An Investigation of the Effects of Opiate Withdrawal Syndrome on Interrogative Suggestibility

- A portfolio of academic, clinical, and research work submitted in respect of the degree PSYCH.D. in Clinical Psychology

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by
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SUMMARY OF PORTFOLIO

The portfolio is intended to demonstrate a range and depth of knowledge concerning clinical skills and issues. It is divided into 3 sections. The first is the academic sections, which contains a selection of essays completed over the three years. The clinical section contains summaries of experience from the clinical placements as well summaries of case reports. The research section contains a literature review from Year 1, a small scale research project, combined with research on placement from Year 2, and the large scale research project undertaken for Year 3.
SUMMARY OF ACADEMIC SECTION

The academic section is intended to demonstrate knowledge and understanding of a range of clinical issues. The 5 essays presented here are chosen to most represent the breadth and depth of work covered in the 3 years. They are presented in the order in which they were written in order to demonstrate a development of critical analysis during the course. The essays concern issues of consent related to people with learning disabilities, models of psychiatric rehabilitation for people with long-term disabilities, bereavement models related to children, issues of suicidal behaviour in older adults, and the influence of two therapeutic models on systemic thinking.
PEOPLE WITH LEARNING DISABILITIES ESSAY

TITLE: Concern has been raised regarding a relationship between two clients of the same sex, but of differing levels of ability living in a staffed home. What are the areas that need to be considered when reflecting on this relationship, with specific reference to consent and policy areas?

DATE: YEAR 1
INTRODUCTION

The sexuality of people with learning disabilities is an important but at times neglected issue. Issues of sexuality are often reduced to heterosexual issues, but there is an increasing awareness in the literature that homosexuality needs to be considered as well. This essay considers issues raised by a same sex relationship between two people of differing levels of learning disability within a staffed home. This will be achieved by first considering the social and legal implications of the situation and then looking at what can be done in terms of policy.

Social Implications

It will be helpful to consider why sexuality is an issue within learning disability.

Kempton and Kahn (1991) provide a historical perspective of sexuality and people with learning disabilities. Between 1880 and 1940 people with learning disabilities were seen as criminals and promiscuous. There were fears that society would be over-run and that it was necessary to keep such people in check. A solution of selective breeding was proposed which involved involuntary sterilisation and segregating people with learning disabilities from society in institutions.

Several authors describe a further belief that still colours our attitudes today (e.g. Craft, 1987; Robbins, 1990). Many people with learning disabilities are seen as children and there is a concurrent assumption that children are asexual. This can lead to a denial of a person's sexuality and possibly a further belief in the need to protect people from becoming sexual.

By the mid-20th century, there was a growing body of research indicating that the views from the Eugenics movement were unfounded (Clare and Murphy, 1995). Kempton and Kahn (1991) and Clare and Murphy (1995) summarise 3 important findings. People with learning disabilities were found to be generally less fertile than the rest of the population. There was a realisation that other factors contributed to crime. The difference that any children from people with learning disabilities
make to the overall prevalence of learning disability in the population is very small.

During the sixties and seventies, people with learning disabilities benefited from progress made in civil rights and sexual freedom. There was an increasing recognition of the problems of institutionalisation (e.g. Goffman, 1970). The principles of normalisation developed by Nirje in Scandinavia dealt with the needs of people with learning disabilities to have normal experiences in line with the rest of the population. The upshot of all these changes was an increasing recognition of i) how people with learning disabilities had been devalued by society, and ii) how people with learning disabilities should have the same values and rights to socially valued experiences as the rest of the population.

However, rights and values may be interpreted differently by different populations and there has been much criticism of how philosophies, most notably normalisation, have been implemented. Importantly for this essay, normalisation can be criticised on two accounts. In emphasising "normal" experiences, it can detract from the needs that people may have that require help that is not a "normal" expectation. Normalisation also does not place an emphasis on having a socially valued role. Wolfensberger tried to account for this in his reformulation of normalisation in terms of "social role valorisation" (Wolfensberger, 1995). However, this is still weighted towards normal experiences rather than taking up the challenge of allowing people with learning disabilities to be socially valued as a population in their own right.

Such problems in philosophy have contributed to problems in giving people with learning disabilities the experiences they need. It can be suggested that community living covertly still denies the sexuality of people with learning disabilities. The gender of clients within a home may not be considered when it is being set up and there may be no division of labour among the sexes within the home. It can be argued that such practice ignores sex roles, which is a further experience related to sexuality that is denied to this population.

In terms of experience, it is important to realise that friendships are an important aspect of developing sexuality and sexual relationships, yet this is often not considered as a suitable task for teaching.
People with learning disabilities may be denied the normal peer experiences for learning about sex that those without such disabilities have. At some level there may be some recognition of this among staff. Robbins (1990) in his survey of attitudes towards sexuality in people with learning disabilities noted that social services staff often saw homosexual acts between clients as clumsy experimentation. This may be so, but it may also be the preferred orientation for those clients.

**Legal Implications**

People with learning disabilities are considered to be vulnerable to abuse and there are legal guidelines for their protection. However, these may not be widely known or understood (Robbins, 1990). Staff may be either unaware of the implications of certain events or conversely may be over-cautious if a person with learning disabilities displays any sexual behaviour. It is therefore necessary to consider what behaviour is considered legal, for who, and under what circumstances.

Lawful acts are those carried out within marriage, therefore anything outside of marriage is considered unlawful, but not necessary illegal. With the introduction of the Sexual Offences Act (1967), homosexual acts between men are no longer illegal, but only for consenting adults over the age of 18 (a more recent amendment), with consent and in private. Consent shall be discussed later, but in private means that only two people may be involved in the act and that it should not be viewed by any other parties. This effectively rules out homosexual activities of cottaging (going to public toilets to have sex or to meet men to have sex with) and cruising (using other public places, such as parks, to have sex or to meet men to have sex with). If a client lives in a home where they do not have access to a private place, such as a lockable room, then this effectively prevents them from being allowed homosexual acts. There is no law specific to homosexual acts between women. Buggery is an offence under the Sexual Offences Act (1956) but not if it is covered under the laws governing homosexual acts. Pornography is not illegal to purchase or own, but it is an offence to display it in public places. There are different issues concerning the exploitation of women and whether the material is appropriate for an individual's level of psychosexual development. Finally rape, although an offence, only concerns intercourse between men and women and does not relate to homosexual
acts. Where consent is not given, such acts would be considered under the laws governing indecent assaults.

An area where the legal implications are unclear is section 28 of the Local Government Act (1988), where it is an offence to promote homosexuality. It is not clear yet what level of tolerance this allows.

Only people with severe learning disabilities and those under the age of 16 are considered to be unable to give consent by law. This effectively means that the age of consent for lesbian activities is 16 years and over (Sexual Offences Act, 1967). It is illegal for someone without a severe learning disability to have sex with someone with a learning disability. Those with mild or moderate learning disabilities are subject to the same laws as the rest of the population. They are no longer protected by the laws of guardianship, which are now limited to those who are considered mentally or severely mentally impaired. The result of the legislation is that it is legal for two individuals with severe learning disabilities to have sex as neither could be considered to understand that this was illegal. However, the Criminal Law Revision Committee (Robbins, 1990) has recommended that homosexuality between two men with severe learning disabilities should remain an offence.

A further legal aspect is that staff must be seen to be upholding the law and where they suspect it is being broken then if they do not take action, they are also liable to prosecution.

Consent
In the above section, much of the law appears concerned with whether consent is or can be given, however there do not appear to be clear explanations of what constitutes consent. Craft (1987) makes a useful distinction between understanding and behaviour. If applied to consent, this would imply a demonstration of more than acquiescence from the individual. Anecdotal evidence would suggest that people with learning disabilities can be more compliant than other populations. Parker and Abramson (1995) view informed consent as involving two constructs: (a) an ability to understand the nature and consequences of the sexual act, and (b) an ability to understand and use choice when deciding to engage in sexual acts. Sundram and Stavis (1994) further emphasise the need for there to
be no coercion and for the individual to apply their knowledge in a manner consistent with their beliefs.

The lack of apparent protocol in this area could lead to some variability in decisions. This idea is supported by Parker and Abramson (1995) who found that different professional groups did not necessarily independently evaluate both of the concepts required for consent in all circumstances.

When considering someone's ability to state their choice, it is important to consider the possible power imbalance between individuals. People with learning disabilities may be socially isolated and economically disadvantaged (Cambridge, 1996), making activities such as cottaging an attractive but risky possibility. A person with a learning disability may not feel on an equal footing with someone without, such as a member of staff and there is the potential for abuse. It may be that there is an equal danger of this happening between two individuals of differing levels of learning disability and that one may be taking advantage of the other.

Policy
"Policy" for this essay will relate to the practical things that can be done for clients.

Although services are aware of the philosophical importance of enabling clients to live normal and valued lives, these are not always backed up with guidelines/policies of how to put this into practice. This absence of guidelines can result in staff encountering situations that they are not equipped to deal with and also result in clients suffering and being put at risk. There is some support for this view in case examples provided by Sundram and Stavis (1994). Policies should help staff in their potentially conflicting roles of protecting clients and enabling them.

Protecting Clients
For this case, one should determine whether an offence has been committed. If there has been abuse, then it becomes a legal matter, which may involve a prosecution. This will undoubtedly have
ramifications for staff and clients. It is the author's view that such prosecutions are rarely successful. This is no way suggests that such action should not be undertaken. However, one must consider likely effects on staff and clients, which may hinder or facilitate such a process. Staff may be reluctant to take action for a variety of reasons. They may be uncertain of what is expected of them. They may feel that the offender was not fully aware of what was happening. If action is taken without clear explanation, the clients may feel that they are being punished. If no offence has been committed, but it is clear that one or other of the clients is unable to consent, then action must be taken to prevent an offence. Here it is useful to bear in mind Wolfensberger's (1995) view that every action/inaction will have an if...then... consequence. For example, if the clients are carefully monitored or separated, then one may expect them to feel punished. If one is able to teach the client why their action is wrong, then one may prevent the situation from occurring.

Enabling Clients

If it is apparent that the clients are able and willing to consent then it will be necessary to consider how they can be enabled and supported to express their individual sexuality.

Before we look at the client however, we will look at the attitudes of staff and parents which will reflect their behaviour towards work concerning people with learning disabilities and sexuality. Robbins (1990) in an extensive survey of the attitudes of parents and social services carers in Avon towards sexuality in learning disabilities noted that there was a wide variability in attitudes, but that there were recurring themes.

Parents' own psycho-sexual development and their attitudes towards sexuality are important. There are influences from moral, religious, and generational views. Their attitudes towards their own sexuality may be affected by giving birth to a handicapped child. Their own experiences may also influence what they expect for their own children. Although a client over 18 without severe learning disabilities is able to express their sexuality as they wish, it should be realised that this may have a significant impact on their relationship with their parents. Both clients and parents may need reassurance and support to deal with the consequences. Parents in particular may need reassurance
concerning safety over what they perceive as "liberal" approaches to sexuality.

Both Robbins (1990) and Craft (1987) note that some parents may deny their children's sexuality possibly in the belief that they will be unable to deal with adult roles and responsibilities. There is a further belief that sex education may awaken dormant feelings and desires that the individual will be unable to handle. Kempton (in Robbins, 1990 p.14) notes that parents can be reassured when they see that most people with learning disabilities will adopt traditional and stereotypical roles, as these are more structured and easier to understand.

The majority of social services staff in Robin's survey felt that sexuality was an important part of normal living for people with learning disabilities. However, there was also a feeling that staff should have the right not to deal with issues that could raise conflicts with their own views. When discussing sexual exploitation, staff were unclear what this constituted when it involved two people with learning disabilities. There was a tendency to define any sexual activity between two people as sexual exploitation as well as a tendency to police clients and minimise sexual contact. Homosexual behaviour did not appear to cause much harm, but this appears to be partly due to the belief that it is just misdirected expression, rather than actual homosexual behaviour. Contraception was seen as protection against pregnancy rather than as a health issue and this is a particular concern for sexually active homosexual men. Cambridge (1994) notes that some people with learning difficulties have HIV infection or AIDS and some have died from AIDS related illnesses. In view of this there is a need for services to be proactive.

Many of the above attitudes may hinder the enablement of sexual expression. These attitudes may stem from personal beliefs, experience and education. In order to get co-operation for work with sexuality one may have to balance education and training with respect for individual beliefs. There are various packages for sexuality training. Sumarah, Maksym, and Goudge (in Toomey, 1993) suggest that those directed towards increasing sensitivity and developing confidence in dealing with sexual behaviours usually bring about favourable change in attitudes which is maintained over time. There
is also a need to tailor such packages for the socio-cultural context that they are due to be used in. Cambridge (1994) in writing about learning disabilities and HIV emphasises four aspects of training, which take in the main areas discussed in this essay:

a) The rights of service users,
b) Practical aspects, such as assessing for informed consent,
c) The legal position and a consideration of societal attitudes,
d) Service response, particularly deficits in knowledge and skills.

As well as policies for staff, there is a need for work with parents and carers. Toomey (1993) notes that parents often have less punitive and restrictive attitudes towards sexuality than care staff. Toomey also raises the importance of gaining the support and sanction of management for any initiatives in sex education.

**Practical Help for the Client**

No individual is alike and it will be difficult to generate a standard policy for everyone. In view of this, some form of Independent Programme Plan would be useful, but this then raises a difficult issue of confidentiality. Who needs to be aware of the individual's lifestyle?

Several authors have discussed the need for sex education for clients with learning disabilities (e.g. Craft, 1987; McCabe, 1993). However there is limited data on the validity and effectiveness of such programmes (McCabe, 1993). Lindsay, Michie, Staines, Bellshaw, and Culross (1994) have provided some evidence that attitudes can be changed through sex education programmes. One direction of change was to a more liberal acceptance of homosexuality. It is evident that increasing knowledge about sexuality is important, but it is likely that individuals would also benefit from work on social skills, such as in developing friendships, as well as sexual skills. Any form of teaching that can make ideas more concrete should be considered. An important element of teaching for both staff and clients should be the dangers of unprotected sex, such as HIV and AIDS.
In addition to sex education, it is important to consider the individual's lifestyle and environment. It may be that they do not have the opportunity for a private relationship within their home, which may increase their willingness to explore other environments.

One area that has received very little attention is that of supporting clients in a homosexual lifestyle. Cambridge (1994; 1996) makes the interesting point that people with learning disabilities who are homosexual are not an accepted part of the gay scene. This prevents such people from accessing important support and information. However, a useful concept from gay rights movements is that of self-advocacy and it is important to try to connect people with appropriate groups.

**Summary and Conclusions**

This essay has discussed the importance of recognising that people with learning disabilities have basic rights to be able to express and develop their sexuality. There are social factors that prevent people from gaining the experiences necessary to make sense of sexuality. In addition there is confusion over the legal implications of such people expressing any sexuality, which can result in over-protectiveness or people being exposed to abuse. Any actions of staff or parents will be influenced by their attitudes, which can be very variable.

In conclusion it will be important in a situation involving two clients of the same sex, but different levels of ability, to determine whether both parties give consent to the relationship. Consent will involve a relationship between knowledge of the act, ability to say "yes" or "no", level of learning disability, and balance of "power" within the relationship. If consent is apparent then a combination of education and support for clients, staff, and parents or carers is likely to provide an environment where the individuals' rights are acknowledged and protected.
REFERENCES


Wolfensberger, W. (1995). An "if this, then that" formulation of decisions related to social role valorization as a better way of interpreting it to people. *Mental Retardation, 33*(3), 163-169
LONG TERM DISABILITIES ESSAY

TITLE: What is psychiatric rehabilitation? Discuss with reference to at least three models of intervention.

DATE: YEAR 1
INTRODUCTION

This essay aims to discuss psychiatric rehabilitation in 3 stages. It will consider the task of rehabilitation and the population that it is appropriate for, the setting in which rehabilitation takes place, and finally the process of rehabilitation and specific models of intervention.

THE TASK

Definitions of rehabilitation

Psychiatric rehabilitation is generally concerned with people who have suffered some form of mental illness. The nature of these illnesses means that many people suffer enduring disabilities (Shepherd, 1988: cited in Pilling, 1991, p.16).

Definitions of rehabilitation vary according to the model of intervention that each author subscribes to, although they all have aspects in common.

Wing and Morris (1981) suggested that sufferers of long-term mental illness suffer severe social disablement. They saw rehabilitation as a process of identifying the causes of disablement, in order to prevent or minimise them, while at the same time helping the individual achieve success in social roles and increase their self-esteem and confidence through using and developing their own talents. This definition stems from a model of disability that sees social disablement as a function of 3 factors:

1) Social disadvantages that were present before the illness, such as poverty, and lack of social skills.
2) Symptoms of the illness or disorder, such as hallucinations or apathy.
3) Adverse personal reactions to having been ill and also the reactions of others.

Other definitions place more emphasis on the strengths rather than weaknesses of clients.
Anthony, Pierce, Cohen, and Cannon (1981: cited in Pilling, 1991, p.16) felt that rehabilitation should be aimed at increasing individual strengths in order to help clients achieve maximum potential for independent living and meaningful careers. This would be in the context of their own environments.

A similar emphasis on skills was proposed by Bennet (1978: cited in Pilling, 1991, p.15). However Bennet felt that people should have segregated environments where there were more opportunities for meeting specific needs. This includes opportunities for developing individual skills, appropriate social roles, and for the provision of long-term support.

The idea of social roles featured more prominently in Wolfensberger's Social Role Valorisation theory (1980: cited in Pilling, 1991, p.14). He conceptualised many of the problems that sufferers with long-term illnesses encounter as being understandable given the low social value that society places on the experience of mental illness. Therefore rehabilitation can be seen as being concerned with the enhancement of social image and personal competency.

Problems of mental illness

Prevalence

According to a study of the prevalence of mental illness, by Goldberg and Huxley in 1992 (cited in Pullen, 1994a, p.17), it was estimated that about a quarter of the population in Britain could expect to suffer from a mental disorder in any one year. Goldberg and Huxley also proposed that people have to pass through various "filters" of care in order to get to the next levels, eg. clients will not be seen by the psychiatric services unless referred by their GP. From this they felt that many people with a psychiatric condition are not seen by the psychiatric services. Pullen argues that an important part of rehabilitation, in addition to managing severe handicaps, should be dealing with prevention (Pullen, 1994a, p.19).
Prevention
Pullen divides prevention into 3 categories. Primary prevention is seen as preventing possible illnesses by targeting vulnerable people, eg. by offering bereavement counselling. Secondary prevention involves quick and effective treatment of episodes of illness. Tertiary prevention is concerned with minimising the handicaps, as described by Wing and Morris, that can result from illness.

The illness
The types of mental illness that psychiatric rehabilitation is aimed at concern schizophrenia and other psychoses, neuroses, and personality disorders. In addition, rehabilitation principles are also useful in dealing with people with learning disabilities (Pullen, 1994a, p.21-28).

The outcome of such disorders will vary with such factors as diagnostic group, precipitating factors being removed, the benefits of the "sick" role, and the effectiveness of treatment. Some illnesses will improve spontaneously, others may be interspersed with periods of recovery, while others will affect people for the rest of their lives. Goldberg and Huxley (1992: cited in Pullen, 1994a, p.30) note that different factors promote the loss of symptoms at different times. In primary care, a positive attitude of subjective social support appears important, while for people who reach the psychiatric services, the actual level of social support appears more important. For those in psychiatric care, factors such as length of previous history, personality and constitutional factors, and long-standing social difficulties are more relevant.

Pullen (1994a, p.30) notes that even if someone has a partial or complete recovery from an illness, they may still have to contend with stresses related to coming to terms with having been ill, as well as coping with other people's attitudes to them, and also whether the illness will return.

Patient groups
Shepherd (1984, p.7) conceptualised different groups of patients. The old long-stay are those who
have been in hospital a long time and grown old there. In addition to their illness, many have become physically frail, requiring more care. When considering the drive to decrease long-stay hospital beds, Pullen (1994b) cites Mahoney (1988) in saying that between 1976-1986, twice as many long-stay mental hospital patients had died in hospital, as were discharged. The new long-stay are the people who, despite efforts to maintain them in the community, are being added to the hospital population. The new long-term are those who are maintained in the community, but will have repeated and extended involvement with the psychiatric services. This group will hopefully suffer less social disablement than the first two groups by not suffering the effects of institutionalisation.

The importance of families
In addition to the patients, it is important to consider what part their families have in rehabilitation. Szasz (1960: cited in Elliot, 1994, p.133) and Laing (1967: cited in Elliot, 1994, p.133) challenged the notion of psychiatric illness, suggesting that it could be seen as either a social construct or the product of dysfunctional families. Elliot (1994, p.133) feels that although these views have largely been abandoned, families are often seen by professionals as being potentially destructive or having little to contribute to the process of rehabilitation. This not only ignores the contributions that families make, but also ignores their need for support in their own right.

Families need help in making sense of their relative's illness, even if an accurate diagnosis is not clear. They are often excluded from planning discussions (Elliot, 1994, p.137) even when they may be providing the accommodation for the patient. Families also need to be able to plan for the future. The emotions when taking stock of their situation have been likened to a protracted grief reaction (Elliot, 1994, p.138). Elliot cites Gibbon et al (1984) in saying that studies show the vast majority of families experience emotional and physical hardship when caring for someone with a long-term mental illness.
THE SETTING

History
The current climate of rehabilitation is perhaps better understood with some background to its history.

Since the Victorian era, care for the mentally ill has been undertaken in large Victorian mental hospitals (Shepherd, 1984, chap.2). By the 1950's attitudes had begun to change and there was a drive towards "community psychiatry" (Pullen, 1994b, p.38). At the same time, there were advances in pharmacological treatments for mental illness, meaning that many symptoms could be controlled.

The community psychiatry movement was given added impetus through the publication of the concept of institutionalisation (Barton, 1959; Goffman, 1961: cited in Pullen, 1994b, p.38), which described the conditions and effects of long-stay hospitals. Psychiatric hospitals were seen as causing additional problems and handicaps for the patient. They created a segregated community that had to conform to a rigid, depersonalising regimen. This meant that the patient had little or no control over decisions concerning them and were deprived of normal social roles. It was felt that discharging patients to more normal environments would result in improved functioning and behaviour.

There were criticisms of the deinstitutionalisation movement. It was recognised that institutionalisation could happen in small units as well as large hospitals. In addition, people's behaviour was not solely due to their environment. Premorbid abilities and handicaps resulting from mental illness also need to be taken into account.

In the 1980's there was additional political pressure to close the hospital beds, despite the apparent lack of community resources. Discharging patients without adequate follow-up resulted in the recognition of "revolving door" patients who would deteriorate in the community until needing readmission.
Community care and recent changes

Despite these criticisms, care in the community is currently seen as a more satisfactory setting in which to deal with mental illness, because of the negative effects of hospitalisation. Another theme of community care is that any treatment available within hospitals can also be available outside.

However it should be made clear that community care does not mean closing all hospitals, but rather it involves a shift in emphasis to caring for people within the community. In addition, it should not be expected that the community will care for sufferers of long-term mental illness.

In "Better services for the mentally ill" (DHSS 1975: cited in Pullen 1994b, p.40), it was acknowledged that local authorities in Britain were not providing the resources needed for community care. In addition to suggesting that funding should be shifted away from in-patient services towards out-patient services, the paper also recommended the formation of specialist multi-disciplinary teams who would be based in the district general hospital.

Many of the changes in services for the mentally ill have been motivated on social or political concern, rather than research. However more recently, there have been studies comparing different service provisions.

Langsley, Machotka, and Flomenhaft (1971: cited in Pullen, 1994c, p.53) were able to show that patients for whom hospital admission seemed necessary could be maintained in the community by using a Family Crisis Team. Marx, Test, and Stein (1973: cited in Pullen, 1994c, p.55) were able to improve the functioning in the community of a group of patients who had previously not been considered capable of sustained community living.

However these models, although effective, were not continued after the initial research period, even though they were shown to save money (Pullen, 1994c, p.57). Services need to be ongoing and
available on a 24 hour basis. They must be flexible to individual needs. Pullen (1994c, p.56) noted that chronic patients tend to drop out of treatment if they have to attend a clinic and so services must also be assertive in seeking their clients out.

There are still problems with community care. Following an investigation into a spate of suicides in the Southwest of England, Morgan (1992: cited in Pullen, 1994c, p.57) drew attention to the risk of fragmentation to the service, along with conflicting ideologies and difficulties in monitoring and evaluating dispersed resources. Fragmentation of services can increase the danger that individuals will fall through the net without seeing the services they need. MENCAP and the National Schizophrenia Fellowship (Pullen, 1994c, p.57) have also expressed concern that decreasing hospital beds will make it difficult for sufferers to obtain them when they are needed. No study has yet shown that hospitals are redundant.

THE PROCESS

Having discussed the task and setting of rehabilitation, we can now consider what the process actually entails.

Any intervention will involve a period of assessment and perhaps diagnosis, which will guide a management plan, which in turn will need to be reviewed.

Assessment

Assessment is important in providing an objective baseline of a person's skills, strengths, and weaknesses from which to monitor change. This is the stage where a problem list will be defined. One of the requirements of the Community Care Bill 1990 is the assessment of need. This is intended so that clients and carers can identify problems or difficulties, which are priorities for them. These needs can then be matched to services and available resources.
In rehabilitation, assessment focuses on an individual's functional performance and their ability to cope with day-to-day living. Various methods are used. These can include direct observation of functioning, checklists, questionnaires, schedules, and interviews. Some require more training than others. None of these techniques are perfect and all have disadvantages. For example, people do not behave in the same way in all situations. This may lead one observer to rate an individual differently to another observer. In view of this it is important to have more than one source of information.

Hume (1994, p.67) considers the timing of assessments important. As well as having a baseline, it is important to continue assessment at regular intervals. This has the dual purpose of a) documenting any changes, and b) preventing people from being overlooked if they are unobtrusive. It is also important to remember that just because someone can perform a task, it does not necessarily mean that they will be motivated to do so when on their own.

When considering what to assess, Hume (1994, p.69) suggests that people do not have to be accomplished at all aspects of life. In this he reflects the needs approach to rehabilitation, in focusing not just on someone's skills, but also on their situation and what they need to be able to function. Common areas that are looked at include mental state, cognitive function, personal life skills, social skills, domestic skills, leisure, work, and community living skills.

Evaluation and research are also aspects of rehabilitation. It is important to monitor the services that people receive in terms of quality assurance and efficacy of interventions and resources.

Diagnosis

This is only possible with a comprehensive assessment. However, it has advantages and disadvantages (Pullen, 1994a, p.24). Amongst its disadvantages, it may give a false sense of security as people can forget how difficult it was to reach even a tentative diagnosis. A diagnostic label can also affect the
expectations of patient, family, employers, and clinical team. This can be further complicated by the pejorative values attached to some labels, such as personality disorder.

This issues have to be weighed up against the advantages of diagnosis. It can give some indication of the natural history of a condition, allowing people to plan ahead as well as to consider treatments that might be beneficial. A diagnosis may also give relatives and patients a sense of relief in that there is an explanation for what is happening. In addition to these points, a diagnosis condenses a lot of complex information about an individual and can be used to compare individuals in research and service planning.

Management
Choice of management is influenced by the models of mental illness that are chosen. There are many ways of conceptualising a patient's condition, but according to Pullen (1994d, p.76), the most important models are as follows: Behavioural model; Organic model; Psychotherapeutic model; Social model; and Medical model. Pullen (1994d, p.79) notes that most treatments can be used in any setting and so the decision on where to treat should be based on social rather than strictly medical criteria. No one model can explain the range of psychiatric conditions and Pullen (1994d, p.78) recommends using more than one model in an intervention.

However the above models can be seen as attempting to cure mental illness. Treatments can involve psychotropic medication, psychotherapy, social treatments (in trying to reduce stress for the patient), electroconvulsive therapy, and even psychosurgery (as detailed in Pullen 1994d, p.81-84). Such "cure" models are inappropriate in rehabilitation for several reasons. Chiefly, the disabilities of people in long-term care are by definition chronic. "Cure" approaches are likely to have been tried already, yet the problems may still remain. This can be demoralising for both staff and patient when a "cure" approach does not work. Also by focusing on symptoms and dysfunctional behaviours according to diagnosis, treatment is less likely to be tailored to the individual. "Cure" models can also be criticised for not giving much guidance on how to help people with disabilities function in daily life.
It is apparent that, although treatments are important, models of intervention need to take a long-term look at an individual and aim to help people achieve the best level of functioning in daily life that they can realistically achieve.

Wing and Morris (1981) took a broader approach with their model of disabilities. Problems are seen not just in terms of illness, but also with regard to the way an individual responds to their illness and also the social disablement that can result. Although a broader approach, it still focuses on the individual.

However this approach does have problems. It can lead to creating a long list of problems with no way of prioritising them, which can be demoralising to staff and patients. It also fails to point towards specific interventions that can help functioning.

Skills models emphasise the more positive aspects of an individual by identifying strengths as well as weakness. This can then provide a clear direction for an individualised intervention in terms of skills training. Such an intervention can also be very structured.

Unfortunately, focusing only on someone's skills and deficits means that broader aspects can be ignored. For instance, the interaction of someone's needs and the way they function within their environment are not taken into account. Such an approach can detract from important, but non-skills based tasks, such as coming to terms with a disability. In addition this approach can, like the cure models, result in someone not improving, which can make patient and staff feel demoralised.

A needs approach (e.g. Bennet, 1978: cited in Pilling, 1991) involves focusing on what someone really needs to be able to do to survive, rather than just what would be useful. By thinking in such terms, one has to consider the interaction and pattern of someone's needs, rather than each in isolation. One also must consider an individual's environment and the support and resources that it contains. This allows
the possibility of a variety of solutions, although it should be recognised that some needs may simply not have adequate solutions. The broader range of possible solutions limits the possibility of failure that skills and "cure" models can have.

The disadvantages of such an approach are chiefly around defining what constitutes a need. A need can relate to just about anything from psychological states to basic necessities. In addition, there can be conflicts between who decides what the needs are, whether it is the individual, others around them, or mental health professionals. A similar conflict arises in who evaluates a service (Hume, 1994, p.72). Should it be the patient, the mental health professionals, or financial administrators? It is also possible for needs to be defined according to which resources are available.

Summary
In summary, psychiatric rehabilitation is a long-term process, that extends beyond simple treatments aimed at curing people. It needs to consider all aspects of the individual and their environment, not just skills or disabilities. Its aim can be seen as trying to help people maintain or improve their functioning in daily living.

When considering the best setting for rehabilitation, research supports dealing with and supporting people in the community and trying to prevent hospital admissions as an effective and viable option. Services need to be comprehensive and flexible in dealing with people with long-term needs. However it is also apparent that there is still a need for psychiatric hospital beds as well.

It is also important to consider what can be done to prevent or minimise disabilities associated with mental illness. Finally, when considering rehabilitation, one should take care not to exclude the patient's family from the process.
REFERENCES


CHILD AND ADOLESCENT ESSAY

TITLE: Critically evaluate the models of bereavement in relation to children, and discuss their clinical relevance.

DATE: YEAR 2
INTRODUCTION

In a review of studies on the effects of bereavement on children, Rutter (1966: cited in Black, 1978) found over twice as many children that attended a psychiatric clinic had lost a parent by death than would be expected from comparable death-rates in the general population. He also noted that disorders could develop some years after a bereavement. In one-third of his clinic sample there was a gap between 5 years or more between the death and the onset of symptoms. Depression and alcoholism in women have also both been associated with childhood bereavement (Birtchnell, 1972). Although such findings are not without criticism (Black, 1978), the general implication is that bereavement in childhood can have far reaching effects. In addition to understanding the mechanics of bereavement and how it relates to children it is important to consider how one can intervene to prevent problems later in life. This essay attempts to summarise the main theories of bereavement, look at how they apply to children, and their clinical relevance.

Psychodynamic and ethological models of bereavement

The psychodynamic and ethological (i.e. attachment) theories are considered by some authors to be the most influential, internationally and such was the finding in a study by Middleton, Moylan, Raphael, Burnett, and Martinek (1993). Indeed, one might expect this, given that it is one of the older psychological models and so has had more time to be read internationally. Other models can be argued to reflect the immediate culture and time from which they have been derived (Kastenbaum, 1992).

Furman (1974) defines mourning as “the mental work following the loss of a love object through death.”. This mental work focuses on decathexis, the withdrawal of emotional energy from the loved object, so that it may be reinvested in another. The drives for this appear to come from reality testing and narcissistic satisfactions in being alive. Essentially the bereaved person learns through repeated experiences in everyday life that the lost object is definitely lost. The ego is then confronted with whether to share the same fate or to survive. It is the sum of narcissistic satisfactions that an individual experiences in daily
life that persuade the ego that life is worth living. A person is driven to survive then by having to acknowledge the reality of the loss and by comparing the pleasures of living with its alternative, extinction. Such survival is considered to necessitate the withdrawal of libido from the loved object.

Bowlby (1980) felt that the differences between adult mourning and child mourning had been greatly exaggerated by the above model and argued that the psychodynamic model of bereavement did not fit with the observable facts. He described children separated from their mothers as going through 3 stages: protest, despair, and detachment. Bowlby focused on the dyad of mother and child, stating that they have a biological need to be together and that this forms the basis of their attachment behaviour. Bowlby predicted that if this need for attachment were not met or the bond was broken, such as through the death of the mother, then the child was at risk of growing up being unable to form secure attachments. Bowlby appears to play down the narcissistic desires to live by emphasising the biological drive to survive.

Stage theories of bereavement
Parkes (1986) has drawn on the ethological approach of Bowlby in devising his stage model of grief in adult life. He has used observations of the reactions of widows and widowers to describe 5 stages that the bereaved typically go through. Although the stages are viewed as a progression, he acknowledges that the progression is different for each person and the stages need not lead from one to other. Parkes, in line with Bowlby, also suggests that reactions to bereavement can be viewed as biologically adaptive. The 5 stages that Parkes proposes follow a bereavement are: alarm; searching; mitigation; anger and guilt, and the formation of a new identity. Although these stages are seen as a progression, Parkes acknowledges that each individual is different and so the expression of grief through these stages can also vary. The overriding theme is that most of the behaviours within each stage would be adaptive if the person were not lost for ever.
Kubler-Ross (1969: cited in Corr and Doka, 1994) has also considered stage-based models of bereavement, although her work appears to be more concerned with the preparation for death. She describes 5 stages: denial, anger, bargaining, depression, and acceptance. Again these are not fixed or immutable. Kubler-Ross emphasises the spiritual (not to be confused with religious) aspects of children and sees the possibility of hope in coping with dying. She acknowledges that even very young children can have a concept of death, although it may be a pre-conscious awareness and not an intellectual understanding. Children are seen as having an intuitive understanding from early on, which later becomes more intellectual after the age of 6, and then finally spiritual as the child enters adolescence.

**Task models of bereavment**

Task models place more emphasis on grief as a developmental task. Worden (1991) described four tasks of mourning:

- Task I: to accept the reality of the loss
- Task II: to work through to the pain of grief.
- Task III: to adjust to an environment in which the deceased is missing.
- Task IV: to emotionally relocate the deceased and move on with life.

Uncomplicated mourning or normal grief is taken to be the working through of these tasks. Such a model is useful in that it does suggest what people need to do to move on after a bereavement, and also how people can be helped in this. Again the view is of grief as a dynamic process.

**The child's reaction to death**

As Black (1978) points out, much of the research has been done on clinical populations, which can be considered to be self-selecting. Silverman and Worden (1993) describe the results of the Harvard child bereavement study, which attempted to examine what the typical reactions to grief were in children. This study concerned children who were 6 years or over. About a fifth of the children showed some dysfunctional behaviour in the first few months after the bereavement. When asked, the children themselves described
sadness and confusion. There was also a high amount of somatic symptoms. It was clear that children tried to maintain some form of connection with the deceased. It was also clear from the study that children were not just coping with the death of a parent, but also with the death of a way of life. There would be changes in daily routine, more so if it was the main carer, i.e. mother, that had died, as well as changes in sharing and support that was available. It was more difficult for adolescent boys to openly express their feelings. Unsurprisingly, there was an effect on the children of how the surviving parent was able to cope and how they could help their children in turn.

The child's concept of death
Lansdown and Benjamin (1985) have suggested that a full understanding of death entails awareness of a number of components: separation, universality, causality, irrevocability, appearance, insensitivity, cessation of body functions. In a review of the literature by Stambrook and Parker (1987) they summarise that the understanding of death is generally different according to the age of the child, but that there was little agreement as to the nature of the developmental trend and the ages at which different beliefs are held. There were some commonalities however. Death is seen at first as a temporary and reversible state, and then later as an internal, biological process where all bodily functions are stopped. Stambrook and Parker make the point that it is difficult to compare cohorts across cultures. Different influences can influence a child’s development of a concept of death. Possible influences include prior exposure to death, religious upbringing, life circumstances, cognitive development, emotional development, social class, and the mass media. It would be very difficult to tease these factors out, but it is important to bear in mind that they could all contribute to a child acquiring a concept of death faster than its age-related peers. There has been some attempt to link Piaget’s theory (1959; 1960: cited in Stambrook and Parker, 1987) with a developing concept of death, but the implication of this is that children will not be able to understand death until early adolescence when their cognitive structures allow for formal operations. This may well be when the concept of death becomes more complex, but it is still apparent that younger children have a developing concept, which can cause them distress.
Relation of bereavement models to children

The implications of the psychodynamic model are that a child will not recognise a loss until they have developed object constancy, which is thought to start around 6 months of age. Further, the younger child will be too dependent on the lost carer for daily skills and fulfilment of narcissistic desires to be able to withdraw emotional energy from them. The less reliant they are, the less endangered they are by decathecting from the loved object. The child is thought to use mechanisms of denial, and identification to protect itself. Denial can be a way of cushioning the impact of the event, allowing the individual to deal with changes in circumstances initially and then come to terms with the bereavement later. Identification with the deceased is seen as a way of preserving them, and eliminates the need for painful decathexis. Such identification can lessen with time and can be seen as adaptive, as something to tide the child over until they can decathect with the lost object. However it can also be seen as maladaptive in that it prevents cathexis with new objects. Given that children are likely to have difficulty with strong emotions, idealisation in their identification with the deceased can be a way of dealing with ambivalence in the relationship.

The psychodynamic model perhaps overemphasises the child’s defences as pathological. They may be better understood as Silverman and Worden suggest, as a measure of the child’s adaptation to the loss. Another criticism of this model is that it is based on clinical observations of patients. This is a difficulty with most bereavement models. One can argue that such a model may not apply to the wider group of bereaved children who are not referred to psychological services.

Bowlby’s work neatly describes stages which young children may go through when separated from their mother, but does not help in understanding loss of other significant individuals to the child, such as siblings. It does try to develop a common model of mourning that would apply across the life span, with attachments in adult life being seen as falling in love. However Bowlby’s assertion that early disruption of attachment bonds
would lead to significant relationship problems has not been totally supported by research. Sylva and Lunt (1993) summarise research findings into 2 groups of contradictory evidence. The first suggests that human babies do not bond irreversibly to only one person, that they can form early attachments with several carers. The second being that in ethological research, the supposedly irreversible initial imprinting can indeed be reversed.

Corr and Doka (1994) note that it is easy to stereotype people in stage models, although one might argue further that it is easy to stereotype people using any model. Parkes’ model is derived from the experiences of adults and so does not fit instantly with children’s experiences. There is a feeling from Parkes’ model that when one has accepted a new identity, then one’s grief work is over. However a point made by Raphael (1984) is that people may feel the loss years later when they come across a memory that has not been decathected yet. Bowlby (1980: cited in Parkes, 1986) has pointed out that there is no obvious end to yearning and that it can be reevoked years later. Although stage models do not deny that grief is a dynamic process, they provide a relatively static way of viewing it. However they do provide an understanding of the different emotions that are part of mourning.

Worden’s model concerns the adult individual rather than children and the systems within which they function. Children may not have the skills to accept the reality of the loss and may be unable to work through to the pain of their own grief without substantial help and perhaps vocabulary from others. Other authors have adapted Worden’s task model in ways that could be useful in relation to children. Children do not exist in a vacuum and it is important to consider their social networks. Walsh and McGoldrick (1988: cited in Corr and Doka, 1994) have suggested two tasks for the family system:

- **Task I**: to share acknowledgement of the reality of death and to share the experience of loss.
- **Task II**: to reorganise the family system and to reinvest in other relationships and life pursuits.
Fox (1988: cited in Corr and Doka, 1994) has further elaborated the tasks for children with consideration for their cognitive and emotional abilities:

- Task I: to understand or begin to make sense out of what has happened or is happening.
- Task II: to grieve or express emotional responses to loss.
- Task III: to commemorate in some formal or informal manner the life of the person who has died.
- Task IV: to learn how to begin to integrate the loss into one’s life in order to go on with the everyday activities of living and loving.

Doka (1993: cited in Corr and Doka, 1994) has also considered the spiritual aspect of children and suggested a fifth task, that is to rebuild faith and philosophical systems challenged by loss.

However Kastenbaum (1992) notes that much of the work of task models has arisen from life-span developmental psychology, where each stage of life is seen as a series of tasks to be completed. He criticises it as not being supported by or derived from systematic research. He feels that under task models, death is seen as a task that one should learn to deal with and that this is an assumption or an opinion, which is taken to be truth. He also takes the view that this field of psychology has developed from and reflects an American tradition and culture that emphasises the work ethic. The implication of this is that such a model may not be useful in diverse cultures. Finally, he suggests that by viewing death as a task within a life-span developmental model, this has inadvertently made death the problem of the old and of only “academic interest to the young”.

Clinical implications of models

None of the models are able to account for all of the aspects of mourning in children, although each points to particular aspects of clinical relevance. The psychodynamic model emphasises the difficulties young children will have in recognising the loss as permanent. Psychodynamic and ethological theories emphasise that children will react to separation and loss with anxiety and that the management of such situations has implications for their
future development. In addition the psychodynamic model recognises the usefulness and importance of identifying with the deceased as part of a grieving process. Stage-based theories highlight the importance of understanding the child’s feelings and behaviour. Children are less likely to show their distress through repeated crying, but are more likely to show disruptive behaviour, low mood, and somatic complaints. Task-based theories emphasise the need to consider the child’s understanding of death, in order to help them with grieving, and the work involved in “relocating the deceased”. All of the models give weight to the practical aspects of caring for children while they are still developing independence.

Both Bowlby’s and Parkes’ models could be argued to have an overemphasis on biological adaptation and with the exception of Kubler-Ross, none of the models really help in considering the child’s spiritual understanding of the loss. Kubler-Ross’ work does raise the importance of this as well as understanding the child’s development of a concept of death is a dynamic process. However, as Corr and Doka (1994) point out, Kubler-Ross has not provided any further evidence since her original publication to support her stage model and it has not been supported by further research by Metzger (1979: cited in Corr and Doka, 1994), and Schulz and Aderman (1974: cited in Corr and Doka, 1994).

Work with children and grief can relate to the child themselves, their family, and their social groups (i.e. school, playgroup) (Dyregrov, 1990; Smith and Pennells, 1995). In working with the child, Dyregrov (1990) summarises 4 useful guidelines. The child needs open and honest communication about the death. The child may need help in making the loss real. The child may need time for cognitive mastery of the death. The child may need assistance in stimulating emotional coping. There are various methods to achieve this, such as play therapy (Caroll, 1995, in Smith and Pennells, 1995) or more direct work techniques. If the family is unable to meet all the child’s needs due to their grief, then work may be needed with the whole family (Monroe, 1995: cited in Smith and Pennells, 1995). Parents may need some support in looking after themselves and dealing with their own grief. The social groups of the child are also important. Smith and Pennells (1995)
note that some children have a difficult time dealing with their peer group when they return to school. It is possible to do grief work within the classroom, even including it as part of the curriculum (Ward, 1996).

In summary, models of bereavement when considered together point out the need to help children in the areas of practical daily living, understanding the concept of death, having an outlet for their emotions and behaviour, and in being able to relocate the deceased in their lives.
REFERENCES


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INTRODUCTION

This essay will consider the factors involved in suicidal behaviour in older people. It asserts that elderly suicide warrants special attention in terms of its rates when compared to younger populations and in terms of the special problems that older adults have to deal with. It will consider current rates and trends of suicide in later life and will then examine specific high-risk factors in elderly suicide.

Current rates and trends

Elderly suicide rates are higher than for younger populations. For example in America, elderly suicide rates are 50% higher than the rest of the population (Osgood, 1992). This trend is the same worldwide, although the ratios may differ (Vecchia, Lucchini, and Levi, 1994).

The rates of elderly suicide can vary over time, but there is no single trend for variance worldwide, thus implying that sociocultural influences on suicide are important. Osgood (1992) describes a decline in elderly suicides in America from the 1930’s to the 1980’s, where rates started to increase again. Lindesay (1991) describes how rates fell in the 1960’s in England and have remained reasonably constant over the last decade, although the choice of method for suicide has changed.

Such statistics are likely to be an underestimate due to the various methodological problems in collecting the data. Suicides may not be recorded as such and there may be stigma in recording such data. Covert suicides due to factors such as neglect may not be recognised. Most studies do not consider fluctuation from district to district, although in a study by Cattell and Jolley (1995), there was no significant difference over time.

A closer examination of rates and trends

A closer examination of elderly suicide rates show that they vary according to different demographic factors, notably gender, age, ethnic background, and socioeconomic status.
Elderly males are generally more at risk than females and this distinction is generally found worldwide (Vecchia et al, 1994). Osgood (1992) asserts that the risk for males increases linearly throughout life, while for females the risk peaks during mid-life and then declines. Suicide risk appears to vary within old age. The old-old (75+) appear to be more at risk than those aged 65-74 (Osgood, 1992), although the extremely old (90-100) as a subgroup appear to be less at risk (McIntosh, Santos, Hubbard, and Overholser, 1994). Bromley (1974) has suggested that this subgroup is a highly select cohort, being the hardiest of the original cohort and perhaps low in self-destructive tendencies.

Race makes a difference to suicide risk with white elderly males being more at risk than males from ethnic minorities. Men from both groupings are more at risk than women from either grouping (McIntosh et al, 1994). Rates also vary between different ethnic minorities (McIntosh and Santos, 1981).

Instability in socioeconomic status appears to be a risk factor in suicide. Marshall (1978) links postwar improvements in financial security to improvements in suicide rates, while Zweig and Hinrichsen (1993) found that among depressed patients who had already made one suicide attempt, high socioeconomic status was associated with increased suicide risk. Rich, Warsradt, Nemiroff, Fowler, and Young (1991) also found that men were more likely to have economic stresses than women. It may be that stability with what one has known is the common factor and that those with an uncertain financial status, whatever it might be, will be most at risk.

The trends of elderly suicide rates can be partly understood in terms of period and cohort differences. Period effects relate to significant events and changes in society and the environment. Lindesay (1991) describes how in England, the detoxification of the domestic gas supplies coincided with a decrease in elderly suicide rates. It also appears that the elderly are less likely to change to a different method of suicide than younger populations (Lindesay, 1986).
Rates may be affected by ways in which elderly cohorts differ from previous populations. Lindesay (1991) suggests that an increase in cohort size can lead to an increase in competition for limited resources. This may be a problem for the 'baby boomer' generation, thus suggesting an increase in elderly suicide rates. There has also been a larger proportion of women among the elderly since the 1930's (Osgood, 1992). As women are a lower risk group than men, this may partly account for the decline in elderly suicide rates in America since the 1930's. Conwell (1995) notes that current cohorts of younger adults have higher suicide rates than current older cohorts had at that younger age and suggests that this could lead to an increased rate of suicide when the current younger cohorts age. Another possibility is that those most at risk will kill themselves earlier, leading to a decreased rate.

It is possible that when the elderly attempt suicide there is in general a more serious intent to die. McIntosh (1985) cites the ratio of suicide attempts to completions as being 200:1 for adolescents and 4:1 for the elderly. Farberow and Shneidman (1957) classified suicide notes according to age and according to Menninger's (1938) triad of suicidal wishes. These were 'to kill', 'to be killed', and 'to die'. They found that the wish to die was more likely in the elderly notes than in the younger ones. The assumption that is made for young adults of suicide being on a continuum of ideation to attempt to completion (Schmid, Manjee, and Shah, 1994) may not be so valid for older adults. Osgood (1992) suggests that another reason for the larger completion rates is that the elderly are more frail and also more likely to take steps to avoid discovery.

**High risk factors**
The factors considered so far may be statistically associated with suicide but do not predict it. Intrapsychic factors and difficult experiences related to growing older may be more clinically significant and account for the remaining variance.

**Developmental Tasks**
Erikson (1963) has suggested that individuals need to accomplish developmental tasks that vary with age. The task of old age is considered to be one of achieving ego
integrity, i.e. coming to terms with one's life. Failure to do this is considered to result in despair. It may be that illness interferes with this process resulting in despair for some people.

Retirement can produce increased stress, particularly for men. Retirement brings about the loss of job along with whatever it meant for the individual. It can be argued that in a Western society, people are valued according to their productivity and that retirement decreases one's perceived value. It is possible that men define themselves more in terms of their work than women. Therefore for men, there may be an increased chance of loss of status. Miller (1979) has argued that this is a major factor for white, elderly males. Atchley (1980) notes that suicide rates do not increase at or immediately after the age of retirement. Shepherd and Barraclough (1980) found that timing and abruptness of retirement differentiated between completed suicides and matched controls. McIntosh et al (1994) have suggested that it is the process of retirement that is important. Peretti and Wilson (1978) found that those individuals who were involuntarily retired tended to show more anomie and egoism (thoughts indicating little integration or influence by society) and that anomie was associated with a more frequent contemplation of suicide.

Social Isolation and Interpersonal Factors

Social isolation is considered to increase with old age and to be a high risk factor for suicide. Social isolation is likely as one is more likely to have lost friends and relatives in old age. A further risk is that one is less likely to be found if socially isolated, allowing a suicide attempt to be more successful (McIntosh et al, 1994). In addition, there will be less opportunity for rewarding social interactions. Li (1995) found that marriage was a protective factor in suicide. She found that widowed men were more likely to commit suicide than married men. However there was very little difference between widowed and married women. She concluded that women were better at coping with bereavement than men. Cattell and Jolley (1995) also found that marriage was a protective factor. Furthermore in their study, it was apparent that living alone was not a statistically significant risk factor. It appears that there is a qualitative aspect of social isolation. Murphy and Kupshik (1992) suggest that how someone perceives
their isolation in relation to societal norms is important. In considering the difference between men and women, it would be interesting to know whether women are more likely to retain social networks than men and whether they are more willing to accept help and input.

For those who are not physically isolated, interpersonal factors are also important. In a prospective study of suicide attempts by depressed older adults, Zweig and Hinrichsen (1993) found that psychiatric symptoms in the spouse or adult child, strain in the relative-patient relationship, and the number of difficulties related to the care of the depressed older patient emerged as salient risk factors for a suicide attempt.

Environmental factors

Admission to nursing homes does not appear to protect against suicide. Osgood believed that suicide is underreported in such institutions in America (Osgood, Brant, and Lipman, 1990: cited in Osgood, 1992). Such a population is likely to be more vulnerable anyway due to ill health, social isolation (particularly from their previous friends and family), and losses associated with the move to institutional care (e.g. loss of independence). Osgood et al (1990) found that 20% of nursing institutions reported suicidal behaviour among their residents. This study showed that institutional factors, such as high staff turnover and large resident populations were related to increased risk of elderly suicide. In addition, it was found that 80% of those involved in suicidal behaviour used indirect methods, such as refusing to eat, drink, or take medication. In a study of motivation for suicide, Loebel, Loebel, Dager, Centerwall, and Reay (1991) found that 14% of 60 suicides had left evidence that the anticipation of being placed in a nursing home was a significant trigger to the act.

Physical factors

Physical illness is more likely in old age and is associated with an increased risk of suicide. Increasing physical frailty is inevitable with age-related biological changes. Rich, Warsradt, Nemiroff, Fowler, and Young (1991) found that the frequency of illness as a stressor was greater with the elderly than with younger groups. McIntosh et al (1994) believe that chronic illness affects an individual's quality of life and identify
several studies showing an association between physical illness and suicide, particularly for elderly men. Physical illness is more likely to be an issue for elderly completers and attempters than for younger or middle-aged populations (e.g. Conwell, Rotenberg, and Caine, 1990; Lyness, Conwell, and Nelson, 1992). It has been identified as a major stressor in the old-old (Rich, Warsradt, Nemiroff, Fowler, and Young, 1991). Cattell and Jolley (1995) found that 65% of their sample of suicide victims had problems of ill health. Chia (1979) and Chynoweth (1981) have identified it as more often a contributing factor in men than women.

Chronic pain is associated with ill health and suicide but it appears to be the perception of the pain that is important. Cattell and Jolley (1995) found that physical ill-health and pain were significant risk factors in their study of suicides and believed that this association with suicide was largely mediated through mood factors. McIntosh et al (1994) suggest that chronic pain can lead to a subjective experience of helplessness and hopelessness, which is in turn related to depression. In view of this, one would expect terminal illnesses to lead to an increased risk of suicide. Cattell and Jolley (1995) did not find any evidence to suggest that people who committed suicide had prior awareness of a terminal illness. McIntosh et al (1994) reviewed the available literature on suicide and concluded that although some tumour sites are associated with an increased risk of suicide, in general few cancer patients do commit suicide. It would appear that mood and perception of illness are very important in determining suicide risk.

A related aspect is that of physical changes that occur with ageing. Suicidal acts are associated with reduced serotonin binding sites in the frontal cortex (Arora and Meltzer, 1989) and there is a fall in these binding sites with age (Marcusson, Morgan, and Winblad, 1984). Lindesay (1991) suggests that such changes in conjunction with the experiences of ageing described under psychosocial aspects above may increase some people's vulnerability to suicide in old age.
Psychological problems

Psychological autopsies suggest that affective disorders, substance-use disorders, and schizophrenia are the most common psychiatric disorders associated with suicide (Beskow, Runeson, and Asgard, 1990).

Depression is seen to be highly associated with suicide in the elderly. Cattell and Jolley (1995) found that 61% of their retrospective study of suicides had depression. Zweig and Hinriches (1993) observed that the rate of suicide attempts in their sample of depressed older adults was almost 30 times the 0.3% lifetime incidence of suicide attempts among elderly subjects reported by Blazer, Bachar, and Manton (1986). Draper (1994) observed that depressive illness was present in 87% of suicide attempts referred for psychiatric assessment in Sydney. He also identified a complimentary relationship between physical and mental illness with age and gender differences. Those with major depression tended to be female, have a high level of suicidal intent, psychosis, and past psychiatric history, but to be low in physical illness. Those with minor depression and personality dysfunction were associated with a lower level of suicide intent and higher levels of psychosocial stressors. In many the minor depression appeared to result from a poor capacity to deal with chronic illness in the context of poor relationships, social isolation, and alcohol/substance abuse. Woods (1996) has suggested a relationship between hopelessness and suicide, but this is not so clear. However Schmid et al (1994) found that they were able to distinguish between suicide ideators and attempters. The chief difference they identified was that ideators were more likely to be Catholic or Jewish, while attempters were more likely to be protestant. They suggested that ideators may differ from attempters on characteristics of depression, whether they were suffering anxious, agitated, or delusional depression. In addition, Zweig and Hinriches (1993) did not find a relationship between suicide and hopelessness in their study. It may be that hopelessness is associated with suicide ideation, but not attempt.

The importance of substance-misuse as a risk factor appears to have been largely unrecognised in the literature (Osgood, 1992) perhaps due to the fact that many alcoholics do not survive into old age (Conwell, Rotenberg, and Caine, 1990) and so
may not account for a large proportion of elderly suicides. In Draper’s study (1994), 32% of suicide attempters were found to have problems of alcohol/substance misuse. Those that do survive demonstrate increased problems of health, poverty, and isolation. McIntosh et al (1994) believe that this can lead to depression and then to self-destructive behaviour. Murphy (1992) identified the following risk factors in alcoholics over the age of 45 who committed suicide: major affective disorder; little social support; unemployment; threatened or actual affectional loss within 6 weeks; serious medical problems; living alone; talking about or threatening suicide. Many of these factors will be more likely in the elderly.

Although schizophrenia is associated with suicide in psychological autopsies, this relationship varies with age and in later life it does not appear to be a big problem. Psychotic depression appears to be the most common psychiatric illness associated with suicide in later life (Dorpat and Ripley, 1960). McIntosh et al (1994) note that disorders, such as schizophrenia or bipolar depression rarely emerge for the first time in later life and therefore their impact on statistics is minimal.

Personality problems may be risk factors for suicide. In distinguishing ideators from attemptors, Schmid et al (1994) found a relatively low frequency of psychosocial stressors in their sample and linked this to the observation that longstanding instability, rather than acute crisis, is important in suicidal ideation (Leenaars, 1992). Duberstein, Conwell, and Caine (1994) have implicated a neurotic, emotionally constricted personality style as a risk factor in later life. Draper (1994) found that 26% of suicide attempters had a personality dysfunction.

Organic brain impairments may be a risk factor, but their presence appears to impair the ability of an individual to carry out a suicide attempt successfully. Draper (1994) identified 3 different organic brain syndromes in his study. These were due to an acute illness, delirium, and dementia. All appeared to interfere with the capacity to plan and coordinate an attempt.
Prevention of suicide

It is possible that ageist attitudes in health professionals can contribute to suicide behaviour in the elderly. Although there is no systematic research to support the assertion, Lindesay (1991) believes that therapeutic nihilism and ageism can decrease the motivation to intervene. The elderly may be made to feel a burden on their relatives or the relatives may insist that the elderly person is not resuscitated. Medical professionals may avoid using medication or only use it in sub-therapeutic doses. The implication is that it would be better for everyone if the elderly person died and the perhaps unspoken assumption is that the individual is a burden. There is more that can be done to prevent suicide particularly at the primary health care level. Cattell and Jolley (1995) observed that specialist services were in touch with only a small proportion of those that killed themselves, while 43% of this population had been in touch with their General Practitioner in the month before their suicide. The vast majority of suicides occurred at home, suggesting that there is an important role for community services to play. Studies by Rutz, Von Knorring, and Walinder (1989; 1992) suggest that post-graduate education for General Practitioners about depression is associated with a decrease in suicide rates. Another possibility is to consider prescribing practices. Although medication can provide someone with the opportunity for suicide, as Lindsay (1991) notes, some medication will decrease the amount of suicidal thoughts and one can consider medication that is not so toxic in overdose.

Summary and Conclusions

Some patterns can be drawn from the statistics of elderly suicides. Elderly suicide attempters tend to be more successful than younger populations in their attempts. Those most at risk of suicide appear to be white elderly males, who do not have financial stability. The variance in the rates of suicide over time can be linked to sociocultural factors and differences in cohorts.

High risk factors relate mostly to intrapersonal factors and difficult experiences associated with ageing. Difficult experiences include retirement, social isolation and interpersonal stresses, and placement in a nursing home. Intrapersonal factors include
the presence and perception of physical illness and pain, depression, substance-misuse, and personality disorders.

In conclusion, it is apparent that the elderly have a higher rate of suicide than younger populations. Some of the risk factors of suicide can be identified and there is much that health professionals can do to alleviate them and so decrease the incidence of suicide. In addition it may be that there are things that health professionals are not doing that unwittingly contribute to the likelihood of suicide.
REFERENCES


SPECIALIST FAMILY THERAPY ESSAY

TITLE: Compare and evaluate the contributions to systemic thinking of the Milan and Narrative approaches

DATE: YEAR 3
INTRODUCTION

In the development of family therapy, there has been a move from the perspective of the individual to the perspective of the system. There appears to be two major influences on this movement. In clinical practice, therapists began to acknowledge the influence of family systems on clients, which could limit or increase the effects of individual therapy (Barker, 1992). In addition, some theorists began to adopt systems thinking and cybernetic explanations for family therapy (Jones, 1993). The aim of this essay is to compare and evaluate the contributions to systemic thinking made by the Milan and Narrative approaches.

A useful definition of systemic thinking from Jones (1993:p.2) is of “a group of elements in interaction with one another over time, such that their recursive patterns of interaction form a stable context for individual and mutual functioning”. Some important features of a system with respect to families according to Jones’ definition include whether it is open or closed, how the elements are understood, and how the system is defined. Families are assumed to be open systems in that they interact with other individuals and contexts. Individuals within families are understood from the perspective of how they interact with others. Finally, the distinction of a system is defined by its participants and observers. Although this is a very general definition, and is by no means all inclusive, it will serve as a context for understanding the contributions of the Milan and Narrative approaches.

The individual approaches will be considered within Burnham’s (1992) framework of approach (or epistemology), method, and technique for evaluation of theory and practice.

The Milan Team

- Approach

The Milan approach is strongly associated with the work of the Selvini Palazzoli, Boscolo, Cecchin, and Prata. They in turn were strongly influenced by Bateson’s (1979) theory of mind. The Milan Team appear to have understood the family system
in terms of Bateson’s criteria of mind (Tomm, 1984a). This has led to the following assumptions in their work with families where a member suffers from an eating disorder or from schizophrenic symptoms.

1. Mental phenomena are assumed to reflect social phenomena. The Milan Team emphasise that people are social creatures (Tomm, 1984a). Systems are understood in terms of patterns of behaviour and relationships. The implication is that it is more useful to understand interpersonal patterns, rather than intrapsychic patterns.

2. A circular epistemology is assumed to be more useful in understanding social phenomena than a linear epistemology (Tomm, 1984a). This stems from Bateson’s (1979) notion that mental processes require circular (or more complex) chains of determination. A circular epistemology assumes that in order to understand person B’s behaviour, one must consider how B affects and is affected by person A. A linear epistemology considers cause and effect, which although useful, can neglect the way in which people in a society can recursively affect each other.

3. Interaction between parts is triggered by difference (Tomm, 1984a). In view of this, relationships are understood in terms of difference, i.e. the difference between two individuals suggests a possible relationship between them. Such differences represent information about the system. The Milan Team suggest that our use of language can impede our understanding of relationships. Our use of language predisposes us to look for linear causal relationships, rather than difference relationships. The team suggest that objectifying certain terms (e.g. an eating disorder becomes an eating behaviour) can encourage one to look for relational connections, rather than linear or intrapsychic ones.

4. Families are assumed to be evolving systems (Tomm, 1984a). This implies that families that appear stuck are actually in the process of changing. It may be their view of the world (or ‘map of the territory’) or their behaviour patterns that have not changed. Although it is understood that the family’s map of the territory does not
reflect the intrinsic reality, there is an idea that these world-views need to be updated with new life circumstances.

- **Method**

Change is seen to be achieved by modifying the family’s belief systems (Tomm, 1984b). This is achieved through eliciting ‘new’ information. Such information constitutes anything related to the family’s beliefs or behaviours, but that is presented in a way that the family can reflect on. This may be gained through interview with the family or through the prescription of rituals (or behavioural experiments).

- **Techniques**

There are 3 principles to the interviewing process: hypothesising, circularity, and neutrality (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). Hypothesising is encouraged to guide the therapist’s questioning. The hypothesis needs to connect all the family members. The hypothesis is seen as potentially useful, but not necessarily true so that it can be rejected if need be. Circularity informs the questions, i.e. questions are about differences and about the context of both behaviour and meaning. Questions are continually phrased in order to bring out some relational aspect of the situation (Penn, 1982a; 1982b). Neutrality should be the interviewer’s stance. The interviewer is seen as neutral (but not distant) to the family’s patterns. In essence, no member of the family should feel that the therapist has sided with any other members in particular.

Much of the Milan technique has been standardised. Each session follows a set format (Gelcer, McCabe, and Smith-Resnick, 1990). There is a pre-session meeting in order to generate hypotheses. The session itself involves the team observing the therapist and family, while the therapist interviews the family. The intersession break allows the therapist to discuss hypotheses with the team and to decide on a prescription. The prescription is given to the family as either a ritual to carry out or a reframe of the family’s situation. Once the family have left there is a post-session discussion of the feedback. Reframes are positive connotations of the family’s behaviour. Sessions are typically once a month. Clinical practice indicated that more change occurred after a
month than with shorter intervals (Selvini Palazzoli, Boscolo, Cecchin, and Prata, 1978). Milan techniques take into account the difficulty of being objective. To this end, the team has used one-way mirrors with other therapists observing the interaction between therapist and family. This team is then used to reflect on the relationships between the interviewing therapist and the family.

The essence of the Milan approach has meant that the team members consider it as still evolving. Cecchin (1992) has accepted the limitations of trying to be a neutral observer and has outlined the concept of the ‘therapist’s curiosity’ instead. The original team have split with one group defining an invariant approach where the rituals and prescriptions are not altered, while the other group has defined a variant approach where the rituals are altered for each family (Gelcer, McCabe, Smith-Resnick, 1990). The behaviour of reflecting on one’s own approach and changing it is likely to impact on those studying it.

**Narrative Therapy**

- **Approach**

The Narrative approach can be considered as a different paradigm that is influenced by the social constructionist position. It is in opposition to the modernist paradigm that assumes that there are objective truths of reality that can be identified, particularly through a scientific approach (Searle, 1995). The social constructionist position suggests that one interprets the world through one’s own particular worldview, but more importantly that this worldview is a product or construct of the society that one is part of (Freedman and Combs, 1996). In turn, the individual helps to co-create a particular worldview through their own behaviour and language. In essence, one cannot arrive at an objective truth, as one is heavily influenced in such a process by one’s own culture, context, and history. The narrative metaphor (White and Epston, 1990) is of a person’s story that extends through time. It is used to describe how a person’s worldview is developed over time and is related to Bateson’s concepts of a ‘map of the territory’ and of ‘time’ (Freedman and Combs, 1996).
Such a metaphor makes important assumptions with regard to how people interact with their wider cultures and with regard to language. In therapy, the narrative metaphor is used to provide an understanding of how an individual’s worldview has been constructed within the constraints of the different contexts that a person exists in (White, 1991). There is an assumption that the individual’s worldview is influenced by and negotiated with other individuals that they come into contact with. A further assumption is that this negotiation is mediated through language. It is argued that our worldview is recursively influenced by language in that language can legitimise a concept, although that concept may not be an intrinsic reality (Freedman and Combs, 1996; Searle, 1995). The implication here is that our social realities are organised and maintained through the language or narrative that we use.

This has implications for therapy in that one doesn’t want to just swap one subjective truth for another without a good rationale. Therapy then involves a deconstruction of a person’s narrative or worldview with reference to the wider contexts that were involved in the original construction. This includes family, wider social circles, institutions, culture, dominant philosophies and ideologies, etc. With regard to therapy, changes are thought to involve changes in language and thinking (Freedman and Combs, 1996).

However the therapy itself must be subjected to same deconstruction in order to avoid giving the individual a new set of beliefs without the context that they were derived from. A person’s worldview is developed within a certain context. A different worldview, although helpful, may not fit the context that the person exists within (Gergen and Kaye, 1992).

- Method
Change is achieved through the adoption of an alternative narrative that is still meaningful to the individual. The essence of this approach is to deconstruct beliefs and attitudes within the context of an individual’s society and culture.
-Techniques

Techniques in the Narrative approach are less standardised than in the Milan approach. Indeed White (1991) warns that applying the approach and techniques will not be successful if one does not believe in the principles of the approach.

All the techniques reflect the need to deconstruct the individual’s narrative with reference to their dominant narratives. People are initially encouraged to externalise the problem, that is, to provide an account of the effects of the problem on their lives, and particularly how it has affected their view of themselves. They are then encouraged to map the influence that these views or perceptions have on their lives. The result is that people identify less with their problem narratives and have the freedom to explore alternative possibilities.

Alternatives are derived from contradictions in the person’s previous narrative. The individual is encouraged to identify an event/time that did not accord with their expectations. If this event was preferable to the normal course of events, then it is treated as a mystery to be unravelled. The aim is to identify an alternative way of being that still makes sense to the individual.

To unravel the mystery, the therapist uses ‘landscape of action’ questions and ‘landscape of consciousness’ questions (White, 1991). Landscape of action questions help the person identify the sequence of events around the unique outcome. Landscape of consciousness questions help the person to review the meanings that the events held for them concerning the unique outcome and to ‘retell’ their stories in a different manner. Another form of questioning is ‘experience of experience’ questions, which encourage the person to provide an account of what they imagine another person’s experience of them to be.

Comparisons between approaches

Various comparisons can be made between the two approaches.
Both conform to the ideas of second-order cybernetics. In contrast to first-order cybernetics, the observer is seen as part of that which is being observed and involved in constructing that which is being observed (Jones, 1993). The emphasis is on the recursive connections between systems (Jones, 1993). The Milan Team acknowledge that the therapist cannot be a neutral observer, but continue to strive for it. The Narrative approach places importance on how individuals will co-construct social realities, e.g. that of knowing therapist and ignorant client (White, 1991).

Both approaches value the patient’s own story. The Milan approach assumes that a particular problem is a solution to changes in an evolving system and does not dictate alternatives. The Narrative approach suggests that many other therapies merely replace one unhelpful narrative with a therapist’s belief system and asserts that this may be no more valid than the client’s own story.

Both approaches reframe the client’s problems, although from different perspectives. The Milan approach makes use of positive connotations in order to avoid blame and offer the family a more helpful way of viewing their own behaviour. The Narrative approach encourages a person to externalise their problem rather than see it as a necessarily intrinsic part of their view of self.

Both acknowledge that an individual’s or family’s world-view does not represent an objective reality. The Milan approach implies that there is an objective reality, but that it is unknowable. The Narrative approach questions the assumption that there is even an objective reality and asserts that realities are socially constructed (Freedman and Combs, 1996).

**Evaluation of the approaches**
The Milan approach has made several key contributions to systemic thinking.

The adoption of a circular epistemology has provided alternative explanations for problems. Burnham (1990) contrasts it with earlier strategic (Haley, 1976) and structural ideas (Minuchin, 1974). The focus is shifted to how each individual could
contribute to the maintenance of a problem system. The Milan approach has also shifted the idea of families as homeostatic systems to one of evolving systems, although how much this was influenced by the particular types of problems that they were seeing is uncertain. It can be argued that there are problems in families for which the Milan approach is unsuitable, e.g. families where one individual has a problem with addiction (Gelcer, McCabe, and Smith-Resnick, 1990).

The circular epistemology has led to a change in the understanding of interventions. The content of each session can be regarded as interventive. Circular questions encourage the family to provide information on the system, however they answer. Such information can also lead to a more positive connotation of the problem. Although positive connotations are not unique to the Milan approach, they are an important facet of it.

The Milan approach has perhaps raised awareness of second-order cybernetic ideas and their relevance to how one works therapeutically. The recognition of the difficulty for the therapist to be an observer and the way the Milan Team use a team and one-way mirror has led to further developments of the approach. For example, Andersen (1987) has advanced the idea of using a reflecting team with families. The Milan approach can be seen as a constructivist approach, which is in line with some of Maturana’s (cited in Dell 1984) ideas of structural determinism. Essentially, although there may be an objective reality, it can only be understood through the limitations of our own structure (or family worldview). Such a structure determines how one can communicate with another, but each interaction can lead to a further change in structure.

The Narrative approach can also be considered to have made important contributions to systemic thinking.

Perhaps the most fundamental contribution has been in focusing on the social constructionist epistemology. This has allowed increased reflexivity in considering the therapeutic approach. Gergen and Kaye (1992) argue that traditional psychotherapies,
when examined using this paradigm, act to replace patient worldviews with therapist worldviews. They highlight the difficulty in accepting a new set of views (or narrative) without the context that particular worldview was developed within. A further outcome has been a framework for considering issues of power within therapy, which is particularly important for dealing with cases of abuse. White (1991) draws on Foucault’s idea that language is an instrument of power (Freedman and Combs, 1996). People are in a position of power if they are able to participate in discourses that shape society where others cannot. This can result in ‘dominant discourses’ that people internalise. This is an important issue for the therapist-client relationship in order to avoid repeating such discourses. This increased framework for understanding the therapist’s influence perhaps allows for a more egalitarian and collaborative approach with the client.

The emphasis on the wider framework of social constructionism has allowed the objectification of events and problems. Such techniques as externalisation give people with chronic problems a chance to develop alternative meanings to their lives, which may be more fulfilling than a particular, less adaptable therapeutic approach may allow.

**What are the limitations of such approaches?**

The chief limitations of the Milan approach perhaps lie in its constructivist assumptions. The behaviour of a system may be determined by its structure. However this does not explore how that structure came to be, which is particularly relevant for social organisms. This leads one to question how applicable biological paradigms (Dell 1984) can be to social organisms.

The structured and prescriptive nature of the Milan approach can lead to power imbalances. There is an implicit assumption that the team knows better than the family how it should change. There is a danger of swapping family epistemology for the therapist’s epistemology (Gergen and Kaye, 1992). There is a further possibility that if this novel approach is too removed from what the family expects, then they will not engage with therapy.
The epistemology of the Narrative approach also has limitations. Although it includes the societal element that the Milan approach lacks, it can still be argued that the focus is too narrow. The focus is still on the individual, albeit through their worldview lens or own internal world, rather than on their relationships with others (Gergen and Kaye, 1992). The implication is that an individual is committed to one narrative, rather than many, which limits their opportunities for change.

The methodology can perhaps be limited by the qualities of the therapist. There is an emphasis on the therapist to be adaptive, creative and original. In such an unstructured approach, this may be hard to replicate. In view of this, it is not clear what understanding the therapist is expected to reach of their own constructs. This is important in considering how therapist understands the narratives of others. In addition, the techniques of this approach may also be too far removed from the patient’s expectations in order to engage them.

Summary and Conclusions
In summary the following points can be made about the Milan and Narrative approaches. They have both promoted understanding from the perspective of second-order cybernetics. They both value the patient’s story and seek a collaborative approach. They both acknowledge that a person’s worldview or map is not the territory that it represents. They can both be described as cognitive approaches, which involve reframing of the original problem.

The Milan approach has prompted the adoption of a circular epistemology in family therapy and it has resulted in replicable techniques with which to explore a circular epistemology. However it does not tend to consider the societal influence and context. The Narrative approach has advocated post-modernist thinking in therapy and particularly has provided a framework within which to consider the issue of power within therapy. However, as an approach, it loses some of the systemic perspective in its focus on the individual.
In conclusion, both approaches represent significant shifts in the understanding of families and their problems. A move from the Milan approach to the Narrative approach can be considered as a shift in emphasis from a biological constructivist paradigm to a societal constructionist paradigm. Both approaches are valid and relevant and perhaps both should inform the other in a recursive fashion.
REFERENCES


SUMMARY OF CLINICAL SECTION

The clinical section is intended to demonstrate the breadth of the trainee’s clinical experience with regard to client groups and therapeutic models whilst on placements. Background details to each placement are followed by the placement contract and then a case summary of the case report relevant to that placement. In order that the reader can get an overall impression of the experience gained, the clinical details are contained in a 3 page summary at the end of this section.
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<tr>
<td>SUPERVISOR:</td>
<td>Caron Gaw</td>
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Bethlem & Maudsley NHS Trust (Croydon)

Supervisor: Caron Gaw
Trainee: Christopher Hall
Start Date: 13 October 1995
End Date: March 1996
Number of days in placement: 
Supervision day and time: Wednesday pm.
Date for mid placement review: 10 January 1996

Aims and objectives for placement as agreed on 20 October 1995

Assessment and Interview Techniques

To do some basic formal cognitive psychometric assessments eg. Beck Depression Inventory, WAIS-R.

To Communicate findings to client(s), supervisor and relevant other Mental Health workers.

To be introduced to Department’s assessment procedure and have opportunity of observing, participating and conducting these as assessments.

To become familiar with assessment and formulation techniques in their application to a variety of psychological disorders.

To learn how to link assessment and formulation into a coherent logical framework from which particular approaches to treatment can be carried out.

To clarify the methods of assessment and where and how and when to obtain further relevant details from other parties ie. GP/CPN/Psychiatrists etc.

Overall to develop an understanding of assessment in conjunction with other forms of evaluation when determining a person’s suitability for psychological therapy.

Type of Patient

To include a balanced mix of patients with regards to age, sex, and sociological background.

To include a range of psychological problems including anxiety disorders, depression, adjustment & adaptation difficulties, loss and possibly some limited basic neuropsychology.

If possible to obtain a balance between acute and chronic work, especially of clients with longer term mental health problems, acute & rehabilitation.

If possible to include both individuals and couple work.
If possible to include OCD, eating disorders, substance misuse.

To observe disability issues.

**Clinical Interventions**

To develop basic counselling skills.

To develop an understanding of various psychological approaches

  ie. Cognitive Behaviour Therapy/Psychotherapy

To develop the above and be able to apply these in clinical settings.

To receive instruction and supervision in the development of a behavioural programme.

To participate in at least one group either as co-therapist/observer.

**Indirect work including settings and systems**

To participate in an in-patient ward round.

To be exposed to the general organisation and running of the department by joining weekly meetings to consider academic and organisational issues if possible.

If possible participate/join in any relevant course run either within or external to the region which supervisor feels appropriate.

To participate in any teaching seminars given by supervisor or other departmental members.

Observe work undertaken by CPN’s/Dietitians or other core Mental Health professionals.

If possible experience of non-NHS facilities - Social Services and Voluntary Agencies.

To participate in a Primary Care Clinic.

**Research**

To research background information relevant to clinical work.

**Teaching and Consultation**

To develop teaching skills by presenting case history or academic report to supervisor or department.
Report Writing

To develop clarity and a style of communicating with which to share relevant details about patients with other agencies.

To follow departmental guidelines with respect to above.

To develop some awareness of medical legal issues regarding Report Writing.

To liaise with supervisor before any reports are sent out.

Arrangements for ending placement

To be discussed at MPR.

Organisational Issues

To develop some awareness of
  NHS structure/reforms/developments and their impact on Clinical Psychology Services.
  Clinical Psychology issues ie. RPAC/MPAG etc.

Extra Issues:

Signed........................................ Dated 10/1/96
SUMMARY OF AMH CASE REPORT

The AMH case report concerns the assessment and treatment of a 57 year old man who had a phobia of going on holiday.

The client experienced symptoms of anxiety, such as palpitations, panic, restless sleep, and loss of appetite during the fortnight before going on holiday each year. This had been a problem since first taking his family abroad on holiday. He would deal with his anxiety by devising strategies in which to avoid the holiday with his family altogether or to think of alternative routes home from the holiday destination. The client was able to identify several catastrophic thoughts related to taking holidays. Interestingly, the client had no fear of flying and was currently employed in the security business, which necessitated flying around Britain and Ireland.

It was hypothesised that the automatic thoughts were related to an unhelpful belief that the client held in which he was solely responsible for the smooth running of the holiday. It was thought that this belief was in turn related to a core belief, which the client interpreted as a danger of losing his family. These unrealistic beliefs were maintained by the client's avoidance strategies and thus were never adequately challenged.

The intervention involved helping the client to recognise how his thoughts were connected with his beliefs, and to identify where these beliefs had come from. The client was then encouraged to experience the stress of planning a short holiday in imagination and to identify and challenge his thoughts during the session. Following this the client was helped to confront his feared situation through graded exposure by planning a short bread.

The outcome of intervention was successful in that the client was able to recognise and challenge his unhelpful beliefs and by the end of treatment had arranged a short holiday with much less anxiety than he had experienced previously.
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<tr>
<td><strong>DEPARTMENTAL ADDRESS:</strong></td>
<td>Geoffrey Harris House</td>
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<tr>
<td></td>
<td>Coombe Road</td>
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<td>Croydon</td>
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<td><strong>TRAINEE BASE:</strong></td>
<td>Geoffrey Harris House</td>
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<td><strong>SUPERVISORS:</strong></td>
<td>Heidi Adshead</td>
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<tr>
<td></td>
<td>George Lee Choon</td>
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<td><strong>PLACEMENT DATES:</strong></td>
<td>YEAR 1: Apr 1996 to Sep 1996</td>
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PLACEMENT CONTRACT

SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

Supervisors: Heidi Adshead and George Lee Choon

Trainee: Christopher Hall

Start Date: 17th April 1996

End Date: 20 September 1996

Number of clinical days: 69 - MIN 60 *

Date of mid-placement visit:

PLACEMENT STRUCTURE:

Days on placement will be Wednesday, Thursday and Friday. There will one half day per week clinical study during placement time. Each day is a 7½ hour working day. Attendance at placement is not expected when there are research/academic days/blocks at University, or for agreed holidays.

1. ESSENTIAL SUPERVISION

AIMS

1. Agreed weekly supervision will be for 1½ hours and will take place on Wednesday from 9.30am to 11.00am with Heidi Adshead and one hour with George Lee Choon. Additional informal support/supervision sessions will take place as necessary. Weekly supervision sessions to be minuted in note form by Heidi and George and notes kept in file accessible to Chris.

2. For the first month of placement, Chris will have the opportunity to observe Heidi and George in a wide range of clinical situations, clinical activities, direct and indirect clinical work, meetings, case conferences, etc., in order to familiarise himself with the work of a Clinical Psychologist in the Learning Disabilities speciality.

2. ESSENTIAL KNOWLEDGE

Chris will gain the knowledge of current thoughts and practice regarding psychology services for people with learning disabilities throughout the course of this placement. Information will be gathered through reading, discussion and supervision.
AIMS

1. During each essential weekly supervision session opportunities will be made available for Chris to explore and discuss clinical practice. This discussion should build on the core skills and knowledge gained by Chris in the clinical course lectures.

2. Chris will have time each week and during the induction period to read current literature in this area relevant to his clinical practice in order to expand his essential knowledge.

3. Chris will attend a refresher course in Breakaway Techniques.

3. ESSENTIAL CLIENT WORK

Chris will gain experience of the three phases of assessment, intervention and follow-up involved in the work with clients in this speciality. At least one complete piece of direct work will take place as a minimum, however, it is expected that the opportunities for Chris to work with at least six clients in this way will be made available.

ASSESSMENT

AIMS

Chris will be made aware of a range of methods of assessment and clinical investigation either through practical application, demonstration or discussion. Emphasis will be placed on the appropriateness and applicability.

1. Direct observations of clients' behaviours and situation

2. Psychometric assessments selected on the basis of the needs presented by the clients and should include the WAIS-R, Leiter, BPVS.

3. Interviews (structured and semi-structured) with clients, staff, family

4. Functional analysis - collecting base line information through direct observation of client behaviours

5. Skills assessments eg., functional performance record, HALO

6. Behaviour checklist, eg., Adaptive Behaviour Scale
INTERVENTION

AIMS

Chris will gain experience of a range of methods of intervention, eg., the constructional approach, change of antecedents and consequences and setting conditions.

1. Chris will work with the following clients through all phases of assessment, intervention and follow-up; at least six clients on clinical problems as referred, deciding on appropriate methods of intervention following discussions with the supervisor.

2. Individual work with each client will also involve direct work with the parents, family and other carers.

RANGE OF CLIENTS

1. Chris will work with a range of individual clients, varying with respect to age/level of disability/sex/ethnic background.

2. Chris will become familiar with a range of people, by spending time in appropriate establishments with people who have varying needs, eg., York House, Cherry Orchard Day Centre, various Lifecare Houses.

3. Chris will accompany Heidi and George in their work with people who may have varying individual differences

4. Chris will also have experience of clients, where referrals permit, who have difficulties in the following areas:

   • Sexuality issues
   • Bereavement and loss
   • Skills teaching
   • Inter-personal skills, assertiveness, anger management
   • Challenging behaviour
   • Anxiety or depression (cross speciality application of psychological models and skill)
   • Residential placement
5. This experience will be through:

- direct clinical work
- supervision
- observation of Heidi/George
- reading

INDIVIDUAL PLANNING

Chris will attend Life plan meetings to observe the process and facilitate understanding of tailoring the process to individual needs.

ESSENTIAL INDIRECT WORK

INDIRECT CLINICAL WORK

1. Chris will gain experience of indirect work by working with the staff group in Lifecare houses, advising on programmes, care plans and overall needs of residents living in the house. This work will build on the work already established by the psychologist involved in the house and will give Chris the experience of working in a clinical role maintaining change that has already been established within a system, working indirectly through staff and carers.

2. Chris will gain experience of indirect work by working through parents/carers during individual work

SERVICE LEVEL WORK

AIMS

Chris will familiarise himself with the work of other professionals within the Community Team and Services for People with Learning Disabilities

1. By attending fortnightly speciality psychology meeting at which service level issues and clinical are discussed.

2. During the course of the essential supervision sessions Heidi, George and Chris will discuss Heidi and George’s role working at service level

3. By attending planning meetings and working parties, etc., at a senior level with Heidi and George in order to be acquainted with organisation at that level.
WORK WITH NON-PSYCHOLOGISTS AND OTHER PROFESSIONALS

AIMS

Chris will familiarise himself with the work of other professionals within the Community Team and Services for People with Learning Disabilities

1. By meeting with the various professionals working within this service and if possible by observing them in their different professional work roles.

3. By meeting with managers of the Health and Social Services Authority and discussing their roles within the overall organisational structure.

WORK WITHIN THE ORGANISATION

RANGE OF SETTINGS

AIMS

Chris will have the opportunity to work in a range of different settings, at least 2 settings are essential, however the opportunity to spend time in more than these two settings will be made available. These will include the client’s own home, day services, social services, school, further education college and Lifecare houses.

TEACHING

AIMS

1. Chris will have the opportunity to prepare one piece of formal teaching as part of the in-service training programme for staff working within Lifecare.

ADDITIONAL CLINICAL PRACTICE

GROUP WORK

AIMS

Chris will liaise with Heidi to develop a Group. He will to interview potential candidates for the group and facilitate the group. The group will last for a minimum of eight sessions. As part of the setting-up process for the group, Chris will review the literature on groups for people with learning disabilities.

Heidi Adshead  
Supervisor  
George Lee-Choon  
Co-Supervisor  

Chris Hall  
Clinical Psychologist in Training  

9 May 1996  
ghh312c/ha/gk
SUMMARY OF PLD CASE REPORT
The PLD case report concerns the assessment and treatment of a 23 year old woman with severe/profound learning disabilities for a problem eating behaviour.

The client lived in a group home and staff had become concerned over her tendency to bolt food. It was thought that she may choke on her food. In addition, the behaviour meant that staff were reluctant to take the client out for meals in the wider community.

Assessment was informed by a constructional approach to behaviour theory. It was hypothesised that the behaviour may either be intrinsically rewarding to the client, extrinsically rewarded by social interaction from staff, or that it was related to physical discomfort due to dental problems.

Over the course of the assessment, the behaviour reduced. An intervention was still proposed, given that the frequency of the behaviour was erratic. Efforts were made to restructure the client’s environment prior to mealtimes in order to minimise possible triggers to the behaviour. Efforts were also made to reinforce incompatible behaviour during mealtimes. The intervention was carried out by care staff in the home, with appropriate supervision from the trainee. The client had also been referred for a dental check-up.

The outcome of the intervention was that the frequency of the “bolting” behaviour remained very low and that the client’s mood was reported to be improved prior to mealtimes.
<table>
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<tr>
<th><strong>PLACEMENT:</strong></th>
<th>Child and Adolescent</th>
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<tbody>
<tr>
<td><strong>DEPARTMENTAL ADDRESS:</strong></td>
<td>West Park Hospital</td>
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<td>Epsom</td>
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<td>Surrey</td>
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<tr>
<td><strong>TRAINEE BASE:</strong></td>
<td>West Park Hospital and St. Ebba’s Hospital</td>
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<tr>
<td><strong>SUPERVISORS:</strong></td>
<td>Penny Bebbington</td>
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<td></td>
<td>Shona Lowes</td>
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<td><strong>PLACEMENT DATES:</strong></td>
<td>YEAR 2: Sep 1996 to Mar 1997</td>
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CONTRACT FOR PLACEMENT FOR EXPERIENCE WITH
CHILDREN AND ADOLESCENTS FOR THE
UNIVERSITY OF SURREY DOCTORATE IN CLINICAL PSYCHOLOGY.

LENGTH OF PLACEMENT: 6 months
2. 10. 96 - 1. 3. 97

NAME OF TRAINEE: Chris Hall.

NAMES OF CO-SUPERVISORS: Penny Bebbington, Shona Lowes

ADDRESS: Cavell House, St Ebba's, Surrey Heartlands NHS Trust,
Hook Road, Epsom, Surrey KT19 8QJ.

TEL: 01372 72212 Ext 4063

There will be a total of 2 hours each week supervision with both supervisors.

AIMS OF THE PLACEMENT:

1. To achieve at least an acceptable standard in the core competencies as applied to Children and Adolescents as specified in the Clinical Placement Handbook.

2. To introduce the trainee to this client group and give experience within the full age and problem range.

3. To develop his awareness of their needs.

4. To have experience of the range of possible psychological assessments, therapeutic interventions and theoretical models.

5. To gain experience of the wider system of inter-professional and inter-agency net working.
**OBJECTIVES.**

1. To observe children within the normal range of development in a variety of settings, individual and group.
2. To enable the trainee to communicate effectively with children at different developmental levels.
3. To select, use and interpret norm referenced and criterion referenced tests.
4. To plan and undertake at least part of therapeutic interventions in one model.
5. To communicate the formulation method and outcome of all intervention in writing.
6. To present a psychological intervention to a multi-disciplinary group.
7. To observe the work of other professionals in multi-disciplinary teams to gain understanding of the interrelationship.

**METHODS.**

**A: Professional Development**

1. To attend meetings of the Psychology Department held on alternate weeks.
2. To attend a range of meetings including the Child Clinical Psychology service and the District Child Development Team and the Child and Adolescent Psychiatry Team.
3. To attend a Child S.I.G. Meeting.
4. To present a case report to a multi-disciplinary group.
5. To give a Seminar to the department.

**B: Visits and Observation**

1. To spend at least one hour observing children in a playgroup and a nursery.
2. To observe other professionals working therapeutically with children individually and in groups, including a Speech & language Therapist, a Physiotherapist and Occupational Therapist.
3. To observe the work of another Psychologist in assessment and therapy sessions.
4. To attend sessions of the Junior Opportunity Group run for multiply disabled children.

5. To visit a special school.

C: Assessment

1. To apply the WISC III and the pre-school test of development, and another test of intelligence.

2. To use the PIP to take a history.

3. To carry out an observational assessment using a structured format as a basis for behavioural analysis.

4. To construct a family tree for a child.

5. To participate in assessing a young person who is in-patient at the Regional Adolescent Unit.

D: Intervention

1. To carry through the process of treatment in 3 selected cases.

2. To be included in working with a child from a different ethnic background.

3. To participate in family interview and therapy sessions.

4. To be involved in the assessment and intervention in a group for Parents whose children have sleep difficulties.

5. To work jointly with supervisors in assessment and intervention of a range of individual cases.

E: Teaching

1. To assist in a Workshop run for Health Visitors designed for sharing skills about behavioural/developmental problems.

Penny Bebbington,  
Clinical Psychologist  

Shona Lowes,  
Clinical Psychologist

Chris Hall,  
Clinical Psychologist in Training

Supervisors
SUMMARY OF CHILD AND ADOLESCENT CASE REPORT

The child and adolescent case report concerns the assessment and treatment of an 11 year old boy who suffered from facial tics.

The client was aware of two forms of involuntary tics concerning his face. The frequency of the tics varied during the day, but became more frequent when the client was worried about something. He had been helped to deal with these tics previously using relaxation, but did not apply this in any systematic fashion. The tics had developed following the completion of a final operation for Perthes Disease.

It proved difficult to elicit any automatic thoughts that may have affected the tics and a behavioural formulation was reached instead. It was hypothesised that the tics may have started as purposeful movements related to being in pain or distress, related to the Perthes Disease. Such movements were suggested to have become associated with anxiety according to the model of Classical Conditioning, and were likely to be reinforced by parental concern.

Several behavioural strategies for managing tics were considered and it was decided to focus on relaxation and distraction. In addition, it was felt that some training in study skills may help, given that the majority or reported stress was related to schoolwork.

At the end of the intervention, there was no real change in state-dependent anxiety, which was within one standard deviation of the mean for the client’s age group. The client did not complete self-monitoring tasks with relation to the tics, which meant that there were no objective measures of outcome. Subjectively, the client believed that he would be able to manage a reoccurrence of tics in the future.
<table>
<thead>
<tr>
<th><strong>PLACEMENT:</strong></th>
<th>Older Adults</th>
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<tbody>
<tr>
<td><strong>DEPARTMENTAL ADDRESS:</strong></td>
<td>Amyand House Day Hospital</td>
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<td>Strafford Road</td>
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<td>Twickenham</td>
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<td>Middlesex TW1 3HQ</td>
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<td><strong>TRAINEE BASE:</strong></td>
<td>Amyand House Day Hospital</td>
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<tr>
<td><strong>SUPERVISOR:</strong></td>
<td>Dr Farzad Shamsavari</td>
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<tr>
<td><strong>PLACEMENT DATES:</strong></td>
<td>YEAR 2: Apr 98 to Oct 97</td>
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</tbody>
</table>
OLDER ADULTS SPECIALIST TRAINING CONTRACT

Trainee: Chris Hall

Supervisor: Farzad Shamsavari

Dates: From 09.04.1997 to October, 1997

Base: Amyand House, Strafford Road, Twickenham

Supervision: 1½ hrs per week

Study Time: Fridays in alternative weeks (½ day per week)

Placement goals:

1. Clinical work

1.1 Experience with the range of formal tests and check lists used for the assessment of cognitive functioning and dependency levels or neuro-psychological assessment, of older people. In particular, familiarity with the following tests:

Camdex
Dementia Rating Scale
Meams
CAPE
Rivermead Behavioural Memory Scale
GHQ

1.2 Experience with formal and other (interviewing, observation) methods used for the assessment of functional or behavioural disorders in older adults for example:

HAD
Beck Inventory
Self-report measures
Functional analysis.
1.3 Experience with different approaches to the treatment and rehabilitation of older adults:

- Behavioural
- Cognitive
- Counselling

1.4 Experience of work with:

- Individuals
- Couples
- Families
- Groups

1.5 Experience of work with both sexes and a range of ages and ethnic groups as much as possible.

1.6 Experience of observing and/or working in different settings:

- Residential Homes
- Patients' Houses
- Day Centres
- Day Hospital
- Primary Health Care Settings
- Assessment and respite wards
- Continuing Care Wards

1.7 Experience with a wide range of mental health problems in older adults, for example:

- Depression
- Phobias
- Relationship problems
- Cognitive change
- Adjustment difficulties
- Behavioural problems

1.8 Experience in planning and setting up groups for clients and/or carers. Also experience in observing and offering feedback on groups which are already running.

1.9 Experience in collaborating with other professionals in client work.

1.10 Opportunity to observe and discuss a case in a Health Psychology setting and visit the services which are available.
2. Organisational work

2.1 Attending the MHE clinical meetings, business meetings and working party as appropriate.

2.2 Attending meetings of the Department of Psychology.

2.3 Attending the regional meetings of the Elderly Special Interest Group.

2.4 Contributing to the training and/or supervision of staff in Amyand House Day Hospital.

Supervisor: 
Dr Farzad Shamsavari
Chartered Clinical Psychologist

Trainee: 
Chris Hall
Clinical Psychologist in Training
SUMMARY OF OLDER ADULT CASE REPORT
The older adult case report concerns a 69 year old woman, who was assessed for cognitive deterioration.

The client presented with a recent history of cognitive deterioration, including poor concentration, mild dysphasia, garrulous speech, and increased lack of social support following progressive lack of mobility. The referral questioned whether the client was likely to be suffering a Frontal Lobe Syndrome or Early Dementia of the Alzheimer Type.

The assessment involved interviewing the client, other members of the family, the GP, and administering a battery of tests. The literature for the likely disorders was reviewed and the following tests were included in the battery: the Wechsler Adult Intelligence Scale (Revised), the Nelson Adult Reading Test, the Cambridge Cognitive Assessment, the Controlled Oral Word Association Test, the Modified Wisconsin Card Sorting Test, the Trail Making Test, and the Complex Figure Drawing Test.

It was concluded that the pattern of impairments was consistent with Alzheimer's disease and concurrent vascular disease. Her symptoms of frontal lobe pathology were hypothesised to be related to her premorbid personality. A recommendations for a further assessment of her daily living skills was made.
<table>
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<tr>
<th><strong>PLACEMENT:</strong></th>
<th>Specialist Placement in Family Therapy</th>
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<tbody>
<tr>
<td><strong>DEPARTMENTAL ADDRESS:</strong></td>
<td>Ridgewood Centre</td>
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<td>Old Bisley Road</td>
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<td>Frimley</td>
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<td>Surrey GU16 5QE</td>
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<td>Ridgewood Centre</td>
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<td><strong>SuPervisors:</strong></td>
<td>Annette Lumsden</td>
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<td></td>
<td>Tracy Harris</td>
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<td><strong>PLACEMENT DaTEs:</strong></td>
<td>YEAR 3: Oct 97 to Apr 98</td>
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FAMILY THERAPY PLACEMENT
TRAINEE CONTRACT

AIM

1. To develop practical skills and theoretical understanding of systemic through a range of clinical, team, supervision, and academic experiences.

OBJECTIVES

1.1 Develop an understanding of systemic theory:

a) Consider the different models of family therapy, namely:
   - the Milan Team approach
   - the structural approach
   - the strategic approach

b) Consider the influence of social constructionism and narrative approaches on family therapy models

1.2 Develop systemic skills in the following areas:
   - hypothesising
   - circular questioning
   - interventions
   - video tape review
   - reflecting team discussions
   - issues of self within therapy
   - ethical issues

1.3 Apply systemic skills and theories within clinical practice:
   a) Trainee to offer systemic therapy in at least 4 cases as a Keyworker
   b) Trainee to offer systemic therapy in at least 8 cases as a Co-worker
AIM
2. To develop a systemic approach that informs general clinical practice as well as specific family therapy:

OBJECTIVE
2.1 To consider theory and practice within supervision

2.2 To consider how a cognitive approach can be accommodated within a systemic approach.

2.3 To observe other professionals using a family therapy approach in different contexts, including the following:
a) the Family Therapy Team
b) the Child and Family Consultation Service
c) other psychologists working individually

2.4 To reflect on personal preferences, values, and prejudices in relation to therapeutic approaches for adults.

AIM
3. To participate within a family therapy team:

OBJECTIVES
3.1 To be involved in team meetings and discussions

3.2 To work jointly with other members of the team on clinical cases

3.3 To contribute to the strategy for family therapy in the new trust
AIM

4. To consider research within a family therapy perspective:

OBJECTIVES

4.1 To complete a brief literature search on standardised assessment and outcome measures in relation to family therapy

4.2 To devise a pilot questionnaire and administer it

Signed by:

Annette Lumsden
Chartered Clinical Psychologist

Tracey Harris
Chartered Clinical Psychologist

Chris Hall
Clinical Psychologist in Training
SUMMARY OF SPECIALIST FAMILY THERAPY CASE REPORT

The Family Therapy case report concerns a married couple, who were experiencing difficulties in communicating with each other. The husband, a 30 year old man, was the identified patient and had been referred due to feeling a failure in his marriage and at work.

The couple were assessed and treated using the Milan approach to Family Therapy. This involved a reformulation of the couple’s difficulties before and after each session. The bulk of the intervention was aimed at encouraging the couple to gain a wider, more systemic understanding of their situation through the use of circular questioning.

The couple had a new baby following what was a traumatic pregnancy for the two of them, where the wife had been close to death. As a result the couple were now afraid to have a sexual relationship. The wife had a child from her first marriage. Following the new birth, the relationships within the family had altered with the result that the husband was less close to his stepson and the wife found it hard to bond to her baby.

It was initially hypothesised that the difficulties in communication were a consequence of the changes in the family hierarchy. Following the second session, the couple were seen as trying to develop new roles with each other, while having difficulty in letting go of the old ones. Following the third session, the couple’s pattern of not listening to each other and jumping to assumptions was identified. In the fourth session, the couple’s incompatible beliefs about arguments were gently challenged.

The couple did not attend any further sessions, but contacted the service at a later date to discuss parenting problems. Further formulations and limitations of the approach with this family are considered.
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<tr>
<th><strong>PLACEMENT:</strong></th>
<th>Specialist Placement in Addictions</th>
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<tr>
<td><strong>DEPARTMENTAL ADDRESS:</strong></td>
<td>Springfield University Hospital</td>
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<td>London</td>
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<td><strong>TRAINEE BASE:</strong></td>
<td>Springfield University Hospital</td>
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<tr>
<td><strong>SUPERVISOR:</strong></td>
<td>Dr Paul Davis</td>
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<tr>
<td><strong>PLACEMENT DATES:</strong></td>
<td>Apr 1997 to Sept 1997</td>
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SECTION 1: APPROACH

AIM: The trainee will understand cognitive models related to addiction and its
treatment by the end of the placement. These include:
- relapse prevention
- motivational interviewing
- cycle of change
- Beck’s model of substance abuse

ACTIONS:
The trainee will read the appropriate literature and discuss it during supervision.
The trainee will give a short presentation of either a case or a topic to a staff group.
The trainee will attend, as either co-facilitator or observer, groups on in-patient wards
that deal with the above approaches.

AIM: The trainee will have an understanding of cognitive models of personality
disorder and their treatment, including:
- Beck’s model of personality disorders
- a schema-focused model of treatment
- Dialectical Behaviour Therapy

ACTIONS:
The trainee will read the appropriate literature and discuss it during supervision.
The trainee will discuss clients that are either seen by trainee or supervisor in the light
of such models.

SECTION 2: METHOD

AIM: The trainee will be able to apply CBT methods of treatment for addiction in
terms of formulation and treatment plans.
ACTIONS:
The trainee will work with at least 4 individual cases.
The trainee will facilitate/co-facilitate relapse prevention groups on in-patient wards.
The trainee will write 4 assessment reports.
The trainee will write 4 closure/progress reports.

AIM: The trainee will be able to apply CBT principles to the treatment of personality disorder.

ACTION:
The trainee will work with at least 1 individual case, where personality disorder is being treated.
The trainee will adapt a specialist CBT approach for personality disorders to addictions.

ACTION:
The trainee will apply specialist CBT approaches to at least 1 individual case.

SECTION 3: TECHNIQUES

AIM: The trainee will be able to apply specialist CBT techniques including:
- motivational interviewing
- relapse prevention techniques

ACTION:
The trainee will apply techniques during group work and individual treatment.
The trainee will discuss the application of these techniques during supervision.

AIM: The trainee will be able to apply general cognitive and behavioural techniques including:
- social skills training
- mood management skills training
- relaxation
ACTIONS:
The trainee will apply techniques during group work and individual treatment.
The trainee will discuss the application of these techniques during supervision.

SECTION 4: ADDITIONAL GOALS
AIM: The trainee will have some experience of working with adolescents.

ACTION:
The trainee will either observe or take on an adolescent case for assessment or treatment.

SECTION 5: USEFUL EXPERIENCES
AIM: The trainee will have the chance to meet with heads of speciality related to the psychological services and addiction services.

ACTIONS:
The trainee will meet with heads of specialities, including:
- heads of psychological specialities based at Springfield University Hospital
- head of addiction services
The trainee will attend speciality meetings, including:
- in-depth ward round for the addictions services
- addictions speciality meeting
- personality disorders special interest group
- addictions special interest group

Signed by:

Mr Chris Hall
Clinical Psychologist in Training

Dr Paul Davis
Consultant Clinical Psychologist
SUMMARY OF AMH PLACEMENT EXPERIENCE

11 clients were seen for individual work and 9 were seen for group work. The client group included inpatients and outpatients. The range of problems identified for assessment and/or treatment included phobias, panic attacks, cognitive impairment, depression, generalised anxiety, intellectual impairment, drug and alcohol abuse, and adjustment difficulties. Therapeutic approaches included Cognitive-Behaviour Therapy and Behaviour Modification.

The trainee was able to attend CMHT case allocation meetings, the Psychological Therapies Service Departmental weekly meeting, and a hospital management meeting concerning the running of a long-term disabilities ward. Visits were made to an AMH Resource Centre, and AMH Day Hospital, a Social Services-run AMH Day Centre, and the local charity headquarters of MIND. The trainee was able to observe a Clinical Psychologist working in a Primary Care setting weekly and to observe a Community Psychiatric Nurse for a day. Other relevant experience included teaching ward staff about managing problem behaviour by environmental change.

SUMMARY OF PLD PLACEMENT EXPERIENCE

9 clients were seen for individual work and 5 were seen as part of an anger management group. The clients were a mixture of those living in community homes, outpatient referrals, and those attending a Day Centre for PLD. The range of problems seen for assessment and/or treatment included concern over functional independence, problem eating behaviour, concern over parenting skills, intellectual impairment, self-injurious behaviour, depression, bereavement, and skills training. Therapeutic approaches included behaviour modification and bereavement counselling.

A range of other professionals were observed, including creative therapists, speech and language therapists, a physiotherapist, a dietician, and a challenging behaviour team. The trainee was able to take part in meetings including a communication day for the Trust, a client life-plan meeting, multi-disciplinary referral meetings, fortnightly psychology department meetings. The trainee attended in-service courses on breakaway techniques and autism. Other relevant experience included the use of an
interpreter in order to interview a refugee, liaison with a clinical psychologist from the National Deaf Service in order to work with a client, and visiting the Regional Challenging Behaviour Assessment Unit.

SUMMARY OF CHILD AND ADOLESCENT PLACEMENT EXPERIENCE
19 clients were seen individually or with a supervisor. All clients were outpatients and were either seen in their own homes or at a health service clinic. The range of problems seen for assessment and/or intervention included phobias, encopresis, disruptive and problem behaviours, sleep problems, eating problems, delayed development, facial tics, failure to thrive, post-traumatic stress, and cognitive impairments. Therapeutic models included Cognitive-Behaviour Therapy and Behaviour Modification.

Whilst on placement, the trainee was able to attend meetings of the Junior Opportunity Group for children with special needs, the Child Development Team, nurseries (hospital and independent), the AGM of the charity GASP, a Social Services case review, a Speech and Language Therapy group for Dyspraxia. Other relevant experience included attending a Special Interest Group presentation on Adolescents and Cancer, participation with a Family Therapy Team, and assisting in a presentation on toileting problems for Health Visitors.

SUMMARY OF OLDER ADULT PLACEMENT EXPERIENCE
16 clients were seen individually and 9 were seen in an assertiveness group. The range of problems seen for assessment and/or intervention included bereavement and adjustment difficulties, low self-esteem, low motivation for self-care, depression and low mood, generalised anxiety, cognitive impairments, marital difficulties, phobia, and substance abuse. Therapeutic approaches used included Cognitive-Behaviour Therapy and Behaviour Therapy.

Whilst on placement, the trainee was able to attend meetings at the day hospital and of the CMHT, and a service planning meeting for the User’s Group. The trainee was able to visit an acute in-patient unit, day centres, a day hospital reminiscence group, and
residential homes. Other relevant experience included presenting a journal article on “Brief Motivational Interviewing” to the CMHT.

SUMMARY OF SPECIALIST FAMILY THERAPY PLACEMENT EXPERIENCE
26 families were seen as part of the family therapy team. 6 of these were seen where the trainee was in the role of keyworker. The range of problems seen for assessment and/or intervention included marital difficulties, parenting problems, depression, alcoholism, generation difficulties, low self-esteem, self-harm, sexual problems, adjustment to trauma, adjustment to mental illness, agoraphobia, stepfamily difficulties, panic attacks, and obsessive-compulsive disorder.

Whilst on placement, the trainee was able to attend meetings concerning an imminent Trust merger, and regular Psychology Department meetings. The trainee was also able to participate in family therapy sessions with the Child and Family Consultation Service and to observe another clinical psychologist using family therapy models both with a family and with an individual client.

SUMMARY OF SPECIALIST ADDICTIONS PLACEMENT EXPERIENCE
6 clients were seen individually. This client group consisted of outpatients and inpatients. The trainee co-ran the Relapse Prevention Group on the detoxification ward and the Cognitive-Behaviour Therapy Group for residents on the Recovery Ward. The number of clients on the detoxification ward varied from week to week, but was typically about 11. The CBT group typically had 6 members. All clients had a problem with addictive behaviour. The range of problems seen for assessment and/or intervention also included anxiety, depression, adjustment problems, relationship difficulties, personality disorders, anger, chronic pain, and low mood. The main therapeutic approach was cognitive-behavioural.

Other relevant experiences included liaison with other addictions agencies including the Regional Drug Service, Community Drug and Alcohol Teams, and the High Support Service for people with Addictive Behaviours.
SUMMARY OF RESEARCH SECTION

This section is intended to demonstrate skills related to research, particularly the abilities to critically evaluate previous research, to identify clinically relevant research questions, and to collect, analyse, and interpret data appropriately. The section is divided into 3 parts. The first contains a literature review related to cognitive theories of post-traumatic stress disorder, carried out in the first year of the degree. The second sub-section concerns a small scale research project, which was service-related and carried out in the second year of the degree. This is concerned with the study of behavioural treatments for childhood sleep disorders. The final sub-section is a large scale research project concerning the effects of opiate withdrawal symptoms on the interrogative suggestibility of opiate-dependent individuals.
Individual Differences in PTSD

TITLE: Individual differences in the development of post-traumatic stress disorder

SUPERVISORS: Dr Elizabeth Campbell
Dr Peter Simpson

DATE: YEAR 1
INTRODUCTION

The construct of posttraumatic stress disorder (PTSD) has only been recognised as a diagnostic disorder since 1980 (American Psychiatric Association [APA], 1980), however the after-effects of suffering from trauma have been recognised and described by various names, such as shell-shock and chronic combat fatigue, during the last century (Saigh, 1992). Since the description of diagnostic criteria for this disorder (APA, 1980; 1987; 1994), research into this area has multiplied (Litz and Keane, 1989).

Essentially PTSD is seen as a characteristic set of symptoms following a trauma (APA, 1994). A trauma is taken to be serious actual or threatened harm to the physical integrity of the individual or others. The individual will have suffered intense fear, helplessness or horror. The characteristic symptoms are described as persistent reexperiencing of the event, persistent avoidance of stimuli associated with the trauma, and persistent symptoms of increased arousal. The symptoms must be present for more than a month for a diagnosis to be made, implying that such reactions to an event that is outside normal experience can be seen as typical. It is only when they cause clinically significant levels of distress or interfere with normal functioning that the symptom cluster is seen as a disorder.

When considering how PTSD symptoms arise, it is important to note that not all people who suffer a trauma will develop full-blown PTSD. It is the intention of this essay to consider theories related to individual differences in PTSD, in particular why some people develop the disorder and not others. This review will examine etiological theories and research that relate to individual differences.

Why focus on individual differences?

Early conceptualisations of models were able to account for the symptoms in PTSD,
but not for the variance that is seen. Several authors have reviewed the earlier literature and its limitations (Jones and Barlow, 1990; Kolb, 1988; McGuire, 1990).

Keane, Zimering, and Caddell (1985: cited in Jones and Barlow, 1990) developed a behavioural model to account for PTSD. This was based on Mowrer's two-factor theory of fear and anxiety (Mowrer, 1947). Various cues that were present during the trauma were assumed to be learnt through classical conditioning and capable of eliciting the feelings that were present during the trauma. This association was then felt to be maintained through operant conditioning whereby the individual avoids or escapes these cues and is rewarded each time by a decrease in anxiety. Keane et al (1985) went on to propose that the vast array of triggering stimuli could be explained by stimulus generalisation and by further higher-order conditioning. In addition to this, extinction would require the person to be in the same aversive state as during the trauma due to the principles of state-dependent learning.

The biggest drawback of this theory is that it is unable to account for the heterogeneity in symptom presentation of PTSD and in particular why not all trauma victims develop PTSD. Several authors have since drawn upon cognitive and information-processing ideas to account for individual differences.

Current theoretical work in this area considers two aspects of the traumatic event: how the event is perceived by the individual; and how the event is encoded in memory.

**The perception of the trauma**

Peterson and Seligman (1983) have used their work on learned helplessness in depression to account for the symptoms of PTSD. They have argued that a traumatic event, such as victimization, is uncontrollable and unpredictable. A belief in future events being equally uncontrollable and unpredictable is hypothesised to bring about depression. The likelihood of this happening is dependent on the attributions an
individual makes about the event concerning the cause, the generality over time, and
the generality over situations. People who attribute the cause to themselves, and feel
that they will experience problems in all areas of life for as long as they can imagine
will, in this theory, experience low self-esteem, self-blame, and depression.

However this theory was only intended to account for the symptoms of passivity and
numbness in PTSD and offers no explanation for the anxiety, avoidance, and
reexperiencing that occurs. Later work by Abramson, Metalsky, and Alloy (1989) in
learned helplessness also emphasised the importance of the perceived consequences of
an event, however it is still not clear how this theory could account for all the
symptoms characteristic of PTSD, although it does stress the importance of the
meaning of the trauma to the individual.

Foa, Zinberg, and Rothbaum (1992) proposed an animal model of PTSD, suggesting
that the effect of uncontrollable, unpredictable shocks will be mediated by the
expectation an animal has. Although symptoms such as reexperiencing could not be
observed in animals, the authors suggested that the wariness and other symptoms of
avoidance shown by animals in the presence of the original or similar stress cues could
be an indirect measure of this. If one accepts this argument then the authors cite
numerous studies to show that animals exposed to extensive uncontrollable,
unpredictable shocks develop symptoms of persistent arousal and increased generalised
fear, increased discrete fear, lasting opioid-mediated analgesia and opioid system
sensitisation. Interestingly this effect is also seen if the animal experiences just one
shock which is intense and in the presence of previously rewarding stimuli.
Experiencing repeated shocks could be analogous to experiencing repeated traumas
and experiencing one shock in the presence of previously rewarding stimuli could be
analogous to having beliefs of feeling safe and in control shattered by a traumatic event.

Foa and Riggs (1993) elaborate on this idea when considering PTSD in rape victims
and suggest that the impact of a trauma will be mediated by schema about "oneself" and about the "world". An important dimension of the self-schema is how competent and reliant an individual sees themself as. The world schema is important in considering how safe or dangerous the world is. These schema are used to make sense of information that is received.

Foa and Riggs (1993) outline two suggested mechanisms whereby these schema interact with the memory record of the trauma to produce PTSD symptoms. People with rigid schema that view themselves as being competent and the world as being safe will be thrown into confusion by a traumatic event over which they have no control and which shows the world to be a dangerous place. Such information is in direct contrast to what they believe and expect. Their previous notions of predictability and control are shattered so that for them every situation may be unpredictable and uncontrollable, putting them into a continuous state of arousal.

Those that have suffered repeated trauma may already have schema that reflect a view of the world as unsafe and of themselves as incompetent. However in this case, these schema are assumed to be dormant and only triggered by the traumatic event. For this group, their view of the world as a dangerous place over which they have little control is reinforced. This is suggested to again put the trauma sufferers into a state of permanent arousal, always expecting trouble. Foa and Riggs (1993) are not clear if one should expect two different pathologies of PTSD from this. There is an argument for this from Foa, Riggs, and Gershuny (1994) who conducted a factor analysis of assault victims' symptoms, finding two patterns. They suggest that there are two patterns of posttrauma reaction, one characterising PTSD, the other characterising a phobic reaction.

Those with more flexible schema, such as "the world is sometimes dangerous" and "I can control some things but not others", will be able understand the event as it does not
conflict with their schema and so there is no reason to think of themselves or of the world as having changed.

The second aspect of the information processing paradigm is that of the memory record of the trauma.

**Memory record of trauma**

When considering the memory record of the trauma from an information processing paradigm, there has been an attempt to explain in addition to the events recorded, how the structure of the record may also affect the course and expression of PTSD symptoms.

Several authors (e.g. Foa and Kozak, 1986; Rachman, 1995) have reported the work of Lang (1977) on the proposed structure of fear memories. Lang suggested that information concerning fear is grouped together in schema that serve as a protocol for escape and avoidance. Such schema would contain information about the feared situation (stimuli), information about cognitive, behavioural, and physiological reactions to the feared situation (response), and information about the meaning of the stimulus and response elements.

Foa and Kozak (1986) extended this idea to traumatic events. They have suggested that the meaning element also includes the likelihood and valence of the feared situation. The meaning of a trauma is life-threatening as opposed to just dangerous. Foa, Steketee, and Rothbaum (1989) went on to suggest that PTSD fear structures differ from everyday fears in 3 ways; the fear responses are more intense; the threshold for activation is lower; and there are more elements in a PTSD fear memory than in an everyday fear memory. The implication is that PTSD fear memories are more easily activated than other fear memories. Further to this, Foa and Riggs (1993) have proposed that traumatic memories are also very fragmented and disorganised with
weak associations between the different fragments.

The degree of fragmentation of the memory is hypothesised to be related to individual differences (Foa and Riggs, 1993). Those with strong safety schema will have difficulty in comprehending the event, leading to a poorly organised record. Those with strong vulnerability schema are predicted to have these schema activated by the event, which would magnify the difficulty in processing the trauma information. Although Foa and Riggs do not make it clear how these triggered vulnerability schema would interfere with processing, one possibility is that the individuals become preoccupied with what they expect to happen.

**Processing the trauma**

The above theories point to a record being formed of the traumatic event. The content and structure of the record is likely to be related to the experience and intensity of the event itself and possibly to predispositional schema about safety and control (Foa and Riggs, 1993). The symptoms of PTSD can be seen as arising out of the activation and processing of the trauma record.

Litz and Keane (1989) expanded on the original behavioural theories for PTSD. They suggested that exposure to a stimulus that was approximate to those involved in the actual trauma then reactivates the traumatic memory network. This is experienced as intrusive thoughts and memories and leads to hypervigilance in the search for further evidence of danger. This search can lead to misinterpretation of other cues which further increase arousal activating more trauma images, and can become a vicious cycle. To break it the individual attempts to avoid any reminders of the trauma. This may involve cognitive avoidance (e.g. ignoring internal sensitivities) and behavioural avoidance of external cues. This however still does not account for individual differences in PTSD.
Foa and Riggs's model (1993) attempts to explain PTSD symptoms as a result of trying to integrate a fragmented memory record into rigid schema about the self and the world. The aversiveness of the memory leads the individual to try to avoid it, but further to that the fragmentation of the memory makes it difficult to recall the entire record. Different cues may only trigger selective aspects of the trauma. This prevents the sufferer from viewing the whole event objectively and changing any of the information. Foa and Riggs have hypothesised that the memory record stays in "working memory" until it is accommodated into the individual's schema. The validity of a concept of working memory is questionable, but it suggests that such a memory record remains easily accessed at least in parts if not as a whole. This can account for the reexperiencing of the event. Foa and Riggs go further to suggest that when the reexperiencing becomes too much, the individual may "shut down the system" although the process by which this is done is not clear. Possibly, it involves cognitive avoidance (i.e. distraction) as suggested by Litz and Keane (1989).

Chemtob, Roitblat, Hamada, Carlson and Twentyman (1988) provide a cognitive action theory of processing to explain PTSD. Information is conceived as being represented by interconnecting nodes. Learning is due to either the formation of new nodes or the formation of new connections between nodes. Information is also felt to be arranged hierarchically. The activation of one node may activate or inhibit others. This is a more detailed theory of the traumatic memory network. Chemtob et al's work (1988) has focused on war veterans and suggests that the structure underlying PTSD symptoms was functional during a battle situation but inappropriate during civilian life. A threat arousal node is hypothesised to exist which when activated will activate other nodes such as threat appraisal and threat memories further down the hierarchy. The threat arousal node is assumed to be always weakly potentiated in PTSD sufferers, but is usually kept in check by inhibition from other contra-indicated nodes. Ambiguous information serves to stimulate the threat arousal node which then activates threat related nodes, leading to the experience of intrusive memories. Although ordinary
arousal and intentions are felt to inhibit threat arousal, in a PTSD sufferer even small arousal can lead to the activation of the threat structure.

Chemtob et al (1988) have attempted to give an information processing structure which can account for an attentional bias towards threat. Such bias is hypothesised to exist for anxiety disorders resulting in misinterpretation of ambiguous cues (Beck, Emery, and Greenberg, 1985). Such a bias would lead the individual to attend to more and more ambiguous threat cues, resulting in a positive feedback loop. However Chemtob et al (1988) also predict that as more information processing capacity is taken up with focusing on threat, the individual's ability to process the information decreases. Numbing and hyperarousal are explained by the person being unable to retrieve information initially, but then as the trauma network is activated, having difficulty in suppressing that information.

The threat structure as described by Chemtob et al (1988) is felt to be part of normal functioning. However people with PTSD are felt to differ in 3 ways. It is suggested that there is a higher resting potential in the threat arousal node, making it easy to activate. The speed (gain) with which the positive feedback loop leads to increases in arousal level is thought to be faster in people with PTSD and such people are also felt to have higher thresholds for any damping mechanisms and by implication, one assumes to experience more sustained anxiety. Chemtob et al explain individual differences by suggesting that some individuals may have a high gain within their information processing systems anyway. Another possibility is that life threatening events can cause a permanent change to the degree to which the threat arousal is potentiated. Kolb (1988) in particular has applied classical neurological theory to PTSD, suggesting that repeated overstimulation of neurological systems such as those involved in emotional stimulation in the face of threatened death, can lead to fatigue. However this does not explain why some people should develop PTSD after a trauma and not others and is perhaps more pertinent to the long-term effects of chronic PTSD.
Support for predispositional factors

Chemtob et al (1988) have suggested that some individuals may have a higher gain than others in their information processing systems. In essence this suggests that individuals that can be aroused more quickly may be more susceptible to developing PTSD. It is not obvious how this would happen, although one mechanism may be that due to high gain within the information processing system, threat arousal networks are more rapidly formed. However, this theory is prompted by the recognition that individuals with PTSD can be characterised by the gain of their arousal positive feedback loop. This characteristic may well be associated with a permanent change in the arousal system as a result of experiencing trauma. If this were so then the model proposed by Chemtob et al (1988) would be inadequate to explain why some individuals developed PTSD in response to a trauma and not others. The notion of permanent change is still worth considering. Gil, Calev, Greenberg, Kugelman, and Lerer (1990) used a comprehensive test battery to assess 12 PTSD patients, 12 psychiatric patients, and 12 normal controls. They found cognitive functioning was impaired in the PTSD and psychiatric groups. However the performance of these groups were similar, so any deterioration may not have been attributable to an aspect peculiar to PTSD, although the cognitive problems were not secondary to alcohol, drug abuse, or head injury.

Horowitz (1986: cited in Jones and Barlow, 1990) advocated an approach that overlaps cognitive and psychodynamic theories. He proposed that PTSD arose from a conflict between a need to accommodate trauma information into the individual's schema and a desire to avoid the aversive memories. He felt that there is a drive for completion which compels the individual to keep coming back to the traumatic event. Unfortunately this theory does not really help us to understand individual differences in PTSD, but it does suggest the importance of schema in PTSD.

If one theorises that PTSD is related to the schema an individual has (e.g. Foa and
Individual Differences in PTSD

Riggs, 1993) or possibly a characteristic way of processing emotional information (e.g. Chemtob et al, 1988), then one would expect demographic variables, such as age, race, marriage, and socio-economical status to have an equivocal relationship with posttrauma reaction. One would hypothesise that they would only have an effect in as far as they influenced the formation of individual schema about safety and control.

Several studies have examined demographic variables with respect to posttrauma outcome in retrospective accounts and the results of these studies are equivocal (Foa and Riggs, 1992). For example, Atkeson, Calhoun, and Resick (1982) found that victimization when younger caused less difficulties than when older, while Becker, Skinner, and Abel (1982) found no such correlation. Ruch and Chandler (1983) found that married victims were more likely to show distress after a trauma, while Kilpatrick, Saunders, and Amick-McMullan (1989) found no such difference. Ruch and Chandler also found that non-whites had more difficulties post-trauma, while Burnam, Stein, and Golding (1988) found no such difference. Atkeson et al (1982) also found that people with a lower socio-economic status were likely to have more problems posttrauma, while Kilpatrick et al (1989) found no such relationship. All of these studies have been cited by Foa and Riggs (1993) as evidence in support of their schema theory, however a closer look at the methodology calls their validity into doubt.

There are two main points to consider. The methodology of these individual studies is such that it is hard to compare them and make any conclusions or generalisations. In addition, contradictory evidence about possible correlations is neither proof that there is no correlation nor proof that there is or isn't any causal relationship. When considering the individual methodologies, a number of problems are raised. With the exception of Kilpatrick et al (1989), these studies were carried out before diagnostic research criteria for PTSD were agreed upon. The result of this is that the studies take in a heterogeneous group of individuals, not all of whom may be considered to have been suffering from PTSD. Although Kilpatrick et al (1989) used the Diagnostic Interview Schedule (DIS) for diagnosis, this measurement has been suggested to lead
to an under-estimate in PTSD recognition due to false-negatives, at least in combat veterans (Saigh, 1992). This problem of heterogeneity has been compounded by the sampling measures used in most of the studies, which typically relied upon volunteers. One could argue that volunteers may represent a skewed population, especially if one considers that a great deal of rape and abuse goes unreported (Foa and Riggs, 1993). A further complication is that subjects in different studies were sampled at different times after the traumatic event and it is possible that posttraumatic symptoms change or develop over time. The result of this is to make it difficult to compare research studies to each other. The nature of posttraumatic research is that it will often be retrospective. It is difficult to justify research that involves waiting for traumatic events. In view of this it will always be difficult to attribute results to predispositional factors, when they may well be due to permanent changes as a result of the trauma. In summary, the contribution of demographic studies so far is so open to methodological flaws that it is impossible to generalise from the studies or compare them with each other. The statement that demographic variables are not directly involved in the development of PTSD is as yet unproved.

Both Foa and Riggs' model and Chemtob et al's model would predict that aversive events prior to the trauma could have an effect either on the individual's safety and control schema or on their traumatic network. Severe life changes that are experienced as stressful or previous victimization should lead to a worse prognosis posttrauma. Ruch, Chandler, and Harter (1980) took a retrospective look at the victims of assault to see if they had suffered significant events in the previous year. They found that severe life changes or no life changes in the year prior to the assault were associated with people having a worse outcome posttrauma than those who had experienced minor life changes. The fact that people with mild life events fared better might suggest that they had more flexible schema and were able to accommodate the trauma information more readily. However merely looking at the past year may not give a good indication of what that individual's personal schema are and there is an
assumption here that suffering severe life changes is related to schema about the world being uncontrollable and unpredictable, while suffering no changes is assumed to be related to rigid schema of the world being predictable and controllable.

The objective characteristics of a traumatic event that contribute to a post-traumatic response will not be discussed in detail as these may be the same or similar for two individuals and so would not explain any difference in reaction. However the meaning that an individual may ascribe to the trauma can differ. It has already been discussed how an individual's schema about themselves and the world can be challenged by a traumatic event according to the theory described by Foa and Riggs (1993). One prediction of this would be that individuals who are attacked and raped by friends or acquaintances would show a more severe post-traumatic reaction than those attacked by strangers. An attack by a friend would be more of a challenge to one's ideas of safety. Several studies have looked at this relationship and produced conflicting results. Ellis, Atkeson, and Calhoun (1981) found that people suffered more anxiety and depression when raped by strangers. Frank, Turner, and Stewart (1980) found no relationship, while Sales, Baum, and Shore (1984) found that people suffered more post-rape symptoms when raped by acquaintances. However, these studies all suffer the methodological problems described for the demographic studies in that they did not include a diagnosis of PTSD and thus could have represented heterogeneous groups, they used volunteers and those suffering from PTSD may have avoided volunteering, and there was no check to see if the acquaintance or friend really was included in a schema of safety. This prediction still remains unproved.

Another area of literature that may have some bearing on individual differences has been that of coping styles seen in victims of trauma. Folkman and Lazarus (1980: cited in Spurell and McFarlane, 1993) have suggested that coping styles can be divided into problem-focused, such as seeking support, and emotion-focused, such as detachment. In a study involving the survivors of a bushfire disaster, Spurell and McFarlane (1993)
examined the relationship between coping strategies and posttrauma functioning using The Ways of Coping Questionnaire (Folkman and Lazarus, 1985) and the affective disorders, anxiety disorders and PTSD sections of the Diagnostic Interview Schedule. They found that more forms of coping, including problem-focused and emotion-focused, were associated with subjects with DIS-diagnosed disorders than with non-disordered subjects. Interestingly they also found that subjects with acute PTSD appeared to place emphasis on problem-focused strategies, while those that developed chronic PTSD placed more emphasis on emotion-focused strategies. Blake, Cook, and Keane (1992) also found that combat veterans with PTSD were more likely to use emotion-focused coping than controls although this was also so with combat veterans without PTSD who were seeking mental health treatment.

It is possible that emotion-focused coping represents a way of cognitively avoiding reminders of the trauma. Although this would provide short-term relief, it would not allow the individual to process the trauma completely. Folkman and Lazarus (1980: cited in Spurrell and McFarlane, 1993) have reported that problem-solving strategies are engaged when a threat is perceived as solvable, while emotion-focused strategies are engaged to cope when the threat is not solvable. It is possible that using problem-solving strategies in the event of a trauma may represent an unrealistic attempt to control the situation and this could support the notion that people with rigid schema of control are more susceptible to developing PTSD. In contrast, emotion-focused coping may represent complete acceptance, perhaps to the point of a learned helplessness. This could represent the strategy shown by someone who has experienced repeated trauma and formed self and world schema of not being in control and being unable to predict danger. Such schema would suggest that this problem (the trauma) and potentially any others are unsolvable. However these explanations do not fully account for why individuals who do not develop PTSD symptoms do not appear to use more adaptive coping mechanisms. It is possible that other strategies are involved that have not been assessed. It may also be that using fewer strategies
represents a more realistic approach to what can be achieved. This would fit with those individuals showing less pathology as having more flexible schema about their own abilities to cope and the world's dangerousness. Most importantly, studies on coping strategies in the event of a trauma do not show cause and effect. It is possible that the coping strategies are due to changes brought about through experience of the trauma.

Kushner, Riggs, Foa, and Miller (1992) examined controllability and the development of PTSD in victims of assault. They suggested that the construct of controllability in this case involved perceived controllability felt during the assault, expected controllability over future assaults, and perceived controllability over aversive events more generally. They found that PTSD symptoms were likely to be more severe in victims who perceived a lack of control over aversive events more generally. This highlights the importance of controllability in the development of PTSD and supports the notion that either schema of general uncontrollability are activated or previous rigid schema of being in control are shattered and the individual is unable to predict when they will be able to control events again. However this may again be a result of the trauma rather than a predisposing factor. The trauma could still be seen as lowering the activation threshold for a threat network without increasing the resources available to an individual. Such a view does not require the presence of specific controllability schema.

Problems with schema theory
There are some conceptual difficulties with examining schema theories, which have been summarised by Wells and Matthews (1994, p.48). There appears to be a proliferation of schema ideas in clinical psychology, with no clear architecture, levels of control, or definitions agreed upon amongst theorists. More interestingly, when considering self-schema, Segal (1988: cited in Wells and Matthews, 1994) argues that there is little support for the notion that self-relevant constructs are highly inter-related.
It is possible to argue for the non-existence of schema, instead theorising a semantic network representation as suggested by Bower (1981: cited in Wells and Matthews, 1994) or Chemtob et al (1988). Individual elements may be weakly or strongly associated with each other, rather than having fixed connections. This could also account for any possible influences of generic knowledge on processing, which is something that schema theories do not necessarily consider.

**The memory record and individual differences**

It has been suggested that PTSD sufferers show a memory bias for threat-related information (e.g. Litz and Keane, 1989). Zeitlin and McNally (1991) found that combat veterans with PTSD showed better memory recall for combat-related words than veterans without PTSD, but not controls. This does appear to support the idea that the traumatic memory record is extremely large. However, it may be that this information is felt to be more important to the individual and so could be explained by being more significantly placed in an information processing hierarchy (e.g. Chemtob et al, 1988). It may also be that they store this information at the expense of other information. McNally, Litz, Prassas et al's (1994) finding that veterans with PTSD recalled fewer autobiographical incidents than controls could perhaps support this.

**Processing the trauma and individual differences**

According to the models discussed (e.g. Chemtob et al, 1988; Foa and Riggs, 1993; Horowitz, 1986), PTSD symptoms are seen as arising out of the difficulties people have in processing the traumatic event.

Several studies have looked at how PTSD sufferers process information (e.g. McNally, English, and Lipke, 1993). One method of assessing this has been to use a modified form of the Stroop task where individuals are asked to name the colours of words that are presented to them, some of which are threat-related. Several studies have found that individuals with PTSD show significantly longer response times in colour naming
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threat-related words (Foa, Feske, Murdock et al, 1991; McNally, Kaspi, Riemann et al, 1990; McNally, English, Lipke, 1993). Wells and Matthews (1994, p.59) give a discussion of the limitations of the Stroop task. Merely presenting words cannot mimic the various forms of experience that contribute to triggering the traumatic memory network. The task does not take into account the visual attention allocation strategies that may be used. In addition one can only hypothesise as to the mechanism of the processing difficulty. It may be that a threat-related word acts as a cue, triggering unpleasant memories, which the individual needs to screen out before continuing with the task. Another possibility is that the word acts as a cue to look for other danger signals before continuing with the task.

Although this does not directly examine how individual differences may affect the onset of PTSD, it does suggest that there is a processing difficulty in PTSD. It is useful to consider in that it does not throw up evidence that would invalidate the information processing paradigm, even if it is unable to show any causal link.

Summary and conclusions

The information processing paradigm has been used to explain the individual differences seen in the development of PTSD symptoms. Two principle theories have been described in the literature. It has been suggested that some people are biologically predisposed to developing an easily activated threat network due to having a faster gain in their information processing feedback networks (Chemtob et al, 1988).

Alternatively, it has been suggested that some people have rigid schema about controllability and predictability with regard to threats that predispose them to developing PTSD symptoms (e.g. Foa and Riggs, 1993). The symptoms themselves are seen as arising from a difficulty in processing either everyday information (i.e. misinterpreting it as a threat) or the traumatic memory.

To date, researchers have not examined the biological hypothesis, although it has been
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acknowledged (e.g. Kolb, 1988). There is some support for the schema hypothesis, although much of the research findings are inconclusive at best or non-applicable at worst. Support for the schema hypothesis includes the influence of previous life experiences (Ruch et al, 1980) and the role of controllability (e.g. Kushner et al, 1992) on the development of PTSD. It should be noted however that the two theories of biological and personality predisposition are not incompatible and each may influence the other.

It will be important for future research to integrate the personality aspects with the biological factors. When considering further research directions, one must acknowledge the difficulties in doing retrospective research. Essentially in examining the PTSD population, it will be difficult to differentiate a causal factor from a possible reaction to the trauma. Having said this one can make predictions of the characteristics of the population and test these. It would still be useful to examine the demographic aspects with respect to how they may influence the formation of schema, but perhaps more useful would be to look at life experiences, coping styles, and characteristics of the trauma situation with respect to the schemas that one would expect to find.

Complementary to this area of research would be research examining protective factors of PTSD, notably the coping styles that are used by people who do not go on to develop the disorder and how these may differ from PTSD sufferers. Although this review has not dealt principally with the memory and processing aspects, research on individual differences could benefit from examining how schemas may affect the formation and fragmentation of the memory record. A final point to consider would be whether one needs the concept of schema in this research and whether one can reduce them to specific concepts that may be weakly or strongly associated with each other.
PTSD References


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Behavior Therapy, 20: 199-214


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ABSTRACT

This study aimed to compare the treatments for children with sleep problems when given in an individual or group format, with reference to a control group. It was hypothesised that treatment outcomes would differ in terms of support as perceived by the parents, the self-esteem of the parents, the compliance with the tasks set, and the skills learnt from the interventions. It is concluded that the groups showed no significant differences in support, self-esteem, or compliance. The sleep group showed a greater improvement in terms of a reduction in problem severity and gains in the number and type of skills over the individual treatment group. These findings are discussed with reference to limitations in the design and implications for further study.
INTRODUCTION

Sleep disorders occur commonly in children and can have serious effects upon both the children and their carers. However, they can be overlooked when associated with other problems or not taken seriously. Stores (1996) argues that health professionals should be aware of links between sleep disorders in childhood and psychiatric and psychological problems. Different treatments are available for different sleep problems, but their efficacy is not adequately researched or understood. It is important to understand what is effective for different disorders and how best to deliver such a treatment, rather than to follow a protocol naively. To this end, this study aims to look at issues concerning the use of behavioural techniques used in treating childhood sleep disorders either in sleep groups or individually.

The range of sleep problems

Sleep problems can be classified into three groups (although there is some overlap): sleeplessness; excessive sleepiness; and parasomnias. This review will focus on sleeplessness as it is considered a common problem in early childhood and is the focus of much behavioural treatment. For a further understanding of excessive sleepiness and parasomnias (disorders of arousal) see Stores (1996).

Sleeplessness problems fall into a further three categories. Children may have difficulty in settling to sleep at night. They may wake frequently during the night, but be unable to settle back to sleep without the presence of their parents. Waking during the night is considered normal and only a problem if the child cannot resettle itself (Ferber, 1985). The third problem arises when the child has achieved all the sleep they require, but wakes too early for other members of the household. The aetiology and associated factors vary with age, so the likely causes and maintaining factors for infants will be different from those for adolescents.
Defining a sleep problem

Although sleeplessness is common, there are individual differences in what parents will consider a problem. Scott and Richards (1988) found 10% of 1 year olds who were waking 5 or more nights per week were not regarded as a problem to their parents.

Objective criteria for sleep problems allow comparisons to be made across studies. However studies have used varied criteria (Daws, 1993) and not all have defined their criteria adequately enough to allow comparison. Some have used categorical data, such as whether the child woke up in the night or had trouble settling. Others have used ordinal or interval data concerning how often the child woke up or for how long they were awake. Two studies have used composite scores, which are devised by taking the averages of various categories relating to sleep behaviour (e.g. number of times the child woke in the night, the time taken to settle the child to sleep, etc.) and then rated them on a scale of severity (Richman, Douglas, Heather, Lansdown, and Levere, 1985; Minde, Popiel, Leos, Falkner, Parker, and Handley-Derry, 1993).

However, objective criteria alone has the disadvantage of not taking the parent's subjective distress into account, which may be what determines an initial referral for help.

The wide range of definitions and criteria used in assessing sleep problems makes it difficult to compare research. Although some attempt has been made to establish more objective measurement methods, there does not appear to be a consensus. There are no strict criteria as to what constitutes a problem of sleeplessness and it may be more useful to consider the subjective report of the parent and a composite measure of severity that includes data concerning settling problems, night-waking problems, and early morning-waking problems.

Effects of sleep problems

Definitions do not describe the effect of a sleep problem, which is often to disrupt the sleep of others, namely the parents (Bidder, Gray, Howells, and Eaton, 1986).
is some suggestion that sleep problems can be associated with behaviour problems in pre-schoolers (Szyndler and Bell, 1992; Wilson, 1996). Stores (1996) summarises studies suggesting that treatment of toddler’s sleep disorders can lead to improvement in the child’s behaviour and in mother-child interactions (Minde, Faucon, and Falkner, 1994; Wolfson, Lacks, and Futterman, 1992). He also notes that chronic sleep disturbance due to obstructive sleep apnoea is associated with a range of learning and behaviour problems (Guilleminault, Korobkin, and Winkle, 1981).

Kerr and Jowett (1994) suggest that sleep problems in young children can affect the coping abilities of parents, although they do not describe how. Errante (1985) notes that the effects of sleep disturbance on parents can appear similar to the symptoms of post-natal depression and that sleep problems may contribute to or be confused with post-natal depression. Durand and Mindell (1990) in a single case study found that both parental depression and marital satisfaction improved when the child’s sleep problems resolved. Wilson (1996) suggests that children wake naturally and then disrupt parents during their sleep cycle, leaving them tired the next day in comparison to their children. Chavin and Tinson (1980) conducted a study into the effects of sleep disruption on family life and found that families often reported feeling desperate and in need of outside support, with 8% admitting administering severe abuse to their child. Haslam (1992) notes that parents who resort to violence often have other problems and lack the ‘safety valves’ that most parents have.

**Epidemiology**

Kerr and Jowett (1994) in their review of the literature cite that problems in settling to sleep have been found in 22% of 9 month olds, 15-20% of 1-2 year olds, and 16% of 3 year olds. Problems in night-waking have been found in 20-30% of 1-2 year olds 14% of 3 year olds, and 8% of 4 year olds (Weir and Dinnick, 1988; Kerr and Jowett, 1994; Richman, 1981; Jenkins, Owen, Bax, and Hart, 1980). Waking and settling problems are thought to occur together in 55% of cases of 1-2 year olds and 29% of 3 year olds (Weir and Dinnick, 1988; Richman, 1981; Richman, Stevenson, and Graham, 1975). Two-thirds of children with sleep problems at 36 months, still had problems 5
years later (Weir and Dinnick, 1988; Richman, Stevenson, Graham, 1982), suggesting that waiting for children to “grow out of it” can be a stressful option.

Population studies of night waking are likely to be an under-estimate, but parents who believe their children have a sleep problem are likely to give reliable reports. Anders, Keener, Bower, and Shoaff (1983) and Anders and Keener (1985) found that some children wake during the night and settle themselves back to sleep without any parental involvement, suggesting that parental reports of night waking might not be accurate. However, Minde, Popiel, Leos, Falkner, Parker, and Handler-Derry (1993) filmed both ‘good’ and ‘bad’ sleepers at night and found that both groups woke up about 3 times per night, but that the ‘bad’ sleepers tended to cry for their parents in order to help resettle them. Parents of ‘bad’ sleepers were more accurate about the number of night wakings than parents of ‘good’ sleepers.

It appears that some children do ‘grow out of’ their sleep problems while others do not. There is a normal developmental change in children’s sleeping patterns (Horne, 1992). One possibility is the prolonged use of daytime naps when the child no longer needs them or needs them as much could interfere with night-time sleeping. There are also individual differences (Horne, 1992) between children with some requiring more sleep than others. Minde et al (1993) found that children with poor sleep were up for an extra hour a day when compared to children who did not have a sleep problem. This difference was maintained after successful treatment for sleep problems. There is a question as to whether such a difference was present before the onset of the sleep problem.

The aetiology and presentation of some sleep problems can vary with age. It is not clear what distinguishes those who ‘grow out of’ their sleep problem from those who do not. One might suggest that there is an interplay between parental expectation, individual differences in a child’s sleep requirement and changes in environmental influence, but there is no evidence to support this. There is no report in the research literature that sleep problems vary with gender.
Treatment of sleep problems in pre-schoolers

There appear to be 3 predominant approaches to treatment: the medical model; the behaviour modification model; the attachment model. Ferber (1985) notes that much of the advice given to parents seeking help for sleep problems may be based on anecdotal information and that there is a need for sound research evidence on which to base treatment options.

Medical model

This model suggests that the symptoms of a sleep problem can be explained directly or indirectly through an organic or physical problem with the body. Treatment is likely to be through surgery or medication and aims either to correct the cause of the problem or to alleviate the symptoms. It has some merit in that some sleep disorders do have established physical causes. Ferber (1985) suggests that medical and developmental factors are usually easy to recognise.

However the issue is less clear when it comes to medication. Many children may be prescribed antihistamine or choral drugs for sleeplessness. Chavin and Tinson (1980) found that 71% of children referred to them had been given drugs, but that most parents considered them ineffective. In a double-blind drug trial of a hypnotic, Richman (1985) found only a slight improvement in sleep, which was not permanent. Parents may be reluctant to use medication for sleep problems and research has not examined how this may affect their compliance.

Behaviour modification model

This model uses social learning theory. The likelihood of a behaviour occurring is dependent on a child’s expectations, reinforcement of the behaviour, and the presence of a triggering stimulus. If a child believes that reinforcement may follow a behaviour, such as sharing the parental bed following crying, then they are more likely to act out the behaviour. Triggering stimuli, such as waking up alone, then becomes associated
with the behaviour and the reinforcement. Such a model assumes that behaviour can be controlled by altering the antecedents and consequences related to the behaviour. The idea of generalisation assumes a behaviour that is rewarded in one set of circumstances may be tried in other situations. Differential reinforcement refers to the experience that if a behaviour is only successful in obtaining reinforcement on intermittent occasions, it can become very resistant to change.

Several studies have supported this approach to treatment (Kerr and Jowett, 1994), although they have typically dealt with small numbers without control groups.

**Attachment model**

The effectiveness of the behavioural modification approach has more recently been questioned. Hewitt, Heatherley, and Ibrahim (1996) found that a pre-bedtime routine was not necessarily associated with whether the child slept well. They suggested that the difference may lie in the quality of the emotional contact between parent and child. Daws (1993) stresses the importance of attachment between mother and child and notes that some parents may have difficulty implementing behavioural strategies due to failing to resolve their own attachment issues.

Attachment theory concerns the models of relationship that both mother and child have. The child’s attachment is dependent on the quality and history of its caretaking experiences. The quality of these early attachments is thought to affect how the individual deals with later relationships. We can consider that going to sleep at night involves a separation for the infant or child from its carers. Daws advocates dealing with sleep problems by treating the carers with a psychodynamic approach. This involves helping the parents to recognise the way they deal with certain relationships, to understand why this is so, and to think about how they may wish to change this.

Although Daws states that improvement rates are similar to those shown in behaviour modification, this approach has yet to be evaluated in a scientific manner with regard to sleep problems (Kerr and Jowett, 1994). As there is no research concerning the
efficacy of this approach, this review only considers the literature on behavioural approaches.

Efficacy of behaviour modification approach

Behaviour modification approaches have a popular appeal. They are easily administered in a variety of settings. They emphasise a collaborative approach with parents and allow a recognition of progress through the early identification of goals. They can be taught to other health professions, i.e. health visitors, and applied just as effectively (Crawford, Bennet, and Hewitt, 1989).

Much of the research applying behavioural modification approaches within sleep clinics has been supportive of its use (Jones and Verudyn, 1983; Richman et al, 1985; Boomer and Deakin, 1991; Galbraith, Hewitt and Pritchard, 1993; Roberts, 1993). Ratings on outcome measures concerning whether goals set were either fully or partially achieved varied from 73 to 90%. Interestingly Galbraith et al (1993) found that parental satisfaction did not appear to be related to whether targets were met or not, with almost all parents approving of the sleep clinic. Perhaps parents felt obliged to respond positively to the help they had received or they found other aspects of the therapeutic experience useful. With regard to children’s behaviour improving with their sleep, Richman et al (1985) found equivalent results in their study. They also found no significant improvement in a malaise inventory with parents. It may be that parents improved in other ways that were not picked up by this measure.

The generaliseability of these studies is limited by the variation in designs and the lack of control groups. Selection criteria for inclusion in the studies is not always clear and for at least two studies was weighted towards children with severe sleep problems (Jones and Verudyn, 1983; Richman et al, 1985). Only Richman et al’s study (1985) made clear the exclusion of children with learning disabilities. The upper age range of children accepted, when it was made explicit, could vary between 5 and 6 years. This year coincides with the child’s start at school and may be a significant environmental factor in the sleep problem. Little attention was paid to early morning waking.
problems. There were differences in the emphasis of behaviour management. Most studies emphasised altering the reinforcement contingencies and using graded approaches, although Galbraith et al (1993) only emphasised cueing bedtime behaviour with a consistent and predictable approach. Outcome measures were not standardised across studies. All used forms of sleep diaries that were completed by parents and most used the achievement of goals as a measure of success. Some attempted to measure parental satisfaction, either by questionnaire or by a simple scale. Galbraith et al (1993) limited their outcome measures to changes in the time taken to settle, the number of night-wakings, and parental satisfaction. Richman et al (1985) included a malaise inventory of neurotic symptomology for the parents and a behaviour checklist of the child's current behaviour. Richman et al (1985) created a composite sleep score from the sleep diaries which was considered to have internal consistency by Minde et al (1993).

A further limitation is the lack of control groups. It can be argued that spontaneous remission of a sleep problem is unlikely in a short space of time (Jones and Verduyn, 1983), and so a control group is unnecessary. However epidemiological studies give no indication of this other than that some sleep problems do improve naturally. In addition, Richman et al (1985) were aware that there were too few numbers to assess how behaviour problems may change with sleep problems and this issue remains unanswered.

The similar success rates suggest that behaviour methods were useful regardless of severity of problem or which methods were used. However the percentage that were not helped may represent a different group again. There was not enough information on treatment failures to evaluate this. Equally one cannot rule out the possibility of other aspects of therapy being effective. Boomer and Deakin (1991) emphasised that the prestige of the clinics may have affected parental expectation and hence parental behaviour in following programmes and that to get to the clinic in the first place, parents had to be motivated.
Treatment of Sleep Problems in Young Children

It would appear that behaviour modification as a treatment for sleep problems is beneficial, but conclusions about its generalisability are limited by variations between the studies investigating its effectiveness.

**Effects of sleep groups**

Sleep groups are often seen as a cost-effective way of dealing with a common problem, but it remains to be seen whether this view is given sufficient empirical support in research. Non-specific elements of treatment are important to consider. Balfour (1988) found in an evaluation of sleep groups run by psychologists and health visitors that positive aspects of group work were reported for all involved. Parents cited issues such as: 'knowing that they were not alone with the problem', 'being pushed to solve the problem', 'gaining useful strategies', and 'gaining confidence to be firmer'. Parents also continued to meet for informal support following the end of the sleep group. Health visitors believed that they gained new skills and were able to generalise some of these skills to dealing with other behaviours. Psychologists believed that training health visitors in this way would enable them to hand many sleep problems over to the domain of the health visitor. Galbraith et al (1993) found that few parents referred to the actual treatment techniques as being the most useful aspect of a sleep programme.

Szyndler and Bell (1992) believe that sleep and day time behaviour problems are often linked. They found that mothers within groups often brought up additional behaviour problems and reported that the behavioural techniques discussed within the groups were applied to other behaviours also.

Messer, Lauder, and Humphrey (1994) believed that group therapy would be more efficient in terms of the time spent with clients, when compared to seeing people individually. Crawford et al (1989) found that it was efficient and cost-effective to have health visitors doing sleep management work in the client’s home. This would be a further advantage to co-running a group with a health visitor.
Kupych-Woloshyn, McFarlane, and Shapiro (1993) in working with adult insomniacs in sleep groups found that participants cited the following as therapeutically beneficial: 'support and cohesion of group', 'acceptance', 'relief at not being alone', and 'ventilation of feelings'. Admittedly, this involved a different population and a different treatment method, but there is still the suggestion that being in a group can have subjective benefits for the participants. It is important to consider whether the same is true of parents of children with sleep problems. Balfour's study (1988) lends support to the idea that parents may well feel isolated with their problems.

However not all the research is supportive of behaviour modification as a treatment for sleep problems. Weir and Dinnick (1988) looked at behaviour modification treatment with individuals compared with a waiting list control group and found that both groups showed equal improvement. They suggested that the health visitors' training in techniques had not been adequate. A study comparing group treatment with a waiting list control group also found equal improvement (Messer, Lauder, and Humphrey, 1994). The groups were jointly run by a psychologist and health visitor, suggesting that it is not the health visitor's training that is crucial. Furthermore, Messer et al (1994) found that the treatment group reported less positive feedback about their well-being than the waiting list control group.

Walters (1993) found that 19% of families attending her sleep clinics needed more in-depth psychotherapeutic help, beyond the behaviour modification approach. This could suggest that sleep groups may be inappropriate for one-fifth of families referred. However, it should be acknowledged that Walter's district and sample may not be representative of the population as a whole. Districts may differ in the ratios of socio-economic status within their population and in their referral procedures for example.

It would appear that although sleep groups may be run on claims of cost-effectiveness and additional support, data supporting such claims is equivocal.
HYPOTHESES

Several hypotheses have been generated from the above review. It is assumed that some behaviour problems (e.g. tantrums) may be maintained by parental contingencies similarly to sleep problems and therefore it is hypothesised that parents who learn behavioural techniques may be able to apply them (generalise) to other behavioural problems. It is assumed that a sleep problem affects parental coping abilities, which in turn affects self-esteem. As parental satisfaction is not always related to changes in sleep behaviour, it was hypothesised that self-esteem is affected by treatment. In group work, parents may develop a realisation of need for change and therefore change in self-esteem is predicted in either direction. Changes in parental support have been emphasised in some studies. It was hypothesised that parents seeking professional help with sleep problems will not feel supported initially, but will feel more so after attending a sleep group than if they had just received individual treatment. Regular attendance at a sleep clinic and participation in a group have been implicated in compliance. It was hypothesised that attending a sleep group would encourage more treatment compliance than being seen individually.

There has been a lack of standardised measurements of support in previous studies, although it is recognised that perceived support to parents can increase following group treatment. One interpretation of this is that perceived support increases following a change in self-esteem and an increase in behaviour management skills. The presence of support as perceived by the parents will be systematically measured as will changes in self-esteem and changes in the level of skills. Several previous studies have not utilised a control group. This could account for extraneous variables. This study will compare individual with group treatment with the inclusion of a waiting-list control group. In summary, the hypotheses of this study are:

1. Participants treated within a group will show greater treatment compliance than those treated individually.
2. Participants treated within a group will perceive increased levels of support compared to those treated individually.
3. Participants receiving individual or group treatments will show increased sleep management skills compared to those in the control group.

4. Participants receiving individual or group treatments will generalise their sleep management skills to other areas of child management.

5. Participants treated within a group will show greater changes in self-esteem pre and post-treatment than the control group or those treated individually.
METHOD SECTION

Choice of participants

Participants were families with children under 5 years old who were referred to the Child Psychology Service where the main complaint was of sleep problems. 3 types of sleep problem were considered: problems of settling; problems of night-waking; and problems of early morning-waking. A further criterion was that the children would not have learning disabilities. Children were assessed for these criteria via an initial informal assessment. This consisted of checking the referral form/letter for these details and if necessary calling the family involved.

As families were referred, they were approached as to whether they would be interested in participating in the study. It was made clear what would be involved and that participation was voluntary and would not influence their right to treatment. A consent form (see appendix B) was devised and the whole project was passed by the local ethics committee. In total 27 families were considered for the study initially. 8 of these were excluded due to not meeting the criteria. None refused who were asked.

Sample size

27 families were referred for sleep problems in all. 8 did not meet the selection criteria and were rejected from the study. 7 participants were selected for sleep group treatment. 1 of these did not complete the Culture-Free Self-Esteem Inventories. 6 participants were selected for individual treatment. 1 of these moved prior to the completion of treatment and it was not possible to collect follow up data for this individual. 6 participants were selected for the control group.

Modes of treatment

The sleep management group met for 4 sessions fortnightly. An initial talk was given to parents on the nature of sleep problems, how they are maintained, and normal
childhood sleep patterns. Parents were then encouraged to devise their own goals for treatment and advised by the psychologist on how best to achieve them. The goals and their progress were reviewed each week in a group discussion and amended if needed. Parents undergoing individual treatment were seen at their homes by a psychologist. The number of sessions varied. Treatment was similar, except that they were not given an initial talk on sleep problems. In both groups, the behaviour modification approaches emphasised a consistent and predictable approach as well as altering the reinforcement contingencies and using graded approaches.

Allocation to groups

3 groups were proposed for the study. Each group was expected to contain 6 individuals, the total for the study being 18. The groups were as follows:

1. Parents who attended a sleep management group.
2. Parents who were seen individually by a psychologist for sleep management problems.
3. Parents who were on the Child Psychology Waiting List. This was the control group.

Random allocation was not possible due to certain service limitations. The dates for the sleep group had already been fixed and there was not a large enough pool of referrals available. Instead the first 6 referrals that met the inclusion criteria were entered into the sleep group, the second 6 were entered into the individual treatment group, and the following 6 were entered into the control group. There was no reason to expect that this would introduce any bias as there is no evidence of seasonal variation with sleep referrals. In addition it was decided to compare the groups for severity of problem in order to check that there was no bias (see results).

Little change was made to everyday clinical practice. If a referral was deemed urgent, then it would be prioritised, regardless of its position on the waiting list. In one case this meant that a subject was moved from the control group to the individual treatment
group and in a second case, the problems were deemed too complex to meet the inclusion criteria and the person was not involved in the study. There was a chance that this would introduce bias into the individual treatment group and so there was further reason to compare the groups for severity of the problem.

**Measures**

There were no standardised questionnaires available for this research and so new ones were devised that were based on measures reported in the literature and more specifically that considered likely targets for behavioural change. They considered the following sections: demographic details, the child’s sleep environment, the problem severity, support details, current sleep management, parental feedback about the efficacy of the treatment and on what they had learnt from the treatment sessions.

Demographic details were gathered concerning age and gender of child, ages and occupations of parents, presence of other siblings and other histories of sleep problems, and ethnic background. The Child’s Sleep Environment details concerned whether they had their own room, a cot or a bed, and a comforter.

The Problem Severity details concerned settling time, night-waking and how it was dealt with, early morning-waking, night terrors, and the presence of day-time naps. Individual information on the Problem Severity was further converted into a composite score. A composite score gives some indication of more widespread difficulties. It is also useful in that it prevents the need for repeating many statistical tests. It is possible that if one uses several tests then one may achieve a significant result by chance. Participants were asked about the following categories and their responses were graded on a scale of 0 - 4, where 0 was the lowest severity and 4 the highest (see appendix for details of coding categories): time taken to settle; number of wakings per night; number of nights that child woke in previous week; average time spent awake after waking; number of nights that child ended up in parent’s bed; time that child wakes in morning. Finally the individual scores were summed to form a composite score.
Support details involved asking parents whether they believed that they received support for their sleep problem. Current Sleep Management details concerned what methods parents currently used to settle their children. Parental Feedback Details asked about parent’s subjective opinions of improvement, what they had got out of the treatment, and what skills they had learnt.

Parental self-esteem had not been measured in previous studies concerning the behavioural treatment of sleep problems. The Culture-Free Self-Esteem Inventory [CFSEI] (Battle, 1992) was believed to be an appropriate measure of parental self-esteem. The CFSEI has been standardised on adults as well as children. Separate forms are available for adults and cover general self-esteem, social self-esteem, and personal self-esteem. Test-retest reliability for adults ranges from 0.79 to 0.92 and concurrent validity for the child forms with the Coopersmith’s Self-Esteem inventory ranges from 0.66 to 0.91.

Compliance was measured using sleep diaries and a devised compliance measure. Sleep diaries are a typical part of behavioural treatment and so were not an extra intrusion on the participants. In addition, they could be used to check the problem severity as reported on the questionnaires. The compliance measure asked the clinicians to assess at each session whether the subject had completed the sleep diaries and had attempted the previous week’s task.

Procedure

Baseline measures were obtained for sleep environment, problem severity, measure of support, and CFSEI for all 3 groups. The sleep group baselines were collected at the start of treatment in person. All other questionnaire measures were collected by telephone, while the CFSEIs were administered through the post.

After treatment, follow-up measures were collected for the sleep environment, problem severity, measure of support, and CFSEI. In addition the questionnaire sections on
parental feedback on the efficacy of the treatment sessions; and parental feedback on what they had learnt from the treatment sessions were also administered. Again this was achieved over the telephone, while the CFSEI was sent through the post. The compliance measure for the treatment groups was obtained from the clinicians at the end of treatment. For the control group, the questionnaire sections on sleep environment, problem severity, and measure of support, in addition to the CFSEI were administered after 6 weeks.

**Statistical analyses**

Non-parametric tests of difference were used as the samples were too small to be able to make parametric assumptions. The Kruskal-Wallis One-Way Analysis of Variance by Ranks was used as a test to compare more than 2 independent samples where the data were ordinal. The Fisher Exact Test for 2x2 Tables was used as a test to compare two groups on a variable, where there could be no overlap of the variable (i.e. it was either present or not), and the numbers were small. The Wilcoxon Matched-Pairs Signed Ranks Test was used to compare before and after scores within a group where the data were ordinal.
ANALYSIS OF RESULTS

BACKGROUND VARIABLES

Table 1: Comparing means and standard deviations for background variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sleep group Mean (SD)</th>
<th>Individual group Mean (SD)</th>
<th>Control group Mean (SD)</th>
<th>Significance test</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of child (in months)</td>
<td>24 (9.73)</td>
<td>20.67</td>
<td>17.67</td>
<td>t=2.36</td>
<td>p=0.31</td>
</tr>
<tr>
<td>Maternal age</td>
<td>37.1 (5.96)</td>
<td>33.8 (3.76)</td>
<td>29.8 (4.36)</td>
<td>t=3.55</td>
<td>p=0.17</td>
</tr>
<tr>
<td>Paternal age</td>
<td>36.8 (7.15)</td>
<td>34.6 (3.87)</td>
<td>34.5 (5.27)</td>
<td>t=0.35</td>
<td>p=0.84</td>
</tr>
<tr>
<td>Duration of problem (months)</td>
<td>14.14 (6.01)</td>
<td>19.67</td>
<td>16.67</td>
<td>t=0.85</td>
<td>p=0.63</td>
</tr>
<tr>
<td>Severity of problem (composite score)</td>
<td>12.57 (2.82)</td>
<td>13.00 (4.05)</td>
<td>14.67 (4.32)</td>
<td>t=0.91</td>
<td>p=0.63</td>
</tr>
</tbody>
</table>

N.B. All probabilities are 2-tailed.

There were no significant differences between the groups for the above background variables.

Child’s gender

All groups contained children of both gender, there being 3 males in the sleep group and 4 males in both the individual and control groups.
History of other treatments and other concerns with the child

Table 2: Presence of previous help and other concerns over child’s behaviours

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sleep group</th>
<th>Individual treatment</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of previous help</td>
<td>3</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Presence of other concerns</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

More participants from the individual group reported receiving previous help from health professionals than did the sleep and control groups. There was no significant difference between the sleep and individual group (Fisher Exact Test, 2-Tailed $p=0.27$) or between the individual and control group (F.E.T., 2-Tailed $p=1.00$).

More participants in the individual group had other concerns with their children than in the sleep or control groups. There was no significant difference between the sleep and individual treatment groups (F.E.T., 2-Tailed $p=0.10$).
EXPERIMENTAL VARIABLES

Treatment compliance

Table 3: Percentage of compliance with tasks set

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sleep group</th>
<th>Individual treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Percentage of compliance with tasks set</td>
<td>72 (36)</td>
<td>94 (13)</td>
</tr>
<tr>
<td>Percentage of compliance with sleep diary</td>
<td>82 (37)</td>
<td>100 (0)</td>
</tr>
</tbody>
</table>

Both the sleep and individual treatment groups showed a high compliance with tasks. One individual from the individual treatment group was only seen once and it was not possible to ascertain compliance with intervention and one individual from the individual treatment group was not available for follow-up.

Both the sleep group and individual treatment group showed high compliance with the sleep diaries. For the individual treatment group, one individual was not offered sleep diaries and the follow-up information was unavailable on another.
Perceived parental support

Table 4: Change in support in groups

<table>
<thead>
<tr>
<th>Support</th>
<th>Sleep group Pre-</th>
<th>Sleep group Post-</th>
<th>Individual treatment Pre-</th>
<th>Individual treatment Post-</th>
<th>Control group Pre-</th>
<th>Control group Post-</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>4</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>No support</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Perceived support did not change much following intervention. It was not the case that most already believed that they had support as 3 from the sleep group and all of the individual treatment group did not acknowledge having any support.

Presence of problem-solving skills

Table 5: Numbers of participants reporting types of skill

<table>
<thead>
<tr>
<th>Category</th>
<th>Sleep group</th>
<th>Individual treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific behaviours in sleep management</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>General understanding of child’s sleep behaviour</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Principles of modifying behaviour</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

The comments that participants made when asked if they had learnt new skills were grouped into 3 categories, which were decided upon as a post-hoc measure. These were as follows:
- a knowledge of specific behaviours related to sleep problems. e.g. "Not to allow the child to sleep in the parents' bed."

- a more general understanding of the child's sleep behaviour. e.g. understanding the associations that children make when going to sleep.

- principles of modifying behaviour. e.g. being consistent in one's approach, and setting limits and keeping to them.

In response to the question about skills, 2 individuals from each group also made comments about coping and not being alone with the problem. e.g. "How others have problems and seeing how they cope.", "Reassuring to know that there were others with the same problem."

Numbers of sleep management skills learnt

<table>
<thead>
<tr>
<th>Sleep group</th>
<th>Individual treatment</th>
<th>Fisher's exact test (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number who identified new skills</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>

Parents from both groups found it hard to pinpoint specific skills that they might have learnt from the interventions, even with prompting. There was a significant difference between the two groups.
Generalisation of skills to other areas of child management

Table 7: Comparison of generalisation of skills between sleep group and individual treatment group

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sleep group</th>
<th>Individual treatment</th>
<th>Fisher’s exact test (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. who acknowledged</td>
<td>5</td>
<td>1</td>
<td>p=0.24</td>
</tr>
<tr>
<td>generalisable skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. who noticed other improvements in child’s behaviour</td>
<td>3</td>
<td>0</td>
<td>p=0.20</td>
</tr>
</tbody>
</table>

There was no significant difference between the sleep and individual treatment group in the numbers who believed that they had learnt skills that could be used in other situations. There was no significant difference between the sleep and individual treatment groups in the numbers who noticed other improvements in their child’s behaviour.

In addition, the presence of other concerns does not appear to relate to the generalisability of skills after treatment.

This does not appear related to the numbers of participants who originally had other concerns about their children (1 from the sleep group and 4 from the individual treatment group).

Changes in self-esteem

Wilcoxon Matched-Pairs Signed-Ranks tests were carried out on the CFSEI scores before and after for each group.
Table 8: Changes in self-esteem within Sleep group

<table>
<thead>
<tr>
<th>Variable</th>
<th>Significance test</th>
<th>Significance (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem total</td>
<td>$z=-0.11$</td>
<td>$p=0.92$</td>
</tr>
<tr>
<td>Social self-esteem</td>
<td>$z=-0.18$</td>
<td>$p=0.85$</td>
</tr>
<tr>
<td>General self-esteem</td>
<td>$z=-0.45$</td>
<td>$p=0.65$</td>
</tr>
<tr>
<td>Personal self-esteem</td>
<td>$z=-0.64$</td>
<td>$p=0.52$</td>
</tr>
<tr>
<td>Defensiveness score</td>
<td>$z=-0.92$</td>
<td>$p=0.36$</td>
</tr>
</tbody>
</table>

Table 9: Changes in self-esteem within Individual Treatment group

<table>
<thead>
<tr>
<th>Variable</th>
<th>Significance test</th>
<th>Significance (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem total</td>
<td>$z=-1.63$</td>
<td>$p=0.20$</td>
</tr>
<tr>
<td>Social self-esteem</td>
<td>$z=-1.89$</td>
<td>$p=0.06$</td>
</tr>
<tr>
<td>General self-esteem</td>
<td>$z=-0.93$</td>
<td>$p=0.36$</td>
</tr>
<tr>
<td>Personal self-esteem</td>
<td>$z=-1.89$</td>
<td>$p=0.06$</td>
</tr>
<tr>
<td>Defensiveness score</td>
<td>$z=-0.45$</td>
<td>$p=0.65$</td>
</tr>
</tbody>
</table>

Table 10: Changes in self-esteem within Control group

<table>
<thead>
<tr>
<th>Variable</th>
<th>Significance test</th>
<th>Significance (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem total</td>
<td>$z=-1.34$</td>
<td>$p=0.18$</td>
</tr>
<tr>
<td>Social self-esteem</td>
<td>$z=-1.00$</td>
<td>$p=0.32$</td>
</tr>
<tr>
<td>General self-esteem</td>
<td>$z=-1.60$</td>
<td>$p=0.11$</td>
</tr>
<tr>
<td>Personal self-esteem</td>
<td>$z=-0.82$</td>
<td>$p=0.41$</td>
</tr>
<tr>
<td>Defensiveness score</td>
<td>$z=-1.00$</td>
<td>$p=0.32$</td>
</tr>
</tbody>
</table>

None were significant within-group differences for $p=0.05$ or less.

The individual and control group samples were incomplete. Only 5 were available for the individual group and only 4 were available for the control group. It is possible that the numbers were too small to show any significant difference. However there is
nothing to suggest that self-esteem, as measured using the CFSEI, is significantly altered following treatment.

**MISCELLANEOUS MEASURES**

**BACKGROUND VARIABLES NOT CONSIDERED RELEVENT TO GROUP DIFFERENCES**

Categories of presenting problems

Table 11: Types of sleep problems

<table>
<thead>
<tr>
<th>Category</th>
<th>Sleep group</th>
<th>Individual treatment</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Settling</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Night-waking</td>
<td>7</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Early-rising</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Parents were asked to report on the severity of problems, such as ease of settling, night-waking, and early rising. If a score other than 0 was indicated, then that area was considered a problem. Night-waking and early rising appeared to be the main problems. Settling did not appear to be a problem for many in the sleep group or individual treatment group, but was more so for those in the control group.

**Change in number of approaches used**

Parents in all groups used a wide variety of approaches simultaneously to settle or resettle their children.
Table 12: Changes in the number of approaches used to settle the child

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sleep group Mean (SD)</th>
<th>Individual treatment Mean (SD)</th>
<th>Control group Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of approaches used before treatment</td>
<td>7.00 (1.15)</td>
<td>7.83 (3.54)</td>
<td>8.17 (1.17)</td>
</tr>
<tr>
<td>No. of approaches used following treatment</td>
<td>2.29 (1.50)</td>
<td>4.80 (2.49)</td>
<td>4.67 (2.16)</td>
</tr>
<tr>
<td>Difference in number of approaches used before and after</td>
<td>4.71 (1.98)</td>
<td>3.00 (4.00)</td>
<td>3.50 (2.07)</td>
</tr>
</tbody>
</table>

All groups showed an improvement in the number of approaches used at follow-up.

A difference score was calculated from the number of approaches used before and after. There was no significant difference between the groups in the reduction of approaches used (Kruskal-Wallis statistic=2.73, d.f.=2, 2-Tailed p=0.26).

**Goals of treatment**

Goals of treatment were both long-term and short-term, involving graduated steps and learning skills. They have been summarised below into long-term objectives by the researcher.
Table 13: Summary of long-term and short-term goals of treatment

<table>
<thead>
<tr>
<th>Individual</th>
<th>Sleep group</th>
<th>Individual</th>
<th>Individual treatment group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject 1</td>
<td>To gradually decrease contact at bedtime</td>
<td>Subject 1</td>
<td>To decrease contact at bedtime and allow the child to resettle itself</td>
</tr>
<tr>
<td>Subject 2</td>
<td>To ignore the child to allow it to resettle itself</td>
<td>Subject 2</td>
<td>To decrease contact and allow the child to settle itself</td>
</tr>
<tr>
<td>Subject 3</td>
<td>To stop using the dummy as comforter</td>
<td>Subject 3</td>
<td>To ensure the child remains in their own bed plus to gradually shift the bedtime</td>
</tr>
<tr>
<td>Subject 4</td>
<td>To decrease contact when resettling</td>
<td>Subject 4</td>
<td>To ensure the child falls asleep in its own bed</td>
</tr>
<tr>
<td>Subject 5</td>
<td>To ignore the child to allow it to resettle itself</td>
<td>Subject 5</td>
<td>To lessen drinks at night plus to ignore the child to allow it to resettle itself</td>
</tr>
<tr>
<td>Subject 6</td>
<td>To ensure the child remains in their own bed</td>
<td>Subject 6</td>
<td>data unavailable</td>
</tr>
<tr>
<td>Subject 7</td>
<td>To decrease contact at bedtime and when resettling</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N.B. Subjects are not matched.

Six of the sleep group goals are primarily associated with night-waking problems, and one is associated with settling. Three of the individual treatment group goals are associated with night-waking, four are related to settling problems and one is related to early morning-waking.
OUTCOME DATA NOT PART OF HYPOTHESES

Change in severity of problem over time

A difference score was calculated for the before and after composite scores. For the sleep group, mean difference score=2.71, SD=2.43, range=0-6. For the individual treatment group, mean=2.40, SD=4.98, range=-1-10. For the control group, mean=2.50, SD=6.12, range=-6-13.

Wilcoxon Matched-Pairs Signed-Ranks Tests were conducted within groups in order to see if the differences in composite scores before and after were significant. The improvements within the sleep group were found to be significant (z=-2.02, 2-Tailed p=0.04). No significance was found for the other 2 groups (individual treatment, z=-0.41, 2-Tailed p=0.68; control group, z=-1.16, 2-Tailed p=0.25).
Chart 1: A drop-line chart showing the difference in sleep severity before and after treatment for each subject.
It can be seen from the chart that all but one of the sleep group had scores below 14, while this was only true for 3 of both the individual and control groups. A median split analysis was carried out (see table below). There was no significant difference between the sleep and individual group (F.E.T., 2-Tailed p=1.00) or between the sleep and control group (F.E.T., 2-Tailed p=1.00).

Table 14: Median Split Analysis of Composite Scores

<table>
<thead>
<tr>
<th></th>
<th>Sleep group</th>
<th>Individual group</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than median</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Less than or equal to median</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Usefulness of the intervention

Table 15: Differences between groups for usefulness of intervention, subjective change in sleep behaviour, and attribution of any change to intervention.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sleep group</th>
<th>Individual treatment</th>
<th>Fisher’s Exact Test (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. who found the intervention useful</td>
<td>7</td>
<td>2</td>
<td>p=0.045</td>
</tr>
<tr>
<td>No. who noticed a change in child’s sleep behaviour</td>
<td>6</td>
<td>3</td>
<td>p=0.52</td>
</tr>
<tr>
<td>No. who attributed any change to intervention</td>
<td>6</td>
<td>2</td>
<td>p=0.22</td>
</tr>
</tbody>
</table>

All participants of the sleep group found it useful, while only 2 of the individual treatment group believed that this was so. One member of the individual treatment
group was unavailable for follow-up. There was a significant difference between the sleep and individual treatment group.

There was no significant difference between the two groups in terms of noticing any improvement in the children’s sleep behaviour.

Six out of seven participants in the sleep group attributed any change to the intervention, while only two from the individual treatment group made a similar attribution. However the difference was not significant.
DISCUSSION OF RESULTS

The aim of this study was to consider whether two modes of treatment could be distinguished from each other on the basis of certain treatment outcomes. The members of the sleep group were expected to feel more supported, show a greater change in self-esteem, show greater compliance, and show more generalisation of skills than the individual group post-treatment. A control group was used due to the realisation that changes may be due to factors outside of treatment, such as normal maturation. Information on effectiveness was also collected, but the study was not intended to evaluate which method was most effective.

Compliance

The type of treatment did not appear to affect compliance, but it is not possible to draw definitive conclusions. Both the sleep and individual treatment groups showed a high compliance with tasks set. Although at first glance the distribution between the groups appears similar, only 4 participants from the individual treatment group were rated for this, which is too few to adequately compare. Both the sleep group and individual treatment group showed high compliance with completing the sleep diaries, but again the incompleteness of the individual treatment group scores prevents one from drawing conclusions. It is possible that the number of sessions that parents chose to accept or attend reflected their motivation and affected their compliance. However, there was no difference in attendance between the groups.

Perceived changes in support

The support perceived by parents did not appear to be influenced by treatment. Perceived support did not change much following intervention. One person in each group believed they had more support at follow-up and one person in the control group believed that they had less. It was not the case that most already believed that they had support as three from the sleep group and all of the individual treatment group did not acknowledge having any support.
Sleep management skills

There was a significant difference in the number of skills displayed after intervention between the sleep and individual treatment groups. Participants from the sleep group reported more skills overall and appeared to be more likely to mention ones relating to understanding the sleep behaviour and the principles of modifying behaviour than did the individual treatment group. Parents from both groups found it hard to pinpoint specific skills that they might have learnt from the interventions, even with prompting. It may be that parents did not identify the new knowledge as helpful skills.

Generalisation of skills

Although it was not significant, there was a trend for the sleep group to generalise their skills. Five out of seven participants in the sleep group believed that they had learnt skills that could be used in other situations. Only one out of five participants in the individual treatment group believed that they had learnt generalisable skills. This question was not put to the control group. Interestingly one of the control group had learnt skills at follow-up from a self-help manual. In addition, there was a trend for the sleep group to notice other improvements in their child’s behaviour. Three from the sleep group noticed other improvements in behaviour. None from the individual treatment group noticed any other improvements. This does not appear related to the numbers of participants who originally had other concerns about their children (One from the sleep group and four from the individual treatment group). However, these differences did not reach statistical significance.

Self-esteem

There was no significant change in self-esteem within the groups. There were also no significant differences between the groups on self-esteem. However five out of six of the sleep group had baseline scores that were below the fiftieth percentile compared
with three out of five in the individual group and three out of six in the control group. The sleep group appeared to have lower self-esteem to start with.

**Complexity of problem**

Although, there are not many significant differences between the groups, there was a trend for the individual group to have the most complex problems. Although not significant, there was a trend for more participants in the individual treatment group to have a history of other treatments for the problem, to have more other concerns about their children, and to have had the sleep problem for a longer duration than for other groups. It may be that with a larger sample, such differences would be more significant.

**Treatment outcome**

There was also a trend for the sleep group to have a better outcome. The sleep group improved significantly in terms of problem severity. Sleep group goals tallied better with the problems as identified by the researcher than individual group goals did. The sleep group showed more subjective improvement as rated by the parents. More in the sleep group found the intervention useful and attributed improvement to the intervention than in the individual treatment group. However given that the sleep group improved most in terms of severity, this is hardly surprising.

**Consistency in approach**

One of the principles of the sleep management programmes was that people should be consistent in their approach. If people were using several approaches before treatment, then they should be using fewer, but more consistently, following treatment. All the groups showed a decrease in the number of approaches used to settle their children.
Spontaneous remission

The study also highlighted the issue of spontaneous remission. Although it was not a significant change, some of the control group showed improvement in problem severity. Without a control group, one may attribute some success inappropriately to treatment. It also highlights the factor that not all parents wait passively on a waiting list. Some may seek other sources of help, such as self-help books.

Limitations of study

There are various difficulties with the research design that limit the conclusions of the results.

The measure of compliance had questionable internal validity. The measure had a variable baseline and so was perhaps a misleading comparison. This was due to people being seen a different number of times. Therefore someone could be seen once and still get 100% compliance. The measure was possibly too basic to draw out any difference. Attempting a task does not reflect a person’s effort in trying to achieve it. It may have been more useful to consider how much a subject complied with a task in conjunction with whether they achieved the task as well. It may also be that type of treatment cannot alter compliance when it is high already.

The measure of perceived parental support was very limited and needed a fuller definition. It was not clear what parents understood by the term and there was no systematic measure of actual support. The implication of this is that what was measured was a diffuse and vague variable, which could vary from person to person according to their own understanding. It was not clear what parents might have wanted or regarded as necessary in order to feel supported. A more continuous measure might have indicated this. However, one disadvantage of continuous measures is that participants may tire of them.
It is still possible that the increase in skills was related to some other factor that was not measured. Indeed one control subject sought help from a self-help book while on the waiting list. What was needed was a measure that applied to all 3 groups. In addition, the fact that the sleep group reported more skills than the individual treatment group makes it more likely that they will be able to generalise their skills than the other group. A further possibility is that the teaching style of the sleep group led to a difference in the type of information retained. A related point is that one might also have expected those with other concerns about their children’s behaviour to have made more effort to generalise their skills, but this did not appear to be the case.

The measure for consistency of approach is likely to have been too broad. It may be that as a baseline measure, parents reported all the methods they had ever used, rather than just those being used currently. This was not clear from the question or the responses.

The mode of treatment included a further source of variation in the study design. Participants were either seen at their homes or in a clinic. Other studies have considered treatment comparisons within clinics. It is unclear what further affect being treated at home may have on outcome. For example, perhaps it would affect compliance through parents having other distractions or alternatively, a home visit might make parents feel more supported.

The researcher was also aware of which groups participants were assigned to, which could be a source of researcher bias. However one would have expected a bias in favour of the hypotheses, which was not the case. In future it would be more appropriate for the researcher to be blind to the subject’s grouping.

The use of composite and difference scores also had limitations. Composite scores were used which avoid the need to use a statistical test repeatedly, thus limiting the chance of a Type I error. However it also limits some of the specificity of the individual scores. Difference scores were occasionally used to compare between groups. Such scores obscure the effect of variable baselines, although they are
adequate to compare the power of an effect. However if the data are only ordinal, one has to treat any relative differences with caution as the intervals between data points may not be equally spaced.

A further limitation concerned measuring handling strategies and more specifically, the achievement of goals set. The goals set were not measured initially because it was believed that asking people about their overall handling strategies before and after treatment would give an indication of change in behaviour. In addition, the control groups did not have goals, but could still be compared on their overall strategies. However, the overall strategy as described by parents did not always include the set task or goal. In addition, it was possible for several goals to be set and for participants to work towards them in a graduated way. By not measuring the achievement or not of goals set in treatment, one is left with the possibility that any changes were still due to extraneous factors. There is an implicit assumption that compliance is related to goal achievement. It may have been more useful to measure compliance in conjunction with goal achievement.

In addition, there is an issue over whether measures reflect the parental or the researcher’s view of the problem. Classification of the problem was according to the researcher and, at least in the area of settling problems, did not always tally with the parents subjective view of a problem. Only one individual in the sleep group reported that their child did not settle easily, but a further individual was included in the settling problem category for this group by the researcher, because the behaviour was severe enough to contribute to their composite sleep problem score. Similarly while 2 individuals in the individual treatment group believed that their children had problems settling, only one reported a behaviour severe enough to affect the composite sleep problem score. As has been noted previously, there are individual differences in what is considered a problem (Scott and Richards, 1988; Daws, 1993). Measures will depend partly on to whom the outcome is important.
Generalisability of research

Random allocation was not possible, but it was thought that using time would be as effective. However time did not appear to be a good random allocator. Although the groups were similar on baseline differences of sample characteristics and of sleep environment, they differed, albeit non-significantly, on the presenting problems. The individual group was more severe in terms of other concerns about the child, problem duration, and problem severity. The control group also appeared to differ slightly having more evidence of settling problems. This variation would indicate that selection into groups was not random and that this sample may not generalise to the larger population of children with sleep problems. It is possible that referrals could have come in batches from different sources, reflecting a systematic bias.

The manner of data collection also introduced variability, which would limit generalisability of findings. It was difficult to access participants as after treatment, they had no contact with the service. It was decided to use telephone interviews. However it was hard to find convenient times to talk to parents, and it was sometimes impossible during work hours. Telephone interviews had the disadvantage of lacking analogue data (body posture, etc). Parents would also be subject to other distractions in their home and so would not necessarily be completely focused on the interview. The difficulty in catching people also led to an inevitable variability in data collection times. There was a variable time delay in gathering the follow-up data that applied to all 3 groups. This may have allowed some more time for reflection and improvement than others. It may help in future to have the questionnaire administered by the researcher or clinician at the first and last appointment. In a larger study it may be more appropriate to allow parents to complete it themselves as part of treatment. One would have to allow for a certain amount of wastage.

The small sample size in this study limits the generalisability of the findings. The sample size was limited by the number of referrals made to the service. Significant differences may have been masked by the small sample size. In addition, the sample
size limited the statistical analyses used to non-parametric tests, which have less power than parametric tests to detect significant differences.

The research instrument was unstandardised, which could lead to variation between administrators. Standardised forms for the research questions were unavailable. As much as possible, forms were administrated by the researcher. The clinicians were involved in the initial data collection but not the follow-up. They were aware of which participants were in which conditions, however they were not expected to alter their clinical practice. The inter-rater reliability was not checked and it is possible that there was some variance in collecting baseline data. However the questionnaires were thought to provide little scope for such variance due to the wording of the questions.

The lack of certain measures for the control group limited the conclusions that could be drawn. It was not possible to compare for skills learnt, the generaliseability of those skills, subjective change in sleep behaviour, and any other improvements in behaviour. This would have to be controlled for in further research, because as was seen at least one control subject sought another avenue for help.

**Meaning of research results**

**Compliance**

Although treatment did not appear to affect compliance, it is likely that the measure was not valid enough. In view of this, it is argued that the research design did not prove an adequate test of the hypothesis that treatment in a group would increase compliance with treatment.

**Support**

Type of treatment did not appear to be related to perceived support. However, given the limitations of the measure, this cannot be conclusive. It was originally hypothesised that perceived support may be related to self-esteem. However neither
showed any change and so this has not been adequately tested. It may be that the sleep
group was atypical. One parent reported that she expected the group to involve more
discussion between the parents. If the group did not provide support as expected then
one might not expect anyone to continue feeling support once the intervention had
been withdrawn.

**Sleep management skills**

The sleep group appeared to be able to identify more skills. However, it is not possible
to say if this was due to being treated in a group format or to some other factor of the
sleep group. Given that individual work can be tailored to the individual, it may have
been that the presentation of the behaviour modification approach differed significantly
between the treatment groups.

**Generalisation of skills**

There was no difference between the groups for generalisation of skills. However
given the trend for the sleep group to show more generalisation, it is likely that the
lack of significant difference is at least in part attributable to the low power of the
study in detecting differences. A larger sample would be one way of redressing this.

**Self-esteem**

There was no difference between the groups, although the sleep group appeared to
have lower self-esteem to start with. It may be that they were more willing to accept
the rationale behind treatment of needing to change their own behaviour in order to
change their child’s. A further possibility is that parents see the sleep problem as a
problem with their child and so their own self-esteem is unaffected whether the
problem is alleviated or stays the same.
Treatment outcome

There does appear to have been a difference in treatment outcomes, with the sleep group showing more of an improvement than the other two groups. However, there is an implication that the individual treatment group had more complex cases. In view of this, it is possible that the individual treatment group may have been more difficult to treat than the sleep group and therefore any difference in outcome may have been due more to the group than the treatment.

Previous research found that parental satisfaction was unrelated to behaviour change. In this study, however, parental satisfaction did appear related to behaviour change. The sleep group showed a significant improvement in severity of sleep problem, and significant differences from the individual group in deciding that the approach was useful and in the number of skills learnt. Although the differences were non-significant, the sleep group in comparison to the individual group also appeared to show more generalisation of skills, more recognition of any change, and to attribute the change to the intervention. This could suggest that the number of skills learnt is important. It may be that if parents can see and understand the practical application of the skills generally, they will be more satisfied. One implication is that parental satisfaction is related to increased competence and a feeling of success. Parental satisfaction does not appear related to other improvements in the child’s behaviour or to perceived support.

Implications for future research

In addition to the improvements mentioned above, there are areas for further study. It would be interesting to know what parents wanted in terms of support and how this might differ. It may help in deciding if some people are more appropriate for group work than others. This could allow interventions to be tailored to facilitating an increase in support for some individuals or an increase in skills for others. A closer examination of the skills that are developed may differentiate the types of treatment,
but it would be important to consider how skills may change for a control group as well.

Conclusions

In conclusion, compliance, support, and self-esteem appeared unaffected by the treatment received. It did appear that the sleep group had a better outcome overall, particularly in terms of problem severity and number of skills learnt. They also appeared to develop more skills than the individual treatment group and to develop more sophisticated skills. However the individual treatment group did appear to have more complex problems in the first place. The limitations of the design limit further conclusions. Further research is suggested to examine in more detail the types of support considered by parents and the types of skills that are developed, particularly in contrast to a comparison group.
REFERENCES


<table>
<thead>
<tr>
<th>APPENDICES</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Composite score for severity of sleep problem</td>
</tr>
<tr>
<td>B</td>
<td>Materials</td>
</tr>
<tr>
<td>C</td>
<td>Ethical approval information</td>
</tr>
</tbody>
</table>
APPENDIX A: Composite score for severity of sleep problem

Participants were asked about various aspects of sleep behaviour and the answers were rated on a scale from 0 to 4 as follows:

1. The time taken for the child to settle at bedtime.
   - less than 15 minutes 0
   - 16 to 30 minutes 1
   - 31 to 45 minutes 2
   - 46 to 60 minutes 3
   - more than 60 minutes 4

2. The number of times the child wakes per night on average.
   - never 0
   - once 1
   - twice 2
   - three times 3
   - four times or more 4

3. The number of nights the child woke in the previous week.
   - never 0
   - once 1
   - twice 2
   - three times 3
   - four times or more 4

4. The average time spent wake after waking at night.
   - does not wake 0
   - 0 to 5 minutes 1
   - 6 to 15 minutes 2
   - 16 to 30 minutes 3
   - 31 minutes or more 4
5. Number of nights that the child ended up in the parents bed in the previous week.

<table>
<thead>
<tr>
<th>None</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>1</td>
</tr>
<tr>
<td>Two</td>
<td>2</td>
</tr>
<tr>
<td>Three</td>
<td>3</td>
</tr>
<tr>
<td>Four or more</td>
<td>4</td>
</tr>
</tbody>
</table>

6. The time the child wakes in the morning.

<table>
<thead>
<tr>
<th>Time</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.00 am onwards</td>
<td>0</td>
</tr>
<tr>
<td>6.30 to 6.59am</td>
<td>1</td>
</tr>
<tr>
<td>6.00 to 6.29am</td>
<td>2</td>
</tr>
<tr>
<td>5.30 to 5.59am</td>
<td>3</td>
</tr>
<tr>
<td>Before 5.30am</td>
<td>4</td>
</tr>
</tbody>
</table>

The individual scores were then totalled to reveal the composite score.
APPENDIX B: Questionnaire

Please note that questions 1 to 28 are also completed pre-treatment.
Questionnaire to be completed be investigator.

SLEEP PROBLEMS QUESTIONNAIRE

Part II (After treatment)
Demographic details Date: ....................

1. Name of child: ...........................................

2. Sex of child: male female

3. Date of birth of child: ....................

4. Address: ...........................................

5. Parents:
   - Mother
     - age: ............................
     - occupation: ............................
   - Father
     - age: ............................
     - occupation: ............................

6. Does your child have any other siblings?
   Please tick as appropriate
   No ( )
   Yes ( )
   If yes, please give their ages

7. Have you received any other treatment, help, or advice with respect to this sleep problem?
   Please tick as appropriate
   No ( )
   Yes ( )
   If yes, please describe
   1........................................................
   2........................................................
   3........................................................
8. Do you have any other concerns about your child's behaviour or development?

Please tick as appropriate

No ( )
Yes ( )
If yes, please describe what they are

9. What is the ethnic background of your family?

Please tick as appropriate

White ( )
Black-Caribbean ( )
Black-African ( )
Black-Other ( )
Please describe ......................
Indian ( )
Pakistani ( )
Bangladeshi ( )
Chinese ( )
Any other ethnic group ( )
Please describe ......................

10. Have any of your other children ever had sleep problems?

Please tick as appropriate

Yes ( )
No ( )
Not applicable ( )

Background details

11. Does your child have a room of his/her own?

Please tick as appropriate

Yes ( )
No ( )
If no, please describe who he/she shares with

12. Does your child sleep in a cot or a bed?

Please tick as appropriate

Cot ( )
Bed ( )
13. Does your child have a comforter (toy, cloth, thumb) or require anything else in order to get to sleep e.g. sucking bottle/dummy)?

Please tick as appropriate
- No ( )
- Yes ( )

If yes, please describe

Your child's sleep pattern

14. How long has your child had a problem with sleeping? ................................

15. Do you have a set bedtime routine?

Please tick as appropriate
- No ( )
- Yes ( )

If yes, please describe what happens (where, who, when, what)

16. Does your child go to bed and fall asleep easily?

Please tick as appropriate
- Yes ( )
- No ( )

If no, please describe what happens. Include time start putting him/her to bed, times fall asleep and what happens in between.

17. On average how long does it take to settle your child to sleep each night?

Please tick as appropriate
- Less than 15 minutes ( )
- 16 to 30 minutes ( )
- 31 minutes to 45 minutes ( )
- 46 minutes to 60 minutes ( )
- More than an hour ( )
18. On average how often does your child waken during the night?

Please tick as appropriate
- Never ( )
- Once a night ( )
- Twice a night ( )
- Three times a night ( )
- Four times a night ( )
- Five or more times a night ( )

19. How many nights in the last week did your child waken during the night?

(please circle one) 0 1 2 3 4 5 6 7

20. How long does he/she stay awake?

Please tick as appropriate
- Does not wake ( )
- 0 - 5 minutes ( )
- 6 - 15 minutes ( )
- 16 - 30 minutes ( )
- 31 - 60 minutes ( )
- More than an hour ( )

21. What happens when he/she wakes? (What does he/she do, how does he/she eventually fall asleep again?)

22. Where does your child fall asleep again?

Please tick as appropriate
- Their own bed/cot ( )
- Their parents bed ( )
- Other ( )
- If other, please describe

23. How many nights in the last 7 days did your child end up in your bed? .............
24. Is there any evidence that your child has night terrors?
   Please tick as appropriate
   No ( )
   Yes ( )
   If yes, please describe
   ......................................................................

25. At what time on average does your child wake in the morning? ............... 

26. Does your child have a nap during the day?
   Please tick as appropriate
   No ( )
   Yes ( )
   If yes, please describe. Is there a regular time? Where do they fall asleep and how? How long on average is the nap?
Current sleep management

27. What approaches have you tried in dealing with the problem?

<table>
<thead>
<tr>
<th>Approach</th>
<th>Please tick</th>
<th>Frequently effective</th>
<th>Sometimes effective</th>
<th>Not effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine from doctor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicine bought from chemist (e.g. phenergen)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drink</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cuddle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ignore</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Return child to own cot/bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take child into own bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent remains in child's bedroom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nightlight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevent child from leaving his/her own bedroom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rewards</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please describe)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Support questions

28. Do you feel you currently have any support in dealing with this problem?

Please tick as appropriate

No    ( )
Yes   ( )

If yes, please describe
Parental perceptions of sleep management sessions

29. Do you think that these sleep management sessions have been helpful to you?
   Please tick as appropriate
   No ( )
   If no, please describe why?

   Yes ( )
   If yes, how have they been helpful?

30. Have you noticed any improvement in your child's sleeping difficulty since having these sleep management sessions?
   Please tick as appropriate
   Yes ( )
   No ( )

31. Has your child's sleeping difficulty got worse since having these sleep management sessions?
   Please tick as appropriate
   Yes ( )
   No ( )

32. If there have been any changes do you think that they have been due to having these sleep management sessions?
   Please tick as appropriate
   Yes ( )
   No ( )

33. What did you like most about the sleep management sessions?

34. What did you like least about the sleep management sessions?
Skill questions

35. What do you feel that you have learnt from these sleep management sessions?
   Please tick as appropriate
   - Being consistent ( )
   - Setting limits ( )
   - Reinforcing inappropriate behaviour ( )
   - The associations children make to go to sleep ( )
   - Other ( )
   If other, please describe

36. What was new to you in these sessions?

1........................................
2........................................
3........................................
4........................................
5........................................

37. Have you noticed any other improvements in your child's behaviour or development since having these sleep management sessions?
   Please tick as appropriate
   - No ( )
   - Yes ( )
   If yes, please describe
38. Do you feel that you have learnt anything from the sleep management sessions that has helped you with other aspects of your child's behaviour or development?

Please tick as appropriate

No ( )
Yes ( )

If yes, please describe

Your signature............................................................

Thank you for completing this questionnaire.
APPENDIX B: Sleep Diary

SLEEP DIARY

<table>
<thead>
<tr>
<th>DAY &amp; DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time woke in the morning</td>
</tr>
<tr>
<td>Mood on waking</td>
</tr>
<tr>
<td>Time of nap(s) in the daytime</td>
</tr>
<tr>
<td>Time to bed</td>
</tr>
<tr>
<td>Time to sleep:-- (Note what happened before he/she fell asleep) How did he/she eventually settle?</td>
</tr>
<tr>
<td>Time(s) woke in the night. What you did. Times went back to sleep again.</td>
</tr>
<tr>
<td>Time you went to bed</td>
</tr>
</tbody>
</table>

MOOD SCALE:-

1 2 3 4 5

Very Unhappy Average Very Contented
APPENDIX C: Ethical information

Sleep Research Consent Form

Aims of Research

The aim of this study is to compare group sleep management sessions with individual sleep management sessions. We hope that the information we gain from this study will help both health workers and parents in deciding which way of providing assistance with childhood sleep problems is most useful.

What research will entail

The research will entail you being asked to complete questionnaires (with the researchers’ assistance) about your child’s sleeping pattern, the amount of support you feel you receive in dealing with the problem, skills you may learn during the sleep management sessions, and how confident you feel in dealing with your child’s behaviour generally. These questionnaires will be completed before the sleep management sessions start and when they end.

You do not have to take part in this study. Your decision as to whether you do or not will not affect your right to attend the sleep management sessions or when your referral is seen. Please note that all information will be confidential and any written reports will maintain anonymity.

What subject consents to

I consent to being involved in this research project and understand that I may withdraw at any time if I wish.

Name:

Signature:

Date:

Thank you for your time.
SH/AJR
18th February 1997.

Chris Hall,
Clinical Psychologist in Training,
Child Psychology Dept.,
West Park Hospital.

Dear Ms Hall,

RE: A COMPARISON OF SLEEP GROUPS AND INDIVIDUAL TREATMENT FOR PARENTS WITH CHILDREN WITH SLEEPING PROBLEMS - REF: 71CHSP(52) - to be quoted on all future correspondence please

The Eastern Surrey Local Research Ethics Committee discussed the above research submission at its meeting on 14th February 1997 and I am pleased to inform you that approval has been given to commence this study. The Committee would also like to thank you for a proposal which was well-prepared.

Yours sincerely,

Selina Harris,
Manager - ESLREC

c.c. Professor Carruthers
c.c. Mrs S. Wyatt

(EthApp)
<table>
<thead>
<tr>
<th><strong>TITLE:</strong></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>RESEARCH/FIELD</strong></td>
<td></td>
</tr>
<tr>
<td><strong>SUPERVISOR:</strong></td>
<td>Dr Paul Davis</td>
</tr>
<tr>
<td><strong>DATE:</strong></td>
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ABSTRACT

This study aimed to compare the effects of suffering from opiate withdrawal syndrome on interrogative suggestibility. It is argued that opiate-dependent individuals are likely to be more suggestible when suffering from withdrawal symptoms and that this may affect the likelihood of them giving a false confession when interviewed by the police. Participants on a waiting list for a detoxification unit were compared with those in the unit suffering from withdrawal symptoms. No difference was found between the groups for suggestibility, but it was found that the two groups did not differ as expected for withdrawal symptomology. The limitations of the research and the meaning of the results for model of interrogative suggestibility suggested by Gudjonsson and Clark (1986) are discussed.
INTRODUCTION

The reliability and validity of confessional evidence is an important legal and psychological issue for concern. If it is unreliable, a conviction may be made unjustly. It has been argued (Gudjonsson, 1992; Gudjonsson and Clark, 1986) that people can be encouraged to make false confessions through questioning. In order to avoid this, it is important to understand who might be vulnerable to such suggestion. It will be argued that opiate-dependent individuals are likely to be a vulnerable group and hence in need of study. This review will consider the interaction of the opiate withdrawal syndrome with interrogative suggestibility.

Rationale for this area of study

The confession plays an important role in British law. It is possible for suspects to be convicted on the basis of their confession alone (Gudjonsson, 1992). This is not always so in other countries, such as Scotland and the United States of America, where corroboration is required with regard to confessional evidence. A confession is also likely to increase the likelihood of conviction (Gudjonsson, 1992, p.205). Such reliance on the confession allows the possibility of suspects being convicted due to false confessions. This is something that can and does happen. Brandon and Davies (1973, cited in Gudjonsson, 1992), looked at 70 British cases of 'wrongful imprisonment'. These were cases that had been overturned either by the Home Secretary or the Court of Appeal between 1950 and 1970. They found that after mistaken identification, self-incriminating confessions were the most common cause of wrongful imprisonment. Gudjonsson (1992) cites several studies of miscarriages of justice in the United States of America (Borchard, 1932; Rattner, 1988; Bedau and Radelet, 1987) where self-incriminating confessions, although not the most common cause of wrongful imprisonment, were indeed evident.

A further problem is that it is hard to appeal against a conviction on the basis of the confession in British law. Cases may be referred to the Court of Appeal, which confines itself to questions of law and the evaluation of new evidence. It is not concerned with the evaluation of guilt or innocence directly. Should such an appeal
fail, then the case can be referred to the Home Secretary. It is obvious that more is required than for someone to just retract their confession. Gudjonsson (1992, p.233) makes the point that the studies into miscarriages of justice mentioned above indicate that the legal system is not good at discovering, admitting to, and doing something about errors that are made. This makes it vitally important to consider the reliability of the confession in the first place.

Opiate-dependent individuals are worthy of research in their own right, due to their increased risk of involvement with the legal system. The possession of non-prescribed opiates is in itself an offence. There is also a recognised association between opiate use and criminality. Kouri, Pope, Powell, Oliva, and Campbell (1997) looked at the relationship between crime and substance abuse in a sample of 133 consecutively evaluated male prisoners in the United States (US). Although they found no significant correlation between the type of diagnosis and the type of crime committed, they did report that among the prisoners, 95% obtained a diagnosis of dependence on one or more substances and 58% were intoxicated at the time of the offence. Hser, Prendergast, Anglin, Chen, and Hsieh (1998) conducted a regression analysis using social indicators and drug use rates to estimate a likely prevalence that 1,296,000 arrestees would be using an illicit drug across 185 cities in America. About 11% of individuals seen by forensic medical examiners in police custody in London are drug misusers (Payne-James, 1992). It also appears that the majority of drug users in police custody are recidivists (Payne-James, Dean, and Keyes, 1994). In view of this, opiate-dependent individuals are likely to come into contact with the criminal justice system and to be interrogated by the police.

The management of drug users in police custody varies in different parts of the country, which can have implications for their testimonies. Stark (1994) surveyed the Association of Police Surgeons of Great Britain. These doctors were very aware of the increasing drug problem. Many reported negative attitudes to drug misusers. 61% did not consider that symptoms and signs of mild opiate withdrawal were a general barrier to interview. 21% were willing to give methadone to a drug misuser prior to an interview, 59% would give symptomatic medication and 24% would give no
Interrogative Suggestibility and Opiate Withdrawal

medication. Although there are guidelines on the clinical management of drug misuse and dependence (Department of Health, 1991: cited in Payne-James, Dean, and Keys, 1994), there are no national guidelines for police surgeons managing drug users in police custody. It is likely that many drug users go through a police interview experiencing some symptoms of withdrawal. Due to this increased risk, and the effects of opiate-dependency and opiate-withdrawal, research into interrogative suggestibility is indicated with this group.

Research is important as the issue begins to be addressed by clinical psychology. Psychologists are increasingly being asked to act as expert witnesses in court and to comment on the reliability of confessional evidence. Increased theory and research is needed in order to guide clinical decision-making and practice.

Background to research area

Importance of police interview

Interviews can be considered as one of the most important methods for gathering information for the police. Gudjonsson (1992) points out that forensic evidence may be hard to obtain, leaving interviews as the only source of information. Interviews may be the only source of less tangible information, such as intent.

According to Gudjonsson (1992), police interviews follow a standard format, although there is some variation. In the orientation phase, the police need to a) state the purpose of the interview, b) introduce participants, and c) fulfil legal requirements. In the listening phase, the subjects describes what has happened, while the police formulate questions. In the questioning phase, the police ask specific questions. In the advising phase, the subject checks their statement and the police inform them of what further action is to be taken.

Importance of types of questioning

There is a need for reliability in statements obtained by the police. By this it is meant that the evidence is valid (i.e. an accurate record of what happened) and complete.
Statements may be required for different purposes and the police may use different questioning styles for this. It will be seen that different types of question can influence the response from the interviewee. Different types of questions may prove helpful or unhelpful, according to the type of information required by the interviewer.

**Types of questions that can be asked**

The police will use varying types of questions in an individualised interview. The interview does not follow a standardised format as the police may not be fully aware of all the information needed at the outset (Gudjonsson, 1992). Some avenues of interest may only become apparent as the interview/investigation proceeds. The police may use open or closed questions. Open questions, such as ‘What happened next?’ allow the respondent a variety of responses and invite some description or elaboration. Closed questions allow a restricted response. A closed question has been defined by Richardson, Dohrenwend and Klein (1965: cited in Gudjonsson, 1992) as ‘a question which can be adequately answered in a few words’. Such questions allow the interviewer to narrow their focus to certain details. Gudjonsson (1992) divides closed questions into three further categories; types that require some identification; types where the respondent has to select a response from several given; types involving a yes-no response. A leading question is defined by Gudjonsson (1992) as one that indicates the wanted answer. One might expect the police to use leading questions where they have relevant information prior to asking the question.

**Effects of different questioning styles**

It will be clear that different types of questions can have different effects upon the respondent. Open questions allow for much more flexibility on the part of the respondent, but this can result in too much irrelevant information for the interviewer. Closed questions allow the interviewer to focus on specific areas and details, but as anyone familiar with multiple-choice tests will recognise, the answer that the respondent wants to give may not be an option. The interviewer may be in danger of ‘putting words into the respondent’s mouth’ that are not accurate. Leading questions have the intention of making it clear what the respondent should answer. There is evidence that leading questions can distort an individual’s response (Loftus, 1979;
Stern, 1938: cited in Gudjonsson, 1992). It will be obvious that if leading questions are used by an interviewer with inaccurate or incomplete antecedent information, they can lead to distorted responses that do not represent factual information. What is meant by antecedent information, is the information that the interviewer has prior to formulating and asking a question (Gudjonsson, 1992). Of course, not all people will produce distorted responses to leading questions. It will be a mixture of environmental and personality variables that dictate this.

**Interrogation techniques**

It is possible that manipulative tactics, when used, can lead to false confessions. There is certainly evidence to suggest that they are used, for example as described in the police interrogation manual written by Inbau, Reid, and Buckley (1986: cited in Gudjonsson, 1992). The manipulative tactics described are based upon extensive observation of ‘successful’ interviews and upon interviewing suspects after they had confessed. Although the tactics are not explicitly researched, Gudjonsson (1992) points out that they are based upon psychological mechanisms. He does not, however, explicitly state what these are, except that they involve “manipulating the suspect into confession by playing on their vulnerabilities and using trickery and deceit”.

Gudjonsson (1992) reviewed 4 studies on the use of interrogation with British police (Irving, 1980; Softley, 1980; Walsh 1982; Williamson, 1990). Manipulative and persuasive tactics were evident in all of the studies prior to the introduction of the Police and Criminal Evidence Act 1984 (PACE). Since PACE, there appears to have been a shift from manipulative tactics to a more confrontational approach where the emphasis is on gaining a confession, rather than discovering what went on (Moston, 1990: cited in Gudjonsson, 1992). Despite this, self-incriminating statements made outside the interview room are still used (Heaton-Armstrong, 1987: cited in Gudjonsson, 1992). It may well be that manipulative tactics are still in use, just not during the official interview. There is no evidence to directly support this supposition.
Interrogative Suggestibility

Interrogative suggestibility refers to the process of asking leading questions that suggest a response, which results in distorted responses. Gudjonsson and Clark (1986) produce a more refined and useable definition:

"...the extent to which, within a closed social interaction, people come to accept messages communicated during formal questioning, as the result of which their subsequent behavioural response is affected" (p.84).

According to Gudjonsson (1992), this definition has the advantage over others of being operationally testable.

There are 5 components of the definition, which together, allow it to be tested. Firstly, the social interaction is closed, i.e. people do not come and go. Secondly, the interview involves a questioning procedure, where the recall of factual information is important. Thirdly, the questions are leading, in that they suggest an answer based on certain assumptions, that may or may not be correct. Fourthly, the interviewee must accept the suggestion, finding it plausible and credible. Lastly, the respondent must give a behavioural response to the question. It is not enough for the respondent to silently accept it. This last component may be questioned as to whether it is necessary as people may well accept suggestions without giving a definite answer. However, without it, the operational definition is not fully testable.

Gudjonsson outlines 4 features of this definition of interrogative suggestibility that distinguish it from other suggestibilities. Interrogative suggestibility involves a questioning procedure in a closed social interaction. Interrogative suggestibility concerns memory rather than motor or sensory experiences. Interrogative suggestibility involves uncertainty. Interrogative suggestibility involves a stressful situation with important consequences for the respondent.

Outline of Gudjonsson’s and Clarke’s model of interrogative suggestibility

Interrogative suggestibility can be conceptualised in two forms: yield and shift. Yield refers to the act of accepting suggestions from the interviewer. Shift refers to the ability of an interviewer to change a respondent’s answers. Gudjonsson (1984) has
shown that shift and yield are conceptually distinct through the use of factor analysis. These two aspects of interrogative suggestibility and their different implications for witness testimony, are integrated into Gudjonsson’s and Clark’s model for interrogative suggestibility.

The Gudjonsson and Clark model asserts that interrogative suggestibility will be mediated by the coping strategies that the respondent is able to bring to the aspects of uncertainty and expectation related to the interview situation. Firstly, the social situation must be defined, i.e. a closed social interaction involving questioning. Next the model predicts that the interviewee will adopt a ‘general cognitive strategy’ that will facilitate either a suggestible or resistant response. When questions are asked of the respondent, they raise issues of uncertainty and expectation. The questions and their context are cognitively appraised by the respondent. This involves drawing on general coping strategies to deal with the uncertainty and expectation involved and results in either a suggestible or resistant behavioural response.

Uncertainty refers to whether the interviewee knows the right answer to the question or not. It is obvious that this is influenced by the respondent’s ability for memory recall. If the respondent does know the answer, but still agrees with the interviewer, then this should be considered as evidence of compliance, rather than suggestibility.

Uncertainty is also related to interpersonal trust. Interpersonal trust refers to whether the interviewee thinks the interviewer is trying to trick them or not. Suspicion is hypothesised to increase the rejection of suggestions offered. Interpersonal trust is dependent on the respondent’s ability to detect trickery. A large amount of uncertainty will make it difficult to accurately detect trickery.

Expectation refers to what the respondent believes is expected of them. Gudjonsson asserts that this is a prerequisite for a suggestible response. The respondent is thought to be reluctant to state their uncertainty, due to beliefs that they are expected to know the ‘right answer’ and that they should be able to give it.
According to this model, anyone can be suggestible if the necessary conditions are met. Yield is predicted to occur under conditions of uncertainty, good interpersonal trust, and expectation of success. Shift is predicted to occur under the same conditions, but following negative feedback. Such feedback may be explicit or implicit. The response to feedback is assumed to be related to the previous behavioural response, e.g. a suggestible response followed by positive feedback is likely to lead to further suggestible responses. Resistant behaviour followed by negative feedback, may or may not lead to suggestible responses. This depends on whether the feedback is accepted or rejected and how acceptance affects the general cognitive strategy.

False confessions may possibly arise from a combination of the police interrogation and psychological factors of the suspect. Kassin and Wrightsman (1985) suggest 3 distinct types of false-confession: voluntary, coerced-compliant, and coerced-internalised. Voluntary false confessions are made without pressure from the police and may be due to a variety of motivating factors within the individual. Both coerced-compliant and coerced-internalised confessions result from police pressure. The former is made for some immediate gain (e.g. escape from the situation). The latter results from the suspect coming to believe the police’s version of events and distrusting their own memory.

Evaluation of the Gudjonsson and Clark model
The main criticism levelled at this model is that it may be too complex. Schooler and Loftus (1986) suggest the concepts of uncertainty, interpersonal trust, and negative feedback can be explained by a single cognitive process of discrepancy detection. Irving (1987) suggests that the whole idea of interrogative suggestibility can just as easily be accounted for by the concept of compliance.

Gudjonsson (1992) himself suggest that the approaches are largely complementary. The idea of a discrepancy detection is derived from experimental psychology and concerns a person’s ability to detect discrepancies in what is suggested and what they remember. It is assumed to depend on the strength of the original memory and the manner in which the post-event suggestion is made. Schooler and Loftus cite several
articles to support this concept. However it does not account for Gudjonsson’s and Clark’s concept of expectancy. It seems likely then that there is more than one cognitive process involved. However, the idea is useful, as Gudjonsson and Clark do not attempt to explain the likely cognitive processes involved.

Compliance is, by definition, different from interrogative suggestibility and is unlikely to account for all the variance. Essentially compliance does not necessitate the acceptance of the suggested information, while interrogative suggestibility does. Behaviourally they will appear similar, but cognitively they differ.

**Opioids and the opiate-withdrawal syndrome**

Opioids is a general term for drugs whose effects are similar to those of morphine, while opiates is a specific term for substances either present in or derived from opium (Madden 1990). These substances exert an inhibitory effect on nerve impulses, which leads to a calming effect. These effects are further enhanced by intravenous injection or smoking. Repeated use of these drugs can lead to tolerance. The mechanisms of tolerance may be that the body metabolises the drug more quickly or that the threshold level for neuronal inhibition is increased. These changes persist after the drug is withdrawn and manifest in a withdrawal syndrome.

The characteristic syndrome associated with opiate withdrawal is outlined in the DSM-IV (APA 1994). It includes the following symptoms: dysphoric mood, nausea or vomiting, muscle aches, lacrimation or rhinorrhea, pupillary dilation, piloerection or sweating, diarrhoea, yawning, fever, and insomnia. Madden (1990) likens it to an uncomplicated episode of influenza.

Anxiety is also a key feature of withdrawal and may result from misperceptions about the syndrome. Madden (1990) asserts that there is a mythology among opiate users about the severity of the abstinence syndrome, but does not cite evidence to support this. Janiri, Agnes, Ciaramella, di Giannantonia, and Tempesta (1987) reported that anxiety was the most commonly reported symptom during detoxification. Phillips, Gossop and Bradley (1986) reported that expectation of problems in withdrawal rather
than the previous dosage of drug used was related to actual severity of symptoms during detoxification. Senay, Dorus, Goldberg and Thornton (1977) reported that anxiety about withdrawal exacerbated symptoms and caused patients to abort detoxification. There is an implication that anxiety about withdrawal is common and is likely to be a powerful motivator in avoiding unpleasant symptoms.

**Rationale for opiate-withdrawal syndrome to affect interrogative suggestibility**

It is argued that opiate dependence and the withdrawal syndrome are likely to affect interrogative suggestibility in some manner and that this is a valid area for research. The interrogation situation is suggested to be stressful for non-opiate-dependent individuals, leading to an impaired ability to use judgement and legal rights. Models of suggestibility (Gudjonsson and Clark, 1986; Schooler and Loftus, 1986) imply that under certain conditions, people can be made more vulnerable to suggestibility. It is reasonable to consider how the interrogation situation may be more stressful to individuals experiencing the discomfort of withdrawal symptoms. There is some evidence to suggest that withdrawal is a genuine problem during interrogation. In a study of Icelandic prisoners, Sigurdson and Gudjonsson (1994) found that a third of those interviewed reported having experienced withdrawal symptoms from either alcohol or drugs whilst being interviewed by the police.

An individual's perceived need for drugs may make them more compliant. The argument is that an opiate-dependent individual may comply with police requests in order to be let out of custody, so that they may acquire further drugs. Softley (1980) observed interviews of 218 criminal suspects at 4 police stations in England. In about 7% of initial interviews, police hinted that unless suspects co-operated, they would be detained for a longer period at the police station. This study was carried out before the implementation of the Police and Criminal Evidence Act 1984 (PACE) and it may well be that such practice is no longer prevalent. Research carried out by Irving and McKenzie (1989: cited in Gudjonsson, 1992) suggests that the implementation of PACE has led to a decrease in manipulative and persuasive tactics used by the police.
Opiate withdrawal syndrome may affect suggestibility in Gudjonsson’s model at the level of uncertainty. Withdrawal or intoxication could result in the subject becoming confused. This could result in them being less certain of their perceived account of events. Memory lapses resulting from intoxication would also make the suspect less certain. Gudjonsson and Clark’s model (1986) predicts that uncertainty will increase suggestibility.

Opiate withdrawal syndrome may also interfere with coping strategies. Confusion resulting from withdrawal could also interfere with the subject’s general coping strategies. Gudjonsson (1988) found that subjects who used avoidance strategies of coping, such as denial and wishful fantasies, were more suggestible than those who used more realistic appraisal strategies. The increased anxiety associated with withdrawal could affect coping strategies. In addition, one may suspect the physical discomfort associated with withdrawal to distract the individual and again interfere with coping strategies.

Some factors already known to affect interrogative suggestibility

Compliance
Gudjonsson has shown compliance, as measured on his Gudjonsson Compliance Scale, to be modestly correlated with suggestibility (Gudjonsson, 1990). In his study, he correlated the GCS scores from 119 subjects with their GSS1 scores. He obtained correlations with Yield 1, Shift, and Total Suggestibility of 0.4, 0.53, and 0.54 (p<0.001). He goes on to suggest that compliance and suggestibility are both associated with personality (Gudjonsson 1992). Gudjonsson (1990) did not find a significant correlation between compliance and intelligence (r<0.08). Gudjonsson defines compliance as when a “person concerned is fully aware that his or her responses are being influenced, and an affirmative or a compliant response does not require personal acceptance of the proposition”.

Intelligence

Intelligence correlates negatively with suggestibility, but is subject to range effects. Gudjonsson (1983) found IQ as measured by the Wechsler Adult Intelligence Scale correlated negatively with Yield 1 and Shift. Gudjonsson (1988) analysed the relationship with normal and forensic subjects and found correlations with Full Scale IQ to be -0.52 and -0.58. However he reported (Gudjonsson, 1992) that IQ's above 100 did not correlate significantly with suggestibility, while IQ below 100 correlated significantly. Tata (1983: cited in Gudjonsson, 1992) looked at IQ as predicted from the Nelson Adult Reading Test and suggestibility on GSS1 and found no significant correlation where the range of scores was between 106 and 125. It appears that if the person has an IQ in the average range or above, then intelligence has a negligible effect on suggestibility. Gudjonsson (1992) attempts to explain this.

It may be that, as Gudjonsson (1992) suggests, suggestibility is affected by a person's ability to understand a situation and to draw on appropriate problem-solving action. Gudjonsson (1990) found that suggestibility correlated most with the Picture Arrangement, Similarities, and Comprehension sub-tests of the WAIS-R and least with Digit Span and Information. He concluded that suggestibility, with regard to intelligence, would be related to logical reasoning, sequential thought, and social awareness. People who score poorly on such ability tests are less likely to be able to gauge a situation correctly and to draw upon the appropriate response. However, for those who can, then intelligence becomes less of a factor in their suggestibility.

Memory

Memory for events appears to correlate negatively with suggestibility, but as with intelligence, it is not a simple linear relationship. Gudjonsson (1988) reported correlations between verbal memory on GSS and suggestibility as being between -0.5 and -0.6 for normal subjects with lower correlations for forensic patients (Gudjonsson, 1992). Gudjonsson (1983) also reports that the faster memory recall deteriorates, the more suggestible that person is.
It may be that it is recall for stories that affects suggestibility rather than a poor memory in general. Schooler and Loftus (1986) suggest that similarities between the memory and suggestibility items of the GSS could account for the correlation. Gudjonsson (1987) looked at this by administering the GSS1 and GSS2 to 3 groups of subjects with the sequence being counterbalanced. He found no differences between the correlations of memory and suggestibility between or within subjects. However, both the GSS1 and GSS2 are likely to have the same similarities within their scales and so this test may not have been valid. A more valid approach may have been to employ a separate memory test in addition.

Anxiety

Anxiety has been shown to be a mediating factor in suggestibility. Gudjonsson (1983) found a significant, but low, correlation between total suggestibility and neuroticism \((r=28, p<0.05)\), as measured by the English version of the Eysenck Personality Questionnaire (EPQ; Eysenck and Eysenck, 1975; cited in Gudjonsson, 1992). However Haraldsson (1985) found no significant correlation using the Icelandic version of the EPQ (Eysenck and Haraldsson, 1983; cited in Gudjonsson, 1992). This study used university students. Gudjonsson (1988) reports that state anxiety is more strongly correlated with suggestibility than trait anxiety, as measured by the STAI. In this study, he also reported that Shift and Yield 2 were more strongly correlated with anxiety, asserting that state anxiety is associated with how subjects react to interrogative pressure rather than specifically to leading questions.

Coping strategies

The coping strategies that a person uses to deal with questioning correlate with suggestibility. Gudjonsson (1988) asked people about the strategies that they had used to cope with the interrogation. These were divided into 3 groups according to ‘methods of coping’ (Billings and Moos, 1981).

- Active-cognitive, where subjects try to manage the situation with cognitive coping statements.
- Active-behavioural, where subjects try to manage the situation with behavioural strategies.
Avoidance coping, where subjects attempt to avoid critical appraisal. Gudjonsson found that those who used avoidance coping had higher suggestibility scores than those who used the other two strategies.

Review of previous studies

Only two studies to date have looked at interrogative suggestibility in opiate users (Murakami, Edelmann, and Davis, 1996; Davison and Gossop, 1996).

Murakami, Edelmann and Davis (1996) compared 12 patients undergoing methadone detoxification with 19 patients who were undergoing rehabilitation, were off drugs and were no longer suffering withdrawal symptoms. They were compared on interrogative suggestibility, compliance, self-esteem, opiate withdrawal symptomology, and state-trait anxiety. The Detox group had a higher total suggestibility and more withdrawal symptoms, health problems and pre-test state anxiety than the Rehab group.

However, the Rehab group may have been self-selecting and less suggestible for other reasons than absence of withdrawal symptoms. Many in the detoxification group discharged themselves before completion of treatment and therefore did not enter rehabilitation. The Rehab group had slightly longer drug histories and opiate histories and were significantly more involved in crime. Previous involvement in crime has been shown to have a modifying effect on suggestibility (Gudjonsson, 1992). Therefore the lower level of suggestibility in the Rehab group could be due to this factor alone, rather than levels of withdrawal as the authors concluded.

Davison and Gossop (1996) used a within-subjects design to compare interrogative suggestibility and compliance in heroin addicts when on opiates, withdrawing from opiates, and when drug-free. They found that interrogative suggestibility and compliance did not differ significantly over the three conditions. However, a subgroup of vulnerable individuals appeared to be more suggestible when on opiates. Although anxiety for this subgroup increased during withdrawal, suggestibility was only significantly different between being on opiates and being drug-free.
Unfortunately over half the subjects left before the end of treatment. As in Murakami et al’s study, it may be that those that remained formed a subgroup that were less suggestible. The Rehab group in Murakami et al’s study were more involved in crime. This was not measured in Davison and Gossop’s study and remains a possibility. A further problem, highlighted by Davison and Gossop is that there may have been practice effects in using the Gudjonsson Suggestibility Scales at fairly short intervals. This can be overcome by sampling different individuals at the different points in time.
HYPOTHESES

Opiate withdrawal symptomology is predicted to be associated with interrogative suggestibility. According to the Gudjonsson and Clark (1986) model of interrogative suggestibility, anything that would make a person more uncertain about their memory recall, more likely to trust the interviewer, or to feel more of an expectation to give a response is likely to increase suggestibility. Gudjonsson (1992) also maintains that this process is mediated by the coping strategies that an individual can bring to bare on their situation. The opiate withdrawal syndrome is argued to be likely to affect suggestibility by making the individual more easily confused and less able to utilise their coping strategies. One possibility is that the person will be less able to recall verbal events and another suggestion is that the increase of anxiety associated with withdrawal may also affect coping strategies.

The research hypothesis is summarised in the following predictions:

1. The Detox group will show a higher level of interrogative suggestibility than either the Waiting List group or the Recovery group.

2. The Detox group will show a higher level of anxiety than either the Waiting List group or the Recovery group.

3. The Detox group will show a low level of verbal recall than either the Waiting List group or the Recovery group.

4. It is expected that both anxiety and memory recall (as measured by the Gudjonsson Suggestibility Scales) will account for significant amounts of the variance in interrogative suggestibility.
METHOD SECTION

Participants
56 individuals were approached to participate in the study. 43 agreed to be involved. 6 did not meet research criteria, 3 refused to participate, and 4 did not return, having agreed to take part. In-patients undergoing methadone detoxification as part of the assessment and treatment at the National Addictions Service, Springfield University Hospital in London, patients on the waiting list for this programme, and those who had been through the addiction unit, but who were still on the recovery ward were approached to take part.

The main criteria for inclusion in the study was that the patient either was going through, had been through, or was intending to go through a methadone detoxification programme. This included people with a polydrug problem. It was reasoned that even if other drugs were involved, the effects of opiate withdrawal would still be prominent and liable to affect interrogative suggestibility. Possible applicants were screened for the following exclusion criteria. Those who had a learning disability, were unable to read, had a recognised severe memory deficit, or who were intoxicated at the time of interview were not eligible for inclusion in the study. In addition, those people who were assessed on the waiting list, but who did not subsequently enter treatment, were due to be excluded from the statistical analysis. This was to ensure that the treatment group were from the same population and not different from the waiting list group in terms of self-selection. In the event, it was not possible to exclude those who subsequently did not enter treatment due to the limited numbers involved.

Design
This was a between-participants design, where the participants were assessed at one point in time only. This was in order to get around the difficulty of repeating the GSS, which would be necessary in a within-participant design. It is argued that the repetition of the GSS may appear ‘false’ to the participant and that they may recognise the subterfuge.
For ethical and clinical reasons, it was not possible to randomly allocate participants to each group. Instead it was assumed that individuals were allocated to the detoxification group on the basis of the length of time spent on the waiting list, i.e. no one was prioritised. In view of this, it was assumed that there would be no significant differences between the groups.

Measures

**Substance Abuse Assessment Questionnaire (SAAQ; Ghodse, 1995)**
The SAAQ is a structured interview, which covers several areas relevant to the evaluation of treatment for opiate-dependency. It was used to obtain information on demographic characteristics, drug and alcohol use, and forensic history. These measures were used to compare the two groups and ensure that they did not differ significantly on background characteristics. The SAAQ consists of 10 subscales, although only 4 were deemed necessary for this study. These were:
- Initial information; concerns general demographic information, including sex, ethnic group, marital status, dependants, current living arrangements, accommodation, education, occupation.
- Drug-use assessment; concerns current and previous use of drugs.
- Alcohol use assessment; concerns current and previous use of drugs.
- Forensic assessment; concerns offences committed or convicted of.

Although the questions are structured, the scale has not been standardised as its major use is for clinical research. It was used, because it has the advantage of being designed for a British population and because it has been used for the same purposes as this research (e.g. Ghodse, 1995).

**National Adult Reading Test (NART; Nelson, 1991)**
The NART was used as a screening test to detect people with learning disabilities. Gudjonsson has reported that IQ correlates positively with interrogative suggestibility in people with below average IQ (Gudjonsson, 1992). Therefore it was necessary to control for this. The NART is a standardised test of reading ability. It consists of 50 words, which the participant is asked to read aloud. They are then scored according to
whether their pronunciation is correct or not. NART scores have been correlated with IQ scores obtained using the WAIS-R. The obtained NART score can be used to calculate a predicted IQ score for the WAIS-R.

This measure was thought to be more convenient than the combination of the Schonell Graded Word Reading Test and the WAIS-R as used in Murakami et al’s study (1996). Murakami (1996) used the Schonell to measure reading ability as it is considered to be more sensitive at the lower range. However, from her results, participants scored in the low average to high average IQ range. In view of this, the NART was appropriate for reading ability and could also be used to estimate IQ.

Nelson (1991) reports that the reliability coefficient of the NART using a split-half technique to be 0.93. The NART has been validated with patients with dementia (Nelson and McKenna, 1975: cited in Nelson, 1991) and with patients with evidence of bilateral cortical atrophy (Nelson and O’Connell, 1978: cited in Nelson, 1991) and was found to be a useful test of reading ability to estimate premorbid IQ levels in dementia.

**Opiate Withdrawal Symptom Questionnaire (OWSQ; Ghodse, 1995)**

The OWSQ was used to measure occurrence and severity of withdrawal symptoms. It was predicted that the 2 groups would differ in withdrawal symptom severity and so this scale was included to validate this. This is an 18-item questionnaire that allows the participant to rate the severity of any symptom from 0 (none) to 3 (very much/continuously). The participant is asked to complete the questionnaire themselves. Although this scale has not been standardised, it has been designed for a British population and has clinical validity (Ghodse, 1995).

**Gudjonsson Compliance Scale (GCS; Gudjonsson, 1997)**

The GCS was designed to measure uneasiness or fear of people in authority and avoidance of conflict and confrontation (Gudjonsson, 1989). Compliance was measured in order to distinguish suggestible responses form compliant ones. The GCS is a self-report questionnaire consisting of 20 true-false statements. It is the only standardised measure of compliance available. The internal reliability of the GCS, as
measured by Cronbach's alpha coefficient, is 0.71. Test-retest reliability for forensic patients tested 1 to 3 months apart was 0.88. The GCS has been found to correlate with other variables, to which it should be theoretically related, such as social desirability, neuroticism, and social conformity. Gudjonsson cites this as support of the scale's construct validity (Gudjonsson, 1992).

**Gudjonsson Suggestibility Scales (GSS; Gudjonsson, 1997)**
The GSS was designed to measure interrogative suggestibility. The scale assesses a person's responses to 'leading questions' and negative feedback', when being asked to answer questions on a short narrative. This is the key experimental measure that is expected to change. A short narrative is read to the participant, after which they must recall the story from memory. After a delay of 50 minutes, they must recall the story again and answer questions based on it. They are then given negative feedback i.e. that they got some questions wrong and must repeat all of them. They are also told to be more accurate. Any change to their previous answers contributes to the Shift score, while giving in to misleading questions is scored as Yield. The two scores are added together to give a Total Suggestibility score. This is the only available scale to assess interrogative suggestibility. Gudjonsson argues that the scale has high test-retest reliability in that the parallel form GSS2 correlated highly with GSS1. Construct validation studies on the GSS have been reviewed by Grisso (1986: cited in Gudjonsson, 1992), who indicates that this is a reliable and valid tool for measuring interrogative suggestibility.

**Severity of Dependence Scale (SDS; Gossop, Darke, Griffiths, Hando, Powis, Hall, and Strang, 1995)**
The SDS was designed to measure the degree of dependence experienced by users of different types of drugs. By measuring this variable, it was hoped to be able to control for it. The SDS contains 5 items, which are all linked to psychological components of dependence. The scale is given to participants to complete themselves. The SDS was chosen, because it was standardised on a similar population and is brief to administer. All of the items loaded on 1 factor. The scale was also found to correlate positively...
Interrogative Suggestibility and Opiate Withdrawal

for other indicators of dependence, such as dose, frequency of use, duration of use, daily use and degree of contact with other drug users (Gossop et al, 1995).

*Spielberger State-Trait Anxiety Inventory (Spielberger, 1969)*

The STAI was designed to assess state and trait levels of anxiety. Gudjonsson has reported that interrogative suggestibility is strongly associated with state anxiety. It was therefore necessary to attempt to control for this. The STAI consists of two tests, each containing twenty items. Participants are asked to rate themselves on 4-point scales with questions that refer to either their current (state) or their typical (trait) levels of anxiety. The STAI has been used in interrogative suggestibility research previously and has a standardised form for adults. This measure has relatively good test-retest correlations for the trait anxiety scale and high internal consistency for both scales.

**Procedure**

**Recruitment**

Participants were considered eligible according to the criteria described above. In-patients were approached on the second day after admission, while they were still being assessed for an appropriate starting level of methadone. In agreement with the Murakami et al study (1996), it was thought that a) withdrawal symptoms would be noticeable, but not too severe to prevent participation, and b) this length of time would be similar to being detained in police custody. There were no specific criteria for when to interview those on the waiting list. In-patients were seen on the ward, while those on the waiting list were seen at the clinic from which they were due to collect their prescription. Patients who were on the recovery ward following detoxification from opiates were also approached. Again there were no specific criteria for when to approach them.

Participants were informed of the aim of the study, that it was to look at the physical and psychological health of people going through detoxification. It was thought that to advise them of the true nature of the study would influence the results adversely.
This was the procedure suggested by the Murakami et al, 1996) study. Participants were then advised about confidentiality and asked to sign a consent form.

**Administration**

The tests were administered in the following fashion. The GSS1 was administered first and following the procedure described by Gudjonsson (1997). Participants were advised that it was a memory test and that their answers would be tape recorded for the ease of the examiner. The story was then read to them and they were asked to recall it. The second part of the GSS1 was administered 50 minutes later. During this time, the remaining measures were administered. This consisted of the state anxiety measure, the opiate withdrawal index, the four sub-tests from the SAAQ, the GCS, the NART, the trait anxiety inventory, and finally the SDS. After 50 minutes had elapsed, participants were asked to recall the earlier narrative. Following this, they were asked the leading 20 questions, given negative feedback and asked the questions again with the instructions to do better. Participants were then asked to complete the state anxiety inventory as a post-test measure with instructions to complete it according to “how they felt whilst answering the second set of questions”.

**Data analysis procedures**

Kruskall-Wallis One-Way ANOVAs were used to check for any differences between the groups that might indicate that they were from different populations. The same test was used to determine any difference between the groups in terms of suggestibility. Correlational analyses were conducted on all the experimental variables.
DATA ANALYSIS OF RESULTS

BACKGROUND VARIABLES

Background variables consisted of demographic data and variables that were known to have a likely influence on suggestibility, but that could be controlled. They were useful in considering whether the sample groups differ from each other.

Table 1: Mean, standard deviations, and range for background variables for whole sample (n=43)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard deviation (S.D.)</th>
<th>Range</th>
<th>Is there a normal distribution?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NART-estimated IQ</td>
<td>97.7</td>
<td>9.4</td>
<td>80-117</td>
<td>yes</td>
</tr>
<tr>
<td>Dependence</td>
<td>11.1</td>
<td>3.1</td>
<td>2-14</td>
<td>no</td>
</tr>
<tr>
<td>Age</td>
<td>33.4</td>
<td>8.0</td>
<td>18-52</td>
<td>yes</td>
</tr>
<tr>
<td>Education</td>
<td>10.8</td>
<td>1.3</td>
<td>6-13</td>
<td>no</td>
</tr>
<tr>
<td>Drug/no</td>
<td>11.4</td>
<td>3.4</td>
<td>6-24</td>
<td>no</td>
</tr>
<tr>
<td>Drug history</td>
<td>20.7</td>
<td>7.5</td>
<td>6-40</td>
<td>yes</td>
</tr>
<tr>
<td>Opiate history</td>
<td>11.2</td>
<td>7.0</td>
<td>2-30</td>
<td>yes</td>
</tr>
<tr>
<td>Previous treatments</td>
<td>3.4</td>
<td>1.6</td>
<td>1-6</td>
<td>yes</td>
</tr>
<tr>
<td>Conviction no</td>
<td>10.7</td>
<td>14.8</td>
<td>0-71</td>
<td>no</td>
</tr>
</tbody>
</table>

Overall

It can be seen that most of the variables have a wide spread with the exception of Education and Previous Treatments. Such wide spreads indicate the heterogeneity of background characteristics displayed in this population. There is no such thing as a typical 'addict'.
Education

The number of years spent in school (this does not include further education, such as degree courses etc.) would be expected to be about 11 years as this is a statutory requirement of children in this country. Interestingly perhaps, the mean falls just below this figure.

Previous Treatments

Previous Treatments refers to the number of types of previous treatment taken for addiction, rather than the number of treatments as such. Given the nature of services for people with addictions in Britain, it can be hard to say where one treatment ends and another begins. In view of this, it is easier to record the number of types of treatment that the individual has tried.

NART-Estimated IQ

All of the sample have an NART-estimated IQ within the normal range, with an equal spread around the population mean IQ of 100. This meets one of the major criteria set for participants for inclusion in the study.
Gender

Pie chart 1: Proportion of male to female participants

It can be seen that about a third of the participants were women. There is no reason to think that women are any less likely to suffer from problems of addiction than men and so this may not represent the entire population, but instead a more chaotic sub-population.
It can be seen that the majority of the population was white. This is due, at least in part, to the culture specificity of the tests, which meant that people were disadvantaged if they were not fluent in English.
Employment

Pie chart 3: Categories of employment

- other
- child care/housewife
- self-employed
- unemployed

It can be seen that the majority of the population sample were unemployed.

Differences between groups

It is assumed that each group is drawn from the same population. In order to check this, the groups were analysed for differences with respect to the background variables. Given that so many analyses were undertaken, a finding was taken as significant if its probability was less than 0.1.
### Table 2: Means and statistical differences between the sample groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>Detox Mean (SD) n=18</th>
<th>Waiting list Mean (SD) n=16</th>
<th>Recovery Mean (SD) n=9</th>
<th>Test of significance</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NART-estimated IQ</td>
<td>96.7 (9.4)</td>
<td>98.2 (9.3)</td>
<td>98.9 (10.4)</td>
<td>F=0.2</td>
<td>NS</td>
</tr>
<tr>
<td>Dependence</td>
<td>10.4 (3.8)</td>
<td>11.6 (2.2)</td>
<td>11.6 (2.7)</td>
<td>Chi2=0.5</td>
<td>NS</td>
</tr>
<tr>
<td>Age</td>
<td>30.9 (7.7)</td>
<td>34.9 (7.5)</td>
<td>35.9 (8.7)</td>
<td>F=1.6</td>
<td>NS</td>
</tr>
<tr>
<td>Education</td>
<td>10.8 (1.4)</td>
<td>10.9 (0.9)</td>
<td>10.4 (1.4)</td>
<td>Chi2=1.8</td>
<td>NS</td>
</tr>
<tr>
<td>Polydrug use Drug history</td>
<td>11.6 (3.9)</td>
<td>10.6 (3.3)</td>
<td>12.7 (2.4)</td>
<td>Chi2=4.0</td>
<td>NS</td>
</tr>
<tr>
<td>Drug history</td>
<td>18.6 (7.7)</td>
<td>21.8 (6.6)</td>
<td>22.9 (8.2)</td>
<td>F=1.3</td>
<td>NS</td>
</tr>
<tr>
<td>Opiate history</td>
<td>9.7 (7.3)</td>
<td>11.4 (5.3)</td>
<td>13.6 (9.0)</td>
<td>F=0.90</td>
<td>NS</td>
</tr>
<tr>
<td>Previous treatments</td>
<td>2.9 (1.4)</td>
<td>3.1 (1.5)</td>
<td>4.8 (1.4)</td>
<td>F=5.4</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Convictions</td>
<td>9.8 (13.0)</td>
<td>7.1 (6.5)</td>
<td>19.6 (25.1)</td>
<td>Chi2=1.1</td>
<td>NS</td>
</tr>
</tbody>
</table>

### Table 3: Statistical differences between groups for categorical variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Test of significance</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Fisher’s exact test</td>
<td>NS</td>
</tr>
<tr>
<td>Ethnic group</td>
<td>Fisher’s exact test</td>
<td>NS</td>
</tr>
<tr>
<td>Occupation</td>
<td>Fisher’s exact test</td>
<td>NS</td>
</tr>
<tr>
<td>Alcohol problem</td>
<td>Fisher’s exact test</td>
<td>NS</td>
</tr>
</tbody>
</table>

For the above table, a chi2 test was unreliable and Fisher’s Exact tests were used instead. This involved combining the Waiting List groups and Recovery groups.
The ratio of men to women for each group was as follows. For the Detox group, there were 11 men and 7 women. For the Waiting List group, there were 12 men and 4 women. For the Recovery group, there were 7 men and 2 women.

With the exception of Previous Treatments, the groups do not appear to differ significantly for background variables. It is assumed that the groups are all from the same population. Therefore, it is appropriate to conduct tests of difference and correlations with the experimental variables. However, it must be acknowledged that the large standard deviations and potentially skewed distributions for some variables, such as Convictions and Opiate History, may have lessened the chances of detecting significant between-group differences in the baseline measures.

The significant difference for Previous Treatments (F=5.4, p<0.01) may well be due to the nature of the Recovery group. This group is a selected sample of those who have been through the detoxification ward. As such, it represents a further type of treatment that many from the waiting list and from the detoxification ward do not reach. In view of this, one might expect it to be significantly different in terms of Previous Treatments. However, one cannot rule out the possibility of unmeasured variables having an influence on suggestibility, and so any analyses are repeated without the Recovery group in order to detect any difference.
Comparison data

Table 4: Comparing sample means with data from Murakami et al (1996) study

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sample mean (SD)</th>
<th>Detox mean (SD) (from Murakami et al, 1996)</th>
<th>Significance test</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>33.4 (8.0)</td>
<td>29.5 (5.1)</td>
<td>t=3.24</td>
<td>p=0.002</td>
</tr>
<tr>
<td>NART-estimated IQ</td>
<td>97.7 (9.4)</td>
<td>99.4 (15.3)</td>
<td>t=1.17</td>
<td>p=0.247</td>
</tr>
<tr>
<td>Drug history</td>
<td>20.7 (7.5)</td>
<td>12.3 (4.8)</td>
<td>t=-7.24</td>
<td>p=0.000</td>
</tr>
<tr>
<td>Opiate history</td>
<td>11.2 (7.0)</td>
<td>8.3 (4.8)</td>
<td>t=-2.62</td>
<td>p=0.012</td>
</tr>
<tr>
<td>Previous treatment</td>
<td>3.4 (1.6)</td>
<td>2.2 (2.1)</td>
<td>t=-4.84</td>
<td>p=0.000</td>
</tr>
<tr>
<td>Polydrug use</td>
<td>11.4 (3.4)</td>
<td>5.3 (1.2)</td>
<td>t=-11.69</td>
<td>p=0.000</td>
</tr>
<tr>
<td>Convictions</td>
<td>10.7 (14.8)</td>
<td>2.0 (2.2)</td>
<td>t=3.78</td>
<td>p=0.001</td>
</tr>
</tbody>
</table>
Table 5: Comparing sample means with data from Murakami et al (1996) study

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sample mean (SD)</th>
<th>Rehab mean (SD)</th>
<th>Significance test</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(from Murakami et al, 1996)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>33.4 (8.0)</td>
<td>31.7 (6.7)</td>
<td>t=1.43</td>
<td>p=0.159</td>
</tr>
<tr>
<td>NART-estimated IQ</td>
<td>97.7 (9.4)</td>
<td>96.3 (11.0)</td>
<td>t=0.99</td>
<td>p=0.326</td>
</tr>
<tr>
<td>Drug history</td>
<td>20.7 (7.5)</td>
<td>15.9 (7.0)</td>
<td>t=4.13</td>
<td>p=0.000</td>
</tr>
<tr>
<td>Opiate history</td>
<td>11.2 (7.0)</td>
<td>10.8 (6.7)</td>
<td>t=0.32</td>
<td>p=0.754</td>
</tr>
<tr>
<td>Previous treatment</td>
<td>3.4 (1.6)</td>
<td>2.3 (2.2)</td>
<td>t=4.42</td>
<td>p=0.000</td>
</tr>
<tr>
<td>Polydrug use</td>
<td>11.4 (3.4)</td>
<td>5.2 (1.6)</td>
<td>t=11.88</td>
<td>p=0.000</td>
</tr>
<tr>
<td>Convictions</td>
<td>10.7 (14.8)</td>
<td>5.9 (3.5)</td>
<td>t=2.09</td>
<td>p=0.043</td>
</tr>
</tbody>
</table>

This sample showed some similarities and some differences from the Murakami et al (1996) samples. In terms of age, NART-estimated IQ, opiate history, and previous treatments, there did not appear to be any differences. However there were large differences in drug history and polydrug use. It must be remembered that different questionnaires were used to collect this data. It is possible that the differences represent a difference in either the questionnaires or in the criteria used by the researchers. Drug history in this study includes the start of tobacco use. It is not clear if Murakami et al (1996) used the same criteria. Still it must be considered that this current sample may indeed differ from previous research. However it is argued that it
still is taken from the same population and may be more representative, given that it does not include people in rehabilitation.

**EXPERIMENTAL VARIABLES**

This section is concerned with the experimental variables related to the research hypotheses. It should be noted that because the Recovery group differed from the Detox and Waiting List groups in terms of previous treatments, the analyses were carried out both with and without the Recovery group.

Table 6: Means and statistical differences between the sample groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>Detox Mean (SD)</th>
<th>Waiting list Mean (SD)</th>
<th>Recovery Mean (SD)</th>
<th>Test of significance</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total suggestibility</td>
<td>13.7 (3.8)</td>
<td>12.2 (4.7)</td>
<td>12.9 (4.0)</td>
<td>F=0.5767</td>
<td>NS</td>
</tr>
<tr>
<td>Yield 1</td>
<td>6.7 (2.7)</td>
<td>6.1 (3.3)</td>
<td>6.9 (2.6)</td>
<td>F=0.2151</td>
<td>NS</td>
</tr>
<tr>
<td>Yield 2</td>
<td>10.4 (3.6)</td>
<td>8.2 (3.0)</td>
<td>7.4 (3.4)</td>
<td>F=3.0978</td>
<td>NS</td>
</tr>
<tr>
<td>Shift</td>
<td>7.0 (2.8)</td>
<td>6.1 (3.8)</td>
<td>6.0 (2.7)</td>
<td>F=0.4477</td>
<td>NS</td>
</tr>
<tr>
<td>State 1</td>
<td>51.9 (10.0)</td>
<td>48.0 (13.2)</td>
<td>39.9 (14.9)</td>
<td>F=2.8329</td>
<td>NS</td>
</tr>
<tr>
<td>State 2</td>
<td>47.9 (10.2)</td>
<td>46.6 (11.9)</td>
<td>47.4 (8.9)</td>
<td>F=0.0721</td>
<td>NS</td>
</tr>
<tr>
<td>Trait</td>
<td>52.2 (11.2)</td>
<td>54.4 (6.2)</td>
<td>51.3 (11.6)</td>
<td>F=0.3482</td>
<td>NS</td>
</tr>
<tr>
<td>Compliance</td>
<td>10.5 (4.0)</td>
<td>10.8 (4.1)</td>
<td>10.4 (5.2)</td>
<td>F=0.0304</td>
<td>NS</td>
</tr>
<tr>
<td>Recall 1</td>
<td>16.2 (4.3)</td>
<td>16.2 (8.5)</td>
<td>17.1 (5.4)</td>
<td>F=0.0656</td>
<td>NS</td>
</tr>
<tr>
<td>Recall 2</td>
<td>14.2 (5.0)</td>
<td>14.3 (7.5)</td>
<td>15.2 (5.2)</td>
<td>F=0.0945</td>
<td>NS</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>26.9 (12.7)</td>
<td>21.9 (7.7)</td>
<td>8.2 (12.7)</td>
<td>F=8.6090</td>
<td>p&lt;0.001</td>
</tr>
</tbody>
</table>
Table 7: Means and statistical differences between the sample groups, excluding Recovery group

<table>
<thead>
<tr>
<th>Variable</th>
<th>Detox Mean (SD)</th>
<th>Waiting list Mean (SD)</th>
<th>Test of significance</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>13.7 (3.8)</td>
<td>12.2 (4.7)</td>
<td>t=1.06</td>
<td>NS</td>
</tr>
<tr>
<td>suggestibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yield 1</td>
<td>6.7 (2.7)</td>
<td>6.1 (3.3)</td>
<td>t=0.52</td>
<td>NS</td>
</tr>
<tr>
<td>Yield 2</td>
<td>10.4 (3.6)</td>
<td>8.2 (3.0)</td>
<td>t=1.96</td>
<td>NS</td>
</tr>
<tr>
<td>Shift</td>
<td>7.0 (2.8)</td>
<td>6.1 (3.8)</td>
<td>t=0.78</td>
<td>NS</td>
</tr>
<tr>
<td>State 1</td>
<td>51.9 (10.0)</td>
<td>48.0 (13.2)</td>
<td>t=0.97</td>
<td>NS</td>
</tr>
<tr>
<td>State 2</td>
<td>47.9 (10.2)</td>
<td>46.6 (11.9)</td>
<td>t=0.36</td>
<td>NS</td>
</tr>
<tr>
<td>Trait</td>
<td>52.2 (11.2)</td>
<td>54.4 (6.2)</td>
<td>t=-0.72</td>
<td>NS</td>
</tr>
<tr>
<td>Compliance</td>
<td>10.5 (4.0)</td>
<td>10.8 (4.1)</td>
<td>t=-0.22</td>
<td>NS</td>
</tr>
<tr>
<td>Recall 1</td>
<td>16.2 (4.3)</td>
<td>16.2 (8.5)</td>
<td>t=-0.02</td>
<td>NS</td>
</tr>
<tr>
<td>Recall 2</td>
<td>14.2 (5.0)</td>
<td>14.3 (7.5)</td>
<td>t=-0.04</td>
<td>NS</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>26.9 (12.7)</td>
<td>21.9 (7.7)</td>
<td>t=1.37</td>
<td>NS</td>
</tr>
</tbody>
</table>

**Suggestibility**

There were no differences between the groups for any of the suggestibility variables.

**Anxiety**

There were no differences between the groups for any of the anxiety variables.

**Compliance**

There was no difference between the groups for compliance.

**Memory**

There was no difference between the groups for immediate or delayed recall.
Withdrawal

It was assumed at the outset that the groups would differ for severity of withdrawal symptoms. This needed to be verified before any further comparisons of the groups could take place. The Detox group was expected to differ from the Waiting List and Recovery groups, while there was not expected to be a significant difference between the Waiting List and Recovery groups. Although the groups did differ from each other \((F=0.0008, p<0.001)\), it was not in the manner expected.

The Scheffe test was used to identify which groups differed, because it is appropriate for uneven groups.

Table 8: Withdrawal means for each group and significance

<table>
<thead>
<tr>
<th></th>
<th>Detox group</th>
<th>Waiting List</th>
<th>Recovery group</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detox group</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>26.9</td>
</tr>
<tr>
<td>Waiting List group</td>
<td>NS</td>
<td>-</td>
<td>-</td>
<td>21.9</td>
</tr>
<tr>
<td>Recovery group</td>
<td>p&lt;0.05</td>
<td>p&lt;0.05</td>
<td>-</td>
<td>8.2</td>
</tr>
</tbody>
</table>

The Detox and Waiting List groups do not differ significantly for withdrawal. The Recovery group is significantly different from both the Detox and Waiting List groups. It would appear that people on the waiting list also suffered from withdrawal. The assumption that the Detox and Waiting List groups would differ on this variable is false. Interestingly, even in the recovery ward, some people were experiencing withdrawal symptoms.

However, the Recovery group is too small to compare with both the Detox and Waiting List groups combined. In view of this, the data was recoded into high and low withdrawal around the median and to see if these two groups differed in terms of suggestibility. This is similar to the approach taken by Davison and Gossop (1996),
who recoded suggestibility into high/low suggestibility. Given that withdrawal was originally seen as an independent variable, it makes sense to recode this instead of suggestibility, although the end result will be comparable.

**High and low withdrawal**

The participants were regrouped into two groups of either high or low withdrawal around the median value (median=20). These two groups were then compared for differences in suggestibility and memory.

**Table 9:** Means, standard deviations, and tests of significance for high/low withdrawal groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>High withdrawal Mean (SD)</th>
<th>Low withdrawal Mean (SD)</th>
<th>Test of significance</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>13.0 (4.6)</td>
<td>12.9 (3.4)</td>
<td>t=-0.12</td>
<td>NS</td>
</tr>
<tr>
<td>Suggestibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yield 1</td>
<td>6.5 (2.9)</td>
<td>6.7 (2.9)</td>
<td>t=0.21</td>
<td>NS</td>
</tr>
<tr>
<td>Yield 2</td>
<td>8.5 (3.6)</td>
<td>9.7 (3.5)</td>
<td>t=1.09</td>
<td>NS</td>
</tr>
<tr>
<td>Shift</td>
<td>6.6 (3.3)</td>
<td>6.2 (2.9)</td>
<td>t=-0.43</td>
<td>NS</td>
</tr>
<tr>
<td>Compliance</td>
<td>9.8 (3.4)</td>
<td>11.8 (5.0)</td>
<td>t=1.49</td>
<td>NS</td>
</tr>
<tr>
<td>State 1</td>
<td>51.0 (12.4)</td>
<td>43.6 (12.6)</td>
<td>t=-1.93</td>
<td>NS</td>
</tr>
<tr>
<td>State 2</td>
<td>46.8 (11.0)</td>
<td>48.1 (9.7)</td>
<td>t=0.42</td>
<td>NS</td>
</tr>
<tr>
<td>Trait</td>
<td>52.5 (9.0)</td>
<td>53.3 (10.7)</td>
<td>t=0.27</td>
<td>NS</td>
</tr>
<tr>
<td>Recall 1</td>
<td>15.8 (6.3)</td>
<td>17.1 (6.3)</td>
<td>t=0.68</td>
<td>NS</td>
</tr>
<tr>
<td>Recall 2</td>
<td>13.9 (5.8)</td>
<td>15.2 (6.3)</td>
<td>t=0.67</td>
<td>NS</td>
</tr>
</tbody>
</table>
Table 10: Means, standard deviations, and tests of significance for high/low withdrawal groups excluding Recovery group

<table>
<thead>
<tr>
<th>Variable</th>
<th>High withdrawal Mean (SD)</th>
<th>Low withdrawal Mean (SD)</th>
<th>Test of significance</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=23</td>
<td>n=11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total suggestibility</td>
<td>13.0 (4.7)</td>
<td>13.1 (3.3)</td>
<td>t=1.49</td>
<td>NS</td>
</tr>
<tr>
<td>Yield 1</td>
<td>6.4 (2.9)</td>
<td>6.6 (3.3)</td>
<td>t=0.57</td>
<td>NS</td>
</tr>
<tr>
<td>Yield 2</td>
<td>8.9 (3.3)</td>
<td>10.5 (3.8)</td>
<td>t=1.96</td>
<td>NS</td>
</tr>
<tr>
<td>Shift</td>
<td>6.7 (3.5)</td>
<td>6.5 (2.9)</td>
<td>t=1.51</td>
<td>NS</td>
</tr>
<tr>
<td>Compliance</td>
<td>9.7 (3.5)</td>
<td>12.7 (4.3)</td>
<td>t=2.23</td>
<td>p=0.033</td>
</tr>
<tr>
<td>State 1</td>
<td>50.6 (12.8)</td>
<td>48.9 (9.0)</td>
<td>t=0.39</td>
<td>NS</td>
</tr>
<tr>
<td>State 2</td>
<td>46.7 (11.3)</td>
<td>48.6 (10.4)</td>
<td>t=0.46</td>
<td>NS</td>
</tr>
<tr>
<td>Trait</td>
<td>51.5 (8.6)</td>
<td>56.7 (9.7)</td>
<td>t=1.59</td>
<td>NS</td>
</tr>
<tr>
<td>Recall 1</td>
<td>16.3 (6.3)</td>
<td>16.1 (7.2)</td>
<td>t=0.04</td>
<td>NS</td>
</tr>
<tr>
<td>Recall 2</td>
<td>14.1 (5.7)</td>
<td>14.5 (7.1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There is no significant difference between the high and low withdrawal groups for suggestibility. The groups only differed in terms of compliance and this was only so if the Recovery group was excluded.

**CORRELATIONAL VARIABLES**

As the groups did not differ as expected for the withdrawal measure, it was decided to continue analyses using correlations. It must be remembered that the measures were not chosen with correlations in mind.
<table>
<thead>
<tr>
<th>Recall 1</th>
<th>Recall 2</th>
<th>Compliance</th>
<th>Withdrawal</th>
<th>Truth</th>
<th>State 1</th>
<th>State 2</th>
<th>Truth</th>
<th>Yield 1</th>
<th>Yield 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interrogative Suggestibility and Opiate Withdrawal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 11: Correlations for experimental measures
### Table 1:

<table>
<thead>
<tr>
<th>State</th>
<th>Yield 1</th>
<th>Yield 2</th>
<th>Total Yield</th>
<th>Compliancy 1</th>
<th>Compliancy 2</th>
<th>Recall 1</th>
<th>Recall 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shih</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>State 2</td>
<td>0.0212</td>
<td>0.0220</td>
<td>0.0214</td>
<td>0.0228</td>
<td>0.0217</td>
<td>0.0214</td>
<td>0.0214</td>
</tr>
<tr>
<td>Shih</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>State</td>
<td>0.0532</td>
<td>0.0535</td>
<td>0.0534</td>
<td>0.0538</td>
<td>0.0537</td>
<td>0.0536</td>
<td>0.0536</td>
</tr>
<tr>
<td>Shih</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>State 2</td>
<td>0.0113</td>
<td>0.0128</td>
<td>0.0115</td>
<td>0.0132</td>
<td>0.0129</td>
<td>0.0126</td>
<td>0.0126</td>
</tr>
<tr>
<td>Shih</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>State 1</td>
<td>0.0797</td>
<td>0.0815</td>
<td>0.0803</td>
<td>0.0832</td>
<td>0.0827</td>
<td>0.0824</td>
<td>0.0824</td>
</tr>
<tr>
<td>Shih</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>State 2</td>
<td>0.1118</td>
<td>0.1131</td>
<td>0.1124</td>
<td>0.1162</td>
<td>0.1157</td>
<td>0.1154</td>
<td>0.1154</td>
</tr>
<tr>
<td>Shih</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Shih</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
</tbody>
</table>

**Correlations for experimental measures excluding the recovery group**

Interrogative Susceptibility and Opine Withdrawal
Interrogative Suggestibility and Opiate Withdrawal

Suggestibility
Post-test anxiety correlates significantly with total suggestibility and with Yield 1. It must also be noted that there is no significant correlation between suggestibility and withdrawal.

Memory
There is no significant correlation between suggestibility and memory unless the Recovery group is excluded, in which case, the correlation reaches significance.

Anxiety
Pre-test anxiety correlates with post-test anxiety and trait anxiety. If the Recovery group is excluded, the correlation between pre-test anxiety and trait anxiety does not reach significance.

Anxiety and withdrawal
Pre-test anxiety correlates with withdrawal, but post-test anxiety does not.

Anxiety and compliance
All anxiety measures correlate with compliance.
Normative data comparisons

Table 13: Detox group means compared with normative data for adults

<table>
<thead>
<tr>
<th>Variable</th>
<th>Detox mean (SD)</th>
<th>Adult norms mean (SD)</th>
<th>Significance test</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>13.7 (3.8)</td>
<td>7.5 (4.6)</td>
<td>t=6.97</td>
<td>p=0.000</td>
</tr>
<tr>
<td>Yield 1</td>
<td>6.7 (2.7)</td>
<td>4.6 (3.0)</td>
<td>t=-3.29</td>
<td>p=0.004</td>
</tr>
<tr>
<td>Yield 2</td>
<td>10.4 (3.6)</td>
<td>5.6 (3.8)</td>
<td>t=-5.66</td>
<td>p=0.000</td>
</tr>
<tr>
<td>Shift</td>
<td>7.0 (2.8)</td>
<td>2.9 (2.5)</td>
<td>t=-6.29</td>
<td>p=0.000</td>
</tr>
<tr>
<td>Compliance</td>
<td>10.5 (4.0)</td>
<td>9.0 (3.5)</td>
<td>t=1.58</td>
<td>p=0.132</td>
</tr>
<tr>
<td>Recall 1</td>
<td>16.2 (4.3)</td>
<td>21.3 (7.1)</td>
<td>t=5.03</td>
<td>p=0.000</td>
</tr>
<tr>
<td>Recall 2</td>
<td>14.2 (5.0)</td>
<td>19.5 (7.5)</td>
<td>t=4.54</td>
<td>p=0.000</td>
</tr>
</tbody>
</table>

Table 14: Detox group means compared with normative data for court referrals

<table>
<thead>
<tr>
<th>Variable</th>
<th>Detox mean (SD)</th>
<th>Court referral norms mean (SD)</th>
<th>Significance test</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>13.7 (3.8)</td>
<td>10.2 (5.7)</td>
<td>t=-3.95</td>
<td>p=0.001</td>
</tr>
<tr>
<td>Yield 1</td>
<td>6.7 (2.7)</td>
<td>5.9 (3.7)</td>
<td>t=-1.27</td>
<td>p=0.220</td>
</tr>
<tr>
<td>Yield 2</td>
<td>10.4 (3.6)</td>
<td>7.3 (4.2)</td>
<td>t=-3.67</td>
<td>p=0.002</td>
</tr>
<tr>
<td>Shift</td>
<td>7.0 (2.8)</td>
<td>4.3 (3.2)</td>
<td>t=-4.14</td>
<td>p=0.001</td>
</tr>
<tr>
<td>Compliance</td>
<td>10.5 (4.0)</td>
<td>11.1 (4.5)</td>
<td>t=-0.63</td>
<td>p=0.535</td>
</tr>
<tr>
<td>Recall 1</td>
<td>16.2 (4.3)</td>
<td>12.0 (7.4)</td>
<td>t=-4.08</td>
<td>p=0.001</td>
</tr>
<tr>
<td>Recall 2</td>
<td>14.2 (5.0)</td>
<td>10.2 (7.1)</td>
<td>t=-3.42</td>
<td>p=0.003</td>
</tr>
</tbody>
</table>
### Table 15: Waiting List group means compared with normative data for adults

<table>
<thead>
<tr>
<th>Variable</th>
<th>Waiting List mean (SD)</th>
<th>Adult norms mean (SD)</th>
<th>Significance test</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total suggestibility</td>
<td>12.2 (4.7)</td>
<td>7.5 (4.6)</td>
<td>t=-4.02</td>
<td>p=0.001</td>
</tr>
<tr>
<td>Yield 1</td>
<td>6.2 (3.3)</td>
<td>4.6 (3.0)</td>
<td>t=-1.94</td>
<td>p=0.071</td>
</tr>
<tr>
<td>Yield 2</td>
<td>8.2 (3.0)</td>
<td>5.6 (3.8)</td>
<td>t=-3.43</td>
<td>p=0.004</td>
</tr>
<tr>
<td>Shift</td>
<td>6.1 (3.8)</td>
<td>2.9 (2.5)</td>
<td>t=-3.43</td>
<td>p=0.004</td>
</tr>
<tr>
<td>Compliance</td>
<td>10.8 (4.1)</td>
<td>9.0 (3.5)</td>
<td>t=1.78</td>
<td>p=0.095</td>
</tr>
<tr>
<td>Recall 1</td>
<td>16.2 (8.5)</td>
<td>21.3 (7.1)</td>
<td>t=2.40</td>
<td>p=0.030</td>
</tr>
<tr>
<td>Recall 2</td>
<td>14.3 (7.5)</td>
<td>19.5 (7.5)</td>
<td>t=2.78</td>
<td>p=0.014</td>
</tr>
</tbody>
</table>

### Table 16: Waiting List group means compared with normative data for court referrals

<table>
<thead>
<tr>
<th>Variable</th>
<th>Waiting List mean (SD)</th>
<th>Court referral norms mean (SD)</th>
<th>Significance test</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total suggestibility</td>
<td>12.2 (4.7)</td>
<td>10.2 (5.7)</td>
<td>t=-1.70</td>
<td>p=0.109</td>
</tr>
<tr>
<td>Yield 1</td>
<td>6.2 (3.3)</td>
<td>5.9 (3.7)</td>
<td>t=-0.35</td>
<td>p=0.730</td>
</tr>
<tr>
<td>Yield 2</td>
<td>8.2 (3.0)</td>
<td>7.3 (4.2)</td>
<td>t=-1.18</td>
<td>p=0.258</td>
</tr>
<tr>
<td>Shift</td>
<td>6.1 (3.8)</td>
<td>4.3 (3.2)</td>
<td>t=-1.94</td>
<td>p=0.071</td>
</tr>
<tr>
<td>Compliance</td>
<td>10.8 (4.1)</td>
<td>11.1 (4.5)</td>
<td>t=-0.28</td>
<td>p=0.781</td>
</tr>
<tr>
<td>Recall 1</td>
<td>16.2 (8.5)</td>
<td>12.0 (7.4)</td>
<td>t=-1.99</td>
<td>p=0.065</td>
</tr>
<tr>
<td>Recall 2</td>
<td>14.3 (7.5)</td>
<td>10.2 (7.1)</td>
<td>t=-2.17</td>
<td>p=0.046</td>
</tr>
</tbody>
</table>
Table 17: Recovery group means compared with normative data for adults

<table>
<thead>
<tr>
<th>Variable</th>
<th>Recovery mean (SD)</th>
<th>Adult norms mean (SD)</th>
<th>Significance test</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>12.2 (4.7)</td>
<td>7.5 (4.6)</td>
<td>t=-4.09</td>
<td>p=0.003</td>
</tr>
<tr>
<td>suggestibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yield 1</td>
<td>6.2 (3.3)</td>
<td>4.6 (3.0)</td>
<td>t=-2.67</td>
<td>p=0.028</td>
</tr>
<tr>
<td>Yield 2</td>
<td>8.2 (3.0)</td>
<td>5.6 (3.8)</td>
<td>t=-1.65</td>
<td>p=0.138</td>
</tr>
<tr>
<td>Shift</td>
<td>6.1 (3.8)</td>
<td>2.9 (2.5)</td>
<td>t=-3.45</td>
<td>p=0.009</td>
</tr>
<tr>
<td>Compliance</td>
<td>10.8 (4.1)</td>
<td>9.0 (3.5)</td>
<td>t=0.84</td>
<td>p=0.427</td>
</tr>
<tr>
<td>Recall 1</td>
<td>16.2 (8.5)</td>
<td>21.3 (7.1)</td>
<td>t=2.36</td>
<td>p=0.046</td>
</tr>
<tr>
<td>Recall 2</td>
<td>14.3 (7.5)</td>
<td>19.5 (7.5)</td>
<td>t=2.47</td>
<td>p=0.039</td>
</tr>
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</table>

Table 18: Recovery group means compared with normative data for court referrals

<table>
<thead>
<tr>
<th>Variable</th>
<th>Recovery mean (SD)</th>
<th>Court referral norms mean (SD)</th>
<th>Significance test</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>12.2 (4.7)</td>
<td>10.2 (5.7)</td>
<td>t=-2.04</td>
<td>p=0.075</td>
</tr>
<tr>
<td>suggestibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yield 1</td>
<td>6.2 (3.3)</td>
<td>5.9 (3.7)</td>
<td>t=-1.15</td>
<td>p=0.282</td>
</tr>
<tr>
<td>Yield 2</td>
<td>8.2 (3.0)</td>
<td>7.3 (4.2)</td>
<td>t=-0.13</td>
<td>p=0.901</td>
</tr>
<tr>
<td>Shift</td>
<td>6.1 (3.8)</td>
<td>4.3 (3.2)</td>
<td>t=-1.89</td>
<td>p=0.095</td>
</tr>
<tr>
<td>Compliance</td>
<td>10.8 (4.1)</td>
<td>11.1 (4.5)</td>
<td>t=-0.38</td>
<td>p=0.714</td>
</tr>
<tr>
<td>Recall 1</td>
<td>16.2 (8.5)</td>
<td>12.0 (7.4)</td>
<td>t=-2.81</td>
<td>p=0.023</td>
</tr>
<tr>
<td>Recall 2</td>
<td>14.3 (7.5)</td>
<td>10.2 (7.1)</td>
<td>t=-2.90</td>
<td>p=0.020</td>
</tr>
</tbody>
</table>
Table 19: Group means and normative data for anxiety

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sample group (female) Mean (SD)</th>
<th>Adult (male) Mean (SD)</th>
<th>Detox Mean (SD)</th>
<th>Rehab Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State 1</td>
<td>47.9 (12.9)</td>
<td>35.2 (10.6)</td>
<td>35.7 (10.4)</td>
<td>47.0 (12.0)</td>
</tr>
<tr>
<td>State 2</td>
<td>47.3 (10.4)</td>
<td>35.2 (10.6)</td>
<td>35.7 (10.4)</td>
<td>45.1 (11.1)</td>
</tr>
<tr>
<td>Trait</td>
<td>52.8 (9.6)</td>
<td>34.9 (9.2)</td>
<td>34.8 (9.2)</td>
<td>49.5 (9.5)</td>
</tr>
</tbody>
</table>
DISCUSSION OF RESULTS

Summary of hypotheses and what was expected

Before a discussion of the results and their implications, it may help to consider the original hypothesis and what was expected. According to Gudjonsson and Clark's model, interrogative suggestibility is related to the factors of uncertainty, interpersonal trust, and expectation. It has been argued that the experience of opiate withdrawal syndrome may influence the factor of uncertainty. In view of this, the main hypothesis of this study was that the presence of opiate withdrawal symptoms would make a person more suggestible to leading questions. It was predicted that the Detox group would show significantly higher suggestibility scores than the Waiting List group and the Recovery group. An underlying assumption was that all three groups would differ significantly for withdrawal symptomology.

A further hypothesis was that any effect of withdrawal on suggestibility would be mediated by the variables of anxiety and memory for recall. State-dependent anxiety has been associated with withdrawal by previous authors and was hypothesised to increase the factor of uncertainty. It was expected that the Detox group would show significantly more state-dependent anxiety than the Waiting List or Recovery groups. Memory for recall has been negatively associated with suggestibility and was hypothesised to be adversely affected by the effects of withdrawal, i.e. a person may concentrate less on trying to recall things, because they are feeling unwell. It was predicted that the Detox group would show a poorer memory for recall than both the Waiting List or Recovery groups.

Finally, it was recognised that compliance may be a confounding factor. This was measured, but with the expectation that it would not vary between the groups.

Suggestibility

Contrary to expectations, there were no differences between the Detox, Waiting List, and Recovery groups for suggestibility. There was a slight trend for the Detox group to be higher for total suggestibility, Yield 2, and Shift. These differences were small
and were not considered statistically significant. It is unlikely, given how small the differences are, that they would be clinically significant. This said, it is reasonable to concluded that the groups did not differ in terms of suggestibility.

One can consider two possible explanations for this result. It is possible that one must reject the alternative hypothesis and conclude that there is no association between withdrawal and interrogative suggestibility. If this were so, then it would be in support of Davison and Gossop's findings, where they also failed to find a direct association. This idea will be considered in more detail when one come to discuss withdrawal in more detail. It may still be possible, as they suggest, that there is a sub-group of individuals who do become more suggestible when on opiates. However, this was not testable using this research design.

Some of the correlations could be interpreted as being in support of the hypothesis, but only tentatively. Yield and Shift both contributed about 50% to the variance of total suggestibility, but this is hardly surprising as they both make up the measure of total suggestibility. Yield 2, which is not generally reported as a suggestibility measure, was found to correlate significantly with Yield 1 and Shift. Again this would be expected and provides some evidence of internal validity for the measure. The correlations that are more interesting are those between Yield 1 and post-test anxiety (State 2) and between Yield 1 and Recalls 1 and 2. Similar correlations are found with Yield 2, but not with Shift. These shall be discussed in detail under the respective variables of anxiety or memory recall. A further note of caution should be made regarding the strength of correlations. With the exception of Yield and shift, nothing correlated with total suggestibility more than \( r=0.32 \). This means than most of the experimental variables could not account for more than 10% of the variance. Although a correlation may possibly be proved significant if a larger sample were used, one would not consider it clinically significant if it accounted for less than 10% of the variance.

**Withdrawal**

Withdrawal did differ between the groups, but not in the manner suggested. The recovery group had lower withdrawal than either the Detox or Waiting List groups as
expected. However, there was no difference between the Detox or Waiting List groups themselves.

Such a result severely compromises the ability of this study to test Gudjonsson and Clark’s model of interrogative suggestibility. The implication is that the Detox and Waiting List groups both suffered high levels of withdrawal symptomology. It had been assumed that those on the Waiting List were reasonably well-controlled methadone users. However, it must be concluded that their use was not well controlled and indeed probably quite chaotic. There was some evidence of this in the apparent difficulty in recruiting subjects. This will be discussed further under ‘limitations of study’. given that the Detox and Waiting List groups did not differ for withdrawal, this design cannot be considered a reasonable test of the hypothesis, and so by implication, not a reasonable test of the Gudjonsson and Clark model.

One solution to the unhelpful distribution of withdrawal is to artificially redistribute it into two groups of high and low withdrawal. There is a precedent for this. Davison and Gossop (1996), after finding no differences in suggestibility between their groups decided to divide the whole sample into high suggestibility and low suggestibility around the median. It was felt in this study that it would be more appropriate to divide the group according to withdrawal as this was considered a more likely independent variable and more appropriate to the original research question. It was seen that there was no significant difference for suggestibility between the groups.

There was no evidence from the correlations to support the hypothesis that withdrawal was associated with suggestibility. The only experimental variable that correlated with withdrawal was pre-test anxiety. This itself had been expected. Previous research has identified a link between withdrawal and anxiety, and this would seem to support that with pre-test anxiety accounting for about 30% of the variance of withdrawal. However, the lack of any other significant correlations is disappointing. The evidence is in favour of the null hypothesis, suggesting that withdrawal is not associated with suggestibility.
Anxiety

There were no differences between the Detox, Waiting List, and Recovery groups, which was contrary to what was expected. State anxiety was expected to differ between the groups. There was a trend for pre-test anxiety to be lower for the Recovery group than for either the Detox or the Waiting List groups, but this did not reach significance. There were no apparent trends for State 2 or Trait anxiety. It would appear that only the Recovery group showed a within-subjects difference in that post-test anxiety was higher than pre-test anxiety.

There was no significant difference between the high and low withdrawal groups for anxiety. There was a slight trend for State 1 to be higher for high withdrawal and for Trait to be higher for low withdrawal, however these differences were felt to be too small to be clinically significant.

In light of the withdrawal and suggestibility results, these findings do not yet indicate that the null hypothesis should be accepted. The lack of difference in state anxiety between groups does not support the idea that state anxiety is associated with withdrawal or suggestibility. Given that the groups did not differ for withdrawal, it would be odd if they then differed for anxiety. Although this does not support the initial hypothesis, it also does not mean that it should be rejected. The same can be said for the trait measure. It was not expected to find a difference between the groups, regardless of how subjects were distributed in terms of suggestibility. The one anomaly appears to be the trend for the Recovery group to have a lower pre-test anxiety score that increases following the interview. This suggests that people who are not experiencing withdrawal find the interview experience anxiety-provoking in some way. For those already experiencing some withdrawal, it may be that the interview cannot make them more anxious than they already are.

The correlations between Yield 1 and post-test anxiety and between total suggestibility and post-test anxiety may not support the hypotheses as they appear to. It was predicted that state anxiety would correlate with suggestibility and particularly yield, but only as a mediating variable for withdrawal. Pre-test anxiety was found to
Interrogative Suggestibility and Opiate Withdrawal

correlate with withdrawal, but not with suggestibility. Post-test anxiety correlated with suggestibility, but only when the Recovery group was included. However when the Recovery group is excluded, the amount of variance in suggestibility that State 2 accounts for decreases from 9% (Yield 1) or 10% (total suggestibility) to 6.8%. It would seem that the interview experience is associated with some increase in anxiety, but only in the Recovery group where anxiety was slightly lower to start with.

Another possibility is that state anxiety pre and post is associated with suggestibility as predicted by the hypothesis, and that more subjects are required to reach significance. However the correlations between State 1 and suggestibility appear low (accounting for less than 10% of variance) and one would argue that the trend is not sufficient to support this idea. In summary, it would appear that state anxiety is not associated with suggestibility to any significant extent in this sample.

**Memory for recall**

There were no differences between the groups for memory recall, which was contrary to expectations. Initially, it was expected that the groups would differ for recall as well as for suggestibility and anxiety. However, there were no significant differences or apparent trends between the groups. There was a trend for Recall 2 to be lower than Recall 1. The Recovery group mean was about 1 point higher than the Detox or Waiting List groups, however such a difference is perhaps too small to be considered a trend. In addition, such a small difference would not be of clinical significance.

There were no significant differences between the high and low withdrawal groups for recall. There was a slight trend for the high withdrawal group to have the lower recall, however this did not hold when the Recovery group was excluded. This would suggest that recall is higher in the Recovery group than in the others. This could suggest a weak relationship between recall and suggestibility.

The lack of significant findings does not immediately rule out the alternative hypothesis. Although one had expected to find a difference between the groups, this was on the assumption that one found a difference in suggestibility. Considering that the results were not significant for suggestibility, one would not expect to find a
difference for recall either. Again the results do not support the original hypothesis, but it cannot be rejected yet either.

The correlations do not appear to support the study hypothesis. It was expected that recall would correlate negatively with suggestibility and withdrawal. There was no correlation with withdrawal. Correlations between Yield 1 and recall were only significant when the Recovery group was excluded. Correlations between Yield 2 and recall also became more significant when the Recovery group was excluded. If recall affected yield through affecting concentration and so uncertainty, one would expect the correlation between yield and recall to hold with or without the Recovery group. The fact that the correlation increases when the Recovery group is excluded suggests that the relationship does not hold true for the Recovery group. There are two possible explanations for this. There could be a ceiling effect of yield. It is possible that over a certain level, recall ceases to affect yield, which is plausible. One might expect there to be a point over which, the individual is satisfied with his or her memory recall. However, for this to be so, one would expect a significant difference in recall between the Recovery group and the Detox and Waiting List groups. This is not evident. Another possible explanation is that maybe people in withdrawal attribute their poor memory to that state. Such an attribution may compel them to be more suggestible. However, for those not in withdrawal, poor recall may be seen as a trait and attributed to own failings. This may provoke cognitive strategies along the line of “If I cannot remember, I cannot reasonably answer the question.”.

Compliance
As expected, there was no difference between the groups for compliance. There were no significant differences in the means and no likely looking trends.

There was no significant difference between the high and low withdrawal groups for compliance unless the Recovery group was excluded. As expected, most of the Recovery group were taken from the low withdrawal group. This suggests that for the Recovery group, the compliance mean must decrease the average. However there is
no obvious difference between the means of the groups. One can argue that the uneven numbers of the three groups could exaggerate any difference.

One would not have expected compliance to alter, regardless of how suggestibility was distributed within and between the groups. This merely confirms the null hypothesis for this variable. This result is less interesting without any significant differences in suggestibility between the groups. However, it does support the idea that compliance, as a trait, does not alter according to withdrawal.

Contrary to expectations, there was an association between compliance and anxiety. The compliance measure was found to correlate with State 1, State 2, and Trait. This association held even then the Recovery group was excluded. This raises several possibilities. It may be that anxiety still affects uncertainty, which leads to a more compliant response. It could also be that more compliant people will feel anxious following negative feedback as they may not see how to put the situation right. This need not affect their suggestibility. Indeed one might expect anxiety to go down if they became more suggestible as the may feel that they were making the right response at last. I could also be that coping strategies mediate between trait anxiety and compliance. i.e. Anxious people may use avoidance strategies, such as being compliant, in order to cope with or avoid difficulties.

**Normative Data**

It is useful to consider how this sample is representative of the population of opiate-dependent individuals as a whole. It has already been argued that the individual groups differ from each other with regard to background variables. The SAAQ is a clinical instrument and therefore only able to give qualitative data. As such, it does not provide any normative data. In view of this, it was decided to compare the current sample with the data provided in the Murakami et al (1996) study. In theory, the current study was assessing the same client population, particularly so for the Detox group.
Although there are some significant differences between the samples, it is argued that these are likely to be due to measurement differences or that such differences are unlikely to be significant in terms of the model being tested. The samples do not differ in terms of estimated-IQ or length of opiate history. It is important that estimated-IQ does not differ, because as has already been reported, a lowered IQ is negatively associated with suggestibility. It is not thought that the length of opiate history should necessarily affect suggestibility, although it could be argued that coping strategies could be linked with duration of opiate use. However, given the wide variation in age, one would expect a variation in coping strategies. In addition, there will be other factors that affect development of coping strategy and age is likely to be of minimal importance. In summary, these findings would fit the hypothesis that the samples, although divided by time, have been drawn from the same population.

However, there are several background variables that do appear to differ between the samples. These are length of drug history, number of previous treatments, and polydrug use. The sample also differs from Murakami’s Detox group for age and for number of convictions. A likely explanation for the first 3 categories, is that they are not comparable between the groups. Different questionnaires were used and it is possible that these contained different measurement criteria. For example, in the current study the length of drug history usually included the age at which the person started smoking. This may have inadvertently lengthened the drug history if the same criteria were not applied in the Murakami et al (1996) study. The same could be said of previous treatments and polydrug use. One must also consider the variables of age and number of convictions. It has already been argued that differences of age are not theorised to be important. Indeed Gudjonsson (1992) has reported that no significant relationship has been found among adults for age and suggestibility or compliance. The number of convictions cannot be explained away as above. It has been shown to influence suggestibility (Gudjonsson 1992). The sample does not differ significantly from the Rehab group, but only from the Detox group. This may be skewed by the larger mean in the Recovery group. It is possible that this represents a real difference between the groups. However, it must be remembered that comparisons are being
made with another sample and not a population mean. This result should not make us overly cautious.

When this sample is compared with the population normative data provided by Gudjonsson, it would suggest that opiate-dependent individuals are more suggestible. All of the groups differ from Gudjonsson’s adult normative data for suggestibility, but the data is not conclusive. This difference appears to vary across the groups. The Detox group differs on all suggestibility measures as well as for recall. The Waiting List group only differs for total suggestibility, Yield 2 and Shift. The Recovery group only differs for total suggestibility. This would suggest that the groups differed for suggestibility, but this is not evident in difference scores between the groups. The data here appears equivocal. The sample does appear to be more suggestible than an adult population, but it can not be said that the groups differ in suggestibility between each other. It was also noted that the samples did not differ from Gudjonsson’s norms in terms of compliance. There was no reason to expect that they would.

There is some support for using court referral normative data as comparative data. Neither the Waiting List or Recovery groups differ significantly from the court referral normative data. The Detox group was significantly higher than the court referral normative data. This was expected. If one consider the number of convictions for each group, it appears that the court referral and opiate-dependent individuals are likely to overlap.

**Background variables**

There are some findings from the background variables that warrant discussion. The sample appears to be heterogeneous. By this it is meant that for most of the background variables, such as age, polydrug use, opiate history, and number of convictions, there was a wide spread. There is unlikely to be a typical profile for an opiate-abuser. This is something to consider when deciding on selection criteria. It can be hard enough recruiting opiate-dependent individuals, let alone selecting them on more narrow criteria. This is not to say that one should select anyone, but it is an indication of the difficulties of research in this group.
Some explanation needs to be considered for the ethnic and gender make-up of this sample. There was a ratio of about 2 men to 1 woman. Although not expected, this does appear to be the trend for addiction services generally (Davis, 1998; personal communication). It may be that this service deters women. It is not suitable for those with child-care commitments to spend about 6 weeks in hospital. One must also consider that in this culture, it may be that it is more acceptable for men to admit to a drug addiction than for women.

The ethnic make-up of the sample was essentially white. It is unlikely that addiction problems are confined to the white population. It is possible that people from minority groups are not encouraged to attend the addictions service. This could be due to inappropriate outreach programmes. Within the detoxification unit itself, it is possible that minority groups feel uncomfortable and do not wish to return or encourage others. It is likely, then, that this sample does not represent the entire addictions population. However, it is likely to representative of those who attend this aspect of the addictions service.

Limitations of study
Before drawing any definite conclusions, one must consider the limitations of the study. The withdrawal and compliance measures may have been too broad-based to give meaningful information. Withdrawal information was based on the previous 24 hours. This would appear to be necessary, given that some of the symptoms would not be expected to be continuous, such as diarrhoea. However, it was observed that for some individuals, withdrawal symptoms appeared to fluctuate during the day. Indeed in two cases, the participant felt unable to manage the interview in the afternoon, but was able to do it the evening. The implication is that it was possible for participants to rate themselves highly on withdrawal symptomology without necessarily feeling that uncomfortable when they undertook the suggestibility measure. A similar argument can be put forward for the compliance measure. The GCS measures compliance as a trait, but several participants reported that their responses would be different in different situations, for example, if they were drug-free. It would be interesting to see
whether compliance varies according to a person’s state. Several participants reported that they would comply with police requests and questions simply because they wanted to escape the situation quickly. This would have serious consequences in itself for the validity of any confessions.

The validity of the withdrawal scale as a research measure also limits analysis of the results. It is acknowledged that the withdrawal measure may not represent a fixed interval scale and there has been no research into its psychometric properties. The measure was only intended to be used as a clinical instrument in order to check that the groups did indeed differ for withdrawal. It was not chosen to be used in correlational analyses. Indeed, it was a post-hoc decision to look at correlational analyses. Therefore, any differences or lack of may actually be due to weaknesses in the scale.

Given that the psychometric properties of the withdrawal scale have not been established, it may be that the division of the sample into high and low withdrawal around the median was not the best analysis. Another possibility was to choose a more extreme dichotomy, such as presence of withdrawal or no withdrawal. Although, given the distribution of results with this sample, such an analysis would not have worked in this study, it may be worth considering in future studies. Upon reflection, it is considered that an analysis of data using a grouping of high or low suggestibility may have been more appropriate.

The study design could not accurately reflect a police interrogation. Participants were not detained against their will and there was no potentially significant outcome for them as a result of the interview as there may have been if they were being interrogated. In view of this, the suggestibility measure may appear far removed from the reality of their experiences with police for many participants. This is perhaps a necessary limitation of the study. It would not be ethical to recreate the police interrogation situation. In view of this, it is likely that the measures for anxiety and suggestibility could be lower than would reasonably be expected from an interrogation situation. Therefore any significant difference may be masked.
There is some question over the validity of self-report measures. It can be argued that estimates of drug-use, for example, may be an over-estimate in order to be allowed more prescribed medication. This is a difficult argument to refute. However, the researcher attempted to distance himself as much as was appropriate from responsibility over the participant’s treatment. In addition, it would appear that participants would have little to gain from distorting the truth. Payne-James, Dean, and Keys (1994) cite a study by Brown, Kranzler, and Del Boca (1992) that suggests that self-reporting concerning the use of drugs is valid.

It is possible that lack of expected results may be due to the limitations in the design of the study. It is feasible that a larger sample may have produced a more significant association between withdrawal and suggestibility, although there do not appear to be any trends to support this. The discrepancy between a police interview and a research interview may result, as said before, in a less extreme range of suggestibility scores. In addition, the measures used, particularly for withdrawal, may have been too broad to show a relationship. By this, it is meant that the timing of measures is likely to be important for this research question. If too wide a range of time is covered, then the resulting measure may not be relevant.

Even if one were to reject the null hypothesis, and accept an association between withdrawal and suggestibility, it may be that there are intervening variables. The most likely would include personality traits, such as self-esteem and coping strategies. Reactions to withdrawal symptomology may be in part mediated by such traits, which in turn would affect suggestibility.

**Generalisability**

Differences between studies and the scarcity of normative data for this population make it hard to generalise for the findings. This study has considered a similar population to that sampled by Murakami et al (1996). However, the use of some different measures (SAAQ versus OTI) mean that it is hard to say whether any differences are real or are due to different measurement criteria. This difficulty is
compounded by the lack of appropriate normative data for a UK population of opioid-dependent individuals.

It is possible that this current sample represents a chaotic sub-group of the population. There were considerable difficulties involved in recruitment, which would point to this. Although the majority of those asked on the Detox unit agreed to take part, it was very difficult even to meet those on the Waiting List. Individuals could be given an appointment day, rather than appointment time in order to collect their prescription and meet their key-worker. It was very common for the client not to attend that day and they then might not contact the service again for weeks. Even when they were met and asked to participate, several individuals agreed to do it at a later date and then were not seen for days or weeks. It must be emphasised that this is an extremely difficult population to carry out research with. It is possible that those people on the waiting list for detoxification at the in-patient unit were actually too chaotic to undergo detoxification in the community. Such individuals may differ in environmental and intrapersonal variables from the rest of the opiate-dependent population. It is not possible to say this conclusively. Indeed it may well be that those who volunteered from the Waiting List group differed from those who volunteered in the Detox group. However, the results do not seem to support this.

A further difficulty in generalising from the results is that participants were not selected randomly. It was hoped that by taking people in the order in which they were admitted for Detox and the order on the waiting list, that this would approximate to randomisation. However, it was not feasible to see people in any order for the Waiting List. It was also apparent that some individuals would be prioritised on the basis of clinical need, usually related to pregnancy. Again this may have resulted in a more chaotic sub-population being sampled.

The problem of standardisation with regard to withdrawal may also limit generalisation. Participants were interviewed on their second day of assessment, following Murakami et al’s (1996) protocol. Although this was closer to what could be expected in a police interview situation, it meant that the level of withdrawal could
not be explicitly controlled. However, it was likely that in setting a more specific withdrawal level, then some subjects would have discharged themselves before reaching this level. This was an unfortunate trade-off that had to be considered.
CONCLUSIONS

It would appear that this research design has not been a good test of the research question. There was no difference between the Detox and Waiting List groups in terms of withdrawal. This makes it hard to conclude anything from the lack of difference in suggestibility between the groups. However, it has still been possible to consider the research question using the correlations of variables, although the inappropriateness of the withdrawal measure for this further limits conclusions.

It would appear that suggestibility is not affected by withdrawal. There are no significant correlations between withdrawal and suggestibility or even any likely looking trends. Indeed the highest correlation with total suggestibility was State 2. This only accounted for about 10% of the variance of suggestibility. Even if other correlations could be shown by more powerful analyses to be significant, they would not account for an important or interesting amount of variance.

However, there is some support for the mechanisms of anxiety and recall in affecting suggestibility as hypothesised. Post-test anxiety correlates with yield, albeit in a weak way. It is possible that the administration of the interview can be anxiety provoking. Alternatively, it may be that the anxiety has an effect on increasing yield. It is likely that the relationship between anxiety and suggestibility is not straightforward and is itself influenced by other variables, such as pre-test anxiety. The correlation is strongest for State 2 and Yield 1 ($r=0.3038$). The size of correlation must make one question the importance of the variable. There is also a small correlation between yield and recall ($r=-0.3306$), but again the size must make one question its importance. The strengths of these measures are small enough to consider them as having only minor effects on suggestibility with this group.

The findings are argued to support Gudjonsson and Clark's model, but only in a limited way. There is weak evidence that anxiety and recall are associated with withdrawal. It is still possible that the mechanism by which suggestibility is affected, e.g. uncertainty, still holds true, but that withdrawal does not influence this as had been
expected. In support of the model, it should be noted that the directions of correlations occur in the predicted direction, i.e. recall correlates negatively with suggestibility, while anxiety correlates positively with it.

The discrepancies in the results are considered to be due to inadequate power analyses. It was apparent that the groups differed with respect to normative data, but not with respect to each other in terms of suggestibility. It is likely that there were differences between the groups, but that these were too small to be picked up in this study. It is further argued that such small differences were not clinically significant.

**Further speculations**

It is possible that both anxiety and recall affect suggestibility by increasing uncertainty. However, although the correlation evidence is supportive, it is also small. It may be that there is a further intervening variable. One could postulate that it is how anxiety and recall affect coping strategies that accounts for the small correlation. These variables would be likely to have different affects according to the coping strategies.

It is also interesting to consider the influence of compliance more fully. Compliance has been shown to correlate with state and trait anxiety. Given that it is a trait measure itself, it is possible that it in part determines the anxiety felt by individuals. It would also be interesting to consider the concept of compliance as a state measure.

**Future research**

This study has by no means reached a dead-end in this avenue of research. A better test of the hypothesis should be considered. A more select group over a longer time-span would be achievable, whereby people are assessed on admission and compared with those in the recovery ward before going into rehabilitation houses. There will still be a problem of people dropping out before reaching the recovery ward and such a study may sacrifice some of its generalisability. Another possibility would be to investigate participants being cautioned by the police. However, it is hard to see how this would be practical, considering the job of the police; or ethical, in that feasibly it could add to the distress of a participant. What may be of more interest, would be
research into how people comply when under pressure and what attributions they make when complying.

Professional implications

There are two possible implications from this study. The first concerns the issue of using the GSS when it may heighten anxiety in some people. It may be that care should be taken when administering state-dependent tests. Those that are affected by anxiety may be adversely affected if administered immediately after the GSS. Further study into this area would be of interest.

The second implication concerns whether individuals may be overly compliant if going through withdrawal. It may still be that opiate-dependent individuals are at risk of false-confessions, but are well aware of it. There would also be an ethical issue of whether the person can be considered capable of informed consent if they are undergoing withdrawal. However, this is taking the issue to an extreme and the reality may not be quite so daunting.
REFERENCES


*Addiction, 90*, 607-614


APPENDIX A: Materials
# SUBSTANCE ABUSE ASSESSMENT QUESTIONNAIRE

Name of interviewer: .................................................................

| INDEX NO | [ ] [ ] [ ] [ ] [ ] | 1-5 |
| STUDY NO | [ ] [ ] | 6-7 |
| CARD NO  | [0] [1] | 8-9 |

## SECTION I (a)

### INITIAL INFORMATION (General Assessment)

1. Date of Interview: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] 10-15

2. Place of Interview: [ ] -16

1. Treatment Centre
2. Hospital
3. Home
4. Other (specify): .................

3. Date of Referral: [ ] [ ] [ ] [ ] [ ] [ ] [ ] 17-22

4. Client's Name: [ ] [ ] [ ] [ ] [ ] [ ] [ ] 23-24

5. Client's Address: 

                               .................................................................

                               .................................................................

                               .................................................................

                               [ ] [ ] [ ] [ ] [ ] [ ] [ ] 25-30

   Tel NO: .................................

   Post Code: .................................

---

SUBSTANCE ABUSE ASSESSMENT QUESTIONNAIRE

6. Client's Sex
   1 Male   2 Female

7. Client's date of birth: [ ] [ ] [ ] [ ] 32-37

For example, 1 September, 1963 = [0][1][0][9][6][3]
99 99 99 = Not Known

8. Client's age: [ ] [ ] 38-39

9. Ethnic group:
   [ ] [ ] 40-41
   01 White
   02 Indian
   03 Pakistani
   04 Bangladeshi
   05 Chinese
   06 Black Caribbean
   07 Black African
   08 Black Other*
   09 Other*
   99 Not Known

   *Specify..........................

10. Marital status:
    [ ] [ ] 42
    1 Single
    2 Married/Cohabiting
    3 Separated
    4 Divorced
    5 Widowed
    9 Not known

11. Number of children: [ ] [ ] 43-44

12. Ages of children to nearest whole year:
    [ ] [ ] 45-46
    [ ] [ ] 47-48
    [ ] [ ] 49-50
    [ ] [ ] 51-52
    [ ] [ ] 53-54

Should the client have more than 5 children please place the youngest child's age in the first two boxes and the eldest child's age in the last two boxes.
13. Does Client have a......

1 Yes 2 No 8 Not applicable 9 Not known

Family Doctor [ ] -55
Social Worker [ ] -56
Probation Officer [ ] -57
Other Professional Care Worker, [ ] -58
Please Specify........................................
Name and address of key person:

........................................
........................................
Tel:........................................

14. Source of Referral: [ ] [ ] 59-60

01 Self
02 Family/Friend/Cohabitee
03 Family Doctor/Community Health Centre
04 Accident&Emergency/Hospital
05 Other Drug Clinic
06 Psychiatric Service
07 Police
08 Probation/Courts/Lawyer
09 Social Services
10 Voluntary Agency/Hostel
11 Other (Specify).................................
99 Not Known

15. Current Living Arrangements: [ ] [ ] -61

01 Alone
02 With Spouse or partner
03 With Spouse/Partner and children
04 Self and children
05 Friends/Hostel
06 Parents
07 Other (Specify).................................
99 Not Known
16. Type of accommodation at address:................................. [ ] [ ] 62-63
01 Parental home
02 Owned by Client and/or his/her spouse/partner
03 Rented house/flat
04 Squat
05 Hospital
06 Therapeutic Community
07 Probation Hostel
08 Prison
09 No fixed abode
10 Other (Specify)..............................................
99 Not Known

17. Education - Number of years of schooling completed

88 Still attending
99 Not Known

18. Schooling: ............................................................................................. [ ] [ ] -66
1 No formal education
2 Special Educational Needs
3 No Qualifications
4 High School Qualifications
5 Professional Qualifications
6 Degree/Diploma

19. Occupational Status: ......... [ ] [ ] 67-68
01 Unemployed
02 Employed
03 Self-employed
04 Child care/Housewife
05 Student
06 Armed Forces
07 National Service
08 Retired
09 Voluntary Work
10 Other (Specify)..............................
99 Not Known

20. Current/usual job .................................................. *[ ] [ ] 69-70
*Local Coding System to be used
21. Longest period of unemployment:

years [ ] [ ]
months [ ][ ] 71-74

88 Not applicable (still at school/college)
99 Not known

22. Longest period in same job:

years [ ] [ ]
months [ ][ ] 75-78

88 Not applicable (still at school/never employed)
99 Not known

INDEX NO: [ ] [ ] [ ] [ ] [ ] 1-5
STUDY NO: [ ] [ ] 6-7
CARD NO: [0] [2] 8-9

23. How many jobs has Client had since leaving school?

number [ ] [ ] 10-11

88 Not applicable (still at school/college)
99 Not known
00 Never employed

24. Reason for attendance

1 Yes  2 No  8 Not Applicable  9 Not Known

Financial [ ] -12
Job [ ] -13
Family/Relationships [ ] -14
Medical [ ] -15
Psychological [ ] -16
Housing [ ] -17
Pregnancy [ ] -18
Accident and Emergency [ ] -19
Needle Exchange [ ] -20
Other (Specify)  [ ] -21
25. Are there any other Agencies involved with the Client? [ ]

1 Yes  2 No  8 Not Applicable  9 Not Known
If Yes, specify...........................................................
...........................................................
...........................................................

26. Has Client received treatment for their drug use before? [ ]

1 Yes  2 No  8 Not Applicable  9 Not Known
### Substance Abuse Assessment Questionnaire

#### Section I(b)

<table>
<thead>
<tr>
<th>Substance Profile</th>
<th>Ever used</th>
<th>Age at first use</th>
<th>Duration of use</th>
<th>Frequency of use over last 30 days</th>
<th>Most usual route over last 30 days</th>
<th>Source over last 30 days</th>
<th>Box Code</th>
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<tr>
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<td>10-1</td>
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<tr>
<td>02 Methadone</td>
<td>[ ]</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>17-2</td>
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<tr>
<td>03 Other Opiates</td>
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<td>06 Other Sedatives</td>
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<td>09 Amphetamines</td>
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<td>66-7</td>
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*OTC = Over the Counter Medications*
## Substance Abuse Assessment Questionnaire

### Index No: [ ] [ ] [ ] [ ] [ ] 1-5

### Study No: [ ] [ ] 6-7

### Card No: [0] [4] 8-9

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<th>Substance Profile</th>
<th>Ever used</th>
<th>Age at first use</th>
<th>Duration of use</th>
<th>Frequency of use over last 30 days</th>
<th>Most usual route over last 30 days</th>
<th>Source over last 30 days</th>
<th>Box Code</th>
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<td>[ ] [ ] [ ]</td>
<td>[ ] [ ] [ ]</td>
<td>17-2</td>
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<td>13 Solvent/Inhalants</td>
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<td>[ ] [ ] [ ]</td>
<td>38-4</td>
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<td>[ ]</td>
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<td>[ ] [ ] [ ]</td>
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<td>[ ] [ ] [ ]</td>
<td>45-5</td>
<td></td>
</tr>
</tbody>
</table>

*OTC = Over the Counter Medications*

2. How were you introduced to drug taking? [ ] -52

1. Partner
2. Sibling
3. Friend or acquaintance
4. Parent or relative
5. Drug dealer
6. Doctor (include therapeutic addicts)
7. Other (please specify)
8. Not Known
3. How long do you consider that you have had a "drug problem"?

   Years  |  Months  |  53-56

   [ ] [ ]  |  [ ] [ ]  |  

   99  Not known

For example, four and a half years = [0][4] [0][6]

4. Have you experienced any of the following symptoms over the last six months?

   1 Yes  2 No  9 Not known

| Opiate Withdrawals | [ ] | -57 |
| Sedative Withdrawals | [ ] | -58 |
| Convulsions | [ ] | -59 |
| Hallucinations | [ ] | -60 |
| Paranoid State | [ ] | -61 |
| Depersonalisation | [ ] | -62 |
| Derealisation | [ ] | -63 |
| Flashbacks | [ ] | -64 |

5. How soon after you wake up in the morning do you use drugs?

   [ ] -65

   1. Immediately
   2. After breakfast/a few hours
   3. After several hours
   4. Not known

6. How much money do you estimate you spend in an average week on drugs?

   Please state Currency: ___________________________

   [ ] [ ] [ ] [ ] [ ] [ ] [ ] 66-73

7. Have you been absent from work for more than 2 days in last month because of drug use?

   [ ] -74

   1 Yes  2 No  8 Not applicable  9 Not known
8. In last 12 months how many weeks have you been totally drug free?
   Insert number of weeks [ ][ ] 75-76
   99 Not known

<table>
<thead>
<tr>
<th>INDEX.NO</th>
<th>1-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDY NO</td>
<td>6-7</td>
</tr>
<tr>
<td>CARD NO</td>
<td>8-9</td>
</tr>
</tbody>
</table>

9. Have you ever received any of the following treatments for your drug use?

   1 Yes  2 No  9 Not known

<table>
<thead>
<tr>
<th>Treatment</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through voluntary/self-help group</td>
<td>-10</td>
</tr>
<tr>
<td>Through your Family Doctor</td>
<td>-11</td>
</tr>
<tr>
<td>Private Practice</td>
<td>-12</td>
</tr>
<tr>
<td>Substance Misuse Team(outpatient/community)</td>
<td>-13</td>
</tr>
<tr>
<td>As inpatient</td>
<td>-14</td>
</tr>
<tr>
<td>As resident in rehabilitation</td>
<td>-15</td>
</tr>
<tr>
<td>Other (please specify):</td>
<td>-16</td>
</tr>
</tbody>
</table>

Please state when and where treatment took place, if known:

<table>
<thead>
<tr>
<th>Date</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ][ ]/[ ]/ [ ]/ [ ]</td>
<td>[ ]17-22</td>
</tr>
<tr>
<td>[ ][ ]/[ ]/ [ ]/ [ ]</td>
<td>[ ]23-28</td>
</tr>
<tr>
<td>[ ][ ]/[ ]/ [ ]/ [ ]</td>
<td>[ ]29-34</td>
</tr>
<tr>
<td>[ ][ ]/[ ]/ [ ]/ [ ]</td>
<td>[ ]35-40</td>
</tr>
</tbody>
</table>

10. How many cigarettes (tobacco) do you smoke in a day?
    [ ][ ]41-42

   98. Occasional smoker
   88. Does not smoke
   99. Not known

11. How soon after you wake up in the morning do you smoke?
    [ ] -43

   1. Immediately
   2. Within the first hour
   3. Within three hours
   4. Evening Only (i.e. 6.00pm onwards)
12. ASSESSMENT RATING (Drug Use)

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Do you see your present &quot;drug use&quot; as:</td>
<td>[ ] 44</td>
</tr>
<tr>
<td>1 No problem</td>
<td>2 Moderate problem</td>
</tr>
<tr>
<td>9 Not known</td>
<td></td>
</tr>
<tr>
<td>(2) Do you think you need help because of your drug use</td>
<td>[ ] 45</td>
</tr>
<tr>
<td>1 No need</td>
<td>2 Moderate need</td>
</tr>
<tr>
<td>9 Not known</td>
<td></td>
</tr>
<tr>
<td>(3) Does interviewer think Client's drug use is:</td>
<td>[ ] 46</td>
</tr>
<tr>
<td>1 No problem</td>
<td>2 Moderate problem</td>
</tr>
<tr>
<td>9 Not known</td>
<td></td>
</tr>
<tr>
<td>(4) Does interviewer assess Client's need for help with drug problem as:</td>
<td>[ ] 47</td>
</tr>
<tr>
<td>1 No need</td>
<td>2 Moderate need</td>
</tr>
<tr>
<td>9 Not known</td>
<td></td>
</tr>
</tbody>
</table>

NOTES:
### SUBSTANCE ABUSE ASSESSMENT QUESTIONNAIRE

#### SECTION III

<table>
<thead>
<tr>
<th>INDEX NO</th>
<th>STUDY NO</th>
<th>CARD NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ]</td>
<td>[1] [2]</td>
</tr>
</tbody>
</table>

#### ALCOHOL USE

1. Do you consider you have ever had problems with alcohol?
   - 1 Yes 2 No 9 Not known

   [ ] -10

2. Do you consider you have current problems with alcohol (within the last 12 months)?
   - 1 yes 2 no 9 not known

   [ ] -11

3. Have you ever been convicted of alcohol related offences?
   - 1 yes 2 no 9 not known

   [ ] -12

   *For example, drink/driving, drunk and disorderly, breach of the peace*

4. Are you suffering financial hardship due to the amount you spend on alcohol?
   - 1 yes 2 no 9 not known

   [ ] -13

5. Do you think your relationships are suffering due to the amount of alcohol you drink?
   - 1 yes 2 no 9 not known

   [ ] -14

6. Have you been absent from work for more than two days in the last month because of drink?
   - 1 yes 2 no 8 not applicable 9 not known

   [ ] -15
SUBSTANCE ABUSE ASSESSMENT QUESTIONNAIRE

7. Number of standard drinks consumed in an average week:
   grams [ ] [ ] [ ]  16-18
   or units [ ] [ ] [ ]  19-21

Calculation Formula:

1 Unit of alcohol = 8gms of absolute alcohol

No. of alcohol units =

3 Alcohol By Volume (ABV) X amount of beverage (in ml)

8. Have you experienced any of the following symptoms over the last six months related to alcohol consumption?

   1 Yes  2 No  9 Not known

<table>
<thead>
<tr>
<th>Symptom</th>
<th>[ ]</th>
<th>-22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning drinking</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>Morning nausea/vomiting</td>
<td>[ ]</td>
<td>-23</td>
</tr>
<tr>
<td>Shakes</td>
<td>[ ]</td>
<td>-24</td>
</tr>
<tr>
<td>Sweating</td>
<td>[ ]</td>
<td>-25</td>
</tr>
<tr>
<td>Anxiety/panic attacks</td>
<td>[ ]</td>
<td>-26</td>
</tr>
<tr>
<td>Depression</td>
<td>[ ]</td>
<td>-27</td>
</tr>
<tr>
<td>Loss of memory</td>
<td>[ ]</td>
<td>-28</td>
</tr>
<tr>
<td>Blackouts</td>
<td>[ ]</td>
<td>-29</td>
</tr>
<tr>
<td>Delirium Tremens</td>
<td>[ ]</td>
<td>-30</td>
</tr>
<tr>
<td>Convulsions</td>
<td>[ ]</td>
<td>-31</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>[ ]</td>
<td>-32</td>
</tr>
</tbody>
</table>

9. On average how many days in a week do you consume alcohol?  [ ] -33

   9 not known

10. What is your usual style of drinking?  [ ] -34

   1 Weekend/other short episodes
   2 Bouts of more than two days
   3 Steady, daily
   4 Other, specify.................................
   8 Not applicable
   9 Not known
11. If you drink in bouts what is their average duration?

   days          weeks          months
   [ ][ ]        [ ][ ]        [ ][ ]        35-40

12. What is the average length of time between bouts?

   days          weeks          months
   [ ][ ]        [ ][ ]        [ ][ ]        41-46

13. In the last year how many weeks have you been alcohol free?

   [ ][ ]        47-48
   88 Not applicable
   99 Not known

14. How long do you think you have had a problem with alcohol?

   Years          Months
   [ ][ ]        [ ][ ]        49-52
   88 Not applicable
   99 Not known

15. Have you ever had treatment for your problem with alcohol?

   [ ]-53
   1 yes
   2 no
   8 Not applicable (i.e. no alcohol problem)
   9 Not known

If the answer to question 15 is no treatment leave all boxes blank and go to next question.

16. Treatment received:

   1 yes    2 no    9 Not known
   Family Doctor treatment [ ]-54
   As hospital outpatient [ ]-55
   As hospital inpatient [ ]-56
   Community Alcohol Team [ ]-57
   Non-statutory/Voluntary agency [ ]-58
   Other (specify): [ ]-59
16. Treatment received:

Please state when and where treatment took place, if known:

<table>
<thead>
<tr>
<th>Date</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]/[ ]/[ ]</td>
<td>[ ]10-16</td>
</tr>
<tr>
<td>[ ]/[ ]/[ ]</td>
<td>[ ]17-23</td>
</tr>
<tr>
<td>[ ]/[ ]/[ ]</td>
<td>[ ]24-30</td>
</tr>
<tr>
<td>[ ]/[ ]/[ ]</td>
<td>[ ]31-37</td>
</tr>
</tbody>
</table>

17. ASSESSMENT RATING

(1) How do you rate your alcohol use? [ ] 38
   1 No problem  2 Moderate problem  3 Serious problem
   9 Not known

(2) Do you think you need help with an alcohol problem? [ ] 39
   1 No need  2 Moderate need  3 Serious need  9 Not known

(3) How does interviewer rate Client's alcohol problem? [ ] 40
   1 No problem  2 Moderate problem  3 Serious problem
   9 Not known

(4) Does interviewer think Client needs help with alcohol problem? [ ] 41
   1 No need  2 Moderate need  3 Serious need  4 Not known

NOTES:
## SUBSTANCE ABUSE ASSESSMENT QUESTIONNAIRE

### SECTION IV

<table>
<thead>
<tr>
<th>INDEX NO</th>
<th>[ ] [ ] [ ] [ ] [ ] [ ] 1-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDY NO</td>
<td>[ ] [ ] 6-7</td>
</tr>
<tr>
<td>CARD NO</td>
<td>[1] [4] 8-9</td>
</tr>
</tbody>
</table>

**FORENSIC ASSESSMENT**

1. Have you ever been involved in any criminal activity?
   - 1 Yes
   - 2 No
   - 9 Not known
   
   If answer to this question is No: STOP HERE, leave all intervening boxes blank, and go to question 11.

2. At what age did you first become involved in criminal activity?
   - 99 Not known

3. Do you at present have any court cases pending?
   - 1 yes
   - 2 no
   - 9 not known

   If answer is Yes, please specify for what offence(s):  
   *Local Coding System to be used.*

   ......................
   .................  
   *[ ] [ ] 13-14*

4. Are you at present on:.....
   - 1 Yes
   - 2 No
   - 9 Not known

   Condition of treatment
   - [ ] -15
   Probation
   - [ ] -16
   Suspended sentence
   - [ ] -17
   Deferred sentence
   - [ ] -18
   Parole
   - [ ] -19
   Other, specify.......................  
   - [ ] -20
6. Which of the following types of offences have you ever committed, and number of convictions?

1 yes 2 no 9 Not known

<table>
<thead>
<tr>
<th>Offences</th>
<th>Committed Before Drug use began</th>
<th>Committed After Drug use began</th>
<th>Number of convictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug related</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ] [ ] 23-26</td>
</tr>
<tr>
<td>Driving</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ] [ ] 27-30</td>
</tr>
<tr>
<td>Public disorder</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ] [ ] 31-34</td>
</tr>
<tr>
<td>Violence against property</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ] [ ] 35-38</td>
</tr>
<tr>
<td>Crimes of acquisition</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ] [ ] 39-42</td>
</tr>
<tr>
<td>Sex offences</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ] [ ] 43-46</td>
</tr>
<tr>
<td>Violence against the person</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ] [ ] 47-50</td>
</tr>
</tbody>
</table>

7. Have you had any periods of imprisonment? [ ] [ ] 51-52

If yes, code number of times, i.e. three times = [0][3]
99 = Not known.
88 = Never been in prison

8. If you have been in prison, what was the longest sentence served?

<table>
<thead>
<tr>
<th>days</th>
<th>months</th>
<th>years</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

53-58

99 Not known
9. Whilst in prison did you continue to use drugs?

1. Yes, frequently
2. No
3. Yes, occasionally
9. Not known

[ ] - 59

10. Of the crimes committed since the onset of drug use, what percentage do you estimate were committed whilst intoxicated?

99. Not known

percentage %

[ ][ ] 60-61

11. ASSESSMENT RATING (Forensic/Legal)

(1) How severe would you rate your legal problems as being at the moment?

1. No problems at all
2. Moderate problem
3. Serious problem
9. Not known

[ ] - 62

(2) Do you think you need help with your legal problems at present?

1. No need
2. Moderate need
3. Serious need
9. Not known

[ ] - 63

(3) Does the interviewer think the Client's present legal problems are:

1. No problem at all
2. Moderate problem
3. Serious problem
9. Not known

[ ] - 64

(4) How much help does the interviewer think the Client needs with legal problems?

1. No need
2. Moderate need
3. Serious need
9. Not known

[ ] - 65

NOTES:
Opiate Withdrawal Symptom Questionnaire*

Patient's name: ___________________  Patient study no. __________

Please rate the absence or presence of the following symptoms over the past 24 hours using the following scale at approximately the same time each day.

Scale  
0 = none/not at all  
1 = slightly/little/occasionally  
2 = moderately  
3 = very much/a great deal/continuously

Over the last 24 hours to what extent have you:

Enter date ____________
Enter time ____________ am/pm

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Been yawning</td>
</tr>
<tr>
<td>2</td>
<td>Had muscle cramp</td>
</tr>
<tr>
<td>3</td>
<td>Had pounding heart</td>
</tr>
<tr>
<td>4</td>
<td>Had a runny nose</td>
</tr>
<tr>
<td>5</td>
<td>Been sneezing</td>
</tr>
<tr>
<td>6</td>
<td>Experienced pins and needles</td>
</tr>
<tr>
<td>7</td>
<td>Had hot/cold flushes</td>
</tr>
<tr>
<td>8</td>
<td>Had diarrhoea</td>
</tr>
<tr>
<td>9</td>
<td>Had gooseflesh</td>
</tr>
<tr>
<td>10</td>
<td>Felt sick</td>
</tr>
<tr>
<td>11</td>
<td>Had stomach cramps</td>
</tr>
<tr>
<td>12</td>
<td>Had difficulty sleeping</td>
</tr>
<tr>
<td>13</td>
<td>Felt aches in bones or muscles</td>
</tr>
<tr>
<td>14</td>
<td>Felt twitching and shaking</td>
</tr>
<tr>
<td>15</td>
<td>Felt irritable/bad tempered</td>
</tr>
<tr>
<td>16</td>
<td>Been sweating</td>
</tr>
<tr>
<td>17</td>
<td>Had runny eyes</td>
</tr>
</tbody>
</table>
| 18 | Felt craving  
*Total score (leave blank)*

# National Adult Reading Test (NART)

**SECOND EDITION**

Answer/Record Sheet

<table>
<thead>
<tr>
<th>Name:..................................................................................................................</th>
<th>Date of test:.......................................................................................................</th>
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<table>
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<th>Error</th>
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<td>SIMILE</td>
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<tr>
<td>DEPOT</td>
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<td>BANAL</td>
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<tr>
<td>AISLE</td>
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<td>QUADRUPED</td>
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<tr>
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<td>CELLIST</td>
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<tr>
<td>PSALM</td>
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<td>FACADE</td>
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<td>GIST</td>
<td></td>
<td>LABILE</td>
</tr>
<tr>
<td>GOUGE</td>
<td></td>
<td>CAMPALENLE</td>
</tr>
</tbody>
</table>
Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it applies to you personally. If the statement is true as applied to you then circle T; if it is false as applied to you then circle F.

1. I give in easily to people when I am pressured. T F
2. I find it very difficult to tell people when I disagree with them. T F
3. People in authority make me feel uncomfortable. T F
4. I tend to give in to people who insist that they are right. T F
5. I tend to become easily alarmed and frightened when I am in the company of people in authority. T F
6. I try very hard not to offend people in authority. T F
7. I would describe myself as a very obedient person. T F
8. I tend to go along with what people tell me even when I know that they are wrong. T F
9. I believe in avoiding rather than facing demanding and frightening situations. T F
10. I try to please others. T F
11. Disagreeing with people often takes more time than it is worth. T F
12. I generally believe in doing as I am told. T F
13. When I am uncertain about things I tend to accept what people tell me. T F
14. I generally try to avoid confrontation with people. T F
15. As a child I always did what my parents told me. T F
16. I try hard to do what is expected of me. T F
17. I am not too concerned about what people think of me. T F
18. I strongly resist being pressured to do things I don't want to do. T F
19. I would never go along with what people tell me in order to please them. T F
20. When I was a child I sometimes took the blame for things I had not done. T F
SEVERITY OF DEPENDENCE SCALE

Name .................................................................

Please think of your opiate use during a typical recent period of drug taking when you answer these questions.

Please answer each question by circling one response only.

1. Did you think that your opiate use was out of control?
   - Never
   - Sometimes
   - Often
   - Always or nearly always

2. Did the prospect of missing a fix (or dose) make you very anxious or worried?
   - Never
   - Sometimes
   - Often
   - Always or nearly always

3. Did you worry about your opiate use?
   - Never
   - Sometimes
   - Often
   - Always or nearly always

4. Did you wish you could stop?
   - Never
   - Sometimes
   - Often
   - Always or nearly always

5. How difficult would you find it to stop or go without opiates?
   - Impossible
   - Very Difficult
   - Quite Difficult
   - Not Difficult

Thank you very much for your help.
### SELF-EVALUATION QUESTIONNAIRE

**STAI Form Y-2**

**Name ____________________________________________ Date __________________________**

**DIRECTIONS:** A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you *generally* feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

<table>
<thead>
<tr>
<th>Statement</th>
<th>ALMOST NEVER</th>
<th>ALMOST ALWAYS</th>
<th>SOMETIMES</th>
<th>OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. I feel pleasant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. I feel nervous and restless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. I feel satisfied with myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. I wish I could be as happy as others seem to be</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. I feel like a failure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. I feel rested</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. I am “calm, cool, and collected”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. I feel that difficulties are piling up so that I cannot overcome them</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. I worry too much over something that really doesn’t matter</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. I am happy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. I have disturbing thoughts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. I lack self-confidence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. I feel secure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. I make decisions easily</td>
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<tr>
<td>35. I feel inadequate</td>
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<tr>
<td>36. I am content</td>
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<tr>
<td>37. Some unimportant thought runs through my mind and bothers me</td>
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<tr>
<td>38. I take disappointments so keenly that I can’t put them out of my mind</td>
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<tr>
<td>39. I am a steady person</td>
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<tr>
<td>40. I get in a state of tension or turmoil as I think over my recent concerns and interests</td>
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</tbody>
</table>

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**SELF-EVALUATION QUESTIONNAIRE**

Developed by Charles D. Spielberger
in collaboration with
R. L. Gorsuch, R. Lushene, P. R. Vagg, and G. A. Jacobs

**STAI Form Y-1**

---

Name ____________________________________________ Date ____________ S _____

Age ________ Sex: M _____ F _____

---

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel *right* now, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>1. I feel calm</td>
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<tr>
<td>2. I feel secure</td>
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<td>3. I am tense</td>
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<td>4. I feel strained</td>
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<td>5. I feel at ease</td>
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<td>6. I feel upset</td>
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<td>7. I am presently worrying over possible misfortunes</td>
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<td>8. I feel satisfied</td>
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<td>9. I feel frightened</td>
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<td>10. I feel comfortable</td>
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<td>11. I feel self-confident</td>
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<td>12. I feel nervous</td>
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<td>13. I am jittery</td>
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<td>14. I feel indecisive</td>
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<td>15. I am relaxed</td>
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<tr>
<td>16. I feel content</td>
<td></td>
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<tr>
<td>17. I am worried</td>
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<tr>
<td>18. I feel confused</td>
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<tr>
<td>19. I feel steady</td>
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<tr>
<td>20. I feel pleasant</td>
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</tbody>
</table>
SUGGESTIBILITY SCALE INSTRUCTIONS

Before the story is read out to the subject, the following instruction is given:

"I want you to listen to a short story. Listen carefully, because when I am finished I want you to tell me everything you remember."

Anna Thomson/of South/Croydon/was on holiday/in Spain/when she was held up/outside her hotel/and robbed of her handbag/which contained £50 worth/of travellers cheques/and her passport./She screamed for help/and attempted to put up a fight/by kicking one of the assailants/in the shins./A police car shortly arrived/and the woman was taken to the nearest police station/where she was interviewed by Detective/Sergeant/Delgado./The woman reported that she had been attacked by three men/one of whom she described as oriental looking./The men were said to be slim/and in their early twenties./The police officer was touched by the woman's story/and advised her to contact the British Embassy./Six days later/the police recovered the lady's handbag/but the contents were never found./Three men were subsequently charged/two of whom were convicted/and given prison sentences./Only one/had had previous convictions/for similar offenses./The lady returned to Britain/with her husband/Simon/and two friends/but remained frightened of being out on her own./

After the story has been read out, the subject is told the following:

"Now tell me everything you remember about the story."

Subjects are then told that they are going to be asked Questions about the story and instructed to answer them as accurately as they can.

SUGGESTIBILITY .......

Subjects are then told............

"You have made a number of errors. It is therefore necessary to go through the questions once more and this time try to be more accurate."

Repeat 20 questions.
<table>
<thead>
<tr>
<th>Questions</th>
<th>YIELD 1</th>
<th>YIELD 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the woman have a husband called Simon?</td>
<td></td>
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<td>2. Did the woman have one or two children?</td>
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<tr>
<td>3. Did the woman’s glasses break in the struggle?</td>
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<td>4. Was the woman’s name Anna Wilkinson?</td>
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<td>5. Was the woman interviewed by a detective sergeant?</td>
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<td>6. Were the assailants black or white?</td>
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<td>7. Was the woman taken to the central police station?</td>
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<td>8. Did the woman’s handbag get damaged in the struggle?</td>
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<td>9. Was the woman on holiday in Spain?</td>
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<tr>
<td>10. Were the assailants convicted six weeks after their arrest?</td>
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<td>11. Did the woman’s husband support her during the police interview?</td>
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<tr>
<td>12. Did the woman hit one of the assailants with her fist or handbag?</td>
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<tr>
<td>13. Was the woman from South Croydon?</td>
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<tr>
<td>14. Did one of the assailants shout at the woman?</td>
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<td>15. Were the assailants tall or short?</td>
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<tr>
<td>16. Did the woman’s screams frighten the assailants?</td>
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<tr>
<td>17. Was the police officer’s name Delgado?</td>
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<tr>
<td>18. Did the police give the woman a lift back to her hotel?</td>
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<tr>
<td>19. Were the assailants armed with knives or guns?</td>
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<td></td>
</tr>
<tr>
<td>20. Did the woman’s clothes get torn in the struggle?</td>
<td></td>
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</tr>
</tbody>
</table>
### Summary of Administration

1. S is required to listen to the story.
2. S gives free recall.
3. S gives delayed recall after 50 minutes.
4. S is asked the 20 interrogation questions (give Yield 1).
5. S is given critical feedback.
6. The 20 questions are repeated (giving Shift and Yield 2).
APPENDIX B: Ethical approval and consent form
9 February 1998

Dr Chris Hall  
Clinical Psychologist in Training  
Psychology Dept.  
University of Surrey  
Guildford  
Surrey GU2 5XH

Dear Dr Hall,

Interrogative suggestibility: The effects of opiate withdrawal on interrogative suggestibility - 98.6.12

The Local Research Ethics Committee of 28 January 1998, considered your application and members raised several questions that need resolving before permission can be given for the study to go ahead.

(1) The application form needs the SDU leader's signature.

(2) Members were worried that patients might be left in a paranoid state as a result of the study. What precautions have you in place to avoid this? One possibility is that there might be careful debriefing of patients to explain what has gone on. Clearly, it is most important that the questions are put in a way that will not threaten or undermine the subjects, and members wondered what training you have had in undertaking the trial as described. This is obviously a very sensitive area and the way in which questions are put, could enormously affect the response of subjects at the time of the interrogation and afterwards.

I look forward to receiving your response to the above points. Perhaps your letter should be written in conjunction with Professor Ghodse.

With best wishes,

Yours sincerely

Dr Joe Collier  
Vice-Chair/Clinical Secretary  
Local Research Ethics Committee
Ann Mash
3898
Dear Mr Hall,

Re: Interrogative suggestibility:  
The effects of opiate withdrawal on interrogative suggestibility - 98.6/12

Thank you for your letter of 24 February 1998

I am now happy to give Chair’s approval for the study to go ahead, subject to ratification by the full Local Research Ethics Committee.

Yours sincerely,

[Signature]

Dr Joe Collier  
Vice-chair/Clinical Secretary  
Local Research Ethics Committee
PARTICIPANT CONSENT FORM

I, ____________________________, give my consent to participating in the research conducted by Chris Hall, Clinical Psychologist in Training with Paul Davis, Consultant Clinical Psychologist, Pathfinder Addiction Services.

I have been informed of the nature of the research and the procedures involved. I have been promised complete confidentiality and anonymity, and should I feel these have been breached in any way, I understand that I may withdraw from the research at any time.

Signed: ____________________________

Date: ____________________________
PARTICIPANT INFORMATION SHEET

Aim

The aim of this study is to consider the general physical and psychological health of patients undergoing methadone detoxification.

We are asking for the participation of individuals who are on the methadone detoxification programme and of those who are on the waiting list for this programme.

What participation involves

Participants will be asked to answer various questionnaires related to the study. The total length of time that this is expected to take will be 1 hour.

Important information

• Your right to treatment is not affected by whether you choose to participate in this study or not.

• All information gathered in this study will be confidential. No identifying information will be used in the write-up of this study.

• Should you choose to participate in this study, you may still withdraw from it at any time.

• Participation in this study will not affect when or how you will be seen for treatment.

Investigator:
Mr Chris Hall
Clinical Psychologist in Training
Contact Phone Number: 0181-672-9911 ext. 42250