typical and general phases of a counselling session.

Possibly because of the limited capacity of participants to facilitate the session, and perhaps exacerbated by that limitation, there was parallel limited use of other skills and competencies in the CSCT, particularly therapeutic alliance, core counselling conditions, reflecting, and questioning. Observation of the videos showed that little time was spent on developing the therapeutic alliance in terms of rapport and/or building relationships, with the majority of counsellors taking the position of expert who was there to solve the problem for the client. Only 4 of 24 participants showed evidence of taking steps to establish a form of connection with their client and/or to express the importance of working together to solve the problem. Similarly, there was a lack of core counselling conditions. For example, unconditional regard (one of the core conditions in the CSCT) means to show care without evaluation or judgement (Geldard et al. 2016) – yet 14 of 25 counsellors made some form of judgmental statement during their session (e.g., "you should be showing more respect to your Auntie" or "you need to stop drinking alcohol"). Although these statements on their own might seem acceptable in some circumstances, they were generally offered without adequate listening nor exploration of contextual issues. Similarly, a lack of empathy was noted via limited attempts to explore how the client was 'feeling' as opposed to what they were 'doing'.

Finally, there was a general lack of usage and/or poor application of microskills throughout the sessions. It is virtually impossible to demonstrate the aforementioned competencies of developing a therapeutic alliance, meeting the core conditions, or effectively facilitating a counselling session without adequate use of underlying basic counselling microskills such as reflection and questioning. For example, there was not a single incidence of reflection of feeling across all 24 counselling sessions and only two incidences of reflection of content, yet these key fundamental skills are crucial in relationship development and problem exploration. Similarly, there was not a single incidence of summarising, or drawing together what the client had expressed, during the sessions. In what seemed to be a desire to get to the crux of the matter, there were very few instances of expressions of warmth, 'checking in' with the client, or of encouraging the client to talk, which resulted in long ineffectual silences. The style of questioning used was, predominantly, task- rather than process-focussed, that is, it focussed on particular details and events rather than exploring the client's underlying thoughts and feelings. In many cases, the questions were loaded or judgmental, for example, "Do you think you should be doing that when you are living under

your Auntie's roof?" or "Why did you do that?". While half of the sessions drew to an abrupt close, the other half were drawn out with the use of repetitive comments and questions, possibly in an attempt to meet the '30-min requirement'.

Discussion

The purpose of the current paper was to report on the counselling knowledge and skills held and applied by PNG nationals working as counsellors in their country. Results showed, via content analysis of interview data, limited evidence of understanding the purpose and process of counselling, of the value or use of theoretical frameworks that guide counselling, or of the skills that are required to be an effective counsellor. Similarly, there was limited evidence of the application of basic counselling skills displayed in the video-recorded sessions (via CSCT scores and observational data), specifically in regard to attending, reflecting, questioning, therapeutic alliance, core counselling conditions, or facilitating a counselling session. Further, the qualitative observational data of the video sessions provided additional evidence of the lack of understanding of counselling purpose and practice that was evident in the interviews. These results are in keeping with DFAT's (2017) report, on counselling across the Pacific Region, that showed a lack of understanding and application of basic counselling, that motivation to help leads to inappropriate counselling, and that therapeutic approaches are used by only a minority of counsellors.

There are some noteworthy differences between the DFAT report and the current study. First, the results presented here were PNG specific, rather than Pacific Region wide. Second, the present results drew on the experiences of 25 front-line counsellors (representing almost as many organisations), which is a considerable increase on the eight PNG organisations who reported generally, rather than specifically, on their counsellors in the DFAT report. Third, the current study used in-depth interviews and video-recorded counselling sessions to assess counselling knowledge and skills as opposed to a brief online survey. As a result, the findings of the current study provide a much clearer and more comprehensive picture of PNG counsellors' knowledge and skills.

There seems little mileage in exploring here, in any depth, details about the lack of knowledge and skills displayed by counsellors in PNG. Rather, three key acknowledgments should be made. First, the findings presented in this study are not surprising given the relative newness of the formalisation of counselling in PNG, including the lack of counselling training available and the infancy of the PNG Counsellors' Association (which, when further developed, will lead to national training and practice standards and accreditation processes). The second acknowledgment is that the participants in this study were sincere and committed counsellors who desired to provide the best possible service to their clients who were, simply, hamstrung in their abilities to deliver effective counselling because of a lack of understanding of basic counselling skills, knowledge, process, or approaches. Third, that without a foundational understanding and the capacity to provide primary and essential counselling skills and competencies, counsellors are not likely to be helpful and effective or, at worst, may provide unfounded or damaging advice which prolongs their clients' exposure to harmful situations and inadvertently results in perpetuating problems. In short, the present findings represent a realistic picture of the counselling situation in PNG – that counselling is provided by well-meaning individuals who are seriously, and possibly dangerously, under-skilled due to a lack of training.

There may be other reasons for the lack of evidence of knowledge and skills found in this study, for example, cultural differences in the way counselling is conducted and therefore PNG counsellors hold a different body of knowledge and set of skills to those assessed in this study. However, the current study did assess knowledge and skills that are commonly and internationally known and practiced as those that are most effective. Alternatively, there may have been a degree of discomfort or 'awkwardness' about being videoed in simulated counselling sessions and therefore participants were stymied in displaying their skills. However, videoed simulations are widely considered to be an acceptable, appropriate, and as 'close to real life as possible' methodology for assessing counselling skills.

Working on two key competing premises – (1) that PNG counsellors lack counselling knowledge and skills and (2) that there has never been a greater need for skilled and knowledgeable counselling practitioners in PNG (DFAT 2017) – we will now turn to recommendations for redressing the current situation. Indeed, as mentioned earlier in this paper, steps have already been taken, for example the newly established PNG Counsellors' Association is developing practice standards and registration processes to regulate the counselling profession. However, on the basis of the findings in this study, there is a certain and absolute need to develop a strong training program that delivers both essential and advanced counselling knowledge and skills to front-line PNG counsellors. The immediate intention of such training is clear, that is to enhance understanding and practice of the counsellors involved. However, the long-term intentions of a well-developed training program should not be underestimated. For example, it could be the basis for establishing a counselling culture that recognises and delivers best practice counselling knowledge and skills. It could also work to develop a core group of PNG counsellors who can, in turn, provide training, supervision, and professional development to others.

Such a training program should focus on three key areas. The first key area is the counselling knowledge and skills that were assessed in the current study, that is those that are the most basic, fundamental, and globally recognised for effective practice. In regard to skills and competencies this would include attending behaviour, reflection of content and feeling, questioning, relationship and rapport, core counselling conditions (e.g., empathy, respect), and phases of a counselling session (e.g., opening a session, exploring priorities). In addition, curricula should include the understanding and application of the purpose and process of counselling, and the basic principles on which effective counselling is conducted, e.g., working collaboratively, supportive and active listening, planning strategies, and ethical considerations and behaviour.

The second key area is counselling theories, which provide a necessary framework for guiding the counselling process and, ultimately, determining appropriate action (Ivey et al. 2018). As noted earlier, there was no evidence to suggest that the participants in this study applied any specific theoretical approaches to their counselling. The theories included in the training should be those most suited to PNG practice, specifically, evidence-based theories that are most likely to lead to positive interventions in relation to the individual and social problems that are prevalent in PNG. For example, Cognitive Behavioural Therapy (CBT) should be included because it has consistently proven to be effective in addressing the therapeutic needs of both the victims and perpetrators in domestic violence situations (Condino et al. 2016; Johnson and Zlotnick 2009). Similarly, Motivational Interviewing should be included in such a training program because of the vast amount of evidence that suggests it has a high degree of success in treating both alcohol problems and substance abuse issues (Madson et al. 2016; Miller et al. 1988). Further, in teaching these theoretical frameworks, the knowledge and skills from the first key area should be drawn on and reiterated in the context and application of particular theories.

The third focus of the training is that it should be designed and delivered in the context of counselling in PNG. Specifically, training content should include sessions in particular areas that have been identified as problematic in PNG, such as family violence, gender-based violence, alcohol and drugs, gambling, mental health, HIV/AIDS, and suicide. In delivering this content, the first and second key areas of training should be integrated, such as how microskills and basic principles of counselling, and particular theories and frameworks, are best applied in the context of specific individual and social problems. Concepts such as 'working through the phases of facilitating a counselling session' and 'developing a relationship with the counsellor' should be considered within the context of short interventions, which is typical practice in PNG (DFAT 2017). Ethical issues such as 'confidentiality' should be explored in the context of counselling in villages where the interconnectedness between people is strong, valued, and often boundaryless. It may be that some aspects of training need to strike an appropriate balance between ideal practice and the reality of counselling in PNG. Finally, because of the dearth of access to experienced counsellors and counselling organisations, PNG trainees should be exposed to good practice examples of practitioners and counselling services as models that they may be able to apply in PNG.

Although this paper has outlined a broad approach to training across three key areas, a more detailed design should incorporate avenues for analysis of training needs and outcomes. For example, what are the best teaching and engagement methods for Papua New Guineans? What knowledge and skills are most effective for Papua New Guinean counsellors? What is the most appropriate counselling skills framework that should be taught, practiced, and assessed? What is the best way of assessing the acquisition and development of knowledge and skills over time? And, of course, has the training program resulted in increased knowledge and skills? Answers to these questions have not only the potential of enhancing counselling practice in PNG, but of informing counselling and associated counselling training across the Pacific Region. For a country and region in desperate need of counselling interventions (Adu Krow et al. 2013; Grundy et al. 2019) the answers to these questions cannot come soon enough.

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Declarations

Ethics Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the Griffith University Human Ethics Protocol (2018/924) and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study.

Conflict of Interest The authors declare they have no conflict of interest.

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