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**Academic Section**

This section comprises of five essays written over the three-year course. Four essays cover topics pertaining to the core client groups - Adult Mental Health, People with Learning Disabilities, Children and Adolescents, and Older Adults. One essay covers a specialist topic in Narrative Therapy.
Both behaviour therapists and cognitive therapists may use behavioural techniques in the treatment of anxiety disorders and depression. However, the underlying theoretical rationales of these techniques differs. Critically evaluate these different theoretical rationales by drawing on the literature from anxiety and depression.
Both behaviour therapists and cognitive therapists may use behavioural techniques in the treatment of anxiety disorders and depression. However, the underlying theoretical rationales of these techniques differs. Critically evaluate these different theoretical rationales by drawing on the literature from anxiety and depression.

Introduction
There are three key criteria for critically evaluating the theoretical rationales behind cognitive and behavioural therapy. The first is clinical effectiveness: is the treatment based on the rationales clinically effective? If it is not, then there is a strong case for arguing that the underlying rationale for treatment was either wrong or, at least, incomplete. Additionally, if one finds evidence of effectiveness, it is then necessary to show that the improvements can be traced back to the theories underlying treatment conceptualisations. Secondly, do the theoretical rationales have an evidence base in experimental psychology? Finally, the theories need to account for the clinical presentations of people with anxiety disorders and depression. In this essay I will describe common techniques and their differing rationales. Next, I will take a shared technique to illustrate how it is differentially used by therapists with different orientations. As there is an extensive literature on the anxiety disorders and depression, for the purposes of this essay I will concentrate on the literature relating to panic disorder and agoraphobia (DSM-IV; APA, 1994) among the anxiety disorders and Major Depressive Disorder (DSM-IV) for the depressive disorders. I will then critically evaluate the differing approaches against the key criteria. As Wells (1997) indicates there is more than one cognitive theory for the treatment of anxiety disorders and depression. Here, therefore, I shall largely look at the theories generated by Aaron Beck’s work on the emotional disorders because his writings have produced a generic model, which has been refined by others to develop models for specific disorders. For the behaviour therapies, I shall evaluate a number of models, which have their empirical roots in classical and operant conditioning.

Behavioural techniques and the rationales underlying them
In depression, behavioural techniques in common include activity monitoring and scheduling and graded task assignment. In anxiety disorders, shared techniques include graded exposure, relaxation, assertion training and social skills training. While it is difficult to generalise, broadly speaking the cognitive rationale for the use of behavioural techniques in
treatment of the emotional disorders is this: the client is maintained in the disorder primarily by the way he thinks about himself and the environment (Beck, A. 1976). In therapy, the client becomes a scientist collaborating with the therapist to test the hypotheses of cause and effect reflected by his thinking. Behavioural techniques, then, are behavioural experiments, in which what the patient thinks, becomes the subject of an investigation. The results of these 'experiments' are then used to identify, reality-test and challenge the client's existing thoughts and beliefs. Behaviourists, on the other hand, largely draw on the paradigms of classical and operant conditioning to justify the use of behavioural techniques. Put simply, in depression, for example, therapists use behavioural techniques to increase positive reinforcement and decrease negative reinforcing environmental events in the lives of their patients. In anxiety disorders, therapists are generally aiming for clients to unlearn maladaptive conditioned stimulus-conditioned response (CS-CR) events and habituate to aversive stimuli.

How the rationales are used in practice is best illustrated by examining their use in specific treatment regimes. In vivo and interoceptive exposure is used by both cognitive and behavioural therapists in the treatment of panic disorder. A widely used cognitive model of panic disorder was proposed by Clark (1986). He states that “individuals experience panic attacks because they have a relatively enduring tendency to interpret a range of bodily sensations in a catastrophic fashion.” Clark includes thoughts and images as internal stimuli that can trigger this catastrophic misinterpretation. The cognitive therapist, therefore invites his patient to expose himself to either interoceptive cues or real-world feared stimuli in an attempt to provide evidence to the client that his hypothesis – that exposure will lead to personal catastrophe – is not proven. The “experiment” is then used as one strand of evidence to challenge the patient’s “incorrect” catastrophic assumptions. Behaviourists also use exposure techniques to treat panic disorder. For example, Goldstein and Chambless (1978) put forward a learning theory model for interoceptive conditioning in panic disorder. They argued that in the first stage, through temporal contiguity a neutral stimulus – a normal bodily sensation - is associated with an unconditioned stimulus that innately elicits fear in the patient. The neutral stimulus now acquires aversive properties and becomes a conditioned stimulus (CS), which elicits fear and anxiety. After a number of attacks, patients become hyperalert to bodily sensations and appraise them as signals of oncoming panic. As patients carry the CS with them, the fear becomes generalised so external situations also produce panic. Interoceptive and in vivo exposure is therefore used to extinguish the maladaptive
learning through the process of habituation. The client’s interpretation of events is not important; new learning through the rearrangement of environment conditions is.

**Critical evaluation – clinical effectiveness**

One way to critically evaluate the theoretical rationales is to examine outcome studies. If the outcomes are poor, then it is difficult to have confidence that the rationales are correctly or completely premised (whilst acknowledging that success in treatment does not always signal an understanding of the cause of a disorder). As cognitive theories are premised on the basis that cognitive change is a necessary and sufficient condition for therapeutic change, then cognitive treatments which do not include behavioural elements should be sufficient to bring about change. As cognitive change is also necessary for relapse prevention, cognitive theorists predict that long-term recovery in the emotional disorders is more assured where there is specific cognitive change than through behavioural change alone. The client is equipped with new ways of thinking and problem-solving which act as a protection against future problems. Outcome studies which report follow-up measures must be considered, therefore, to test the hypothesis that cognitive therapy is superior to behaviour therapy in preventing relapse.

A number of outcome studies in panic disorder (Amtz and van de Hout, 1996) and agoraphobia (Williams & Falbo, 1996) indicate that cognitive therapy alone is effective. It is difficult to explain these results from a learning theory perspective. Marks, Basoglu and Noshirvani (1994) argue that treatment studies up to that time were not sufficiently robust to say whether cognitive therapy (and exposure techniques used by behaviourists) worked because clients changed their misinterpretations of bodily sensations. They argued that successful cognitive treatment could possibly be explained through patients learning general problem-solving techniques such as problem definition and goal-setting or by fostering a sense of control. But this argument is weak. Nearly all studies on treatment effectiveness contain a control group, which controls for therapist factors such as attention. Most studies, as cited in Clark (1999), find significant group differences between CT and exposure treatments and a range of control treatments. It is, therefore, difficult to explain symptom change without exposure to the feared situation or interoceptive cues — except by accepting the central role of cognitive processes in panic disorder and agoraphobia. It can be seen, then, that cognitive therapy alone is sufficient for the treatment of panic and agoraphobia and that this finding cannot be explained either in behavioural terms or by generic therapeutic factors,
such as therapist attention. The behavioural rationale is, then, weakened by the finding that CT alone is sufficient for improvements in these conditions.

However, treatment studies do indicate that CT is not a necessary condition for effective treatment in these particular anxiety disorders. A number of studies cited by Rachman (1997) (e.g. Margraf and Schneider, 1991) have shown that exposure-only therapies are effective in the treatment of panic disorder. So, cognitive therapy alone is not necessary for clinical effectiveness. However, it has been argued that exposure therapies in panic work by producing change in key cognitions regarding threat appraisal and catastrophic interpretation of discriminative stimuli. A number of studies (e.g. Burke et al., 1997) have found cognitive change following exposure-only procedures. It could be, then, that cognitive therapy and exposure techniques work through a common mechanism – cognitive change. This does throw into question the theoretical rationale of behavioural techniques with these disorders, which at its most fundamentalist has no place for the role of cognitive events.

But outcome studies do still leave questions marks over the cognitive, as well as the behavioural rationale. Some studies (e.g. Williams and Falbo, 1996) have found that exposure only therapy for agoraphobia and panic bring about significantly more cognitive-restructuring in key panic and phobia-related cognitions than a cognitive approach. This does not sit easily with a rigid cognitive rationale, which justifies the therapeutic task of challenging client beliefs on the grounds that without such challenge the necessary cognitive shift will not happen. Additionally, as argued above, CT by targeting key cognitions, should produce better long-term outcomes. There is mixed support for this prediction. Clark et al. (1994) found that patients who continued to misinterpret bodily sensations at the end of treatment did show worse outcome at follow-up than those that did not. However, some studies (Burke et al., 1997; Ost et al., 1995) do not support the prediction that cognitive-behavioural therapy (CBT) will be significantly superior to other treatment methods in reducing relapse rates.

Outcome studies for panic disorder and agoraphobia do, then, provide stronger evidence for the robustness of the cognitive rationale than the behavioural. At best, it appears both cognitive and behavioural approaches are sufficient to produce improvement in patients. However, there is evidence that the common mechanism of improvement is through cognitive change – holding out the possibility that cognitive change alone is sufficient for therapeutic change. But proponents of CT lack strong evidence from long-term follow-up studies.
confirming the prediction that CT and CBT will have lower relapse rates than behavioural treatments.

**Effectiveness – clinical implications**

The results of the outcome studies do have clinical implications for the management and rehabilitation of people with emotional disorders. Durham and Turvey (1987), in a study of generalised anxiety disorder, found that at six-month follow-up participants who received CT largely maintained improvements while behaviour therapy (BT) recipients deteriorated. But they also found that on follow-up, of those who received CT “virtually no patients were symptom-free” and that one third were not significantly improved from their pre-treatment levels. As the authors point out, the results indicate that clinicians need to consider appropriate forms of continuing “management and rehabilitation once the limitations of active treatment have become apparent.” Clinicians will also have to be careful not to apply portmanteau treatments for idiosyncratic presentations of apparently similar problems. For example, Williams and Falbo (1996) warned that their study revealed that agoraphobics were not a homogeneous group and both CT and BT were less effective at reducing panic attacks with subjects high in agoraphobia, than those low on agoraphobic measures. Roth (1997) makes the same call for psychological assessments tailored to the individual in treating depression, as studies indicate treatment approaches vary in effectiveness according to clinical presentation.

**Critical evaluation – the empirical status**

The second critical criteria for the theories is their empirical base. The extent to which a theory both generates hypotheses and is supported by the experimental evidence is a critical measure of the robustness of therapies derived from the theory. For the purposes of this essay, Beck’s (1987) theory of depression (cited in Haaga et al. 1991) and Seligman’s (1975) original learned helplessness theory will be taken as an example of the cognitive and behavioural models respectively.

Beck’s model of depression places cognitive disturbance at its heart. Beck does not ascribe causal status to cognitive disturbance, but says that “deviant cognitive processes” are “intrinsic” to the depressive disorder. Beck speculated that the early experience of a person who develops depression is characterised by loss, which leads to the formation of dysfunctional schemas. These schema – relatively stable cognitive structures which guide the appraisal and interpretation of events – lie dormant until activated by another loss event.
Beck introduced personality modes of sociotropy and autonomy as an additional vulnerability factor for depression. Loss events will only trigger depression if they are congruent with the personality mode. Once reactivated the dysfunctional schemas – containing unconditional negative beliefs about the self (e.g. “I am worthless”) and maladaptive rules (e.g. “I must be perfect, or I will be rejected”) – are the cognitive set by which all situations are appraised and interpreted. Beck postulates that the thoughts of depressed people are characterised by a negative triad about the self, current events and the future and by cognitive biases – such as attending only to negative aspects of a situation – which maintain the depressive disorder. One other feature of the disorder is that these depressed cognitions are automatic; that is repetitive and not readily controllable.

A number of testable hypotheses have been derived from this theory. The model predicts that dysfunctional beliefs will be stable before, during and after a depressive episode. It is also hypothesised that the personality modes of patients will need to be congruent with loss events, for the latter to act as a trigger to depression. It is predicted there will be information-processing biases, that depressed people will display the cognitive triad and that people with depression will display thinking that is more loss-oriented than people with anxiety. In an extensive review, Haaga and his colleagues (1991) analyse a number of studies supporting the predictions. Depressed patients do have more negative attitudes than non-depressives or themselves in remission (Eaves and Rush, 1984, cited in Haaga et al. 1991). There is also evidence that the negative cognitive triad of thinking is present in, and specific to depression. Relative to non-depressed controls, depressed patients are more self-critical (Blatt et al., 1982, cited in Haaga et al., 1991) and are more hopeless about the future (Abramson et al., 1978, cited in Haaga et al., 1991). Overall, Haaga and his colleagues (1991) found support for cognitions of increased negativity, increased hopelessness, specificity of themes of loss and mood-congruent encoding of memories. They also found weak evidence for the prediction that depressed subjects had exclusively negative cognitions compared with patients with other psychological disorders. The hypothesised cognitive distortion in appraising situations, seems rather to reflect a bias: Krantz and Gallagher-Thompson (1990), found that in hypothetical scenarios, depressed patients do tend to draw more negative conclusions than controls about negative scenes, but not with neutral or positive scenarios (cited in Haaga et al., 1991).

There are also a number of weaknesses with Beck’s theory as a diathesis-stress model of depression. For example, there is little evidence to suggest that dysfunctional core beliefs are
stable aspects of personality. In a study of depressed subjects in remission from their symptoms, Blackburn et al. (1990) found that dysfunctional beliefs were at a normal level. Additionally, in a prospective study of students, Lewinsohn and his colleagues (1981) found that dysfunctional beliefs about the self, reduced expectation of future positive outcomes, higher expectations of negative events, and measures of helplessness, did not predict which students went on to develop depression.

It can be seen, then, that a major cognitive model for depression is not fully supported by experimental evidence. The descriptive aspect of Beck’s theory of depression is largely, but not completely supported. As a diathesis-stress model, there are significant weaknesses. What, then, of a behavioural model of depression.

Seligman (1974) (cited in Davison and Neale, 1994) drew on experimental studies in animal learning to propose the “learned helplessness” theory of depression. With its empirical base in learning theory, in its original form it is one of the behavioural theories of depression. Seligman found that dogs in a Skinner box who received inescapable shocks, at first attempted to avoid the shocks but then became passive. When the same dogs were exposed to shock they could escape, it was found that they did not acquire the avoidance response as efficiently as control dogs. In other words, the animals showed helplessness in the face of aversive stimuli they were unable to control and an inability to learn new behaviours when the contingency conditions changed. Experiments with humans have yielded supporting evidence (e.g. Klein and Seligman, 1975; cited in Davison and Neale, 1994). Seligman proposed that depressed people displayed this characteristic passivity and lack of problem-solving in the face of environmental events.

A number of studies have failed to confirm the hypothesis that people who feel helpless do not engage in problem-solving behaviour. Davison and Neale (1994) cite a study by Wortman and Brehm (1975) which indicates that subjects induced to feel helplessness become more skilled at certain performance tasks. Another key anomaly came from the clinical observation of depressed subjects. In particular, clinicians noted themes of responsibility and guilt for their actions. These feelings indicate that the client could have avoided a negative event, which, in turn implies controllability. The model predicts people will report a lack of control. Significantly, Seligman himself had to turn to attribution theory to explain what was actually seen in depression – in other words, he had to add the crucial element of how subjects interpreted the meaning to themselves of aversive events. In short,
he added cognitive elements to the learning elements, exposing a significant weakness in
behavioural theories.

Rachman (1997) makes a cogent argument for saying that one of the weaknesses of cognitive
therapy, compared with behaviour therapy, is that the former is not grounded in cognitive
science but is developed entirely from clinical observation. Behaviourism, on the other hand,
was about lawfulness in behaviour - built on the laws of learning derived from empirical
studies. Rachman cites Teasdale’s criticism that, for example, for cognitive therapists even
key terminology such as “cognitive processing” diverged from the understanding of the term
in cognitive psychology. In particular, until recently there had been little attempt to link
cognitive therapy with the underlying neuroscience. Brewin (1989) has usefully tried to link
the two and answer a critical question for both cognitive and behavioural approaches: how is
therapeutic change mapped on the brain? Neither tradition has tried to answer what
neurology underlies an S-R connection or a dysfunctional schema. Brewin (1989) suggests
that behavioural techniques such as in vivo exposure create new situationally available
knowledge, in the form of new memories which share enough of the contextual features of
the old maladaptive memory to be preferentially accessed in future. Such work has
cites studies by Williams et al. (1988) and Eysenck, M. (1982) which have established that
attentional biases do occur during emotional experience and that memories, involving recall,
often are mood-related. Wells (1997) draws on information-processing tasks for evidence of
the robustness of Clark’s model of panic disorder. Rachman predicts that attempts to link
cognitive therapy with neuroscience and cognitive science will continue.

The integrity of cognitive and behavioural theories for depression, then, are undermined by
the evidence from laboratory studies and clinical observation. Judged on this criteria, both
theories are incomplete, although there is stronger empirical support for Beck’s cognitive
theory of depression than Seligman’s behavioural theory. It was just such evidence that
prompted behaviourists, such as Seligman, to include a client’s meaning of an event in their
models of psychopathology, thus weakening the behavioural rationale underlying the use of
behavioural treatment techniques.

The centrality of the meanings subjects ascribe to situations has been demonstrated in a
number of areas of psychopathology. Post Traumatic Stress Disorder (PTSD) provides a good
example of where learning theories cannot adequately account for the empirical data. Foa,
Sketkee and Rothbaum (1989) cite a number of studies (e.g. Sales, Baum & Shore, 1984), which found that perceived threat was a better predictor of the onset and maintenance of the disorder than actual threat.

Such studies severely weaken the behavioural paradigm and provide support for the theories underlying the cognitive rationale for anxiety disorders and depression. For the clinical psychologist this finding has significant implications for practice. It suggests that some behavioural techniques may inadvertently become a factor in maintaining a condition, if the behavioural procedures reinforce the “meanings” which are preventing the client from recovering.

**Empirical status – clinical implications**

Safety behaviours are behaviours patients engage in to prevent a feared event from happening. From the cognitive perspective, they prevent the patient coming into contact with information and experiences which are incongruent with their negative beliefs. Safety behaviours thus prevent disconfirmatory evidence of threat and loss appraisals from being processed by the client. A behavioural explanation proposes that safety behaviours such as escape and avoidance prevents full or incomplete exposure to the feared stimulus thus preventing extinction of the conditioned response. Wolpe (1958) (cited in Davison and Neale, 1994) drew on learning paradigms to develop systematic desensitization for the treatment of phobias in humans. It had been shown that emotional states such as anxiety could be inhibited if a person were in a state of relaxation (reciprocal inhibition). This has lead to the widespread use of the behavioural technique of teaching relaxation to clients with anxiety disorders, including panic disorder. However, cognitive therapists have argued that without cognitive change, the teaching of relaxation in feared situations could be construed as teaching a new safety behaviour, which does not eliminate the central maintaining factor; namely, that the client believes certain bodily sensations or mental events signal imminent personal catastrophe. Patients will continue to hold such beliefs – and the belief that it is only the use of relaxation techniques that prevent the feared catastrophe occurring – if negative cognitions are not challenged. Clark (1999) cites a study by Salkovskis, Clark, Hackman, Wells and Gelder (in press) to determine whether safety behaviours actually prevent disconfirmation of panic patients’ negative beliefs about bodily sensations: “As predicted, the dropping of safety behaviours condition led to a significantly larger decrease in negative beliefs and produced a significantly greater improvement in anxiety in a subsequent behaviour test.” Effective practice is both an ethical and organisational imperative for
clinical psychologists. If techniques such as applied relaxation undermine effectiveness by leaving clients vulnerable to relapse through continued incomplete exposure to the feared stimuli, then therapists must take note of the importance of considering the theoretical rationales by which they practice.

**Critical evaluation – the match between models and clinical presentations**

There are also problems for both theories on the third criteria – their ability to account for the clinical presentation of anxiety disorders and depression. Both behavioural and cognitive theories underlying the use of behavioural techniques are open to the criticism that they are unitary theories. Biological and social factors in the etiology and maintenance of anxiety disorders and depression are marginalised. According to the behavioural paradigm, patients are passive recipients of environmental events and histories of learning. Elaborate attempts are made to eliminate intrapsychic factors from the explanation of abnormal behaviour, but the examples given above (e.g. around “meanings”) indicate the weakness of this approach. On the other hand, the cognitive paradigm appears to place too great an emphasis on intrapsychic factors. Yet, the observed course of, say, depression would appear to contradict a purely intrapsychic approach. Major depressive disorder is time-limited and spontaneously remits in six months (Keller and Shapiro, 1992; cited in Roth and Fonagy, 1997). It is difficult to explain spontaneous remission using Beck’s model. The model states that a vicious circle is established which is driven by dysfunctional negative schema about the self, the world and the future. Any new information about the self, world or future is organised within this negative cognitive framework. The theory predicts that without cognitive restructuring recovery will not take place. The theory also limits the possibility of spontaneous cognitive restructuring: “positive” information, incongruent with negative beliefs, will be ignored or negatively reframed. Spontaneous remission in depression, therefore, cannot be easily explained by cognitive theory. It can be seen from this example, then, that cognitive theory is inadequate to explain the complexity of the clinical presentation of depression.

Unitary models also have difficulty accounting for comorbidity. Thirty-nine percent of agoraphobics, 35 per cent of people with panic disorder and 17 percent of people with generalised anxiety disorder also have depression (Davison and Neale, 1994). Wells (1997) has argued that the strength of cognitive theories is their specificity. Specific cognitive models for the anxiety disorders have emerged from generic models (such as Beck’s), which have proved invaluable to clinicians. But Clark’s model of panic (1986), which can underpin
treatment for panic disorder, provides little guidance for clinicians' faced with a client with both panic and depression. Does the client hold a separate cognitive set for the depressive features – as outlined by Beck – and thus holds two discrete cognitive sets? If so, do they interact in some way? If not, does the client presenting with comorbidity hold a specific cognitive set integrating threat and loss appraisals? If so, what does this look like? Alloy and colleagues (1990) (cited in Davison and Neale, 1994) proposed that the learned helplessness model of depression explained the comorbidity of anxiety with depression. They suggest that when a client expects he will be unable to influence the environmental contingencies of a situation, he will appraise the situation as dangerous and therefore be anxious. When the prediction of helplessness is fulfilled, negative views of the self and the future develop and depression sets in. Such models are rare in the field. Integrative models drawing on the strength of the specificity of cognitive models need to be developed.

**Integrative models**

A wider picture of the emotional disorders would be helpful. As indicated above, both cognitive and behavioural techniques are effective in panic disorder without agoraphobia. Other studies indicate the same pattern of effectiveness in other anxiety disorders. For example, in a randomised control trial, Marks, Lovell, Noshirvani, Livanou and Thrasher (1998) found that both prolonged exposure and cognitive restructuring were therapeutic alone and were each superior to relaxation in the treatment of PTSD. Medication has also been shown to be effective in a range of anxiety disorders and depression. Such diversity of findings confound the main-effects model, upon which both cognitive and behavioural therapy rest. Marks and his colleagues (1998) suggest that diverse findings on effectiveness can be integrated by viewing emotions “as response syndromes, loosely linked reactions of many physiological, behavioural and cognitive kinds.” Different therapeutic approaches may act on one strand or factor of the syndrome more than another. Some treatments may act on several strands simultaneously. Marks and his colleagues, referring to the effectiveness of both CT and behavioural approaches in PTSD, argue: “Exposure gradually alters behaviour, physiology and cognitions by habituation...Cognitive restructuring might distance sufferers from strident feelings and facilitate dealing with them by changing perspectives; it may include habituation via behavioural experiments including exposure, but this is not essential. Relaxation might be a way to reduce arousal and then other problems...Each treatment might act on particular emotional strands, which in turn help unravel other aspects of the disease.” A dose-responsiveness approach is required.
Such an approach implies that unitary models will be most useful when they map the symptom presentations of the disorders precisely and comprehensively. Brewin (1989) argues that panic disorder, for example, is a circumscribed disorder, which can be traced to a specific faulty belief and cognitive process; in this case, interpretative bias. Phobic disorders, for example, can be conceptualised as a faulty behavioural response; making it amenable to behavioural techniques. The cognitive and behavioural strands of the skein are painted in bright colours and can be easily and usefully unravelled. But depression and generalised anxiety disorders (as Brewin, 1989 suggests) are not circumscribed. The strands are complexly interwoven. In therapy, depressed clients report emotions or physiological arousal or actions as triggers of negative thoughts that, in turn, maintain the other three strands. As Williams (1997) suggests, access to autobiographical memory is also distinctive in depressives. Depression is more complex than just expressing interpretative bias to specific stimuli and requires more complex modeling.

Brewin (1989) has examined some of the commonalities behind the actual clinical practice, to try to develop a model that integrates behavioural and cognitive models with cognitive science. He argues that cognitive therapists use behavioural methods because they “create new situationally accessible memories that will be preferentially accessed in the future.” In addition, he argues that, in depression, for example, by verbally isolating, identifying and challenging negative automatic thoughts, the therapist seeks to alter verbally accessible knowledge to counter inappropriate stimulus classification and to avoid the accessing of nonconscious situational memories. New semantic categories and classification rules are generated. It would appear that because clients, in being taught to act differently in phobic or distressing situations, will always think about the situation – that is produce new categories of threat or loss appraisal or self-efficacy and control – cognitive change will go hand-in-hand with behavioural change. Brewin (1989) usefully suggests a conceptual framework based on cognitive science which seeks to explain how cognitive and behavioural approaches, in most cases, complement each other.

**Conclusion**

It has been shown, then, that cognitive and behavioural therapies do have different rationales for shared techniques. Judged against three critical criteria – effectiveness, empirical basis and as explanations for actual clinical presentations – the theories underlying the rationales
have been shown to be incomplete. The evidence indicates that in panic disorder, there is great cohesiveness between theory and practice in cognitive therapy. With depression, cognitive theory and therapy has less cohesiveness. Learning theory is particularly weak at explaining much of the empirical evidence. This can have serious clinical implications, as shown with safety behaviours. It has been suggested that the common weakness of both approaches is that they are unitary models of disorder. Outcome studies showing significant cognitions shifting together with behavioural and physiological changes indicate the need for a multi-factor or syndrome model of anxiety disorders and depression. Wells (1997) suggests that cognitive models will become more closely wedded to information-processing paradigms in psychology, rooting cognitive approaches more firmly in a research base. Brewin's (1989) conceptualisation that cognitive approaches seek to enrich verbally accessible knowledge, while behavioural approaches elaborate situationally accessible knowledge provides a conceptual framework for thinking how therapeutic change can be linked to cognitive science and information-processing models. Such moves will bring more sophisticated models of the emotional disorders.
References


People with Learning Disabilities Essay

What is the impact of others expectations on the communicative abilities of people with learning disability and how might a clinician work with these issues?

June 2000

Year 1
What is the impact of others expectations on the communicative abilities of people with learning disability and how might a clinician work with these issues?

Introduction
Some kind of deficit in communicative ability is implicit in the label “learning disabled”. As Leuder (1989) suggests, any difficulty in articulation results in an increased frequency of the “normal” communicative partner clarifying or rephrasing unprompted what the other person has said (Sabsay and Kernan, 1983). The result of such conversational “repairs” are paradoxical; instead of being cooperative as intended, they reproduce the existence of mental handicap by displaying the participating individuals’ different levels of competence and consequently the incompetence of the handicapped person.’ (Leudar, 1989). What is also implicit in the label “learning disabled” is that the labelled person has both a need and a potential to communicate, whether fulfilled or not. It is the contention here that the communicative potential of people with learning disabilities (PLD) is often unfulfilled. Historically, researchers have concentrated on the communication skills deficits of PLD (e.g. Rondal, & Edwards, 1997) as an explanation of the communication problems they face. By drawing on literature which indicates that communication is a transactional social process, it will be suggested that it is the unrealistic expectations that others hold of their communicative abilities, which stifle PLD’s communicative potential. At its extreme, it will be argued, the impact is immense: it can increase the likelihood of challenging behaviour. Theory needs to be presented that explains why others might have inaccurate expectations of the communicative abilities of PLD, with empirical evidence to support the observation. It will, then, be necessary to show that it is the expectations of others, as well as real ‘deficits’ in communication abilities in some PLD, that have both an immediate and a long-term impact on the daily lives of PLD. It will be assumed for the purposes of drawing general conclusions from this essay that PLD are a homogeneous group with a homogeneous range of communicative abilities. Their communication partners and the quality of those exchanges will also be assumed to be uniform. These assumptions are clearly unfounded,
however. The implications of such assumptions, which underlie many of the theories behind the research, will be examined and challenged when considering what a psychologist can do when working clinically with these issues.

**Communication as a social, transactional process**

Van der Gaag and Dormandy (1993) define communication as follows: `communication is conveying some message a communicator has in mind and its interpretation by an addressee.' Thus communication may take the form of a behaviour as well as a language or a sign. A raised eyebrow can be a greeting, a warning, surprise. It might, however, not be a communication because it either lacks intent on the part of the communicator to convey a meaning or because an addressee is unable to interpret the intent. For a speaker to be successful in communicating, that is convey to another person (a listener) what he has in mind, two factors are involved. As Van der Gaag and Dormandy point out, the speaker needs to know enough about the listener in order to choose the right topic and speech style. Second, the listener needs to know enough about the speaker 'in order to make inferences as to the purpose of the communication and to interpret the message that was meant to be conveyed.' Perkins (1995), cited in Bartlett and Bunning (1997), stresses that successful communicative interaction is not just the sum of two halves, i.e. the communication partners, but rather the co-construction of discourse to which both people contribute. Studies of language development in children (e.g. Dunham & Dunham, 1992) also indicate communicative exchanges are transactional. Carers respond to infants early vocalisations as if they had communicative significance and in return infants have been shown to be equal and influential partners in carer-infant exchanges. From a radical behavioural perspective, language development and communication in adulthood requires responses to be contingent on both sides. Where there are difficulties in this contingency schedule, communication breakdowns on both sides can emerge. Communication, then, is a transactional and social process. The implications for a person with LD (learning disabilities) with any physiological, cognitive or psychological constraints on communicative ability are likely to be profound, affecting the quantity and
possibly the quality of his/her transactions. If one communicates in an exceptional manner one "establishes and indeed reproduces a non-standard communicative world." (Leudar, 1989). Prevalence rates of communication problems in the learning disability population indicate that a considerable number are at risk of establishing this non-standard world.

**Prevalence rates of communication problems in PLD and their environments**

Remington (1998) cites a study by Garcia and Dehaven (1974) indicating that 80 per cent of people with severe/profound learning disabilities had communication problems, while McLean, Brady and McLean (1996) found that caregivers reported that 59 per cent of PLD showed limited symbolic communication, 19 per cent showed limited non-symbolic communicative intent and 21 per cent showed no evidence of any intentional communication. A survey of clients in day centres and longstay hospitals completed by Blackwell, Hulbert, Bell, Elston, Morgan, Robertshaw and Thomas (1989) and cited by Bartlett and Bunning (1997) concluded a total of 62 per cent of the population had identifiable communication problems.

**The nature of the communication problems**

A participant observation study (Kernan & Sabsay, 1989) of a mixed gender group of people with a mild learning disability living in the community in the US indicated the kinds of communication problems faced by this population. Within a heterogeneous range of communicative styles, the authors found consistent "deficits" in the person with LD. PLD in social exchanges variously provided piecemeal information, omitted necessary and included unnecessary information, perseverated and ran unconnected thoughts together in the same sentence. The consequence was that a listener had to attend more carefully and be more patient. Often the result was an end to the transactional process and a disregarding of the wishes of the person with PLD. Referring to the "deficient" communicative style of PLD in the study, the authors said: 'Parents impatient with their rambling, confusing or incomplete explanations or stories often step in and speak for them. Doctors and social workers frequently turn to whatever non-retarded
persons has accompanied their clients for explanations of the purpose of a visit or the presenting problem and sometimes treat their clients as non-persons altogether...' The study found problems not only in how some of the subjects spoke but also in what they spoke about even when they spoke coherently. The authors ascribe this to subjects having a history of institutionalisation, and limited educational and employment opportunities as well as cognitive and, sometimes, sensory impairments. Kernan and Sabsay found a third communicative problem located in their subjects. They found evidence that their subjects, made aware of their difficulties in communication, often wore a "cloak of competence" (Edgerton, 1993) in which they tried to display greater skills than they possessed. The authors concluded that listeners' reactions varied but often they were drawn into a 'benign conspiracy' in which 'they attempt to protect such individuals' fragile self-esteem, either by not revealing they are aware of their incompetence or by helping to cover up failings.' In other words, there is no attempt to clarify the subjects intended meaning or to explore ways to enhance the client's communicative abilities.

Kernan and Sabsay's study showed how communicative deficits located in PLD generated impoverished communicative interchanges which became established as chronically impoverished communicative environments, with PLD not expected to contribute to exchanges in a valued or respected way - they became "non-persons". Beveridge and Hurell (1980) found that more than 50 per cent of communicative initiations by PLD were ignored by staff in residential units. Coupled with the finding that PLD are less likely to ask for help to solve a problem than a non-disabled population (Beveridge, 1989), and it is clear to see that communicative environments are impoverished and are likely to become increasingly so in a spiral of decreasing initiations and responses. Learning theory indicates that communication might extinguish in such a non-contingent communicative environment.

There is evidence, then of communication 'deficits' in PLD and contingent impoverished communicative environments, which in a transactional model (Sameroff & Chandler, 1970) impact on each other. But is there evidence to suggest that non-disabled partners
have expectations of the communicative process that has an impact on the person with LD?

**Evidence for under-estimations**

Leudar (1989) investigated whether the communications of PLD and “average” populations were judged against the same conversational conventions. In other words, he used linguistic pragmatics to investigate whether carers had differing expectations of PLD than “average” people. Leudar drew on the work of Grice (1975) and others, who have identified a number of maxims which partners expect to operate in conversation. Carers, who had known a person with a learning disability for at least three months, were asked to rate whether their client affirmed or violated the maxims. Questionnaires were completed on 157 PLD with an average age of 29 (range 16-45) and an estimated IQ range of 25-70. The PLD lived in a variety of hospital and community settings. They were compared with ratings by non-carers of their friends’ conversational conventionality.

Using factor analysis, Leudar found that the same conversational maxims appeared to apply to a person with LD as to the average person, as predicted, with one significant exception. Carers did not assume that PLD were a competent source of evidence for the truth of what they said. Carers also perceived them to be less sincere about what they communicated. Leudar also found that carers perceived that PLD produced significantly more communications which violated the maxims. Leudar was able to illustrate how people questioned the validity of the communications of PLD with some qualitative examples (Instructors are non-learning disabled; trainee is learning disabled):

Instructor 1: (to another instructor) Where is John?
Trainee: Gone shopping
Instructor 1: (addressing the other instructor) Is John gone shopping with P.?
Instructor 2: Yeah
Studies cited by Leudar (e.g. Sinclair & Coulthard, 1975) have shown that this type of dialogue - where the evidence presented by one party is called into question - is typical of teacher-child interactions. ‘Such [pragmatic] structures are typical when participants in dialogues are asymmetrically empowered,’ concluded Leudar.

**Evidence for over-estimations**

By contrast, there are indications that significant others sometimes have unrealistically high expectations of the communicative ability of PLD. It is unclear why this happens but two factors are likely to contribute. Carers are unlikely to be trained in language development and processes (see the UK Social Services Inspectorate Report (1989), cited by Bartlett and Bunning (1997). However, this is only likely to result in overestimations if PLD themselves appear to show expressive or receptive language skills beyond their actual abilities. Kernan and Sabsay’s participant observation study (1989) cited above appears to confirm the existence of such a “cloak of competence”. Whatever the full reason for over-estimation, there is evidence of its existence.

Purcell, Morris and McConkey (1999) studied the staff perceptions of the communicative competence of PLD. Twenty-four staff working in residential services and day services reported on the communicative ability of 28 clients who were described as being ‘a representative sample of adults in one (NHS) administrative area.’ Staff rated clients for hearing, receptive and expressive language and general use of communication. Staff also rated non-verbal signs and communication functions before and after interacting with clients in a 15-minute session. Clients were also assessed by speech and language therapists (S&LTs) both directly and in videotaped interactions with staff. Staff rated clients’ verbal comprehension very highly; 37 per cent were judged to understand language some of the time; 59 per cent most of the time and four per cent all the time. S&LTs gave clients significantly lower ratings for verbal comprehension. Staff had difficulty in identifying clients’ non-verbal signals. Overestimation was also found by Bartlett and Bunning (1997) in a study of six people (age range 26-48) with a learning disability who had some verbal means of communicating from single words to simple
phrases. Their keyworkers were recorded interacting with the clients in a free conversation condition and while looking together at selected pictures. Staff consistently over-estimated the comprehension level of clients. Significantly, the greater overestimations were evident in the “free conversation” condition. The small sample size, and the study’s concentration on purely verbal measures, limits its conclusions. However, it does indicate over-estimation might occur and that it is more pronounced in non-task oriented settings.

**A model for over-estimations**

Bartlett and Bunning (1997) propose a model for the vicious circle of overestimation. They argue that staff, imbued with the philosophy of ‘normalisation’ (Wolfensberger, 1983), encounter PLD with real communicative limitations but hold high expectations because of the philosophy of an ‘ordinary life’. Unrealistic opportunities are presented to use the communicative skills which the client fails, thus establishing negative or diminished experiences which, in turn, will lead to more restricted communication skills use. They continue: ‘The overall effect of this pattern of devaluation is likely to be poor self-esteem and isolation of adults with learning disabilities and their exclusion from communicative partnerships.’ The fault in this model is that it posits circularity of effect but the circular logic leads one back to the premise that staff maintain high expectations of clients. Yet the authors themselves describe how breakdowns in communications would lead staff to lower their expectations of individual clients.

**The impact**

It has been shown, then, that other people do overestimate or underestimate their partner’s communicative ability. But what exactly is the impact? Taking O’Brien’s 1981 model (cited in Bartlett & Bunning, 1997) of the ‘deviancy career’ of a person with a learning disability, one would expect that on an individual level it would lead to a lack of opportunities to communicate and a deterioration in communicative performance. Additionally, based on the principles of operant conditioning, one would expect to find that where the client’s communications were not contingently reinforced, they would
extinguish. As biological survival dictates that a person – especially one with a disability who might rely on others – cannot stop expressing needs, it seems extinction of communicative intent is impossible. Learning theory would indicate that other behaviours which are contingently rewarded by the meeting of a person’s needs would be reinforced. In other words, where there is a historic and continued breakdown in communication problems, that, at the extreme, challenging behaviours might emerge.

**Challenging behaviours**

Emerson (1995) defines challenging behaviour as ‘culturally abnormal behaviour of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to ordinary community facilities.” It would be wrong to suggest that challenging behaviour is caused by a chronic and complete breakdown in communication between PLD and their communicative partners. For example there is evidence that neurobiological processes may be involved in the maintenance (and possibly the aetiology) of the challenging behaviours of at least some people (Carr & Smith, 1995). However, two strands of evidence indicate that challenging behaviour sometimes serves a communicative function. First, prevalence rates of challenging behaviours (Emerson, Alborz, Reeves, Mason, Swarbrick, Kiernan and Mason, 1997, cited in Emerson, 1998) amongst a cohort of 393 people varied according to a number of ‘risk’ factors. One of these was that challenging behaviour was correlated with people with additional sensory impairments, reduced mobility or specific impairment of communication. (The fact that other risk factors included gender and age warns us to exercise caution about a one-factor explanation for the complexity of challenging behaviours). People with specific syndromes, including autism, are also more ‘at risk’. Studies of autism indicate that there is an interaction between communication difficulties and specific syndromes. There is evidence that early communicative functioning in autism correlates with later social development (Bailey, Philips and Rutter, 1996). There are specific language problems associated with autism. There is general language delay. There are pragmatic
deficits, pronominal reversal, delayed echolalia, neologisms and idiosyncratic usage of language. There are difficulties in building conversational interchanges and a lack of prosody to communicate social and affective information. Clements (1998) argues that work on social and cognitive development illustrates that particular types of language interaction have an impact on the development of social understanding and internal controls. He argues: ‘Explanations about feelings, reasons and mental states may be particularly influential in promoting in the [developing] child an understanding of others and internalising controls.’ While a number of other factors, such as limited social cognition, are undoubtedly a factor in behavioural problems in autism, Bailey et al. (1996) conclude that ‘language delay is a good predictor of social and educational outcomes and is strongly associated with severity of behavioural symptoms, social and cognitive performance and familial loading.’ What emerges from the example of autism then, is that communication problems interact in a specific way with cognitive and biological constraints in the development of impoverished communicative environments and, in extreme cases, behavioural challenges.

The second strand of evidence for the link between impoverished communicative environments and challenging behaviours comes from intervention studies, in which challenging behaviour is treated as chiefly serving a communicative function. Emerson (1998) cites two studies in which facilitating the communication of clients with challenging behaviours produced reductions in the behaviours. Steege et al. (1990) taught two children with severe multiple disabilities to press a micro-switch which activated a tape-recording requesting a break from self-care activities. There was a significant reduction in the escape-motivated self-injury which the children had previously exhibited. Bird et al. (1989) taught two men to either exchange a token or to use a manual sign for ‘break’. This intervention, which focussed on improving communication, led to a number of changes. There was a rapid reduction in the challenging behaviours; there was an increase in spontaneous communication; and both men spent more time on-task and requesting to work. As Emerson suggests Bird et al’s findings indicate that
facilitating appropriate communication may act to moderate stress through increasing a client’s perceived control over an aversive event.

One must caution against suggesting that just because something reduces challenging behaviour, that it explains its aetiology. However, the weight of the evidence presented above suggests that the expectations of others around communication have a serious impact on PLD.

**Social learning theory: a model for understanding the impact?**

Bandura’s social learning theory (1971) provides a theoretical framework for understanding how misconceptions in the transactional process of communication can lead to the disadvantaged party, the person with a learning disability, experiencing a cycle of failure and perceived powerlessness. To communicate effectively, both the PLD and his communication partner have to believe that they are capable of engaging in the appropriate behaviours and that these behaviours will attain the communicative goal. For the person with a learning disability, who is expected by his partner to have little communicative ability, outcome expectations may be lowered because even when s/he has reached the required communicative standard his/her communications are ignored. Beveridge and Hurell’s (1990) finding that staff react to only 50 per cent of PLD communicative initiations, indicates that this might be the case. Further research is needed to establish whether this is the process by which outcome expectations are lowered. In addition, where efficacy expectations are unrealistic (see the evidence cited above) then both partners will be likely to perform poorly. Situations are perceived from both sides as uncontrollable and effort is reduced. This model could provide an explanation for the low rates of PLD initiations and staff response to the communication initiatives of PLD (Beveridge and Hurell, 1980), leading to a lack of communicative opportunities for the PLD, a failure to meet his/her needs and, in some extreme cases, challenging behaviour. Staff beliefs about PLD’s ability to learn is likely to act as a mediating factor in this process.
What clinicians can do

It is vitally important, therefore, that psychologists have strategies to enhance the effectiveness of their communicative exchanges with PLD. Psychologists can take action both on the individual and systems level. One of the key implications of the studies suggesting others both under- and over-estimate abilities, is that it is necessary to liaise with other staff, especially speech and language therapists, to establish the communicative competence of the client before interviewing him or her. In discussing interviewing PLD in legal settings, Bull (1995) indicates a number of pitfalls to avoid. These include avoiding:

- Leading questions that suggest the answer being sought (including being sensitive to non-verbal communication as a form of leading question).

- Pressuring clients into saying more than they wish, which can lead to confabulation.

- Repeating questions on the same point, which can cause people to deviate from the original response presuming it was wrong.

- Using complex grammatical structures

Bull cites a study by Sigelman et al. (1981) which indicates that 'mentally retarded people may be especially likely to give biased answers that are influenced by question structure and wording.' The most common response bias found in the study was a bias towards acquiescence in response to yes-no questions. Sigelman et al. found evidence for the usefulness of using pictures rather than verbal communication. They found that more interviewees answered either-or questions in pictorial form than in verbal form, and that such answers were more consistent with each other than those to verbal questions, and they were free from the acquiescence response bias. A psychologist needs to make use of such research knowledge and bear in mind Bull’s instructions when interviewing people with learning disabilities.
Other approaches also suggest themselves from the empirical work into the communicative environments PLD often face and generate. Most importantly, a psychologist should always value the communicative potential of the speaker. Kernan and Sabsay (1989) found that listeners, faced with a speaker speaking unclearly, attempted to understand the communication according to two criteria: an awareness of the discomfort of the interlocutor in trying to put across his message; and the perceived importance of what is being said. In other words some communication attempts were considered too trivial to try to understand correctly. It is clearly important that psychologists must not devalue their communicative partners by ignoring or pretending to understand the communication when it is not understood. The other important message is always to check that you have understood. As it is impossible to measure success in communication, because one can never be sure what another person has in mind, it is imperative to reflect back to the PLD what your understanding is of what they have communicated (Van der Gaag and Dormandy, 1993). Acquiescence bias means it is likely that sometimes your reflection will be approved when it is wide of the mark, but the practice lessens the possibility of misunderstandings.

When dealing with challenging behaviour, which may have a communicative function, it is important to consider a constructional approach and investigate whether it is better to improve the client’s functional communication than to extinguish the behaviour. As Emerson (1998) notes the keys to success in this approach are two-fold:

- The replacement response must be truly equivalent to the challenging behaviour
- It must be a more ‘efficient’ response than the person’s challenging behaviour

Emerson defines more ‘efficient’ to mean ‘that the new replacement response should require less effort than the person’s challenging behaviour and should lead to more frequent, rapid and higher quality reinforcement.’ This second criteria suggests that for a
psychologist to help a PLD fulfil his/her communicative potential the former must not only work with the individual in the way indicated but also with carers.

In any behavioural intervention success must be measured not only by a reduction in the unwanted behaviour (and, in constructional approaches, an increase in an alternative appropriate behaviour) but also in the maintenance of improvements and whether they generalise to other settings, particularly the daily living conditions of the client. Interventions aimed at improving communication must be measured on the same criteria. Working with carers is essential to achieve success on these criteria. To achieve maintenance, regular reviews of the use of the “new” functional communication needs to take place for, as Emerson points out, challenging behaviours often emerge in the first place because staff are responding preferentially (over more appropriate communications) to the challenging behaviours. Therefore without reviews there is a risk that ‘the response efficiency of the alternative behaviour will reduce (e.g. care staff not attending to socially appropriate requests for breaks or attention) and challenging behaviour will re-emerge.’

If language and communication is viewed from a developmental perspective, partners in communication can also be viewed as teachers, helping not only to maintain communication but also to foster on-going improvements. As Butterfield and Arthur (1995) indicate ‘positive experiences in being able to successfully communicate intentions act as a powerful reinforcer in the process of learning how to effectively communicate with others.’ Receptive communicative partners can foster communication development in all areas of communication – “how” we communicate; “what” we communicate; and “why” we communicate. Receptive partners can: a) create opportunities for quality interactions [the “what” of communication] (b) attend to client initiated behaviours and be responsive in predictable and consistent ways [the “why”] and (c) provide “scaffolding for the next level of development [the “how”]. Working with the others, then, a psychologist needs to ensure they recognise the existing level of a client’s communication abilities and accept development can take place; educate and
perhaps, train others in the above skills and knowledge of communication development stages (e.g. from pre-intentional to intentional communication); and ensure there is an ever-increasing social interactive focus in carer-client interchanges (adapted from Butterfield and Arthur, 1995). Liaison with speech and language therapists and even service-provider managers would be necessary to achieve this wider objective.

Psychologists need to draw on research findings to argue for structures that allow clients greater integration into mainstream society (e.g. Cole & Meyer, 1991, who found in a longitudinal study that children with a severe learning disability segregated from their normal peers regressed in social competence).

The transactional model of communication proposed above indicates that in some instances, psychologists are also likely to have to challenge the beliefs and attitudes of the client him/herself (speech and language therapists may be better equipped to tackle skills deficits). Cognitive-behavioural work for clients at a symbolic level of communication may address low self-esteem. In social learning terms, the psychologist here is intervening at the level of efficacy-expectations. Assertiveness training might be indicated where the client was displaying signs of weaving “a cloak of competence”. In social learning terms, such training would be seeking to change outcome-expectancies.

A psychologist, then, can use his/her knowledge to be a responsive partner. S/he can liaise with other professionals to educate, train and support carers. S/he can use research skills to agitate for improvements in service delivery; and s/he can work on psychological barriers faced by clients to fulfilling their own potential. Optimally, because of the transactional nature of communication, a psychologist needs to work with client and carer in action together.

The danger of generalising: lessons from developmental literature

It is important before drawing a conclusion to review the literature on the language development of children with disabilities to sound a note of warning against making overgeneralised statements. Conti-Ramsden (1989) argues that many studies of the
development of language in children with learning disabilities have produced often inconclusive and contradictory results (for example, on the question of the role of the parents' interactional style on language development). Price (1989) reports a range of methodological difficulties with studies on this question. She challenges how readily the results from one study can be compared with other studies, given the heterogeneity of the samples, and possible variations in age, stage of language development, setting and data collection and analysis. Large numbers of studies have used unrepresentative samples – either very small numbers or a narrow white middle-class socio-economic band or children with Down’s Syndrome, who are easy to identify but represent only 10 per cent of the learning disabled population. Measurement problems include the difficulty that mean length of utterance (a favoured measure) is a crude measure of pragmatic skills and receptive and expressive language. These concerns also apply to studies of adults and their communication difficulties.

Conti-Ramsden’s conclusion is pertinent to the adult population: “Child language research with non-handicapped children has revealed the individuality of children, the different interacting styles parents and children manage to mesh together as well as the enormous range of variables that impinge on the interaction.” Studies (e.g. Wootton, 1989) have shown a fluid not static mother-child communication dyad which varies across situations. Interventions, then, need to be individually tailored because idiosyncratic communication patterns are determined by both partners and by environmental and biological constraints. In dealing with user-carer dyads, Conti-Ramsden recommends psychologists consider characteristics of both parties. For the user, issues to consider are aetiology of the disability, institutionalisation, severity of the disorder, language learning style, temperament and motivation. For the carer, issues are attitudes to handicap, believed severity of the disability, believed user’s communicative ability, personality, motivation and degree of organisational support.
Conclusion

It has been shown that PLD often have their communicative potential stifled by others. Learning theory provides one model for considering how to change the pattern when working individually with PLD. However, because communication is a social process the importance of working with others and with PLD and others in interaction is paramount. To begin to make satisfactory interventions, individually tailored programmes are indicated taking into account not only the communicative constraints dealt with in this essay, but also recognising the complex interplay of biological, cognitive, behavioural and social factors (see the evidence cited above on autism). In addition, clinicians might have to adopt a "political" role, either by role-modelling respect for the communicative abilities of their clients or by challenging wider societal obstacles to greater community integration. Further research is indicated, particularly to ascertain under what conditions expectations vary and change. Work in the field of self-fulfilling prophecies (Jussim, 1986) might inform this activity.
References


Psychiatric classification is irrelevant to the understanding and treatment of mental health problems in childhood and adolescence. Discuss.

Introduction
Psychiatric classification lies at the heart of much treatment and research into child and adolescent problems (Sonuga-Barke, 1998) and the organisation of mental health services and resources for this client group. In this essay, the history and current organisation of present-day psychiatric taxonomies will be examined to understand their role and aims. The strengths and weaknesses of psychiatric classification systems will be examined and the implicit assumptions behind the system (Sonuga-Barke, 1998) challenged. Pilgrim (2000) argues that the alternative to psychiatric classification is psychological formulation. This alternative view will be examined with particular reference to interactional psychological models.

History of child classification:
Classifications are intended to help us deal with complex phenomena by abstracting certain attributes as a basis for grouping individuals or disorders. Each category of a taxonomy represents a hypothetical construct defined by attributes that are singled out from all other attributes that characterise individuals (Achenbach, 1985). The first modern system of classification for mental health problems was published by Emil Kraepelin in 1883. Kraepelin regarded each mental health problem as discrete from others, having its own genesis, symptoms, course and outcome. As in medical science, it was presumed different “diseases” required different treatments, requiring a system to allow professionals to identify different “diseases”. The current major categorical classification systems – the Diagnostic and Statistical Manual IV (DSM-IV) (American Psychiatric Association, 1994), and the International Classification of Diseases 10 (ICD-10) (World Health Organisation, 1992) - were developed in response to the need to standardise a multitude of classification systems which it was considered were preventing professionals from identifying “disorders” and communicating with each other accurately about cases (Kendell, 1975). These systems, however, focussed mainly on adult disorders and it became apparent that a classification system for child and adolescent mental health problems was required (Rutter, 1965).
The early child and adolescent classification systems were heavily influenced by psychoanalytic thinking, which lead to confusion as psychoanalytic terms were disputed and there was little empirical justification for the categorisations (Cantwell & Rutter, 1994). It was felt that systems based on symptomology and systematic reviews of empirical data would lead to greater consistency among clinicians and therefore have greater clinical utility (Cantwell & Rutter, 1994).

**Current Systems of Psychiatric Categorical Classification for childhood and adolescent disorders:**

Both ICD-10 (WHO, 1992) and DSM-IV (APA, 1994) classify childhood disorders, while disorders presenting in adolescence are classified partly in these childhood schemes and partly within adult categories (Gelder, Gath & Mayou, 1991). The categories are based on symptom-patterns, which are described by a single diagnostic term. Each category includes statements drawn from research literature about age of onset, course, degree of impairment and complications, predisposing factors, prevalence and sex ratio. The explicitness of the diagnostic criteria was designed to reduce diagnostic unreliability caused by descriptive inadequacies in previous systems (Cantwell & Rutter, 1994). A multiaxial system was introduced to force clinicians to consider a wide range of information (Davison & Neale, 1994), including information not only on abnormal behaviour but also on general medical conditions, psychosocial and environmental problems and current adaptive functioning. The system allows a range of information on mental health problems and wider contextual issues to be coded simply, without losing information lost to a single-axis classification system (Carr, 1999). Achenbach (1985) notes that the two major versions of the Kraepelinian taxonomy – DSM and ICD – defined disorders via debate and negotiation between practicing psychiatrists, as much as on the basis of empirical data. He notes that there is an especially weak empirical basis for the childhood disorders, because few had been properly researched when they were first devised and there were no research diagnostic criteria to improve the reliability and validity of the clinical concepts (i.e. hypothetical constructs) on which these were based.
Strengths of psychiatric classification:

Communication between professionals:
Psychiatric classifications typically include a clinical description of a problem and the identification of factors associated with etiology, maintenance, course and possible management of the problem and thus forms the basis of sound clinical practice (Carr, 1999). The systems lay claim to a number of practical and empirical merits. First, psychiatric classification acts as an aid to communication between professionals (Klein and Riso, in press, cited in Cantwell & Rutter, 1994). A single diagnostic term provides an efficient, simple summary of a large quantity of information. For example, if a clinical psychologist is referred a child with autistic disorder, s/he would expect to find in the child’s presentation a triad of deficits in social development, language and behaviour (Wing, 1981).

Research facilitation:
Psychiatric classification also has heuristic value. It can help the development of a body of knowledge about conditions. Only after a diagnostic category has been formed can people who fit its description be studied systematically and factors, such as aetiological factors, and maintaining factors be uncovered and treatments developed. As Mendels (1970, cited in Davison and Neale, 1994) notes it was first necessary to recognise a subtype of learning disability, phenylketonuria, before developing dietary treatments. Without the classification of the subtype, dietary treatments on a random group of people with a learning disability would have shown an insignificant response and the treatment would have been discarded.

Clinical utility
Psychiatric classifications are also diagnoses (Achenbach, 1985). A formal diagnosis abstracts attributes that link an individual to similar individuals presumed to have the same disorder. Diagnosis, in itself, can have benefits. Kanner first described autism in the 1940s. In the last decade alone, since pervasive developmental disorders were classified in DSM IV and ICD 10, there has been a seven-fold increase in the number of children diagnosed with an autistic spectrum disorder (ASD). Since it is unlikely that there has been a rise in the overall prevalence of ASD, it can be assumed that before classification many children with ASD went untreated and their families unsupported. Now, with a diagnosis, families can be given information on
prognosis and strategies for management and the child can access educational support and a range of training, including communication-skills training (Carr, 1999). Additionally, as ASD can have genetic aetiologies, diagnosis paves the way for some parents to have genetic testing and genetic counselling (J. Turk, personal communication). On the other hand, if a child has autistic features but fails to meet the strict criteria for autistic disorder, the failure to fit a formal classification can result in health and education authorities withholding special clinical and educational support.

*Passport to resources:*
To be classified with a psychiatric classification involves being labeled in a particular way. Clausen and Yarrow (1955, cited in Cantwell & Rutter, 1994) indicate that to lay people it means that “abnormal” behaviour is perceived as an illness process, out of the control of the “diseased” person. Although, there are a number of concerns that labeling in this way brings negative consequences, there are a number of studies (e.g. Gove and Fain, 1973, cited in Davison & Neale, 1994) which suggest that labeling may not have harmful consequences. Like externalisation (White & Epston, 1990), it can encourage families to view behaviour which is unpleasant as understandable and not malicious (it should be noted that externalisations and behavioural formulations can also have this effect, without pathologising the child). It can serve to prevent children and families being isolated. Psychiatric classifications serve as the basis for delineating and developing self-help support groups, in which parents can share experience and knowledge of a problem. As parental isolation is often a predisposing factor in childhood problems and parental adjustment and social support networks are protective factors (Carr, 1999), the role of classification here should not be under-estimated.

*Criticisms of psychiatric classification with childhood and adolescent problems:*

*Reliability:*
The extent to which a classification system produces the same observation each time it is applied is the measure of its reliability (Werry, 1992). Considerable effort has been put into improving inter-rater reliability of both the DSM and ICD systems, which were bedevilled by low inter-rater reliability. The major mechanism for doing this has been to largely excise theoretical diagnostic terms and replace them with diagnostic criteria based on atheroretical and observable signs and “symptoms”. Reliability has improved from previous systems, but for both DSM-IV and ICD-10 “the demonstration of satisfactory reliability remains a central problem (Carr, 1999).” In a review...
of seven clinic-based studies involving structured interviews with 750 children by Hodges et al., (1989, cited by Carr, 1999) interrater reliability for conduct disorder, attention deficit disorder, depression and anxiety disorders fell below the threshold for “satisfactory” reliability. The problem, however, does seem to be one of training, on the one hand, and the clinical context, on the other. Sonuga-Barke, 1998, notes that reviews indicate that where clinicians are given special training or use a standardised diagnostic interview (e.g. the Diagnostic Interview Schedule for Children; Costello et al., 1984) reliability is acceptably high. With training, then, reliability can be raised to acceptable levels but there remains a practical clinical difficulty. The problem for practising clinical psychologists is that in the clinical context they are drawing on a number of different sources of information not just a diagnostic interview schedule (with children it can include the child, his family, schoolteachers, and other health professionals) all of which are open to various biases (Achenbach, 1985) and his/her own experience (also open to biases, Achenbach, 1985) in order to make “diagnoses”.

Co-morbidity:
Epidemiological data shows that the co-existence of two or more supposedly separate child psychiatric conditions far exceeds that expected by chance (Caron & Rutter, 1991). A study by McConaughy and Achenbach (1994) using parental and child self-report on dimensional behaviour scales found 40 per cent of children with aggressive behaviour also reported attention problems and 43 per cent of children classified as “anxious-depressed” cases also reached caseness criteria for attention problems. DSM IV and ICD-10 treat co-morbidity differently and thus produce different rates of co-morbidity (Rutter, 1988). In ICD-10 the clinician is expected to choose the diagnosis which most closely matches the symptom pattern, reflecting the assumption based on a physical medical paradigm, that a mixed clinical picture represents a slightly atypical manifestation of one disorder, rather than the co-occurrence of two separate conditions (Rutter, 1988, cited in Cantwell & Rutter, 1994). Clinicians following DSM IV are encouraged to diagnose a separation condition for each condition where diagnostic criteria are met and to make multiple diagnoses. But each approach has problems. Let us take the ICD-10 system as an example. The ICD-10 system is based on a medical model of conditions being discrete disease-like entities. In the realm of childhood and adolescent disorders, with the exception of a limited number of conditions, for example, the pervasive development disorders, this model does not fit with psychological models of dysfunction. Dysfunction in psychological models is conceptualised in bio-psycho-social terms and abnormal behaviour is often seen as different in
severity not kind to "normal" behaviour. Second, as there is a lack of empirical evidence on how mixed clinical pictures should be diagnosed (Cantwell and Rutter, 1994), there is a danger of the wrong hierarchical rules being followed in ICD-10. This has considerable implications for the claim that ICD-10 classifications aid understanding and treatment with child and adolescent mental health problems. Without clarity in hierarchical rules of classification, clinicians and clients are left to decide on treatment approaches without a clear evidence-based rationale for the chosen approach. Additionally, there is the possibility that the comorbid combination represents a distinctive syndrome in its own right. Clinicians following the ICD-10 and DSM-IV approaches are then faced with the possibility of treating the client inappropriately. The high levels of co-morbidity in the child field also undermine the clinical utility of the existing psychiatric systems. It suggests that pure, unmixed cases are no more prototypical of clients with a "disorder", than mixed cases (Clark et al., 1995), leaving the clinician with little understanding or guidance in treatment for many of his clients. Indeed, there is evidence to suggest that people with diagnostic co-morbidity have worse prognoses (Keller et al., 1992, cited in Clark et al., 1995), meaning clinicians following existing psychiatric classifications have less ability to help their most needy clients.

Validity
The validity of diagnostic categories involves demonstrating that cases share common critical criteria, from having common predisposing factors to sharing commonality of course and response to specific treatment. As there is no single measure of validity, external validating criteria for psychiatric classifications include statistical groupings of data, epidemiological data, course of the "disorder", genetic data, psychosocial risk factors, neuropsychological patterns and responses to treatment.

In a major review of psychiatric classifications for childhood and adolescent mental health problems, Cantwell and Rutter (1994), who support the use of psychiatric classifications, report that "in no case is their validity fully established and in some instances there are very few, if any, validating data. For most the evidence provides partial support, albeit sometimes strong, but uncertainty remains on key details." These authors, however, err on the side of optimism. They suggest that differentiation of a number of conditions has major clinical meaning; that is, that clients so classified share characteristics relating to aetiology, phenomenology, prognosis and response to treatment. They argue there is sufficient evidence to suggest discrete clinically
meaningful entities for depressive disorders, schizophrenia, hyperkinetic disorders, conduct disorders, autism, Rett’s syndrome, severe mental retardation, mild mental retardation, specific developmental disorders of language, Tourette’s syndrome, obsessional disorders and anorexia nervosa.

Autism provides a good example of a disorder, in which evidence from a range of validating criteria converges to differentiate a child diagnosed with autism from a child diagnosed with another mental health problem. Epidemiological data provided support for the separation of autism from schizophrenia, which were originally linked (Rutter,1972, cited in Cantwell & Rutter, 1994). Autism, hyperkinetic disorders and speech and language disorders, have an early onset, marking them off as possibly different clinical entities than, say, schizophrenia or major depression, which have a marked rise in incidence in adolescence.

The longterm course of autism provides supporting evidence for its differentiation from specific developmental language disorders (SDLDs). Rutter et al. (1992, cited in Cantwell & Rutter, 1994) have found children with autism have poor social outcomes, in terms of employment and independent living, compared with those diagnosed with an SDLD, and have persistent stereotyped behaviour and other language abnormalities. These findings complement twin and family studies, which indicate that autism is strongly genetic (Rutter,1991, cited in Cantwell & Rutter, 1994). Again genetic data indicates the discreteness of autism from schizophrenia, which shows no increase in familial loading. Neuropsychological data also converges to indicate autism is distinct from other forms of learning disability and from SDLDs. Deficits in mentalising capacity (Frith, 1991) and particular linguistic features appear distinctive to autism, although it would be wrong to suggest that there is a specific pattern of cognitive deficits which is diagnostic on its own (Baron-Cohen et al., 1993).

However, even with the ICD-10 classification of pervasive developmental disorders, of which childhood autism is a subcategory, there is a debate over the validity of the current classification. Some authors argue whether ‘childhood autism’ (ICD-10) is distinct from Asperger syndrome (Frith, 1991) or whether they are meaningfully bound together under the grouping, autistic spectrum disorder.

Although Cantwell & Rutter (1994) say there is strong validating data for hyperkinetic disorders,
The claim needs examination and illuminates the validity problems of ICD-10. Validating support for the distinct hyperkinetic disorders category comes from epidemiological evidence, long-term course, neuropsychological patterns and its response to drug treatment. However, the evidence in a number of these areas is questionable. The adult outcome for conduct disorders in childhood is particularly poor when the disorder is of early onset, when it is associated with hyperactivity/inattention and when it arises in the context of family discord. This has prompted some to question whether hyperkinetic disorders constitute a distinctive syndrome or rather are a variety of conduct disorder with hyperactivity as a risk factor (Taylor, 1994). There is also research data (Jones, 2000) which questions whether hyperkinetic disorders can be distinguished from learning disability on the basis of a distinctive pattern of cognitive deficits, as proposed by Kaufman (1994, cited in Jones, 2000). Finally, the finding that children with hyperkinetic disorders respond to stimulant drugs is again suggestive but not conclusive of a discrete “disorder”, as children not diagnosed as having ADHD respond to these powerful drugs.

**Interventions:**
The test of clinical utility for practising clinicians is how a taxonomy helps in guiding the treatment of a condition. Using psychological models a classification has to inform thinking about the aetiology, maintaining factors and prognosis of a specific presentation (Carr, 1999), as these things form the basis of formulation which guides treatment. There is not scope in this essay to consider each aspect in turn, but an analysis of aetiology and prognosis will indicate the current systems’ limitations in these areas.

**Prognosis:**
Psychiatric classification in isolation gives little clue as to prognosis, which is based on a number of factors including age of onset, severity of symptomology, knowledge of the “disorder” process and strengths and weaknesses of the individual and the system s/he inhabits. The major exceptions to this are in the cases of pervasive developmental disorders and learning disability. Autism, particularly when it co-occurs with a learning disability, has a poor prognosis (Gillberg, 1990). This can be identified within current multiaxial systems. Similarly, there is some evidence that children diagnosed with moderate or mild learning disability show degrees of social impairment into adulthood (Richardson and Koller, 1992, cited in Cantwell and Rutter, 1994). This is also identifiable in psychiatric classification systems. However, significant personal and
contextual protective factors, which can be used for judging the prognosis of a referred child with a range of problems, are not identified within psychiatric classification systems. For example, Rolf et al. (1990) found that a child's temperament, a high IQ and high self-esteem were associated with positive adjustment. On a contextual level, Carr (1995), has found that children are more likely to benefit from treatment where there is good co-ordination within multidisciplinary teams or in interagency work. There is evidence that family, parental, social network and quality of schooling (Carr, 1999) act as protective factors improving prognosis across a range of presenting problems.

Aetiology:
Since the early versions of DSM there has been a deliberate move away from a theoretical model, where etiological mechanisms could be inferred, to a descriptive taxonomy (Achenbach, 1985). However, because of this move, psychiatric classification of child and adolescent disorders in DSM IV and ICD-10 is significantly lacking in clarity or transparency about both risk factors and aetiological mechanisms. With risk factors the problem is that a single important risk factor may lead to a range of quite different disorders through diverse mechanisms. Being the child of a parent with a depressive disorder increases the risk for a wide range of disorders (Rutter, 1990; cited in Cantwell and Rutter, 1994). Major depressive disorders in children may be genetically mediated in part (Harrington et al., 1993). But depression can also interfere with parenting and act as a vulnerability for attachment disorders (Carr, 1999). Or it can generate family discord, which is likely to create an increased risk for conduct disorders (Rutter & Quinton, 1984, cited in Cantwell and Rutter, 1994). Psychiatric classification does not illuminate which factors mediate these risk pathways. Cantwell and Rutter (1994) admit: "if aetiological considerations are to play any role in classification it will be crucial to proceed from the identification of broad risk factors to the delineation of specific risk mechanisms." The current psychiatric systems, they admit, have yet to undertake that development.

Additionally, in psychiatry there are many multifactorial disorders where there is no single specific or necessary or main cause and hence no basis for organising the classification system. With Conduct Disorder, for example, there is a plethora of hypothesised aetiological mechanisms – for example, the arousal theory supported by evidence by Raine (1988, cited in Carr, 1999) that children with conduct disorders have lower arousal levels than "normal" children and thus are less responsive to rewards and punishments. This theory competes with other biological theories,
cognitive theories, psychodynamic theories, social learning theories and systems theories, all of
which have an evidence-base in research. The psychiatric classification Conduct Disorder, then,
does not delineate for the clinician which aetiological mechanism is at work. This is a serious
weakness of the system in terms of understanding and treatment. Kendell (1989) argues that an
understanding of aetiological mechanisms constitutes the single best means of developing
effective prevention and treatment strategies.

**Ethical considerations:**

*Labelling:*
The proposition that to give a person a psychiatric classification places them in danger of being
stigmatised (Szasz, 1974), is worth consideration by practitioners with every client group, but
especially those dealing with children and adolescents. In many cases, the latter have not chosen
to see a clinical psychologist and they can be treated without their consent (Division of Clinical
Psychology of The British Psychological Society Professional Practice Guidelines, 1995), as long
as consent is gained from a recognised parental authority. As noted above, there are some
advantages to labelling, but this potential disadvantage has to be considered. Diagnosis carries an
explicit and pejorative message about the way a child will behave. There is some evidence this
can have a negative effect on the parent/child and child/professional dynamic (Johnson, Rasbury
& Siegel, 1986), although it is difficult to be sure about the direction of the effect - whether the
stigma of diagnosis or the behaviour disrupts the relationship. The other concern is that the child
sees him/herself as defective – diagnoses highlight problem behaviours not strengths – and this
becomes a self-fulfilling prophecy (Carr, 1999).

It can be seen, then, that, in general, psychiatric classification is often irrelevant in the
understanding of childhood mental health problems. Problems of validity, for example, limit the
degree to which existing psychiatric taxonomies help us develop process models (particularly, of
maintenance) and contribute to diagnosis being a limited tool for communicating clinically
important information between professionals (and children and their carers).

**Psychological formulation as alternative to psychiatric classification**

Sonuga-Barke (1998) challenges the claim that prevalent diagnostic categories are essentially
atheoretical. He argues that the DSM and ICD classification systems reflect a medical “disease-
process” model in which disorders are seen as the characteristic of the individual (endogeny) rather than the result of an interaction between the individual and the environment. Such an approach does not fit easily with psychological approaches. Psychology is obviously a broad church, but at its most fundamental it conceptualises the development and maintenance of psychological problems in terms of risk factors, precipitating factors, maintaining factors and protective factors which exist either in personal or contextual domains and are embedded in the interactions between the two (Carr, 1999). The assumption of dysfunction centred in the individual ignores the possibility that problems are manifestations of complex interactions between children and members of their social and community networks. For example, with Conduct Disorder, problems which contribute to its development and maintenance include family systems factors, parental factors and social network factors (Carr, 1999). Patterson’s coercive family process theory of conduct disorder (1982) provides one example of an interactional model, rather than endogenous psychiatric model. The theory is based on operant conditioning principles and involves a number of interactional processes, including a hierarchy of negative reinforcement between parent and child. Partial support for the validity of such a non-endogenous conceptualisation comes from studies which indicate that it is effective to provide parent management training for conduct disorders in which the therapist works on altering the parent’s reinforcement contingency without working with the referred child (Kazdin, 1997). It can be seen, then, that there is evidence to challenge the implicit assumption that a child with Conduct Disorder has some kind of categorical condition confined to his own behaviour.

**Psychological formulation versus psychiatric classification - idiographic .v. nomothetic approaches:**

To compare psychiatric classification with psychological formulation is to compare nomothetic and idiographic approaches to classification (Achenbach, 1985). The nomothetic psychiatric approach suggests that all children diagnosed with a particular disorder share common attributes. The danger of this for the practising clinician is that it may not allow the clinician to move from the general presentation to the specific client manifestation in a way that will guide treatment. A case study illustrates this problem. Simon (not his real name) was referred as a 15-year-old following concerns that his schoolwork had deteriorated after he had been involved in a fatal coach crash. A boy he had befriended on the coach trip was one of ten killed in the accident. Clinical interview revealed that Simon was having intrusive thoughts about the incident but was
using thought avoidance to rid them from his mind. The DSM-IV classification of Post-Traumatic Stress Disorder fitted the presentation well. However, although it would have guided the clinician to look for intrusive thoughts about the accident it would have been silent on the relevance of the phenomenon, except as an indicator of dysfunction. An idiographic psychological approach (e.g. Ehlers and Steil, 1995) would indicate the need to specify the content of the intrusive thoughts and the meaning ascribed to them by this particular client. In this case, such an inquiry revealed that Simon repeatedly remembered getting off the coach and not helping his friend. This had a strong personal meaning to Simon associated with shame. Such specification of the symptom helped guide the selection of treatment (cognitive-behavioural therapy) and the implementation of treatment (CBT to challenge specific beliefs about shame).

Psychological formulation as an alternative to psychiatric classification is not without its problems, however. It is an idiographic approach, in that it refers to the detailed portrayal of the individual as a unique entity. The focus in psychological formulation is ‘on a network of inferred constructs that define the individual’s personality and explain his or her behaviour (Achenbach, 1985)’. But idiographic portrayals of individuals are difficult to compare. It is, therefore, difficult to identify similarities among cases and consequently it is difficult to develop a body of knowledge in a domain required to develop specific treatments and models.

In addition, an idiographic approach may well face greater problems of reliability than the current approach. Psychological formulations are complex, requiring information on predisposing, precipitating, maintaining and protective factors. Additionally, in particular in the field of child and adolescence, formulations are based on a number of different sources, which introduces increased scope for unreliability. In many cases, particularly the more complex ones that are found in clinical samples, it would be difficult to find two psychologists who would agree on a formulation.

**Alternative Classification systems:**

**Dimensional Approaches:**

Achenbach (1991) used multivariate statistical techniques to analyse data from over 2000 children, parents and children which indicated that many of the behavioural difficulties of referred clients reflect scores on two major behavioural dimensions. The posited dimensions are
internalizing behaviour problems, such as crying, worrying and withdrawal and externalising problems such as fighting and disobedience. In dimensional systems, symptoms are assessed on a continuum of graded severity. The severity of a condition is often the best indicators of prognosis (Keller et al., 1992; cited in Clark et al, 1998). Clark et al., 1998, have argued that assessing the severity of a dysfunction may be more helpful than specifying the precise nature of a disorder, particularly where there are high levels of co-morbidity (as in childhood psychiatry) which make it difficult to specify the precise nature of the disorder. Dimensional conceptualisations offer other benefits to the clinical psychologist. Carr (1999) indicates that reliable and valid behaviour checklists and ability tests can be easily incorporated into clinical assessments. Improvement or deterioration can be assessed along dimensions and procedures can be manualised.

There are problems, however. The multivariate methods on which dimensions are constructed are poor at identifying rare syndromes or those that contain a single symptom, such as encopresis (Cantwell and Rutter, 1994). Dimensional systems are also not well developed, currently, and development will involve complex decisions, similar to those faced by the current categorical taxonomies. Clark et al., 1998, say the major problem will be deciding which types of dimensions are required and which specific dimensions are most valid for classification purposes in mental health. Werry (1992) puts the case for a combination of current nosologies and dimensional approaches in the childhood field. The dimensional approaches, he argues, would be most suitable for assessing personality features, which figure highly in childhood psychiatry in presentations of externalising behaviours, such as conduct disorder.

**Conclusion**

A phenomenological system that is categorical is not in itself undesirable. The clinical context, where resources are limited, is one in which categorical decisions about who has treatment and who does not have to be made daily. Additionally, child mental health problems cover a broad span and as the above review indicates in some areas – especially where disorders have a strong genetic base (e.g. autism) or have single symptoms (e.g. encopresis) – psychiatric classifications aid understanding and treatment. However, psychological formulations and dimensional approaches exist which can complement psychiatric classifications. It is not necessarily a question of competition between the two (Werry, 1992). However, it must be remembered that “diagnoses apply to disorders, and not to people. “ (Cantwell & Rutter, 1994). As has been noted above diagnosis does not tell us everything which is clinically useful about a client. Used in a
holistic, complementary way, a psychiatric classification can be helpful. In ADHD, for example, the classification which highlights the presence of a triad of behavioural “symptoms”, alongside psychological formulations focussed on how the child’s behaviour may be a factor in maintenance – contributing to coercive interactional processes between parent and child (Patterson et al., 1982), academic attainment difficulties and peer-relation problems - and on protective factors, such as appropriate strategies for maximising academic attainment at school, will inform a multisystemic treatment package.

Target and Fonagy (1996) point the way forward in the short-term if our understanding of childhood problems – and our treatments – is to improve. They argue what is needed is the development of standardised measures of childhood functioning covering symptomology AND developmental achievements and processes which must be integrated into thinking about a child’s difficulties (Target & Fonagy, 1996).
References


Specialist Essay (Narrative Therapy)

Can Breakwell's integrated process theory of identity (1986) contribute to the understanding of theory and practice in Narrative Therapy

June 2001

Year 2
Can Breakwell’s integrated process theory of identity (1986) contribute to the understanding of theory and practice in Narrative Therapy?

Introduction

"Constructivist therapy is not so much a technique as a philosophical context within which therapy is done, and more the product of the zeitgeist than the brainchild of any single theorist…“ (Anderson, 1990, cited in Neimeyer, R., 1993).

Anderson’s observation can be applied to narrative therapy, a constructivist approach to clinical psychology developed in the 1980s, at first in parallel, and then, in collaboration by Michael White and David Epston. As the quotation suggests, the theoretical foundations of narrative therapy reside not in psychology – either social, cognitive, developmental or clinical – but in philosophy and literary criticism. White and Epston (1990) write that the understandings of philosopher Foucault and literary critic and philosopher, Derrida, underlie the attitudes and practices of narrative therapy. The zeitgeist is that of postmodernism, with its commitment to the idea that ‘the belief systems and apparent “realities” one indwells [sic] are socially constituted rather than “given”, and hence can be constituted very differently in various cultures (or subcultures), times, and circumstances, although they might appear to carry the force of necessity to those that inhabit them’ (Neimeyer, R. A., 1993).

Postmodernism is evident in the language of narrative therapy, which echoes the language of postmodernist literary criticism (e.g. “stories”, “narratives”, “deconstruction”, and “discourses”). Narrative theory does not mention vocabulary such as “cognition”, “schema”, “assimilation” and “learning”, or the discourses connected with other clinical psychology traditions, especially cognitive approaches to clinical psychology. There appears to be no bridge between the language of elements of modernist psychology and that of narrative therapy. In this essay, it shall be argued that this present day lack of communication between the two traditions creates difficulties for clinical psychologists wishing to practice narrative therapy in the NHS and for both clinical psychology and narrative therapy themselves. It will be suggested that links can be established by viewing narrative therapy through the lens of a constructivist theory of identity devised in the field of social psychology. The implications for the development of narrative therapy theory and practice will be considered. As with all well-embedded “re-authored” stories, I will start by suggesting that links between social psychology and narrative therapy have continuity with events in the past.
The evolution of narrative therapy:
The link between narrative therapy and other psychological traditions contains a number of stories. Some have been authored. For example, Zimmerman and Dickerson (1994) show how narrative therapy has continuity with second-order cybernetic thinking in family systems therapy. But other strands in this story are less well elaborated into narrative therapy’s identity. Kelley (1998) notes how narrative therapy, based on the work of White and Epston (1990) developed in relation to postmodernist influence and in relation to constructivist and constructionist therapy approaches developing in North America and Europe. White and Epston (1990), perhaps because of the Antipodean cultural context in which they practised, where indigenous peoples were being marginalised, drew on the works of French philosopher Michael Foucault. It appears that Foucault was of particular interest to White and Epston because of his thinking around how social power forges the knowledge people use to interpret their own lives. However, White and Epston also drew on constructivist ideas, particularly those of Bruner and Bateson. As Kelley (1998) indicates, however, constructivist ideas themselves have their roots in Kelly’s Personal Construct Theory (Kelly, 1955). Kelly’s theory was to profoundly affect social psychological research into identity and spawned a large body of research. There is then a historic link between a theory of identity construction espoused by social psychologists and present day narrative therapy. However, this “territory” remains largely unstoried in the narrative sense.

Is the lack of a “thickened” (White, 1992) alternative story linking narrative therapy with social psychology a cause for concern, however? It might not be if narrative therapists worked in isolation, but as social constructionists they know the importance of political, cultural and social context in generating problems and solutions. In the context of clinical psychology practice in 2001 in the NHS, the weakness of links with other psychological traditions is problematic.

Problems associated with the isolation of narrative therapy from its psychology roots.
The most significant problem is that there is almost no experimental research into the effectiveness of narrative therapy. A trawl through PsycInfo databases under the keyword “narrative therapy” reveals 165 entries. However, not one of these articles is an account of even a control-group design, let alone a randomised controlled trial into the effectiveness of narrative therapy for adults with mental health problems. There are a number of case studies, however, these are not experimental in design, but are descriptive, anecdotal accounts used to
illustrate the theory and practice of narrative therapy. Reviewing the family therapy literature in 2000, Etchison and Kleist found just four experimental studies into narrative therapy.

A number of reasons have been advanced for the scarcity of research. R. Neimeyer (1993) has stated that research into constructivist methods is limited because of the therapy’s recent emergence. This is a weak argument. Eye-movement desensitisation reprocessing (EMDR) for trauma is of more recent origin and has generated dozens of experimental studies. Gale (1993) suggested that the epistemological and methodological differences between constructivist and positivist paradigms have played a part. Outcome and effectiveness research traditionally adopts the positivist approach. As Etchison and Kleist point out, constructivist researchers are more at home with qualitative methodology where the subjectivity of the researcher is acknowledged and valued and where emphasis is laid on the meaning research participants attach to their experience (Smith, 1996). Researchers’ historical lack of training in qualitative methodology and a historical bias to quantitative approaches in psychology journals also undoubtedly contribute to the lack of outcome and effectiveness research into narrative therapy. It is also possible, however, that the epistemological and philosophical gap between narrative therapy and mainstream clinical psychology “realist” discourse is promoting hesitancy in researchers who favour a narrative approach to therapy. The language of text discourse on which narrative therapy is based emphasises deconstruction as the prime research endeavour, not hypothesis-testing, theory-generation or effectiveness measurement.

Whatever the reasons, the scarcity of research into narrative therapy creates professional and ethical problems for clinical psychologists working in the current NHS. There is both a managerial, professional and ethical imperative to apply evidence-based practice wherever an evidence-base exists. There are no research studies into the effectiveness of narrative therapy which meet the strictest established research criteria used by the National Institute for Clinical Excellence or the Cochrane Collaboration. In practice, a clinician who wants to advance the cause of narrative therapy is faced with not being able to practice his/her preferred approach, especially where the evidence-base points to substantial improvements using other approaches (such as using cognitive-behavioural therapy for panic disorder). Ethical practice requires that at least clients be informed of alternatives to the narrative approach and their chances of success. Clinical governance requires clinicians to prove – in terms of outcome and efficiency – that they were justified in not using the “standard” approach. The continued development of clinical psychology itself – as well as narrative therapy - is jeopardised because research into innovative practice is constrained in this way.
It would be significant and helpful to both the modernist and postmodernist traditions, then, if a bridge could be reconstructed between the two in the field of clinical psychology. The obvious place to look for such a bridge is in the field of social psychology. You would look here because as suggested before a link already exists in Kelley's construct theory (which heavily influenced both social psychology and narrative therapy) and because the view of identity in narrative therapy and in current social psychology are influenced by social constructionist ideas. It will be suggested that Breakwell's integrated process model of identity (1986) from the social psychology domain might help reconstruct the bridge.

The theory underlying narrative therapy
To search for common ground, one first needs to describe the territory called “narrative therapy.” One of the difficulties of narrative therapy is that it is a broad church that has taken on a number of different forms (Neimeyer R., 1993). In this essay I shall concentrate on narrative therapy as defined by Michael White and David Epston (1990). The key to understanding narrative therapy lies in the text analogy. White contrasted the study of human behaviour using the analogy of text against the analogies drawn from the positivist physical sciences. Under the text analogy, social organisation is constructed as behavioural texts, problems constructed as the performance of oppressive, dominant stories, and solutions comprise of opening a space for the authoring of alternative stories. The use of the text analogy 'enabled the interaction of persons to be considered as the interaction of readers around particular texts...(and) to conceive of the evolution of lives and relationships in terms of the reading and writing of texts, in so far as every new reading of a text is a new interpretation of it, and thus a different writing of it.' (White and Epston, 1990). Moving from the interpersonal level to the intra-psychic level, White and Epston argued that people engage in meaning-making to order to make sense of their lives and this can be best understood in terms of stories or self-narratives. 'The success of this storying of experience provides persons with a sense of continuity and meaning in their lives, and this is relied upon for the ordering of daily lives and for the interpretation of further experiences.' (White and Epston, 1990). As Carr(1998) indicates this means narrative is identity: "the narrative approach rests on the assumption that narratives are not representations of reflections of identities, lives, and problems. Rather narratives constitute identities, lives and problems."

Crucially, a person's dominant self-narrative also establishes the criteria for data/text selection into the ongoing texts resulting in people paying a price for storying their lived experience through dominant narratives. Lived experience is richer than discourse, so some parts of our experience (the possible alternative self-stories we have of ourselves and that others have
about us) go unstoried and remain ‘amorphous, without organisation and without shape.’ (White and Epston, 1990). Problems, then, occur either because a client is being situated in stories that others have about him/her and his/her relationships, and that these stories are so dominant that they allow insufficient space for the performance of the person’s preferred stories, or that the client is actively engaging in stories she finds unhelpful, unsatisfying or dead-ended, and which do not encapsulate the person’s lived experience or run counter to the lived experience (White and Epston, 1990). Such positioning occurs because dominant social and cultural discourses become reified into objective “truths” about life against which individuals make comparisons and evaluations of their own lives. For example, young women in Western society might internalise the dominant discourse that to be valuable and attractive they must be slim, subjugating other discourses around what is valuable and attractive in young women. In narrative terms the therapeutical process is concentrated on the process of re-authoring personal narratives, which "changes lives, problems and identities because personal narratives are constitutive of identity." (Carr, 1998).

From theory to therapy.

Therapy, then, in narrative terms, involves the client being invited to re-author their own narratives, deconstructing dominant narratives and re-visioning their stories (Davis-Berman & Berman, 1998). For clients to be coming to therapy, they or those in power around them must consider the client to live in a problem-story. This problem-saturated story is often internalised and experienced as the sum of the person. The client believes, say, “I am stupid and I have always been stupid” or “I am depressed” to the exclusion of alternative descriptions. One of the therapist’s and client’s tasks is to identify “unique outcomes”, which are moments in which the client resists the invitation of the problem to organise his life around ways that support the problem and cohere with the problem-story. White and Epston (1990) recommend that the identification of unique outcomes can be facilitated by the deconstruction of the problem-saturated story. Deconstruction involves exposing the underlying assumptions that background a problem-story, which often appear to the client as a fact or rule about the world. Deconstruction challenges the notion that beliefs are “facts” (based on the postmodernist challenge to objective reality). Externalising the problem-saturated story is a favoured technique of deconstruction in narrative therapy. Externalisation promotes agency, so that clients 'experience a capacity to intervene in their own lives and relationships, and the identification of unique outcomes. Deconstruction allows clients, not necessarily to move out of problem stories but to stand in a different relationship to them’ (Epston, 1992). Clients are then required to ascribe meaning to the unique outcomes and to plot them into an alternative self-narrative or other-narrative. As alternative stories become available to be performed, clients are encouraged to identify expressions of lived experience
which would otherwise have gone unstoried and to review the effect of these expressions in
their lives and relationships (White, 1990). Alternative stories can be "thickened" (White,
1995) by the client recruiting an audience to witness the performance of the new story (White

The problems of narrative therapy and its construction of identity and identity change.
Narrative theory suggests that self-narratives, while capable of being changed and moulded
are "stable structures of the mind that dictate what information will be processed in what
way." (Strand, 1997). Unlike structural family therapists who argue that what needs to be
restructured is interactions between individuals, narrative therapists believe that what needs to
be restructured is the intraindividual constructions of problematic situations. Yet as Strand
(1997) points out the theory offers 'surprisingly little in terms of describing the mental
structures in need of restructuring.' It lacks explanatory power over the process of re-
authoring. For example, narrative theory does not explain why some stories are more
amenable to be re-authored than others and it does not predict whether some individuals are
more amenable to a narrative approach than others. It is in seeking to address these issues that
a process model of identity should be considered.

Breakwell's integrated process model of identity (1986)
Breakwell's integrated process model of identity (1986) is one model from a social
psychological tradition which appears useful as a link between the two traditions. The model
of identity proposed by Breakwell is social constructionist in nature in that identity is not
considered stable and unitary but as "a dynamic social product, residing in psychological
processes, which cannot be understood except in relation to its social context and historical
perspective." (Breakwell, 1986). The structure of identity as proposed by Breakwell is easily
recognisable in the discourse of narrative therapy. Breakwell contends that identity structure
consists of two planes: the content dimension and the value dimension.

The content dimension 'encompasses both those characteristics...considered the domain of
social identity (such as group membership, roles etc.) and of personal identity (values,
attitudes, cognitive style etc.)' (Breakwell, 1986). The traditional view of social and personal
identities being separate is abandoned because 'seen across the biography, social identity is
seen to become personal identity.' As Kitzinger (1998) has it, the two "interpenetrate each
other" in a dialectical relationship. The content dimension is organised in terms of degree of
centrality, hierarchical arrangements of the elements and the relative salience of components.
Content, however, is not static and is responsive to changes demanded by the social context.
In narrative therapy terms characteristics considered the domain of social identity can be equated with subjectivities, while those of personal identity relate to subjectivities shaped by and shaping discourses.

Each element in the content dimension has a positive or negative value attached to it, which constitutes the value dimension. The value dimension is subject to revision as a consequence of changes in the social value systems and modifications in the individual's position in relation to social value systems (Breakwell, 1986).

There is, then, in this conception of personhood a strong overlap with narrative therapy. The idea of the individuated self is deconstructed and other models of personhood/identity are presented. The role of time as being biographical, rather than an objective reality also threads through both discourses. Both theories also rest on the implicit assumption that human systems are characterised by self-organising development, evolving in such a way as to protect their internal coherence and integrity (Matron & Valero, 1987, cited in R. Neimeyer, 1993).

Crucially, however, Breakwell describes the processes and the principles by which an individual's sense of identity responds to changes (or "news of difference" as narrative therapists would have it) in the environment. The processes of identity are guided by principles which define desirable states for the structure of identity. In western culture the current prime principles are: continuity, distinctiveness and maintaining or increasing self-esteem (defined as a feeling of personal worth or social value). These three principles will vary in their relative salience over time, across situations and on a developmental dimension. These principles guide the processes maintaining identity structure: assimilation and accommodation (which are components of the same process) and evaluation.* The two processes constantly interact. This process-model generates a theory of what defines a threat to identity (or a problem for a client). A threat to identity occurs when these two processes are unable to comply with the principles of continuity, distinctiveness and self-esteem.**

Breakwell makes a distinction between occupying a position in which identity is threatened and actually experiencing threat. She argues that if coping strategies are effective, occupancy of a threatening position may lose its power to threaten. Some interventions in narrative therapy can be conceptualised as effecting this shift. For example, if a client presents with a dominant story that he cannot control his anger. One narrative strategy would be to identify the alternative story embedded in unique outcomes when the client had controlled his anger and allow the client to enter into this story. As life will always continue to evoke anger-inducing situations, it could be said that the strategy has been to help the client stay in a
threatening position but not to experience threat. In identity terms the principle of self-esteem has become more central than continuity.

Breakwell (1986) theorises that threats to identity can produce coping responses on an intra-psychic, interpersonal and group/intergroup level (See Appendix 1). She proposes that the choice of coping strategy is determined by an interaction between the type of threat involved and the salient parameters of the social context, the prior identity structure and the cognitive capacity of the individual. She further argues that suboptimal coping strategies will be maintained as long as the constellation of factors that produced the choice remains unchanged.

Conceptualising narrative therapy using Breakwell’s model:
An example from clinical practice will demonstrate how Breakwell’s theory can help conceptualise narrative therapy practice. Anne (name changed) is a single mother with two children, who is presenting with obsessional behaviour around throwing away food which is not entirely fresh, with cleanliness; with a fear of taking medication; with mood swings; and with almost daily panic attacks. She was raised in a family which reflected the dominant cultural discourse that “abnormal” behaviour was considered deficient and a sign of weakness. Since leaving home, Anne has maintained a peer group that has espoused such discourses. The “weakness” belief also reflects the wider social/cultural discourse, which has real threatening effects in terms of “abnormal” people being isolated and marginalised. Anne herself reflects the dominant discourse in seeing the panic attacks as “a sign of weakness”. She believes it is “girl-ly” to show vulnerability. If she has a panic attack she likes to hug her eldest daughter to make her feel “rational” again. Anne cannot always remember being particular with food. She says the problem started with the birth of her first child six years ago. She sometimes pretends with her friends that she has no problems (but is now “fed up with pretending all my life”) and sometimes she avoids going out altogether because she fears the disapproval of friends if she had a panic attack. Unlike a cognitive-behavioural approach,

*Assimilation refers to the absorption of new components into identity structure; accommodation refers to the adjustment which occurs in the existing structure to find a place for the new elements. The process of evaluation entails the allocation of meaning and value to identity contents (Breakwell, 1986).

** A threat to identity can originate externally (e.g. if a person is made redundant) or internally, if a person seeks to alter his position in the social matrix in accordance with one principle only.
a narrative therapist would not concentrate on the “diagnosis”. A narrative therapist might externalise problem and map the effect of the problem on Anne and vice versa. S/he would search for the dominant story, particularly focusing on how the client identifies problems and then ascertaining how the client perceived the behaviours as a reflection on her preferred identity as a mother, friend, daughter etc. (White, 1995). Breakwell’s theory allows the narrative therapist to conceptualise why this particular behaviour would be considered a “threat” to this woman’s identity structure. As content and value dimensions of her identity contain a positive valence for normality and healthiness, to assimilate the new “abnormal” behaviours would not comply with the principle of self-esteem. The continuity principle is also contradicted by the emergence of the behaviours seven years ago. Assimilation-accommodation cannot take place, therefore Anne remains in a threatening position. Additionally, Breakwell’s model allows the therapist to conceptualise Anne’s current interpersonal coping strategies as wavering between isolation and passing. The alternative story, which will enable the identity processes to take place, will be found where Anne resists the invitations to adopt these sub-optimal strategies.

**Breakwell’s model as an explanatory tool in narrative therapy**

Breakwell’s model allows the clinician to hypothesise about what stories are unhelpful and why some stories are more amenable to being re-authored than others are. White and Epston (1990) offer some pointers to the clinical decision of what story to look out for, particularly when the clinical presentation is mixed. They suggest that the therapist looks out for discourses that are “oppressive”. Tomm (1987) suggests that the therapist listens out for negative external conversations which have become internalised by the client. For example, if family and peers and partners repeatedly tell a person they are useless, then the person’s identity structure interpenetrated by its social context will assimilate the information into its content and value dimensions. Chen, Noosbond and Bruce (1998) recommend listening for problem self-descriptors that are “totalising” (such as “I am an alcoholic”), which involve the client in the belief that s/he is defined entirely by his/her drinking. Breakwell’s model provides a more specific guide to considering how to define the problem story. It is a story that violates one or more of the three principles. Most obviously, it will be a story that lowers self-esteem. Interestingly, Breakwell’s model suggests that to accommodate the story into identity structure the story over time will have to harmonise with at least one of the three principles. Most commonly, problem-stories appear to adhere to the principle of continuity. For example, a depressed person who feels he is incompetent, will story his life as one of continual and continuing incompetence.

Breakwell’s model also guides the clinician and client in choosing which alternative stories to co-construct and how to go about it. Again, the model indicates that the story must be
consonant with one of the three principles. The continuity principle provides an example. Alternative stories cannot just be the opposite of the dominant oppressive story, unless the client indicates by their language that the opposite view of them has existed in their store of lived experience but in unstoried, disorganised form. Taking the example of Anne given above, it might be inappropriate to focus on a unique outcome in which she indicated that she was “strong” not “weak”. Further questioning would be required to explore whether this alternative self-view was one that had some continuity with Anne’s lived experience and that fitted with Anne’s vision of her personhood into the future. The therapist and Anne would then be engaged in embedding this re-authored story in Anne’s personal and interpersonal history and into her current context.

**Process issues in narrative therapy**

The key feature of Breakwell’s model is that in integrating a number of existing theories and evidence in social psychology on identity she added a model of the processes underlying identity structure and content. Again, the ideas on process may advance the practice of narrative therapy, or at least provide a conceptual framework for reflective practice. Breakwell refers to three major processes: assimilation and accommodation and evaluation. Narrative therapy is mainly concerned with accommodation and evaluation. Assimilation is not its primary concern, in as much that therapists are concerned with joining with clients to story existing areas of their lived existence not new material, “to notice and reconstitute their lives along lines they may prefer, and to develop more preferred versions of themselves.’ (Zimmerman and Dickerson, 1994). The process of assimilation in narrative therapy may occur after alternative stories have been co-constructed in the therapeutic conversation and the client recruits “witnesses” to enactments of the re-authored self. If a woman who is subject to domestic violence forms a self-help group, regaining a sense of efficacy and agency, then action in this domain may form new material regarding power and gender to be assimilated by the identity structure.

However, authoring alternative stories primarily involves accommodation of existing, but unstoried identity content, and changes in evaluation of existing content. In Breakwell’s model the two processes stand in a dialectical relationship; changes in the content of identity brought about by accommodation will effect changes in the evaluative process and value dimension which in turn will effect changes in the content dimension and so forth. Similarly, this dialectical relationship can be seen in narrative therapy. Taking Anne’s example, if unique outcomes can be identified that suggest an alternative story of personal strength, and even communal/gender strength and Anne notices this news of difference, then, in terms of Breakwell’s model, accommodation of unstoried identity structure is taking place. With such
accommodation, concerns around eating and taking medicines would be expected to be re-evaluated as Anne stands in a new relationship to her "problems". This new stance in relation to eating and medicines would in turn engender fresh experiences in which lived experience expressing personal strength and power could be more readily assimilated as it is more readily attended to and positively valued.

Limits of narrative therapy?
One part of Breakwell's model throws up an interesting question around the limits of narrative therapy. Breakwell argues that identity structures are the product of the interaction of the biological organism with its social context. Therefore, "the parameters of the biological organism...set the ultimate constraints upon the development of identity and provide the capacities necessary for the operation of identity processes." (Breakwell, 1986). Breakwell (1986) does not argue that more differentiated identity structures are in any way more "mature" or "better" than less developed ones, but she does suggest that cognitive capacity will effect the processes. Strand (1997) argues that cognitive development does limit narrative therapy, even among adults without cognitive impairment. He says for deconstruction in narrative therapy to be successful the client must be able to see that his/her self-identity is socially constructed; that is the client must be able to take a meta-position on identity as a basis for reconstructing a new reality. Some clients, he argues, are not at that cognitive developmental stage and will therefore respond better to a solution-focussed approach, in which therapist and client remain closer to the client’s current construction of reality. Against this, Michael White’s use of narrative therapy with children provided some of the first anecdotal evidence of the effectiveness of the narrative approach, and Silvester (1994) has developed the approach for group assertiveness work with people with a learning disability.

Research, narrative therapy and Breakwell’s identity model.
As noted earlier there is a big research gap around narrative therapy in the context of clinical governance in the NHS. As Kelley (1998) notes when writing about narrative approaches in the context of the managed care market in the US, there are a number of ways in which narrative therapists can present their work in a framework acceptable to a managerial and scientific community wedded to empirical research approaches. Case-studies (White and Epston, 1990) and clinical practice indicate that narrative therapy is briefer than insight-oriented approaches and is therefore an efficient use of resources. Narrative therapists do discuss and label problems and, if required, could apply DSM-IV labels while “still keeping the narrative language and thinking for working with clients” (Kelley, 1998). Narrative therapists help individuals and families stop, control and alleviate specific problems that are oppressing them and such goals are easily defined in outcome terms. For these reasons there is
no pragmatic reason why narrative therapy could not be the subject of traditional empirical outcome research. However, as narrative therapists do not assume the linear relationships which underlie statistical procedures in positivist research methodology, they have been traditionally resistant to it. This essay suggests that other methodologies such as ethnographic approaches, stochastic modelling and transcript analysis could also be useful (Kelley, 1998). Additionally, as Kelley (1998) suggests repertory grids, devised to measure clinical changes using Kelley's Personal Construct Theory, could also be used. Training in the use of repertory grids would be required. However, such methodology alongside other qualitative and quantitative techniques could help narrative therapists talk more easily with a wider psychological community. Breakwell (1986) herself also advocated a catholic approach to methodology in the task of understanding better the "individual and ideological system" in identity.

**Conclusion**

The story of narrative therapy can accommodate a link with the wider psychological, even modernist, community without threatening its distinct identity. The argument put forward here is that not only is this possible, by thinking of narrative therapy and practice in terms of an integrated model of identity favoured in social psychology, but that it is necessary. If one only takes the area of research, the importance of bridging the communication gap between narrative and other approaches is palpable and paramount. To bridge the gap and foster research would be of benefit to the development of narrative therapy theory and practice and to the practice of clinical psychology itself. For example, one possible way forward would be to draw on the identity work in social psychology of Berzonsky (199, cited in Neimeyer, G. and Metzler, A., 1994), which might help narrative therapists reflect on the styles of storying adopted by clients and how these styles effect the process and content of generating re-authored alternative stories (see Appendix 2).
References


Appendix 1:

Breakwell's model for coping with threats to identity (1986):

Breakwell (1986) argues that intra-psychic coping strategies rely on the process of accommodation-assimilation to either deflect or accept the implications of the threat. Deflection tactics entail the refusal to modify the content or value dimensions of identity. Deflection tactics include denial, transient depersonalisation, belief in the unreality of the self, fantasy, and reconstrual and reattribution. Another strategy involves a the process of evaluation revising the value placed upon either the existing or prospective content of identity (See fig.1 below):

Interpersonal coping strategies rely upon changing relationships with others in order to cope with the threat. These include isolationism, negativism, passing and compliance. Group strategies include engendering group support for a dilemma, and using a group as a context for consciousness-raising, Groups can bring about change in the social structure or in the ideological milieu (Breakwell, 1986).
Appendix 2:

Berzonsky (199, cited in G. Neimeyer and A. Metzler, 1994) proposes that individuals adopt one of three styles in processing information which pertains to their identity structure and content.

These are:

1. **Information-oriented individuals**, who are marked by active efforts to seek, process and utilise self-relevant information prior to developing firm personal beliefs or commitments.

2. **Normative-oriented individuals**, who are marked by a reliance on available prescriptions and standards of referent groups and who place special emphasis on conserving existing beliefs and cordon off aspects of identity.

3. **Diffuse-oriented individuals**, who are marked by heightened attention to situational demands and whose behaviour and self-beliefs are strongly shaped by immediate contexts.
Older Adults Essay

Critically discuss the argument that psychodynamic psychotherapy is inappropriate for older people compared with other approaches.

December 2001

Year 3
Critically discuss the argument that psychodynamic psychotherapy is inappropriate for older people compared with other approaches.

Introduction.
Freud famously wrote in his 1905 paper 'On Psychotherapy' that clients near or above the age of 50 were contraindicated for psychoanalytic psychotherapy because 'near or above the age of 50 the elasticity of mental processes, on which treatment depends, is as a rule lacking – old people are no longer educable...'. He went on to say that psychoanalytic psychotherapy was also impractical with this group because 'the mass of material...would prolong the duration of the treatment indefinitely.' Since he made his comments psychoanalytic therapy has been accepted enough for it to be enshrined in the National Service Framework for Older People (DoH, 2001) as a treatment option for older adults with depression. However, there is still resistance to the idea of using psychoanalytic psychotherapy for older adults among psychoanalysts themselves and among referring psychiatrists. Bateman and Holmes (1995), while taking issue with Freud, list "older patients" among "special groups" in their introduction to psychoanalysis. Turner (1992) cites a study by Ford and Sbordone (1980) which revealed that psychiatrists were less likely to refer older patients than younger ones for psychotherapy in general, including dynamic therapies, on the grounds that older clients had a poorer prognosis than their younger counterparts. In this essay, the evidence for the appropriateness of psychodynamic psychotherapies with older adults will be examined. The criteria for judging "appropriateness" will be wide. It will include an examination of Freud’s criteria. The process of cognitive changes in normal development will be examined briefly to see if the psychotherapies are inappropriate on the basis of “mental inelasticity”. As Freud was basically arguing that for process reasons psychoanalytic therapy was inappropriate, theory and process issues will also be examined. The essay will also tackle time and cost effectiveness – Freud’s second prohibition. However, the criteria of appropriateness will also be extended to include modern NHS concerns with clinical effectiveness.

In this essay, the term psychodynamic psychotherapy will be taken to include both psychodynamic and psychoanalytic approaches as much of the theoretical literature and case studies concentrates on psychoanalytic approaches and much of the research literature lumps both together as “insight-oriented” therapy. Psychodynamic psychotherapy will be compared with cognitive-behavioural therapy and pharmacotherapy, in the main, as these are the best researched and most prevalent alternative treatments in the NHS. Older adults will be taken to
mean clients over 65, as this is the age-related criterion for service provision and the age often used to define older adults in research studies.

**Clinical effectiveness:**

It is widely accepted that older adults can have the same range and severity of psychological problems as younger adults, although with sometimes differing presentations. Anxiety disorders provide a good example. A community sample study in the US found combined 1-month prevalence of phobia, panic and obsessive compulsive disorders in older adults was 5.5% (Flint, 1994; cited in Niederehe and Schneider, 1998). Additionally, evidence suggests that depression and anxiety disorders are more frequently chronic and recurring than with younger adults. Murphy (1994, cited in Niederehe and Schneider, 1998) found that 25-33% of older adults failed to make a complete recovery from depression.

A meta-analysis by Scogin and McElreath (1994) of 17 studies of psychosocial treatments including cognitive and psychodynamic therapies for depression revealed that all treatments were more effective than no-treatment conditions, with treatment effect sizes comparable to psychosocial treatments for younger adults. The analysis revealed no advantage for one treatment approach over another. However, analysis of a series of randomised-controlled trials by Gallagher, Thompson and their colleagues comparing various psychosocial interventions for depression with each other and a delayed-treatment control group reveals a more complex picture. Gallagher and Thompson (1982, 1983) compared treatment outcomes for 30 adults with an age range of 59-90 on three treatment conditions – behavioural, cognitive, and insight-oriented psychotherapy. Patients received 16 sessions over a 12-week period and were followed-up four times over a one-year period. Their findings paint a more complex picture of treatment efficacy. While each therapy gained an equal treatment response, improvement was maintained more effectively one-year post-treatment for clients treated with behavioural or cognitive therapy than with insight-oriented therapy. Additionally, the authors found that both cognitive and insight therapies were less effective depending on the severity and sub-type of depressive disorder. They also found that the insight-oriented psychodynamic psychotherapy achieved favourable outcomes compared with pharmacological treatments for younger adults with depression. The results of this study need to be treated with caution. Like most clinical effectiveness studies in older adults the sample size is small, indicating that replication is needed to be confident about generalising the results. The study also included an unspecified number of people under 65, with no indication whether there was a treatment-by-age effect. Additionally, since the study was completed in the early 1980s a new class of anti-depressant drugs has become available. The suggestion that insight-oriented psychotherapy is more effective than some drug therapies needs to be treated with caution, therefore. Another
problem is that for this trial, as with many other controlled trials in this area, the type of psychodynamic psychotherapy offered had to be adapted to fit the limits of time and staff training, and may not be a reflection of the more traditional “real” psychodynamic approach.

The same research team (Thompson et al., 1987) replicated the study with a larger sample \((n=91)\) in 1987 and published findings on follow-up data in 1990. Again, the authors found that each treatment approach was more effective than a delayed-treatment control. However, they found that contrary to their 1982 study improvements were maintained equally among the treatment conditions. Indeed, they found higher rates of remission in psychodynamic psychotherapies, although the difference compared with the cognitive approach was not statistically significant. Notably, they again found a significant group of clients – 30% spread equally among the three treatment conditions - did not respond to any treatment approach.

Case studies have been widely utilised to explore the effectiveness and discuss the processes of psychodynamic approaches with older adults. The use of case studies was widely used by Freud and has an important place in the development of psychodynamic theory and practice. However, caution must be exercised when using case studies to provide evidence for efficacy of a particular treatment approach. The obvious dangers are that the individuals involved may not be representative of the population at large and that it is difficult to disentangle cause and effect. Moreover, case studies are usually selected for publication on the basis that the therapist considers them a success. Bearing in mind this caveat, case studies indicate that psychodynamic psychotherapies can be effective with a range of presenting conditions. Sandler (1978), for example, reports on a successful 8-year analysis of a 58-year-old man with narcissistic concerns to please others and with fears about dying. Gorsuch (1998) used brief analytic methods to treat a 75-year-old woman whose asthma attacks were being exacerbated by stress. These studies are suggestive - although not conclusive - of the utility of both traditional long-term analysis and brief methods and complement some of the findings from controlled group studies. They pose a challenge to Freud's strictures on age - one of the subjects was 25 years older than his suggested limit - and on volume of material - Gorsuch (1998) effected changes in 14 sessions.

There have been few studies into the most effective treatment modality for psychosocial approaches to depression in older adults. Steuer et al. (1984) conducted one of the major studies comparing group CBT with group psychodynamic therapy. Subjects with chronic depression ranging in age from 55 to 78 received 48 sessions of treatment over nine months. The results were not unequivocally successful. Both groups showed statistically significant reductions in symptoms, which appeared not to be due to spontaneous remission as
participants had on average suffered from depression for four years prior to therapy. However, three-quarters of the sample who completed therapy still had moderate to severe depression as rated on the Beck Depression Inventory (Beck et al., 1961). Success rates were equivalent for both treatment conditions. There was a hard-to-treat group (15%) who did not benefit at all. Again, caution must be exercised in interpreting the results, and the study needs replication. However, the group results are rather worse than those achieved through individual treatment. Significantly, the authors did not find that group CBT was more effective than group psychodynamic psychotherapy, in contradiction to findings with younger adults. It may be then that psychodynamic group approaches are as effective as the CBT group approach.

Studies suggest that the use of pharmacotherapy for treatment of depression may be limited for some older adults because of reduced tolerance and severe side effects (Strauss and Solomon, 1983, cited in Thompson et al., 1987). In their review Niederehe and Schneider (1998) conclude that the research base is suggestive not conclusive in indicating that psychosocial approaches are as effective as drug therapy. Studies directly comparing treatment approaches with drug therapy have concentrated on CBT and Interpersonal Therapy (IPT), not on psychodynamic approaches and on a limited number of anti-depressants. The research base, however, is sparse and more studies are needed. The picture that is emerging, however, is that CBT and drug therapy in combination can work more quickly and effectively than either treatment approach alone (Niederehe and Schneider, 1998).

Despite the prevalence of anxiety disorders in older adults (Roth and Fonagy, 1996), research in this area with an older population is both sparse and of limited quality by current standards (Niederehe and Schneider, 1998). Niederehe and Schneider (1998) report that there is only one randomised control study with clients with diagnosed generalised anxiety disorder. Stanley and Beck, 1995 (cited in Niederehe and Schneider, 1998) found that both CBT and supportive psychotherapy was effective in treating clients with chronic comorbid anxiety and depression, with an advantage for CBT in dealing with some specific anxieties.

**Summary of clinical effectiveness findings.**
The research literature indicates that psychodynamic approaches are as effective in treating some clients for depression and anxiety as other treatment approaches. Individual treatment approaches seem more effective than a group approach in both CBT and psychodynamic therapy. Combined drug and CBT treatment appears to work quickly and effectively with quite severe depression. Additionally, there appears to be a sizeable hard-to-treat group (ranging from 15-30%) for whom psychosocial approaches are not helpful and there is another group for whom pharmacotherapy is either impractical or unacceptable. However, there are a
number of gaps in the research. There is little research into the over 75s and into anxiety disorders. Questions need to be answered regarding the effectiveness of psychodynamic and CBT approaches for clients with severe Axis 1 disorders. More research is needed into the effectiveness of both approaches with older adults with Axis 2 disorders.

The appropriateness of psychodynamic psychotherapy - development considerations:
Since Freud (1905) indicated that there were process issues that impede successful psychodynamic approaches, there have been a number of theoretical developments on ageing which make it an obligation for psychotherapists of any persuasion to consider older adults for psychotherapy. Specifically, these theories suggest that older adults, as much as younger adults, are engaged in an ongoing developmental process with two possible results – psychological healthiness or psychological problems. Ethically, psychotherapists are obliged to consider offering treatment where psychological health is threatened. Two developments will be discussed here.

Erikson (1959):
Erikson (1959) adopted an epigenetic approach to psychological development. He formulated eight phases of life in which the growing individual is faced with new phase-specific tasks that require resolution to move to the next phase. The task for the older adult is to reconcile the mistakes and achievements of the past to achieve ego integrity. Success or failure in this task will result in either an old age faced with integrity or an old age faced with despair. A case example illustrates how this theory can shed light on the presentation of depressive symptoms in older adults. Peter (not real name) was a man in his 70s who had suffered a stroke and was currently on a specialist rehabilitation ward. Rehabilitation staff were concerned that he was depressed and might have dysexecutive function. Assessment indicated that Peter did not fit the DSM-IV criteria for depression. However, it revealed that he had strong emotions about past family losses and about his past achievements and failures. Without direct prompting and with great emotion he recounted his proudest moment and his biggest regret of his life. He hated the idea of ageing, which he viewed as an inevitable, inexorable process of loss. He also spoke of his attempt to come to terms with his past life and its mistakes. This case can be formulated in terms of Peter’s current struggle to resolve the integrity v. Despair dilemma. The appropriateness of using psychodynamic approaches to treat Peter will be discussed later, but the case indicates how Erikson’s theoretical framework – developed since Freud – allows therapists not only to consider using a psychosocial intervention but also a way of thinking to guide an intervention.

Scientific gerontology:
Knight (1999) argues that perspectives from scientific gerontology indicate strongly that NORMAL ageing is not associated with psychological problems and therefore, where there are problems, there are strong imperatives to consider treatment. He cites research (Rybash, Hoyer and Roodin, 1986, cited in Knight, 1999) that suggests older adults can develop expertise founded on experience and a movement to post-formal reasoning based on an understanding of the dialectical nature of argument and social change. Knight (1999) also cites research (e.g. Labouvie-Vief, DeVoe & Bulka, 1989) which indicates older adults can be more emotionally mature than their younger counterparts.

**Summary of developmental considerations:**
The ongoing development of theories of ageing since Freud’s time, then, does indicate that psychotherapists — including psychodynamic therapists — should consider older adults for treatment on the basis of need and that therapists have a theoretical framework in which to formulate and make interventions effective.

**Appropriateness — client-related factors:**
Indeed, a number of authors argue that rather than older adults making less appropriate clients for psychodynamic psychotherapy, advancing years makes them clients who are more willing to face the challenge of insight-oriented therapy. Newton et al. (1986) suggest that ageing and experience prepare older adults for self-examination by reducing the defence of narcissism characteristic of younger adults. They also cite Weinberg’s 1970 suggestion that older adults may have an increased capacity to delay gratification and accept the pain necessary to achieve psychotherapeutic gains. King (1974) is one of many authors who has argued that the nearness of death may add impetus and focus to the therapeutic process. King (1974) also argues that as older people often suffer real losses as they age, the immediacy of the losses makes it more incumbent on the client to face underlying anxieties.

**Appropriateness — normal ageing and cognitive factors**
Current research indicates that Freud’s contention that people over 50 lack the mental elasticity of younger people, is at best, a huge oversimplification and at worst wrong. Freud does not define mental elasticity, but the context suggests he was talking about overall intellectual and problem solving ability. The research is too extensive and complex to go into here, but a summary will be provided. Research from cross-sectional data indicate that there is a general overall intellectual decline but it occurs from age 60-70, not earlier. Dividing intelligence into fluid and crystallised intellectual skills (Horn & Cattell, 1967, cited in Woods & Britton, 1985), research (cited in Woods & Britton, 1985) suggests that on many tests older people perform one or two standard deviations below their younger counterparts in tests of
fluid skills, putting many into the category of people with a learning difficulty. This is clearly an artefact of the tests, as many older people function in daily life normally or at a high level. One possible explanation is that older people use their crystallised abilities to compensate for losses in fluid cognitive abilities. In a review of the literature on everyday problem-solving ability, Willis (1996) found that older people increasingly use prior experiential knowledge and "well-honed procedural strategies" to solve problems. In fact, he describes the process as more "efficient" (in terms of needing less information to act) than problem-solving in younger people. Indeed, Willis (1996) argues that research indicates older people make decisions about their own health more quickly than younger people do. The finding on fluid ability may just reflect a cohort effect. Labouvie-Vief et al. (1974) argue that apparent intellectual deficits in older adults reflect a lack of practice and familiarity with the tasks involved in an IQ test and nothing else. Older people, then, are efficient problem solvers, who make flexible use of crystallised cognitive abilities to compensate for losses in fluid cognitive skills.

Freud’s contention also assumes homogeneity in intellectual functioning which is not borne out by research. Summarising a 20-year longitudinal study, Siegler and Botwinick (1979, cited in Woods & Britton, 1985) found that "a sizeable proportion" of older adults declines intellectually "very little". This finding of heterogeneity in intellectual decline suggests factors other than age-related ones are playing a part in "mental elasticity". Among the many factors to be found to effect IQ are concurrent illness and closeness to death. Rabbitt et al. (1997) have found that physical problems interfere with intellectual functioning. Physical problems can occur at any age, although they increase in prevalence with age. The clinician needs to assess for physical problems, not assume intellectual rigidity on the basis of age. Additionally, as early as 1961, the phenomenon of pre-death intellectual decline was observed by Kleemeier (cited in Woods & Britton, 1985). Both fluid and crystallised abilities decline dramatically in the 18-months prior to death. But again, apart from the fact that in most cases clinicians cannot know when a person is due to die, this decline is not age-related (although it is more likely to occur in older adults). Patients coming to therapy may be or may not be in this pre-death group. The clinician cannot bar older people on the false assumption of homogeneity of older adults with regards to this phenomenon. It can be seen, then, that Freud’s assumption on mental inelasticity has been shown to be false. Older people are often good problem-solvers but they use different strategies than younger people. Intellectual decline is not universal by any means. Other non age-related factors (e.g. physical illness) are more important than age-related factors in determining intellectual functioning.

Appropriateness – time (and cost) restraints:
The above research also bears on Freud’s second argument, that the amount of material the older client will bring to therapy makes insight-oriented work impractical. A number of studies cited in the effectiveness research above (e.g. Gallagher & Thompson, 1982, and Gorsuch, 1998) indicate that brief analytical approaches produce symptom reduction in older adults with depression. In the NHS context, where efficiency of treatment forms such a key component of effectiveness, this indicates that psychodynamic psychotherapy cannot be deemed inappropriate on the basis of length of treatment (at least with depression). Additionally, the research on problem-solving cited above (Willis, 1996) gives a theoretical basis for indicating that older adults can utilise brief approaches: many older adults make health-related decisions more quickly and use efficient means of problem-solving.

**Summary of ageing, cognitive and time factors:**

There is, then, no theoretical – in terms of psychological and intellectual development – or practical reason – in terms of time and resources – why older adults should not be offered psychodynamic therapy as well as other therapies. In empirical terms, too, while more research is needed, the indications are that, especially for depression, psychodynamic psychotherapies are effective and may be as effective as other treatment approaches. However, most writers on psychodynamic psychotherapy argue that therapists need to modify their practice with older adults. This begs three questions: is modification really needed? If it is, does psychodynamic psychotherapy require greater modification than other approaches? and how does it need to be modified?

**Do psychodynamic and other approaches need to be modified to be appropriate?**

To take the last question first, a range of authors have put forward age-related factors to argue the need for modification of psychodynamic therapy. Newton et al., 1986, put the arguments eloquently. They argue that with some older adults, especially those who are isolated through bereavement, the therapist should shed his/her traditionally neutral analytic stance. For example, they argue therapists might enter into “symbolic giving” by being empathic and reaffirming to provide gratification for the client’s psychological neediness and to contain his/her dependency needs. They also argue that to build the therapeutic alliance, which is the bedrock and template for change in the psychodynamic tradition, the therapist should be more active in helping clients address concrete concerns. Understanding transference in different ways than with younger clients is also invaluable, according to many authors, including King (1974). A client will have a wider network of significant attachments than simply the parental relationship, which dominates work with younger adults. King (1974) reports that therapists may, therefore, take on the role in the transference relationship of anything from grandson/daughter to a parent or teacher. Knight (1999) argues that countertransference issues
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can be different than with younger adults and are a notable obstacle to psychotherapists doing psychodynamic work with older adults. For example, ageism may block the work. Newton et al. (1986) give the example of a younger therapist feeling uncomfortable because of ageist taboos on older adult sexuality when the client develops sexual fantasies regarding the therapist in an eroticised transference. Additionally, King (1974) has argued that Freud and other psychotherapists' traditional reluctance to treat older adults might be the result of their own fears about death and ageing, which by countertransference prevents therapy beginning in the first place. Knight (1999) argues that psychodynamic psychotherapists should not avoid therapy with this group, but should learn about the group from other disciplines – notably scientific gerontology - and tackle the therapeutic issues through informed peer supervision.

It could be argued that the resources in terms of training and practice required to modify psychodynamic psychotherapy will, where resources are stretched, make it inappropriate for work with older adults, compared with other treatment approaches. However, there are indications that modifications are required to cognitive-behavioural therapy as well. Dick et al. (1999) argue cognitive therapists, like their psychodynamic counterparts, may have to adapt their own beliefs about older adults regarding mental elasticity and to gain supervision for countertransference issues (such as fear of getting old) to work effectively. Additionally, because of the complexity of many referred cases, treatment will often be multi-disciplinary and require the therapist to gain experience in consulting with other disciplines. Cognitive therapy may also need adaptation to deal with cohort-effects. For example, clients born before the war may need more socialisation to the role of psychology in general and the model of CBT in particular as a collaborative venture, argue Dick and her colleagues (1999). Old age also poses some philosophical challenges to CBT, which in turn have implications for CBT practice. Niederehe and Schneider (1998) cite a number of studies (e.g. Hassan and Pollard, 1994) which indicate that anxiety and depression in older adults is linked to an increasing number of real-life stressors such as the death of family and friends. Yet Aaron Beck (1976), who developed CBT, places CBT in a strict positivist frame; therapists, for example, are expected to challenge clients' cognitive "distortions" about the difficulties of their lives. Faced with many realistic concerns about the present and the future, older adults pose a challenge to this rationalist CBT approach.

The final question regarding modification of traditional approaches, concerns the question of whether modification is really required. As indicated above, there are instances where modification is necessary. However, there is a danger in assuming the homogeneity of older adults and, as Knight (1999) notes, in automatically equating ageing with some sort of loss. For example, Knight (1999) cites research evidence which undermines a number of Newton et
al's claims (1986) about adapting psychotherapy to meet the changed needs of older adults. For example, Newton et al. (1986) argue that one of the key tasks of psychotherapy with older adults is to tackle regression caused by physical and social frailty. Knight (1999) argues that frailty is NOT the pre-requisite of the old and that there is evidence that regression in the face of frailty will take place whatever the age of the client.

It follows, then, that the decision as to whether psychodynamic therapy is more appropriate for a specific client with a specific problem should largely be based on the same criteria for such a decision with younger clients: on the duration and severity of the presenting problem, on the disposals available after assessment, on effectiveness criteria, on the wishes of the client, and on the assessment of the psychological robustness of the client to accept interpretations and the nature of his/her defences (Malan, 1979).

**Appropriateness - age-related parameters:**

However, as suggested above, the clinician is also required to include age-related parameters in his/her thinking on psychodynamic psychotherapy as an appropriate disposal. In practice, this starts with the assessment. Turner (1992), drawing on the work of Nemiroff and Colarusso (1985) which emphasises how every phase of development during the life cycle is equally important in psychological adaptation, indicates that a full lifelong development history should be taken, not just the early life. Niederehe and Schneider (1998) note that the presentation of psychological problems may differ between older and younger adults, yet standard diagnostic criteria (DSM-IV, for example) are based on younger clinical samples. Clinicians working in any modality therefore need to adapt their thinking in order to make an accurate assessment for depression, for example. Again, clinicians working in any treatment modality will need to assess for cognitive limitations caused by illness or disease, which are more prevalent in older adults. Dementia, for example, causes global cognitive impairment which presents challenges to both psychodynamic and CBT approaches. Clinicians need to be able to assess for a differential diagnosis between dementia and depression.

**An individualised assessment approach**

Additionally, the timing of a disposal may effect whether psychodynamic or other approaches are appropriate. For example, Gallagher-Thompson and Steffen (1994) found that 71% of clinically depressed older adult caregivers treated with psychodynamic psychotherapy or CBT achieved symptom remission with no overall difference between treatment mode. However, those who had become caregivers more recently benefited more from psychodynamic treatment, while those who had been caregivers for more than 3 years and six months benefited more from CBT. Additional factors that come into play in deciding on the
appropriateness of a disposal for a particular treatment would include, severity of the condition (Gallagher and Thompson, 1983) and the setting in which the older person lives (studies indicate limited effectiveness for CBT for depression for residents of nursing homes; Kemp et al., 1991; cited in Niederehe and Schneider, 1998).

**An illustrative case study:**
The complexity surrounding the decision as to the appropriateness of a certain treatment disposal in older adults can be encapsulated in the case of Peter, cited above, who was referred with possible depression and executive functioning difficulties. As already stated, a psychodynamic intervention drawing on the work of Erikson (1959) was indicated at assessment. However, when the appropriateness is judged according to complex criteria which need to be applied when dealing with older adults – including the clinical context in which the referral is made, the presentation of the condition, physical and cognitive factors - then the decision to treat, how to treat and when to treat becomes less clear cut. In Peter’s case the deciding interacting factors were timing, the referral context and the natural course of the disease process. Peter was recovering from a stroke on a specialist stroke rehabilitation ward. During the two-week assessment process, rehabilitation staff reported that Peter’s rehabilitation was no longer being impeded by his psychological adjustment to stroke. It was, therefore, decided not to offer Peter further psychological treatment at that point. There was the danger that the challenges involved in the psychodynamic approach would actually impede his rehabilitation. However, as the assessment revealed that Peter had attachment-separation issues, it was decided to review Peter again three weeks prior to his discharge home. It could be speculated that Peter’s “recovery” during assessment implicates the “disease” process as a factor. Cognitive recovery can be rapid in the first few weeks following a stroke and it is possible Peter was making a natural recovery, particularly with regard to executive function, which was allowing rehabilitation to progress smoothly. Clinical decisions regarding the appropriateness of a psychodynamic intervention need to incorporate this range of knowledge and understanding.

**Conclusion:**
Since Freud famously declared against psychodynamic approaches for older adults, times have changed. With the caveats of the limitations of research in this field in mind, both controlled clinical trials and anecdotal case studies into the efficacy of psychodynamic approaches have shown that psychodynamic therapy can be as effective with older adults as cognitive-behavioural and pharmacological treatments. There is a need – and therefore a professional obligation - for psychological treatment in general to be available to older adults. As effectiveness studies indicate that some clients may not respond to other treatment
approaches or by nature of the client presentation respond better to psychodynamic psychotherapy, it is important that the latter be offered as part of a comprehensive NHS provision. It has been argued that older adults may have more psychological robustness and motivation than younger adults to face the challenges of an insight-oriented therapy. Empirical studies also indicate that mental inelasticity is not normal in old age and therefore is not an automatic bar to therapy. Likewise, the effectiveness of brief analytic approaches indicates that Freud’s concern with the length of therapy should not serve as a bar. Psychodynamic therapies may need to be adapted with older adults, but other approaches may also need to be modified. The "appropriateness" of a disposal to a psychodynamic therapist must take into account a number of age-related and non age-related factors and the key to getting this right is a thorough assessment of psychological, physical and contextual factors.
References


Clinical Section

This section contains summaries of clinical experience gained in four core placements and two specialist placements. Also contained in this section is a summary of the five case reports written for each core placement, plus one specialist placement. The five clinical case reports are submitted in full in Volume Two of this portfolio, along with placement contracts, supervisor evaluation forms and full records of clinical activity.
Summary of Clinical Experience
Core Adult Mental Health Placement

PLACEMENT DETAILS

Dates: October 1999- March 2000
Supervisor: Dr Juan Delport, Chartered Clinical psychologist
Setting: Surrey Hampshire Borders NHS Trust
Base: Guildford CMHT

Summary of experience:
The placement provided valuable grounding in assessing and treating people individually within a cognitive behavioural model, and in one case using an integrated CBT and person-centred approach. Cases ranged from the relatively simple to the complex as most of the individual cases were referred via other members of the CMHT. There was ample opportunity to conduct psychometric assessments appropriate to this setting. I was also introduced to the wider professional role of the clinical psychologist in the CMHT, working jointly with my supervisor on assessments in the attached day hospital and in-patient facility, and directly observing the work both of individuals and teams (e.g. The Rapid Response Team) within an adult mental health setting. I began to develop formulation and intervention skills in CBT and through my supervisor's interest in other models was introduced to some Transactional Analysis. I also developed a sense of the importance of reflection and supervision.

Clinical skills and expertise:
Experience was gained with a range of presenting problems: dysthymia, generalised anxiety, specific phobia, panic with dual diagnosis of alcohol misuse, co-morbid PTSD with childhood sexual abuse and depression, and anger problems. Experience was also gained in psychoeducation in the context of relapse prevention in recurrent depression. A variety of assessment procedures were used, including the WAIS-III, STAXI, BDI, RISC, WCST, and the Horowitz Impact of Events Scale.
Core People with Learning Disabilities Placement

PLACEMENT DETAILS

Dates: April 2000- September 2000
Supervisor: Dr Dawn Thomas-Bawa, Chartered Clinical psychologist
Setting: Boumewood Community and Mental Health NHS Trust
Base: St Peter’s Hospital, Chertsey.

Summary of experience:
The placement gave the opportunity to work in a number of different models and see how they could be applied across the mild to moderate range of learning disability. Models ranged from cognitive behaviour therapy to applied behavioural analysis. There was also the opportunity to act in a consultancy role to another health professional and to work as a joint facilitator in a social skills group. My neuropsychological skills were developed through an extended assessment of one young client. There was the chance to see the way a clinical psychologist fits into multi-agency working with this client group and to see some of the patient-related organisational issues, such as equitable access to services (in the form of trying to find appropriate interpreting services) and advocacy in this field. I also had the opportunity to present a seminar to fellow clinical psychologists and other allied health professionals.

Supervision gave me the opportunity to reflect upon not only formulation and intervention skills but also team-working and some of the professional and ethical challenges of working with people with learning disabilities. I observed work in a range of settings from a Social Services’ run Day Service to voluntary-sector care homes.

Clinical Skills and Expertise:
I assessed and implemented individual treatments with people with a number of presenting problems, including: dementia in a person with Down’s Syndrome, challenging behaviour in a person with a dual diagnosis of moderate learning disability and mental health problems, depression, and anxiety. I also joint facilitated and devised a social skills group for people with a moderate learning disability. Neuropsychological and psychometric measures I used included a WAIS-III, Rivermead Behavioural Memory Test, Battery for Assessment of Dysexecutive Function, the Halo, The Boumewood Assessment for Dementia in Down’s Syndrome, VOSP and TROG. I also familiarised myself with “Not a child anymore”.

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PLACEMENT DETAILS

Dates: October 2000- March 2001
Supervisor: Olga Watts, Chartered Clinical Psychologist
Setting: South West London & St.George’s Mental Health NHS Trust
Base: Teddington outpatients clinic (Tier 2 service).

Summary of experience:
I worked with children from less than two years old to 15 years. I worked in a variety of different modalities from individual therapeutic work and joint working with a psychodynamic psychotherapist to being part of a family therapy team and working with a clinical psychologist and child psychiatrist in a specialist ADHD clinic. Models of working included behavioural, narrative, CBT and systemic. I had the chance to observe assessments at a pilot tier 3 brief intervention clinic and with the family therapy team. I was given an opportunity to observe children in schools, at home and in nurseries and gain a great degree of understanding of normal child development through this and observing the work of a health visitor and a community paediatrician. I was involved in the life of the CAMHS team, attending team meetings regularly and jointly working with other team members. There were training opportunities to learn about recent developments in attachment theory and in theory and practice in autistic spectrum disorder.

Clinical skills and expertise:
I worked with a number of presenting problems: school refusal, PTSD with bereavement, eating problems, sleep management, behavioural problems at home, ADHD, aggression, truanting, depression, social communication problems and behavioural problems at school. I used. I became competent in direct behavioural observation and functional analysis in ADHD, in the Parent-Child Game, in the WISC III and I also used the Culture Free Self-esteem Inventory.
Adult Mental Health Specialist Placement 1 – Narrative Therapy

PLACEMENT DETAILS

Dates: April 2001 – September 2001
Supervisor: Dr Margaret Henning, Chartered Clinical Psychologist
Setting: Sussex Weald & Downs NHS Trust
Base: Outpatient Psychology Department, Adult Mental Health, Horsham.

Summary of experience:
I developed my assessment, formulation and treatment skills in Narrative Therapy by working solo with individual clients, working jointly with my supervisor on one case, and through supervision (individual, joint and in a group). I also developed skills in applying the models of systemic narrative therapy and structural family therapy through being a member of the reflecting team in the family therapy clinic. I worked with individuals, couples and families. I gained a greater understanding of the wider role of the clinical psychologist through observing my supervisor consult to a staff team and by evaluating the pilot family therapy clinic. There was the opportunity to develop my oral communication skills through two joint presentations of the theory and practice of Narrative Therapy to fellow clinical psychologists and other members of the pilot family therapy team. Professional development was enhanced through supervision and regular attendance at the AMH psychology team meetings and through attendance at two CMHT allocation meetings. Supervision encouraged reflection both on my clinical style and on the wider professional and ethical implications of using Narrative Therapy.

Clinical skills and expertise:
Presenting problems ranged from: anger management, depression with suicidal ideation, OCD, specific phobia, panic, generalised anxiety disorder, marital discord, health anxiety, self-harming behaviour, habitual anti-social behaviour, binge-drinking and pathological jealousy. I used a number of clinical measures including the CORE and conducted a formal risk assessment devised by West Sussex Mental Health Services.
Older Adults Core Placement

PLACEMENT DETAILS:

Dates: October 2001- March 2002
Supervisor: Dr Ian Kneebone, Chartered Clinical Psychologist
Setting: Surrey & Hampshire Borders NHS Trust
Base: Farnham Road Community Hospital.

Summary of experience:
There was an opportunity to develop individual assessment, formulation and intervention skills in behavioural, CBT and rational-emotive therapy and Reminiscence Therapy models. I worked both as part of the multi-disciplinary team serving an acute and long-term stroke rehabilitation ward and as part of the team serving the Day Hospital. Neuropsychological skills were developed through the application of a neuropsychological assessment of one man and an extensive dementia assessment on another. I also developed group work skills in the context of running a Reminiscence Group with clients at the local Alzheimer's Society and through contributing to the pilot Living with Parkinson's Disease Group run at the Day Hospital. For the latter, I also consulted to other health professionals on how to establish evaluation measures for the group. I developed an understanding of the wider organisational context and my oral presentation skills through presenting to the Unit Manager the implications of the NSF for Older People, after attending a one-day PSIGE workshop on the initiative. Research skills were developed through conducting a Literature Review on measures used by the service. There were ample training opportunities with training days on stroke, on the NSF for Older People and on rehabilitation services. I also regularly presented psychological information to carers of people on the stroke ward.

Clinical skills and expertise:
Presenting problems ranged from post stroke depression, Adjustment Disorder, anxiety, possible early dementia, aggression and fear of falling, Alzheimer's Disease and Parkinson's Disease. Psychometric measures included the CAMDEX, tests of verbal fluency, the Hayling & Brixton tests of executive function, the MEAMS, the NART and use of the BASDEC. I also familiarised myself with Doors and People.
Specialist Placement 2 – Cognitive Behaviour Therapy (AMH)

PLACEMENT DETAILS:

Dates: April 2002 – September 2002
Supervisor: Dr Metka Shawe-Taylor, Consultant Clinical Psychologist
Setting: Surrey Oaklands NHS Trust
Base: Dorking CMHT and Surrey Mentally Disorders Offenders Team, Reigate.

Summary of experience gained:

The placement has enabled me to consolidate and develop my assessment, formulation and intervention skills in cognitive behaviour therapy with individual clients. I worked with a number of clients with complex presentations who often had personality issues as well as mental health problems. Supervision allowed me the space and time not only to explore clinical and theoretical issues but also to reflect on my therapeutic style. There have also been discussions of power differentials in therapy, organisational issues and ethical questions. Skill development was fostered through directed reading, direct observation of the supervisor, being observed and using video and audiotapes of sessions. I gained insight into a psychodynamic approach by directly observing a psychodynamic assessment. My CBT clients varied in age from 18 to 58 and were referred with a variety of presenting problems. I conducted a neuropsychological assessment as well as working with a Mentally Disordered Offender on a probation order and complex cases referred by the Community Mental Health Team. Attendance at psychology meetings and the CMHT allocation meeting broadened my understanding of the role of a clinical psychologist in an Adult Mental Health service.

Clinical skills and expertise:

Client presenting problems included social phobia, dysthymia, sickness phobia, OCD, anger problems, depression, bipolar disorder, body image disorder and Trichotillomania. I conducted a full WAIS-III and used a number of measures including the BDI, BAI, and Padua Inventory.
Clinical Case Report Summaries
Adult Mental Health Case Report Summary

Assessment and treatment of a woman with dysthymic disorder using cognitive behaviour therapy.

A 42-year-old white South African woman (JK) with dysthymic disorder was assessed and treated using cognitive behaviour therapy. JK, who was married without children, was referred to the psychology service at her local CMHT by a community psychiatric nurse. She was referred with possible depression and concrete suicidal ideation and feelings of isolation, alienation and hopelessness. Initial assessment involved a clinical interview, a self-monitoring diet of eating habits and administration of the Beck Depression Inventory. She presented saying she had been depressed for 20 years with problems with maintaining friendships, low motivation and fatigue. She also complained of binge-eating, which she felt was out of control. Other difficulties included maintaining a good relationship with her husband's family and marital problems. She scored 23 on the BDI, indicating moderate depression. Assessment indicated that JK fitted the diagnostic criteria for Dysthymic Disorder. Although she subjectively reported 'bingeing' when she was unhappy, she did not meet diagnostic criteria for Binge-eating Disorder. An informal risk assessment - in the form of questions at the clinical interview - indicated JK was at low risk for suicide. It was initially formulated that the cognitive model of depression accounted for JK's symptoms. Her depression was maintained by the triad of negative cognitive schema, cognitive biases and situationally activated negative automatic thoughts. Core beliefs centred around being unloveable and inadequate. Other maintaining factors included subjective binge-eating, which contributed to low self-esteem and helplessness, social expectations and behaviour, which caused hopelessness and self-criticism and her difficult relationship with her husband's family, which reinforced her sense of loss and beliefs about being unloveable. Cognitive behaviour therapy was implemented over 14 sessions aimed at initially reducing binge-eating and challenging negative automatic thoughts. In view of the chronicity of the problem, CBT was also applied to identify and challenge dysfunctional assumptions and core beliefs. A constant theme was to 'decentre' JK from her depression through education, cognitive restructuring. Behavioural, educative and cognitive approaches were adopted to
challenge beliefs about binge-eating. Cognitive restructuring techniques, including the downward arrow technique, Socratic questioning and behavioural experiments were used to identify and challenge negative automatic thoughts, intermediate assumptions and core beliefs. Imaginal recall was also used to explore core beliefs. Behavioural techniques included asking JK to keep pleasure and mastery diaries. JK's BDI score dropped to the subclinical range and suicidal ideation had disappeared for the first time in many years. There was also a reduction in the frequency and intensity of negative laden thought, an alleviation of low mood and reductions in motivational symptoms of depression. While the initial formulation stood, new evidence which emerged during the intervention formed the basis for a reformulation. It was proposed that JK also had a core belief around the theme of control and this theme was conceptualised as having important implications for her interpersonal difficulties. Professional issues of how a new trainee deals with a complex, chronic case were discussed. The use of supervision and self-development of CBT skills by therapist use of Dysfunctional Thought Records were put forward as solutions. The issue of how to decide the focus of therapy - binge eating or depressogenic thinking - was also raised and the need for collaborative working was emphasised. The ethical issue of adopting an intrapsychological model of depression with a woman who had low self-esteem was also considered.
Neuropsychological Assessment of a 17-year-old man

A neuropsychological assessment of a 17-year-old man (PE) with reported learning disabilities was carried out. PE, who was currently living at home with his middle-aged adoptive parents, was referred to assess behavioural difficulties and whether he could live and work outside the family home if his adoptive parents became too old to continue to look after him. Initial questioning revealed that the behavioural difficulties were now infrequent and did not now constitute a concern to his adoptive parents and the community nurse, who initially referred him. The referral questions were then concentrated on PE's independent living skills and were: "What was PE's current level of cognitive functioning?" and "Could identification of his cognitive strengths and weaknesses guide attempts to increase his independent living skills?" The initial assessment involved separate interviews with PE and his adoptive parents. The interviews indicated PE might have Asperger Syndrome and that he might have a learning disability. An extended neuropsychological assessment was therefore conducted to test these hypotheses and generate new ones with the aim of providing a knowledge-base upon which new constructional approaches could be developed. PE was assessed over nine sessions. His mother completed an assessment of his independent living skills, the Hampshire Assessment of Living with Others (Shackleton-Bailey & Hampshire Social Services, 1980), and he was observed on a shopping trip by the author. PE undertook tests of general intellectual functioning, memory, executive function, visual and spatial perception, praxis and communication and language abilities. The results indicated that PE did not have Asperger Syndrome. However, they showed he had performed at a level indicative of mild intellectual impairment. Dyspraxia was also indicated. The results highlighted PE's cognitive strengths and weaknesses, which were used as the basis for management recommendations for PE's adoptive parents, his college teachers and social services' staff. PE's strengths and weaknesses were reformulated using self-esteem protection theory (Frankel & Snyder, 1978), with reference to PE's current family system and with reference to communication theory in PLD (Bartlett & Bunning, 1997). The assessment was critiqued in terms of the author's difficulty in communicating the assessment results to PE in a way that was sensitive to his fragile self-esteem. The issues of the author requiring greater familiarity with the test materials to reveal increased amounts of valuable qualitative data to complement the quantitative data was discussed. The report also included a discussion of the ethical issue of conducting a neuropsychological assessment - which involve testing people on sometimes difficult novel tasks in the absence of normal external reinforcers - on a young man whom it was
hypothesised already had low self-esteem. The possible harm to PE was weighed against the benefit such an assessment might have in terms of encouraging the appropriate development of his skills and in increased participation in domestic, vocational and community-based activities.
Children and adolescents case report summary

Assessment and management of an 11-year-old girl refusing to attend school

The report describes the assessment and management of an 11-year-old girl, Tracey, who had been refusing to attend her new secondary school on any day for five weeks and who had been attending intermittently for the four previous weeks. Tracey was referred by her GP to the Child and Family Centre and had been initially assessed by a child psychotherapist as part of a pilot multi-disciplinary assessment project aimed at identifying urgent cases and treating them quickly. Further assessment included an interview with the child and her parents, a diary kept by Tracey's mother and telephone interviews with the child's education welfare officer and her headteacher at her previous school. Tracey was also assessed using the HoNOSCA score sheet, a psychiatric assessment used as a standard measure in the pilot clinic. A comprehensive history as recommended by Carr (1999) was taken, which included Tracey's attachment history, developmental history, history of the beliefs about the problem and the identification of school and child factors which might be maintaining the problem. There was no evidence of a mood disorder. Tracey's school refusal was formulated in behavioural terms. Negative reinforcement in the form of escape from aversive feelings - anxiety about school - was maintaining the problem. Additionally, the fact that Tracey's parents had been inconsistent in giving in to Tracey's demands not to attend school acted as an intermittent reinforcement schedule to the avoidance behaviour. Failed attempts to return Tracey to school had created a sense of learned helplessness in Tracey, her parents and school officials. Additionally, developmental factors and child factors, including Tracey's difficulty in communicating her feelings and social isolation at school were considered as vulnerability factors in Tracey's school refusal. An alternative formulation that Tracey was primarily suffering from separation anxiety was considered. A multi-component approach based on a functional analysis of the behaviour was adopted. Intervention focussed on extinguishing the avoidance behaviour through a programme of graded exposure and contingency management as well as improving Tracey's communication deficits through role play and brief therapy methods. Some narrative therapy techniques were also used to reverse the problem-saturated account of life held by Tracey and her parents. Relapse prevention measures were built in from the start of the intervention with a particular emphasis on developing Tracey's social network within and outside school. Cultural and age-appropriate contingencies in the form of money towards a mobile phone for Tracey was built into the reward system of the graded exposure hierarchy. A target of Tracey returning to school for two full weeks was set. Narrative therapy techniques included externalisation of Tracey's anxiety - which became Mr Anxiety - which provided a plausible model of the operation of anxiety in a case where the
adolescent had shown no inclination to examine her beliefs about attending school. A brief therapy technique called Mission Possible was also used for its child-centred qualities and because its "project" structure mimicked some of the tasks Tracey was missing by refusing school. Liaison with the school to ease Tracey's return was also implemented in the intervention phase. At the time of writing Tracey had returned to school for eight consecutive days. Contextual organisational difficulties in conducting a more thorough initial assessment were discussed and the implications in terms of missing information about separation anxiety were explored. The problems of trying to balance a quick assessment with the possibility of wasting time on interventions based on inadequate information was considered in terms of the organisational needs and the needs of a child for a speedy return to education. Failure by the therapist to fully collaborate with the externalisation was also discussed in terms of dangers to the therapeutic alliance. The difficulty of trying to integrate behavioural and narrative approaches was examined in terms of weakening the narrative approach and the difficulty Tracey had in developing a new self-narrative based on unique outcomes. The clinical dilemma of knowing how far to explore the role of threats of abandonment or family discord in school refusal was discussed in view of the current case in which the client, Tracey, refused to be interviewed separately from her parents. The issue is discussed in terms of endangering the therapeutic alliance, which is considered an indicator of a good prognosis in cases of school refusal.
Specialist placement (narrative therapy) case report summary.

Narrative Therapy for a working 36-year-old man who felt the "need to escape" by binge-drinking.

Narrative therapy for a working 36-year-old man (Peter) is described. Peter was referred to the psychology department by his GP with binge-drinking, which was causing problems at home. Initial assessment involved a clinical interview informed by the theory of Narrative Therapy, and client-completion of the CORE (Clinical Outcomes in Routine Evaluation) Outcome Measure. Assessment revealed that Peter's binge drinking began soon after he married and was at its peak (with weekly binges) soon after the birth of his first child, eight years previously. Since then, it had tapered off to four binges in the previous calendar year. At the time of referral, Peter and his wife were expecting their second child. Assessment also revealed that Peter had two dominant problem-saturated narratives. He storied his existence with the narratives 'I am unable to resist the need to escape' by drinking, and "I have failed as a husband and as a father and in my preferred view of myself.' Assessment indicated that Peter's wife also viewed him as 'unable to resist the need to escape' by drinking. Assessment also revealed exceptions to the dominant narrative or unique outcomes when Peter resisted the oppression of the identified problem stories. The identified exception to the first story was that Peter had not drunk in the four months prior to therapy, and to the second story, that he had looked after his eldest daughter alone when his wife was hospitalised giving birth to their second child. The CORE global score indicated Peter was within a clinical population of white European males on all domains, except in the risk domain. It was initially formulated that by storying his lived experience through his problem narrative, alternative stories of resisting the urge to escape by drinking were left either unvalued or unstoried altogether. Within the wider system, there was a disjunction between Peter's preferred view of himself and his perception of his wife's view, creating communication problems and feeding the life of the problem. 'News of difference' between Peter's response to the first pregnancy and the second was going unrecognised because of the jointly authored story of Peter's 'weakness'. On a wider cultural level, Peter had been recruited by his upbringing and the hard drinking milieu of his working environment into attitudes and practices.
which fuelled difficulties with his wife. In particular, Peter held views of being a good
father and a true man which were at variance to his wife's, which meant when there were
problems at work Peter escaped by drinking rather than talking to his wife about them.
Intervention was based on the precepts of narrative therapy (White, 1995) as well as on
psychoeducational work on lapse/relapse in addictive behaviour (DiClemente &
Prochaska, 1998) within a narrative therapy framework; for example, the 'need to escape'
was reframed in terms of normality not abnormality. The use of Narrative Therapy, in
spite of the absence of an evidence-base for this form of treatment, was discussed in
terms of the similarities between narrative therapy and other evidence-based approaches
and indications in the case presentation that a Narrative approach would be both effective
and efficient. To enhance personal agency against the problem story "I can't resist the
urge to escape' and to deconstruct the attitudes, beliefs and practices underpinning it,
externalisation techniques were used. Landscape of action and landscape of
consciousness questions were used to embed the alternative story of personal strength in
the face of the need to escape and to highlight news of difference between the first and
second pregnancies. Relapse prevention work focussed on psychoeducation and on
externalisation, with Peter reviewing the weapons he could use against the urge to
escape. Peter began to self-generate alternative stories of strength, which indicated he was
ready for discharge, as did a reduction of his CORE score to a subclinical level.
Reframing of the need to escape in terms of temporarily letting go of his responsibilities
was also used to prepare Peter for discharge. At discharge, there had been no episodes of
binge drinking for eight months. The success of the case and information subsequently
gained during the intervention did not indicate any need for a substantial reformulation.
The need to have conducted a more formal risk assessment and to have involved his wife
directly in the therapy was discussed. The clinical and ethical issue of whether to
challenge Peter's own view of himself as not being an alcoholic was discussed in terms of
theoretical models of change in addiction and the Narrative Therapy tenet of the therapist
not imposing his expertise on the client in co-authoring new stories and to resist the
cultural practice of imposing 'totalising' descriptions on individuals with multiple
strengths and characteristics.
Assessment and management of dysexecutive function and adaptation to stroke in a 71-year-old man.

The assessment and management of dysexecutive function and adaptation to stroke in a 71-year-old man (AD) who had suffered a left-hemisphere ischaemic stroke is described. The man, who had suffered a stroke alone at home four weeks prior to the referral, was referred by a physiotherapist in the multi-disciplinary rehabilitation team serving an inpatient acute stroke unit in a community hospital. He was referred because he was rushing things and did not respond to verbal feedback on his efforts in rehabilitation. He was also irritable with staff and was showing signs of pathological emotionalism. Staff wanted to know if he had cognitive deficits of which they were unaware and whether he was depressed. A flexible, hypothesis-testing approach was adopted for the neuropsychological assessment. One pre-assessment hypothesis was that AD had dysexecutive function. Assessment measures were a short test of semantic and phonological fluency, the Hayling Sentence Completion Test and the Brixton Spatial Anticipation Test. Qualitative data from a clinical interview into AD’s possible cognitive problems and his emotional difficulties was also used for this part of the assessment. The results were not indicative of gross dysexecutive function. However, the findings were not in line with AD’s occupational achievements so pre-morbid functioning was estimated by administration of the National Adult Reading Test. It indicated AD was performing below his pre-morbid level and might have subtle dysexecutive function without insight. It was also hypothesised that AD was depressed. This was assessed through a psychometric measure of depression adapted for older adults and through a clinical interview. Neither the psychometric measure nor the clinical interview indicated AD met diagnostic criteria for a depressive disorder. However, he did meet criteria for acute Adjustment Disorder. The initial formulation was based on a biopsychosocial model of emotional problems and drew heavily on Ellis’ rational-emotive model of emotional disorders. The cognitive and physical deficits caused by the stroke were interacting with AD’s musturbatory beliefs about ageing and independence to create difficulties in the high-demand high-dependency environment of the rehabilitation ward. A multi-level intervention was implemented. Psychoeducation and self-instructional training (Meichenbaum, 1979) were used to alleviate AD’s dysexecutive problems. Psychoeducation and the development of problem-solving skills were used to ease the distress and embarrassment caused by emotional lability. AD also took part in individual rational-emotive therapy to help him adjust to the losses of stroke. Staff were also informed of AD’s cognitive and emotional difficulties and
advised about their impact on his rehabilitation. There was a mixed outcome partly due to AD falling ill and being transferred to another hospital after four intervention sessions. Although there were subjective indications that AD had not taken on the precepts of rational-emotive therapy and some staff continued to view AD as being depressed and a difficult man, the overall goal of AD resuming his rehabilitation programme more constructively was achieved. The case was reformulated within the framework of Erikson’s life-cycle developmental theory (1966) and Hildebrand’s (1995) developmental theory. The role of grief and mourning in AD’s presentation was also considered. The difficulty with balancing the demands of the acute rehabilitation ward for quick answers with completing an adequate neuropsychological assessment were discussed and the author’s solution to this quandary was critiqued. Difficulties in not involving the wider system in the self-instructional training and in implementing the rational-emotive therapy were considered. There was also a discussion of the ethical dilemma of whether or not a clinical psychologist should implement a therapeutic intervention (in this case, grief work) which might distress a patient in the short-term in a setting where the client needed to be free of psychological obstacles in the short-term to help maximise his physical recovery.
Research Section

This section contains the Service Related Research Project completed on placement in Year 1, the Literature Review completed in Year 2, and the Major Research Project completed in Year 3.
Service Related Research Project

The supervisory process in clinical psychology training: the expectations and experiences of trainees

July 2000

Year 1
The supervisory process in clinical psychology training: the expectations and experiences of trainees.

Abstract:
The expectations and experiences of placement supervision by 127 clinical psychology trainees at six Clin PsychD courses in the Thames area and South-East of England were examined. First, second and third year trainees completed a postal questionnaire, which generated quantitative and qualitative data. Outcome measures were a codified categorisation of the trainees' evaluation of the components of effective and ineffective supervision, a rank-order of their priorities for supervision and a rating of their experience of supervision. There was a significant difference in the importance placed on the domain of Skills Acquisition in supervision according to whether the trainee's preferred theoretical orientation was cognitive behavioural therapy or psychodynamic. Age, gender or year of training were not found to significantly affect rank ordering of the importance of the six domains of supervision examined in the questionnaire. Content analysis indicated trainees wanted to develop core competencies in a relationship in which they were valued, given constructive feedback and explicit rationales. The findings of the study are compared with the limited literature on supervision for clinical psychologists and implications for the training of supervisors and trainees are considered.
**Introduction**

In a review of mental health nursing in 1994, the NHS Management Executive defined clinical supervision as "...a formal process of professional support and learning which enables the individual practitioner to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in complex clinical situations."

In the context of training in the psychotherapies, clinical supervision has been a key component since the time of Freud (Burley, 1998). Today, it continues to be essential. The British Psychological Society requires that trainee clinical psychologists are supervised on placement. Pruitt, McColgan, Pugh and Kiser, (1986; cited in Carroll, 1994) found that in a related field – psychiatry – supervision was cited by practising clinicians as the single most influential experience of training. Good quality information about supervision is also important because it consumes so much of a qualified clinical psychologists’ time (Robiner and Schofield, 1990, cited in Green, 1998).

A proliferating literature has emerged investigating models of effective supervision for supervisors in a range of human sciences (e.g. Brown & Bourne, 1996, cited in Green, 1998; for social work supervision) and for supervisors’ of trainee clinical psychologists (e.g. Green, 1998). Carroll (1996) has proposed a generic model for supervisors in the human sciences.

On a three-year Clinical Psychology doctorate course trainees are supervised by between five and six different field supervisors in five or six different settings. Nonetheless, there is little in the literature that draws on the experience of clinical psychology trainees themselves. Pratt (1999) held “informal discussions with a small number of trainees and supervisors” about their expectations of each other. Green (1998) used grounded theory to analyse the experience
of 100 clinical doctorate trainees, identifying five key elements in effective supervision. Hitchen et al. (1997) surveyed trainees on the small Oxford Training course with an 80 per cent response rate, asking them to describe one helpful and one unhelpful incident in each of four areas of experience. The trainees conceptualised good supervision as having four areas of good practice: practicalities; monitoring/teaching; the supervisory relationship; and supervisor awareness of the trainee-supervisor-course system.

Literature on the generic process of supervision for trainees in human sciences indicates that supervision may be part of a continuous educative process - the developmental model (Krause and Allen, 1988; cited by Carroll, 1994) - in which supervisees at different levels of experience express different preferences for the activities of supervision. Carroll (1994) cites a number of studies (e.g. Cross and Brown, 1983) which support the view that supervisory tasks change to meet the developmental level of supervisees. In a study of 56 cognitive psychotherapists in Sweden, Perris (1997) found a higher preference for theoretical issues among trainees with less than four years experience and a preference for process-oriented supervision in more experienced trainees. However Carroll himself (1994) found evidence to support the claim of further studies (e.g. Worthington, 1987) that there is no change in what tasks supervisees expect supervisors to deliver during the course of training.

There is, then, a significant gap in knowledge of trainees’ expectations and experience, which, in view of the transactional nature of supervision (Burley, 1999) limits the utility of existing supervision models. The current study aims to begin the process of filling this gap in the empirical base needed to build models of placement supervision applicable to trainee clinical psychologists. There are no quantitative studies of trainee clinical psychologists which address whether expectations for supervision match their experience of the activity. The current study
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also aims to fill this gap.

The current study will test the developmental hypothesis that supervisees at different levels of experience express different preferences for supervisory activity (Holloway, 1987).

Method

Design: A postal questionnaire design was used providing quantitative data (analysed using multivariate statistical techniques and descriptive statistics) and qualitative data analysed using content analysis (Day, 1993).

Participants: Three hundred first, second and third year trainee clinical psychologists at six ClinPsychD courses in South-East England. Respondents = 127 (42%).

Measures: A questionnaire was devised to evaluate the views on placement supervision of trainees.

a. Deriving the Questionnaire: The literature indicated six domains of supervision were likely to be important: Skills Acquisition, Supervisory Relationship, Quality Control, Knowledge, Process and Practicalities (See Table 1 for definitions)

Table 1: Definitions of the six domains of supervision

<table>
<thead>
<tr>
<th>Skills Acquisition</th>
<th>Learning and practising technical skills e.g. Socratic questioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisory relationship</td>
<td>Having a constructive relationship with your supervisor</td>
</tr>
<tr>
<td>Quality control</td>
<td>Supervision as a means of ensuring minimum standards of care</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Sharing knowledge over and above skills acquisition</td>
</tr>
<tr>
<td>Process</td>
<td>Discussion of therapeutic processes including client-therapist dynamics</td>
</tr>
<tr>
<td>Practicalities</td>
<td>Arrangements for supervision and your working environment</td>
</tr>
</tbody>
</table>
A series of statements were generated by the author to reflect each domain. Subsequently, a workshop was held with eight first-year clinical psychology trainees on the same course as the author. Its purpose was two-fold; first, to check the proposed domains of supervision were comprehensive; second, to check that the domains were comprehensible. Secondly, the same trainees undertook a card-sort of 58 statements on supervision to validate their presence in particular domains. A statement was included in the questionnaire if five or more participants (60 per cent) categorised it into the same domain. 51 out of 58 statements reached criteria (See Appendix 1; Table 1). Two statements - 'In supervision I expect to discuss ethical issues' (50% agreement level) and 'In supervision I am encouraged to reflect on my practice' (50%) - were retained in the Process category despite failing to reach criteria as it was felt their omission would result in the final questionnaire not reflecting important aspects of supervision.

Another statement which failed to meet the criterion – ‘In supervision I discuss formulations of my clients’ difficulties’ – was reworded and included in both the Skills Acquisition section and the Knowledge section, to which participants in the card sort had in equal numbers ascribed it. Again, it was felt a key aspect would be lost without it. Three separate statements referring to access to a desk, computer and telephone were linked as one as they were deemed to duplicate each other. The remaining statements which failed to reach the criterion were discarded.

b. The questionnaire: Information on 'Age', 'Gender', 'Year of training', 'Number of placements' and 'Preferred theoretical orientation' was gathered. Participants were required to rank-order the importance of the six identified domains of supervision (Skills Acquisition, Supervisory Relationship, Quality Control, Knowledge, Process and Practicalities). They were also required to rank order for importance and rate, for frequency of delivery statements under each of the six domains. There were also three open-ended questions relating to expectations of supervision, and critical incidents (Flanagan, 1954, cited in McCrea and Milsom, 1996) of good and bad supervision. See
Appendix 2 for a copy of the questionnaire. * Some questionnaires were misprinted with a 1 - 4 rating scale (instead of 1 - 5) for "Quality Control". To ensure within-domain consistency, all trainees' ratings of 5 in this domain were entered as 4 on the database.

**Procedures:** Approval for the project was granted by Surrey University's Advisory Committee on Ethics (See Appendix 3). Letters requesting permission to mail participants were sent to Clin Psych D course directors. Two Universities out of eight declined to participate.

Participants were recruited via these letters (See Appendix 4). There were two mailings (the second to increase the response rate) in April and August 2000.

**Analyses:** Descriptive statistics were used to analyse the data. Non-parametric tests (Mann-Whitney U Test and Kruskal-Wallis) were used to test for between-group differences in rankings and ratings. Content analysis (Day, 1993) was used to analyse the qualitative data derived from the open-ended questions.

**Results:**

**Participants:**

127 trainees completed the questionnaire, which represented a 42 per cent response rate. (See Tables 2, 3, 4, 5 and 6 below).
### Table 2: Frequencies by age:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Valid</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>under 25</td>
<td>11</td>
<td>8.7</td>
<td>8.7</td>
</tr>
<tr>
<td>25-30</td>
<td>93</td>
<td>73.2</td>
<td>82.5</td>
</tr>
<tr>
<td>31-35</td>
<td>16</td>
<td>12.6</td>
<td>95.2</td>
</tr>
<tr>
<td>36-40</td>
<td>5</td>
<td>3.9</td>
<td>99.2</td>
</tr>
<tr>
<td>41plus</td>
<td>1</td>
<td>0.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>126</td>
<td>99.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>127</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

### Table 3: Frequencies by gender:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Valid</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>male</td>
<td>20</td>
<td>15.7</td>
<td>15.9</td>
</tr>
<tr>
<td>female</td>
<td>106</td>
<td>83.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>126</td>
<td>99.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>127</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

### Table 4: Frequencies by Year of Training:

<table>
<thead>
<tr>
<th>Year</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>49</td>
<td>38.6</td>
<td>38.9</td>
</tr>
<tr>
<td>2.00</td>
<td>40</td>
<td>31.5</td>
<td>70.6</td>
</tr>
<tr>
<td>3.00</td>
<td>37</td>
<td>29.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>126</td>
<td>99.2</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>127</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

### Table 5: Frequencies by Number of placements:

<table>
<thead>
<tr>
<th>Number</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>3</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>2.00</td>
<td>45</td>
<td>35.4</td>
<td>38.1</td>
</tr>
<tr>
<td>3.00</td>
<td>4</td>
<td>3.1</td>
<td>41.3</td>
</tr>
<tr>
<td>4.00</td>
<td>39</td>
<td>30.7</td>
<td>72.2</td>
</tr>
<tr>
<td>5.00</td>
<td>9</td>
<td>7.1</td>
<td>79.4</td>
</tr>
<tr>
<td>6.00</td>
<td>26</td>
<td>20.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>126</td>
<td>99.2</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>127</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Table 6: Frequencies by Preferred Theoretical Orientation:

<table>
<thead>
<tr>
<th>Orientation</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>cbt</td>
<td>69</td>
<td>54.3</td>
<td>55.2</td>
<td>55.2</td>
</tr>
<tr>
<td>systemic</td>
<td>10</td>
<td>7.9</td>
<td>8.0</td>
<td>63.2</td>
</tr>
<tr>
<td>psychodynamic</td>
<td>7</td>
<td>5.5</td>
<td>5.6</td>
<td>68.8</td>
</tr>
<tr>
<td>eclectic</td>
<td>10</td>
<td>7.9</td>
<td>8.0</td>
<td>76.8</td>
</tr>
<tr>
<td>cbt and systemic</td>
<td>11</td>
<td>8.7</td>
<td>8.8</td>
<td>85.6</td>
</tr>
<tr>
<td>other</td>
<td>12</td>
<td>9.4</td>
<td>9.6</td>
<td>95.2</td>
</tr>
<tr>
<td>7.00*</td>
<td>6</td>
<td>4.7</td>
<td>4.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>125</td>
<td>98.4</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

*7.00* = Systemic & psychodynamic

There were two trainees who failed to provide information in this section, but who were retained in the study because they provided qualitative data which was not analysed by these demographics.

Trainees expectations of clinical supervision:

For the total sample (n=125), the most important domain of placement supervision (1 = most important; 6 = least important) was Skills Acquisition (mean ranking 2.56). Practicalities was the least important element (See Table 7 below)

Table 7: Rank order in importance of the six domains of supervision (most important first):

<table>
<thead>
<tr>
<th>Domain of supervision</th>
<th>Mean ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills Acquisition</td>
<td>2.56</td>
</tr>
<tr>
<td>Supervisory Relationship</td>
<td>2.59</td>
</tr>
<tr>
<td>Process</td>
<td>2.98</td>
</tr>
<tr>
<td>Knowledge</td>
<td>3.33</td>
</tr>
<tr>
<td>Quality Control</td>
<td>4.25</td>
</tr>
<tr>
<td>Practicalities</td>
<td>5.16</td>
</tr>
</tbody>
</table>

In the second part of the questionnaire trainees were required to rank order for importance a list of statements grouped under each domain heading. Tables 8 and 9 contain the most important and least important statements in each domain.
Table 8: The most important statements in each domain with the mean rank

<table>
<thead>
<tr>
<th>Domain</th>
<th>Mean rank</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skills Acquisition</strong></td>
<td></td>
</tr>
<tr>
<td>1. I develop skills in formulating my client's difficulties</td>
<td>1.54</td>
</tr>
<tr>
<td>2. I discuss how to devise and implement treatment plans</td>
<td>2.46</td>
</tr>
<tr>
<td><strong>Supervisory Relationship</strong></td>
<td></td>
</tr>
<tr>
<td>1. In supervision I am given constructive criticism</td>
<td>1.62</td>
</tr>
<tr>
<td>2. In supervision I am valued and respected</td>
<td>2.59</td>
</tr>
<tr>
<td><strong>Quality Control</strong></td>
<td></td>
</tr>
<tr>
<td>1. It is important that through supervision clients are guaranteed the best care</td>
<td>2.48</td>
</tr>
<tr>
<td>2. Supervision helps guarantee I am not harming my clients</td>
<td>2.78</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td></td>
</tr>
<tr>
<td>1. In supervision I discuss formulations of my client's difficulties</td>
<td>2.13</td>
</tr>
<tr>
<td>2. In supervision my supervisor makes explicit theory-practice links</td>
<td>2.22</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td></td>
</tr>
<tr>
<td>1. In supervision I am encouraged to reflect on my practice</td>
<td>3.34</td>
</tr>
<tr>
<td>2. In supervision I learn how to work with clients when therapy is stuck</td>
<td>3.96</td>
</tr>
<tr>
<td><strong>Practicalities</strong></td>
<td></td>
</tr>
<tr>
<td>1. In supervision I must be supervised weekly</td>
<td>1.54</td>
</tr>
<tr>
<td>2. I negotiate a contract detailing my learning needs and the ways they will be met</td>
<td>2.72</td>
</tr>
</tbody>
</table>
### Table 9: The two least important statements in each domain with their mean rank

<table>
<thead>
<tr>
<th>Domain</th>
<th>Statement</th>
<th>Mean rank</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skills Acquisition</strong></td>
<td>1. I role-play appropriate interventions with clients</td>
<td>7.57</td>
</tr>
<tr>
<td></td>
<td>2. I develop skills in how to run a group</td>
<td>7.16</td>
</tr>
<tr>
<td><strong>Supervisory relationship</strong></td>
<td>1. In supervision I am encouraged to be a lifelong learner</td>
<td>6.32</td>
</tr>
<tr>
<td></td>
<td>2. I am able to see my supervisor outside prescribed times</td>
<td>5.76</td>
</tr>
<tr>
<td><strong>Quality Control</strong></td>
<td>1. My supervisor monitors that my personal problems are not detrimentally enacted in therapy</td>
<td>5.36</td>
</tr>
<tr>
<td></td>
<td>2. My supervisor regulates how I am managing a caseload</td>
<td>4.83</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td>1. I discuss with my supervisor the prognosis of certain client presentations</td>
<td>9.55</td>
</tr>
<tr>
<td></td>
<td>2. My supervisor is an expert in the model I wish to practice on placement</td>
<td>9.08</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td>1. In supervision I discuss power differentials in therapy</td>
<td>8.24</td>
</tr>
<tr>
<td></td>
<td>2. In supervision I examine my prejudices regarding clients</td>
<td>7.19</td>
</tr>
<tr>
<td><strong>Practicalities</strong></td>
<td>1. My supervisor ensures I have secretarial support</td>
<td>4.76</td>
</tr>
<tr>
<td></td>
<td>2. In supervision I discuss arrangements for meeting other members of the team/dept.</td>
<td>4.50</td>
</tr>
</tbody>
</table>

**Main effects:**

Non-parametric tests (Mann-Whitney U Tests and Kruskal-Wallis) were run to investigate main effects on the rank-order of the six domains of supervision. There was a significant main effect for “Preferred Theoretical Orientation” on mean ranking of Skills Acquisition (Chi-square=16.3, df=6; p<0.05). 19 pairwise post-hoc tests were run to identify the source of the effect (p<0.01). A significant difference (z=3.30; p<0.01) was found between trainees who preferred CBT (mean ranking of Skills Acquisition = 2.26; median = 1) and those who preferred a Psychodynamic orientation (mean ranking = 4.57; median = 4).
There were no significant main effects of Age, Gender, Year of Training or Number of placements.

**Trainees' experience of training:**

Mean ratings for each of the domains of supervision indicated that each was delivered “SOMETIMES” on placement (see Table 10):

<table>
<thead>
<tr>
<th>Domain</th>
<th>Mean rating</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills Acquisition</td>
<td>3.14</td>
<td>1.78 - 4.22</td>
</tr>
<tr>
<td>Supervisory Relationship</td>
<td>3.61</td>
<td>2.00 - 5.00</td>
</tr>
<tr>
<td>Quality Control</td>
<td>3.10*</td>
<td>1.71 - 3.43</td>
</tr>
<tr>
<td>Knowledge</td>
<td>3.31</td>
<td>1.92 - 4.92</td>
</tr>
<tr>
<td>Process</td>
<td>3.17</td>
<td>1.80 - 5.00</td>
</tr>
<tr>
<td>Practicalities</td>
<td>3.90</td>
<td>1.67 - 5.00</td>
</tr>
</tbody>
</table>

*1-4 rating scale: see Method section above

There was no main effect for 'Year of Training' or 'Preferred Theoretical Orientation' on the trainees' rating of their experience of supervision.

Tables 11 and 12 show the two statements representing the most frequent and least frequent experience in each domain (rating scale key: 1=Never experienced on placement; 2=Rarely; 3=Sometimes; 4=Often; 5=Always). There was a high degree of concordance between the trainees' highest and lowest rankings and ratings for each statement.
Table 11: The two statements representing the trainees' most frequent experience of supervision with their mean rating.

<table>
<thead>
<tr>
<th>Skills Acquisition</th>
<th>Mean rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I discuss how to assess my clients' presenting problems</td>
<td>3.96</td>
</tr>
<tr>
<td>2. I discuss how to devise and implement treatment plans</td>
<td>3.88</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervisory Relationship</th>
<th>Mean rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In supervision I am valued and respected</td>
<td>4.13</td>
</tr>
<tr>
<td>2. I am able to see my supervisor outside prescribed times</td>
<td>3.90</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Control</th>
<th>Mean rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It is important that through supervision clients are guaranteed the best standard of care</td>
<td>3.57</td>
</tr>
<tr>
<td>2. Supervision helps guarantee I am not harming clients</td>
<td>3.44</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Mean rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My supervisor shares his/her knowledge of the client group with me</td>
<td>4.21</td>
</tr>
<tr>
<td>2. In supervision I discuss formulations of my clients' difficulties</td>
<td>4.11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process</th>
<th>Mean rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In supervision I learn how to work with clients when therapy is stuck</td>
<td>3.69</td>
</tr>
<tr>
<td>2. In supervision I am encouraged to reflect on my practice</td>
<td>3.58</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practicalities</th>
<th>Mean rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In supervision I must be supervised weekly</td>
<td>4.50</td>
</tr>
<tr>
<td>2. I negotiate a contract detailing my learning needs and the ways they will be met</td>
<td>4.38</td>
</tr>
</tbody>
</table>
Table 12: The statements representing trainees' least frequent experiences of supervision with their mean ranking.

The two least experienced statements in each domain were:

Skills Acquisition

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I role-play appropriate interventions with clients</td>
<td>1.52</td>
</tr>
<tr>
<td>2. I practice technical skills appropriate to my intervention</td>
<td>2.34</td>
</tr>
</tbody>
</table>

Supervisory Relationship

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am encouraged to question my supervisor about how s/he practices</td>
<td>2.96</td>
</tr>
<tr>
<td>2. I can argue with my supervisor over aspects of theory and practice</td>
<td>3.23</td>
</tr>
</tbody>
</table>

Quality Control

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My S. monitors that my personal problems are not detrimentally enacted in therapy</td>
<td>2.27</td>
</tr>
<tr>
<td>2. My supervisor checks I am implementing evidence-based practice</td>
<td>2.78</td>
</tr>
</tbody>
</table>

Knowledge

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am advised about alternative approaches without necessarily adopting them</td>
<td>2.73</td>
</tr>
<tr>
<td>2. My supervisor advises what therapeutic approach works for whom</td>
<td>2.86</td>
</tr>
</tbody>
</table>

Process

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In supervision I examine my prejudices regarding my clients</td>
<td>2.47</td>
</tr>
<tr>
<td>2. In supervision I discuss power differentials in therapy</td>
<td>2.51</td>
</tr>
</tbody>
</table>

Practicalities

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In S. I discuss arrangements for meeting other members of the team/dept</td>
<td>3.57</td>
</tr>
<tr>
<td>2. My supervisor ensures access to a desk, computer and telephone for me</td>
<td>3.67</td>
</tr>
</tbody>
</table>

Qualitative data:

There were three questions on the questionnaire, where participants could express their views on placement supervision in their own words. These answers were analysed using content analysis (Day, 1993) with initial classifications generated from the data and not based on pre-existing categories. These categories were then streamlined to major themes. These themes were checked for reliability in a blind rating of a random selection of 20 questionnaires by a
qualified clinical psychologist. There was $r=0.66$ for question 3a (Placement gains); $r=0.75$ for question 3b (Best supervision); and $r=0.33$ for question 3c (worst supervision). (See Appendix 5).

**Qu. 1: What do you expect to gain from placement supervision that you do not get from any other element of the course?**

18 classifications were initially identified (See Appendix 6a). These generated nine categories (a number of statements were classified into more than one category representing the richness of replies. Frequency counts are shown in brackets):

A. Putting theories and the evidence-base into practice with individual clients in real situations

   (n =110)

B. A relationship in which the trainee’s clinical competence is developed and evaluated

   (n=76)

C. Access to the unique qualities and perspectives of qualified clinicians (n=23)

D. A place to discuss process and ethical issues. (n=18)

E. A place where the trainee experiences a supportive, personal focus and can discuss personal development issues (n=12)

F. An opportunity to discuss different roles with different client groups (n=5)

G. An element that ensures the trainee is meeting minimum standards of clinical practice

   (n=4)

H. A relationship in which the trainee experiences organisational and service issues (n=4)

I. Where all aspects of client work are inter-woven (n=2)

See Appendix 6 for fuller descriptions of the categories
Qu 2. Please could you describe your best single episode of supervision as a trainee clinical psychologist. Please explain why it was helpful.

23 classifications were initially identified (See Appendix 6b). Two respondents were unable to identify any single best episodes of supervision. Initial classifications generated eight categories (frequency counts in brackets):

A. The supervisor creates a supportive and risk-taking environment (n=62)
B. Helping the trainee to develop his/her clinical skills and knowledge (n=50)
C. Helping the trainee develop generic therapeutic skills (n=31)
D. The supervisor uses role-plays and is observed by and observes the trainee with a client (n=22)
E. Encouraging the trainee to reflect on his/her practice (n=15)
F. Supervision is well organised (n=11)
G. The supervisor provides a role-model for the trainee (n=9)
H. The supervisor is restorative (n=6)

See Appendix 6 for fuller descriptions of the categories

Qu 3. Please could you describe your worst single episode of supervision as a trainee clinical psychologist. Please explain why it was unhelpful.

Twenty-four initial classifications were generated by this question (See Appendix 6c). Eleven participants could not name any worst single experiences of placement supervision. The classifications generated nine categories (frequency counts in brackets):

A. Supervision lacked rigour with a lack of direction, clarity and rationales (n=40)
B. Supervisors were considered 'incompetent' (n=23)

C. Unhelpful supervisory style (n=20)

D. Supervision was marred by organisational problems (n=20)

E. Supervisors who did not respect and disempowered their trainees (n=17)

F. Supervisors were unaware of the trainee's needs and level of experience (n=16)

G. The feedback in supervision was critical not constructive (n=14)

H. Supervisors offered a limited insight into the therapeutic process (n=9)

I. Technical shortcomings (n=2)

See Appendix 6 for fuller descriptions of the categories

Discussion:

Trainees' expectations of what is important among supervisory elements:

The results indicate that Skills Acquisition and the Supervisory Relationship are the elements of supervision most highly valued by trainees. Examination of both the codified categorisation of the qualitative data and selected statements by trainees (See Appendix 7) complements this finding. Trainees want to develop core competencies in formulation, assessment and intervention in a relationship in which they are valued, given constructive feedback and explicit, clear rationales for the supervisor's guidance. The results are broadly in line with findings from other studies. For example, Pratt (1999) found trainees valued from supervisors: clear and explicit theory-practice links; teaching and monitoring with constructive feedback; emotional support; and accepting the trainee as a trainee not as an additional staff member.

Green (1998) identified promoting experiential learning and having a strong supervisory alliance as two of the five elements of ideal supervision. The present study found that trainees
place least importance on Practicalities and Quality Control. Carroll (1994) also found that trainee counsellors considered administrative aspects of supervision least important. By contrast, Hitchen et al. (1997) found trainees included Practicalities among the four elements identified for good supervision. The discrepancy with Hitchen et al. (1997) could result from the forced ranking methodology of the current study. Indeed, the qualitative data indicates well-organised supervision is valued by trainees.

There is little in previous studies to indicate whether trainees value the Quality Control function of supervision. Only Green (1998) found trainees identified an element similar to the one outlined in this study. The current study found students placed the function 5th out of six in importance and it is rarely mentioned in the qualitative data. This compares sharply with the supervisors’ perspective as indicated in many models of supervision. Proctor (1991: cited in Hawkins & Shohet, 1999) for example, lists the normative function, which includes quality control, as one of just three major elements in supervision.

Trainees’ experience of supervision:

The descriptive statistics indicate that all elements of the complete supervision package are being delivered equally by supervisors. However, trainee statements relating to worst supervision indicate individuals can identify exceptions to this. For example, trainees (n=15) complained that supervision was badly organised, while others (n=10) said supervisors did not make explicit theory-practice links.

There was no main effect of any of the demographic variables on the trainees’ rating of their experience of supervision. Other studies concentrate on the expectations, not the experiences of trainees. While the two are obviously linked, there is no direct evidence of trainee experiences.
to compare with the current study. However, one might have predicted that supervisors' themselves would at least vary the content of supervision to match the trainees' year of training. The current study indicates that there is no such shift. It is possible, however, that a design weakness masked differences in the trainees' experience of supervision. Participants showed a central tendency response bias on the Likert rating scale. This may have been avoided by using a six-point, rather than five-point scale. Additionally, the use of the Likert scale forces participants to average out their supervision experiences in a way that might lose the variation of that experience. Never discussing formulations on one placement and always discussing them on another, becomes “sometimes” discussing them.

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**Developmental influences on the ranked importance of the supervisory elements:**

The developmental hypothesis was not confirmed – Year of Training did not significant affect ranking. However, the trainee's Preferred Theoretical Orientation did significantly affect the overall ranking of Skills Acquisition. Trainees with a preference for CBT ranked Skills Acquisition significantly more highly than those with a psychodynamic orientation. Previous studies cast no light on this as they did not record the theoretical orientation of the trainees. The current result could be a reflection of the questionnaire design. Participants were given Socratic Questioning as an example of Skills Acquisition for the ranking exercise. Overt mention of a CBT skill may have biased the results (Moser & Kalton, 1985). On the other hand, it makes theoretical sense that trainees who are psychodynamically-oriented place process issues above skills acquisition. This finding has implications for training. As well as trainees finding out the preferred orientation of the supervisor, supervisors should find out the orientation of their trainees if trainee-supervisor expectations are to be matched.

Like Carroll (1994) the present study did not find support for the developmental hypothesis of
supervision and training for social scientist practitioners. There are two possible explanations. First, the design of the current study may not have been sensitive to such a model of trainee development. The six elements of supervision identified for comment by participants in the current study reflect the trainee’s “tasks”; they mainly reflect observable and evaluated elements, such as skills in formulation, which trainees have to “pass”. However, many developmental models (e.g. Hawkins and Shohet, 1999) are based on psychodynamic principles; they identify for the supervisor the intra-psychic developmental stages the trainee is supposed to progress through from being a novice to an expert. There is a clear mismatch between the task-orientation of the present study and the process-orientation of developmental models. The second explanation is that the needs of trainees do not fundamentally change over six placements. It could be that trainees are faced with such range and depth of experience (five or six different client groups) that they remain focused on acquiring core competencies within a collaborative relationship. Alternatively, as Carroll (1994) posits, trainees may not be aware of how they can develop through supervision and that courses need to educate trainees about supervision. Further research is needed in this area. Qualitative methods would be appropriate to tease out trainees’ thinking on this point.

**Training implications:**

As suggested above the current findings do not fit easily with models of supervision provided for the training of supervisors. For example, Proctor (1991; cited in Hawkins & Shohet, 1999) says supervision involves three main processes. These are formative, restorative and normative. The present study indicates that trainees have an almost exclusive focus on the formative function. Restorative functions are mainly noticed when they are absent (see categories in “Worst supervision”). To many trainees, the normative function largely remains invisible. New models of supervision for trainee clinical psychologists need to take account of trainees’ strong focus on formative/educative processes.
References


Pratt, P. (1999). Trainee forum: what do trainees and supervisors want from each other? 
*Clinical Psychology Forum, 129, 46-48.*

Skills

1. In supervision I discuss formulations of my client’s difficulties

2. In supervision I am taught how to assess my clients’ presenting problems

3. In supervision I discuss how to devise and implement treatment plans

4. In supervision I role-play appropriate interventions with clients

5. In supervision I practise technical skills appropriate to my intervention

6. In supervision I learn how to generate hypotheses

7. In supervision I discuss how to prevent therapeutic drift

8. In supervision I am advised how to write reports for other professionals

9. In supervision I am instructed on the use of psychometric tests

10. In supervision I am advised how to work collaboratively with clients

11. In supervision I learn how to run a group
Supervisory Relationship

12. In supervision I am given honest feedback

13. In supervision I am given constructive feedback

14. In supervision I am encouraged to question my supervisor about how s/he practises

15. In supervision I am given rationales for suggested interventions

16. In supervision my supervisor is receptive to feedback from the mid-placement visit

17. In supervision I am challenged to justify my clinical judgement

18. In supervision I am valued and respected

19. In supervision I can argue with my supervisor over aspects of theory and practice

20. In supervision it is important for it to be clear how I am being evaluated
Quality Control

21. It is important that through supervision my clients are ensured the best standard of care

22. Supervision helps guarantee I am not harming my clients

23. My supervisor monitors that I am not practising beyond the limits of my competence

24. Supervision ensures I am not abusing power differentials in therapy

25. My supervisor sees that my personal problems are not detrimentally enacted in therapy

26. In supervision I examine my prejudices regarding clients

27. Through supervision I make sure I know the range of treatment options available to clients

28. My supervisor regulates how I am managing a caseload

29. My supervisor checks that I am implementing evidence-based practice
Knowledge

30. In supervision my supervisor shares his/her knowledge of the client group with me.

31. In supervision I discuss with my supervisor the prognosis of certain client presentations.

32. My supervisor recommends appropriate readings.

33. In supervision my supervisor explicits the theory-practice links.

34. Supervision supplements my theoretical knowledge about clients.

35. My supervisor advises what therapeutic approach works for whom.

36. My supervisor gives advice on the use of psychometric tests.

37. My supervisor advises which assessment and outcome measures to use.

38. In supervision I am advised about alternative approaches to clients without necessarily adopting them.

39. It is important that my supervisor is an expert in the model I wish to practise on placement.
Process

40. In supervision I expect to discuss ethical issues

41. In supervision I am made aware of professional and personal boundaries in therapy

42. In supervision I am guided on how to reflect on my relationship with my client

43. In supervision I discuss my client’s relationship with me

44. In supervision client difficulties in reaching treatment goals are identified

45. In supervision I learn how to work with clients when therapy is stuck

46. In supervision I learn how to maintain and develop a therapeutic alliance

47. In supervision I am encouraged to reflect on my practice

48. In supervision I discuss power differentials in therapy

49. In supervision I am encouraged to be a life-long learner
**Practicalities**

50. It is important to have an organised induction period

51. In supervision I must be supervised weekly

52. I am able to see my supervisor outside prescribed times

53. My supervisor ensures I have secretarial support

54. My supervisor provides access to a desk for me

55. In supervision I discuss arrangements for meeting other members of the team/department

56. As part of the supervisory process I have a supervision contract spelling out my learning needs and the ways they will be met

57. My supervisor ensures I have access to a computer

58. My supervisor arranges access to a telephone
Appendix 1:

Table 1: Original statements about supervision and the number of subjects (n=8) who sorted them into proposed categories for the questionnaire. Criteria for inclusion (n=5).

* Some subjects failed to sort all statements into the existing categories.

<table>
<thead>
<tr>
<th></th>
<th>Skills</th>
<th>Supervisory Relationshi</th>
<th>Quality Control</th>
<th>Knowledge</th>
<th>Process</th>
<th>Practicalities</th>
</tr>
</thead>
<tbody>
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<td>4</td>
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Appendix 4: Letter sent to participants

Dear Trainee Clinical Psychologist

PsychD – Service Related Research Project
Trainee clinical psychologists’ expectations and experience of placement supervision.

My name is David Glasman and I am a trainee clinical psychologist at the University of Surrey. With the support of the Surrey University ClinPsychD Course Placement Committee, I am conducting a Service Related Research Project into placement supervision. With your help, we aim to give trainees throughout the Thames and London region a voice in the evaluation of placement supervision.

As part of enhancing clinical training, the Surrey Placement Committee and I are keen to explore trainee clinical psychologists’ expectations and experience of placement supervision. We are surveying trainees who are currently on Clinical Psychology Doctoral courses in the Thames and London region. There is a proliferating literature for supervisors on what constitutes effective supervision. Few studies, however, have been made of the experience of trainees, such as yourself, who regularly change supervisors and placements. The aim of the current study is to explore the trainees’ perspective and to make recommendations for changes in the training of supervisors and trainees in the region.

Please find enclosed a questionnaire. I am disseminating this questionnaire to all trainees in the region. All questionnaires are anonymous and confidential. There is, of course, no obligation to take part in the study. If you decide not to take part it will in no way affect your training. Key findings will be fed back to participating courses and the placement committee at the University of Surrey. Each form comes with a freepost label and no postage is required. Could you return it by .... If you have any queries contact me on 01483

Thank you for your time and cooperation. I know you are busy and I much appreciate your help.

Yours sincerely,

David Glasman, Trainee Clinical Psychologist
Supervised by Dr Linda Dowdney, Chartered Clinical Psychologist.
Appendix 5

Categories generated in a blind rating by a practising clinical psychologist and the degree of agreement with categories generated by the researcher:

1. To Qu 3a on the questionnaire:
   a. Skills and knowledge acquisition/sharing; development and advice.
      Matched with the researcher's category A. (Appendix 6)
   b. Constructive feedback re. Clinical skills.
      Matched with researcher's category B. (Appendix 6)
   c. Evaluation and quality control.
      Matched with researcher's category G.
   d. Reflective process.
      Matched with researcher's category D.
   e. Theory-practice links/evidence-based practice
      Matched with researcher's category A.
   f. Different theoretical perspectives discussed
      Matched with researcher's category C.
   g. Relevant case material discussions
      Not matched with any of the researcher’s categories.

2. To Qu 3b on the questionnaire
   a. Theory-practice links
      Matched with researcher’s category B.
   b. Different theoretical perspectives/ways of working
c. Reflective process
Matched with researcher’s category E.

d. Constructive feedback
Matched with researcher’s category A.

Appendix 5 cont’d

e. Skills and knowledge acquisition/sharing
Matched with researcher’s category B.

f. Supervisor’s qualities – listened to, empathic
Matched with researcher’s category categories A and H

g. Supervision style – time allowed, structured
Matched with researcher’s category F.

h. Relevant case material discussed.
Not matched in the researcher’s categories

3. To Qu 3c. on the questionnaire

a. Poor supervision structure
Matched to researcher’s category D.

b. Supervisor qualities – poor, defiant manner
Matched to researcher’s category C.

c. Irrelevant case material discussed
Matched to researcher’s category A.

d. Lack of knowledge and skills acquisition/sharing
Matched to researcher’s category A.
Appendix 6: Themes generated from trainees' responses to three open-ended questions about supervision on the questionnaire.

Qu. 1: What do you expect to gain from placement supervision that you do not get from any other element of the course?

18 classifications were initially identified (See Appendix 6a). These collapsed into nine categories, four of which incorporated five or less responses but which did not fit easily into other categories.

A. Putting theories and the evidence-base into practice with individual clients in real situations. (1, 3, 4 and 15 in Appendix 6a). The term “getting your hands dirty” came to mind when reading these responses. The unifying theme was of a relationship where trainees could take the elegant theories and test them against the roughness of distressed clients in the “real world”.

B. A relationship in which the trainee’s clinical competence is developed and evaluated. (2, 9, 10, and 13 in Appendix 6a). The emphasis here is on the trainee - not on the theories (as above). It’s about becoming a competent clinician and some of the ways that goal is achieved, particularly with the supervisor offering constructive criticism.

C. Access to the unique qualities and perspectives of qualified clinicians. (6 in Appendix 6a). This category is distinct in its unique focus on the qualities of the supervisor.

D. A place to discuss process and ethical issues. (5 in Appendix 6a). This formed a separate category from the development of clinical competence. Respondents in this class were talking about a specific element of teaching which they did not expect to discuss extensively in the academic module. It was about meeting a teaching need, not a clinical development need; although obviously the two areas overlap.

E. A place where the trainee experiences a supportive, personal focus and can discuss personal development issues. (7, 12 and 16 in Appendix 6a). This category was about the trainee as a person, who appreciates individual teaching and nurturing and the privacy of the supervisory relationship.
Appendix 6 cont’d

F. An opportunity to discuss different roles with different client groups. (14 in Appendix 6a). This is distinct from C. above because it is about access to different roles and client groups not to a unique supervisor.

G. An element that ensures the trainee is meeting minimum standards of clinical practice. (8 in Appendix 6a). This category is distinct from B. above in that it is not about developing competence but about existing competencies and supervision as a safeguard against poor practice.

H. A relationship in which the trainee experiences organisational and service issues. (17 in Appendix 6a). This category stands alone because it draws in an agency which impinges on supervision, which is external to the trainee, the supervisor, the client and the course.

I. Where all aspects of client work are inter-woven (11 in Appendix 6a). Respondents in this category see the value of placement supervision in its capacity to integrate aspects from the rest of the course, bringing the course together in a single, personal experience.

Qu 2. Please could you describe your best single episode of supervision as a trainee clinical psychologist. Please explain why it was helpful.

23 classifications were initially identified (See Appendix 2b). Two respondents were unable to identify any single best episodes of supervision. These generated the following eight categories:

A. The supervisor creates a supportive and risk-taking environment (4, 5, 6 and 10 in Appendix 6b). This category is distinguished by highlighting the climate in which trainees develop skills and confidence, rather than the processes by which they develop them. The environment is a distinct one ranging on a continuum of supervision being a place where a trainee feels safe to show his/her ignorance to one which is stretching and challenging. Trainees are valued and respected in this climate. Constructive criticism both creates and epitomises this climate.
Appendix 6 cont’d

B. Helping the trainee to develop his/her clinical skills and knowledge (2, 3, 13, 15 and 16 in Appendix 6b). This category is distinct from other categories which emphasise trainee development because it is about skills and knowledge acquisition following client-oriented discussions between trainee and supervisor. It includes a number of techniques employed by the supervisor including making explicit theory-practice links and reformulating using different models.

C. Helping the trainee develop generic therapeutic skills (9, 12, and 18 in Appendix 6b). The distinctiveness of this category is it refers to trainee development prompted by therapist-oriented discussion. It includes specific strategies, such as the supervisor discussing transference issues.

D. The supervisor uses role-plays and is observed by and observed the trainee with a client (7 and 22 in Appendix 6b). Several respondents referred to specific helpful techniques. Being observed was helpful in two ways, allowing the supervisor to know the trainee’s level to accurately evaluate the trainee and when it was followed by constructive criticism.

E. Encouraging the trainee to reflect on his/her practice (12 in Appendix 6b). A number of respondents highlighted that they were made to reflect on their practice in ways in which the process of reflection was more important than skills building.

F. Supervision is well organised (14 and 21 in Appendix 6b). This category is self-explanatory. Examples cited included having an agenda for meetings, regular supervision and sufficient time to meet the trainee’s training needs.

G. The supervisor provides a role-model for the trainee (1 in Appendix 6b). A number of respondents emphasised the personal and professional qualities of the supervisor as an inspiration to them, without citing specific strategies they employed. The model included being an “expert” and being “up-to-date”.

H. The supervisor being restorative (17 and 19 in Appendix 6b). This category is distinct from A above in that it refers not to an educative supportive role, but to a more personal support, containing anxieties and nurturing confidence.
On 3. Please could you describe your worst single episode of supervision as a trainee clinical psychologist.

Please explain why it was unhelpful.

Twenty-four initial classifications were generated by this question (See Appendix 6c). Eleven participants could not name any worst single experiences of placement supervision. The classifications generated the following nine categories:

A. Supervision lacked rigour with a lack of direction, clarity and rationales (9, 10, 11, 13 and 14 in Appendix 6c). Participants here complained of a range of unfocussed discussions with their supervisors including a lack of rationales for suggested interventions and no theory-practice links. Supervisors appeared to be trying to assist and educate trainees but were lacking rigour in their approach.

B. Supervisors were considered 'incompetent' (1 in Appendix 6c). This category is distinct from A. where supervisors were judged to be unfocussed rather than outright incompetent. Examples of "incompetence" included a supervisor advising using a self-help book, a supervisor ignoring the evidence-base and a supervisor being out of touch with current psychological developments.

C. Unhelpful supervisory style (5 and 6 in Appendix 6c). This category is distinct from A. in some ways, although it shares some characteristics, especially the sense that trainees were frustrated in their attempts to learn from the supervisor. This category focuses more on supervisors who closed down discussion by their style, rather than were unfocussed during discussions. Opportunities for the trainee to learn and gain in confidence were curtailed.

D. Supervision was marred by organisational problems (2, 3, 20 and 24 in Appendix 6c). Problems included supervisors not providing sufficient time, lack of communication between joint supervisors and a lack of liaison with course tutors.

E. Supervisors who did not respect and disempowered their trainees (4 in Appendix 6c). The over-riding theme of this category was of the supervisor not treating the trainee as a collaborator in the learning
process. The tone of the responses indicated trainees felt belittled, even humiliated, not just lectured at (see C.). There were no reported cases, however, of sexually inappropriate behaviour.

F. Supervisors were unaware of the trainee's needs and level of experience (14 and 22 in Appendix 6c). H below partially overlaps with this category, with respondents citing particular areas of practice which were overlooked. This category is distinct, however, in that participants cited a general insensitivity to their needs both clinical and emotional. Some supervisors were accused of lacking empathy when the trainee needed support.

G. The feedback given in supervision was critical not constructive (11 in Appendix 6c). Focussed discussion did take place and the supervisor knew the trainee's level of ability, but the supervisor was critical and not constructive, which made learning difficult and left the trainee feeling unconfident.

H. Supervisors offered a limited insight into the therapeutic process (16, 18 and 19 in Appendix 2c). The missing element for trainees with these supervisors were discussions about therapeutic process and ethical issues. The category also included those who felt insufficiently intellectually challenged in supervision.

I. Technical shortcomings (21 in Appendix 6c). Two trainees complained of not observing their supervisor.
Appendix 6a:

Original classifications of responses to the question: “What do you expect to gain from placement supervision that you do not get from any other element of the course?”

1. A chance to test the theories in practice
2. A place to develop my individual therapeutic style
3. A chance to look at specific cases in-depth
4. Exposure to the realities of working as a clinical psychologist
5. An opportunity to discuss process and ethical issues which are not taught extensively in the academic module
6. Access to the unique qualities and perspectives of qualified clinicians
7. Access to a personal, intense educative experience
8. An element that ensures I am meeting minimum standards (Quality control) of clinical practice
9. A place where I am encouraged to reflect on my practice
10. A place to receive accurate constructive feedback on my clinical development
11. Where all aspects of client work are interwoven
12. To have my confidence boosted and given support
13. A relationship in which my clinical competence is developed and evaluated
14. An opportunity to discuss differing roles with different client groups
15. A relationship in which the psychological evidence-base is tested in practice
16. A relationship where personal development issues are addressed
17. A relationship where you discuss organisational and service issues
18. A place where I get advice on case studies and the service-related project
Appendix 6b:

Original classifications of responses to the question: "Please could you describe your best single episode of supervision as a clinical psychologist. Please explain why it was helpful."

1. The supervisor provided a role-model for me to follow.
2. The supervisor made clear and explicit theory-practice links.
3. Useful new knowledge was imparted and skills developed.
4. The supervisor criticised me constructively.
5. The supervisor was supportive and created a "safe space" in which to show ignorance and make mistakes.
6. I was respected and my contribution was valued.
7. I was observed by or I observed my supervisor with clients.
8. The supervisor encouraged me to develop self-initiative.
9. The supervisor was facilitative not didactic.
10. Supervision was intellectually challenging.
11. My supervisor highlighted a dynamic process between myself and the client.
13. My supervisor discussed a case with me prior to me intervening, broadening my understanding.
14. My supervisor gave sufficient time to discuss client work.
15. My supervisor reformulated a case using a different model than the original formulation.
16. My supervisor used explicit evidence-based practices.
17. My supervisor provided a "containing" environment for my anxieties.
18. When stuck on a case, my supervisor used guided discovery to enable me to move forward.
20. My supervisor respected my level of experience.
21. Supervision was well structured, including records, agendas and contracts.
22. My supervisor illustrated issues by using role-plays.
Appendix 6c:

Original classifications of responses to the question: “Please could you describe your worst single episode of supervision as a trainee clinical psychologist. Please explain why it was unhelpful.

1. My supervisor was incompetent
2. There was a lack of support from the course team
3. Supervision was badly organised
4. My supervisor did not respect me and disempowered me
5. My supervisor was defensive when challenged
6. My supervisor was didactic and did not listen to me
7. My supervisor was anxious and treated me as if I was supervising him/her
8. My supervisor failed to observe me with clients
9. Supervision was chatty and without structure
10. My supervisor did not make theory-practice links
11. My supervisor always said “I was doing fine” without giving constructive criticism
12. My supervisor concentrated on my weaknesses, without reinforcing my strengths
13. My supervisor did not provide a rationale for his/her suggestions
14. My supervisor did not provide clear guidance
15. My supervisor had little understanding of my needs, strengths and weaknesses
16. My supervisor never talked about therapeutic process
17. My supervisor commented on my dress sense
18. Supervision was not intellectually challenging
19. Supervision was superficial
20. There was a mismatch between what was being taught on the course and what the supervisor had to offer
21. I did not observe my supervisor
22. My supervisor gave me too heavy a workload
23. My supervisor broke some distressing news about a client without tact or support
24. I had two supervisors who gave me conflicting advice on a case
Appendix 7:

Illustrative statements by trainees about best supervision:

“Supervisor was very knowledgeable about theory and practice in the field and made continual links throughout supervision.”

“Supervisor gave me space to reflect and discuss different hypotheses, formulations and techniques, rather than stating from the outset how to do it.”

“Supervisor agreed to observation (both ways) and openly identified his own mistakes – helped challenge my ideas about it not being acceptable to make mistakes.”

“Throughout, my supervisor was complimentary, positive and excellent, while giving constructive criticism which left me feeling more skilled and confident.”

“She listened to my worries and asked me a series of questions which guided my thinking about each of the assessments... and helped me clarify my thoughts, so I could see the aims and value in what I was doing. I left supervision feeling better about my work and feeling empowered. My supervisor had helped me answer my own questions, which increased my confidence. She did this without being judgmental or directive.”

“Supervision provided up-to-date theory in more than one model, guidance of how to integrate it into my work creatively... in the context of a relationship which was very encouraging, reflective, treated as a fellow colleague – believed in and trusted.”

Illustrative statements by trainees on worst supervision:

“Having a supervisor who insisted on checking and correcting each report at least three times before allowing me to send it. I felt demeaned and deskilled and also didn’t feel like I was learning anything from the experience as many of the changes involved changing my style of writing...”

“Supervisor was nearly always critical and aloof. I felt frightened to bring issues to supervision and thought that points I considered important were dismissed. I lost confidence in my skills.”

“Support from college but no changes made re. The placement for future trainees.”

“Being told what to assess and what intervention to use without discussion. Also experience of supervisor formulating for trainee. No scope for learning, generation of own ideas.”

“One supervisor was rather vague in her formulations and advice for intervention. She generally suggested I ‘wonder with’ people. This was unhelpful because my personal preference was for more active interventions and because of the lack of any explicit rationale for this approach.”

“No support, not listened to, dumped with cases nobody else wanted. No guidance on how to manage, assess, intervene – worked in a way I thought sensible as given little other help... No understanding of my needs... shattered my confidence with a client group.”
Appendix 8

Feedback sent to participating courses – summary of findings
The supervisory process in clinical psychology training: experiences and expectations of trainees.

Summary of method and findings.

Method

**Design:** A postal-questionnaire design was used providing both quantitative data analysed using multivariate statistical techniques and descriptive statistics, and also qualitative data analysed using content analysis.

**Participants:** Three hundred first, second and third year trainee clinical psychologists at six ClinPsychD courses in South-East-England. Respondents = 127 (42%), of whom 93 (73.2%) were aged 25-30 and 16 (12.6%) were aged 31-35. Women made up 106 of the sample (83.5%), which is representative of national figures for trainee clinical psychologists. Participants came from all three years of training, with 49 first-years (38.6%), 40 second-years (31.5%) and 37 third years (29.1%).

Cognitive-behavioural therapy (CBT) was the preferred theoretical orientation of 69 participants (54.3%), with “CBT/Systemic” the next most popular orientation with 11 respondents (8.7%) of the sample.

**Measures:** A questionnaire was devised to evaluate the views on placement supervision of trainees.

- **Deriving the Questionnaire:** The literature indicated six domains of supervision were likely to be important: Skills Acquisition, Supervisory Relationship, Quality Control, Knowledge, Process and Practicalities (See Table 1 for definitions)

  A series of statements were generated by the author to reflect each domain. Subsequently, a workshop was held with eight first-year clinical psychology trainees on the same course as the author. Its purpose was two-fold; first, to check the proposed domains of supervision were comprehensive; second, to check that the domains were comprehensible. Secondly, the same trainees undertook a card-sort of 58 statements on supervision to validate their presence in particular domains. A statement was included in the questionnaire if five or participants (60 per cent) agreed it fell into the same domain. 51 statements reached criteria. Two statements - 'In supervision I discuss ethical issues' (50% agreement-level) and 'In supervision I am encouraged to reflect on my practice' (50%) - were retained despite failing to reach criteria as it was felt their omission would result in the final questionnaire not reflecting important aspects of supervision. Another statement which failed to meet the criterion – ‘In supervision I discuss formulations of my client’s difficulties’ – was reworded and included in both the Skills Acquisition section and the Knowledge section, to which participants in the card sort had in equal numbers ascribed it. Again, it was felt two key aspects would be lost without it. Three separate statements referring to access to a desk, computer and telephone were linked as one as they were deemed to duplicate each other.

- **The questionnaire:** Information on 'Age', 'Gender', 'Year of training', 'Number of placements' and 'Preferred theoretical orientation' was gathered. There was a list of six domains (see Table 1 below), validated in the card-sort, which participants were required to rank order. Respondents were also required to rank order in importance and rate - for frequency of delivery - statements about supervisory activities, generated by the literature and validated by the card-sort. There were also three questions relating to expectations of supervision, and critical incidents of good and bad supervision.

**Analyses:** Descriptive statistics were used to analyse the data. Non-parametric tests (Mann-Whitney U Test and Kruskal-Wallis) were used to test for between group differences in rankings and ratings. Content analysis (Day, 1993) was used to analyse the qualitative data.
Table 1: Definitions of the six domains of supervision

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<td>Skills Acquisition</td>
<td>Learning and practising technical skills e.g. Socratic questioning</td>
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<td>Supervisory relationship</td>
<td>Having a constructive relationship with your supervisor</td>
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<td>Quality control</td>
<td>Supervision as a means of ensuring minimum standards of care</td>
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<td>Knowledge</td>
<td>Sharing knowledge over and above skills acquisition</td>
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<td>Process</td>
<td>Discussion of therapeutic processes including client-therapist dynamics</td>
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<td>Practicalities</td>
<td>Arrangements for supervision and your working environment</td>
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Executive Summary of findings:

1. *Skills Acquisition* and the quality of the *Supervisory Relationship* are most valued by trainees.
2. Qualitative data indicates that trainees value *Skills Acquisition* and the *Supervisory Relationship* most when they interact. This study indicates that all trainees, regardless of year of training and preferred orientation (with one exception – see 7. Below), see supervision placement as a place to develop core competencies in formulation, assessment and intervention in a relationship in which they are valued, given honest and constructive feedback and explicit, clear rationales for the supervisor’s guidance.
3. Trainees also value supervisors who are supportive.
4. What trainees regard as unhelpful supervision is generally the mirror image of what is valued. Unhelpful supervision is described as one in which core competencies are not developed and the trainee feels unvalued, and that s/he is given destructive criticism. Unhelpful supervisors also do not give clear and explicit rationales for their guidance.
5. Additionally, trainees indicate that it is unhelpful when supervisors are unaware of the trainees’ emotional and training needs.
6. What trainees want from placement supervision does not change according to their stage in training.
7. The trainees’ preferred theoretical orientation did affect – in one way – what they wanted from training. Trainees with a psychodynamic orientation placed significantly less emphasis on *Skills Acquisition* than those with a CBT orientation.
8. Supervisors are delivering all elements of the supervision practice equally, although individual trainees can identify exceptions to this general picture.
9. The high level of concordance between rankings and ratings indicates supervisors are delivering what trainees want.
10. Trainees are less concerned with the *Quality Control* aspects of supervision.
11. Trainees place relatively little value on evidence-based practice and supervisors rarely check on this aspect of the trainees’ work.
12. In terms of therapy *Process*, trainees place more importance on reflective practice and making interventions effective than discussing power differentials or ethical issues.
13. Discussions of power differentials and ethical issues are being marginalised in supervision.
14. Supervisors are delivering roughly the same training package regardless of the trainee’s year of training.
15. Current models of supervision do not fit comfortably with trainees’ expectations of supervision. For example, Proctor (1991) argues supervision involves three main processes. These are formative/educative (where skills, understanding and ability is developed through reflection on and exploration of the trainee’s work with his/her clients); restorative (where supervisors respond to the inherent stresses of work) and normative (where the trainee is developed as an NHS
employee standards are monitored and the supervisor interfaces with the wider organisation). The present study indicates trainees have a strong focus on formative/educative processes, while the normative function of supervision remains largely invisible to them. Additionally, in the restorative function, trainees want more than containment, they want active encouragement and support.

16. In view of the transactional nature of supervision, future research might concentrate on qualitative analysis of trainees and supervisors discussing training together.

A sample of illustrative statements by trainees about best supervision:

"Supervisor was very knowledgeable about theory and practice in the field and made continual links throughout supervision."

"Supervisor gave me space to reflect and discuss different hypotheses, formulations and techniques, rather than stating from the outset how to do it."

"Supervisor agreed to observation (both ways) and openly identified his own mistakes – helped challenge my ideas about it not being acceptable to make mistakes."

"Throughout, my supervisor was complimentary, positive and excellent, while giving constructive criticism which left me feeling more skilled and confident."

"She listened to my worries and asked me a series of questions which guided my thinking about each of the assessments...and helped me clarify my thoughts, so I could see the aims and value in what I was doing. I left supervision feeling better about my work and feeling empowered. My supervisor had helped me answer my own questions, which increased my confidence. She did this without being judgmental or directive."

"Supervision provided up-to-date theory in more than one model, guidance of how to integrate it into my work creatively...in the context of a relationship which was very encouraging, reflective, treated as a fellow colleague – believed in and trusted."

A sample of illustrative statements by trainees on worst supervision:

"Having a supervisor who insisted on checking and correcting each report at least three-times before allowing me to send it. I felt demeaned and deskilled and also didn’t feel like I was learning anything from the experience as many of the changes involved changing my style of writing..."

"Supervisor was nearly always critical and aloof. I felt frightened to bring issues to supervision and thought that points I considered important were dismissed. I lost confidence in my skills."

"Support from college but no changes made re. The placement for future trainees."

"Being told what to assess and what intervention to use without discussion. Also experience of supervisor formulating for trainee. NO scope for learning, generation of own ideas."

"One supervisor was rather vague in her formulations and advice for intervention. She generally suggested I ‘wonder with’ people. This was unhelpful because my personal preference was for more active interventions and because of the lack of any explicit rationale for this approach."

"No support, not listened to, dumped with cases nobody else wanted. No guidance on how to manage, assess, intervene — worked in a way I thought sensible as given little other help...No understanding of my needs...shattered my confidence with a client group."
Literature Review

How useful has the Health Belief Model been in predicting treatment adherence in clients with severe and/or chronic mental health problems?

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Year 2/3
How useful has the Health Belief Model been in predicting treatment adherence in clients with severe and/or chronic mental health problems?

Introduction:
Non-adherence* to treatment is a major problem in modern healthcare both in physical illness and for people with mental health problems. It has a personal cost. There is also a cost in time and resources for the NHS. Relapse has been linked to poor medication compliance (Goodwin & Jamison, 1990; cited in Keck et al., 1997) leading sometimes to hospitalisation or referrals for further therapy. Although there is now a challenge to the view that non-adherence rates to medication regimes by clients with mental health problems (Blackwell, 1997) are greatly higher than for those with physical disorders, improving non-adherence in mental health is a major challenge with great potential benefits. Cramer and Rosenheck (1998) in a review of 10 studies estimated that clients took on average 65% of prescribed antidepressants with a range of 40-90% (compared with adherence rates to medication regimes for physical disorders of 76%, with a range of 60-92%). Non-adherence in conditions requiring long-term treatment is especially problematical. Lin et al. (1995) found that non-adherence to antidepressant medication increased from a rate of 28% in the first month to 44% in the third month. Non-adherence to anti-psychotic medication has been estimated to be higher still, although there is debate as to the level and to the reasons with Cramer and Rosenheck (1998) concluding that it might be due to the inaccuracy of methods used to measure compliance in this client group. Buchanan (1992) reported in a two-year prospective study of treatment compliance of people with schizophrenia that 50% of his sample were poorly compliant two years after discharge from hospital, while in their review study Cramer and Rosenheck (1998) reported a mean compliance rate of 58% (range: 24 - 90%).

* Although there are different definitions of “adherence” and “compliance”, in the current review the terms will be used interchangeably, because they are used in this way in many studies under review.
A number of social cognition models have been developed which aim to explain and
predict both what makes people act to prevent ill health and whether they will adhere
to treatment for acute and chronic illness. One of the first and most highly researched
models is the Health Belief Model (HBM), developed by Rosenstock in 1966 and later
by Becker and his colleagues through the 1970s and 1980s (Janz and Becker, 1984).
The model was, however, developed with physical disorders in mind (Rosenstock,
1966) and research into its predictive utility has largely concentrated in health
promotion areas such as dietary compliance and in medication adherence in chronic
physical conditions, such as diabetes (Ogden, 2000). In recent years there has been
considerable interest in developing intervention strategies to overcome non-adherence
in psychological therapies (for example with the development of Motivational
Interviewing and Compliance Therapy) and a number of researchers have studied the
utility of the HBM in predicting non-adherence in people with mental health problems.
The current paper aims to review the existing literature in the area and answer: does
the HBM provide a useful model for predicting treatment adherence behaviours in
people with mental health problems? If it does, are particular behavioural determinants
as set out in the HBM more predictive than others are? If it does not, does the HBM
need modification for mental health behaviours or is a new model required? And,
finally, does any model of adherence in the field of mental health need to be disorder-
or treatment-modality specific?

**Method of review:**

PsycINFO and Medline was used to search literature from 1967 to the present.
Keywords used in the search were ‘health belief model’, ‘treatment compliance’,
‘psychological illness’, ‘depression’, ‘schizophrenia’, ‘bipolar disorder’ and ‘affective
disorder’. Additional papers were selected from references in the studies identified in
the search. The search indicated a need to limit the current review in two ways. First,
that it concentrated largely on adherence to physical treatments for functional
psychological conditions in the form of medication. There were no studies that
attempted to consider the HBM’s utility in predicting compliance in psychological
therapies as measured solely by, for example, attendance in therapy or homework
completed in Cognitive Behavioural Therapy. Second, that the present review concentrated on severe and chronic mental health problems. Again, the weight of the literature considering the HBM focuses on this particular population sample.

**The Health Belief Model:**

The HBM is a social cognition model designed to identify the variables that underlie health-related decisions, and to assess their ability to predict behaviour (Armitage and Conner, 2000). Originally, it included five determinants of health behaviours; perceived susceptibility to illness, perceived severity of illness, perceived benefits of treatment, perceived costs or barriers to treatment; and cues to take health action (cues to action). Since its development, Rosenstock and Becker have added two more determinants; the degree to which one is motivated to remain healthy; and the degree to which a person believes he/she can control their health behaviours (Ogden, 2000). All components are regarded as independent predictors of health behaviour (Armitage and Conner, 2000).

**Methodological difficulties in conducting the current review:**

One of the criticisms levelled at the HBM is that the determinants are not operationally defined (Stroebe and Stroebe, 1995). This lack of definition means care must be exercised in comparing results between studies. For example, Smith et al., 1999, in a study on adherence with anti-psychotic depot medication define the benefits component of the HBM as including secondary benefits of medication, such as being more calm and able to socialise, whereas other studies do not indicate whether they include this in the term or just refer to primary benefits of symptom relief. In the current study, differences in the HBM component definitions will be noted where they are apparent.

As noted above, the model itself has evolved to include extra components. As the authors of most studies do not give a detailed account of which version of the model they are using, it can be difficult to compare studies with confidence.
A further difficulty, which has been the subject of a number of separate reviews (e.g. Cramer and Rosenheck, 1998), has been how adherence is defined and measured between studies. Adherence has been defined and measured in terms of blood serum lithium levels, pill counts, attendance at outpatient clinics, patient self-report and his/her doctor’s opinion, and microelectronic monitoring systems. As Cramer and Rosenheck (1998) note no system has proved completely reliable. Self-report measures, for example, generally give an overestimation of compliance (Cramer and Rosenheck, 1998). These problems also apply to medication adherence measurement with physical disorders. Such inconsistency in measurement again makes comparison of studies hazardous. The current paper will note how studies have tried to measure adherence, with the caveat that no method of measurement has been found to be highly reliable (Cramer and Rosenheck, 1998).

Differing definitions of adherence also cause difficulties of comparison. For example, Budd et al., 1996, used a different way to identify compliers to antipsychotic medication than Pan and Tantam (1989). The former’s definition may have lead to very clear differences between compliers and non-compliers, thereby maximising the health beliefs underlying the differences. Budd et al., 1996, produced conflicting results to Pan and Tantam’s (1989) study, possibly as a result of this difference in adherence definition.

**Studies into the HBM and treatment adherence in affective disorders:**

There have been two major studies (Connelly et al., 1982; Adams et al., 2000) which have explicitly tested hypotheses about compliance in affective disorders using the HBM as a theoretical framework. Additionally, there have been a number of studies which have examined determinants of compliance in ways that could be equated with the HBM. One of those studies has been included in this review: Lin et al., 1995, because it is a well-designed recent study, which extends the sample population by
drawing participants from a primary care setting. Unlike other studies excluded here, it also specifically examines the cues to action determinant.

Connelly et al., 1982, used the Health Belief Model framework to determine how the perceptions of patients receiving lithium carbonate maintenance treatment for mood disorders with regard to their illness, treatment, mood and side effects related to medication-taking and appointment-keeping behaviour. It is an important study because it is one of the first to use a standardised measure of the HBM. The sample consisted of 24 men and 24 women randomly admitted to two US outpatient clinics. Perceptions of treatment were measured by structured questionnaire – the Standardised Compliance Questionnaire – which measures the severity, costs, and benefits HBM determinants. The authors also devised a self-rated scale to measure the client’s mood at the time of completing the questionnaire. The results were analysed using multiple regression and correlation analyses.

The authors found that severity, costs and benefits were not significantly correlated with adherence levels, but being married, and the perception that the participant was receiving continuity of care were significantly correlated with adherence. Regression analyses indicated that the HBM components accounted for 7% of the variance in adherence behaviour; taking into account the mood of the client brought the figure up to 15%.

The study has a number of strengths. It is a prospective study with adherence levels measured both before and after participants completed the questionnaires, thus avoiding problems caused in retrospective studies on adherence of memory biases and also avoiding possible bias against poor adherers by physician-raters. Additionally, it used two separate measures of adherence; serum lithium levels and attendance at outpatients’ clinics. Adherence was defined as the maintenance of therapeutic serum lithium levels and attendance at 75% or more outpatient appointments over a 9-month period. While there are drawbacks to both methods (e.g. see Cramer and Rosenheck, 1998, on problems of therapeutic drug monitoring), using two adherence determinants provides more certainty that adherence is being measured accurately. Additionally, this study by examining two adherence methods – and finding that some participants were
adherent in one domain and not another - highlights that adherence is a multi-faceted concept and can be operationalised in different ways that reflect the complexity of the treatment regimes offered to patients. It challenges the idea that for this sample population medication compliance is the only measure of adherence.

The study has a number of weaknesses, however. There is no power analysis but the sample is small and may lack power to detect an effect of the HBM determinants on adherence behaviour. Participants in the sample were receiving a variety of modalities of service, which may have impacted on health beliefs and adherence levels. These were left uncontrolled in the design. Additionally, some clients were taking other medication, which might affect perceptions of side effects (costs) and benefits of adhering to medication.

Adams and Scott (2000) is the most recent study investigating the utility of the HBM in predicting compliance among patients with affective disorders. It should be noted, that the study again uses service-delivery criteria for selecting a sample population, on the basis of clinical utility. Participants were selected from UK outpatient departments for patients with severe and disabling mental disorders. They are included in this section because the majority (67%) has affective disorders. It should be noted that 33% have schizophrenic illnesses and no attempt is made to analyse the results according to diagnosis.

Thirty-nine participants meeting a diagnosis of chronic and disabling mental disorder, in receipt of disability benefit and being prescribed long-term prophylactic medication for mental disorder took part in the study. The authors measured components of the HBM using a reliable and valid instrument, and used a standardised questionnaire to assess the side effects of medication. However, the authors had to add questions on susceptibility, severity and cues to action as these were not measured on the HBM measurement instrument. Adherence was measured by written and verbal self-report and an assessor blind to all other study data analysed the adherence information to categorise participants into High, Partial or Non-adherers. Dysfunctional attitudes, personality traits and health locus of control were measured as potential modifying factors on adherence behaviour. Non-parametric analyses were used to identify
variables that differentiated between High and Partial-adherers categories, with a strict significance level (p<0.01) to reflect the small sample size. Multiple regression analyses and logistic regression analyses were also run.

Adams and Scott (2000) found that severity and benefits significantly differentiated between high and partial-adherers. These two HBM components accounted for 43% of the variance in adherence behaviour. They also found that factors outside the HBM significantly differentiated adherence behaviours. Participants scoring high on “dependency” and “need for approval” scales were high adherers, as were those with an external health locus of control.

The study has a number of strengths. It generally uses measures with good reliability and validity. The authors defend their use of self-report measures for adherence, by pointing out that no measure is perfect and that the level of adherence reported by subjects was in line with adherence measured in other ways and in other studies.

There are problems with the study, however. The most important is that the authors themselves devised three questions on the susceptibility, severity and cues to action components of the HBM. There is no indication of whether and how they were piloted and no reliability and validity data for the questions are given. Given the finding that severity was a good predictor of adherence, this is a worrying omission. Another problem is that this is a small sample for linear regression analysis. Despite the authors’ protestations, the reliance on self-report measures of adherence as the only measure is a weakness and falls short of the gold standard of triangulation.

Lin et al., 1995, studied adherence to antidepressants in a US primary care population. The authors did not directly test the HBM but they did look at the effect of educational packages and medication side-effects, which could be described as “external cues to action” and “costs” respectively.

The sample consisted of 155 adult participants, who were diagnosed with depressive disorders and had been prescribed antidepressant medication which they were supposed to take for at least three months. The majority of the sample were women.
(72.3%) with a mean age of 47 years. The participants were split into two groups for the benefit of comparative analysis – early adherers (those who adhered for less than 30 days) and late adherers (those who adhered for between 30 and 90 days). Adherence was measured by participant self-report.

The authors found that side effects (costs) were associated with early nonadherence at severe levels but not at mild or moderate levels. However, side effects did not predict nonadherence in late adherers. External cues to action, in the form of educational messages regarding medication usage and behavioural strategies, were also associated with good early adherence. For late adherers, however, the only significant predictor was whether the participant had used antidepressant medication previously.

The study has a number of strengths. It uses a community sample and is designed to examine medication adherence with some complexity. Chiefly, it employs a longitudinal design which allows the authors to compare short-term adherence to longer-term adherence.

There are a number of weaknesses, however: the sample is educationally above average limiting the study’s generalisability; adherence is measured through self-report, which is unreliable; and the patient report of care, side effects and adherence is based on recall which may be subject to memory bias.

However, the study illuminated a number of problems with other studies into the HBM. It demonstrated that the model is too static. For example, Lin et al., 1995, found that the side effects of medication (costs) affected adherence in a complex way which was dependent both on the time side effects were experienced, what side effects were experienced and how many. The HBM does not allow for such complexity making it difficult to interpret the results of studies which support or counter costs as a significant factor of medication adherence. Additionally, the study indicates that elements not included in the model can be significant predictors of health behaviours (in this case, previous experience of using medication).
Summary of findings:

Due to the very limited number of studies explicitly using the HBM framework, it is impossible to make firm statements about the determinants of HBM in medication adherence behaviour in affective disorders. However, based on the above studies and on information from a review study into the utility of the HBM in predicting medication adherence in affective disorders (Cohen et al., 2000), a number of trends emerge. Susceptibility and costs are poor predictors; severity is a good predictor; for benefits and cues to action the evidence for and against predictive utility is evenly balanced.

Other factors that are correlated with medication adherence in affective disorders:

A number of other determinants of adherence to medication regimens in affective disorders have been identified in the studies in this review.

Patient-related factors:

Connelly et al., 1982, found that married patients were significantly more likely to adhere to lithium carbonate than patients who were single. Adams and Scott (2000) found personality characteristics and beliefs about locus of control were significant predictors.

Illness-related factors:

While Keck et al., 1997, did not find any association between elevated mood and lithium adherence, Connelly et al., 1982, did find that elevated mood was associated with greater non-adherence.
Drug-related factors:

Lin et al., 1995, found that people who had used anti-depressants before were likely to be more compliant. Keck et al., 1997, found that in-patients with bipolar disorder who were hospitalised for acute mania were more likely to be non-compliant to combinations of mood stabilising drugs.

Other factors:

In a review article, Cohen et al., 2000, found a number of studies that identified doctor-related factors, such as continuity of care, to be predictive of adherence behaviour. Additionally, social influences and normative beliefs have been highlighted. For example, in bipolar disorder, what friends, family and spouses believe about medication has been found to be a good predictor of adherence to a medication regimen. Positive attitudes to medication in the patient and his/her significant others has been highly associated with good adherence (Jamison et al., 1979).

Studies into the HBM as predictive of medication adherence with patients with schizophrenia.

Considering the reported efficacy of antipsychotic medication in easing positive symptoms of schizophrenia (Shepherd et al., 1989, cited in Roth and Fonagy, 1996), the seriousness of the consequences of non-compliance in many cases and the high rates of non-compliance (see above), there are remarkably few studies which use the HBM framework to predict adherence behaviour in people with schizophrenia. All four have been included in this review.

One of the most important is the study by Budd et al., 1996. It is important because it seeks to readdress some of the shortcomings of other studies into this model; especially the issue of the reliability of measures of the HBM and the criteria used to measure compliance.
Budd et al., 1996, recruited 20 compliant and 20 non-compliant people meeting DSM III-R criteria for schizophrenia from two depot neuroleptic clinics in South Wales. The groups were matched on key demographic characteristics. Participants completed two questionnaires on Health Beliefs and Health Locus of Control, which reliably measured three HBM components (susceptibility, severity, and benefits). Reliability coefficients indicated that costs was not reliably measured by the instruments. Compliance was measured according to an accepted research definition (Curson et al, 1985; cited in Smith et al., 1999) on the basis of appointment attendance records and acceptance of medication at those appointments. The results were analysed using stepwise discriminant function analysis.

The authors found that only susceptibility significantly differentiated between compliers and non-compliers on its own. However, the authors found that severity and benefits were highly intercorrelated with susceptibility leading them to conclude that compliance was highest in those participants who believed they were susceptible to relapse, also believed the relapse would be severe and that medication helped prevent relapse.

As noted above, this study has the advantage of using reliable, operationally defined measures of the HBM and of compliance. However, the smallness of the sample inhibits claims about the generalisability of the findings.

One of the biggest studies which examined the utility of the HBM in predicting adherence behaviour was by Kelly et al. 1987. The sample population was 107 psychiatric outpatients with chronic mental health problems and who were prescribed maintenance antipsychotics. They had been living in the community for less than one year following discharge from hospital. 72% of the participants was diagnosed with a schizophrenic illness; while 14% had affective disorders. All participants were ex-servicepeople with a psychiatric disability related to their military service. Five components of the HBM were operationally defined and measured by structured interview. Medication adherence rates were estimated using separate self-report measures on long-term compliance and errors in taking medications in the seven days prior to the interview.
Kelly et al., 1987, ran Pearson correlations on the HBM components and ran multivariate regression analyses to see the degree of variance in adherence behaviours explained by combinations of HBM components. The regression analyses revealed that 20% of variance in reported long-term compliance was explained by cues to action, susceptibility and benefits, while 17% of variability in reported errors in medication taking was accounted for by the determinants susceptibility, severity and benefits.

One of the study’s strengths is that it gives a clear operational definition of the HBM components. This makes it easier to compare with other studies which define the HBM components. Additionally, the authors use multivariate analysis techniques, compared with many studies (e.g. Connelly et al., 1982) which just consider bivariate relationships between individual components of HBM and adherence behaviour.

The major problem with the study is that the specificity of its sample population makes it difficult to generalise its findings. Not many psychotic clients, even in the US, are veterans of the Vietnam War. It’s possible that, as ex-soldiers, compliance rates may be artificially high, or that as ex-servicemen with disability payments linked to illness that they may exaggerate the strength of their beliefs in the susceptibility to illness and severity of illness categories.

Pan and Tantam (1989) used the HBM to test a series of hypotheses about the medication adherence behaviour of patients on depot neuroleptic maintenance treatment for schizophrenia. A group of 40 regular adherers – measured by attendance records and medication charts – was matched with a group of irregular adherers. Their health beliefs were measured by a four-part questionnaire, devised by the authors. Only items achieving a test-retest reliability correlation coefficient of 0.6 were included in the questionnaire after initial piloting.

The authors found that neither severity, susceptibility, benefits or costs (side effects) was predictive of adherence behaviour. The only thing that distinguished the two
groups were that the irregular attenders were significantly more depressed than regular attendees.

The significance of this study, which appears to cast doubt on the utility of the HBM for people with long-term psychoticism, is severely weakened by the selection of the sample population. By using the selection criteria they did, non-attenders were missed out completely, while irregular attenders may not have been particularly irregular attenders. For example, it was possible that their last missed appointment was as late as four months before the study. In other words, Pan and Tantam’s (1989) findings may have been subject to ceiling effects with their measures of health belief unable to distinguish between regular and irregular attenders.

In the most recent study, Smith et al., 1999, investigated a matched sample of 20 compliant and 20 non-compliant UK outpatients who had been diagnosed as schizophrenic at least two years before the study began. Compliance was measured according to the criteria of the Budd et al. study (1996) above. Smith et al.’s study (1999) was qualitative. Health beliefs were gauged in a semi-structured interview and the results were analysed using content analysis.

The authors found that susceptibility predicted adherence behaviour, with compliers more likely to perceive themselves as susceptible to relapse than non-compliers. Benefits also differentiated the two groups. Compliers were more likely to talk about the benefits of taking medication. Non-compliers were significantly more likely to talk of costs, especially in terms of medication side effects.

The strength of the study lies in introducing qualitative methodology to this area. For example, it revealed that compliers did have costs to taking medication, spontaneously reporting medication side effects. However, the content analysis revealed that for compliers, it was beliefs about perceived susceptibility to illness that over-rided costs concerns. Despite analysing the results in terms of the HBM, the authors also avoided HBM-framed bias in the participants’ responses by having a highly open-ended interview based on motivational interviewing techniques.
Although, the methodology was sound, there is concern that the small size of the sample limits the generalisability of the findings. However, it could be argued that the sample selected from a South Wales outpatient clinic is typical.

**Summary of findings:**

Based on the above studies, one review study on HBM and schizophrenia (Hughes et al., 1997) and one general review of medication compliance in schizophrenia (Fenton et al., 1997), the following summaries can be made about HBM components.

**Susceptibility:**

Three studies (Budd et al., 1996; Kelly et al., 1987; and Smith et al., 1999), which directly examined the HBM, found this dimension of the model was a good predictor of adherence behaviour. However Pan and Tantam (1989) did not find susceptibility to be a good determinant.

**Severity:**

There are equivocal results from the studies. Budd et al., 1996, found severity was predictive but added little to the variance when susceptibility was included in the analysis. However three studies (Kelly et al., 1987; Pan & Tantam, 1989; Smith et al., 1999) did not find severity differentiated between compliers and non-compliers.

**Costs:**

The weight of the evidence points to costs not being predictive of adherence behaviour. Three studies (Budd et al., 1996; Kelly et al., 1987; and Pan and Tantam, 1989) found it was not predictive, compared with one that did (Smith et al, 1999).
Benefits:

Three studies (Budd et al., 1996; Kelly et al., 1987; Smith et al., 1999) found high perceived benefits of medication was correlated with high adherence with anti-psychotic medication. One study (Pan and Tantam, 1989) contradicted this finding. Fenton et al., 1997, also cite studies which include benefits as a good predictor of adherence.

Cues to action:

This area has rarely been studied. Only Kelly et al., 1989, looked at external cues and found their presence or absence was predictive of adherence.

Other factors:

In a major review of the empirical and clinical findings of the determinants of medication compliance in schizophrenia, Fenton et al., 1997, cite studies which indicate factors not addressed in the HBM account for some of the variability in adherence behaviour. The major ones are the existence of a dual diagnosis; the strength of environmental factors, such as adequate service provision; and clinician-related factors, especially the strength of the therapeutic alliance between doctor and patient (see Fenton et al, 1997, for citations).

**Does the HBM provide a useful model for predicting adherence behaviours in mental health?**

Bearing in mind the caveat that the review covers a limited range of mental health problems, a number of comparisons can be made. The review above indicates that for none of the determinants of the HBM is there unanimous support. This compares unfavourably with the model in the domain of physical illness (see Ogden, 2000, for a review). However, in the domains of susceptibility, benefits and costs there is a trend
towards predictive utility. How does this compare with findings from the physical domain? Studies in the physical domain (cited in Ogden, 2000) indicate there is a mixed picture for susceptibility predicting adherence behaviour. As in affective and schizophrenic disorders, benefits is a good predictor. Costs in the physical domain has proved a good predictor of compliance, compared with the present review which indicates it is not helpful in determining medication adherence in affective and schizophrenia disorders. In the physical domain the literature (cited in Ogden, 2000) indicates that cues to action is a good predictor of compliance health behaviours, whereas the present review indicates that this determinant has generally been ignored in mental health and more studies are needed which include this component.

**Conclusion:**

The above review indicates that the HBM model as it stands needs to be modified and developed to have clinical utility in predicting compliance behaviour in mental health. For example, the review indicates that a generic model may not be appropriate. Different determinants of the model appear to be significant as predictors of adherence behaviours depending on the disorder under examination. Additionally, individual determinants, for example costs, appear to affect adherence in a complex way, which includes temporal factors, rather than in a simple linear way (see Lin et al., 1995). A number of studies (e.g. Kelly et al., 1987) indicate that the factors interact in a way left unexplained by the HBM.

There are also indications (e.g. Pan and Tantam, 1989) that a number of other factors, not included in the model, are important determinants of adherence behaviour. These appear to relate to wider systemic factors, such as the views of significant others to adherence behaviour (e.g. Connelly et al., 1982) and lay constructions of illness and health behaviours particularly where the diagnosed condition is chronic and the treatment is on-going (e.g. Pan and Tantam, 1989).

The above review may be of limited use in deciding the utility of the HBM in mental health interventions, where psychological treatments as well as, and in combination with pharmacotherapy are common. However, the present review lends support to the
hypothesis that for conceptual reasons the HBM may have limited value in predicting adherence behaviours to psychological regimes. The model does not accommodate, for example, the difference in salience and perceived cause and effect between physical and mental health problem "symptoms"; and cultural issues, such as stigma around mental illness which might inhibit action and shape health beliefs.

**Implications for future research:**

There is a great need for more standardisation in quantitative studies of the HBM model. For example, health beliefs are measured in different ways in each of the reviewed studies. Yet, Ludwig et al., 1990, report that there exist two measures of the effect of health beliefs on compliance (The Compliance Self-Rating Scale; Bender et al. 1986; and the KK-Scala; Linden et al., 1988; cited in Ludwig et al., 1990) which have high reliability and moderate concurrent validity in predicting adherence behaviours. These could be used to help standardise studies and aid comparison between studies.

There is scope for further qualitative studies. Only one (Smith et al., 1999) has been undertaken and this revealed a degree of complexity around one domain in the HBM model (costs) otherwise obscured in quantitative studies. Qualitative data from other studies (e.g. Lin et al., 1995), which is included in the results but not analysed in a rigorous way, indicate that lay perceptions of illness concepts in mental health are complex and need to be considered in the development of a health compliance model for mental health.
References


July 2002

Year 3
Abstract
Cognitive behaviour therapy (CBT) has been recommended in recent Department of Health initiatives as one of the treatments of choice for depression. CBT has been shown to be effective both at posttreatment and at follow-up. One of the chief aims of CBT is to enable the client to become a CBT self-therapist (Beck, J., 1995) following CBT treatment for depression, which is now recognised as commonly being a chronic condition. Yet there have been no studies of whether adults who have had CBT for depression actually become CBT self-therapists, despite the proliferation of theories on CBT’s prophylactic qualities. The current exploratory study used qualitative methodology to answer the questions: “Do adults who have had CBT for depression use CBT after completing treatment? If they do, how is CBT used to self-manage their mental health? What hinders or helps people as self-therapists? And what is the experience of being a self-therapist after CBT for depression?” Nine adults who had received either individual or group CBT for recurrent/chronic depression in NHS adult mental health psychology departments were interviewed. Interviews were conducted at the participant’s home using a semi-structured interview schedule at least three months after s/he completed therapy. Interpretative Phenomenological Analysis (IPA: Smith, 1996) was used to analyse the data. Eight of the nine participants were actively using CBT techniques in some shape or form. Four superordinate themes emerged (The experience of being a self-therapist; The use participants made of CBT; Challenges to doing self-therapy; Fitting self-therapy into the wider picture). The results indicated that complexity marked the use made of CBT. Each active self-therapist used techniques directly related to CBT or engaged in self-therapeutic activities which were idiosyncratically adapted from the therapy. A number of factors hindering the use of CBT as self-therapy were identified. Participants found being a self-therapist hard work, and experienced emotional disturbance with regularity and expressed continuing fear of the power of depression. Adaptation of CBT for self-therapeutic purposes rested on a number of factors, which included the participant’s self-beliefs, his/her view of CBT, his/her view of what s/he most needed when therapy began, and his/her prior and ongoing experience of depression. The results are discussed in the light of theories about the mechanism of change in CBT and social cognition models of health behaviours. With the caveat against generalising from qualitative studies, it is tentatively concluded that the results lend support to the compensatory skills model of CBT (Barber and DeRubeis, 1989) and Teasdale’s “decentering” model (2000) for this particular clinical and therapeutic group. The results also indicate that social cognition models may aid understanding of self-therapeutic processes following CBT for depression. A number of implications for clinical practice, especially the importance of end-of-therapy plans and booster sessions in the maintenance phase of CBT treatment for depression, are discussed.

NB: Some of the identifying details of this research have been changed to maintain client anonymity and confidentiality.

1.0 Introduction

1.1. The problem of depression: severity, recurrence and chronicity:

Each year in Great Britain one woman in 15 and one man in 30 will be treated for depression (Meltzer, Gill, Petticrew & Hinds, 1994). Depression is a major risk factor in suicide and in cardiovascular disease. It has also been associated with chronic illness and with developmental problems in the offspring of depressed mothers (National Service Framework for Mental Health, HMSO, 1999). Globally the World Health Organisation (WHO) has predicted that mood disorders including depression will rise from the world’s fourth greatest cause of illness burden (a composite based on mortality and morbidity) to second by the year 2020 (WHO, 1996, cited in Frank & Thase, 1999). In addition to the high incidence, there are high rates of recurrence in depression. It has been estimated that more than 80% of patients experience repeated episodes, with an average of four lifetime episodes of major depression lasting 20 weeks each (Judd, 1997). Depression is also marked by chronicity. In the National Institute of Mental Health (NIMH) Collaborative Depression Study, a prospective study of almost 1,000 depressed patients who were treated at five US centres, 25% of the first 316 patients reported having a pre-existing minor chronic depression, which had lasted for at least two years before the onset of the index episode of major depression (Keller & Hanks, 1995). Forty-two percent of these "double depressed" reported chronic minor depression lasting 10 years or more. Furthermore, the observed course of double depression indicated a higher and faster rate of relapse: repeated episodes of major affective disorder were more likely in patients with double depression compared with major depression alone (Keller & Hanks, 1995).
1.2. Effectiveness of CBT in treating depression and preventing relapse:

Depression is now a priority target for the NHS. For example, in the National Service Framework for Mental Health (NSF for Mental Health; HMSO, 1999) NHS trusts at primary care level are charged by the Department of Health with developing assessment and management protocols for depression. In the document’s guidance notes, NHS trusts are advised that cognitive behaviour therapy (CBT) is among the structured therapies that are effective in treating depression. In a review of 28 studies CBT was found to be superior to waiting list control, antidepressant drug treatment, behaviour therapy and other psychotherapies (Dobson, 1989). However, methodological weaknesses mar Dobson’s analysis. For example, it included a number of nonrandomised studies and studies which may have been unduly influenced by researcher allegiance (Robinson, Berman & Neimeyer, 1990). However, further studies, which do not share the same methodological weaknesses, indicate CBT’s effectiveness. In a meta-analysis of 48 controlled studies, which only included trials that had randomised groups, Gloaguen, Cottraux, Cucherat and Blackburn (1998) concluded that at the end of treatment CBT achieved significant symptom reduction compared with waiting list, antidepressants and a group of miscellaneous therapies. The authors found no superiority for CBT compared with behaviour therapy. In a review of nine meta-analyses, Sanderson and McGinn (1999) conclude that all indicate a clear superiority for CBT over no treatment or wait list controls and that six found significantly greater treatment effects for CBT compared with other psychotherapies.

In the NSF document (HMSO, 1999), CBT is also singled out as being the one psychological therapy for which there is evidence that it reduces relapse rates in depression. In the Gloaguen et al. meta-analysis cited above (1998), eight studies involving 132 patients diagnosed with either unipolar depression or dysthymia, and comparing CBT with pharmacotherapy not just at the end of therapy but at 12 and 24 months post-treatment, were analysed. CBT significantly delayed relapse compared with pharmacotherapy in five out of the eight studies, with a non-significant trend in the same direction in one of the other trials. On average, only 29.5% of patients treated with CBT alone or in combination with medication relapsed after 12 months compared with 60% of those treated with antidepressant medication alone. Robinson et al. (1990) found in their meta-analysis that in the nine studies that conducted follow-up studies, posttreatment and follow-up effect sizes were very similar, indicating durable treatment effects for CBT for depression. Despite the methodological problems of follow-up studies and one major study indicating no improved relapse rates at 18-month follow-up for CBT compared with imipramine, placebo plus clinical management and interpersonal therapy (Shea, Elkin, Imber et al., 1992), a recent review concluded that the majority of studies
indicate CBT provides protection against symptom relapse or recurrence and may have lower relapse rates than pharmacotherapy (Sanderson & McGinn, 1999). For clinical and organisational reasons, therefore, it is important to try to understand more about how cognitive therapy works and what might be the processes underlying its prophylactic powers. The current study aims to illuminate the CBT client’s post-treatment perspective with a view to exploring the prophylactic process in CBT.

1.3. Current status and knowledge of self-therapy in depression following CBT:

A key assumption about CBT’s effectiveness in delaying relapse is that it enables clients to develop techniques which they continue to use on the completion of therapy. As one leading CBT author put it: “The goal in cognitive therapy is to facilitate the remission of the patient’s disorder and to teach the patient to be her own therapist, not for the therapist to solve all her problems.” (Beck, J., 1995). Clinicians should, then, help clients develop as self-therapists. Clients should develop end-of-therapy plans (Beck, J., 1995) and self-therapy “blueprints” (Wills & Sanders, 1997). J. Beck, for example, recommends client and therapist discuss how the client can do self-therapy by holding at home sessions which parallel the structure of a clinic CBT session. Topics for self-therapy include homework setting, problem-listing and possible cognitive restructuring or problem-solving to resolve difficulties (see Appendix 1). However, despite the emphasis in CBT placed on self-therapy, the questions of whether clients with depression become self-therapists at all on termination and what it means to be a CBT self-therapist have not been studied. Traditional quantitative outcome studies (Blackburn, Eunson & Bishop, 1986; Evans, Hollon, DeRubeis, Piasecki, Grove, Garvey & Tuason, 1992) do not, for example, test the first question, and therefore it is not possible to say whether improvements credited to CBT are attributable to the initial therapy “curing” depression, or to clients maintaining their own symptom reduction by the activity of being a self-therapist, or a combination of the two. Such traditional approaches have not therefore thrown light on whether there is any connection between becoming a self-therapist and the onset of relapse. Other outcome studies (Rush, Weissenburger & Eaves, 1986; Williams & Falbo, 1996)) using quantitative methods have sought to test various hypotheses about the specific prophylactic ingredients of CBT (such as whether there have been changes in clients’ dysfunctional attitudes at discharge and whether these have been maintained at follow-up). But again, these studies do not show whether self-therapy activity has taken place, its frequency, its form, its content, its degree of success and whether it is linked to the maintenance of protective cognitive schemata.
1.4. Current theoretical basis of CBT for depression:

Cognitive behaviour therapy for depression is 'an active, directive, time-limited, structured approach...based on an underlying theoretical rationale that an individual’s affect and behaviour are largely determined by the way he structures the world’ (Beck, Rush, Shaw & Emery, 1979). A. Beck (1989) argues that the key cognitive content in depression is characterised by the client perceiving experience in terms of negative beliefs about him/herself, the world and the future. This triad of negative cognitive schemata, hypothesised to develop because of an early experience of loss and triggered by a later loss, is used to organise perception and to govern and evaluate behaviour (A. Beck, 1989). Cognitive therapists also theorise that an individual’s cognitive structure is organised at three different levels: unconditional core beliefs at the deepest most ingrained level; intermediate conditional assumptions and, at the level most available to consciousness, automatic thoughts (Brewin, 1989). Traditional approaches to CBT for depression have focussed on a range of strategies aimed at challenging the content of intermediate beliefs and automatic thoughts. Cognitive, behavioural, a mixture of cognitive-behavioural, and preventative strategies have been indicated (Fennell, 1989). More recently, clinicians have stressed the importance of trying to either modify or provide alternative cognitive schema at the level of core beliefs, particularly where the depression is chronic* and linked to personality structures (e.g. Young, 1990; Padesky, 1994). Teasdale (1997) has presented a model of depression hypothesised to explain the condition's high rate of recurrence. He proposes that, during a major depressive episode, patients make repeated associations at the cognitive and neuronal level between depressed mood and negative thinking, which come to characterise thinking patterns when the recovered patient experiences low mood. Reactivation of these patterns during low mood intensifies the depressive feelings, which are then maintained by "self-perpetuating cycles of ruminative cognitive-affective processing" (Teasdale, 1997). Teasdale and his team (2000) have developed mindfulness-based cognitive therapy (MBCT) from this theory as adjunctive therapy to prevent relapse following a pharmacological intervention in the acute stage of the condition. Unlike traditional CBT the emphasis is on changing not the content of the client's thoughts but his/her relationship to them.

*Chronic major depression is diagnosed when full criteria for a major depressive episode is met continuously for at least the past two years; dysthymia is characterised by a chronic depressed mood that is present more days than not for at least two years but with symptoms less severe than those of major depressive disorder. (DSM-IV; American Psychiatric Association, 1994)
1.5. What are the prophylactic ingredients of CBT for depression?

Since its inception, debate has raged as to what constitute the active ingredients of CBT for depression. Arguments have been made for specific CBT factors and for general therapeutic factors being the active and prophylactic ingredients. Among the theorists interested in the specifics of CBT, Hollon, Barber & DeRubeis (1988) propose three possible mechanisms; that CBT modified depressogenic beliefs and or cognitive processes involved in the maintenance of the beliefs (the accommodation model); that it does not induce schematic change but rather leads to the deactivation of depressogenic schemata and the activation of pre-existing benign ones (the activation-deactivation model); that CBT leads to patients acquiring a set of skills to curtail negative thinking, including meta-cognitive skills in planning or problem-solving (the compensatory skills model). Barber and DeRubeis (1989) then elaborated on these theories, suggesting that the compensatory skills model best described what happened in CBT for depression. Alternatively, Williams (1997) and Teasdale (2000) argued that cognitive therapy for depression was effective at delaying or preventing relapse in depression by breaking the previously strong connection in the client between mood disturbance and the elaboration from it of large amounts of negative self-referrent cognitions. In addition CBT lessened the client's use of mood as "a criterion of the truth of negative thoughts, assumptions and fears." (Williams, 1997).

Such cognitive accounts have been challenged, however. Some have argued that it is the behavioural components of CBT that are essential. Early acceptance of the treatment rationale allows clients to change their behaviour in such a way that enables them to come into contact with positive reinforcers in the environment (Jacobson & Gortner, 2000). This claim has been backed by a component analysis of CBT (Jacobson, Dobson, Truax, Addis, Koerner, Gollan, Gortner & Prince, 1996) in which depressed patients were randomly assigned to one of three treatments, believed to represent one of three possible prophylactic ingredients of CBT: behavioural activation (BA), where only interventions designed to increase patient activity without challenging thinking were allowed; an automatic thought treatment, where activation and thought modification was attempted; and full CBT, where activation and modification of core beliefs and intermediate assumptions was attempted. None of the three treatments was more effective than the others at the end of the acute treatment phase. At 2-year follow-up, there was even a trend towards the BA treatment being more effective than full CBT at preventing relapse. Other authors have offered different accounts of the mechanisms of change in CBT. Shaw and Segal (1999) have concentrated on the specificity of techniques promoted by CBT and its emphasis on self-help promoted by within-therapy homework. Bordin (1979) argues that a strong therapeutic alliance is the active ingredient. Shaw and
Segal (1999) conclude that the active ingredients of CBT for depression are not yet known with certainty.

These theories have implications for clients with depression as self-therapists following CBT. For example, if Hollon and colleagues’ (1988) accommodation model is correct one would not expect clients to become self-therapists, while with the activation-deactivation model one would predict little self-therapeutic activity except in the face of key depressogenic schemata activating events such as “loss” events. By contrast, under the compensatory skills model one would expect to see high self-therapeutic activity with clients actively trying to overcome dysfunctional thoughts and engaging in problem-solving. If Williams’ (1997) and Teasdale’s (2000) hypothesis is correct one would expect clients to be self-therapists because they would still be experiencing mood disturbances but not experiencing an overwhelming accompaniment of negative thoughts. When negative thoughts did occur, clients would use rationality and reality testing rather than emotion as the criterion by which to judge them. Similarly, with Jacobson and Gortner’s model (2000) one would predict that clients, while undertaking self-therapeutic activities, would not place any emphasis on making cognitive challenges in overcoming distressing situations. At the level of practice, if self-therapy becomes a mirror of within-therapy activity, one would expect to see clients, for example, challenging thinking patterns, possibly at the core belief level (J. Beck, 1995), facing rather than avoiding activities, testing and evaluating beliefs, and problem-solving (Padesky & Greenberger, 1995). However, given the importance within CBT theory of an idiosyncratic conceptualisation of clients' problems (Clark, 1999) and the collaborative nature of CBT (J. Beck, 1995), it is not possible to predict the specifics of self-therapeutic activity for any given individual. The current study, then, will not actively test out the theories and the link between theory and practice, but will use these to inform the Discussion section.

1.7. Other possible theoretical approaches to the activity of being a self-therapist:

Whatever the prophylactic ingredients of CBT, it is hypothesised in the current study that being a self-therapist is best conceived of, not as a static state, but as a dynamic process. Other theoretical models of behaviour aimed at understanding health changing behaviour have implicated that clients undergo a dynamic process (e.g. the Transtheoretical Approach to Change; DiClemente & Prochaska, 1998). However, there are currently no process models which allow one to predict who amongst people who have a mental health problem would use psychological therapies after they have finished therapy and how they would use them. The nearest we have are social cognition models of health and illness behaviours, which were
originally and primarily developed to account for behaviour to maintain **physical** well-being in a healthy person (a "health behaviour" as defined by Kasl and Cobb, 1966, cited in Ogden, 2000) and for behaviour when a person is experiencing symptoms of a physical illness (e.g. Leventhal's illness-representation model, 1980). Two models are of particular interest for the current study: the Health Belief Model (HBM; Rosenstock, 1966; Janz & Becker, 1984) and Self-Efficacy Theory (SET; Bandura, 1977), which has been superseded by the Health Action Process Approach (HAPA; Schwarzer, 1992).

The HBM was designed to identify the variables that underlie health-related decisions, and to assess their ability to predict behaviour (Armitage & Conner, 2000). Originally, it included five determinants of health behaviours: perceived susceptibility to illness; perceived severity of illness; perceived benefits of treatment; perceived costs or barriers to treatment; and cues to take an action to maintain health (cues to action). Since its development, Rosenstock and Becker have added two more variables (Ogden, 2000): the degree to which one is motivated to remain healthy; and the degree to which a person believes s/he can control his/her health behaviour. All components are regarded as independent predictors of health behaviour (Armitage & Conner, 2000).

The HBM has a number of weaknesses and has been criticised for ignoring the irrational in decision-making in favour of a rational cost/benefit approach (see Ogden, 2000 for a review). However, it is relevant to the current study on two counts. It is the most widely studied of all the social cognition models of health behaviours and therefore has the widest evidence-base and, of all the models, it is the one that has been most widely used to study areas of mental health including long term medication compliance in affective disorders. There are significant differences between being a self-therapist following CBT for depression and taking antidepressant medication for an ongoing often severe mood disorder (for example, clients taking medication are “managed” by a doctor on an ongoing basis, not left to manage alone). However, there are some similarities; for example, both groups will have experience of mood disorder and be required to perform a “health behaviour” in order to maintain their mental health. The strengths, weaknesses and findings of the studies into medication adherence in mood disorders are reviewed elsewhere in this Portfolio (See Literature Review). In summary, however, the limited number of studies does not allow for definitive statements about the role of HBM variables in medication adherence in affective disorders, but a number of trends emerge. **Susceptibility** and **costs** are poor predictors; perceived **severity** of illness is a good predictor; for **benefits** and **cues to action** the evidence for and against predictive utility is evenly balanced. In addition, medication adherence behaviour in affective disorders is influenced by a number of other variables, including patient-related factors, illness-related...
factors and drug-related factors. For example, previous use of antidepressants was significantly associated with adherence to antidepressant medication (Lin, von Korff, Katon, Bush, Simon, Walker & Robinson, 1995). Service-related factors – such as continuity of care – have been found to be predictive of adherence behaviour (Cohen, Parikh & Kennedy, 2000) as have positive attitudes to medication among significant others in the client’s life (Jamison, Gerner & Goodwin, 1979). Different determinants of the HBM are significant depending on the disorder under examination. Additionally, individual determinants, for example, costs, appear to affect adherence in a complex rather than a simple linear way, with the amount of time in receipt of medication a significant factor (see Lin et al., 1995). There are indications that the seven determinants in the HBM are not independent variables but interact in ways not specified by the model (Kelly, Mamon & Scott, 1987).

There are considerable gaps, then, in one of the major theoretical models of health-related behaviour (the HBM) as an explanatory or predictive tool of treatment “adherence” in long-term psychological therapies without the overt support of the therapist. The empirical evidence lends support to the hypothesis that the HBM may have limited value in predicting adherence to psychological – not medical - regimens for conceptual reasons. For example, the model does not accommodate: the difference in salience between physical and mental health problem “symptoms” as cues to enact a “health behaviour”; cultural issues, such as stigma around mental illness which might inhibit action and shape health beliefs; the predicted increased importance of the prior therapeutic alliance between doctor and patient where therapy involves talking as opposed to prescription (see Fenton, Blyler & Heinssen, 1997, for citations on the importance of the therapeutic alliance in adherence behaviours in schizophrenia); and the role of irrationality and emotion in turning health intentions into health actions (Ogden, 2000).

Although the HAPA (Schwarzer, 1992) has not been applied empirically to study behaviours that regulate mental health, there are conceptual and empirical reasons for considering it may be helpful in understanding self-therapy in the context under consideration in this study. It is based on ideas of psychological and behavioural self-regulation (Fiske and Taylor, 1991), which themselves have there roots in a theory widely used to inform practice in clinical psychology including cognitive behaviour therapy - social learning theory (Bandura, 1977). Bandura (1977) posited that people were motivated to change dysfunctional beliefs and that human motivation and action are regulated by forethought, that is by beliefs about what people expect to happen (“expectancies”). Three expectancy beliefs underlie health actions: situation-outcome expectancy; action-outcome expectancy and self-efficacy expectancy (Conner & Norman, 1998). Situation-outcome expectancies represent beliefs about what
outcomes will occur without interfering personal action; action-outcome expectancies represent the belief that a behaviour will or will not lead to a given outcome; and a self-efficacy expectancy represents a belief that a behaviour is within or not within one's self control. Self-efficacy Theory (SET; Bandura, 1977) has been tested in situations akin to (but not the same as) being a self-therapist. Strong self-efficacy beliefs have been found to be a key factor in patients with arthritis engaging in physical exercise in a self-management programme (Holman & Lorig, 1992; cited in Schwarzer & Fuchs, 1998). Outcome-expectancies and self-efficacy beliefs, along with other lifestyle changes and a network of social support, have also been found to be key cognitive variables in successful dieting and weight control and in predicting relapse prevention in addictive behaviours (see Schwarzer & Fuchs, 1998, for a review). The latter area – addiction – has parallels with being a self-therapist for depression. Most addicts involved in empirical studies would have had psychological therapy and face daily issues of psychological and behavioural self-management. SET, however, concentrates on explaining the intention to act but fails to recognise that intention and action are not always correlated (Schwarzer, 1992). The Health Action Process Approach (Schwarzer, 1992) was therefore developed. It is a two-stage model proposing different variables and interactions at two stages of a health action; the motivational stage (where a person chooses a health goal) and a volitional stage (where a person plans and enacts the behaviours required to attain the goal). In the motivational stage clients draw on self-efficacy and outcome expectancies to help form an intention to adopt a precautionary behaviour or to change a risk behaviour. At this stage, it is also necessary for clients to perceive they are at risk. In the volitional phase, a number of variables are important. Clients form detailed action plans with proximal goals and algorithms of action sequences. Self-regulation through cognitive processes is then required to maintain the action. For example, self-efficacy beliefs determine the amount of effort and persistence in attaining health goals and help keep competing activity at bay. At the volitional stage action plans and action control through self-regulatory cognitive processes are also required for a person to refrain from a risk behaviour.

It is this emphasis on the processes underlying the volitional stage that is of interest in the current study. CBT self-therapists, who have completed therapy for depression, are conceptualised as being in the volitional stage in this two-stage process. The HAPA, however, has not been tested on mental health behaviours and has been little tested on behaviours designed to maintain physical well-being. The limited studies on healthy-eating behavior (Schwarzer & Fuchs, 1998) and self-examination for testicular cancer (Barling & Lehmann, 1999) indicate that the HAPA might prove a useful model for predicting behaviour in the
volitional phase and that self-efficacy expectancies could be a key variable maintaining ongoing health-related activities.

1.8. The research questions:

There are, then, no studies into the specific question of whether clients who have cognitive therapy for depression become self-therapists after therapy and whether they do so in the ways predicted by the theory and practice of cognitive therapists themselves. Additionally, there are no studies examining the applicability of social cognition models of health behaviour to this context. The present study aims to redress this gap in our knowledge.

It explores the following research questions:

1. Is CBT actively used by a group of adults after they have been discharged from CBT treatment for long-term depression?
2. If it is used, how is it used to self-manage mental health?
3. What hinders or helps participants be self-therapists?
4. What is the experience of being a self-therapist in this context?

These questions were explored qualitatively through an examination of the first-hand accounts of a group of adults who have had CBT for depression. The accounts focus on the experience of managing depression without the support of a therapist at least three months after treatment has finished. The interpretation of the data was informed by, but did not seek to test, the Health Belief Model (Rosenstock, 1966) and the Health Action Process Approach (Schwarzer, 1992), as well as by the theories of change mechanisms in CBT outlined above.

1.9. Why use qualitative research methodology?

The current study adopts a qualitative approach for a number of reasons. The epistemology of qualitative approaches acknowledges that meanings and actions are linked to contexts (Glaser & Strauss, 1967) and provides a research methodology which allows access to the creation of meanings and actions within a social context (Willig, 2001). Social cognition models of health behaviours and illness representations indicate that clients are not simply passive recipients of medical or psychological treatments, but actively create meanings based on the information they receive (Leventhal, Meyer & Nerenz, 1980). Their beliefs and attitudes towards a range of factors including self-efficacy, attitudes towards health, beliefs of susceptibility to illness, affect how they interpret and use information in a medical context (Ogden, 2000). Compared
with medical consultations, clients and therapists engaged in psychotherapy are involved in even more complex processes where information and meanings are negotiated, not simply exchanged (Elliott & Shapiro, 1988). A research methodology which can capture meaning-making in context is therefore appropriate to answer exploratory questions about becoming a self-therapist; that methodology is qualitative.

Qualitative methodology is also indicated where, as has already been noted, there is little extant research (Turpin, Barley, Beail, Scaife, Slade, Smith & Walsh, 1997) and an exploratory study needs to be done. Given the complexity of a psychotherapy treatment and the complexity of depression as a mental health problem, it would be difficult in the absence of a theoretical base to isolate particular variables as required by quantitative methodology. Variables affecting “adherence” to CBT treatment for depression are likely to be numerous, if, for example, factors dictating medication adherence in clients with schizophrenia (arguably a less complex process) is taken as a guide (Fenton et al., 1997).

A qualitative research approach is particularly pertinent in health service research (Dingwall, Murphy, Watson, Greatbatch & Parker, 1998). It can bridge the gap between the nomothetic approach embodied in randomised control trials into the effectiveness of particular treatments and the idiopathic delivery of those treatments to individual clients: “the more individualised the intervention becomes, the greater the role that qualitative work is likely to play in its evaluation.” As noted above, CBT requires an individualised approach (Clark, 1999). It is only by understanding what happens at this nomothetic-idiopathic gap and by understanding through qualitative research the processes by which therapeutic work is sustained and reproduced can a service – in this case, the delivery of CBT for depression – become more efficient and effective (Dingwall et al., 1998). There is, therefore, a service imperative for adopting a qualitative approach which explores factors that influence the effectiveness of CBT interventions for depression in adults at the level of individual clients.

As has already been noted, there are no current models or theories for how people become self-therapists after CBT for depression. Social cognition models of health behaviours have been devised with physical health behaviours in mind (Ogden, 2000). This absence of theory provides a fourth reason for adopting qualitative research methods. Although Glaser and Strauss’ claim (1967) that qualitative approaches largely utilise inductive rather than deductive methods of acquiring knowledge of the world has been challenged (Dingwall et al, 1998), it is widely agreed that on the whole qualitative methodology encourages theory generation (Henwood and Pidgeon, 1992) in a way that quantitative approaches do not. Where there is no existing theory – or where existing theories are likely to need to be substantially
challenged – as in the area under consideration in the present study, a qualitative approach is indicated to allow the beginning of theory-building. Specifically, the methodology in the current study should help to explore the gaps in the theories of health behaviours in the context of mental, as opposed to physical health.

2.0 Method

2.1. Participants:

Five men and four women who had each had cognitive therapy for depression were recruited for the study. For detailed exclusion and inclusion criteria see Appendix 2. Adults aged over 18 were chosen because for children depression often manifests itself differently than for adults (Carr, 1999) and is subject to either different psychological approaches altogether or to adapted cognitive therapy approaches. Selecting only working age adults, therefore, reduces the number of confounding factors in drawing conclusions about the relationship between the therapy, depression and the experience of being a self-therapist. It also allows the findings to be applied to mainstream NHS adult services and a key standard in the National Service Framework for Mental Health (HMSO, 1999). Clients with psychotic features and with dual diagnosis were also excluded for the similar reason that CBT for these groups is markedly different than for those with either depression or co-morbid anxiety and depression (Beck, Wright, Newman & Thiese, 1993; Birchwood & Tarrier, 1995).

Any clients judged to have been depressed following a one-off loss or other life event with good prior adjustment were also excluded. The main reason for this was practical. The phenomenon under investigation was "self-therapy" after CBT and it was hypothesised that those with a more recurring pattern of depression would be more likely to be continuing to use the techniques. Patients who report chronic minor depression have a significant likelihood of experiencing relapse, recurrence, chronicity and residual subsyndromal symptoms in the interval between full criteria episodes of illness (Keller & Hanks, 1995). Additionally, a recurrent presentation is more representative of depression (Judd, 1997) than a single episode presentation with good prior adjustment. Selecting participants on the grounds of chronicity therefore strengthens the study's "applicability", a key quality criterion in qualitative research (Conrad, 1987, cited in Smith, 1996). The inclusion criteria did not stipulate selection on the basis of strict research definitions of depression because in clinical practice clinicians do not use them. The inclusion criteria selected thus best meet the qualitative quality criteria of "applicability". Taken together the inclusion and exclusion criteria produced a sample which was "homogenous" in key aspects of depression and of service provision as recommended for
good Interpretative Phenomenological Analysis (Smith, 2002). Exclusion criteria regarding self-harm and research participation were required by the presiding ethical committees in the trusts at which the research was conducted.

For participants' demographic details, see under Analysis.

2.2. Procedure:

2.2.1 Recruitment strategy:

Once ethical approval was obtained (Appendix 3), participants were recruited via psychological therapists – chartered clinical psychologists and community psychiatric nurses specialising in CBT – working in adult mental health psychology departments and community mental health teams in two NHS trusts. Participating therapists were asked to identify all clients who met the selection criteria from either their current workloads or from clients they had discharged within the last three months. Potential participants were then sent information on the study (Appendix 4) with an opt-in slip to be sent directly to the researcher. When describing the study care was taken not to convey to participants that the research was centrally concerned with establishing how they had used cognitive therapy since completing treatment for fear of altering their self-therapeutic activity by priming. The study was described as concentrating on “how people cope after they have been treated with cognitive-behavioural therapy for depression”, a form of words approved by each trust’s ethics committee. Potential participants were then contacted directly by the researcher with no further involvement of the participants’ former therapists. To try to ensure clients had been in receipt of recognisable CBT, participating therapists were required to complete for each participant the Cognitive Therapy Skills Checklist (Padesky & Greenberger, 1995) devised to help therapists evaluate their clients' CBT skills development (Appendix 5). A score of 5 out of 15 was set as a criterion of the participant having had CBT, as such a score indicates that, at the very least, therapists tackled the role of negative automatic thoughts in depression and explained the model and rationale of CBT for depression. Each therapist scored 12 or more for each participant, indicating that participants received CBT which covered the three levels of cognition in A. Beck’s depression model (automatic thoughts, intermediate beliefs and core beliefs).

2.2.2 Interview procedure:

Participants were interviewed face-to-face in their homes. Written consent to be interviewed was obtained before the interview and at the end of each interview (Appendix 6). The
researcher used a semi-structured interview (Appendix 7) which lasted between 50 and 80 minutes. Interviews were audio-taped and transcribed verbatim (see Appendix 8 for a sample transcript).

2.3. The interview schedule:

The interview schedule (Appendix 7) was constructed by consulting with a current clinical psychologist with a specialist knowledge of cognitive therapy and with a senior research tutor on the doctorate in clinical psychology course at the University of Surrey; by drawing on literature relating to interview construction (Moser & Kalton, 1977); and by drawing on literature relating to social cognition models of health behaviour (Conner & Norman, 1998).

A semi-structured interview format was used. The interview started with questions regarding demographic information and proceeded to open-ended questions on the participant's understanding of CBT, their current use or non-use of CBT and their beliefs and attitudes regarding depression. Participants' were prompted to consider specific examples of their use of cognitive therapy and to consider any limitations or restrictions on current use (see Appendix 7).

2.4. Analytic strategy:

The data was analysed using Interpretative Phenomenological Analysis (IPA; Smith, 1996; Smith, Jarman & Osborn, 1999). IPA has been used to analyse qualitative data on a range of topics relating to health and well-being (Jarman, Smith and Walsh, 1997; Smith, 1999). IPA is phenomenological in that it is concerned with establishing the essence or nature of the phenomenon under question (Willig, 2001), in this case, the essence of the clients' experience of managing their mental health after having had cognitive therapy for recurrent depression. It is also phenomenological in that the data analysis is grounded in the participants' accounts, which are privileged over the account given by the researcher (Smith, 1996). One of IPA's aims is to allow the researcher to gain an "insider's perspective" of the phenomenon (Conrad, 1987, cited by Smith, 1996). However, it is also acknowledged in IPA that the process and end product of research inevitably represents a co-construction between the researcher and his research material (Smith et al., 1999).

An idiographic case-study approach to IPA was employed as recommended for sample sizes of 15 or under (Smith et al., 1999). Two transcripts selected at random were read and re-read and margin notes were made of key phrases or processes. An initial list of subordinate themes
was generated. Two transcripts rather one were selected because it was felt that as the aim was to generate commonalities in accounts (while preserving their individuality) this aim could only be served by comparing two accounts. Smith et al.,(1999), acknowledge that IPA is a new method and there are no hard and fast rules to how it is applied, as long as themes are shown to be grounded in the data and the aim of generating rich, diverse specific instantiations of the psychological phenomenon under scrutiny is achieved (Osborn & Smith, 1998). A research group of four other clinical psychology doctorate researchers and a senior research lecturer at the University of Surrey also looked at one of the transcripts and generated themes independently, which were compared and contrasted with the themes identified by the main researcher as part of a process of triangulation. The main researcher and his academic research supervisor then checked the initial theme list to ensure it was grounded in the data, to check for idiosyncratic interpretations and to generate superordinate themes. The main researcher then read the remaining seven transcripts to look for comparisons and differences with the initial set of identified superordinate and subordinate themes and a final list of themes was generated. The research supervisor then read the emerging analysis to ensure themes were grounded in the participants’ accounts.

3.0 Research quality checks:

The criterion of quality measures in research should match the epistemological stance underlying the research (Madill, Jordan & Shirley, 2000). In the current case, quality criteria should fit IPA’s contextual constructionist epistemology. Therefore, quality in IPA should be measured on two main criteria: the degree to which the research has grounded observations in the contexts that have generated them; and the degree of researcher reflexivity (Willig, 2001). Using Elliott, Fischer and Rennie's (1999) guidelines the latter two criteria, can be translated into four criteria: “Owning one’s perspective”, “Situating the sample”, “Grounding in examples”, and “Providing credibility checks.”

3.1.1 Owning one’s perspective - the main author's interpretative stance:

IPA acknowledges that participants’ accounts are not only constructed by the participants but have to be interpreted by researchers to bridge the gap between the idiosyncratic account and the wider scientific community (Smith, 1996). The researcher’s values and assumptions and conceptions are necessary preconditions for making sense of the participants’ narratives. In the present study, the main researcher is a trainee clinical psychologist, who has a particular
interest in CBT. There are four values and assumptions held by the main researcher which are pertinent to the present study. The main researcher shares the realist ontological stance, which underlies IPA, that there is a meaningful (although not direct) link between what a person says about an experience and the experience itself. As a clinical psychologist I have imbibed the "positivist" values underlying the scientist-practitioner model and am concerned with looking for "lawful" connections in experiences. As a trainee clinician, I have developed the assumption, based on clinical experience, that there will not be a clear linear transfer of skills and understanding from the cognitive therapist to the client. Finally, drawing on my own experience of trying to change behaviour I hold the assumption that being a self-therapist will be a complex experience governed by "holistic" considerations such as the participants' past experience and future visions and a raft of competing demands and psychological, environmental, social and physical needs.

These values and assumptions have shaped the research at every point. In trying to find a research question the main researcher was influenced by his position as a trainee clinical psychologist trying to learn about the theory of CBT and trying to master its practice. He was considering questions which paralleled to some degree the questions a client faces when having CBT for depression; in particular, "How do I become a (self)therapist?" and "How do I learn this thing called cognitive behaviour therapy?" In practical terms, the main researcher tried completing forms to challenge negative thoughts as recommended by CBT authors (e.g. J. Beck, 1995) to develop his skills as a cognitive therapist. In this sense, the trainee position should help the author take the "insider's perspective" required by IPA (Conrad, 1987; cited in Smith, 1996). At the research design stage, the culture of clinical psychology training with its focus on the scientist-practitioner model influenced the generation of the wording of the interview schedule (with its emphasis on the techniques and ways of thinking in CT rather than the feelings that go with managing depression). At the data collection stage, there were indications that the main researcher was perceived by participants as being connected with the mental health system the latter had just passed through (participants were enlisted via their cognitive therapists), which may have influenced how they answered questions. One possibility was that they would try to appear "model" clients. At the data interpretation stage, the main researcher was influenced by his assumptions that there would be a non-linear connection between the therapy learned in session and its implementation in practice and by his assumptions about "holistic" concerns shaping CBT's use. It is possible that the main researcher was primed to pay attention to data that appeared to support an emergent theme of "Fitting therapy into the wider picture" and to look for complexity in the superordinate theme, "How cognitive therapy was used by the participant". To counter this possibility, themes are
operationalised and illustrated by quotations from the participants’ accounts, allowing peer interrogation of the interpretations made (Elliott et al., 1999).

3.1.2 Situating the sample:

Researchers should describe participants and their life circumstances in some detail to allow readers to assess the applicability of the findings (Elliot et al., 1999). In the current study relevant participant details are described under Demographic details. The list contains some personal details to allow the reader to situate each participant in context and to preserve the individuality of accounts which characterises the IPA method (Smith, 1996). The accounts given in the Analysis section contain narrative changes to preserve the anonymity and confidentiality of clients as required for ethical reasons, but are preserved in such a way as to allow the participants’ context to be understood.

3.1.3 Grounding in examples:

Examples of the data should be used to allow readers to assess the fit between the data and the researcher’s interpretations (Elliott et al., 1999). The current study has attempted to meet this quality criterion.

3.1.4 Providing credibility checks:

The researcher endeavoured to ensure the credibility of his analysis and avoid idiosyncratic interpretations (Elliott et al., 1999) by having one transcript read by a group of four fellow trainee clinical psychologists engaged in using IPA in their research. The group identified themes from this interview, which were discussed and incorporated into the emerging analysis. A senior research psychologist read a draft of the analysis along with a number of transcripts. The aim was to ensure that identified themes were supported by the data.

4.0 Analysis

4.1.1 Participant demographic and therapeutic information:

IPA's epistemological concern with understanding meanings and experience in context requires an individualised approach to participants' demographic details (Willig, 2001).
Table 1 gives participants' demographic details. Full employment details have been omitted to help preserve confidentiality.

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Ethnic Origin</th>
<th>Employment</th>
<th>Marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bob</td>
<td>51-55</td>
<td>White-British</td>
<td>Yes</td>
<td>Single</td>
</tr>
<tr>
<td>Jan</td>
<td>31-35</td>
<td>White-British</td>
<td>Yes</td>
<td>Single</td>
</tr>
<tr>
<td>Meg</td>
<td>26-30</td>
<td>White-British</td>
<td>Yes</td>
<td>Partnered - not co-habiting</td>
</tr>
<tr>
<td>Harry</td>
<td>66-70</td>
<td>White-British</td>
<td>Retired</td>
<td>Married</td>
</tr>
<tr>
<td>Peter</td>
<td>46-50</td>
<td>White-British</td>
<td>Yes</td>
<td>Married</td>
</tr>
<tr>
<td>John</td>
<td>56-60</td>
<td>White-British</td>
<td>Yes</td>
<td>Married</td>
</tr>
<tr>
<td>Mary</td>
<td>46-50</td>
<td>White-British</td>
<td>Yes</td>
<td>Married</td>
</tr>
<tr>
<td>Sarah</td>
<td>51-55</td>
<td>White-British</td>
<td>Yes</td>
<td>Single</td>
</tr>
<tr>
<td>Terry</td>
<td>36-40</td>
<td>White-British</td>
<td>Yes</td>
<td>Single</td>
</tr>
</tbody>
</table>

Table 1: Participants' demographic information

Table 2 gives participants' therapeutic details. Seven (78%) had been in receipt of individual cognitive therapy, two (22%) had taken part in group cognitive therapy. The length of time that had elapsed since therapy ranged from three months to 10 months (mode: 4 months and mean: 6.5 months). The length of time the participants described themselves as being depressed prior to having cognitive therapy ranged from two years to 20 years, indicating that each participant fulfilled the selection criteria for having a chronic depression. Six of the sample (67%) had received previous “talking” therapies for depression or services from a community mental health team. Therapies included individual CBT, twin counselling, Christian pastoral counselling and the support of a community psychiatric nurse. Two (22%) were currently taking anti-depressant medication.
<table>
<thead>
<tr>
<th></th>
<th>Mode of therapy</th>
<th>Length of therapy</th>
<th>Time elapsed since therapy</th>
<th>Time depressed prior to therapy (Client estimate)</th>
<th>Previous therapy</th>
<th>On antidepressant drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bob</td>
<td>Individual CBT</td>
<td>4 months</td>
<td>6 months</td>
<td>5 years</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Jan</td>
<td>Group CBT</td>
<td>2 months</td>
<td>4 months</td>
<td>15 years</td>
<td>Yes: anxiety management</td>
<td>No</td>
</tr>
<tr>
<td>Meg</td>
<td>Individual CBT</td>
<td>6 weeks</td>
<td>4 months</td>
<td>7 years</td>
<td>Yes: indiv. CBT</td>
<td>No</td>
</tr>
<tr>
<td>Harry</td>
<td>Group CBT</td>
<td>2 months</td>
<td>6 months</td>
<td>20 years</td>
<td>Yes: indiv. CBT</td>
<td>No</td>
</tr>
<tr>
<td>Peter</td>
<td>Individual CBT</td>
<td>6 months</td>
<td>7 months</td>
<td>2 years</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>John</td>
<td>Individual CBT</td>
<td>4 months</td>
<td>9 months</td>
<td>10 years</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>Mary</td>
<td>Individual CBT</td>
<td>6 years</td>
<td>3 months</td>
<td>15 years</td>
<td>Yes: counselling</td>
<td>No</td>
</tr>
<tr>
<td>Sarah</td>
<td>Individual CBT</td>
<td>5 months</td>
<td>10 months</td>
<td>7 years</td>
<td>Yes: CPN</td>
<td>No</td>
</tr>
<tr>
<td>Terry</td>
<td>Individual CBT</td>
<td>5 months</td>
<td>9 months</td>
<td>14 years</td>
<td>Yes: Indiv. dynamic</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Table 2: Participants' therapeutic details**

### 4.1.2 Summary of themes

Four superordinate themes emerged from the interviews - the experience of being a self-therapist; how cognitive therapy was used by the participant; challenges to doing self-therapy; and fitting self-therapy into the wider picture. Subordinate themes were identified which elaborated the superordinate themes and sought to identify the commonalities while retaining the complexity and diversity of the participants' experience (Smith, 1996).

* In the present study, when quotations are cited empty brackets ( ) indicate where material has been omitted; information in square brackets [ ] has been added to clarify material; and ellipsis points (…) indicate a pause in the participants’ speech. Pseudonyms have been used and some details have been changed to preserve anonymity.
4.2 The experience of being a self-therapist.

4.2.1 Holding in mind the idea of being a self-therapist

Underpinning all the activity described in the later sections is the evidence that eight of the participants (89%) did actually hold in mind a concept of themselves as actively engaged in maintaining their own emotional well-being. None of the participants, however, conceptualised his/her activity as the medical activity implicit in the term “self-therapist”. None used the term or described what s/he was doing as “treating” her/himself. However, two participants (22%) did describe some of their use of the techniques in the language of doing experiments on themselves as expected by the discourse of cognitive therapy. Sarah described using the techniques with increasing confidence the more she “tested” them and Mary described thinking in advance of approaching anxiety-provoking situations as challenges to test her new skills.

Identifying oneself in the self-therapy role was directly linked to the ongoing use of practices associated with the therapy. Harry, the one participant who did not use active strategies after therapy, described his post-therapy life without any reference to being aware of a role as a self-therapist. He referred to using distinctly non-therapeutic skills – identified as being diplomatic with others – when asked whether he ever dwelt on depression and the stresses caused by other people:

...now it just doesn’t occur to me that something could set me off again because I feel confident enough to deal with them diplomatically or occasionally I can evade things, but above all diplomatically...

Rather than being a self-therapist Harry saw himself as a potential therapist to others, saying he felt he should join the Samaritans. In contrast, Mary indicated that she thought of therapy even in the most intimate moments of her life when she referred to holding her seven-year-old daughter’s hand in public as a “safety behaviour” (a technical term from CBT). Sarah referred to initiating self-therapeutic activities as using “tools” that she carries everywhere she goes.

John described the tools and skills he gained in cognitive therapy as ‘a part of my life, it’s a thing I do, it’s a way of life.’ John, who said he believed depression could not be “cured” but that one could learn to manage it, described how for him holding therapy in mind is a
conscious task compared to "non-depressed" others. Holding therapy in mind was a necessary condition of enacting self-therapy. Referring to coping with life's problems, he said:

You [researcher] don't think about it, I do think about it. I have to think about it in order to make the process start. Like this morning when I woke up in an absolute... I felt really, really low, and then one has to consciously drag yourself up out of here and begin to think straight and put things on paper if necessary and things like this.

Although, no participant used the term "self-therapist", further evidence that therapy was held in mind was evident in participants' expressions of responsibility for the management of their own moods. Meg remembers that a key moment in therapy was when she was taught that it was her responsibility to be an active self-therapist:

But it was interesting, it was, "Actually Meg no-one else can do this for you, you have to do this, this is your responsibility," and that is what he [cognitive therapist] taught me as well.

4.2.2. Being a self-therapist is hard work

Keeping self-therapy in mind and then enacting it, however, were not easy. Meg personified how much like hard work it was:

If I am not listening to myself because the negative thoughts are so loud in my head, I physically have to speak to myself to stop them.

It is as if she is wrestling with some demon that is threatening to overwhelm her. Throughout her narrative, there is a sense of fragility in her confidence in the success of the self-therapy enterprise. She spoke as if she was struggling in the space between wellness and illness:

There are times when I sit in the car and start getting really quite low and physically have to talk out loud and say, "Meg, grow up. You are fine, you have everything going for you." I have literally got to physically talk myself out of it. Sometimes I have to hear myself do it.

Jan described being a self-therapist as "mentally draining", John described overcoming a period of low mood alone as having to "consciously drag" himself out of it and Mary described how it took a "few days" to "get to grips" with one particularly painful episode using self-therapy.
A number of factors underlie the degree of struggle, including the degree a person views her/himself as susceptible to relapse and the degree to which the tenets of CBT appear to fit with the participants' own beliefs and views of themselves. For example, although Jan finds being a self-therapist hard work, she is able to relieve the pressure by having time off from the role. Less threatened by the possibility of relapse than Meg, she does not have to be on her guard all the time:

*Sometimes if I am here on my own of an evening and I am feeling particularly relaxed I will just switch off from everything and do whatever I want, eat what I want, do what I want, um, and don't worry about it.*

Bob found it hard to maintain the role of self-therapist because he experienced an uncomfortable fit between what the therapy was steering him to do – say "No" to other people's demands – and his strong sense of responsibility to others. Failures to be assertive since therapy had resulted in difficult emotions:

*I sometimes feel, I won't say guilty, but disappointed that I can't maintain or match whatever it is that I need to do.*

In contrast, Peter, who often referred to how the therapy was a good fit for his pre-existing skills and his disposition towards rationality, defined cognitive therapy not only in terms of his understanding of it but also in terms of its degree of difficulty:

*It means trying to assess what it is that is behind this [depression] and to find methods, ideas if you like to try and find a way to get out of it. Little exercises you can use when you are in a situation where you are under stress, which are easy to do.*

As with all work, however, participants experienced being a self-therapist as an ongoing project, not one that could be forgotten or resolved. Meg described needing to keep working to build on the changes she experienced in therapy:

*I can't rest on my laurels: I have to work hard on my thoughts because that is actually what affects my relationships with people.*

John explained why he had not been as disturbed by the termination of CBT sessions as he was when one of his previous attempts to overcome depression came to an abrupt halt:
...the therapy hasn't ended. The therapy is still going on because I am still using it.

The attitude that keeping depression at bay requires ongoing work on their part is related to the participants' beliefs about depression and their ongoing experience of emotional disturbance. Jan's ongoing self-therapeutic activity is driven by her experience of depression:

*Depression is not something you can control by taking a couple of months off and hoping it will go away or going on holiday and you will come back de-stressed. It's something you have got to work on. And a lot of it is the way you think and you have got to work on it over a period of time.*

Earlier she had described how she had unsuccessfully attempted to overcome depression by quitting her job and going on holiday.

Additionally, each participant in the group – with the exception of Harry – described their continuing use of self-therapeutic techniques in the context of ongoing emotional difficulties. For example, Peter used the techniques when he became upset when his parents' house was burgled; Mary used them when she was “knocked...every single way, mentally, emotionally and physically” by reminders of her unhappy childhood.

However, despite the general difficulty in maintaining the self-therapist role, most participants continued to use it because they identified the techniques with successfully keeping depression at bay. Asked why s/he continued to use some of the therapeutic techniques months after completing therapy, each active user (89% of the sample) said it was because it worked.

### 4.2.3 Still living in the shadow of depression.

The experience of being a self-therapist was framed by the participants' ongoing experience of depression. Despite the study excluding participants who did not benefit from therapy, each participant expressed at least some ongoing vulnerability to having a depressive relapse and to experiencing depression as a kind of constant companion. None of the active participants talked of “curing” depression through CBT, only of managing it. This sense of living in the shadow of depression appeared to underlie health action, as predicted by the “susceptibility” element in the Health Belief Model (Rosenstock, 1966). However, subtle differences between
the model and the current accounts emerged. Implicit in the model is the sequence that the susceptibility belief comes first and the action follows in a neat linear way, but in the current study participants' therapeutic activity and their experience of depression came together. In this study, susceptibility to depression is an experience, not a belief. It is felt sometimes constantly and sometimes in a crisis. John described the daunting presence of depression in his life:

*It is like there is a big weight there, which is there all the time. You have to actually work at it to...not to get out of it, you have to work to get over it. You have to push yourself beyond the limit of this depression in order to function throughout the day, to function normally.*

Depression here has the physical quality of an obstacle standing between John and a “normal” life. Literally, it requires effort to overcome. For others, the feeling of susceptibility springs to life in a crisis. Peter experienced the shadow of depression when his parents’ house was burgled:

*It was awful, absolutely awful. I felt dreadful about it, but () I thought, “Damn it, I’m not going to let it get me this time, I’m not going to do it...”*

Every participant described depression in personality terms. Meg is typical in ascribing to herself “depressive tendencies”. Such descriptions of themselves might be predicted from the selection criteria for the study, which focussed on people with more than one depressive episode. The descriptions are also loaded with indications that not only do participants consider themselves susceptible to depression but also that the experience of depression was personally frightening. Again this would be predicted by the severity dimension outlined in the Health Belief Model (Rosenstock, 1966). Meg combined the two dimensions – severity and susceptibility – when she described why she was a self-therapist, despite the hard work it required:

*I know how low I was and I know how quickly I could get there if I don’t use it [the self-therapy]. And when I am at a low state...I think I have almost like, depressive tendencies.*

Indeed, how participants experienced depression in the past and how they continue to experience it appeared to shape the form in which they become self-therapists. For example, Peter, who described how the main benefit of CBT was that it re-taught him how to “stop and think” in difficult situations, experiences depression as inhibiting his rationality:
I think the big thing about depression () is that they [other people] feel you ought to be able to get yourself out of it, pull yourself together, shake yourself up, sort it out, but the real thing is that you can't do that, it's not possible to do it. You lose the ability to think rationally – I certainly do – and I just totally lose it.

Jan, on the other hand, had a self-therapeutic style characterised by activity scheduling and maintaining incremental “improvements” across all parts of her life including housing, dieting and smoking. In the past, she experienced depression as the result of losing control of individual aspects of her life:

I am aware that it [depression] could come back, I am not kind of thinking I am immune to it now. But I have to be in control all the time. I think I am quite vulnerable still and I think unless I keep control of aspects of my life, like work and keeping my flat in order and paying the bills and all sorts of things, I have to be in control. But it is the only way I can cope with it, but in the past, um, I haven't had that control and when its gone out of control, then things went wrong.

Sarah's experience of depression was different again and her use of the therapy appears connected with this experience. As a Church missionary she believed it was “wrong” to be depressed and admission of depressive feelings was tantamount to “failure”. Unsurprisingly, she experienced depression as a sudden collapse which appeared to come out of nowhere:

I don't think I really knew I was depressed before and I didn't even recognise that I was depressed until somebody told me I was, the doctor that told me I was depressed. I said, “No, I'm not.”

As a self-therapist Sarah’s style is characterised by being able to identify her feelings and judging how appropriate they are in the situation in which she finds herself not by trying to stop them before they arise. She believes that she has a “tendency” to be depressed but that that no longer should carry a stigma:

Being depressed isn't wrong and I thought it was wrong: I thought I was a total failure, but now I understand that it isn't, it isn't wrong, it's an illness, the same as anything else; that it can be dealt with.

Harry, on the other hand, while graphically describing the depth and severity of his depression, believed that it was not a threat to him now:
Since [therapy], I have gained confidence enough to think I can tackle just about anything and everything that is going to come at me provided I am one step ahead.

Keeping one step ahead, as noted above, referred to being diplomatic with people or avoiding difficult situations, not with being an active self-therapist. His current experience of depression - as not being a threat now - may have contributed to his ongoing self-therapeutic inactivity.

4.2.4. Believing "I can do it":

A sense of self-efficacy is a variable in a number of social cognition models which predict whether a person will enact a health behaviour or not (For example, the Health Action Process Approach; Schwarzer, 1992). A number of participants openly voiced self-efficacy beliefs with regard either to being competent at doing "therapeutic" activities or in "changing" themselves in relation to depression.

Asked about why he implemented a range of techniques based on his therapy, John said:

*It's come about...my mind is more settled, I suppose, that's what it is. I am able to work it better. It's like changing the oil in a gearbox, everything seems to work better.*

Peter echoed this sense of improved self-efficacy and linked it directly with his improved ability to manage his depressive behaviours by facing difficulties rather than avoiding them as he did in the past:

*Because most of the time things happen to you everyday, they may seem bad at the time, but if you think, "Well, hang on let's put this in context. This is not really so bad, this is not really so great and it's not a problem, I can handle this." And what it [therapy] did do was give me the ability to say, "I can handle this; I can handle stuff."*

Sarah talked about how the sense of self-efficacy had grown outside therapy as she came to use the techniques for herself and see that they worked:

*As I was using it and testing it out and finding it was working then, you know, I feel I can use this() I have got more confidence in it and more confidence in myself that I know I can make it work for me.*
By contrast, Terry, who did not use self-therapy outside the parameters of those he had discussed specifically with his therapist, appeared to look to others to instil him with a sense of self-efficacy:

*I also have a problem with self-confidence and there again I am looking for backup from other people, friends and family etcetera and if that doesn't go right then the depression kicks in again.*

On the other hand, Harry, who was the one participant who was not an active self-therapist, also showed high self-efficacy as indicated by his confidence in wanting to be a therapist to others. However, his lack of activity appeared to have been prompted by have high self-efficacy linked to a strong inclination to discount the risk of relapse. High self-efficacy is sometimes associated with underestimating risk and reducing the intention to enact a health behaviour (Schwarzer, 1999).

### 4.3 How cognitive therapy was used by the participant.

This theme explores how the therapy experience was translated into the experience of being a self-therapist months after CBT had terminated. Clinical practice of cognitive therapy and studies of therapeutic process (Elliott,) lead one to predict that there would not be a neat linear relationship. The current study indicates that some techniques were directly translated from therapist's office to the participant's home. However, in many instances, neither techniques nor cognitive models are consistently translated in easily recognisable ways. This theme illustrates that each individual participant uses therapy in a variety of ways (none uses one specific or general technique alone). It also highlights that self-therapy for this group of people is seldom CBT in any pure form. It can be less than CBT: less systematic, comprehensive and specific. It can be more than CBT: involving other knowledge and skills, involving general feelings of self-efficacy, and placing less emphasis on using techniques than on changing relationships.

#### 4.3.1 Using specific CBT techniques without any obvious adaptation

Each participant, with the exception of Harry, used at least one recognisable cognitive behavioural technique or drew specifically on the educative aspects of the approach. Mary provides a good example. She described a number of techniques to overcome the anxiety
aspects of her condition and rated graded desensitisation (she uses the term herself) as the most useful. She also makes use of the educative aspects of CBT:

[The therapy] helped me realise that any mother with a child like this would be anxious – that’s normal. So there’s anxiety that is normal, anxiety that is not all bad. When it reaches a certain level, yes; when it starts effecting your life, yes.

Faced with a particular occasion when distressing negative memories of her own childhood are generated by a parenting class on creating positive memories for her own child, Mary described the process of identifying negative thoughts, writing them down, challenging them and coming up with alternative statements:

I sat down and wrote down the negative things I was feeling, what it had churned up yet again, um. It hadn’t churned up anything new. So I dealt with that and then I saw the situation of how it is today and how really I have got to learn to live and put that on one side and then think about positive things, what sort of memories we are creating for our own daughter, and over a few days really got to grips with it.

The specific technique creates a space for Mary to see the situation in a new perspective and to experience cognitively mediated affective change. Alongside challenging negative automatic beliefs, participants mentioned the following recognisable and specific cognitive techniques for managing depression: tackling “errors of thinking” (Meg), learning to be assertive (Bob), using problem-solving techniques (John) and activity scheduling (Jan).

Universally, however, the use of specific techniques shaded into an idiosyncratic use hinted at in Mary’s extract above, where the thought challenge is supplemented by other considerations. In Mary’s case this involves needing time to “get to grips with it” and a self-appraisal of what her crisis has taught her; that she “has got to learn to live...and think positive things.”

4.3.2. Using CT-adapted or CT-inspired self-therapeutic approaches

Despite the reported use of specific cognitive techniques, the participants more commonly reported using approaches either idiosyncratically adapted from therapy or directly inspired by the therapy. In the latter category, therapy is experienced as a springboard to approach difficulties in ways that they had not been approached before. The renewal of self-confidence would come into this category. In the former, the germ of specific cognitive skills is
recognisable in a self-therapeutic approach, but unlike in 4.3.1 above, it is either so simplified or so altered as to not count as the use of a specific skill or knowledge acquired in therapy.

4.3.2.1 Using CT-adapted self-therapeutic approaches

In keeping with the underlying theory of cognitive therapy - that depressive emotional and behavioural responses are mediated by cognitions, which become the focus of therapy - a number of participants identified that, since therapy, they had changed the way they used thinking. However, some participants do it in ways not predicted by the theory (J. Beck, 1995). At least three participants (33% of the active self-therapists) used “physical” means to intercede between experiencing negative emotions in the old depressogenic way and instigating rational cognitive challenges. Peter, for example, spoke of needing to engage in some activity to “break the [negative emotional-behavioural] loop”. Describing a recent time when he had made a mistake at work and had to instigate self-therapy, he said:

*I got into a stage where I was just sitting there at my desk, totally frozen by this thing, I was just so horrified by it and at that point, I just thought, “No, sit down, analyse this thing, what can I do about it, there is no point worrying about this and how can I get out of this.” So I did find myself doing that. Actually what I did was I just got up from my desk, went out of the building and took a walk. And then I came back and started thinking quite rationally.*

Later he described his habitual way of dealing with depressive emotions:

*...when I feel something coming on I actually try to get out of the loop and I think, “Stop, let’s just get out sideways” and go and do something I want to do or just pick up a book and read for a bit or do something to just stop the cycle and that gives me a breathing space to think about it and that increasingly is enough.*

Jan, too, describes using physical activity to break “a negative cycle of thinking”. She said:

*I know now that I have to kind of do something physically to switch off. For example, I might get involved with a film on tele, whereas normally it would just be on in the background, or, I have got a bike, so I could go out on my bike, or I’d groom the cat, or something like that.*

This physical riposte to the negative thoughts would be done in conjunction with consulting her CBT notes and questioning whether what she was thinking was “really true”. As noted above, Meg’s struggle to switch to rational thinking from the realms of her emotions requires
a physical intervention on her part. She has to “physically...talk myself through”; she has to speak aloud questions asking for evidence for and against her negative automatic thoughts. She described that before therapy she would not have tried to disengage with the emotion but would have gone “into [her] little hole”. But now:

*I'm sort of a bit more grown up, I guess, I say, “Calm down, gentle breathing, what's the truth here, what's actually going on here, what is meant here, how are you reacting? God, look at your reaction and the impact.”*

She has to try to physically relax to begin the cognitive process.

Although Sarah does not have to use physical means to intercede between emotions and reasoning, she does highlight that not “dwelling on” negative emotion is her key use of CBT. Using CBT in this way is idiosyncratic in that she does not seem to need to follow the detachment from emotion with any active cognitive challenges:

*I don’t know if you can control the [depressive] feelings. I think you can control the way you react to feelings. Our feelings come, um, you can’t always stop the feelings coming. The difference is how I now react to it, rather than...to just dwell on the feeling and feel even worse would take me into depression, but to be able to deal with in ways I have learnt to deal with it can bring me out and help me get on a different path.*

Later she described overcoming low mood by recognising that she had good reason to be tired and tearful and then saying to herself, “Stop, OK, time-out...and just give yourself a breathing space.” She did not actually take any time out in the form of having a break from the situation. It was sufficient to use CBT as a guide to recognise that she needed to not dwell on the emotion. Therapy has taught her to "stop and think", rather than act on emotion as if it was the criterion of truth (Williams, 1997). Using rational thinking of any sort – rather than the disputational thinking of weighing up the evidence for and against automatic thoughts and core and intermediate beliefs encouraged in CBT – is Sarah’s main weapon against depression:

*I am just able to stop and say, "Just hold on a minute; just sit and think about things and don’t let this get on top of you and push you under.”*
Other forms of adaptation of CT strategies are also evident. Mary shows an adaptation of avoiding withdrawing and instigating thinking when she describes how she has learned to "just talk to friends" so "it wouldn't all go up then like a pressure cooker".

4.3.2.2. Using CT-inspired self-therapy

This theme reflects the fact that although no participant claimed to be "cured" by therapy, changes had taken place in therapy which were recognised by the client and attributed to the cognitive therapy. These changes which were inspired by therapy continued to be used post-treatment. Mary talked about how she had built on the gains she made in therapy as well as the gains she had made as a self-therapist:

While my husband was away I went out for lunch in town with a friend of mine. That's the first time I've done that. I wouldn't have taken that risk of doing it, but I did. I did think about that. I didn't know whether she would drive or I'd drive, because when I am anxious I like to drive because I know where I like to park and it will be the nearest place. I just went with it. Beforehand I did think, "Whatever happens I can cope with it," and I did and we had a good meal out. I was slightly anxious at one point but thought, "it's OK."

Although she does evoke a couple of self-efficacy statements, this can hardly be called a direct use of CBT techniques and rationale. Instead, there is a strong sense of acting rather than thinking ("I did (take a risk)"; "I just went with it."). She compares the pre-treatment Mary ("I wouldn't have taken that risk") with the Mary she is now ("but I did"). The risk can be taken because she has changed. At the same time the risk-taking constructs and confirms the activity of doing self-therapy. She is using therapy-inspired changes to overcome difficulties.

Meg uses the metaphor of the therapy and the therapist giving her the key to unlock the door. Without the cognitive therapist she would still be faced with a locked door. Therapy showed her the way and she is using that now:

...he almost unlocked the door, he gave me the key to unlock it and now I've almost opened it and am walking through. He didn't give me a huge amount but he started me on the road to find out.
Her image of being currently engaged in the process of opening a door unlocked by another suggests how the therapy continues to inspire her and guide her now, even though she has taken over the work.

John describes how he can now face things problems rather than "running away" for days on end without telling anyone. Again although he developed specific techniques, for him the key thing therapy gave him was "confidence" even though his confidence was not specifically targeted in therapy. Its return is the chief benefit of the therapy and it underpins the specific strategies he does use:

*What I needed from the therapy and what I got, I believe, is the confidence, which has returned.*

For Bob the therapy was used in a way that freed up other resources and reinforcements, in the form of giving him the "backing" and "encouragement" to take up a job after years working at home as a single father. The therapy and the alliance with the therapist were used directly in a way that still has positive repercussions for how Bob is as a self-therapist.

4.3.3. Using the "presence of the knowledge" of CBT

This theme refers to the use participants made of a psychological model of their difficulties, which was understood and provided sufficient knowledge and reassurance in previously problematic situations that no specific distress-relieving strategies were required.

Peter described how he habitually overcomes situations now which previously he would have found overwhelming and conveyed how often it was sufficient just to have the knowledge of the cognitive model:

*I don't actually say, "What's this stage, what's that stage?", I don't do it. I think it is almost at a subconscious level. I feel the presence of the knowledge, if you like. It sounds odd to say it, but I feel it is there.*

He went on to describe how he made use of the cognitive model of depression not directly but as "stored knowledge in the back of my mind" which enabled him to overcome feelings of helplessness when faced with difficult situations.
Sarah appeared to have accepted a psychological model for the existence and maintenance of depression, which allowed her to accept her feelings and not feel "a total failure" and to protect herself more effectively in the future:

Now I understand that it [being depressed] is not wrong. I would be willing to ask for help sooner.

For Jan, too, a new psychological knowledge enables her to see that she must not just ignore stresses at work. But again, rather than necessarily enacting a specific strategy, the new psychological knowledge and self-knowledge of what triggers her depression are often sufficient to cope. Referring to how she now copes with a stressful time at work, she said:

Whereas in the past I wouldn't have addressed that I would have just carried on. [Now] I wouldn't take my notes [CT challenges to negative thoughts] but it is still in the back of my mind.

4.3.4. Remembering the cognitive therapy and/or therapist.

A number of participants used memories or images of the therapy or their therapist either as a moral support for the experience of being a self-therapist or as a guide to how to be a successful self-therapist when faced with a particularly challenging situation. The experience of the therapy/therapist which lay in the past was brought into the present via memory.

When she was asked about whether her view had changed on whether depression was manageable, Meg remembers what Barry, her cognitive therapist, had said to her:

Yeah. It is easy when you know how. I remember Barry saying that to me.

She is using her memory of therapy to inspire her and support her sense of self-efficacy in the face of depression. She also draws on the memory of what her therapist said to provide a rationale for her being a self-therapist:

One of the things Barry said to me was you have to continue doing this; it isn't something that you are going to be cured, it is like putting an elasterplast over a scratch, like putting a plaster on an amputation. You know, you have to keep nursing it.
The memory is recalled as a guide when faced with the obstacle that being a self-therapist is hard work. Likewise Mary drew on her relationship with her therapist to support her increasing sense of self-efficacy. Her interpretation of her therapist putting her forward as a possible research participant allowed her to face the research interview and continue to tackle her anxiety:

*Obviously I built up a great trust and confidence in a therapist and then I thought, "Well, she must feel I would be able to do it [the research interview], in order to put me forward," and that finished the issue for me, really.*

For Mary, though, remembering therapy was not always helpful. She remembered the awful feeling when she attempted in therapy to conquer her anxiety about using escalators. The memory ("I hated every second of it") is used to explain why she had not tried to tackle this particular fear as a self-therapist.

Participants who used therapy in this way commonly had a positive experience of therapy and more particularly of having formed a strong therapeutic alliance. Peter united the two ideas when he described how he tackles current problems:

*I do think, "If I was sitting with Clifford [cognitive therapist], what would he say to me?" and I try to think of it that way because I ended up having a great deal of trust in this guy()and I thought, "What would he say, if he was in this situation," and I would try to put myself into his situation. This may sound strange, I talk to myself as if I am him and thinking, "how would he do this?"*

This is not just about thinking what strategy he needs to use. Peter is drawing on his trust in, and his memory of an individual therapist to guide his self-therapy.

4.5 Challenges of doing self-therapy

This theme refers to the fact that each participant reported that there were times when they faced crises or lapses in their self-therapeutic activity. Often these moments of crisis were linked to perceived limitations of the CBT model as a way of coping with the complexity of the participants' everyday lives.

4.5.1 Dealing with crises or lapses
Each active self-therapist reported having to deal with a crisis or lapse. A common process emerged when dealing with a crisis. A crisis was identified when the participant experienced emotions or recognised situations and behaviours that signalled the threat of a depressive relapse. Self-efficacy beliefs and/or attitudes regarding the need to keep working as a self-therapist were invoked, along with a self-therapeutic activity. Typically the latter consisted of a brief self-statement around the need to think - the most fundamental and distinctly recognisable cognitive technique - and face the situation rather than act on the emotion of being overwhelmed and then avoiding the problem.

Mary recalls the experience of dealing with the emotional crisis of thinking about her childhood; an experience which "had really hit me and thrown me, knocked me every single way..." She said:

*The next day that was still very much with me, but I definitely used the therapy, challenged my thoughts - I didn't make contact, that was the first thing to think, "I'll phone somebody at Bowden Hall [where cognitive therapist works]," but I thought, No. I really saw it as an opportunity to use things. I have felt as bad as that before but with professional help have come to terms with it. But I thought, "No, I know there is nothing more that can be said to me, I know what to do." So I sat down and I wrote down the negative things that I was feeling, what it had churned up yet again, um...it hadn't churned up anything new. So I dealt with that and then I saw the situation of how it is today...*

She draws confidence from her sense of self-efficacy and couples this with invoking notions that it is her responsibility now (a theme which was shared by a number of others, including Meg). This is followed by the use of a specific recognisable cognitive therapy technique. For Mary, the whole episode affirmed her efficacy as a self-therapist and encouraged her to keep using the techniques: "I had really achieved something".

Meg too uses emotional cues - about feeling unhappy in her relationships - to take stock and reinstate self-therapy. She then talks to herself, invoking the attitude that it's her responsibility now to be a self-therapist and that keeping depression at bay will require ongoing work:

*My God...it was like actually, "Meg, it's not about them, it's about you and thinking, "Right, I really need to start working again." I had lapsed.*
Bob talked about how he woke up one day feeling particularly bad and immediately was scared he might relapse: "The day I was particularly bad actually feared <sic> me a bit because I thought, "Oh no, I hope I'm not going back." He followed this by becoming active - going to work when he did not feel like it - and then later using a recognisable cognitive strategy of "evaluating" what had made him so "stressed" that day.

4.5.2. Reaching limits on the utility of cognitive therapy in self-therapy

Each participant identified situations in which it was either not possible to use the therapy or where cognitive techniques seemed ineffectual. The essence of being a self-therapist for this particular group was that cognitive therapy did not provide the whole answer.

Three participants, a third of the sample, cited occasions when they simply did not recognise the need to implement self-therapeutic techniques. They then found that the emotion or anxiety they were experiencing was too great to implement thinking strategies. Mary provides an example where she became overwhelmed by anxiety when faced with going to the airport:

I suppose I didn't jump on it quick enough, looking back on the situation, my initial negative thoughts, I didn't stop them quick enough so physical feelings came on board as well and then I was like floundering and took the very easy option out then.

Sarah and Peter also talked about failing to recognise the warning signs and then being "too far gone" into the area of negative emotion to implement self-therapy. Peter said: "You've got to have a certain amount of rationality left to use these tools."

Emotional closeness or intimacy was a barrier for a number of people, who described the difficulty they had using thinking strategies when faced with their immediate family. Participants described not being able to break familiar well-rehearsed patterns and responses with family members. Terry talked about always in the past finding his family too smart for him, and how when he now went home he was immediately drawn into the familiar role of being "pushed aside". Meg, who is very close to her mother and twin sister, described her difficulties with them:

I do use it [self-therapy techniques], but it doesn't have the same impact, it's not strong enough almost, I kind of need an injection of something when I am with them, because they kind of have an impact on me.
The medicine of self-therapy is not strong enough in this intimate circle with its lifetime of patterns of interacting.

Peter noted that he felt that the intrapsychic focus of CBT, which precluded direct involvement of his wider social system, placed limitations on it. For him, it would have helped if his wife understood and experienced the therapy.

Bob, also had problems with using the techniques with his family but for different reasons. His had to do with his sense of discomfort with adopting the approach advocated in therapy - sometimes saying "No" to requests. Again, it was the closeness of the tie that made this particular use of the self-therapeutic technique especially uncomfortable. He described having to refuse his daughter's request to visit him. He could not tell her himself but made his son tell her instead: "I didn't want to upset anybody", Bob explained.

Finally, three participants said that implementing cognitive strategies as suggested in therapy was simply not practicable given the time and circumstances. Sarah sometimes felt she did not have the quiet and space to "stop and think" because she lived in cramped accommodation with her mother. Jan could not use the techniques when she was waitressing because there simply was not sufficient time, though she tried to "be aware of it (the therapy)" and might make notes later. Peter, too, said the pressure of the moment did not always allow the time or space required to apply the techniques properly:

"It's not something that you draw on quickly and say, "Right, here we go, here is my set of tools and let's use it." It is something that comes from contemplation afterwards."

Sometimes, the therapeutic mode is simply forgotten. In Mary's case, other psychological preoccupations - in the form of wanting to lose weight - drove the self-therapist role from her mind. Recalling how she failed to challenge negative thoughts and emotions during a period of a week, she said:

"I think it was just me getting too obsessed with the weight again. I wasn't prepared to think about anything else but the fact that I must lose weight..."

4.6 Fitting cognitive therapy into the wider picture
This theme reflects the participants' accounts of CBT as something experienced within the wider context of their lives. It introduces the idea that the participants had therapy at a particular point of time in their lives and the meaning of the therapy - and how it was used - was shaped by the participants’ views of life before and after therapy. It also reflects the participants’ accounts of shaping their use of therapy in the light of the other knowledge and skills they bring to therapy, including their knowledge of their own style of doing things and their personality. Additionally, the theme highlights that participants considered other resources aided them as self-therapists apart from what was learned in therapy.

4.6.1. Adapting therapy to me

Many participants adapted therapy in ways that suggest their development as a self-therapist was heavily influenced by a number of factors: by their prior experience of trying to tackle depression; by their aims for therapy; and by the beliefs which shape their personality. Meg expressed a common theme that adapting therapy was necessary to become a self-therapist. For her, it led to a sense of ownership. She said it would be impossible to be a self-therapist without adapting the therapy to her personality:

"It's [her version of cognitive therapy] a lot stricter than Barry's [cognitive therapist]. I know what I will listen to and what I will not listen to and Barry's to a degree was quite touchy/feely and quite a nice way of doing it, but I think I'm quite...the way I talk to myself in my head is very direct, very black and white, which is me anyway(). Yeah, I think it is important to put Meg's stamp on it [the therapy], because you understand, you understand yourself."

Her adaptation was based on her self-knowledge but it created tension because seeing things in black and white does not fit well with the cognitive therapy model, in which black and white thinking might be classified as an “error of thinking” which needs altering (Beck, 1989). Despite the tensions, Meg was a self-therapist who used recognisable cognitive techniques. Putting the “Meg stamp” on the work created difficulties but it underpinned her activity as a self-therapist.

For Bob, the single father, such was the mismatch between his core beliefs about life and the exhortations of the cognitive model, that there were times when he appeared not to be able to adapt the model at all to meet his goal of overcoming depression. He had lived his life under
the precept of always putting others before himself and the pressure of being assertive encouraged in therapy sat uneasily:

*I wouldn’t want to be a hard man or be nasty to them [other people] or be rude to them. That’s not always easy.*

For Bob, adapting cognitive therapy was a struggle. By contrast, Peter, who did not find self-therapy hard work, saw a clear fit between his personality and the emphasis on rationality in the therapy. He admitted to only having to consciously draw on cognitive therapy techniques 10 per cent of the time six months after completing therapy and equated his ability to use “the presence of the therapy” with its fit with his personality. He described himself as “a fairly rational person” who “liked” approaching problems rationally. The therapy also reinstated his pre-existing skills of problem-solving which he had used when in the Navy. The form in which he practised as a self-therapist (challenging negative thoughts, problem-solving) is closely linked to his personality and skills prior to entering therapy. Likewise, John spoke of how, in therapy, he rediscovered his old skill of breaking an apparently insurmountable task into a series of surmountable mini-tasks. As a self-therapist, it was this skill, which he had in his repertoire but had temporarily lost, that he most commonly used.

In Terry’s case, the use he made of therapy was both closely adapted to his current need and also to his perception of the purpose of therapy. Therapy focussed on his goal of being more at ease at work. In that it succeeded:

*I feel more confident definitely and it has helped me with other people, but mostly with the work environment, because I am there in this job for such a long time, I have really focussed on that...*

But nine months after the end of therapy Terry identified his “real” problem as his relationship with his family. He felt inadequately resourced by the therapy to deal with that and had reverted to taking anti-depressant medication. The difficulty in generalising therapy appeared linked to his belief about the nature of his problems and its connection to therapy, of which he had had a number of forms over 14 years. He looked back over his past and his therapy history and said:

*I had so many different issues at one point, you know, where do you start? And gradually filtering it through and sorting it... it’s like sorting out files and a filing cabinet... gradually I*
sort out, we [me and my therapists] sorted out quite a bit, but the last lot [problems with his family], um, is getting a bit too much for me.

He has adapted his use of therapy to match his conception of it as sorting out one file at a time. However, this was limiting his ability to be a self-therapist, especially with regards to generalising the cognitive therapy skills he had acquired.

John, though, had a more positive experience of taking from therapy (and using as a self-therapist) exactly what he wanted when he began it. He needed the return of "confidence" and that was "what I (John) got".

4.6.2. Using other resources to maintain well-being.

Participants drew on a range of other resources to maintain well being apart from what they had learned in therapy. In some cases, these resources were already available before therapy started, in others therapy helped make available additional sources of strength.

For Peter, CBT swept away the stigma of admitting to others that he had problems. He became free to talk to friends about his problems in a way that was an integral part of his activity as a self-therapist. Using cognitive techniques was the way he started to solve his problems but final resolution was achieved by talking to trusted friends:

I do actually think it [the cognitive therapy] makes me think first. But that just gets me off the bottom, it doesn't actually take me much further than that and it's after that that you talk to the friends and that's where you resolve the thing completely...

Bob used therapy as a support to get a full-time job, although he had made the decision to apply before therapy. At the time of the research interview, he had begun work and rated it as important to him in maintaining his well being (because it boosted his "self-confidence") as techniques he drew directly from the therapy. For Jan, too, having a job with a company that recognised her mental health needs was as important as doing the therapy. She had started work before she began therapy.

Other individuals valued other resources. John considered that what he learned in therapy helped maintain his well being in conjunction with his use of anti-depressant medication. Neither was more important than the other was. Others, like Peter, considered medication
unhelpful. While Sarah, a devout Christian, regarded her religious faith as equally important as therapy.

It was notable that Terry, who said since therapy had ended he had started to take anti-depressant medication again, was unable to identify other resources that helped him overcome depression. He said that "family and friends" would have helped but he did not have any close enough or understanding enough to support him.

4.6.3 Cognitive therapy as one part of a long-term process of change which includes other beneficial strategies

Three participants identified that they had already begun the process of learning to manage depression before going into therapy. John identified that he had gained control of his drinking and had been on anti-depressant medication, which had allowed him to gain sufficient control of his emotions to "know that I wanted more than this". CBT was the next step. Being a self-therapist (along with medication) was how he continued on his road of managing depression. Jan, too, traced her ability to manage depression back beyond the start of therapy. Before then she had started to get "a bit of routine in (her) life". This routine forms part of her view of her recovery - along with using CT techniques - in the present and far into the future.

5.0 Discussion

5.1 Summary of findings

Eight of the nine participants in the current study (89%) were using CBT in some shape or form and in some situations at least three months after completing therapy.

Each active participant held in mind the idea of him/herself as a self-therapist; in other words, each saw him/herself as needing to do things differently than in the past and related this activity to managing his/her own mental health. For most participants, self-therapeutic activity felt like hard work. Additionally, each self-therapist still regularly experienced emotional disturbance or regularly appraised situations in ways that required self-therapy. For some this occurred daily. The active participants still felt they were highly susceptible to depression, with each identifying depressive feelings or low mood as characteristic of his/her personality. In addition, the active self-therapists expressed a strong belief in their ability to use specific
therapeutic skills or to change past behavioural patterns associated with being depressed. Depression was viewed not in terms of cure, but in terms of ongoing management.

Complexity characterised how CBT was used to self-manage mental health. Each active participant used specific CBT techniques, rationales and understandings of depression and its maintenance. However, they also used idiosyncratic adaptations of the techniques; for example, at least three participants (33%) interceded physical activity between experiencing low mood and activating cognitive challenges to their depressogenic thinking. Additionally, some participants used the changes they underwent in therapy - in terms of self-confidence and feeling supported - to disrupt depression-maintaining patterns in the present. The knowledge and skills gained in therapy and held in mind were sufficient for some to self-manage their mental health. At other times, memories of the therapy and the therapist were invoked to either encourage or guide self-therapeutic activity. Seven of the nine participants (78%) employed resources and knowledge other than those derived from CBT as part of their self-therapeutic activity.

Supplementing this habitual use of CBT, seven of the participants (78%) used CBT as part of their way of dealing with crises. Crisis management involved identifying a situation with possible depressive relapse; invoking self-statements about self-efficacy and determination to maintain well-being; and implementing a CBT-derived technique. For some, it also involved evaluating after the event the benefits of implementing the new CBT techniques.

A number of factors hindered effective self-therapeutic activity. Participants identified that they sometimes lacked the skill to effectively appraise a situation as emotionally disturbing. They then found they were "too far gone" with their emotional reaction to activate effective cognitive challenges. Interpersonal intimacy, especially with emotionally-close family members, was also identified as a limit to being a self-therapist at times. Wider systemic limits, such as Peter’s wife not understanding what CBT meant to him, were also identified. Participants also cited practical limitations on CBT use, especially not being able to implement strategies because of other real-world demands on time and attention. Participants also had simply forgotten some techniques. Additionally, one participant, Sarah, described how competing psychological demands - her desire to lose weight - led her to not keep in mind her role as a self-therapist for depression.

In the current study what helps a participant be a self-therapist was not directly identified as a superordinate or subordinate theme, although a number of trends emerged. It appears important for a participant to have in mind that s/he is a self-therapist and that CBT provides
an effective basis for that activity. It helps if there is a good fit between the precepts and skills of CBT and the client’s own belief system, self-identity and pre-existing skills. Being an active self-therapist was also underpinned by a sense of self-efficacy.

The analysis also highlighted two other areas of importance. First, some participants viewed CBT as a process of self-improvement which began before therapy and which contained other change elements. Second, all participants adapted the techniques and precepts of CBT in ways that were shaped by specific factors. Adaptation was moulded by a participant’s view of himself and how to behave in the world; by his/her view of what CBT was and the purpose of psychological therapy; and by the participant’s view of what s/he most needed when s/he entered therapy (which was, in some cases, dictated by the participant’s prior and ongoing experience of depression).

5.2 Implications for theories about the mechanism of change in CBT

There was little evidence for or against significant change at the level of core beliefs about the self, the world and the future as proposed in the accommodation model (Hollon et al., 1988). Where there was some evidence of belief change was in the area of self-efficacy (“I can handle this”, as Peter said) and in the area of personal responsibility with regards to both implementing CBT techniques and overcoming low mood and past behaviour patterns. This accords more closely with hypotheses about therapeutic change mechanisms in the learned helplessness theory of depression (Abramson, Seligman and Teasdale, 1978), in which cycles of depressive behaviour are established as the patient appraises s/he has insufficient resources to change low mood cycles, rather than the more complex model proposed by Beck (1989). However, sampling issues and interview schedule design may account for this finding. A number of participants had extremely brief cognitive therapy (Jan and Meg, for example, had between six and eight sessions). Padesky (1999) argues that to achieve change at the core belief level, therapists may need to work with clients weekly for more than one year. Additionally, although participants were encouraged through open-ended questions to elaborate their thoughts and feelings underlying self-therapeutic activity, they may have felt socially constrained about talking about negative core beliefs. Clinical practice suggests that some clients take many hour-long sessions before disclosing such beliefs. In addition, if one follows Potter’s idea of interviews representing co-constructions in a particular context, participants may have expressed self-efficacy beliefs for the rhetorical purpose of impressing an interviewer identified with the service provider (Potter, 1996).
The activation-deactivation model (Hollon et al., 1988) received little support in the current study. The participants reported experiencing the negative emotions which prompted self-therapeutic activity on a sometimes daily basis. For this group of participants being a self-therapist was characterised by a strong sense of the imposing presence of depression. Although it was not explicitly evident in the accounts, it can be safely inferred that depressogenic schemata were not deactivated. As above, this may be accounted for by sampling issues, including the length of treatment. In addition, the current sample consisted of clients who reported chronic or recurrent depression problems. That depressogenic schemata were still present accords with literature on the recurrence of depressogenic symptoms and depressogenic cognitions continuing following treatment especially in clients with dysthymia or double depression (Keller & Hanks, 1995).

The current study does fit the compensatory skills model (Barber and DeRubeis, 1989). Some participants used CBT in ways that fitted this model. John used problem-solving and Mary used planning to curtail negative thinking, as predicted by the model. However, the current study lent greatest support to Teasdale's (2000) & Williams's model (1997), which argue that clients develop through CBT a different relationship to their negative thoughts, learning to "decentre" from large amounts of negative thought and feeling associated with low mood. Peter specifically referred to knowing he has to “break the loop” when faced with being overwhelmed by a mistake at work, while Sarah spoke of knowing she must not “dwell” on negative emotions but react differently than she did in the past to them. For these participants practising self-therapy involves trying to stop mood disturbance setting in train large amounts of negative self-referent cognitions. Additionally, however, self-therapy involves disrupting not only self-referent cognitions but also negative patterns of behaviour. John and Peter, for example, spoke of effective self-therapy as not only thinking differently but also not withdrawing in the face of low mood (as they would have done prior to therapy). In this context, CBT can be seen as promoting changes in coping styles (Billings & Moos, 1984). Some participants changed from an emotional discharge coping style to coping styles marked by affect-regulation, and appraisal-focused and problem-focused coping*.

*Billings & Moos (1984) identified a number of coping responses in people with unipolar depression when under stress. Emotional discharge coping involved six responses including tried to reduce tension by drinking, eating or smoking more, or by taking increasing doses of medication, or by taking feelings out on other people. Affect-regulation involved six responses including trying to see the positive side of things, telling self things that helped self feel better and exercising more to reduce tension. Appraisal-focused coping involved logical analysis of the stressful situation and included considering several alternatives for handling a problem and stepping back from a situation and being more objective about it. Problem-focused coping involved seeking out more information about a problem (including discussing a problem with a friend or other informed person) and problem-solving (including making an action plan and following it, and not acting too hastily or following a first inclination).
The finding that participants rated engagement in activities as an important component of being a self-therapist lends support to Jacobson's and Gortner's contention (2000) that behavioural elements are active prophylactic ingredients of CBT. The present study did indicate, however, that the cognitive shift envisaged by Teasdale (2000) was not one that was easily achievable. It was not easy to switch "minds" from a negative configuration to the configuration developed during therapy. As four participants (44% of the sample) indicated, they adapted CBT by interceding a physical activity between the recognition of depressogenic feelings and the activation of specific CBT techniques to challenge and evaluate negative thoughts. There needed to be a physical act to set in motion the mental process of "breaking the cognitive cycle" believed to underlie the effectiveness of CBT for depression (Fennell, 1989). This finding can perhaps be understood in the context of depression acting at emotional, physiological and behavioural levels as well as cognitive levels and accords with new directions in cognitive therapy in which affect and physiological response are considered essential targets for intervention (Padesky & Greenburger, 1995; Mills & Williams, 1997), such as in Barnard and Teasdale's (1991) Interacting Cognitive Subsystem approach. It also begs the question whether depressogenic thinking in people with long-term depression is a habit and requires the creation of routines—sequences of behaviours repeated on a regular basis—as advocated by Sutton (1994) to change addictive behaviours. CBT could be seen as establishing alternative routines to the routines associated with depressogenic thinking.

5.3 Implications for social cognition models of health behaviour, especially the Health Belief Model (Rosenstock & Becker, 1974) and the Health Action Process Approach (Schwarzer, 1992).

Of the six independent variables said to underlie intention to maintain health in the Health Belief Model, five were mentioned in the current study. The participants' experience of being a self-therapist was characterised by experiencing a vulnerability to relapse and by a belief that depressive "tendencies" were a stable part of their character, which is equivalent to susceptibility in the HBM. Although each had a different experience of depression which could be objectively described as being severe to moderate, each experienced his/her depression as subjectively severe and indicated this by fearing relapse. Severity and susceptibility therefore provided the frame in which self-therapeutic activity took place. Costs and benefits also underpinned self-therapy, as indicated by how often fear of relapse and identification of current gains was cited as a motivating thought in reactivating CT techniques in the face of a crisis. "Cues to action" was also an important factor in activating self-therapeutic behaviour. Cues took many forms but most common was emotional disturbance.
No participant mentioned using a self-therapy session or self-therapy blueprint as a cue for action. There were also times when participants failed to recognise a “cue for action” until it was almost too late (for example, Sarah with her anxieties about her weight).

However, a number of other variables, not included in the model, also appeared to mark the experience of being a therapist. These included self-efficacy and the perception of a good therapeutic alliance as evidenced by the theme, “Remembering the cognitive therapy and/or the therapist”. Additionally, participants showed just as much concern about what they saw as the limits of therapy as its costs. Many of these limits centred around self-efficacy, especially in the face of emotional intensity. In clinical terms, therefore, as with health promotion in the field of HIV prevention (Abraham & Sheeran, 1993), it might be better to focus interventions on promoting self-efficacy rather than highlighting costs, as indicated by the HBM. Finally, although participants did weigh up the costs and benefits of self-therapy as predicted by the HBM, decisions to act were also influenced by other factors, often laden with emotion. In this study, maintaining mental health is often associated with hard work, reacting to crises and acting out of strong fear of a depressive relapse (as Meg does).

The Health Action Process Approach (Schwarzer, 1992) is differentiated from other social cognition models of health behaviour in its emphasis on the importance of self-efficacy expectancies, and on health behaviour taking place in two distinct phases (the motivational phase and the volitional phase). Self-efficacy was associated in the current study with persistence in maintaining self-therapy, as has been shown by previous research (Locke & Latham, 1990). The type of self-efficacy identified in the current study was “coping self-efficacy” (Schwarzer & Fuchs, 1998), which refers to a person's believing in advance of a lapse that they could cope with high risk situations. However, there was little sign of the predicted “recovery self-efficacy” (Schwarzer, 1992), which refers to the belief that after a lapse one will recover and not have a full relapse. Conceptually this may be because in areas such as alcoholism, to which the HAPA has been applied, a lapse is clearly indicated by having a drink or getting drunk, whereas relapsing into depression is a less discrete event making it difficult for participants to label and therefore instigate “recovery self-efficacy”.

There was also an apparent contradiction between the participants’ experience of “coping self-efficacy” and their experience of self-therapy as hard work and subject to feelings of vulnerability to relapse. This suggests, perhaps, that for people with long-term depression the feeling of self-efficacy following treatment is fragile and possibly not static and comprehensive (as implied in the HAPA model). In addition, self-efficacy expectancies did not appear to be the key variable underlying self-therapy in this context. As indicated earlier, a
number of other variables including situation-outcome expectancies (in the form of expecting to experience a relapse in the face of certain internal and external pressures) were highlighted in participants' accounts.

The current study lends some support to Schwarzer's two-stage model of health behaviour (Schwarzer, 1992). Participants by taking part in and completing therapy showed they had passed through the motivational stage. In the volitional stage (which is the subject of the current study) participants did enact detailed action plans with proximal goals (e.g. John drew up lists of his tasks before each working day with the aim of reducing his anxiety about being unable to cope) and did use self-efficacy beliefs to bolster persistence. However, there were differences in emphasis from the two-stage model proposed by Schwarzer (1992) who argues that in the maintenance phase of a health behaviour – the volitional phase – concerns about severity and susceptibility should be relatively distal and inactive. The current study indicates that, in the context of people trying to maintain mental health following CBT for chronic depression, the volitional stage – maintaining therapeutic gains – is marked by a state of constant exchange with the motivational stage. A participant, living a 'real' life with its multiple stresses, constantly needs to draw on his/her motivation to maintain his/her health. It seems likely that this flux between motivation and volition is rooted in the participants’ ongoing experience of depression and their belief it cannot be cured but needs to be managed. Management is an ongoing process which requires hard work and vigilance. This may signal a fundamental difference between social cognition models of health behaviour for physical problems and those for mental health.

This is not to abandon social cognition models altogether as the basis for modelling self-therapy in the current context. The findings did indicate that being a self-therapist is a dynamic process, with participants experiencing setbacks and successes, cycling between motivational and volitional states and charting their own course as self-therapists. Social cognition models are the best existing foundation on which to model this process. For example, the current study supports Conner and Norman's contention (1998) that at least three cognitive variables underlie health maintaining activity: the intention to act; self-efficacy beliefs and outcome-expectancy considerations. As indicated above, however, other variables play a significant part and linear two-stage models appear incompatible with the current findings. One possible productive avenue which could guide future development of models for maintaining health in this context, is with work with self-identity (Conner & Norman, 1998). The current study indicates the importance of participants holding in mind some notion of themselves as self-therapists. The closer the fit between the therapy and the person's self-identity, the less hard work being a self-therapist was and the more likely self-therapeutic
activity would take place and be perceived as being successful. In addition, chronic illness literature indicates that the experience of a chronic condition causes psychological distress if sufferers cannot accommodate the illness with their self-identity (Kelly, 1992, cited in Osborn & Smith, 1998). In the current study, participants allied themselves with their condition (linking it to pre-existing personality) and thereby were able to construct a rationale for self-therapeutic management. This may not be the case with other clients, for example those with acute depressive conditions. Any new health behaviour model for maintaining mental health, then, would have to be both complex and context specific.

5.4 Implications for clinical practice

The findings have wide implications for clinical practice. Current practice lays stress on practical issues - such as identifying potential obstacles to self-therapy and problem-solving solutions to them - when drawing up end-of-therapy plans (J. Beck, 1995). However, the current study indicates that therapist and client need also to explore beliefs about depression, the client's view of therapy and its relation to depression and about the rationale and precepts of cognitive therapy. For example, the current study indicated that each client adapted therapy in ways that were shaped by such beliefs. In Bob's case, for example, his understanding that cognitive therapy required him to be a 'hard man' with his family could have been uncovered and discussed and a possible source of non-adherence overcome. For Terry, his view that therapy was about clearing one cluttered file after another could have been tackled to encourage generalisation of the skills he acquired. For participants in this study, the way cognitive therapy was utilised extended beyond the use of specific techniques and knowledge of cognitive therapy alone. The clinical implication is that therapists need to discuss end-of-therapy plans in the context of how clients can draw on all their resources to maintain therapy gains. The finding that clients use a range of specific and CT-adapted skills also suggests that in the delivery of CBT, therapists may find it hard to judge what is most helpful to clients and it is, therefore, important to provide a choice of alternative techniques which the client then explores as a self-therapist.

The current study did find that being a self-therapist is a dynamic process, which may be better understood by stage of models of change, such as the Transtheoretical Model (DiClemente & Prochaska, 1998) or the HAPA (Schwarzer, 1992). This carries major implications both for the within-session delivery of CBT and for end-of-therapy planning. Attitudes towards being a self-therapist and the possibility of cycling between motivational and volitional stages in this process would become an important focus of therapy. In this context, therapists may also need to acknowledge that being a self-therapist is going to be
hard work and might be associated with ongoing vulnerability to depression. The finding that self-therapists in this context have to work hard and experience vulnerability to depression supports the case which has already been made (Kovacs, Rush, Beck & Hollon, 1981) for routinely offering booster sessions with clients with a similar clinical presentation to the current sample. Booster sessions may also overcome the problem of simply forgetting parts of the therapy, identified as a limit to CT self-therapy by some participants. Additionally, the importance of memory was highlighted by the 'Remembering the therapy' theme and should encourage clinicians to consider giving clients audio-tapes of sessions as an aide memoire, along with written handouts.

Clinicians might also pay close attention to what participants see as potential limits to their use of CT post-therapy. The current study indicated that clients themselves were very clear about what the limits were, but none reported s/he had plans in place to overcome them. Current good practice on exploring obstacles to self-therapy and solutions should be sufficient to ensure limits are explored. Participants often identified wider systemic factors limiting self-therapeutic activity and it may be that cognitive therapists might need to draw on systemic models to explore these areas. Additionally, the importance of promoting self-efficacy, which is already emphasised in current practice (Fennell, 1989) was highlighted. Promoting self-efficacy appears to be central because self-therapeutic activity for this group is based on a belief that depression cannot be cured but can be managed using CBT. Interestingly, for this sample, feelings of self-efficacy were strongest when the participant felt that both s/he and her/his therapist were joint agents of change in therapy, indicating the importance of establishing a strong therapeutic alliance and collaborative working.

5.5 Limitations of the current study

Because of the idiopathic nature of the research design, generalising from the findings should be treated with caution. At best, the findings from the current study can only be applied to adults fitting the inclusion and exclusion criteria set out in the study (Smith, 2002). It is not valid to claim, for example, that clients with major depression disorder without prior episodes or those of ethnic origins other than White-UK would present as self-therapists in the same way. However, the applicability of the findings to other NHS clients rests on the degree to which the current sample is homogeneous and representative of NHS clients having cognitive therapy for depression (Smith, 2002). The sample might be unrepresentative in two ways. The quality and quantity of the cognitive therapy might not reflect prevailing practice as indicated earlier. For long term depression, therapy lasting more than one year and promoting cognitive change at the core belief level has been recommended, especially when there are indications
of Axis II disorders (Padesky, 1999). The existence of Axis II disorders (DSM-IV, 1994) was not controlled for in the current study. Secondly, the opt-in sample selection process - adopted for ethical reasons - could have led to a selection bias in favour of those participants who were likely to be most accommodating to the researcher and be active self-therapists on completion of therapy.

While it is acknowledged in the IPA approach that the participants' words do not reflect "fixed, inner attitudes" (Osborn & Smith, 1998), IPA does privilege the participants' accounts as if they reflected some inner reality (Willig, 2001). In the current study, perhaps more than other IPA studies, there is reason to challenge whether participants' accounts were accurate reflections of their feelings, thoughts and actions. To meet one rhetorical aim of their account, that of explaining what made them a good client, (Potter, 1996) participants may have wanted to present themselves to the interviewer as good, hard-working self-therapists. Also, as noted above, there might have been a selection bias, which might have produced participants who were keen to accommodate the researcher. There was, however, some evidence in support of IPA's realist ontology position in the current study: at least one participant (Harry) said he was not a self-therapist; participants gave detailed elaborated examples of how they implemented self-therapy (indicating that their claims to be active self-therapists were supported by evidence in the form of action); and no one claimed to be the perfect self-therapist, with all admitting to crises and limitations.

Finally, the first named research author cannot claim to have strictly bracketed his foreknowledge of cognitive therapy and health behaviours in ways that maximised the phenomenology of the study (Willig, 2001). For example, in the interview schedule he may have prompted a response bias with regard to identifying salient beliefs about depression (around susceptibility etc.) and missed other important beliefs (Conner & Norman, 1998). However, the first author has attempted to attenuate this possible bias by personal reflexivity, allowing the reader to interrogate the full context of the research process.

5.6 Directions for further research

Within a qualitative framework, further research could improve on the current design to capture more clearly the essence of the experience of being a self-therapist in this context, which is the goal of IPA (Willig, 2001). The search for the meaning of the experience might be aided by using IPA again but having a different interview schedule, focussed more on the participants' wider belief system regarding depression and mental health and examining self-
therapy in the context of self-identity. One could ask more direct questions about what self-referent and other-referent meanings around implementing CBT techniques and knowledge.

Taking a quantitative approach, the current research lays the foundation for the development of a measure of whether a person with recurrent or chronic depression will become a self-therapist following CBT. As the current research shows variables to be measured would include not only the client's use of specific and/or adapted-CT techniques, but also self-efficacy beliefs, beliefs about vulnerability to depression, perceived outcome-expectancies, therapeutic alliance and perceived limits to CT use. If such a measure could be developed, between-group controlled studies could be done to answer the key question of whether being a self-therapist is required to delay relapse onset in depression and what aspects of self-therapy (and therefore CT itself) serve to most protect the client.
References:


Shea, T.


Appendix 1
Appendix 1: An example of a guide to self-therapy sessions for CBT (Beck, J., 1995)

Beck recommends that client and therapist draw up a guide to self-therapy before the end of treatment and discuss how it will be instigated and any obstacles the client perceives in being a self-therapist (for example, the interfering thought, “This is too much work”). The author provides a template for a client self-therapy session as follows (in abridged form):

1. Set agenda:
   What important issues should I think about?

2. Review Homework:
   What did I learn? If I didn’t do homework, what got in the way (practical problems; automatic thoughts)? What should I continue to do for homework?

3. Review of past week(s):
   Other than a specific homework assignment, did I use and cognitive therapy tools? Looking back, would it have been advantageous to use the cognitive therapy tools more? How will I remember to use the tools next time? Did any problems come up? If so, how well did I handle them? If the problem recurred, how could I handle it next time?

4. Think about current problematic issues:
   Am I viewing this realistically? Is there another way of viewing this? What should I do?

5. Predict possible problems that may occur between now and the next therapy session?
   What problems may come up in the next few days? What should I do if the problem does arise? Would it help to imaging myself coping with the problem?

6. Set new homework:
   What homework would be helpful? Should I consider doing a Dysfunctional Thought Record? Monitoring my activities? Working a behavioural hierarchy? Scheduling pleasure and mastery activities? Reading therapy notes? Doing a positive self-statement log?

7. Schedule the next self-therapy appointment?
   Clients are encouraged to try a self-therapy session once a week initially, then tapering it off to once a month and then every season and finally annually.
Working Title
Tackling depression: the role of cognitive therapy

Participants

Age: Adults aged over 18.

Gender: Men or women

Exclusion criteria:

1. Any client judged to be depressed following a one-off loss or other life event, with good prior adjustment

2. Any client displaying psychotic features.

3. Any client with drug or alcohol dependency as well as a diagnosis of depression.

4. Any client who is currently considered at risk of self-harm or harm to others.

5. Any client who is known to be participating in another research study.

6. Any client who does not show improvement by the end of therapy.

Inclusion criteria:

1. Any client who is being treated with group or individual CBT for a primary diagnosis of depression, as defined either by DSM-IV criteria or by scores of 20 or more on the Beck Depression Inventory at the start of therapy.

2. Age 18 or over.

Researcher: David Glasman, Trainee Clinical Psychologist, DClin. Psych., University of Surrey

Supervised by: David Brock, Consultant Clinical Psychologist, Horley CMHT.
Mick Finlay, Research Tutor and Lecturer in Psychology, University of Surrey

Contact: David Glasman on Tel: or email

E.S.L.R.E.C Ethics Approval granted: May 2001. Ref no. 11DGCB(299)

R & D Approval granted: June 2001
Dear Mr Glasman,

RE: THE USE CLIENTS MAKE OF COGNITIVE-BEHAVIOURAL THERAPY FOR DEPRESSION AFTER THERAPY HAS FINISHED

REF: 11DGCB(299) - to be quoted on all future correspondence please

Thank you for sending us the above research submission and I now confirm that Chairman's Approval has been given to go ahead with this trial.

In future, the Committee would like to follow up all new trials. Therefore, we would be grateful if you could send us an update after a period of a year from the commencement of the study with the following details:-

1. Is the research still continuing?
2. If it is, which stage has it reached:-
   2.1. Data being collected
   2.2. Data being analysed
   2.3. Research being written up
   2.4. Research published.

N.B. If you are sending any Protocol Amendments to us, please ensure that you highlight the areas of change.

Thank you for your trouble.

Yours sincerely,

Selina Harris,
Manager - ESLREC

c.c. JC

c.c. MO
Dear Mr Glasman

The use clients make of the rationale and techniques of cognitive-behavioural therapy after treatment is concluded: an exploratory study using interpretative phenomological analysis

I am pleased to be able to inform you that at its meeting held on 13 November 2001 the Ethics Committee approved the above study.

The Committee's decision was based on its review of the following documents:

i) The South West Surrey LREC application form dated 29 October 2001

ii) The Participant Information Sheet – Research (version undated)

iii) Research Consent Form 1 – Pre-interview (version undated)

iv) Research Consent Form 2 – Post-interview (version undated)

v) The Interview Schedule

The Committee’s approval is subject to the following conditions:

i) No deviations from or changes of procedures set out in the above documents should be initiated without prior written approval of the Committee.

ii) If the start of the project is delayed by more than year from the date of approval, the project should be re-submitted to the Committee for further review.
iii) The Committee should be provided with a copy of the report on the outcome of the study or a copy of any published document.

iv) You omitted to sign the Application Form. Please provide the Committee with a signed version of the document.

v) You will need to complete the text in the Participant Information Sheet under the heading 'Who has reviewed the study?'

Yours sincerely

[Signature]

JOHN KERSLAKE
Co-ordinator
Appendix 4
Participant Information Sheet - Research

Working Research Title:

Coping with depression: the role of cognitive-behavioural therapy.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives and your GP if you wish. Ask us if there is anything that is not clear, or if you would like more information. Take time to decide whether or not you wish to take part.

Consumers for Ethics in Research (CERES) publish a leaflet entitled 'Medical Research and You'. This leaflet gives more information about medical research and looks at some questions you may want to ask. A copy may be obtained from CERES, PO Box 1365, London N16 0BW.

Background and purpose of the study:

I am a trainee clinical psychologist at the University of Surrey, conducting a research study which looks at how people cope after they have been treated with cognitive-behavioural therapy for depression. Although it is believed therapy is helpful, there has been little research on how it helps people once treatment has finished. I am undertaking this research to develop a fuller understanding of what happens when therapy finishes.

Those who volunteer will be required for just one interview lasting approximately one hour at some time between September 2001 and March 2002. There are no other requirements.

Why have I been approached?

You have been approached to take part because you have been identified by your therapist as a potential participant in a study of how people cope after cognitive-behavioural therapy for depression. I am seeking people aged between 18 and 65 who have completed treatment for depression using a cognitive-behavioural therapy approach. I hope to recruit between 10 and 15 people for the study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide not to take part, it will not affect the standard of care you receive. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect the standard of care you receive.
What will happen if I take part?

Those who volunteer for the research will be interviewed for approximately one hour about their experiences since treatment finished. You will also be asked to supply some demographic details, such as ethnicity and your age range. The interviews will be audio-taped. At the end of the interview, if the interviewee wishes to talk further, I will be happy to arrange another meeting. A consultant clinical psychologist will also be available to talk further, if necessary. Interviews will take place at a location that is convenient for you. You will not required to do anything else and you will require no special preparation before the interview. I am using a research methodology, called qualitative research, which places particular value on hearing individuals’ direct experiences.

What are the possible disadvantages and risks of taking part?

As you will be interviewed about coping with depression, there is a slim chance you will find your participation distressing. However, a number of safeguards have been put in place: the interviewer/researcher is a trainee clinical psychologist who is trained to be aware of signs of distress; the interview will be about how you are coping having seen improvements during your treatment; the interview will be terminated immediately if you become distressed; if you become distressed after the interview, you can contact the interviewer/researcher if you need to talk further and a consultant clinical psychologist, if necessary.

What are the possible benefits of taking part?

There will be no direct clinical benefit to you in taking part in the research. However, I hope that the information we get from this study may help us develop more effective cognitive-behavioural therapy for future patients with depression. I also hope that those who take part will find it helpful to talk about their experiences.

Will anyone need access to my medical notes?

I will not need access to your medical notes. I will also not need direct access to the notes kept by your therapist but I may need to ask your therapist to check details on my behalf. The details I may need to check will not involve what you disclosed to your therapist during therapy, but will include things like your scores on questionnaires the therapist used to measure your progress during therapy. This information will be passed to me by your therapist without me seeing your file.

Will my taking part in this study be kept confidential?

All information collected about you during the course of the research will be kept strictly
confidential. Your therapist will NOT have any access to what you say at interview and
the interview will not enter your medical record. Measures will be taken to ensure your
anonymity. The audio-tapes of the interviews will be erased immediately after they have
been transcribed. Your name on the transcript will be replaced by a letter, and any other
names and locations, which could identify you, will be omitted. These precautions will
apply when I discuss the research with my supervisors and when the research is written
for publication. On completion of the research, I also propose to present the findings to
the community NHS trust’s mental health staff as part of their education programme. All
information at the presentation will be anonymised.

What will happen to the results of the research study?

This research is being conducted as part of my Doctorate in Clinical Psychology. It will
form my doctoral thesis which will be bound and kept by the British Library and form the
subject of a viva voce examination. I also hope that the research will be published in a
scientific journal. The approximate publication date would be late 2002 or early 2003. As
stated above, all identifying details will be omitted in any report or publication. The
results may also be used for educational purposes as stated above.

Who has reviewed the study?

The East Surrey Local Research Ethics Committee has reviewed and approved this study.

What do I do now?

If you wish to take part in the study, please complete the enclosed Participant Reply Slip
and send it to me in the stamped addressed envelope provided. I will then contact you.

Further Information:
If you would like to find out more about the research, please ring me on 01483 578843.

If you agree to take part in this study you will be given a copy of this information sheet
and a signed consent form to keep.

David Glasman
Trainee Clinical Psychologist
Department of Psychology
School of Human Sciences
University of Surrey
Guildford GU2 5XH

Working Title: Tackling depression: the role of cognitive therapy.

Name of client: 
Name of therapist: 
Date form completed: 

Please rate the degree to which you feel your client has developed the following understanding and techniques of cognitive therapy.

Key to scale:
0 = Not at all
1 = Sometimes
2 = Frequently
3 = Most of the time

Cognitive Therapy Skills Checklist
(Adapted from Clinician’s Guide to Mind over Mood by Padesky with Greenberger (Guilford, 1995)

Skills developed by client: 
Rating

1. Understands the interaction between thoughts, moods, behaviour, physical reactions and environment.
2. Understands the cognitive model.
3. Recognises the connection between thoughts and moods
4. Identifies moods
5. Identifies automatic thoughts
6. Identifies hot thoughts
7. Identifies evidence in support of a hot thought as well as evidence that does not support the hot thought
8. Generates alternative explanations to the hot thought based on the evidence collected
9. Designs and implements experiments to test automatic thoughts
10. Develops action plans to solve problems
11. Experiences a mood shift as a result of Thought Records, experiments and/or action plans
12. Identifies underlying assumptions and core beliefs
13. Recognises and records evidence that is contrary to underlying assumptions and core beliefs
14. Identifies new core beliefs and assumptions
15. Recognises and records evidence that is consistent with new assumptions and core beliefs.
Appendix 6
Patient identification number for this study:

**Research Consent Form 1 – Pre-interview**

Research Title:

*Tackling depression: the role of cognitive therapy*

Name of researcher:

David Glasman

Please initial box

1. I confirm that I have read and understand the information sheet dated……...☐
   For the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I consent to an audio-tape being made of the research interview and to all or parts of this recording being transcribed for the purposes of research and education. I understand that all information which could identify me will be anonymised. I understand that if I withdraw my consent, the audiotape information will be erased immediately. ☐

4. I agree to take part in this study. ☐

   Name of participant............... Date.......... Signature.................

   Name of researcher............... Date......... Signature............... 

On behalf of those involved with this research project, I undertake that, in respect of the audio-tape(s) made with the above participant, professional confidentiality will be ensured, and that any use of audio-tapes or transcribed material from audio-tapes will be for the purposes of research only. The anonymity of the above participant will be protected.

Name of researcher............... Date.......... Signature.................

1 for participant, 1 for researcher
Major Research Project

Participant identification number for this research:

Research Consent Form 2 – Post-interview

Project Title:

Coping with depression: the role of cognitive-behavioural therapy

Please read the following paragraph and, if you are in agreement, sign where indicated.

I agree that the purposes of this research, and what my participation in it would entail, have been explained to me in a manner that I understand. I have given consent to be interviewed about my experiences of coping following cognitive-behavioural therapy for depression. I have been interviewed and know I have been audio-taped. Having been interviewed and an audio-tape having been made of the interview, I also consent to all or parts of this recording being transcribed for the purposes of research.

Name of participant ......................... Date ............... Signature .................................

On behalf of those involved with this research project, I undertake that, in respect of the audio-tape(s) made with the above participant, professional confidentiality will be ensured, and that any use of audio-tapes or transcribed material from audio-tapes will be for the purposes of research only. The anonymity of the above participant will be protected.

Name of researcher ................. Date ........................ Signature.................................

1 for participant, 1 for researcher
INTERVIEW SCHEDULE

Participant identifier no.

Date of interview:

1. What is cognitive therapy?

Each participant in this study has undergone a specific approach to treating depression called Cognitive Therapy.

1a. Can you tell me what the term cognitive therapy means to you?

[Prompts:
Did it encourage you to handle specific situations in particular ways?
Did it encourage you to think in particular ways?
What specific skills or techniques did you learn?
What did you learn about how depression works?
Why were you encouraged to think in particular ways?]

1b. Not everyone learns about using these skills and ways of thinking to tackle depression from therapy. Where did you learn about using these techniques to tackle depression?

2. Current management of depression

In the current study, I am interested in whether and how people make use of the things they learned in therapy after they have finished treatment. In therapy you would have been encouraged to use various skills and ways of thinking to tackle your depression.

2a. Do you use any of the skills and ways of thinking you learned in therapy now?
[if no: go on to section 3]
[If yes:]
Which skills and ways of thinking do you use?
Can you give me the most recent example of when you used these skills and ways of thinking?
Is this a typical example of how you use these skills and ways of thinking?
[If yes, go on to 2b]
[If no:]
Can you give me an example which is typical of your use of the skills and ways of thinking you learned in therapy?

2b. How often do you use these skills and ways of thinking to tackle depression?

Research into using psychological skills to tackle depression suggests there are times that people don’t always use the skills.

2c. Are there times (situations, moods or when you are with certain people) when it does not feel right or convenient to use those skills and ways of thinking?

2d. Are there times when you think you should use the skills and ways of thinking and you don’t?
[If yes:]
Can you give me the most recent example?
What prevented you from using the skills and ways of thinking that you learned?
2e. Why do you continue to use the skills and ways of thinking you learned in therapy to tackle depression?

2f. Since therapy ended, have you always used these skills and ways of thinking in the same way as you do today?

(if yes: Can you tell me why?

(if no: In what way has it changed? Can you tell me why it has changed?

2g. Do you ever find yourself not using the skills and ways of thinking and if so what do you do to ensure you continue using them after that?

3. Non-use of CBT depression-management skills and ways of thinking

You said you do not use the skills and ways of thinking you learned in therapy to tackle depression.

3a. Can you tell me why you don’t use them?

3b. Since therapy ended, have you never made use of the skills and ways of thinking you learned in therapy?

(if no: go on to next section)

(if yes: In what way has your use of the skills changed? Can you tell me why there has been a change in your use of the skills and ways of thinking learned in therapy? Did you make attempts to restart the techniques? If so, what did you try and what factors made you stop.

** For all participants

4. Use of other methods to tackle depression

4a. Apart from what you learned in cognitive therapy, does anything or anybody else help you tackle depression?

(if no: go to section 5)

(if yes: 4b. If you had to rate which things, including the cognitive therapy techniques, were most helpful, how would you rate them? Use a scale of 0=no use whatsoever; 100= most useful all the time.

5. Beliefs about and attitudes to depression

I would like, finally, to ask you some general questions about your beliefs and attitudes towards depression, as research suggests this affects the way people use the treatment they have received.
5a. If someone told you they were depressed, what would you imagine they meant by that?

5b. If someone told you they were depressed, do you think they would be in for a long haul or a short stretch? Can you specify as closely as possible how long?

5c. How much do you think you can keep depression in check so that it does not dominate your life?

5d. Has your view of what depression is changed over time?

Previous attempts to manage depression:

6a. Before you started cognitive therapy, did you make previous attempts to tackle depression?

   (If no:
   Can you tell me more about that?

   (If yes:
   What attempts did you make?
   Did you feel you were successful or not?
   What factors helped or hindered those attempts?

Prompts and probes

Could you tell me more about that?
What makes you say that?
What happened then/ after that?
Why do you think that happened?
Appendix 8
Transcript
Patient id. No. 2

Can you tell me what the term cognitive therapy means to you?

It means to me, erm… looking at ways that you think about things and feel about things and trying to deal with them in a positive way and that can mean ingrained kind of beliefs that you could be trying to change in order to make yourself feel better and to maybe put in long-term depression lines, to hopefully prevent it recurring again.

Can you give me a specific example that comes to mind?

Having had serious depression at one point I can recognise now when I am feeling a bit down.

So it’s something about helping you recognise the signs?

Yeah, it’s about helping recognise the signs and trying to deal with it positively, erm… looking at, it is an issue of looking at something negatively if you can try to change it to make yourself feel better rather than dwelling on it, so, erm, as an example, for example, recognising the signs to start with.

Do you also connect with specific techniques you might use?

Yeah, when it comes to your… the way you are thinking, you kind of analyse it a bit and think well, you know, we were given specific names because we were given notes about different thought processes, but, you know, is it an error, are you making an error in your thinking, is it true what you are thinking, have you got any evidence to show that your thinking is really correct. That kind of thing, and then analysing it and turning it around to your advantage.

So it’s about kind of thinking in certain ways and using some skills or specific techniques?

Techniques…?

For you it’s more about thinking?

It affects me more the thinking patterns and so, because its something that’s built up with me over my adult lifetime its something that i am learning to address and I have done mainly in the last year or so. So its kind of like everything in my life I am adopting the cognitive-behavioural therapy techniques to.

Not everyone learns that way of using these techniques to tackle depression. Did you learn that in your six weeks of CBT or have you gathered over the years that way of thinking about things from other places?

I was aware of it before because I have done anxiety management courses and it is a similar type of think, but I must say that I haven’t really applied it as much as I have since I have done the course. The course made me much more aware and I have got to as stage now when I want to make a lot of changes and that is the line i am now going down. But I was aware of it before, but I had so many changes I had to make ands a lot of that was physical, so I have concentrated on doing exercises, which I still do anyway, but I have used the thinking processes more. As an example, two and a half months ago I gave up smoking. I was a heavy smoker. I decided that the time was right, I was feeling better and I have stuck with it but I have had to apply a lot of the techniques to that in itself; so, erm..

You have used it for something other than…

Use it specifically as a goal, we were asked to set a goal and that was mine and I’m on my way to achieving it.

Study about use after finish. It does sound as if you are still using what you learned than now?
Well, personally, yes. I think it depends on what stage the person is when they go into the group. They could go into it...there were a couple of people in my group who were in the midst of depression and I had been out of it for a long time. So I think it depends what stage you are at and how determined you are to change yourself. But I was at...I wasn't even sure I was going to do it because I had done the anxiety management courses and I had a community nurse at the time, who has now gone, because I don't need her anymore, so to speak. She said about it but I said "oh no not another course" but I'm so glad that I did it because...I never really kindof, I didn't really know what to expect in regards to...I know you can do it to change things if you are anxious and stressed but I never knew you could apply it to stop depression occurring again so I'm quite pleased that I did it, I'm really pleased I did it. I am using it myself because I am quite determined I want to change my habit of patterns, but I don't know that would apply to everyone.

Very specifically now, if you think of ways you specifically use it. You have mentioned smoking and also mentioned preventing, heading off depression. Can you say how you might do that on a daily basis or think of a recent example?

Several things. Firstly, I try and plan my time because now that I am working again - I work part time - and the rest, evenings and weekends tended to be my, the times when I would feel down, so I make sure now that I'm, for example in the winter especially because it gets dark a bit early so any time between three till six, I hate that period now in the winter when it gets dark, so I make sure now that I am busy at that time or at least I am still out if I have finished work and I don't come home or I go to my sister's or something, so I am specifically am aware of that, whereas in past winters I am sure that it has contributed to me being down even though I have been aware of it because I have not really done anything about it.

How did the therapy help with that awareness. Was it something about understanding how depression works or did you specifically bring that issue up?

No, I didn't bring the issue up. But part of the course was at the beginning was to talk about what depression was to people and what caused it, so it would have been something which I mentioned then. So it is making myself more aware really, of the different things that make me down and that's one of them. So I thought well I can do something about that physically rather than mentally by being out of the house and not sitting here in the dark and blah, blah, blah and erm...and planning my time: we were given some blank timetable sheets with the days of the week and one of the jobs, part of the homework was to fill it in for that week and, although I don't use it regularly, I know that my bad times are evenings and weekends so I try to make sure I am busy I am not in all day, getting out of the house is important. That's another thing. I also keep my notes to hand of all the different thinking errors...

Can you give me an example when you...you keep your notes to hand, so you write things down...?

I don't write things down but I refer to the notes, so if I've got a particular worry...

Notes you were given on the course, and those notes refer to the thinking errors that might make you depressed, like all or nothing thinking, when you think this is the worst thing that might possibly happen?

Exactly, yeah.

So you might physically get them out and look at them?

Oh yes I do, I get them out and look at them...

Would you do that in public or at home? Do you actually carry them around with you?

I tend to keep them indoors because I find that... I have always found it difficult to relax indoors, possibly because I have never had my own place. This is the first time I've had my own place, I've always lodged everywhere so I have never felt very happy with where I have lived. I have been here now for four years and it is gradually coming, but I still have a problem with evenings and weekends. And so, an example might be that...I tend to feel more anxious of an evening...so say after six when I have had my dinner its like "what am I going to do now" , I might start to feel a bit down. That's when my
mind starts racing and I start thinking may be of negative things or... you know, I've just had dinner so "maybe I shouldn't have eaten that" or "Am I going to get fatter?". Because I am on my own I get into a negative cycle of thinking and that's when I have to stop myself because I am aware of it now and I look at my notes, I pull them out and I think "Is that really true what I am thinking?" or "what can I do to make myself feel better?" And I know now that I have to kind of do something physically to switch off. For example, I might get involved with a film on tele, whereas normally it would just be on in the background, or, I have got a bike, so I could go out on my bike, or, I'd groom the cat, or something like that. So, yeah, I would pull them out.

So it's something very helpful for you to have at home?

Oh yeah, definitely.

Have you ever carried it around and used it, say, when you have been a waitress and somebody has said something nasty to you and you have got upset...?

No, because I have to think quickly on my feet at work, but I am still aware of it. So if I'm..., for example, as a waitress and especially at the moment its extremely busy and I know from the past that I have let the stress of work carry me along and I have not dealt with it, whereas now at work, even though I am only doing part-time hours it is quite a stressful job sometimes and so if I can take a step back and say to myself, "Is not going to make it any easier to be stressed to do this job so I might as well destress myself and remove myself from situations. If I wanted to go off and have a break they would let me because they are aware of the depression I have had, so they are very good. So... whereas in the past I wouldn't have addressed that I would have just carried on. I wouldn't take my notes necessarily but it is still in the back of my mind. Also I make notes at home, I carry a notebook and I tend to write things down.

What sort of things might you write down. When might you use it?

At the moment, my thoughts have been taken over by giving up smoking. So I ma focussed on one thing and I am writing a lot of notes about that. But I suppose in a way you could say that that in itself is an example because if I looked at it very negatively that could make me feel more down, in fact in the last couple of months I did have one particular week when I was feeling down and I didn't know whether it was the fact that I, the distress of giving up smoking or what it was and I thought it was probably a combination of things. But I find that... if I write notes about giving up smoking or positive things and things that I..., if I start to think negatively, I'll switch off and start to feel something good about it, then that helps. And I'll write down how I have been feeling in weeks when I am having a bad week, write down how I have been feeling when I am having a good week or a good day so I can refer back to it, which is something I actually did when I was in the midst of depression. It was something I was told to do...

Who told you to do that?

When I was in hospital... well, not told me. They said it was a good idea to do when I got out to keep a record of how I felt and I did and I have still got my diary...

So that was something you actually learned outside your six-week course, that's something you have been doing for a while?

At the time I did it, because when I had my breakdown, that was at the end of 1998, so that was nearly three years ago; for a time I did it because I wasn't actually living here I was living with my Mum and when I moved back here it was quite scary and I did carry it on for a while, but, you kind of don't after a while, but I find writing things down helpful, so from time to time I will.

I just want to get this straight. Is this something which you carried into the course, you already had that strategy as a way that can be helpful for you, so it wasn’t specifically the cognitive therapy

No

But did the course reinforce that as being useful?
Definitely, the course definitely reinforces...erm, it reinforces the use of techniques and stuff. It's not something you can just read and then take it home and forget about. If you really want to stop yourself getting depressed again I think you really have to use what they give you. You have a choice, do you know what I mean. Its like, erm, again like giving up smoking, every time I see an advert on tele they're pushing it, pushing it, pushing it and that's great because its reinforcement and sometimes you can get a bit complacent and think I can't be bothered to try that anymore, I just want to sit here and have a cigarette and a drink and forget all about it, but you have to keep...it's hard work.

How often do you use what you learned in cognitive therapy?

On a daily basis.

There is research in how they use these things. It suggests people don't always use these things and that is normal. For you are there particular times, situations, moods, when you are with certain people, when you think you should use the skills but can't use?

Erm...

I suppose you talked about this when you are a waitress and you have to think on your feet...?

Yeah...times when you are busy like that at work, I wouldn't have time to get out my notes and think what does this situation apply to, so I try and do the best I can at the time. But it is something I often think about when I finish my shift. I might be sitting on the bus on the way home and think, well this happened today at work. I try not to make it a constant thing with everything because it is hard work and its mentally draining, but if there is something specifically that is on my mind, then that is the time I feel I have to think about it, if something is playing on my mind. But I don't apply it to every single thing, because you just couldn't. You know at work it is difficult. When I am out with friends especially if I have had a few drinks then I don't always need to be using it, but its not something that's on my mind, that I need to address, then I can relax a bit. Sometimes if I am here on my own of an evening and I am feeling particularly relaxed I will just switch off from everything and do what ever I want, eat what I want, do what I want, erm, and don't worry about it. But no, I just think its something now that I am going to keep using until I get where I want to get.

Are there are times when you think you should use them and don't. Are there times when you think it would have been useful? You don't have to say yes or no, there's no right or wrong answer?

I think sometimes I still - obviously it takes some time to change your habits - and I think I still sometimes think in a way that is not doing me very well...I am trying to think. I can't think of a specific example.

It might be an example; two things perhaps. You might be dwelling on something that if you had applied the techniques you would be able to dismiss; or perhaps you have applied the techniques, thought about the evidence for and against it and you have decided that this belief you have doesn't really hold water but it doesn't really shift. Those are the two things that might happen, that I can think of but there might be other things for you?

Erm...I can only really use the example for the moment of giving up smoking, because that's my main...you know there have been times when I know in my mind I am thinking, I am focussed and everything and there might come a time, I don't know any situation, where for example somebody is smoking around me or something and it suddenly makes me think about and I think, "maybe, I'll just have one." In the last two months there have been two occasions where I have had a couple of puffs, two cigarettes. At those times, its kindof like, "Yes, I know all the reasoning" and "NO, I know I shouldn't have one, its not going to do me any good but sod it I'm going to have one anyway." And kindof everything just goes out the window? There's that as an example. And afterwards you start really thinking about it again and you think, "Oh no, I shouldn't have done that." But sometimes...

Sometimes, yeah?

It's an impulse, you just do it.
2: What was the other thing you said about?

That maybe you have used the techniques, but maybe I still hold the belief, but sometimes I still feel down about something. There's no right or wrong answer to this.?

Yeah, I know where you are coming from and there probably is, but I just can't think of an example, but that does happen, I'm sure it does happen.

Why do you continue to use what you learned in cognitive therapy?

Because specifically, I don't want to get depressed again. I don't want to go back to... I don't want to go back to, I don't want to hold my habits, physically and mentally that lead me to get depressed in the first place. And I want to make myself a better person for me and I don't feel that I have really done that in my adult lifetime, I really don't. I have been successful in jobs and different things. I've had god full-time jobs, I've got a good education, I've got a good family, al loving family, I've really got everything I want but I have just not been happy. I have struggled in relationships, hence why I am on my own at the moment and there are so many things I could apply the use of cognitive therapy to; for example, relationships is one big issue, because I find that, you know, if I meet someone and I really like them I would sit by the phone waiting for it to ring and that’s when you think yourself into a bit of a "Oh they don't like me, it must be me, blah, blah, blah," But no, I would apply the therapy to that as well. There are so many...

You are using it because it is feeling that it has been effective?

Oh definitely, it does work, but it is hard work because... it is, I think, changing the habits of a lifetime. The way you think becomes a habit. I just think if I carry on like that, there is a good chance I could get depressed again. So I have changed everything. I have changed, the hours I work at the moment. I am on a special work scheme, so I only do a certain amount of hours and I still receive some benefits and there is a future for me at the hotel I'm at, I'm hoping to go into the conference side of things. I am doing the waitressing because I want to build my confidence up. Erm...so I have changed the sort of job I am going to do; the people I mix with; basically everything, a lot of things. But still I know its going to be an ongoing process, there's not going to be one particular end result, its going to be something gradually that I can see is changing already using those techniques.

Since the course has ended have you always used the techniques in the same way?

I don't think it has followed any particular pattern, but definitely the notes we were given on the thought processes and the thinking errors and that kind of thing is something that I have used day-to-day, not necessarily getting them out but in my mind. Occasionally I might use the week planner or the day planner if I think that I'm not going to be particularly busy - but at the moment I am - so there is no particular pattern, but there is nothing I think that I have particularly changed.

So you have used them in the same way because it feels right is fairly effective and appropriate?

Yeah, I can see how it applies to me.

Do you ever find yourself not using those skills and are there ways you prompt yourself to use them, or does this all take place in your head?

Yeah, for example, I had a week recently, three weeks ago when I had a particularly down week, as I said to you. It was kindof, that was the week I ended up having a puff of a couple of cigarettes and by the Friday I didn't know if it was that. I thought if it was that [not smoking] that was really getting me down then I ought to do that, not to prove to myself that I don't need it, but what is all the fuss about. And also the weather had changed or the clocks had changed and it had got particularly dark and it was miserable - I don't mind it like today but it when it is raining and grey - but I started questioning - because I love my job, I really love my job - and I had started questioning that week whether I liked my job at all. It was bothering me that I was questioning it because I thought had not felt like that at all. Then I thought to myself, by the weekend by Friday night I really had to use the techniques to think to
myself, well, you know "it could be a combination of things and I'm not going to judge about my job until I feel a bit better and I'm not going to...I know that going back to smoking is not going to make me feel any better and I know that I can't change the weather but I can do something about what I do." So I kind of had to really work hard that weekend to think about all these things.

So it might have been that during that week you had been applying the techniques but it hadn't been having the effect and you were getting more and more questioning about your life and then you recognised I really have to work on this?

Yes, because by the Friday. I don't recognise when I am feeling down or getting depressed and life kind of you know when you are busy it carries you away and sometimes you still don't recognise exactly what it is, it just creeps up on you and by the Friday I felt particularly tearful, I was crying all day and I haven't had that for a long time. It was bothering me. But I thought, "No, I've got to get myself out of this" and I knew I could do it and erm, so I did start the techniques, so on the job front I thought, well, I wasn't going to worry about it until I went in on my next shift, which wasn't until the following Tuesday and then see if I felt better and see if it was all back to normal, which it was. I felt absolutely fine and I'm still loving it. So I thought to myself obviously it was worth thinking positively about it because I could have sat there and dwelled on it all weekend and thought I don't know if I'm want to go in next week. I thought, No, I'm going to switch off and worry about it when next week comes, I'll do it then and everything's been fine. The same with feeling down. All of a sudden having had a couple of puffs of a cigarette, decided that that wasn't just the issue, it was a combination of things, I thought I'm not going back to that and I just picked myself up and by the Monday I felt back to normal.

It almost seems as though you were using it, you were very tearful and that acted as a cue for you that you have got to work very hard?

Yes, definitely. I could of... um, it is hard when you are in a situation to use the techniques all the time. You know, when you are really, I think when you are feeling down it is hard to use them and by Friday that week I was. But then, I thought I have really got to get myself out of it, whereas during the week it kind of built up and I hadn't really...

It had been harder to use them?

I just think it was the first time I had felt pretty awful in a long time and I thought I don't want to go down that road, so what can I do to change it. Whereas sometimes its harder, its hard work to use them when you are feeling down but that is probably the time when I think you need them most. But day-to-day when I am feeling OK, its still hard work but you can do it more easily.

Apart from what you learned in that six-week course does anything or anybody else help you tackle depression?

As I mentioned my, I do a lot of exercise and I try to eat healthy. I must admit I have gone on to the chocolate now - one addiction for another - but I try to eat healthier and I know that does play a part: if you can try and do...I haven't got a car but I've got a mountainbike and I bike or walk everywhere so I am quite used to it, I do it everyday. I know that helps me and relaxation techniques, which I did learn on the course, and I have got personal headphones so I can cut off all the noise and I listen to relaxing music, and I do all the bodily relaxation techniques - I do yoga. My family are brilliant. My Mum has had depression herself, so she understands and they are always there for me if I want to talk. Just knowing that Beechcroft is there is wonderful because although, I have only just recently, kind of decided I have had a community nurse for three years and I can do it on my own. Now I have got the techniques to do it on my own, but the course really brought them out. But Beechcroft is there, if ever I want to go in there, or there is any problem I have, but I haven't got that regular one-to-one contact, but I'm quite pleased about that because I want to do things on my own now. There are a lot of things. My friends help me. Obviously having a pet helps because she is quite de-stressing when she is quite; erm, lots of things.

Does having a job help?

Yes
Was that something you had anyway?

No. I had a full-time job before I ended up having a breakdown and it was a fairly stressful job. I worked in a call centre and I did shift-work. I actually had a lot of problems at work, because I had a lot of time off sick and not coping, but I never addressed any of my problems then and I got disciplined and it just snowballed. But I was out of work from then -m December 98 - until June of this year, when I started this job. I actually went on a job search course, which is offered by a local charity called ESRA, and they basically, it is for people who have been through depression and, it is a free course and they go through your options etc. and it was a really good course. I did that in October last year and I didn’t feel ready to start work straightaway. There is no pressure to start. I have done a bit of voluntary work because I wanted to do something over the last couple of years. There is an elderly lady I help out, things, and I do a bit of babysitting but not a proper job. Since I have started work, it has just been wonderful. I am so glad I did it, but getting started was the hardest thing after being depressed it really was.

Did you start the job before you did the cognitive therapy course?

Yes.

So it was something you put into train yourself?

Yes. Again I think for people who haven’t, there’s people on the course that are at a similar stage I was at last year when I started my job search course in October. There were people on the course that were at that stage and they were really worried about even thinking about going back to work and I think the techniques could help that, because again if you think positively and you think you can do it and you do it properly and you don’t just go rushing straight back in and you think about then it can work. It worked for me and I’m so glad I’m working now. I know I couldn’t cope with full-time work still because I have had weeks and at the moment we are busy and I am doing an extra day and I’m finding that quite tough, but I want to do it because I have only got two more weeks of working an extra day and then we are back to normal in January. So, I know I would still find it tough to be doing full-time work, but at least I am working and I am happy and I have got routine in my life again, which is good.

If you had to rate things on a scale, could you say what techniques you use and how you would rate them?

Can I just get my notes out, because there are so many things we did [gets notes and looks at them]. I have got a sheet on all the, the notes on all the rational thinking and how it plays an important role in depression, so thinking errors and "shoulds" and "musts" and all that kind of thing.

How much do you, what would rate in turn of actually challenging thinking errors, how useful?

Oh, 10 out of 10. Definitely. Definitely one of the biggest things for me. Also writing down, for example, this sheet was the situation, how you felt, the automatic thoughts and the thinking error. So using an example, we had to write down week to week the situation you were in. I don’t tend to do that so much now, because, erm, I kindof can do it in my head, but nevertheless I still read through some of the previous examples I had...so, personally, it doesn’t help me so much, so 8 out of 10. But it’s still useful. And then the diary keeping, the activities for the week. When I need it, it is great, seven, eight out of ten but I don’t use it on a daily basis because pretty much my weeks are planned out and I like my routine, but I think it could be for people who haven’t got a job or...

But for you, in your situation?

Yeah, seven. I often do refer to other people. I must start saying how I feel. I’m always like that. Basically, they were the main things we used on the course. So mainly, it was the thinking errors and that kind of thing, which were the most useful for me.

Can I ask about beliefs about depression? If someone told you they were depressed what would that mean to you?
Um...well, I mean, I don't know because to different people it means different things. It depends on how well I knew the person. If my Mum told me she was depressed, I would know that she probably needed some help and would need medication or something, whereas to a friend at work, who I didn't know particularly well, they could just be having a down week or a down day and I don't know how depressed they are because I don't know how they do it.

This is a long way of asking what does depression mean to you, for you?

Well, depression for me is kind of a pretty serious illness. It affects me as a person, how I relate to other people and affects my life day to day, so, for me, it's pretty awful thing to have. But I know what real depression is and I don't think a lot of people, who haven't had it, do, and that's where the problem lies.

Well, I know what depression is, but it means different things to different people.

A very serious problem?

It is very serious.

What did it mean at its most serious?

Well, you can have depression in different forms, but for me, when I was at my worst depressed, I was suicidal and I felt like nobody understood and it's a very lonely feeling, because it's so horrible. You feel so down that you can't describe it. It's not just like feeling fed up or feeling tearful. When I was at my worst, I couldn't do anything for myself. I could do was curl up in a ball and hope it would go away, which it obviously didn't and I ended up in hospital. But I don't think I would have survived it, I think I probably would have committed suicide if I hadn't been taken into hospital because I felt so awful. And I didn't feel it was something I was in control of, it was something I had to do. So it is something which, if it gets to its worst, really is out of control, you are out of control.

One of the questions I was going to ask you was how much you think you can actually control depression?

When you are at your utmost worst depressed, I think you need someone else to take over for a while. So I think that when people need to be3 hospitalised. So I think if I didn't have my family, if my Mum hadn't taken me in the day she had, I don't know what would have happened. So if you are lucky enough to have that support, support is important, but if you haven't got it, I don't know. I think when you are at your worst you need someone to take over.

And as you move through that, beyond that?

As you start to get better. I mean once I had been in hospital for 10 days I started to feel a bit better. It was the fact that I had no responsibilities so I was just being fed at certain times, I was just being given medication at certain times, I didn't have to think about any responsibilities. I think if I didn't have that, those responsibilities taken away from me I don't think I would have got through it.

The stage you are at, how much do you feel you can control depression?

Well, because for me personally I know that I am still on medication and that plays a part, but that's not everything. I am hoping that at some point in the future I can reduce it or come off it, but that's not something that, I would take lightly and I know I have to make a lot of changes before I think about that. So, to me, now I know what it's like to be seriously depressed...um...

It sounds to me you are trying to exercise control, as if you feel it is controllable.

I am aware that it could come back, I am not kind of thinking I am immune to it now. But I have to be in control all the time. I think I am quite vulnerable still and I think unless I am in control of aspects of my life, like work and keeping my flat in order and paying my bills and all sorts of things, I have to be in control. But it is the only way I can cope with it, but in the past, um, I haven't had that control and when its gone out of control then things went wrong. So I think its important to have it under control and that means for me keeping on my medication and using cognitive therapy, for me they are the two things...
Although you don't think you are immune to depression, I get the impression that you do feel if you do the right things it is controllable?

Yes. Oh definitely, it is controllable.

What's your impression, whether depression is a short-term thing or a long-term thing?

Oh, it's both. I think depression is such a wide-scoped thing that someone who's never had it before might have serious depression for a month and then they might never get it again. I think it depends a lot of the person, their chemical make-up, circumstances of their lives and er, a lot of things, but I think it could be both.

For you does it feel long-term?

Long-term.

Has your view of depression changed over time?

Yes. I first had depression when I was sixteen. I was doing my exams then, my O levels. I was pretty bad then, but not as bad as this time, so I was on medication. So I have been on medication on and off nearly all of my life. And, to me, my view of tackling it in the past was take my medication, sign myself off work, so I'm not working, you know, de-stress myself that way and then go back to work and everything will be fine. I've done that over the years and, of course, I would be in work one year, two years, and then I would get depressed again. So over the years...you know it has really radically changed for me in the last two years, since I had my breakdown. Its probably the best thing that could have happened to me, because it really led me to think what led me to get like that in the first place so my view of depression now has changed. Depression is not something you can control by taking a couple of months off work and hoping it will go away or going on holiday and you will come back de­stressed. It's something you have got to work on. And a lot of it is the way you think and you have got to work on it over a period of time and that's something I've discovered since I had my breakdown, whereas before its was "Okay, I'll take some time out."

So for you its not just a matter of trying to avoid the issue and hope it will go away, it's actually about confronting the problem and using some skills...

Yeah, confronting the problem. Yeah, but you can only do it if you really want to. I mean obviously you have got to be determined that you don’t want to get like that again and you want to do things properly and that's what I am, personally.

Before you started therapy, did you make other attempts to tackle depression since you were 16?

Only since I've had my breakdown and before the course, so we are talking of a period of a couple of years, because the course was only recently. You know, I took up doing more exercise, thinking that would help. What prompted me to do that was one of the things I was offered when I came out of hospital was a badminton class which was a free evening and it was something that was offered through the service. That really helped because the times I went I felt so good and it prompted me to carry on, so there was that, and in the process I lost six stone, because I was 18 stone. So in the last two years I have lost six stone. So the exercise was one. Getting a bit of routine into my life with a bit of voluntary work; spending more time with my family, quality time with my sisters and their children, so keeping myself busy that way; but since the course, is really when I have applied the other techniques.

Did you think those things you were talking about were successful?

Yes

But still went on the course, why?

Because I felt as though... one thing is, I am always open to suggestions and my community nurse thought it would do me some good and I was only hesitant because I had been on a similar one for the
anxiety and I thought it would be the same thing. But nevertheless, it proved me wrong, in the way that dealing with depression you can apply the techniques and, um, so ...sorry I forgot the question.

I was wondering why you went on the course if you felt other things were helpful?

I just felt I needed to...I don’t know it suddenly built up in me and I just thought I really needed to change my way of thinking. It was just something that gradually built up in me and I felt that if this was the course that was going to do it, then I would try it. Maybe it might just be the boost that I needed because once you have been doing other things for a long time you get a bit complacent about it. I got used to cycling everywhere, and I was thinking what can I do next, so I really felt that needed changing, so that’s why I went on it.